BERITA ORTOPEDIK

THE NEWSLETTER OF MALAYSIAN ORTHOPAEDIC ASSOCIATION

MESSAGE FROM THE PRESIDENT

Dear Colleagues,

I sincerely hope that this newsletter finds you in good health and well-being. That is the most important thing in life. This whole year, we have seen the pandemic sweep through the world, striking young and old alike without fear of favour, affecting our lives immeasurably. Malaysia has not been spared and we are presently experiencing the second (or third) wave. It has affected a large portion of the general population and our East Malaysian countrymen are fighting the good fight as we speak. The effects may be long-lasting, some of which may not even be evident now.

The previous council had encountered the corona virus attack with resilience and determination, and I would like to express my sincere gratitude to them. Facing a lockdown between the months of March to June, Covid-19 not only forced us to cancel our Annual Scientific Meeting (ASM) but delayed our Annual General Meeting (AGM) to mid-August. It is thus with a slight delay that I introduce the first issue of Berita Ortopedik following the appointment of our new executive board for 2020/2021. In the three meetings that we have had so far, they are showing an indomitable spirit which I hope will bring many a change to the Association in the time we have in office.

Our priority is to "Build Bridges". There are several **key areas** that we identified in our first meeting: Sub-specialty and International Societies, Education and the National Curriculum, National Specialty Register, Ministry of Health (MOH), Academy of Medicine, Universities, Private sector (both hospitals and practitioners), MMC and finally within MOA - the journal (MOJ) and our Annual Scientific Meeting.

In October, we formulated a plan to work with the Specialty Interest Groups (SIG) and the sub-specialty societies to create a calendar of events throughout the year so our members can pick and choose what they would like to attend. We came up with the idea that MOA will have a grand meeting one year and a smaller meeting the next year, so the other societies could alternate with us and also help reduce the burden of cost on the sponsors.

Next up, we had three meetings so far with the Practice division of the Ministry of Health with regards to the new Fee Schedule that was initiated in 2015 and should be coming up in the middle of next year. A few issues regarding wound dressings, intra-articular hyaluronic acid injections and facet block injections have been on the agenda and we are working very hard to put our points across.

With the corona virus still looming in the horizon, we have tightened our belts considerably (reduced costs by almost 40%) and are taking a closer look at the tax computation to make

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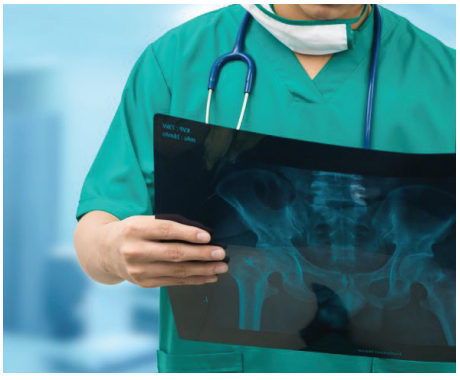

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it more reflective of our reduced budget. Innovative ideas at generating alternative sources of income are also being pursued. We are hopeful too, that the education arm will be kick-started soon.

The National Orthopaedic Curriculum is almost ready and is in its final stages of being compiled. The first and second drafts have been discussed with the stakeholders in January 2019 and again in July 2020 with strides made in improving its effectivity and subsequent implementation in stages. We hope it is completed soon and submitted for approval from the relevant authorities early next year. This will mark a significant milestone in medical education and help to streamline postgraduate orthopaedic teaching nationwide in terms of standardising intake, training, assessment and accreditation.

It aims to help establish best practices, increase collaboration and maintain the quality of both our trainees and trainers. MOA would like to extend a hand in the education part, perhaps in collaboration with our esteemed members, be it in terms of webinars, courses or zoom discussions.

The 50th ASM in conjunction with the 40th AOA meeting will be held from 22nd to the 26th of June 2021, a five-day event, the first four days of which will be virtual. This is the first time in our history that we will be attempting this, so we are indeed excited about it. Our scientific chair, Prof. Azlina Amir Abbas and her team have a stimulating scientific programme in the wings, with debates, discussions, contests and virtual booths where you can 'walk in'! The last day will be a physical meeting including the various awards ceremony and our AGM. Please do mark your calendar!

As you can see, the council has been busy working very hard these few months to push MOA to scale new heights. This coherent determination is very refreshing, and I am so glad to be working with such an enthusiastic team! The council wants to make a difference over the next couple of years as well as help its members by advocating for their rights. We hope you will support us in this endeavour and encourage your colleagues and younger members to join. We have exciting events planned year-around and will keep you informed, so keep a lookout!

Dr. Sharifah Roohi Syed Waseem Ahmad
President, Malaysian Orthopaedic Association
November 2020

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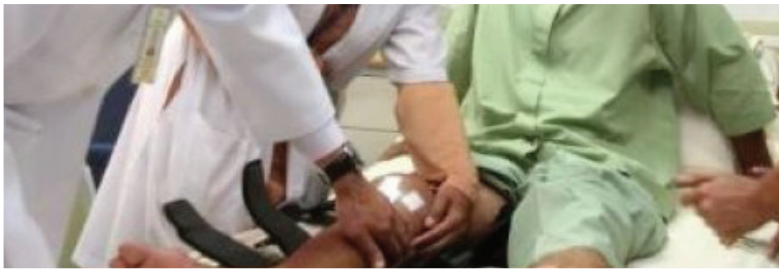

MOA and the Fee Schedule Committee

In 2015, the MOA was engaged by the Ministry of Health (MOH) to help revise or add some new orthopaedic procedures into the 13th Fee Schedule (amendment to the existing schedule). Many meetings, Presidents and Councils later, we were asked this year (2020) to look through the prepared draft of the said new orthopaedic procedures to be listed therein. The committee was appointed by the Fee Committee of the MOH and consists of: Prof Dr. Jamal Azmi, Prof. Dr. Azlina Amir Abbas, Dr. Sharifah Roohi, Dr. Suhail Abdullah, and Prof. Dr. Chris Chan.

Our first meeting was held on 7th July and some of us were new to this, some not. Luckily, we had Prof Jamal Azmi and Prof Azlina to help guide us along. The meeting was basically to rephrase some descriptors and to go over parts of it. We understand it is a work in progress and though it has some new procedures added, there will also be some omissions. An example of this is that the Practice division of the Ministry had decided to remove the "dressing code". This being due to the charges for wound dressing being abused by certain practitioners and the fact that they are usually being performed by nurses.

The Ministry officials kindly consented to another meeting to discuss this matter and various cases were brought up to illustrate their argument on the 8th of October. We put forth our point that those who have correctly applied the code should not be penalised for those who have abused it. Finally, a concession was given and a charge for post-operative dressing was allowed for replantation cases and flaps. This is still being formalised. An MMA code for dressings still exists, which can therefore be used should the need arise.

The second point to be made is that the Council has **also** decided to set up a **separate Fee Committee** consisting of all the SIG heads **or** their representatives. Any challenging queries made by the Insurance agencies to Consultants' coding of cases to the MOH shall be referred to this Committee to look into. We hope that in this way, a more neutral unbiased approach is taken to handling such issues.

We look forward to working together with both our members and stakeholders to bring about resolution to differences.

Prepared By:
Prof Sharifah Roohi

The Magician from Kurgan

"The year 2021 will mark a century since the birth of an orthopaedic icon from Kurgan, Russia named Professor Gavriil Ilizarov. To commemorate this, we will be sharing his story over the next three issues."

Part 1: How it all started

As we lament the rapid spread of Covid-19 to every corner of the world today, the spread of the Ilizarov method in those days was not as swift as one would expect. It was considered a method that was "ahead of its time" but unfortunately due to timing, ideological warfare and social stature, it took more than three decades for this technology to spread worldwide. With the Cold War ongoing, and the Ilizarov method originating from within the Iron Curtain, its breakthrough was perceived with great skepticism and resistance. As a matter of fact, even acceptance from within the Soviet Union was far from being smooth sailing. Due to jealousy and political rivalry within the country's orthopaedic fraternity, the method was deemed a hoax by Ilizarov's counterparts and further developments of his discovery were kept within Kurgan.

An artwork depicting a younger Professor Ilizarov. Portrait displayed in Kurgan Hospital.

Like many great stories, Professor Gavriil Abramovich Ilizarov came from a humble background of a poor Jewish family living in Bialowieza, Poland. He was born on the 15th of June 1921 to illiterate parents and was the eldest of six siblings. After he was born, the whole family moved to Qusar, Azerbaijan to live with his paternal grandfather. Due to his social circumstances he could only enter elementary school at the age of eleven but was able to quickly catch up with the rest of his peers. He went to medical school in 1939 at the age of eighteen in Simferopol, Crimea after graduating from Buynaksk Medical Rabfac – an establishment to prepare peasants and workers for higher education. When World War II broke loose and the Nazis invaded, the Soviet Union moved the medical school from Crimea to Kazakhstan in an effort to protect its medical resources.

Professor Ilizarov graduated from medical school in 1944 and was posted to Dolgovka, a village in Kurgan province of western Siberia as a general practitioner. This remote area was considered as an area of exile since the time of Peter the Great in the 1600s and he was the only physician in an area the size of a small European country. It was only possible to fulfill this colossal of a responsibility with the trust that the patients had in him and Ilizarov's own courage and belief in his abilities. To make matters worse, he had to work in a facility that was outdated, but his experience in military field surgery after finishing medical school held him in good stead.

During the troubled times of World War II, Professor Ilizarov had to treat many wounded and invalid soldiers who returned home from the war. The conventional treatment of fractures at the time was mainly using plaster cast and skeletal traction. Open reduction and internal fixation was not widely used, as antibiotics were not readily available. He was intrigued by the length of time that these fractures took to unite, with some even ending up with non-union altogether. Professor Ilizarov reported up to 20 percent of tibia fracture and 70 percent of femur fracture patients ending up with significant altered functionality. Patients were literally disabled and unable to get back to work. Realizing that there was no real solution to these problems, he then decided to devote his career to the field of orthopaedics.

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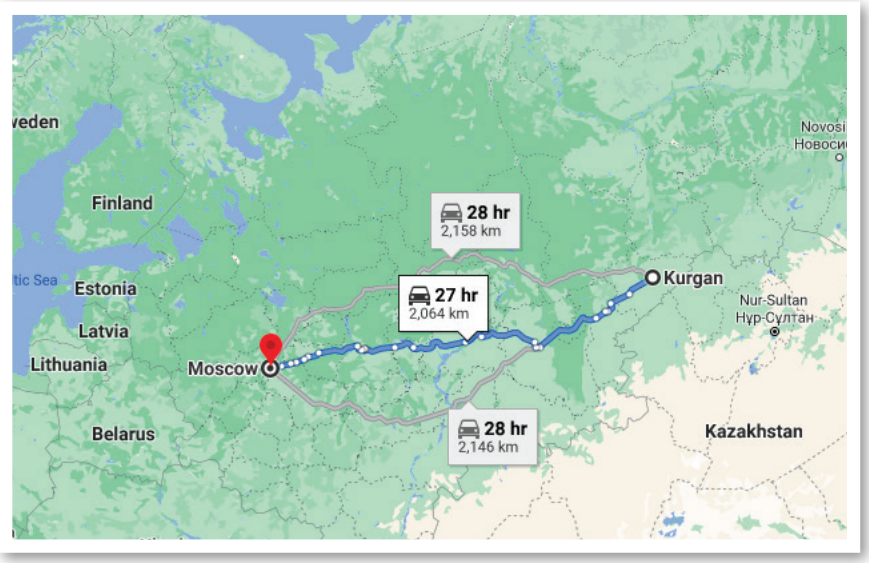
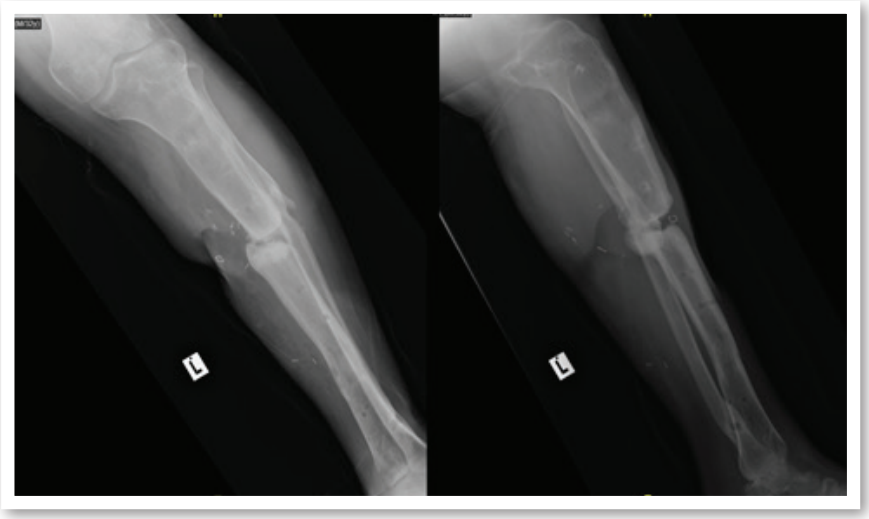


Kurgan is located more than 2000 kilometers away from Moscow, in western Siberia.



Ilizarov encountered many wounded soldiers during World War II with fracture nonunion and malunion that were treated with conventional methods.

A horse with a shaft bow around the neck, also known as "Duga". (Courtesy of Ms. Maria Grechukhina)

Based on his observations in wound healing, Professor Ilizarov believed that bone healing could also happen quickly. Primary intention was considered as the fastest way to allow a wound to heal. This idea together with the well-accepted principle of fixation stability to achieve bone healing encouraged him to think about a device that could provide stable fixation with good compression of fracture ends. At the same time, he also believed in the preservation of the biologic environment around fracture ends to ensure more rapid bone healing. With all these factors considered, he then decided to use an external fixator device for his patients with fractures.

The idea of ring external fixators came from a horse harness called "Duga" - a shaft bow whose ends were connected to a carriage by metal shafts. This device reminded Professor Ilizarov of skeletal traction used for treatment of long bone fractures, and the initial testing of stabilizing broken broomsticks with some sort of prototype was unsuccessful. In 1950, he was offered a post within the general surgery department of Kurgan Regional Hospital, which included managing orthopaedic trauma patients. Here was where he developed a ring construct with crossing wires through the bone that progressed into the Ilizarov rings that we know today. Again, Professor Ilizarov tested the device on broken broomsticks and he was convinced that he was able to achieve fracture site compression with a stable external fixation. He registered the device for patent in 1952 and was accepted in 1954. (To be continued)

PreparedBy:
Dr Muhammad Lutfi Abdul Rashid
University Malaya Medical Center

I would like to acknowledge the generous help from Professor Saw Aik, Professor Tunku Sara, and Dr Basir Towil in the preparation of this article.

In-between Cases with Prof Tunku Sara

Pantry talk on the musings of Malaysia's first female orthopaedic surgeon

It was a rainy Monday afternoon when Prof Sara and I were sitting in the pantry having lunch. We just emerged from a 4-hour long OT where she helped me with a paediatric cleft foot reconstruction. Having just officially retired from service, she still exudes optimism and vigor, a force of positive energy that never fails to make heads turn in her direction.

As I knew that I wouldn't be seeing her as often now that she is retired and only comes to the hospital when needed (she is now appointed as a visiting specialist in UMMC), I jumped onto the opportunity to pick her brains for any pearls of wisdom that she would like to share on a career as a female orthopaedic surgeon, and life in general.

"Prof! Why did you choose orthopaedics? Was it tough getting into training back then when it was all-boys?" I asked her.

Startled by my question, she looked up from her meal and without missing a beat, exclaimed, "Absolutely not!" After a slight pause, she continued, "I had a lot of encouragement from my seniors. After graduating from London, I returned and did my housemanship in UM. From there I was quite attracted to orthopaedics because I thought that it was such an upbeat field; you can fix a lot of things quite fast, you see. My lecturers were supportive in a teasing sort of way. You know, there were no other ladies before that except Prof Zaliha who was doing rehab under the ortho department. It was an all-boys network until suddenly this girl comes along..." she said with a twinkle in her eye. "I had to laugh at all their dirty jokes which sometimes were not so funny, but OK lah! Just join in the gaiety. But I really did think that I would like to join the fraternity where we can do good in that kind of way."

"Did you do your entire orthopaedic training here?" I interjected.

"Nah," she replied. "I joined the SLAB programme, then went to Singapore to do FRCS and also a fellowship in hand as hand was the hot topic at the time. Those days we trained ad hoc, there was no proper structure or programme. After sitting for my FRCS exams in the UK, I came back and worked as a lecturer for a while. When I got my sabbatical, I went across to Australia to do more hand and micro stuff under Prof Michael Tonkin and Prof Wayne Morrison." She had a distant look on her face. "Oh, I also went to Italy for a while to learn some Ilizarov," she added and looked at me expectantly.

Encouraged by her robust answers, I pressed on, "Was there anyone who encouraged or inspired you in particular?"

A pause ensued as she savored her food and pondered the question. "There is this one lady hand surgeon in Singapore. Her name is Kanwaljit Soin. She is a super dynamic lady; she became a member of parliament before and all that. She was very inspiring. But particularly, she never ever laughed at any of the boys' dirty jokes, as a principle. She will just look at the guy in a withering manner!" She exclaimed. "I didn't quite live up to that, maybe because I thought all of them were funny!" She laughed. "Or maybe I just didn't want to look at anyone in a withering way. You know, I just felt like one of the boys." She smiled.

"What was your favourite surgery during your trainee days?" I continued to ask.

Prof Sara took a bite out of the Granny Smith apple she was holding and said "I loved and still like small tiny flaps around the finger. I find it so intricate and useful yet not that difficult if you plan it nicely."

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"Do you have any outstanding cases in particular that you remember during training?" I followed up.

Munching, she replied "I trained under Professor Robert Pho in Singapore. He was the pioneer of the vascularized fibular graft technique and he was world famous for it. He even treated a kid who came all the way from the UK. It was in the papers and all. He had fellows coming from all over the world to learn the technique from him. I learnt a lot about the graft. Had a lot of sleepless nights monitoring the patients… It really taught me about microsurgery, how rewarding it can be and also how destroying it can be. The amount of care that you need to put into this procedure because of the very nature of it."

"I'm sure work has been very busy for you, being a renowned hand surgeon and all. How did you manage to juggle work and life Prof?"

"Work-life balance is tricky!" Prof Sara answered. "You must always remember that family is priority, and yet you can't let down your patients! I guess there were times when I may have let down both, sadly." She paused. "The thing is that, the best work-life balance is after you have retired!" She bursts out in another bout of laughter. "No really, it is a difficult juggling game. You really have to pick your battles. What is important, you do. What is a bit less important, you may have to forgo or sacrifice. There is no way to get a perfect balance. Things can get all over the place!" She exclaims. "Sometimes you feel like you are closing the seams on this side and then it bursts open over the other end!"

"Your husband isn't in the medical field, right? How did you meet him? Was it difficult for him to accept your work commitments?" My curiosity piqued.

"Ahh.. How I met my husband?" Prof Sara reminisced. "My mum and I used to walk the dog daily. One day, we noticed a tea chest outside our neighbour's house across the road. You know, back in those days when students move back from studying overseas, they pack their stuff back in one of those tea chests because it is the cheapest way to move things back. My mum asked me who do I think has moved back? And I replied that I did not know, our neighbour must have some kid studying abroad!"

"The next week when we were walking the dog," She continued. "My mother-in-law (then neighbour) comes rushing out and calls at me 'Girl, girl, come here! Come and meet my son!' So I thought, oh my god she is trying to get rid of this boy! When we went into her house and I saw that he looks pretty normal, not like he was missing anything or had a scoliosis or something, suddenly he looked quite attractive!" She gushed. "We have a lot of differences in upbringing and stuff back in the 80's. We went out a few times and got together and in the end, we managed to sort out our differences and made a go at it and Alhamdulillah we're still going!" Prof Sara beamed.

By then, our meals have long finished. As we made our way to the back of the pantry to clear our rubbish and put away our utensils, I managed to squeeze in one last question for her.

"Do you have any words of wisdom that you would like to share with all the other ladies out there who strive to become orthopaedic surgeons?"

Prof Sara smiled earnestly at me and said. "In general, you spend a lot of time at your job, just try your best to make sure it is something that makes you happy. Do something you enjoy, where you are contributing in the best way you can, surrounded by interesting, good people. Nowadays there are many aids, but it remains a balancing act, as we are the centre of our families. So, also choose what you can manage. If you need to push yourself for varying periods of time to get where you want to be, then factor that into the balance."

She added after a moment of hesitation, "Actually, I am not sure about my master planning or foresight! I think I ended up in the right place just by good intention and God's grace. If you do things earnestly from the goodness of your heart, insyaAllah God will help you along the way." Prof Sara radiated a smile that truly warmed me from the inside. Touched, I thanked her for her time and expertise in helping me out with the surgery. We then parted ways in the OT corridor.

Prepared By:
Dr Nik Aizah

The New Era Pandemic Lockdown:
A Chronicle From Different Walks Of Life

It all began in Wuhan, China with the first case being reported in December 2019 that rapidly took over the globe. Is it a biological warfare? This zoonotic virus; was it a direct transmission from bats or an intermediate species (Pangolins)? Or was it a constructed virus business deal gone wrong amidst the wholesale food market in Wuhan? The mind can't help but conjure such factitious postulations. The fact as stated by WHO, 23rd April 2020, "All available evidence for COVID-19 suggests that SARS-CoV-2 has a zoonotic source. Researchers that looked into the genomic features of SARS-CoV-2 found no evidence of a laboratory construct." However, the focal essence of this pandemic may not be the origin but how it impacted work and transformed our social lives. Narrating here are a few chosen chronicles of orthopaedic surgeons who contributed despite the pandemic.

Prof. Dr. Vivek Ajit Singh

Orthopaedic Oncology Consultant

Your unit was working full force despite the lockdown. How was your experience operating?
"First of all, we couldn't stop our services like other units because we deal with cancer. All our patients require emergent treatment.

What difficulties did you face?
Of course, we had the fear of contracting COVID from patients coming all over the region for treatment, but our biggest concern was for patients with an established diagnosis and surgery planned. If surgery was postponed,,, the treatment given may not suffice and the planned surgery may not be feasible."

What was your overall experience?
"We were not given a regular operating list. Therefore, we used the emergency list. Our referrals increased as we were one of the few tertiary centres in the region still providing Orthopaedic Oncology services. We even had patients from Sabah and Sarawak for treatment. These referrals required urgent treatment therefore, we were operating almost daily."

Any fear of transmitting the virus to your family since you were on the field full force?
"Yes. The fear was always there, but we took the necessary precautions."

Did you physically distance yourself from family as a precaution?
"Didn't feel the necessity for that but, upon reaching home I would immediately change and shower. During that time, we also minimized exposure to patients. We only came during rounds and operating, and rest of time work from home. Our teachings for master students were conducted online."

We know you are someone that is physically active in sports. How did you cope with no gym access?
"I got the necessary gym equipment delivered to my house and used to workout at home.

Was that enough for training?
"It was adequate."

Looking back at the lockdown, would you have done things differently?
"If I knew the lockdown was coming, I would have stocked up on the gym equipment earlier."

Dr. Mohd Rusdi Bin Draman @ Yusof

Orthopaedic Trauma Surgeon)

What was it like to be working during the COVID lockdown?
"It was a blessing in disguise. I had the privilege to serve and contribute to society."

How did it change your practice?
"Screening prior to surgery made things complicated by delaying emergency cases. Adhering to protocol added extra steps but was necessary. Only emergency cases could be catered to e.g. open fracture and DFU with sepsis... electives were cancelled."

How did it affect your personal/ social life?
"Nothing much changed, except more confined at home. Took this opportunity to make it as productive and systematic as possible e.g. spring cleaning and reorganization. Social life was altered to the new norm; awarded more free time but still needed to work. So, interaction was mostly with colleagues and got to know them better."

Looking back at the lockdown, would you have done things differently?
"No. Nothing much."

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Dr. Timothy Cheng

4th Year Ms.Orth. registrar/ Hostel Warden

What was it like to be working during the COVID lockdown?
"Work was rather slow paced as orthopaedic wards were converted into COVID19 wards. The orthopaedic MOs were rostered to the emergency department to help."

How did it change your practice?
"We had very little orthopaedic related work as UMMC was converted into a COVID19 Centre."

How was it being a surgeon and contributing to front liners? Any fears/concerns?
"Swabbing patients and operating on them made us realize that no one is spared from the virus – anyone can be infected."

How did it affect your personal/ social life?
"I only went out to takeaway food and purchase essential items. Daily workout routines were done at home. Solo running sessions after the relaxation of the MCO also helped to ease and clear the tired mind."

Tell us a bit of your experience being a warden and sourcing out help for the stranded students.
"30 undergraduate students were stuck in the hostel. Food was provided by an in-house café; groceries were purchased by the wardens in bulk. "IPT Pulang" was initiated towards the end of MCO where a coordinated effort by the ministry of health and higher education was undertaken to send the students back home."

You helped source out PPE and other monetary help for the hospital. Could you tell us a bit about your drive and experience?
"I am a part of KitaJagaKita – an online platform connecting people who can offer help with people who need help. Some of us from this online platform started myPPEHub.com to coordinate the distribution of PPE from NGO/donors to healthcare centres. It wasn't easy getting the NGOs on board, but we managed to distribute about 150000 items of PPE over the course of 3 months."

What is your inspiration/drive for all the selfless deeds for charity?
"Wanting to make a difference and to help others who are in need."

Looking back at the lockdown, would you have done things differently?
"Nope, I would not."

Dr. Liew Mei Yi

2nd Year Ms.Orth. registrar, Trauma Team

What was it like to be working during the COVID lockdown? How did it change your practice?
"Clinical work in the Department of Orthopaedics took a backseat to cater to managing and treating confirmed and suspected COVID cases. We still encountered several orthopaedics-related cases; often life-threatening ones which could not be sent to other hospitals. Otherwise, most cases would be directed to other hospitals that were not COVID centres. We had to also limit the number of patients for follow up at the outpatient clinics to comply with hospital policy."

How did you feel about orthopaedic training?
"Due to fewer MVAs, we didn't get enough orthopaedic exposure. We had to help out at the frontline to share the load. I certainly felt lost as a junior masters of Orthopaedics trainee, not knowing how training is going to be like in the next few months and anxious about having to manage conditions I don't normally encounter in my daily practices. Over time, I developed a better perspective to coping with this pandemic; I'm firstly a health care provider and I chose this profession to help those in need. Which is exactly what I did."

We know you are sociable and love to try different sports. So how did you feel/cope with this being put a halt?
"Certainly, a struggle. Cafes and gyms, my favourite go-to for leisure, were closed. Phase 1 MCO seemed doable at that time. However, I could not wait to get back to my social activities. By Phase 2 and 3, I was starting to get restless. I also tried to maintain good physical and mental health by eating healthy and continued working out at home either using body weight or modifying items found at home into functional workout movements.

It was fulfilling to empower people in my life with support and workouts. Several months later, a friend had confided in me that she was able to persevere through the anxieties and pressures experienced during that time because of my support. As a health worker, I was able to mobilise more freely. I had volunteered with a local church and an NGO to help shop and deliver food/ necessities to high risk groups. It was certainly an eye-opener for me to see people from different race and socio-economic status helping out."

Looking back at the lockdown, would you have done things differently?
"Work out ways on how to provide continuing care to Orthopaedic patients in need. Right after lockdown was over, we saw a surge of patients with delayed presentation, some of which were life and limb threatening."

I thank the surgeons who shared nuances of their life for this article and to everyone else that has contributed to fight this pandemic. May God bless you all and may you keep inspiring others to thrive despite the odds. I pray the future carves a safer path for all of us. With a second wave ensnaring around the corner, let us all "HOPE" a little; it is stronger than fear.

Prepared By:
Dr. Amber Haseeb

Malaysian Society for Hip and Knee Surgeons (MSHKS) 2nd Annual General Meeting (AGM), 22nd August 2020

2020 will certainly go down as a memorable year in history as we witness how the global COVID-19 pandemic has transformed our world, forcing change in many aspects of our lives. Many in-person conferences, meetings and events across the world were cancelled and postponed indefinitely as a result of social distancing rules and restrictions placed on global travel in order to contain the pandemic.

The Malaysian Society for Hip and Knee Surgeons' (MSHKS) plan of hosting its first conference, which was originally scheduled from 13-15 March 2020 was similarly put on hold as the first wave of coronavirus crisis hit the world. However, it was still essential for our society to hold its 2nd AGM within the calendar year to fulfill requirements set by the Registrar of Societies (ROS). The council members stepped in to put together a 'hybrid meeting', incorporating a mixture of in-person and virtual attendance so that the strict standard operating procedure (SOP) implemented by the ROS were adhered to. At the same time, this allowed for participation by members who were unable to physically attend the meeting.

The MSHKS successfully held its 2nd AGM on the 22nd of August 2020 using this hybrid approach. On this day, the in-person meeting was held in a meeting room in Kuala Lumpur. 5 councils members and 1 internal auditor were physically present, following the SOP endorsed by the ROS. The meeting was chaired by the President, Dato' Dr Badrul Shah Badaruddin and was broadcasted via the Zoom Meeting platform to a total of 24 members who dialed in from all over the country, attending the meeting remotely.

Several matters were discussed during the AGM. These include:

1. **Defining the vision and mission statements of the MSHKS to provide clear guidance on the future direction of the society.**

   Vision of MSHKS:
   - » To provide education, training and sharing of information in management of hip and knee problems particularly related to degenerative joint diseases.

   Missions of MSHKS:
   - » To achieve liaison with similar bodies and other experts within the region and internationally in order to promote sharing of knowledge and working together to establish the best clinical practices in the area of hip and knee joint management.
   - » To encourage friendship and networking among members of the society.
   - » To initiate a National Registry for hip and knee joint surgeries and to encourage clinical research in the field of hip and knee joint diseases both locally and internationally.

2. **Reshuffling the structure of the MSHKS Council to ensure continuity in all efforts and to plan in a more effective manner.**

During the next AGM in 2021, all council members will have to be re-elected. The top 3 posts for the President, Vice President 1 and Vice President 2 / Secretary of the society will be held for a term of 2 years. At the end of the tenure, there will be automatic promotion of the Vice President 1 post to the President post and the Vice President 2/Secretary post will automatically be promoted to the Vice President 1 post. Thus, in subsequent AGMs, only elections for the posts of Vice President 2 / Secretary, Treasurer and the 2 council members will be held.

The 2nd AGM of the MSHKS started at 16:00H and ended successfully at 17:00H on 22 August 2020. The meeting concluded on a positive note and both council and society members were enthusiastic in embracing the new direction of the society despite the challenges posed by the current pandemic. We hope to conduct our 1st MSHKS conference in 2021 to further cement our vision and missions.

Council members, who physically attended the AGM. From left to right: Dr Chan Chee Ken, Dr Chua Hwa Sen, Dr G Ruslan Nazaruddin Simanjuntak, Dato' Dr Badrul Shah Badaruddin, Prof Dr Azhar Mahmood Merican & Dr Fahrudin Che Hamzah.

Prepared By:
Dr. Chua Hwa Sen
MSHKS Council Member

Travelling Fellowship Program of MOA/KOA to 63rd Annual Congress of Korean Orthopaedic Association 2019

- 17th October -24th October 2019

It was a great honour for me to represent the Malaysian Orthopaedic Association (MOA) on a Travelling Fellowship Program supported jointly by the Korean Orthopaedic Association (KOA) in conjunction with the 63rd Annual Congress of KOA in Seoul, South Korea. There were 5 representatives from MOA: Dr Mohd Hadizie, Dr Faissal Yasin, Dr Mohd Rusdi and Dr Nik Aizah. The first half of the program was the annual congress of KOA which took place in Grand Hilton Hotel, Seoul and the latter half were hospital visits arranged by KOA based on our subspecialty. I was fortunate to be attached to Seoul National University Hospital and learn from the Hand and Reconstructive Microsurgery surgeons there: Prof. Lee Young Ho and Prof. Baek Goo Hyun.

Five Malaysian Travelling Fellows: (Left to right) Dr Nik Aizah, Dr Hadizie, Dr Faissal, myself, Dr Rusdi.

63rd Annual Congress of KOA

The 63rd Annual Congress of KOA started on 17th October with a comprehensive scientific program from each subspecialty across 8 halls. There was a mixture of Korean and English language used in these sessions. The KOA travelling fellowship program started in 2012 with participants from 6 countries in Asia. This year, KOA invited 52 travelling fellows from 16 countries across Asia. Special itineraries were prepared for travelling fellows hosted by world-renowned experts in each field of orthopaedic surgery.

These included the opportunity to visit a hospital for scientific exchange, observation, close interaction with faculty, as well as social or cultural events. A travelling fellows forum was held for knowledge exchange and MOA was represented by Dr Faissal Yasin with his paper titled "The Clinical Outcome of Pulmonary Metastectomy in Musculoskeletal Sarcoma Patients in a Single Centre: A Retrospective Cohort Study" and Dr Mohd Hadizie with his paper titled "Functional Outcome of Surgical Stabilization of Acetabular Fracture - Our Series".

The second day of the conference was Asia Pacific Orthopaedic Association (APOA) President Forum. We met the distinguished Presidents from the APOA countries and the Secretary General of APOA, Dr Jamal Ashraf. Our Malaysian Orthopaedic Association (MOA) president Dr Chye Ping Ching presented her thoughts on Women in Orthopaedics in Malaysia, which is very inspiring and relevant to my journey in orthopaedics. The third day was a live surgery broadcast from Korea University Anam Hospital, demonstrating

With Dr Chye PC, our MOA President at the Presidential Dinner

With Dr Jamal Ashraf secretary general of APOA (2nd from left), Dr Aishah from Saudi Arabia (5th from left) and Dr Sholahudin from Indonesia (2nd from right)

uni-portal and bi-portal lumbar discectomy/decompression surgery. The presidential dinner was spectacular with Taekwondo/ K-Pop fusion performance.

Seoul National University Hospital

I received a warm welcome from the Hand & Microsurgery team led by Prof. Baek Goo Hyun and Prof. Lee Young Ho. The team has 5 professors and 5 clinical fellows, with a well-organized schedule for clinics, surgery and research.

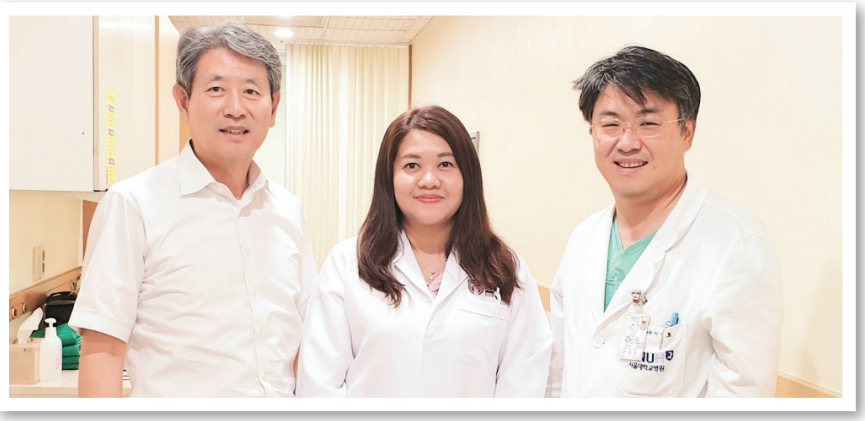
Seoul National University Hospital (SNUH) was built in 1907, then known as Daehan Hospital. It is now an 1800-bedded facility with a patient load of 3 million per year. It has state-of-the-art architecture and medical facilities.

Prof. Baek is a world-renowned Hand surgeon, a giant in Congenital Hand surgery. Prof Lee is an expert in nerve surgery and hand trauma. I was privileged to learn from both professors in the clinic, during teaching sessions and in the operating theatre during my 1 week visit in SNUH.

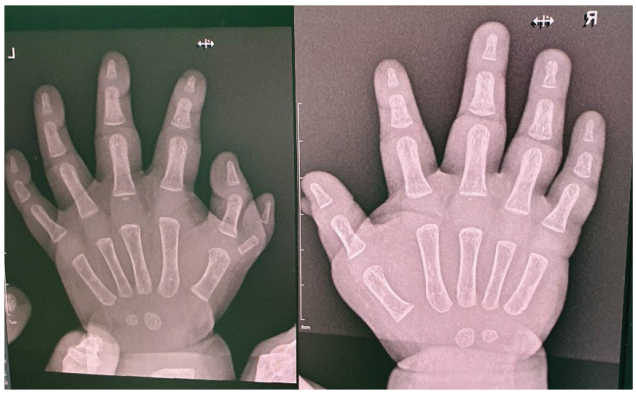
This exchange-fellowship program was indeed an eye-opener for me. The experience, knowledge-sharing and new friendships gained are invaluable to my orthopaedic career. I would like to express my gratitude to Seoul National University Hospital and the KOA organizing committee for arranging accommodation and transport. Hopefully, the friendship of KOA/ MOA will grow and flourish and keep nurturing orthopaedic surgeons from both countries.

Iconic clock tower of SNUH built in 1907.

History of SNUH displayed at the main lobby.



Seoul National University Hospital visit. (Left to right) Prof Baek GH, myself, Prof. Lee YH.



A case of left pre-axial polydactyly Wassel type 4 excision done in operating theatre.

Prepared By:
Dr Liew Siew Khei,
Hand and Reconstructive Microsurgery Unit,
Department of Orthopaedic,
University Putra Malaysia.

Association of Southeast Asian Nations (ASEAN) Travelling Fellowship 2019

We have just returned from two exceptional weeks traveling to Brunei, Malaysia, Myanmar and Indonesia. Representing the Pacific region, we travelled with Mr Rupesh Puna from New Zealand and joined with six other orthopaedic surgeons from Southeast Asia (Malaysia, Indonesia, Thailand, Myanmar, Philippines and Singapore). We visited hospitals, met with local surgeons, toured beautiful cities and ate exceptional food.

In each location, both of us presented on a topic we are passionate about. Our presentation topics were **"Diversity in Orthopaedics"** and **"Video Production for Orthopaedic Surgeons – Case Presentation: Minimally Invasive Lateral Approach L4 Osteosarcoma Vertebrectomy Piecemeal"**.

In Bandar Seri Begawan in Brunei, we witnessed first-hand unity in diversity. There were 15 orthopaedic surgeons from India, Pakistan, Bangladesh, Myanmar and Brunei for a population of 430,000 people. The surgeons were all working towards a single goal of treating and caring for patients with musculoskeletal injuries and pathologies. Of the many surgeons we encountered, two female orthopaedic surgeons took time off their busy schedules to take us on hospital visits, touring the country's main attractions and dine with us at local restaurants. We also had a chance to meet junior doctors who were not on the training program and we shared our journeys in orthopaedics, hoping to positively influence them to pursue this wonderful career. We learnt from them what they perceived to be hurdles in becoming orthopaedic surgeons, especially for the females, and the things we can do as mentors to assist them.

Kuala Lumpur was our second destination where we visited two university hospitals. The local orthopaedic surgeons showcased their generosity in teaching the junior members of their departments with a dedicated full day of teaching per week in both the hospitals. These included case conferences with patients, presentations of the week's cases, lectures and bedside clinical teaching. We were amazed by the extensive research facilities and available resources at both hospitals, which have made Malaysia a world class centre for orthopaedics.

Our third stop was Yangon in Myanmar, where we were enchanted by the warmth of the people and the natural beauty of the region. Coming from Australia where we are well resourced, we often forget that there are many different ways to treat various orthopaedic conditions. In Myanmar, patients routinely wait more than a week for treatment of long bone, hip and spinal fractures. This is due to a variety of factors including theatre availability and patients having to source funds to buy their own implants. The biggest take-home message was how fortunate Australia is to have the medical system that it does. The challenges are great but the local orthopaedic surgeons are making great inroads in patient care and doing some exceptional surgery. The visit reminded us that we have to always remember the basic orthopaedic principles when we manage and treat patients. We need to think outside the box and remember that we can do wonderful things with what we have but only if we try.

The opportunity to attend the ASEAN Travelling Fellowship was insightful, educational and inspiring. The experience was one we will not forget. The ability to travel to four different countries in Southeast Asia and meet with like-minded orthopaedic surgeons has not only resulted in a new-found appreciation for Australia's health system but also life-long friendships. The fellowship involved equal portions of hospital tours, educational visits, social activities and sightseeing. The generosity, collegiality and knowledge sharing of our hosts was exceptional.

We would encourage anyone who is passionate about global health and believes in sharing surgical experiences, techniques and learnings to apply. The travelling fellow/s will meet many interesting people, experience different cultures and have discussions on a broad range of issues. The next ASEAN Travelling Fellowship will be in November 2021.

In October, Melbourne will host fellows from Brunei, Myanmar and Malaysia. We hope those of you in Melbourne will join us in welcoming them and take the opportunity to meet them at the Australian Orthopaedic Association Annual Scientific Meeting 2020.

By:
Ms Juliette Gentle
(Northern Hospital, Melbourne)
and
Mr Alvin Pun
(Austin Health, Melbourne)

The Role of Expert Evidence in Medical Negligence Claims

In medical negligence cases, the burden is on the patient to demonstrate that the medical practitioner's treatment, diagnosis or management of the patient falls below the standard of care expected of a medical practitioner in a similar position. The outcome of these cases turns primarily on the expert evidence led in court. Indeed, the Federal Court's decision in Zulhasnimar bt Hasan Basri & Anor v Dr Kuppu Velumani P & Ors [2017] 5 MLJ 438 affirmed the Bolam test as the operating test to determine a doctor's standard of care for diagnosis, treatment and management. The Bolam tests states that:

"A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. … Putting it the other way round, a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view."

In Zulhasnimar, the Federal Court acknowledged that the technical and scientific aspects of medicine, which involve differences of opinion in diagnosis and treatment, mean that the courts are often faced with matters which they are not generally equipped to resolve without the aid of expert medical evidence.

The case of Muniasamy a/l Murugian v Salleh bin Sukir & Ors (unreported), which was recently decided by the Court of Appeal, underscores the significant role of expert evidence. Importantly, this case illustrates how widely medical expert evidence can differ, how the courts should approach differing opinions and why medical men must embrace their expert roles in medical claims.

Brief Facts

Following a road traffic accident, the patient was diagnosed with a closed fracture lower third of left tibia/fibula and degloving injury over the left foot. The 2nd Defendant, an orthopaedic surgeon, carried out a closed reduction of the patient's left tibia and fibula and attached an external fixator.

Following the patient's discharge, the patient complained of pain at the proximal-most external fixator pin-site. The 2nd Defendant carried out a removal of the external fixator, an open reduction and internal fixation for the left tibia and fibula.

At a subsequent consultation, there was pus discharge from the surgical wound at the left tibia and proximal-most external fixator pin-site. The 2nd Defendant carried out a wound debridement and inserted antibiotic-loaded beads into the patient's wound. Unfortunately, at the next review, there was discharge from the wounds, increased swelling at the patient's foot and lower leg, and necrosis at the degloving wound flap at his sole.

The 2nd Defendant then referred the patient to the 3rd Defendant, a consultant plastic surgeon. The 3rd Defendant discussed the option of removing the internal plates. However, the patient was not keen on this option.

In the next 2 months, antibiotic cover was provided and the 3rd Defendant carried out multiple wound debridements, started the patient on vacuum therapy, and undertook 2 skin grafts on the patient. The grafted areas on the patient's left foot healed, but the skin graft on the patient's left leg took only by about 50%.

The patient then decided to see the 4th Defendant, another consultant orthopaedic surgeon. The 4th Defendant first removed the fibula implant and removed the tibia implant around 5 months later. At the end of the treatment with the 4th Defendant, the patient's wounds healed.

The patient brought an action in negligence against the driver of the motor vehicle involved in the road traffic accident, all the specialists who had treated him and the hospital.

At the crux of the issues that needed to be decided at trial was the decision to treat the infection with the internal plates in situ.

Experts' Views

The medical experts at both sides of the divide had completely opposing views.

The patient called a senior orthopaedic surgeon who criticised the specialists who treated the infection without removing the internal plates. He was equally critical of the 4th Defendant for the multiple surgeries undertaken.

The 2nd Defendant did not call any expert to testify in support of his treatment of the patient.

The 3rd Defendant called a senior consultant plastic surgeon who gave expert testimony that it was acceptable for a plastic surgeon to manage a case that involved treating necrosing skin of the foot by excision and reconstructing the defect with skin grafts. The expert also testified that, given

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that the patient was unwilling to remove the implants, it was acceptable for the 3rd Defendant to treat the infection with the plates still in situ.

The 4th Defendant's staged removal of the implants was well supported by the expert evidence of a senior and experienced orthopaedic surgeon. After cross-examination of the 4th Defendant's expert, the patient in fact withdrew his claim against the 4th Defendant mid-trial.

Decision Of The Court

At the end of the trial, the High Court agreed with the patient's expert's views and entered judgment in favour of the patient. The 3rd Defendant and the hospital were dissatisfied with this decision and appealed to the Court of Appeal. The 2nd Defendant did not appeal.

At the Court of Appeal, it was argued that the High Court Judge should not prefer one medical expert evidence over another, unless the expert evidence in question does not withstand logical analysis. In medicine, it is not uncommon for doctors to have differing approaches to the same medical concern. As long as the differing approaches by the experts called by a defendant doctor are reasoned and logical, the court must accept that the defendant doctor's treatment is supported by a responsible body of medical men. The patient cannot therefore be said to have satisfied the Bolam test and the case must be dismissed.

The Court of Appeal unanimously upheld the arguments proffered and the High Court judgment against the 3rd Defendant was set aside with costs awarded against the patient.

Take Home Points

The Court of Appeal's decision underscores the importance of involving experienced specialists who can provide sound and logical expert medical evidence in medico-legal claims. If senior doctors are disinclined to assist, the cases before the courts will be determined without the benefit of balanced and sound views to ensure that a just decision is made by the bench.

Although the inconvenience of being involved in court proceedings is no doubt a factor that may weigh heavily against medical men agreeing to volunteer their services in court as experts, it is vital for the medical profession to realise that each case decided in court may well be a judicial precedent for the next case. And obviously, in the next case, another member of the profession will be the defendant.

By:
Raja Eileen Soraya binti Raja Aman (Partner) and
Harish Nair (Senior Associate).
Messrs. Raja, Darryl & Loh

Article Courtesy of Messrs. Raja, Darryl & Loh

Starting Your Investment Journey in The New Normal

It's been a volatile year for global markets in 2020. Pummelled by the COVID-19 pandemic, risk assets endured a fierce sell off in the 1Q'2020 as economic activities came to a grinding halt with a complete shuttering of businesses. Global equities succumbed to one of the steepest and quickest correction ever witnessed in early-March.

However as sharp and quick as the rout began, the recovery has also been swift and ebullient. Due to unprecedented stimulus measures injected by governments and central banks, benchmark gauges have rebounded strongly driven by ample liquidity. The US stock market has even surpassed its pre-COVID-19 peak despite infections continuing to rise in the country. To any casual market observer, the new normal investment realm can be confusing terrain to navigate as the gap between the real economy and the stock market continues to widen. This is especially as traditional macroeconomic theories no longer apply in a world of negative interest rates and unlimited quantitative easing (QE).

For investors looking to start their investment journey in 2020, it can be an unnerving time to do so. But in times of uncertainty, it is crucial that all investors whether seasoned or new take a step back to reassess their goals and go back to fundamentals. Whilst the markets will ebb and flow, it is far more important for investors to stay the course and practice diversification in their portfolios. Here is 5-step guide investors can follow to an effective asset allocation: -

1 Defining Investment Objectives

It's the first step in the asset allocation process that often gets overlooked. But really, it is the most important part that you should invest the most time with before modelling a portfolio. Asking yourself basic questions such as who I am, what your aspirations are, as well as expectations can help define your objectives. Are you a millennial looking to build and accumulate wealth? Or are you someone in your mid-50s looking to prepare for retirement and have a steady income stream?

Once you've established these answers, it's crucial then to be as specific as possible and to be able to quantify your financial objectives. How much wealth do you want to build exactly? How much does your current lifestyle cost and how much do you need to sustain it? For example, someone in their mid-50s will need to determine how much wealth they would like to accumulate by the time they reach retirement, as well as the rate of return % they need to achieve as a hedge against inflation. All these considerations are important because it lays down the parameter of your investment objectives, so that your portfolio is geared towards achieving its stated purpose.

2 Gauging Your Risk Tolerance

Determining your risk-tolerance is the next step in the asset allocation process. Understanding what your risk-tolerance is can also be gauged by asking yourself basic questions such as your age, monthly income & expenditure and other types of commitment you have. Different psychological profiles and imprints often determine what type of person you are and if you are a risk-taker or risk averse.

But it is critical here to separate what your risk-tolerance and risk-acceptance are, as the two gauges measure different things. For example, an investor in their mid-20s may be more inclined to take on more risk because of his youthful exuberance and more daring nature. Therefore, he has a high risk-acceptance.

But if you consider the fact, that if he is already married with a child along the way, as well as parents and in-laws to take care off, his capacity to take on risk is limited. As such, the investor has a low risk-tolerance and would not be able to stomach an aggressive portfolio that is highly tilted towards riskier asset classes.

3 Time Horizon & Liquidity Needs

Next, an investor would need to determine their investment time horizon and liquidity constraints. Think of these two factors as the levers shifting the gears of your portfolio that will ultimately determine your capacity to invest and by how much.

For instance, an investor in their mid-20s who does not need the principal sum and returns back

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from the investment for the next 8 – 10 years would have a long investment horizon and hence a higher capacity to invest. This would allow the investor to take on more risk and be more exposed towards longer-dated instruments or riskier asset classes that only show returns at a later stage. Such asset classes typically include small-caps or growth stocks that are high-risk and typically exhibit strong earnings and growth only at a later cycle. Thus, investors with a shorter investment horizon should avoid such asset classes.

Similarly, as an investor you should also assess your liquidity needs and determine how much you are willing to set aside from your wealth as investments. It's crucial that you understand that this is a separate pool of wealth that is different from your own savings account that you use for your own daily sustenance and allowance. Thus, as much as possible, you should avoid dipping into either pools of wealth and using your savings for investments and vice-versa.

You need to give time for your portfolio to work and to compound returns. Opting to cash-out from your portfolio can be disruptive to your investments especially at a crucial stage of the market cycle when it is starting to rebound.

4 Understanding Different Asset Classes

These are the 'building blocks' of your portfolio. There are 3 broad asset classes for an investor to work with, i.e. equities, fixed income and cash.

Equities are the riskiest asset class but has the potential to provide the highest returns. Common instruments include ordinary shares or equity funds that an investor can easily buy into.

Fixed income also known as debt is a less risky asset class that provides more stable but often lower returns. Investors may be able to gain exposure to this asset class by investing in bonds directly or through bond funds.

Cash or cash-equivalents are the most liquid asset class and typically provide little to no returns especially in inflationary periods. But they serve its importance by being extremely liquid to quickly move in and out of a market correction as well as a buffer during an emergency.

There are also other types of asset classes including REITs, commodities, precious metals, real estate or even alternative asset classes such as private equity or debt. But more importantly, you need to really understand what it is that you are investing into and the underlying asset class of the product before deciding to include it in your portfolio.

5 Constructing Your Portfolio

Finally, you are ready to construct your portfolio. There is no single method or approach in building the 'perfect' portfolio, as each portfolio would need to be customised according to the needs and risk-profile of the investor. But there are some model blueprints that an investor can follow as a start.

For more risk-inclined investors, they can invest in a more aggressive portfolio composed of 70% - 80% in equities and the rest in fixed-income. On the flip side, a more risk-averse investor should have a higher tilt towards fixed-income of between 70% - 80% in bonds, with minimal holdings in equity and some in cash. A risk-moderate investor could have equal exposure to both asset classes.

Underpinning all these considerations in the asset allocation process is the simple principle of diversification of not putting all your eggs in a single basket. Diversification strives to minimise risk in a portfolio by investing in a mix of different types of asset class that are not or less correlated, so that gains from one asset class can offset losses from another.

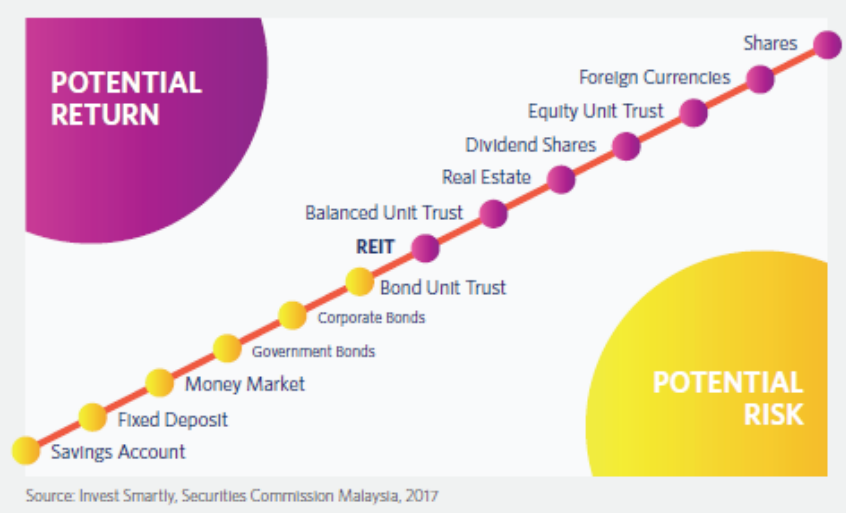
It is a risk mitigation technique that has been proven to outperform over the long run by protecting against losses, whilst maintaining sufficient exposure to capture market growth.

Knowing Is Half the Battle

Starting your investment journey can be especially daunting during such volatile market conditions. But as the saying goes, "Never let a good crisis go to waste." Anyone can invest if you have a plan and a robust asset allocation to ride through the market peaks and troughs.

Speak to us about your investment needs by calling us at our toll-free line **1800 88 7080** or **WhatsApp +6012 606 8685**. Visit our website **https://affinhwangam.com/** to learn more.

By:
Affin Hwang Asset Management



Source: Invest Smartly, Securities Commission Malaysia, 2017