

**Plenary**

***CHALLENGES IN SUSTAINING FACULTY DEVELOPMENT PROGRAMMES:  
LESSONS LEARNT FROM MORE THAN TWENTY YEARS OF TRYING***

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***SYNOPSIS:***

Faculty Development Programme (FDP) encompasses all the activities that help faculty members to improve their capacity to become more effective instructors as well as to perform other components of their multi faceted tasks such as conducting research, contributing to administrative activities and writing publishable materials (Jason, 1980). It is a tool for improving the educational vitality of our institutions through attention to the competencies needed by individual teachers and to the institutional policies required to promote academic excellence (Wilkerson, Irby, 1998). One of the main long term objectives of FDP in the medical and health sciences field, is the preparation of excellent teachers who will in turn be able to train and mentor future generations of excellent health workers who will be able to provide excellent health care services to patients and the community to improve health outcomes and quality of life. Therefore, it is imperative that educational institutions start the loop by offering sound and relevant FDP for its teaching fraternity. For successful faculty development to happen, changes must take place at three basic levels ie attitudes, process and structure. There must also be serious efforts to identify areas of needs of the targeted programme participants at needs assessment. The School of Medical Sciences, Universiti Sains Malaysia, embarked on a systematic FDP since 1986. We have learnt a lot in the course of more than two decades of offering the programme: lessons from pleasant and gratifying as well as trying and challenging circumstances. This presentation will highlight some of the more important challenges we faced in trying to sustain our institutional FDP (such as needs assessment, relevance, acceptance and cost effectiveness) as well as strategies that were employed to overcome some of the difficulties with planning, implementing, evaluating and sustaining the FDP. Findings of our FDP evaluation over the past 22 years are summarized and will be presented to assist our future directions in faculty development and also to be shared with other institutions that are just embarking on a similar FDP pathway.

**Plenary**

***GASTROESOPHAGEAL REFLUX IN CHILDREN: MANAGEMENT ISSUES***

*Quak Seng Hock*

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Gastroesophageal reflux (GER) is common in young infants and some 30-40% of healthy infants would have clinical features of GER in the first few months of life. Vast majority of these children would improve symptomatically with age. They may present with various symptoms related to feeding such as regurgitation, vomiting, irritability and failure to thrive. However, if their symptoms are not related to the gastrointestinal tract, diagnosis may be delayed. Various mechanisms are postulated for the common occurrence of GER in young children. These are related to the feeding practice, maturity of anti-reflux mechanisms at the lower oesophageal sphincter, as well as some medical interventions during the perinatal period. Although the causes of GER at this age are heterogeneous, there seems to be some uniformity in its treatment in most paediatric centres. Non pharmacological treatment is the most frequently utilized modality of treatment. This includes feed thickeners and posturing. However, the efficacy is debatable. Antacids, prokinetic agents and proton pump inhibitors are the common pharmacological agents used. Surgical treatment is reserved for those with failed medical treatment or those with structural abnormalities at the lower oesophagus. GER in premature infants is a quite unique. The clinical presentations are often not related to the gastrointestinal tract and there are a number of predisposing factors such as tube feeding, artificial ventilation and the use of medications which may affect the maturity of the lower oesophageal sphincter.

## **Plenary**

### ***INJURY PREVENTION – ROLE OF EMERGENCY PHYSICIAN AND BEYOND IN “HELPING PATIENTS & SAVING LIVES”***

*CW Kam*

Consultant & Chief, A&E Department, Tuen Mun Hospital, 23, Tsing Chung Koon Road, Hong Kong.

The proficient poly-trauma care is not only limited to the first golden hour (of multi-disciplinary approach with horizontal task assignment), but includes expeditious definitive management, critical care and rehabilitation. Needless to say, it begins from prevention. Injury & the prevention are both multi-faceted issues which rely on an inter-specialty strategy to solve the dilemma and problems. When grouped with poisoning, trauma is the fifth killer disease in HK after cancer, coronary heart disease, chest infection and stroke in 2006 (HK Annual Digest of Statistics). The Annual Attendance of all the HK AEDs in 2007 amounted to 2 million with around 20% (0.4 million) belonging to the trauma category. The figures in AED of Tuen Mun Hospital (TMH) in 2007 revealed 52 deaths among 38,199 trauma patients with 13.4% (5,135) admitted for in-patient treatment. While Trauma Life Support in the AED can provide the secondary prevention of injury by damage control to preserve the organs and to restore the normal body functions. The subsequent counseling to diminish risky behaviour and to modify the perilous environment is the tertiary prevention to reduce the future recurrence. It is apparent that AED may not substantially contribute to the primary prevention, aborting the incident before it occurs owing to the lack of infrastructure to perform adept data collection, archive, analysis, dissemination & making impact to legislation which can be the best elixir (therapy) to attain injury prevention when most men in the street tend to focus more on efficiency & convenience instead of safety. Furthermore, the figures in 2007 of TMH AED indicated that injury types comprised of industrial (25.5%), domestic (24.2%), sports (7.6%), traffic (6.7%), family violence (1.2%) and self-harm (1%). 28% belonged to the unclassified type (school, pavement or others) showed that the database was far from mature to reveal the authentic nature of injuries encountered. The review of a recent case of multiple trauma (traumatic hemoperitoneum due to liver laceration and acute subdural hemorrhage) revealed a hospital expenditure of \$0.3 million, including the operation, staff, imaging and drug costs but loss of earning capacity and psycho-social impact to family had not yet been added. While most resources are currently placed in the secondary prevention, the most exciting component of trauma management (damage control treatment) as televised in the ER series, we have to re-engineer our judgment by using the Haddon Matrix (Host, Vector, Environment) to transform our attitude. The role of Emergency Clinicians (doctors & nurses) is pivotal and yet not holistic. Treating the trauma & providing the counseling is only at the micro-level. Setting up the surveillance system to judiciously use the data to improve the outcome is the meso-level. Working on the community education and with the policy makers to legislate against risky behaviour and environment is the macro-level. The multi-strata approach must be artfully coordinated to timely administer the trauma antidotes while precluding destructive competition among the various sectors of health care providers, administrators & politicians. A Central or Global Registry on Injury Surveillance would help align our perspectives to identify the focal point to enhance the concerted effort from HK to Malaysia and whole world. The views and inputs of all the conference participants would certainly help refine the proposed solutions to heighten the safety of our communities. While the definitive treatment for injury is operation, the best therapy is prevention ! Moreover, trauma can be an infectious disease managed by the public health approach.

**Plenary**

***SLEEP APNOEA SYNDROM : THE PERFECT KILLING MACHINE***

*Abdullah Sani Mohamed*

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The perfect murder is one where the murderer cannot be caught nor identified. Sleep apnoea syndrome is a condition which kills patients but the death is normally assigned to other illness. A patient with ischemic heart disease and sleep apnoea dies in his sleep. His nocturnal oxygen saturation falls in the apnoic episodes to less than 60% and this tips him to decompensate and dies. The death certificate will not state sleep apnoea as the cause. A patient with a nasopharyngeal carcinoma (NPC) causing obstruction at the nasopharynx and all the symptoms of sleep apnoea dies in his sleep. Again, the cause of death will be recorded as NPC, not sleep apnoea. Imagine if you will, a bus driver with sleep apnoea. If he falls asleep at the wheels and plunges the bus down the ravine resulting in multiple deaths, no autopsy by any CSI team in the world can prove sleep apnoea causing the accident. By now, you will get an idea why sleep apnoea is dubbed "The perfect killing machine". The story is far from over. For even when you can diagnose sleep apnoea and treat patients surgically with fancy operations on the palate, nose and base of tongue, over the years, the disease returns, finding ways to obstruct the airway. It is a life long disease requiring life long vigilance. When the patient thinks he is cured, he tends to indulge in more eating causing obesity and return of sleep apnoea. The use of a continuous positive airway pressure (CPAP) devise is widely regarded as the gold standard treatment. Even this is dependant on compliance. Severe sleep apnoic patients cannot "survive" being without the devise for more than 3 – 4 days. And to make matters worse, CPAP does not cure the disease, just relieves the symptoms. Sleep apnoea syndrome must be given the recognition it deserves. And steps must be taken to prevent or decrease its incidence by preventing obesity, as obesity is one of the major causes of sleep apnoea.

**Plenary**

***CONTINUOUS INNOVATION HEALTHIER COMMUNITY : CONTRIBUTIONS AND CHALLENGES IN COMMUNITY DENTISTRY***

*Raja Latifah Jallaludin.*

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The lecture will begin by tracing the history of dentistry and will end by predicting the future of dentistry. It will trace innovations along the historical path that have contributed to the oral health of the community and suggest future innovations that could possibly bring about positive changes to oral health. It also includes a SWOT analysis of some of these major innovations that have evolved over the last century for the benefit of humankind.

**Plenary**

***PERSONALIZED MEDICINE: PROMISES AND REALITIES***

*Bin Tean Teh*

Director, VARI International, Van Andel Research Institute, MI 49503 USA.

Recent advances in cancer research and their translation into clinical application in diagnosis and treatment will be presented which will also include the trends of technology and biomedical research in the next five years. However, the high cost of personalized medicine and molecular therapy is well known and few people in developing countries have the funds for it. What can be done to circumvent this dilemma? What roles can the academic scientists play to combat this problem? The lecture welcomes thoughts, suggestions and active participation from the audience.

**Plenary**

***FUNCTIONAL GENOMICS AND CANCER***

*Mohamed Saifulaman Bin Mohamed Said*

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Genomics and its extension, functional genomics has opened up new vast new areas of knowledge and understanding of the molecular processes that are occurring within our cells. This body of knowledge has been applied to many endeavours, particularly within the field of cancer. In this talk, I will highlight how functional genomics has provided a sound basis for the molecular events underlying cancer and how this, in turn has helped to increase the accuracy and speed of diagnosis, the rational approach to cancer drug discovery, the advances in cancer treatment by novel treatment modalities right up to prognostication and monitoring after treatment. Current trends on the predictive use of genetic signatures for diagnosis, prognosis, prediction of response to chemotherapy, among others will also be presented and discussed. A number of molecular based treatment modalities in clinical trials will also presented and discussed.

**Plenary**

***CRANIOFACIAL TRAUMA***

*Peter J. Anderson*

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Craniofacial Surgery as a new specialty, only really becoming established since the pioneering work resulting from the management of traumatic injuries produced during world war one and more recently by the improvements in surgical management of Craniosynostosis Paul Tessier in France. However, injuries which can be considered to be craniofacial trauma have been produced for hundreds of years prior to the development of the dedicated surgical specialists. The changing aetiology of these injuries and how this may depend on culture will be shown along with the management of these injuries. This will include the improved outcomes as a result of innovative surgical approaches and the application of new technologies to treating these conditions.



## **Plenary**

### ***PREVENTIVE STRATEGIES FOR THE EMERGING CHALLENGE OF AGE-RELATED MACULAR DEGENERATION***

Au Eong Kah Guan

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Age-related macular degeneration (AMD) is a severe ocular disease characterised by progressive deterioration of the macula, the most sensitive central back portion of the retina. Data from the World Health Organisation show that AMD is the most common cause of blindness in developed countries and ranks third after cataract and glaucoma as a leading cause of blindness worldwide. As the life expectancy and proportion of elderly people in Asia increase, the prevalence of AMD is expected to correspondingly increase. Thus, AMD is likely to emerge as a major public health challenge for many countries in the near future. Recent advances in our understanding of AMD have prompted a need to reassess our approach to fighting blindness from this sight-threatening condition. Traditionally, physicians have played a key role in the diagnosis and treatment of AMD patients and have referred those who are afflicted with irreversible visual impairment for visual rehabilitation. More recently, new insights into the natural history and risk factors of AMD as well as recent evidence from animal and clinical studies have suggested possible strategies for primary and secondary prevention of AMD. Primary prevention is preventing a disease from occurring in the first place. Any primary preventive strategy will have to raise the awareness of AMD and its modifiable risk factors so that at-risk behaviours can be changed to reduce the risk of AMD development or progression. For example, it has now been firmly established that cigarette smoking is positively associated with AMD development and progression in a dose-dependent fashion, and smoking cessation reduces the risk of developing AMD to that of non-smokers after 20 years. Anti-smoking campaigns to encourage smoking cessation and discourage non-smokers from starting the habit are therefore potentially helpful to reduce AMD development and progression. A diet rich in green leafy vegetables, which contain antioxidants and macular pigment, has also been found to reduce the risk of AMD. Unfortunately, the awareness of AMD and its risk factors among the general public is currently low, and more efforts are needed to highlight this blinding condition. Secondary prevention is preventing a disease from getting worse after the onset of the condition. A major multi-centre randomised controlled trial has shown that for patients with moderate AMD, or advanced AMD or visual loss due to AMD in one eye, supplementation with a combination of antioxidants (vitamin C, vitamin E and beta-carotene) and zinc can reduce the risk of progression to advanced AMD. Physicians should screen persons 55 years and older with regular dilated fundus examination to determine their risk of developing advanced AMD. Those at risk should consider nutritional supplementation to reduce this risk. The use of Amsler grid or preferential hyperacuity perimetry to monitor for metamorphopsia suggestive of choroidal neovascularisation so that treatment can be instituted early will also help to reduce morbidity from wet AMD. In conclusion, the increasing impact of AMD, coupled with the limited and expensive therapy available for its treatment, have led many investigators to search for factors that could be modified to prevent the onset or alter the natural course of AMD. The identification and modification of risk factors has the potential for greater public health impact on the morbidity from AMD than the few treatment modalities at hand.

## **Plenary**

### ***MALAYSIAN HEALTH PROMOTION BOARD - FUNCTIONS AND PRIORITY AREAS***

*Lekhraj Rampal*

Deputy Chairman, Malaysian Health Promotion Board, Chairman, Action on Smoking and Health Committee, Malaysian Medical Association, Professor, Faculty of Medicine and Health Sciences, Universiti Putra Malaysia, 43400 Serdang, Selangor, Malaysia.

In 2002, Prof. Dr Lekhraj Rampal, Chairman, Action on Smoking and Health Committee, Malaysian Medical Association (MMA) requested the Government through the Minister of Health Malaysia to increase tax on tobacco and tobacco products. The revenue obtained from the increase in tax was to be used to establish a health promotion foundation to provide funding for tobacco control and cessation activities conducted by NGOs, sports and cultural organizations and for the victims of tobacco and tobacco products. The Cabinet of Ministers Malaysia decided in August 2002 to establish a Malaysian Health Promotion Foundation to meet this objective. It was agreed that the Foundation will be a statutory body established under an Act of Parliament. It would be governed by an independent Board consisting of representatives from relevant Ministries, NGOs, and professionals who possess expertise relevant to health promotion. It was originally proposed that the fund for supporting and sustaining the activities of the Foundation would be derived from dedicated taxes on tobacco and tobacco products. It was later decided that the increase in dedicated taxes was not for tobacco and tobacco products alone but also for alcohol. The name was changed from Malaysian Health Promotion Foundation to Malaysian Health Promotion Board. An Act to provide for the establishment of the Malaysian Health Promotion Board and for matters connected therewith was passed by parliament and gazette in 2006.

The objectives of the Malaysian Health Promotion Board are: - (a) To develop the capacity of organizations, including health related and community based organizations for health promotion; (b) To plan and implement health promotion programmes and activities for the benefit of the community, with a particular focus on youth; (c) To develop and support multi-strategy programmes that promotes and support healthy lifestyles and healthy environments through various settings and sectors. (d) To develop and support programmes to improve population health by preventing, reducing or stopping the use of tobacco products. (e) To fund research relevant to health promotion. (f) To fund and support sporting, recreational and cultural organizations to promote healthy lifestyles and healthy environments.

The Functions of the Board are: (a) To prepare guideline for giving grants, to evaluate grant applications and to disburse grants to any health or health related organizations. (b) To determine the terms and conditions for giving grants or financial assistance from the Fund, including the amounts that may approved in respect of each application. (c) To plan, develop and implement action, plans and programmes for strengthening and developing capacity for health promotion. (d) To asses and determine the types and extent of health promotion activities to be supported by the Board. (e) To liaise, assist and collaborate with other international organizations with similar missions and objectives for mutual support and development and progress of health promotion in the world. (f) To consult with relevant government agencies and departments and non-governmental organizations affected by the operation of this Act.

Priority Areas: The priority areas identified by the Malaysian Health Promotion Board are: (i) Tobacco and alcohol – Health Promotion, Prevention and Control. (ii) Promotion of healthy lifestyles, including promotion of exercise and physical activities and healthy eating. (iii) Environmental health including healthy settings. (iv) Mental health. (v) Cancer prevention. (vi) Diabetes prevention. (vii) Cardiovascular disease prevention. (viii) Injury and accident prevention. (ix) Sexual health (including HIV/AIDS). (x) Research in health promotion. (xi) Promoting health through sport and cultural activities. The paper will also discuss the current situation and how Non Government Organisations (NGOs) in Malaysia could apply for funding from the Malaysian Health Promotion Board.

**Plenary**

***THE SEA ORCHID PROJECT – PROGRESS TO DATE***

*Jacqueline J Ho*

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The SEA Orchid project is a Wellcome Trust funded research project designed to answer the question: Can the health of mothers and babies in Thailand, Indonesia, Philippines and Malaysia be improved by increasing capacity for the synthesis of research, implementation of effective interventions, and identification of gaps in knowledge needing further research in those countries? It has a before and after design starting in 2005 and finishing in 2008. The study took place in 9 centres in 4 SEA countries and was supported by 3 Australian centres. The 2 study sites in Malaysia are Hospital Ipoh and USM. Pre-intervention primary data consisted of an audit of 1000 consecutive births. Secondary data examined research activity, research synthesis activity (Cochrane systematic review authoring), clinical practice guideline development, evidence based practice knowledge and evidence based practice teaching in the undergraduate medical curriculum. An educational intervention took place in 2006 and 2007. The educational intervention in Malaysia consisted of evidence-based practice workshops for health professionals, systematic review workshops, a workshop on evidence-based medicine in medical curricula, and workshops for medical librarians. Two Train-the-Trainers workshops were also held. Four Consultants and a Nurse were selected as Clinical Educators of whom three received training in Australia. In addition several others attended one or two-month long fellowships in Australian project centres. These included a labour room nurse, a neonatal nurse, a librarian, a paediatrician, a neonatologist and an obstetrician. Three Australian based educators carried out teaching tours to the project sites. The primary and secondary baseline data for the 9 hospitals will be presented as well as the Malaysian intervention. Pre-intervention and outcome data for the research synthesis activity will be presented. Final outcome data will be available in the second half of 2008.