E-BULLETIN
MEDICO LEGAL SECTION

1st edition: October 2018
First and foremost, I would like to congratulate Medico Legal Section, Medical Practice Division on the success of publishing their first e-bulletin. I appreciate the time and effort spend to put out such a comprehensive e-bulletin.

In general, Medico Legal Section was established in year 2004 under Medical Practice Division. The Section is responsible in coordinating and managing medico legal complaints against Ministry of Health (MOH) healthcare facilities and staffs. With the publication of this bulletin, it is hoped that MOH staff will be more aware of the healthcare situation in MOH facilities and eventually improve the treatment and services provided. Nevertheless, we are also able to gain knowledge through the interesting case studies shared in this e-bulletin.

As healthcare providers, we are committed to provide the best service to the public. Let’s take a positive attitude towards all medico legal complaints in order to improve our healthcare services. I sincerely hope this e-bulletin will be beneficial to all MOH staff and I would also like to wish Medico Legal Section a continued success.

YBhg. Dato' Dr. Haji Azman Bin Abu Bakar
Message from the Deputy Director of Medico Legal Section

A significant number of Ministry of Health staff are unaware of the function of Medico Legal Section. With the publication of this e-bulletin, I hope that this Section will not only be recognized for managing medico legal complaints but also plays an important role in engaging with our stakeholders by conducting various courses and seminars pertaining to medical law and ethics.

I would like to express my gratitude and appreciation to those involved directly and indirectly in producing this e-bulletin.

Dr. Ahmad Fareed bin A Rahman

Message from the Director of Medical Practice Division

I would like to take this opportunity to congratulate the Medico Legal Section in publishing its inaugural e-bulletin for the benefit of the Medical Practice Division and Ministry of Health (MOH).

The current trend in medico legal complaints in MOH facilities are steadily rising with time and need to be curbed immediately.

The aim of this e-bulletin is to create awareness among MOH staff regarding the increase of medico legal cases in MOH and to keep them abreast with current medico legal issues. It will also keep them informed about programmes organized and conducted by the Medico Legal Section to reduce the number of medicolegal cases.

Lastly, I wish the editorial team all the best and hope that continuous commitment and effort is shown to sustain the publication of this e-bulletin.

Dr. Ahmad Razid bin Salleh
Introduction of Medico Legal Section

The Medico Legal Section was established back in 2004 under the purview of the Medical Practice Division, Ministry of Health (MOH) as part of an initiative to tackle medical malpractice complaints and claims. Its main functions are to coordinate investigations with medico legal grievances and also overseeing medical negligence lawsuits filed against MOH and its facilities.

The Ministry, facing a steep increase in litigation cases with high pay outs, formulated a no liability compensation scheme better known as ex gratia in 2006. Its aim was to curb the number of litigation cases against MOH, thus reducing the high pay outs and it has been successful in doing so ever since.

The Medico Legal Section also conducts periodical trainings and courses for MOH healthcare providers at various levels of service. Apart from raising awareness and avoiding potential malpractice, it also ensures that MOH has capable experts to conduct medico legal inquiries and appear in court if necessary.

Analyzing data and trends of medico legal cases in MOH facilities is another key function of this Section. The information gathered is studied and appropriate actions are taken to prevent similar incidents with the hope of improving standards of service within MOH.
Expert witness

An expert witness may be sought by the parties in legal proceedings, or a disciplinary inquiry of the Malaysia Medical Council (MMC) or other organizations hereinafter termed as ‘adjudicating bodies”, unless otherwise stated.

Who is an expert witness?
1. A registered medical practitioner is qualified to testify as an expert if he has special knowledge, skill, experience, training or education sufficient to qualify him as an expert on the subject to which his testimony relates. Such special knowledge, skill, experience, training or education must be shown before the witness may testify as an expert.
2. An expert witness’s special knowledge, skill, experience, training or education may be shown by any admissible evidence, including his own testimony.
3. An expert witness may be appointed by any party in legal proceedings or a disciplinary inquiry.

Qualifications of an expert witness
Prior to admitting an expert witness and / or an expert report to an adjudicating body, the adjudicating body shall have to be satisfied that:

a) he has the appropriate expertise and experience;
b) he is familiar with the duties of an expert;
c) there is no actual or potential conflict of interest; and
d) he has been fully and properly instructed by the party requesting his evidence.

Responsibilities of an expert witness
The duty of the expert witness is to assist the adjudicating body on matters that are within his expertise and he must maintain neutrality at all times. This duty is paramount and overrides any obligation of the expert to the party who has instructed him or by whom he is compensated.

The expert’s opinion should be independent, providing objective and unbiased opinions on matters within his expertise. A useful test of independence is that the expert would provide the same opinions if instructed by an opposing party. If an expert changes his opinion at any time, such changes should be communicated immediately to the adjudicating body and the other parties in the proceeding.

Conflict of interest
RMP involved in the management of the same patient, as the RMP in the legal proceedings or disciplinary inquiry, shall not appear as an expert witness in such legal proceedings or disciplinary inquiry.

If there is any matter that gives rise to a potential conflict of interest, such as any prior involvement with one of the parties, or a personal interest, this shall be disclosed to the instructing party, the opposing parties and the adjudicating body without any delay.

An expert is not disqualified from giving evidence by reason only of a pre-existing relationship with the party that proffers the expert as a witness, but the nature of the pre-existing relationship shall be disclosed. The expert should make it clear whether and to what extent, the opinion is based on the personal knowledge of the expert (the factual basis for which might be required to be established by admissible evidence of the expert or another witness).

Reference:
MMC guideline on expert witness
ACTIVITIES

Expert Witness Training Course

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31 July — 2 August 2017

An Expert Witness Training was organized from 31st July 2017 until 2nd August 2017 at Hotel Avillion Admiral Cove, Port Dickson. There were a total of 56 participants which consisted of MOH Consultants and Specialists from various speciality and representatives from Medico Legal Section. The objective of the training is to coach the Specialists on how to be an Expert Witness which includes report writing and the legal proceedings involved.

The speakers were invited from Attorney’s General Chamber (AGC), MOH Legal Advisor Office, lawyers from private firm and also Specialists who are actively involved as an Expert Witness. The course successfully created awareness on the importance of the Expert Witness role in medical litigation cases.

Among the interesting lectures delivered during the training were Principle of Medical Negligence, Injecting Law into Medical Practice, An Expert’s Perspective, ABC of Reducing Medical Litigation, Role of Medical Expert and others. A Mock Trial Session was also conducted at Port Dickson’s Magistrate Court by the lawyers from AGC. It was definitely a great eye opener to all the participants regarding their roles in court as an Expert Witness.

Dr. Tan Chiou Sheue
MEDICO LEGAL SEMINAR IN COLLABORATION WITH STATE HEALTH DEPARTMENT 2017

In 2017, Medico Legal Section, Medical Practice Division had successfully collaborated with its Medico Legal Unit counterpart at the State Health Department to organise Medico Legal Seminar. There were a total of 3 State Health Department involved at different location which included Pulau Pinang, Kedah and Terengganu.

The objectives of the seminar were to give exposure and develop awareness among the healthcare providers from healthcare facilities under Ministry of Health with issues related to medico legal and the management of potential medico legal complaints involving healthcare providers and services. The participants included Specialist, Medical Officers, Nurses and Assistant Medical Officers from various discipline.

Dr. Hasnur

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Workshop on Updating Guidelines on Management of Medico Legal Cases has been held on 26 to 28 of September 2017 at Avillion Hotel, Melaka. The purpose of this workshop is to review the guideline which was first published in 2007.

The participants for this workshop were the healthcare providers from the hospitals and State Health Department who are experienced and actively involved in managing medico legal cases at various levels. The workshop was led by the officers from Medico Legal Section, MOH.

The guideline aims to ensure efficient management of the medico legal cases by improving the work process and the format of inquiry report. The challenges and impacts of the medico legal cases towards the MOH were also discussed during the workshop. It was a fruitful workshop in order to update the guideline with the co-operation from the participants.

Dr. Syahiran
Case report
Mr. S was diagnosed with Pulmonary Tuberculosis after having symptoms of cough and weight loss for the past 3 weeks. He was started on Akurit-4 (Ethambutol, Rifampicin, Isoniazid, Pyrazinamide) daily for 2 months. Initial eye examination prior to commencement of the drugs revealed visual acuity of 6/7.5 over the right eye and 6/9 over the left eye. After two months of DOTS, (direct observation therapy, Short course) patient was reviewed and his sputum was still positive for Acid Fast Bacilli (AFB). A decision to continue intensive phase was decided. On the 4\textsuperscript{th} month follow-up, the medical officer continued the current treatment (daily Akurit-4) with an appointment to see the respiratory physician in 2 weeks. According to Mr.S, he complained of blurring of vision and was told by the doctor to get prescription glasses. There was no documentation in the medical records. Two weeks later Mr.S presented himself with a referral from a Private Ophthalmologist for blurring of vision. Examination at the time shows visual acuity right eye 6/60 and left eye 2/60. A diagnosis of toxic optic neuropathy secondary to anti-TB medication likely ethambutol was made.

Expert Opinion
The panel is of the opinion that the side effect (optic neuropathy) would have been prevented if the complication was detected earlier and anti-TB modified accordingly. There were many opportunities to enquire about complications as patient was given medication via DOTS at the healthcare facility.

Learning points
1. When communicating to patients, it is important to emphasise possible medication side effects and to advice them to come immediately once they occur.
2. To adhere to the Tuberculosis Clinical Practice Guideline which states that at each clinic visit, patients taking ethambutol should be questioned regarding possible visual disturbances
3. The medical records were inconsistent with the doctor and patients account. Clinical records must be objective, clear and legible.
4. Early involvement of Respiratory Physician is important for persistent smear positive tuberculosis.

Dr. Mohamed Faruqi Uzair bin Mohamed Sidek
CASE VIGNETTE

Case report

Madam A is a known case of diabetic on insulin therapy. She was found less responsive at home by her husband hence ambulance was called. An ambulance was dispatched to the scene and a medical assistant had attended the case. The initial assessment noted hypoglycemia with dextrose (DXT) reading of LO. A branula was set over the right dorsum and 50cc of Dextrose 50% was given over the branula. She had then regained her consciousness. She was brought to Emergency Department and triaged to Yellow Zone. She was started on intravenous normal saline drip at a rate of 250cc/hour. Two hours later, her DXT reading was found to be 1.7 mmol/L. However, she was asymptomatic and able to tolerate orally. Another 30cc of Dextrose 50% was given to her and she was started on IV drip maintenance of Dextrose 10% through the same branula. She was then sent to observation ward for further management and the hand was noted to be swollen with skin discoloration during the vitals monitoring.

She was referred to orthopedic team and diagnosed as venous congestion of right hand secondary to fluid extravasation. She was admitted to ward for further observations and underwent an emergency fasciotomy on the following day. Intra operatively, noted compartment syndrome due to blood discharge. She was on daily review but unfortunately, the condition worsens which requires right elbow amputation.

Expert opinion

Extensive tissue necrosis of the right hand took place after infusion of dextrose in the hospital setting. The first administration of dextrose was necessary because the patient was unconscious and was hypoglycemic. However, during the second hypoglycemic episode, patient was still alert despite the low DXT level. The patient should have been given oral dextrose instead of intravenous.

Dr. Nor Azizah binti Mohamed Yusuff
**Case Vignette**

**Case report**

Madam X 35 years old, gravida 2 para 1 at term admitted to hospital with symptoms of labour. Four hours into labour, noted she wasn't progressing and her cardiotocograph had shown signs of foetal distress needing her to undergo an emergency lower segment cesarean section. The cesarean section was uneventful. A healthy baby was delivered with good APGAR score. Patient then allowed home with plan for suture removal at a government polyclinic. On day 7 post operation, patient went for the planned removal of sutures on the abdomen. However, during the visit patient was coughing and hacking away so badly that her abdomen burst. She was sent to hospital and had to undergo an emergency laparotomy with diagnosis of burst abdomen secondary to persistent cough and treated for community acquired pneumonia.

Because her coughing problem wasn’t picked up and treated by any personnel, she had contracted her illness to her new born baby. Her baby passed away with cause of death pertussis with the only infective source being the patient. A thorough investigation was done, and she was diagnosed to have pertussis.

During the investigation, it was found that:

a) She had been complaining of cough for 1 week prior to the admission for labour and this was documented in the patient’s antenatal book. However, no action was taken regarding the complaint;

b) During admission to hospital, the primary team failed to obtain a detailed history by interview or looking at the patient’s antenatal book;

c) During the admission in the ward post-delivery, it was documented patient had complaint of cough to a house officer and prescribed with anti-tussive however the plan was not carried out.

**Learning points:**

Pertussis is a rare disease to occur amongst adults. Tuberculosis would have been a more logical differential diagnosis in this patient as she is an adult and it is a more common disease to occur in Malaysia.

The incident could have been avoided at multiple points throughout the patient's encounter with medical personnel.

**Understanding Whooping Cough**

Whooping cough is a contagious disease that affects the lungs. Caused by a bacteria called "Bordetella pertussis", why it is also called "pertussis".

**Symptoms**

At first, whooping cough has the same symptoms as the average cold:
- Mild coughing
- Sneezing
- Runny nose
- Low fever (below 102°F)
- Diarrhea (early on)

After about 7-10 days, the cough turns into “coughing spells” that end with a whooping sound as the person tries to breathe in air.

Because the cough is dry and doesn't produce mucus, these spells can last up to 1 minute. Most people with whooping cough have coughing spells, but not everyone.

Infants may not make the whooping sound or even cough, but they might gasp for air or try to catch their breath during these spells. Some may vomit.

Dr. Mohd Syafiq Ismail bin Azman/
Dr. Tan Chiou Sheue
UPCOMING EVENTS

Medico Legal Technical Meeting 2019
Medico Legal Course for Medical Officer Gred 44/48 in collaboration with Institute of Health Management, MOH.
Medico Legal Seminar (roadshows)
Expert Witness Training 2019
Guideline on Management of Medico Legal Cases Workshop
Cerebral Palsy Guideline Workshop
CME