

BERITA Anestesiologi

Newsletter of the • Malaysian Society of Anaesthesiologists
• College of Anaesthesiologists, Academy of Medicine of Malaysia



Malaysian Society
of Anaesthesiologists



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Message from the President of MSA

It is all too soon and suddenly, here I am writing as the President of Malaysian Society of Anaesthesiologists. I thought it was just a few years ago that I got involved in this 'business' of having to attend the regular Executive Committee (EXCO)

meetings, but now realize that I have been sitting there through five ex-MSA Presidents!

After being a committee member, then Secretary, and then as President-Elect, I can assure you that MSA has evolved and matured; slowly but surely with each President and EXCO team contributing, with their own strength and style. Sure, there are many successfully resolved stories, but there are also stagnant issues and difficult sensitive problems that we have been through. EXCO meetings have ranged from amicable and sombre to loud and hearty, very often late but almost never boring. To all members, rest assured that this voluntary responsibility is taken seriously with your interest in mind.

To Dr Mary Suma Cardosa, our Immediate Past President who has this knack for writing, ability for vast networking and who possesses wide knowledge on social and professional etiquette, I salute you and thank you for taking our Society to great heights. You are now not only the President of the College of Anaesthesiologists, AMM but also President of the Confederation of ASEAN Societies of Anaesthesiologists

(CASA) and President-Elect of the Malaysian Medical Association (MMA)! The anaesthetic fraternity is proud that you have taken our name to a higher platform! The only worrying thing Mary is that I'm no pro like you, so it will not be easy for me to fill your shoes – like this message for one!

Annual General Meeting and Annual Scientific Meeting 2009

Our AGM was successfully held in late March 2009 at One World Hotel, Kuala Lumpur, this year. Earlier that morning we had two very interesting talks arranged and chaired by Dato' Dr Subrahmanyam Balan. Thank you Dato' for making the small scaled meeting a complete one.

At every AGM, there is always a fear that we will not achieve a quorum, hence the elaborate and attractive scientific program to lure members. Of those who attend the talks, many disappear before the AGM. I sincerely hope that this attitude of members will change because we need your participation, opinion and company. No one will be forced into accepting positions they don't want, if that is your main worry. Perhaps it is time for members to come, see and hear what the EXCO has done the past year. We want to feel appreciated as well.

16th ACA & 7th NCIC

Our AGM was downsized to make way for the highly anticipated, double event in Kota Kinabalu, Sabah from the

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The Executive Committee of the Malaysian Society of Anaesthesiologists and the Council of the College of Anaesthesiologists are very pleased to announce that the National Credentialing Committee at its meeting on 15th June 2009 has approved our name change from 'Anaesthesiology' specialty to "Anaesthesiology and Critical Care". As such our specialty in the NSR will be known as "**Anaesthesiology and Critical Care**" and the subspecialty "**Intensive Care**".

Our name change is now confirmed with this final approval. Although the name change does not alter the criteria for its registration, it is hoped that it will reflect the critical care aspect of our work and allay concerns of members who do not qualify to register in the 'Intensive Care' subspecialty and are yet committed to serve patients with such needs.

2nd to 5th July 2009 – THE COMBINED 16th ASEAN CONGRESS OF ANAESTHESIOLOGISTS and 7th NCIC MEETING themed “FORGING AHEAD TOGETHER”. The Organizing and Scientific Committees are in high gear and optimistic as we have already received a total of 1200 registrants and speakers, and the number is growing!

The Opening Ceremony and Quintin Gomez Oration will be on the evening of 2nd July 2009 and the ASEAN Nite on 4th July 2009. Book your pre-congress workshops early, choose and plan your concurrent workshops, scan through the program carefully as there is a wide range of scientific topics listed, with up to five concurrent symposia (not including the concurrent workshops) to choose from and mark the times for your free paper or poster presentation. Many of us will also be tourists there (can you just hear Mt Kinabalu calling?), so there's plenty to do in the Land Below The Wind! Just go to www.aca2009.com.my and be convinced!

Activities for 2009 / 2010

One of our Society's known strengths is the never ending flow of continuing professional development (CPD) activities. Now we will strengthen this even further with the formation of Joint Committees for CPD with the College of Anaesthesiologists, AMM. In the Klang Valley, the regular rotational centers are UKMMC, UMMC, HKL and IJN, and we hope more will join in. Perhaps the private centers and anaesthetists would care to team up as well. Next we have to encourage peripheral hospitals as we have allocated yearly regional funds but these are many a time unused! Please contact your MSA state representatives to make use of this benefit for members. May I also remind organizers to remember to request for CME points for your activities. Everything has to go on record now.

Dr Shireen Sree Jayan continues to be the editor of our quarterly newsletter '**Berita Anestesiologi**', in spite of her being in Singapore doing her specialty training. This time she will be assisted by Dr Julina Santhi Johami. Dr Shahridan Mohd Fathil now oversees our **website** (www.msa.net.my) and Dr Azmil Farid Zabir is assisting him. Thank you all for your willingness, it is much appreciated! I remember those days when it was extremely difficult to get volunteers. So, members please feel free to write in or contribute your ideas and articles. These two avenues, plus our MSA mailing list will keep us all in touch. There will also be new changes in place so keep an eye on them!

Our **membership** database (618 members as of March 2009) is now presentable after being scrutinized and updated professionally by Dr Mary Cardosa, but as she said, the data will be outdated in time. If you find that you do not get our messages and notices, get into the members section of www.msa.net.my and update your email address.

As you know, the subscription to the UM's **virtual library** could not be renewed to the disappointment of many. No other local university has this facility for societies like us currently. We are still searching for a replacement, so if you do know of a suitable source with reasonable fees, please get in touch with us.

Our yearly 16th October **National Anaesthesia Day** multi-centre celebration will again be open to takers this year. It is an effort to publicize our specialty, spread the goodwill and promote friendship amongst anaesthesiologists and friends. Hospital Sultanah Aminah JB has notified us that they have a big surprise up their sleeves. Would any other hospital care to participate? Please inform us of your plans as there is a subsidy offered.

Our **K Inbasegaran Research Fund** is still available for members with research interests but short of funds. The requirements are on our website. Kindly spread the word around as it can be very useful for some.

Although the Academy Council has agreed to it, we are still waiting for an official reply from the National Credentialing Committee (NCC) with regard to the application of **name change of our Specialty** to 'Anaesthesiology and Critical Care' and subspecialty 'Intensive Care'. We will keep you informed, but in the meantime, members who are specialists are urged to register at the NSR under 'Anaesthesiology'. You can also opt for recognition in the subspecialty 'Intensive Care' according to its criteria or the grandfather's clause (up till 23rd August 2009 only!).

AGM / ASM 2010

We have just had one EXCO meeting so far but we are already planning our AGM / ASM 2010. This time it will be held outside of Kuala Lumpur, specifically in Johor Bahru. The Organising Committee will be headed by Dato' Dr Subrahmanyam Balan and the Scientific Committee will be co-chaired by Prof Marzida Mansor and Prof Lim Thiam Aun. With these important people in place, preparations will be underway.

Our anaesthetic fraternity has grown so big that we hardly know one another. It's about time the seniors, juniors and the in-betweens get together. Our specialty is the bond that keeps us close but we can do even better if we socialize and make efforts to know each other better.

So, for a start, let us all meet, strengthen and renew relationships in Kota Kinabalu, Sabah, next month at the 16th ACA & 7th NCIC!

See you all there!

Assoc Prof Datin Norsidah Abdul Manap

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Message from the President, College of Anaesthesiologists

Since I have just taken over this position, I would like to thank members for having the confidence and trust to allow me to head the College, and I would like to thank Dr Namazie Ibrahim, the outgoing President of the College for his dedicated service and leadership over the past two years.



The Role of the College

What is the role of the College? Does the college have a unique role or are we just a duplicate of the MSA? This may not have been very clear in the past, and certainly needs clarification. I believe that the College can, and should, have different roles from the MSA and both bodies are necessary and should complement each other.

During my term as President, I hope to be able to clarify the role of the College - and to look at other areas that the College can get involved in. Looking at the Annual report of the College, the activities can be divided into 3 main areas:

1. Managing the National Specialist Register for the discipline of Anaesthesiology
2. Conducting CPD activities, mostly through our Special Interest Groups (SIGs) and together with the MSA
3. Drawing up Practice Guidelines for our specialty

In this issue of the Berita, I will only touch on the first role (in the NSR). The other two roles will be elaborated upon in subsequent issues. I welcome ideas and input on what other role the College can and should do apart from the above, or how we can be more effective in what we are already doing.

National Specialist Register (NSR)

Many Specialty Colleges in other parts of the world are the bodies that set the criteria and standards for specialty training and conduct the necessary examinations for the conferment of specialty certification. However, in Malaysia, this is the domain of the Universities, who award the Masters Degrees for the various specialties. The Specialty Colleges in the Academy of Medicine Malaysia are involved in the registration of specialists, by drawing up the necessary criteria for registration as a specialist, and nominating members from the universities and private sector to the specialty subcommittees. These specialty subcommittees are responsible for reviewing and approving applications for specialist registration, and make recommendations to the National Credentialing Committee (NCC) that the applicants be credentialed as specialists. The NCC is headed by the Director General of Health, and has representatives from the Ministry of Health and the Academy of Medicine.

Extracts from www.nsr.org.my

Purpose of the NSR

The National Specialist Register will ensure that doctors designated as specialists are appropriately trained and fully competent to practise the expected higher level of care in the chosen specialty. With the National Specialist Register in place, doctors will be able to identify fellow specialists in the relevant specialties to whom they can refer either for a second opinion or for further management. Importantly, the National Specialist Register protects the public and will help them to identify the relevant specialist doctors to whom they may wish to be referred or may wish to consult. The National Specialist Register is in fact an exercise in self-regulation by the medical profession, striving to maintain and safeguard the high standards of specialist practice in the country, having the interest and safety of the public at heart.....

The Process

....The specialist register is time-based and renewable every 5 years upon proof of continuing professional development and continuing medical education activities by individual specialists.

Intensive Care as a Subspecialty

Members have recently received an email from Dr CC Tan, Chairperson of the Intensive Care Section, MSA, regarding registration under "Intensive Care" in the NSR, informing us that "the Specialty Subcommittee for Intensive Care has come out with the criteria for credentialing as an intensivist", and that "Members are advised to go through the criteria and apply for registration under 'Intensive Care' if you wish to do so."

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This has resulted in some confusion and disquiet among anaesthesiologists – some are uncertain whether they should register or not (as they practice some intensive care) and some (especially the younger anaesthesiologists) are unhappy because the exemption ("grandfather") clause does not apply to them. The reasons for this is clarified in the letter from Dr C C Tan (in this issue of Berita)

Below are some of the questions received from one of our members. As these questions will probably be in the minds of many others, I am reproducing them here, with the answers, from Prof T A Lim, Chairman of the Anaesthesiology Specialty Subcommittee, and myself.

Q Since I still practise intensive care, I presume that I have to register.

A This is not the case. An anaesthesiologist need not register provided he / she practices Intensive care within the limits specified in the Anaesthesiology Credentialing document. (See below for more elaboration on this point).

Q Do I have to fill the whole form again?

A No, if you have marked Intensive Care on your original form AND have provided all the necessary information on that form.

Q Should I get (my referrees) to write the referral letters or do I just submit their names?

A You need only to submit their names.

Q I was under the impression that all anaesthesiologists will be registered under 'Anaesthesiology and Intensive Care'."

A The College is preparing a working paper to be submitted to the National Credentialing Committee for the name of our Specialty to be changed to "Anaesthesiology and Critical Care" (not Intensive care). This has been agreed to by the Academy of Medicine Council, but has still not gone to the NCC yet. We hope that they will agree, but it is still not done because the NCC has not met for a while.

To elaborate further on whether an anaesthesiologist practicing intensive care needs to register as an intensivist:

The idea of changing the name of the Specialty of "Anaesthesiology" to "Anaesthesiology and Critical Care" was so that everyone can continue practising Intensive Care without patients or administrators questioning them whether they are qualified or not. However, the name change is just that - a name change - it does not change what an "anaesthesiologist" is qualified to do, and this includes practising intensive care.

If you read the documents, it is clear that it is not necessary for an anaesthesiologist to register as an intensivist as the list of competencies (see below) allows you to continue managing patients in ICU when you are registered as an anaesthesiologist. Note that the document specifically states that you need not register in a subspecialty if you practice "within the limits" specified.

Quoting from the NSR document on credentialing:

"5. Core clinical competency of a Specialist in Anaesthesiology

A specialist holding the credentials of an anaesthesiologist is considered to be competent in all the three areas listed below, i.e. Anaesthesia, Intensive Care and Pain Management.

An anaesthesiologist need not be registered in a (sub)specialty if he/she practises within the limits specified below.

"B. Intensive Care

- Selection and triage of patients appropriate for intensive care
- Provision of appropriate care for the critically ill patients in the

Intensive Care Unit

- Management of the post-operative patient on the mechanical ventilator
- Management of the post-operative patient who requires intensive monitoring
- Management of the patient with multiple injuries from trauma
- Management of the patient with multi-organ failure
- Management of the medical patient who requires adult life support
- Management of the brain dead patient for organ donation
- Transportation of the critically ill patient "

(There are another two sections - A. Anaesthesia and C. Pain management but these have been left out in the interest of space).

I think it is important for each and every one of us to be familiar with the document on credentialing (available from the NSR website) and have it handy with us in the (unlikely) event that we are questioned by anyone -- hospital administrator, patient / patient's relative, insurance company / third party payor etc. -- about whether we are "qualified" to do intensive care, or for that matter, administer anaesthesia and do all the procedures that we are trained to do.

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According to Prof TA Lim, "the document outlining the competencies of an anaesthesiologist was deliberately written very broadly so that anaesthesiologists will not be excluded from performing any ICU procedure. That means an anaesthesiologist can claim to be competent in any ICU procedure, and can do the procedure provided he / she can justify his / her competency to the hospital privileging committee.

"The Anaesthesiology document was drawn up in that fashion in order to allow JUNIOR government anaesthesiologists unhindered access to ICU management without the need for additional training after the local Masters programme. This is to ensure the current level of service in the government hospitals until such time Intensivists can take over the primary role."

I apologise for the lengthy discussion on the NSR, but I hope that this clarifies some of the confusion especially regarding the practice of Intensive care by anaesthesiologists.

I also hope that those who have still not registered with the NSR will do so as soon as possible. Even though it is not yet a requirement by law (the Medical Act 1971 needs to be amended first), it is good for us to register and be listed in the register of specialists under the NSR.

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News from the World Federation of Societies of Anaesthesiologists

In this edition of News from the WFSA, the focus will be on the work of the Safety and Quality of Practice Committee, chaired by Prof Alan Merry of New Zealand.

The goal of the WFSA is to improve the standard of anaesthesia world-wide. The Safety and Quality of Practice Committee is contributing to this through several projects.

WFSA Web Site (www.anaesthesiologists.org) This has been an important part of improving communication with member societies. Safety and Quality of Practice Committee member, Dr Nian Chih Hwang, contributes an Alerts Section which he updates regularly.

Standards: The International Standards for Safe Anaesthesia developed by an independent task force, endorsed by the WFSA at The Hague, and published in 1993, have been revised as part of a WHO Global Challenge, Safe Surgery Saves Lives. Many people assisted with this task, notably Iain Wilson, Meena Cherian, Olaitan Soyannwo, Jeff Cooper and John Eichhorn (who was part of the original task force). The revised standards were endorsed by the General Assembly of the WFSA in Cape Town in March 2008. They can be viewed on the Website.

The Executive of WFSA has also endorsed a standard promoting the interoperability of anaesthesia equipment, and this too can be seen on the website.

Global Oximetry Project: This was a collaborative project between WFSA, AAGBI and GE Healthcare, to provide low cost pulse oximeters in a package that included education, collection of data and agreements with local anaesthesia providers and healthcare administrators to achieve long-term sustainable change in practice. The GO Committee was initiated from the Safety and Quality of Practice Committee, with Dr Gavin Thoms as our representative and overall Chair. Sub-projects were undertaken in Uganda, the Philippines, Vietnam and India. The aim was for each sub-project to be self-funding. GE Healthcare donated a total of 58 oximeters, 125 sensors and training materials. They also provided considerable logistical support (hosting teleconferences, delivering the oximeters, providing maintenance etc). GE proved to be a great partner in this effort and we are grateful for their support for this important effort. We are particularly grateful for the ongoing commitment of Mark Philips and Colin Hughes.

The participating anaesthesia professionals have completed logbooks and data was presented at the World Congress in Cape Town. A final report is in preparation, to be followed by peer reviewed publications.

For a variety of reasons, the tripartite structure was wound up in Cape Town and the GO project returned to the

oversight of the WFSA Safety and Quality of Practice Committee. It remains the Committee's single most important activity.

WHO, Safe Surgery and Pulse Oximetry: Alan Merry and Iain Wilson have also been involved in the World Health Organisation Safe Surgery Saves Lives project (not as representatives of WFSA) and have been very gratified to see the development of a universally applicable checklist with considerable relevance to the promotion of teamwork in the operating room and support for the importance of anaesthesia in safe surgery. This check-list is receiving some high-profile attention around the world.

The WHO has now developed a follow-on initiative to advance the idea of Global Oximetry. This builds on the work of the WFSA GO project and involves Alan and Iain and also several members of the WFSA Executive committee including Angela Enright, Florian Nuevo, Gonzalo Barreiro and Rob McDougall. Working with other members of the WHO team, specifications for the ideal oximeter have been developed and an educational package is being put together. Applications to be a pilot site in this effort are available on the WHO website and have been circulated to WFSA member societies. This is a very exciting development and should lead to improved peri-operative patient safety around the world.

The Virtual Anesthesia Machine (an independent educational project under the direction of Dr Sem Lampotang) is supported by the SQPC. A link to this project is in place from the SQPC section of the WFSA website.

Crisis Management Manual: We are very grateful to the Australian Patient Safety Foundation for allowing the SQPC to place a link from the WFSA website to the APSF Crisis Management Manual.

Incident Reporting: Professor Quirino Piacevoli is responsible for a new project to make incident reporting available to countries that do not currently have access to this facility.

Drug Safety: Efforts to promote clearer, more standardised presentation of information on the labels of drug ampoules will be an activity of increased importance for the SQPC over the next four years.

Professor Merry would welcome contact if you have any comments or suggestions or would like to contribute to any of this Committee's activities.

Angela Enright
President

Alan Merry
Chair SQP Committee

In an era of rapid advancement in medical sciences and technology, anaesthesiologists need to advance their scientific knowledge and clinical competence throughout their careers. The internet has affected every aspect of our professional life and web-based education has become a new means of continuing professional development (CPD).

In terms of convenience, anaesthesiologists who have very busy schedules or who are unable to leave their places of practice, can log on and learn at their own pace and place, whenever the need arises. Web based programs cross geographical boundaries and can be accessed by a large number of learners at the same time. Anaesthesiologists can learn with and from their peers across the globe, hear international experts and watch videos of rare but serious clinical conditions. They can repeat aspects to consolidate learning, and even leave for an emergency call and return to the same place in the program. Internet resources for anaesthetists are rising rapidly and the more popular ones include: virtual anaesthesia text book (<http://www.usyd.edu.au/su/anaes/VAT/VAT.html>), a project initiated by Chris Thompson which aims to organize all known web pages into a textbook format using "chapter organiser". Another source of anaesthetic educational material is available from Gasbone (<http://gasbone.herston.uq.edu.au/>) by Allan Palmer. In Keith Ruskin's GASNet (<http://gasnet.med.yale.edu/>), any member can ask the group for opinions on diagnosis, procedures or policies and obtain prompt reply from self-styled experts. The Australian and New Zealand College of Anaesthetists (<http://www.anzca.edu.au>), as well as the Royal College of Anaesthetists UK (<http://www.frca.edu.uk>) both have websites that offer educational materials. The World Anaesthesia Society (worldanaesthesia@mac.com) runs weekly tutorials which may be accessed freely on a variety of topics: general anaesthesia, obstetrics, paediatrics, regional, intensive care and basic science.

From an international perspective, figures from the United States show that in 2006 over a quarter (26%) of continuing medical education (CME) activities across clinical disciplines were web-based, up from 0.01% in 1998.^{1,2} Accessibility, convenience and availability have ensured popularity, but one wonders if web based learning actually work. Other issues often raised by clinicians include: the need of evidence for the effectiveness of web based learning and making smart choices when choosing web based programs. Effective web based learning programs need to

Web based CME

a piece of cake!

consider how adults learn, and how clinicians develop skills in clinical problem solving. Programs also need to actively overcome any barriers to learning.

The Ministry of Health has been planning for on-line CME and CPD programmes for some time. Implementation is at various stages of development and will be a permanent feature for healthcare

personnel in public sector. Recently the Malaysia Medical Association has also launched a member section where doctors can participate in on-line continuous professional development activities.

LIFE-LONG LEARNING

McAvoy and Fraser³ described how the principles of adult learning, articulated by Brookfield⁴ and Knowles,⁵ expound the principles of adult learning which can be adapted for many other medical disciplines. Anaesthesiologists need to maintain a continual state of growth in knowledge and skills. Individual anaesthetists have a unique package of experience and values of their own. Experiences of others can be a source for learning.

Learning at this stage must be self-directed and learning often occurs in real life context.

External input to their learning experiences often promote interest and enforces learning behaviour. Once the individual sees learning as relevant to their future, a life long habit will be developed. Taking into consideration each individual's set patterns of learning and the presence of competing interests from activities of everyday life; one can wisely make a choice of the most suitable program available. Web-based programs fulfill many of these principles, for example, interactive programs use past experience as a source for learning.

Clinical problem solving is more than a generic skill, experienced clinicians use models or schemas developed from clinical cases very often in a problem-based learning format. Expert clinicians have accumulated a large bank of illness scripts or so called 'encapsulated' knowledge where junior clinician can benefit from using them.⁶ Clinical knowledge must be accessible when solving patients' problems and is best learnt in context⁷ such as through on-line case-based learning. Fitts⁸ identified three stages of developing skills: cognitive, practice fixation and autonomous. In the initial cognitive stage a model is developed of the sequence and processes of the skill. In the practice fixation stage the detail of the skill is added and practiced and becomes fixed in the person's mind. In the final autonomous phase, using the skill becomes an unconscious action. This frees up brain capacity to absorb

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new information. The initial cognitive phase of clinical skills can be learned online and in the near future will be practiced online with virtual simulators. Our emotional, physical, psychological and social situations often affect our ability to learn. Doctors who are angry, anxious or guilty about a mistake they have made may not be able to learn. Education programs that facilitate reflection on critical incidents and provide debriefing experiences are more likely to promote learning⁹ and this can be built into web-based programs.

WEB-BASED CPD PROGRAMS VIA MSA WEB SITE

With a website available, MSA can embark on simple CME programme. In such programmes, basic learning needs should be targeted after careful analysis with participation of practicing anaesthesiologists and when appropriate, patients and carers, are involved in the program design and development. Clear goals and program objectives need to be specified. The use of multimedia, hyperlinks and web-based communication tools should be planned ahead to enhance learning. Anaesthesiologists in teaching institutions, together with educators and information technology specialists should collaborate during the program development stage.

Active learning is encouraged through, self-directed learning with material based on actual clinical practice cases and problems. Provide ample participant interaction and feedback to participants from facilitators and encourage participant self assessment and participant reflection. High order thinking is promoted through learning tasks requiring, critical analysis, application of knowledge and skills done in a problem-solving format.

On-line communication is monitored and facilitated by anaesthesiologists experienced in teaching or clinical educators. Information technology help is available by easily reached resources. Content is regularly checked and updated to ensure validity.

VALUE OF CPD

Improved patient outcome is one of the aims of CPD programs but this is difficult to attribute to one intervention. Patient outcomes are dependent on the patient, their situation, the practitioner and their context and health system. Practitioners can be randomised to different educational interventions but this cannot be double blind. Because measuring change in patient outcomes is hard, CPD programs are often assessed by proxy measures such as their impact on clinician satisfaction, clinician knowledge or skills or clinician performance. Despite this there are systematic reviews of what is effective in professional development. This evidence directly links to what is known about the development of clinical skills and knowledge and adults as learners.

Davis et al¹⁰ reviewed 99 randomised controlled trials of CME strategies that objectively assessed doctors' performance and/or health care outcomes. Effective change strategies included reminders, patient mediated interventions, outreach visits, opinion leaders and multifaceted activities. Audit with feedback and educational materials were less effective and formal CME conferences or activities, without enabling or practice reinforcing strategies, had relatively little impact. Further work showed some evidence that interactive CME sessions, which enhance participant activity and provide the opportunity to practise skills, can effect change in professional practice and, on occasion, health care outcomes. Based on a small number of well conducted trials, didactic sessions did not appear to be effective in changing physician performance.¹¹ Cantillon and Jones¹² looked at whether CME made a difference in general practice. Their findings echoed the two Davis studies and recommended that CME should be based on the work that GPs do. Significant event audits, peer review, group based learning and reminders by computer have all been shown to be effective educational strategies for general practice. Needs assessment is an important component of CME, but relying entirely on individual doctor's self assessment of their learning needs may be problematic. Mansouri and Lockyer¹³ assessed the impact of the moderator on the effectiveness of CME. They concluded that there is a larger effect size when interventions are interactive, use multiple methods over time and are designed for a small group of physicians from a single discipline.

ONLINE-LEARNING, THE WAY TO GO

Web based CPD can be effective. An instructional format of multimedia enhanced learning tutorials supplemented by asynchronous computer mediated conferencing for case based discussions was effective in enhancing knowledge, confidence and Self- reported practice change outcomes by physicians across a range of clinical subject matter areas.¹⁴ Two reviews concluded that web based CME was effective but not superior to traditional methods in terms of gain in learning or satisfaction.^{15,16} The key to the effectiveness of education is its design not the medium of its delivery. Web based CPD should facilitate self directed learning.¹⁷ The first stage is to provide opportunities to identify learning needs through self assessment and then through reflection on clinical performance identify critical or salient events that might affect learning. Next, the program should provide clinicians with opportunities to explore and understand the personal theories underpinning their own practice.¹⁸ Quality programs should then enable the acquisition of new knowledge and skills in a clinical context.^{19,20} The materials should combine evidence and expertise and assist health care delivery systems to develop.²¹ Group learning serves as a source of interaction and helps to shape the image of change and the practice of medicine. This can be built into web based learning by allowing individual participants to share their contributions with other participants asynchronously. Assessment of learning and feedback should be incorporated.

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CONCLUSION

Effective web based CPD for anaesthesiologists should follow the principles governing adult learners and target on the development of scientific knowledge and clinical skills. Learning should be case-based and interactive, not passive; didactic teaching sessions alone are ineffective. Merely placing didactic materials online is unlikely to improve patient outcomes. By offering programs on-line which promote active learning, critical thinking, self reflection and help practitioners achieving professional development and in implementing changes in their clinical practice, the anaesthesia society and College can enhance CME and CPD with greater acceptance from members of the profession.

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Letter to the Editor

With reference to Dr Mary Cardosa's message (MSA president, March 2009), I would like to inform our colleagues that so far, we have had no problems with the 50% fee for the anaesthetic charges for the second operation.

But I would also like to give you my viewpoint on this – I feel that it is only right that we charge an additional anaesthetic fee for the second operation, as obviously, the anaesthesia is not the same if a second operation is done. It is not merely remuneration for the increased time spent with the patient – we have delivered more drugs – anaesthetic agent, relaxants, opioids – gotten more stressed, and gotten more tired. So we would have delivered MORE anaesthesia than if surgery had stopped. I think the people who ruled that (there should only be one charge as the anaesthetic is the same) think that anaesthesia is "one jab and we're done" and fail to realize that administration of anaesthesia is a CONTINUOUS process, i.e. it is being administered every second of every minute. Furthermore, new problems arise with prolonged anaesthesia.

To put it in another way – same induction (possibly different too, as may be influenced by duration of surgery), different maintenance, different reversal (complicated by longer maintenance) so not the same anaesthetic!!

Another point – the Private Healthcare Facilities and Services Act is very specific in terms of anaesthesia for procedures. For example, if a repair of artery is done with a fixation of fracture, the anaesthesia would have been given for "fixation of fracture and repair of artery" and not just "fixation of fracture". So this would be a wrong code in terms of the Act. But unless the Act can specify every possible permutation and combination of procedures done, the best compromise would be as the MMA schedule proposes, i.e. 50% charge for the anaesthesia for the second surgery.

"Sleeprajah"

The Combined ASA / NZSA Annual Scientific Meeting

Wellington • 10th – 14th October 2008

by Dr Mary Cardosa

I attended the above conference as a guest of the Australian Society of Anaesthetists (ASA) when I was still the President of MSA. It started with the welcome reception hosted by the Mayor of Wellington, Kerry Prendergast. In typical Aussie / Kiwi style, the occasion was very informal, with lots of wine and bits of nibbles, and was held in the office of the Mayor in the Town Hall, a beautiful old building which is not earthquake-proof and was therefore almost demolished a few years ago, but was subsequently restored by one of the Mayors. I was pleased to see quite a number of familiar faces, people who had been registrars at the same time as me, as well as people like John Russell who had been a Part 1 course tutor in the days when I was doing my Masters, Dick Willis who visited Malaysia during his term as President of the ANZCA a few years ago and Leona Wilson, current President of the ANZCA, who had visited us in Malaysia recently.

Wellington is notorious for its windy weather, and it had lived up to its reputation - the trade exhibition had to be relocated at the last minute because the marquee that had been erected in the car park of the convention center had been blown away by "a puff of wind".... So the trade exhibition was in several different locations, with booths along corridors as well - but overall, it seemed to work out quite well.

Apart from the usual plenary lectures and symposia, the ASA has a lot of workshops and Problem based learning sessions. These cover a variety of topics from Ultrasound guided nerve blocks to what to do with the impaired anaesthetist, to magic! (Unfortunately all the sessions were filled, and it was

not possible to attend any without pre-booking). These are small group interactive sessions on specific topics and last for 45-60 minutes, with a small fee for attending each session (about NZ\$20 in this conference). However, I believe that the sessions give the opportunity to interact directly with experts (instead of just listening to a lecture) and are probably worthwhile. We will be running similar sessions at the forthcoming 16th ACA / 7th NCIC in Kota Kinabalu in July – the challenge will be getting people to pay extra for these sessions! They are hard work, and the people running them will not be able to attend the concurrent symposia, but I hope that the response will be good and participants will find them useful.

I was privileged to be invited to attend the meeting of the Overseas Development and Education Committee (ODEC), chaired by Rob MacDougal from Perth. This committee consists of a group of dedicated individuals who have all spent time working in developing countries, mainly in the Pacific (Fiji and other Pacific Islands), East Timor, Indonesia, Mongolia, Vietnam and Cambodia. The ASA also has an annual visitor from the Pacific Islands, and this year I was lucky enough to meet Pua from Tuvalu, which is the smallest country in the Pacific, with a population of 100,000 people living on several small coral islands. Pua is the sole anaesthetist in her country, and since she finished her training in Fiji more than two years ago, she has been on call 24X7 for 365 days a year; this was the first break she had had since graduating with the diploma in Anaesthesia, a course that was set up at the Fiji School of Medicine in Suva by the Australians, who still send a senior

registrar over to Suva for 3 months every year. Serema from Fiji was also there, and she spoke about their problems with shortage of anaesthetists in the outlying islands, and also problems with training of anaesthetic assistants and with maintenance of equipment (sounds familiar?).

Eric Veerde is a Dutch anaesthetist who has been working in Timor for the past two and a half years, and in that time has been training nurse-anaesthetists - the first Timorese physician anaesthetist is currently being trained in Fiji, and hopefully will complete the full 3 years training. One of our Malaysian anaesthetists, Dr Laila, was over in Timor for a couple of weeks in 2006 to do some teaching for their nurse anaesthetists, and it is possible that more of us can contribute to the Timorese training in this way.

It occurred to me that we in Malaysia are pretty well off compared to many developing countries (it is estimated that 50-60% of people in the developing world do not have access to safe anaesthesia), and that perhaps we should be thinking of how we can participate in some of these programs to help in the education of anaesthetists and anaesthetic assistants in some of our neighbouring countries. However, when I brought this up to the MSA Exco, some pointed out that perhaps we should be looking at our own country first, as there are still many remote areas where trained anaesthetists are not readily available.

The ODEC holds an annual course for Australian anaesthetists interested in working in developing countries, to prepare them for the conditions of working in "less-than-ideal" situations. They learn how to use the EMO machine and how to do simple maintenance of anaesthetic equipment. This year's course was attended by Angela Enright, the President of the WFSA. Another big project run by the ODEC is the PTC - Primary Trauma Course - conducted in countries like Indonesia, Mongolia and Vietnam. They carry out the course together with anaesthesiologists like

Continued on page 11

Eddy Rajardo from Indonesia and they do training of trainers so that the local people then take over and continue the training. ODEC is also involved in a course together with the AARS (Asian Australasian Regional Section) of the WFSA which focuses on teaching methods for anaesthetists. This is something else that we can bring to Malaysia, which would benefit our members especially since the numbers of Masters students in public hospitals are increasing year by year.

The theme of the Conference was "Communication". The opening lecture, the Kester Brown lecture, was delivered by a Medical ethicist from the UK, Daniel Sokol, who gave a very

interesting perspective about "truth-telling" in medicine and how to make a decision about whether to "tell a lie" to a patient or not. He mentioned that most of us tell "lies" all the time, or at least, we may tell the truth but not the "whole truth" e.g. telling the relatives of a patient who has already passed away that his/her relative is "very ill" and they should come immediately to ICU. He gave us a few scenarios where perhaps telling a "lie" was not wrong, e.g. when a person with a ruptured AAA who has little chance of survival asks you (the anaesthetist) before induction "I am going to be alright, aren't I doctor?"

Another interesting session was on decision-making and how we doctors base our decisions mainly on past experience, especially experiences in the recent past, rather than actual objectivity, or evidence. An algorithm for making decisions based on evidence (probability of an event occurring, based on studies done) was presented, and it may be good to try this out when we are facing a situation (non-emergency) where there are a few choices.

Overall, the conference was good not just from the scientific point of view but also from the networking which sometimes is the major benefit that one gets from attending conferences.

E

NSR for Intensive Care

QUESTION

There is an outcry among young anaesthetists that the formulation of the grandfather clause has not taken into consideration their concerns and views. The MSA representatives in the specialty subcommittee for intensive care should not only fight for the seniors but the younger anaesthetists as well. The grandfather clause is now only restricted to anaesthetists who qualified before 1st January 2003! The NSR was officially launched on 24th August 2006 and was given 3 years grace period until 23rd August 2009.

So, if anaesthetists were allowed to be registered as intensivists under the EXEMPTION CLAUSE, then whoever became specialists before the launching of the NSR should be included. The implementation of the grandfather clause should not be backdated to 2003, but enforced on the date of the start of NSR.

REPLY

I write to confirm that the date of 1st January 2003 is the date when the fellowship programme for intensive care training was formally established. Hence those who graduate from the Masters after this date are aware of such programme. That is the rationale behind this date.

We must make it clear to our young anaesthetists that there is no discrimination against them in this respect. The Society stands for everybody, young and old.

I hope this clarifies. I welcome any suggestion or comment.

Dr Tan Cheng Cheng

Chairperson, Intensive Care Section,
Malaysian Society of Anaesthesiologists

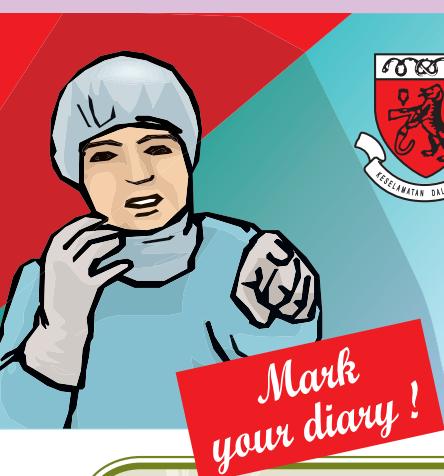
MSA AGM ON 29TH MARCH 2009

By DATO' DR SUBRAHMANYAM BALAN

The MSA AGM was held on 29th March 2009 at the Jasmine Room, One World Hotel, First Avenue, Bandar Utama City Centre, Petaling Jaya. A total of 68 delegates attended the AGM which was preceded by two medical talks from 8.30 am to 10.00 am. Two eminent specialist were on hand to deliver lectures to the enthusiastic morning crowd of anaesthesiologists. Prof Teodoro Herbosa, Visiting Professor from Philippines, was on hand to speak to the audience on Updates in Fluid Resuscitation in Hypovolaemic shock and also provided interesting insights into trauma services.

Dr Lim Teck Onn, Director of Clinical Research Centre, NIH, was next with his talk on the "Research Opportunities in Anaesthesiology and Intensive Care" where he told the audience of the various ways in which anaesthesiologists can jump on the band wagon of research. His plea for more research from anaesthesia was timely.

The talks were followed by a brief refreshment break and this was followed by the AGMs, by Intensive Care Section, Malaysian Society of Anaesthesiologists and lastly, College of Anaesthesiologists, AMM. The meetings were all conducted smoothly judging from the happy disposition of all the delegates present and followed by a sumptuous buffet lunch was at the hotel. The AGM was officially over at 2.00 pm.



Malaysian Society of Anaesthesiologists & College of Anaesthesiologists, AMM

Annual Scientific Meeting 2010

Theme: "*Taking Anaesthesiology to Greater Heights*"

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To the following who passed the M Med Anaesthesiology Examinations in May 2009

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TO
Dr Mary Cardosa on being elected as the President-Elect of the Malaysian Medical Association
&
Dato' Dr Subrahmanyam Balan for his second Dato'ship award