BERITA ANESTESIOLOGI

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

Malaysian Society of Anaesthesiologists

College of Anaesthesiologists Academy of Medicine of Malaysia

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Affiliation towards the World Federation of Societies of Anaesthesiologists

Prof Y K Chan, *President, Malaysian Society of Anaesthesiologists*

In April this year, the Malaysian Society of Anaesthesiologists (MSA) joined approximately 120 other anaesthetic societies from the rest of the world in participating in the activities of the World Congress of Anaesthesiologists (WCA) held in Paris. The World Federation of Societies of Anaesthesiologists (WFSA) to which the MSA is affiliated, organizes the WCA once every 4 years. This year approximately 12000 anaesthesiologists from around the world gathered together in the Congress de Palais, Paris, France to attend yet another world event for our discipline. The next WCA would be held in South Africa in Johannesburg, South Africa in 2008 and the one following that in 2012 in Argentina.

Besides organizing the WCA to allow anaesthesiologists from around the world to meet, the WFSA also helps to organize regional meetings in the various continents and these are termed WFSA-affiliated meetings. Meetings under these arrangements include the AOSRA (Asia – Oceanic Societies of Regional Anaesthesia) and AACA (Asia-Australasian Congress of Anaesthesiologists).

The WFSA also coordinates many special projects to try to raise the level of anaesthetic care especially in the less developed countries. This includes training in anesthesiology in the less endowed countries where mortality is at its highest, and organizing exchange programs in anesthesiology so that there is greater information transfer between the rich and the poor countries in the discipline. In addition, equipment from the rich countries that may still be of some use is shipped to the poorer countries so that the community can benefit to a certain extent from this inheritance.

The WFSA is headed by a President who stays in office for 4 years. The most recently elected President is Anneka Meursing from Holland. The immediate past president is Dr Kester Brown from Australia. Dato' Dr Lim Say Wan from Malaysia was president from 1992 to 1996. The secretary and treasurer also play vital roles in the running of the society and they are assisted by Exco members who hail from the various continents. The WFSA has many committees and two of our own MSA members were actively involved in Statutes and Bylaws Committee (Dato' Dr K Inbasegaran) and Pain Relief Committee (Prof Ramani Vijayan). Some committees are formed ad hoc just for a short term purpose, a good example being the Nominations Committee, which was responsible for vetting and selection of Executive Committee members to the WFSA.

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The General Assembly for representatives of all the societies is held every 4 years. The individual Society is represented by a number of representatives proportionate to the number of declared membership of the Society. The President and his Executive Committee however communicate more frequently, usually by email, but come the WCA, the President and his Exco meet face to face to iron out problems before the General Assembly.

For the WFSA to survive and carry out its functions, it requires funding, which is derived from collecting subscriptions from member societies. Each society pays according to its registered membership. Previously it was USD1.50 for each member but in the recent general meeting, the decision was made to increase the membership fee to USD 2 per head. Besides subscriptions, the WFSA also collects a percentage of the profit made by individual societies who host the WCA or WFSA affiliated congresses.

The WFSA, which is 50 years old this year, is one of the few specialist societies in the world that gathers all the societies of one discipline under its umbrella and attempts to give members a sense of fraternity. When attending one of these functions, one feels a sense of belonging especially during the opening and closing ceremonies as well as during the Harold Griffith Lecture where all participants gather together in one place. Representatives of the various societies cannot but feel awed at the enormity of the gathering during the general assembly. There is a sense of pride in being a part of a global organization which exists to help individual societies make a difference to the quality of practice and delivery of anaesthesia in their own countries. We all need members to participate, be it in their own countries or on a global scale. Dato' Dr Lim Say Wan has shown that it is possible for a Malaysian to be WFSA president! We can start on this road by playing an active role in our society first and work towards playing a useful role in the world body. On this note, I express the hope of seeing you all more often in our society functions and perhaps, in Johannesburg, in 4 years time. E

Malaysian Society of Anaesthesiologists

EXECUTIVE COMMITTEE 2004 – 2005

President	**Prof Chan Yoo Kuen**
President Elect	**Dr Ng Siew Hian**
Immediate Past President & Chairman	**Dato' Dr K Inbasegaran**
Hon Secretary	**Dr Mary Cardosa**
Hon Treasurer	**Dr V Kathiresan**
Committee Members	**Assoc Prof Norsidah Manap**
	Prof Wang Chew Yin
	Datin Dr V Sivasakthi
	Dr Joseph Manavalan
	Dr Thoriroh Abdul Razak
	Dr Ng Kwee Peng (co-opted)

College of Anaesthesiologists, Academy of Medicine of Malaysia

COUNCIL 2004 – 2005

President	**Prof Ramani Vijayan**
Hon Secretary	**Assoc Prof Lim Thiam Aun**
Hon Treasurer	**Dr Nirumal Kumar**
Council Members	**Prof Chan Yoo Kuen**
	Dr Joseph Manavalan
	Dr Mohamed Namazie Ibrahim
	Dr Ng Kwee Peng
	Dr Tan It

Calendar of Events

Future Events

2 JULY 2004

Dinner Talk by Dr Diana Khursandi

(sponsored by MSA)

Topics : Doctors' Health, Breaking Bad News

Renaissance Hotel, Kuala Lumpur

Dr Khursandi is the founder of the Welfare of Anaesthetists Special Interest Group (SIG) of the ANZCA, and has just retired from anaesthesia. She has been invited to give some talks in Malaysia at this time and agreed to be 'shanghai-ed' by the MSA (courtesy of Mary Cardosa) to speak to, and discuss with us, some of these welfare issues. Sounds interesting and definitely relevant to all of us.

26 – 28 AUGUST 2004

5th MOH-AMM Scientific Meeting

(Incorporating the 7th NIH Scientific Meeting)

Theme : Quality and Medical Professionalism

Sunway Lagoon Resort Hotel, Petaling Jaya

Pre-conference workshops giving tips on how to 'Commercialise Your Research' (in other words – make money from your ideas), write scientific papers and tell us a little more about medico-legal issues have been planned. Find out more about issues relating to Patient Safety, Ethics, Clinical Governance, Benchmarking and Standards of Care, Cost Effectiveness Analysis and Economic Assessment, Organ Donation and Transplantation, and much more .....

More information from : acadmed@po.jaring.my

24 – 26 SEPTEMBER 2004

2nd National Conference on Intensive Care

Theme : Challenges in ICU

Hilton Hotel KL, KL Sentral

An impressive Faculty of speakers has been lined up including Felicity Hawker and David Tuxen (Aust.), Jean-Louis Vincent (Belgium), Charles Gomersall (HK) and intensivists from Indonesia and Singapore, besides our own talent. A whole gamut of intensive care related topics covering everything you thought you knew, do know and had better know. How? What? When? Why? Come and find out.....

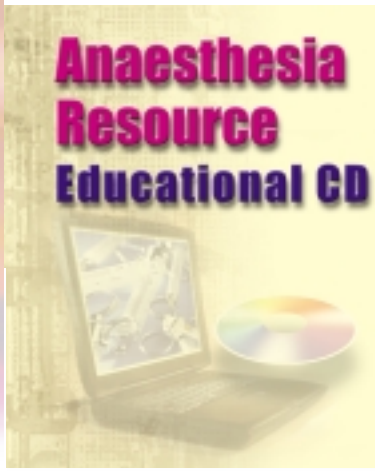
Conference Secretariat
Critical Care Medicine Section
Malaysian Society of Anaesthesiologists
19 Jalan Folly Barat, 50480 Kuala Lumpur
Tel : 603-2093 0100, 2093 0200
Fax : 603-2093 0900
Email : secretary@ncic.org.my

25 – 26 SEPTEMBER 2004

KK Hospital Biennial Obstetric Anaesthesia Scientific Meeting 2004

Kandang Kerbau Hospital, Singapore

Obstetric anaesthetists may be interested.



The Association of Anaesthetists has produced a CD and has kindly agreed to provide this FREE of charge to MSA members. This CD contains a number of valuable resources and the contents are as follows:

- **4 year archive of "Anaesthesia" (official journal of the AAGBI)**
- **Complete archive of "Update in Anaesthesia" (education journal from "World Anaesthesia")**
- **Primary Trauma Care manual**
- **Resuscitation Council guidelines**
- **Anaesthesia at the District Hospital**
- **Clinical use of Blood**
- **WHO world formulary**

If you wish to obtain a copy of the CD, please email cdresource@aagbi.org or write to Carol Gaffney, AAGBI, 21 Portland Place, London W1B 1PY, United Kingdom.

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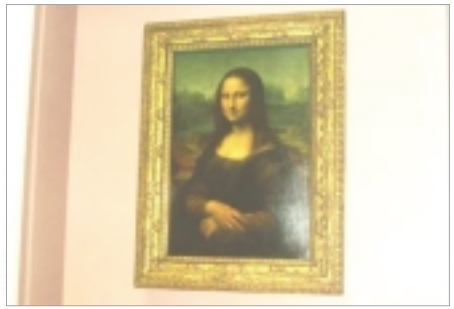
has a proximal socket for attachments of a lightweight LCD screen. Once the ILMA is inserted into the patient's airway the i-pod is attached to its socket to enable one to view the laryngeal inlet thus facilitating intubation of the trachea through the ILMA.

On 22 April I presented my poster entitled `Sedation with TCI propofol for patients undergoing ERCP among 3 major racial groups in Malaysia'. It was great to share my experience with other interested delegates and also to exchange views with other presenters.

In between attending sessions at the conference, I didn't miss the opportunity to see more of Paris. One of the convenient ways of sightseeing was using the hop in - hop off tourist bus. It takes one around Paris and stops at all the attractions. My first stop was Arc de Triumphe, the world's largest traffic roundabout and the meeting point of 12 avenues. It was built in early 1800's to commemorate Napoleon's imperial victories. A 2 km walk from the Arc down Paris's famous street, the ave des Champ-Elysees, will take one past fast food restaurants, overpriced cafes and shops selling designer labeled items. Well, it was purely window-shopping for me.

The most famous landmark in Paris, the Eiffel Tower was magnificent. A lift ride to the top guarantees one an awesome and breathtaking bird's eye view of Paris. I could barely stand on the topmost platform.

Because of the strong wind blowing and the unexpected heavy downpour made the weather bitterly cold. Not too far away from this spectacular monument is River Seine. A cruise down the Seine was most enjoyable and enabled me to appreciate Paris's beauty by nighttime. Hmmm, the beauty and the chill of early spring will definitely cause romance to bloom.



A must for all visitors, the Louvre is home to extra-ordinary collections of art pieces. This is the world's largest and most famous museum, and home to Leonardo da Vinci's Mona Lisa. It actually takes more than one day to cover this 800-year-old fortress, which became a public museum 3 centuries ago.

WCA2004 was indeed a memorable one. E

Critical Care Medicine Section

Message from the Chairperson – Dr Ng Siew Hian

It has been two years since CCMS restarted its activities and resumed its role as the professional body representing the interests of intensive care in this country. As the chairman of the section, I take this opportunity to update you on some of the major issues discussed at the CCMS Executive Committee Meeting.

The 2nd national conference on intensive care has been organized and is now in its final stages of preparation. The success of the first conference convinced us that health care providers in the intensive care setting in this country are keen on regular scientific updates in this rapidly developing discipline. The issue of whether to organise such scientific meetings as part of anaesthesia meetings or as meetings focusing only on intensive care was debated upon. There are pros and cons but the Committee felt that a major consideration in the development of intensive care is its ability to collaborate with clinicians from other disciplines in particularly the pediatricians and this can only be done through a meeting dedicated solely to intensive care.

The Exco is aware of the fact that nursing is an important component in the management of patients in the intensive care units. The development of intensive care nursing must be in tandem with the development of intensive care medicine. In our last meeting, it was decided that an Intensive Care Nursing (ICN) group should be set up within the Section. Some key nursing staff will be identified to lead the group. We feel the time is now right for such a nursing group to be formed, since the number of ICU nurses as well as those with post-basic intensive care nursing qualification has increased significantly over the last ten years. We hope our ICU nurses will soon have their own continuous nursing education programme and in time to come, set up their own professional body or even a registered society.

Another issue discussed was that of the role of CCMS as a professional body. Should the role of CCMS be confined to organising conferences and running CME / CNE programmes? This would be what is expected of CCMS based on the MSA model. My personal view is that CCMS should play a more active role in academic issues such as in the formulation of clinical practice guidelines and consensus statements. Professional statements on intensive care practices developed by local professional bodies provide useful patient care information for clinicians especially those working in the peripheries. These statements set standards of care and are powerful tools which can be used to lobby for funds to effect changes in clinical practice. The Consensus Statement on Infection Control Measures in ICU developed by the CCMS Expert Committee which will be launched during the September conference will prove to be an extremely useful document for health care workers and have a major impact on patient care.

In order for intensive care to leap-frog to a higher level of care, there must exist in this country a critical mass of anaesthetists who are certified in intensive care. Currently, the European Diploma in Intensive Care (EDIC) appears to be the only programme which is within our reach. Besides a two year training in a recognised centre, candidates have to travel to a European country twice for the examinations and this can be a big financial burden to the candidates. To encourage our specialists to attain EDIC certification, the Exco has agreed to provide financial subsidy of RM 3000 to any candidate (must be a member) who passes the final examination. We realise that this is only a short term measure which benefits a small number of members. As for long term solutions, CCMS will explore the possibility of bringing in foreign examiners to conduct examinations in our local ICUs.

Finally, do support our 2nd National Conference which will be held from 24 - 26 September at the brand new KL Hilton Hotel at Sentral. We promise you a rich scientific programme and a memorable experience. E

By The Way

Editor

Future Developments in the MSA

As we have mentioned before, a software company has been identified to set up and maintain a secure website for the MSA to enable members to access and directly enter their activities for the MOPS programme. Negotiations are on going and we hope to accomplish this by year end.

The EXCO has also been looking into subscribing to a virtual library for members to gain access to. The Universiti Malaya and Universiti Kebangsaan Malaysia Medical Libraries both offer packages which we feel are worthwhile and are considering. However, online membership obviously comes with passwords and obviously we should enable members to get the passwords online (ie from our website) both for efficiency and convenience as well as to enable frequent changing of password to prevent unauthorised usage. At the moment our MSA website is not a secure site, so we will probably engage the services of the software company to handle this as well. Also, this will require all members who wish to make use of this facility to update their membership data in order for personal passwords to the site to be given, and so on and so on .....

So, there are many hurdles to clear before our hyperspace plans become a reality. However, for a start, we would very much appreciate it if all members could update their membership data if there have been any changes from before. The forms can be accessed from our website, filled in electronically and submitted directly to the MSA at the Academy House. Please take time out to do this next time you surf the net, to help facilitate our transition into the 21st century.

Many plans are in the pipeline. If any of you have any ideas, objections, feedback, anything, please let us know. E-mail me or the MSA at the academy or write in. Now is the time to give us your views.

Have you updated your Membership Data? Forms are in MSA website. Just fill in and click on 'SEND'.

MMA Fee Schedule

Editor

This issue was brought up during the last MSA AGM in March. Some members felt that their interests were not being looked after by the society, specifically, the pegging of the anaesthetic fee to the surgeons' charges. This was discussed at the last Exco meeting, which has prompted me to write this, to try to clarify the situation as it stands today. By no means have I any intimate knowledge of this matter despite the fact that I am in private practice, and therefore should be more familiar with charges since my livelihood depends upon it. The simple fact is that charges vary depending on the institution in which one works. No one seems very clear about the actual history and basis of the MMA Fee Schedule, so this article represents my own personal view and to my limited knowledge, the facts stated are true.

There is a widespread misconception that all anaesthetic services are charged one third of the surgeons' fee. This is not strictly correct. With reference to the MMA's specialist fee schedule (first brought out in 1987 and currently in its 4th edition), the anaesthetists' and surgeons' fees are not linked in any way at all. Depending on the procedure, the complexity, level of expertise and duration are taken into account separately for anaesthesia and surgery in determining the quantum to be charged. Generally, for simple, short surgical procedures, the anaesthetist's fee tends to approximate that of the surgeon's. There appears to be a minimum anaesthetic charge of RM230 (Minor 1). However, generally also, as the surgical procedure increases in complexity, the anaesthetic fee decreases in percentage as compared with the surgeon's fee. On average, the anaesthetic fee does hover around 30 – 35% of the surgeon's, but can be as much as 55 – 60% on rare occasions. Also bear in mind that the MMA schedule was meant as a guideline and additional charges when warranted can be made. The MMA has also stated that the fees in their schedule are among the lowest compared with advanced and newly industrialized countries. So perhaps it is no wonder that many specialists have expressed dissatisfaction with the schedule.

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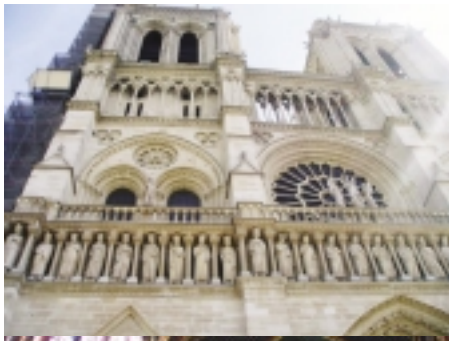
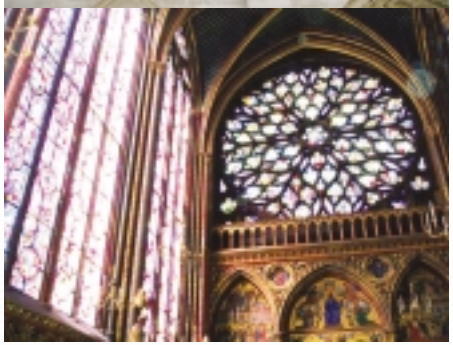
REPORT ON WCA 2004

By Dr Sekar Shanmugam

I arrived in Paris on 16 April 2004 with great excitement and anticipation of experiencing a few days in a historic city full of heritage and architecture and of course, the food and wine. After sorting out my luggage at the Charles de Gaulle International Airport, I hurried off to my hotel in the Latin Quarters. Braving my way through the subway (metro), I was initially confused and lost in the early morning rush hour. With some assistance from the trendy Parisian people, I managed to grasp the way to use the impressive metro that runs punctually every few minutes covering whole of Paris with 14 different lines.

The Royal Cardinal Hotel, although sounding grand, is only a bed and breakfast 2 star hotel, which cost me nearly 100 euros (RM460) per night. Upon hitting the streets of the Latin Quarters, I marvelled at the beauty of Paris – almost like a scene out of a movie or a postcard. Notre Dame Cathedral, not too far away from my hotel, is magnificent, with its Gothic architecture. Once inside, the sight of its spectacular rose windows was simply amazing.





Over the next two days, a pleasant stranger whom I met on the flight to Paris gave me an opportunity to travel to Belgium. A 90 minute train journey from Gare du Nord station in Paris got me to Brussels, Belgium. One of the main attractions here is the Grand Place which is an imposing 15th century market square, one of Europe's most impressive central squares. I also visited the Atomium (a giant sized atom, to commemorate the 1958 World Fair), mini Europe, the Manneken-Pis (statue of a urinating boy originated from here) and drove pass the headquarters of EU and NATO. I tried everything Belgium is famous for - cafes, chocolates, waffles. Even had time to catch a midnight movie in Brussels largest Cineplex (home to 32 silver screens), Mel Gibson's Passion of Christ.

I was back in time from Brussels on 18 April to attend the opening ceremony of WCA2004. Only bread, cheese and cocktails were served, disappointing many people and resulting in some having to go out to seek their own dinner.

The sheer size of the WCA only sank in when I attended the first day on 19 April. There were 200 pharmaceutical trade exhibition booths, 10 - 20 concurrent scientific sessions every hour and almost 200 posters being presented every day. One is really spoilt for choice, making it difficult to decide where to go. The big names in anaesthesia were all here and what an opportunity it was to rub shoulders with the big guns.

Two interesting products caught my attention when I went around the trade booths. The AnaConda, an inhalational sedation control system that allows one to connect this small gadget filled with volatile agent to the breathing circuit to achieve titratable ICU sedation / anaesthesia. The other item was the LMA i-pod, a new generation of intubating laryngeal mask airway (ILMA), which

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New Paradigms in Pain Management

26 – 28 March 2004, Mutiara Hotel, Kuala Lumpur

By Dr Mary Suma Cardosa, Chairperson, Organising Committee

The Annual Scientific Meeting of the Malaysian Society of Anaesthesiologists for 2004 was held at the Mutiara Hotel, Kuala Lumpur on March 26 – 28 2004. The theme was "New Paradigms in Pain Management", and the meeting was jointly organized with the College of Anaesthesiologists, Academy of Medicine Malaysia, and the Malaysian Association for the Study of Pain.

The scientific programme, put together most ably by Professor Wang Chew Yin, Scientific chairperson for the Scientific meeting, covered a range of topics related to the management of various types of pain. This included acute, chronic and cancer pain, as well as analgesic techniques for obstetrics, paediatrics and ambulatory surgery. Overseas speakers included 3 anaesthetists from Australia – Professor Peter Kam from Sydney, Dr Timothy Semple from Adelaide and Professor Stephan Schug from Perth; and Dr Ian Russell, from Hull, UK. We also had two speakers from Singapore, Dr Alex Yeo and Dr Serene Lim, and a number of local anaesthetists and other experts speaking at the conference. The Scientific programme included 5 Plenary talks, 6 symposia, 2 problem based learning sessions and one pro-con debate.

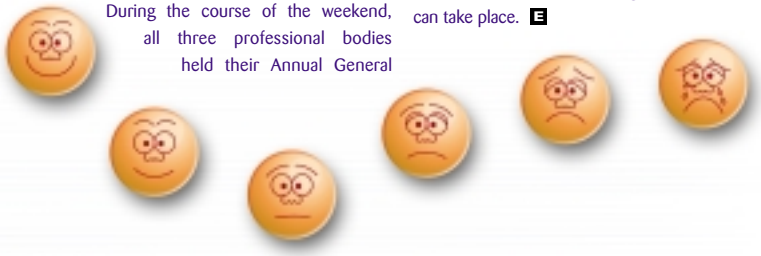
Two free paper sessions were convened, one for the MSA Award and the other for the Young Investigator Award. 6 papers were presented at each session. The best paper in the Young Investigator Award won a cash prize of RM3,000, donated annually by Astra Zeneca, while the best paper in the MSA Award won a cash prize of RM1,000, donated by the MSA itself. Three books on pain management were donated by the International Association for the Study of Pain (IASP) and were given out as lucky draw prizes, with one winner per day.

During the course of the weekend, all three professional bodies held their Annual General Meetings (AGMs) either during lunch breaks or at the end of the afternoon programme.

The conference was well attended, with 415 registrants, consisting mainly of anaesthetists (specialists and trainees), nurses and medical assistants from various government and private hospitals throughout the country. There were also a few doctors from other specialities including rheumatology, surgery and palliative care. Participation in the trade exhibition was also good, with 24 booths taken up by companies exhibiting a range of equipment and drugs. The main sponsor of the conference was Pfizer who provided secretarial support for the organizing committee, provided a hospitality suite during the conference and sponsored a lunch symposium.

Feedback from participants and speakers were very positive, and the conference went off with no major hitches. Pain management is a challenging field which has still a long way to develop in Malaysia, although the past decade has seen the growth of anaesthesiology-based acute pain services, and the setting up of a few chronic pain clinics managing chronic cancer and non-cancer pain. Anaesthesiologists already possess many of the basic skills needed for good pain management, and we hope that the conference has given further insight to anaesthesiologists about our potential role in the management of all kinds of pain, especially difficult cancer pain and chronic non cancer pain.

The conference would not have been possible if not for the hard work of the organizing committee and the secretariat, and I would like to thank all the members of the organizing committee for working so well together, and special thanks goes to Pfizer for their tremendous support, and of course to our indomitable Miss Kong without whom no conference can take place. E



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How the MMA fee schedule came about is shrouded in mystery/history. Reliable sources indicate that in the beginning, a few members of the MMA applied to the association to be sit in the proposed subcommittee purely on a voluntary basis and in a personal capacity (as opposed to representing any society). The first schedule was modeled after that in the UK and as time passed newer editions were brought out with, presumably, roughly the same members in the subcommittee. I believe among the anaesthetists, Dr Damodaran has been involved in this committee since its inception. The chairperson of the subcommittee is elected / appointed by the MMA Council every year. So, the members of this subcommittee do not officially represent their respective societies, nor are they answerable to the societies for their input to the schedule. The MMA has not requested the various medical professional bodies to be officially represented in the subcommittee. Perhaps we should take the bull by the horns and officially apply to do so. And see what happens.

Moving on... The current system (or lack of it) of billing for professional services in this country is extremely variable. As mentioned earlier, charges differ from hospital to hospital. Some hospitals have their own fee schedules and 'packages' (which, by the way, are unlikely to give higher rates than the MMA schedule) which, upon signing a contract with the hospital, the specialist has committed himself to abide by. This is apart from the 'discounts' given by the hospital to corporate clients and insurance companies. In these situations, the anaesthetic fee is commonly tagged at 35 or 40% of the surgeons'. In hospitals which do not have their own fee schedule, surgeons determine their own charges and I suppose they have the choice of following the MMA schedule for lack of any other guide, or charge whatever they see fit.

While some professional charges can still be determined by the individual specialist, the situation when dealing with patients covered by insurance is not so straight forward. I believe many health insurance companies will accept the MMA schedule of fees. However, some insurance agencies go for the last pound of flesh and work out discounted rates with hospitals for including them in their panel of hospitals. Unfortunately, not only are hospital related services discounted but doctors' fees as well. They can't do this you may say, but they can and they do. Most doctors accept this fact and life goes on, but there are instances when insurance companies place unacceptable conditions or limitations on their coverage which are not compatible with good medical practice. Or fail to settle their debts. Major dilemma. There's no choice but to continue accepting their credit – or is there?

Medical insurance companies are aware of a crucial fact – money talks. We live in a capitalist world and market forces rule, so it wouldn't be surprising if in the not too distant future, we find ourselves in the same predicament as doctors in North America, where Insurance Determines All, including your ability to practice. In an ideal world, doctors would practice good medicine, receive appropriate renumeration, have satisfied patients and there would be no complaints. But it's not a perfect world and then again, neither are we.

As usual, comments are welcome. We appeal to anyone who can shed some more light on this issue to let us know. E

NEWS FLASH!!!

Editor

The MSA has just been contacted by the MMA Health Insurance Committee which is in the process of reviewing the 4th edition of the MMA schedule of fees which was edited in 2001 and published in 2002. They are requesting input from consultants in each specialty with regards to changes to names of operations and any proposed amendments to the fees for the purpose of the 5th edition.

We have been requested to give the MMA our feedback by the end of June (impossible) so we would appreciate it if any and all suggestions can reach either Dr Y K Chan at chanyk@um.edu.my or myself at drkpng@hotmail.com by the 25 July 2004 at the latest. This is the golden opportunity for those of us who are dissatisfied with the current state of charging affairs to have your say and propose your alternatives. No guarantee that any of our suggestions will be accepted but this is a start and better than nothing.

Please respond fast.

More News from Down Under

By Dr Thong Chwee Ling

G'day everybody! I had just returned from Perth a couple of days ago after attending the ANZCA ASM. I had signed up for the meeting months ago via the internet, paid for registration through cyberspace, and received the receipt for payment and programmes through e-mail. I purchased my plane tickets through the net as well. Flying domestic can be an expensive affair. There is no such thing as cheaper return flights, so one needs to look out for deals. I bought my ticket to Perth during a Qantas sale, to the chagrin of my mates who missed out, but had to buy a more expensive ticket back to Sydney on Virgin Air, which in turn, is cheaper than the regular Qantas flights.

The hotel I stayed in did not provide breakfast; only coffee and tea were served at the conference site in the morning. How I missed the wonderful sponsored lunches back home – here we stood in line, handed in our meal coupons and collected our lunch in brown bags. We sat at small tables or on the staircases outside the conference hall in the sunshine eating either salads or sandwiches, with a fruit and a choice of mineral water, fruit juice or a soft drink. Very healthy, but give me those heavy lunches anytime! I can confidently say that it did not make any significant difference to the incidence and severity of postprandial narcolepsy. Our Muslim colleagues made do with vegetarian fare.

The meeting, as expected, had a mix of lectures, workshops, problem-based learning discussions and stalls from the pharmaceutical industry. Unlike our own ASM, there was no single theme but a spectrum of topics including pain, intensive care, training in anaesthesiology and even indemnity related issues. I had the pleasure of meeting old friends and making new acquaintances. I met Kamisah, formerly of Hospital Melaka and Paeds Institute who is based at the Princess Margaret Children's Hospital in Perth. Another Malaysian in Perth is Hoe Kah Siong from IJN, now based at the Royal Perth Hospital. There were also a number of Malaysians who now call Singapore home, including a fellow house officer from HKL, Tan Chee Keat. Some of you may remember Chee Keat who started her anaesthetic training in HKL in 1995 but moved to Singapore in 2000. In 4 short years, this remarkable woman passed the MMed Anaes (Singapore) as well as the FANZCA exams and is now an associate consultant with NUH. I got acquainted with Alex Sia, who was an invited speaker. Alex hails from Muar but now works in Kandang Kerbau Hospital. Gary Tham was another Malaysian who now calls Adelaide home.

(L to R) Chwee Ling, Kah Siong and Chee Keat

(L to R) Raha catching up with Tham

I spent a few days after the meeting traveling around Western Australia, and I found those days far more interesting than the meeting (my apologies to the learned speakers!)

As for work, I had a most interesting patient a month ago. I was on-call and was informed just before dinner. I visited the patient in ICU and classified her as ASA VI E - yup, a brain dead organ donor. The patient had a subarachnoid bleed secondary to an aneurysm and the family had agreed to multi-organ donation. Unfortunately the organ retrieval was planned for midnight and I had to anaesthetize another patient for a laparotomy prior to that. It was going to be a 'no-sleep' night.

The consultant on call was unable to give me any advice as he had not done one for ages. So I spoke to Adrian, who was one of the 3 NSW state transplant coordinators and told him I was a novice in this. All he could tell me was, make sure the patient is relaxed, one gram each of cefotaxime and methylpredisone after 'induction' and do whatever I needed to suppress her reflexes and to make myself comfortable!

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The patient came into OT intubated, urinary catheter in-situ with a triple lumen and an arterial catheter in her femoral vein and artery respectively. I connected her to the anaesthetic machine, started isoflurane, gave pancuronium and half a gram of fentanyl for skin incision and sternotomy. The incision was from manubrium sterni to symphysis pubis. I was asked to venesect 400 mls from her for preparation of pneumoplegia, used to improve lung tissue survival. The liver surgeon started first, by freeing the liver from its supports, leaving its blood supply intact. The liver was divided into two, as there were two designated receipients. By the time this was done, she had already lost a liter of blood, excluding the amount I had venesected earlier. I now regretted the fact that I did not have alternative access to the patient – the liver surgeon had ligated the distal aorta and the arterial tracing was horrendous. (I suppose the situation is similar to monitoring stump pressure during carotid endarterectomy, but in this case, who needs to know the stump pressure to the lower limb?) I strapped on the NIBP cuff and had to resort to phenyleprine to maintain blood pressure as I did not have adequate venous access to replace the lost volume. The ABG done showed metabolic acidosis, which I tried hard to compensate with hyperventilation, her Hb had dropped to 7g/dL, and urine output was low – hardly ideal conditions for a donor! The cardiothoracic team stepped in and requested for 3mg/kg of heparin. I tried to aspirate blood from the triple lumen in the groin and got nothing. The line was probably kinked as I could inject saline into it. Praying hard, I injected the heparin anyway and flushed the line vigorously. I maintained an outward appearance of calm while it was turmoil inside – was the whole thing going to turn into a disaster due to my ignorance in providing care for the donor? The surgeon cannulated the great vessels and placed the cross clamp. Phew! No disasters – the heparin must have gone in. Cardioplegia was run into the aorta while pneumoplegia was run into the pulmonary vessels. Ventilator and monitors were turned off when she went into asystole. The surgical team poured sterile ice into her abdominal cavity. The surgeon then requested I manually keep the lung inflated at TLC while he placed a row of staples across the trachea. He then placed a second row of staples more proximally and divided the trachea in between. Unfortunately he had forgotten to tell me to pull back the ETT and I had a failed extubation at the end, literally, as the second row of staples had stapled the ETT firmly to the trachea. The heart and lungs were removed en bloc. Liver, pancreas, kidneys and corneas were then harvested. The whole procedure took just under six hours.

I managed to speak to Adrian about the organ transplant program in NSW. After the first brain stem function test, the area health transplant coordinator – there are 7 area healths in NSW – will be contacted. This coordinator will then speak to the next of kin and obtain consent. The next of kin will also determine which organs are to be removed. One of the 3 state transplant coordinators who take turns doing the call is informed. There are coordinators for each organ and they will then be contacted to look for suitable receipients. If none are found within the state, the state coordinator will contact coordinators from other states. Organ retrieval teams will then be organized and transported to the donor hospital. The donor hospital, in this case, St George, would provide the OT, staff and anaesthetist for the retrieval. The cardiothoracic team hailed from St Vincent's, and accompanied the heart and lungs back to their hospital. The liver team was from Westmead Hospital. One of the kidneys came back the next morning to be transplanted into one of our own patients. The whole system runs fairly well, and I was the only greenhorn in the OT that morning.

Since that fateful day, I had done some reading into providing anaesthesia for organ retrieval and am better prepared to tackle the next organ retrieval! Interested parties should refer to Management of the Multiorgan Donor by Weeks and Daly in Australasian Anaesthesia 2000.

I received a letter from Adrian a couple of weeks ago to thank me for my 'assistance and support'. In his letter, he detailed how 7 people benefited directly from the donor's generosity. One person received a combined heart and lung transplant, the liver was divided between a child and an adult, both kidneys were successfully transplanted while two others received the gift of sight. Her pancreas was used for research into diabetes and islet cell transplantation. Nursing staff who participated in the organ retrieval received similar letters from Adrian. Organ transplantation may be in its infancy in Malaysia, but I hope transplant coordinators will remember to send letters of appreciation to all concerned as it is a great morale booster and makes the long hours feel worthwhile.

I would like to thank those to wrote me since my first article made the light of day. All comments and enquiries are welcomed at chwee69@hotmail.com. Last but not least, I would like to congratulate all successful candidates in the final part of the anaesthesia exams and say, welcome to the family. Cheers!