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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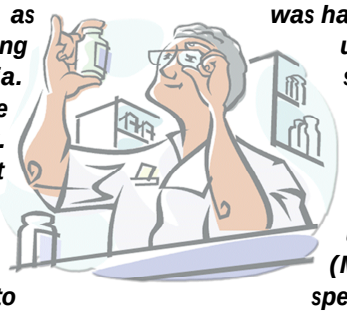
FROM THE PRESIDENT'S OFFICE

ANAESTHESIA IN THE EARLY SEVENTIES IN PENANG HOSPITAL

Some reflections of a bygone era

K Inbasegaran

I started my anesthetic career in the department of anesthesia in Hospital Penang in September 1974. At that time the hospital was known as the General Hospital Penang and was the main hospital in Northern Malaysia. We were the referral center for most of the hospitals in Kedah, Perlis and Northen Perak. I was posted to the anaesthesia department under some unusual circumstances. After a short stint in the Armed Forces (called National service in those days although it quite means something else today) I was posted to Penang Hospital. Although I stated to the Pengarah quite clearly that I wanted to do internal medicine, she informed me that the department was "full" and I could chose to do anaesthesia or wait in the outpatient department until a vacancy came up in medicine. I decided to go to OPD and within a week I was so stressed out by a lot of "patients" demanding medical certificates and sometimes threatening to do something unpleasant to me or my car! Some of the medical officers in the OPD had novel techniques of handling such situations. One of them used to arrive a little late and he would come out of his room, survey his patients and inform them to form two queues; those who wanted to be seen and treated and those who just wanted medical leave. He would clear his entire morning crowd in a couple of hours while the rest of us were struggling with our share of patients!



At the end of the second week I requested a transfer out of OPD and landed in anaesthesia.

At that time anesthesia activities were purely restricted to giving anesthetics, preoperative assessments and very much little else. There were 4 operating rooms in the main block which was supplemented by an eye operating room and a obstretic operating room in a separate facility which was half a mile away. Nevertheless it was a very busy set up and as I remember it we had almost every surgical speciality and it included cardiac surgery (only closed heart), neurosurgery, and later an urologist was posted some time later. Most of them migrated to Australia later and this included Mr David Chelvanayagam who was the urologist and the neuorosurgeon as well (Mr Swaran Singh). There were 2 anaesthetist specialists, one Dr Subrahmanyan who is now retired and Dr Radha Sakarapani who migrated to Australia in the seventies. There was a complement of 4-6 medical officers of varying experience and the number was more or less consistent at most times. I was the anaesthetic registrar and my fellow surgical registrars were Dato Naidu, (who is a surgeon in Alor Setar), the late Mr Razali Hashim, Mdm Leela a surgeon who is in private practice, Mr Zakaria Mahamooth who is urologist in private practice in Melaka and so many others whose names I cannot recall.

Anaesthesia was very simple in those days and mostly consisted of what we called "GOH" i.e gas, halothane and oxygen.

A lot of cases were done under spontaneous ventilation using halothane and a Magills circuit with/without an endotracheal tube and some these patients took almost an hour to wake up at the end of surgery. It was a very popular technique for all types of cases including thyroid surgery. All the rest were done under controlled ventilation and the only muscle relaxants available were

continue on page 2

In this Issue

➥ continued from page 1

suxamethonium, alcuronium and curare. We became very versatile in the use of "intermittent suxamethonium" for cases of short and medium duration. Much to their credit the surgeons were very fast and I remember the late Dr Razali Hashim who was a cardiac surgeon in UH in the eighties who used to do an appendectomy on a single dose of suxamethonium from skin to skin! Even the obstreticians rarely took more than 25 minutes for a C section and we got away with one or two doses of suxamethonium. The average learning time for a new medical officer in anaesthesia was around 3 weeks and that was a very fast learning curve. I like so many others before me was petrified at our first call. The anaesthetic machines were the old Boyles apparatus and some of these can be seen in the museums of our hospitals. Before we obtained the newer temperature compensated vaporizers it was fitted with the Goldmans vaporizer, an interesting device where you actually had to guess the concentration delivered! Centrally supplied piped gases were unheard and we used cylinders of both oxygen and nitrous oxide. As we always used high flows these cylinders had to be changed quite frequently.

My mentor was Dr M K Subrahmanyan who encouraged me to take up anaesthesia. One day, he gave me a couple of books in anaesthesia and some on basic sciences and told be to start reading and if I found them interesting to start thinking of anaesthesia as a career. One of the books he gave me was actually a text on the history of anaesthesia told in a story form. It was really a fascinating and intriguing account of anaesthesia and perhaps that started me on a career in anaesthestics! I decided to try for the Australian Faculty exams in September 1975 after one year of anaesthesia and obtained my part one then. Those days the exams were held in Kuala Lumpur and both the theory and the vivas were held there which made it very convienient to do the exams.

Regional anaesthesia was not very popular at that time and the only local anaesthetics available was chincocaine and procaine. We used spinal anaesthesia mostly for lower limb surgery. I was reading up on epidural anaesthesia and one day gave a successful epidural using a 19G spinal needle and 2% lignocaine. Touhy needles were unknown at that time and only became available in the eighties. There was very limited intravenous equipment and we used stainless steel needles (19G to 17G) for maintaining IV lines. In some of these cases where patients had to be positioned after induction and where access was a problem we had to pray that the needles do not come out or tissue out during surgery! There was no intensive care unit but we kept major cases in the recovery room overnight or even for two nights. We tried not to ventilate these patients as the morbidity was rather high (tubes slipping out in the middle of the night!) and somehow managed most of these cases quite successfully. There was no monitoring to speak off and the main monitor in the words of my mentor and teacher Dr Subrahmanyan was the "educated and trained finger on the pulse" and the "educated hand" ventilating the patient. Blood pressures and respiration and pulse rate were measured and recorded on a A4 sheet of paper which was the only documentation. Somewhere in the late seventies we acquired some simple ECG monitors which gave a "bouncing ball"trace which was difficult to decipher and sometimes even difficult to see! The main premedication used for major cases in those days was Omnopon (a mixture of opiates) and scopolamine both given IM. The patients used to arrive to the OT half anaesthetized by this potent mixture and in some cases did not require any IV induction! Kids were anaesthetized using the T piece and halothane and hypothermia was a major problem which was treated with warm water bottles placed in the axilla and groin. The theaters were very old without any scavenging system and high flow anaesthesia was the order of the day. All new trainees in anesthesia used to complain of being very sleepy and non productive after a day in the OT which played havoc with their family lives.

One of the early anaesthetists who worked in Penang was Dr John Nunn who worked with the British Army after the war. Among his exciting inventions was a device called the "Nunns" bag. This was used for dental extractions in difficult children and it consisted of a 2 liter bag which was filled with 1 liter of oxygen and 1 liter of cyclopropane. The children were induced with a few breathes of this deadly mixture and within seconds the patient was still and the surgeon able to extract whatever needed to be extracted. We then quickly gave oxygen and positioned the patient laterally and head down for recovery to occur. At that time it never occurred to me why the child looked tremendously flushed and with a bounding heart beat soon after induction; ignorance was indeed bliss!

We had a lot of orthopedic cases mostly trauma and at that time we use to have a lot of booby trap injuries amongst soldiers serving in North Perak. These unfortunate men will be flown in by helicopters which landed right on the Polo ground in front of the hospital and brought to the casualty and then to OT. That was the first time we saw cases of adult respiratory distress among some of them who had severe blood loss and relatively poor fluid resuscitation before transfer. It was a new thing then and few of us had read about the syndrome which was at that time being described in journals.

My experience in Penang was really exciting and there was never a dull moment in the operating room. The surgeons were rather colorful characters and many of them had volatile temperaments. As operating time was rather limited and emergencies had to be done as and when they occurred there was a lot of arguments etc as to who had right of way. Sometimes these arguments translated into flying instruments and we medical officers had to quick on our feet to keep out of harms way! There was however great camadarie among the medical officers and during our calls we used to start on the emergencies soon after 6 or 7pm and keep going up to 2 or 3am. Then we all would get into a car and go up to Chowrasta Road Market for some nice hot Nasi kandar before going home. The medical officer or houseman who did his first appendix or strangulated hernia would pay for the meal!

Almost 10 years later in October 1983 I was to come back to Penang this time as consultant and head of department but that is another story.

BERITA ANESTESIOLOGI

QUALITY AND ANAESTHESIA

K Inbasegaran

The concept of quality in medicine made its debut in medicine more than 3 decades ago. It perhaps followed this concept being introduced in industry where the objectives were excellence in product quality, competitive pricing and where the needs of the customer were paramount. Demming introduced this to the Japanese industry which in turn made Japan the most prolific and excellent quality producer of consumer goods for the world.

In medicine the quality movement itself went through several phases of development. Starting off with clinical audit, it moved to quality assurance and later to quality improvement and then to continous quality improvement.

Audit involved retrospective study of patient cases with emphasis on outcomes. Quality assurance involved doing the same thing but with and added component of putting into place remedial measures and then doing another study to see if improvements have indeed taken place 2. It thus completes the "circle" of a quality activity. Today the more acceptable way of carrying out quality activities is by quality improvement putting into place several methodologies each suitable for a particular clinical situation. The change in terminology from assurance to improvement is to expect the caregivers to continuously improve the delivery of health care and not just accept the status quo once they feel they have achieved a certain level of quality. Thus for anaesthesia it may involve mortality and morbidity audits and remedial measures, protocols, guidelines, and clinical practice guidelines which are being changed all the time and I have addressed some of these in the earlier issues of the Berita. Others may include incident monitoring and cost analysis of anaesthetic processes. Some of these may be applicable to hospitals and departments and others on a national basis. The two key features are lies in the continous evaluation of results and improving the process of care all the time. Another aspect of quality management that is somewhat related to the overall concept is risk management. Here the view is that risks are always inherent in a system and emphasis is on ways to reduce risk i.e increase safety for the patients and reduce complaints as well as potential litigation. Damage control following adverse incidents is a key feature in risk management strategies.

Quality in medicine is furthur complicated by how it relates to the perception of the various players in health 3. Thus the patients perception of quality medical care will vary from that of the care giver. The health manager or administrators perception of quality may vary from that of the care giver as well as the health economists or third party payers. Patients may give priority to caring attitudes and politeness of staff, timeliness as well as "hotel comforts" of the hospital. They also value time spent with the caregivers in explanation of their problems etc. Doctors on the other hand view many view quality more objectively in terms of outcomes, complications of treatment etc. The health managers as well as those who pay for the system may include optimal use of resources, throughput of cases and cost control in treatment.

In our public hospital system i.e the Ministry of Health or MOH we have had quality improvement activities in clinical departments for more than two decades covering almost all aspects of patient care. The MOH's quality improvement activities are probably the most intense and widest in scope in any organization both locally and internationally. Ever since we started on this the "quality arm" of the MOH has permeated through every aspect of its activities. Thus we have quality assurance activities, audits both local and national, NIA's or National Indicators, hospital based QA activities, department based activities and whole host of others. We have also quality or Q days, quality conventions where papers and activities are presented and recognitions given to individuals and presentations. The MOH has one whole division of its staff involved in quality and standards and hospitals and states have quality committees which meet regularly to discuss quality in our workplaces. There is no doubt that we are investing large amounts of time, money and effort on this not to mention massive documentation. The ultimate objective of the MOH is to "integrate and institutionalize" quality in all our daily activities. Nationally we have seen the formation of the Malaysian Society of Quality in Health or MSQH which among its activities is given the responsibility of accreditation of hospitals.

Anaesthesiology too has its fair share of activities in quality improvement and for the rest of this article I shall highlight some of them and what we have learnt or improved from them.

1. MORTALITY AUDITS

The National confidential enquiry into Perioperative deaths or POMR as it is often called is the largest ongoing audit of a specific outcome i.e perioperative death 4. The audit covers a total of 27 public hospitals and since it inception in 1992 has evolved from being merely an audit to a quality assurance program with the POMR committee playing a leading role in remedial measures. To date we have analysed more than 6000 perioperative deaths over a million surgeries in 10 years and published three reports. These reports are available from the Ministry of Health Quality and Standards division and there is a wealth of information available for those who are interested. With respect to anaesthesia we found that anesthetic related deaths formed a small portion of the total number of

continue on page 4

➥ continued from page 3

preventable deaths most being surgical related. The committee of independent peer assesors found that from July 96 to Dec 97 in 11 deaths (0.7%) out of 1517 periopeative deaths, anaesthetic complications were the direct cause. The main causes of deaths due to anaesthetic complications were hypoxia due to gastric aspiration or failed intubation at induction of general anaesthesia (3 cases) and complications following spinal anaesthesia (5 cases). Other causes include undetected oesophageal intubation, anaphylaxis from intravenous anaesthetic agent and complications from untreated hypotension in the recovery room. In many other studies from developed countries anaesthetic deaths have dropped from 1 in 2600 to 1 in 185000 over a 40 year period. Clearly using pure mortality statistics as an indicator of quality may not be adequate as the incidence is quite low in most circumstances. However the use of mortality studies has its own benefits as each mortality will inevitably highlight certain shortcoming in the system or the standard of the practitioner. It forms the starting point in an investigation that will detect a number of inadequacies. Mortality figures do give some form of reassurance to the and the health industry at large that surgery and anaesthesia is of reasonably high standard.

2. ANAESTHESIA INCIDENT MONITORING

This form of quality improvement activity centers around reporting of any incident that has the potential to harm or has actually harmed a patient. The rationale behind such activities is that there are more incidents than actual complications and that analysis of such cases will bring up certain shortcomings in the system that can be corrected. Both the above activities are dependent on reporting rates by doctors in the departments and from our experience can be very variable. In particular, our experience from the incident reporting system has been very satisfactory. Incidents are discussed in departmental meetings in an open manner and lessons learnt from them are usually not forgotten. In certain cases, we have been able to correct some system faults. Preventive strategies from incident studies form an important part of remedial measures. The mortality reporting as well as the incident reporting are anonymous and non punitive with the emphasis on correcting system faults rather than placing blame on an individual. In all quality studies it is often stated that most of the time it is the system that is at fault rather than the individual and that faulty systems perpetuate error time and again. Thus in the case of a unexpected difficult intubation if a system to deal with it is not in place then it can recur with adverse consequences. Having an appropriate system to deal with difficult intubation means having a drill that is understood by all the doctors in the department and having the necessary equipment at hand. The skill factor although important is secondary as in a proper system a more skilled person may have to called in at the appropriate time.

3. ONE OFF STUDIES

These are studies that are done to answer a specific question and are very popular in department based QA studies. For e.g. a common one is to find out the rate of postponement of elective cases for surgery over a period of time. The results are used to put into effect remedial measures and the next study done to show if that is effective. One problem is to benchmark as to what should be the value we are trying to achieve.

4. ANAESTHESIA OUTCOMES

As stated earlier death and major complications are rare outcomes not sensitive enough to assess the quality of the services. What about minor outcomes. A better way would be for anaesthesia practitioners working as a group to decide which of the outcomes they will want to track as part of their quality improvement efforts. A study done by Macario and colleagues1 reported that the five items a group of anaesthesiologists wanted to track were in order; incisional pain, nausea, vomiting, preoperative anxiety and discomfort during IV insertion. This was from a group doing mostly ambulatory practice. A group doing cardiac surgery may want to track different outcomes. The advantage of such an approach is that quality improvement indicators can be tailored to a particular kind of anaesthetic practice.

Many Colleges now require specialists to take part in Maintenance of Professional Standards (MOPS) and quality improvement activities are one of the key components besides CME. Our college is working along the same lines except that we may have quality improvement activities as an option.

REFERENCES

1. Macario A , Weinger M et al. Which clinical outcomes are common and important to avoid. Anaesthesia and Analgesia May 1999; vol 88; No 5.
2. Lagasse S et al. Defining quality of Perioperative care by control of adverse outcomes. Anaethesiology May 1995; Vol 82., No 5.
3. Fung D; Cohen M. Measuring patient satisfaction with Anaesthesia care: a review of current methodology. Anaesthesia and Analgesia. Nov 1998; Vol 87; No 5
4. Perioperative mortality review. The third report, July 1996 to December 1997. Ministry of Health Malaysia. Standards and Quality Division

ANNUAL DIALOGUE WITH MINISTRY OF HEALTH

Prof Y K Chan and Dr Satber attended the recent Ministry of Health (MOH) Dialogue to highlight again the issue of shortage of anaesthesiologists.

The Ministry is trying its best to increase the number of surgeons of all types so as to improve the specialist doctor: population ratio and to ensure a better health care delivery system. The MSA would like the Ministry to recognize that the number of qualified anaesthetists may become the rate limiting factor in this endeavour to improve patient care as one anaesthetist can only provide up to 3-4 full day lists per week so that for every 3 new surgeons (refers to surgeons of all disciplines including obstetricians & gynaecologists) trained, the MOH must try to ensure that there is one trained anaesthetist.

It was suggested that in order to achieve this, a database of all specialists must be formulated to determine the current ratio and if it is not 1:3 to determine how far off we are from what is desired. We would otherwise face the phenomenon of the underemployed surgeon without realizing it. There should be more incentive given to the training of anaesthetists as this is not a popular discipline in terms of glamour involved. The provision for allowing promising post-graduates from the Universities to be retained as trainers so that the Masters programme in the Universities can expand to train more anaesthetists was also emphasized. The latter was the issue that was brought up last year in the same MOH dialogue.

The MOH says they have a database of all government specialist. For the private specialists, there is a specialist registry with the Academy of Medicine, Malaysia. The database computes a ratio of anaesthetists: surgeon ratio at 1:4.3 and although the ratio is below the desired level, the MOH is trying its best to improve the numbers. The number of intake for the Masters programme in Anaesthesiology and the number who graduated each year are as follows:

	1999	2000	2001	2002
Intake	32	36	43	48
No who graduated	12	20	30	24 *

(up to June)

The numbers of intake and numbers who graduate each year definitely are improving. The MOH will also consider the applications of those who graduate from the Masters of Anaesthesiology programme to join the universities as lecturers if the applicants have at least served the MOH for 2 years as a specialist. This will be considered in relation to the needs of the services. The Jabatan Perkhimatan Awam (JPA) is also prepared to accept any suggestions on the correct ratio or norms on the number of specialists required for the optimal functioning of the Ministry of Health.

The objective of bringing up the issue is to create an awareness of our contribution and how we may become the rate-limiting step in the process of improving the level of care at the specialist level. We believe we have achieved the objective even if it is to just bring it sublimely to the minds of the policy makers.

[ACTIVITIES 2002/2003]

Report by Prof Y K Chan

MEMBERSHIP DATABASE

Of the approximately 450 members registered with the society, about 160 have yet to be in information into the database. This input is important so that it will allow us in this era of electronic communcation to keep in touch with our members more effectively. Members can download the form from the website or request it from chanyk@um.edu.my and return the form to the Academy for filing. To date, we still have around 160 members whose data is incomplete. Members are also requested to update their database whenever they move from their usual base or when other details about them change.

ASEAN JOURNAL OF ANAESTHESIOLOGY (VOL 3 NO 2)

The journal is currently into its 4th issue and there is a great demand for it. Unfortunately members whose addresses are not up-to-date may not be receiving it because issues sent to the wrong addresses are always returned to the Academy.

AGM/ASM

The 2003 AGM will be held on the 26th of April, 2003 at the Legend Hotel in Kuala Lumpur. It promises to be a very exciting AGM as it is the year where various office-bearers will be elected into office. This is also accompanied by a very interesting 3 day scientific programme on intensive care. Do book early in order to avoid disappointment

NATIONAL ANAESTHESIA DAY

National Anaesthesia Day has been observed on various days in October and November, 2002 to increase the public awareness of the contributions of anaesthetists to the public. It was held with a lot of fanfare in Malacca where it was officiated by Raja Nazrin Shah and also in two other states, Penang and Sabah.

TALKS

Various talks were held for the society. Of note were that contributed by the examiners of the Conjoint Anaesthesiology Examinations between University of Malaya and University Kebangsaan Malaysia in November 2002. Coordinators in the peripheral hospital are encouraged to draw on the funds allotted them from the society .

ANNUAL MEETING WITH MINISTER OF HEALTH

We had a meeting with the Dato' Chua Jui Meng in August, 2002 where we highlighted how we may be the rate-limiting step in the Ministry's effort to improve delivery of surgical services to the country. We would appreciate further ideas / contributions / suggestions of problems to be brought up so that we can thoroughly study the problem before it is highlighted usually around the month of August each year.

continue on page 6

MAINTENANCE OF PROFESSIONAL STANDARDS

There is increasing pressure to ensure that members of the various profession maintain certain standards in their delivery of care to patients. In order to do so , members need to keep up to date with developments in their field of interest. Documentation of this process can be a tedious process but Dato' Inba has come up with a suggested format that should allow members to do so with minimal hassle. Members will be requested to offer input to further develop the document so that we can collectively push ahead to monitor our own personal development in the not too distant future.

SPECIAL INTEREST GROUP ACTIVITIES

The group with interest in airway has been very regular with their workshop on management of the airway. The most recent one coincided with the Asian Australasian Congress of Anaesthesiologists and it was a resounding success. For those who have yet to participate in one of these airway workshops look out for the next one

The obstetric anaesthesia group has arranged for a one day weekend meeting to be held in the UMMC on "Obstetric analgesia / anaesthesia – what's new" on the 18th of January, 2003. The emphasis in this particular meeting is to allow medical officers to catch up with some recent developments in obstetric anaesthesia provided by a team of dedicated local anaesthetists with interest in the field assisted by specialists from other fields to aid in the discussion of the management of the HIV parturient.

The paediatric group has similarly arranged for a workshop from the 23rd- 25th of February, 2003 with a one-day session to be held in the Sunway Lagoon Resort and smaller group sessions with hands-on demonstration with telecast participation in the auditorium in the Paediatrics Institute of Kuala Lumpur on the subsequent days. Two very prominent paediatric anaesthetists, Professor Adrian Thomas Bosenberg (S. Africa) and Professor Raafat S Hannallah (Washington DC) will be key speakers in the workshop focusing on "Challenges and controversies in paediatric regional anaesthesia." Register early to prevent disappointment.

FELLOWSHIP

Congratulations to Dr Yong Boon Hun and Assoc Prof Norsidah Manap for being conferred the fellowship in the recent conferral in October, 2002 at the Armada Hotel. Members of the council turned up to support these two members. Ordinary members who have been in the college for more than 10 years or who have published extensively are encouraged to become fellows.

[MUKASURAT MALAYSIAN SOCIETY OF ANAESTHESIOLOGISTS]

When the Executive Committee first met in March this year, we had only one thing in our mind i.e. to organise a national conference, which hopefully will mark the beginning of a subspecialty. Long under the charge of the anaesthetic fraternity, we feel that intensive care has come of age and it's time for it to stand on its own.

As the year draws to an end, the preparation for the national conference reaches its final lap. The scientific programme and the speakers have all been confirmed. However, the recent political hiccup between Australia and its neighbouring countries has given us some sleepless nights and we pray that this will not stop our three main speakers from coming to Malaysia.

The support from the health care companies has been most encouraging and to date, all the trade booths have been taken up. We are indeed grateful to have B Braun as our main sponsor and to serve as the secretariat for the conference. We promise you an exciting conference and we hope you will come in full force to support this inaugural national meeting and to make it a success. The conference will be held at The Legend Hotel, Kuala Lumpur from 25-27 April 2003.

Another exciting event that is taking place is the National Audit on General ICUs in Ministry of Health hospitals. Data collection in the fourteen participating units started in July this year and so far, nearly 3000 patients have been recruited. Through the efforts of the site coordinators and the nurses, the quality of the data collected has been excellent and we have generated some interesting information such as standardised mortality rates, number of patients denied intensive care, readmission rates and a host of other information on clinical practice and resource utilisation. We are hopeful that the information obtained from the audit will provide future directions for the development of intensive care in Malaysia. A preliminary report of the findings will be presented at the national conference.

Members of the Executive Committee have worked hard in the last nine months and I take this opportunity to thank them for their effort. We have a great team at CCMS and we will continue to serve for the future of intensive care.

11th ASIAN-AUSTRALASIAN CONGRESS OF ANAESTHESIOLOGISTS

The organisers posing HRH Raja Nazrin Shah

Faculty and participants at the Pre-Congress Airway Workshop

Overseas delegates at the Congress Banquet

Dr Suresh won the MSA-AZ Young Investigator's Award

Opening Ceremony

Feasting

The Malaysian Society of Anaesthesiologists was given the privilege of hosting the 11th Asian Australasian Congress of Anaesthesiologists from the 10th to 13th July 2002.

The Malaysian Society of Anaesthesiologists appointed the following to be in the Organising Committee.

Chairman : Dr Sylvian Das
Deputy Chairman / Trade Exhibition : Dato' Dr K Inbasegaran
Hon Secretary : Dr Augustine Yew
Hon Treasurer / Trade Exhibition : Dr V Kathiresan
Scientific Chairperson : Prof Ramani Vijayan
Congress Facilities : Dr Nirumal Kumar
Registration / Hotel : Assoc Prof Lim Thiam-Aun
Publications / Publicity : Dr Satber Kaur
Social : Dr S S Thevan
Executive Secretary : Ms Y M Kong

The Organising Committee started functioning from late 1999 and xxx a total of xxx are xxx. AstraZeneca offered their services for secretariat purposes and we thank them for it. Most of the meetings were held at the secretariat office.

After lunch looking around Hotel Shangri-La was chosen as the Conference Venue. The choice was made based on charges, convenience and location.

OPENING CEREMONY

The Opening Ceremony was held in a grand manner on the evening of the 10th July and we had the privilege of having by His Royal Highness Sultan Azlan Shah, the Sultan of Perak who is also the patron of the Academy of Medicine of Malaysia performing the Opening Ceremony.

REGISTRATION

A total of 890 delegates attended the conference. Of this, 371 delegates were Malaysian and the rest were foreigners from a total of 27 countries.

SCIENTIFIC PROGRAMME

A very elaborate scientific programme under the chairmanship of Prof R Vijayan was set up. There was a total 83 invited speakers from a total of 19 countries. The breakdown of the Scientific session was as follows:

Plenary Lectures	–	6
Symposia	–	24
Poster Discussion	–	2
Pro-Con Debates	–	5
Panel Discussion	–	2
Case Discussion	–	4

Dr Kester Brown,President, World Federation of Societies of Anaesthesiologists

Dr Sylvian Das welcome the guest of honour, HRH Raja Nazrin Shah

Opening of the Trade Exhibition

In addition there was also a pre-congress workshop held a day before the congress on 9th July 2002.

The workshops were on
1) Airway Management
2) Imaging in Peri-Operative Management

TRADE EXHIBITION

The Trade Exhibition during the Congress was a tremendous session mainly due to the efforts of Dato' Dr K Inbasegaran and Dr V Kathiresan.

A total of 65 booths were displayed 37 companies participating. In fact, more companies wanted to participate but could not do so for lack of space.

SOCIAL PROGRAMME

The social programme were organised in a manner that was very enjoyable to the delegates, thanks to the efforts of Dr S S Thevan and Dr Augustine Yew.

A dinner for the invited speakers was held on 9th July 2002.

The Congress Banquet was held on 11th July 2002 and the Informal Night which was themed as "Malaysia Night" was held on 12th July 2002 at Hotel Istana.

ACCOMPANYING PERSON PROGRAMME

There was a separate programme drawn up for accompanying person which included a half day city tour and a day trip to Malacca.

On the whole, the congress was very enjoyable both academically and socially. It was generally felt that the congress was well organised and I would like to place a record here my deepest appreciation and gratitude to the members of the organising committee for their dedication and hard work. I would specially like to thank Miss Kong for her contributions without which it would have been difficult.

In conclusion, I would like to thank Istana Perak, Ministry of Health Malaysia, College of Anaesthesiologists Malaysia, Malaysian Airlines and the various companies and all the contributions to the success of the congress.

Dr Sylvian Das
Chairman
Organising Committee

MALAYSIAN SOCIETY OF ANAESTHESIOLOGISTS

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Editorial

Apologies are due to all members of MSA and the College for this delayed issue of Berita Anestesiologi. I am afraid that the delay is largely my fault, due to personal reasons. I hope that all will find this issue enjoyable. This issue was largely put together by our excellent Executive Secretary, Ms Y M Kong, and my most grateful thanks are due to her.

This is a bumper issue, combining two issues of Berita, as a recompense for the delay! I would again like to request articles from all members to make the Berita relevant to all regions and subspecialties. I am sure you don't want the same people writing all the time – let's hear your voice!

All submissions to Berita should be addressed to the Executive Secretary, Ms Kong, email address: acadmed@po.jaring.my, or by snail-mail to her at Malaysian Society of Anaesthesiologists, 19 Jalan Folly Barat, off Jalan Ledang, 50480 Kuala Lumpur.

Satber Kaur

NATIONAL CONFERENCE ON INTENSIVE CARE
25 TO 27 APRIL 2003
THE LEGEND HOTEL, KUALA LUMPUR

PROGRAMME

25 APRIL 2003

0800 - 0830	REGISTRATION		
0830 - 0930	Plenary 1: Clinical outcome in intensive care - are we doing better?		
0930 - 1015	OPENING CEREMONY(Director General of Health)		
1015 - 1045	TEA/ TRADE EXHIBITION		
	Symposium 1	**Symposium 2** (Pediatric)	
1045 - 1110	1. First SIRS, and then?	1. Transfusion in the critically ill child	
1110 - 1135	2. Biochemical markers in sepsis	2. Fluid balance and glucose metabolism in the critically ill child	
1135 - 1200	3. Fluid management in septic shock	3. Sedation and analgesia in the pediatric ICU	
1200 - 1225	4. Pharmacotherapy in sepsis		
1230 - 1430	LUNCH		
1430 - 1615	**Workshop 1**	**Workshop 2**	**Interactive Case Discussion on Practical Management in**
	Critical Care Nutrition for Nurses	**Percutaneous tracheostomy**	1. Severe head trauma (1430 – 1520)
			2. Sepsis and CRRT (1520 – 1610)
1615 - 1645	TEA		
1645 - 1745	Free paper		

26 APRIL 2003

0800 - 0900	Plenary 2: Health Technology Assessment In Intensive Care Practice – the current status	
0900 - 1000	National audit on 14 adult intensive care units in Malaysia: A preliminary report	
1000 - 1045	TEA	
	Symposium 3	**Symposium 4**
1110 - 1135	1. Mechanical ventilation of the asthma patient: a critical review	1. Enteral and parenteral nutrition: when and how?
	2. Respiratory mechanics at the bedside	2. Infection control measures in ICU
1135 - 1200	3. Newer modes of mechanical ventilation	3. Severity scoring systems and organ dysfunction models
1200 - 1225	4. ARDS: Putting it all together	4. Clinical information system - The Malaysian experience)
1225 - 1250	5. Difficult weaning	5. When should life support be foregone?
1250 - 1400	LUNCH	
	Symposium 5	**Symposium 6** (Pediatric)
1400 - 1425	1. Global and focal monitoring in acute cerebral damage	1. Acute renal failure and renal replacement therapy
1425 - 1450	2. New Insights in Intensive Care Management of Head Injury	2. Acute lung injury -ventilatory strategies
1450 - 1515	3. ICU acquired paralysis	3. Cerebral function monitoring
1515 - 1540	4. Approach to patient with altered conscious state	4. Management of cardiac dysfunction
1540 - 1605	5. Recent advances in the management of acute stroke	
1605 - 1630	TEA	
1630 - 1745	AGM	

27 APRIL 2003

0800 - 0900	Plenary 3: Tissue oxygenation: Which site to monitor gut, subcutaneous, visceral , muscle? Making sense of it all	
0900 - 1000	Plenary 4: Acute renal failure and renal replacement therapy in the critically ill	
1000 - 1030	TEA	
	Symposium 7	**Symposium 8** (Nursing))
1045 - 1110	1. Management of the post-operative critically ill patient	1. Nursing education for intensive care
1110 - 1135	2. New role of insulin in the critically ill	2. Should patients be physically restrained?
1135 - 1200	3. Avoiding multi-resistant organisms in ICU	3. Communication skills
1200 - 1225	4. Abdominal compartment syndrome	4. Incident monitoring in intensive care
1225 – 1250	5. Acid-base balance – The Stewart approach	5. Evidence-based practice in nursing
1250 - 1400	CLOSING CEREMONY AND LUNCH	

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