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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

Season's Greetings to all our members, and Best Wishes for a Great New Year 2009. Another year has ended and it is always a good time to review what we have done over the past year and perhaps to take stock of where we are and what we are heading for in the new year.

In 2008, the MSA has carried out a lot of CPD activities, not just in KL-Klang Valley where our CPD activities are still being held on a regular (rotational) basis, but also in other parts of the country. I am really happy to see active participation from anaesthesiologists in other states, and the MSA is ever-willing to support your activities with funding and publicity. This year, we will be spending a lot of our energy on organizing the 16th ASEAN Congress of Anaesthesiology, and we will not be having our usual Annual Scientific Meeting in March / April; however, I hope that the CPD activities in the different states will continue to flourish.

I would like to apologise for the delay in getting this issue of the Berita Anesthesiology out – this is mainly because we wanted to be able to convey the important decision regarding the name of the Specialty to members. Nevertheless, we have made this into a "bumper" issue, to reflect appropriately all the activities that have been going on in the past 6 months or so.

The name of the Specialty – To change or not to change?

This has been the subject of much debate amongst our community over the past two years or so, soon after the National Specialist Register was announced. There are a number who would like the name of the Specialty to be changed to "Anaesthesiology and Intensive Care" – to reflect the practice which started long ago, and continues today, that anaesthesiologists also look after patients in intensive care units. At the same time, there are also those who feel that the name "Anaesthesiology" should be retained as anaesthesiologists are clearly credentialed in three areas, namely anaesthesiology, intensive care and pain management.

At the same time, there are anaesthesiologists and physicians who are now doing full time intensive care and wish to be registered as "Intensivists" in the Specialist Register as a subspecialty under Anaesthesiology. Unfortunately the decision is not solely up to us. The Council of the Academy of Medicine of Malaysia had ruled that the name of the Subspecialty and the name of the Specialty cannot contain the same words, i.e. we cannot have the specialty name as "Anaesthesiology and Intensive Care" and a subspecialty called "Intensive Care".

The Executive Committee of the MSA and the Council of the College of Anaesthesiologists held a special meeting to discuss this, and after considering the different viewpoints and the limitations set by the Academy Council, we decided to recommend that the name of the Specialty be changed to "Anaesthesiology and Critical Care," and the Subspecialty be called "Intensive Care".

"Critical Care" is the term that was commonly used previously and is still thought to be synonymous to "Intensive Care"; some interpret the term is being broader than Intensive care, i.e. it also includes emergency department and resuscitation work. For our purposes, however, it would serve to indicate to the public that we as anaesthesiologists are also competent in resuscitation and care of the critically ill patient.

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The National Specialist Register document on Anaesthesiology states
"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."

The NSR document gives the following list of competencies under intensive care, i.e. all anaesthesioogists registered under the NSR are deemed able to do the following:

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

The President of the College, Dr Mohamed Namazie, has informed the Academy Council regarding this decision, and they have approved the change in name, subject to approval by the National Credentialling Committee. We will be bringing this up at the forthcoming College and MSA AGMs in 2009 for endorsement by our members.

National Anaesthesia Day 2008 – 16th October

This year we decided to encourage as many hospitals as possible to celebrate National Anaesthesia Day by offering a small grant to every hospital that was interested in holding an activity in conjunction, and we were very happy with the response – as you will see in this issue of the Berita, several hospitals held exhibitions and other activities to raise the awareness of the public regarding the important role that we as anaesthesiologists play in the perioperative care of patients. Congratulations to everyone for their great efforts! We hope that more hospitals will celebrate National Anaesthesia Day next year and in the years to come – we should make good use of this opportunity to publicise the work that we do, and you will find that the public is fascinated to learn what goes on in the operating theatre – the mock up theatre is always a big hit with them! At the same time, the expanding role of the anaesthesiologist as a perioperative physician can be emphasized, as well as our role in pain management and intensive care.

MSA Membership Database

We spent about three months "cleaning" the MSA database, but still have not managed to update 100% of the database. We have been sending notices of CPD activities and other notices via email in order to save cost; I hope that those who have not been receiving any news or notices from the MSA will contact the Secretariat (acadmed@po.jaring.my) to give us your updated email address so that we can keep in touch with you. Also, if you have not paid your membership fees, please contact the secretariat to find out how much you owe, and send us a cheque. We need your support to be able to continue with our activities, and to be able to advocate and lobby for the interests of anaesthesiologists.

Research and Publications

The MSA is continuing to encourage our members to do research and to write articles for publication, and we have awarded the K Inbasegaran Research Grant for 2008 to Dr Ng Lip Yang from UMMC. This grant was started with a donation from the widow of the late Dato Dr K Inbasegaran, and the MSA will continue giving the award annually. We are also striving to continue to publish the MSA Yearbook on an annual basis; while this serves as an update for our members on various topics related to our field, it also gives the opportunity to our own members to write articles for publication. Putting together this publication is no easy task, and Prof Marzida Mansor has taken up the challenge for 2009. We hope that members benefit from and appreciate the Yearbook, and welcome feedback and suggestions on how to improve it in the future.

16th ASEAN Congress of Anaesthesiologists (ACA) and 7th National Conference on Intensive Care (NCIC)

Preparations for the above conference, to be held from 2nd – 5th July 2009 in Kota Kinabalu Sabah, are "full steam ahead". We have almost finalized the scientific programme which will feature a good mixture of overseas and ASEAN speakers as

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well as local speakers. We are also planning an exciting social programme and the trade exhibition booths are being taken up quickly! The final announcement will be out in February 2009, and I hope that many will take this opportunity to attend the conference and have a nice holiday in Sabah as well. With the competition between airlines, there are now more cheap flights to Kota Kinabalu, so I hope to see you there!

Annual General Meeting 2009

Because of the 16th ACA / 7th NCIC conference, we will not be holding the ASM this year. Therefore, we will be having our AGM in Kuala Lumpur on Sunday, 29th March 2009 – there will be a couple of lectures, followed by the annual meetings of the Intensive Care Section, the MSA and the College of Anaesthesiologists, followed by lunch. I hope you will also make an effort to come for this, as this year we elect our President-elect for the term 2009 / 2011 and we also have a number of important issues to discuss.

Saying goodbye is never easy…

It was with much sadness that we said goodbye to two of our colleagues from the anaesthetic fraternity at the end of this year – Dato' Dr Lim Say Wan passed away on 1st December 2008 while Dr Anthony Manavalan passed away on 12th December 2008. Both were very senior anaesthesiologists who were amongst the pioneers in our specialty in this country, and have contributed significantly to the development of the specialty. Although they had retired from practice, they continued to be in touch with anaesthesiologists each in his own unique way. Dato' Dr Lim Say Wan was a former President of the World Federation of Societies of Anaesthesiologists (1992 – 1996) and did much to raise the profile of Malaysian anaesthesiologists in the international arena. May they both rest in peace.

"For death is no more than a turning of us over from time to eternity." ~ William Penn

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February 2009

Message from the President

College of Anaesthesiologists, AMM

The last couple of months has seen a flurry of activities pertaining to the future of our speciality. Foremost among them was the joint meeting between the College Council and the Exco of the Malaysian Society of Anaesthesiologists (MSA) and the representative from the Intensive Care Section (ICS). We had to decide on the nature of our speciality and the place of intensive care in this. A group of anaesthesiologists had requested that intensive care be made a registrable subspecialty in the National Specialist Register (NSR). This was discussed at the Annual General Meeting of the College as well as the MSA in April 2008 in Pulau Langkawi. The members felt that if intensive care becomes a specialty with its own criteria for registration, the anaesthesiologists who practice intensive care may be at a disadvantage in terms of recognition. A compromise was reached to rename the basic specialty which will reflect intensive care / critical care. Several combinations were discussed by the College Council and these suggestions were published in the earlier edition of the Berita Anestesiology and feedbacks and comments were solicited. Unfortunately, there weren't many.

The joint meeting of the College Council and the MSA Exco agreed to the following proposals

1. Specialty of "Anaesthesiology" in the NSR be changed to "Anaesthesiology and Critical Care".
2. "Intensive Care" shall remain as a subspecialty of Anaesthesiology and Critical Care
3. A subcommittee for credentialing intensivists be formed consisting of representatives from all specialties (not exclusively anaesthesiologists) who have qualifications in intensive care or have undergone Fellowship training in intensive care.

This was tabled at the Council meeting of the Academy of Medicine of Malaysia and was accepted subject to approval by the National Credentialing Committee. At the same meeting we were told by the Master of the Academy that "Intensive Care" will be considered as a separate specialty and not a subspecialty to which I raised an objection but unfortunately my objection was not heeded. We have made representation to the Chairman of the National Credentialing Committee to keep Intensive Care a subspecialty of Anaesthesiology. Other specialties, e.g. Internal Medicine, who may wish to have Intensive Care subspecialty as well, may do so provided the registration criteria remain the same for all specialties and there is only one subcommittee for credentialing the subspecialties.

Training in Anaesthesiology

Today an increasing component of current anaesthesiology practice occurs outside of the operating room. These areas include preoperative assessment clinics, post anaesthesia care unit (PACU or recovery room), inpatient wards, intensive care and high dependency wards, imaging and catheterization departments, endoscopy units, labour and delivery suites, pain clinic and the accident and emergency department. An anaesthesiologist is frequently called to these non OR sites where rapid assessment of acutely ill and unstable patients, precise communications with other professionals and ancillary personnel and leadership in triage and direction of immediate life-saving methods and effective management are required.

The training of anaesthesiologists must take into consideration the expanding role of the anesthesiologists as a perioperative physician and necessary changes must be made to the curriculum of the training programmes in the Universities. Interdisciplinary rotation during training will enhance the effectiveness of the anaesthesiologist as a perioperative physician. The post Masters training in subspecialties need to be strengthened if the duration of the Masters programme cannot be lengthened to accommodate the changing requirement of the specialist. There must be emphasis on effective communication with all levels of the hospital staff, patients and the family members. High level of professionalism is expected of the specialists and consultants and this requires communication skills. Commitment to ethical principles including confidentiality of patient information is vital together with sensitivity and responsiveness to patients' culture, age, gender, disabilities and medical conditions. The training programme must justify the name change to "Anaesthesiology and Critical Care". The trainers have a heavy responsibility on their shoulder to impart these values by example.

Obituary

In the first ten days of December 2008 we lost two great stalwarts of our speciality namely Dr Anthony Manavalan and Dato' Dr Lim Say Wan. Many of the members will know Dato' Dr Lim Say Wan, who represented the best of Malaysian anaesthesiologists in the international arena and rose to become the President of the World Federation of Anaesthesiologists. He played a major role in the

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activities of the Malaysian Society of Anaesthesiologists for decades and was also once the Education Officer of the Faculty of Anaesthesiologists of the College of Surgeons of Malaysia, the precursor of the College.

Dr Anthony Manavalan, was a doyen of the anaesthesiologists who came to then Malaya as an expatriate contract officer in 1960 and served in several government hospitals in the country before starting private practice at the newly formed Pantai Medical Centre in 1974. He together with Dato' Dr Lim Say Wan was among the founders of the Centre. Dr Manavalan or Tony as he was fondly known to his contemporaries was an exemplary anaesthesiologist who was always willing to help and teach the young medical officers who came under his wings. I had the privilege of working with him in the University Hospital where he used to do a list once a week in the 1970's. The simplicity of the way he managed patients was amazing and left an indelible mark on those who worked with him. He was a fatherly figure loved by all and, enemies, he had none.

To the families of these two great men I extend our heartfelt condolences and pray that they will find solace during this time of loss and sadness. Together with them we mourn the loss of these fine men who have passed on. Their contributions to the College and their dedication to our specialty will be remembered and cherished by all of us.

May I take this opportunity to wish all our Christian members a Merry Christmas and a joyful and happy new year and also to our Chinese members, Happy Chinese New Year.

As always the President would love to receive comments and suggestions or complaints about issues pertaining to our College and specialty. He can be contacted at: mnamazie@gmail.com

Dr Mohamed Namazie Ibrahim

5th Paediatric Anaesthesia & Analgesia Workshop

Hospital Sultanah Bahiyah, Alor Setar, 20th – 21st June 2008

The constant need to update ourselves on recent advances in techniques on paediatric anaesthesia and the need to create more interest in this sub speciality has given birth to the annual Paediatric Anaesthesia & Analgesia Workshop.

Running into its 5th year, the workshop which is co-organized by the Special Interest Group in Paediactric Anaesthesia, College of Anaesthesiologists, Academy of Medicine of Malaysia, Department of Anaesthesiology & Intensive Care, Hospital Sultanah Bahiyah and Aesculap Academy Malaysia was held in Hospital Sultanah Bahiyah, Alor Setar, Kedah from 20th – 21st June 2008. This year, we had 37 Specialists and Medical Officers from various hospitals across Malaysia.

Apart from boasting local and foreign speakers, another highlight of this workshop was the Introduction to Ultrasound Guided Regional Anaesthesia. It was a privilege to have with us Assoc Prof Dr Manoj Karmakar from the Department of Anaesthesia and Intensive Care, The Chinese University of Hong Kong, Prince of Wales Hospital to share with us his wealth of knowledge, expertise and experience on this topic. He presented a lecture on the Role of Ultrasound in Paediatric Regional Anaesthesia before proceeding to demonstrate the techniques.

The first day of the workshop commenced with a series of lectures which covered topics such:

- *Fluids & Electrolyte Therapy in Children by Dr Sushila Sivasubram*aniam
- *Management of URTI in Children by Prof Dr Lucy Chan*
- *Peripheral Nerve Blocks in Children by Dr Felicia Lim*
- *Role of Ultrasound in Paediatric Regional Anaesthesia by Assoc Prof Dr Manoj Karmakar*

Case discussions on Fluid Resuscitation and Airway Foreign Body were also incorporated into the programme to enhance the participants understanding and knowledge in this sub speciality. Participants were encouraged to contribute without reserve their opinions, suggestions and possible solutions to the cases presented. There was also an afternoon session on a demonstration of the use of ultrasound in children. The anatomy of the various upper limb and lower limb nerves and vessels including the anatomy of the caudal space was demonstrated in 2 model children.

To put theory into practise, the faculty demonstrated various blocks (dorsal, caudal and ilioinguinal nerve blocks) on fourteen cases during the hands-on sessions in the Operating Theatres, on the second day of the workshop, using both, the conventional and Ultrasound Guided method. Assoc Prof Dr Manoj K Karmakar highlighted the benefits and simplicity of using the Ultrasound Guided method to identify the target nerve. There was also a station for the candidates to practice on the phantom limbs with the ultrasound machines.

The feedback received from the participants was very encouraging and all have benefited a lot from this sharing of expertise and knowledge.

Malaysian Society of Anaesthesiologists & College of Anaesthesiologists, AMM

Annual General Meeting / Annual Scientific Meeting 2008

25th – 27th April 2008

Awana Porto Malai Langkawi, Kedah, Malaysia

Speech by **Datuk Dr Noor Hisham Abdullah** at the Opening Ceremony

First and foremost I would like to thank the Malaysian Society of Anaesthesiologists for inviting me to join you at your annual dinner. I am very happy to be here and to have this opportunity to interact, with all my good friends and colleagues.

Surgeons and anaesthetists are like a pair of scissor, with two blades hinged together. At times we may moves in opposite direction, we argue and fight but when the two blades come together, we make a good cut. We need each other to function as a team. Both sides of the blades are equally important to make a good pair of scissor. A good pair of scissors can do wonders, so to speak.

As a surgeon, I have always appreciated the role of the anaesthesiologist as a member of the team in the operating theatre. I am happy to note that the anaesthesiologists are **venturing more** and **more outside** their comfort zone of the operating theatre, to become actively involved, not just in intensive care, but also in the management of acute and chronic pain, and to further involve themselves in emergency medicine.

Anaesthesiologists would have to play an important role in improving the delivery of surgical services to the patients, by setting up anaesthetic clinics for preoperative assessment, as well as in day care services. Although in most hospitals the infrastructure for the ambulatory care has been provided, I believe we have not fully utilised and developed the day care services, to achieve a milestone in reducing our in-patients hospital admission.

One of the perennial challenges facing us is the shortage of anaesthetists. There are currently about 500 anaesthetists in the country, giving us a ratio of 1 anaesthetist to 54,000 populations. In developed countries, the ratio is one anaesthetist to 10,000 populations, and I think that in Malaysia we should project towards that figure, although our target is more modest, at 1 in 30,000. We will need to double the number of anaesthesiologists in order to achieve this target and hopefully within the next 10 years.

Shortage of anaesthetists results in insufficient operating time and hence long waiting lists for surgery, particularly in the government hospitals. As one of the short term measures; the cabinet recently approved the overtime claims for doctors to run elective lists on Saturdays; this will increase the OT time and hopefully reduce the waiting time for elective surgery. I hope that all hospitals where this has been approved will make full use of this opportunity which will in turn benefit the patients that we serve.

On a long term basis, the Ministry of Health has significantly increased the intake of anaesthetic trainees for the Master's programme; each year the Ministry tries to increase the number of intake to at least one third of the total number of the surgical specialty intake.

The first thing I did when I took office is to prepare a paper on retention packages and benefits to our specialist. These incentives are early promotion, increase allowances, opportunity for extra incomes, continuous training and education, coupled with some other family and personal perks. I am always on your side as I believe a hungry man is an angry man.

Once the Ministry of Health has fed and treated us well (or rather treated you well) in return you are expected to deliver high quality care that will eventually be gauged by the key performance index of each discipline.

The extra income incentive has been announced, we already have the **locum** and **full paying patients** in place. In the Ministry of Health we do encourage, locum and all you need to do, is to inform us and get an insurance cover.

As for the **Full Paying Patients scheme**, the pilot project was started in Selayang and Putrajaya Hospitals and will soon roll out to other major hospitals. We have our teething problems and for the last eight months the specialists have not been paid.

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I have brought this issue up and address the 40% fee cut from our professional fee (you can define this as fee splitting). The good news is now you get no professional fee cut at all and the long overdue backdated payment soon.

The third incentive for extra income is the RM 200 an hour for operating on public patients on Saturday. Medical officer assisting will get RM 80. Here I would like to draw your attention that we treat our specialist equal, both surgeon and anaesthetist will be equally paid RM 200 an hour basis. Unlike the MMA fee schedule anaesthetist only gets 30% of the surgeon fee.

More importantly many specialists have been promoted to JUSA C in the recent years and I have reorganised the retention packages and benefits for training, scholarships and few other family perks to be announced by the Minister or DG soon. Believe me this is certainly not the time to resign; the details of these packages and benefits can be discussed in a closed door forum.

The Ministry will continue to support the development of anaesthesia and intensive care service in the country. A substantial amount of funding has been allocated this year for the continuing progress of the service. And I must say anaesthesia and intensive care service is one of the medical services that have received the most substantial allocation.

Apart from human capital development, the Ministry has allocated;

- RM 20 M for asset procurement and replacement
- RM 6.9 M additional annual operating budget for anaesthesia and intensive care service
- RM 6.9 M for the implementation of elective surgeries on Saturday

In recognition of the importance of a proper pain management, not only in post operative care but also for those who suffer from various chronic conditions, the Ministry is committed to facilitate the development of Acute and Chronic Pain Service in our hospitals.

The working paper on the development plan put forward by Dr Mary Cardosa and team has been endorsed recently and six critical implementation strategies have been identified by the Medical Development Division. A Director General Circular on the implementation of 'Pain as 5th Vital Sign' is expected to be issued soon this year. I sincerely hope that the anaesthetic fraternity will continue to work hand in hand with the Ministry to make this a reality.

Apart from infrastructure and human capital development, it is essential to ensure our work processes and systems in delivering medical services are coordinated, efficient and of high quality. For this reasons, the Ministry is advocating all clinical disciplines to review, standardise and document their respective operational policy as to promote optimal utilisation of resources, strengthening departmental organisation, better inter departmental collaborations, evidence-based medicine and outcome orientated services.

I therefore, would like to commend the anaesthetic and intensive care fraternity for being the first clinical service to have produced the Operational Policy for Anaesthesia and Intensive Care Service for the Ministry of Health hospitals. The book is comprehensive and covers a wide range of issues such as organisation, manpower requirement, policies and procedures, quality and audit. It will be a useful guide for both health care providers and managers in the provision, planning and development of medical services.

Once again, thank you for your kind invitation. I hope that my presence here will emphasise to you the recognition that the Ministry gives to your specialty and I look forward to continuing this very special relationship, and together we will strive to bring anaesthesia and surgical services in Malaysia to greater heights and remember we are a pair of scissors. I wouldn't want to delay the dinner further as a hungry group is a dangerous group. Thank you once again wassalam. E

A View on **Merging** of the **Malaysian Society of Anaesthesiologists** and the **College of Anaesthesiologists** in Malaysia

Dear Doctors,

I am an Anaesthetic Registrar halfway through specialty training practicing in Auckland, New Zealand. I grew up in Kampar, Perak and keep in touch with medical developments back home in Malaysia as it is my intention to return after completing training. I have an interest in medical education, having served on the New Zealand trainee committee for the Australian and New Zealand College of Anaesthetists (ANZCA) in 2007, and am also pursuing a postgraduate diploma in Clinical Education.

In the most recent issue of Berita Anestesiologi, I noted with interest the subject of merging the Malaysian Society of Anaesthesiologists (MSA) with the College of Anaesthesiologists (CoA), Academy of Medicine of Malaysia.[1] I can only assume that this discussion has emerged to ensure that there is no duplication of roles between the two organisations and / or to provide anaesthesiologists in Malaysia with a unified (and hence stronger) voice and presence. I have tried to form an opinion on this matter by examining the roles of both organisations within the Malaysian context and as well as comparing the situation with similar organisations in other countries. Let me state here that I am not a member of MSA (although I look forward to joining in the future) and I have never practised medicine in Malaysia. Therefore, I apologise in advance for any omissions that may be due to my lack of local knowledge.

The objectives of the MSA include the following: To promote the art and science of anaesthesiology; To co-ordinate the activities of anaesthesiologists; To represent anaesthesiologists and protect their interests; To encourage and promote co-operation and friendship between anaesthesiologists; To achieve liaison with similar bodies and other specialties in other regions.[2] The CoA considers itself the “academic arm” of anaesthesiologists in Malaysia and lists its primary objective as 'the advancement of the art and science of anaesthesia and related disciplines'.[3] It also lists the following as part of its activities: Credentialing and accreditation; Development of consensus statements, clinical practice guidelines and standards of care; Quality assurance and clinical audit; Organisation of sub-specialty scientific meetings; Assisting in the facilitation of postgraduate training; Research.[3] Mention is made about working closely with the MSA.[3]

The MSA website carries ICU guidelines published by the Ministry of Health, has links to four clinical practice guidelines (one developed by MSA and three by the CoA), has details on continued professional development activities, carries articles of public interest about anaesthesia, hosts the maintenance of professional standards (MOPs) programme, and publishes current news relating to anaesthesiology in Malaysia via Berita Anestesiologi (which is billed as a newsletter for both the MSA and CoA).[4] The CoA website carries the same clinical practice guidelines and has a link to the specialist register.[3]

Both organisations have distinct objectives but based on what can be accessed from their respective websites, one may conclude some CoA activites are being conducted by the MSA. The Ministry of Health and Academy of Medicine of Malaysia have recently jointly established a process for credentialing specialists, with the CoA playing a significant role in the credentialing of Anaesthesiologists.[5] I am not privy to any other activities that are carried out by the CoA and it seems to be the case that some CoA activities are coordinated by the MSA.

Singapore has a health system not dissimilar from ours, with specialty training conducted by a university and having both a Society and College of Anaesthesiologists. The Singapore Society of Anaesthesiologists (SSA) states its objectives as: To form a united voice of anaesthesiologists; Promote continued education and training; Promote links between local and international medical societies.[6] The generic objectives of the Academy of Medicine, Singapore are very much similar to its Malaysian counterpart, focusing on postgraduate education, specialist certification and maintenance of standards.[7] However, the Academy of Medicine, Singapore is much more involved than its Malaysian counterpart in specialty training, which in Singapore is jointly administered by the Academy of Medicine and the National University of Singapore via the Joint Committee on Specialist Training.[8] The section for the College of Anaesthesiologists,

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Singapore contains clinical practice guidelines and continued medical education details (including meetings jointly conducted with the SSA).[9]

In Australia and New Zealand, specialty training and continued professional development is solely administered by ANZCA, an organisation independent from the government or universities. The Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists both deal mainly with the welfare of its members (with a significant focus on continued education) and the former also publishes the Anaesthesia & Intensive Care journal.[10,11]

In Malaysia, specialty training in anaesthesiology is conducted by the anaesthesiology departments of three public universities. In Universiti Kebangsaan Malaysia, for example, applications are conducted through the Unit Pusat Universiti and entry into the programme is based on faculty recommendation but ultimately requires approval from the Lembaga Pusat University.[12] The conduct of Malaysian public universities is under significant government control. There is however a representative of the CoA sitting on the Conjoint Board for Anaesthesiology[13] which is involved in administering the training programme, although I am unclear of the board's exact composition or role.

The curriculum for anaesthesiology training in Malaysia was jointly developed by the Faculty of Anaesthesiologists of the College of Surgeons of Malaysia (predecessor of the CoA) and the Department of Anaesthesiology of University of Malaya in the 1970's, with the intention that the postgraduate colleges were to conduct specialty training and examinations.[13] However, a bill put forward to Parliament to allow this was rejected and the government instead instructed the universities to take on that role.[13]

I am of the opinion that the MSA and CoA should remain separate bodies, with the CoA taking on a larger and more active role in specialty training. Ideally, training should be conducted solely by the College, as a body that is made up of anaesthesiologists that could control matters of entry into training, syllabus, examinations, certification, standards and discipline. However, this is unlikely to occur due to heavy government regulation of medical training. I would be curious to know if any specialty college in Malaysia has voiced a similar view. It should be acknowledged that university resources are a valuable asset to specialty training in its current form. However, a single institution to administer training would streamline the process, ensure transparency, maintain standards and carry more clout. With the current system, advancement in training issues may be hindered by the presence of three separate anaesthesiology departments, each ultimately controlled by their medical faculty and university which have their own interests at heart (again, I am unclear of the exact role or authority of the Conjoint Board for Anaesthesiology). A college that is allowed to administer training would be allowed to look after the interests of its fellows, members and trainees. It would also be financially independent. ANZCA, for example, receives 37% of its income from trainees (registration, annual and examination fees) and a further 34% from member subscription and entree fees.[14] If the CoA had 40 trainees in each year of training throughout the country and charged RM2000 per year for the privilege, that alone would generate an annual income of RM320,000 (assuming four years of training).

In conclusion, I feel that the CoA should try to take on a large a role as possible in all academic and credentialing aspects of anaesthestic practice in Malaysia in order to ensure that Malaysian anaesthesiologists are in control of their own affairs. Total control is extremely unlikely to be granted, going by previous government action. Another course of action could be the CoA seeking more representation (i.e. a majority) on the Conjoint Board for Anaesthesiology with proper elucidation of its role and expansion of its authority if necessary. The MSA should remain an organisation committed to the welfare of anaesthesiologists and raising the profile of the profession. Continued education activities should be jointly organised by the MSA and CoA with the latter administering the credentialing and recertification process of practicing anaesthesiologists.

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E

Feedback on the **Proposed Name** of our **Specialty**

I read with interest in the "Berita Anestesiologi", the article from Prof Lim regarding the Malaysian Society of Anaesthesiologists proposed change in the name of the Anaesthesiology specialty to Anaesthesiology and General Intensive Care or Anaesthesiology and Critical Care or Anaesthesiology and Intensive Care, to name a few. This, it was stated in the article, was partly in response to the separate registrable specialty on the NSR i.e. either in Anaesthesiology or Intensive Care.

I understand that the Malaysian Society of Anaesthesiologists has suggested the change in name, to reflect the scope of work that anaesthesiology encompasses i.e. both OT and General Intensive Care Unit. The MSA is gathering feedback from all its members. For me, I have no objection in either but was just wondering whether later on, our other colleagues will put it upon us to add Pain Specialist in our resume since we anaesthesiologist also do pain management? The other thing is that, the National Credentialing Committee has already recognized that all anaesthesiologists can also manage ICU which I think will protect us medico-legally too. Will a change in name make a big difference?

Furthermore, I noticed that there is a suggestion to call the subspecialty in Intensive Care as Fellowship in Advanced Intensive Care Medicine or Intensive Care Medicine or Critical Care Medicine. I looked into the MOH website for subspecialty programme and noted that none of the above fits the bill. The official name is actually known as Fellowship in Adult Intensive Care.

I do hope that the MOH and NSR can standardize the names. It gets a bit confusing when the fellowship candidates themselves get confused when they have to explain to their counterparts when they are overseas.

Just a thought,

Rohana

HKL / Serdang Hospital

E

A poster presentation by Professor Fernando Alemanno from Italy describing a methodology of middle interscalene brachial plexus block.

(Reprinted with permission from the author)

WORLD CONGRESS ANESTHESIOLOGY 2008 - CAPE TOWN

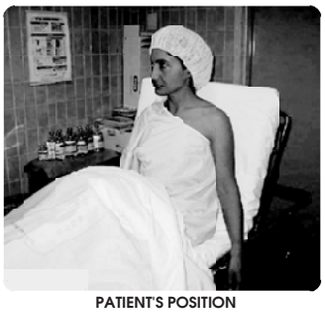
THE MIDDLE INTERSCALENE BLOCK

F. Alemanno M. D.

UNIVERSITY OF VERONA - ITALY

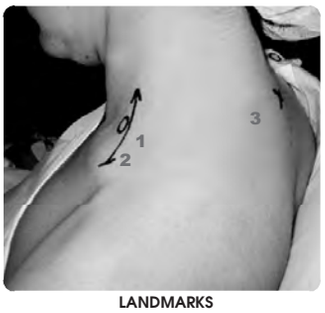
The idea is to cannulate the neurovascular bundle by inserting a 35-40 mm needle lateral to the subclavian artery pulse.

Illustration by Poul Buckhoj (modified).
From Winnie A.P. "Tecniche Perivascolari di Blocco del Plesso Brachiale"; Verduci, Roma 1984. Concession kindly granted



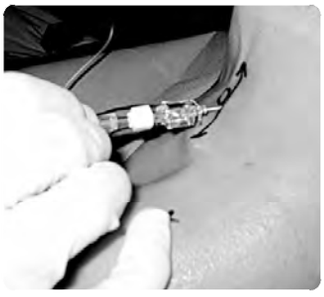
PATIENT'S POSITION

Sitting upright, with a raised headrest



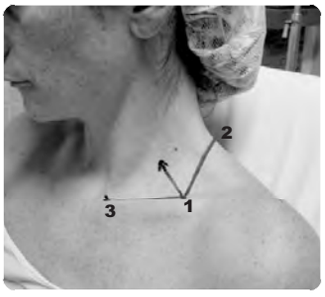
LANDMARKS

1 Pulse of the subclavian artery, marked with an O
2 the midpoint of the clavicle, marked with a dot
3 the spinal process of C7 which is marked with an X



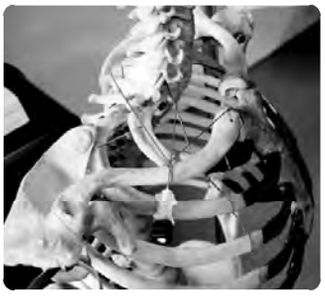
TECHNIQUE

The 35/40 mm needle is inserted, following a strraight line which from the midpoint of the clavicle is the lateral tangent to the O. If no twitch is evoked, small adjustments are made reinserting the needle in an anterior or posterior direction until a twitch of deltoid or biceps muscle is obtained with an intensity current of 0.3 mA

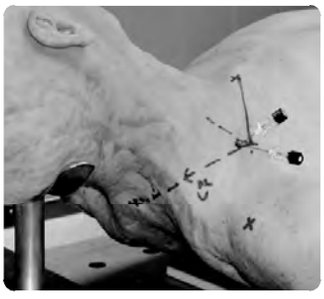


TECHNIQUE

If the subclavian artery pulse is not present, we refer to 3 bony landmarks:
1) the midpoint of the clavicle;
2) the spinous process of C7;
3) the sternoclavicular joint.
By connecting the midpoint of the clavicle to the other two we obtain an angle whose bisecting line leads to the brachial plexus



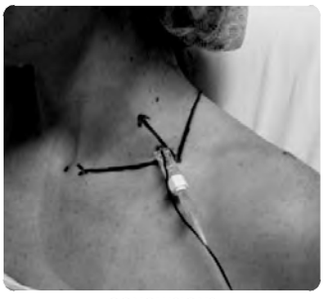
Here the angle was reconstructed with a blue thread on the skeleton.
The 22 G spinal needle takes the place of the bisecting line.
The impression of the subclavian artery (red) and the position of the brachial plexus (yellow) were marked on the first rib



The angle was drawn on the cadaver and two 22G spinal needles were inserted:
towards the spinal process of C7 and along the bisecting line of the angle remaining on the transverse plane of C7

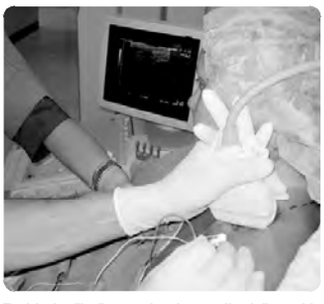
THE TARGET HAS BEEN REACHED !

You can see the brachial plexus between the scalenus anterior muscle (with the frenicus nerve) and the scalenus medium muscle (with the suprascapular nerve)



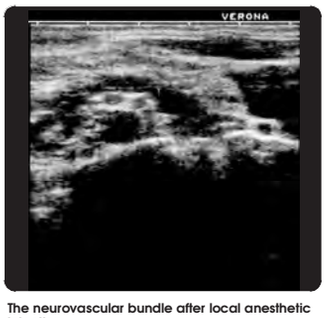
CONCLUSIONS

1 The bony landmarks are reliable
2 The angle's bisecting line leads towards the brachial plexus



The block with ultrasound and nerve stimulation guide

Here, on the left, the subclavian artery and the brachial plexus are visible



The neurovascular bundle after local anesthetic injection.
You can see the subclavian artery and the brachial plexus covered by the anesthetic cloak

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Regional Anesthesia and Pain Medicine, Vol. 31, No 6 (November - December), 2006: pp 563-568

Ultrasound Guided Regional Anaesthesia Workshop

by **Dr Shireen Sree Jayan**

The Ultrasound Guided Regional Anaesthesia (USGRA) Workshop was conducted in Melaka organised by the Department of Anaesthesiology and Intensive Care, Hospital Melaka and the Malaysian Society of Anaesthesiologists on the 25th and 26th July 2008 with invited speakers Dr Wing Hong Kwok and Dr Carina Li from Department of Anaesthesia & Intensive Care, Prince of Wales Hospital, The Chinese University of Hong Kong, Shatin, NT, Hong Kong.

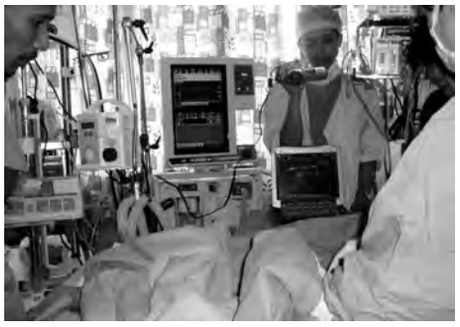


The facilitators guided us systematically through the basic principles of Ultrasound and went on to elaborate on Ultrasound Guided Nerve Blocks for upper and lower limbs. The afternoon on the first day was filled with hands on workshops on human models where each of the participants were given an opportunity to put into practice what was learnt during the morning lectures under the watchful eye of the facilitators. There was also training in needle advancement and redirection by using a simulated patient or "blue phantom," which has its role in facilitating needle placement. We were advised to go to http://www.usgraweb.hk/ website for further information regarding Ultrasound Guided Regional Anaesthesia.



The next morning, after a night of "*Ikan Bakar*" and "Grilled Fish", was the session on patients going for surgery and participants were taken into the Operating Theatre (OT) where they were able to either be in the theater suite where the blocks were conducted or watch on a screen, the procedure and the Ultrasound Image in the comfort of the waiting room of the General OT, Hospital Melaka. During the latter part of the morning there was also a session in ICU where central venous and arterial line cannulation was demonstrated under ultrasound guidance.





We were indeed very fortunate to have in our presence these experts in this field where lots of confidence and wisdom was acquired by the participants and as a whole the event was truly an enlightening and fruitful experience in this era where the use of Ultrasound is increasing in anaesthesia, intensive care and pain management.

HISTORY OF ANAESTHESIA

The first demonstration of ether anaesthetics occurred on 16th October 1846. Morton administered it for an operation at the Massachusetts General Hospital.

In 1847, James Simpson used chloroform which was used at the Royal Infirmary for labour. The woman was so pleased with the analgesia that she named her newborn baby, the first baby to be born under chloroform, "Anaesthesia"!

Local anaesthesia was discovered in 1884. Koeler demonstrated the use of cocaine for topical analgesia in the eyes in Vienna. Spinal anaesthesia was introduced by Bier in 1898, and shortly extradural anaesthesia by Sicard in Paris 1901.

The first Boyle's anaesthesia machine made its appearance in 1917. This enabled the anaesthesiologist to give a mixture of anaesthetic gases and vapours in specific concentration. In England, Magill and Roebotham introduced the use of endotracheal intubation for the purpose of giving anaesthesia. In 1930's, intravenous anaesthesia using barbiturates was introduced. This was followed in 1942 by muscle relaxants, which facilitated surgery greatly for surgeons.

Hospital Tuanku Fauziah, Kangar, Perlis

Report by Dr Ismail Ahmad

We celebrated the National Anesthesia Day by conducting an exhibition held at the main corridor in the specialist clinic block. The place was chosen to ensure good public audience. "Know Anaesthesia" was chosen as the theme to educate the public on the important role of anaesthetic services. Two banners were placed at the main hospital gate and the entrance of the specialist clinic block. Repeated announcement through the hospital PA system was also made.

The opening ceremony was officiated by the acting hospital director. The exhibition consisted of photo displays and videos, showing the whole range of anaesthetic activities in the operation theatre and, outside too. Pamphlets were also distributed to provide information regarding the services provided. Advantages and risks of the anaesthetic techniques were written down.

As a whole the exhibition received very encouraging responses, particularly the video session which did really catch the attention of members of the public. The visitors had a number of questions regarding our services. We strongly felt the objective of providing information to the public with regards to our services was fairly well achieved and we plan to go out from the hospital for next year.

Opening ceremony by Pengarah Hospital

Exhibition section

Visits by public

Hospital Tengku Ampuan Rahimah, Klang, Selangor

Report by Dr Nor Hafizah Bt Mohd Yunus

On 16th October 2008, the Department of Anaesthesia and Intensive Care, HTAR, Klang conducted an exhibition to celebrate the World Anaesthesia Day. It was held at the foyer of Ambulatory Care Centre, HTAR, Klang.

The objective of the exhibition was to educate the public regarding the importance of perioperative care and the services provided by the Anaesthetic team. This was achieved by displaying posters regarding history, services and activities of Anaesthesia and Intensive Care Unit. Besides that, we also set up a mock Operation Theatre and Intensive Care Unit.

To encourage more participation from the public, we organized a quiz based on the posters displayed. Attractive prizes were given away to all participants. Surprisingly, the public was very curious to know about anaesthesia by posing a lot of questions to the organizing committee.

Judging from the overwhelming response from the public, we felt that we had achieved our objectives.

A vote of thanks to the pro-active and committed team members who contributed to the success of this event.

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Hospital Melaka, Melaka

Report by Datin Dr Sivasakthi Velayuthapillai

The National Anaesthesia Day is celebrated on 16th October every year and in conjunction with this we planned several activities to commemorate this historical event. To kick off the celebration, Dr Zainal Abidin and Dr Shireen Sree Jayan spoke on National Anaesthesia Day at a radio talk show (Melaka FM) on 14th October 2008. The Department of Anaesthesia and Intensive Care also put up a poster presentation at the foyer of the hospital from 14th to 21st October 2008 which focused on the scope of services provided by the Department.

The highlight of our National Anaesthesia Day celebration was the official launching of "PAIN AS THE FIFTH VITAL SIGN" by Yg Bhg Puan Hajjah Norpipah Abdol, State Chairperson for the Committees of Women Affairs, Family Development and Health on the 21st October 2008. During the launch we also presented a brief video show educating the public on the history and role of anaesthesia in the medical care of a patient.

Official Launching of State Level National Anaesthesia Day 2008 Celebration

Dr Shireen Sree Jayan giving a talk on Pain as the 5th Vital Sign

Hospital Raja Permaisuri Bainun, Ipoh, Perak

Report by Dr Kavita Bhojwani

The National Anaesthesia day was celebrated in Hospital Raja Permaisuri Bainun, Ipoh over two days – 16th and 17th October 2008. The venue was the entrance foyer of the main block. It was an extremely informative experience for the public.

We had posters displayed which explained different aspects of anaesthesia as well as an on-going video. Medical officers, staff nurses and paramedics were on hand throughout the day and were able to distribute patient information sheets and answer queries. Anaesthetic clinic, daycare anaesthesia, intensive care, pain management and other anaesthetic services were some aspects highlighted. The public also took part in a quiz for which prizes were given.

We also had booths where blood pressure and blood sugar levels were checked. On display were the GA machine and ventilator, airway adjuncts, as well as equipment for regional anaesthesia. This seemed to be quite popular with the public.

The event as a whole was a resounding success and we look forward to next year's event.

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Northern Region, Ipoh, Perak

Report by Dr Kavita Bhojwani

Updates in Anaesthesia & Intensive Care 2008 • Hospital Raja Permaisuri Bainun, Ipoh, Perak

The Department of Anaesthesia and Intensive Care along with MSA and PGMES Hospital Ipoh held a one day seminar - "Updates in Anaesthesia & Intensive care" for the Northern region on 21st November 2008.

A total of 175 participants including doctors, nurses and paramedics from both government as well as private hospitals attended this one day event. The esteemed speakers included Dr Tai Li Ling, Consultant Anaesthesiologist and Intensivist from Hospital Kuala Lumpur, Dr Lim Wee Leong, Head of Department of Anaesthesiology and Intensive Care Hospital Sungai Buloh, as well as Mr Shankar Santhiram, a trainer from E/Q Training & Development.

After registration of the participants, Dr Lim Wee Leong then presented the weekly hospital CME pertaining to the Current Guidelines for ICU Management of Traumatic Head Injuries.

The Update program was kicked off at 9.00 am by Dr Kavita Bhojwani, Head of the Department of Anaesthesia and Intensive Care, Hospital Raja Permaisuri Bainun (HRPB) warmly welcoming the various participants to the Update. The programme was then officially declared open by Dr Zaidah bt Hussain, Pengarah HRPB, Ipoh, after her introductory speech.

Dr Tai Li Ling, a Consultant Intensivist from Hospital Kuala Lumpur then proceeded to give the first talk of the day discussing the latest Updates in Mechanical Ventilation. She focused her talk primarily on ARDS and lung protective strategies. ARDS has always been a cause of severe morbidity and mortality in ICU and she discussed on how an ICU clinician may help to improve outcome in this group of patients.

The second slot was taken by Dr Lim Wee Leong, Head of Department and Consultant Neuroanaesthetist of the Department of Anaesthesiology and Intensive Care Hospital Sungai Buloh. His topic of discussion was Transport Guidelines for Critically-ill patients as defined by "Medical Transport and Principles of SAFE Transport Guidelines".

After a brief tea break, Dr Tai Li Ling continued her talk, delving into Ethics in ICU. This talk was very relevant as it discussed multiple facets of ethics in this age of frequent litigations. Her talk emphasized on the four principles of Medical Ethics, namely, Autonomy, Beneficence, Non-Malficence and Justice. She also touched on the areas of Ethical problems in ICU.

Updates in Neuroanaesthesia was then the next topic of discussion with Dr Lim Wee Leong once again helming the rostrum. He gave a quick introduction on the physiology of brain cells, their susceptibility to injury and recovery as well as neuroprotective strategies in anaesthesia. He also touched on the long-term sequelae of Traumatic Brain Injury (TBI).

The programme then took a breather for lunch as well as the Friday prayers. The participants were also able to visit the 14 booths.

After lunch, participants were given tips on improving their presentation skills with a talk by Mr Shankar Santhiram, Consultant Trainer of E/Q Training & Development. E/Q Training & Development is a Soft Skills provider for team building, effective presentation skills, leadership skills and as well as motivational training. It is based in Bukit Kiara, Kuala Lumpur, their clients include multinational companies such as Hitachi, Petronas, York and even Kementerian Kesihatan Malaysia (KKM). Mr Shankar spoke on the Components of an Effective Presentation which consist of 3 elements as *You (as a Presenter)*, Content (the objective of the presentation) and Audience. He also touched on being a Good or Poor communicator as well as Guidelines for the Perfect Presentation.

The programme was then officially closed at 4.45 pm after Mr Shankar concluded his talk.

The participants went back eager to practice the new knowledge gained.

Continued on page 16

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Queen Elizabeth Hospital, Kota Kinabalu, Sabah

Report by Dr Lily Ng Mooi Hang

This year would mark the last of the World Anaesthesia Day celebrations at the foyer of Queen Elizabeth Hospital, Kota Kinabalu, with the gloom of our impending evacuation from the Tower Block. Doomed for demolition, as deemed as unsafe, the tower has been the home of the Department of Anaesthesiology and Intensive Care for many long years. For me it has been for as long as 15 years, and for some of the senior anaesthetic medical assistants (Penolong Pegawai Perubatan), it has been even longer.

Pengarah Hospital despite her schedule, showing her support.

World Anaesthesia Day 2008 President of MSA, Dr Mary Cardosa with Dr Lily Ng at Queen Elizabeth Hospital, Kota Kinabalu.

Dr Mary Cardosa with Dr Lily Ng and staff at foyer of Queen Elizabeth Hospital during their exhibition.

The first celebration was in October 2002. Extensive operating theatre and intensive care paraphernalia were exhibited. That year saw the very exciting lifelike appearance of Resus-Anne undergoing surgery, with simulation of her vital signs on a Phillips multichannel monitor, unique and a first indeed. Ventilation by a bag-in-bottle ventilator was facilitated via an endotracheal tube.

Our display this time around was modest with a display of Resus-Anne undergoing surgery, poster exhibition of the work of anaesthetists, pain, risk of herbals to patients undergoing anaesthesia and surgery and cardiopulmonary demonstration with hands-on practice.

Student doctors and nurses, including those from Africa, together with their tutors fascinated by the lifelike Resus-Anne, who had heartbeat and chest that rose with each ventilation.

Members of the public and student nurses eager to learn more about the technique of airway management and chest compression.

Hospital Sultanah Aminah, Johor Bahru, Johor

Report by Dato' Dr Subrahmanyam Balan

Malaysian Society of Anaesthesiologists Johor celebrate World Anaesthesia Day 2008 on 16th October 2008.

The main focus of this celebration was in Sultanah Aminah Hospital where large banners highlighting World Anaesthesia Day were displayed at strategic areas in and around the hospital.

In conjunction with World Anaesthetic Day 2008 a poster exhibition showing various anaesthetic activities and history of anaesthetic was held for one week at the foyer of hospital. Anaesthesia staff members were on hand to explain to members of the public on the subject of anaesthesia.

E

5th Biennial Meeting on Cardiopulmonary Bypass

(8th to 10th August 2008)

On the auspicious date of 8th August 2008, which coincided with the opening ceremony of the Olympics in Beijing, the Perfusion Society, Johor Bahru, with Hospital Sultanah Aminah as co-organizer, successfully organized the **5th Biennial Meeting on Cardiopulmonary Bypass**. The venue was The Zon Regency Hotel, Johor Bahru. This was the second meeting organized by the society. The first one was in 2004 at the same venue. Our objective was to highlight updates, recent trends and challenges in Cardiopulmonary Bypass.

There was a turnout of about 490 delegates, local and from abroad. Other than perfusionists, cardiac anaesthetists, surgeons and cardiologists among the delegates, there were also paramedics, pharmacists and physiotherapists. Local delegates were mostly from MOH and private hospitals. There were also perfusionists and paramedics from India, Indonesia, Brunei and Thailand.

We put together a comprehensive scientific programme including perfusion, cardiac anaesthesia and surgery, cardiology, intensive care and allied health to cater to the wide spectrum of interest in cardiac services. A total of 35 speakers both local as well as distinguished foreign speakers from Singapore, India, Australia, Norway, Germany, China and the USA presented topics in the plenary and concurrent symposium sessions. They were also lunch and dinner talks sponsored by the pharmaceutical companies.

We were honoured that YAM Tunku Mahkota Johor, officiated the meeting and visited some of the 64 booths by the pharmaceutical and medical equipment companies at the expo hall. To add colour, there were life performances of traditional music like *"angklong"* and *"keroncong"* during coffee breaks and also entertainment by clowns.

The next morning about 50 delegates took part in the aerobic session. We were fortunate that one of our perfusionists was a qualified aerobic instructor.

At night, delegates were treated to Gala Dinner and entertained by local entertainers from Warisan Johor. Delegates from Hospital Umum Sarawak also put up a very colourful traditional dance. Lucky delegates walked away with prizes won in the quiz and lucky draw.

On the whole, it was a successful meeting and it would not have been possible without the hard work of the organizing committee, secretariat and most importantly the delegates who had taken their time and effort to attend this meeting.

Dr Raha
Hospital Sultanah Aminah, Johor Bahru

Needling Techniques Workshop

31st July to 1st August 2008

The ancient fine art of Acupuncture made a point recently with the two day Needling Techniques Workshop held on 31st July and 1st August 2008.

The event which was conducted by Dr Kavita Bhojwani, Pain Management Specialist, Hospital Raja Permaisuri Bainun, with support from Malaysian Association of the Study of Pain was well attended by Pain Management specialists and trainees from KL and Ipoh alike.

The first day of the workshop consisted of brief lectures on historical aspects and rudiments of acupuncture, including anatomical landmarks of specific points. The day ended with a lively session where participants practiced the needling techniques and moxibustion among and upon themselves!

Techniques learnt were put to good use the next day. During the two hour hands-on session, we applied needling techniques on fifteen of the regular acupuncture patients of Hospital Raja Permaisuri Bainun with various conditions ranging from osteoarthritis, SLE, migraine, post thoracotomy wound and even phantom limb syndrome. We cannot thank these wonderful patients enough for providing us this opportunity to learn.

Of course, all good things must come to an end. And so this workshop concluded with a simple ceremony where participants were awarded certificates of attendance by Dr Kavita before both patients and participants proceeded to enjoy a sumptuous lunch spread!

Dr Nandhini Krisnan
Pain Management Clinic
Department of Anaesthesia & Intensive Care
Hospital Raja Permaisuri Bainun, Ipoh, Perak

Work of Anaesthesiologists

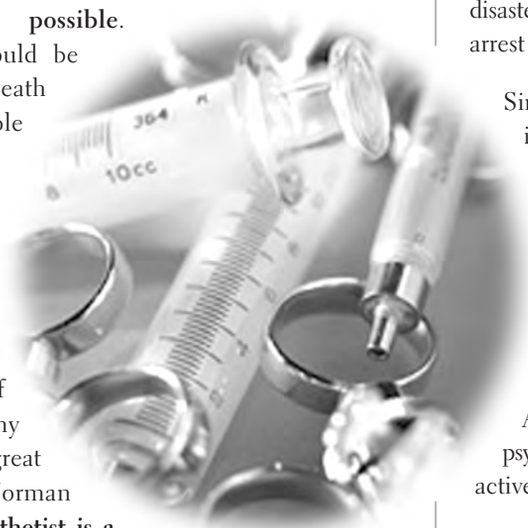
"Anaesthesia" was coined by Oliver Wendell Holmes, a professor at Harvard; because he said "it would be repeated by the tongues of every civilized race of mankind." **Indeed the in modern times, services of anaesthesiologists are required in ninety percent of departments in big hospitals. Anaesthesiologists are in very high demand around the world**.

The importance and need for surgery and anaesthesia was brought to the forefront by the two world wars. In 1948, anaesthesia was recognized as a specialty of equal status with other medical and surgical specialties. Nowadays anaesthesiologists practice one of the most complex disciplines of medical specialization.

The scope of anaesthesia also has widened tremendously in recent decades. No longer is the anaesthesiologist, a doctor in the background. In the USA, he ranks high among the highly paid doctors. People in general have many wrong ideas about anaesthesia, which need to be dispelled. **Many harbor the wrong notion that anaesthesiologists are NOT doctors and are assistants to surgeons**.

A measure of the advances made in safety and expertise in anaesthesia is the number of older and very young people who have operations in today's world. Age is no longer a barrier & even centenarians over 100 years old have been anaesthetized without a hitch. Neonates from day 1 of life undergo major surgery successfully with help from paediatricians and intensivists.

Painless surgery is made possible only by anaesthesia. Anaesthesia is one of the greatest achievements or discoveries in the history of medicine, making the rapid progress in surgery possible. Without it, surgery would be sheer torture, and death might be a preferable release in many cases.



People who are about to undergo an operation often worry about anaesthetics because they are putting their lives in the hands of a stranger, and any mistake could be of great consequence. Dr Norman Moore said, "**The anaesthetist is a person apart, the patient's life is in his hands**. The ease and perfection of an operation largely depend upon his skill……." The real concern of anaesthesiologists is to keep vital organs functioning properly. Meticulous attention to physiological needs of patients intraoperatively will result in high survival from surgery.

Giving anaesthesia is like not following a cookbook recipe. Everyone is different and each anaesthetic is carefully tailored to the health status of the patient, and requirements of the surgery. The anaesthesiologist is actually someone who "watching over you while you sleep" (from Shakespeare). Machine monitors cannot replace the careful observation by a doctor. Information from a monitor also needs clinical interpretation.

Early action taken during a critical incident will avert a major disaster. Better still steps should be taken where possible to avoid critical incidents, from occurring.

Anaesthesiologists are now expanding their roles as "**perioperative physician**" and no longer are just found in the operating theatre. His pivotal role in healing is not limited to pre-operative assessment, intra-operative management or post-operative care any more.

He is also the authority in the management of critically ill patients in intensive care and high dependency units. The most difficult part an intensive care specialist has to face working in the ICU is having to make decisions relating to life, its quality and its value because of increasing technological advances in medicine and science.

Anaesthesiologists are good at prioritizing, and it has been said that "the best doctor to have around in a crisis is an anaesthesiologist." Highly skilled in emergency situations, assisting in the vital care of breathing, resuscitation of heart and lungs and life support. They may be amongst the first people at disaster sites and medical emergencies, serving on "crash" cardiac arrest and resuscitation teams.

Since 11th September 2001, anaesthesiologists have been seen increasingly to play a very important role in chemical and germ warfare, tapping their expertise in life and multiorgan support.

The high level of professional care, commitment and knowledge on pain relief and pain management, is also utilized in helping patients in labour room, or in wards suffering from chronic pain or are for palliative care.

Anaesthesiologists too work in radiotherapy, dentistry and psychiatry, and if the facilities are available, they are also actively involved in teaching & research.

Dr Lily Ng Mooi Hang
Head & Senior Consultant Anaesthesiologist
OT & ICU Services Sabah

CME: Intensive Care

Dr Tai Li Ling

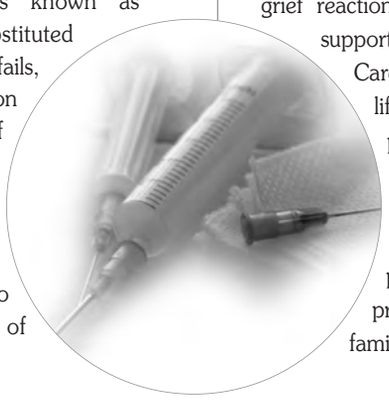
The Final Journey

"Mr. L, a 57 year old retired teacher had been enjoying good health prior to this hospital admission. He was admitted with severe abdominal pain and diagnosed with acute peritonitis. He underwent an emergency laparotomy which revealed gross faecal peritonitis and a perforated mass in the transverse colon. A Hartmann's procedure was performed. He was in septic shock and was admitted to the intensive care unit post-operatively. He had been on the ventilator for a week. He developed nosocomial sepsis and was on renal support therapy. He was agitated and restless whenever sedatives were reduced and required restraints on several occasions. He was not tolerating his enteral feeds. He was not showing any signs of getting better, if anything only signs of getting worse. His wife and daughter visited him daily. They were updated regularly regarding his condition. They were upset, confused and cried on every visit. His wife kept saying that she did not want her husband to suffer and yet not ready to bid farewell."

The focus of medicine has shifted from its early days of providing comfort care to curative care. The advancement in science and technology in modern medicine has enabled many patients to lead longer and healthier lives. However, science and technology too has its limits. Sometimes doctors fail to acknowledge that all of us die when we are at the end of our lives. We are made to believe that we have failed in our duty, if we cannot save patients from death. Death has become the enemy to be beaten at all costs. We fail to realize that when patients are at the end of their lives, life-support therapy no longer prolongs lives but merely prolongs death. The goal of intensive care of saving live shall change to maximizing comfort and ensuring a dignified death when patient is at the end of his live.

In 1997, Institute of Medicine in US, defined a good death as "one that is free from avoidable suffering for patients, families and caregivers in general accordance with the patients' and families' wishes". How can we improve the quality of end-of-life in the dying patients in the intensive care units? When death is imminent, the goals of care for that particular patient need to be reassessed. What is the realistic outcome of continuing medical care in that patient? The doctor should consider the likelihood of effectiveness of treatment, benefits, risks and burdens of treatment and most importantly the patient's wishes and values. Most patients at the end-of-life who are in the in intensive care unit do not have medical decision-making capacity. Discussions regarding end-of-life decisions shall be made with the patient's family. It is important to have clear, honest and effective communication between the medical team and the family. The doctor needs to determine the accuracy of the family's knowledge and degree of acceptance of the patient's condition and prognosis. In our local setting, advance directive or court-appointed guardian is an exception rather than the norm and the surrogate decision-maker is typically a family member or family members making the decision by consensus.

Family members shall be updated regularly regarding the patient's current condition, prognosis, benefits and burdens of treatment. All members of the medical team shall discuss the plan of care for the patient who is the end of his life. The surrogate shall not be left to make the decision unguided. He shall never be asked the question "What do you want us to do for your loved one?" or worse "Do you want everything to be done for your loved one?" Those questions make the surrogate feels that he is deciding whether his loved one lives or dies. Instead the surrogate shall be asked to focus on the patient and instead ask "If the patient is listening to our discussion, what will he want if he can decide for himself?" This is known as the principle of substituted judgment. Only if this fails, decision shall be made on the best interest of the patient taking into consideration the patient's wishes, beliefs and values regarding quality of life or also known as the principle of the best interest.



When death is imminent and the decision is agreed upon to terminate curative care, it is by no means stopping to care for the patient. It is shifting the goal of care from preventing death to providing symptom control and comfort care, thus allowing a dignified death for the patient and also providing emotional care for the family till the patient succumbs to his illness. When death is imminent, withdrawal or withholding of medical care which is unlikely to benefit the patient is medically appropriate. Neither is the doctor obliged to fulfill requests to provide life-support therapy in this situation. However, in situations where prognosis is uncertain or the family is unable to accept the inevitability of the patient's death, a time-limited trial of an intervention may be an option. Further family meetings and discussions shall ensue and in most instances the family will come to terms and accept that death is now inevitable after observing that everything has been done for the patient.

Once the decision on withdrawal of therapy has been made, the process of dying in the intensive care unit is usually short, within minutes to hours and rarely days. Pain and symptom control must be managed adequately. Stop all unnecessary medications and investigations. The family shall be briefed beforehand on the last hour's processes to reduce fear and frustrations. They shall be informed about the details of the process of withdrawal of life-support measures and be assured that the patient will experience the course of a comfortable and peaceful death. Team members must be frequently present to address the family's physical, emotional and spiritual needs. The patient and family shall be provided with privacy as far as possible and the family allowed spending as much time with the patient.

After death occurs, the care shall shift from the patient to the family. Assess the family's grief reactions and if necessary, provide support or refer to the relevant team. Careful management of end-of-life care will lead to smooth passage and comfort for the patient and his loved ones. Poor management results in incomplete life closure, possible suffering, difficult and prolonged bereavement for the family.

IN MEMORIAM

Dato' Dr Lim Say Wan

The Malaysian Society of Anaesthesiologists has lost a member who has contributed so much to anaesthesia and anaesthesiologists all over the world. I personally have lost a colleague and very close friend of over 50 years.

Say Wan excelled in everything he did. He was a champion in badminton, was involved in the formation of the Squash Rackets Association of Malaysia and excelled in golf.

He was dedicated to anaesthesia and the medical profession. As his wife, Jeannie, always remarks, his societies and work came before his family. They were always "last", but he was a devoted husband, father and grandfather.

His contribution to the Malaysian Medical Association, Academy of Medicine of Malaysia and the medical profession are enormous but I will confine myself to the Malaysian Society of Anaesthesiologists.

As President, he was a unifying force. He initiated the idea of the Confederation of Societies of Anaesthesiologists (CASA) with guidance from Prof Dr Quintin Gomez. As Dr A Damodaran was busy, he and I, President-Elect of the Society, went to Manila to help inaugurate CASA. We made many trips to Manila and the last time we were both caught in the camp.

He was instrumental in forming Asian Oceania Society of Regional Anaesthesia and personally encouraged Malaysian and Asean anaesthetist to join it. Today, AOSRA is a very successful organization.

Slowly but surely, he worked his way up the ladder in the World Federation of Anaesthesiologists and became the President – an achievement no other doctor in any organization has been able to emulate, stand corrected.

We, the Malaysian Society, organized the Second Asean Congress. Tun Dr Mahathir Mohamad graced the occasion. I was then the President. Say Wan was able to invite the President of the World Federation to grace the occasion and he was amazed that the Malaysian Society was able to get the Prime Minister of the country to grace the occasion.

That speaks volumes for us and we are forever grateful to Dato' Dr Lim Say Wan.

By Dato' Dr S Jenagaratnam

IN MEMORIAM

Dr Anthony S Manavalan

We mourn the passing of Dr Anthony Sebastian Manavalan who died on 12th December 2008.

Dr Manavalan was the second locally qualified anaesthesiologist in Malaysia. He came to the then Malaya in 1960 and served in the government service at Hospital Ipoh and as Head of Department of Anaesthesia in Hospital Kuala Lumpur.

He then went on to work at the Lady Templer Hospital in Cheras and was one of the pioneer anaesthetists in the country to do cardio-thoracic anaesthesia at the Lady Templer Hospital. In the late seventies and eighties, he was a visiting consultant to the University Hospital, University of Malaya.

He was among the founder consultants who started Pantai Medical Centre in 1973 where he worked till he retired in 1997.

Dr A S Manavalan was a very active member of the Malaysian Society of Anaesthesiologists being one of its pioneer members and is also a past president of the Society. He was one of the longest serving Treasurers of the Society. He is noted for the hard work that he put in, in his own quiet manner for the Society in spite of his busy schedule of work at Pantai Medical Centre. He was also a past Dean of the then Faculty of Anaesthetists of the College of Surgeons in Malaysia.

Medic-Alert Malaysia today is what it is because of Dr Manavalan's efforts. He single-handedly ran the Association and made known its functions to the public.

If one speaks to contemporary surgeons of his era, all of them without hesitation will say that he was one of the "**coolest**" anaesthetists that they have encountered. In fact at his funeral service, his very close friend and colleague Datuk Dr R S McCoy who delivered the eulogy referred to Dr Manavalan on the "**Roger Federer of Anaesthesia**" because of his quiet and cool nature. A quiet and unassuming skilled anaesthetist, he served his profession till he retired in 1997.

Being basically a family orientated person he spent his retired life at home with his wife and grand-children, till he succumbed to a long standing illness on 12th December 2008.

He is survived by his wife and five children and several grand-children. Anaesthesia in Malaysia has indeed lost one of its illustratrous pioneer members.

By Dr Sylvian Das