BERITA ANESTESIOLOGI

JILID 7 BIL 1 JANUARY 2005

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

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Ask What You Can Do for the Society …

Prof Chan Yoo Kuen, President, Malaysian Society of Anaesthesiologists

Happy New Year!! I really hope 2005 brings better tidings all around for you and your loved ones. I believe you have your New Year resolutions in place but just in case you do not, may I offer some suggestions that you can take up to make life better for you as well as the Society.

May we suggest that you get on line into the Society website and get yourself enrolled into the database for Maintenance of Professional Standards (MOPS). If you have any difficulty getting into the website or you have problems accessing the database get Ms Kong to help you.Do it regularly as and when the event presents itself so that you do not have to suffer the consequences of procrastination at the end of the year! In our mad scramble to see how much we have done, come the end of the year as part of our assessment,those of us who do not meticulously put our house in order invariably leave a huge chunk of our achievements out!! The Society has paid a fair amount to bring this facility to you – it is time the Society asks you to take advantage of this and get your professional life in order…

In order that 2005 ensures that you are in the thick of the things, may we suggest that you open the website too for access to the University Malaya Medical Library that the Society has made available to you. We have to pay a fee of almost RM 4000 to allow any 3 of you to access at any one time. All details about access to the on-line library can be obtained after you have accessed into the MOPS database as the password has to be kept secure to prevent non-qualified users from clogging up the library!

If updating through reading is not good enough,may we suggest that you attend some anaesthetic conferences that are coming our way very soon. The AGM together with the accompanying scientific programmme promises to be very exciting. For the first time in the history of the Society, it will be held away from the Klang Valley in the island of Penang on 18 to 20 March. Do make it a point to mark the date in your calendar and bring your family along as well. If you insist on staying put in the Klang Valley, there is another meeting in September from 9 to 11, the 3rd National Conference on Intensive Care which will be held in the Sunway Pyramid Convention Centre in the Sunway Pyramid, Petaling Jaya. For those of you who wants to seek knowledge away from our shores and would also like to have some traditional excitement thrown in I would suggest that you keep yourself free to travel to Vietnam. The Asean Congress will be held in Hanoi from 23 to 25 November this year.

If self improvement is not what you want but improvement of the Society is what you are looking for – may we suggest that you contribute articles to the bulletin that is coming out quite regularly. Even if it is some pictures of some anaesthetic related events or something you think the anaesthetic community should know or hear about, the editor would be very appreciative of your contribution. In fact you may even want to consider stepping into the shoes of our editor, Dr K P Ng,who has done a marvelous job so far but may not find enough time to continue being our editor for too long. If you have more time on your hands and would like to contribute something regularly could we ask that you come forward to be an Executive Committee member in the Society. The AGM will be held in March and we are looking for contributing members to come forward as Executive Committee members to support the myriad activities that the Society has slowly got itself involved in.

We may also like to enlist you – those whom we have been able to reach so far, to get other members of the anaesthetic community whom we have been unable to reach, to get back into the fold. We are a small community but we have been able to do a lot of things because there are a few who have worked relentlessly for the mass! To these I must say a big thank you but I would like to encourage all those who have not been able to contribute due to other commitments to make time this year for a new resolution – to ask what you can do for the Society!!

In this Issue …

Message from CCMS Chairperson, Dr S H Ng

3rd National Conference on Intensive Care

As soon as the 2nd national conference was over in October, the organizing committee wasted no time and started planning for the 3rd conference in 2005. For a change and away from KL city, we decided to hold the next conference at the Sunway Pyramid Convention Centre at Bandar Sunway. The convention facilities are ideal for meetings of our scale (600 – 800 delegates) and with the opening of the NPE, the hotel is now easily accessible and without the traffic jam! Three speakers of international status have so far confirmed their participation i.e. Dr David Tuxen (Australia), Dr Charles Gomersall (Hong Kong) and Dr Julian Bion (UK). We promise you an exciting scientific programme and we look forward to seeing you on 9 to 11 September 2005.

Proposed name change from CCMS to ICS

The Executive Committee will be tabling a motion in the next MSA AGM to seek a name change from Critical Care Medicine Section to ICS (Intensive Care Section). This change is necessary as intensive care is now a well-defined subspecialty and world wide, more intensive care societies are formed without attempting to encompass the other areas of acute care e.g. emergency medicine, pre-hospital care and other acute care e.g. burn, respiratory care. CCMS/MSA was formed in the early eighties and was modeled on the Society of Critical Care Medicine (SCCM) in the US, the icon of intensive care at that time. However, in the last twenty years, both intensive care medicine and emergency medicine have matured and there is now a trend to go separate ways. A search in the internet showed that there are only four critical care societies in the world i.e. US, Canada, Hong Kong and India. The rest of the countries are represented by intensive care societies (UK, Scotland, Europe, Australia and New Zealand, and all Asian Pacific countries). In some, it is the society of anaesthesiology and intensive care medicine (Scandinavian, France, Germany and Czech). CCMS/MSA has never included and will not involve emergency care and other acute care outside the confines of the ICU and it is therefore logical for us to rename our section as Intensive Care Section (ICS). I am confident that you will give your approval during the AGM.

Surviving sepsis campaign road-shows

CCMS will be organizing a series of road-shows in 2005 to create awareness and educate doctors in the management of sepsis. This is a part of a global effort to improve the outcome of sepsis which has been identified as the main cause for admission to intensive care units. I refer you to Dr Nor'Azim's article in the same issue for more details.

EDIC certification and CCMS subsidy

In the last two decades, intensive care units are increasingly being managed by intensivists. In countries where anaesthetists have traditionally played a major role in the management of ICU, more anaesthetists have sought certification in intensive care medicine. Almost all the ASEAN countries have started their local training programme and certification in intensive care. In Malaysia, I envisage that this will become feasible when we have attained a critical mass of intensivists, perhaps in the next three years. To achieve that, CCMS and the Ministry of Health are encouraging more anaesthetists to seek training and certification under the European Diploma of Intensive Care (EDIC) programme. This is in line with the Ministry of Health's policy to develop intensive care as a subspecialty and not a base specialty.

EDIC certification requires undergoing two years of training in recognised ICUs (both local and/or overseas) and passing an examination (Part I MCQ and Part II clinical). As an incentive, CCMS offers a subsidy of RM 3000 to its members who passed the final exam. Meanwhile, we are exploring the possibility of getting the European Society of Intensive Care Medicine (ESICM) to hold part of the exam in Malaysia. If you are interested in doing the programme, please get advice from any of the following members who are EDIC holders: Prof Patrick Tan (UMMC), Dr Tai Li Ling (HKL), Dr Shanti R D (HKL), Dr Nor'Azim Mohd Yunus (UMMC) and Dr Basri (IIU, Kuantan) or contact me directly.

On behalf of CCMS and the Executive Committee, I wish you a Happy New Year.

Surviving Sepsis Campaign

By Dr Nor'Azim Mohd Yunos

Malaysian Surviving Sepsis Working Group, Critical Care Medicine Section, MSA

The high rate of mortality from severe sepsis has long been a concern in intensive care medicine. Various efforts have been put into looking at ways to improve the outcome of severe sepsis. These range from the large number of clinical trials, focusing on various interventions to treat severe sepsis, to the clinical guidelines by various authorities. Despite all these, the outcome in severe sepsis remains unsatisfactory. Mortality between 30 and 50 percent has been reported, with a higher figure of 50 to 60 percent when shock is present. More worrying is the fact that the incidence of sepsis is increasing, at an estimated rate of 1.5 percent per year. With growing use of invasive procedures and immunosuppression in medicine, coupled with growing numbers of elderly and vulnerable people, the incidence of sepsis is bound to increase even further.

Lack of awareness among health care givers of the seriousness of this condition has been identified as one of the root causes of poor outcome. Patients with severe sepsis are often under-diagnosed and are not given appropriate therapy during the early stages when the sepsis is still potentially reversible. Another observation as well, is the lack of uniformity in the application of proven successful interventions of severe sepsis. Such haphazard treatment of these sickest of patients contributes to low reliability of their care and eventual failure in the attempt to reduce mortality.

Against this background, the Surviving Sepsis Campaign was launched in 2002. It is a collaborative effort of the European Society of Intensive Care Medicine (ESICM), Society of Critical Care Medicine (SCCM) and International Sepsis Forum (ISF). The essence of this campaign is the Declaration of Barcelona, signed by major leaders and supporters in intensive care during the ESICM congress in Barcelona in October 2002. The Declaration called on healthcare professionals, governments, healthcare agencies and the public to adopt the following 6-point action plan to reduce the incidence of sepsis mortality by 25% within 5 years (starting in 2002):

1. ***Awareness:*** *increase awareness of healthcare professionals, governments, health and funding agencies, and the public of the high frequency and mortality of sepsis.*
2. ***Diagnosis:*** *improve the early and accurate diagnosis of sepsis by developing a clear and clinically relevant definition of sepsis and disseminate it to our peers.*
3. ***Treatment:*** *increase the use of appropriate treatments and interventions by disseminating the range of care options and urging their timely use.*
4. ***Education:*** *encourage education of healthcare professionals who manage sepsis patients by providing leadership, support and information to them about all aspects of sepsis management, including diagnosis, treatments and interventions, and standards of care.*
5. ***Counselling:*** *provide a framework for improving and accelerating access to post-ICU care and counselling for sepsis patients.*
6. ***Referral:*** *recognise the need for clear referral guidelines that are accepted and adopted at local level in all countries by initiating the development of global guidelines.*

The campaign includes three phases:

I. Declaration of Barcelona

II. Evidence-based Guidelines:

A group of international intensive care and infectious disease experts, representing 11 organisations from Northern America and Europe have met in June 2003 to produce evidence-based guidelines for management of severe sepsis and septic shock. These guidelines have been presented during both ESICM and SCCM annual congresses and have been published in both Intensive Care Medicine and Critical Care Medicine journals.

III. Education and Awareness:

Dedicated to providing information and education on various aspects of sepsis management, based on the evidence-based guidelines above. This phase also evaluates the impact of the guidelines on clinical outcome.

The Critical Care Medicine Section (CCMS) of MSA realised that Malaysia should not be left out of such a comprehensive global effort at improving the outcome in severe sepsis. Hence, a Malaysian Surviving Sepsis Working Group (MSSWG) was formed, under the auspices of CCMS and sponsorship by Eli Lilly, comprising local intensive care experts. This working group, linked to the Steering Committee of the international Surviving Sepsis Campaign, will be responsible for implementing the campaign in Malaysia. The Malaysian Surviving Sepsis

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Campaign was officially launched by Prof Dr Jean-Louis Vincent, a world-renowned intensivist and key figure in the Steering Committee, during the recent 2nd National Intensive Care Conference in September 2004.

MSSWG has held several meetings to plan programs for the local Surviving Sepsis Campaign, which will in particular focus on the objectives of Phase III of the campaign. The main program will consist of a series of road shows to be held throughout the country, aiming to increase awareness and to educate on recent advances in the management of sepsis. The target group of these road shows will be the Medical Officers, not only from Anaesthesiology but other relevant specialities like Internal Medicine and Surgery. By targeting this group, it is hoped that severe sepsis will be detected earlier, with timely and uniform treatment provided.

Each road show will be conducted for a full day on a working Saturday It will be a mixture of lectures by members of MSSWG themselves, as well as interactive sessions where cases of severe sepsis will be presented and their management discussed. The road show will also promote the use of Evidence-based Guidelines for Management of Severe Sepsis and Septic Shock, adopted from guidelines by the International Surviving Sepsis Campaign. Posters and pocket guides will be distributed to further disseminate awareness of these guidelines. As the number of participants will be limited, letters will be sent to Hospital Directors to nominate Medical Officers from relevant Departments. Five road shows have already been planned for 2005. The venues are:

1. *Hospital Selayang, 29 January 2005 (for Klang Valley)*
2. *Hospital Kuantan, April 2005 (for East Coast region)*
3. *Hospital Alor Setar, June 2005 (for Northern Region)*
4. *Hospital Ipoh, August 2005 (for Perak)*
5. *Hospital Johor Bahru, November 2005 (for Southern Region)*

It is our eventual aim that the year 2006 will see the road shows reaching East Malaysia.

Apart from holding road shows, MSSWG is also hoping to start a Malaysian Sepsis Database. The plan is to integrate this with the ongoing National ICU Audit involving all MOH hospitals. Efforts are also being made to involve all teaching hospitals (UMMC, HUKM, HUSM). At present, discussions are still held with the various parties involved, with the target of commencing it by the latter half of 2005.

Let's hope that the Malaysian Surviving Sepsis Campaign will succeed in creating more awareness of the seriousness of sepsis and in bringing about a more streamlined and evidence-based approach to managing sepsis in this country. Ultimately, we hope that more lives in this country will be saved from sepsis.

Successful Candidates in the Masters in Anaesthesiology Examinations – November 2004

FINALS

UKM Conjoint M. Med (Anaes)

Dr Hanapi b Mohd Tahir
Dr Malarvilee a/p Paul Samy
Dr Zarina Abu Kasim

UM Conjoint M. Anaesthesiology

Dr Muralitharan a/l Perumal
Dr Aminuddin bin Ahmad

USM M. Med Anaesthesiology

Dr Ng Kim Swan
Dr Sobha d/o K K Gopala Kurup

PRIMARY

UKM Conjoint M. Med (Anaes)

Dr Ismail Tan b Mohd Ali Tan
Dr Williemena Ong Hsu Chang
Dr Tan Hung Ling
Dr Sidney Saw Lee Teng

PRIMARY

UM Conjoint M. Anaesthesiology

Dr Jeyanthi a/p Kunadhasan
Dr Ling Kwong Ung
Dr Tan Kok Hui
Dr Wong Kang Kwong
Dr Nor Hayati binti Mohd Said
Dr Yap Huey Ling
Dr Lim Ern Ming
Dr Ina Ismiarti binti Shariffuddin
Dr Jeswinder Kaur a/p Jaswant Singh
Dr Ushananthini Kolandaivei
Dr Mohd Shahnaz bin Hasan
Dr Vineya Rai a/l Hakumat Rai

By The Way ...

Members access to Online Library

Remember the MSA MOPS website that was launched at the 2nd NCIC in September 2004? Well an additional service is now in place for all registered members courtesy of the MSA – the University Malaya Medical Library Online. Please check out the MOPS website for details on the procedures to obtain the password to access this virtual library. Our subscription started 1 January 2005.

Fund Raising Drive

Academy of Medicine of Malaysia and Academy of Family Physicians of Malaysia

By now some of you would have heard that the two Academies have agreed to jointly build the Academies of Medicine Building on the Joint Colleges Land next to the Istana Budaya and the National Library in Jalan Tun Razak, Kuala Lumpur, for the purpose of having a building which will support the educational and training activities of the Academy of Medicine of Malaysia and the Academy of Family Physicians. A fund raising exercise has been initiated to raise RM2 million in order to enable commencement of the construction.

In aid of this, the fund raising committee has sent out an appeal to all Academy members for donations to the Academy Education and Development Fund (tax exempt), and organised a fund-raising dinner on Saturday, 30 April 2005 and a Charity Golf Competition on 13 March 2005. Many attractive prizes are being offered to participants of these events, particularly in the lucky draws for donors for the dinner. For more information contact Ms Kong at the Academy of Medicine of Malaysia, Email : acadmed@po.jaring.my

News from Down Under

By Dr Thong Chwee Ling, December 2004

I logged onto the department website, perusing the roster for the following week. Oh, this will be 'fun' – the peritonectomy list on Tuesday. I had never heard of this procedure for pseudomyxoma peritonei until I got here. I recall days when surgeons spent hours operating on patients with advanced disease, trying to decipher the anatomy before them. Often it was palliative, and sometimes it was an open-and-close procedure.

Not with Prof David Morris. St George Hospital has become a referral center for pseudomyxoma peritonei. He operates on one patient a week, and occasionally, there are re-do surgeries. A few years ago, a procedure like this could go on for 24 hours resulting in massive blood loss and transfusion with DIC. Transfusing more than 20 units of packed cells and a whole truckload of blood products was usual. Not in recent years though, as the surgeon got over his learning curve (but don't anyone mention it to this particular surgeon!) and most operations are completed by sundown. The other reason is because the surgeon got Prof Peter Kam, a master of massive blood loss and transfusion, as his regular anaesthetist. In the few cases I assisted Prof Kam in, we transfused not more than 6 units of packed cells.

We start at half past seven in the morning. An arterial line, a triple lumen central line and a Swan sheath are inserted into the patient. After induction, aprotinin, morphine and actrapid infusions are set up. Intraoperatively, the patient receives 2 to 3 liters of albumin 4% and crystalloids as required. The surgical team opens up the abdomen and proceeds to tease the tumour away from the bowel, stomach, liver and whatever else the tumour is stuck to. Splenectomy is performed and often, a stoma is fashioned. The process is tedious and blood loss may be appalling.

We do regular ABG, FBC and coagulation screens intraoperatively. All electrolyte abnormalities are corrected. However, Prof Kam does not rely too much on the coagulation screens to decide on the patients' need for blood and blood products, as the lab results are always a tad too late. It is not just WHAT we give patients, it is also a matter of WHEN we give it, he once said as he handed me a copy of "Minimizing dilutional coagulopathy in exsanguinating hemorrhage: a computer simulation" (Hirshberg A et al, J of Trauma 2003; 54:454-463).

Occasionally things can turn rather dramatic during surgery. I recall a patient whose IVC, and possibly the hepatic vein, were injured during dissection around the porta hepatis. The surgeon managed to clamp the IVC infrahepatically, but he could not clamp the distal part of the IVC. We called in a cardiothoracic surgeon who performed a sternotomy and managed to control the IVC from

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above. Luckily the hepatic vein was intact and the IVC was repaired. What really impressed me was the response of my nurse. When the surgeon first informed the anaesthetic team the gravity of the problem, my nurse alerted a colleague who came to provide an extra pair of hands and the Level One infusor was in OT within minutes.

Once the surgeon is satisfied with the dissection, the team will build a silo over the incision. Heated intraperitoneal chemotherapy (HIPEC) is then used. This involves the cycling of heated chemotherapy (42 degrees) into the peritoneal cavity using a cardiac bypass machine for 90 minutes. All non-essential staff leave the OT (this is usually my cue for a long coffee break while Prof stays behind to baby-sit the patient) while the remaining staff, including the perfusionist, have to don personal protective equipment. Not pleasant, especially since the mask reminds me of the N95 we used during SARS....

We control the patient's core temperature with hotlines and forced air warming (Bair Huggers) intraoperatively, but all these are turned off and ice packs are placed around the patient's head and neck during HIPEC. Despite measures taken, nasopharyngeal temperature can rise to above 38 degrees during HIPEC. The surgical team performs a leak test after closure of the rectus. This is because often the patients get a few more rounds of intraperitoneal chemo in the ICU and any leak may be disastrous.

Performing major procedures like this cost money, and Prof Morris is not above getting the media to help raise funds. With the permission of the patient, he once invited a TV crew to film the surgery. I had to duck behind the anaesthetic machine to make sure I did not appear on national TV.

All good things must come to an end. There have been many memories, both pleasant and not-so-pleasant. The first few months were the most difficult – trying to fit in and make new friends; having to convince the consultants and the anaesthetic nurses that this visiting fellow from Malaysia could actually speak English, intubate the trachea and perform 'difficult' tasks like putting in an epidural or a central line. Yes, I do know what a ProSeal is, and yes, I am quite adept with the bronchoscope for difficult intubation. Okay, so I didn't know what a Jackson operating table was all about (it's a pretty cool table where Stryker frame meets OT table – you can turn a patient with spinal injuries prone without the usual heave-ho), and although I have done stereotactic craniotomies in UMMC, I certainly did not know what a **frameless** stereotactic craniotomy was. (I have since done quite a number). I have rarely provided services for endoscopy back home, paeds being the exception. I ran my first endoscopy list in Australia with a consultant. Since then, I run 2 to 4 gastroscopy, colonoscopy and ERCP lists on my own every month – not my favourite thing in the world, since one ends up anaesthetising some of the oldest, sickest patients in town in a remote part of the hospital. Recently a woman with cholangitis was listed for emergency ERCP. She weighed at least 150kg. The thought of having to intubate a fat woman with no discernable chin in a tiny room in the radiology department far away from any help was daunting. The thought of having to then put her into the prone position broke my heart (and probably my back as well). Then having to share her airway with a gastroenterologist with limited understanding of anaesthesiology.... All this while I would be sweating under the lead apron, with the GA machine at the foot end of the table and anaesthetic trolley in a far-flung corner of the room, having to manouvre among the C-arm, the endoscopist and his 3 assistants, the radiographer and a kilometer of extension wires on the floor – did I mention the room was really tiny? Then an angel pointed out the table could *only* take weights of up to 120kg – the case was cancelled.

I had a couple of run-ins with racists as well, but generally things have been fine. One evening, I looked up from the anaesthetic chart to catch Ross Crouch, a blond haired, gray eyed scrub nurse roll his eyes heavenward as the orthopaedic team struggled to fix a fracture. His circulating nurse, Vicki Wong ("My husband and I migrated from Hong Kong in 2000") scampered around fetching equipment from the orthopaedic cupboards. As the orthopaedic team which consisted of Sami Farah (Egyptian descent), Tavor Hovav (Israeli fellow) and Zoltan Szomor (from the country previously known as Yugoslavia) struggled on, my anaesthetic nurse Oanh Pham (Vietnamese descent) sat beside me and cracked a joke in English, with a decidedly Aussie accent. We laughed. Malaysia is not the only multi-racial country in the world.

Five things I will not miss about Australia:

1. The weather. I remember my misery in winter, sitting in front of my tiny heater as the wind from Botany Bay (barely two km away) howled and rattled my windows and chilled me to the bones. More misery getting out of bed in the morning. One tiny heater is inadequate! Going through a 40 degree heatwave in summer with nary an air conditioner nor a fan in my apartment.

2. Having to anaesthetise overweight patients. I have lost count of the number of my patients with BMI of 40 and above. BMI of below 25 is an exception, not the rule.

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3. Having to anaesthetise patients in their 80's and 90's with medical histories that will not fit into your anaesthetic charts. Some of them are barely fit for a haircut. There will always be at least one of these patients presenting for emergency hip surgery or endoscopy every day. This is in addition to the other half dozen geriatric patients who come in for DOSA (day of surgery admission) or day surgery.

4. Working with the threat of being sued – Sydney has one of the highest rates of malpractice suits in the world.

5. The flies – they are everywhere!

Five things I will miss about Australia:

1. Generally, the higher standard of anaesthetic nursing. (Unfortunately the two worst nurses I ever had are also here)

2. The gentle showers, as compared to the downpours we get at home.

3. Living so close to the ocean – it is possible to go for long coastal walks every weekend.

4. The sane working hours.

5. A much better way of accessing information about a patient. Often one can get good history from the patient (they can list their medications and allergies instead of telling me they take a yellow pill for hypertension) or just pick up the phone and ring their GP, or get his cardiologist to fax his angiogram results over.

The craziest thing I have ever done? Jumping out of a plane at 8000 feet…. I had always wanted to go skydiving, and when the opportunity to go on a tandem jump came, I signed up! On that day, I met three Englishmen (Aussies call them 'poms') who, like me, were going for their first jump and wondering what made them do this mad thing. We had to read and sign a few forms. Then I met Doug, the instructor with whom I would make my jump. Doug helped me get into my gear; I got a pair of goggles which allowed me to keep my spectacles on – of course I wanted to see where I was going! A few minutes of instructions and then 9 of us – 4 scared 'victims' with our respective instructors and a cameraman got into the plane.

I had declined to have photos and videos taken of my jump – I had already busted my budget doing this. Besides, I didn't think I would need photos or videos to help me remember this occasion – no way will I forget the experience! Doug jumped into this tiny plane and I followed. There were no seats, only two small beams along the floor. Doug sat with his back to the pilot on one of the beams and I sat in front of Doug. Then the other 3 pairs and the cameraman climbed in and I realized first in last out! I turned to Doug and said, "Please don't drop me!"

At 4000 feet, Doug told me to sit on his lap. He then hooked my gear to his gear, tightened and checked everything. My back was strapped so closely to his chest that I could feel his every breath and then he said, "Where I go, you go." At 8000 feet, the door opened, one of the poms and his instructor sat on the ledge. Suddenly whoosh – they and the cameraman disappeared. The second pair edged to the ledge and whoosh – gone too. And the third….

Doug and I slid on our bums and I placed my feet on the ledge outside the plane. The wind was so strong my right leg was blown off the ledge. "Position!" Doug yelled and I extended my neck and crossed my arms on my chest. I remember thinking that I was not in position because my right leg was just hanging in mid-air… suddenly I lurched forward and AAAIIIEEEE…..

The feeling is totally amazing. We somersaulted in the air as we hurtled to the ground. The wind was roaring in my ears – I couldn't even hear myself scream. For a split second, I was falling backwards and I could see the blue sky and clouds. Doug tapped me on my shoulder and I assumed a new position – my back was arched while my arms were out (just think of the "Hands up!" position in the cops-and-robbers shows). I was now floating on my belly and I could look around at the ground, the river, the sea, everything.

Jumping out at 8000 feet allows only 15 seconds of freefall as the parachute is deployed at 5000 feet. To think I fell 3000 feet in 15 seconds… I felt Doug tug at the cord and as the chute opened out I felt us decelerating. I was pulled into an upright position, and the harness around my legs bit into my thighs as they bore my weight. As we drifted downwards, I felt I had all the time in the world. Doug showed me how to steer the chute. As we neared the ground, Doug yelled "Position!" and I flexed my hips and knees. I landed on my bum, and we were dragged for about 3 meters before coming to a stop. I was back on terra firma, my wildest ride had ended.

I cannot help but draw parallels between my jump and our work as anaesthesiologists. Our patients come to us, fearing the big unknown, just the way I felt as I sat at the door of the plane. They had to sign consent forms, just as I had to sign disclaimer forms. When Doug told me "Where I go, you go" I felt as if it was like me telling my patients that they would all right, that I would take care of them. I had to trust Doug, someone I had met just minutes before the jump, and hoped that he had checked his equipment (including the spare chute!) and would know what to do if things went wrong, just as our patients come to trust us after just a

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10 minute consultation. They too hope that we have checked our equipment and will know what to do if things go wrong. They hope that we will not 'drop' them. At least the science involved in parachuting can be understood by secondary level physics students. We haven't even figured out how some of our drugs work – and yet our patients put their lives in our hands.

There are so many people to thank. Friends I knew from school who now call Sydney home; thanks for looking out for me. Anaesthetic consultants, fellows and registrars from whom I learnt and shared ideas with, especially Lorraine, who signed off as "fellow-sufferer @ St George". Nurses, porters and patients. Last but not least, Prof Peter Kam, who has been a wonderful teacher and mentor. Looking forward to seeing family and friends again in Malaysia.... Cheers!

EVENTS

PAST EVENTS

24 – 26 SEPTEMBER 2004

2nd National Conference on Intensive Care

Hilton Kuala Lumpur, Sentral Station, Kuala Lumpur

Theme : Challenges in ICU

Another successful and enjoyable event. Thanks and congratulations to the organizers! (who, by the way, are already at work on the next conference)

14 OCTOBER 2004

National Anaesthesia Day

Kuching, Sarawak

The event was organized very successfully by Dr Norzalina and colleagues in Kuching for which the Executive Committee would like to extend their deepest appreciation for their hard work and efforts.

14 OCTOBER 2004

National Anaesthesia Day

Auditorium Sri Baiduri, Hospital Melaka, Melaka

by the Department Of Anaesthesia & Intensive Care, Hospital Melaka

We celebrated Anaesthesia Day in the Melaka State on 14 October. We had a very grand ceremony, officiated by Y A Bhg Toh Puan Dato' Datin Seri Utama Zurina Binti Kassim, wife of the Governor of Melaka at our Hospital Auditorium. We also concommitantly launched the Opening of our High Dependency Ward.

This event was attended by 400 people which included NGO's and members of the public. We had a "Operation Theatre Scene", a CPR and Intubation Demonstration as well as a video and poster presentation, depicting the scope of our services.

We also had participation from the anaesthesia units of the private hospitals and Terendak (Army) Hospital in Melaka. Posters were also displayed at the foyer of Hospital Melaka for a week. The event was publicized over the radio and the public were impressed. We too were happy with their response.

FUTURE EVENTS

28 – 30 JANUARY 2005

Basic Pharmacology Course for Anaesthetic Medical Officers

Hospital Pulau Pinang, Pulau Pinang

For more info, contact Dato' Dr Jahizah Hj Hassan at Hospital Pulau Pinang.

24 FEBRUARY – 1 MARCH 2005

6th South Asian Conference of Anaesthesiologists, 2nd Conference of the South Asian Regional Pain Society and the 21st Annual Scientific Session of the College of Anaesthesiologists of Sri Lanka

Colombo and Kandy, Sri Lanka

For more information, please contact Ms Kong at the Academy House.

18 – 20 MARCH 2005

Annual Scientific Meeting MSA/AGM MSA, College of Anaesthesiologists and CCMS

Bayview Beach Resort, Penang

Announcements regarding the ASM have been circulated. Please book your leave as well as hotel room for you and your family! Reliable sources guarantee an informative scientific programme and a fun-filled social programme with entertainment provided by members from each state among others. Don't miss it! Not to forget that the Young Investigator's Award and MSA Award are both up for grabs for he or she who presents the best free paper on any original work in Anaesthesiology and Intensive Care. Prestige aside, the prize money is worth having a go at too!

Also please be informed that the Annual General Meeting of the College of Anaesthesiologists will be on 18 March 2005 @ 1630hr while the MSA/CCMS AGM is slotted for the 19 March 2005 @ 1615hr.

9 - 11 SEPTEMBER 2005

3rd National Conference of Intensive Care (3rd NCIC)

Sunway Pyramid Convention Centre, Petaling Jaya, Selangor

Hold your horses, 1st announcement not out yet... but mark your diary.