VOLUME 38 • ISSUE 2 • JULY 2024

BERITA ANESTESIOLOGI

MALAYSIAN SOCIETY OF ANAESTHESIOLOGISTS

COLLEGE OF ANAESTHESIOLOGISTS, AMM

STEPPING OUT OF COMFORT

SUPER GASMAN

Message from the PRESIDENT OF MSA

Dato' Dr Yong Chow Yen

Dear Esteemed Colleagues and Members,

Greetings. I hope this issue of Berita Anestesiologi finds you in good health and spirit.

Reflecting on the theme of "Stepping out of Comfort" in this issue of Berita, may I share with you an excerpt from Wikipedia that I extracted on 29th June 2024. Please bear with me as it is a bit of a read:

'US Airways Flight 1549 was a regularly scheduled US Airways flight from New York City's LaGuardia Airport to Charlotte and Seattle, in the United States. On January 15, 2009, the Airbus A320 serving the flight struck a flock of birds shortly after takeoff from LaGuardia, losing all engine power. Given their position in relation to the available airports and their low altitude, pilots Chesley "Sully" Sullenberger and Jeffrey Skiles decided to glide the plane to a ditching on the Hudson River. All 155 people on board were rescued by nearby boats. There were no fatalities….. The time from the bird strike to the ditching was less than four minutes.

A few months after the crash, Captain Sullenberger, while being interviewed, was asked how he was able to execute a nearly perfect water landing. He replied, "One way of looking at this might be that for 42 years, I've been making small, regular deposits in this bank of experience, education, and training. And on January 15, the balance was sufficient so that I could make a very large withdrawal".

It is worth noting that at the time of the event, 57-year-old Captain Sully, a former fighter pilot of the United States Air Force, was an extremely accomplished pilot. He had logged 19,663 total flight hours, including 4,765 in an A320; he was also a glider pilot and an expert on aviation safety.

As anaesthesiologists, our daily lives consist of navigating challenges, where a seemingly routine case can suddenly turn into an unexpected life-threatening emergency, some familiar, some unfamiliar. During moments of unfamiliarity, we are called upon to stretch our knowledge and skills beyond what are comfortable. Under this circumstance, for our patients to have the best chance of survival, we will need bank deposits as substantial as Captain Sully's.

In our bank accounts, in addition to knowledge, skills and experience, we need deposits of traits essential for our profession, where earning compound interests frequently require us to step out of our comfort zones. Embracing continuous learning, adapting to change and innovation, cultivating resilience, and fostering personal and professional growth through support and collaboration make navigating unfamiliar territory easier. I hope as you read this issue of the Berita, you will find in the articles the journeys the authors have taken beyond their comfort zones and the personal growth that comes with it.

There is another person involved in the US Airways Flight 1549 incident that we could probably identify with as well. Air traffic controller Patrick Harten described, *"It may sound strange, but for me the hardest part of the event was when it was over. During the event, I was hyper-focused….. but when it was over, it hit me hard"*. Patrick Harten was unable to return to work until a month after the event and felt normal only a year later (JAMA. 2015;313(4):361-362). After the incident, Captain Sully couldn't sleep or concentrate for three months, and he didn't return to flying for nearly half a year. This was notwithstanding the fact that the US National Transportation Safety Board described the incident as "the most successful ditching in aviation history".

My dear colleagues, there are many lessons anaesthesiologists can learn from this incident. If you can find the time, I urge you to read the article "What I Learned About Adverse Events from Captain Sully: It's Not What You Think" (JAMA. 2015; 313(4): 361-362) by Marjorie Podraza Stiegler. The article discusses the consequences of critical incidents affecting even the most experienced among us, regardless of a successful outcome. It highlights what we can learn from the aviation industry on managing pilots and staff after incidents, which ultimately is a safety issue.

Another piece of information from this incident that I found insightful was a reminder to be mindful when judging others. Flight simulations showed that the aeroplane could have returned to

LaGuardia had it turned toward the airport immediately after the bird strike. However, the Board found that the scenario did not account for real-world considerations and affirmed that ditching provided the highest probability of survival, given the circumstances.

I appreciate you reading my ramblings and reflections on our Berita's theme. Let's go through some updates on happenings since my last message.

MyAnaesthesia 2024, 2nd to 4th August 2024, Kuala Lumpur

MyAnaesthesia 2024, the Annual Scientific Congress (ASC) of the Malaysian Society of Anaesthesiologists (MSA) and the College of Anaesthesiologists (COA), Academy of Medicine of Malaysia, will be held at Shangri-La Kuala Lumpur. The Scientific Committee is working relentlessly to ensure the scientific programme meets your needs. This year, the theme is MyAnaesthesia 2024: Where Science Meets Art".

The response to abstract submissions by Malaysian and foreign researchers is overwhelming. I hope the entire fraternity will turn up to support our budding scientists in their presentations.

The pre-congress workshops are designed to improve your skills in managing challenging patients. The Organising Committee is keeping the cost extremely low and affordable as part of our commitment to ensure our members have access to training and upskilling.

Annual General Meeting (AGM) of MSA 2024

Our AGM will be held on Friday, 2nd August 2024, from 1700-1830 hrs at the ASC congress venue. Your presence is essential for the betterment of our Society and fraternity. Please attend to exercise your voting rights as a member. We appreciate suggestions and feedback on how we can improve to serve our fraternity.

New MSA Office Suite at Putrajaya

We are happy to announce our new office suite at Medical Academies Building in Putrajaya. Please find below the address of the MSA/CoA office suite:

Malaysian Society of Anaesthesiologists & College of Anaesthesiologists, AMM
Unit 3.3, Level 3
Medical Academies Malaysia Building
No. 5, Jalan Kepimpinan P8H
Presint 8, 62250 Putrajaya, Malaysia.
Tel: 03-89960700

Members are most welcome to drop by to visit the secretariat.

National Anaesthesia Day (NAD) 2024, 12th October 2024, Kuala Terengganu

The theme of NAD 2024 will follow the annual WFSA theme: 'Workforce Well-Being'. Activities for the national-level NAD 2024 celebration, which is being organised by the Department of Anaesthesiology and Intensive Care, Hospital Sultanah Nur Zahirah, under the capable leadership of Dato' Dr Ridhwan Noor, have already started with a video competition announcement, which is available on the MSA FB page.

Applications for a grant of RM1,000.00 towards expenses incurred by hospitals celebrating NAD 2024 are trickling in. Please note that applications must be made before the event, latest by 31st August. The terms and conditions for application are available on the MSA website at htpps:// www.msa.net.my.

COA-MSA-MLSM Expert Witness Training Workshop, 8th June 2024

As promised, the first Expert Witness Training Workshop catering to the legal needs of our fraternity was held on 8th June 2024. It was attended by 42 senior anaesthesiologists from all over Malaysia. With this, we have established a list of anaesthesiologists amongst us who are committed to being called upon as expert witnesses should our members require assistance.

MSA would like to express our deepest appreciation to the Medico-Legal Society of Malaysia, which generously came in full force to ensure we have an in-depth understanding of how to be an expert witness. In addition, MSA would like to thank Universiti Malaya Medical Centre for providing a conducive venue for the workshop.

CPD Activities

MSA, in collaboration with COA, successfully organised three webinars under our KITE series recently: "Patient Blood Management" on 18th May 2024, "Fluid Therapy in Critically Ill" on 13th June 2024, and "Anaesthesia Provision in GAZA: Experience of Mercy Malaysia Anaesthesia Team" on 4th June 2024.

MSA has sent out a survey named "AWARE" on awake tracheal intubation (ATI) in collaboration with the European Airway Management Society. Malaysian anaesthesiologists participating in this survey will provide insight into the practice of ATI in our country compared to international data.

In collaboration with Merck Sharp & Dohme, the KITE Series co-organized an

evening talk in Penang on 28th June 2024. The topics covered updates in neuromuscular blockers guidelines and the risk of residual muscle paralysis, which is a significant concern in our practice. A similar event was held in Kuala Lumpur on 20th July 2024.

MSA would like to express its sincere appreciation to all the speakers and moderators who contributed to the success of these activities.

Fee Schedule

There seems to be continuing confusion with anaesthesia charges for certain procedures in the currently enforced fee schedule. Members can contact us if there are doubts.

Malaysian Journal of Anaesthesiology (MyJA)

The June 2024 edition of MyJA is published. It is freely accessible at www.myja.pub.

Membership

As of 1st July 2024, our membership stands at 658 life members, with 157 ordinary members and 50 associate members in good standing.

I wish you happy reading.

Contents

Published by:
Malaysian Society of Anaesthesiologists (MSA)
Unit 3.3, Level 3, Medical Academies Malaysia Building
No. 5, Jalan Kepimpinan P8H, Presint 8, 62250 Putrajaya, Malaysia
Email: secretariat@msa.net.my

Berita Anestesiologi is published every four months.

Message from the EDITOR-IN-CHIEF

Dr Anand Kamalanathan

Ladies and gentlemen, anesthesiologists and anaesthesia enthusiasts, welcome to the July 2024 edition of Berita Anestesiologi! I know what you're thinking: "What could be more thrilling than giving a bolus of propofol and ensuring patients are comfortably snoozing through surgery?" Well, brace yourselves because we're about to embark on a journey that takes you out of the sterile, fluorescent-lit halls of the hospital and into the wild, wacky world beyond!

Outside the OT, anaesthesiologists are not just masked medical magicians but Super Mario-like heroes, masters of household chores, artisan extraordinaires, and, unsurprisingly, leaders par excellence. Yes, folks, we're talking about the life anaesthesiologists lead outside the confines of their medical realm when they step out of their comfort zones. Spoiler alert: it's not all about perfect IV insertions and calculating paediatric dosages.

First, let's dive into the extravagant world of real-life superheroes. Picture Dr Shahridan Fathil, the stoic regional and ultrasound expert, a seasoned veteran in war-torn conflict zones, meticulously blocking every nerve feasible and saving lives without using his array of gadgets. The precision required for regional anaesthesia without ultrasound clearly requires high skill on the battlefield. Or take Dr Lukman Mokhtar, who swaps his carefree fishing rod every weekend and instead volunteers to be part of a rescue mission for the first time in his life, thousands of miles away in Gaza. Apparently, there is more to life than sipping coffee in the pantry - who knew?

After hours of controlling the chaos in the paediatric OR and academia, Professor Dr Ina Ismiarti Shariffuddin returns home to her own little whirlwind: embarking on the path of medical education. She's perfected the art of multitasking and leadership-simultaneously reviewing Master's students' theses, discussing pharmacokinetics with trainees and completing her assignments in medical education. If that's not peak performance under pressure, I don't know what is.

But the fun doesn't stop there! One of our colleagues has taken her talents to the canvas. Who needs 'Leonardo Da Vinci' when Dr Lakshmi Thiyagarajan is whipping up artistic masterpieces? From propofol to painting brushes, this anaesthesiologists can do it all while managing household chores and raising school-going children. Imagine the intensity of a bleeding parturient and the precision of a brush stroke - that's the kind of magic happening here.

We would also like to welcome a new member to this Berita dream team, Dr Iskandar Khalid, who is currently pursuing his fellowship in Regional Anaesthesia at Toronto Western Hospital, Canada, and shares two articles on advancing daycare arthroplasty with us. While this subject matter is present in our country, it has yet to be the norm. A poignant reminder then for us to step out of our comfort zones to relearn, readapt and realign our management with best practices.

In this edition, we're celebrating these unsung moments, these glorious glimpses into the multifaceted lives of anaesthesiologists. So as you read through, remember; the next time you see your colleague deftly handling a syringe or managing an airway with grace, just think - they might also be a champion salsa dancer, an amateur boxer, or the reigning king of karaoke night.

So sit back, relax (hopefully without precedex), and enjoy this humorous, heartfelt exploration of life beyond the OT. Here's to stepping out of our comfort zones and embracing the wonderful chaos that awaits.

Stay inspired, stay entertained, and remember: the world is your OT or, at least, your oyster. Cheers.

PALL® Medical

Virtual Hospital
MULTI-BARRIER FILTER CONCEPT

Protect your patients and staff against the SARS-CoV-2 virus!

- Validated removal of SARS-CoV-2 in Europe under CE mark*
- SARS-CoV-2 retention efficiency > 99.999 % demonstrated on Ultipor® 25, Ultipor® 50 and Ultipor® 100
- Intended for Protection of Patients, Staff and Devices in Anesthesia and ICU

*These products have not been cleared for this claim by the FDA

We know that breathing in particle pollution can be harmful to your health, but what do we know about health effects of particles infused into patients?

Visit the Virtual Hospital

https://filtration-tour.app.cytiva.com

For more product information, please reach out to Ms. Yin Yin Chan
EMail: yin.yin.chan@cytiva.com or Mobile: +60 123231220

cytiva

CONGRATULATIONS !!!

Congratulations to our Past President, Dr Mary Suma Cardosa, who was recently elected as the President-Elect of the International Association for the Study of Pain (IASP). May your new role be as impactful and transformative as the legacy you have already created in MSA.

Congratulations to Professor Dr Ina Ismiarti Shariffudin, current CoA President, for being one of six leaders from Malaysia to be conferred the prestigious fellowship by the Academy of Medicine, Singapore.

Mercy Malaysia Gaza Team 3
MISSION IN A WAR ZONE

by Shahridan Mohd Fathil
Gleneagles Hospital Medini Johor
Johor, Malaysia

Introduction

On 7th October 2023, fighters from Hamas stormed out of Gaza and attacked Israel, resulting in 1139 fatalities, of whom 695 were civilians.[1] Israel claiming the right to self-defence has since waged a brutal war on Gaza with impunity. As of 12th June 2024, the war has claimed the lives of 37202 Palestinians, with women and children making up 52% of the number.[2] The healthcare system in Gaza has been destroyed. Only 17 out of 36 hospitals remain somewhat functional.[2]

The Malaysian Medical Relief Society (Mercy Malaysia) responded to the complex humanitarian emergency by deploying Special Cell Emergency Medical Teams (EMTs) to Gaza from mid-February until the end of May 2024. The fourth team had to be evacuated in batches due to the Rafah ground invasion by the Israeli military.[3]

Emergency Medical Team

The EMT initiative under the World Health Organization (WHO) aims to enhance the capacity of national health systems to lead the activation and coordination of rapid response capacities in the immediate aftermath of a disaster, outbreak, and/or other emergency, as well as to improve the quality and timeliness of health services provided by national and international EMTs.[4]

On 16th March 2023, MERCY Malaysia EMT was the first Non-Governmental Organization (NGO) from Asia to be certified as the 38th member out of the current 40 EMT Global Classified teams.[5] Special Cell EMTs consist of a few senior specialists, offering supplementary specialised care integrated into EMTs or functioning national hospitals. They are required to provide the necessary apparatus, supplies, and maintenance for their specific specialty.[6]

Mercy Malaysia Gaza Team 3

The response of International EMTs is coordinated by the EMT Coordination Cell (EMTCC) to effectively address the demands arising from the collapse of the healthcare system in Gaza.[7] EMTCC vets through the initial application of EMT deployment, and eventually gets approval from Coordination of Government Activities in the Territories (COGAT), an Israeli authority that monitors the entry and exit into the Occupied Territories, and in the case of the current conflict, the operation of EMTs inside Gaza.[8] COGAT needs to approve all movements and location of the EMTs as part of the deconfliction process.

Team 3, a Special Cell EMT, consisting of 2 orthopaedic surgeons, 1 anaesthesiologist, 1 general practitioner, and 2 liaison officers was deployed into Gaza from 17th to 29th April 2024. We traveled from Cairo into Rafah, Gaza with many other EMTs in the WHO convoy.

Like the previous two Mercy teams, we were stationed at the Kuwaiti Specialised Hospital (KSH), one of the two functioning hospitals in Rafah then. KSH is a charity hospital with a limited number of beds. A field hospital of tents was set up nearby to increase the bed capacity. KSH was only equipped with basic radiological and laboratory services. It did not have a CT scan or a blood bank.

Perioperative Care

My main duty was to provide support to my team's 2 orthopaedic surgeons. A total of 371 orthopaedic patients were consulted, treated, and operated on by Team 3. The majority of the cases were

Dr Shahridan performing E-FAST on a victim of a MCI after an Israeli airstrike

the result of war injuries, mainly the complications of previous damage control orthopaedic surgeries: chronic bone infection, fracture complication, and deformity; and untreated injuries. There were also non-traumatic orthopaedic conditions such as soft tissue tumours and contractures being treated surgically. The Operating Theatre (OT) consisted of two Operating Rooms (ORs). Due to the absence of laminar flow in the OT, implant surgery was totally avoided.

Peripheral nerve blocks (PNBs) were provided for the majority of the orthopaedic surgeries either as the sole anaesthesia technique or for postoperative analgesia. This was made feasible with the availability of a donated cart-based ultrasound system in the OT; while the PNB needles and Local Anaesthetics (LAs) were brought by our team. The opioid sparing analgesic effect of PNBs enabled earlier ambulation and eventual discharge.

My secondary duty was to assist the Palestinian anaesthesiologists in providing anaesthesia for Caesarean Sections, Urology, and General Surgery cases. The two ORs were each equipped with a new donated Draeger anaesthesia machine. While the machines are new, the monitoring may be substandard due to the unavailability of specific modalities. It was interesting to note that the only spinal needles available were cutting needles. The local anaesthesiologists were not so concerned with post-dural puncture headaches when asked.

Mass Casualty Incident

There was a constant and irritating reconnaissance (and combat) drone hum in the background which eventually became a white noise. A drone flying at a low altitude evident by the louder hum during the night typically indicates that an airstrike is imminent. The airstrikes typically occur late at night. When a detonation from the airstrike can be heard, and the subsequent shockwave felt, we prepared ourselves to respond to a mass casualty incident (MCI).

Throughout the mission, we responded to 5 MCIs. We made ourselves helpful in the Red Zone tent set up in the hospital compound. Unfortunately, the majority of the victims of the MCIs were women and children. From the briefing by Team 1 before the mission, I believe then there was an urgent need for a Point-of-care ultrasound (POCUS) for the MCIs. With the initiative of the Society of Critical and Emergency Sonography Malaysia, with funds raised by members and public donations, a phased array probe of the Kosmos ultraportable ultrasound was purchased. The ultrasound proved to be useful in guiding resuscitative efforts by using focused echocardiography and ruling in or out chest and abdominal trauma by using Extended Focused Assessment with Sonography for Trauma (E-FAST) in the MCIs. This was well received by the doctors and hospital administration.

During the mission, we managed to diagnose two cases of intraabdominal bleeding using E-FAST despite stable hemodynamics. These and other severely injured cases were transferred to other better-equipped hospitals for more definitive care. Due to the limited resource environment, we had to make unusual clinical decisions. A pregnant mother who suffered severe brain injury evident by the oozing brain matter from the back of the head underwent a "perimortem" caesarean section while still gasping in the Red Zone. A man with a gaping hole in the back was left to die despite initially having a beating heart. The acute orthopaedic injuries from the MCIs were brought to the OR for emergency surgery. Due to the emergency nature and poor preparation of these patients, the preferred anaesthesia whenever feasible was PNBs.

Dr Lutfi Rashid, orthopaedic surgeon performing a tendon repair on a bomb blast victim of a MCI under peripheral nerve block in a blackout with some assistance from Dr Zool Raimy, general practitioner

One satisfied patient; spreading the joy of RA in Gaza

Drs Shahridan and Lutfi looking for a shrapnel in the thigh of a bomb blast victim with the Kosmos handheld ultrasound

Capacity Building

As there was a demand for E-FAST training for the doctors, of whom the majority are junior, two training sessions were conducted which involved a didactic lecture and a hands-on demonstration on a patient or model. The ultraportable ultrasound was donated at the end of our mission to the hospital.

On-the-job ultrasound-guided regional anaesthesia exposure was offered to the local anaesthesiologists as well as to the anaesthesia technicians. Apart from PNB equipment, Team 3 also brought various Laryngeal Mask Airways donated by the industry.

Well Being

The experience in many post-disaster missions did not prepare me for Gaza. After the first MCI, I had trouble sleeping. The fear of becoming a humanitarian aid worker victim like in the case of the World Central Kitchen convoy was balanced off with the optimism that the Israeli military will not attack a deconflicted zone again.[9] Over time I put my trust in God. The camaraderie with team members significantly allayed our anxiety.

Attitude and Skills of Disaster Anaesthesiologists

For anaesthesiologists who practise in modern, well-equipped medical facilities, reacting to a crisis is not instinctive. The environment is inhospitable and resources are very limited. Advanced diagnostic modalities may not be readily accessible. Reverse triage is crucial to distinguish patients who are expected to survive. Healthcare professionals must strive for optimal clinical outcomes with limited resources while prioritising patient safety. Additionally, they should be ready to collaborate as a team, adapting to various roles and contexts. Acquiring abilities in strategic planning, hospital organisation, and resource optimisation is crucial for a disaster anaesthesiologist.[10]

Regional anaesthesia (RA) particularly ultrasound-guided PNBs in disaster has advantages. First, the simplicity of the technique in an environment where advanced monitoring, patient history particularly with significant language barrier, and laboratory facilities are limited makes RA a valid option. Secondly, recovery from general anaesthesia in high-risk cases would necessitate the use of an intensive care unit (ICU) or post-anaesthesia care unit bed, which is a scarce resource in a disaster setting. Third, by avoiding the use of general anaesthesia, the demand for oxygen, which is already in short supply in a field hospital, is reduced. Finally, the limited availability of medical and nursing personnel, coupled with challenges of communication with patients after surgery, necessitates an anaesthetic technique that minimises postoperative pain and the need for opioids.[11] RA promotes 'Enhanced Recovery after Surgery' in disaster.

POCUS technology has become widespread in contemporary medicine. The applications of this technology range from evaluating life-threatening trauma and resuscitation to the described ultrasound-guided RA above. The handheld ultrasound equipment is comparatively less expensive, easily transportable, and equipped with user-friendly interfaces, which makes them highly suitable for use under the challenging circumstances of an MCI or disaster.[12]

Palestinian people

The Palestinians have suffered a great injustice. Despite a genocide being inflicted on them, the Palestinian people are very resilient. I found them very warm and appreciative of our assistance.

I would like to end with a quotation by John Stuart Mill, "The only thing necessary for the triumph of evil is for good men to do nothing".[13]

Apart from the mission above, I had previously volunteered with Mercy in post-natural disaster missions in Nias and Jogjakarta, Indonesia; Kashmir, Philippines, Kelantan, and in a complex disaster mission in the Malaysian Field Hospital, Cox Bazaar, Bangladesh; and with Médecins Sans Frontières (MSF) in their East Mosul Project after the war against Islamic State.

The innocent faces of the internally displaced children in a refugee camp in Rafah. Team 3 was doing hot meals distribution at this camp

by Md Lukman Bin Mohd Mokhtar
KPJ Pahang Specialist Hospital
Pahang, Malaysia

Mercy Malaysia Gaza Mission Team 4

GET COMFORTABLE BEING UNCOMFORTABLE

I was approached by our esteemed Editor not long after my return from the mission.

I'm not much of a writer and never have been, even when I was in academia. But, somehow, this time, the words from my mission teammate, Mr Haniif, the surgeon, echo constantly in my mind: "We were given the chance to set foot on the blessed land, not just to be silent". That gave me the push whenever I needed one to complete this maiden write-up of mine in this newsletter.

This is the first time in my entire 28-year career as a doctor that I have joined as a medical humanitarian volunteer. This is a stark contrast to the anaesthetists in the earlier three teams of this mission, who are considered 'veterans' and 'seniors' and have joined various missions in other disasters or conflict areas.

We are all aware, by now, that this particular armed conflict is unprecedented in recent history in terms of its superlative degree of aggression, violence, destruction and transgression of various humanitarian and international laws, which saw heavy casualties involving healthcare workers, health infrastructures, humanitarian aid workers, journalists and other parties who are supposed to be protected even during war.

Those thoughts triggered an escalating anticipatory anxiety as the departure date approached, more so for someone like me who's a complete freshie or newbie in this aspect, so to speak. Plus, there were some big shoes to fill if I were to compare myself to the earlier teams and whether I could measure up to handle the immense and critical task. Honestly, there were numerous times when self-doubt crept in and cranked up the anxiety scale several notches up from its already elevated baseline.

Why take the plunge, given the very high stakes and the level of danger that may be involved? Honestly, this Palestine conflict is not something new, and I have been following this issue as far back as 2009 (15 years ago) when it came to my attention via Facebook, which was most popular at that time. Needless to say, the issue stuck with me not only from a humanitarian standpoint but also more importantly due to the profound religious connotations and the conflict region is indeed within the blessed holy land for religions of Abrahamic faith, namely involving Judaism, Christianity and Islam.

Why now? In the yesteryears, I was tied up with family and paternal obligations, prioritising bringing up and raising a family. Now, the children are independent young adults (my utmost admiration and respect goes to my other teammates who are raising young families but have still committed to participate in this mission). Furthermore, previous conflicts or 'wars' in Palestine were of lesser magnitude and dissipated within weeks. The present 'war' situation is beyond dire and impossible to ignore. Therefore, it has become a calling, an obligation, a responsibility to be present physically on the ground to offer whatever help within one's capacity and expertise.

Everything added up nicely when Mercy Malaysia was looking for anaesthetists as integral team members to complete the quorum of the Specialised Cell Team (SCT) as per the requirement by WHO-EMT (Emergency Medical Team) for Gaza deployment, which primarily comprised surgeons, orthopaedic surgeons and anaesthetists. I jumped at the earliest available opportunity, with the full support of an understanding spouse and family, and as the saying goes, the rest is history.

I have never been more glad that a decision made over two decades ago to commit to anaesthesia as a career has enabled me to pursue this path and contribute to an important cause for humanity during such a critical need. Truth be told, no amount of preparation would get one ready for whatever was waiting ahead. Multiple briefings provided important information on the

material needs for such a mission. Mental, spiritual and physical preparations are emphasised and up to oneself to work on. If there is a strong will on one's part, then there's always a way.

The advantage of being deployed in a later team is that we could gather invaluable information from members of earlier teams, especially regarding amenities, work routine and expectations, updates on situational progress, and medical items that need replenishment or are severely lacking. Having said that, the situation in an armed conflict is highly fluid, and whatever happened in earlier teams may not be duplicated or experienced by the next. Each team went through episodes of its own unique journey and experiences. A true example was what Team 4 went through with the onset of the Rafah ground invasion and border closure that got us stranded behind enemy lines with worrying uncertainty about an exit plan and the terrifying reality of being caught in cross-fire or direct military assault. We had to undergo the process of hibernation, red alert situations and multiple emergency evacuations due to warnings of impending attacks in the vicinity of our hospital.

Modern technology has contributed to the evolution and transformation of anaesthesia practice. Visualisation gadgets such as ultrasound and video laryngoscopes have become standard practice.

Conflict zones may not have these luxuries, and more often than not, the premises, furnishing, equipment, and assistance are bare basic and, at times, even compromise an essential requirement, e.g. capnography (only one out of the two theatres in Rafah Kuwaiti Hospital has functioning capnography). I felt awe and admiration that the local Palestinian anaesthetists have been working in this situation over the months/years doing whatever cases with such a bare setup. It is sobering to note how fortunate we are in our peaceful country to have everything at our disposal that we sometimes take for granted.

Serving in such an area sometimes necessitates returning to the basics, relying on raw sensory inputs, gut feelings and instincts that have been developed, conditioned and reinforced over many years of encountering similar situations throughout our practice. A very useful principle of 3A needed to be practised and applied for survival in these situations: ACCEPT, ADJUST, ADAPT.

Things may not go as intended or expected, but we must accept this, adjust accordingly and quickly adapt to the situation to move forward and be functional.

I have never been more grateful to have gone through my early days in anaesthesia in the era of the late 90s up till about 2010. Most of my practice, in government and private, when difficulty and hardship helped to mould and harden oneself, when there were not many gadgets to assist, when intubation was only by conventional laryngoscopy and adjuncts, procedures were by manual identification of anatomical landmarks, under the teaching and guidance of skilled teachers, bosses and seniors... fast forward, those were priceless experiences that helped a great deal in facing these austere conditions.

My Journey from Anaesthesiology to Medical Education

STEPPING OUT OF MY COMFORT ZONE

> ***"If we teach today as we taught yesterday, we rob our students of tomorrow".***
>
> ***- John Dewey***

My loving and supportive family - missing my third daughter, Dina Alisha, who could not attend the graduation ceremony.

With over two decades of experience in the dynamic field of anaesthesiology, my professional journey has been both joyful and enriching. I began my medical career as a medical officer in the Anaesthesia Department at Hospital Kuala Lumpur (HKL) in 2000, where I was immersed in the complex, fast-paced environment of operating theatres and intensive care, providing care for patients from diverse backgrounds. I was fortunate to be trained by many skilled and dedicated consultants at HKL. Completing my postgraduate training in 2007 at Universiti Malaya further honed my skills and deepened my understanding of the pivotal role anaesthesiology plays in perioperative patient care. As my career progressed, I developed a growing interest in a subspecialty that both challenged me and aligned with my evolving interests: paediatric anaesthesia. This led me to pursue further training, completing a fellowship in paediatric anaesthesia in 2012 and obtaining certification in anaesthesia for paediatric liver transplants in 2019. Each step of this journey has been not just about personal growth but also about enhancing patient care and outcomes.

Transitioning into academia, I joined the Faculty of Medicine at Universiti Malaya in 2008 with a clear vision: to cultivate future anaesthesiologists who are as passionate about patient care as they are knowledgeable in their field and to perform clinical research that could add new information to the body of knowledge in Anaesthesiology. Believing firmly that mastery in teaching comes from being an expert in the subject, I embarked on this new chapter without formal training in teaching. Instead, I leveraged my clinical experience to teach effectively, aspiring to enrich my students' learning experiences while continuing to perform my clinical duties with dedication and enthusiasm. My experiences in clinical practice and as an examiner for the Conjoint Masters in Anaesthesiology examination had shown me that understanding the theory behind our actions is just as crucial as the hands-on skills we perform. This duality of practical and theoretical training forms the backbone of effective medical education and ultimately leads to better patient outcomes.

"Learning is a lifelong journey"

by Professor Ina Ismiarti Shariffuddin
Department of Anaesthesia, Universiti Malaya
Kuala Lumpur, Malaysia

Embarking on the path of medical education was a transformative decision, catalysed by my experience as one of the authors for the National Postgraduate Medical Curriculum for the Anaesthesia fraternity This role unveiled a profound truth: expertise in a subject, while essential, is not sufficient on its own. The effectiveness of a clinical teacher hinges on his ability to intertwine various forms of knowledge. This realisation sparked a desire for me to delve deeper into the art of the teaching and learning processes. It became clear to me that effective teaching is not just a simple transmission of knowledge; it involves nurturing the ability to communicate complex ideas clearly and compellingly. Central to this, is mastering the art of questioning, reasoning, and explaining - tools that awaken curiosity and understanding in students, inspiring a deeper engagement with learning.

This journey into medical education has been a deliberate step outside my comfort zone. It required long hours in classes and multiple group discussions with health professionals from various backgrounds to cultivate this new knowledge. In addition, for a degree with mixed coursework and exams, we had to endure multiple assignments and end-of-semester exams. My journey in Medical Education has been driven by a commitment to not only impart knowledge but to transform how future medical professionals think, analyse, and respond to the challenges of healthcare. By fostering these skills, I aim to equip my students with more than facts - they will learn to approach problems with a critical, inquisitive mindset.

In this course, I had the opportunity to meet great teachers and colleagues who shared the same interest and vision of improving the delivery of clinical teaching and training to produce competent healthcare providers, ensuring the best patient outcomes. One of the most significant challenges was adapting my clinical expertise to an educational framework. The transition required learning and applying educational theories, which initially seemed daunting. Concepts like the Zone of Proximal Development, Self-Determination Theory, and Experiential Learning were new. The importance of planning our teaching, especially as clinical teachers, teaching on the run, and incorporating the latest technology in our teaching, was emphasised. Acquiring this knowledge enlightened me about the profound impact these theories could have on teaching and learning. Additionally, participating in group discussions with health professionals from various backgrounds enriched my perspective. These interactions highlighted the importance of inter-disciplinary collaboration in healthcare education. It was a humbling reminder that stepping out of one's comfort zone often leads to growth and innovation.

As an anaesthesiologist, I recognise that an integral part of our practice includes being a leader. There is a strong need for skilled leaders to advocate and navigate patient-centred and organizational outcomes. In our daily practice, we engage in leadership roles through supervising treatment teams, leading patient cardiac and pulmonary resuscitations, and facilitating effective communication among patients, families, and other consulting physicians. Although many physicians possess inherent leadership qualities, this does not necessarily make all of us effective leaders. Transforming these qualities into effective leadership requires deliberate learning and practice.

In this Medical Education course, I was introduced to the many facets of being a leader. The implementation of leadership training allowed me to observe a variety of leadership styles and understand the context in which each style can be most effective. To be an effective leader in the medical environment, one must know how to adapt to the different leadership styles required at different times. Leadership in medical education is not only about managing teams and making decisions but also about mentoring and developing future leaders. As experienced anaesthesiologists, we have the responsibility to guide and support our junior colleagues, helping them develop their leadership skills and advance in their career. This mentorship creates a ripple effect, where the culture of effective leadership is perpetuated, leading to sustained improvements in patient care and organizational performance.

My mentor once told me; "A wise man, is someone that knows what he knows not". Identifying the gap in my knowledge to fulfil my duties as a teacher has led me to this path. My journey from anaesthesiology to medical education has been a humbling yet rewarding and transformative experience. Stepping out of my comfort zone has hopefully allowed me to contribute to the future of healthcare in a meaningful way. By blending clinical expertise with educational innovation, I strive to inspire the next generation of anaesthesiologists to approach patient care with knowledge, compassion, and a critical and inquisitive mindset.

NB: *I would like to express my heartfelt gratitude to my family for their unwavering support and to my colleagues in the Department of Anaesthesia, Universiti Malaya for allowing me the opportunity to explore this new path.*

Gaza Medical Humanitarian Mission

ANECDOTE OF A MISSION FRESHMAN

by Md Lukman Bin Mohd Mokhtar
KPJ Pahang Specialist Hospital
Pahang, Malaysia

"Doctor! Doctor! We have still so many cases waiting, around 20 more cases, need to hurry up! Maybe you can cut some steps… ok? "The words from the Kuwaiti Specialty Hospital (KSH) Director, Dr Suhaib, a urologist, somehow jolted me like a sonic boom from a fighter jet doing a low altitude fly-pass at supersonic speed.

It was my very first day as a medical volunteer in this hospital and it was also the first time ever in my entire 28-year career as a doctor, that I have joined as a medical humanitarian volunteer.

I came in with Mercy Malaysia under the World Health Organization Emergency Medical Team (WHO-EMT), specifically for Gaza deployment, under the arrangement as a Specialized Cell Team (SCT) that comprised mainly of surgeons, orthopedics and anesthetists.

First day starting in any new place is already challenging as we all know. What more starting at this hospital which is in an armed conflict zone for many months and has lots of shortcomings and compromises due to the dire circumstances. Really didn't know what to expect and how the first day would be like.

I only managed to get some short but useful pointers from Dr Mafeitzeral that the GA technicians were really good and helpful, and to look for these names - Mohammad and Hamzah. There will also be a local Palestinian anaesthetist, on daily rotation, who could lend a helping hand if needed and we will both run one operating room each, assisted by the GA technicians.

Language barrier is the most notable hurdle, especially when communicating with the patients and that tend to slow things down significantly as I struggled to get some basic history and explained details to the patients through a translator, usually the GA technician or any available staff.

The clock showed about 2 pm and I was just about to perform a spinal block for my fourth case of the day, another urology stenting case. That was the time when Dr Suhaib came in with his somewhat firm reminder. His concern was valid and understandable.

The theatres had been running late till past midnight since the arrival of the Urology team two days earlier; a significant surge in numbers and working hours.

Honestly, I was still somewhat in a daze, still orientating and adapting myself to this new challenging environment, the various stimuli, the equipment or lack thereof, their workflow and routine, getting to know their names and who's who and what's where and now another task which I had to speed up.

There was a visiting urology team from Kuwait for a week in KSH and they plan to slot as many urology cases as possible during this period to fully utilize their presence and expertise and get as many cases treated as possible.

This was also understandable since many of these seemingly 'less-emergency conditions' e.g. urological calculi, prostate cases, kidney issues have been largely neglected and unattended to since the war broke out.

The healthcare system all over Gaza has been stretched to prioritize for trauma

cases of those injured due to the 'war' - the shootings, tank shellings, bombings and air strikes causing Mass Casualty Incidents (MCI).

During all the previous Mercy Malaysia teams' presence, they were the only international group of volunteers present in KSH, but it seemed during Team 4, we encountered a unique experience of working with another international NGO team. The more the merrier, perhaps.

As I was slowly injecting spinal heavy Marcaine, there was this internal monologue making a mental audit of how the first day had progressed.

"Am I that slow? … Guess not, anaesthesia was pretty standard nothing unusual"

"Cut some steps? … Like what else? We're down to the most basic already …"

"Pretty much I'm doing what I would've done back home; mostly spinal for urology cases… seems about right. Why not GA? … spinal is safer, easier to monitor and painless post op".

Then I recalled the first case of the day and realized why things were not moving as fast as desired. The Operation Theatre opened their doors at 8 am. We started not far off as scheduled. It was a paediatric case, a young child with bilateral ureteric stent for removal. The surgeon assured me it would take around 15 minutes and naturally for such a short procedure I decided to hold mask with an oral airway while giving Sevoflurane with Oxygen (there's no medical air or nitrous oxide supply available).

The surgeon encountered some unexpected difficulty and after 20 minutes it was nowhere near completion. The patient was stable, breathing spontaneously and inhaling Sevoflurane delivered via the paediatric Mapleson F circuit.

Another 20 minutes went by, and then another 40 minutes… the stents were still stuck and unable to be removed despite various attempts, instruments and techniques, even after changing hands from one urologist to another. Apparently, the stents had been encrusted and embedded within calculous deposits making simple retrieval impossible. Lithoclast had to be used to break the calculous encasing the stent first. After two hours of holding mask, finally! Alternated between left and right hand if fatigued and at times took turns with the GA technician, we finished the first case and patient was reversed uneventfully.

Quite a shocker for a start at a new place!

But that's the reality here, not uncommon to find paediatric patients with calculi, with ureteric stents, perhaps the chronic dehydration for months, scarcity of clean drinking water definitely predisposed the population to these issues.

The third case was another encrusted stent and also was prolonged, which explained the cumulative delay for that day. Common occurrence in Gaza it seems.

Back to that fourth case, spinal done, case was ongoing and I made some mental calculations and deliberated on what was informed about speeding up, and got further information from the staff that most patients were treated on a daycare basis in KSH, they were discharged as soon as possible. KSH has limited beds and nursing staff to cater for inpatients. Doing urology cases under

spinal would be ideal, but it also meant the patients would be stuck for hours before they could be mobilized home. Additionally, transition between cases would be much longer in order to perform spinal and get it working.

From then on, to accommodate local requirements, I had to do a bit of a personal reset, unlearn and relearn… as the saying goes "When in Rome, do as the Romans do" so as far as urology cases go, spinals were only performed for TURP. The bulk of the cases was under GA with LMAs; faster induction, rapid turnover, early discharge - Even then, the theatres still run continuously till way past midnight for subsequent days. What an experience!

GOOD FOR THE SOUL

ART

by Lakshmi Thiyagarajan
KPJ Perlis Specialist Hospital
Perlis, Malaysia

The first question I get asked is, 'How do you find the time?'

The second thing usually said is, 'Wow, were you always good at art?'

The answer to the first question, I don't always have time, but I try to squeeze in time to paint. As for the second question, I don't believe anyone is born good at anything. Even the famous singer Ed Sheeran said, "No one came out of the womb being a professional at what they do. It takes constant practice and failure" (yes, failure!).

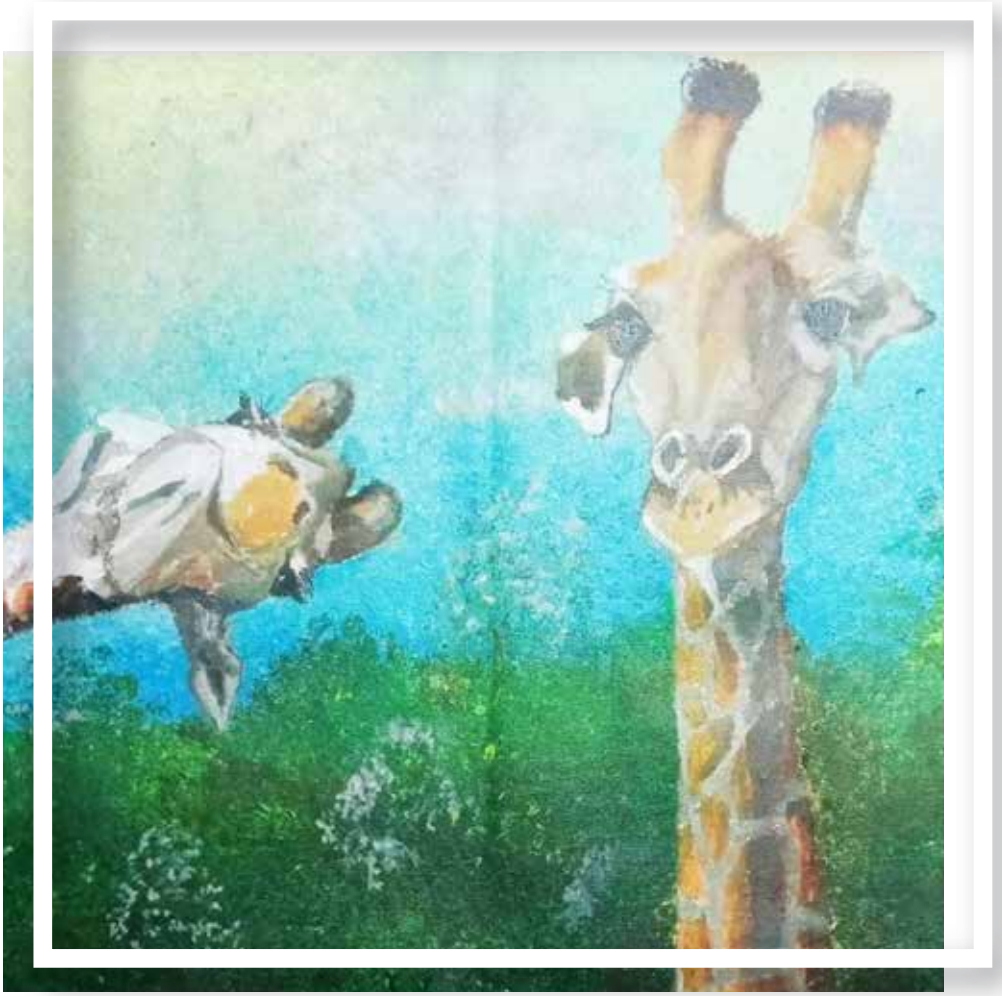
I can vouch for the failure part. I have always dabbled in art from a young age; ever since I could hold a pencil. My parents used to say the only thing keeping me quiet would be paper and colour pencils. I would be busy for hours!

However, this does not mean I was great at drawing everything. My childhood and teenage years passed by with getting decent grades in art but nothing remarkable. I was not encouraged to enter competitions. My art teacher never gave my artwork more than a passing glance and a sniff. I had no proper guidance but then again, I guess I was more focused on studies and sports. I would entertain myself with painting and other of crafts like cross-stitching as a hobby. Some of these pieces still hang in my childhood home, like the batik art-piece I did for SPM exams. When I look at it now, I am horrified. Such unrefined work! But I was pretty proud of my efforts back then.

Fast forward 30 years, medical school, three qualifications later, and many years of working, the COVID-19 pandemic happened.

Many will recall it as one of the worst times in their lives and the history of the world. I share the sentiments. However, this period gave me a huge gift - the gift of TIME.

I needed to distract myself to avoid worrying. So, I ordered some online kits



for paint by numbers and started doing them at 5 am while my children were still asleep. After a few pieces, I started gaining confidence and wanted to do my own drawings. I didn't have that many ideas so I would surf online for interesting photos and try to copy them. I would post my efforts on Facebook and started getting some attention from friends. One of them reached out one day and asked me if I ever considered selling my work. How flattering!! I didn't really think the paintings were that good and I had lots to learn, but I ended up selling her a piece. And that was how it all started.

Have I sold many pieces? The answer is no. I've sold some.

Do I paint solely to sell? The answer is no. I paint to soothe my soul.

If what I paint catches the eye, friends are welcome to private message me to enquire on how they can purchase.

There have been some friends who have commissioned a piece. They send me a picture or a photo that they like and ask me to do something similar. So far, I've received a good response! My favourite commissioned work is a 2 x 3 feet piece of the Great Wall of China which now proudly hangs in the home of a friend above her piano.

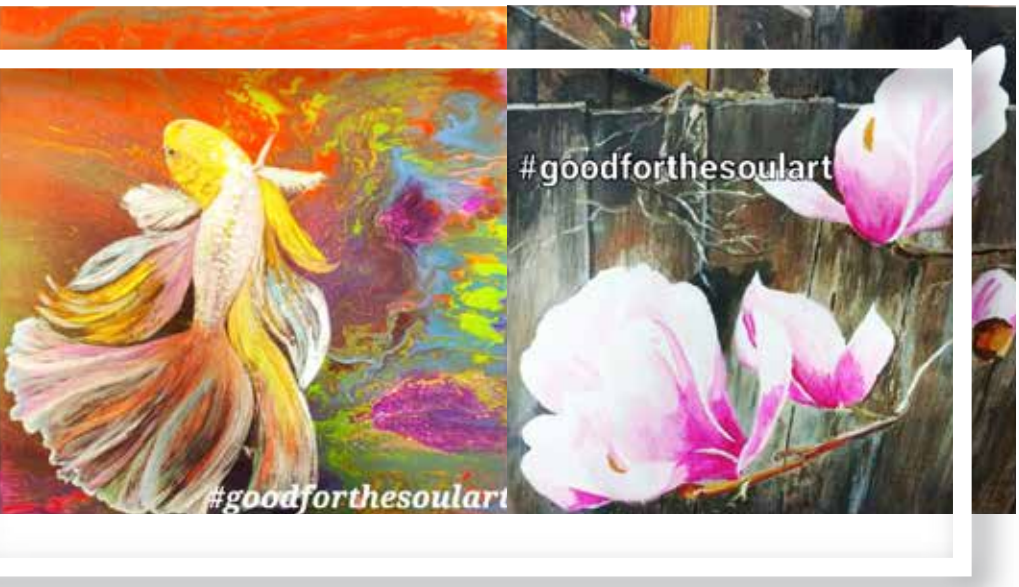
I love colourful and happy paintings. I like having something on the wall that will lift my spirits or to even laugh at every time I look at it.

Those who admire my paintings feel the same way. If I can do that, inject a bit of happiness into your life, and distract you from this dreary world even if only for a while, I feel my work is done.

To the naysayers who criticise my work…they may not like the subjects that I paint. There have been comments on how I should paint more flowers, how no one likes funky chickens…well, the only person I paint for is me… so I just shrug it off.

For those who have taken up a hobby even at a later age, keep at it! Whether it's cycling, gardening, art, or music…do it to make you happy!

If you would like to view more of my art, go to my Facebook page at Lakshmi Thiyagarajan and search for ##goodforthesoulart on my Facebook page!



Advancing Daycare Arthroplasty
A PATIENT'S EXPERIENCE

It is seven o'clock in the morning in the city of Toronto. Mrs B, a 68-year-old retiree, is taking a sip of water with her medications. She sits in her favorite winged chair in her living room, in a house she has called home with her husband for the past forty years. Mr and Mrs B had taken the plunge and left behind their family and country of birth in their early 20s with the dream of better job prospects in North America. For almost four decades she had been a schoolteacher but, since retiring, now finds herself mostly dividing her free time between tending to her garden and caring for her grandchildren.

Today, however, is not a typical morning for Mrs B. In a couple of hours, her son will be driving her to a nearby hospital, where she is scheduled for a robotic total knee arthroplasty (TKA). Mrs B has always felt blessed and grateful to have led a fairly healthy life. She describes never being admitted to a hospital nor needing an operation beyond the odd dental procedure. However, years of worsening throbbing pain in her right knee from decades of wear and tear, culminating in severe osteoarthritis has made life difficult for her to bear. These days she struggles to carry out even her basic daily activities. She is especially distraught by the inability to perform her prayers or care for her garden without pain, as well as being no longer able to take her grandchildren for walks to nearby parks. The thought of surgery and potentially spending a night or more in the hospital away from her beloved family is daunting and terrifying, nevertheless, the promise of reclaiming mobility leaves Mrs B determined to see the procedure through.

Just a week ago, Mrs B had a preoperative assessment with an anaesthesiologist. She found it amazing that the meeting was done virtually using telemedicine within the comforts of her home, arguably one of the positive consequences of the COVID pandemic. Her 14-year-old grandson had helped to set up her camera and microphone on his laptop. With her husband and son at her side, a detailed assessment and discussion took place, encompassing her anaesthetic plan and post-op pain management strategies. Mrs B felt both pride and relief when she was deemed 'fit for surgery', and even more pleased when she was told she would be eligible for the procedure to be done as a day case through an ambulatory arthroplasty pathway.

It is now ten in the morning and Mrs B has been dropped off at the hospital with her husband and son. They soon find their way to the preoperative care unit (POCU) where she is warmly welcomed by the POCU staff, checked in and changed. She feels reassured by the efficiency and professionalism of the staff, and is told that her operating room (OR) is running right on schedule, with her being the third TKA in today's OR list. A nurse takes a set of Mrs B's vitals as they go through a checklist. Shortly after, she is reacquainted with her orthopedic surgeon and meets the anaesthesiology fellow assigned to her case. With her husband and son in attendance, the doctors review the planned procedure and go through the plan for the day. They provide plenty of reassurance which helps calm her nerves and alleviates her anxiety. She then bids farewell to her family and is transported to the block room in a wheelchair.

In the block room, Mrs B is introduced to the Regional Anaesthesia (RA) team, who in addition to the fellow, comprises a consultant anaesthesiologist, resident, anaesthesia assistant (AA) and nurse. While chatting to the nurse who checks her in, she barely notices as the AA puts her on the monitors and pops in an

by Iskandar Bin Khalid
Toronto Western Hospital
University Health Network
Canada &
Hospital Canselor
Tuanku Muhriz UKM
Kuala Lumpur
Malaysia

by Lui Ken Yi
Toronto Western Hospital
University Health Network
Canada

intravenous line on her hand. A pre-block safety check is carried out and Mrs B expresses amusement as a small smiley face is drawn with a marker on her right thigh. With the block area cleaned and prepped, she receives an intravenous sedative, described by AA as 'like having a couple of glasses of wine', which further amuses Mrs B as she has never had a drop of alcohol in her life. The RA fellow then performs an adductor canal block (ACB) and places a block catheter at her midthigh, followed by a spinal anaesthesia by the resident.

The whole process takes just below 30 minutes. It is not long before the spinal anaesthetic kicks in and for the third time in the block room, Mrs B chuckles, this time due to the funny feeling she now experiences in her lower limbs.

Now in the operating room, Mrs B is feeling anxious again. The thought of someone 'hammering away at her knee' while she is awake scares her and she starts thinking if she has made a mistake. The anaesthesiologist quickly notices her growing anxiety, and promptly provides reassurance and allays her fears. After another safety check a propofol infusion is started and Mrs B is off to sleep. She wakes up and is told her surgery is done while the orthopaedic resident bandages her wound. She describes having 'the best nap I have had in ages' and jokingly asked for 'some of the white stuff to bring home'. While being transferred to a stretcher, she overhears the orthopaedic surgeon on his phone, telling Mr B that everything has gone well. Mrs B is fast tracked to the Daycare Surgery Unit (DSU). As she leaves the OR, Mrs B expresses profound relief that the procedure is over and she thanks the entire team for a job well done.

The DSU is bustling with activity. A nurse checks Mrs B's vitals then she is given a glass of juice to take with tablets of acetaminophen and celecoxib. Her husband and son arrive at her bedside, both get bearhugs as she jokes that 'they're not getting rid of me that easily'. The RA fellow drops by and attaches an elastomeric pump to her ACB catheter which provides a continuous infusion of local anaesthetic. Mrs B and her family are given a patient information sheet in addition to a detailed explanation on the workings and care of her ACB catheter. After just over an hour in the DSU, Mrs B starts feeling the return of sensation in her lower limbs. She does feel a slight increase in pain at the surgical site, however this is well-controlled with the multimodal regimen provided by the ACB catheter and oral analgesics. Under the patient yet watchful eye of the physiotherapist, Mrs B begins active movement of her lower limbs. Not long after she is able to transfer independently to the edge of the bed, starts weight-bearing and gently mobilizes with a walker. Encouraged by her husband and son, and eager to see her grandchildren, Mrs B pushes herself to ambulate and complete the staircase exercise. She passes the physiotherapist's tests with flying colours and is given the greenlight to return home. Less than 12 hours from waking up this morning, Mrs B is back in her favorite winged chair in her living room, surrounded by her doting family.

The next couple of days posed new challenges for Mrs B on the road to recovery, including managing her pain and gradually increasing her activity levels. Nonetheless, each passing day brought tangible and noticeable improvements and she was able to navigate her daily tasks with greater ease. She also receives a daily telephone call from the acute pain service (APS) team. Three days after surgery, her son pulls out the ACB catheter as per the patient information sheet and applies a band-aid.

It's a month after surgery and we call Mrs B to find out how she's doing. The benefits of her knee replacement have become clear. Mrs B is back to her usual activities and is now more active than ever. The chronic pain which once hindered her lifestyle has diminished significantly. She is able to pray, tend to her garden and walk her grandchildren to the park pain-free.

She has regained her sense of independence and describes having a new lease of life. As we say our goodbyes the conversation ends with Mrs B expressing profound gratitude to her entire care team for the experience she had.

Conclusion

The authors are currently enrolled in RA and pain fellowships at the Toronto Western Hospital where Mrs B was one of many patients who has benefitted immensely from daycare total joint arthroplasty. In November 2021, the first daycare TKA in Malaysia was performed by a team from the Subang Jaya Medical Centre. Over the years, several other hospitals in Malaysia have followed suit, nevertheless, the number of total knee and hip arthroplasties performed as a day case remains low with the service largely unavailable or underutilized. While there certainly are many barriers to overcome, perhaps it is time to ask why not rather than why when discussing our role as anaesthesiologists in advancing daycare total joint arthroplasty in our practice. Perhaps it is time to step out of our comfort zone to ensure that more Malaysians are provided the high standard of care which Mrs B was privileged to experience.

Advancing Daycare Arthroplasty through REGIONAL ANAESTHESIA

Daycare total joint arthroplasty (TJA), encompassing total knee or hip replacement has emerged as a transformative approach to patient care in orthopaedic surgery. TJA performed in an ambulatory setting in contrast to conventional inpatient hospital admission offers patients the convenience of same-day discharge which minimizes hospital length of stay, reduces costs, and accelerates recovery. Effective pain control via multimodal analgesia is a key prerequisite for successful ambulatory surgery. In recent years, the utilization of regional anaesthesia (RA) techniques has gained momentum in daycare TJA, revolutionizing perioperative care and enhancing patient experience. Central neuraxial and peripheral nerve blocks (PNB) are increasingly being recognized as suitable options to provide anaesthesia & analgesia in daycare TJA. In Malaysia, daycare TJA remains limited to a relatively small number of centres. Here we share our experience from the perspective of a RA service in a tertiary care centre which conducts a large volume of daycare TJA.

Patients are typically first screened by the orthopaedic surgeon, with patient selection being generally liberal and not limited to ASA 1 or 2 patients. The elderly, the obese and those with multiple comorbidities, traditionally seen as unsuitable for ambulatory surgery, are now often included among candidates for daycare TJA. Patients are then seen in the preassessment (anaesthesia) clinic, whether in person or virtually utilizing telemedicine, where a thorough assessment is performed and detailed information on the likely anaesthetic plan is provided and discussed before deciding on the most suitable option.

Our centre in the heart of Toronto, Canada, features a four-bedded block room, fully equipped and staffed by a team comprising of anaesthesiology consultants, fellows, residents, anaesthetic assistants and nurses. Patients will be brought to the block room ahead of their planned surgery to allow adequate time for RA to be performed in a parallel processing pathway. Spinal anaesthesia and PNB feature routinely in our RA protocol for daycare TJA. Unless contraindicated, spinal anaesthesia with a short-acting local anaesthetic (LA) (i.e, mepivacaine) is used to achieve surgical anaesthesia followed by a PNB for purposes of post-operative pain management. The choice of RA technique used is often dictated by patient factors in addition to anaesthesiologist and surgeon preference. Commonly used RA techniques at our institution are:

Total knee arthroplasty: Adductor canal block (ACB) (single shot or continuous catheter technique) and periarticular local infiltration analgesia (LIA) with or without Infiltration between popliteal artery and capsule of the knee (iPACK) block.

Fig A: Adductor canal block (ACB) catheter placement

Total hip arthroplasty: Pericapsular nerve group (PENG) block or Iliopsoas plane block (IPB) or lumbar erector spinae plane (ESP) block with periarticular LIA.

The search for the holy grail, the ideal pharmacological agent for RA remains. As most LA produce a relatively short duration of action, we routinely employ the use of perineural adjuncts, including dexamethasone and adrenaline, to

by Lui Ken Yi
Toronto Western Hospital
University Health Network
Canada

by Iskandar Bin Khalid
Toronto Western Hospital
University Health Network
Canada &
Hospital Canselor Tuanku Muhriz UKM
Kuala Lumpur, Malaysia

prolong anaesthesia and analgesia. Our institution also provides a continuous adductor canal block (CACB) programme using a nerve block catheter and elastomeric pump infusion system. The CACB is utilized for selected patients, particularly those with pre-existing chronic pain, significant preoperative analgesic requirements or contraindications to use of non-steroidal anti-inflammatory drugs (NSAIDs) and/or opioids. Risk of catheter dislodgement, a fairly common problem with nerve block catheters, is minimised with the use of an adhesive 'Epi-Guard' dressing to secure the catheter.

Fig B: Final ACB catheter placement with 'Epi-Guard' dressing to secure catheter

Often the RA procedure itself may trigger patient anxiety and elicit significant discomfort and pain. Therefore, patients in our centre are routinely given sedatives such as midazolam or propofol with or without a short-acting opioid to help mitigate the cascade of psychological and physiological stress. Non-pharmacological sedoanalgesia techniques such as music and immersive virtual reality are occasionally used as an adjunct to pharmacological methods.

Patients are then wheeled to the operating room where sedatives are again routinely employed to ensure patient comfort throughout surgery. Once the operation is completed, the majority of patients are able to bypass the post-anaesthesia care unit (PACU) and are instead fast-tracked to the daycare surgery unit (DSU) unless patient, anaesthetic and/or surgical reasons necessitate more extensive monitoring in the PACU.

In the DSU, a multidisciplinary team comprised doctors, nurses, physiotherapists and pharmacists provide dedicated care towards ensuring patient readiness for discharge, including patient education, post-operative nausea and vomiting (PONV) management, joint mobilisation, weight-bearing and ambulation whilst maintaining adequate analgesia. Family members and caregivers are also actively involved in this process and are often a vital source of motivation and encouragement for the patient. Once medical and physiotherapy goals are met, discharge and follow-up plans are

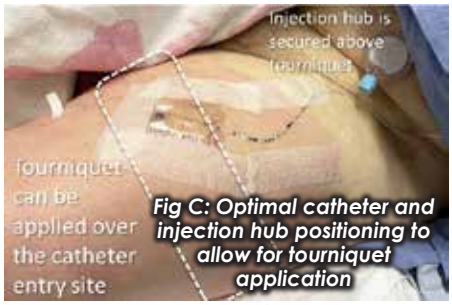


Fig C: Optimal catheter and injection hub positioning to allow for tourniquet application

drawn up and shared with the patients and they are cleared to return home.

Achieving Successful RA for Daycare Arthroplasty

While RA offers compelling benefits in daycare TJA, several considerations should guide its implementation:

1. **Patient Selection:** Not all patients are suitable candidates for RA. Factors such as pre-existing medical conditions, anatomical considerations, and patient preferences should be carefully evaluated in the pre-assessment (anaesthesia) clinic to ensure safety and efficacy.

2. **Multimodal Analgesia:** RA should be integrated into a multimodal analgesic regimen, combining various non-pharmacological and pharmacological analgesic modalities to optimize pain control while minimizing side effects. Current evidence suggests that peripheral nerve blocks, performed with long-acting LA in combination with intravenous or perineural dexamethasone, provides the longest and most optimal sensory block. In time, newer and novel LA agents and extended-release LA formulations such as liposomal bupivacaine (Exparel) may prolong the duration of analgesia with single-shot peripheral nerve blocks, however evidence for their use remains sparse at present.

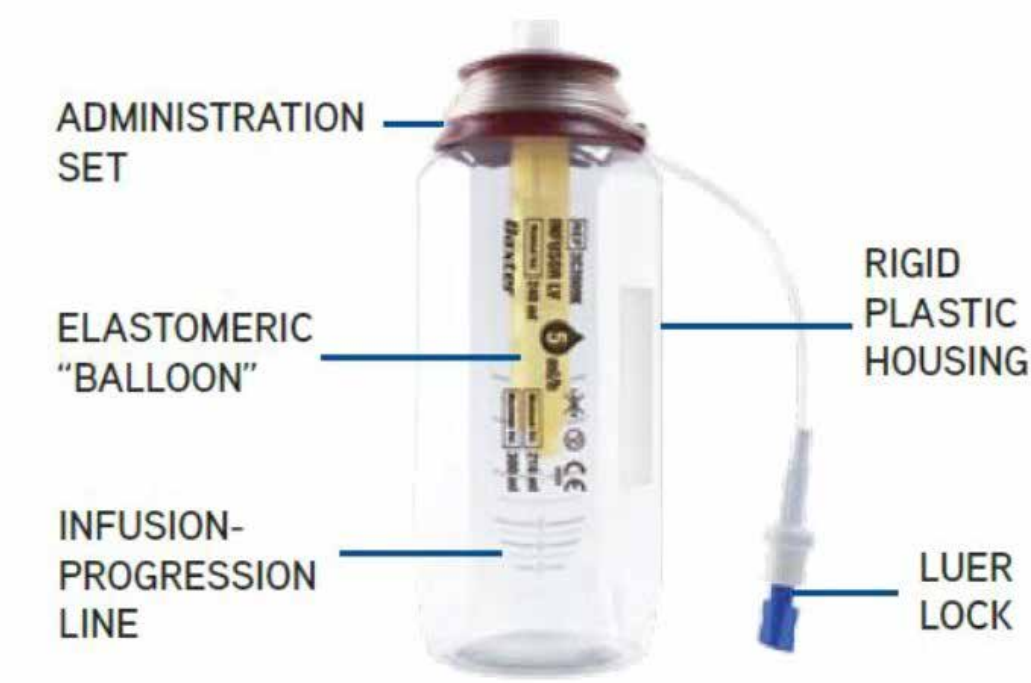
Fig D & E: Elastometric pump which provides up to 48-72 hours of continuous infusion of local anaesthetic

3. **Patient Follow-up:** In the ambulatory setting, patients are often discharged before the effects of RA have fully worn off, hence in our institution, patients are usually followed up with a phone call the following day to allow assessment of nerve block resolution and detection of potential complications. During the phone call, patients are also provided education on the use of multimodal oral analgesics to prevent rebound pain. Those discharged with a block catheter will also be advised on catheter care, detection of catheter related complications and ultimately are guided on the process of self-catheter removal.

4. **Training and Expertise:** Achievement of core and advanced competency in RA is a crucial prerequisite for successful use of RA in daycare TJA. Competency- and simulation-based medical education in RA should be adopted into anaesthesia training programmes to ensure safe and effective use of RA without supervision.

Future Directions:

A seamless integration of RA into daycare TJA represents a significant advancement in perioperative care. There is no doubt that RA is pivotal in the success of daycare TJA, offering superior pain management, reduced opioid consumption and enhanced patient satisfaction. Future research endeavours should focus on further refining RA techniques, optimizing analgesic protocols, and evaluating long-term outcomes, including patient satisfaction, functional recovery, and healthcare resource utilization. Further planning and discussion among stake holders would enable us to step out of our comfort zone and gradually provide greater patient access to ambulatory arthroplasty in Malaysia, simultaneously aligning with aspirations of transforming our country into one of the leading medical tourism destinations in Asia.



References

1. Lazic S, Boughton O, Kellett CF, Kader DF, Villet L, Rivière C. Day-case surgery for total hip and knee replacement: How safe and effective is it? *EFORT Open Rev*. 2018 Apr 27;**3**(4):130-135. doi: 10.1302/2058-5241.3.170031. PMID: 29780620; PMCID: PMC5941652

2. Nijs K, Ruette J, Van de Velde M, Stessel B. Regional anaesthesia for ambulatory surgery. *Best Pract Res Clin Anaesthesiol*. 2023 Sep;**37**(3):397-408. doi: 10.1016/j.bpa.2022.12.001. Epub 2022 Dec 16. PMID: 37938085

3. Tan ESJ, Tan YR, Liu CWY. Efficacy of perineural versus intravenous dexamethasone in prolonging the duration of analgesia when administered with peripheral nerve blocks: a systematic review and meta-analysis. *Korean J Anesthesiol*. 2022 Jun;**75**(3):255-265. doi: 10.4097/kja.21390. Epub 2021 Dec 29. PMID: 34963269; PMCID: PMC9171542

4. Wiesel, Joshua & Findlay, Bernadette & Ooi, Li & Stevens, Jennifer & Hadzic, Renata. (2023). Peripheral nerve catheter securement: A narrative literature review. Journal of Perioperative Nursing. 36. 10.26550/2209-1092.1271

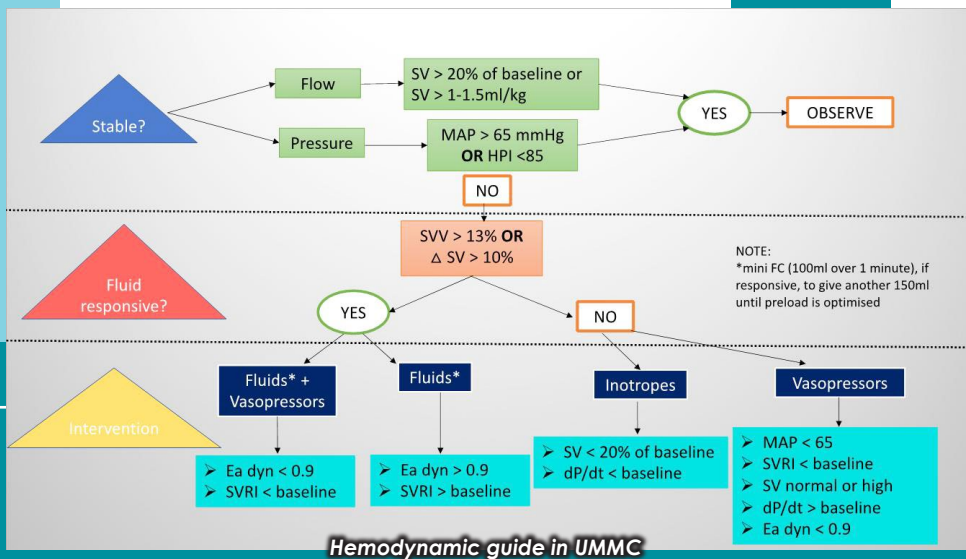
5. Ramlogan RR, Chuan A, Mariano ER. Contemporary training methods in regional anaesthesia: fundamentals and innovations. Anaesthesia. 2021 Jan;76 Suppl 1:53-64. doi: 10.1111/anae.15244. PMID: 33426656.

6. Jaramillo, Sandra & Giraldo, Juliana & Morales, María. (2023). Teaching regional anesthesia: current perspectives. 10.5772/intechopen.1002924

Introducing a New Helper to Anaesthesiologists
TECHNOLOGY

by Fiona Chu Mei Yeen
Universiti Malaya Medical Centre
Kuala Lumpur, Malaysia

by Mohd Fitry Zainal Abidin
Universiti Malaya Medical Centre
Kuala Lumpur, Malaysia



Hemodynamic guide in UMMC

Who has not heard of ChatGPT? The growing sentiment is that artificial intelligence may soon replace us humans in every aspect of life... I'm kidding (I think). At least, not so soon. However, we cannot deny that technology significantly impacts our daily lives and, noticeably, it has seriously impacted the healthcare system in recent years. With advancements in medical technology, we can now monitor, diagnose, and treat our patients better and improve clinical outcomes.

One good recent application of technology that anaesthesiologists and intensivists would receive with open arms is gadgets that aid in real-time monitoring parameters of critically ill patients either in the operation theatre, intensive care unit or any other critical care unit. Real-time monitoring is welcomed and cherished as each second could be precious to dear life.

Some great and recent examples in advanced haemodynamic monitoring are pulse contour analysis, a minimally invasive cardiac output monitor and point-of-care viscoelastic tests. These innovations have greatly improved the quality of perioperative care for a wide range of patients, such as those who undergo major non-cardiac surgery (e.g., cytoreductive surgery (CRS) and hyperthermic intraperitoneal chemotherapy (HIPEC)) in which massive bleeding and major fluid shifts are anticipated. Optimal fluid management will be a great challenge for the managing anaesthesiologists. Appropriate depth of anaesthesia is vital in preventing awareness, and excessive anaesthetic depth could risk the patient developing postoperative delirium, amnesia, and haemodynamic instability intraoperatively. Many depth of anaesthesia monitors are available in market, and most of us are familiar with Bispectral Index (BIS) monitoring. Beyond the routine index number, processed electroencephalogram (EEG) also gives us a clue on the raw EEG waveforms, and through proprietary algorithms, parameters such as the power spectrum (PS), density spectral array (DSA), and spectral edge frequency (SEF) are derived and increasingly monitored during anaesthesia.

We are pleased to share a case of a 59-year-old woman with no known medical illness who was diagnosed with peritoneal carcinomatosis from a primary malignant ovarian tumour and scheduled to undergo cytoreductive surgery (CRS) and hyperthermic intraperitoneal chemotherapy (HIPEC) on 28th March 2023 at Universiti Malaya Medical Centre (UMMC) under general anaesthesia. After induction, a minimally invasive advanced haemodynamic sensor system was attached to the left radial arterial catheter. The baseline stroke volume (SV) and systemic vascular resistance index (SVRI) were set and recorded at the phlebostatic axis. Her baseline SV was 80 ml, and SVRI was 1640 dynes s m^2/cm^5. This information is essential as it can help to determine whether the patient needs fluid or inotropic or vasopressor support perioperatively due to bleeding, ongoing fluid loss, fluid shift, or vasodilatation and also to avoid excessive fluid administration leading to hypervolaemia.

Her anaesthesia was maintained with inhaled volatile anaesthetic,

sevoflurane, and TCI Remifentanil with guidance from a BIS monitor, aiming at 40-60 with SEF at 14-16 Hz.

Intraoperatively, she was given intravenous maintenance fluid (crystalloid-sterofundin) 400 ml/hour to replace evaporative fluid loss from a large laparotomy wound of about 7 ml/kg/H. Any bleeding was initially replaced with intravenous human albumin 5% at a ratio of 1:1.5 (blood: human albumin 5%). Arterial blood gas (ABG) was taken every two hours to monitor ventilation, haemoglobin, electrolytes, dextrose, lactate, and acid-base balance. Her haemodynamic status was monitored continuously via FloTrac.

At two hours intraoperatively, SV dropped more than 20% and mean arterial pressure (MAP) was less than 65 mmHg. A fluid challenge of 100 ml of sterofundin was given over one minute, and SV showed fluid responsiveness (increment by 10%). Hence, another 150 ml of sterofundin was given until SV returned to baseline reading. The estimated blood loss at that moment was 150 ml with three litres of ascitic fluid.

At four hours intraoperatively, SV dropped more than 20%, MAP was less than 65 mmHg, and SVRI dropped less than baseline; another mini fluid challenge of 100 ml sterofundin was given, and Noradrenaline infusion was started at 0.02 mcg/kg/min due to the non–fluid responsiveness state. The estimated blood loss at that moment was 700 ml, and 1 unit of packed cell transfusion was started. Her baseline haemoglobin level was 10 g/dL.

At six hours intraoperatively, the surgeon queried if the patient could be having coagulation issues as the bleeding was difficult to stop and there was persistent oozing from raw areas. Estimated blood loss at that moment was 1.3 litres with a haemoglobin level of 9.6 g/dL with stable haemodynamic status. A blood sample was sent for viscoelastic testing. The test revealed no clotting disorder; hence, no blood product transfusion was given. Instead, intravenous tranexamic acid 1 g was given stat and 8-hourly.

Advanced haemodynamic monitoring showed stable haemodynamic status. Hence, the intravenous maintenance fluid was kept at 400 ml/hour of sterofundin.

After the colorectal team completed cytoreductive surgery, HIPEC commenced with intraperitoneal cisplatin for one hour. ABG showed mild metabolic acidosis and the lactate level before starting HIPEC was 1.0. The highest temperature recorded during HIPEC was 37.9 degrees Celsius.

Her highest intraoperative noradrenaline infusion was 0.1 mcg/kg/min. The total estimated blood loss was 2.8 litres. She was given two units of packed cell transfusion, five litres of sterofundin, and 1.6 litres of human albumin 4%. The operation lasted 18 hours, and the patient was sent to the ICU for post-operative monitoring and ventilation. Continuous haemodynamic monitoring was also done in the ICU.

Noradrenaline infusion was able to be weaned off at eight hours post-operation. She was extubated well to face mask at 11 hours post-operation. She developed mild postoperative acute kidney injury, not requiring any renal replacement therapy, which subsequently resolved, and she was discharged well on day eight post-operation to home.

If we do not have advanced haemodynamic monitoring to guide us in this major, long-duration intrabdominal operation, we could have over- or under-fluid resuscitated the patient. Overzealous fluid resuscitation could result in peripheral oedema, bowel oedema, acute pulmonary oedema, cardiac failure, electrolyte imbalances, and coagulopathy. Hypervolaemia could lead to haemodilution, resulting in unnecessary packed cell transfusion. On the other hand, inadequate fluid resuscitation could result in hypoperfusion, shock, and multiorgan injury due to hypoperfusion. These complications are nightmares for anaesthesiologists, intensivists, surgeons and, of course, for the patient. Therefore, we try our best to avoid these complications perioperatively and make the best use of technology and medical gadgets to guide our management of critically ill patients.

Viscoelastic tests guide anaesthesiologists to avoid unnecessary blood product transfusions such as cryoprecipitate, platelets, and fresh frozen plasma. In addition to avoiding potential risks of blood product transfusion, this reduced wastage and alleviated the financial burden of the transfusion department. Thus, these blood products could be reserved and given to those who truly need them, as they are often precious and a finite resource.

Nevertheless, nothing is free; this comes with a cost, as using advanced haemodynamic monitors and viscoelastic testing is costly and dependent on their availability in healthcare facilities. Not all facilities or patients can afford these expensive monitoring perioperatively. However, we have to remember that morbidity or mortality costs are way higher than that. The purpose of this article is to share our experience in conducting anaesthesia for a major non-cardiac surgery using these physiological monitors to aid us in achieving homeostasis perioperatively and a better recovery profile. Regardless, we shall not be entirely dependent on these technology gadgets until basic physiology knowledge is neglected and clinical correlation with a patient's condition is lost.

Medic Aid Free Surgical Camp @ Hospitals Beyond Boundaries, Cambodia

by Vimal Varma
Hospital UiTM Sg Buloh
Selangor, Malaysia

by Navina Thiagarajah
Avisena Specialist Hospital
Selangor, Malaysia

> *The best way to find yourself is to lose yourself in the service of others.*
>
> *~ Mahatma Gandhi*

In a world where access to healthcare remains unequal, free medical services stand as a beacon of compassion and equity. Rooted in the belief that health is a fundamental human right, these initiatives strive to bridge the gap, offering vital care to those who might otherwise go without.

The Humanitarian Malaysian Medical Aid Society (MEDIC AID), in partnership with Hospitals Beyond Boundaries (HBB), recently organized a Free Surgical Camp for children at the HBB Phnom Penh, Cambodia, held from 22nd to 24th March 2024. This marks the fourth iteration of this mission, with the inaugural camp taking place in 2017. Since its inception, this initiative has positively impacted the lives of thousands of children, providing them with much-needed medical assistance and care.

The present operating team comprises eleven core members headed by Dr Syariz Sehat, a paediatric surgeon from Avisena Women's and Children's Hospital (AWCSH), and two anaesthesiologists, Dr Navina Thiagarajah (AWCSH) and Dr Vimal Varma (Hospital Universiti Teknologi MARA Sg Buloh). Senior clinical nurses Mrs Rosiani Paulus, Siti Rahmah Ali Babdar, and Nurul Shadida selflessly took time off to organize and assist the doctors to ensure successful and clean surgeries were performed. Our team also received invaluable support from Mr Azar Faizi from Medic Aid who handled our travel plan & transport in Phnom Penh.

The Medic Aid Society is a non-governmental organization (NGO) engaged in humanitarian efforts across Malaysia since 2020. This Society provides a platform for like-minded individuals to help in a non-profit organization, mainly focusing on health and education for under-privileged populations. Meanwhile, Hospitals Beyond Boundaries (HBB), established in 2012 by young Malaysian doctors, operates as an NGO recognised by the United Nations (UN). Their mission focuses on enhancing the health of

vulnerable communities through sustainable healthcare initiatives. Originating with a mobile clinic, HBB has expanded to establish a community clinic and now operates its own hospital dedicated to serving marginalized communities in Cambodia.

After weeks of preparing the essential surgical and anaesthesia equipment, our team arrived in Phnom Penh on the afternoon of 22nd March. We were deeply honoured to receive a warm welcome from the CEO of HBB Phnom Penh, Dr Roly, and representatives from the Tourism Ministry of Cambodia.

We travelled directly from the airport to HBB, Phnom Penh. The local medical professionals and staff who were in command offered invaluable assistance, facilitating our efforts to organize the patients and prepare the minor operating theatre. Following a brief introduction and briefing of plans, we commenced our surgeries

immediately. Dr Syariz examined, diagnosed and determined the required surgical procedures for the children while Dr Navina conducted a thorough pre-operative assessment, assisted by local personnel who served as translators.

Surgical cases were set to commence by 2.30 pm the first day. We expressed our profound gratitude to Schmidt Medical for providing us with portable vital signs monitor, including a capnograph. Special thanks to Dato' Dr Jaseemuddeen for loaning us his Mindray Target Controlled Infusion (TCI) pump, enabling us to administer total intravenous anesthesia (TIVA) during the surgeries. Conducting surgeries and performing remote anaesthesia in a small hospital poses its own risks. However, with great planning and

teamwork, we were able to conclude the first day on a positive note with the successful completion of four hernia and circumcision surgeries.

The second day started early at 6.00 am, with six surgeries planned for the day to be completed by noon. We were graced by the presence of Dr Wan Abdul Hannan, CEO, and co-founder of HBB, and Dr Izza Arsyika, General Secretary of HBB, who both were very helpful during this mission. Upon completion of all six surgeries, we departed from the HBB clinic after ensuring all patients had recovered well post-anesthesia.

In the evening, we were deeply honoured to receive an invitation to the 'Majlis IFTAR Ramadhan' hosted by the esteemed Prime Minister of Cambodia, Samdech Hun Manet. This memorable event brought together over 6,000 people of diverse communities from around the world. Following a sumptuous meal, the team gathered for a brief recap of the trip, identifying any challenges encountered and discussing plans for the next mission.

With a mixture of emotions, including a sense of fulfillment and a touch of sadness, we bid farewell to Phnom Penh on 24th March and returned to our homeland. We are hopeful that our next mission will afford us the opportunity for a more extended stay, allowing us to extend our services to a greater number of patients in need.

For us, the anaesthetists, these missions not only bring a sense of satisfaction but also serve as invaluable lessons in resilience and adaptability. Operating in challenging environments teaches us to be more tactful, has open communication, and be resourceful in delivering expert care to those who need it most.

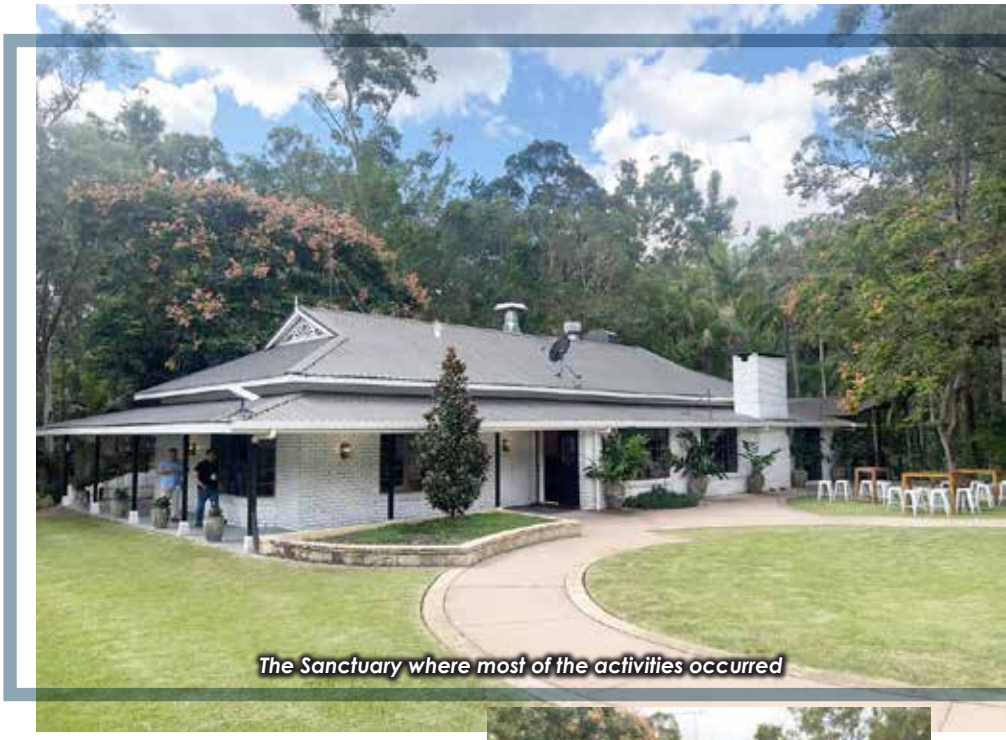
EMERGING LEADERS CONFERENCE 2024

Australian and New Zealand College of Anaesthetists

by Muhammad Amir Ayub
Hospital Melaka
Melaka, Malaysia

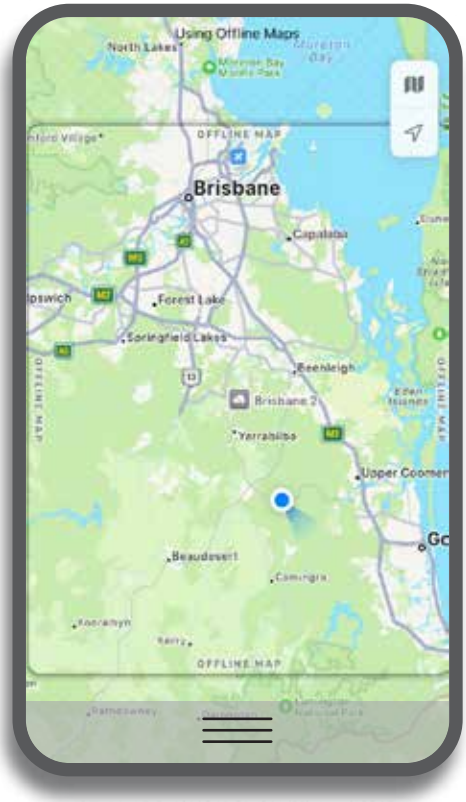
The Australian and New Zealand College of Anaesthetists (ANZCA), in conjunction with its Annual Scientific Meeting, organized its Emerging Leaders Conference (ELC) from 30th April to 2nd May 2024 at the Cedar Creek Lodges at Tamborine Mountain in the Australian state of Queensland. This was approximately an one-hour drive from Brisbane.

Members of international sister colleges were invited to attend the event along with ANZCA fellow; this included those from Papua New Guinea, Singapore, Hong Kong, and Malaysia. Representing Malaysia was Professor Dr Ina Ismiarti Shariffuddin (President, CoA AMM) and I (Hospital Melaka). We assembled at the Brisbane Convention and Exhibition Centre, where we were brought to the mountainous region by bus. It would be difficult to talk about the conference without writing a novel; I'll try to summarize the event with photos as well as I can.



The Sanctuary where most of the activities occurred

We are here!



Note the location of the ELC in comparison to Brisbane

The conference was held in a general format of individual talks, followed by panel discussions and copious amounts of coffee. The background and topics presented were incredibly diverse. It's clear that to be a leader, you generally do not have to start off perfectly; on the contrary, it was good to hear about all the setbacks these accomplished people had to endure. The theme was 'Breaking Barriers' and it was truly reflected in how everyone had an opportunity to speak with each other regardless of background and past or current position. No question was too stupid or controversial. Calling everyone by name without titles allows the delegates to speak up, ask anything, or express out their opinions.

Sessions covered a wide range of topics from a wide variety of speakers. Various themes included experience sharing, practical talks like navigating hospital systems to achieve goals, introspection (into one's unconscious biases), and listening to multiple perspectives. The

background of the speakers extended well beyond anaesthesiologists and included a paraplegic emergency physician and a business CEO. There was also a session entitled "You can't ask that!", a forum that fit the bill exactly as a conference with the theme "Breaking Barriers".

There was an enormous opportunity to share experiences and perspectives. Along with representatives from the sister colleges, there were also "Australians" who actually came from other countries/health systems such as Canada and England. During breaks/meal times, your table partner could be a high-ranking leader in the world of anaesthesiology; the ice just needed to be broken.

There were too many lessons learned but I'll highlight quotes that stood out to me specifically. Among them include:
"We have to always think about the stupid s#@t we should stop"
"Pick up the red carpet"
"The higher the ladder you go up, the less feedback you get"
"If you want executive capacity, you need to be in a leadership role"
"Show authenticity"

In summary, this was an essential programme. I think it is pivotal for any person to go through such a leadership course, and a similar programme should be emulated here in Malaysia.

Discussions after a "cleansing" session with one of the aboriginal (First Nations) people of the region; tensions and reconciliation between the First Nations and Caucasians were a constant theme throughout.


Yours truly with the presidents of the Australian and Malaysian colleges


How do you describe a panel chaired by the ANZCA president and its members; an ex-United Nations medical director, a female anaesthetist with Red Cross experience including managing Ebola and war-torn Yemen, the presidents of the College of Anaesthesiologists of Ireland, Malaysia and Hong Kong?


The conference dinner, where I was seated with the college president and the main organizing committee


Ms Nurulhuda highlighting key elements in an effective expert report

MSA-CoA Expert Witness Training Workshop

AN ENLIGHTENING EXPERIENCE

by Sarah Aliah Binti Mohd Azman
Department of Anaesthesiology
Universiti Malaya Medical Centre
Kuala Lumpur, Malaysia

Event Overview

On 8th June 2024, the MSA-CoA, in collaboration with the Medico-Legal Society of Malaysia and Universiti Malaya Medical Centre (UMMC), hosted an Expert Witness Training Workshop. This event was attended by a diverse group of professionals eager to enhance their skills and knowledge in the field of expert witness testimony. The workshop aimed to provide introductory training through lectures, discussions, and practical insights into the role and responsibilities of an expert witness.

Opening Remarks

The workshop began with opening remarks from two distinguished figures. Professor Dr Ina Ismiarti Shariffuddin, President of the College of Anaesthesiologists (CoA) and Dato' Dr Yong Chow Yen, President of the Malaysian Society of Anaesthesiologists (MSA), welcomed the participants and highlighted the importance of expert witnesses in the legal system. Both speakers conveyed a clear message: the role of an expert witness is not just to provide information but to do so in an impartial and easily comprehensible manner to those who may not have the same level of technical expertise. They urged participants to take full advantage of the day's sessions, engage actively in discussions, and strive for excellence in their practice as expert witnesses.

Lecture 1: Who is an Independent Expert?

Dato' Dr Mohamed Hassan Mohamed Ariff delivered the first lecture, titled 'Who is an Independent Expert?'. His presentation provided a thorough exploration of the concept of an independent expert and the critical role he plays in legal proceedings.

Dato' Dr Hassan began by defining what constitutes an independent expert. He described an independent expert as a professional who possesses specialized knowledge or expertise in a particular field and is called upon to provide impartial and objective opinions to assist the court in understanding


Dato' Dr Hassan Mohamed Ariff enlightening the audience on "Who is an Independent Expert?"


Interactive Session on Reported Case Studies

Interactive Session on Reported Case Studies

technical or complex issues. Unlike lay witnesses, whose testimonies are based on personal observations, expert witnesses draw upon their specialized knowledge to offer informed opinions.

A significant portion of the lecture focused on the ethical and professional standards required of an independent expert. Dato' Dr Hassan emphasized that maintaining independence is paramount. This means that experts must provide their opinions without bias or influence from the parties involved in the case. He stressed that the credibility of an expert witness hinges on his ability to remain impartial and objective. To illustrate this point, Dato' Dr Hassan shared examples from his own experience, highlighting instances where the integrity of expert testimony was challenged due to perceived bias. Dato' Dr Hassan also discussed potential conflicts of interest that experts may encounter. He advised participants to be vigilant about disclosing any relationships or circumstances that could be perceived as conflicts of interest. Transparency is essential to preserve the court's trust and the parties involved. He provided practical tips on managing and avoiding conflicts of interest, including thorough documentation and clear communication with legal counsel.

Another key aspect of the lecture was the discussion on the qualifications and expertise required of an independent expert. It was explained that experts must have a deep and current understanding of their field. Continuous professional development and staying updated with the latest advancements and research are crucial. He encouraged participants to pursue ongoing education and training to enhance their knowledge and skills.

Dato' Dr Hassan concluded his lecture by emphasizing the importance of effective communication. He pointed out that an expert's ability to convey complex information in a clear and understandable manner is just as important as his technical expertise. The ultimate goal of an expert witness is to assist the court in making informed decisions. Therefore, his testimony's clarity, coherence, and persuasiveness are critical.

Lecture 2: Writing an Effective Expert Report

The second lecture, presented by lawyer Ms Nurulhuda Mansor, focused on 'Writing an Effective Expert Report: The Nuts and Bolts'. Ms Nurulhuda Mansor, an experienced lawyer with extensive experience in preparing and reviewing expert reports, delivered a comprehensive and practical guide on the essentials of drafting an expert report. She began by emphasizing the importance of an expert report in legal proceedings, describing it as a vital document that can influence the outcome of a case. An effective expert report, she noted, must be clear, concise, and comprehensive, providing all necessary information in a manner that is accessible to non-experts, including judges and juries.

Ms Nurulhuda also discussed common pitfalls to avoid when writing an expert report. These include using overly technical language, which can confuse non-expert readers, and failing to explain the basis for the expert's opinions adequately. She stressed the importance of proofreading and reviewing the report to ensure accuracy and clarity.

In addition to the structure and content, Ms Nurulhuda highlighted the significance of the expert's tone and language. She advised to maintain a professional and objective tone throughout the report and avoid emotive language or any indication of bias. The goal, she reiterated, is to provide a clear, impartial, and well-supported opinion that can withstand scrutiny in court. She concluded her lecture by sharing examples of effective expert reports and engaging the participants in discussing best practices. She encouraged attendees to ask questions and share their experiences, fostering a collaborative learning environment.

Lecture 3: Reported Case Studies

The third lecture, 'Reported Case Studies,' was presented by lawyer

Ms Charlaine Adrienne Chin. Ms Charlaine, an accomplished legal practitioner with extensive experience in litigation, provided an in-depth analysis of several notable cases where expert witnesses played crucial roles. Her lecture aimed to illustrate the practical application of expert testimony in real-world scenarios and to highlight the challenges and successes encountered by expert witnesses in the courtroom.

Ms Charlaine began by explaining the importance of case studies in understanding the dynamics of expert witness testimony. She noted that while theoretical knowledge is essential, studying actual cases provides invaluable insights into the practicalities of the role. By examining real-life examples, experts can learn from the experiences of others and gain a deeper appreciation of the complexities involved in delivering effective testimony.

Lecture 4: The Role of Experts and Experts' Report in Mediation

The fourth lecture, delivered by lawyer Ms Shanti Abraham, was titled 'The Role of Experts and Experts' Report in Mediation'. Ms Shanti, an esteemed mediator and legal expert, provided an in-depth exploration of how expert witnesses can effectively contribute to the mediation process, emphasizing their unique roles compared to traditional litigation.

Ms Shanti began by outlining the fundamental principles of mediation. Mediation is an alternative solution that involves a neutral third party, the mediator, who assists the disputing parties in reaching a mutually acceptable agreement. Unlike litigation, mediation is a collaborative process that aims to find a resolution that satisfies all parties involved. It is often quicker, more cost-effective, and less adversarial than court proceedings.

Group Discussion Session

In mediation, experts play a crucial role in providing unbiased, technical information that can help clarify complex issues. Ms. Shanti emphasized that the primary function of an expert in mediation is to assist the parties in understanding the technical aspects of the dispute, thereby facilitating informed decision-making.

Group Discussion Sessions

Following the lectures, participants engaged themselves in group discussion sessions. These sessions allowed attendees to delve deeper into the topics covered, share their experiences, and discuss challenges faced in their respective fields. The interactive format encouraged collaboration and

A Courtroom Experience: Convincing the Bench with Tan Sri James Foong Chuen Yen

exchang of ideas, fostering a deeper understanding of the material presented.

Special Dialogue: Court Room Experience - Convincing the Bench

The workshop concluded with a special dialogue on 'Court Room Experience: Convincing the Bench', led by an esteemed retired judge; Tan Sri James Foong Chuen Yen.

Tan Sri Foong shared invaluable insights from his years of experience on the bench, providing practical advice on how expert witnesses can effectively present their testimony and convince the court of their findings. He emphasized the importance of credibility, clarity, and confidence in the courtroom. Effective communication is paramount for expert witnesses. Tan Sri Foong provided several tips on how to communicate effectively in the courtroom. Simplicity and clarity are key. As medical professionals, confidence and composure are important. Being responsive and remaining neutral is essential. Impartial information assists the court in the decision-making process.

Cross-examination can be a challenging aspect of courtroom testimony. Tan Sri Foong offered the following advice on handling cross-examination effectively: anticipate questions, stay calm and composed during the examination, admit limitations and remain consistent and firm. Experts should confidently state their conclusions during the session.

Conclusion

The MSA-CoA Expert Witness Training Workshop was a resounding success, providing participants with a wealth of knowledge and practical skills. The combination of expert lectures, interactive discussions, and real-world insights ensured that attendees left the workshop better prepared to serve as credible and effective expert witnesses. The event highlighted the critical role of expert witnesses in the legal system and underscored the importance of ongoing training and professional development in this field.

Event Committee Members with Professor Dr Ina Ismiarti Shariffuddin, President of College of Anaesthesiologists & Dato' Dr Yong Chow Yen, President of Malaysian Society of Anaesthesiologists (MSA)

Asia Pacific Neurocritical Care Conference 2024

A RESOUNDING SUCCESS

The Asia Pacific Neurocritical Care Conference (APNCC) is a biennial conference in Malaysia and the wider Asia Pacific region, entirely dedicated to the neurocritical care sciences for adult and paediatric populations. This conference aims to improve care for adult and paediatric patients with life-threatening neurological or neurosurgical illnesses. It also seeks to improve patient outcomes through the sharing of knowledge and skills among local and global multidisciplinary teams.

Following the successful virtual Neurocritical Care Conference (NCC) in 2022, the esteemed Malaysian Society of Neuro Anaesthesiology and Critical Care (MSNACC) and Persatuan Kakitangan Anestesiologi Hospital Umum Sarawak (PEKA-HUS) once again organised APNCC 2024 at the Borneo Convention Centre, Kuching (BCCK), far in the Land of the Hornbill, from the 28th to 30th June 2024.

This pivotal gathering was made possible through collaborations with renowned international societies such as the Neurocritical Care Society, the Society for Neuroscience in Anesthesiology and Critical Care, and the Paediatric Acute and Critical Care Medicine Asian Network, embodying the theme of 'Strength Through Diversity'.

This year's conference was different from the past. It was the first in-person neurocritical conference conducted since the COVID-19 pandemic, and it provided many opportunities to learn, network, and explore the latest advancements in neurocritical care.

The conference commenced with three dynamic pre-congress workshops: 'Emergency Neurological Life Support', 'Neuromonitoring - External Ventricular Drain/ Intracranial Pressure Monitoring; Electroencephalography', and the engaging "Point of Care Ultrasonography (POCUS) in Neurocritical Care" on 28th June 2024. These sessions garnered enthusiastic participation, setting the stage for a robust exchange of ideas and skills.

On 29th June 2024, APNCC 2024 welcomed 422 attendees from 21 countries, a testament to its international appeal and relevance. Under the adept leadership of Dr Peter Tan and Dr Chor Yek Kee, alongside Associate Professor Dr Lee Jan Hau leading the scientific committee, the conference progressed smoothly. The committee gathered 39 distinguished local and global experts to share their knowledge and experience at this meticulously curated conference.

by Valentine Lim Kim Yong
Hospital Umum Sarawak
Sarawak, Malaysia

by Samuel Tsan Ern Hung
Universiti Malaysia Sarawak
Sarawak, Malaysia

It featured 9 plenary sessions, 15 symposia, and a distinguished biomedical industry lecture, all focusing on cutting-edge advancements and future trends in neurocritical care.

The conference received impressive responses from enthusiastic young doctors worldwide, eager to showcase their research studies and case reports. Five outstanding posters were chosen for best poster presentation, and another three were contested for best oral presentation. The papers presented impressed both the international and local judges.

The conference concluded with closing remarks by Dr Peter Tan and the passing of the baton of organising the next APNCC 2026, in Penang to Dr Cheah Saw Kian from the Universiti Kebangsaan Malaysia. The event culminated in a highly anticipated lucky draw, with the lucky winners winning Apple Airpods and Apple Watch.

Overall, the APNCC 2024 was an unequivocal success. It transcended its role as a mere academic conference to become a pivotal platform for knowledge exchange, skills enhancement, and international networking. It not only enriched participants' clinical knowledge but also reinforced collaborative efforts to optimise patient care. Finally, we would like to express our heartfelt gratitude to all faculties, organisers, sponsors and participants who made APNCC 2024 a success. We hope to see you all again at APNCC 2026!

POCUS in Neurocritical Care workshop

Emergency Neurological Life Support Workshop

Awardees of Best Oral and Poster Presentations

Group photo taken after Faculty Dinner in Hilton, Kuching

See you in APNCC 2026, Penang!

Sabah's MyGRODA (Grief Response and Organ Donation Awareness) Workshop in Tawau, Sabah

One for the album

The COVID-19 pandemic brought an unexpected halt in tissue and organ donation-related activities and transplant services. The hospital workforce was redirected to primarily fulfil the overwhelming surge of ICU and medical ward admissions nationwide. Fortunately, the momentum for tissue and organ donation-related services has gradually increased over the past two years. This year, Sabah's MyGRODA event was held in Tawau from 11th to 12th June 2024, on the east coast of Sabah, with an encouraging fifty participants involving 21 hospitals in the state.

As of early June 2024, Sabah records an encouraging five successful tissue donations in Kota Kinabalu. Adding a feather to the cap, the team from Queen Elizabeth Hospital of Kota Kinabalu was awarded second place as the best organ and tissue procurement (TOP) team during the recent 27th Malaysian Society of Transplantation Annual Scientific Meeting in May 2024. While Sabah is the furthest state from most of the primary transplant-related services, we plan to establish and expand our very own transplant services in Sabah soon. Thus, this mission comes with the need for awareness, training of TOP team members and familiarity with the tissue and organ donation process.

MyGRODA in Sabah was a two-day event that fulfilled the scope of helping TOP team members of the respective hospitals in Sabah to understand the process and challenges of organ and tissue procurement in Malaysia. Moreover, the event provided a platform to understand the grief process of family members and to navigate the uncomfortable process of approaching the decision makers of potential tissue and organ donors. The event was officiated by the Director of Tawau Hospital, Dr Norlimah Arsad. The TOP team of Tawau Hospital co-organised this event with the support of our Consultant Anaesthesiologist, Dr Chia Peh Wui.

At an opening lecture, Mr Low Lieh Yong, the coordinator of Sabah's Transplant Resource Centre set the stage on the current updates of organ donation and transplantation in Malaysia, with a special focus on Sabah's progress. The lecture began with an introduction to transplant services in Malaysia, which was initiated in 1997. He explained the constraints of establishing the services nationwide, mainly due to a shortage of dedicated staff for the TOP team and a need for more awareness of the benefits of tissue and organ transplants. He also explored the complexities of the types of donors and helped to cast a vision on meeting the growing needs of tissue and organ recipients in Sabah. The icing on the cake was his shared experience serving as a TOP team coordinator in Sabah, withstanding several challenges. In his own words, "After 100 rejections, the 101st attempt could be the good news we have been waiting for".

Mr Low also further described the procurement process and its subsequent impact. For example, a single cornea could benefit up to three recipients. He also mentioned the multidisciplinary effort within a hospital and the specific job descriptions for each discipline to ensure a better

by Priscilla Manymuthu
Hospital Tawau
Sabah, Malaysia


NTRC's Deputy Directoy, Dr Hasy Haron, sharing on communicating with grieving family members


Welcome address by Dr Norlimah, Tawau Hospital's Director


Sabah's Transplant Coordinator, Chief Low Lieh Yong, shared on the progress of transplant services in Malaysia including Sabah

outcome. He emphasized that our religious beliefs and ethnic diversities can work in our favour as we approach families of potential donors.

Dr Abdul Jabbar, the Deputy Director and Consultant Anaesthesiologist of Universiti Malaysia Sabah (UMS), delivered his lecture on the workflow of donor management. He shared some valuable tips on successful organ donation procurement in Sabah, citing personal experiences during his tenure at Queen Elizabeth Hospital, Sabah. The talk included the current guidelines on brain death assessment and maintenance of organs in ventilated potential brain-dead patients. Matron Mazni from the National Transplant Resource Centre (NTRC) enlightened the participants on donor identification and the salient information required while communicating with the National Transplant and Procurement Management Unit following successful identification of a donor as well as approaching medicolegal cases.

The event's second day focused on communication skills and grief response. Dr Hasdy Haron, the Deputy Director of NTRC, shared important pearls on approaching family members for organ donation. This perhaps remains the most important factor in successful organ procurement as we need to transcend the barriers of grief, cultural and religious beliefs, and other factors that may inadvertently affect the decision-making process of potential donors' next-of-kin. While developing empathy may be an ongoing process for healthcare workers, the workshop narrows down common misconceptions from past conversations with families of potential donors. The culmination of the lectures was a role-play session that allowed doctors, nurses and medical assistants to practise approaching family members and identifying the stage of grief. We often assume that the communication is similar to a family update in intensive care, but it is evidently much more complex as it involves breaking bad news, explaining brain death and finding an opportunity to explore the family's desires on tissue and organ donation.

Could tissue and organ donation create a fair and just service that provides a second chance at life for the long list of potential recipients? Could this also address organ trafficking? These questions made up some of the meaningful conversations during our MyGRODA workshop, even during the meal breaks. We hope this workshop continues to receive support and its cause becomes the heartbeat of healthcare practitioners.

We invite all Berita MSA readers to visit your My Sejahtera App today to check your status as a pledger. Please take two minutes to fill out the form and update your details on the user-friendly app if required. These two minutes can make a difference. If you are a pledger, please inform your closest family members of your decision to be a pledger. Should you have further queries, please do not hesitate to discuss it with the TOP team representative of your hospital (for MOH hospitals) or visit dermaorgan.gov.my/ntrc/


The organisers and participants of the MyGRODA workshop in Sabah

Report on **FONA WORKSHOP**

Saturday, 11th May 2024 at RCMP UniKL, Ipoh, Perak

A total of 43 anaesthesiologists from the private hospitals in Ipoh and Teluk Intan, and government hospitals namely Hospital Raja Permaisuri Bainun Ipoh, Hospital Taiping, Hospital Teluk Intan, and Hospital Slim River gathered on Saturday 11th May for an afternoon workshop on FONA.

The workshop started at 2.00 pm with Dr Yee Meng Kheong welcoming the participants to the workshop and to those from outstation, to Ipoh on behalf of the Malaysian Society of Anaesthesiologists and the College of Anaesthesiologists, AMM. He noted that there was a registrant from Hospital Kajang and two from IIUM Kuantan. He introduced Associate Professor Dr Mah Kin Kheong who is the Deputy Dean (Academic), RCMP UniKL, and thanked him for the arrangement to use the facilities at the University. Associate Professor Dr Mah then introduced the speaker for the first session of the workshop, Associate Professor Dr Mohd Fahmi bin Lukman from Tuanku Mizan Armed Forces Hospital, Kuala Lumpur. Associate Professor Dr Mohd Fahmi is Head of Unit for Anaesthesiology and Intensive Care, Faculty of Medicine and Defence Health, National Defence University of Malaysia. He touched on CICO/CVCO (cannot intubate/ventilate, cannot oxygenate), its incidence, situations most commonly at risk, when to declare a failed intubation, when to call for help!, and how to best manage the situation - optimise face mask ventilation (one or two persons), consider any alternative methods, and if all fails, FONA (front-of-neck access). He showed the use of ultrasonography to identify the cricoid, thyroid cartilages, and the cricothyroid membrane. The two techniques of FONA are scalpel cricothyrotomy and the Seldinger technique.

Encik Budiman Harun Alrashid from Surai Medik then had his Team demonstrate the Quicktrach I & II and the ScalpelCric for FONA. The participants saw the demo and had some hands-on session.

by Yee Meng Kheong
MSA Perak State Representative
Ipoh, Perak, Malaysia

We broke for tea and continued the second session at 4.10 pm with Professor Dr Chan Yoo Kuen from UMMC on 'How to pre-empt a medico-legal case with the airway'. Professor Dr Chan emphasised the importance of 'oxygenation' always, as the basis of life, going down to the mitochondrial level of why we need oxygen. She emphasised to always have alternative plans whenever one thinks of the airway and don't get fixated on just one method! It is important to have clinical notes to show that there were plans for securing the airway. Dr Loke Yee Heng, moderator for the session then introduced Dr Milton Lum Siew Wah. Dr Lum being an O&G specialist admitted he was out of his comfy zone as he addressed the participants, all anaesthesiologists. He touched on 'How to lose a medico-legal case'. From his experience of more than 120 court cases, he commented that doctors tend to expose themselves unnecessarily by not communicating with their patients when required. No proper documentation of what the doctors claimed to have done or not to have been done was made. He talked of mediation and arbitration, and how it could benefit both parties. He felt one of the biggest disadvantages to the anaesthesiologist would be that he's not there to defend himself when things go wrong. The surgeons probably will answer for us and that may not be to our advantage or best interest!!

There was a lively discussion on how much documentation we actually do in the patient's case notes. Most of the time, we note them in our anaesthetic chart, and that itself is an integral part of the patient's notes. I have always documented a difficult airway in my anaesthetic chart but not in the patient's notes, looks like I need to review my practice.

by Noornadia Noorzaidy
Hospital Sungai Buloh
Selangor, Malaysia

by Kang Ker Cheah
Hospital Sungai Buloh
Selangor, Malaysia

BASIC MECHANICAL VENTILATOR WORKSHOP

Hospital Sungai Buloh 2024 (Beyond ICU)

Hospital Sungai Buloh's Basic Mechanical Ventilator workshop was first started in the second half of 2022. It was an initiative put into action by a group of dedicated specialists and medical officers from the Department of Anaesthesiology and Intensive Care of Hospital Sungai Buloh. It began with a seed of desire amongst our group, to share knowledge and experience with our department's junior doctors regarding basic mechanical ventilation. This was a response to the compromised training of junior doctors during the heights of the COVID pandemic and its heavy burden on those involved in anaesthetic and critical care services. We were determined to step out of our comfort zone and commit our time to invest in the growth and learning of our young generation of doctors. Our drive to take action was spurred on by the glaring need to address the gaps in the knowledge and training of junior medical officers.

Now we fast forward to the latest edition of our Basic Mechanical Ventilator workshop (Beyond ICU), recently organised on 6th March 2024. In a step forward from our workshops held in previous years, we extended our invitation for this year's full day course to junior doctors from the Medical and Emergency & Trauma Departments of Hospital Sungai Buloh, as well as doctors from Anaesthesiology and Intensive Care Departments from hospitals across the Klang Valley. This move to open up workshop slots to doctors not only from our own department was a small step outside our circle of comfort. It bears hope to foster inclusivity amongst those who are involved in the care of the critically ill. The course achieved the maximum attendance of 30 participants which included 25 doctors from Anaesthesiology and Intensive care (including four from Hospital Sungai Buloh) and 5 doctors from the Medical and Emergency & Trauma departments. This workshop, which started out with humble beginnings as an initiative for our own department's junior doctors, has now cast a wider net of influence to allow inclusivity of doctors from other hospitals and other specialties as well.

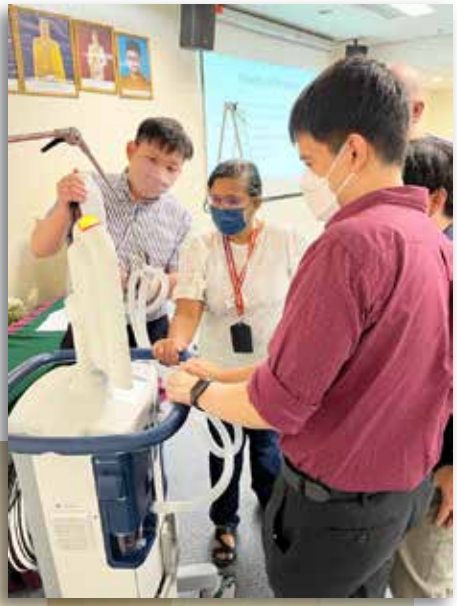
Our workshop was conducted in collaboration with Medtronic Malaysia Sdn Bhd. With no registration fee required and meals provided for, our aim was to open learning opportunities and benefit all junior doctors within the healthcare system to master the basics of mechanical ventilation and to be able to apply this knowledge in an appropriate manner in the clinical setting.

The workshop began with a pre-test session followed by lectures on the different core topics by dedicated anaesthesiologists from Hospital Sungai Buloh, including subjects such as 'Respiratory Physiology: Basics of Mechanical Ventilator and Applied Physiology', 'Invasive Mechanical Ventilator Modes', 'Non-invasive Mechanical Ventilator Modes' and 'Ventilator Dyssynchrony'. The course also featured mechanical ventilator product specialist, Ms Yap PY, who gave a lecture and facilitated an interactive hands-on session.

Lectures in the afternoon were followed by an interactive hands-on session to further consolidate participants' knowledge obtained from each talk. For the hands-on session, participants were divided into four groups of 7 to 8 individuals, to rotate through the four stations. One of the stations emphasized on the ventilation strategy in obstructive airway diseases particularly in acute severe bronchial asthma, which is one of the most common cases seen in the emergency and critical care setting. Additionally, for every case scenario, participants were able to apply their knowledge of weaning from mechanical ventilation. We believe the workshop has benefited all the participants as reflected on the overall greater scores of their post-test sessions.

The workshop ended with positive feedback from the participants. While some wished that the course was longer, most expressed their satisfaction and stated that this course had greatly increased their knowledge and understanding on the clinical applications of mechanical ventilation.

As the saying by Benjamin Franklin goes "Tell me and I forget. Teach me and I remember. Involve me and I learn," we believe involving junior doctors from other departments is essential and important in our efforts to improve overall quality of patient care. Our department, specifically members of the group who have championed this course, take pride in the milestones achieved from the birth of this workshop to the most recent edition. What began as a seed we planted has taken on roots and continues to grow till this day, one junior doctor at a time.



by Sebastian Sundaraj
Department of Anaesthesia
and Critical Care
Hospital Tengku Ampuan Rahimah
Klang, Malaysia

by Fatin Amirah Binti Ahmad Kamal
Department of Anaesthesia
and Critical Care
Hospital Tengku Ampuan Rahimah
Klang, Malaysia

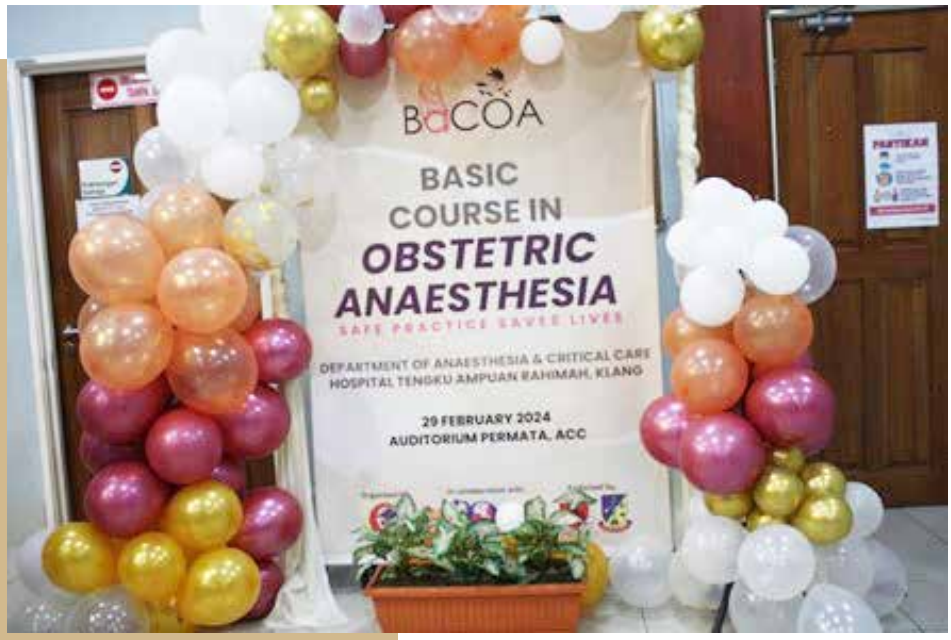
Basic Course in Obstetric Anaesthesia (BaCOA) 2024

The fifth edition of the Basic Course in Obstetric Anaesthesia (BaCOA) was successfully organised by the Department of Anaesthesia and Critical Care, Hospital Tengku Ampuan Rahimah (HTAR), Klang on 29th February 2024 at Auditorium Permata, Ambulatory Care Centre (ACC) in collaboration with Persatuan Obstetrik Anestesia Malaysia (POAM) and endorsed by the College of Anaesthesiologists, Academy of Medicine of Malaysia and the Malaysian Society of Anaesthesiologists (MSA).

Since its inception in 2019, the BaCOA has been hosted by various state hospitals around Malaysia and it is planned to be held biannually. HTAR, being a hospital with one of the highest obstetric patients load in the state is proud to be the inaugural host from Selangor this year. This course was a single day course and on this occasion was attended by 96 participants from all over Malaysia including Sabah and Sarawak.

It was a great honour to have Dr Ummi Kalthom Binti Shamsudin, the Selangor State Health Director, to officiate the course, accompanied by Dr Selvamalar Selvarajan (HTAR Director), Dr Hj Mohd Rohisham Bin Zainal Abidin (Head of Anaesthesia and Critical Care Speciality, Ministry of Health), Dr Muralitharan Perumal (Head of Anaesthesia and Critical Care Department, HTAR), Dr Mohd Azizan Ghazali (POAM) and Dr Sebastian Sundaraj (Organising Chairperson). Dr Ummi then proceeded to visit the newly officiated Intensive Care Unit Kencana located on the 3rd floor of the Main Block accompanied by Dr Lee See Pheng, ICU Intensivist.

The theme for BaCOA 'Safe Practice Saves Lives', precisely highlights the goal of this course which was to deliver safe anaesthesia to mother and child in line with the mission of the Ministry of Health Malaysia. The content of this course focused primarily on basic concepts that are of great importance



in Obstetric Anaesthesia including basic physiological and pharmacological changes that occur during pregnancy and its implication in daily clinical practice. Current anaesthesia and analgesia techniques for Lower Segment Caesarean Section (LSCS) and various modes of labour analgesia were also explored. Various anaesthetic emergencies involving obstetric patients were highlighted and the appropriate management in these situations were detailed.

A total of nine lectures was delivered by renowned Obstetric Anaesthetists in Malaysia including Dr Hj Mohd Rohisham Bin Zainal Abidin, Dr Thohiroh Binti Abdul Razak, Dr Norliza Binti Mohd Nor and Dr Rahimah Binti Abdul Rahim. We were also fortunate to have Dr Mohd Fakhri Hilmi Bin Danial, an Obstetric Anaesthesia Trainee, as a speaker in this event. Speakers were interactive throughout the course with some speakers traversing through the auditorium aisles with microphones in hand which kept participants at the edge of their seats.

The long day of lectures was also awakened with laughters from the interesting lecture on Verbal Anaesthesia by Dr Rohisham. Throughout the course, participants were encouraged to ask questions electronically which resulted in an array of discussions, limited only by time.

For the first time in BaCOA's history and to the delight of participants, prizes were awarded to the top three scores in the post-course test which included a power bank, backpack and external storage device. Congratulations to the winners!

We hope the BaCOA series continues to be the ideal platform for early exposure in Obstetric Anaesthesia. See you at the next BaCOA!

Anaesthesia Bootcamp 2024
SETTING THE STAGE FOR TRIUMPH

On 24th to 25th February 2024 and 9th to 10th March 2024, the Department of Anaesthesiology and Intensive Care UiTM organised a boot camp for primary Anaesthesiology Master candidates. This boot camp was held over two weekends and consisted of written and viva voce examinations.

By integrating mock written and viva sessions, they effectively simulated the rigours of the actual assessment process. Moreover, extending participation to candidates from other universities fostered a collaborative learning atmosphere, enriching the educational experience for all involved. This initiative cultivated familiarity with examination formats and stressors and empowered candidates to fine-tune their study approaches based on performance insights. The structured layout, spanning two weekends with dedicated sessions for each component, underscored the programme's commitment to thorough preparation and holistic development.

Written Examination: 24th to 25th February

The first session was the written mock examination, with a significant turnout of 95 participants from esteemed universities like Universiti Malaya, Universiti Sains Malaysia, Universiti Islam Antarabangsa and Universiti Kebangsaan Malaysia. The diversity of perspectives enriched the learning environment. This two-day boot camp started with pharmacology subjects on the first day, followed by physiology on the second day. The timed nature of the examination, with 40 SBA questions and three SAQ questions per day, closely mirrored the constraints of the actual assessment, sharpening candidates' time management skills.

Following the examination, there was a discussion led by Professor Dr Karis Misiran. This post-exam analysis provided invaluable insights, allowing candidates to compare their responses to the answer scheme and identify areas for improvement. Embracing constructive criticism in this manner fostered a growth-oriented

by Nurafza Binti Ahmad Hisham
Universiti Teknologi MARA
Selangor, Malaysia

by Vimal Varma
Universiti Teknologi MARA
Selangor, Malaysia

mindset among candidates, enhancing their preparedness for the actual examination.

Viva Voce Examination

Another important component of the boot camp was the mock viva voce session, attended by 38 candidates. Esteemed anaesthesiologists like Dr Aziam Ibrahim and Dr Wan Aizat, as examiners, alongside other UiTM lecturers, undoubtedly added significant value to the experience. Dr Aziam's role as a coordinator and supervisor for parallel pathway FCAI and primary Masters in Hospital Serdang, coupled with Dr Wan Aizat's experience as an examiner for Conjoint Masters Anaesthesiology exam, ensured a high evaluation standard.

The conclusion of such experienced professionals lent credibility to the mock examination process and provided candidates with exposure to diverse perspectives and assessment styles. This opportunity to engage with experts in the field likely facilitated a deeper understanding of anaesthesiology principles and enhanced candidates' ability to articulate their knowledge under scrutiny.

The post-viva discussion session, where candidates and examiners gathered to review overall performance, was a crucial opportunity for reflection and guidance. Professor Dr Karis's expertise and insights, gleaned from extensive experience in anaesthesiology Masters examinations, proved invaluable during this debriefing session. His guidance on strategies to excel in the real viva examination gave candidates practical advice and reassurance as they prepare for the final assessment.

It was wonderful to hear that participants found the boot camp highly beneficial in preparing for the primary examinations. The positive feedback underscored the value of such comprehensive preparatory initiatives. The fact that most respondents highlighted the exposure to real exam situations as a key benefit spoke volumes about the programme's effectiveness in simulating the challenges candidates will face during the actual examination. This feedback not only validated the efforts put into organising the boot camp but also served as motivation for future iterations. Knowing that participants found the experience useful reinforced the importance of providing similar opportunities for candidates to enhance their readiness and confidence before undertaking significant assessments.

Overall, the boot camp successfully fulfilled its objectives and met the needs of aspiring anaesthesiologists. We believe we have succeeded in **"Setting the Stage for Triumph!"**

Dengue Update 2024

DENGUE - A GLOBAL HUMAN THREAT

Dengue outbreaks in Malaysia lead to substantial humanitarian implications upon individuals, communities and the healthcare system. Thus, there are significant challenges in managing and treating severe dengue patients, with high mortality rates.

It is commendable that Hospital Ampang Society of Anaesthesia and Intensive Care (HASAIC) has taken proactive steps to address the surge of dengue cases in Malaysia, particularly in the Klang Valley. Organising the Dengue Update course for the second time demonstrates a commitment for ongoing education and awareness among healthcare professionals. The HASAIC hosted the course at the Hospital Ampang Auditorium on 19th February 2024. Additionally, this course was also available on the Zoom platform for virtual participation. This ensured that healthcare professionals could access critical updates and information on dengue management and prevention regardless of their location.

A total of 157 participants attended either virtually or physically. This allowed the course to reach a significant number of healthcare professionals. It enabled them to enhance their understanding of dengue-related issues and improve their ability to respond effectively to the ongoing outbreaks. The course was officiated by Dr Sany, Head of the Anaesthesiology and Intensive Care Department, who provided valuable insights into the importance of staying updated on dengue management and prevention strategies.

The Dengue Update course covered a comprehensive range of topics aimed at enhancing the knowledge and skills of healthcare professionals in managing dengue cases. The course was started off by Dr Goh (Hospital Ampang anaesthetist), who presented on the pathophysiology of severe dengue. Dr Hidayah's presentation on the role of Point-of-Care Ultrasound (POCUS) in management of dengue was incredibly informative, especially given her expertise as a consultant emergency physician and co-author of the "Dengue in Emergencies Manual". The day went on with case discussions led by Dr Rashidah (Hospital Ampang infectious disease physician). Dr Azlyna (Hospital Selayang anaesthetist) provided comprehensive insights into the management of dengue cases from both the infectious disease and

by Venusya Ganesh
Hospital Ampang
Selangor, Malaysia

In conclusion, let us apply the latest knowledge and skills to our clinical practice, striving to provide the best possible care for patients affected by dengue. Let us also continue to collaborate, learn from one another, and stay updated on the latest advancements in dengue management so that, together, we can make a meaningful difference in combating this important public health challenge.

anaesthetic perspectives. Finally, Dr Shanthi Ratnam's presentation on the management of severe dengue in the intensive care unit (ICU) undoubtedly provided valuable insights into the care of critically ill patients with this condition. The positive feedbacks we received from participants underscored the value of such educational initiatives in fostering professional development and enhancing patient care. However, we also recognised that there is room for improvement, particularly in optimising the virtual aspects of the course. Moving forward, we are committed to implementing feedback-driven enhancements to ensure an even more engaging and seamless learning experience for all participants.

Welcoming the Anaesthesiologists

APRIL/MAY 2024

CERTIFICATION OF COMPLETION OF TRAINING FCAI- Parallel Pathway

Aun Yiteng
Hau Jett Lin
Liow Ying Tian
Wong Chee Leong
Yeoh Jie Cong

INTERNATIONAL ISLAMIC UNIVERSITY MALAYSIA

Chiang Wei Bian
Cindy Chong Hwa Cian
Guna Nesan A/L Sevapragasam
Har Siang Thai
Khuzaimah binti Mat Yusoff
Lim Seng Fatt
Nur Zila binti Md Mukhtar
Sheena Francine Devi
Ting Bick Kiing
Wong Yeng Fai

UNIVERSITI KEBANGSAAN MALAYSIA

Chai Jian Hai
Harmeet Kaur A/P Daleep Singh
Hidir bin Hassan
Khor Chiang Wei
Lee Kian Hong
Lim Jia Ying
Lim Wei Kiat
Neo Xue Ping
Tan Wen Yen

UNIVERSITI MALAYA

Fatin Shazwani binti Yunus
Foo Wei Li
Hafizah binti Aris
Hasnita binti Mohd Tarik
Jauharatunnur binti Ishak
Iyngaran A/L Ravindran
Kenny Lim Khai Chiat
Kim Bao Zhen
Miriam binti Azizi
Nadia Raffela binti Ab Halim
Nor Azhani binti Amiruddin
Tee Hui Fong
Teoh Huo Yen

UNIVERSITI PUTRA MALAYSIA

Khoo Lee Min
Nur Nabillah Fahana binti Roslan
Suriakumar A/L Karuppiah

UNIVERSITI SAINS MALAYSIA

Ahmad Fikri Muhammad Mustafa
Dhanya A/p Jaya Gobi
Goh Sing Looi
Humaira Kamarul Zaman
Husniyah Zainol Abidin
Loh Lynn Hooi
Nik Nabihah Adros

my GLOVE ART

courtesy of

CHEF IN BLACK

Anaesthesiologists
CREATE

Sardine Cornish

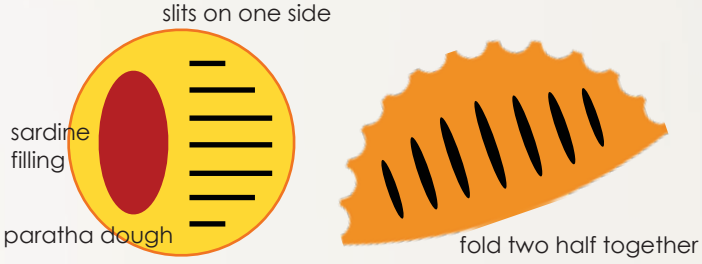
courtesy of
CHEF IN BLACK

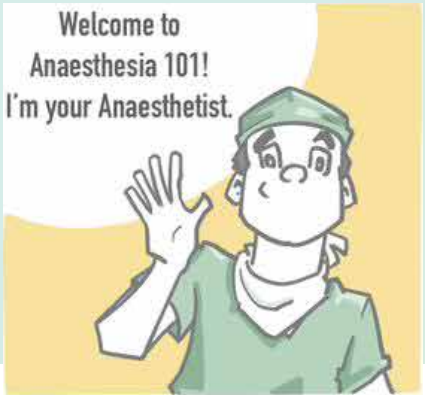
INGREDIENTS

1. Instant paratha
2. Canned sardines *(or tuna)*
3. Shredded cheese *(mozzarella or your preference)*
4. Red onions
5. Portobello mushrooms *(or whatever kind you have)*
6. Olive oil
7. Parsley
8. Salt & pepper
9. Paprika
10. 1 egg

METHOD

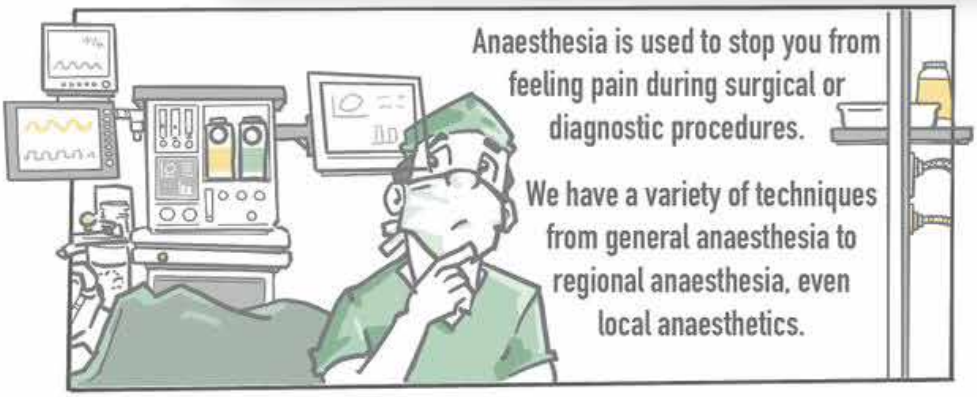
Heat the frying pan with olive oil and sauté the onions (cubed or thinly sliced). Add the sardine and stir. Add in the mushroom (sliced or diced). Add in salt and pepper to taste. Sprinkle some paprika. Set it aside to cool while you prepare the pastry. Make striations on one side of the paratha. Put the filling (cooked sardine) on the other side of the paratha. Sprinkle the cheese on top (as per your liking). Fold it over and make creases on the edge to seal the filling in. Beat the egg and baste it on top of the cornish. Sprinkle parsley on top and air fry at 180 degrees for 10-12 minutes. Enjoy..

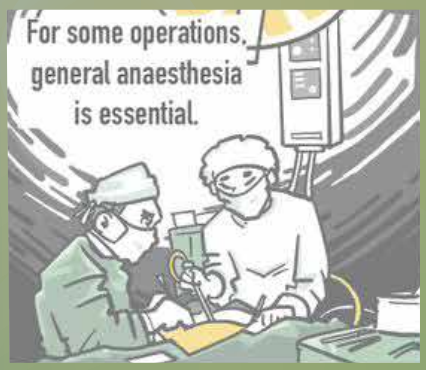


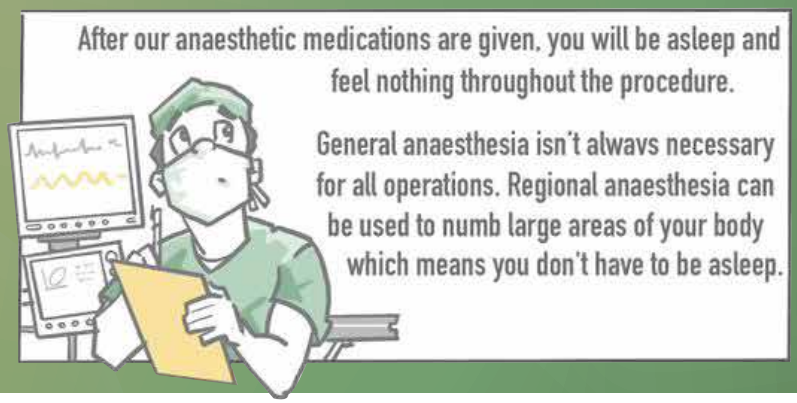

Welcome to Anaesthesia 101! I'm your Anaesthetist.


Anaesthetists are doctors with specialist training in anaesthesia and also in the treatment of intensive care, pain management and emergency care (resuscitation).
ICU
We generally work in the operating theatre (OT) and the intensive care unit (ICU).


Here's the operating theatre!


Anaesthesia is used to stop you from feeling pain during surgical or diagnostic procedures.
We have a variety of techniques from general anaesthesia to regional anaesthesia, even local anaesthetics.


For some operations, general anaesthesia is essential.


After our anaesthetic medications are given, you will be asleep and feel nothing throughout the procedure.
General anaesthesia isn't always necessary for all operations. Regional anaesthesia can be used to numb large areas of your body which means you don't have to be asleep.


The ICU handles severe potentially life-threatening cases from serious accidents to major surgeries, even those with a sudden decline in health.


Back to work!

Message from the

PRESIDENT OF THE COLLEGE OF ANAESTHESIOLOGISTS, AMM

Professor Dr Ina Ismiarti Shariffuddin

Dear Colleagues,

'Time flies, and we are the pilot'

The tenure of the 2023-2024 Council of the College of Anaesthesiologists (CoA) is drawing to a close. This period has seen its share of challenges, yet our collective efforts have enabled us to navigate these complexities with resilience and dedication.

Parallel Pathway

One of the cornerstone initiatives under the CoA guardianship has been the Parallel Pathway (PP) programme, specifically the Fellowship of the College of Anaesthesiologists of Ireland (FCAI) in Malaysia. This programme, initiated in 2014 under the guidance of the immediate past Director-General of Health, Tan Sri Dato' Seri Dr Noor Hisham Abdullah, has flourished, with its first trainee graduating in 2019. Currently, the issue of the PP programme is under parliamentary evaluation. While we await the decision, CoA remains steadfast in its commitment to ensuring the smooth operation of the programme and securing its accreditation as a professional certification in Malaysia. The FCAI Committee, led by Dr Hasmizy Muhammad is planning more in-house training courses in the coming months to bolster the training provided to our FCAI candidates.

Expert Witness Workshop

Another complex area we went through this year has been the medicolegal landscape. Although not a new challenge, its impact on our fraternity has increased. It is crucial that our members practise safe medicine, following evidence-based medicine. Additionally, we believe, our members who are called as expert witnesses to the court should be the eye of the judiciary system for Anaesthesiologists at work. Thus, they should be trained to serve as unbiased expert witnesses in court. To this end, CoA, in collaboration with the Malaysian Society of Anaesthesiologists (MSA) and the Medico-Legal Society of Malaysia (MLSM), successfully organised the first expert witness training programme for anaesthesiologists on 8th June 2024 in Universiti Malaya Medical Centre. This workshop was an eye-opener for many, elucidating the critical role anaesthesiologists can play in the courtroom. Further details on this workshop will be reported in this edition of Berita Anestesiologi.

MSA/CoA Office in Putrajaya

We are also thrilled to announce the completion of the Medical Academies Building in Precinct 8, Putrajaya. CoA and MSA has jointly taken up an office suite at Level 3 of the building. This building with state-of-the-art facilities has an auditorium, exam and meeting rooms and a simulation centre. The official opening to be officiated by HRH Sultan Nazrin Shah on 29th September 2024 marks a new chapter for us. We look forward to conducting courses through our Special Interest Groups (SIGs) and collaborating with UKM and AMM to host the National AHA Advanced Cardiac Life Support courses in the simulation centre. We encourage our members to utilize these facilities to their fullest potential.

Emerging Leader Conference, Brisbane, Australia

Our ties with international sister colleges, namely the College of Anaesthesiologists of Ireland, the College of Anaesthesia Singapore, and the College of Anaesthesia Hong Kong, were reinforced through the Emerging Leaders Conference (ELC), hosted by the Australian & New Zealand College of Anaesthesiologists from 30th April to 2nd May 2024. ANZCA provided each College with the opportunity to bring its own emerging leader to the conference, equipping them with essential foundational knowledge for effective leadership. Under the theme 'Breaking the Barriers', a range of issues and challenges was discussed,

continued on page 60

continued from page 59

including those faced by female anaesthesiologists in leadership roles. Dr Amir Ayob has provided a comprehensive report on this enriching experience in this edition of the Berita Anestesiologi.

Below were other activities, organized or co-organised by CoA since I last wrote in the Berita.

NO	DATE	ACTIVITIES
1	23rd March 2024	Webinar in "Neuroanaesthesia Series: Revisiting Awake Craniotomy"
2	11th May 2024	"FONA Workshop" at Campus RCMP, UniKL, Perak
3	18th May 2024	Webinar on "Patient Blood Management in Anaesthesia"
4	20th - 21st May 2024	Assessment of FCAI Parallel Pathway Training for 21 Trainees held at Hospital Tunku Azizah, Kuala Lumpur • Assessment 1 - Eleven candidates • Assessment 2 - One candidate • Assessment 3 - Four candidates • Assessment 4 - One candidate • Assessment 5 - Two candidates • Assessment 6 - Two candidates
5	4th June 2024	Webinar: "Anaesthesia Provision in Gaza: Experience of Mercy Malaysia Anaesthesia Team"
6	13th June 2024	Webinar on "Fluid Therapy in Critically Ill"
7	26th June 2024	The 5th Volume of MyJA published
8	28th Jun 2024	"Bridion Relax & Reverse Class"

Looking ahead, we have several significant events on the horizon:

Asian Society of Paediatric Anaesthesiologists 2024

This annual gathering of paediatric anaesthesiologists in the Asia region, themed 'Safe and Sustainable Anaesthesia for Every Child,' promises to be an exciting opportunity for knowledge exchange and networking with experts in paediatric anaesthesia across the continent. The meeting will be held at the Borneo Convention Centre Kuching, Sarawak, from 11th to 14th July 2024.

Medication Safety Guideline

This guideline is to be launched at the upcoming MSA and CoA Annual Scientific Congress. This guideline, written by a writing group spearheaded by Associate Professor Dato' Dr Wan Rahiza Wan Mat, aims to minimise drug errors in our daily work.

57th Singapore-Malaysia Congress of Medicine

This meeting is jointly organized by the Academy of Medicine, Singapore, and the Academy of Medicine of Malaysia, with support from the Hong Kong Academy of Medicine and the College of Obstetricians & Gynaecologists, Singapore, serving as the co-organizer. The theme for this year is 'Relooking Women's Health'. Scheduled for 19th to 21st July 2024 in Singapore, this meeting will provide a platform for leaders from these three countries to network and collaborate for the advancement of medicine.

MSA & CoA Annual Scientific Congress, MyAnaesthesia 2024

With the theme 'Where Science Meets Art," this congress will be a cornerstone annual event for anaesthesiologists in Malaysia, designed to foster the exchange of ideas and collaboration. An exciting array of social and scientific programmes has been arranged by the team led by Dato' Dr Yong Chow Yen. CoA encourages all members and non-members to join this meeting, envisioning it as a fruitful time for everyone to get updated, rekindle old friendships, and forge new ones.

Biennial MOH-AMM Meeting

This meeting will be held from 20th to 22nd August 2024 with the theme 'Navigating the Future: Synergizing Evidence for Sustainable Health System Reform Policies'.

In this event, AMM will be inducting its new members and conferring fellowship to those who have qualified. Alhamdulillah, this year we will see a big number of Anaesthesiologists to be conferred as fellows and inducted as members into AMM.

I would like to extend my heartfelt gratitude to the Council Members, the secretariat and, most importantly, all our members for their unwavering support throughout this year. As we close this chapter and look forward to new beginnings, let us continue to support one another and uphold the highest standards of our profession.

eISSN 3009-1926