NEWSLETTER

PAKISTAN SOCIETY OF ANAESTHESIOLOGISTS
KARACHI - CHAPTER

Volume: 25
Issue 01, March 2022

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EDITOR'S NOTE

Dear Colleagues
Assalam o Alaikum.
Here is PSA newsletter of March 2022 after a break of about a year due to Covid-19. Alhamdulillah Covid-19 is almost over now. This newsletter is dedicated to our 40th PSA Karachi annual conference March 19-20, 2022, with theme of **"Journey towards Excellence-Vision 2025"** so it consists of different articles about teaching and training of anesthesiology in Pakistan by our senior educationists, hopefully, this journey will lead towards excellence. I hope anesthesia fraternity benefit from it. Suggestions to improve are always welcome.

Prof. Zahid Akhtar Rao
Editor, Newsletter PSA Karachi
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Would the derecognition of FCPS FOR GMC -UK registration help to curb the brain drain of qualified anesthesiologists or would it be a source of demoralization

This is a question that remains a discussion topic amongst various anaesthesia circles specially amongst our freshly passed FCPS anaesthesia colleagues nowadays. Everyone has their own explanation for the situation and the reasons for this derecognition. Obviously, we are not the decision-maker here. The decision-making authority lies with the Royal College of Anaesthetists who have advised the GMC to remove the College of Physicians and Surgeons, Pakistan fellow ship in anaesthesiology from their acceptable postgraduate qualification lists.{This was communicated to me by the GMC in response to my email query on the subject)

We all know that CPSP has worked extremely hard over the years to get recognition for our qualifications by the Royal College of Anaesthetists. There was a time when very few people expressed any interest in doing FCPS anaesthesiology but then, with the saturation in the other specialties in Pakistan, and realizing the importance of anaesthesia as an important specialty not only in Pakistan but around the world resulted in many young doctors pursuing it and doing FCPS from Pakistan.

This exemption was granted after several negotiations and discussions and then extending an invite to the Royal College of Anaesthetists recommended examiners to our FCPS anaesthesia exams. The GMC under the head of acceptable postgraduate qualifications used to write "If you have one of the postgraduate qualifications listed below, we can accept that as evidence that you have the necessary knowledge, skills and experience to apply for full registration with a license to practice." and FCPS anaesthesia from CPSP was once included in the list of their accepted post-graduate qualifications.

The assumption that this will prevent the brain drain of qualified anaesthesiologists from the country is not logical. We all have our reasons for staying or leaving the country. The percentage of FCPS anaesthesiologists opting to go out and utilize this route of GMC registration when it received this recognition is very low. On the other hand, we have seen anaesthesia academic departments in both the public and private sector in Pakistan flourishing during the last two decades. We have also seen many colleagues going out of the country and then coming back to join various academic anaesthesia departments. Had brain drain been an issue because of this recognition, we would not be seeing so many FCPS anaesthesiologists heading the anaesthesia department in almost every city of Pakistan. So even when our colleagues were getting an opportunity to go out to the UK and get GMC

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registration and then worked as specialist registrars or as a consultant, the number was very low.

Naturally, our younger colleagues passing the FCPS exams must be concerned as to whether this derecognition means that they do not possess the required skills to safely practice anaesthesia. This is not the case as another option is available for those who have passed FCPS anaesthesia (fresh fellows or those who have maximum 4 years since they have done FCPS). These training slots are suitable for those who are interested in going to CPSP accredited training institutes in UK for gaining experience in a specialized anaesthesia facility as senior registrar. We also know that our training and examination standards are such that our fellows are always considered the best of the best once they joined overseas anaesthesia departments. This aspect of our training and examination can not be overdone by some royal college removing our qualification from the list of GMC recognition. The limitation of tier two training slots however is that it is limited to a maximum period of two years and also, they will not allow fellows to register for FRCA exams as a result of derecognition of our FCPS anaesthesia qualification by GMC and royal college of anesthetists currently.As a young mind, they might be feeling slightly demotivated as this step prevents them from opting to work in UK for an unlimited period and to improve their financial status. Since FCPS anaesthesia is no more a recognizable qualification for GMC registration, they cannot appear in FRCA examinations now based on FCPS anaesthesia. This obviously may result in demoralizing and demotivation of these young colleagues. A nation cannot progress if the younger generation is demotivated.

All of us who are well placed in this country have a duty towards looking after the future of our newly passed FCPS anesthesiologists. We should do the following to address this issue.

1. Pakistan society of anesthesiologists should discuss this issue in their meetings and also write to the Royal College of Anesthetists to seek a reason for this derecognition.
2. The faculty of anaesthesia at CPSP should find out the conditions imposed by the Royal College of Anaesthesia at the time of giving initial recognition to FCPS anaesthesia.
3. The major role has to be played by CPSP counsel and for that, both the Pakistan Society of Anaesthesiologists and the faculty of anaesthesia at CPSP should convince the CPSP counsel that this recognition is important for our newly passed FCPS anaesthesiologists.
4. The CPSP should start renegotiating with the Royal College of Anaesthetists and convince them to include FCPS anaesthesia as an acceptable registerable qualification for GMC

Dr. Fazal Hameed Khan
MBBS, FCPS, EDIC
The Puri Bai and Noor Mohammad Ali Momin Endowed Chair
Professor of anesthesia and Associate Dean for Faculty.
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How can we improve current practices of teaching and training in Anaesthesiology to bridge the gap between international developments and need at the national level?

High-Income Countries (HIC) achieved excellence in training by working on the principle of andragogy; setting clearly defined learning outcomes, providing planned learning experience, and ensuring cycles of continuous formative assessment and feedback. Specific and measurable learning outcomes encompass necessary core competencies including medical knowledge, technical skills, interpersonal communication skills, professionalism, teamwork, and their application into complex clinical situations. With clearly defined outcomes, the trainees are taken through planned learning experiences to ensure they have the necessary clinical exposure to ensure, once certified, they are prepared to assume the responsibility of patient care independently. Regular formative assessment and feedback by the faculty using validated workplace-based assessment tools is central to this approach. Shortage of workforce in Low- and Middle-income countries (LMIC) keeps their trained professionals engaged in service delivery that leaves training dependent on apprentice model. Trainees learn through observation and mimicking, with little constructive feedback; learning occurs by chance with the likelihood a trainee may not gain a critical experience during the period of training. Lancet Commission report includes Pakistan among the countries where a large segment of the population does not have access to surgery, mainly due to shortage of trained surgery and anaesthesiapersonnel. A survey conducted by World Federation of Societies of Anaesthesiologists has estimated the global workforce density for physician anaesthetists of 6.09 providers per 100,000 population while highlighting huge variation between high income and LMIC countries with the density ranging from 1.36 per 100,000 population in Africa to 18.60 per 100,000 in Europe. Sadly, Pakistan is among the two out of 11 countries of Southeast Asia region that did not contribute any data to the study. We are still waiting for reliable data. In a commentary on the Lancet Commission report, Fauzia Khan highlighted the need to collect and publish data on burden of surgery and workforce density in the country. She cited 3100 trained anaesthesia personnel for a population of more than 18 million. This is the number of doctors with postgraduate qualification (FCPS or equivalent) or additional qualification (MCPS/DA etc.) holding an active license from Pakistan Medical Commission. This translated into 1.64 physician anaesthesiologists per 100,000 population, and this number includes

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anaesthesiologists serving overseas. The population of Pakistan, according to 2017 statistics was 207.68 million and is estimated to have increased north of 220 million while the number of doctors holding an active license from PMC is 3488 (1.585/100000), 1133 out of 3488 hold FCPS or equivalent qualification; majority are working in tertiary care hospitals in urban centers that leaves rural and semi urban areas unserved or served by untrained personnel.

The challenge is twofold, to cover the need gap while ensuring our product meets the global standards. This will require concentrated effort from the speciality, and significant resource allocation and support from institutions and the state. Seemingly, the most workable solution at the moment is to continue with the two-tier training model with FCPS or equivalent trained as specialists and MCPS/DA pathways for service delivery in marginalized areas.

There are 1111 residents currently under training for Fellowship in Anaesthesia in 102 recognised institutions, with 235 registered supervisors. This does not take into consideration the trainees in MD/MS and MCPS programs mostly supervised by the same trainers and the fact that these trainees are not evenly distributed, some of the trainers supervising way beyond stipulated quota of residents. In the face of increasing demand for training opportunities, training regulators relaxed the limit on the number of trainees permitted under a supervisor at the cost of quality of training. This recipe will not work, one has to look for a solution that enables the system to train more people without compromising the quality of supervision. One workable solution is to create two tiers of supervision, a clinical supervisor who monitors the clinical work on daily basis, and educational supervisor responsible for overall progress of trainees in the program. Currently, a person must wait for at least five years after fellowship and go through a series of workshops for recognition as a supervisor, with no assigned role in the training programs during this period. Peer learning is embedded in all postgraduate training programs. This involves senior residents guiding their junior colleagues in dealing with the complexities of clinical work. People are more receptive to instructions and feedback coming from their peers and delivered in an informal setting. Fresh postgraduates can be inducted as clinical supervisors after 6 months of training to apply workplace assessment tools with the responsibility to ensure the clinical tasks are aligned with training goals. This will actively engage a large cohort of qualified specialists waiting on the side-lines in residency training and relieve the educational supervisor to focus on overall progress of training and enable them to supervise a larger cohort of trainees.

Anaesthesia is a hands-on specialty where only way to master a skill is to practice again and again. Simulation-based medical education (SBME) provides safe learning environment for learning, practice and evaluation. SBME is used widely to provide core skills and crises management training. Simulation allows residents to experience clinical scenarios that are infrequent but critical to anaesthesia practice. They are used to evaluate trainees as well as teach non-technical skills. Non-technical skills are imparted through role modelling and workshops as well. While high fidelity SBME can be expensive but a possible solution to help in LMIC is to work with vendor partner's grants, Government agencies, and Philanthropic contributors. Oleg Turket and colleagues have cited the experience of Rwanda and Tanzania where simulation was effectively used for training in collaboration with HIC. These projects need to be piloted in our environment. Once tested, simulation-based training should be embedded in the curriculum to ensure critical skills are learned in a systematic manner.

Our country offers two parallel pathways to postgraduate qualification, FCPS and university programs with separate entrance criteria, curriculum and exit exam. These programs are running in the same unit with one person supervising the training of residents from both pathways. With a complete disconnect between two programs, until recently, a consultant ended up supervising twice the permissible maximum number of residents allowed in a program. This dichotomy needs to be addressed to ensure a unified, structured training program with a single entrance and exit criteria.

CPSP in their effort to improve the quality of training introduced competency-based curricula and introduced e-logbook to monitor the training. Focus of training at the grass-root is still on the candidate's ability to recall the information provided in the text during exit exam. This disconnect between what is learned from the book to pass the exam and daily practice needs to be addressed by the leadership of the profession. Training programs have to assume greater responsibility for the quality of their training and create an environment where work is treated as opportunity to learn rather than forced labour.

Pakistan has multiple healthcare delivery models that include public, private, corporate, trust and military hospitals. Each one has a unique organisation structure and business model. There cannot be a single cookbook recipe to deal with the logistics of clinical rotations, resident supervision and working hours. The training programs in this case should not be too prescriptive, training regulators should clearly define the desired end of training competencies, outline the training pathways and give the programs a degree of freedom to achieve the objective of delivering a competent anaesthesiologist.

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Workplace Based Assessment Causes of Failure in Implementation in Pakistan

Workplace based assessments (WPBAs) were introduced to ensure continual improvement in learning experiences, to change the concept from "assessment driven learning" to "learning driven assessment"[1], and to bring objectivity, novelty and holistic approach in assessment. The concept quickly gained acceptance in renowned educational institutes of medicine throughout the world.

Workplace based assessment incorporates a number of assessment tools including directly observed procedural skills (DOPS), case-based discussions (CBDs), mini clinical evaluation exercises (mini-CEX), 360^{0}multi-source feedback (MSF)[2], students' portfolios, anaesthetists'/surgeons' non-technical skills[3], etc. These tools allow the system to assess top tiers of Miller's pyramid i.e., demonstration of learning ("shows") and performance integrated in to practice ("does"). However, most of these are still used as formative assessment tools rather than for summative assessment.

Though, College of Physicians and Surgeons, Pakistan (CPSP) and a number of medical universities have tried to include WPBAs in their postgraduate program but have not been able to implement the system in its true spirit. Possible causes of this "failure" may include:

1. **Poor change management:** Most of the institutes in Pakistan, including CPSP, have tried to implement the WPBA system without prior awareness campaign amongst the trainers. There have been no detailed discussions, deliberations, or training workshops on this highly demanding system of assessment.
2. **Lack of awareness on part of facilitators and learners:** While discussing the subject with many senior supervisors and teachers and the postgraduate students I personally have noticed that a large number of them are not even aware that such a system even exists, or else they have a very vague idea about the system.
3. **Lack of training of assessors:** No appropriate system of training of assessors on WPBA tools still exists. This results in poor understanding and lack of interest on part of assessors.
4. **Lack of will on part of trainers:** Since the system requires continuous extra physical and mental work with no reward, most of the instructors are not willing to implement it.
5. **Lack of support from the institutions:** The organizations do not see any incentive in the implementation of a system that put extra financial burden on them in terms of material and human resource, but does not increase even their national/international rating as teaching institutes.
6. **Lack of adequate number of trained supervisors:** There is no structured training program that can mould clinicians into clinicians-cum-educators. Just after five years of their postgraduate diplomas they are given the added responsibility of postgraduate training in addition to their existing clinical work.
7. **Lack of availability of time:** Since clinical work has to be done side by side by both trainers and learners, the time management becomes very difficult. WPBAs need much more extra time for the implementation.
8. **Quality of multisource feedback:** Quality feedback from the trainers requires not only the time and training, but also honesty of opinion and lack of prejudice. Bias/favoritism could be detrimental and may cause decrease in motivation of the learners.
9. **Conflicting evidence of effectiveness:** Miller and Archer[4] published a meta-analysis of different surveys in 2010 in BMJ. The review is limited to the studies conducted in UK. Though most of the studies showed more than 50% of candidates showing satisfaction in almost every tool of WPBA, but the fact remains that almost 50% showed dissatisfaction in a number of tools such as mini-CEX and DOPS. The analysis concludes that MSF was the most commonly accepted tool for improvement in medical education provided it is implemented with complete honesty and true letter and spirit. Unfortunately, this last factor lacks in most of our setups. As a culture we Pakistanis are courteous, and most of us don't have the courage "to call spade a spade".
10. **Satisfaction of students:** Level of satisfaction of students in most UK institutes where WPBAs are implemented in true letter and spirit has been far from satisfactory. Dean and Duggleby (2013)[5], surveyed 1065 Foundation Programme doctors in the UK, identifying a small majority (61.2 %) rating WPBA's as being of 'some', 'moderate' or 'great' value to their training. In a similar study conducted by McKavanagh et al. (2012)[6], also considering Foundation Programme doctors (n = 215), 60 % disagreed with the statement that generating an e-portfolio of WPBAs 'created a positive learning experience'[6].

Possible Remedies: Few possible suggested remedies are

1. **Training of trainers:** Training of trainers is essential to make an effective WPBA system. After completion of training CME/CPD points, certification, and increased job opportunities in teaching hospitals can be good incentives.
2. **Training as part of job description of consultants:** There could be a certain mandatory number(at-least 40 50%), who should be employed as clinicians-cum-trainers in every teaching hospital. They should be adequately compensated. This should be enforced by government's regulatory bodies.
3. **Development of smartphone/tablet applications:** Since there is a reasonable increase in paperwork, which puts extra burden on trainers; development of smartphone/tablet applications can be a "smart" solution.

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Conclusion: Increasing awareness of general population in medical care,demands a comprehensive training system of healthcare professionals that not only imparts sufficient knowledge, but also ensures adequate skills including clinical, managerial and communication skills. Workplace based assessment can address all these requirements if implemented with commitment and dedication.

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Analysis of the pressures and issues faced by residents during their post graduate training program

Introduction

Every medical education programme, whether undergraduate or postgraduate, necessitates a systemof ongoing analysis, policy development, and re-evaluation of the techniques that have been implemented. Unfortunately, our country suffers from a severe lack of such vital research, resulting in inconsistent training quality, increased stress, maladaptive coping techniques, and a sense of abandonment among the majority of trainee doctors. Despite the fact that there is a strong national interest in doctor training, there has been little progress in more than a decade so this literature aims to point out several shortcomings and identify previously unnoticed flaws in our training programmes that are bottlenecks in the provision of clinical services

At all levels of health care, anaesthesia is a necessary component of the delivery system. It is a core function in practically all branches of medicine, including surgical operations, preparatory services, and diagnostic services. In the last few decades, anaesthesia has evolved into a complete medical specialty with a well-established presence in allied fields such as critical care medicine, emergency medicine, and pain therapy. Being in the field of anaesthesia has its own set of pros and cons.

The ability to cope with the competence in multiple domains of medical practice is the primary challenge that residents confront when they enter the training programme. Many residents are unaware of the field's history because they were never taught/introduced to the fundamentals of the anesthesia during their undergraduate programme and once they start their training they carry high responsibilities as they frequently face stressful scenarios such as management of unanticipated difficult airways, cardiac arrest, and other life-threatening emergencies, which cognitively overburdens them and causes in them feelings of negativism about their job, which affects healthcare systems at various levels. Apart from that anesthesia trainees mainly deal with patients who are
partially or fully unconscious so they're less likely to build a connection and rapport with patients and feel unappreciated even after giving their best .

Moreover, there is an inadequate rotation structure and component for various anesthesia subspecialties, which has a negative impact on individual training. Individuals are required by CPSP to complete rotations in the relevant subspecialty, but the institute fails to do so due to a shortage of faculty, clinical service demands, and rotational subspecialty inavailability. In addition, evaluations of rotational training are often informal and unrecorded in institutions where it is conducted.

Assessing the outcome of any educational experience requires reliable and rigorous assessments. Workplace-based assessment, as a formative tool, has the power to affect trainees behaviour by informing and advising them about their learning needs and inspiring them to grow, thus steering learning in the proper direction and such assessment process must be agreeable to both the trainers and the trainees.

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Unfortunately such assessments are used for summative purposes (i.e., examinations/certification) usually, as the focus of workplace-based evaluation is on evaluating trainee's performance rather than their learning. Trainees frequently go extended periods of time without being explicitly assessed and receiving organised feedback. Also when evaluating a trainee's clinical practice and procedural abilities, "higher-order" skills such as situation awareness, decision-making, teaching and training ability, interactions with patients and colleagues, teamwork ability, and leadership are usually disregarded. The best way to incorporate latest techniques and pre eminent methodology is via active participation in conducting and infusing researches. Our residency programmes must evolve in order to provide trainees with the flexibility they need to facilitate lifelong learning by providing the residents proper resources, both financial and educational while actively instilling in them the importance of researches. Mentorship is becoming more widely regarded as an important part of medical education training and growth and has massive benefits for both the mentor and the mentee. The ability of post-graduate trainees to self-direct their learning is perhaps the most important distinction between graduate study and other types of education, yet it is not without challenges. Furthermore, post-graduate trainees faced substantial challenges during the 2020/21 academic year as a result of the global pandemic (COVID-19).Trainees then turn to supervisors and look for mentors to tell them exactly what to do or provide them with a structure that guides them through the training process. But "inadequate supervision; a lack of communication between supervisor and student; the student's misconception of standards, requirements, and the supervisor's role and functions, time limits, limited mentor availability, and generational disparities" are all obstacles to their effective learning.

In addition to the above mentioned issues, another overlooked problem faced by residents is the pro supervisors policy wherein, almost all feedback submitted to CPSP is in the hands of their supervisor. This can be resolved by instituting a Multi-source feedback, also known as 360-degree assessment, that includes performance data and comments for an individual trainee by multiple assessors rather than simply the supervisor as it will serve as a justified and fair method of assessment.

Although the workplace provides excellent learning opportunities, the learning period can be stressful for trainees undergoing specialisation training.Trainees require social help due to their clinical commitments and expectations, as well as their inability to regulate and manage their workloads as social support is beneficial not only for stress management, but also for establishing interpersonal bonds and professional identity.

Another widely faced challenge by almost all the post graduate trainees is lack a predictable work schedule; the work pattern, due to high numbers of on-calls and longer than expected night shifts especially in private hospitals, due to some unanticipated extensive surgeries requiring trainees to work extended hours to accommodate the changes, and a higher likelihood of working during weekends and holidays, resulting in an imbalance between personal and professional lives. Some specialties are notable for their gender imbalance and masculine work culture. Female trainees usually face challenges as a result of gender bias attributable to subtle or not so subtle discrimination, which often leads to emotions of not fitting into their work environment and is likely to impact the quality of clinical training. During their training, trainees especially females are subjected to workplace harassment, as well as discrimination, with consultants being the most common perpetrator. To ensure a healthy, progressive atmosphere, we require strict policies and cultural change in our workplaces.

There is a lot of room for growth in the recognized and partially acknowledged attributes of our training programs .Improved outcomes necessitate regular monitoring of training programmes as well as repeated validation of supervising mentors. Annual feedback surveys involving residents are critical for enlightening the authorities and alleviating trainee complaints.

Dr. Muhsan Sultan Abbasi
Fazaia Ruth Pfau Medical College,
PAF Base Faisal, Karachi.

OBITUARY

SURG CDR ASIM GHAURI SAHEED

Surg Cdr Muhammad Asim Ghauri (Shaheed) FCPS Anaes, FCPS,CCM has been posted as Anaesthetist/ Critical care consultant November 2018 in PNS Shifa.

Since the outbreak of Covid-19 pandemic and 1st reported case of Covid-19 in Pakistan in February 2021, PNS Shifa he was in-charge of that COVID-19 ICU along with non COVID ICU.

His excellent feat of professional dedication medical judgement knowledge coupled with his professional commitment and devotion made him not only popular among patients, colleagues but administration as well.

He suffered COVID-19 and remained admitted in COVID ICU but during this admission in the ICU he kept guiding his fellow colleagues about the patients and their treatment. As soon as he recovered, resumed his duties with full zeal and without fear. On 3rd August 2021 once again he suffered from COVID-19 3rd wave and once again he was admitted in COVID ICU but this time he could not beat Corona and embraced shahadat on 14th of September at 1415 hrs.

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PROFESSOR REHANA YASEEN

Professor Rehana Yaseen MCPS, FCPS Anaesthesiology was working as Senior Cardiac Anaesthestist at PNS Shifa, Karachi till she left this world on 19th December ,2020. She was diagnosed with leukemia about a year ago and despite her ongoing treatment she continued to work in her beloved field of Anaesthesiology.

She started her extraordinary career from Civil Hospital Karachi in 1983 as medical officer and continued to grow as a well-known seasoned anaesthesiologist to the rank of professor and head of the department in National Institute of Cardiovascular Diseases (NICVD Karachi).Dr. Rehana served as president, Pakistan Society of Anesthesiologists (PSA) Karachi and also president Pakistan Association of Cardiothoracic Anesthesiologists (PACTA) during 20092011, and she remained member Executive Committee of PSA Karachi and PACTA till her death. She was examiner of CPSP and loved teaching trainees of all levels.

She has left behind her husband, two sons and four grandchildren.

DR. JAMEEL AKHTER

Dr. Jamil Akhter MCPS FCPS (Anaesthesiology), Anaesthetist& Ex-Assist Prof. DMC & CHK passed away on 19th November, 2021.

He graduated from Dow Medical College in 1984 and was one of earliest residents in Anaesthesia at the Aga Khan University then left to join government services due to personal reasons. He was well respected by all his colleagues and had reputation of a thorough gentleman in the community of Anaesthesiologists. He practiced and taught in AKUH, Civil Hospital, and Imam Clinic. He regularly participated at PSA conferences and served as clinical coordinator at CPSP to conduct examinations for FCPS trainees. However, he chose to serve people mainly by his personal practice and clinic to which he dedicated 31 years of his life.

He left behind his wife and daughter. His daughter described him as a gifted conversationalist and a great advisor, counselor, and confidante

DR. MUHAMMAD FAHEEM

Dr. Muhammad Faheem was Consultant Anaesthesiologist at the Midland Regional Hospital Mullingar, Ireland. He left his near and dear ones on Feb 3,2022 peacefully at his home.

Apart from being a competent expert in his field, he was well known in the community for his engagement with Islamic center and providing social services. He is being described as a very kind and gentle soul who will be fondly remembered by his wife and three kids, his brothers and sisters, extended family, colleagues and many friends.

DR. FIROZ AHMED QASMI

Dr. Firoz Ahmed Qasmi, a senior anaesthetist, was a Dow Medical College graduate and was associated with Dow University of Health Sciences for eight years.

He left this world on July 25,2021 after fighting COVID for five days on ventilator. He was well respected for his professional integrity and good personality.

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Glimpse of Pre-Conference Workshops

Meeting of PSA Executive Committee for finalizing the Conference arrangement.

Acute Pain Management for Parmedics on 8th March at LNHMC

Point of Care Ultra sound Workshop at PNS Shifa.

Mechanical ventilation in SIUT on 9 March

Airway management W.shop at Fazaia Ruth Pfau Medical College PAF Faisal Karachi

Difficult airway at Hamdard University Hospital

Ultrasound guided lower limb nerve block at Indus Hospital on 12 March

Anaesthesia emergencies simulation training at Dow Medical College

Nerve blocks W.shop at Patel Hospital Karachi

Point of Care Ultra sound W.shop at NICVD

PSA EPM Pre- Conference Workshop at AKUH

Scientific Program 40th Annual Conference.... PSA Karachi

19th - 20th March 2022
Saturday, Sunday
Karachi Marriott
Theme : Journey towards Excellence - Vision 2025

DAY 1. Saturday 19th March 2022

- **Registration** ..... 8.30 - 9:30 am
- **Session - I** ..... 9.30 - 11:00 am
  Anaesthesia Post-graduation at crossroads
- **Session - II** ..... 11.00 am - 12:15 pm
  Minimal Mandatory Standards of Anaesthesia in Pakistan.
  How to enhance the workforce?
- **Session - III** ..... 12.15 pm - 12:35 pm
  Guest Lecture
- **Lunch** ..... 12.35 pm - 01:30 pm
- **Session - IV** ..... 01.30 pm - 03:30 pm
  Clinical Refresher for Practicing Anaesthesiologists
- **Opening Ceremony** ..... 04.00 pm - 07:00 pm

DAY 2. Sunday 20th March 2022

- **Session - I** ..... 08.30 - 09:30 am
  Breakfast Session
  A. Eat all you can ..... 08.30 - 09:30 am
  B. Breaking the ice with experts ..... 09.00 - 09:30 am
  Conference Photograph CBR 09.30 - 09:45 am
- **Session - II** ..... 10.00 am - 11:45 am
  Learning from younger colleagues - Tapping and Encouraging Talent
  A. Residents / Fellow Session
  B. Young Consultants Session
- **Session - III** ..... 11.45 am - 12:45 pm
  Anaesthesia as of 2022
- **Session - IV** ..... 12.45 - 02:15 pm
  "Resident Free Paper Contest" and Poster Session
- **Business Session** ..... 02.15 - 02:45 pm
- **Lunch** ..... 02.45 pm
- **Parallel Paramedics Session** ..... 10.00 am - 1:30 pm