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Editorial
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Transitioning into the post-pandemic era in anaesthesia: a reflection of lessons learnt

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The recent COVID-19 pandemic has significantly impacted the country's anaesthesia and critical care services. Cancellation and postponement of elective surgical cases to curb the spread of infection and redeployment of manpower plus resources for the creation of critical care beds were our main focus.[1] The subsequent human resource challenge to safely staff the beds and the psychological stress suffered by providers due to the hazardous nature of the work dominated the thrust of the administrators during the full force of the pandemic.

Anaesthesiologists at the forefront of safety saw to a rapid proliferation of guidelines produced in record time by our fraternity to protect ourselves and our patients from being infected by the SARS-CoV-2 virus. The Malaysian Society of Anaesthesiologists and College of Anaesthesiologists, Academy of Medicine Malaysia (MSA/CoA, AM) produced recommendations on the appropriate protection during aerosol-generating procedures (AGPs), including the use of powered air-purifying respirators whenever available.2 Being a precious commodity during the pandemic, the safety of the anaesthesiologist became a priority. Even in the event of a deteriorating COVID-19 patient, the anaesthesiologist was advised to don full personal protection equipment (PPE) before attending to the patient.

Successful intubation at the first attempt has never been more critical. It became obvious that anaesthesiologists could not change the circumstances, but still had

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the undeniable responsibility of saving a patient's life, so we needed to adapt. Video laryngoscope usage increased manifold following the recommendation of airway management policies of many Difficult Airway Societies across the world.[3,4] Training our staff in proper donning and doffing of PPE was vital and had to be conducted swiftly during procedures.[5]

Regional anaesthesia, namely central neuraxial or peripheral nerve blocks, was recommended as the technique of choice whenever appropriate to avoid AGPs.[6] It is unclear whether the recommendation has resulted in an increased percentage of regional anaesthesia during the pandemic. However, anaesthesiologists felt safer by avoiding AGPs whenever there was a choice regarding the type of anaesthesia.

It also became obvious to the medical fraternity at large how important the skill sets of anaesthesiologists were in this pandemic. In the face of shortage of intensivists, anaesthesiologists filled in rapidly to care for critically ill COVID-19 patients. The clarification of clinical skills possessed by future anaesthesiologists must be delineated, as we are seen to be equally adaptable to caring for patients in the operating theatre, intensive care unit, or even in the emergency department.[7] The government must therefore plan to train increasing numbers of anaesthesiologists in the future.

From the COVID-19 experience we learned that infection control practices amongst health professionals made a huge difference. Anaesthesiologists are more compliant with hand hygiene, show greater adherence to proper use of N95 masks, practice stringent donning and doffing of PPEs, and plan intubation and ventilation of COVID-19 patients better than most providers from other disciplines.[8] As a result, hospital-acquired infections showed a declining trend; this was definitely a step in the right direction in exemplary behaviour.[9]

Dissemination of information and knowledge has rapidly evolved. It was beyond imagination that academicians, clinicians, and researchers across the world rose to the occasion: communicating and exchanging useful, much needed knowledge virtually and seamlessly. Although this has reached new heights in knowledge transfer, the physical interaction prevalent in the pre-COVID-19 era is missed and still preferred by many.

As we progress into the endemic phase, the dilemma of when a post-COVID-19 patient can undergo elective surgery has surfaced. Following consensus from international guidelines, MSA/CoA, AM recommended a minimum 7-week waiting period after COVID-19 infection for elective surgical cases.[10] In addition, rehabilitation of post-ICU patients has become more relevant as we treat post-COVID-19 infection patients longer in ICU. Hence, a multidisciplinary approach to treating

the patient recovering from COVID-19 is essential to maximally integrate resources for the best outcome.

The COVID-19 pandemic has impacted our lives in many ways; many developed a greater appreciation for life. Tsan *et al.* showed that the burnout rate among anaesthesiologists in Malaysia was very high.[11] We are reminded to focus on our lives and that of our colleagues as we push to save the lives of our patients. The MSA/CoA, along with its Wellness Special interest group, has actively promoted wellness among the anaesthesia fraternity, as it is truly #Kitajagakita. We hope that with the transition to the endemic stage of the pandemic, our fraternity will come out stronger and wiser, assimilating the lessons learnt from our collaboration. This will ensure a stronger team of anaesthesiologists with a brighter future for our discipline.

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