THE HONG KONG COLLEGE OF ANAESTHESIOLOGISTS

香港麻醉科醫學院

NEWSLETTER

February 2004

In this issue …

Volume 13 Number 2 February 2004

Contents

Instruction to Contributors

We welcome contributions from invited guests and members / fellows of the Hong Kong College of Anaesthesiologists. Articles should be prepared with suitable word processing software. Figures, table, pictures and photo-micrographs should be saved in the same file. The file could be sent either by e-mail or by post (on a floppy disc or CD) to the Editor. Please indicate if the material has to be returned after the editorial processing. The article would be printed in the same way as it is submitted. The accuracy of the materials published is the responsibility of the contributors. The contributors must ensure that the materials submitted do not infringe copyright. The editorial board reserves the editorial right for selection of publication.

Disclaimer

Unless specifically stated otherwise, the opinions expressed in this newsletter are those of the author's personal observations and do not necessarily reflect the official policies of the Hong Kong College of Anaesthesiologists.

Editorial

This issue of the Newsletter focuses on training. Many of you would have heard that the College is going to adopt a new training system. In this issue, Dr. CT Hung, Chairman, Board of Education will explain to you the important details. In addition, there will be forums to brief trainers (i.e. fellows) and trainees. Further information can be found in this issue. Please mark your diary and make sure you go to one of them. The College will also start the Effective Management of Anaesthetic Crisis (EMAC) course in the near future. EMAC, originated by our sister college, ANZCA, is now recognized as an important component of anaesthetic training. Although it is designed for trainees, many fellows have found it useful. Indeed, some 20% of the EMAC participants in Australia and New Zealand are specialists. Drs. WH Kwok and Bassanio Law have recently attended one of the EMAC courses at CASMS, Perth, Australia, the busiest simulation center in the world. They have complied an account of what to expect from this intensive 2½-days course. I am sure many of you will start thinking of joining these events after reading their testimonial.
Finally, as many other publications, the Newsletter is going online as well. Indeed, as you are reading this printed copy, the online version has been available in the College website some weeks ago. Please visit the College website www.hkca.edu.hk regularly for the latest information.

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Our Mission to the EMAC Course

The Hong Kong College of Anaesthesiologists is planning to organize simulators courses in Hong Kong for training of crisis management for our anaesthetic trainees. Since similar courses have been running in Australia, known as Effective Management of Anaesthetic Crises (EMAC) Course, Dr. WH Kwok and I have recently been to Australia to attend the EMAC course in order to learn how it is run.


Swan river, Perth

The course was being held at The Centre for Anaesthesia Skills & Medical Simulation (CASMS), University of Western Australia, Perth, Australia. It consists of 2 and 1/2 days (4.3.2004 – 6.3.2004 inclusive) of training intended to provide practical techniques in the management of anaesthetic emergencies. EMAC brings a significant new approach to medical training that emphasizes the behavioural aspect of managing anaesthetic crises. EMAC focuses on the role of the anaesthetist as the team leader in the operating theatre during an anaesthetic crisis and the interaction with the people around us to use their skill and resources effectively, to develop strategies to facilitate decision making and encourages the use of protocols during anaesthetic emergencies.

The course is an intensive and interactive course in the management of injury victims in the first one to two hours following severe injury[1]. Emphasis is placed on life saving skills and a systematic clinical approach.

The basis of the course is to teach a system of care after injury to provide the participant with the basic knowledge necessary to:

1. Assess the patient's condition rapidly and accurately.
2. Resuscitate and stabilise the patient according to priority.
3. Determine if the patient's needs exceed facilities capabilities.
4. As appropriate, arrange safe transfer to definitive care.
5. Assure that optimum care is provided.

The course comprises of lectures, practical skill stations, case scenarios and discussions. Assessment is continuous throughout each stage of the course and includes pre-course and post-course MCQ tests.


CTEC, Perth Australia

Dr. Kwok and I landed in Sydney a few days before we flew to Perth and we met 2 of our fellows who now work and reside in Sydney, Dr. CP Chau and Dr. Doris Lam. Both will contribute

in the next issue of the Newsletter talking about their new lives in Sydney Australia.

We arrived in Perth on 3.3.2004, one day before the starting of the EMAC Course and we were keen to find out where CASMS was.

(Left) Dr. Bassanio Law (author) and (right) Dr. WH Kwok

CASMS is located on the first floor of Clinical Training and Education Centre (CTEC) at the University of Western Australia.

There were 5 modules altogether, with 2 modules running each day. Participants were divided into 2 groups. Each group were further subdivided into 2 half groups, such that one half will be having role play while other half are observers.

There is introduction prior to the starting of each themed module and scenarios were role played by each half group of participants. The other half group who were not participated in the role play were observers gathered in a room where closed circuit TVs are showing what the "actors" and "actresses" are doing in the role play.

At the end of each module, all members from their respective group gathered and the "acting" team would discuss their role, their response in the crises and how things could be done differently and how management could be improved. Feedbacks and guidance were then given by their team trainers. At other times there are games to play which help to demonstrate the importance of team work and experience in handling crises.

A letter of good faith was signed that we would not disclose the content of the simulated scenarios. In essence, module 1 is human performance issue, module 2 is cardiovascular emergencies, module 3 is airway, module 4 is anaesthetic emergencies, module 5 is management of trauma.

I would say it is a truly worthwhile experience.

Our college newsletter has been privileged to grant the permission to reproduce an article from Medical Journal of Australia written by Dr. Richard Riley, who is the clinical director of CASMS

The article will give us an introduction of the history, setup, staffing and workload at CASMS.

"Riley RH et al. **Three years of "CASMS": the world's busiest simulation centre**. MJA 2003; 179: 626-630."[2] Copyright 2003. *The Medical Journal of Australia* - reproduced with permission.

[1] http://www.ctec.uwa.edu.au/ctec_courses.aspx
[2] Copyright 2003. *The Medical Journal of Australia* - reproduced with permission.

THURSDAY

Time		Instructor	Room
08:00	EMAC Introduction and Intro to the Simulation centre	RR	Boardroom
08:15	FAMILIARISATION	AG	

Human Performance Issues: Richard Riley

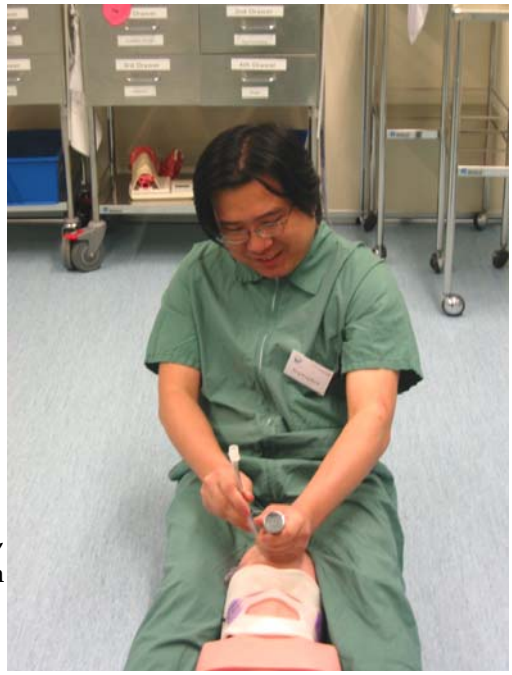
Time		Instructor	Room
08:30	Introduction to HPI	RR/SD	Boardroom
09:00	Discussion		
09:10	NOVA		
09:30	The Zin Obelisk		Sim 3
10:00	Morning Tea		
10:15	Key Points CRM	RR/SD	Boardroom
10:45	Discussion		
10:55	Tennis Ball Game		Sim 3
11:10	Systems approach		Boardroom
11:20	Scenario	RR/SD	Sim 1 & Debrief 3
12:25	**Wrap Up**		
12:30	LUNCH		

Cardiovascular : Wally Thompson

Group 1

Time		Instructor	Room
13:30	Emergency Vascular Access	BL/RR	Skills Room
14:00	Scenario		Sim 1 & Debrief 1
14:40	Scenario		
15:20	Afternoon Tea		
15:30	Ischaemia PBL	CH/WT	Debrief 3
	Rhythm recognition		Sim 3
	Defibrillators & Pacing		
	Cardiac Arrest management		
17:30			

A typical day of hard work, starts at 8 Am and finished at 5:30 PM



The ultimate airway skill, intubate in a sitting position

Three years of "CASMS": the world's busiest medical simulation centre

Richard H Riley, Amanda M Grauze, Claire Chinnery, Ross A Horley and Neil H Trewhella

ABSTRACT

- Medical simulation is a relatively new teaching modality suitable for medical education at all levels, although its long-term benefits have not yet been validated.
- Simulation allows the participant to practise diagnosis, medical management and behavioural approaches in the care of acutely ill patients in a controlled environment.
- Simulators have achieved widespread acceptance in the fields of anaesthesia, intensive care and emergency medicine. More recently, team training for pre-hospital and within-hospital multidisciplinary medical response teams has become popular.
- The increasing number and diversity of courses at "CASMS" parallels the evolution of simulation centres into regional clinical skills centres elsewhere. Such centres are likely to become a cost-effective means of achieving greater consistency in medical skill acquisition and may improve patient outcomes after medical crises.

MJA 2003; 179: 626–630

MEDICAL EDUCATION is undergoing significant change, with curriculum redevelopment and the introduction of new teaching methods, including enhancement with computer-based programs and increasingly sophisticated task trainers and simulators. Leading the change in new teaching techniques is simulation technology.[1-3] Simulators themselves are costly, as is maintaining appropriately trained staff in a realistic clinical environment, with appropriate audiovisual support. Governments, universities and professional medical, nursing and paramedical colleges and societies are likely to acquire such sophisticated training capabilities only through a collaborative approach. In this article we describe the development and operation of a purpose-built medical simulation and skills centre known as "CASMS", the Centre for Anaesthesia Skills and Medical Simulation, at the Clinical Training and Education Centre (CTEC), University of Western Australia.

Development of a simulation and skills centre

CASMS began with one adult anaesthesia simulator and some disused operating equipment in a vacated nursing school building. It was staffed by a core group of six anaesthetists and one registered nurse on secondment from Royal Perth Hospital. This first simulation suite was used for more than a year while a new simulation and skills facility was built. The new building was a major structural addition to the Department of Anatomy and Human Biology at the University of Western Australia. The simulation centre is located on the first floor and a state-of-the-art surgical workshop and lecture room are located on the ground floor. This multidisciplinary medical training facility (CTEC) was officially opened on 1 April 2000.

CASMS contains three complete and independent simulation suites, a skills area, a conference room and an administration area (Box 1). Each suite comprises a simulation room, which can be presented and equipped as an operating theatre, emergency department resuscitation area, recovery room, endoscopy suite, medical practitioner's office, or any other area as the training need requires. An adjoining control room allows course leaders to observe participants, control events, manipulate mannequins remotely, and communicate to role-playing training staff in the simulation room via wireless headsets. An adjacent "debriefing" room is used for tutorials, discussions and formal debriefing sessions after each scenario.

Centre for Anaesthesia Skills and Medical Simulation (CASMS), Clinical Training and Education Centre (CTEC), University of Western Australia, Perth, WA.
Richard H Riley, MB BS, FANZCA, Clinical Director;
Amanda M Grauze, RN, GradDipEd(Higher&Further), Coordinator of Training; **Neil H Trewhella,** CSM, BHSc (Prehospital Care), Senior Training Officer; **Claire Chinnery,** BN, RN, Educational Designer, CTEC.
Medic Vision Ltd, South Perth, WA.
Ross A Horley, Director.
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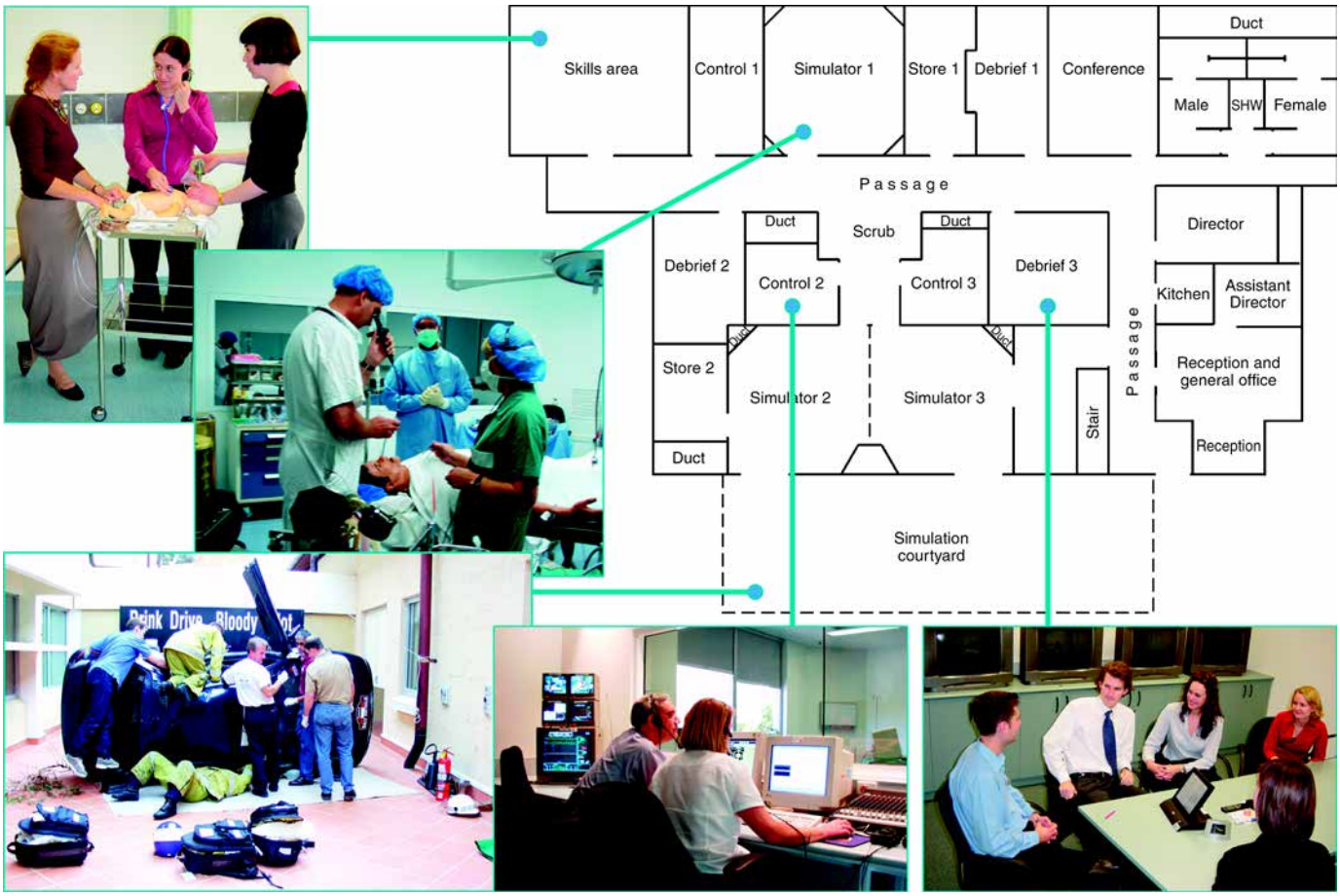
Medical equipment

A simulation and skills centre may contain as many pieces of hospital equipment, medical training simulators, mannequins, and training aids as the facility can afford. Box 2 contains a list of some high-cost equipment and training aids used in courses and workshops offered by CASMS. The high-fidelity anaesthesia simulator has been a very flexible training device. It can easily simulate more than 35 medical and anaesthesia crises (eg, bronchospasm, pneumothorax, malignant hyperthermia, pericardial tamponade, aspiration, and all cardiac arrhythmias). It is now reserved for selected operating theatre scenarios and the Laerdal SimMan is used for most resuscitation courses for medical students, nurses and trainee doctors. Miscellaneous equipment (such as a fog machine to simulate hospital fires or chemical agent dispersion, and a moulage kit to simulate various wounds) has been acquired to increase the variety and authenticity of scenarios.

1: Floor plan and images of the Centre for Anaesthesia Skills and Medical Simulation (CASMS), University of Western Australia



(Architectural drawing copyright, John Flower Architect Pty Ltd)

Audiovisual equipment

A key component of the simulation centre is the audiovisual equipment. Training scenarios are videotaped and played back in debriefing sessions.

Each simulation room comprises two pan tilt zoom cameras and four camera points, a scan converter connected to the simulator's vital signs monitor and digital videotape machines. The cameras and scan converter are connected to individual digital tape machines, which are interconnected to an event logging control system. Via a touchscreen, the operator can simultaneously log key events onto the digital tape machines during video recording. In a debriefing session the operator can view entire tapes or logged events. The touchscreen in the debriefing room provides access to 15 logged events.

Radio headsets are worn by trainers so they can converse with the simulator operator, and ceiling speakers are provided for the "Voice of Big Brother" (which gives the simulation participants additional information). The speaker in the mannequin, which provides the "patient's" voice, is connected to a microphone on the operator's desk.

The audiovisual equipment throughout the simulation centre is connected to a videoconference system so that training activities within the centre can be transmitted to multiple or individual remote destinations.

Staff

A Director of Medical Simulation was appointed from the core group of six anaesthetists, and two extra trainers were employed. With an increasing number and variety of courses, additional instructors have been recruited from other fields.

Instructors at CASMS must hold current or former responsible training positions, or have training qualifications in the discipline in which they practise. Wherever possible, instructors should gain additional qualifications from within their specialty (eg, Quality Assurance and Continuing Professional Development Course from the Royal Australian College of General Practitioners, or Effective Management of Anaesthesia Crises Instructors Course from the Australian and New Zealand College of Anaesthetists), or a recognised training organisation (eg, Certificate IV in

2: High-cost equipment used at the Centre for Anaesthesia Skills and Medical Simulation, University of Western Australia

Equipment	Approximate cost ($)
MedSim high-fidelity anaesthesia simulator (adult simulator with drug recognition and responses, physiological data output, preprogrammed crises)	$250 000
Laerdal SimMan (a medium-fidelity simulator, numerous cardiorespiratory features)	$85 000
Laerdal MPL Crash Kelly (a robust adult mannequin, useful for basic life support and pre-hospital training)	$5 200
Laerdal Airway Management Trainer (bag-mask ventilation, tracheal intubation)	$2 700
Laerdal MPL Megacode Kid with multi sounds (paediatric CPR trainer)	$13 600
Laerdal ALS baby trainer with Heartsim 200 simulator (paediatric arrhythmia trainer)	$4 400
Laerdal Little Anne (basic life support trainer)	$1 250*
Datex Ohmeda AS/3 anaesthesia machine	$67 000
Datex Engstrom AS/3 patient monitor, including anaesthetic agent and gas analyser	$45 000
Datex Engstrom CS/3 patient monitor	$36 000
Drager Evita 4 ventilator (ICU ventilator)	$27 500
Drager Oxylog 2000 (a patient transport ventilator)	$14 500
Hewlett Packard Codemaster 100 defibrillator	$11 000
Phillips Heartstream FR4 defibrillator	$4 000
Olympus fibreoptic bronchoscope, monitor, light source and camera control unit	$36 700

* Cost for 5. CPR = cardiopulmonary resuscitation.

Assessment and Workplace Training, Australian National Training Authority). As the centre has grown, it has become necessary to use a professional website developer, educational designers and a clinical psychologist who has an interest in this field.

Funding

Simulation and skills centres are expensive to establish and maintain, and normally rely on government or institutional subsidies (or both). CASMS was built with funding from the University of Western Australia and a generous gift from a benefactor. Royal Perth Hospital and the Government of Western Australia provided anaesthesia, and some medical equipment, simulators and mannequins, and assistance with staffing costs. Much of the medical equipment was supplied by the manufacturer or distributor under permanent loan or by donation.

Charges for courses are determined by actual costs of course development, participants' abilities to pay, and sometimes by negotiation with the educational coordinator for the relevant medical or nursing organisation or society. Often, *quid pro quo* agreements may be arranged whereby a hospital-based training officer or resuscitation officer assists with or coordinates training of participants from their own hospital to minimise overall training costs. Courses range in price from $100 per person for some half-day skills sessions to over $1000 for labour-intensive, high-fidelity courses run over 3 days.

Courses conducted at CASMS

The courses offered and their target groups are wide-ranging. Courses were initially configured for trainee and consultant anaesthetists, but were quickly tailored to suit the requirements of other acute-care medical and nursing staff. Examples of courses offered include crisis management (for anaesthetists, anaesthesia technicians and critical care nurses), refresher courses in industrial emergencies for industrial paramedics, cardiac defibrillation (for registered nurses), and urinary catheterisation (for medical students). The numbers of courses and participants have grown from 69 courses offered in 2000, involving 471 participants, to 170 courses in 2002, involving 1711 participants.

The simulation centre is ideally designed for any type of training that requires a hospital environment (operating theatre, emergency department, intensive care unit) or a general medical or dental practice. The courtyard area adjacent to CASMS and a service stairway to the air-conditioning plant in the CASMS building have also been used for prehospital or industrial (eg, off-shore oil rig) scenarios for paramedics.

The scenario-based training was pioneered by Gaba and colleagues at Stanford University.[4] This novel style of medical training was well known in aviation and other high-risk industries that involved complex work environments requiring active decision-making. After a period of familiarisation with the simulator and discussion of strategies for managing medical crises, participants take turns at experiencing a medical crisis in an environment that matches their workplace. The scenarios are usually audiotaped and videotaped in real time. Segments of the crisis are replayed where appropriate during facilitator-managed debriefing sessions. An example of a medical crisis during a routine dental procedure (from a "Medical emergencies during dental practice" course) is shown in Box 3.

The future for medical simulation

There is increasing awareness of the need for improved patient safety among the general public and medical defence organisations. Simulation centres play a valuable role in providing a safe environment for training without risk to the patient.[5] The ability of simulation centres to repeatedly present rare and unusual cases to participants is also valuable, at a time when inpatient numbers are declining and fewer real "cases" are available for students and junior staff to experience.

However, for simulation centres to maintain high standards and to continue improving the quality of training available, access to a simulation centre must be increased for

3: Dental scenario: a cardiac event during a routine dental procedure

Setting: A 55-year-old man with known heart disease undergoes a prolonged dental procedure. The patient complains of chest discomfort and the dental nurse notices that the patient has been sweating and now appears grey. He is then unresponsive, pulseless and apnoeic. The dentist and nurse start cardiopulmonary resuscitation (CPR) after a pocket mask is found in a drawer. They call for help from the receptionist. An ambulance is not called. The scenario is stopped when the instructor detects effective ventilation and cardiac compressions.

Laerdal SimMan adult simulator in a dental chair

Debriefing: The facilitator (F) asks the dentist (D) to describe to the group (observing via videolink from a nearby room) what happened and what he was thinking.

F: "Let's go over what just happened."	D: "The patient crashed on me."
F: "When did you first realise you had a crisis?"	D: "When he didn't answer the nurse's question."
F: "What type of emergency was it?"	D: "A cardiac emergency."
F: "What clues were you given that something like this might happen?"	D: "He had a history of heart disease and the procedure was long and stressful. Apparently he was sweating a lot, but I didn't realise that".
F: "Were you prepared for this?"	D: "I am a bit shaky on my CPR skills and you never hear of patients having an arrest in the chair, do you? We are not really prepared for this sort of thing anyway. I don't even know if our receptionist could do much to help out if something like this happens."

A segment of the scenario (patient stops breathing) is replayed.

F: "What do we learn from this?"	D: "There was a long delay before we did anything. I was distracted with the job and then I couldn't believe this was really happening. I guess we didn't know where our emergency gear is kept. We don't have much gear anyway. We should have called for an ambulance."
F: "How could we improve our ability to handle medical emergencies?"	D: "Have a 'resus' kit in clear view, make sure our staff get some training, and organise a system in our practice to follow when this happens".

A discussion follows on emergency equipment needed for dental practices and staff training.

the wider medical and nursing community. Scenario-based training requires a dedicated area that appears no different from the clinical domain that it represents. Medical and audiovisual equipment demands are such that it makes sense to build a dedicated clinical area that is flexible enough to be modified according to the setting, and is well-equipped for inconspicuous videotaping of clinical events. At least one separate area for small-group teaching and post-event discussion is also required. Debriefing sessions are essential in scenario-based training, and are regarded as the most difficult role for instructors. Training in debriefing techniques should be acquired before undertaking scenario-based training.

Sufficient funds to construct several simulation suites in a centre allows for more efficient use of resources. Ideally, surgical skills centres would be collocated with medical simulation centres to foster interdisciplinary courses, and to share support services and lecture rooms. The use of web-based learning materials to be completed before attending the centre also leads to more efficient use of the simulator centre.

Worldwide, there are over 150 centres with high-fidelity simulators and more than a third of medical schools in the United States have at least one simulator. In Mainz, Germany, a shared medical and aviation simulation centre has been established. In Australasia, simulation and/or medical skills centres operate cooperatively and share expertise and even instructors. Currently, the centres are: Southern Health Simulation and Skills Training Centre (Monash Medical Centre, Melbourne); St Vincent's Simulation Centre (St Vincent's Hospital, Melbourne); Sydney Medical Simulation Centre (Royal North Shore Hospital, Sydney); National Patient Simulation Training Centre (Capital Coast Health, Wellington, New Zealand); and Flinders Clinical Skills and Simulation Unit (Flinders University, Adelaide). New simulation centres are planned for Brisbane (Queensland) and Auckland (New Zealand).

Flexibility of educational style is important, and the input of a dedicated medical educationalist is of great benefit. Gaba's scenario-based training methods are only suitable for some courses, and assessment of individual and group performance during simulator-based medical emergencies is complex.[6,7] Other methods, such as problem-based learning, may be particularly appropriate for medical students,[8,9] and outcomes-based learning should be considered as a method of guiding the content of courses and assessment of participants. Continuing development of simulation-specific assessment tools and evaluation of courses are vital.

Remediation for professionals with specific needs is also an area that should be further considered by simulation centres. Simulation centres are ideal for fully assessing individual need in a safe environment and for providing learning opportunities to remedy specific problems.[10,11]

In conclusion, medical simulation centres have a significant contribution to make at all levels of training for healthcare professionals. Despite large start-up and maintenance costs, the increasing need for such collabora-

tive skills centres will ensure their continued success in the Australian healthcare system.

Competing interests

Ross Horley is the Director of Medic Vision Ltd, a specialist audiovisual engineering company.

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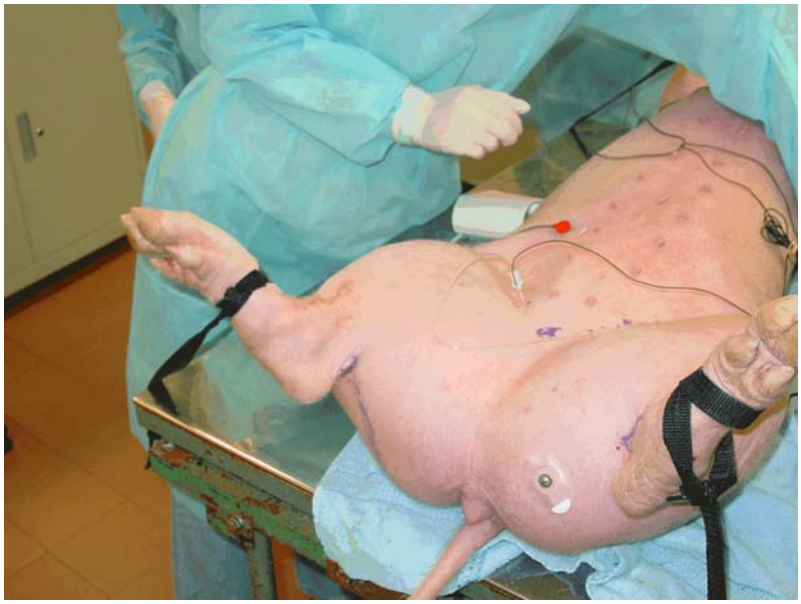
Alternative Method of Teaching Regional Anaesthesia

On 1 December 2003, the Department of Anaesthesia & Intensive Care of Prince of Wales Hospital had organized an "Animal-based Hands-on Regional Anaesthesia Workshop" at the Laboratory Animal Services Centre of the Chinese University of Hong Kong. The workshop allowed hands-on training of regional anaesthesia techniques using pigs as models. Many anaesthetic trainees from PWH attended the workshop. The use of anesthetized pigs allowed trainees the opportunity of repetitive placement of needles onto nerves, and to practice other more advanced techniques (such as catheter placement onto nerve plexuses and ultrasound guided nerve blockade).

For those who are interested in gaining this kind of unusual experiences, please contact Dr. PT Chui and Dr. WH Kwok, Department of Anaesthesia and Intensive Care, Prince of Wales Hospital for more information.

Locating the sciatic nerve using nerve stimulator



Stimulating the femoral nerve

From the Chairman, Board of Education…

Dear Trainees,

To achieve our commitment to serve the people of Hong Kong by promoting the standards of care in anaesthesiology, College has to review and continuously improve the training programme. After years of debate and discussion, College has come up with a training programme that would serve to ensure the quality of training and this new Vocational Training Guide (New VTG) will be effective on 1st January 2005.

As the main essence of the change is to ensure quality, you will notice the difference between the New VTG and the Old VTG is on the requirement for subspecialty anaesthetic experience. In the past, we have enforced rotation to major hospitals to ensure an adequate exposure to different varieties of anaesthetic experience. With the clustering and rationalisation of surgical services, rotation alone would not be able to ensure quality of training. That is the rationale of specifying the experience required for different subspecialties, together with its documentation. This also removes the need to designate hospitals into Categories A, B or C.

To enable easier monitoring of experience obtained by trainees, we have also introduced the electronic log-book system, and the in-training assessment. You would find the details in the New VTG and the related documents on In-training Assessment. Apart from these changes, the other changes in the New VTG are minor. Rotation between hospitals is still a mandatory requirement.

One of the burning questions that would be asked is the transitional arrangement between the Old VTG and the New VTG. I have extracted the relevant parts of the Administrative Instructions for your information.

In the next few months, College with be organising forums to discuss the New VTG with Supervisors of Training (22nd May, 10:30-12:30, QEH M Gd Rm 1) and Trainees (5th June, 10:30-12:30, QEH D Gd Conference Room). I am looking forward to meeting you in the forums. We are confident that the New VTG would serve to improve the quality of training.

Yours sincerely,

C T Hung
Chairman, Board of Education

HONG KONG COLLEGE OF ANAESTHESIOLOGISTS
Vocational Training Guide for Anaesthesiology

1. VOCATIONAL TRAINING PROGRAMME

1.1 Only Members of the College who are registered as trainees with the Education Committee of the College may have their experience accredited towards their vocational training programme requirements as described hereunder.

1.2 These requirements will apply to all trainees joining the training programme on or after 1st January 2005 unless otherwise specified.

1.3 Members of the College must register as trainees with the College within six months of the start of training for the training experience to be accredited, otherwise they will have their experience assessed and accredited as for anaesthetists being trained overseas as specified under Section 1.4.

1.4 Trainees with previous training in overseas training programmes or other non-approved positions will have their experience considered and accredited individually. A fee for such an assessment will be charged in proportion to the duration retrospectively approved subject to a minimum charge. The fee will be determined by Council from time to time. They will need to become Members of the College and register as trainees before any further experience can be considered for accreditation.

1.5 Vocational training in anaesthesiology shall consist of not less than six years after full registration with the medical registration authority.

1.6 The six-year vocational training programme in anaesthesiology shall be full-time and shall consist of the following components:-

1.6.1 Non-anaesthetic clinical experience	6 months
1.6.2 Clinical Anaesthesia	48 months
1.6.3 Intensive / Critical Care Medicine	3 months
1.6.4 Elective Options	15 months

1.7 Non-anaesthetic clinical experience [referred to under section 1.6.1] must be obtained in training units approved by an Academy College in Hong Kong. Training in the other units will be individually approved by the College. Internal medicine, paediatrics, emergency medicine, intensive care and pain medicine are examples of recognised non-anaesthetic clinical experience.

1.8 The Clinical Anaesthesia experience [referred to under section 1.6.2 and 1.6.4] must include an adequate exposure to all of the following CORE areas in anaesthesia. To ensure adequate exposure, a trainee is expected to have managed a minimum number of cases in each core subspecialty1 (as defined in the brackets) over the 6 years of training

1.8.1 anaesthesia for general surgery /urology /gynaecology (500 cases)
1.8.2 anaesthesia for orthopaedics and traumatology (500 cases)
1.8.3 obstetric anaesthesia (100 cases) and obstetric regional analgesia (50 cases)
1.8.4 neuroanaesthesia (100 cases)
1.8.5 thoracic anaesthesia (50 cases)

1.8.6 paediatric anaesthesia (100 cases of children ≤ 6 years, including neonates)
1.8.7 anaesthesia for Head & Neck / ENT/ Oro-facio-maxillary (100 cases)
1.8.8 emergency / trauma anaesthesia (500 cases)
1.8.9 acute pain management (300 patient-days)

1.9 Apart from the CORE areas, some experience in each of the following NON-CORE subspecialties1 would be required, particularly for future subspecialty development. Trainees will be required to complete two modules from category 1 and a minimum of 20 cases from category 2.

1.9.1 Category 1 NON-CORE modules
1.9.1.1 ophthalmic anaesthesia (50 cases)
1.9.1.2 day surgery anaesthesia (100 cases)
1.9.1.3 anaesthesia in non-operating theatre locations including but not limited to Organ Imaging Suite, Endoscopy Suite, Cardiac Catheterisation Laboratory, ECT (50 cases)
1.9.1.4 pain medicine (50 chronic / cancer pain cases)

1.9.2 Category 2 NON-CORE Modules
1.9.2.1 major vascular anaesthesia
1.9.2.2 cardiac anaesthesia
1.9.2.3 transplant anaesthesia
1.9.2.4 neonatal anaesthesia

1.10 Elective options [referred to under Section 1.6.4]

1.10.1 Trainees may undertake the following or a combination of the following as part of their elective training:-
1.10.1.1 clinical anaesthesia
1.10.1.2 intensive / critical care medicine
1.10.1.3 pain medicine
1.10.1.4 other clinical specialties apart from anaesthesia, intensive / critical care medicine and pain medicine (most of the hospital based specialties will be accepted except pathology)
1.10.1.5 research related to anaesthesia and/or intensive / critical care medicine and/or pain medicine

1.10.2 With effect from 1st July 2004, training in elective options in clinical anaesthesia, intensive / critical care medicine and pain medicine must occupy a training post approved by the College. Training in elective options in other clinical specialties must be in training units approved by the College or the respective specialty College in Hong Kong. In case of doubt, prior approval from the College will have to be sought. Research positions must have prior approval of the College.

1.10.3 Elective options are subject to the following limitations:-
1.10.3.1 Not more than 12 months may be spent in research.
1.10.3.2 Not more than 6 months in any clinical specialties referred to under 1.10.1.4

1.11 The minimum period of hospital appointment for approved training is three months.

1.12 Vocational trainees shall undergo rotational training in accredited hospitals in approved rotation schemes/programmes endorsed by the College.

1.13 All trainees are required to carry out and submit a Project to the Education Committee to demonstrate an understanding of research and research methods in medical practice. The submitted Project must have received approval from the Education Committee before vocational

training is considered complete.

1.14 All trainees joining the training programme on or after 1st January 2005 are required to complete satisfactorily the EMAC (Effective Management of Anaesthetic Crisis) course or its equivalent.

1.15 Registered trainees may sit the Intermediate Fellowship examinations of the College at any time. The Final Fellowship examination may be taken after completing at least four years of approved training with at least three years of approved anaesthetic training.

1.16 If trainees fail to complete all requirements for Fellowship at the end of their six-year vocational training period, they are given a further period of three years to complete their Fellowship requirements without the need to occupy a training post. If they fail to complete Fellowship requirements within that time, they must rejoin the vocational training programme for at least one year and until completion of all requirements. During the three-year non-training period pending completion of Fellowship requirements, they must be in clinical appointments, otherwise they must be individually considered by the Education Committee.

1.17 Trainees who repeatedly fail at examinations should be counselled after every third attempt for the same examination or at the end of the six-year vocational training period if they have not completed all examination requirements.

1.18 Trainees who, for whatever reason, stop vocational training and restart training must not have an interruption of more than three years in order to have their previous approved training counted fully. The period of interruption must have been spent in clinical appointments. If these conditions are not fulfilled, their case will be assessed individually by the Education Committee.

1.19 Vocational trainees shall acquire their necessary clinical anaesthetic training experience at accredited hospitals within the rotation programme involving more than one accredited hospital.

1.20 Each vocational trainee shall keep a LOG BOOK in the approved format to document all cases handled. The HKCA electronic log-book will be compulsory for trainees receiving their training in Hong Kong with effect from July 2004. The log book should be audited by the Supervisor of Training of accredited hospitals at least annually to ensure adequate exposure to the various CORE and NON-CORE sub-specialties available in the hospital, having regard to the previous training experience of the trainee. The Supervisor of Training is responsible for the certification that the case load experience meets the requirements that may be stipulated by the Education Committee from time to time. The Log Book(s) will be subject to the scrutiny of the Education Committee on demand.

1.21 For the purpose of accreditation of training, individual hospitals shall be accredited for training in clinical anaesthesia referred to under 1.6.2 in the different CORE/NON-CORE subspecialties.

1.22 All trainees have to undergo regular In-Training Assessments (ITA) with effect from 1st July 2004, in accordance with Administrative Instructions for In-Training Assessment. This assessment complements formal College Examinations and is intended to focus primarily on the attainment of clinical skills, attitudes and behaviour for competent professional practice. The College designated specialist trainers and the Supervisor of Training will undertake ITA with formal documentation. All trainees should have completed ITA satisfactorily before being allowed to attempt the final fellowship examination or exit assessment. When a trainee consistently (2 or more unsatisfactory ITAs) performs below expected standard, not withstanding repeated documented attempts at remediation, the Education Committee needs to be consulted. The trainee can appeal to the College or the Hong Kong Academy of Medicine for any dispute of ITA.

2. FELLOWSHIP EXAMINATIONS

2.1 Candidates for all examinations must be Members and registered trainees of the College.

2.2 A candidate would only be considered for admission to the examination if his application to sit the examination is received together with the prescribed fees on or before the deadline for application to sit the examination, which shall not be more than eight weeks or less than three weeks before the date of the written examination. Late applications will not be considered.

2.3 There shall be at least one overseas external examiner at each examination at the invitation of the H.K. College of Anaesthesiologists.

2.4 Intermediate Fellowship Examination in Anaesthesiology

2.4.1 The Intermediate examination may be attempted at any time.

2.4.2 The Intermediate examination shall consist of written papers and oral examinations in the following subject areas:-

2.4.2.1 Physiology and Principles of Measurement

2.4.2.2 Pharmacology and Principles of Statistics

2.4.3 The oral examination shall be held after the written part of the examination. The interval between the two parts of the examination shall be determined by the Board of Examinations and shall not be more than eight weeks.

2.5 Final Fellowship Examination in Anaesthesiology

2.5.1 Candidates for the Final Fellowship examination must be a Member of the College and a registered trainee at the time of application. He/she shall also occupy an approved training position at the time of the examination, except for the provisions under Section 1.16 of the Vocational Training Programme.

2.5.2 Candidates must have completed at least three years of approved anaesthetic training at the time of the examination, and in their fifth or last year of vocational training, except for the provisions under Section 1.16 of the Vocational Training Programme.

2.5.3 The Final Fellowship examination shall consist of written, oral, and clinical examinations, the format of which will be determined by the College Council from time to time on the recommendation of the Board of Examinations. Candidates will be examined in all aspects of Anaesthesia and Clinical Practice.

2.5.4 The oral/clinical examinations shall be held after the written part of the examination. The interval between the two parts of the examinations shall be determined by the Board of Examinations and shall not be more than eight weeks.

3. ACCREDITATION

3.1 Members of the College, who fulfil all requirements for training and examinations as required under the applicable College Regulations & Bye-laws, are eligible to apply for Fellowship of the College subject to its Memoranda and Articles of Association.

3.2 The application by an eligible Member for Fellowship must be supported by two current Fellows of the College. The application shall be considered by the Board of Censors and the Council of the College in accordance with the Memoranda and Articles of Association and the Regulations & Bye-laws of the College then in force. The decision of the Council to elect such a Member to Fellowship or otherwise shall be final.

3.3 Fellows of the College are considered trained and qualified specialists in the specialty.

4. The contents of this document is taken from the relevant documents of the College for the guidance of trainees and Supervisors of Training. If any part of this document conflicts with the Memorandum and Articles of Association, Regulations & Bye-laws, and Administrative Instructions of the College, the latter documents shall prevail.

Footnote:
1: Please refer to the Appendix on Definition of subspecialty experience

Promulgated: January 1995
Revised: September 1997
Revised: February 2004

HONG KONG COLLEGE OF ANAESTHESIOLOGISTS

Definition of Subspecialty Experience

1. CORE SUBSPECIALTIES

1.1 Anaesthesia for general surgery /urology /gynaecology (500 cases)

- 1.1.1 At least 100 cases shall be at or above 65 years of age
- 1.1.2 General surgery refers to abdominal surgery, breast surgery, minor vascular procedures, lumps and bumps, plastic and other surgical procedures not included under other subspecialties. Abdominal surgery includes surgery for the gastrointestinal tract, hepatobiliary system, pancreas, adrenals and hernia. Minor vascular surgery includes varicose veins, arterio-venous fistulas, small AV malformations, embolectomies of peripheral arteries)
- 1.1.3 Urology includes all types of genitourinary surgery in male (surgery on prostate, bladder, ureter, kidney and penis) and urological procedures in females.
- 1.1.4 Gynaecological procedures include all procedures of general gynaecology, gynaecological oncology and urogynaecological procedures.

1.2 Anaesthesia for orthopaedics and traumatology (500 cases)

- 1.2.1 At least 100 cases shall be at or above 65 years of age
- 1.2.2 Includes a mix of joint replacement (hip, knee) surgery, spine surgery (laminectomy, spinal fusions, instrumentations of spine including scoliosis surgery), microvascular surgery, surgery for fractures and malignancies of bones / related tissues.

1.3 Obstetrics anaesthesia (100 cases)

- 1.3.1 Includes anaesthesia for operative delivery.

1.4 Obstetric regional analgesia (50 cases)

- 1.4.1 Only regional analgesic techniques are counted.

1.5 Neuroanaesthesia (100 cases)

- 1.5.1 Includes a mix of elective and emergency operations on or within the cranium, and on the spinal cord proper.
- 1.5.2 Interventional neuroradiological procedures can be counted.

1.6 Thoracic anaesthesia (50 cases)

- 1.6.1 Includes operations involving a thoracotomy (VAT or conventional), operations/ procedures involving the tracheobronchial tree below the vocal cord and the mediastinum.

1.7 Paediatric anaesthesia (100 cases of children ≤ 6 years, including neonates)

- 1.7.1 Includes all kinds of procedures for children

1.8 Anaesthesia for Head & Neck / ENT/ Oro-facio-maxillary (100 cases)

- 1.8.1 Head and Neck includes parotid, thyroid, parathyroid, larynx, pharynx, upper third of esophagus
- 1.8.2 Some experience in managing difficult airway is required in this subspecialty experience.

1.9 Emergency / trauma anaesthesia (500 cases)

- 1.9.1 Trauma anaesthesia includes the emergency management of poly-trauma patient at the AED or on-site.

1.9.2 Emergency anaesthesia includes anaesthesia for all types of emergency operations.

1.10 Acute pain management (300 patient-days)

1.10.1 Includes a mix of regional and parenteral techniques for providing acute pain treatment.

2. NON-CORE SUBSPECIALTIES:

Some experience in all of the subspecialties listed would be required. Trainees will be required to complete two modules from category 1 and a minimum of 20 cases from category 2.

2.1 Category 1 NON-CORE modules

2.1.1 Ophthalmic anaesthesia (50 cases)

2.1.1.1 All kinds of ophthalmic procedures with a mix of both intra-ocular and extraocular procedures

2.1.2 Day surgery anaesthesia (100 cases)

2.1.2.1 All kinds of procedures done on a day-stay basis

2.1.2.2 Some experience at the pre-anaesthetic clinic would be preferred. The number of patients seen at the pre-anaesthetic clinic will NOT be counted towards the 100.

2.1.3 Anaesthesia in non-operating theatre locations including but not limited to Organ Imaging Suite, Endoscopy Suite, Cardiac Catheterisation Laboratory, ECT (50 cases)

2.1.4 Pain medicine (50 chronic / cancer pain cases)

2.1.4.1 Includes a mixtue of old and new chronic and cancer pain pateints.

2.2 Category 2 NON-CORE Modules

2.2.1 Major vascular anaesthesia

2.2.1.1 Includes anaesthesia for surgery / minimally invasive proecdures on the aorta and other large arteries / vessels.

2.2.2 Cardiac anaesthesia

2.2.2.1 Includes operations involving the heart (open /closed) with or without the use of cardiopulmonary bypass.

2.2.2.2 Operations involving the pulmonary and other proximal vessels may also be counted.

2.2.2.3 A good mix of valvular, ischaemic open and closed heart procedures would be desirable.

2.2.3 Transplant anaesthesia

2.2.3.1 Includes the harvesting and grafting of major organs like heart, liver, lung and kidney.

2.2.4 Neonatal anaesthesia

2.2.4.1 All kinds of procedures being performed on the neonate.

2.2.4.2 Those anaesthetics counted towards the core paediatric anaesthesia category cannot be counted in this category.

3. As there might be some overlap in the definitions of various subspecialty categories, an operation may sometimes be classified under different categories by different trainees or supervisors. This overlap between different subspecialty categorieses although NOT intended is sometimes inevitable. In any case, double counting (a patient being counted under more than 1 subspecialties for the same operative theatre attendance) is strictly NOT allowed. In this instance, if a trainee has to administer an epidural anaesthesia for a parturient to whom an epidural catheter was inserted earlier by the trainee for epidural analgesia, two procedures will be counted.

First promulgated: February 2004

HONG KONG COLLEGE OF ANAESTHESIOLOGISTS

Transition Arrangements for change of Vocational Training Guide

1. The New Vocational Training Guide that counts subspecialty case exposure to document training experience (hereinafter referred to as "New VTG") will take effect on 1st January 2005. Those trainees joining the anaesthesia training programme on or after 1st January 2005 must follow the new VTG.
2. The designation of hospitals into Cateogry A, B or C will no longer exist on or after 1st January 2008. The VTG based on such a categorisation to document training experience (hereinafter referred to as old VTG) will hence cease to be effective on 1st January 2008. All trainees attending the Exit Assessment on or after 1st January 2008 will be assessed based on the new VTG.
3. Trainees joining the training programme between now and 1st January 2005 have to follow the new VTG, unless they have prior accreditated training elsewhere of more than 27 months* and they are very sure that they can complete all their fellowship requirements (including but not limited to training / examination / project requirements) and pass any of the Exit Assessments held before 1st January 2008.
4. Trainees who commence training# on or after 1st January 2002 (those currently in the first, second and third year of their vocational training*, out of the total of 6 years) have to changeover to the new VTG, as the likelihood of them completing all the fellowship requirements before 1st January 2008 is very remote.
5. Trainees who commence training before 1st January 2002 (those currently in the third, fourth, fifth or final year of training*, and those time-expired trainees) can opt to be trained under the old VTG or new VTG. As a lot of time is needed to accredit the past experience of current trainees and convert those into subspecialty experience, individual trainee may have to consider whether it is worthwhile to changeover to new VTG when they are approaching the end of their training.
6. College will issue all trainees who commence training before 1st January 2002 an option form to indicate whether they would opt to be trained under the new VTG. The duly completed option form has to be returned to College before the deadline. The deadline will be different for different batch of trainees. The general principle for setting the deadline is 1 year before expected date of completion of training. Due exceptions / discretions will be made to those who are completing or have completed the training.
7. The option to change to the new VTG, once exercised, is irrevocable.
8. A special one-off arrangement will be made for trainees commencing training before 1st January 2002 who have NOT opted for the new VTG because of the reasonable expectation of completing all fellowship requirements before 1st January 2008. To be eligible for this special arrangement, they must have completed the 6 years of accredited training on or before 1st January 2008, but not yet completing the other fellowship requirements. This group of trainees would be deemed to have fulfilled all the subspecialty requirements of the new VTG once their accredited training records received by College before 1st January 2008 have been assessed and approved.

9. College would try to work out all other forseeable problems that may arise during the transition from old VTG to new VTG as appropriate. In the event of other unusual circumstances that may arise from time to time, College will deal with those on a case by case basis.

10. For those trainees who wish to opt for the new VTG, they have to take note that it is the trainees' responsibility to have a proper documentation of their case experience in the log-book, electronic or otherwise. Trainees who wish to opt for the new VTG have to take all of the following steps:
    - 10.1 Return the option form before the deadline
    - 10.2 Ensure their log-book before 1st July 2004 is in proper order, in terms of documentation, the classification of experience according to the criteria laid down in the new VTG and the number of cases thereof in each subspecialty
    - 10.3 Get the respective Supervisors of Training to endorse the subspecialty experience before 1st January 2004 claimed, based on the properly documented log-book.
    - 10.4 Return all the endorsement forms to the College

11. Based on the duly endorsed forms returned to the College, the College Training Officer in conjunction with the Board of Education, will then accreditate the subspecialty training experience of trainees prior to the implementation of e-logbook (1st July 2004). A copy of the summative assessment will be sent to the trainee concerned, the respective SOT for records. A copy will also be kept by the College. It is not necessary to re-enter those back into the e-logbook.

#: "Commence training" is taken to mean the time of starting the first year of vocational training (out of a total of 6 years)

*: refers to the calculation on the date of promulgation of this document

Board of Examination

Successful candidates for the February/March 2004 Intermediate Fellowship Examination

Title	Name	Hospital
Dr	WONG Lai Sze, Grace	YCH
Dr	LO, Catherine	KWH
Dr	TONG Kam Chiu	KWH
Dr	LUI, Frances	DKH
Dr	NJO Kui Hung, Anthony	UCH
Dr	LEUNG Kam Kin	UCH

Six out of 15 candidates passed the examination. The College is grateful to Dr. Lesley Bromley of RCA, and Dr. Gillian Bishop of ANZCA for their assistance as External Examiners during the examination.

Court of Examiners, Intermediate Fellowship Examination, March 2004
(Left to right)Drs. Andrea O'Regan, Warwick Ngan Kee, Lesley Bromley (RCA), Gillan Bishop (ANZCA), PT Chui (Chairman), KK Lam (Coordinator, Intermediate examination), KF Ng and Gordon Jan.

PT Chui
Chairman, Board of Examination

Recruitment of Examiners

The Board of Examination needs new examiners from time to time. Interested Fellows can obtain the application form and information on duties of examiners, and criteria for appointment of examiners from the College office (Phone: 2814 1029, Fax: 2871 8833, Email: office@hkca.edu.hk,). Application form may also be downloaded from the College website www.hkca.edu.hk

Examination Dates, 2004

Intermediate Fellowship Examinations 2004
Examination Fee: $6,500

July / August	Date
Written	2 July 2004 (Fri)
Oral	13/14 August 2004 (Fri/Sat)
Closing Date	2 June 2004 (Wed)

Final Fellowship Examinations in Anaesthesiology 2004
Examination Fee: $10,000

July / August	Date
Written	9 July 2004 (Fri)
Oral/OSCE	27/28 August 2004 (Fri/Sat) ± 29 Aug (Sun)
Closing Date	9 June 2004 (Wed)

Exit Assessment Date for Year 2004
Examination Fee: $5,000 for Fellow *ad eundem*

08 July 2004 (Thu)
07 October 2004 (Thu)

*Trainees who are qualified to apply for fellowship are recommended to have their respectively applications received at the HKCA office **at least 21 days before** the scheduled Exit Assessment dates, to allow ample time for processing.*

Board of Censor

Admission to Fellowship by Examination, FHKCA

POON Ho Yan
LEE Sumin
LAW Cheuk San

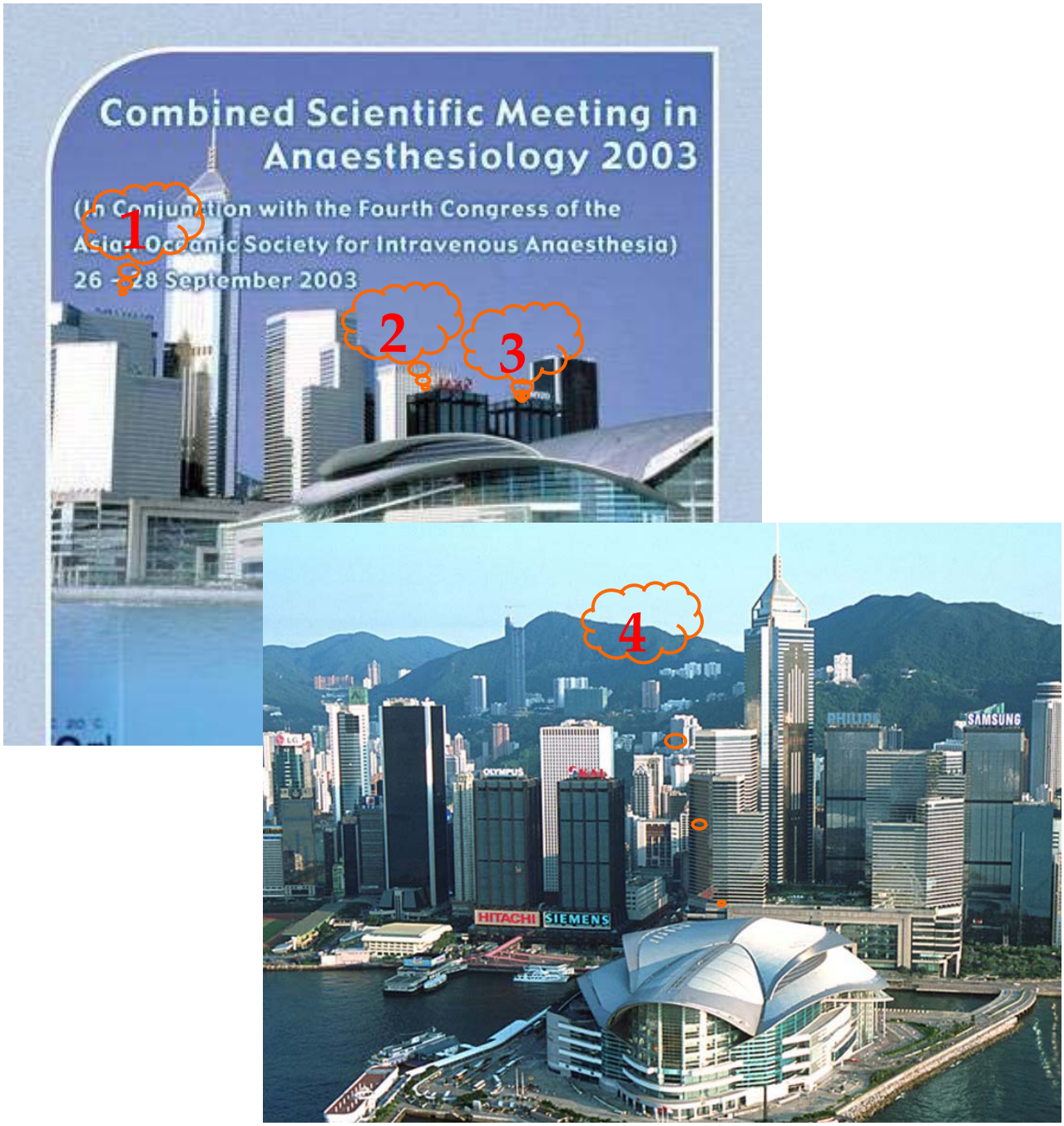
New Members

TAM Lee Ka
MAN Chi Ning

Michael Irwin
Chairman, Board of Censor

What's wrong with this flyer?

Answer: This is a stereoisomer (mirror image).
There were lots of entries. However, there is no answer that correctly pointed out all four errors. We appreciate your effort and hope you enjoy this exercise. Please join us again in the near future. The prize (worth HKD 1,000), donated by GSK, Hong Kong, will now go to the next exercise.



Coming events …

What's on the New VTG, eLog Book…?

Briefing with Supervisors of Training

Date: Saturday 22nd May, 2004
Time: 10:30 - 12:30 AM
Venue: Queen Elizabeth Hospital
Block M, Ground floor, Room 1

Briefing with Trainees

Date: Saturday 5th June, 2004
Time: 10:30 - 12:30 AM
Venue: Queen Elizabeth Hospital
Block D, Ground floor, Conference Room

Combined Scientific Meeting 2004

Jointly organized by Hong Kong College of Anaesthesiologists, Hong Kong Society of Critical Care Medicine and Hong Kong Society of Anaesthesiologists

13-14 November 2004

Confirmed international Intensive Care faculty
- Professor John Marshall, Toronto
- Professor Mervyn Singer, London
- Dr Steve Webb, Australia
- Dr Ross Freebairn, New Zealand

Annual General Meeting 2004
Hong Kong College of Anaesthesiologists

Date: 21 June, 2004
Venue: To be announced
Speaker: Professor Tong Gan
Department of Anesthesiology,
Duke University Medical Center,
Durham, North Carolina.

Sponsored by

WORKSHOPS ORGANISED BY THE INSTITUTE OF CLINICAL SIMULATION
A Collaboration between the Hong Kong College of Anaesthesiologists and the North District Hospital

Anaesthetic Crisis Resource Management (ACRM)

Date:	First Saturday of each month - slots available from February 2004 (1 May, 5 June, 3 July, 7 August, 4 September, 2 October, 6 November and 4 December, 2004)
Time:	08:00 – 18:00
Venue:	Institute of Clinical Simulation
CME points:	HKCA 10 points
Max participants:	4
Fee:	HK$2000 per head
Format:	Each registrant will participate in (1) An introduction on the METI Simulator, the anaesthetic machine for use in the workshop and the theories of crisis management (2) Allocated time for hands-on crisis scenario management on the METI Simulator, rotating through different roles and handling different scenarios (3) A group debriefing session at completion of each scenario

"Group" registration welcome if you can find your own partners to form a group of four. Mutually agreed dates may be arranged. Sessions will be videotaped. All participants in the workshop will be required to sign a confidentiality statement.

(Application form can be downloaded from the College website: *www.hkca.edu.hk*)

Recent Meetings: Anaesthesia, Intensive Care & Pain management

Local meetings 2004

8 - 11 May

HONG KONG SARS FORUM AND THE HOSPITAL AUTHORITY CONVENTION, 2004
Theme: Changing for Sustainability; Venue: Hong Kong Convention & Exhibition Centre; Contact: Secretariat, Tel: 2300 6808 Fax: 2895 0937 Email: hac@ha.org.hk; Web:www.ha.org.hk/haconvention/hac2004/

19-20 June

ADVANCE IN MEDICINE 2004
Venue: Hong Kong Convention & Exhibition Centre, Contact: Department of Medicine & Therapeutics, CUHK, Contact: Tel: 2632 3996; Fax: 2637 3852; Email: suzanne-ng@cuhk.edu.hk

21 June

ANNUAL GENERAL MEETING, HONG KONG COLLEGE OF ANAESTHESIOLOGISTS
Venue: to be announced, Contact: Mr. Daniel Tso, Phone: 2871 8833. Fax: 2814 1029, Email: office@hkca.edu.hk, website: www.hkca.edu.hk

17 - 18 July

9TH HONG KONG MEDICAL FORUM (HKMF 2004)
Venue: Hong Kong Convention & Exhibition Centre. Contact: Executive Officer (Conference & Communications), University Department of Medicine, Tel: 2855 4607, Fax: 2816 2863, Email: medinfo@hku.hk, Web site: www.hku.hk/medicine/

9-11 July

HONG KONG SURGICAL FORUM - JULY 2004
Venue: Lecture Theatre, Professorial Block,Queen Mary Hospital, Phone:2855 4885 Fax:2819 3416 Email:hksf@hkucc.hku.hk; Web: www.hku.hk/surgery

16 August

NEUROCHEMCIAL MONITORING SYMPOSIUM, ICP 2003
Venue: Postgraduate Education Centre, Prince of Wales Hospital. Contact: Division of Neurosurgery, Department of Surgery, The Chinese University of Hong Kong, Tel: 2632 2951, Fax: 26473074, Email: icp2003@cuhk.edu.hk, website: www.surgery.cuhk.edu.hk/icp2003

17 - 21 August

TWELFTH INTERNATIONAL SYMPOSIUM ON INTRACRANIAL PRESSURE AND BRAIN MONITORING, ICP 2003
Theme: to bring research findings into clinical practice. Venue: Hong Kong Convention & Exhibition Centre. Contact: Division of Neurosurgery, Department of Surgery, The Chinese University of Hong Kong, Tel: 2632 2951, Fax: 26473074, Email: icp2003@cuhk.edu.hk, website: www.surgery.cuhk.edu.hk/icp2003

13-14 November

COMBINED SCIENTIFIC MEETING 2004
Jointly organized by Hong Kong College of Anaesthesiologists, Hong Kong Society of Critical Care Medicine and Hong Kong Society of Anaesthesiologists
Venue: Hong Kong Convention & Exhibition Centre

Overseas Meetings 2004

Perth
Western Australia
1 - 5 May

2004 ANZCA ASM
Venue: Perth Concert Hall and Duxton Hotel. Contact: Katie Clarke, Congress West, 3/12 Thelma Street, West Perth WA 6872. Tel: 08 9322 6906 Fax: 08 9322 1734 Email: conwes@congresswest.com.au

Lisbon
Portugal
5 - 8 June

EUROANAESTHESIA 2004, 12TH ANNUAL MEETING OF THE EUROPEAN SOCIETY OF ANAESTHESIOLOGISTS AND 26 ANNUAL MEETING OF THE EUROPEAN ACADEMY OF ANAESTHESIOLOGY
Venue: Lisbon. Contact: ESA, 32 ave de Tervuren bte 30, 1040 Bruxelles, Belgium. Tel: 32 02 743 32 90 Fax: 32 02 743 32 98 Email: secretariat.esa@euronet.be

Quebec
Canada
18 - 22 June

CANADIAN ANAESTHESIOLOGISTS' SOCIETY ANNUAL MEETING
Venue: Convention Centre, Hilton Hotel, Quebec. Contact: Canadian Anaesthesiologists' Society, Susan Wilson, 1 Eglinton Ave, Suite 208, Toronto ON M4P 3A1. Tel: 416 480 0602 Fax: 416 480 0320 Email: meetings@cas.ca Website: www.cas.ca

Sydney
Australia
18 - 22 September

63RD NATIONAL SCIENTIFIC CONGRESS OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS
Venue: Sydney Convention and Exhibition Centre. Contact: ICMS, GPO Box 2609, Sydney NSW 2001. Tel: 02 9241 1478 Fax: 02 9251 3552 Email: asa2004@icmsaut.com.au

Melbourne
Australia
7 - 10 October

29TH AUSTRALIAN AND NEW ZEALAND ANNUAL SCIENTIFIC MEETING ON INTENSIVE CARE
Venue: Melbourne Exhibition and Convention Centre. Contact: The Meeting Planners, 91-97 Islington Street, Collingwood VIC 3066. Tel: 03 9417 0888 Fax: 03 9417 0899 Email: asm@meetingplanners.com.au Website:www.anzics.com.au/asm

Las Vegas
USA
23 - 27 October

AMERICAN SOCIETY OF ANESTHESIOLOGISTS ANNUAL MEETING
Venue: Las Vegas. Contact: ASA Executive Office, 520 N. Northwest Highway, Park Ridge, IL 60068-2573. Tel: 1 847 825 5586 Fax: 1 847 825 1692 Email: mail@asahq.org Website: www.asahq.org/AnnMtg

New York
USA
10 - 14 December

NEW YORK STATE SOCIETY OF ANESTHESIOLOGISTS 58TH POSTGRADUATE ASSEMBLY IN ANESTHESIOLOGY
Venue: New York Hilton Hotel, New York. Contact: NYSSA, Kurt G. Becker, 360 Lexington Ave, Suite 1800, New York NY 10017. Tel: 1 212 867 7140 Fax: 1 212 867 7153 Email: kurt@nyssa-pga.org Website: www.nyssa-pga.org

Formal Project

New Submission Procedure

In the past, anesthetic trainees enrolled in the HKCA and ANZCA programs are required to submit their formal projects to both project officers. Although discouraged, this was often done sequentially. This has resulted in confusion and many projects had been marked twice.

In order to improve resource utilization and to maintain a central database, we now required all trainees (registered with either HKCA or ANZCA or both programs) to submit their formal project proposal or manuscript to Mr. Daniel Tso (office@hkca.edu.hk), Administrative Executive, HKCA.

Mr. Daniel Tso, AE, HKCA, Room 807, Hong Kong Academy of Medicine Building, 99 Wong Chuk Hang Road, Aberdeen, Hong Kong Phone: (852) 2871 8833. Fax: (852) 2814 1029.

This new arrangement will be effective as of 1 July 2004.

Whenever possible, trainees should submit their project **electronically, as an email attachment**. Text files should be written in Word or pdf format (PC or MAC). Figures and photographs should be saved in separate files.

The title of the email should be "Formal Project (name of the trainee)". In addition, **the following data must be included in the email message:**

1. Applicant (Principal Investigator)
   (a) Name: _____
   (b) Phone no: _____ Fax no: _____
   (c) Hospitals where project is (to be) done: _____
2. List all co-investigators: _____
3. Project Title: _____
4. I am currently enrolled in the HKCA / ANZCA / Both program(s) (delete as appropriate)

The project will be assessed according to the existing guidelines published by the corresponding Colleges, HKCA (Guidelines for completion of the formal project. Approved 1995) and ANZCA TE11 (2003)

If you have query or difficulty in putting your project electronically, please contact Mr. Daniel Tso.

Dr. KF Ng
Formal Project Officer, HKCA

Dr. Matthew Chan
Formal Project Officer, RTCHK, ANZCA

Approved Formal Projects

LEE Sumin "A prospective evaluation of health related quality of life in Chinese patients with chronic non-cancer pain"

UNG Sze Man, Eric "Percentage of shunt after the aortic cross-clamp is released in Coronary Artery Bypass Graft Surgery: Is it necessary to ventilate the lungs before separation from Bypass?"

LEE Yeuk Ying, Samantha "Dexmedetomidine infusion as supplement in isoflurane anaesthesia for intraocular surgery"

KWOK On Ki "Airway Obstruction following Carotid Endarterectomy."

Revision Tutorial Course for Clinical Anaesthesiology 2003/04

This Revision Course for our Final candidates was held from 4th to 10th January 2004 at QEH. This is the second consecutive year where Professor Peter Kam (St George Hospital, Sydney, Australia) kindly took up the tutorship, and extended his assistance from our Primary to the Final candidates in their preparation for the examinations.

Peter had a very busy month as he just finished tutoring our Primary candidates in a 2-week full-time revision course; he made a quick trip back to Australia for a fortnight before returning to Hong Kong. Peter picked up a cold on his way, no doubt he was concerned whether it could have been the Avian flu or even SARS! Fortunately, he made a speedy recovery and the course proceeded as scheduled.

This intensive 6-1/2 day course consisted of informative/ interactive lectures, tutorials, short questions practices, revision on anatomy & viva sessions. Like last year, the applications were overwhelming, but we could only accept a maximum capacity of 30.
Overall, the feedbacks from trainees were positive. Many found it extremely helpful in identifying their own areas of deficiency, and as a revision guide in the limited time before the examination. Hopefully, together with the Crash Course in March/April, the participated candidates will find them helpful to reach their goal – passing the exams!

Douglas Fok
Course Coordinator

Obituary

Professor TAN Sri G.B. ONG,

OBE, DSc, MD, FRCS, FACS, M.S.

That the late Professor Ong, who died on January 10th, 2004 was regarded as a pioneer and giant among surgeons everywhere and also as the one who is reputed as having put Hong Kong on the "World's surgical map" is generally well known. What is, perhaps, less well known is: what was his attitude – and opinion of – anaesthesia and anaesthesiologists? Writing as an anaesthetist who had the opportunity, pleasure and, indeed, the privilege of working with Dr.– later Professor–Ong during Prof. Ong's most active and creative years (1954-1982) when he first as Medical Officer, later as Consultant Surgeon, and still later as the first Hong Kong University's medical graduate to be appointed as Head of – and Professor in the Department of Surgery, the University of Hong Kong started attracting – at first attention – later recognition and admiration – for his many original and inventive surgical procedures, I consider myself sufficiently qualified to express my thoughts on the matter. In his long and distinguished surgical career he would have experienced countless occasions of feeling various degrees of happiness and among other matters – also with the standard and quality of the anaesthesia provided for his patients and for his operations. He always expected the best, but this may not have been available at all times. I have it on good authority (his own) that as a newly qualified doctor he was posted as a House Officer to Dr. John (Jack) Gray, M.D.FRCS– the acting Head and Professor, Department of surgery, the University of Hong Kong at the Queen Mary (teaching) Hospital. (Incidentally Prof. Ong regarded Jack Gray very highly and thought of him as his mentor) One day a patient with advanced Pulm. TB (which at the time–the late 1940s was quite rampant in Hong Kong). The then anaesthetist was not able to pass an endotracheal tube. As the operation (thoracotomy and lobectomy) was considered essential, it was decided to give this patient a unilateral "spinal (high) block" (certainly a lesser choice today). Once anaesthesia was established, the operation (thoracotomy) was commenced and the procedure speedily – and nearly bloodlessly – completed swiftly. As would be expected the patient's blood pressure had plummeted to alarming levels and the young medical officer (Dr. G.B. Ong – who had assisted on this occasion) had to spend the rest of the day and all night trying to resuscitate the patient. As this incident occurred before the introduction of monitors and in the absence of all the paraphernalia the "intensivists" have at their disposal these days, and when the term "I.C.U.", "C.C.U." was not even thought of (the Hong Kong Society of Critical Care Medicine was established only in 1983), Prof. Ong may be the first practitioner to have employed Intensive Care (of a kind) in Hong Kong[1] and there was a good outcome, as the patient survived.

His original thoughts and concepts were gaining the attention – leading to admiration - of local and international surgical communities. The accuracy, alacrity and even speed of his (many) original surgical procedures were astonishing. Thus on one occasion (when Prof. Ong was still a surgical consultant with the Medical and Health Department of Hong Kong Government and operating in the "Old Kowloon Hospital"), the Doyen of British (and World) Anaesthesia – Sir Robert Macintosh, who was visiting and staying with this writer, having heard in Oxford (his home base) of Ong's fame, wished to see and witness the then Dr. Ong's operative technique. Sir Robert was himself going to demonstrate his method of anaesthesia (using the Mitchell needle (intravenous) and the E.M.O. (Epstein Macintosh Oxford) vaporizer and the Oxford bellows) on the second patient on the list – a hernia repair. Sir Robert, having planned and intended watching Prof. Ong's operation –Thoracotomy –Ligation and Division of Patent Ductus Arterious on a 7 year-old girl and noticing that this had not started yet, excused himself saying he has ample time to adjourn to the "Anaesthetic Room" to prepare his "tools" for his demonstration and draw up the drugs. When Sir Robert returned to the Operating Theatre about twelve minutes later, Prof. Ong was seen handling the skin incision. "Good!" said Sir Robert, "I see you are just getting in". "So sorry!" said Prof. Ong "we are just closing the skin". So regrettably, Sir Robert missed Prof. Ong's demonstration (he witnessed others, though) but had proof, if proof was needed, of Prof. Ong's alacrity, and expressed his amazement at the speed the procedure was carried out and his regret of having missed it.

Prof. Ong was not always an easy taskmaster. It required considerable effort, skill and experience to provide acceptable anaesthesia for his numerous – including major and pioneering – surgical operations. Nevertheless his attitude to anaesthesia and anaesthetists (and on occasions there would appear some "fission" between him and anaesthetists) can be summarized, on the whole, as positive. He was one of the very first to join the fledgling Society of Anaesthetists of Hong Kong (SAHK) when it was bounded (by Lett and Ozorio)[2] in 1954. He continued supporting the Society, attending its meeting whenever his busy schedule would permit. He was also very helpful and instrumental in arranging – and facilitating – the Faculty of Anaesthetists of the Royal Australasian College of Surgeons (FARACS) in their Asian rounds of examinations – the Primary, for which he would have been examining in Anatomy, had this remained an examination subject and later also the Final. His personal friendship with the then Dean of the Faculty, Dr. N.M. Cass(who was also Chairman of the Board of Examinations), Prof. John Mainland, Maurice Sando and Prof. Laventhal, President of the College were very good "props".

Anaesthesia had not been independent in the realms of the Medical Faculty (the University of Hong Kong). It was under the aegis of the Department of Surgery, where, as the Head of the Department, he and later also his successor Prof. John Wong strived to have anaesthesia promoted to an independent department. Thus, they managed to accomplish (1987).

Prof. Ong was a unique surgeon. His knowledge of anatomy (including surgical) was phenomenal. He had about him an "aura" which could be felt in his presence, particularly in the operating theatre. When he entered, a certain "atmosphere" set in. It was well known that he did not tolerate fools gladly, be it anaesthetists, nursing staff, operating theatre attendants, photographers (in OT) and even his own staff. His great surgical achievements, his grasp and surgical "knack", his legacy, his untiring concern for his numerous patients, his devotion to all the minutiae of his medical-surgical life are being (and will continue being) praised and commented on ever elsewhere. As a host and friend, his generosity and hospitality were

legendary. In fact it would be quite safe to say that Prof. Ong had–during his blessed lifetime – become a "living legend".

As the anaesthetist at (or near) the head, sitting (or sometimes standing) there during Prof. Ong's surgical interventions, I found myself in the unique position to hear the comments by the many visiting "greats" of the surgical world. These were often addressed to me, sometimes they were just muttered to themselves, but audible by me. They included "meticulous technique" …"dazzling" ..."most impressive" ... "fantastic speed" … "precious" …"accuracy" … "control" … "phenomenal dexterous" … "a revelation", just to quote a few. I could– and can– but concur with such sentiments. With Prof. Ong's passing, the Surgical Firmament has been deprived of one of its brightest Stars. Can it ever be replaced? To his grieving family, my heartfelt condolences and deepest sympathy.

Z. Lett, MD, FHKCA, FHKAM, FRCA, FFARCS(Irel), FANZCA, D.A. (RCP &SI)

References :

(1) Lett Z. 1982 Anaesthesia in Hong Kong: Evolution and Present Position. Centre of Asian Studies, the University of Hong Kong
(2) Lett Z. Lo RJW. 1997. Anaesthetic and Intensive Care in Hong Kong. Centre of Asian Studies, The University of Hong Kong

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