THE HONG KONG COLLEGE OF ANAESTHESIOLOGISTS
香 港 麻 醉 科 醫 學 院

NEWSLETTER
September 2004

In this issue ...

Volume 13 Number 3

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

In response to popular requests, the Newsletter is pleased to bring to you a series of articles on anesthetic practice in different part of the world. In this issue, Dr. Henry Liu, a successful anesthesiologist of Chinese origin, will report to you what is happening in the USA. Another fellow, Dr. Carolyne Chau will describe the way as how to get a job in Australia. I hope these articles are stimulating and are informative to those who are finishing their 6-year contracts with HA, and are thinking of working aboard.

Finally, if you wish to share your experience with our fellows and members, please write to us. Please also visit the College website for the latest information.

Matthew Chan
Editor-in-Chief

The Editorial Board

Email: hkeditor@hkca.edu.hk

Address: Department of Anaesthesia and Intensive Care,
Chinese University of Hong Kong, Prince of Wales Hospital,
Shatin, NT, Hong Kong

Phone: 2632 2894

Fax: 2637 2422

Featured article

An overview of anesthesia practices in the USA

Henry Liu, M.D.
Parish Anesthesia Associates, Metairie, Louisiana

Anesthesia as a medical specialty is unique. An anesthesia team must work very closely with the surgery team and the Operating Room (OR) nursing team. Also, the practice of anesthesia involves many monitors and equipment and uses many different medications for each case. Anesthesia providers witness numerous physiological and pathophysiological changes and manipulate these changes over a relatively short period of time surrounding surgery. As anesthesiologists, we are in a unique position to take care of patients. I have practiced anesthesia in the USA for nine years, in addition to 8 years as a surgeon in both China and the USA. My personal experience shows that practicing anesthesia in the USA can be very rewarding.

Abbreviations:

CRNA:	Certified Registered Nurse Anesthesiat
AA:	Anesthesiologist's Assistant
CMS:	Centers for Medicare and Medicaid Services
HCFA:	Health Care Finance Administration
CF:	Conversion Factor
CPT:	Current Procedural Terminology
ASA:	American Society of Anesthesiologists
SCA:	Society of Cardiovascular Anesthesiologists

Anesthesia practices in the USA hail from several decades before Dr. Crawford Long's first general anesthesia in Georgia in 1842 and Dr. William Morton's public performance of inducing anesthesia by ether in 1846 at the Massachusetts General Hospital[1,2]. The first academic anesthesia department in the USA was started by Dr. Ralph Waters at the University of Wisconsin in 1927; and for the last 160 years, anesthesia practices have been evolving and growing not only in the USA but also everywhere else in the world. Anesthesia in the United States is now a separate medical specialty with many subspecialties, which include general anesthesia, regional anesthesia, critical care medicine, office-based anesthesia, intraoperative laboratory diagnosis, intraoperative transesophageal echo-cardiography, acute and chronic pain management.

In 2003, there were over 39,000 members in the American Society of Anesthesiologists (ASA). The true total number of anesthesiologists is difficult to estimate, because there are many practicing anesthesiologists who are not ASA members. There are over 100 anesthesia residency programs in the USA, training about 1,343 residents per year[4]. Anesthesia residency in the USA requires a minimum of four years' training, including one year of clinical base training and three years of clinical anesthesia training. Clinical base training may be in any clinical specialty. Clinical anesthesia training should include rotations to all anesthesia-related subspecialties. Every six months during residency training, the Clinical Competence Review Committee reviews each trainee's clinical performance. If a trainee is believed clinically incompetent, he or she must repeat one year at the same training level. Also, all the trainees are required to take an in-service examination each year. After three years of clinical anesthesia training, the finishing residents will take a written board examination. If they pass, they will be able to take the oral board examination after approximately one year. If they pass both the written and the oral board examinations, they are issued their board certificates. After completing residency, anesthesiologists may choose to pursue their fellowship in order to be more specialized in one or more anesthesia subspecialties. Membership in the American Association of Nurse Anesthetists (AANA) reached 35,052 in 2004. The total number of Certified Registered Nurse Anesthetists (CRNA) is slightly more than 35,052. Schubert, *et. al.*, assumed that about 600 anesthesiologists retire each year[5]; however, this estimate appears rather low. Dr. Grogono believes that the retirement rates are actually around 1,000 per year[4]. Currently, in the USA, 26% of anesthesia practices are physician anesthesiologists only; 41% are physicians and CRNAs, with physician employing CRNAs; 19% are physicians and CRNAs, but hospitals employing CRNAs; and 14% are a combination of the above.

Political considerations

Dealing with the government is part of our daily business. The federal government determines how much the Center for Medicare and Medicaid Services (CMS, which manages Medicare or Medicaid) reimburses us for our services to the patients covered by these two federal programs. For the majority of anesthesia practices, about half of their patients are covered by these two federal programs. To protect our interests, we have to negotiate with the government to secure a fair reimbursement rate and prevent any unfair changes. The federal government has designated the CMS to manage the two federal

Dr. Henry Liu is the Medical Director of Anesthesia Services, West Jefferson Medical Center, Louisiana, and staff anesthesiologist of Parish Anesthesia Associates, Louisiana. Parish Anesthesia Associates

Address correspondence to: Dr. Liu, M.D., 29 English Turn Drive, New Orleans, LA 7013, USA, Email: gasliu@cox.net

programs. (The old name for CMS is the Health Care Finance Administration or HCFA). The CMS determines the Conversion Factor (CF) and CPT (Current Procedural Terminology) code for all medical specialties. CF and CPT are the two leverages that the CMS uses to manipulate physician compensations. CF is calculated using a very sophisticated mathematical formula taking into account a physician's work, expenses, malpractice premium, geographical location, and so on. The CF for anesthesia in 2003 was $17.05/unit; the CF for anesthesia in 2004 was initially $16.43/unit and later revised to $17.5/unit, after ASA launched very aggressive lobbying efforts. However, there has been a 4.5% overall drop in CF for all medical specialties in 2004. The CF for anesthesia also varies widely between different geographical locations. Alaska has the highest CF, with $29.22/unit; Puerto Rico the lowest, with $15.71/unit. Louisiana's CF is $17.67/unit and the national average is $17.5/unit. There are many instances where negotiating with the government brought about favorable results. For example, off-pump coronary artery bypass grafts (OP-CABG) are well known to anesthesia community to be more labor intensive than on-pump CABG. In order to receive more compensation for OP-CABG, ASA and the Society of Cardiovascular Anesthesiologists (SCA) lobbied Congress and the CMS very aggressively - and succeeded: the CMS agreed to set up a new CPT code which allowed greater reimbursement for OP-CABG than for traditional on-pump CABG. The CMS also, at one point, had refused to pay for intraoperative TEE (transesophageal echocardiography) services; after the SCA and ASA fought against this decision, the CMS reversed it. These examples demonstrate that "the more you take part in government, the less government will take part of you"[6]. In fact, some anesthesiologists, tired of trying to influence politicians, became politicians themselves. Dr. Andrew Harris, originally an Obstetric anesthesiologist from Johns Hopkins University, became a very influential state senator in Maryland. Dr. Tom George was elected a senator of Michigan; Dr. Kyle Janek, a senator of Texas; and Dr. Sam Page, a state representative of Missouri.

Medical malpractice insurance has been in a crisis in the USA. Many physicians cannot afford malpractice insurance and consequently are forced to leave their practice. This medical malpractice crisis has caused huge problems in health care in the US; for example, the University of Nevada Medical Center closed its trauma center for 10 days in 2003; Houston's Spring Branch Medical Center no longer delivers babies; Thomas Jefferson University's Methodist Hospital in Philadelphia has closed its Labor and Delivery Unit completely; and in New Jersey, 65% of the hospitals claim they are losing doctors. The state of Mississippi may have the worst malpractice insurance situation in the US. A general surgeon from Memorial Hospital of Gulfport is obligated to pay around $170,000/year for malpractice insurance alone. Mississippi has already lost 30-40% of its doctors in the last 5 years. The reason is obvious: there are too many lawsuits in the state. Jefferson County in Mississippi has only 9,740 residents; but they have had 21,000 plaintiffs from 1995-2000. Most counties in Mississippi must then cope with a severe shortage of physicians. In Yazoo City, there are 14,550 residents, but no practicing obstetrician[7]. Mississippi has become a sort of Mecca of medical lawsuits, since lawyers there may sue physicians without their patients' knowledge[8]. Professional liability insurance premiums for anesthesia practice range from $7,216 to $124,598, while the national average stood at $21,351/year in 2003[9]. Florida has the highest premium for anesthesia malpractice insurance. Our own group in Louisiana pays around $25,000/year for each physician anesthesiologist. So how can we solve this problem? There can be no easy solution, an individual state cap, a national cap, or something else? (Cap means the highest award to a winning medical lawsuit). There are some states in which a state cap has been adopted and it seems that cap helps medical malpractice insurance. A national cap on medical lawsuit award may offer the following benefits: limiting the total compensation for medical lawsuits; changing patients' lottery mentality; and significantly cutting the lawyer's potential profit in a winning case. The government could also restrict Medicare/Medicaid patients from suing government facilities.

The relationship between physician anesthesiologists and CRNAs has been very tricky. In some areas, this relationship is very tense, and they may fight fiercely. As you may know, some CRNAs in the USA have been seeking independence from physician supervision for many years. When I was in Utah and now in Louisiana, I have been one of the representatives of physician anesthesiologists went to state government to testify that physician supervision is necessary when CRNAs administer anesthesia. We simply reinstate the fact that "practice anesthesia is practice medicine, so we need a medical doctor". The AANA argues that, technically, practicing medicine must involve diagnosis and treatment, whereas anesthesia is simply "put patient to sleep and wake them up". They ignored the very important fact that practicing anesthesia involves many diagnoses and treatments preoperatively, intraoperatively, and postoperatively. Influenced by the very assertive lobbying efforts of the AANA, Congressman Jim Nussle (R-IA) introduced the Anesthesia Service Protection Act of 1999 (HR 804) to end physician supervision for CRNAs when they are administering anesthesia. Then the Safe Seniors Assurance Study Act by David Weldon (R-FL) asked the CMS (then the HCFA) to conduct a study to look into the difference(s) between mortality and morbidity between physician anesthesiologists and CRNAs. So Dr. Silber from the University of Pennsylvania conducted a study and found that physician anesthesiologists have significantly less morbidity and mortality compared to CRNAs only[10]. This study has been widely quoted since it is published in 2000. To counterbalance Dr. Silber's study, an attorney working for the AANA analyzed government statistics and concluded that there is no difference in terms of anesthesia mortality between physician anesthesiologists and CRNAs[11,12]. Current federal law states that, *at the federal level*, CRNAs are not required to be under physician supervision during anesthesia administration, the final decision rests with the individual state governments. In accordance with this rule, several states have already opted to remove the requirement of physician

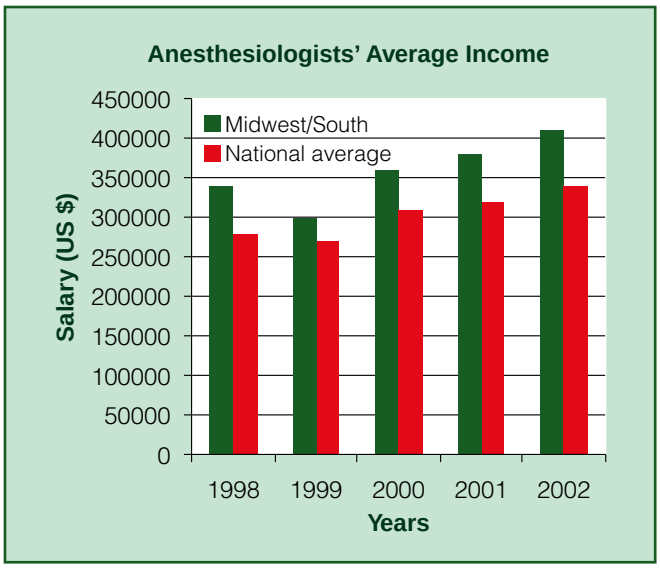
supervision; these states include Iowa, Idaho, Nebraska, Minnesota, New Hampshire, and New Mexico. However, even in these states, most hospitals still require CRNAs to be supervised by physician anesthesiologists if they are to administer anesthesia.

The Anesthesiologist's Assistant (AA) program has been gaining more support in recent years. Most anesthesiologists support AAs; however, most CRNAs oppose AAs, because they consider the AAs in competition with themselves for jobs. According to the states of Georgia and Ohio, as long as physician anesthesiologists closely supervise AAs, the quality of care that AAs provide has no significant difference from that of CRNAs; but hospitals may be able to cut their anesthesia expenses to some extent by using AAs instead of CRNAs. MD anesthesiologists may also use AAs to counterbalance the CRNAs' strong lobbying efforts against the rule of physician supervision. AAs, who are not required to have any healthcare training or experience before they enter the AA training program, have a very limited scope of anesthesia practice, since they are required by law to administer anesthesia only under the close supervision of a physician anesthesiologist. They cannot act independently in an emergency situation and they may not be deployed in military situations without anesthesiologists, although Tricare (a health care system mainly for military personnel) does allow AAs to practice in military health care and VA hospitals. The following states now issue licenses to AAs: Georgia, Ohio, Florida, Vermont, Colorado, and Louisiana; but there are only two AA schools in the USA: one in Georgia, the other in Ohio.

The relationship between anesthesiologists and surgeons is usually good. But there are occasions where an anesthesiologist may have a conflict with a surgeon regarding patient management, or other such issues. The surgeons must realize that they rely on anesthesiologists to manage many perioperative issues for surgical patients, such as their cardiovascular status, homeostasis, and pain management.

The financial considerations

The following figure shows the average income for anesthesiologists in the USA[13]. The averages for the Midwest and South are almost always higher than the national average. The lowest averages occur around the west coast and northeast regions.



The payer mix is very important to anesthesia practice. Anesthesia groups can get much better reimbursement for their anesthesia services if their patients have good private insurance; if they take care of only Medicare/Medicaid patients, they will find it much more difficult to survive the current tough medical environment without government/hospital subsidization. Unfortunately, many hospitals are struggling for just this reason. Charity Hospital in New Orleans, King's County hospital in New York, and Grady Hospital in Atlanta are just a few examples of those hospitals. So how anesthesia practice can secure support from the government or other sources becomes critical. For hospitals like those listed above, which are government facilities and clearly depend on government support, getting said support is not difficult, but the amount of support becomes the issue. For some hospitals, which have an unfavorable payer mix and are not government facilities, government support is usually unattainable. Anesthesia providers in this kind of hospital must work on hospital or community support, or support from other sources. Private insurance payments for anesthesia service stands at $50.55/unit ($26-$105), compared to Medicare/Medicaid's payment of $17.05/unit (13.03-18.77) in 2003 and $17.5/unit in 200414. In order to improve anesthesia reimbursement, anesthesia providers need to keep track of everything that is done to and for their patients; they also need to keep up with coding updates. Fraudulent billing to Medicare/Medicaid (or private insurance) is another major problem. Although federal law states that fraudulent billing can bring the offender up to 9 years in prison, a New York psychiatrist billed Medicare for seeing patients 24 hours a day, 365 days a year; and a Louisiana pulmonologist managed to overbill Medicare for over $1 million in four years.

The professional considerations

Anesthesia practice in USA can be categorized into three different types: academic practice, private practice, and locum tenens practice. Academic practice includes practice in university hospitals or in other academic institutions in which practitioners usually hold an academic appointment; this kind of practice usually provides more stable jobs and relatively fewer headaches for contract negotiation, and teaching can be rewarding and self-satisfactory for some practitioners. However, there are disadvantages for academic practice also. It generally offers a lower income than does private practice and bears academic pressures for promotion. Private practice includes practice in facilities without teaching activities and no academic promotion issues, such as in community hospitals and private clinics. Private practitioners usually enjoy better incomes, less or no academic pressure, more vacation time, and relatively better retirement packages. The disadvantages of private practice include higher workloads, less job stability, and a greater challenge to get into the partnership. **There are many**

solo anesthesia practitioners in the USA. Solo practice may offer an even better income; however, it also offers less vacation time, very limited help, and difficulties in arranging vacations. Locum tenens practice means the practitioner signs a contract with a locum tenens company, who then gives the practitioner assignments to work in one of the hospitals contracted with the locum tenens company. Locum tenens companies usually pay malpractice insurance, lodging, and travel expenses for practicing anesthesiologists. Locum tenens practice has become very popular in recent years and is gaining further popularity due to the potential for higher wages, more flexible work schedules, and lack of need for long-term commitment.

Summary

The shortage of anesthesia providers in the USA will most likely continue in the coming years[4,5]. Therefore, the job market for all levels of anesthesia providers should remain favorable, which means there will be good chances to land better jobs, achieve better business deals, and be able to get into partnerships in shorter periods of time. All anesthesia providers should continue to enjoy their current income level or an even slightly higher. The ASA and all its members will still have to fight persistently with the CMS/government to keep a decent CF for anesthesia services and favorable CPT coding for all anesthesia procedures; this will prove to be a challenging mission. The battle between physician anesthesiologists and CRNAs regarding requirement of physician supervision will continue; however, most hospitals will choose to keep the physician supervision requirement, even in those states in which physician supervision requirement is no longer in place. The medicolegal environment is partially contributing to this. The AA program will gain limited support in more states in the coming years. As long as the anesthesia job market is tight and private practice is more lucrative, academic anesthesia practice will continue to experience difficulties recruiting anesthesiologists. Locum tenens practice is likely to gain a little more popularity due to the continuing shortage of anesthesia providers, higher earning potential, flexible schedule, no need for long term commitment, and other benefits. More and more American medical school graduates will choose anesthesia as their specialty in future years as the income for anesthesiologists is among the highest incomes for medical specialties. In the USA there will be more anesthesia graduates in the coming years and more CRNAs finishing their training. As soon as the job market gets more saturated, locum tenens practitioners will settle down with permanent positions, and locum tenens practice will lose ground.

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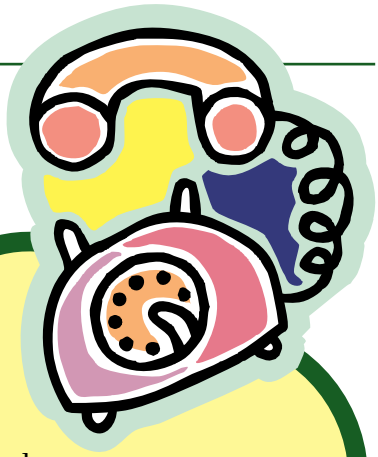
West Jefferson Medical Center is the third largest hospital in metropolitan New Orleans area, it has over 500 beds and it has been ranked one of the top 50 hospitals in USA for the last three years.

Working in Australia...

A life saving wake up call to start my new life



Riiiiiinnnnnnng riiiing, riiiiing riiiiiiiiiiiinnnnnnnnnng, 4am, Vienna, my mobile phone went off.

"Hello....."

"Carolyne, this is Dr. X from St George Hospital, how are you?"

"Fine, fine....."trying very hard to sound awake and orientated.

"The phone is not very clear, are you in Australia?" Can't deny anymore, I thought.

"No, I am in Austria!'

"You are travelling, do you do that a lot?"

"No, I just take the chance while I am unemployed"

"Well Carolyne, you are not unemployed anymore. We sent a letter to you in early February offering you a job as a consultant in St George Hospital, you have to reply within a week if you accept the offer. It is close to the deadline and we still haven't heard from you. Do you want the job?"

"Oh yes, yes!"

This marked the beginning of my life as a consultant anaesthetist in a major teaching hospital in Sydney. In fact I was a medical student in the hospital some years ago!

Settling into my new job has been exciting, but on the other hand it required a lot of adaptations and patience. I am still getting lost in the hospital!

In the theatre, most things are the same, for example..... surgeons usually do the cutting, and the anaesthetists give the anaesthetics!!!!!

Major difference to me is that I am dealing with "Guai Low" and other migrants such as Lebanese patients here. Almost all patients here are >70 kg! And they are very hairy (difficult iv access) and most male patients have moustache. We tie most of our ETT and LMA here. Most patients here have multiple complex medical diseases. The Australian government wants hospitals to have >80% of the elective cases to be same day admission for cost effectiveness. Hence there is preadmission clinic almost everyday. And the first few sessions were really nightmare. Flipping through the papers front to back and back to front trying to find the diagnosis, planned OT, OT date, whether the case was to be a day surgical case, etc. There is always some report we need to retrieve from their GP or Cardiologist. So we have to ring them up. Sometimes we have to arrange hospital interpreter service as well. Hence, preadmission clinic is time and energy consuming!

In the OT, to me the best thing is powder free gloves! There is NO powdered gloves at all! Needleless system is used here for drawing up drugs from vials and also injecting into the iv tubing. I am surprised by the amount of disposable surgical drapes they use here. Everyone uses sevoflurane as maintenance agent, and some registrars don't know how to use thiopentone because they have always used propofol! Almost all patients are induced in the induction room while the nurses prepare the instruments.

Most LMA are removed in the recovery room. The recovery nurses discharge patients to the ward with set protocols and also set up PCAs.

Consultant call here is 1 weekday every 4 weeks and 1 weekend every 4 to 6 weeks. My first call is one and a half month away.

I am still settling in, after 1 month in St George Hospital. It has been helpful that the other staffs are very nice and understanding.

I don't miss Hong Kong, but I miss the people that I worked with, especially those who taught and helped me to be an anaesthetist. I wish to say: Thank you very much!

Carolyne CP Chau
Email: cpchau@hotmail.com
(Dr. Chau is currently a staff specialist in the St. George Hospital, Sydney, Australia)

Board of Education...

Mandatory CME and synchronization of CME cycle, 1 January 2005

This notice serves as a reminder that the mandatory CME for all doctors and the synchronization of CME cycle will start in January 2005. You are advised to refer to the following if you need further information: *HKCA February 2003 Newsletter; HKAM News [www.hkam.org.hk]; HKAM Newsletter Focus Summer 2002 and Summer 2003 issues; Medical Council Newsletter No. 7 [Nov 2002] and No. 9 [Feb2004].*

For Fellows of our College, Hong Kong Academy of Medicine (through our College) is keeping track of the CME scores of individual fellows. Academy will take appropriate actions if the CME score falls short of 90 in each CME cycle. Dr. C.K. Koo, Chairman of HKCA CME Subcommittee, has sent each individual Fellow a letter in April 2004 explaining about the transitional arrangements for the synchronization of cycle and how many CME points each Fellow should obtain before 1st January 2005.

For non-fellows and trainees of the College, they also have to gather enough CME points to renew their practising certificate with the Medical Council. Synchronisation of CME cycle is not an issue here as CME for non-fellows/trainees has so far been voluntary and their CME cycle will start afresh on 1st January 2005. Medical Council has appointed a number of CME Administrators (www.mchk.org.hk) to assist in the administration. Technically, the non-fellows/trainees have to register with one of the CME Administrators (HKAM being one of those), attend the approved CME meetings listed to accrue CME points. They then report to the administrator the CME meetings they have attended and the CME points they have accrued. For those non-fellows / trainees who have not yet registered with one of the CME Administrators appointed by the Medical Council, I would urge you to do so as soon as possible, certainly before 1st January 2005. Registration with the HKAM as CME Programme Administrator is recommended so that when the trainee becomes Fellow of the College, there is no disruption in the reporting of CME activities. Another concern about CME for non-fellows/trainees is that these CME meetings where non-fellows/trainees gain CME points have to be properly publicized and open to all doctors to qualify as accreditated CME meetings. These CME meetings could be the same CME meetings for Fellows but the important point for CME accreditation is that these meetings have to be open to all doctors. The Hospital Authority and Academy of Medicine, both being CME providers, are providing the appropriate channels to publicize the CME programmes. The CME co-ordinators of various training institutions have been alerted to this point as well.

CT Hung
Chairman, Board of Education

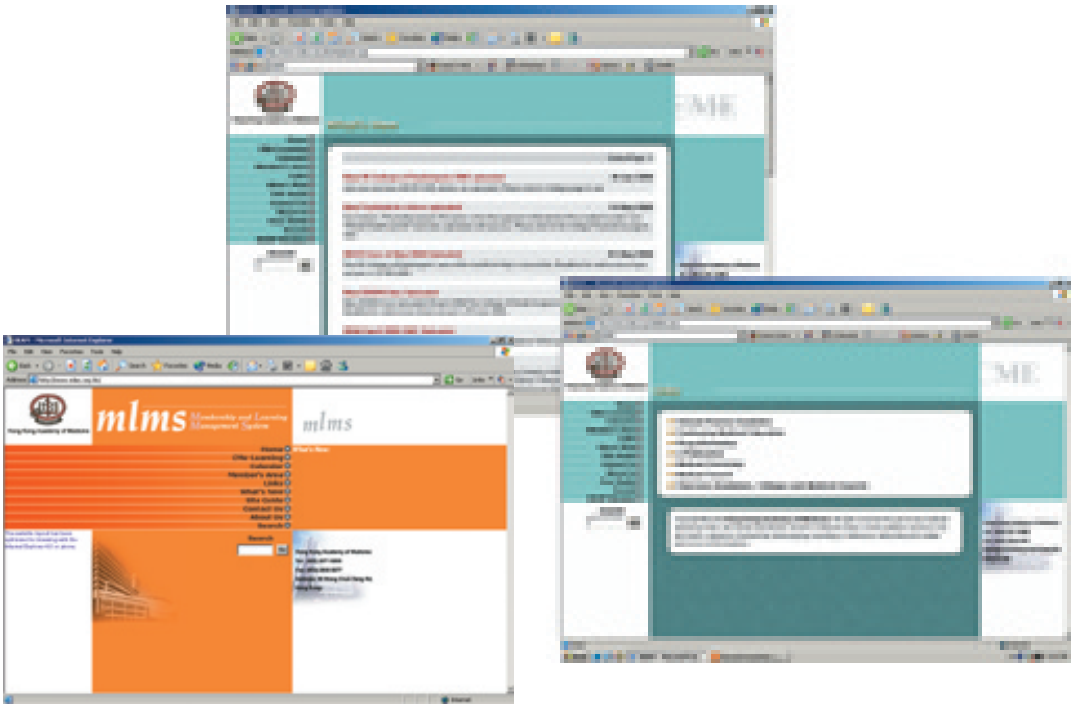
What is MLMS?

MLMS is acronym for Membership & Learning Management System

This network is established by **Hong Kong Academy of Medicine** with a goal of organizing, assessing, and accrediting postgraduate medical specialist training and continuing medical education efficiently. The URL of the site is www.mlms.org.hk.

It aims:-

- to provide an efficient and potentially limitless information resource for the purpose of improving standards of health care.
- to pool expertise in every field of medicine (including dentistry) to edit portal content and accredit CME/CPD activities.
- to facilitate administration, accreditation and certification of CME and CPD.
- to provide around-the-clock CME to doctors via the Internet.



All fellows should have by now received the login ID and the initial password for logging in the site from the Hong Kong Academy of Medicine. The site has strong clerical support from the Academy. On top of the wide range of CME material available, each fellow may also check the CME points they have accumulated.

Every fellow is strongly encouraged to login and browse the site.

Dr. CK Koo
Chairman, CME sub-committee

More learning opportunities...

Regional Anaesthesia Workshop, QMH

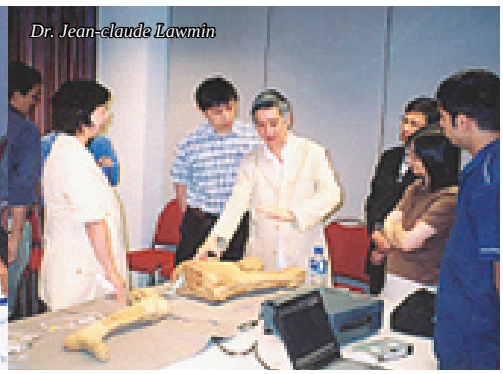

Participants

A regional anaesthesia workshop was held successfully by the Hong Kong College of Anaesthesiologists in the Hong Kong Academy of Medicine Jockey Club Building on 24th April 2004. More than 30 participants from different hospitals and private practice anaesthesiologists joined the meeting. It was sponsored by the B-BRAUN Company.

Dr. Jacobus KF NG, Department of Anaesthesiology, The University of Hong Kong, gave a clear introduction of brachial plexus and lower limb blocks by using catheter technique and ultrasound machine. He showed the ultrasound images of landmark structures surrounding the brachial and femoral nerve sheath and the distending nerve sheath when local anaesthetic solution was injecting into the correct place. He also taught participants how to insert needle in the plane of ultrasound so as to see the whole needle image intersecting with the nerve sheath.


B-BRAUN Company


Professor KF Ng


Dr. Jean-claude Lawmin

Dr. Jean-Claude Lawmin, Department of Anaesthesiology, Queen Mary Hospital, reviewed different methods of sciatic nerve block. Participants could touch the plasticized cadaver with bare hands. He said the sub-gluteal approach of sciatic nerve block was superficial and succeeded with more than 90% with the help of nerve stimulator.

Dr. Libby HY Lee, Queen Mary Hospital, Department of Anaesthesiology, used life and anatomy model showing the pathway and different approaches of brachial plexus block.

It was an inspiring meeting for anaesthesiologists who may routinely perform plexus block with the use of ultrasound machine and nerve stimulator in the future.

Drs. WM Lau and David TH Lim,
TKOH

Board of Examination

Intermediate Fellowship Examination

The July-August examination is the first major change in the Intermediate Fellowship Examination format since its inception in 1996. In response to the previous examiners' comments, 2 viva examination tables were used instead of one for each subject. Candidates were also required to achieve a minimum of 48 marks in both the physiology and pharmacology paper before they could be presented for the oral examination. The format of the examination for the Pharmacology and the Physiology are the same. Each consists of a written paper of 12 short answer questions, and 2 twenty minutes viva voce examinations.

A total of 20 candidates were enrolled for this examination. Two withdrew before the written examination. Three candidates out of 18 did not fulfill the minimum criteria for the oral examination. Finally, 10 candidates (66% of those who attended the viva examination) were successful in passing this examination.

Dr. KK Lam
Coordinator, Intermediate Fellowship Examination

Successful candidates

Name	Hospital
Dr CHIU, Ming Ming Denise	UCH
Dr HUSSAIN, Assad	QMH
Dr KAN, Kwok Yee	AHNH
Dr LAM, Kit Ying	PMH
Dr LAM, Tat Shing	QEH
Dr LAM, Yee Ming Alice	UCH
Dr LAU, Chung Wai	AHNH
Dr MA, Yuen Leung Elina	UCH
Dr WONG, Lai Yee Belinda	PWH
Dr YUNG, Viki	UCH

The College is grateful to Dr. Paul Cartwright (left) of RCA and Dr. Neville Gibbs (right) of ANZCA for their assistance as External Examiners during the examination.

Final Fellowship Examination ..... Success!!

The March/May, 2004 Final Fellowship Examination was held in Queen Elizabeth Hospital. Twenty-two out of 27 candidates passed the examination. The HKCA Final Fellowship Examination Prize was awarded to Dr TAN Kee Soon of Prince of Wales Hospital.

The College is grateful to Dr. Bart McKenzie (left) of ANZCA and Dr. Andrew Mortimer (right) of RCA for their assistance as External Examiners during the examination.

The successful candidates are:

Dr CHAN Siu Man Simon	AHNH	Dr LAU Shuk Hang Angela	UCH
Dr CHEANG Si Ngai	QEH	Dr LEE Yuk Ming Sunny	UCH
Dr CHENG Tsang Dawn	TMH	Dr LOW Kai Ngai Kevin	PWH
Dr CHENG Yat Hung	TMH	Dr LUI Siu Kuen	YCH
Dr CHEUNG Chi Wai	YCH	Dr LUK Chi Wing Irene	PMH
Dr CHEUNG Ning, Michelle	PWH	Dr SIT Yiu Kwong	TMH
Dr CHU Suk Yi	PYNEH	Dr SO Ching Yee	PWH
Dr HO Yau Leung	PWH	Dr TAN Kee Soon	PWH
Dr KWAN Wai Man Gladys	QEH	Dr TSANG Ho Sze	PWH
Dr KWOK Yung	QEH	Dr WONG Chak Man	PWH
Dr LAM Vuu Luong Wylie	QEH	Dr YIP Man, Alexandra	QMH

The Last Exit Assessment for this Year is 7 October 2004 (Thursday)

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.*

Examination Fee for Fellow ad eundem: $5,000

Recruitment of Examiners

I like to remind Fellows that 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).

PT Chui,
Chairman, Board of Examination

Panel of Examiners, March/May, 2004 Final Fellowship Examination
(Back row, left to right) Drs. Anthony Ho, Cindy Lai, Serena Fung, Edward Ho, CL Kwok, Matthew Chan, BH Yong, Simon Chan, Steven Wong, Peter Fung, SK Ng, PW Cheung, KY Lai, YF Chow
(Seated, left to right) Drs. Theresa Hui, TW Lee, PT Chui (Chairman), Bart McKenzie (ANZCA), Andrew Mortimer (RCA), Cindy Aun, CT Hung

Panel of Examiners, July/August, 2004 Intermediate Fellowship Examination
(Left to right) Drs. Matthew Chan, PT Chui (Chairman), James Derrick, Neville Gibbs (ANZCA), Das, Mike Irwin, Paul Cartwright (RCA), BH Yong, Claudia Cheng, KK Lam (Coordinator), CT Hung

Time for Champange

Board of Pain Medicine

1. The next Dip Pain Mgt Examination will be held on 8 October 2004. Dr Roger Goucke has been invited to be our external examiner. During his visit, Dr Goucke will be conducting an Implantable Pain Therapy workshop on 16 October and shall be giving an evening lecture on 18 October. Note the dates in your diary.
2. Over the last six months, the Board of Pain Medicine has received six projects towards the Dip Pain Mgt. Of these projects, two were approved, one rejected and three others are still being assessed. It is advised that trainees should submit a project proposal to the Project Officer before embarking on the project to avoid unnecessary delay in getting the project approved.
3. Dip Pain Mgt trainees and Supervisor of Trainings should note recent changes in the Guideline for Pain Management Training. The new guideline can be downloaded from the HKCA website, www.hkca.edu.hk. The important changes are highlighted here:
   a. Trainees must be registered with and approved by HKCA before training is accredited for Diploma in Pain Management. (Clause 1.1.3)
   b. Trainees must complete a training progress report with their Supervisor of Training every six monthly as long as they remain in the training programme. (Clause 1.6)
   c. Only trainees who are registered with the College for training in DPM, have submitted all required documentation, have paid the appropriate fee and have completed at least six months of approved training requirement including a satisfactory Supervisor of Training Report are eligible to present for the examination. (Clause 1.7.2)

PP Chen,
Chairman, Board of Pain Medicine

Guidelines On Pain Management Training

(PM1V3, August, 2004)

INTRODUCTION

The Hong Kong College of Anaesthesiologists (HKCA) conducts organised training programmes in pain medicine for anaesthesiologists. Two categories of training programme are provided in accredited training centres.

A. Training in pain medicine leading to a post-fellowship Diploma in Pain Management (Dip Pain Mgt).

B. Pre-fellowship pain medicine training that is a component module of the vocational anaesthesiology training programme of the HKCA.

1. Diploma in Pain Management TRAINING PROGRAMME

1.1. Entry requirements:

1.1.1 In possession of FHKCA, OR

1.1.2 Having completed at least 5 years of anaesthesiology vocational training recognised by the HKCA, AND

1.1.3 Trainees must be registered with and approved by the HKCA before any training is accredited for the Diploma in Pain Management. Retrospective approval of up to three months may be granted, but approval is not automatic.

1.2 Duration of training:

1.2.1. The training programme shall consist of not less than twelve months of full time training in a post approved by the College for DPM training. It will normally commence during and some part may be concurrent with the vocational anaesthesiology training programme.

1.2.2. At least six months of training shall be completed after obtaining FHKCA.

1.2.3. In the event of interrupted training,

1.2.3.1 training shall be conducted in blocks of not less than three months.

1.2.3.2. the whole training programme shall be completed in not more than two years for the training experience to be accredited.

1.3 The number of patients managed by the trainee under supervision should be not less than:

1.3.1. One hundred new patients with chronic or cancer pain, and

1.3.2. Two hundred new patients with acute or postoperative pain.

1.4 A log book shall be kept for documentation of training. The log book has to be endorsed by the Director of Pain Management / Supervisor of Training upon completion of training.

1.5 The trainee is required to carry out and submit a project related to acute, chronic or cancer pain, and of such a standard that is acceptable to the College. The project must be completed and approved by the College within three years of completion of training. Otherwise, these candidates have to rejoin the entire training programme again.

1.6 Trainees must complete a training progress report with their Supervisor of Training every six months as long as they remain in the training programme. These reports shall be submitted to the College. A final report on the trainee's performance from the Supervisor of Training shall be submitted to the College upon completion of the one year training period.

1.7 Diploma in Pain Management Examination:

1.7.1. Trainees must satisfy the examiners in a DPM examination conducted by the College. The format of the examination shall be determined by the Council of HKCA on recommendation of the Board of Examinations.

1.7.2. Only trainees who are registered with the College for training in DPM, have submitted all required documentation, have paid the appropriate fee and have completed at least six months of approved training requirement including a satisfactory Supervisor of Training Report are eligible to present for the examination.

1.7.3. The examination must be passed within three years of completion of training. Otherwise, these candidates have to rejoin the entire training programme again.

1.8. The accredited training time, examination passed and the approved project will lapse 3 years after completion of the approved training period in pain medicine. Doctors failing to obtain the diploma within 3 years of completion of the training will have to rejoin the entire training programme again and re-sit the examination.

2. Pre-Fellowship Pain Medicine TRAINING PROGRAMME

2.1 Entry requirements:

2.1.1. Registered HKCA Vocational Trainees in anaesthesiology AND

2.1.2. Having completed at least 12 months of accredited training in clinical anaesthesia.

2.2. Anaesthesiology trainees may take up pre-fellowship pain medicine training either as a non-core anaesthesiology module or as an elective option in the new anaesthesia training programme starting on 1st January 2005

2.3. Trainees doing the pre-fellowship pain medicine training programme do not have to occupy a training post in pain medicine but the training must be conducted in training units approved by College for pain medicine training.

2.4. Training programme shall be conducted in blocks of not less than three months, during which the trainee must be rostered to the module full time (normally equivalent to seven sessions or more per week).

2.5. Pre-fellowship pain medicine training may be accredited for the Diploma in Pain Management only if the trainee occupies a post approved for DPM during the period of training and satisfied all other requirement of training for DPM.

2.6. Documentation of pain management experience should be recorded in a log book as required for documentation of training towards the Diploma for the FHKCA (Anaesthesiology).

2.7. Trainees are expected to manage a minimum of 40 acute pain and 20 chronic or cancer pain patients during a three months block or pro rata.

Board of Censor

Admission to Fellowship by Examination, FHKCA	
CHENG Chun Pong, Benny	CHAN Siu Man, Simon
LEE Hon Ming	KWOK On Ki
CHAN Hing Tsuen	KWOK Yung
CHAN Wai Yee, Winnie	PANG Chi Kwan
SIN Lok Man, Raymond	LUI Siu Kuen
MAN Kwan Yin	

Admission to Fellowship ad *eundem*, FHKCA
CHAU Ching Ping
CHOI Gordon Yuk Sang

Admission to Fellowship by Examination, FHKCA(IC)
CHAU Chin Man

Admission to Diploma in Pain Management, HKCA
YAP Jacqueline Claire Chooi Mae

New Members
WONG Hoi Kay, Tiffany
WONG Chi Pan
CHUNG Yu Fai
KANDAMBY Darshana Hewa

Michael Irwin
Chairman, Board of Censor

Highlights from the Annual General Meeting

The 15th Annual general meeting was held on the 21 June, 2004 at the Picasso & Monet Room, Intercontinental Grand Stanford Hotel, Tsim Sha Tsui East.

In the meeting, members and fellows approved the reports from treasurer and auditor. The annual subscription fee for 2005 will be (AGM 15.07.01)

Local Fellow	HK$ 2,500
Local Member	HK$ 1,250
Overseas Fellow	HK$ 625
Overseas Member	HK$ 313
Senior Member/Fellow	HK$ 50

also resolved to create the “Board of Pain Medicine” and “Board of Intensive Care Medicine” to replace the Pain Management and Intensive Care Committee, respectively. (AGM 15.05.01 to 02)

The business meeting was followed by a scientific symposium presented by Dr. Tong J Gan (Associate Professor, Duke University Medical Center) on “New approach to perioperative pain management”

The event was sponsored by Pfizer Corporation, Hong Kong Ltd

Invitation

Dear friends and colleagues,

It is my great pleasure to invite you to join the Annual Scientific Meeting (ASM) in Anaesthesiology 2004, Organized by Hong Kong College of Anaesthesiologists, Society of Anaesthetists of Hong Kong and Hong Kong Society of Critical Care Medicine, the meeting will be held on 12 – 14 November 2004. Having chaired the inaugural ASM in 1996, it is an honor for me to organize this grand event again – I am sure it will be an excellent meeting.

The theme of the meeting is "An Anaesthetic Odyssey to Intensive Care" and hence we are joined this year by our colleagues from Hong Kong Society of Critical Care Medicine. Over the years, intensive care medicine has developed out of its parent specialty anaesthesia into a subspecialty in its own right. Its importance in the medical community is increasingly recognized, especially after the outbreak of SARS in Hong Kong last year. Indeed, after such an outbreak, we have felt an urgent need to provide more anaesthesiologists and intensivists with the latest knowledge in intensive care medicine. Unlike many others, I have a strong belief that both anaesthesiologists and intensivists share common interests in many areas, and this annual scientific meeting is solely dedicated to our great specialties.

The scientific programme this year will consist of CME Lectures, Symposia and Workshops. We are excited and honoured to host a distinguished and extensive panel of overseas experts, who will provide us with a comprehensive international overview of many interesting topics. Indeed, you are sure to recognize many familiar and famous faces at the meeting.

On behalf of the organizing committee, we look forward to seeing you at the meeting in November for an exciting academic and cultural experience.

Dr. Po-wa Cheung
Chairman
Organizing Committee
Annual Scientific Meeting in Anaesthesiology 2004

Organizing Committee

Chairman:	Dr. Po-wa Cheung		
Health Industry Liaison Subcommittee:	Dr. Yu-fat Chow	Dr. Wing-chi Chu	Dr. Siu-keung Ng
Publicity & Social Subcommittee:	Dr. Douglas Fok	Dr. Kwok-kuen Liu	
Scientific Subcommittee:	Dr. Yu-fat Chow Dr. Man-chun Law Dr. Kwok-fu Ng Dr. Timmy Yuen	Dr. Douglas Fok Dr. Anne Leung Dr. Peggy Tan	Dr. Charles Gomersall Dr. Kwok-kuen Liu Dr. Florence Yap
Honorary Advisors:	Dr. Simon Chan	Dr. Yu-fat Chow	Professor Gavin Joynt

Programme

12 November 2004 (Friday)

13:30 – 16:30 Offsite Workshop – Decision Analysis Workshop

13 November 2004 (Saturday)

09:00 – 12:00 Offsite Workshop – Haemodynamic Workshop
09:00 – 12:00 Offsite Workshop – Radiological Workshop
08:30 – 09:00 REGISTRATION FOR CME LECTURES
09:00 – 10:30 *CME Lecture I*
09:00 – 09:30 What is New in the ICU in the Past 5 Years — Dr. Florence Yap
09:30 – 10:00 Mechanical Ventilation in ICU — Dr. Loretta Yan
10:00 – 10:30 New Monitors of Anaesthetic Depth — Professor Matthew Chan
10:30 – 11:00 COFFEE BREAK
11:00 – 12:30 *CME Lecture II*
11:00 – 11:30 Data Interpretation for Anaesthetists — Dr. Victor Yeo
11:30 – 12:00 Vasopressors — Dr. Judith Shen
12:00 – 12:30 Pre-operative Assessment and Optimization — Dr. Michael Irwin
12:30 – 13:30 LUNCH BREAK / REGISTRATION FOR ANNUAL SCIENTIFIC MEETING
13:30 – 13:45 Opening Ceremony
13:45 – 14:15 *Plenary I* — Change and You — Professor Teik Oh
14:15 – 14:45 *Plenary II* — Tolerance of Anaemia: Compensatory Mechanisms and Limitations — Professor Donat Spahn
14:45 – 15:15 *Plenary III* — Organ Failure is a Good Thing.... If You Survive — Professor Mervyn Singer
15:15 – 15:45 COFFEE BREAK
15:45 – 17:00 *Perioperative Fluid Management Session*
15:45 – 16:05 Perioperative Fluid Therapy: Crystalloids and Colloids — Professor Donat Spahn
16:05 – 16:25 Coagulation Monitoring in the Operating Theatre — Dr. K. F. Ng
16:25 – 16:45 Perioperative Support for Patients with Special Transfusion Requirement — Dr. C. K. Lee
16:45 – 17:00 Panel Discussion
Sepsis Session
15:45 – 16:05 Basic Science of Sepsis — Dr. Steve Webb
16:05 – 16:25 Apoptosis for the Intensivists — Professor John Marshall
16:25 – 16:45 Vascular Hyporeactivity in Septic Shock: Mechanisms and Treatments — Professor Mervyn Singer
16:45 – 17:00 Panel Discussion
17:00 – 17:30 *Australian and New Zealand Intensive Care Society Lecture*
S.A.F.E. Study — Professor Rinaldo Bellomo
17:30 – 18:30 COCKTAIL RECEPTION
18:30 – 19:30 HKCA Congregation
19:30 – 21:30 HKCA Congregation Dinner

14 November 2004 (Sunday)

08:00 – 08:30 REGISTRATION
08:30 – 09:45 *ICU Session*
08:30 – 08:50 Recertification — Professor Teik Oh
08:50 – 09:10 Hong Kong's Response to a Chemical, Biological, Radiological or Nuclear Attack — Mr. Dominic Britain
09:10 – 09:30 Immunonutrition — Dr. Paulo Amin
09:30 – 09:45 Panel Discussion
Free Paper Session
09:45 – 10:15 *Plenary IV* — Sepsis: New Targets, New Strategies — Professor John Marshall
10:15 – 10:45 COFFEE BREAK
10:45 – 11:25 *International Society for Anaesthetic Pharmacology Lecture* — Professor Evan Kharasch
11:25 – 12:40 *Trauma Session*
11:25 – 11:45 Transfer of Trauma Patients — Dr. Ross Freebairn
11:45 – 12:05 Controversies in Trauma Resuscitation — Professor Anthony Ho
12:05 – 12:25 Artificial Oxygen Carriers: Physiologic Principles and Clinical Use — Professor Donat Spahn
12:25 – 12:40 Panel Discussion
Infection Session
12:25 – 11:45 Endotoxemia in the ICU – What does it Mean? — Professor John Marshall
11:45 – 12:05 Meningococcal Meningitis — Dr. Steve Webb
12:05 – 12:25 Dengue and Malaria — Dr. Paulo Amin
12:25 – 12:40 Panel Discussion
12:40 – 14:30 CONFERENCE LUNCH
14:30 – 15:45 *Anaesthetic Crisis Session*
14:30 – 14:50 Systemic Air Embolism after Lung Trauma — Professor Anthony Ho
14:50 – 15:10 Critical Appraisal of Difficult Intubation Equipment — Professor David Chung
15:10 – 15:30 Training in the Management of Anaesthetic Crisis — Dr. T. W. Lee
15:30 – 15:45 Panel Discussion
Antibacterials Session
14:30 – 14:50 MRSA — Professor Mervyn Singer
14:50 – 15:10 Quorum Sensing Agents — Dr. Steve Webb
15:10 – 15:30 Antibiotic Prescribing in Acute Renal Failure — Dr. Gordon Choi
15:30 – 15:45 Panel Discussion
15:45 – 16:15 COFFEE BREAK
16:15 – 17:15 *Medico Legal Issues*
16:15 – 16:45 Safe Medical Practice in Hospital — Mr. Julian Wallace
16:45 – 17:15 Medico-legal Problems for Anaesthetists and Intensivists – Current Issues — Mr. Chris Howse
17:15 – 17:30 Closing Remarks
17:30 – 19:30 WINE TASTING EVENING

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)

Coming event...

Effective Management of Anaesthetic Crisis (EMAC) course in November/December, 2004...

Revision Tutorial Course In Basic Sciences In Anaesthesiology 2004

Dear trainees,

It is my pleasure to announce that REVISION TUTORIAL COURSE IN BASIC SCIENCES IN ANAESTHESIOLOGY 2004 will commence on **29th November, 2004**. The course consists of 2 weeks of fulltime informative lectures, tutorials and mock viva by **Professor Peter Kam**.

REVISION TUTORIAL COURSE IN BASIC SCIENCES IN ANAESTHESIOLOGY 2004 is now open for application. Trainees who are interested please complete the an application form downloadable from the College website www.hkca.edu.hk and return to Dr. CH Koo together with a cheque of **HK$ 2,000** payable to *"The Hong Kong College of Anaesthesiologists"* **before 15th November, 2004**. The course fee for non-HKCA trainee or member is HK$4,000. Maximum number of participants is 30. If the number of participants exceeds 30, priority will be allocated according to the guidelines from the Council meeting of the HKCA. A confirmation letter will be send to you near the middle of November, 2004 if your application is successful.

The venue of the whole course will be held at the Queen Elizabeth Hospital unless otherwise notified. The names of the successful applicants will also be posted in the HKCA web site later.

For further queries contact Dr. Koo at 2958 7410 during office hours or the College Secretary (Mr. Daniel Tso) at 2871 8833.

Thank you for your attention.

Yours sincerely,

Dr. CH Koo
Course Co-ordinator
Revision Tutorial Course in Basic Sciences' in Anaesthesiology
c/o Department of Anaesthesia, Queen Elizabeth Hospital
Tel: 29586176 Fax: 27824725
Email: kooch@hutchcity.com

Revision Tutorial Course In Clinical Anaesthesiology 2004

Dear Trainees,

I am pleased to announce the **Revision Tutorial Course in Clinical Anaesthesiology** for 2004 is now open for registration. The 7 1/2-day course tutor by **Professor Peter Kam**, will run from **Saturday, 11 December to Saturday, 18 December 2004 noon (including the Sunday!)**

The course follows the format of interactive lectures, tutorials and mock viva sessions. Maximum number of participants is 30. Like last year, if the number of applicants exceed 30, priorities will be allocated according to the guidelines set by the College Council. Please make a note that the course is designed for those **who will be taking their final examinations in the immediate year**.

Trainees who are interested please complete the application form (which can be downloaded from the College website: http://www.hkca.edu.hk/PKam2004.htm) & return to Dr D Fok together with a cheque of HK$1500 payable to *"The Hong Kong College of Anaesthesiologists"* before **Friday 26th November 2004**. (The course fee for non-HKCA members is **HK$3000**). The schedule of the course will be announced later. The venue will be held at Queen Elizabeth Hospital unless otherwise notified. Successful applicants will be notified via email and also be posted in the website in the first week of December.

Any queries, please contact me at 2958 7415 or email at dof604@netvigator.com.

Thank you for your attention.

Yours Sincerely,

Dr Douglas FOK
Course Co-ordinator
Department of Anaesthesiology
Queen Elizabeth Hospital

Recent Meetings: Anaesthesia, Intensive Care & Pain management

Local meetings 2004-5

5 October, 2004

EVENING SCIENTIFIC SYMPOSIUM: "WARM HEART, COOL BRAIN"
Organized by the Hong Kong Society of Critical Care Medicine
Time: 19:00-21:15 h, Venue: M Block G/F, Queen Elizabeth Hospital
Speaker: Professor Peter Andrews, University of Edinburgh, Western General Hospital
Contact: Dr. Florence Yap, ICU PWH
Phone: 2632 2735 Fax: 2637 2422 Email: yhyyap@cuhk.edu.hk

13-14 November, 2004

HONG KONG ANNUAL SCIENTIFIC MEETING IN ANAESTHESIOLOGY 2004
Theme: "An Anaesthetic Odyssey to Intensive Care"
Venue: Hong Kong Convention Centre
Key Speakers: Prof. Teik Oh, Dr. Ross Freebairn, Dr. Evan Kharash, Prof. John Marshall, Dr. Iqbal Mustafa, Prof. Mervyn Singer, Prof. Donat Spahn, Dr. Steve Webb
Contact: MediMedia Pacific Limited, Unit 901-903, 9/F, AXA Centre, 151 Gloucester Road, Wan Chai, Hong Kong
Tel: 852 2559 5888 Fax: 852 2559 6910 Email: meeting@medimedia.com.hk
Website: www.hkca.edu.hk

14-16 January 2005

HONG KONG SURGICAL FORUM - WINTER 2005
Venue: 5th Floor Lecture Theatre, Professorial Block, Queen Mary Hospital
Contact: Forum Secretary, Department of Surgery, University of Hong Kong Medical Centre, Queen Mary Hospital
Phone: 2855 4885 Fax: 2819 3416 Email: hksf@hkucc.hku.hk

24 February, 2005

SCIENTIFIC MEETING
"Role of non-opioid analgesics in the prevention of postoperative pain"
Speaker: Professor Paul White, Margaret Milam McDermott Distinguished Chair in Anesthesiology, University of Texas Southwestern Medical Center.
Contact: Dr. Matthew Chan
Phone: 2632 2735 Fax: 2637 2422 Email: mtvchan@cuhk.edu.hk

19-20 March, 2005

ADVANCES IN CARDIAC IMAGING 2005
Venue: Postgraduate Education Centre, Prince of Wales Hospital.
Contact: Conference Secretariat: Department of Medicine & Therapeutics, 9/F Clinical Sciences Building, Prince of Wales Hospital, Shatin, N.T., Hong Kong
Phone: (852) 2632 3194 Fax: (852) 2637 3852 E-mail: cardiology@cuhk.edu.hk
Website: www.mect.cuhk.edu.hk/cardiology/

27-28 August, 2005

COMBINED SCIENTIFIC MEETING IN ANAESTHESIOLOGY 2005
(Official satellite meeting of the 11th World Congress on Pain)
Theme: "East meets West in Pain Medicine"
Venue: Hong Kong Convention Centre
Contact: CSM 2005 Secretariat, c/- International conference Consultants, Ltd, Unit 301, 3/F, The Centre Mark, 299 Queen's Road Central, Hong Kong
Phone: 852 2559 9973 Fax: 852 2547 9528 Email: csm2005@icc.com.hk
Website: www.hkca.edu.hk/csm2005.htm

Overseas meetings 2004-5

Las Vegas, USA
23-27 October, 2004

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, 2004

NEW YORK STATE SOCIETY OF ANESTHESIOLOGISTS 58th POSTGRADUATE ASSEMBLY IN ANESTHESIOLOGY
Venue: Marriott Marquis 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

Colombo, SRI LANKA
24-27 February, 2005

6th CONGRESS OF THE SOUTH ASIAN CONFEDERATION OF ANAESTHESIOLOGISTS
Theme: "Reaching out for excellence across the region"
Venue: Bandaranaike Memorial International Conference Hall (BMICH),
Contact: Secretariat (John Keells Conventions Ltd) 130, Glennie Street,
Colombo 02, Sri Lanka
Phone: 94-11-2306434 / 2439052 Fax: 94-11-2439026 / 2447087
E-mail: jkconventions@walkerstours.com or info@jkconventions.com

Honolulu, Hawaii, USA
11-15 March, 2005

79TH CLINICAL AND SCIENTIFIC CONGRESS OF THE INTERNATIONAL ANESTHESIA RESEARCH SOCIETY
Venue: Hilton Hawaiian Village, Honolulu, Hawaii
Contact: International Anesthesia Research Society 2 Summit Park Drive,
Suite 140, Cleveland, OH 44131-2571
Tel: 216 642 1124 Fax: 216 642 1127 Email: iarshq@iars.org Website: www.iars.org

Tunis, Tunisia
21-25 May, 2005

3RD ALL AFRICA ANAESTHESIA CONGRESS
Venue: Tunis
Contact: Professor Mohamed Salah Ben Ammar, Chairman of the Congress
Email: contacts@aaac-tunis2005.org Website: www.aaac-tunis2005.org

Vienna, AUSTRIA
27-31 May, 2005

EUROANAESTHESIA 2005
Venue: Austrian Centre Vienna
Contact: European Society of Anaesthesiologists, 24 rue des Comiens,
Brussels, Brussels 1000, Belgium
Tel: 11 2743 3290 Fax: 11 2743 3298 Email: secretariat.esa@euronet.be
Website: www.euroanesthesia.org

Sydney, AUSTRALIA
10-12 June, 2005

JOINT FACULTY OF INTENSIVE CARE MEDICINE IN ASSOCIATION WITH ANZICS NSW REGIONAL COMMITTEE INAUGURAL ANNUAL SCIENTIFIC MEETING
Theme: "Neurointensive Care: The Road Ahead"
Venue: Sofitel Wentworth Sydney
Contact: Carol Cunningham-Browne, Executive Officer, Joint Faculty of
Intensive Care Medicine, 630 St Kilda Road, Melbourne VIC 3004
Tel: 03 9510 6299 Fax: 03 9510 6786 Email: jficm@anzca.edu.au

Sydney, AUSTRALIA
21-26 August, 2005

11th WORLD CONGRESS ON PAIN, INTERNATIONAL ASSOCIATION FOR THE STUDY OF PAIN
Contact: International Association for the Study of Pain, 909 NE 43rd Street,
Suite 306, Seattle, WA 98105, USA
Tel: 206 547 6409 Fax: 206 547 1703 Email: IASP@locke.hs.washington.edu

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

Chau CP	A needle-free trancutaneous local anesthetic delivery system (J-tip) to prevent pain during intravenous cannulation.
Choi YS	Compliance with intensive care admission guidelines on triage
So CY	Performance of an oxygen delivery device for weaning potentially infectious critically ill patients.
Kwok Y	A prospective, randomised, double blind, placebo-controlled study on platelet and global haemostatic effects of Ling-Zhi (Ganoderma Lucidum Greenvalley) in healthy volunteers.
Lee HY	The effect of celecoxib on intrathecal morphine induced pruritus in patients undergoing Caesarean section.
Lim BK	A comparison of the effects of vasopressin and adrenaline on the system circulation and renal blood flow: a laboratory based study.
Sit YK	Evaluation of the upper airway anatomy in Chinese population on magnetic resonance imaging and its implications on the design and method of placement of laryngeal mask airway.
Wu Janet	Evaluation of the role of intraoperative warming in prevention of shivering in obstetric patients undergoing spinal anaesthesia for caesarean section.
Sin Raymond	A cohort study of maternal fever after labour epidural analgesia and its impact on maternal and neonatal outcome
Lui SK	Does intraoperative administration of remifentanil increase postoperative pain and morphine requirement?
Chan HT	An unusual cause of a high central venous pressure reading
Lee Anna	Multiregional ropivacaine instillation during laparoscopic cholecystectomy
Lina Chan	Effect of diluent volume on a single dose of epidural ropivacaine for labour analgesia
Li YF	The use of cricoid pressure during tracheal intubation using the Trachlight in Chinese female patients

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TEL: (852) 2559 9973
FAX: (852) 2547 9528
EMAIL: csm2005@icc.com.hk
WEBSITE: www.hkca.edu.hk/csm2005.htm

Obituary

Dr. Kok-Cheung YEO,
CMG, MD, DPH, DTM & H

The Society of Anaesthetists of Hong Kong (SAHK) and the Hong Kong College of Anaesthesiologists (HKCA) are sad to learn of the death of Dr. K.C. Yeo, C.M.G., the former Director of Medical and Health Service (D.M.H.S.) in Hong Kong, who died in the East Sussex Town of Battle in the U.K. on 22nd May 2004. For it was Dr. K.C. Yeo, who as Hon. D.M.H.S.H.K. managed – in 1953 – to get approval for the establishment of the first post of "Specialist Anaesthetist" in the structure of the H.K. Government Service, thus laying the foundation for anaesthesia in Hong Kong to be placed on a firmer footing. Until then anaesthesia was not a separate specialty and was treated in a somewhat haphazard way. And it was Dr. Yeo himself who persuaded the present writer at their vacation address in Nottingham, U.K. – to accept the newly created post and coming to H.K. – when, at the suggestion of the Chief of the "Colonial Medical Service" office in London, this writer travelled to Notthingham (from the Sheffield region, where he was working at the time) to meet Dr. Yeo and his charming wife Florence. Dr. Yeo, as was his want, outlined the pros and cons, and the many challenges, in a very fair manner. As a result and after talking to Prof. Francis Stock (who happened to be on vacation in London) in whose Department of Surgery, the University of Hong Kong, anaesthesia was taught to the students of the Medical Faculty in the then only Medical School, the present writer arrived in H.K. in April 1954 and took up his appointment.

Dr. K.C. Yeo was born on 1st April 1903, the son of Mr. Yeo Kit-Hong. He was educated in the University of H.K. and later also Cambridge and the School of Hygiene and Tropical Medicine of the University of London. On return to H.K. he was appointed (1928) Assistant Medical Officer of Health and Lecturer and Examiner in Public Health, the University of H.K. (1936-37), official Justice of Peace (J.P.) (in 1938), Chinese Officer of Health, Senior Grade in 1939 (which he represented during WW2 and until 1947 when he was promoted to the post of Deputy Director of Medical and Health Services, and also Vice-Chairman of the Urban Council of H.K. 1947-1950. He was promoted to Deputy Director of Medical and Health Services H.K. (1950-52). He was a member of the Legislative Council (1951-57) and was finally promoted to the post of D.M.H.S.H.K. (1952-58). During this time he also held the post of Part-time Professor of Social Medicine at the University of H.K. He retired in 1958 relocating to U.K. where he continued working for the N.H.S. mainly in the field of psychiatry for a number of years.

Dr. Yeo, although of brilliant mind and exceptional organizational process, was of a very kind, unassuming, generous and peaceful nature. As an illustration of this, the writer recalls the occasion when one of the most influential and "powerful" surgeons (and incidentally, also at the time Dean of the Medical Faculty), Prof. Gordon King had written a letter of complaint to him - that the only specialist anaesthetist was during Prof. King's operation day in Queen Mary Hospital, Hong Kong, in the Kowloon Hospital and, therefore, not available for Prof. King. This situation arose because the surgeons in the Kowloon Hospital (Dr. late Prof. G.B. Ong, Mr. Philip Mar, John Chen, Mr. Pang) were also "clamouring" for the presence and services of the then only one "specialist" anaesthetist. Dr. Yeo invited the present writer to his office the next day, showed him the letter of complaint and ruefully said that he understood and suggested that whatever needs to be done should be done but "please do NOT upset Prof. King". Such was his intelligent understanding and our common dilemma.

Dr.Yeo recognized and was convinced that anaesthesia merits the status of a full and independent specialty. He acted on his conviction and by establishing the first post of specialist anaesthetist paved the way for anaesthesia to grow and progress, thereby earning for himself the well deserved respect and gratitude of the anaesthetic community. No doubt many other branches of medicine, including and particularly the surgeons are feeling and enjoying the benefits of his wisdom and enlightment.

Dr. and Mrs. K.C. Yeo, In a Chinese Restaurant, Bexhill 1998

Dr. Yeo was married to Florence (one of the daughters of the late legendany Sir Robert Hotung). They had 3 children, one son – Richard – a prominent surgeon in the U.K. and two daughters, Wendy and Daphne. To them and to their families we would like to express our condolences and deep sympathy.

Z Lett
MD, DA(RCP &Sl), FRCA, FFARCSI, FANZCA, FHKCA, FHKAM(Anaesthesiology)

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Letter to the Editor

Sirs,

Just into the fifth month of my medical school life, I was astonished. I entered medical school with the preconceived notion that the job package of being a doctor included job security. I was proved wrong.

Did I think about getting another career? Yeah. For about ten seconds. Then I decided against it. Otherwise I won't be here writing this. Why didn't I do it? I didn't think there is any career available in Hong Kong that I'll like more. If I was born in someplace else, or if my family had the money to send me to study overseas, I would probably go and study archaeology on my way to fulfill my childhood dreams to become a professional grave digger. I may have made that decision before ever entering into medical school. However as I was neither, so now here I am, having completed my medical school and internship, I have embarked on a new challenge – the first year of my anaesthesiology training.

Did I ever regret it? No. I do not regret a decision that has led me to a job that I enjoy.

I like what I do every day. I am happy with my job though occasionally there is still a bit of worry lingering at the back of my mind. What is going to happen after my contract term? Am I going to be kicked out of HA then? Will this thing known as HA still exist then? Thank God that I rarely worried about my future because I know my future is in the hands of God.

I know some friends who are really troubled by their uncertain future. Some took active measures like studying certain diplomas in preparation for a career in general practice. Some just work day after day, studying for exams in their respective specialties as nothing else can be done.

One of the OT nurses asked me recently why we did not fight when we are being treated so unfairly. I told her HA is just like our Beijing government. You can reason with them, you can plead with them, you can even protest against them. In the end, you get nothing. They will pretend to listen to you. They will even give you some reassurances like election by universal suffrage being their ultimate goal, though those do nothing to allay our worries.

Contract terms, I can handle. In the UK, in the States, most doctors are hired under contract. For me, it is the unfairness of the system that makes me want to hurl and scream like mad at times. People are put in two different systems with different benefits and salaries. No amount of good work can get contract staff any reward while bad work and attitude in permanent staff can go unpunished.

The saddest thing is that we have as much hope that this will change as Beijing is going to grant us the right to choose our own chief executive.

Voice of a first year trainee

Response to this letter should be addressed to the Editor, HKCA Newsletter, Department of Anaesthesia and Intensive Care, Chinese University of Hong Kong, Prince of Wales Hospital, Shatin, NT, Hong Kong Email: mtvchan@cuhk.edu.uk

The Hong Kong College of Anaesthesiologists
Technical Guideline T1, 2004

Recommendations On Checking Anaesthesia Delivery Systems

1. INTRODUCTION

An anaesthesia delivery system includes any machine, equipment or apparatus which supplies gases, vapours, local anaesthesia and/or intravenous anaesthesia agents in order to safely and reliably induce and maintain anaesthesia.

2. PRINCIPLES

2.1 Anaesthesia delivery systems must be serviced at regular and specified intervals.

2.2 The Hospital, Anaesthesia Department or body responsible for the equipment shall keep a detailed record of the service requirements for all anaesthesia delivery systems. These requirements will be based on appropriate Hong Kong Standards, manufacturer's guidelines, and Biomedical Engineering and Anaesthesia Department recommendations. They shall describe calibration protocols and the intervals at which these must be performed.

2.3 A prominent label that is visible to the anaesthetist must be attached to all anaesthesia delivery systems to advise of past service(s) and to indicate when the next service is due.

2.4 To ensure early detection of any failure in an anaesthesia delivery system, appropriate alarms must be present, and patient monitoring as specified in Professional Document PS18 *Recommendations on Monitoring During Anaesthesia* must be provided.

2.5 There must be a secondary facility to maintain oxygenation and ventilation of the patient should failure of the primary systems occur.

3. CHECKING ANAESTHESIA DELIVERY SYSTEMS

3.1 Every anaesthesia delivery system must be checked before use to ensure that it will function correctly. This document requires three different levels of checks:

3.1.1 **Level One check.** This is very detailed and is required a) on any new system and b) on all systems after servicing. This check will usually be performed by the service person - whether from the equipment provider, or from the Biomedical Engineering Department.

3.1.2 **Level Two check.** This should be performed at the start of each anaesthesia session.

3.1.3 **Level Three check.** This should be performed immediately before commencing each anaesthetic.

3.2 The Anaesthesia Department is responsible for:

3.2.1 Defining minimum requirements for each check in accordance with section 4. These must be appropriate for the specific system under test.

3.2.2 Attaching these check-lists to each anaesthesia delivery system where appropriate.

3.2.3 Training and accreditation of the personnel involved with each check as follows:

3.2.3.1 **Level One.** Attendance at a manufacturer’s course or a programme developed by the hospital’s Anaesthesia Department in consultation with a qualified Biomedical Engineer.

3.2.3.2 **Levels Two and Three.** All Anaesthesia Department personnel must be trained and accredited in correct anaesthesia system checking procedures.

4. Protocols

4.1 **Level One check.** This must be performed by a suitably qualified person (usually the service provider) on all anaesthesia delivery systems a) before they enter service and b) following servicing. The check shall include:

4.1.1 **Gas Delivery Devices.**

4.1.1.1 Quantifying and minimising leaks

4.1.1.2 Excluding crossed pipelines within the anaesthesia delivery system

4.1.1.3 Ascertaining the correct functioning of non-return valves throughout the system

4.1.1.4 Ascertaining the integrity of oxygen failure prevention and warning devices

4.1.1.5 Checking the composition of delivered gases and their flowrate

4.1.2 **Inhalational Anaesthesia Devices**

4.1.2.1 Ascertaining that no leakage occurs

4.1.2.2 Checking any thermostat function

4.1.2.3 Calibrating output at both high and low flow rates

4.1.2.4 Checking function of any interlocking or other mechanisms

4.1.3 **Intravenous and Local Anaesthesia Delivery Devices**

4.1.3.1 Checking electrical safety

4.1.3.2 Calibrating output rate and accuracy

4.1.3.3 Calibrating occlusion pressure

4.1.3.4 Checking alarm function and accuracy

4.1.3.5 Ensuring operation of all user functions and parameters

4.1.3.6 Checking serviced mechanisms operate correctly

4.1.3.7 Checking battery performance

4.1.4 **Other Equipment.** The check should include the function, safety and accuracy of any other equipment included within the delivery system (such as to provide for ventilation, scavenging and monitoring).

4.1.5 The check shall verify that the system as supplied complies with the relevant Hong Kong Standards.

4.1.6 Documentation of the check is required and shall include the date, what was checked, the results of the check, and who performed the check

4.2 **Level Two check.** This check is the responsibility of the anaesthetist but may be undertaken by a suitably qualified person (such as an appropriately trained nurse or technician) in accordance with a protocol specific for the particular system at least at the beginning of each session. Thus several different protocols may be required in a single hospital. These will serve to verify the correct functioning of the anaesthesia delivery system before it is used for patient care.

Not all the following checks may be appropriate in some self-checking anaesthesia workstations.

4.2.1 **Service label.** Confirm that the device has been appropriately serviced and is not past its service date

4.2.2 **High Pressure System.**

4.2.2.1 Check oxygen cylinder supply. Ensure that cylinder content is sufficient for its intended purpose.

4.2.2.2 Check that piped gas supplies (where present) are at the specified pressures and that after completing the high pressure system checks, the cylinders are turned off.

4.2.2.3 To confirm that pipeline gas supplies are not crossed, use a multi-gas analyser to check gas composition at the common gas outlet, the inspiratory limb or the -piece.

4.2.3 **Low Pressure System.**

4.2.3.1 Check flow controls. Turn on each gas and observe the appropriate operation of the corresponding flow indicator. Verify the functioning of the anti-hypoxic device.

4.2.3.2 If vaporiser/s are present:

4.2.3.2.1 Check that adequate anaesthetic liquid is present.

4.2.3.2.2 Ensure that the vaporiser filling ports are closed.

4.2.3.2.3 Check correct seating and locking of a detachable vaporiser.

4.2.3.2.4 Test for circuit leaks for each vaporiser in both on and off positions.

4.2.3.2.5 Ensure power is available for electrically operated vaporisers.

4.2.3.3 Ceck for pre-circuit leaks using a protocol appropriate for the specific anaesthesia delivery system.

4.2.3.4 **Breathing systems.** Inspect and check the breathing system to ensure correct assembly and absence of leaks. The precise protocol will depend on the anaesthesia circuit to be used.

4.2.3.4.1 Perform leak test on the breathing system by occluding the patient and rebreathing bag connections, setting a fresh gas flow of 300 ml/min and ensure that the pressure rises to >30 cm H_2O from zero.

4.2.3.4.2 For circle systems, inspect the integrity of the system, its connections and check the unidirectional valves. This can be accomplished with a breathing bag on the patient limb of the -piece. Ventilate the system manually using an appropriate fresh gas flow. Observe inflation and deflation of the attached breathing bag and check for normal system resistance and compliance. Observe movement of any visible unidirectional valves. Check function of adjustable pressure limiting (APL) valve by ensuring easy gas spill through APL when the two breathing bags are squeezed.

4.2.3.4.3 If a carbon dioxide absorber is present, check the colour of the carbon dioxide absorbent. If the absorbent may have dried out by prolonged dry gas flow then it should be replaced in order to avoid the potential for production of carbon monoxide.

4.2.4 **Automatic Ventilation System.** This should be checked according to the manufacturer's recommendations. A test lung (such as a suitably compliant bag) may be used to check the function of the ventilator and the delivery of adequate tidal volume. If a test lung is used, the fresh gas flow should be set to zero, or minimal flow, to help detect leaks in the ventilator. Correct function of disconnection and high pressure alarms and the high pressure relief valve if present should be checked at this time.

4.2.5 **Scavenging System.** Check that the scavenging system is properly connected, the scavenging suction flow is adjusted appropriately and that the scavenging outlet is not blocked. This should be checked after connection to the APL valve and appropriate adjustment of the scavenging gas flow. With the patient outlet occluded and the APL valve open, a full breathing system should not normally empty. If emptying does occur, the absence of negative pressure in the circuit system should be confirmed.

4.2.6 **Emergency Ventilation System.** Verify the presence and functioning of an alternative method of providing oxygen and of controlled ventilation (such as a self-inflating bag).

4.2.7 **Intravenous and Local Anaesthesia Delivery Devices.** These should be checked according to the manufacturer's recommendation and should include that:

4.2.7.1 The device is appropriate for the intended function with special attention to its range of flow rate and occlusion pressure

4.2.7.2 The anaesthetic is correctly loaded and labelled

4.2.7.3 Any program is correct with special attention to:

4.2.7.3.1 Syringe/container type and volume

4.2.7.3.2 Anaesthetic concentration

4.2.7.3.3 Flow rate and units

4.2.7.3.4 Any alarm parameters

4.2.7.4 The device is appropriately powered by mains and/or batteries
4.2.7.5 All connections to the device and onto the patient are secure
4.2.7.6 There is no leakage
4.2.7.7 The device actually functions and the drug is delivered.
4.2.7.8 An anti-reflux valve is installed if sharing a delivery line.

4.2.8 **Other apparatus to be used.** This should be checked according to specified protocols. Attention should be given to:
4.2.8.1 Equipment used for airway maintenance and intubation of the trachea.
4.2.8.2 Suction apparatus.
4.2.8.3 Gas analysis devices.
4.2.8.4 Monitoring equipment. Special attention should be paid to alarm limits and any necessary calibration.
4.2.8.5 Intravenous infusion devices.
4.2.8.6 Devices to mimimise hypothermia during anaesthesia.
4.2.8.7 Breathing circuit humidifiers.
4.2.8.8 Breathing circuit filters.

4.2.9 **Final check.** Ensure vaporisers are turned off and that the breathing system is purged with air or oxygen as appropriate.

4.2.10 Documentation of the completion of the check is recommended.

4.3 **Level Three check.** Immediately before commencement of each anaesthetic, the anaesthetist should:
4.3.1 Check a changed vaporiser using the protocol outlined in 4.2.3.2.
4.3.2 Check a changed breathing circuit using the protocol outlined in 4.2.3.4.
4.3.3 Check any intravenous or local anaesthesia devices using the protocol outlined in 4.2.7
4.3.4 Check other apparatus as specified in 4.2.8

The Hong Kong College of Anaesthesiologists

Room 807, Hong Kong Academy of Medicine Building, 99 Wong Chuk Hang Road, Aberdeen, Hong Kong
Phone: (852) 2871 8833 Fax: (852) 2814 1029 Email: office@hkca.edu.hk website: www.hkca.edu.hk

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