

First Feedback from ESA Fellowships

North Western countries

Anyone who studies who gets the ESA prizes and grants will notice that the successful countries are likely to be found in north western Europe. Whether this is because of superior facilities or literary skills is open to speculation. An initiative has now been set up to improve contacts between the successful few and those who want to learn from them: the ESA Fellowship scheme. It aims to bring anaesthesiologists, near the completion of their training, to centres that offer special experience in the clinical subspecialty of their choice. The hope is that these fellowships may help to transfer some of the specialist knowledge of the major centres of Europe to trainees who have yet to be exposed to such fields of clinical expertise.

Three fellowships awarded in 2005

After advertising, the ESA received 20 applications and awarded three Fellowships; to Dr Desai from Rijeka in Croatia, and Dr Balciunas from Lithuania both of whom wished to visit Papworth Hospital, a well known centre for cardiac surgery in Cambridge, UK, and to Dr Erden from Hacettepe in Turkey, who wished to visit the Department of Anaesthesiology at the Ospedale Maggiore in Milan, Italy. Two of these Fellows have now reported back to the ESA on their experience. Both were



Dr. Erden is shown (back row left) with staff of the Ospedale MAgiore.

anaesthesiologists within two or three years of completing their training, and both found the information on the ESA website. One had harboured desires to work abroad for a number of years, but had never managed to construct a successful plan, and the other working in a cardiac centre in Rijeka, recognised that he would benefit from external influences, and had very clear objectives.

Large choice of host centres

The ESA accepted offers from 41 potential host centres across Europe, on the understanding that some are more likely to see a Fellow than others. Dr Desai told us that 'The list of hospitals was

impressive, and included some of the most eminent European clinical centres. I had an extensive list of what I wanted to learn, and this included the management of heart transplant recipients, ventricular assist devices, and transesophageal echocardiography'. He selected Papworth Hospital in Cambridge, UK, and arrived to take up his Fellowship on August 1st, but only after resolving a problem that had not been foreseen.

Registration refused

The law in the United Kingdom requires that all medical practitioners register with the General Medical Council. For doctors from countries within the

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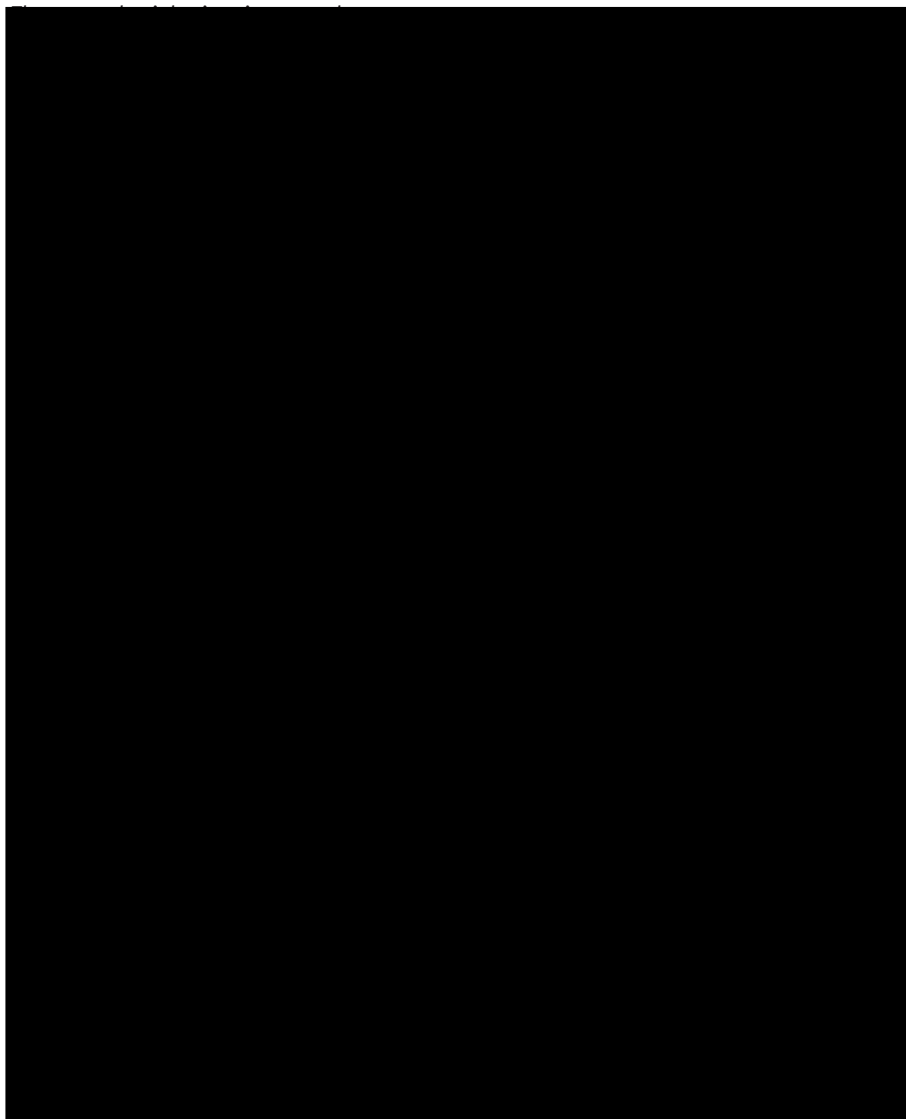
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European Union, this is a formality. Doctors from outside the EU need a sponsor and, in cases like these, the Royal College of Anaesthetists will frequently oblige. They must also pass an exacting language test. Dr Desai failed to satisfy the Council on some points and his registration was refused. He was allowed to continue his visit to Papworth, but only as an observer. Registration would have allowed him to get involved in hands-on clinical care. To compensate for this, the ESA reorganised the attachment so that one half would be spent as an observer at Papworth, and the other as an active participant at the Institute for Clinical and Experimental Medicine in Prague. Dr Erden also experienced a few problems, 'but the ESA was always ready to find a solution'.

Papworth impressed

When Dr Desai started at Papworth he found that 'The list of operations performed there is quite long and complex.



ESA Elects First Council

Eberhard Kochs, ESA Secretary and Peter Simpson, ESA President

Wider representation

The last year has brought substantial changes to the ESA, which has taken a major step forward in unifying the three major European international societies with the successful amalgamation of ESA, CENSA and the European Academy. The ESA now represents in the region of 100,000 anaesthetists in the wider European area, either directly as our members, or indirectly, through NASC (National Anaesthesiology Societies Committee) as members of their own National Societies. This, however, is not the end but just the start of a major move forward in the development of European Anesthesiology, in terms of education, training, standardization, research and even political issues. The potential benefits for us all are enormous. During the past year, the Interim Board has done a tremendous amount of work in setting down all the issues involved and paving the path for the future.

Involving the members

All anaesthetists in Europe are encouraged to take an active part in the ESA, by becoming members and engaging themselves in the work of the Society and its various activities and committees. This has begun by the election of our new Council members for 2006 – 2007 and we welcome and congratulate them all. Although some were Council members of the former ESA, all are now elected to the

new organisation. We are anxious to find ways in which our Council members can become more involved with the work of the organisation and its future strategy and development and we would welcome ideas and suggestions to help us. Every community is critically dependent on its members and the ESA is no exception. We would like to see anaesthetists from all European countries united by and within the ESA and working towards common goals.

Setting course

The new Board and Council have some important and major tasks ahead setting the framework for the future strategic direction of the ESA. Not only do we have to establish all the policies and procedures under which the organisation will function, but also we have to acknowledge and build upon the increased remit which amalgamation has brought to the new ESA. We are very fortunate in many ways, not only because we have inherited a wonderful building in Brussels, together with very dedicated staff who happily are staying with us, but also because each former organisation has brought different and complimentary interests with them. By working together with the Board and Section of Anaesthesiology of UEMS, ESA will have a major involvement in training and examinations. Through NASC, linked to WFSA, we will be directly involved with National Societies throughout Europe, participating in national and regional meet-



Eberhard Kochs



Peter Simpson

ings. In addition, our education, professional development and research programs will be continued and strengthened. Of course, we will have to prioritise our activities, both in terms of aspirations, expectations, time and money and we will need your help to do this. Nevertheless, the potential benefits of a truly European Society of Anaesthesiology are enormous.

We are positive that the forthcoming Euroanaesthesia congress in Madrid will already reflect the combined nature of our future European activity and we are looking forward to meet as many members as possible there. ●

ESA Council election winners 2006-2007

Country	Candidate		
Austria	Spiss Christian	Latvia	Sondore Antonina
Belgium	Singelyn François	Lithuania	Rimaitis Kestutis
Bulgaria	Slavcheva Snezhana	Norway	Mellin Olsen Jannicke
Croatia	Novotny Zdenko	Poland	Knapik Piotr
Czech Republic	Horacek Michal	Portugal	Lemos Paulo
Denmark	Kirkegaard Hans	Romania	Bubenek Serban
Finland	Pere Pertti	Russia	Nicolayenko Edward
France	Chassard Dominique	Serbia and Montenegro	Stevanovic Predrag
Germany	Hoefl Andreas	Slovenia	Vintar Neli
Greece	Fassoulaki Argyro	Spain	Aldecoa Alvarez-Santullano Cesar
Hungary	Csomos Akos	Sweden	Bodelsson Mikael
Ireland	Cunningham Anthony	Switzerland	Kindler Christoph
Israel	Wichelewski Josef Isaac	The Netherlands	Knape Johannes Th. A.
Italy	Solca Maurizio	Turkey	Alkis Neslihan
		United Kingdom	Sneyd Robert

New e-mail addresses for ESA staff

As a result of a server hardware upgrade, all ESA staff now have a uniform e-mail address ending in @euroanesthesia.org, matching the domain name of our website. Our former e-mail addresses will only remain functional until March 31st 2006, so please take a moment to update your address book today with the addresses below.

esa@euroanesthesia.org	Michel De Bisschop Executive Director
abstracts@euroanesthesia.org	Raf Kinnaer Congress Programmes Administrator
events@euroanesthesia.org	Renaud Rollet Events Planning Officer
exam@euroanesthesia.org	Anne Dewaegenaere EDA Exams Administrator
accounts@euroanesthesia.org	Sue Loughlin Accounts Administrator
secretariat@euroanesthesia.org	Cindy Martinez Member Services Supervisor
membership@euroanesthesia.org	Elzbieta Grabiec Member Services Administrator
registration@euroanesthesia.org	Hugues Scipioni Member Services Administrator

The addresses above can also be found on our website (What is ESA -> ESA secretariat).

Generic e-mail addresses have been created for correspondence about the

Research Grants Programme (research@euroanesthesia.org),
Travel Grants (travelgrant@euroanesthesia.org) and the
Fellowship Programme (fellowship@euroanesthesia.org),
and have been updated on all appropriate web pages.

Should you still find a reference on our website to one of our old e-mail addresses, feel free to point this out to postmaster@euroanesthesia.org ●

EUROPEAN DIPLOMA IN ANAESTHESIOLOGY & INTENSIVE CARE

Endorsed by the European Board of Anaesthesiology (EBA)
of the Union of European Medical Specialties (UEMS)

The next Part I (MCQ) Examination and In-Training
Assessment (ITA) will be held in

English, French, German, Italian, Spanish & Russian

on

Saturday 7 October, 2006

In

**Athens, Barcelona, Berne, Budapest,
Cluj-Napoca, Göttingen, Liège,
Ljubljana, London, Lund, Moscow,
Oslo, Paris, Porto, Poznan, Riga,
Rome, Tel Aviv, Uppsala & Vienna**

CLOSING DATE FOR ENTRIES IS:

16 June, 2006

Further information available from:

The Examination Office,
European Society of Anaesthesiology
24 Rue des Comédiens
1000 Brussels
Belgium

Tel : + 32 (0)2 743 32 99

Fax : + 32 (0)2 743 32 98

Email : exam@euroanesthesia.org
www.euroanesthesia.org

New Chairman of European Diploma Examination Committee

Peter Simpson, ESA President

The ESA Board are pleased to announce the appointment of Dr Zeev Goldik as Chairman of the examination committee from 1st January 2006, in succession to Dr Peter Simpson. Born in Argentina and a Spanish speaker, Zeev is Director of the Post-Anaesthesia Care Unit of the Carmel Medical Centre in Haifa, Israel and a lecturer in health management system programs in Haifa University. A strong and active supporter of the European Diploma exam, he has been an examiner, a member of the Part I and II examination committees and a member of Senate of the former European Academy since 1996. As a Board member of CENSA, then NASC and thus of the interim Board of the ESA, his responsibilities have stretched across many aspects of the work of our new Society.



Dr Zeev Goldik.

But it is the extensive involvement and deep understanding of European training that he brings to the examination chairmanship, which is most important for the future, including the vital link to the UEMS Board of Anaesthesiology on which he has been the Israeli representative on since 1996. He has organised the Part I and II of the Diploma since inception in Israel, introducing Russian as one of the official languages. His linguistic abilities have meant that he has examined in the oral Part II exam in a number of centres, acting as Chairman in Spain and Israel. Dr Goldik is very keen to ensure uniformity of quality and standards in the examination and is at present developing ideas for audit of examiner performance across all the Part II centres. A daunting task, but one to which he is very committed and we should be also. We wish him and the examination committee every success for the future. ●

Thirty five applicants

On Tuesday, December 20, 2005 the Research Subcommittee met in Brussels in order to discuss the different grant applications: 35 applications were received, 8 applications for the Research Support grants (three grants up to 15.000 euro) and 27 for the project grants (three grants up to 60.000 euro).

All the applications were reviewed by all Research Subcommittee members (and eventually external reviewers if necessary) and ranked within a system, which was discussed and approved during the last ESA Board meeting on December 5, 2005. Each application was ranked independently and blinded from each reviewer. Thus, according to a pre-defined threshold value applications for final evaluation were selected.

Fourteen shortlisted

From the 8 applications for the Research Support grant, four were selected for a final evaluation, while from the 27 applications

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Membership list

Over the past year the ESA Interim Board debated the issue of ESA member personal data protection, obtained legal advice on the matter from several sources and recently adopted a strict policy.

The issue arose when a former Board member of the European Academy suggested that the new ESA publish a directory of ESA members similar to that published in the *little red book* of the former EAA. Cost was one consideration but more impor-

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Fellowship by Election: Professor T Pasch

By permission of Peter Simpson, we reproduce in full the citation for Thomas Pasch, Interim President of the ESA, at his election to the Fellowship of the Royal College of Anaesthetists of the United Kingdom. This was first published in the Newsletter of the RCA.

Thomas Pasch trained in Münster and Erlangen, graduating in 1966. After six years' research in cardiovascular physiology he entered anaesthesiology training in Erlangen, becoming a staff anaesthesiologist in 1978. He became Associate Professor and was appointed full Professor of Anaesthesiology within the University of Zurich and Chairman of the Institute of Anaesthesiology in 1987, a post which he has held ever since. He has been Medical Director of the University Hospital and Vice Dean for Clinical Affairs in the Faculty of Medicine in Zurich since 2002. He is, or

has been, on the Editorial Board of no less than eight journals and has an extensive research output, publishing over 113 articles in peer review journals and contributing to a wide number of congresses and reviews.

Most importantly, however, Professor Pasch has made a major contribution to the future of European anaesthesiology, not only for many years as a member of the Examination Committee for the European Diploma of Anaesthesiology, but also as President of the European Academy itself. During this Presidency he has been instrumental in guiding the Academy towards amalgamation with the European Society and CENSA, to achieve the ultimate goal – that of the new European Society of Anaesthesiology of which he is one of the two 'Founding Presidents'



Members of the Council, it is for his achievements on behalf European anaesthesiology that we are honouring Professor Pasch today and I am delighted and honoured to present him to you for the award of Fellowship by Election of the Royal College of Anaesthetists..●

Peter Simpson

A Start in France for The New Executive Director



Michel De Bisschop reflects on his first three months with the ESA

Holiday reading

I read the advertisement for an Executive Director in July whilst on holiday in the South of France. I thought this is a job for me, and I sent my application in without a second thought. Returning from holiday I met the Selection Committee, John Popovich and his colleagues at the Secretariat, which only served to reinforce my initial reaction. It was exactly one month after reading the advertisement that I signed the contract in the elegant headquarters and another month later I started my new job.

Holding the team together

The decision taken by the Board of Directors to allow an extension period with John Popovich contributed to a smooth handover and the transfer of experience and information.

The first three exiting months have taught me a great deal. What was there to do at the Secretariat of a non-profit European organisation of medical specialists? I had some ideas, but it quickly became clear that within the content of the job there is great variance. Some tasks repeat on regular base, but most are done only once a year, which makes the job very attractive. As a newcomer, it is important to keep the experience of the existing team. I put managing people at the top of my list of necessary skills. Within the Secretariat are a number of specialists with different experiences and perspectives and I am privileged to have their support.

Progress in three months

In the last month we updated the computer network at the Secretariat and installed our own mail server. This offers greater flexibility and will permit future expansion. As a result of this new e-mail addresses for the staff of the Secretariat, ending with the website name: ...@euroanesthesia.org, are announced elsewhere in this newsletter.

Work in progress

This year all the Staff will be involved in the development of a new information system programmed in Filemaker, with the intention of increasing web links between current and future activities of the ESA.

Computer issues apart, some fine tuning of the policies and procedures of the Society may be required, and consideration given to the longer term. In this it is important to recognise the Society's widened responsibilities in terms not only of organising meetings, but also in education, training, examinations, research and, through NASC, in relating to our members throughout Europe.

The success of Euroanaesthesia and changes in the regulations for industrial sponsorship offers a real challenge for the future Annual Meetings. I am keen to apply my experience in organisational and financial management to potential problems of this nature. The international and cross-cultural aspects only serve to make it all more interesting.

The European Society of Anaesthesiology just had his first anniversary and we can say that we are on the way. I am delighted to be part of the team.●

The Renaissance of Cardiac Massage - New 2005 European Guidelines on Resuscitation

Bernd W. Böttiger, Peter J.F. Baskett, Jerry P. Nolan and David Zideman

New guidelines

Each year in Europe, over 350,000 people die from sudden cardiac death. Some of these lives might be saved by more effective basic and advanced life support, and the new European Resuscitation Council (ERC) Guidelines on cardiopulmonary resuscitation (CPR) aim to achieve this. The guidelines that are based on an International Consensus on Science, were recently published online (www.erc.edu) and in the November/December issue of the journal *Resuscitation*.

International experts

The International Consensus of Science was composed of more than 380 international experts drawn from the European Resuscitation Council and the American Heart Association, under the umbrella of the International Liaison Committee on Resuscitation (ILCOR). They conducted a formal and intensive evaluation of all the currently available clinical and experimental data. The resulting Consensus on Science forms the scientific basis for the new treatment recommendations.

Important new changes

The new evidence-based guidelines recommend several important changes in current CPR practice whether performed by lay people or by health care professionals:

In cardiac arrest, the ratio of chest compression to ventilation has increased from 15:2 to 30:2 (30 compressions followed by 2 ventilations). This also applies if two rescuers are present. Only in children, (except newborns where the ratio is maintained at 5:1) when two professional rescuers are present, the 15:2 ratio is maintained.

Commencing resuscitation should not be delayed whilst lay people check for signs of cardiac arrest. If a victim is not responding and not breathing normally, CPR should begin immediately with cardiac massage and ventilation, starting with 30 chest compressions. If there is reluctance to perform ventilation, uninterrupted chest compressions must be continued

until help arrives. New studies have demonstrated that performance of effective and preferably uninterrupted chest compressions is the key issue with regard to survival.

Automatic defibrillators

The new guidelines recommend the installation of automatic electrical defibrillators (AEDs) that can be used easily by lay people in places where many people congregate (airports, sports arenas and shopping centres). Several studies have demonstrated clearly that early defibrillation by lay persons has led to an increase in survival rates by more than 25 % in such settings.

The new guidelines emphasise the importance of effective and good quality chest compressions from the start of resuscitation. This is also reflected in the changes that have been made regarding the defibrillation process. Defibrillation (monophasic 360 J; biphasic 150 – 200 J) for ventricular fibrillation or ventricular tachycardia should be performed as a single shock followed immediately by two minutes of chest compressions. This replaces the three shock sequence of the 2000 guidelines where, because of this sequence, there were substantial times when chest compressions were not being performed. Similarly, it is not recommended to analyse cardiac rhythm after each shock as this may cause up to 30 seconds further delay a return to chest compressions. Instead, chest compressions must be started again immediately after each defibrillation attempt and continued for 2 minutes before further analysis of the patient.

Cooling to 32 - 34 °C

New therapeutic approaches to post resuscitation care have also been described. Several studies have demonstrated that mild therapeutic hypothermia can increase survival rates and the likelihood of good neurological outcome in cardiac arrest patients. It is now recommended that patients who remain comatose following cardiac arrest should be cooled to core temperature for 12 to 24 hours.

Thrombolysis

Thrombolytic therapy during ongoing CPR should be considered when cardiac arrest is thought to be due to proven or suspected acute pulmonary embolism, and – on a case by case basis – following initial failure of standard resuscitation in patients in whom another acute thrombotic aetiology for the arrest is suspected. Ongoing CPR is not a contraindication to thrombolysis.

The full text and a summary version of the new guidelines including all important changes and the scientific document of the International Liaison Committee on Resuscitation (ILCOR) can be downloaded from the website of the European Resuscitation Council (www.erc.edu). The guidelines will be discussed in detail at the ERC Scientific Congress *Resuscitation 2006* in Stavanger, Norway, May 10-13, 2006, and at the next ESA annual meeting in Madrid, Spain, June 3-6, 2006. Your attendance at either or both of these meetings is welcomed. ●

Further information

- European Resuscitation Council (ERC): www.erc.edu
- European Resuscitation Council Guidelines for Resuscitation 2005
- Resuscitation. 2005; 67 Suppl 1:S1-S189

Comments to: editor@blocked.org.uk



Profile of Anis Baraka

Professor and Chairman, Department of Anesthesiology,
American University of Beirut, Lebanon

Humble beginnings

Anis Baraka was born in Fayoum in Egypt in 1930. 'Fayoum is just a village. My parents did not have a medical background, in fact they were not educated. I was the only person in the village who went to the university'. He went to Cairo to study medicine, graduating in 1953. It was during his time as an intern that he became attracted to anaesthesia, and subsequently entered the residency programme in Cairo University Hospital. In 1961 his thesis was accepted and he was awarded the research degree of MD. He joined the Cairo University Department following this.

Research in Europe

His MD thesis was on the subject of muscle relaxants, and Professor Cecil Gray, whilst visiting the Cairo University, reviewed the manuscript. 'As you know, Cecil Gray is considered the Father of Relaxants in the United Kingdom, and he invited me to join his Department in Liverpool as a Research Fellow. I accepted the offer and travelled to the UK in 1963. It was in Liverpool that I investigated the effect of PCO₂ on muscle relaxants, and also compared the block obtained from different drugs'. These were the first of a series of studies on muscle relaxants that he published in the British Journal of Anaesthesia.

Arrival in Beirut

It was whilst he was in Liverpool that the offer came to go to Beirut. 'Dr Bernard Brandstater, Chairman of Anesthesiology at the American University of Beirut, listened to a presentation of my research and invited me to join the Faculty at the



In conversation with Sir Robert Macintosh.



Anis Baraka, second row, far right, as a Research Fellow in Professor Gray's (centre) 1964 Liverpool Department. Jackson Rees sits at Professor Gray's right hand.

American University of Beirut'. Before leaving the UK he undertook further training at the National Heart Hospital London, and began his long association with the American University in 1965. His bibliography testifies to a formidable research output at this time. He was appointed Assistant Professor in 1966, and ten years later Professor and Chairman of the Department, a post he has now held for almost 30 years.

Civil war

During the 1960s, Beirut had acquired a reputation as a lively cultural and financial centre where east and west mingled freely together. In the 1970s, stability collapsed, and warring factions destroyed the city. There was widespread breakdown of basic services, and there were significant personal risks to those who remained in the city. In Professor Baraka's slide collection are pictures of some of the horrific injuries of victims caught in the strife that continued for 15 years.

'I was in Beirut throughout the war. As a matter of fact I was the only chairman who stayed because I felt my duty was to provide a service for the casualties. I found it interesting that even without supplies of oxygen and nitrous oxide we could still provide effective general anaesthesia and get good results'.



Receiving honorary Fellowship of the Royal College of Anaesthetists from Professor Michael Rosen.

In recognition of his achievements, and particularly his contribution during the war, he received a number of honours, not only from the Lebanon, but internationally. In 1990, the Royal College of Anaesthetists awarded him an honorary Fellowship, and he was appointed to the International Commission of the Ralph Waters Prize. He is a Vice-President of the World Federation of the Societies of Anaesthesiology, and represents them at the Regional Commission of the United Nations. Despite all the plaudits, he still anaesthetizes regularly. 'I only go to my office when there is an official meeting. My present location is in the operating room where I function not only as Chairman of Anesthesiology, but also as Co-ordinator of the Operating Room'.

Academic activity

His Department teaches both undergraduates and postgraduates on a residency programme, with a full range of discussions, reviews, lectures and presentations. 'I allow our Faculty to attend at least one international conference each year, such as the annual meetings of the ESA or the ASA'. His own lectures are full of grainy black and white images interspersed with modern colour prints detailing an astonishing caseload of difficult clinical problems collected from almost half a century of clinical practice.

His curriculum vitae lists 20 pages of publications spanning 40 years, many in the specialty's core journals. 'I consider that academic anesthesia can be considered so only if there is continuing publication. I have 15 Faculty who need publications for promotion, and I always help them achieve their goals'.

Retirement

He officially retired ten years ago, at the age of 65. 'The University keep extend-



The Department of Anesthesia of the American University, Beirut.

ing my appointment, but only one year at a time. Now I am 75, but I do not feel old enough to retire. The best relaxation I have is my work, and I enjoy participating in national and international meetings when I can socialize with my colleagues'. For those about to start a new career in

medicine he gives this advice; 'Never do your job for money, prestige or position. Medicine has a humanitarian message, you do it with love'. ●

Irish by birth

Jeremy Swan was born in Sligo, Ireland, in 1922, the son of two family doctors,

Harold Swan and Marcella Kell5.25ro4070 TD(r)Tj0.e1 0 0 with m.2 005 691 -1.L1922, b768 T79D57(o

John Popovich has left the building

John Popovich left the ESA at the beginning of January 2006 after working as Executive Director for 7 years. He will be a hard act to follow. John was appointed in late 1998 by Alan Aitkenhead (then ESA President), Hans-Joachim Priebe (then ESA Secretary) and Azriel Perel (then ESA Treasurer) late one Friday evening at the Sheraton Hotel at Brussels Airport. He started work at 9 o'clock on the Saturday morning by attending a meeting of the Board of Directors.

Until a few weeks earlier, the ESA had been run from the library of the Department of Anaesthesia at the Erasme University Hospital in Brussels. However, it was forced to leave at short notice, and a small suite of offices was rented in Avenue de Tervuren. The ESA staff at the time were excellent, but lacked the leadership required to run the entire organisation unsupervised. The ESA was growing consis-

tently, and was becoming increasingly complex to administer. We needed an Executive Director with business management skills and, preferably, an appropriate background.

John had been born and brought up near Boston in the United States and had come to Europe in his late teens to study in Switzerland. He developed skills in financial management as well as mastering several European languages, and worked in Switzerland and then, after education in an MBA programme, in Brussels. He had worked, *inter alia*, in publishing and the medical equipment industry. We predicted (correctly) that the skills which he had acquired in these areas would be useful to the ESA, in addition to his experience in business management. However, John had also acquired expertise in property development and renovation, and was an expert at spotting bargains at auctions. We totally failed to predict how valuable these attributes would be to the ESA.



John Popovich.

John's contribution to the ESA has been immense, but I think that there are four areas which are worthy of special mention.

John's first achievement was to convert a small, only semi-professional, organisation into an efficient, totally professional business which could cope with an expanding membership base. He reorganised and re-equipped the Secretariat so that it could cope with dealing with increasing numbers of members and a rising number of attendees at the Annual



24 Rue des Comédiens, at purchase and after renovation.

Meeting. He renegotiated the contract with our Professional Congress Organisers, Options Eurocongress. Options Eurocongress had supported the ESA from its outset and had acted as financial guarantors of the Annual Meetings, but at a not inconsiderable cost. By 1998, the ESA finances were reasonably secure, and John negotiated an agreement which was financially advantageous to the ESA, but which was fair to Options Eurocongress and which ensured that good relations could be maintained between the two organisations. Since 1998, the membership has grown from just over 2,000 to 7,000 at the end of 2005. Attendance at the annual congress has increased from 2,300 in 1997 to over 5,000 in 2005. The management of the Secretariat has been so effective that these vast increases have been accommodated comfortably. At the same time, his management of the staff at the ESA Secretariat was such that he secured their fierce loyalty, and there has been very little turnover of staff.

Perhaps the greatest lesson which I have learnt from John is skill in negotiation. John is undoubtedly an honorary Scot. He is a ruthless negotiator, who secured the best possible price for all activities of the ESA, and demanded, and obtained, enormous discounts if the service provided did not meet the agreed specification.

Particularly in the area of printing and publication, he was innovative and daring, resulting in very substantial savings to the organisation. He became a member of a group of medical specialist societies with aims similar to those of the ESA, with the result that he had 'inside' knowledge on prices when negotiating with congress centres.

With the progressive increase in ESA membership, it became apparent that the offices in Avenue de Tervuren would be insufficient to support the increased number of staff required to administer the organisation. In addition, there were financial arguments in favour of acquiring a property for the Secretariat rather than renting, particularly in Brussels where property prices were reasonable but were predicted to rise rapidly.

John identified a number of potential properties, none of which proved to be ideal. He then found 24 Rue des Comédiens. It was an empty shell of a building which had been, in its day, a beautiful residential property, the first in Brussels with an atrium, which was supported by marble pillars and surrounded by stained glass windows. When the ESA bought the property, all of the marble had been removed, the stained glass windows were missing, there was no plaster on any of the walls and there were holes in most of the floors. Only an individual with amazing foresight could have predicted that the property could have been renovated to its original condition economically. John persuaded the Board of Directors that this could be achieved. He negotiated an agreement that half of the cost of restoration would be borne by the local authority. He selected an architect with appropriate expertise and a building company with a national reputation for restoration of old properties, and personally supervised the design and rebuilding work over a period of about 2 years. During the restoration, he attended countless auctions, acquiring furniture, light fittings and other accessories which would be appropriate for the building. The result has been fantastic. The architectural style of the interior of the house has been retained while modern features have been incorporated to make it a light, airy working environment.

The ESA headquarters building won an award in 2004 for outstanding renovation of a listed building in the Brussels Capital Region, granted by *Quartier des Arts*, a non-profit organisation devoted to preservation of heritage in Brussels.

The fourth area worthy of special mention is John's contribution to the amalgamation process throughout 2004 and in early 2005. Quite properly, John did not take an active role in the decision of the 'old' ESA to take part in the amalgamation process, other than advising about the feasibility of running a much larger and more complex business from Rue des Comédiens. However, once the three organisations had reached political agreement on the amalgamation, John worked tirelessly to ensure that the 'new' ESA would be founded on an unassailable legal and financial framework. His attention to every minute detail of the constitutions and finances of the three organisations ruffled a few feathers, but he knew that it was necessary to fulfil the requirements of the authorities which govern non-profit scientific organisations in Belgium.

John Popovich has not retired. He has left to take on new challenges, first in developing his property in Brussels and then to start a Bed & Breakfast business in Provence (www.provence-lesluniers.com). Always at the forefront of technology, he has purchased the furnishings and fittings over recent months mainly using the new auction medium of e-Bay!

John will remain as a consultant to the Board of Directors until the end of 2006. For the time being, he has left (departed) the building in person. As a result of his achievements, he has also left (bequeathed) the building to the ESA, together with a sound business structure, a very healthy financial position and an outstanding group of staff, as a testament to his achievements as Executive Director. We wish him every good fortune for the future. ●

Value for money in continuing medical education: a personal view

Professor Andrew Smith, Lancaster, UK

Many meetings

Doctors need to keep up to date with the latest knowledge and techniques in order to continue to provide the best possible care for their patients.

Continuing medical education (CME) is often referred to in the UK as continuing professional development (CPD) to encompass the non-clinical aspects of a doctor's work. Whatever its name, it has become a big business, with many courses and meetings vying for the anaesthesiologist's time and money.

Another method of evaluation

Anaesthesiologists in the United Kingdom are perhaps fortunate in that the terms of their contract allow them an average of 10 days per year for 'study leave', where they may be absent from their hospital to take part in educational activities.

In the past, employers have usually contributed to registration fees, travel and accommodation expenses. Some hospitals – my own included – are experiencing financial difficulties and have targeted study leave budgets as one area for saving money. To help us manage this budget most effectively, we thought that a more systematic approach to determining the cost of CME might help.

We obtained the details of a number of national and international meetings in anaesthesia and critical care. These were selected largely by convenience.

I divided the registration fee by the number of hours of educational activity the meeting offered. This gave a raw figure for 'cost per hour'. I also noted how many of the core topics for anaesthetic practice (as defined by the European Union of Medical Specialists in 1998) the meeting addressed. These are topics in which a typ-

ical hospital specialist, participating in the emergency on-call rota, should have up to date knowledge. They are shown in the Box.

The European meetings sampled were:

- European Society of Regional Anaesthesia
- European Association for Cardiothoracic Anaesthesia
- European Resuscitation Council
- European Society for Intravenous Anaesthesia (EuroSIVA)
- International Symposium on Intensive Care and Emergency Medicine
- European Society of Anaesthesiology and a meeting on Anaesthesia and Perioperative Care in the Older Patient.

ESA offers best value

Dividing the registration fees for these meetings by the number of CME credits yielded a figure of between 20 and 40 Euros per hour. The ESA was cheaper again, at 17 Euros per hour. Interestingly, all these meetings provide cheaper CME than most of the national UK meetings, which are typically 55-70 Euros per hour. As far as core topics coverage goes, again the ESA scores well: most specialist meetings may cover at most 3 or 4 of the UEMS core topics, whereas a quick glance at the ESA programme, with its wide range of scientific subcommittees, may easily provide material for 10 or 11 of them. This variety is one the strengths of the ESA meeting, making it ideal for the generalist. A drawback may be that specialist interests will not be dealt with as fully as they would be in a single-specialty meeting.

Budget airfares

Of course, attending meetings incurs other costs: travel, accommodation and subsistence (food and drink). It was necessary to add in the costs for these items too. These costs can be substantial, and are usually more than the meeting registration fee. However, for those determined to keep their costs low, many European cities are served by low-cost airlines. There are also cheaper alternatives to the more luxurious conference hotels. This may not suit anaesthesiologists who feel they deserve a little luxury and, for those colleagues who are combining a meeting with

Summary of UEMS core topics in anaesthesiology

Airways

- strategies for the difficult airway, the 'shared' airway
- bronchoscopy, laryngoscopy, foreign body, failed intubation.

Emergency & Major Surgery

- rapid sequence induction, open chest, major trauma,
- aneurysm the 'critically ill patient'

Fluid Management

- major haemorrhage, fluid resuscitation

Invasive Monitoring

- CVP
- arterial line insertion & management

Intensive Care Medicine

- initiation of ventilatory & circulatory support

Postoperative Complications

- respiratory failure, pulmonary embolism, septic shock

Major Trauma

- assessment, resuscitation, major incident policy

Obstetrics

- anaesthesia & analgesia for labour & delivery
- the sick mother, maternal resuscitation

Occasional Emergencies

- anaphylaxis & other idiosyncratic reactions
- malignant hyperthermia
- cardiac & respiratory arrest
- A&E - drug overdose, drowning, hypothermia

Paediatrics

- common non-specialist procedures
- resuscitation of the newborn

Pain Management

- relief of severe pain (regional techniques & patient controlled analgesia)

Regional Techniques

- spinal
- epidural
- intravenous
- regional anaesthesia
- recognition of complications

Transfer Policy

- initial resuscitation & safe transfer of the critically ill
- paediatrics, neurosurgery, cardiac surgery & major burns

a holiday, or indeed have to use their annual leave to attend at all, 'living rough' may not be an option.

This year the ESA meets in Madrid, which can be reached cheaply by air from the UK. For those prepared to travel lightly, the cost for one hour of CME will be similar to that of many national UK meetings.

Best speakers

There are many reasons for attending meetings, including the opportunity to travel to new places and meet colleagues from all over Europe. Both these are worthwhile in themselves, but as organisers we have to ensure that the ESA meeting programme offers good value for money. It appears that our current formula is successful, as thousands of anaesthesiologists choose to attend each year. Speaking personally, what I find most use-

ful are speakers who:

- Present the most up-to-date research evidence on a clinical topic and interpret it for the practising anaesthesiologist
- Describe how they themselves handle clinical cases – in a way which allows the audience to benefit from their experience and practical tips, almost like working alongside them in the operating theatre
- Stimulate their audience to reflect on their practice and allow them to think in a new way

Few speakers can do all three together!

The formal lecture format is not perhaps the best way of teaching, but it is still possible to be relevant, useful, interesting and thought-provoking.

Reducing expenses

Recommendations for cutting costs are:

- Become a member of any society whose meetings you are likely to

attend. There is always a substantial discount on the registration fee.

- Register well in advance – this is often much cheaper.
- Consider attending local or regional meetings – these are always excellent value.
- Feed back important points from meetings to colleagues, or circulate Refresher Course books or other printed materials.
- Arrange to work with a colleague in another hospital. There is perhaps no better way to keep one's clinical practice fresh and current than by learning from an expert colleague. ●

Andrew Smith is Chairman of the ESA Scientific Subcommittee 1 (Evidence-based medicine and quality assurance). You can contact him at andrew.f.smith@mbht.nhs.uk

ATTENTION

For the attention of the Presidents of the National Societies

- The election of members for the National Anaesthetic Societies Committee (NASC) will take place during the NASC General Assembly in Madrid on Sunday June 4th 2006.
- All ESA Members can apply to their National Society to become the official delegate of their National Society at the NASC General Assembly
- The number of official delegates for each Country is according to the number of their declared members according to the formula in the NASC Policy which can be seen on the ESA website.
- PLEASE NOTE To be allowed to take part in the NASC General Assembly and to present a candidate for the NASC Committee the National Society must have renewed its membership and paid the 2006 membership fees
- Any National Societies wishing to be represented on the NASC may nominate one candidate for the NASC membership election
- All names of nominated official delegates to the NASC General Assembly and the nominated candidate for the NASC member election must be sent to the ESA secretariat no later than 2 months before the General Assembly which means before April 2nd 2006.

More details concerning the election process may be found in the NASC policy on the ESA web site

www.euroanesthesia.org

A personal letter will be sent to each National Society President to remind them of this important dead line. ●

National Societies of Anaesthesia must renew their representation

NASC

The National Anaesthesia Societies Committee of the ESA is the body formed by what used to be the Confederation of European National Societies of Anaesthesia (CENSA). Each national society is eligible to nominate a candidate, and at the NASC General Assembly, eight of those nominated will be elected to serve on NASC. The time has come for the national societies to choose their candidates.

Letter to Presidents of National Societies

Although NASC policy may be consulted on the ESA web site www.euroanesthesia.org the election process is new and unused. Philippe Scherpereel, the current Chairman told us 'Our plan is to send in January a letter to each Society's President inviting them to submit the name of a candidate and to propose the name(s) of their representative(s) to the General Assembly according to the number of their declared members. Each candidate, each official delegate must be an ESA individual member and their Society must have renewed its ESA membership for 2006'.

New Chairman

NASC also needs a new chairman, who must have previous experience of service on NASC. This first election, which will become a bi-annual event, will also take place at the NASC General Assembly that will take place on June 4th during Euroanaesthesia 2006, in Madrid. The NASC General Assembly is closed to ordinary members. Apart from the Board and Officers of the ESA, serving members of NASC, the election candidates and the presidents of the national societies with their Official Delegates, only representatives from the World Federation of Societies of Anaesthesiology are permitted to attend. ●

Routine cholecystectomy

I visited the 36 year old obese young woman who was scheduled for her laparoscopic cholecystectomy on the evening before her operation. I did not anticipate any difficulties. The following afternoon she was brought into the operating room, I set up an intravenous infusion and she went off to sleep with only 100mg of propofol and 10mg of morphine. I omitted to use nitrous oxide because of concerns about nausea and vomiting, and ventilated her on air and oxygen with isoflurane 1 % initially.

Right bronchial intubation

I set up an atracurium infusion, and whilst I was doing this I noticed that the oxygen saturation had fallen to 93%, and the airway pressure was moderately high. I recognised a right bronchial intubation and withdrew the tube. To secure the new position I momentarily disconnected the tube from the ventilator. The pressure fell and the saturation rose to 97%. I busied myself mixing the antibiotics, and noticed that the end-tidal isoflurane was now 0.5%. I turned up the vaporiser, and thought no more about it. It was at this time that the surgical team wandered in, and one of the foreign trainees began to vigorously palpate the abdomen, talking to his colleagues at the same time. It was an uneventful procedure.

Recall

At the end of the procedure she immediately announced that she could remember intraoperative events. I promised to discuss this with her when I had finished the next cholecystectomy. She told me that she remembered hearing the 'foreign' voice of the surgeon, and feeling some discomfort around her umbilicus. After this she went to sleep. I confirmed to her that I had recognised a short period of inadequate anaesthesia at the beginning of the operation, and I gave her an apology for this. She failed to mention my adjustment of the tracheal tube, so clearly she was asleep then, and I estimated that her period of recall spanned between five and ten minutes. In the records I wrote a full account of our conversation.

Counselling

Several months later the Professor of Surgery copied to me a letter from her Family Doctor requesting counselling for her experience. I discovered a psychologist in the University Department who had done this

before, and he agreed to see her. After two assessment sessions he wrote to me say that her symptoms, which included nightmares and loss of confidence, were indicative of post-traumatic stress, and he would start treatment.

Compensation claim

Four months later, the hospital received a letter from a local law practice seeking compensation for the damage I had caused her. In their account, the recalled events had expanded significantly to include a much larger part of the operation than reported initially. If terms were not agreed then the matter would be settled through the courts. I was asked to provide the hospital with a report. My advice was that given the subjective nature of the complaint, and the opinion of the psychologist, any attempt to defend the claim would only increase costs. About a year later the management wrote to me to say that the claim had been settled for € 24,000 approximately. My patient had received € 14,000, and the hospital had spent around € 1,100 on legal fees. The rest of the money, about € 9,000, went to her lawyers.

Reflection

For a long time I suspected that somehow my adjustment of the tube had triggered the problem, but it is only recently that I have understood how this came about. When I disconnected the tube from the ventilator, the bellows would have collapsed. On reconnecting the circuit, I would have pressed the emergency oxygen button to reinflate the bellows. The vapour in the circle CO₂ absorbers was diluted by the oxygen, with lightening of anaesthesia as a result. Low gas flows might be expected to delay normalisation of vapour concentration. I recognise that my error cost an important amount, and I am now much more generous with vapour in young patients than I used to be.

Comments

Bic Steadler:

The induction dose of propofol was too small for a young woman of this size. 1.5 to 2.5mg/kg is recommended. Without nitrous oxide, and with a small dose of propofol, the isoflurane concentration needed to be much greater than that given. After flushing with oxygen, the fresh gas flows needed to be increased to re-establish an anaesthetic concentration of isoflurane. The airway problem briefly distracted attention but sound anaes-

thetia requires that whatever the problem, no aspect is overlooked. I am impressed with how much the lawyers earned from this.

Francis Bonnet:

Recall from anaesthesia has been reported to occur in 0.13 % of cases and may result in posttraumatic stress disorder. Emergency or trauma surgery, or cesarean section are recognised risk factors, but most cases occur during planned surgery and without identified risk factors. Recall may complicate any anaesthetic procedure.

Awareness from anaesthesia is associated with BIS values > 60 and BIS monitoring might decrease the incidence of recall from anaesthesia. But BIS monitoring also leads to a reduction in anaesthetic agents administered during surgery and persisting low values of BIS have been associated with post-operative mortality. Monitoring of cerebral function is therefore only of theoretical benefit and in the case reported, lack of BIS monitoring cannot be considered as a malpractice.

Was awareness avoidable in this case? The main problem was selective intubation, and in this instance the priority was to improve gas exchange until the tracheal tube was fixed adequately. Introducing fresh oxygen in the anaesthetic circuitry at some essential. Although the sequence of events following induction of anaesthesia may have favoured lightening of anaesthetic depth, the priority was to restore adequate arterial oxygen pressure.

In North America, many claims for recall from anaesthesia and memory implicate anaesthetists in judiciary procedures leading to sharing costs. In this instance it should be acknowledged that the anaesthetist rapidly diagnosed a potentially life threatening complication that was managed appropriately. ●


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The French law regarding the end of life: a way for Europe?

Louis Puybasset, Unité de NeuroAnesthésie-Réanimation, Département d' Anesthésie-Réanimation. Hôpital de la Pitié-Salpêtrière, Paris

Together with Sadek Beloucif, André Lienhart for the "French Society of Anesthesia and Intensive Care" Ethical Group

Death prompted legal move



The death of Vincent Humbert, a young traumatic brain injury patient with major neurological handicap, by euthanasia, generated intense emotion in France. In the wake of this, the "Parliamentary Mission for Information on End-of-life Supportive Care" headed by Jean Leonetti has set out the law for the legal termination of life. The French National Assembly passed this bill unanimously in November 2004, and by the Senate, later, without amendment.

The French position is neither to legalize euthanasia, defined as an active medical act ending the life of a patient at his own request, nor to maintain the existing *status quo*, but rather to build up a kind of pragmatic "tool box" that corresponds to the various situations encountered by patients and physicians at the end of life. The situation of patients unable to express their own wishes – in other words the vast majority of our ICU patients – has been specifically addressed. This explains why a description of this French law could be of interest to other European Critical Care physicians.

Implications for intensivists

For patients receiving intensive therapy, the procedure of withholding or withdrawing life support may be initiated by the family or the care-giving/medical team if either of them decides that treatment has entered a phase of "unreasonable obstinacy". This is equivalent to the American concept of "futility", which is defined as the combination of "pointlessness and disproportion". The latter word has significance for ICU doctors because it is necessary to provide hard and proven evidence that there is an imbalance between the treatment and the expected outcome before initiating an end of life procedure.

Four steps

The procedure itself must follow four steps. The first is to take note of the patient's wishes as given in any "advance directives" and the interrogation of the surrogate decision-maker ("trusted person") if such a person was designated in advance by

the patient him/herself. The second step is, after thorough and frank exchange of medical information, to consult the family members to seek their views on the proportionality of the care being given and on their appreciation of the patient's wishes. The law specifies that the opinion of the trusted person prevails over any other non-medical opinion, except for advance directives. The third step is to gather and consult the care-giving team. The fourth step is the medical decision itself, taken by a college of physicians in a consensual manner. This "collegial procedure", aimed at avoiding solitary decisions, does not relieve the doctor in charge of the patient of his own personal responsibility in the decision making process. In this respect, he/she is discharged of his/her penal liability according to article 122-4 of the French penal code as long as the procedure has been followed strictly and as long as the medical evidence on which the decision has been founded has been recorded in the medical file, together with the outcomes of various consultations described above.

This procedure makes it clear that the decision has to be taken by physicians and must be backed by hard evidence. The care-giving team is informed and "consulted". Similarly, families are implicated in the decision process but are not responsible for the decision itself. This sequence has been chosen to prevent unnecessary guilt among family members, should a decision to limit or discontinue active care be taken. However, it is obvious from the reading of the report introducing the law that the process should be aborted and/or postponed if a consensus between the medical team, the care-giving team and the family or the surrogate decision maker, fails.

Living wills are not binding

Any instructions given in advance that set out the patient's wishes regarding the limitation or discontinuation of care at the end of his/her life must have been drafted within the three previous years to be valid. In contrast to Dutch and Belgian laws, these have no binding on doctors. Though only indicative, they will be all the more valuable for the doctor in charge of the patient if they correspond to a patient's foreseeable clinical situation.

Despite the fact that the decision taken is restricted to withholding or withdrawing life support, the law specifies that doctors must use all means at their disposal to ensure dignity in life and death. Treatment that might shorten a patient's life is permitted providing that the surrogate and the family are kept informed. This article creates a possibility for the doctors to increase the level of analgesia and sedation at the end of life to ensure comfort.

Although rare in the ICU setting, the situation of the patient able to express his/her wishes is acknowledged by the law. Physicians should respect choices, including a refusal of mechanical ventilation, artificial feeding or hydration. The patient's decision must be the expression of his/her own will and repeated after a "reasonable lapse of time" (left to the feelings of the medical team in charge of the patient). The obligation for the doctors to respect the patient's wishes does not apply to incompetent patients, such as patients suffering from psychiatric disorders or neurological diseases that have profoundly affected their cognitive capabilities.

Emergency situations

In a case of emergency, neither of the options described above are applicable. The general principle is that "care must not be continued out of unreasonable obstinacy" and may be "withheld or not undertaken" when it appears to be "pointless, disproportionate or have no effect other than the artificial prolonging of life". The doctor in charge should apply this principle according to his/her conscience. In this and other situations the basis for all decisions must be explained in the patient's medical records.

Perhaps every European country will legislate in the coming years on the issue of death in a world where medicine is active at the limits of life. The new French law is offered as a model for those European countries that currently have no legislation. ●

"French Society of Anesthesia and Intensive Care" Ethical Group: M Alazia, E Balagny, J-E Bazin, S Beloucif, G Boulard, C Cohen, A De la Dorie-Leroy, R Gauzit, L Jacob, P Juvin, A Lienhart, N Nathan-Denizot, J-L Pourriat, L Puybasset, P-Y Quiviger, J-P Taroit.

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tatives in over 190 countries and a global field service network staffed around the clock, the company offers customers reliable support. The offering of training helps customers to get the maximum performance from their medical technology investment.

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Clinical healthcare is a highly complex process that relies on wide-ranging knowledge, technology and information resources. The better all of these work together at the acute point of care, the more effective and cost-efficient healthcare can be. Dräger Medical leads in med-

ical technology, with expertise in all areas of patient care process: from Emergency Care and Perioperative Care on to Critical Care, Perinatal Care and Home Care. The CareArea Solutions bring together innovative therapy, patient monitoring, point-of-care information technology, architectural systems and accessories, as well as technical service programs and education & training tools. They provide seamlessly integrated packages that can assist caregivers in their task – which ultimately comes back to efficiency and quality of care. CareArea Solutions link clinical processes and create cross-area advantages including the integration of information, transport solutions, common user interfaces and standardized accessories. These lead to improved operational efficiency and patient outcomes. ●



Innovation throughout the Patient Care Process, for example in Perioperative Care.

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Product News

Computer-assisted anaesthesia for children and newborns

With the new software version 3.05, the Zeus® anaesthesia system also exerts expanded, automatic control of all anesthetic gases that are particularly well suited for use in pediatric ventilation. The Zeus rebreathing system has one of the world's smallest system volumes making it applicable for ventilating children and newborns.

Dräger Medical together with Dr Josef Holzki and his staff at the Children's Hospital in Cologne, Germany, prepared the paediatric application for automatic computer-assisted anaesthesia control (Target Controlled Anaesthesia, TCA®) for series production. Automatic control delivers the exact quantity of anaesthetic gas specific to the patient for fast induction and recovery of the anesthetic gases and also a stable depth of anaesthesia. This reduces anaesthetic costs and prevents children from dehydrating due to excess dry gas. This total rebreathing (closed) system keeps the moisture, which is physiologically required within the breathing circuit and reduces the risk of postoperative complications. Dr Holzki, who is also President of FEAPA (Federation of European Association of Paediatric and Anaesthesia) sees "a

quantum leap in medical technology that for the first time makes it possible to even anesthetize children weighing less than 3 kilograms with a performance like never before."

Expanding clinicians' access to vital patient data

The new Infinity® Symphony Suite takes the valuable information that's accessible at the central monitoring station and makes it available virtually anywhere via the hospital intranet. As a result, Infinity Symphony expands access to vital data, provides a more complete picture for patient assessment, and simplifies consultations with colleagues.

Infinity Symphony is an option for the MultiView WorkStation that lets clinicians view their patients' vital signs from Infinity bedside and telemetry monitors on any PC over the hospital intranet. It provides near real-time and retrospective views (full disclosure) of monitored patient information and ventilation data – with single sign-on and integrated patient selection. Whether at the bedside or a remote location, clinicians can view up to 16 stored waveforms – including ECG, respiratory, hemodynamic, and EEG. They can also access arrhythmia and alarm events and trending, and generate a wide variety of chart-ready reports.

Anaesthesia Afloat

Keith Thompson

Maiden voyage

Imagine a 17,000 tonne ship with six fully equipped operating theatres, an 85 bedded ward, an HDU and over 400 enthusiastic self financing volunteers - welcome to reality, welcome to the Africa Mercy which will set sail on her maiden voyage to Ghana in May 2006.

Challenging work

Only experienced anaesthetists can provide anaesthesia for the various types of surgery to be performed on board. These include maxillofacial, ophthalmic, orthopaedic, plastic and vesico-vaginal fistula (VVF) repair. The environment of the ship docked in one of the world's poorest countries will be tough, with high heat and humidity, and anopheles mosquitoes. You will be continuously aware of the presence of desperately poor people whose only chance of life changing surgery is on the ship. Tours of duty last at least two weeks at a time. Volunteers work amongst a Christian based community of dedicated individuals whose motivation is in helping others much less fortunate than themselves rather than for financial gain.



Fig.1 - 35 yr old Kadiatu(Sierra Leone) pre-op ameloblastoma of the mandible.



Fig.2 - 10 yr old Nicholas(Ghana) pre-op fibrous dysplasia of the maxilla.



Fig.3 - 9 yr old Edoh (Togo) pre-op left maxillectomy.

Gross pathology

Gross West African pathologies like ameloblastoma of the mandible (fig 1), fibrous dysplasia of the maxilla (fig 2), cancrum oris (noma)(fig 3) all provide their own unique airway management challenges. Fiberoptic equipment is readily available. VVF repair in desperate young women, who have been rendered continuously incontinent after the birth of a dead baby, following 4 to 5 days of indescribable labour pains, is particularly satisfying. This requires skill in performing CSE (combined spinal epidural anaesthesia).

Memorable experience

I have worked on board a Mercy Ship for two to three weeks annually since March 1991. This challenging environment leads to strong and enduring friendships amongst volunteers. You also anaesthetise some patients whose names you never forget like 9 year old Edoh (fig 4) who underwent a left maxillectomy in 1995 and a further small procedure in 2003 aged 17 (fig 5). In the future she intends to become a nurse and work on a Mercy Ship.



Fig.4 - 5 yr old Awa (Senegal) pre-op repair of cancrum oris lesion.



Keith Thompson is shown here receiving a medal awarded in recognition of his services to Mercy Ships from Peter Simpson, then President of the Royal College of Anaesthetists.

More volunteers needed

Medical and non medical volunteers are needed to help some of the most disadvantaged people in our world today. Not only will you help heal the bodies and minds of others but in doing so may indeed become changed yourself. Beware, neither patient nor crew member leaves a Mercy Ship untouched by what happens on board. So why not accept a challenge, leave your comfort zone for two weeks or more and travel by plane to a fascinating country to help support a floating bridge between the 'haves' and 'have nots' of our unequal World.●



Fig.5 - 17 yr old Edoh.

More information is available at
www.mercyships.org or email :
keith.t2@ukonline.co.uk .

Correspondence

To the Editor:

It is with interest that we found the recent article on Thoracic Epidural anaesthesia in the "How I do it section" in ESA Newsletter Vol23; 2005.¹ We thought that our slightly different approach may be of interest.

Our unit undertakes about 200 thoracotomies per year. Post operative analgesia consists of high thoracic epidurals in 50%. Paravertebral blockade combined with epipleural block is used in the remainder.

We favour a high epidural approach (T3/4) with the space identified using the hanging drop technique. This technique was first described by Gutierrez in 1930.² The loss of resistance technique was first introduced in 1921 by Sicard and Forestier.²

The hanging drop technique consists of placing a tiny amount of saline into the hub of the Tuohy needle once the stylet is withdrawn (Figure 1). The epidural space is identified once the meniscus is 'sucked' into the hub and it disappears.

In awake sitting patients pressure in the thoracic epidural space is negative relative to the surrounding atmospheric pressure. This is explained by the anatomical continuity between the epidural space and the thoracic cavity (i.e. the intrapleural cavity which has a negative pressure of -5 to -10 cm H₂O) via the para-vertebral space.³

We find using a high level of insertion overcomes the difficulties of midline insertions at mid thoracic levels caused by the steep inclination of the spinous processes.⁴ Using epidurals at high thoracic level has been shown to be effective even for combined abdomino-thoracic procedures.⁵

Using the hanging drop method offers a number of advantages:

1. The problem of holding a needle and heavy syringe full of saline is overcome. One is free to precisely guide the needle with 2 hands, which is technically easier.

2. It is easier to teach a trainee using the "visual" sign of the hanging drop rather than the "tactile" confirmation of loss of resistance, as the supervising anaesthetist does not have to appreciate what the trainee feels. When watching the meniscus disappear one is often pre-warned by an inward tenting or pulsation of the meniscus before it disappears into the needle hub (Figures 2 and 3).

In some patients the ligamentum flavum may actually fail to fuse in the midline – this occurs particularly in cervical and lower thoracic levels.⁶ Indeed, the feel of ligamentum flavum before starting as in loss of resistance (midline approach) is not essential, as one merely has to witness ingress of fluid into the needle once the epidural space has been reached.

3. Any technique has a false positive rate. For the hanging drop this is 2%.³ However, once the space has been identified using hanging drop, any doubt can be resolved by free injection of saline into the space.

In conclusion in awake patients needing a thoracic epidural, use of the high hanging drop technique is technically simpler for trainees to learn with the reassurance that nothing is lost, should one have to revert to the more familiar loss of resistance approach.

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Dr T Strang FRCA

Consultant Anaesthetist

Dr Manjit George MD (Anaesthesia)

Clinical Observer

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Dr Bonnet replies:

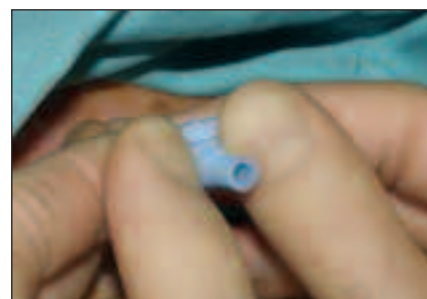
Dr Strang highlights the advantages of the hanging drop technique for performing thoracic epidural anaesthesia. It's true that this technique is easy to perform, especially in the upper thoracic segments, but it has drawbacks. The hanging drop technique is easier to perform in sitting position because sitting exaggerates the negative nature of the epidural pressure. Patients scheduled for thoracic surgery, previously premedicated, are not always comfortable in this position in the operating room. Dr Strang proposes upper thoracic epidural whatever the site of surgery, but there is no guarantee that the tip of the epidural catheter, pushed into the epidural space will reach the segmental level corresponding to the surgical site. An insertion over a too long distance may cause the epidural catheter to go astray. Finally, if a dural puncture occurs there is a risk of an air leak that will lead



drop present



tenting of meniscus



drop sucked in

to pneumoencephalus, which complicates dural puncture more often than previously thought. Post dural puncture headache and neurological focal damage are likely to be worsened by pneumoencephalus. This risk is increased if general anaesthesia using nitrous oxide is performed in the hours following dural puncture. For all these reasons our choice remains to use a classical loss of resistance technique with a syringe filled up with saline, even at the upper thoracic epidural level. ●

To the Editor:

I read the case report "Cause for Complaint: High Cost of a New Knee" published in the ESA Newsletter Volume 24 with great interest. I would like to comment on several aspects of the case:

1. The anaesthetic technique chosen (combined spinal-epidural) was appropriate for the patient and procedure. Regional anaesthesia can be used in various clinical situations and severe chronic obstructive pulmonary disease is one of them. However, it is not a way to avoid dealing with a potentially difficult airway as it is suggested from the preoperative consultation. A difficult airway scenario that can be addressed electively at the beginning of the case has the potential to turn into a difficult emergency situation in the middle of the procedure.

2. Whilst a lot of the attention was given to the slightly elevated level of potassium, there is not enough information to assess the role it played in the sequence of events. For example, there is no mention about the creatinine level. It is difficult to assume that in somebody with normal creatinine and no EKG changes suggestive of hyperkalemia, a potassium level of 5.2 mmol/L would eventually lead to cardiac arrest. Conversely, a normal level of potassium could rise dangerously in a situation of hypovolemic shock and severe metabolic acidosis. A potassium level of 7.2 mmol/L during resuscitation from cardiac arrest could be due to acidosis and hypoperfusion regardless of the initial level.

3. An 80 mg bolus of propofol (almost 1 mg/kg) is enough to produce unconsciousness in most patients. There is no mention about monitoring the level of sedation (such as respiratory rate, ventilation, responsiveness) besides maintaining adequate SpO₂. Heavy sedation could be a contributor to hypotension alongside high spinal level and hypovolemia. Heavy sedation could also cause hypoventilation leading to hypercarbia, respiratory acidosis and hyperkalemia.

4. Last but not least, I could not agree more about the role of the cardiology consultant during the preoperative evaluation. Too frequently we forget that his/her role is to maximally optimize the cardiac status and not to "clear" the patient for anaesthesia. There is only one person who should assess the feasibility of anaesthesia and that is the anaesthesiology consultant. ●

*Catalin Ezaru, MD
Assistant Professor of Anesthesiology
University of Pittsburgh, USA*

To the Editor:

I read with great interest the article entitled "Non-Physician Anaesthesiologists - A Tale of Two Countries." This article was of great interest to me, as an American and an affiliate member, as it reflects history in the making. I would caution my European colleagues that there are many lessons to be learned from the long-standing difficult relations between the Nurse Anesthetists and the Anesthesiologists in the United States. History here may be both illuminating and cautionary.

The term anaesthesiologist should be restricted for use only when the health care profession is a physician. The term means one who studies the art and science of anaesthesia. Non-physicians simply do not qualify. In this case semantics is critical. ●

Sincerely,

*Douglas R. Bacon MD, MA
Department of Anesthesiology
Mayo Clinic 200 First Street SW, Rochester
Minnesota 55905, USA*

To the Editor:

You invited comment on this topic in the newsletter.

I am an antipodean member and was an attendee in Vienna. This was the first time I have attended a European Society meeting and I thought it was superb. I can only endorse Prof Gelb's comments in the article 'How big is too big?'

I missed out on a couple of sessions on the Saturday because of overcrowding. I was a little unprepared for the size of the turnout. However it was fairly easy to pick the popular sessions and make sure of a seat by getting there really early. It might be possible to predict these and to plan for a bigger room for these sessions at future meetings. This was a minor issue.

For the buzz, the size, the science, an alternative to the major American conferences and the sense that the event has reached some sort of critical mass for significance on the international calendar I think it would be shame to cap it or dilute the success with a second meeting.

We already have Madrid and Munich in the diary! ●

Regards

*Dr Patrick Hughes
Melbourne Australia*

To the Editor:

I found the article 'Cause for Complaint: High cost of a new knee' most disturbing! I hope the case presented is a only a fabrication otherwise anaesthesia as a speciality is in serious trouble and steps must be taken to correct what I feel is a lack in basic training. ●

*Dimetri A. Cozantis, Docent
Department of Anaesthesia
Helsinki University*

All the stories published in our Cause for Complaint series are true. Editor

Anaesthesia in Spain I, 1900 to 1950

Franco Grande, Santiago de Compostela (Spain)

Surgery becomes more ambitious

At the end of the 19th century, practically the only anaesthetic used in Spanish hospitals was chloroform. By the turn of the century almost all surgeons were switching to ether, which had been ignored for 50 years. Chloroform was less suitable for a more ambitious approach to surgery that now included abdominal operations. This was an advance that had been made possible by the introduction of antiseptics. Other innovations of the time - cocaine for spinal and local anaesthesia, and anaesthetic mixtures - were slower to be adopted in Spain, but by the 1920s most surgeons accepted subarachnoid anaesthesia and many were also applying cocaine locally (1).



Intra-arterial anaesthesia

It was during this period that a respected Spanish vascular surgeon, José Goyanes Capdevila (1879-1964; Fig.1), developed intra-arterial anaesthesia. In 1908 he experimented with rabbits and dogs in the Physiology Laboratories of the Faculty of Medicine in Madrid, injecting local anaesthetics (cocaine, eucaine), narcotics (morphine hydrochloride, pantopon, scopolamine) or sulphuric ether, and delimiting the field of action by means of tourniquets. Having obtained good results with local anaesthetics, he began to use the new technique on patients at Madrid General Hospital, and in a paper read to the Spanish National Academy of Medicine he reported on four cases in which novocaine was used for lower limb surgery (2). In May 1910 at the Third Spanish Surgery Congress he described the use of intra-arterial anaesthesia in 23 major limb operations (3), and in 1913 he published a

series of 70 cases. Twenty years later he was still using the technique, and at the Ninth Congress of the International Surgery Society in 1932 he described 150 cases of its use in operating on major neoplasias of the upper limbs (5). In addition to Goyanes, a number of other Spanish and foreign surgeons, including Opper in Petrograd, Ransohoff in the United States, Loddo in Würzburg, and Nasseti in Bologna, adopted the technique. However, in spite of achieving better results than Bier's intravenous method, intra-arterial anaesthesia did not become generally popular, no doubt because of technical issues such as the difficulty of avoiding arterial injury with the needles of the day.

First description of the lumbar approach to the epidural space

One technique that rapidly became widespread in the 1920s, in this case for abdominal surgery, was paravertebral anaesthesia. Its popularity was short-lived, and by the 1930s local anaesthesia or ether was being used for abdominal surgery in almost all Spanish operating theatres. It was at this time, in the early 1920s, that Spanish anaesthesia missed a historical opportunity. In 1921, a decade before the studies of Dogliotti, the military surgeon Fidel Pagés Miravé (1886-1923; Fig.2) described 43 cases in which he had administered 2% novocaine by single-shot lumbar epidural anaesthesia, which he called "metameric" anaesthesia. Unfortunately, he published this work only in Spanish journals (6-8), and apparently without much conviction. Very few Spanish surgeons were inspired by his articles to experiment with the new technique, and during his brief spell in Melilla during the Rif War he employed chloroform and spinal anaesthesia rather than epidural novocaine for patients with abdominal wounds. In 1923 he was killed in a road accident and his work fell into oblivion. When Dogliotti read his paper on epidural anaesthesia to the Madrid Congress of 1932, no Spanish surgeon challenged his priority.

Wartime reverses

The outbreak of the Spanish Civil War in 1936, and the economic and intellectual conditions of its aftermath (exacerbated by the international context of World War II), were disastrous for the progress of anaesthesia in Spain. Numerous research projects in university medical faculties were abandoned, and



José Goyanes
Capdevila
(1879-1964)

many surgeons were forced to resort to what were by then rudimentary techniques (chloroform, ethyl chloride, application of cold or even, on occasions, to operating without any kind of anaesthesia. On the positive side, intravenous sodium evipan was used to better effect than later occurred with sodium pentothal at Pearl Harbour. The American surgeon Joseph Eastman Sheehan, who worked with Franco's troops between the autumn of 1937 and the spring of 1938, invited Robert Macintosh and Kenneth Boston, two British anaesthetists to Spain to teach endotracheal intubation. Although a few Spanish surgeons learnt this technique, up-to-date anaesthetic practice was not widely promoted in Spain until the 1950s. The impetus for this was the return home of a number of doctors who had gone abroad to receive specialist training in anaesthesia in Oxford, London or the United States, a move prompted by another visit from Robert Macintosh in 1946. ●

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Brussels, Belgium Contact: www.intensive.org
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- 3-6/6 [Euroanaesthesia 2006](#)
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- 24-28/03 International Anaesthesia Research Society (IARS)
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- 9-11/8 Summer Update on Obstetric Anaesthesia
Trinity College – Dublin, Ireland Contact: www.oaa-anaes.ac.uk
- 14-18/10 American Society of Anesthesiologists Annual Meeting (ASA)
Chicago, United States Contact: www.ASAhq.org
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New York- Marriott Marquis Contact: www.nyssa-pga.org

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