

A Decisive Step Towards Amalgamation of the Three European Anaesthesia Organisations



Hans-Joachim Priebe, MD, ESA, President

On April 19, during the recent World Congress of Anaesthesia in Paris, two Executive members of each of the European anaesthesia organisations – the *European Society of Anaesthesiologists (ESA)*, the *European Academy of Anaesthesiology (EAA)* and the *Confederation of European National Societies of Anaesthesiologists (CENSA)* – formally signed an *Amalgamation Agreement* on behalf of the respective Boards/Executives. This formal *Agreement* defines the transition from the present status of the three European anaesthesia organisations to one single organisation by January 1, 2005, and the structure and function of the new Society.

The signing of this *Agreement* can justifiably be viewed as an achievement in itself. It is a huge step towards the goal of a single European anaesthesia organisation – an organisation that can effectively represent all aspects and interests of European anaesthesiologists. With the formal signing of this *Agreement* we have defined the process for reaching this goal – and turning



ESA - EAA - CENSA Executives celebrate signature of the Amalgamation Agreement.

back has now become considerably more difficult.

Signing of the *Agreement* was not easy and did not, by any means, happen “automatically”. It was the result of long and intense negotiations whose outcome was entirely open and uncertain until almost the last moment.

In view of the differing interests, philosophies and traditions of

the involved organisations, difficult negotiations were inevitable. In the end, however, all of those involved in the negotiations came to recognise their many common interests, and we seized this unique opportunity to form a single European anaesthesia society – knowing that the chance might not come again in the foreseeable future. In addition, we knew that the members of our respective organisations, and

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European anaesthesiologists at large, would have had little, if any, understanding for a failure of agreement on such an important issue. These considerations, together with the constraint imposed by the need to give thirty days notice to all ESA members, to allow voting on changes in the by-laws at the forthcoming General Assembly, facilitated last minute amendments to the *Agreement*.

When looking at the *Agreement*, each organisation may not be fully satisfied with the final "product" because each has conceded something which was initially considered "essential" to preserve. However, the *Agreement* is one which each organisation will be able to "live" with. It is also important to note that – independent of individual preferences – Belgian law mandates that registered non-profit organisations adhere strictly to understandable legal requirements that cannot be set aside.

Whatever some may feel, in the final analysis, all that is important is that each of the most important activities of the present anaesthesia organisations are preserved in the new Society. These activities include organising of an annual scientific meeting of the highest quality, holding the examination for the *European Diploma in Anaesthesia and Intensive Care*, publishing the *European Journal of Anaesthesiology*, awarding grants for research, supporting education in formerly Eastern bloc countries and maintaining close ties to the national anaesthesia societies – to name just a few examples. In the long run, these activities will be more efficient because they will all be organised and co-ordinated centrally (from the headquarters in Brussels) and overlaps will be reduced to a minimum. Most importantly, I am convinced that by representing all aspects of European anaesthesia under one "roof", the scientific and political influence of the new Society will become considerably greater than has been the case for the individual Societies.

Let there be no doubt: we have not yet reached the final goal!



ESA - EAA - CENSA Executives sign the Amalgamation Agreement.

Certainly, signing of the *Agreement* is a *decisive* step towards the final amalgamation of all three European anaesthesia organisations. The signing was a necessary step for a possible amalgamation – but it is not the *deciding* step. Only you, the active members of our Society, can make this final step possible – because only you can approve the *Amalgamation Agreement* and its associated changes in our By-Laws. At the forthcoming Annual Meeting in Lisbon, the Board of Directors will ask the Council and the General Assembly for approval of the *Amalgamation Agreement* and the suggested changes in the By-Laws. Such changes include a change of name from 'European Society of Anaesthesiologists' to 'European Society of Anaesthesiology' (the abbreviation 'ESA' will remain unchanged), several changes in the By-Laws (mainly related to extra sections necessary to include present activities of the EAA and CENSA), and a change to the logo of the "new" ESA. The general structure and organisation of the new Society (including the structures and functioning of Council and Committees) will remain unchanged. The location of the headquarters of the future "new" ESA will be same as now. I can assure you that the "new" ESA will continue along the same democratic path as the present ESA. In the same way, the General Assemblies of the EAA and CENSA will also have to

approve the suggested changes in By-Laws before amalgamation can occur on January 1, 2005.

This is where we stand at the beginning of May. There is every reason to be optimistic – and excited about the future prospects of this new Society. We are close to witnessing a remarkable success story in the history of European anaesthesia. When I wrote in previous editions of the Newsletter on the negotiations about merging the ESA, EAA and CENSA, I was always careful not to make premature predictions. I kept my reports entirely factual. This time, however, I consider that the chances of having a "new" ESA as of January 1, 2005 are very good indeed. The ESA Board of Directors hopes that you will all support and approve the *Amalgamation Agreement* and our proposals for changes in the By-Laws to enable the formation of a single, unified European anaesthesia organisation – the European Society of Anaesthesiology, the "new" ESA. The text of the *Agreement* and the annexes containing the various proposed changes in the By-Laws are available to all ESA members on the ESA website www.euroanesthesia.org. I urge you all to attend the General Assembly in Lisbon to register your approval of the *Amalgamation Agreement* and the new By-Laws. ●

Profile of Brian Pollard, Editor in Chief of the European Journal of Anaesthesiology

Brian Pollard was born in Nottingham, United Kingdom, in 1949. His father was a pharmacist, with his own shop close to the city centre. Despite an interest in medicine, he says it seemed logical to study pharmacy. His pursuit of Higher education took him, in 1968, to the London School of Pharmacy. 'I developed a specific interest in pharmacology, which proved to be particularly valuable, subsequently in my career'. The late sixties were an interesting time in Europe for students, but his main memory of that time was 'being able to drive freely around London, and even find somewhere in the centre to park, without a problem'.

After graduation, he joined the Clinical Research Centre at Northwick Park, in Harrow, North London. 'I very rapidly realised that I wanted a career in medical research'. Several of the best brains in British medicine had recently established themselves in Northwick Park. 'It was a friendly, dynamic, lively place. I had one of the best years of my life. There was so much in the way of opportunity, and the people I was working with were superb. It was a truly academic atmosphere, and I could not even begin to list the things I learnt'.

Brian Pollard found himself working under Professor John Nunn, who ran the Anaesthetic Division, and who had made his name in clinical and academic anaesthesia with a dazzling series of papers on nitrous oxide and oxygenation during anaesthesia. 'If I wished to pursue a career in medical research, I realised I needed a medical degree, and was

offered a place at the University of Sheffield. I wrote up my findings, and went off to study medicine. Following graduation, because of my work with Professor Nunn, combined with my interest in pharmacology, a career in anaesthesia seemed the only logical step. It was just the only thing to do'.

As an anaesthetist, Brian Pollard has an established reputation as an expert in the pharmacology of neuromuscular blocking drugs. 'I liked being able to see the result of the drug action right before my eyes using equipment which was straightforward, and logical to use and understand. I became extremely interested, though my interests have broadened since'.

One of those interests is the training of non-physician anaesthetists. Currently this is unknown in the United Kingdom, and is highly controversial. 'I have always been a sceptic in this area, but I pride myself on keeping an open mind on about as much as possible'. He answered a call for volunteers to pilot a training project, and developed a two-year programme. His ideas were not taken up at that time, but current plans are re-examining a two-year scheme. 'I think that non-physician anaesthetists will become introduced into the UK system, but it has to be managed very carefully'.

He became involved with the European Academy when Dr. Brian Kay in Manchester invited him to a meeting. 'I enjoyed it, and joined'. His first appointment as Editor in Chief was with Current Anaesthesia and Critical Care, from 1989 to 2003. 'I liked organising,



planning, executing and seeing the fruits of my labour in print'. He now relishes his role as Editor in Chief of the European Journal of Anaesthesiology. 'I believe that that the EJA has an important future at the centre of European Anaesthesiology, and I shall do my very best to keep it there. Individual countries have national journals to serve national needs, but Europe and the ESA need one journal that doesn't recognise international boundaries. It will get stronger as Europe moves forward and the ESA grows'.

In 1996, Brian Pollard was appointed Professor of Anaesthesia in the Academic Department of Anaesthesia in the University of Manchester. Less expensive than London, but with a reputation as a city with a buzz, he acknowledges the advantages, but it is not his hometown. 'Basically, I am a country boy at heart. I was brought up with animals all around'. He is about to sell up and move out into Derbyshire, half a step nearer to his hometown of Nottingham. The commute to work will take longer, but he is sure the location will be worth it ●

Prize Policy

Gordon Lyons

Trainee Research Prize

At a recent meeting of the ESA Scientific Committee, the Chairman, Dr Gordon Drummond, announced that the ESA Trainee Research Prize would be dropped. To be eligible to enter the Trainee Research prize, a trainee had to win a competition organised by a national society. Thus, one could consider that the ESA Trainee Prize was given to the champions' champion. As the UK national representative on the ESA Council, I always had a certain amount of difficulty with this because I knew of other subspecialty societies in the UK who awarded prizes for abstracts presented by trainees, who were not eligible to enter. Indeed, such an arrangement, if it had been allowed, would bias in favour of those countries with the most meetings that awarded prizes. So where is the bias in the current arrangement? Possibly in that it favours those countries with the best funded university departments who can offer the best opportunities for excellent research. As someone with a background in clinical research, I am very much aware of the advantage that an understanding of the rules of the game brings,

and this is brought home to me frequently when I review papers submitted for publication from departments that do not share that advantage.

Candidates for the Best Abstract Prize Competition

Detlef Saal (St. Gallen, Switzerland)

Patient Satisfaction with Anaesthesia Care: When to ask the Patient?

Jens Engbæk (Herlev, Denmark)

Return hospital contacts in two Danish Day Surgery units. Readmission, morbidity and mortality.

Robert Hanss (Kiel, Germany)

Heart rate variability predicts severe hypotension after spinal anaesthesia for elective cesarean section

Klaus F. Wagner (Lübeck, Germany)

Pulmonary Vascular Reactivity: New Insights from Transgenic Mice with Excessive Erythrocytosis

Thea Koch (Dresden, Germany)

Perfluorohexane exposure does not result in impaired leukocyte phagocytosis in vitro

Ana Maria Ruiz Pardos (Barcelona, Spain)

Cyclic GMP infusion prevents endothelial dysfunction and acute lung injury induced by cardiopulmonary bypass

Winners of the ESA Trainee Research Prize Competition 2004

Entrants into this competition must have already won an award at national level in their respective countries.

First prize winner:

Dr. Vibeke Brix-Christensen (Denmark)

"Acute Hyperinsulinemia restrains Endotoxin induced Systemic Inflammatory Response. An experimental study in a porcine model"

Second prize winner:

Dr. K. Waerhaug (Norway)

"Activated Protein C Ameliorates Endotoxin-Induced Lung Injury in Sheep".

Third prize winner:

Dr. K.H. Stadlbauer (Austria)

"Vasopressin, but not Fluid Resuscitation, Enhances Survival in a Liver Trauma Model with Uncontrolled and Otherwise Lethal Hemorrhagic Shock in Pigs"

The prizes will be awarded at the Awards Ceremony of the Euroanaesthesia 2004 meeting in Lisbon on Saturday 5th June 2004 at 1700hr

Best Abstract Prize

The ESA also awards prizes for the three best abstracts presented at the annual Euroanaesthesia meetings. All submitted abstracts are scored independently by three members of the relevant scientific subcommittee. The subcommittee chairmen then add up the scores and the highest scorers go into the prize competition, and present their abstracts in a special session. A panel of judges then decide on the three winners. This also is flawed because the abstract scorers are composed of hawks and doves. Some score severely, and some are generous, and it really does not matter when all abstracts are treated the same. But the ratio of doves to hawks is important when output of all the subcommittees is considered together for ranking. A trio of hawks is likely to kill off any possibility of prizes for a given year for a given subcommittee. It is possible to work in corrections for this, but because the abstract scorers are varied each year, any disadvantaged subcommittee is unlikely to be hit two years in succession. All things considered, it is probably better not to introduce

complexities into the system in an attempt to iron out flaws. Corrections are never going to be perfect, their workings might hinder transparency, and they introduce yet another possibility for bias. Flaws might be acceptable provided they affect all equally, and the application of the judging process is sufficiently simple and clear to be understood by all.

Encouraging the Researcher

It is not the well-established five star universities that need encouragement. Career progression may well be dependent on time spent in research, and opportunity and support will be provided. Perhaps it is the beginners and the interested amateurs who have not established themselves, that are in need of encouragement. In terms of European geography, it is to the north and west we look for the former, and to south and east for the latter. Evidence for this can be found in the recipients of the ESA research grants.

It might seem logical to redefine the rules to give something to those who have very little. In practice this is not a feasible option because it involves some form of exclusion, something that leads inevitably to resentment amongst the excluded. A similar argument can be applied to prizes directed solely at trainees. Recognition is valued by all grades, but this can be adjusted for by having prizes that are open to all, and the Best Abstract competition meets this requirement. Perhaps the best that can be achieved here is to have more prizes, to spread the medals more widely, and hopefully more fairly.

Aims

Some thought should be given to the purpose of prizes. Encouraging researchers to submit their abstracts to Euroanaesthesia is one, but other influences such as the timing and place of the meeting, publication in an indexed journal,

ESA Research Grants Programme

Grants awarded to start in 2004 were awarded to:

Dr. Benedikt Preckel (Düsseldorf, Germany) Xenon-induced myocardial protection	58,939 euro
Dr. Laure Pain (Strasbourg, France) Recovery from short duration anaesthesia : Does propofol anaesthesia modify the sleep-awake circadian clock ?	15,000 euro
Dr. Zoe Louise S. Brookes (Sheffield, UK) Elucidating the response of the microcirculation to novel Nociceptin agonists and antagonists: a new therapeutic target?	58,825 euro
Dr. Alexander Brack (Berlin, Germany) Role of polymorphonuclear cells in inflammatory hyperalgesia and antinociception	25,990 euro
Dr. Christian Zöllner (Berlin, Germany) Nociceptor specific ion channel as a potential target for analgesic therapy during inflammation	30,797 euro

and the quality of the experts in the audience, are likely to be a stronger pull. I have links with one association that offers a free ticket to the meeting dinner for all trainees who have abstracts accepted.

This makes the meeting package more attractive for anaesthetists in training, and also ensures that the dinners are not dominated by the boring old farts. Other awards that might be appreciated could include a year of free membership, or free registration at the next Euroanaesthesia meeting. These would certainly tend to keep prizewinners involved with the ESA. When excellence rather than participation in research is to be encouraged, then only a small number of more generous awards would be suitable.

The Editor's View

It is unlikely that any chosen procedure for the selection of winners is going to be completely free of luck, and the best defence against

bias is to have a procedure that is transparent and understandable. It should be recognised that encouraging excellence, and encouraging researchers require different strategies, and at the moment the ESA is too far orientated towards the former. For the latter, generosity on a smaller scale but more widely spread, could liven up proceedings and represent an investment in the future. This is an area in which the ESA can afford to be experimental; the risk is small. ●

Conflicts of Interest

Gordon Drummond, Gordon Lyons



Doctor watchers in the United Kingdom have been following with interest the story of Dr Andrew Wakefield, a London paediatrician. Some years ago, Dr Wakefield published the results of his original research that appeared to link the development of autism with a childhood immunisation vaccine. Resulting public concern has led to a reduction in the uptake of childhood immunisation, something that the Department of Health has deplored. Whether to immunise your child or not is a debate that has filled the columns of the nation's newspapers and magazines for years. Recently, one national newspaper has claimed that Dr Wakefield had negotiated a substantial sum of money in return for expert reports to support families of autistic children seeking financial compensation from the Department of Health for its immunisation programme. It has been alleged that some of the children involved in the legal action also took part in his research. His financial interests and the outcome of his research are allegedly linked. The editor of *The Lancet*¹ who published the paper in question was quoted as saying that he would not have done so had he been aware of this conflict of interest.

Declaration

This story is a good illustration of how a lack of openness can undermine the scientist, science itself and the editor and publication in question. Many scientific publications request all authors to declare any conflict of interest, and declaration does not necessarily result in the rejection of a manuscript. It might be sufficient to draw any potential source of bias to the attention of the reader. Many anaesthetists are dependent to varying degrees on commercial sponsorship of their research, and this is recognised by reviewers and editors, who feel obliged to make links to funding bodies visible to all.

Not just the authors

The peer review process for medical research involves two or three reviewers for each submission, whether a full-length manuscript

Accreditation and Conflicts of Interest

On page 7 of the preliminary programme for Euroanaesthesia 2004 is a notice advising that an application has been made for meeting accreditation. This allows physicians to claim their continuing medical education credits, and is a process that involves three steps. Firstly, accreditation for the scientific programme must be sought from the Institut National d'Assurance Maladie-Invalidité. Once done, the Union of European Medical Specialists must be approached to have the meeting considered by its European Council for Continuing Medical Education. Only when these two hurdles have been overcome, is the American Medical Association amenable to the issuing of accreditation. This allows American participants to receive credits. Each step in the process requires submission of a detailed application form and payment of a fee. The application process asks that a certain number of criteria are met. One of these requires that conflicts of interest are declared.

announcing the findings of original research or a half page abstract. The reviewers may also have funding links, with potential for bias in terms of which abstracts or manuscripts are facilitated, and which are suppressed. The same argument applies to editors, but on a grander scale, and significant involvement with outside bodies has the potential to create major scandals. A new code of conduct for editors of medical journals is currently under discussion.

Not just money

Sources of bias are not exclusively financial. Researchers who share the same field might see themselves in competition, and the potential for bias should be evaluated before they review each other's work. Anaesthesia is not so big a world that friends and even relatives might find themselves judging each other's work from time to time, and the desire to assist and support those we know is particularly strong. Intellectual passion, or conviction that leads to an individual preaching the worth of a particular approach or therapy is another recognised concern. This is not always a transparent issue because unlike other sources of bias, there are not necessarily any outward indicators of what is inside somebody's mind.

The ESA's position

The ESA prides itself on the high scientific standards of its invited speakers and free paper presenters. To protect those standards some form of code of conduct related to conflicts of interest is necessary. Some individuals have already

adopted a personal code and will declare funding sources as part of their lecture. For authors and speakers, further consideration of abstracts and manuscripts is likely to become subject to new rules that are announced for the first time in this Newsletter. The same will apply to invited speakers, and reviewers, chiefly abstract reviewers. Who regulates the editors? There is not a simple answer to this one. At some stage of the procedure trust becomes important. This is why a flawed editor invariably provokes a scandal.

Noncompliance

The essence of codes of conduct is that they depend on trust. Anyone currently involved in the scientific process of the ESA will be aware that promises are not always kept and deadlines are not always observed, and any code of conduct will be broken by a few. This poses two difficulties, firstly a rule that is observed by most and ignored by a few creates resentment, and secondly, the few have the potential to undermine the scientific standing of the ESA and harm its reputation. The ESA has little choice but to close its doors to those who it has good reason to believe have chosen not to follow its code. The code is quite reasonable in its requirements, but standards are not static, and it is appropriate that these requirements are reviewed and extended from time to time. To do anything other than this would be to undermine the integrity of the ESA, its scientific standards, and the scientists themselves ●

Cause for Complaint: Backache after Epidural Anaesthesia

Elective Caesarean section

A 39 year old woman, at term, was scheduled for an elective C-section at then end of an uneventful pregnancy. Her first baby had been delivered with forceps, but an emergency C-section was required with the second. On both occasions, epidural analgesia and anaesthesia were provided to her satisfaction.

Epidural anaesthetic

The anaesthetist in charge decided to use epidural anaesthesia. The patient was placed in the sitting position and an 18 gauge Tuohy needle was inserted into the L4-5 interspace in the midline. The epidural space was identified on the first attempt, using loss of resistance to saline. An initial dose of 4ml bupivacaine 0.5% was injected and the epidural catheter was inserted without difficulty. A further 12ml of bupivacaine was given, and she complained of a moderate back pain, which she described as constricting. The pain disappeared as soon as the injection was stopped. The upper level of the sensory block was detected at T4-6 by pinprick, and the anaesthetist recorded a complete motor block of the lower limbs. The operation proceeded without delay, and a healthy baby girl was delivered, weighing 3860g. Following delivery, she was given 5mcg of sufentanil through the epidural catheter. After being monitored for two hours in the recovery room, she was discharged to her room in the obstetric ward.

Back pain

Later that day, when the block had worn off, she began to experience low back pain. Over the next few days, the intensity of the pain increased, and she became concerned over her ability to adequately look after her baby. None of these concerns were expressed to the staff at the time, and she was discharged home on the third postoperative day without analgesic therapy.

Formal complaint

At home she experienced severe pain, extending from the cervical to the lumbar region, that did not involve the lower limbs. Her concerns about her ability to care for her baby increased. She described the nature of the pain as burning, or constrictive. Her general practitioner gave her tramadol and clonazepam, without effect. A few weeks later, she was investigated by computerised tomography, and then magnetic

resonance imaging, but nothing abnormal was found. In the following months her pain persisted despite various therapeutic regimes that included nonsteroidal analgesics, codeine, paracetamol and antidepressants. After one year she sought redress from the hospital, through the courts, alleging that her epidural anaesthetic was responsible for her back pain.

The Editor writes

Back pain is something that most human beings will experience at some stage in life. One estimate is that at any given time, 40% of the population suffer from back pain. It is not specific to any procedure. The original study, that claimed to find an association between epidural anaesthesia and back pain, was unable to find any association between longterm back pain and anaesthesia for elective C-section. General anaesthesia produced as much back pain as regional blockade (Epidural anaesthesia and longterm backache after childbirth. MacArthur C, Lewis M, Knox E et al. Br Med J 1990; 301: 9). Given that epidural anaesthesia was not performed negligently, the back pain in this instance should be regarded as part of life's normal wear and tear.

The Medical Expert's View

The medical expert commissioned by the judge had to provide responses to the following questions;

- Was epidural anaesthesia an appropriate technique for the C-section?
- Was the epidural performed according to the rules of good clinical practice?
- Was the epidural responsible for the back pain?

At the time of examination, she had left her job as a room maid in a hotel, and was bringing up her three children as a single parent. She was receiving social assistance. She still suffered pain but coped with raising her children, and could perform housekeeping tasks. Physical examination was normal, with no limitation of back movement. Palpation produced pain at the level of T10.

Was epidural anaesthesia appropriate?

In answer to the first question, the medical expert considered that epidural anaesthesia was a valuable anaesthetic technique for C-section. Despite a widespread preference for spinal anaesthesia,

which provides greater comfort, and is quicker, there is no reason to find epidural anaesthesia inappropriate in this setting (McClure J. Regional anaesthesia in obstetrics; in Principals and Practice of Regional Anaesthesia. Wildsmith JAW, Armitage EN, McClure J eds, Churchill Livingstone, London 2003; p251).

Was good clinical practice observed?

Epidural anaesthesia was apparently performed in agreement with established practice. When the injection of the epidural solution gave rise to backache, the injection was rightly stopped. The pain was not suggestive of spinal nerve root damage, and neither did the features of the chronic picture suggest nerve damage. The length of epidural catheter inserted into the epidural space was not reported, but as it was withdrawn soon after the injection of the sufentanil bolus, which was uneventful, no malpractice was detected.

Epidural anaesthesia and back pain

This was the more difficult question. Retrospective studies from the last decade had implicated epidural analgesia in labour with backache, but these were now discredited. Subsequent investigations revealed that many women tended to forget antepartum backache, and looked upon postpartum backache as a new event. A randomised prospective study failed to find a relationship between epidural procedures and backache (Randomised study of long term outcome after epidural versus non-epidural analgesia in labour. Howell CJ, Dean T, Lucking L et al. Br Med J 2002; 325: 357). Lumbar back pain occurs commonly during and after pregnancy. One third of labouring women may suffer back pain after delivery, and in less than 10%, the onset is within hours. At twelve months, less than 10% are still complaining of severe pain. Risk factors for chronic postpartum backache include multiple pregnancies, antepartum backache, and hard physical work. Evidence that C-section might be implicated in back pain is lacking, largely because the question has not been addressed. The expert concluded that the back pain was the result of pregnancy and delivery, and was not related to epidural anaesthesia. ●

Note The names of contributors to our Cause for Complaint series are withheld in the interests of confidentiality.



*From left to right:
Sue Loughlin, Cindy Martinez,
Raf Kinnaer, Anne Dewaegnaere,
Renaud Rollet, John Popovich.*

Meet the

Many of you know me already from the Euroanaesthesia annual gala and staff and unwinding on the Sunday.

Originally I grew up in the Boston area on a scholarship to begin university time. I continued to study and work and undertake post-graduate education.

I joined the ESA in 1998 after having been a Manager for Cobe Laboratories, where I did not enjoy working for such a large company.

My experience working for the Society has been rewarding. The Society has made it possible to be those typical of a small organization and I look forward to the new challenges. I have had the opportunity to work with highly devoted individuals working with the ESA Newsletter.

John Popovich –Executive Director

Graduate in corporate communications from the Université Libre de Bruxelles and after several internships in events organisation, I joined the ESA in November 2002. Of Belgian nationality, with French as mother tongue, I am also fluent in English and Flemish.

As Member Services Supervisor, my work brings me into daily contact with ESA members and anyone interested in acquiring information about the Society and its activities. Some of my responsibilities include registrations to the annual congress, contacts with the sponsoring companies and coordination of the EJA and Newsletter mailings.

Interested in Brussels cultural and social life, I particularly enjoy theatre, exhibitions and concerts. Always ready to discover other cities and new cultures, I am keen on meeting you in Lisbon for a successful Euroanaesthesia 2004.

Anne Dewaegnaere-Member Services Supervisor

Born in 1978 in the south of Belgium, I am fluent in French and Spanish, thanks to my mother who comes from Toledo. My degree is in tourism from the University of Brussels I joined the ESA Secretariat staff in December 2003 in the new Headquarters building downtown. My colleagues welcomed me to a newly renovated building that we are all proud of. It is a real pleasure for me to work in a stylish and original Art Nouveau house. If ever you visit our lovely capital city, I would be pleased to advise on the best places to discover.

As Member Services Administrator, I am in charge of the daily contacts with you, the ESA members, solving queries and providing information. In collaboration with Sue our Accounts Administrator and Anne our Member Services Supervisor, I process the congress registrations and membership applications/renewals including the updates in our database and the weekly mailing of membership cards and confirmations. If you have any questions, comments or suggestions about membership, I will be glad to respond to them.

I look forward to welcoming you at our Annual Meeting in Lisbon, a modern European capital of history, art, sunshine and hospitality.

Cindy Martinez – Member Services Administrator

I am 30 years old, born in Champagne, France, my hometown is different. I am a tutor for adults and when I move, I have to face the continent of Europe, apply for a visa in London and use this "tactical" approach.

I started my career in 1998 and have recently moved to the UK. I am now moving to the UK. The ESA brings me a lot of what we need for Euroanaesthesia. I have seen a lot of people pieces of the puzzle and I am looking forward to the Meeting building my experience.

Renaud Rollet

The ESA Secretariat Staff

I am the person who has a tendency to enjoy himself too much at dinners. It's the most stressful time of the year for all the ESA Secretariat and staying away from the gala dinner has become a survival tactic.

I was born in the Boston, Massachusetts area in the United States, moving to Switzerland in 1968 for my university studies. Finance and languages were my main areas of interest at that time. I worked in Switzerland for 6 years and moved to Brussels, Belgium in 1974 to complete my MBA in the MBA programme of Boston University, Brussels.

After having worked 12 years in the medical industry as European Operations Director, which subsequently became part of the Cobe-Gambro-Hospal group. I did not stay in the group, and I departed one year after Cobe and Gambro merged..

Joining ESA as Executive Director has been both personally and professionally a tremendous progress over the past 5 1/2 years and the challenges have been the organisation growing very rapidly. The future is very bright for the Society and the challenges we will encounter as we continue to progress. I am delighted to work with such a dedicated Board of Directors, and above all, with the equal-enthusiasm with me at the Secretariat who present themselves in this edition of the

Executive Director

I am 33 years old, born in Reims, capital of Champagne. I studied languages in the university of Reims and started feeling the itch for something new. I went to London where I worked as French teacher for adults. After 4 years of hectic life and 8 house moves I had enough of it and opted for repatriation to Brussels with my girlfriend. Brussels, as capital of Europe, appeared to be the perfect compromise between the city and Reims. My son was born 16 months after the "international" move!

My job with the ESA in September 2000 and I have recently changed position within the Secretariat. I am more involved in the multiple planning aspects of the Euroanaesthesia Annual Meeting. Working with the team to ensure the satisfaction of seeing the final product of the meeting help build during the year. Organizing the Euroanaesthesia meetings is like assembling the multi-pieces of a big puzzle made of many different cultures and languages. Lisbon will be my 4th Euroanaesthesia Annual Meeting and still, I feel that it will be another unique experience.

And Rollet – Events Planning Officer

I was born in South Wales in 1953, grew up in Cardiff and received my education in my hometown of Newport.

An interest in figures brought me to accountancy, my first job being in a bank.

After living in various countries, I finally settled in Belgium, where I have the companionship of a Belgian, namely Ray, and a mad cat, called CC. We live in the University town of Leuven.

Having joined ESA in 1998, I enjoy working with and meeting people from other countries.

The Annual Congress is something I look forward to because it gives me a chance to catch up with some of the people I've met on previous occasions. You also get a glimpse of interesting cities all over Europe.

Various hobbies make sure I know what to do with my (never enough) spare time. With a brother living in the USA, travel is high on the list, but music, swimming and reading are equally enjoyed.

Welsh I am and always will be, but working in the heart of Europe, has certainly brought me closer to being a European.

Sue Loughlin – Accounts Administrator

I am 38 years old, of Belgian nationality and living in the Flanders region near Leuven. I enjoy spending my free time with my wife Sabien, my son Seppe (5yrs) and baby girl Franne (1.5yrs).

I joined the ESA in October 2002 as Congress Programmes Administrator, a job title that covers a wide variety of tasks. The main part of it is administrative: following up on the scientific programme, ensuring all faculty receive the proper invitation and documents. I also administer the abstract submission process, from on line submission to publication in the EJA Abstract Supplement.

The more creative part of my job lies in the production of the lay-out of the ESA Newsletter, as well as most of all other Euroanaesthesia-related publications – the congress flyer, Preliminary, Final and Pocket Programme, Refresher Course Book, Gala Menu, Badges and certificates ...

And finally, I try to keep the ESA website as up to date as possible. It goes without saying that the search for improvement of all the above processes is a never-ending undertaking. And – of course - in all aspects of this job, I rely heavily on the input of my colleagues and our congress organizer.

I am looking forward to the next Euroanaesthesia: Lisbon will certainly top Glasgow as far as the weather is concerned. The ESA team will do its best to make all other aspects meet your expectations.

I hope to see you there !

Raf Kinnaer – Congress Programmes Administrator

The Role of Simulation in Training

Enhancing patient safety – attracting good students – research opportunities

Marcus Rall

Kind to patients

In the last ESA Newsletter the problem of simulating and practising drills for dealing with failed intubation and ventilation was aired. Ethical issues and respect for our patients make it impossible for us to use them as learning tools, but the use of modern, realistic patient simulators offers an alternative teaching model for training anaesthetists in difficult airway management. A traditional apprentice approach common to anaesthesia teaching, relies on naturally occurring crises to shape our clinical skills and responses. Our attitude to the acquisition of this kind of experience is that it is 'character building'. Anaesthetists who learn to weather clinical crises might become better clinicians, but this is of little comfort to the patients whose crises have made the lessons possible. Unfortunately even then experience cannot always be relied upon to create excellent clinicians. Not only can teaching with the simulator provide the same experience without a casualty, it can go further and enact all common and uncommon scenarios likely to be encountered. The various types of simulators, realistic manikin based systems, or screen only computer based micro simulators, linked with adaptation of adult learning principles; goal orientation, self directed learning, with emphasis on self-reflection, perhaps with video-debriefing, comprise a 'blended learning system'. Altogether this brings promise of a level of education and preparedness for real-life crises that has not been attained before.

Kind to doctors

Simulation can be made to work on several levels. At the highest level, it is used to train anaesthetists in non-technical skills like communication, decision-making, situation awareness and working together as a team. Planning a complex training session (simulation setting) intended to take a team of experienced clinicians through a crisis scenario, with decisive interventions at key points, requires a sig-

nificant expertise on the part of the simulation instructor.

Guidelines introduced by Gaba and Howard for this kind of training are christened Anaesthesia Crisis Resource Management (ACRM). One of the problems that trainers face is bringing participants to accept and learn from errors and

indecision. The way in which failings are perceived can vary enormously between individuals, and it can be very easy to turn a complicated training sequence into a thoroughly negative experience. Trainers not only have to learn the mechanics of the scenario, they have to understand that a poorly handled session can bruise the psyche of participants. Life and death scenarios can be a source of distress to susceptible individuals, who might then be vulnerable to clumsy criticism from

an incompetent trainer who does not appreciate the power of the situation. If lessons are to be learnt, the experience must be a positive one for the participants. The course of the debriefing, and the atmosphere in which it is conducted are largely dependent on the skill of the instructor. Successful instructors are likely to benefit from a grounding in psychology, as well as the didactics of modern simulation.

At lower levels of expertise, the ACRM format might give way to the more general training of skills and drills. The emphasis here is less on decision learning and more on technical performance. The trainers decide the balance between the two. Pseudo-reality can be made to seem very realistic. The nature of scenario,



Mobile simulator training inside a real helicopter with the German Air Rescue. An example of the versatility of realistic mobile simulation. Substitute the ambulance, in the CT scan, an airliner or just in the bed on transfer inside the hospital (ICU).

Video-assisted debriefing. While the hotseat is in the OR, the rest of the group watches the scenario live on the screen with vital signs and audio. After the session, the whole group discusses ways of improving performance.



Scenario of a realistic simulator session in the OR. The trained anaesthetist (hot seat) is taking care for the patient. The nurse (in the front with headset) and the surgical team are directed by the simulator instructor team. A laparoscopic procedure is replayed on the monitor for realism. Videocameras record the session for the debriefing (one pan-tilt-zoom can be seen in the upper corner)

and the level of training can be adapted to first year residents, nurses and students as required. Specific topics such as airway management, crises in the Intensive Care Unit, management of prehospital emergencies, and disaster and terror training can all be taught in this way. The functional aspects of interdisciplinary team working can also be addressed, especially in situations where the balance of emphasis between decision handling, leadership and assertiveness, and simple technical performance, can be a delicate thing. Sometimes it is this risk of having very human failings exposed and dissected, that deters clinicians from throwing themselves enthusiastically into the process. For most, however, it is lack of opportunity, time, and money.

At present simulation training is largely for volunteers, but doctors of the future may enjoy simulation periodically as part of their continuous medical education. Competency based assessment that is essential for renewal of registration is currently not universal in anaesthesia. Whether the simulator has a role in the process is speculative, at present, and subject to current research. The outcome may eventually offer the combined advantages of improved safety for the patient, together with 'real life' crisis training for the physician, in an open "no-blame" environment. Simulation also offers opportunities for research in education and the study of team performance in crisis situations. Simulation in medicine is likely to be a growth industry.

Reading List

- Howard SK, Gaba DM, Fish KJ, Yang G, Sarnquist FH: Anesthesia crisis resource management training: teaching anesthesiologists to handle critical incidents. *Aviat Space Environ Med* 1992; 63: 763-70

This is the description of the original ACRM simulator course – the worldwide de facto gold standard

- Gaba DM, Fish KJ, Howard SK: Crisis management in anesthesiology. New York, Churchill Livingstone, 1994.

The framework for simulator courses - human factors and CRM - a must.

- Nyssen AS, Larbuisson R, Janssens M, Penderville P, Mayne A: A comparison of the training value of two types of anesthesia simulators: computer

The Society in Europe for Simulation Applied to Medicine – SESAM

SESAM represents the first European society dedicated to the science of medical simulation. Not surprisingly, it was founded by anaesthesiologists who remain at the forefront of the Society. This year it celebrates its 10th anniversary in Stockholm soon after Euroanaesthesia 2004; abstracts will be published in the EJA. SESAM's goals are the advancement of research and training related to simulation, and in support of this it has opened its doors to educators and psychologists, and expanded beyond perioperative scenarios into medicine and paediatric applications.

Details of the 10th anniversary meeting can be found at www.sesam2004.se. Information on SESAM is available at www.uni-mainz.de/FB/Medizin/Anaesthesie/SESAM/welcome.html.

screen-based and mannequin-based simulators. *Anesth Analg* 2002; 94: 1560-5

Interesting article about an actual theme - blended learning

- Greaves et al with contributions of Glavin and Maran. *Clinical Teaching - a guide to teaching practical anaesthesia*. Lisse, Swets & Zeitlinger, 2002,

A whole book about teaching in anaesthesia, including many resources about simulation - a gem.

- Gaba DM, Howard SK, Fish KJ, Smith BE, Sowb YA: Simulation-based training in anesthesia crisis resource management (ACRM): a decade of experience. *Simulation and Gaming* 2001; 32: 175-93

Too short for putting in 10 years of experience, but long enough not to be missed

- Rall, M., Manser, T., and Howard, S. Key Elements of Debriefing for Simulator Training. *Eur.J.Anaesthesiol.* 17(8), 516-517. 2000.

Most people agree that debriefing is the heart and soul of simulation

- Fletcher GC, McGeorge P, Flin RH, Glavin RJ, Maran NJ: The role of non-technical skills in anaesthesia: a review of current literature. *Br J Anaesth* 2002; 88: 418-29

For whoever is interested in performance assessment - a milestone

- Gaba DM: Anaesthesiology as a model for patient safety in health care. *BMJ* 2000; 320: 785-8

Simulators are just one possibility to enhance patient safety - the goal of simulation

- Gaba DM: Human work environment and simulators, *Anesthesia*, 5 Edition. Edited by Miller RD. New York, Churchill-Livingstone, 1994, pp 2635-79

The most extensive source of information on the topic - 6th edition in 2004!

- Chopra V, Gesink BJ, de Jong J, Bovill JG, Spierdijk J, Brand R: Does training on an anaesthesia simulator lead to improvement in performance? *Br J Anaesth* 1994; 73: 293-7

A classic article about a well known problem.

- Larbuisson R, Penderville P, Nyssen AS, Janssens M, Mayne A: Use of Anaesthesia Simulator: initial impressions of its use in two Belgian University Centers. *Acta Anaesthesiol Belg* 1999; 50: 87-93

Do you want to start a simulator? Read what others experienced

- Schwid HA, Rooke GA, Carline J, Steadman RH, Murray WB, Olympio M, Tarver S, Steckner K, Wetstone S: Evaluation of anesthesia residents using mannequin-based simulation: a multiinstitutional study. *Anesthesiology* 2002; 97: 1434-44

The first big simulator study with many centers involved ●

Marcus Rall (Chair elect of ESA Subcommittee "Patient Safety")
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(Literature and further information is available upon request)

Philips Medical Systems in Partnership with the ESA



We have asked each of the ESA Partner Companies to introduce themselves.

PHILIPS

Introducing Philips

Philips Medical Systems is a global leader in diagnostic imaging systems, healthcare information technology, patient monitoring and cardiac devices. Philips also provides customer services such as consultancy to solve problems and advise generally, financing to support purchase packages, and maintenance and repair.

With technologies that can acquire, process, and present information as it is required in the exacting environment of the operating room, Philips is delivering on a commitment to address the needs of anaesthesiologists and peri-operative care teams. Philips offers innovative anaesthesia-specific monitoring, measurements, and decision support technologies specifically designed for this highly specialized field.

Anaesthesia monitors

Philips' range of IntelliVue anaesthesia monitors redefines the way physicians care for their patients. From high intensity operating rooms to procedural sedation, Philips has a scaleable, modular monitoring solution to fit all needs, wherever anaesthesia is delivered. For example, the FAST-

SpO₂ motion-tolerant algorithm is especially suited to anaesthesia recovery patients, the BIS module monitors risk of awareness and the Philips EASI derived 12-lead ECG is especially useful when requiring constant chest access. With Philips, hospitals can benefit from monitor standardization across the healthcare enterprise without compromising specialized anaesthesia features. Philips aims to provide measurement technologies that enhance safety and comfort while providing new levels of clinical accuracy, reliability, and utility.

IntelliVue patient monitors are intuitive to use, offer unprecedented screen configurability, and are ergonomically designed. In addition, they include portal technology, which allows care teams to view real-time physiologic data on the same screen with clinical review applications, digital radiology images, archived data, lab results, medication guidelines and hospital protocols, for example.

OLEH

Developed by the European Society of Anaesthesiologists, the Anaesthesia Online Electronic Help (OLEH) can also be accessed directly from the monitoring screen, via IntelliVue's portal technology. OLEH addresses the need for quick access to authoritative and up-to-date information in the operating room. OLEH provides sections on drugs, peri-operative considerations, surgical subspecialties, fluids and electrolytes, regional anaesthesia, post operative pain management and emergency algorithms. Quick access to

this information can enhance patient safety when information is critical to patient outcomes.

Flexibility

By enabling clinicians to combine Philips patient monitoring with the anaesthesia machine of choice, Philips provides a flexible solution for the OR. Individual components can be upgraded or replaced without the need to replace the whole system, resulting in an anaesthesia workplace that can evolve over time. Philips monitors are tested and approved for all major anaesthesia machines and come with a wide selection of mounting options. This open solution means clinicians can select the most ergonomic combination and most appropriate configuration of anaesthesia machine and monitor to suit specific needs. What's more, the VueLink module enables seamless data integration, providing complete information at the point of care.

To help anaesthetists in the care of their patients, Philips works to improve its products, and will collaborate with more specialised organizations to ensure that its catalogue of products reflect only the state of the art in clinical measurement and information management technologies ●

Selecting Congress Venues - how, who and why?

John Popovich, Executive Director



Every year the ESA membership buy their tickets to a major European metropolis to attend the continent's largest celebration of the science of anaesthesia. It is common to hear the delegates speculate as to why this year's venue was chosen, and where Euroanaesthesia might travel to next year. So I was delighted when the Newsletter Editor asked me to write something about the process of how the ESA goes about selecting a venue for Euro-anaesthesia meetings.

Selection

The number one criterion for selecting a congress venue is that the centre meets the space requirements of the scientific programme and the industrial exhibition. The content of the scientific programme, the number of delegates and the industry participants have increased over the years, and sadly, there are fewer and fewer congress centres in Europe that offer sufficient lecture rooms, auditoria for the opening ceremony, workshops and symposia, and facilities for the abstract presentations and discussions. Sometimes, but less often, insufficient space for the industrial exhibition is an issue (the only reason we have not yet planned a meeting in Prague – a city high on everyone's list.)

Our PCO (Professional Congress Organisers), Options Eurocongress, regularly visit and evaluate centres and formerly report their findings back to me. Together we keep abreast of developments with cities and congress centres with ambitions to expand. (For the past 5 years Rome has been promising to build an ultramodern new congress centre. To this day, there is still no start date; no completion date.) Inevitably the report always produces a list of pros and cons. With these reports we produce a 'short list' of centres that meet our criteria, and more often, centres that could meet our criteria with some modifications and resulting added cost. Modifications usually entail building additional session rooms for the scientific programme and/or the abstract presentations (as we had to do in Glasgow). Building additional rooms is always

very costly and never satisfies the users. In Glasgow, the abstract session rooms, built at a substantial cost, were not sufficiently soundproof. Lectures rooms built for the 1998 meeting in Barcelona were a disaster, judging from the comments and feedback received following that meeting. I recently visited the new congress centre in Munich, which is a fantastic destination, but unfortunately we would have to build at least two large lecture rooms. Because the health and safety restrictions do not allow us to build the walls up to the ceiling, sound-proofing would become a serious issue as it was in Barcelona.

Cost

Other important criteria we look at include the cost of the congress centre as well as the availability and cost of hotels and flights. Does the city have an international airport? The attractiveness of the destination is also very important. Attractive destinations always attract more delegates and their partners. The ability to organise a good social programme is surprisingly important.

Reputation

The reputation of a congress centre is also a critical selection factor. I belong to the AC Forum, an organisation of Executive Directors responsible for organising large annual medical congresses. We meet once or twice a year and throughout the year exchange information and experiences regarding the different congress centres around Europe. It is one of the most important professional organisations I am involved with simply because of the wealth of experience and information the members are willing and able to share. The Executive Directors representing two of the largest congresses in Europe, Cardiology and Radiology, are members of the AC Forum.

Timing

Last but not least, the date we select to host an Annual Meeting has an impact on attendance. We plan our meetings at least three to four years ahead. In fact, we have to do better and plan much earlier because when we do decide on a centre we often find that there are very few acceptable dates left from which we can choose. In

the past, the ESA Annual Meetings were often held in early April because those were the only dates available by the time the decision was made. To book dates in May or early June, considered the peak season for congresses, one has to book at least 4-5 years in advance.

But who ultimately decides? Evaluations and ideas are shared with the ESA Partner Companies but ultimately it is the ESA Board of Directors, based on the input received from the Executive Director, who makes the final decision.

Compromise

Of the six congress centres that I have worked with organising the ESA Annual meetings over the years, there is not, to my memory, a single one that was close to perfect, when looking at the total package. Gothenburg comes close, but on the down side Sweden is a very expensive destination and Gothenburg, as a city, does not have a lot to offer. It was one of our poorest attended meetings despite an excellent scientific programme. Glasgow was very good but the centre was very expensive and we experienced the soundproof problems with the abstract session rooms we had to build. Nice was great, attractive city, inexpensive, plenty of low cost flights, but the congress centre was cramped, and, to our great surprise, health and safety regulations did not allow room overflows (ie. people standing in session rooms when there are insufficient seats).

I'll reserve my final judgement on Lisbon until after the Euro-anaesthesia 2004 meeting. I can confirm that we won't be building rooms, it's an attractive congress centre and Lisbon, without a doubt, is a superb city! Nevertheless, I have become philosophical and accept that we will never please everyone ●

Readers are encouraged to write to the Editor and report their experiences and opinions on the various congress centres where the ESA has held an Annual Meeting.

Contact the editor by email: editor@blocked.org.uk

Tribute to Curtis Lester Mendelson (1913 – 2002)

J. Roger Maltby, Professor Emeritus of Anaesthesia,
University of Calgary, Canada, Maltby@ucalgary.ca

Curtis Mendelson died in West Palm Beach, Florida on October 13, 2002 aged 89. He was born on September 4, 1913 in New York City and graduated MD from Cornell University in Ithaca, New York in 1938. After completing his obstetrics and gynaecology residency at the New York Lying-In Hospital he was on its attending staff from 1945-59, and was a professor at Cornell University from 1950 to 1959.

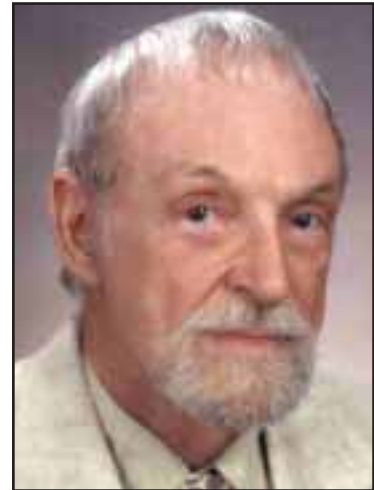
Mendelson's name is equally well known to obstetricians and anaesthesiologists for his classic description of the acid aspiration syndrome that bears his name. He reviewed the records of 44016 pregnancies in New York Lying-In Hospital from 1932 to 1945 and found 66 cases of aspiration of gastric contents during general anaesthesia. The 40 patients who aspirated liquid developed an acute asthma-like attack with cyanosis, dyspnoea, tachycardia, râles and rhonchi. They were critically ill during the acute episode, but stabilised in 24-36 hours and none of them died. Early chest x-rays showed no mediastinal shift, but irregular, soft, mottled densities that cleared in 7-10 days. Next, Mendelson conducted laboratory experiments in which he instilled various liquids into the lungs of anaesthetised rabbits. Hydrochloric acid or unneutralised liquid vomitus caused immediate cyanosis and laboured respiration, chest x-rays showed irregular soft mottled shadows and death occurred in minutes to hours. Distilled water, normal saline or neutralised liquid vomitus caused a brief period of cyanosis and laboured respiration but full recovery occurred within hours with no significant chest x-ray changes.

Mendelson presented his findings to the New York Obstetrical Society in December 1945 and pub-

lished them in the American Journal of Obstetrics and Gynecology 1946; 52: 191-205. He campaigned for antepartum education that stressed nothing by mouth during labour, and for regional blocks and natural childbirth to minimise the use and dangers of general anaesthesia.

Mendelson was director of the Antepartum Cardiac Clinic at New York Lying-In Hospital 1945-59 when rheumatic valvular heart disease was still common in pregnant women. He helped to pioneer the role of open-heart surgery during pregnancy. In 1959, when he was 46 years old, he decided – to the disbelief of his colleagues in New York City – to give up a busy private practice, a full teaching schedule, writing and research projects. He obtained a one-year leave of absence, ostensibly to work as a gynaecologist at Green Turtle Cay Clinic in Abaco in The Bahamas. However, he and his wife felt they had found paradise. Mendelson became an Out-Island doctor, resigned his New York appointments, and carried on a general medical, veterinary and minor dental practice in Green Turtle Cay for 31 years.

Mendelson enjoyed a full life with many interests in addition to his clinical practice. He was the Bahamian representative to the International Game Fishing Association, made world-wide fishing history in 1958 by catching a 498-pound blue marlin and was featured in a centrefold-type action photograph in the National Geographic in February 1967. He was a member of the Flying Physicians Association, the Seaplane Pilots Association, and the English Channel Swimming Association. He made his first unsuccessful attempt to swim the Channel aged 55, but had to give up after 5 five hours owing to rough seas. The following year he started from France and



could see the white cliffs of Dover when hypothermia forced him to give up after 12 hours.

Mendelson served the inhabitants of Green Turtle Cay until 1990 when, at the age of 77, he retired and moved to West Palm Beach, Florida. His first wife Marie, died in 1994 and he is survived by his second wife, Marguerite.

This article first appeared in 'Pencil-Point', the newsletter of the Obstetric Anaesthetists Association. It is reproduced by permission of the editors and the author. Roger Maltby is editor of Notable Names in Anaesthesia, which is available from the Royal Society of Medicine (www.rsmjpress.co.uk) ●



Euroanaesthesia 2004 – Lisbon June 5-8

Expanding the Scientific Programme

For the first time, delegates at this year's Euroanaesthesia meeting will be able to sign up for a series of "Meet the Expert" sessions. Although new to the ESA meeting, such sessions are popular elsewhere and we provide them in response to members' requests. We anticipate enthusiastic uptake. Local experts will provide short presentations on very practical topics, and great importance is attached to the opportunity at the end of the presentation, for the audience to question the presenter, and discuss the issues raised. There may well be other experts, in the audience, who have something to say, too! We will

be looking closely to assess how well these sessions work, and if attendances are high the format is likely to continue as a regular event.

Also new in Lisbon will be a whole day devoted to different aspects of airway management. This will cover many issues, from training, including guidelines, to very practical aspects of apparatus, and will be presented by speakers organised by the European Airway Management Society. The EAMS are an international group of experts who include Archie Brain, the inventor of the laryngeal mask. We are delighted to welcome them to Euroanaesthesia 2004.

Another special feature on offer this year are two workshops on Trans-Oesophageal Echo-cardiography, and we expect a brisk uptake of

places. Finally, we have two workshops on ophthalmic regional anaesthesia, given by Professor Chandra Kumar of Middlesborough, UK. His special interest is ophthalmic anaesthesia and he has considerable experience in demonstrating eye blocks to groups of anaesthetists.

Two art exhibits will take place at the congress centre during the meeting. One organised by Baxter "Art & Anaesthesia" devoted to the Belgian artist Rudi Pillen and the second organised by the Portuguese Medical Auto Club with paintings by its members, medical doctors, on display ●

For more information on the European Airway Management Society contact Professor Ulrich Braun, Email address: ubraun@gwdg.de



Euroanaesthesia 2005 – Vienna May 28-31

For your diary, please note abstracts submission deadline: December 15th, 2004

We are delighted to return to Vienna where the ESA organised a very successful joint meeting with our friends and colleagues from the Austrian Society of Anaesthesiologists (OGARI) in April 2000. The Austrian Society will again support the Euroanaesthesia meeting and in this context have decided to cancel their annual meet-

ing in 2005 and welcome their members to Euroanaesthesia 2005 instead.

Planning is well under way and the National Organising Committee has been established.

Euroanaesthesia 2005 will be a landmark meeting and a turning point in the history of anaesthesia in Europe. In fact, at the Lisbon Euroanaesthesia meeting in June, the general assemblies of the European Society of Anaesthesiologists (ESA), the

European Academy of Anaesthesiology (EAA) and the Confederation of European National Societies of Anaesthesiologists (CENSA) will vote on a proposal of amalgamation into a single new society with a new name –the European Society of Anaesthesiology. Euroanaesthesia 2005 would become a historic first meeting of the new single body representing anaesthesiologists in Europe ●



Euroanaesthesia 2006 – Madrid June 3-6

Please note abstracts submission deadline: December 15th, 2005

Although this will be the first time Euroanaesthesia hosts a meet-

ing in Madrid, it is not the first time we will organise a meeting in Spain. Many of us have very pleasant memories of the large and successful meeting in Barcelona in 1998.

Madrid is a superb city with much to offer and has two congress

centres. The Euroanaesthesia meeting will take place in the larger of the two (IFEMA Convention Center) ●

2004

- 5-8/6 **Euroanaesthesia 2004**
Lisbon, Portugal Contact: secretariat.esa@euronet.be
- 9-11/6 European Association of Cardiothoracic Anaesthesiologists (EACTA)
London, England Contact: www.eacta.org
- 25-27/8 XVIII Edinburgh Anaesthesia Festival
Edinburgh, Scotland Contact: anaes@ed.ac.uk
- 8-11/9 XXIII Annual ESRA Congress
Athens, Greece Contact: info@optionsglobal.com
- 9-12/9 6th European Congress of Trauma & Emergency Surgery
Rotterdam, The Netherlands Contact: www.hetCongresbureau.nl
- 16-18/9 15th ESPNIC Medical & Nursing Annual Congress
London, U.K. Contact: ESPNIC2004@rose-international.com
- 7-9/10 Joint 15th Annual Meeting of the European Society for Computing & Technology in Anaesthesia
and Intensive Care (ESCTAIC) & 11èmes journées de la Société Francophone pour l'informatique
et le Monitoring en Anesthésie-Réanimation (SFIMAR)
Toulouse, France Contact: www.esctaic.org
- 10-13/10 European Society of Intensive Care Medicine (ESICM)
Berlin, Germany Contact: www.esicm.org
- 23-27/10 American Society of Anesthesiologists Annual Meeting (ASA)
Las Vegas, United States Contact: www.ASAhq.org
- 10-14/12 58th Post Graduate Assembly in Anesthesiology
New York- Marriott Marquis Contact: nyssa-pga.org

2005

- 11-15/3 IARS – Honolulu, Hawaii Contact: iarshq@iars.org
- 28-31/5 **Euroanaesthesia 2005**
Vienna, Austria Contact: secretariat.esa@euronet.be
- 1-3/9 6th European Congress of Paediatric Anaesthesia (ECPA)
Cologne, Germany Contact: www.free.med.pl/feapa
- 15-18/9 6th International Symposium on the History of Anaesthesia
Cambridge, United Kingdom Contact: www.histansoc.org.uk
- 22-26/10 American Society of Anesthesiologists Annual Meeting (ASA)
New Orleans, United States Contact: www.ASAhq.org
- 9-13/12 59th Post Graduate Assembly in Anesthesiology
New York- Marriott Marquis Contact: nyssa-pga.org

2006

- 3-6/6 **Euroanaesthesia 2006**
Madrid, Spain Contact: secretariat.esa@euronet.be

*Organisations wishing to advertise their meetings on this page
should submit their requests to esa@euronet.be*



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