Moving forward for our patients

The ESA umbrella covers many people: accredited specialists, trainees, allied professionals, pain, anaesthesia, critical care and resuscitation. The ESA, or more correctly its members and officers, strives to improve the care of all our patients in many and diverse ways. This edition of the newsletter hopefully captures the flavour of some of these activities.

Anaesthesia has always been at the forefront of improvements in resuscitation. Many members will be aware of the new guidelines on resuscitation published just recently. Jochen Hinkelbein, chair of ESA Scientific Subcommittee 13 - Resuscitation and Emergency Medicine, provides members with an update. His message is clear – harder and faster basic life support.

Patient safety is very much in fashion at the moment, but anaesthesia can claim to have been ‘doing it’ for some time. There is plenty more to be done though, and Sven Staender and his colleagues from the new EBA / ESA Patient Safety Task Force offer readers an intriguing glimpse into the future focus around this important topic. The Task Force is very eager to hear from ESA members about your thoughts and experience.

The debate about propofol sedation has (re)ignited. This is one area where politics, science and personal opinion seem to collide. Jannicke Mellin-Olsen, president of the European Board of Anaesthesiology (EBA), tells readers that the EBA is ready to discuss the matter to reach an official political standpoint. No doubt the debate will continue.

On a more individual note, the EBA is looking for individuals to assist with accreditation of e-learning material.

Further afield, there are millions of people worldwide without access to pulse oximetry during anaesthesia and surgery. Our colleagues at the World Federation have made tremendous strides with the Global Oximetry Project and there is an update in this Newsletter. This project relies upon support, both financial and people’s time and energy. There are many ways for ESA members to get involved.

Education has always been a key component of the ESA mission. The European Diploma goes from strength to strength with yet more centres and countries taking part. Regular readers of the Newsletter will be aware how far the EDA has come since its first humble beginnings.

The first ESA Autumn Meeting took place last year in Budapest, and Lennart Christiansson has reported back with the positives and some thoughts for the future.

Of course, Euroanaesthesia 2011 is on its way – please do not forget to register. The programme looks fantastic and the Networking Evening looks like it will be something really special this year.

For a bit of light relief, there is a small historical picture quiz for readers. No prizes but have a go!

So there is lots to get involved with in this Newsletter: updating yourself on resuscitation; giving your thoughts and experiences on patient safety; donations to the global oximetry project; helping with e-learning; submitting your intensive care research; filling in your registration for Amsterdam or just having a go at the quiz over a coffee.
The message is clear: “Harder, faster and more BLS by lay persons” to save 100,000 more lives per year!

JOCHEN HINKELBEIN, CHAIRPERSON OF THE ESA SCIENTIFIC SUBCOMMITTEE 13: RESUSCITATION AND EMERGENCY MEDICINE

After a very intensive process over many years by the International Liaison Committee on Resuscitation (ILCOR), in which more than hundred European specialists for Resuscitation were involved, the new “Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science” of the European Resuscitation Council (ERC) are available.

It is now only a few weeks since the new guidelines have been published online and even less that the print version has been released in the Journal Resuscitation [Resuscitation 2010;81:1219-1451].

The central points of the new guidelines for cardiopulmonary resuscitation (CPR) 2010 are very clear:

- Chest compressions should be “harder and faster” as compared to the old guidelines from 2005: a compression frequency of 100-120 is appropriate, as well as a compression depth of 5-6 cm in adults.
- “No-flow-times” should be reduced to a minimum to provide continuous and optimal cerebral blood flow. Basic Life Support (BLS) should be performed uninterrupted until Advanced Life Support (ALS) can be established.
- Dispatchers should encourage “telephone-CPR” and chest compressions for lay persons.
- Ventilation is important even for trained lay persons: it should be performed 2-times after 30 compressions, i.e. 30:2. “Compression-only” CPR is acceptable only in lay persons who cannot perform or are unwilling to perform mouth-to-mouth or mouth-to-nose ventilation.
- Defibrillation should be performed as early as possible if indicated in VF/VT.
- Fibrinolysis after pulmonary embolism should be considered when it is the cause of a cardiac arrest.
- “Lipid resuscitation” should be used to treat local anaesthetic intoxicity.
- Toxicity of oxygen is a common hazard after return of spontaneous circulation (ROSC) when using high oxygen concentrations. Thus, hyperoxia should be avoided and an oxygen saturation of 94-98% is usually appropriate.
- Hypothermia should always be used after ROSC – even in paediatric or newborn patients.

All these changes are in line with the 2005 changes and can further improve the outcome of patients with cardiac arrest. Only if appropriate and continuous resuscitation attempts are being performed, it is possible to improve resuscitation quality. This is an important key-message which should be everyone in mind!

It is our goal to provide an optimum of resuscitation for a better outcome of patients. Teaching and encouraging doctors, nurses, and medical students as well as lay persons and even school children may increase both resuscitation efforts and resuscitation quality in the future significantly. 350,000 fatalities per year after cardiac arrest and unsuccessful resuscitation attempts in Europe is an enormous number; an additional 100,000 lives could be saved in Europe during a single year when performing CPR according to the new guidelines 2010 (http://www.erc.edu).

Now it is for us to ‘live’ the new guidelines and to improve resuscitation quality!

Further information:

The Council activities: An update

DANIELA FILIPESCU, ESA BOARD OFFICER IN LIASON WITH THE COUNCIL

Membership and role of the Council

The third Council of the new ESA started its term at the beginning of 2010 for the next two years. It consists of 11 re-elected members and 17 new members. Last June, in Helsinki, the General Assembly ratified the new Council.

While the National Societies are represented in the ESA through NASC, on a number-weighted basis, the members of the Council represent individual ESA members.

Any European country (as defined by the World Health Organization) with at least 25 Active members is entitled to elect one representative to the Council, through elections held every two years. Any active ESA member of a European country can stand for election. Two Active members from the respective country should support the candidature.

ESA Council members represent a vital link between the ESA Board of Directors and ESA members. The national representatives in the Council are responsible (as per the By-Laws) for contacts and regular transfer of information between the ESA and its Active members residing in the same country. There are approximately 100,000 anaesthesiologists working in Europe but only a fraction of them are represented in ESA. ESA Council representatives are extremely important for promoting the ESA continuously in their country and to increase the number of membership. Moreover, the Council representatives are supposed to attend the Council meetings, to be constructive with new ideas, to present proposals to the Board of Directors as well as being active in various ESA activities.
According to the current By-Laws of the ESA, the Council elects the members to the Board of Directors (with the exception of the Chairman of NASC), elects the President and Secretary of the ESA and may propose to the General Assembly any amendment to the By-Laws. In this latter case, a carefully worked-out resolution is necessary because the General Assembly who finally makes the decision is not in a position to vote for anything other than yes/no for the proposition.

Council activities

Recently, ESA has developed strategies to make the role of ESA National representatives more vital in the development of future ESA strategies. By implementing the Focus groups within the Council through a great pioneer work, Prof. Klaus Olkkola, the former Board officer in liaison with the Council, strengthened and energised the communication between National representatives. Many new ideas emerged thanks to discussions in the Focus groups. These contributed to the further development of the EJA, the European Diploma in Anaesthesiology and Intensive Care (EDA), cooperative research projects as well as the website. Furthermore, the Focus groups led to the introduction of new activities such as the Autumn meeting and ESA Guidelines.

The new Council met for the first time on 11 June 2010 in Helsinki. During the business part of the meeting, the non-physician registered professionals’ fee and reduced-fee countries were agreed, and the new President for the term 2012-2013 was elected.

The EBA/ESA Patient Safety Task Force presented the proposals for implementation of the Helsinki Declaration on Patient Safety in Anaesthesiology.

The membership task force analysis was also presented. Various solutions for promoting the membership and attracting attendees to the Congress, or to become members were discussed.

The novelty of this Council meeting was the new format, more open to discussion. Standardised reports of the ESA Committees chairs were available well in advance to the Council members. The chairs of various ESA Committees were invited to join the Council during a strategic meeting where the future directions of the ESA activities emerged: opening the scientific subcommittees to all ESA members, coordinating the education and training activities supported by ESA, developing the Clinical Trial Network.

A second meeting of the Council was held in November 2010. This additional Council meeting gave the opportunity to thoroughly discuss important matters for the development of the Society, such as the implementation of the Helsinki Declaration on Patient Safety, the modernisation of ESA structure, the Clinical Trials Network, the relationship between other specialist societies and other professional groups, and the ESA activities outside Europe.

Furthermore, these additional meetings are important to improve the friendship and the collaboration among ESA National Council representatives.

The link between the National Societies and the Council members should also be optimised and the Council members should get more involved in the ESA activities. The goal is to make ESA more competitive and efficient, to increase our visibility outside Europe and widen our initiatives.

In summary, ESA Council is working to find new ideas, opportunities, activities and projects. The contribution and suggestions of all ESA members is essential in order to find the best solutions.

Elections and/or re-elections to the Board of Directors

Elections and re-elections for Secretary, Treasurer and three additional members of the Board of Directors will take place during the Council meeting that will be held on Friday, 10 June 2011 in Amsterdam. Term of office is for two years starting as of 1 January 2012.

The composition, election criteria and method of nomination to the Board are detailed in Section 7 of the By-laws of the Society, which are published on the ESA website.

Attention is drawn to the fact that:

- at any one time, five elected members of the Board of Directors must have been members of Council at the time of their election, and no more than two elected members shall reside in the same country or have the same nationality.
- each candidate for office, whether or not they are a Council member, shall have been an active member of the ESA for at least three years.

Your application will then be forwarded to the Nominations Committee for approval. If you do not wish to go through the Nominations Committee, please send two supporting letters from two active members together with your application.

CV and your reasons for application will be transferred to the Council members for review. Applicants may be asked to make a 5 minutes presentation during the Council meeting that will be held on Friday, 10 June 2011 in Amsterdam.

How to apply?

Please send your CV together with a letter detailing your reasons for application to anne@euroanaesthesia.org no later than Tuesday, 10 May 2011, 23:59 CET.
The First ESA Autumn Meeting
LENNART CHRISTIANSSON, UPPSALA, SWEDEN

The meeting concept
It was with great pleasure that the ESA President could welcome attendees to the first ever Autumn Meeting, which was introduced to serve as an annual satellite to the summer Euroanaesthesia Congress. It is the intention of the Society to extend its educational activities to European countries that for practical reasons cannot accommodate meetings of that size. The ESA was therefore aiming for an inexpensive CME accredited meeting for a limited number of participants. It was anticipated that it would be more convenient for some members to attend such meetings in central and eastern European cities. The ESA also hoped that this new annual meeting would be well received by both trainees and already established anaesthesiologists. The captivating city of Budapest was chosen for the inaugural event.

The programme
For the two-day programme 36 presentations were selected to be given by 19 speakers in two parallel sessions. The two learning tracks were labelled Practice and Foundations, and the 30 minute presentations were to cover state of the art topics of current interest. Notably, among the speakers were the ESA President, the Chairperson of the Scientific Committee (SC) and several Chairs and Members of the SC Subcommittees.

The topics covered: patient safety, aspects of peri-operative monitoring, evidence-based practice guidelines, new techniques in analgesia, management of massive bleeding, news on pharmacokinetics, advances in intensive care and much more. Full programme details are available on www.euroanaesthesia.org under section Congresses – Autumn Meeting 2010 – Scientific Programme.

Paolo Pelosi, ESA President giving the lecture titled ‘Peri-operative Respiratory Management ventilation in morbidly obese patients’ during the Autumn Meeting Session ‘Practice III’

The venue
The Marriott Hotel on the river bank in Budapest provided the meeting with excellent congress services as well as the best possible location. Great support during the meeting was also granted by the local hosting Anaesthesiology Department and the National Society.

The hosting city
The Hungarian capital Budapest is an historic city with settlements dating back to the first century AD. It has kept up with the times though and is host of the European Institute of Innovation and Technology as well as being ranked as being a highly innovative city. Many people consider it to be one of the most beautiful cities in Europe, built on the shores of the Danube. It is an idyllic place to live and a great venue for the first ESA Autumn Meeting.

The Hungarian Society supported the attendance of some young anaesthesiologists to the Autumn meeting this year and ESA wishes to express our gratitude for this support.

Elections and/or re-elections to the Nominations Committee
Elections and/or re-elections of four members of the Nominations Committee will take place during the General Assembly that will be held on Monday, 13 June 2011 in Amsterdam. Term of office is for two years starting as of 1 January 2012.

Role
The Nominations Committee shall advise the Board of Directors about suitable candidates for election to the Board of Directors and for membership of other committees. The Nominations Committee shall comprise the President, the President-Elect or the immediate Past-President, and four Active members who are not currently members of the Board of Directors. The term of office of elected members of the Nominations Committee shall be two years, renewable once. Further details of the role and constitution of the Nominations Committee can be found on the ESA website www.euroanaesthesia.org under section About the ESA – Committees – Nomination Committee.

Application
If you wish to apply, please send your application with CV and two supporting letters (emails are accepted) from ESA Active members to the ESA Secretariat, Anne Dewaegenaere anne@euroanaesthesia.org no later than Friday 13 May 2011, 23:59 CET.
The meeting experience and evaluation

The general atmosphere during the meeting was excellent, but regrettably this first meeting had to face a somewhat lower number of participants than expected (260 in total). The commonest source of information was the ESA website. However, it must be admitted that more promoting through other channels could have been helpful. In the centre of the congress area there was a small but much visited exhibition of high quality.

The format of the meeting was commended by many, in particular so the interaction between the lecturers and the audience as well as the opportunity to discuss afterwards. For the latter purpose it was suggested by quite a few that a ‘get together party’ with the experts should be organised during the next meeting.

Evaluation

To evaluate the meeting a survey was launched. More than two thirds of the meeting participants were happy with the booking process and pre-event organisation, the on-site organisation, the venue and its facilities, the relevance of the topic areas and the presentations that were delivered. After the meeting the presentations were made available on the ESA website for the meeting participants and all ESA members.

The survey also asked for input on how to improve future ESA Autumn Meetings. Among the large number of very constructive suggestions some are listed below:

- more focus on narrower hot topics;
- introduce workshops a/o practical sessions;
- more discussions/interactive sessions;
- concentrate on one learning track only;
- introduce pre-EDA preparatory courses;
- provide presentations on DVD or USB-stick;
- introduce meet the expert sessions;
- involve more local hosts and lecturers;
- introduce a book corner, EDA reading list, etc.

Future plans

In the future we will improve further the organisation of the meeting, based on this first exciting and promising experience. First, we would like to focus the meeting on specific hot topics, and hopefully create a meeting which presents very new scientific and state of art information discussing relevant debates in Anaesthesiology. Second, we will implement hands-on workshops, which are very much appreciated by attendees. Third, discussion and strict collaboration with the National Society of the hosting countries will be helpful to improve the quality and organisation of the meeting.

The ESA is always willing to support any initiative proposed by National Societies, and we do hope that the links and collaborations between ESA and National Societies activities will improve still further in the near future. In summary, the ESA intends to promote this project and make it a new traditional event, not to be missed by its members. Next Autumn Meeting will take place in Krakow, Poland on 11 - 12 November 2011!
European Diploma of Anaesthesiology and Intensive Care: Report from the Examination Committee 2011

ZEEV GOLDIK, CHAIRMAN OF THE ESA EXAMINATIONS COMMITTEE

The Examinations Committee is glad to announce the creation of the Online Assessment Subcommittee. The Online Assessment (OLA) is a preparation and educational tool accessible through the internet allowing individuals and departments to participate in the project any time, at their discretion and according to their respective periods of training. The idea is that the already existing ‘In Training Assessment’ and the new ‘Online Assessment’ will be complementary to each other.

Once again this year, the examinations of the European Diploma in Anaesthesiology and Intensive Care (EDA) have experienced a major boom in the registration of candidates from all over Europe. This is mainly due to the constant developments and agreements reached with several European countries.

Malta
In 2009 Malta adopted the European Diploma Examination (written Part I and Oral Part II) as the official national mandatory examination in Anaesthesia.

This agreement signed by Dr. Carmel Abela as President of the Association of Anaesthesiologists of Malta and by myself as Chairman of Examinations Committee of the ESA was also signed by the country’s Parliamentary Secretary of Health, Dr. Joe Cassar in Palazzo Castellania.

A centre for the Oral EDA Part II was opened in Vienna in September 2010. The examination took place in the impressive building of the University of Music and Performing Arts.

EDA Adoption in Malta

Austria
Following the agreement signed between the Austrian Society of Anaesthesiology (ÖGARI), the Austrian Medical Chamber (Österreichische Akademie der Ärzte) and the ESA making the EDA Part I examination mandatory from year 2010, in February 2009 the Austrian Medical Chamber decided to recognise the EDA Part II Oral exam as "equivalent to the Austrian National final exam in Anesthesiology".

Turkey
Following the approval of the Turkish Board of Examinations, the EDA Part I was adopted officially in Turkey in place of the previous national MCQ Board Examination. The first EDA Part I exam took part in Istanbul in September 2009 and for the second time in 2010 with the participation of 70 candidates.

Poland
The official ceremony of signing of the agreement of adoption of the EDA Part I as mandatory in Poland was signed in Krakow in 2009 by the Polish Society of Anaesthesiology and Intensive Therapy and the ESA. The agreement was witnessed by the Vice Minister of Health. Last September 114 candidates participated at the EDA Part I in Warsaw.

Slovenia
During a meeting held in Ljubljana in October 2009 the EDA Part I was adopted officially as a mandatory examination in Slovenia.

As a result, in 2010 EDA Part I was, for the first time, the mandatory examination in Slovenia.

Glasgow Declaration
In 2009 the Glasgow Declaration produced by CESMA (Council of European Medical Specialty Assessments) was approved by ESA Examinations Committee and ESA Board and supported by the EBA (European Board of Anaesthesia) of the UEMS.

According to this document, the European Diploma Examination is now open to candidates from all countries. The Examinations Committee adapted the EDA eligibility criteria accordingly (see ESA website www.euroanaesthesia.org ).
Other new centres
Every year, new centres are open across Europe. In 2010, the following centres were opened:
Groningen (The Netherlands), Part I and ITA centre hosted by Dr. J.K. Götz Wietasch.
Vienna (Austria), Part II centre hosted by Prof. Martin Dworschak and with the kind support of Mag. Helga Vit.

Romanian and Slovenian became respectively the eleventh and twelfth languages of the EDA Part I. Talks are continuously being led with other European countries wishing to adopt the EDA Part I as a mandatory examination and all developments will be detailed in future issues of the ESA Newsletter.

Numbers and graphs
Part I (2010)
Of the 1114 candidates who sat Part I in 2010, 650 were successful and 464 failed, for an overall pass rate of 58.3%, compared to 56.6% in 2009 and 58.7% in 2008.

The highest Part I score was achieved by a Swiss candidate: Dr. David Freiermuth (pictured) who will be awarded the John Zorab Prize in Amsterdam. Congratulations to him!

2010 John Zorab Prize winner – Dr. David Freiermuth

Part II
In 2010, we welcomed 242 candidates to sit the oral exam, 191 passed and 51 failed, meaning an overall pass rate of 78.9% (compared to 80.5% in 2009 and 71.8% in 2008).

ITA (In-Training Assessment)
Among the 323 candidates who participated in 2010, 52 passed and 271 failed, meaning an overall pass rate of 16.1% (compared to 295 candidates and 23.7% pass rate the year before).

Invitation to EDA Symposium in Amsterdam (2 sessions)
Like every year, the programme of the Euroanaesthesia 2011 Congress will offer a session dedicated to the EDA. We would be delighted to welcome you and to answer your questions about the EDA on this occasion.

Computers will also be set up on the ESA stand for potential candidates to have a first taste of the written examination. A short MCQ test made of questions similar to the ones asked at the EDA Part I examination will indeed be available from these computers.

Join us at the Euroanaesthesia 2011 Congress in Amsterdam!

Examiners Symposium Sunday, 12 June 2011, from 14:00 to 15:30
First presentation: “Oral exams, how to ask and how to answer?”
Speaker: Dr. Zeev Goldik (Haifa, Israel), ESA Examinations Committee

Second presentation: “An awfully simple or simply awful means of assessment”
Speaker: Dr. Jean Pierre Van Besouw (London, United Kingdom), Royal College of Anaesthetists – UK

Third presentation: “Validation of examinations”
Speaker: Dr. Kevin Carson (Dublin, Ireland), College of Anaesthetists- Ireland

Workshop for Examiners Monday, 13 June 2011, from 17:00 to 17:45
(IMPORTANT: Access is limited to the EDA Examiners only)
Speaker: Dr. Zeev Goldik (Haifa, Israel)

Rooms will be confirmed in the final program of the congress distributed on site.
What is HVTAP? Where has HVAP gone?
LENNART CHRISTIANSSON, CHAIRPERSON OF THE HOSPITAL VISITING AND TRAINING ACCREDITATION PROGRAMME (HVTAP)

The role and remit of ESA structures constantly changes so from December 2010, the “Hospital Visiting and Accreditation Programme” changed into the “Hospital Visiting and Training Accreditation Programme” to better reflect its purpose.

As a consequence, all e-mails about the HVTAP will have to be sent to hvtap@euroanaesthesia.org from now on.

The HVTAP is a programme managed by both the European Society of Anaesthesiology (ESA) and the European Board of Anaesthesiology (EBA) of the UEMS.

Together with the European Diploma in Anaesthesiology and Intensive Care (EDA), the HVTAP aims to improve and harmonise the anaesthetic training throughout Europe by ensuring that the accredited centres meet the prerequisites of training in anaesthesia. Representatives of both organisations form the HVTAP Committee, and the visitors of this programme also come from both the ESA and the EBA.

We are glad to announce that the following visitors officially joined the programme as ESA representatives: Dr. Armen Varosyan (Yerevan, Armenia), Dr. Thomas J. Sieber (Chur, Switzerland) and Prof. Wolfram Engelhardt (Offenburg, Germany). Additionally, Dr. Carmel Josef Abela (Malta) and Dr. Mario Zerafa (Malta) were officially appointed EBA visitors for the HVTAP.

After several years of dedicated work for the HVTAP, Prof. Doris Balogh (Innsbruck, Austria) has stepped down and been replaced by Prof. Edoardo de Robertis (Naples, Italy) to represent the EBA on the Committee.

The ESA Secretariat would be happy to answer any enquiry about the HVTAP. Please visit our website www.euroanaesthesia.org, download documents and contact us at hvtap@euroanaesthesia.org to learn more about the programme.

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ESA Dräger Prize in Intensive Care Medicine

The European Society of Anaesthesiology (ESA) is pleased to announce that for the fifth time, in 2011, an annual prize in Intensive Care Medicine will be awarded, sponsored by Dräger.

Guidelines for ESA Dräger Prize in Intensive Care Medicine

1. An annual prize of €10,000 will be awarded to an anaesthesia or intensive care department (not an individual) in Europe. The prize is for a clinical or laboratory, peer-reviewed publication of significant clinical relevance on an intensive care topic published in the previous calendar year, e.g. award in 2011 for a paper published in 2010.

2. Applications are to be made by the authors of suitable papers. One of the applicants must be an active member of the ESA when applying for the prize.

3. A single side of double-spaced A4 paper should accompany submission of a copy of the article, detailing why the authors think they should be considered for the prize.

4. The deadline for submissions is 1 March 2011, 23:59 CET.

5. The submissions will be reviewed by an ESA committee established specifically for this purpose (see below). The committee will classify the submissions as Eligible or Ineligible. A short-list will be drawn up from the Eligible applications.

6. Two external reviewers, selected by the committee, will be asked to assess all short-listed applications, using a predesigned form.

7. The ESA committee supervising the running of the award and making the final decision shall consist of: the Chairman of the Scientific Committee (SC); two active ESA members who have an interest in intensive care, appointed by the Chairman of the SC; the chairman of Subcommittee 12 of the SC (intensive therapy); and another member of Subcommittee 12, nominated by the Chairman of Subcommittee 12 and approved by the Chairman of the SC. The committee will be chaired by the Chairman of the SC. No Committee member, or any of their department, can apply for the prize. At least two members of the Committee will be replaced each year. The Chairman of the SC will chair this committee while he or she remains in office. Representation on the committee from around Europe is preferable. No more than two committee members will be from the same country.

8. No paper which is co-authored by employees of Dräger will be considered. Any financial support from Dräger or any other source for the research must be detailed in the application.

The winner receives free registration to the Euroanaesthesia 2011 Congress to accept the prize during the Awards Ceremony.

Please send your applications via e-mail to: draegerprize@euroanaesthesia.org by 1 March 2011, 23:59 CET.
Stefan De Hert - Scientific Committee Deputy Chairperson

Professor Stefan De Hert has been appointed on 1 September 2010 to succeed Professor Benedikt Pannen and will spend 18 months as deputy before becoming the next Scientific Committee Chairperson (as from 1 March 2012).

Stefan De Hert received his medical degree at the University of Antwerp, Belgium in 1984. Subsequently he completed anesthesiology residency training at the Antwerp University Hospital. After his training he accepted a faculty position in the department and served as vice chairman of the Department of Anesthesiology at the Antwerp University Hospital and Professor of Anesthesiology at the University of Antwerp for over 10 years.

From 2007 to 2010 he acted as Professor of Cardiothoracic and Vascular Anesthesiology at the University of Amsterdam, the Netherlands, and Director of the Division of Cardiothoracic and Vascular Anesthesiology at the Academic Medical Center in Amsterdam. Presently, he is Professor of Anesthesiology and Director of Research at the Department of Anesthesiology of the University Hospital of Ghent.

His early work and PhD thesis, which he defended in 1992, explored the role of the endocardial endothelium in the regulation of myocardial function. His academic interests have focused on peri-operative cardiac function with emphasis on diastolic function, transoesophageal echocardiography, peri-operative organ protective strategies and outcome after anesthesia, haemodilution and volume replacement strategies, and peri-operative cerebral oxygenation.

He has authored and co-authored over 100 articles in peer-reviewed journals and several chapters in different textbooks. He is an Associate Editor of Anesthesiology, the European Journal of Anaesthesiology, and the Journal of Cardiothoracic and Vascular Anesthesia and acts as regular reviewer for several major anesthesiology, cardiology and surgery journals.

Prof. De Hert acted as member and as Chairman of the ESA Scientific Subcommittee on Clinical and Experimental Circulation of the ESA. He is currently a member of the ESA Research Committee and chairman of the Task Force on Pre-operative Evaluation of the Adult Patient of the ESA.

ESA Maquet Anaesthesia Research Award

The European Society of Anaesthesiology (ESA) and Maquet Critical Care (MCC) are pleased to announce a new research award in Anaesthesiology.

MCC’s aim is to support research every year in a particular focus area which may be of importance for perioperative ventilation during complicated anaesthetic procedures. Examples of complicated anaesthetic procedures include paediatric anaesthesia, thoracic anaesthesia, anaesthesia for the obese, or anaesthesia for critically ill patients with acute respiratory failure.

The area of interest for 2011 covers research projects concerning respiratory muscle function during and after anaesthesia.

The research plan of highest interest and importance will be rewarded with €10,000. The aim is to support the development of young or mid-career investigators.

Guidelines

1. Only members of ESA are invited to submit an application.
2. The research can be either basic concept studies or clinical studies in humans and an application of maximum 4 pages (double-spaced A4) should include:
   • Short introduction
   • Study design with objectives, hypothesis and endpoints
   • Data collection and planned analysis
   • Safety parameters when applicable
   • Key references
3. The deadline for application is 1 March 2011, 23:59.
4. All applications should be submitted by email to: research@euroanaesthesia.org

The research plans will be evaluated and prioritised by the ESA Research Committee.

The winner will receive free registration to Euroanaesthesia 2011 Congress to accept the prize during the Awards Ceremony. [II]
The EBA/ESA Task Force Patient Safety

SVEN STAENDER, CHAIRPERSON OF THE EBA/ESA PATIENT SAFETY Task FORCE

Patient Safety in Anaesthesiology

Development of the Helsinki Declaration

Starting in June 2009, representatives from the European Board of Anaesthesiology (EBA) and the European Society of Anaesthesiology (ESA) set up the first draft of the Helsinki Declaration. Many individuals and representatives of national societies have been involved in the drafting and development of this Declaration. The first draft was discussed in a meeting in London with representatives from all over Europe in November 2009. Following that, it was finalised by involving all EBA representatives as well as the ESA Board of Directors. The Declaration in its present form was signed and put into practice in June 2010 at the Euroanaesthesia Congress in Helsinki. The Declaration is the result of a consensus between both the ESA Board of Directors and the EBA and it is signed by all ESA member societies, represented in the NASC as well as patient and industry representatives.

The Declaration recommends practical steps that all anesthesiologists, who are not already using them, should include in their own practice. These are relatively straightforward and where they are currently being used, there is a track record of improving patient safety.

All European anaesthesiology institutions are expected to support the World Health Organisation (WHO) ‘Safe Surgery safe Lives’ initiative including the “Safe Surgery Checklist”, where anaesthesiology plays an important role and where other safety recommendations are made.

The EBA/ESA Patient Safety Task Force

In order to facilitate the implementation of the Helsinki Declaration, EBA and ESA jointly have established a Patient Safety Task Force to take forward this work by providing the tools and protocols anaesthesiologists might need to help them fulfilling their obligations under the Declaration. This Task Force is composed of two ESA and two EBA members, respectively:

- ESA: Sven Staender (CH), Chair, s.staender@spitalmaennedorf.ch
- ESA: Andrew F. Smith (UK)
- EBA: David Whitaker (UK)

Principles and aims of the Helsinki Declaration on Patient Safety

The Declaration builds on earlier statements about safety and quality of care. It represents a shared European opinion of what currently is both worth doing and practical to improve patient safety in anaesthesiology in 2010.

The WHO checklist

With its set of recommendations to anesthesiologists, ready for practical implementation on the one hand, and a number of requirements to be met by institutions providing perioperative anaesthesia care to patients on the other hand, the Helsinki Declaration has now definitely set the course to render anaesthesia safer all over Europe. The challenge to transform these standards and recommendations into actual clinical usage, however, remains. It will undoubtedly require a combined effort by both practicing anesthesiologists and representatives of academia, the institutions offering perioperative anaesthesia care and at last but not least the public sector.

- EBA: Guttorm Brattebø (NO)

The Task Force will work on the following topics derived from the Helsinki Declaration for the next three years:

1. Webpage

A distinct Patient Safety webpage will be set up and maintained by the Task Force. This webpage will be created with the support from the administrative staff from the ESA Secretariat (Anne Dewegenaaere and Raf Kinniaer). On this page we will give all the relevant background information as well as links to documents, templates and other safety resources available on the internet related to anaesthesiology.

2. Template for the safety report

One of the principal requirements is to produce an annual report of measures taken and results obtained in improving patient safety locally.
The EBA/ESA Task Force on Patient Safety in anaesthesiology in Europe will develop a template for such a report. This template will be available for downloading on the task force webpage shortly. This safety report can be used at local or national level. In order to show progress in patient safety in anaesthesiology we invite you to submit your completed safety report annually to the chairman of the EBA/ESA Patient Safety Task Force. With these systematically collected reports we will be able to track and demonstrate the progress in our field in Europe.

3. Protocols

The Helsinki Declaration requires that every department of anaesthesiology in Europe MUST have the following protocols available:

- Pre-operative assessment and preparation;
- Checking equipment and drugs;
- Syringe labelling;
- Difficult/failed intubation;
- Malignant hyperthermia;
- Local anaesthetic toxicity;
- Anaphylaxis;
- Massive haemorrhage;
- Infection-control;
- Post operative care including pain relief.

Links and further information to these protocols will again be available on the task force webpage shortly. If you have examples of such protocols and you are willing to share them, please send an email with that information to the Chairman of the Task Force.

4. Clearing house for IR

One of the other topics mentioned in the Helsinki Declaration is incident reporting. Today incident reporting is used locally in individual departments, hospitals, trusts or even nationally. These reported incidents sometimes have a huge learning potential. In order to share this knowledge about rare, but potential hazardous incidents, we will build up a platform where we will share:

- Individual incidents of outstanding importance;
- National recommendations out of incident reporting systems.

If you are interested in sharing your critical incident or if you are running a national incident reporting system in anaesthesiology and you are interested in sharing the information and/or recommendations out of your system, please contact the Chairman of the Task Force (s.staender@spitalmaennedorf.ch).

5. Drug syringe labelling study

Under the patronage of the University of Geneva (CH), Department of Anaesthesiology (principal investigator Bernhard Walder), a European study on drug syringe labelling practices will be carried out in January/February 2011.

A prospective web-based survey of physicians and nurses in European Departments of Anaesthesiology will therefore be performed between January and February 2011. The survey will be distributed to all ESA members via email. Please be aware of the corresponding information that will be sent to you in January/February 2011.

Everybody had to have his way. This was also inevitable because on the edge of the Continent, leaning on Germany and facing Britain, the Netherlands had to combine influences from two worlds, the Continental and the British.

The Dutch way

Compromises, teamwork and two-sided international influences shaped Dutch anaesthesiology as well. Typically continental were the university hospitals with solid surgical departments under equally solid surgical professors. As in Germany these professors considered anaesthesia a part of surgery and were closely involved in anaesthetic developments.

Examples are: the first overpressure anaesthesia machine in the Netherlands, designed by Professor Zaaijer and his assistant Meiss in 1925, and the hyperbaric oxygen therapy, developed by Professor Boerema in Amsterdam after the Second World War. But besides the university hospitals, large hospitals similar to those in Britain were run either by private enterprises or one of the religious denominations.

In those hospitals there were no permanent medical staff and hence a motley crew of people administered anaesthetics, mainly general practitioners. Actually, the patient’s general practitioner was expected to accompany his patient in the hospital and administer the anaesthetic while the surgeon hopped in to perform the surgery. For instance Maarten Mauve, who would become the first president of the Netherlands Society of Anaesthesiology in 1948, was originally a general practitioner. As well as surgical assistants and general practitioners, in many institutions nurses or technicians under the responsibility of the surgeon administered anaesthetics until the 1960s.
The great debate

When in 1948, as in many other West European countries, anaesthesia became a registered and protected medical specialty a compromise had to be made with the existing anaesthetic practices. A fierce debate developed around the question of who would stay allowed to administer anaesthetics and how many patients could be watched over by one anaesthesiologist simultaneously. This debate lasted for 30 years and led to a wonderful and typically Dutch compromise, “the flexible-one-table-system”. One anaesthesiologist could be responsible for two patients at the same time, provided that he or she is assisted by adequately trained anaesthetic assistants. These anaesthetic assistants are not to be confused with the American nurse anaesthetists.

Contrary to nurse anaesthetists, Dutch anaesthetic assistants are not allowed to administer anaesthetics on their own. They assist the anaesthesiologist and watch over the anaesthetised patient when the anaesthesiologist is busy next-door.

From time to time the validity of this team-based model of anaesthetic care has been debated. In the 1990’s fundamental research was done to determine whether this flexible system led to higher anaesthetic mortality than in countries such as Britain with its strict doctor-based-one-table system. No differences were found. It can even be stated that the team-based-system has been in the frontline of developments. It has proven to be the basis for safety and quality of care in the 21st century.

A good place to start

The Dutch custom and ability to combine, to compromise and to bring people together was probably also the base for another contribution to the history of anaesthesia in the modern world. When after the Second World War most West European countries had some kind of anaesthetic society, the need for an international society was felt.

Several attempts were made but France, Germany, Italy and Britain did not grant each other the initiative of hosting the first meeting and so exposing their kind of anaesthetic care as the model for other countries in the world. In the end a country too small to impress international anaesthesia was granted the honour. For the same reason why in 1918 the Peace Palace, by now the International Court of Justice, was set up in The Hague, the Netherlands, this city and its bath resort with the unpronounceable name of Scheveningen was chosen to house the founding of the World Federation of Anaesthetic Societies in 1955. The fresh Dutch professor of anaesthesiology in Groningen, C.R. Ritsema van Eck did much of the coordinating work and became one of the first vice-presidents of the WFSA.

A good place to go

Like Dutch anaesthesia, Euroanaesthesia is brought forth by a multitude of combinations and compromises. Therefore it must be no surprise that Amsterdam, the capital of the Netherlands, feels good to host Euroanaesthesia 2011.

ESA members should all have received their paper copy of the Preliminary Programme for Amsterdam 2011. For those who have not, it can be found on www.euroanaesthesia.org under section Publications.

Complete information about the scientific programme containing all updates is available on www.euroanaesthesia.org, section Congresses – Euroanaesthesia 2011 – Scientific Programme. For the first time, there is an online version of the programme that allows you to make your own itinerary www.sessionplan.com/esa2011.

Early bird registration ends on 2 March 2011 so do not miss out on the opportunity for a €70 discount. There are four pre-congress educational courses as well which need to be booked separately:

- Crisis in ICU - using simulation training as a tool. Hemodynamic and ventilatory management
- European patient safety course
- Advanced Airway Management – a team approach (the SAMT course)
- European Trauma Course 2011

We look forward to seeing you in Amsterdam.
Meet your colleagues, share your ideas at the Heineken Experience on Sunday evening, 12 June 2011!

The 2011 edition of Euroanaesthesia will be held in Amsterdam from 11th to 14th June 2011. The exciting scientific programme can be downloaded from www.euroanaesthesia.org. Industry has jumped at the opportunity to reach out to thousands of specialists from all over the world. The leading companies producing the latest technological advances in medical equipment and devices and pharmaceuticals will be ready to meet you in Amsterdam.

Euroanaesthesia is also the opportunity for you to share your ideas, thoughts and problems with other specialists and colleagues. Where better to do so than at the Networking Evening on Sunday, 12th June from 7pm to 11pm?

This year we have chosen to host this event at the former Heineken brewery where millions of hectolitres of Heineken beer were brewed until 1988.

Walk around at your leisure and see for yourself how Heineken is bottled. Check out your knowledge of the brewing process and learn all about Heineken's historic heritage. Ever wondered what it's like to be a bottle of beer?

Make sure you take a trip on the 'Bottle Ride.' You start the ride as an empty bottle, following the different processes until you emerge as a filled bottle of Heineken ready to be consumed.

The bottle ride is a moving experience; you will find yourself on a conveyor belt travelling with thousands of other bottles on their path through the brewery!

Following your Heineken experience you are invited to join your colleagues for a walking dinner where you will sample Dutch food specialities sourced from local producers in a convivial atmosphere on the renovated top floor of the brewery. The number of tickets is limited to 600 participants drawn from practitioners, academics and exhibitors, attending Euroanaesthesia 2011, including the sponsor of the event AMBU. The all-inclusive price is 50€ per participant: museum visit, walking dinner, drinks. If you would like to join us please register on line www.euroanesthesia.org.

Picture Quiz

The ESA is a relatively young organisation, but it is founded on the art, craft and science of those anaesthetists who went before. Whilst clearing out some storerooms, the editor came across a varied selection of old anaesthetic equipment.

To test your historical knowledge here are three of the items. There is no prize but the first person to email the editor (newsletter@euroanaesthesia.org) with the correct names and pertinent history of all three will get a mention in the next issue of the newsletter.

If any members have photos of other historical artefacts (or people) the editor will be pleased to publish them in future issues.
During the November meeting of the European Board of Anaesthesiology (EBA)/UEMS, our Maltese hosts invited Commissioner John Dalli of The Directorate General Health and Consumers to join us for part of the meeting. He informed us about his views on the state and the future of healthcare in Europe. He pointed out that we will have a personnel shortage, and that he wanted to see more technology to take care of relevant tasks, so that we human health workers will be relieved of some of our workload.

Dr. Bernard Maillet, Secretary General of the UEMS invited him to co-operate with us, and Dr. Jannicke Mellin-Olsen, president of the UEMS invited him to co-operate with us, and Dr. Jannicke Mellin-Olsen, president of EBA, informed him about all fields of activity in our speciality, including anaesthesia, intensive care medicine, critical emergency medicine and pain, as well as a particular focus on patient safety. Our experience is that although technology is of great help, it will never replace the humans that develop and operate it.

We were all pleased with the meeting, and Mr. Dalli indicated that he would like his institution to co-operate closer with us in the future.

E-learning accreditation material - reviewers needed

E-learning is in high fashion in today’s medical world, but we need to ensure that the e-learning material is of sufficient quality. EACCME (European Accreditation Council for Continuing Medical Education - www.eaccme.eu) needs more reviewers of e-learning material.

In the near future, we hope that the reviewing process will ensure that the reviewer obtains CME (Continuous Medical Education/Continuous Professional Development) credits for the reviewing process. In addition, the reviewer is paid € 200 per ECMEC (European CME credits), equaling about 3 hours work. In addition, the reviewer needs to understand the basic regulations concerning accreditation of e-learning materials.

Current problems are:
- Too few reviewers;
- The reviewing process takes too long (the deadline is four weeks);
- Not all issues have been evaluated.

Hence, we try to develop an agreement with reviewers to ensure that all have the same understanding of the expectations.

Do you think this is something for you – check this document on www.uems.net: UEMS 2008/20 REV The Accreditation of e-Learning Materials by the EACCME

Furthermore, there is increased concern regarding financing of all types of CME/CPD. Unrestricted grants are acceptable, but nothing else. It has been suggested that there will be a specific requirement to report financing of meetings etc., when the accreditation applications are submitted.

EBA to pioneer the UEMS Multi-disciplinary Joint Committee in Pain Medicine

Prof. Margarita Puig, Spain, has agreed to establish and chair this important multidisciplinary committee in the EU. All relevant specialities are invited to join. It is expected that this increased attention to pain medicine in Europe will benefit one of the largest groups of patients.

The Anaesthesia Team in Europe

There is a personnel shortage in Europe, as well as globally. This affects all health personnel categories, and there is a need to look at the most effective and flexible way to utilise our resources.

European countries do not organise our anaesthesia services in a uniform way. In some countries, only doctors provide anaesthesia, in others, the doctors are working with nurses and other personnel – all with a varying background – in varying organisational models. Common to European countries, is that we regard anaesthesia as a medical speciality. The EBA will work together with partners, like the ESMAS, to define desired roles and training for all members of the anaesthesia team.

Procedural Propofol Sedation

It has been a long time since a treatment guideline ignited so much energy and passion as was seen when this article was released a couple of weeks ago: European Society of Gastrointestinal Endoscopy, European Society of Gastroenterology and Endoscopy Nurses and Associates, and the European Society of Anaesthesiology Guidelines: Non-anaesthesiologist administration of propofol for GI endoscopy. Dumonceau JM, Riphaus A, Aparicio JR, Beilinoff U, Knape JT, Ortmann M, Paspatis G, Ponsioen C, Racz I, Schreiber F, Vilmann P, Wehrmann T, Wientjes C, Walder B; NAAAP Task Force Members. (Eur J Anaesthesiol. 2010;12:1016-30.)

The reactions came from several parts of Europe, and they were mostly linked to “Should anyone but anaesthesiologists be allowed to administer propofol sedation?” This was also under considerable debate during the ESA Council meeting in November.

As this question is a political one, and it is linked to other specialities, as well, it is a typical matter for the EBA to deal with, as we did when these guidelines were published:


The most important issue is not to build fences around our speciality, but rather to define competencies that are required to fulfill our tasks. Those defined competencies might lead to the solution that only anaesthesiology trained people are suitable.

Having noticed the discussion that has taken place in the ESA concerning this matter, the EBA as the political anaesthesiology body in Europe, is ready to discuss the matter to reach an official political standpoint. This is a great opportunity for anaesthesiologists to show leadership.

The EU Health Commissioner meets European Board of Anaesthesiology

JANNICKE MELLIN-OLSEN, PRESIDENT OF THE EUROPEAN BOARD OF ANAESTHESIOLOGY (EBA)
The European Society of Anaesthesiology organises a two-part examination, the European Diploma in Anaesthesiology and Intensive Care (EDA) that is endorsed by the European Board of Anaesthesiology. Thanks to the assessment of the candidates by an independent board of European Examiners, the EDA helps anaesthesiologists wishing to apply for high quality posts or wishing to practice in any European country. For more information please visit [www.euroanaesthesia.org](http://www.euroanaesthesia.org) or contact us directly at exam@euroanaesthesia.org.

Have you ever considered a unique opportunity to raise your training to a European level?

Register online for the EDA Part I examination from 1 March 2011 till 28 April 2011!
As one of the six European Society of Anaesthesiology (ESA) Trainee Exchange Programme winners for 2009 I was extremely fortunate to have the opportunity to spend three months in one of the listed host centres. I am a young specialist anaesthesiologist working at the Clínica Universidad de Navarra (Spain), in the Department of Anaesthesia and Critical Care. In the main I perform anaesthesia in complex patients undergoing cardiovascular and thoracic surgery, as well as in patients at risk of cardiac ischemia in non-cardiac surgery. As you might expect, I also undertake a lot of work in our intensive care unit.

The ESA has allowed me to complete my specialist training at Papworth Hospital, which is internationally renowned for their transplant work. It is the UK’s largest specialist cardiothoracic hospital and has some of the best outcomes in the world for transplant and cardio-thoracic surgeries. The hospital has an international reputation for excellence, innovation and exceptional patient care. It serves over three million people in the East of England and leads the national pulmonary endarterectomy programme (pulmonary endarterectomy for chronic thromboembolic pulmonary hypertension). It is the only centre in England which performs this kind of surgery and it does so with excellent results.

I was therefore extremely motivated to undertake specialist training in a centre of international fame such as Papworth.

Papworth Hospital: Theatres, Critical Care and Anaesthesia

The theatre team consists of registered nurses, operating department practitioners, surgical care practitioners, healthcare assistants and ancillary staff. The qualified theatre staff are highly trained and all have a special interest in cardio-thoracic surgery.

Theatre

There are five operating theatres with adjoining anaesthetic rooms on the first floor of the surgical unit. Each theatre is equipped to carry out the full range of cardiac, thoracic and transplant operations. Three theatres have facilities for the remote viewing of operations, in the lecture theatre, by visiting surgeons or staff from other hospitals. There is a four-bedded recovery area adjacent to the five theatres.

Theatre programmes is also a common element of anaesthesia and lung transplantation in Cambridge, UK

The consultant anaesthetists with a specific interest in critical care lead the daily care of all patients admitted to the critical care area, working closely with all other specialists within the hospital.

An ongoing and broad range of active research programmes is also a common element of the department and a specific anaesthetic research unit runs various research studies.

Transplant Service

Papworth is a leading UK adult heart and lung transplant centre. The Papworth team has accumulated over 30 years of experience in transplantation and has carried out close to 2,000 heart and/or lung transplants. A dedicated team of specialist consultants and a specialist nurses provide lifelong care for transplant recipients and their families 24 hours a day. Every patient is treated as an individual and receives holistic care backed up by multidisciplinary expertise.

Papworth’s transplantation research is pioneering. It is mainly focused on donor management and donor organ resuscitation. Current efforts are concentrated on techniques to re-condition and resuscitate unused heart and lung donor organs to improve their function and quality in order to make them good enough to be transplanted.

Allied to its expertise in transplantation, Papworth is one of just five hospitals in the UK designated for Ventricular Assist Device (VAD) surgery. VADs are mechanical pumps that are used to support the heart function in very sick patients with heart failure whilst awaiting transplant.

Participation

As specified by the ESA, I made an initial week long visit after having been accepted by the medical tutor assigned by the centre where I would undertake my training.
On arrival I received a warm welcome and I met Dr. Vuylsteke and other members of the medical staff, which allowed me to gain an insight into the way they work. They then showed me the layout and the organisation of the medical care in the ICU.

Before starting I had to complete an induction course to learn about the organisational systems used at the hospital. The course was given by medical personnel and other members of Papworth. I found the doctors, nurses and staff members to be all very experienced and highly qualified.

The quality of medical care and teaching, in particular in anaesthesia and intensive care, is exceptionally good. I also attended a lecture for the staff, residents and students and I participated in several other scientific events.

Lectures and courses are held every day in Papworth Hospital, on a range of different topics dealing with Anaesthesiology and Intensive Care. Although the lectures are aimed at students, the standard is very high and so the lectures are also attended by post-graduate students and specialists.

Clinical Practice and Academic Study

I spent more than two months gaining experience in the Intensive Care Unit and one month, the last of my three month stay, in the theatres. During my stay I was involved as an observer in the diagnosis, treatment and discussion of many varied clinical cases. It was a real pleasure to listen to the thorough analysis of different diagnostic and therapeutic issues as well as issues of teaching and hospital management: Procedure-Specific Care in Cardiothoracic Critical Care (routine management after cardiac, valve, aortic and thoracic surgery), chronic thromboembolic pulmonary hypertension and pulmonary thrombo-endarterectomy (PTE), management after heart transplant and lung transplant, ventricular assist device, extracorporeal membrane oxygenation (ECMO), transoesophageal echocardiography (TOE), clinical information system, resource management, education and training in cardiothoracic critical care in the Papworth Hospital, and many others.

I learnt the importance of attention to detail in heart, lung transplantation and PTE surgeries, which were new to me.

I was surprised by the use of double hypothermic cardiac arrest phases during PTE operations and the excellent outcomes normally achieved with these patients postoperatively. I carefully read the numerous guidelines and protocols used daily by the staff.

With regard to lung transplantation, I set out to study not only the intra- and post-operative stages but also the medical history of each patient in order to understand the impact of a condition that leads to this terminal state (transplants are the only alternative left for these patients) this being one of the goals of my work plan during my stay. I was able to observe and so draw the conclusion of the importance of establishing protocols for the techniques and use of anaesthesia in order to obtain such good results (all the specialists at Papworth work according to guidelines established by protocols).

With regard to pulmonary surgery I was also very impressed by PTE operations and how extremely well patients usually fared postoperatively. Their postoperative medical care is led by a Consultant Intensivist supported by a multidisciplinary team.

I was given the opportunity to familiarise myself with all the equipment in routine use on the ICU and to look through all the documentation. I was allowed free access to all the protocols, which were often given to me before I needed to ask for them.

During my two months training I was not only an observer, as I was registered with the GMC, but I also participated in clinical procedures such as intubation, central venous and arterial cannulation, sedation and mechanical ventilation weaning. The anaesthesiologists impressed me most by their ability to perform informative TOE and integrate the information obtained into the treatment plan. These are procedures that are also carried out in the Clinic in Spain but in Papworth these procedures were implemented using different equipment or agents and in the context of a more diverse clinical context (critical and complex cardiothoracic patients) so this was a very positive learning experience for me.

Acknowledgements

These three months have a special place not only in my career path, but also in my personal development. It was very fruitful and enriching time for me and I would like to highlight my gratitude to all the ESA staff for the opportunity to receive this training and in particular to Mrs. Anny Lam who provided continuous support throughout my stay.

I would also like to thank Dr. Alain Vuylsteke who was my supervisor and the Director of Intensive Care Unit. I am indebted to all the consultants, registrars, medical staff and nurses that were always keen to help, teach and answer my questions at any time. Special thanks also to Dr. Kamen Valchanov and Dr. Stephen Web who were not only my professional mentors in my daily work but who also took care of me, helped me and gave me many opportunities to learn more. Finally, I wish to thank all the Anaesthesia and ICU doctors of the Clínica Universidad de Navarra who, with their support, made my training possible.

I recommend Papworth Hospital in Cambridge as an excellent host centre for specialists who want to improve their training in cardiac and thoracic surgery.
The idea of providing oximeters to those in need, first came about at the World Congress in Paris in 2004 when members of the WFSA Safety and Quality Committee were discussing ideas around improving patient safety. With the assistance of the Association of Anaesthetists of Great Britain and Ireland (AAGBI) and GE Healthcare, who provided the oximeters, they developed projects in 4 countries – India, Philippines, Uganda and Vietnam. They found that there was a huge need for oximeters, and that significant education was required in how to use them and how to respond to the information provided by them. (Anaesthesia 2009; 64:1051-1060).

At the same time, the WHO was developing its Safe Surgery Saves Lives initiative, led by Dr. Atul Gawande of the Harvard School of Public Health and a surgeon at the Brigham and Women’s Hospital in Boston. This resulted in the provision of a surgical checklist. Studies showed that using the checklist, no matter what resources were available, resulted in a reduction in surgical morbidity and mortality. (N Engl J Med 2009;360:491-499).

The use of a pulse oximeter was included as one of the points on the checklist because of the importance of this form of monitoring to patient safety, but also because it was recognized that a significant portion of the anesthesia world lacked pulse oximeters. In October 2008, WHO gathered together interested parties such as the WFSA, Harvard School of Public Health, procurement experts, industry and others. This group embarked on a project to provide low cost pulse oximeters to anesthesiologists in need of this technology to support the care of their patients. Teams were formed to determine the specifications of a suitable oximeter, to set up a procurement process, to secure financing and to develop educational materials.

A wide range of partners
All have done their work admirably. The chosen oximeter is ISO and CE certified, with all of the qualities and safeguards required. It comes with extra features, such as long-lasting batteries, which make it suitable for use in austere environments.

The successful manufacturer is able to provide this state-of-the art oximeter at the incredibly low cost of $250 US.

This should enable governments and hospitals in low and middle-income countries to purchase oximeters for a fraction of their usual cost. We also hope groups, organizations and even individuals, will donate them to those in need.

The project has gathered new partners such as AAGBI and Smile Train. As well, many people have donated their expertise in areas required by such a huge undertaking, for example management, branding, law and public relations. These are people outside of the anesthesia, and even the medical, world. They are contributing because they believe in the value of the project to improve patient safety during anesthesia and surgery.

Education
Research done as the project developed shows that about 77,000 operating rooms in the world lack pulse oximetry. This equates with about 35 million patients per year having anesthetics without an oximeter (Lancet 2010;376:1055-1061). In addition, there is a lack of oximeters in Recovery Rooms, Obstetric Units, Neonatal Units or Intensive Care Units. The potential for improving patient safety with these devices, supported by appropriate education, is enormous.

The education team has created materials for use in self-learning or for teaching. Each pulse oximeter that is distributed will have a CD-ROM with it which will include materials on the Surgical Safety Checklist and the oximeter. These include a manual describing oxygen transport, use of an oximeter, an algorithm on what to do when the oxygen saturation is falling, two PowerPoint presentations, scenarios for use in teaching, quizzes and a prize-winning video made especially for this project by Dr. Rafael Ortega, an anesthesiologist at Boston University. All of the material has been produced by us in six languages – English, French, Spanish, Chinese, Russian and Arabic. It will also be available free of charge from the WHO website. The content and quality of this material makes it relevant to any anesthesia provider – not just those in economically constrained settings.

Can you help?
We are calling on all of our member societies to assist us with the teaching programmes.

We are pleased to announce that this project will shortly be set up as a not-for-profit organization called Lifebox, with a board led by Dr. Atul Gawande and including representation from WFSA. This will allow us to develop a sustainable structure, generate funds for the donated distribution of oximeters and target on-site education programmes. Importantly, it will allow the WFSA to continue to promote our anaesthesia mission.

We will soon have a website dedicated to this project where, for just $250 including delivery costs, eligible facilities can purchase oximeters for themselves, and donors can buy on their behalf, specifying the recipient if they wish. In time we will maintain a database of global need, so you can see exactly how we are working to target the oximetry gap, and where donations are needed next.

Lifebox aims to distribute 5000 oximeters during 2011, and 12,000 in the first two years, through a combination of sales and donations. If we are to target the 70,000 plus operating rooms worldwide without oximeters, we need your help.

If you would like to donate funds for the supply of oximeters where they are most needed; if you know of sites and anesthesiology providers who are working without pulse oximeters; if you are able to help us with coordinating distribution; if you would like more information about the project, please contact lifebox@anaesthesiologists.org.

Please also watch the WFSA website, www.anaesthesiologists.org, for updates of the work and our lifebox website, www.lifebox.org, which will be accessible early in 2011. II
Future Anaesthesia Meetings

February, 24 - 26
14th ESRA Cadaver Workshop 2011
Contact: www.kenes.com/esra_cad2011
Innsbruck, Austria

February, 26 – March, 2
South African Society of Anaesthesiologists Congress 2011
Contact: info@easternsun.co.za;
www.sasaweb.com
Johannesburg, South Africa

March, 5 - 8
5th Annual Iowa International Anesthesia Symposium
Contact: lorri-barnes@uiowa.edu
Cabo San Lucas, Mexico

March, 31 – April, 4
International Course on Pain Medicine (ICPM 2011)
Contact: www.icpm.net
Porto, Portugal

March, 3 – April, 4
3rd World Congress of Total Intravenous Anaesthesia &
Target Controlled Infusion (TIVA-TCI 2011)
Contact: www2.kenes.com/tiva-tci2011
Singapore

May, 13 - 15
2011 CSA Annual Meeting and Clinical Anesthesia Update
Contact: ayarbough@csahq.org;
www.csahq.org
SanJose, California, USA

May, 27 – 29
6th International Travelling Pain Symposium
Contact: ciaran.wazir@nhs.net;
www.paincentreatgstt.blogspot.com
From London, UK to Maastricht, the Netherlands

June, 11 – 14
Euroanaesthesia 2011
Contact: secretariat@euroanaesthesia.org;
www.euroanaesthesia.org
Amsterdam, the Netherlands

June, 15 – 17
31st Congress of the Scandinavian Society of
Anaesthesiology and Intensive Care (SSAI)
Contact: www.s sai2011.com
Bergen, Norway

September, 7 - 10
30th Annual ESRA Congress 2011
Contact: www.kenes.com/esra2011
Dresden, Germany

September, 13 - 15
22nd International Congress of the Israel
Society of Anaesthesiologists (ICISA)
Contact: team7@congress.co.il;
www.icisa.co.il
Tel Aviv, Israel

September, 29 – October, 2
XVIIIth International Congress of
Anaesthesiology and Intensive Care
Contact: ccbulg@abv.bg
Plovdiv, Bulgaria

November, 2 – 5
New Zealand Anaesthesia ASM 2011
Contact: www.nzasm2011.org.nz
Auckland, New Zealand

November, 11 – 12
ESA Autumn Meeting 2
Contact: secretariat@euroanaesthesia.org;
www.euroanaesthesia.org
Krakow, Poland

March, 25 - 30
15th World Congress of Anaesthesiologists 2012 (WCA 2012)
Contact: www.wca2012.com
Buenos Aires, Argentina

June, 9 – 12
Euroanaesthesia 2012
Contact: secretariat@euroanaesthesia.org;
www.euroanaesthesia.org
Paris, France
Amsterdam, the Netherlands

Euroanaesthesia 2011
The European Anaesthesiology Congress
June 11-14

Deadline abstracts: December 15th 2010
Online submission: www.euroanaesthesia.org

ESA Secretariat
Phone +32 (0)2 743 32 90
Fax +32 (0)2 743 32 98
E-mail: registration@euroanaesthesia.org