Prior to the formation of the European Academy of Anaesthesiology in 1978 there was no formal representative structure for our speciality within Europe. The declared aims of the Academy were to raise the scientific level of the discipline and to improve the training of anaesthetists, both clinically and theoretically, assessing their competence at the completion of training by holding examinations. To achieve this, the Academy held scientific meetings, conferences and seminars, facilitated research and promoted academic and clinical exchange among anaesthetists. However, the Academy had a limit on the number of members and academics and was perceived by many to be an elitist organisation.

In 1992, the European Society of Anaesthesiologists (former ESA) was formed and was immediately open to everyone. Its primary aims were to run a major annual meeting (Euroanaesthesia), replacing the 4-year European Congress and to support educational and research activities by the awarding of grants and fellowships. While the former European Society was concerned with the practice of clinical anaesthesia and supporting its membership, the European Academy had developed formal initiatives such as providing the European Diploma examination, publishing the European Journal of Anaesthesiology (EJA) and running a system of hospital visiting and accreditation of training in conjunction with the Anaesthesiology Board and Section of the European Union of Medical Specialists (UEMS). The fourth organisation which existed at that time was the Confederation of European National Societies of Anaesthesiology (CENSA), which was effectively the European section of the World Federation of Societies of Anaesthesiology (WFSA).

For some years it had become apparent that the roles of all the various organisations were increasingly complementary and so, in 1998, the decision was taken to try and amalgamate the former European Society, the European Academy and CENSA into one organisation. The new European Society of Anaesthesiology, representing every anaesthesiologist in Europe, was established in 2005. Since the formal, declared responsibilities of the parent organisations were essentially different with very little overlap between them, a strong and comprehensive organisation could be established right from the start. The Academy brought an academic and training base, the European Diploma examination, the European Journal and a hospital visiting and accreditation programme. The Society brought a clinical base, an organisational structure and building in Brussels and the experience of running major congresses, and CENSA brought the membership of every National Anaesthesiology Society in Europe. All three contributed funding for academic grants, fellowships and awards and together they were able to offer:

- Links to and representation of all anaesthetists in Europe, taking account of the wide variation in facilities and resources.
- The ability to run major meetings which contain something for everyone, from high quality science to refresher courses, discussion forums, symposia, etc.
- Academic and research activities.
- Education and training activities.
- The running of an established examination system, the European Diploma in Anaesthesiology and Intensive Care.
- The publishing of the EJA.
For the majority of working European anaesthesiologists, this merger was completely logical, bringing with it the strength and influence of a single organisation, which could truly claim to represent European Anaesthesiology. This carried influence not only clinically and academically, but also politically and in the ability to attract commercial funding and sponsorship. But what about the people involved in each of the former organisations and the inevitable effect on their aspirations both personal and for the organisation which they served? To everyone’s enormous credit, personal ambition was set aside in favour of working towards a single goal and towards the success of the new organisation. Had this not occurred, the success of the amalgamation would have been far less easy to achieve, if not impossible.

The creation of the new ESA was undoubtedly a major step forward for anaesthesiology, critical care and pain medicine within Europe and on the world stage. It created probably the largest single representative body for anaesthesiology in the world and setting a clear strategic direction right from the start was essential. We needed to make all our members clearly aware of what the ESA was, what it stood for and how it would make a continuing impact in the future. This meant encouraging the new ESA to move forward on three clear and related paths; consolidating and building on what it was already good at, improving, developing and even changing things which it was not so good at, and also developing new ideas and areas of interest in keeping with the ESA’s position as a key organisation on the world stage of anaesthesiology.

An assessment of the new ESA’s strengths at the outset indicated that it was already good at:

1. Running major meetings such as Euroanaesthesia every year.
2. Being a truly international organisation.
3. Publishing the EJA.
4. Having a strong academic base, which needed to be further supported and developed to attract new research and financial support, which could then further enhance the annual meetings.
5. Organising and running the European Diploma in Anaesthesiology and Intensive Care, which was growing each year and had already become officially recognised in many European Countries.
6. Good and complementary relationships with the anaesthesiology section of UEMS.

In contrast, an assessment of the new ESA’s weaknesses, what it was not good at and what could be improved showed a need to:

1. Support anaesthesiology, critical care and pain medicine, both in terms of training and clinical practice across the whole of Europe and in particular in the newer countries, both the accession States and also those aspiring to join the EU.
2. Promote and protect the interests of its members in individual countries.
3. Encourage the provision of similar standards of quality, efficacy and safety of care for patients, despite differences in available funding.
4. Support the exchange and dissemination of information of interest and with an impact on the field of anaesthesiology, critical care and pain medicine.
5. Enhance the involvement and influence of anaesthesiologists in European medical politics and the development of clinical standards.
6. Provide a variety of educational opportunities which are relevant to everyone.
7. Encourage education, research and scientific progress by raising and harmonising the standards of anaesthesiology.
8. Generate funds to support research and training with grants and fellowships.
9. Find ways of exploiting the ESA’s political influence as a truly major, international Society, both in Europe through UEMS and also worldwide.

So, 8 years on, have our hopes and expectations been realised?

The (new) ESA now provides a comprehensive range of activities to support European anaesthesiology, primarily aimed at sustaining and enhancing the safety, efficacy and quality of care of patients. None of the cornerstones of activity and interest of the three founding organisations has been lost and all have developed and been built upon in a positive way.

The yearly organisation of Euroanaesthesia is on a par with other major international meetings, supporting the clinical and academic interests of all ESA members and this has been supplemented in recent years by the organisation of a second educational meeting in the autumn each year.
The practice of anesthesiology has evolved progressively into one in which groups of anesthesiologists practice perioperative medicine, although each member of the group may not practice all the aspects of the profession.

(D.S. Prough, ASA Newsletter, 1999;63:6)

The EJA continues to be successful. Now ranked 12 of 28 in anaesthesiology worldwide and with an impact factor of 2.231, it facilitates the exchange and dissemination of information related to anaesthesiology, critical care and pain medicine in Europe and beyond. Research and scientific progress are encouraged and supported both in academic meetings and also in the awarding of numerous grants and fellowships and this has a key role in raising and harmonising the standards of anaesthesiology.

Education and training are increasingly successfully delivered by the European Diploma and in-service training examination examinations, linked to individual countries training programmes and through the hospital visiting and accreditation programme run jointly with UEMS. This programme also allows the regular accreditation of centres across Europe, to which trainees in receipt of grants and awards can travel for specific training. The EDAIC is becoming increasingly used in place of national examinations as part of the formal accreditation programme in individual countries. This has had a continuing positive impact of the recognition of training standards between European countries and increasing opportunities for anaesthesiologists to cross national boundaries as part of their training and clinical practice.

Continuous medical education and accreditation of anaesthetists are now formally delivered under the umbrella of the Committee for European Education in Anaesthesiology (CEEA), which provides committees for Continuing Medical Education (CME), Continuing Professional Development (CPD) and Evaluation of Professional Practice (EPP), within the European Society of Anaesthesiology, both through educational CME linked programmes and the EDAIC itself.

The headquarters of the ESA in Brussels is ideally situated to provide the necessary base from which to administer this growing organisation. Sixteen staff under our Executive Director Michel de Bisschop support all the ESA’s activities exceedingly happily and efficiently.

// What still needs improving?

There is still a need to encourage more anaesthesiologists to become individual active members of the ESA, rather than simply as secondary to membership of their national society. This is both for their benefit in that they can then take part in all the ESA’s activities, including committee and board membership, but also to ensure that the ESA can draw on the best talent in the specialty in Europe to allow it to achieve academic and clinical excellence on a par with other major societies in North America, Australasia and Asia. It is also far more difficult to represent and liaise with our members if this has to be done through national societies rather than by direct links.

Achieving medical influence within the European political arena is exceedingly difficult and bureaucratic and although the ESA works harmoniously with the anaesthesiology Board and Section of UEMS, it still lacks the ability to effect major change. While the setting of clinical safety and monitoring standards can be achieved in larger countries reasonably well, for the newer and smaller European countries, the ability to compare their resources with international European standards is very valuable in achieving local change, if such guidance can be set and agreed.

Encouraging the free movement of professionals across national boundaries within Europe is a key part of EU membership and medical professional are no exception. The ESA’s activities are a key component of this, particularly if we are to achieve consistency in the quality and safety of patient care, to which we all aspire. Every country has much to offer in terms of clinical and academic knowledge and experience and the ESA is well placed by increasing its grants and awards programme to support the increased availability of such opportunities for learning and CME.

The creation of the new ESA has been admired and envied by almost every other medical speciality across Europe and beyond. Many wonder how on earth anaesthesiologists from many different countries and cultures were able to set aside national and individual interests for the benefit of development of our speciality. We are undoubtedly now seeing the fruits of this amalgamation and moving from strength to strength, there is much in which to take pride. We must however never lose sight of the need for strategic vision and goals in the future, not so much for our own benefit as for those generations of anaesthesiologists who will replace us in future years. //
We teach all the time. Actually we teach from the very beginning of our medical career. We teach at the patient's bedside, in the operating room, and anytime we discuss a case, a therapeutic technique or a new method of investigation. In most cases, nobody taught us how to teach.

A survey performed some years ago among the alumni of Teach the Teacher course (TtT) showed that 41% of responders had never been taught how to teach, and 81% declared that they learned only by observing how other people did it, and also by simply absorbing other teachers' experience. This situation is very well known in all our countries and hospitals, and a lot of time and energy has been spent in recent years finding a solution which would assure that our training centres perform to the desired standard.

In this issue, we publish a report on the Hospital Visiting and Training Accreditation Programme (HVTAP) team visit to the anaesthesia department at University Medical Centre Utrecht, the Netherlands, signed by Prof Hans Knape, and a letter to the editor, signed by Professor Aypar and Associate Professor Pamuk from the Department of Anaesthesiology from the University Hospital, Hacettepe, Ankara, Turkey. In this letter our Turkish colleagues express their gratitude for being included in the HVTAP program and for the positive verdict of the visiting team. The decision to publish both documents is not a coincidence, but rather reflects a positive approach to this very interesting and efficient program run by the Joint Committee of the European Board of Anaesthesiology (EBA) and the ESA.

The HVTAP assesses the quality of the training program in the anaesthesia departments of European countries, and offers an accreditation document to certify its requirements are met. The 2-day visit consists of a detailed presentation from the hospital staff, discussing the organisation of the hospital, the department and the training structure. The program includes evaluation of the training process and offers proposals and ideas for strengthening the teaching system in the department.

This initiative has a long history. It started in 1989 with the former European Academy of Anaesthesiology program of evaluating the teaching programs of anaesthesia departments all over the continent. (Although accreditation of medical institutions overall dates back to the 1910s in the USA)

Since the late 1980s, tens of anaesthesia departments have been visited by expert teams and received the accreditation certificate, which certifies that the training program in those departments is done on a high level, in conformity with the European demands.

Actually we are speaking about standardisation of the teaching abilities and capabilities of our teaching centres. The aim is that, in the not so distant future, all the European departments which prepare future specialists in Anaesthesiology and related fields will be able to prove that the education system they used is in accordance with internationally recognised standards.

Since the mid-1990s there has been a steady growth of accreditation programs in the EU, as well as in the Balkan states and eastwards into the former Soviet republics. The World Health Organization (WHO) regional office for Europe has developed a hospital accreditation initiative with the aim of helping national governments and structures to organise their own program. This occurs in many countries.

But the EBA/ESA joint program of accreditation of training programs represents a unique initiative, since it acts on a single profession and on a single target: training
programs in Anaesthesiology and related fields. One cannot be surprised that we, the anaesthesiologists, are pioneers in this field. We were the first to develop a European examination and among the first to sign the Helsinki Declaration on Patient Safety. ESA established, in cooperation with EBA, the Patient Safety Task Force. And we were the first medical profession in the world which initiated an education school for those young anaesthesiologists who are incorporated in various programs of “Teach the Teacher”. Anaesthesiology is blessed with a lot of very gifted professionals, who are ready to initiate new programs and implement new projects, all with the aim of improving the level of our profession all over the continent and standardise our daily activities. ESA encourages anaesthesia-teaching departments from all over the continent to apply HVTAP accreditation for their education programs.

The final word goes to the almost 40 senior anaesthesiologists from various European countries, who visited many anaesthesia departments in different countries, evaluated the level of teaching, offered their expertise and advice and decided upon the accreditation of those centres which reached the high standards required.

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**ESA Guidelines Committee Member Vacancy //**

The ESA is seeking to recruit a new member for its Guidelines Committee!

**The Guidelines Committee fulfils the following functions:**

1. Defines the ‘rules’ for the production of guidelines within the ESA
2. Organises and administers the identification and prioritisation of topics, preparation, dissemination and evaluation of ESA guidelines
3. Organises and administers the selection of ESA Guidelines Task forces
4. Collects and evaluates currently available documents throughout Europe
5. Establishes and maintains relationships with other research and clinical societies and groups as necessary in the preparation of collaborative guidelines
6. Defines how to implement guidelines and inform ESA members
7. Carries out other functions related to the promotion and harmonisation of clinical practice as decided by the ESA Board.

**Applicant Requirements**

The Guidelines Committee member will meet the following criteria:

- Being a qualified anaesthesiologist
- Being an active member of the ESA
- Fluency in English
- Previous guideline activity
- Scientific understanding of research evidence
- Previous administrative tasks related to production and implementation of guidelines
- Links with National/European anaesthesiology societies

**Term of Office**

The tenure is for three years, renewable twice for one year (maximum of 5 years).

**Reimbursement**

Travel expenses to attend meetings (usually held twice a year) are provided according to standard ESA reimbursement policy.

**Interested?**

Please send your CV and cover letter to the ESA secretariat at guidelines@esahq.org no later than 30 Nov 2013.

If you would like to discuss any aspect of this position, please contact Maurizio Solca at maurizio.solca@gmail.com.
THE EUROPEAN DIPLOMA IN ANAESTHESIOLOGY & INTENSIVE CARE (EDAIC) IS:
- A multilingual two-part examination
- Organised by the European Society of Anaesthesiology (ESA)
- Endorsed by the European Board of Anaesthesiology (EBA)

THE EDAIC COVERS:
- Basic applied science
- Management of anaesthesia, intensive care, peri-operative care, chronic pain, resuscitation and emergency medicine

The curriculum and exam are set by independent European anaesthesiologists.

Boost your career!
Raise your training to European level.

More information on www.esahq.org
Paper A consists of 60 multiple True/False questions (MTF). Each question has five parts, each of which can independently be T or F. Of these 60 questions, 20 are physiology, 20 pharmacology, 18 physics and equipment and 2 statistics. The following five multiple True/False (MTF) questions have been taken from the EDAIC question bank for Paper A (Basic Science).

The answers to these multiple True/False questions will be published in the next issue of this newsletter.

1. Regarding stretch reflexes:
   A. the knee-jerk is a monosynaptic reflex
   B. the latency of the human knee jerk is 200 ms
   C. muscle contraction is a result of gamma-motor neurone activation
   D. the efferent component arises in anterior horn cells
   E. nerves conducting the afferent component are unmyelinated

2. Drugs which decrease myocardial oxygen demand include:
   A. nitroglycerin
   B. dopamine
   C. sodium nitroprusside
   D. isoproterenol (isoprenaline)
   E. amiodarone

3. Concerning the electromagnetic spectrum:
   A. individual wavelengths are proportional to the reciprocal of their frequency
   B. the frequency of X-rays is lower than of gamma rays
   C. the wavelength of ultraviolet is longer than that of infra-red light
   D. radio waves have a lower frequency than X-rays
   E. oxygen is capable of absorbing the energy of high-frequency ultraviolet light

4. When using indirect measurement of arterial pressure:
   A. the width of the cuff should be 40% of the mid circumference of the arm
   B. use of a normal cuff in an obese person would tend to underestimate the arterial pressure
   C. the systolic arterial pressure is normally slightly below that sensed by direct measurement
   D. Oscillometric methods require the sensing of both static and dynamic pressures changes
   E. in oscillometry the systolic pressure is determined at the point where the first pulse is sensed

5. Student’s unpaired t-test is a statistical technique that:
   A. determines the degrees of freedom
   B. may be applied to a comparison of the means of two samples when the sample sizes are small
   C. avoids the use of the null hypothesis
   D. is used for comparing samples where the data are approximately normally distributed
   E. assumes p < 0.01 for significance
The European Accreditation of the UMC Utrecht as Centre of Excellence for anaesthesiology training. //

HANS TA KNAPE, MD, PHD, FRCA, FFARCSI HON. // DEPUTY TRAINING PROGRAM DIRECTOR // hansknape.osa@live.nl

// The EBA/ESA Hospital Visiting and Training Accreditation Program (HVTAP)

The European EBA/ESA accreditation visit in November 2011 offered our department at the University Medical Centre Utrecht an excellent opportunity to demonstrate our quality improvement programme and its results. We were visited by Prof. De Robertis and Dr. Sieber, and the visit included of course a demonstration of our facilities. However, the main content consisted of presentations of the training programme as such with guidelines, audits, logbooks, interviews, presentations of residents’ PhD involvement, meetings with the experimental and clinical research group and discussions with the trainees, tutors and other team members. The feedback was very helpful in identifying subjects for further improvement and developing new ideas.

We consider the emphasis on continuous quality improvement essential in a time where many changes both internally and externally have an impact on our specialty. When developing our strategy we must take into account the demands on anaesthesiology, not only now but also in five or 10 years’ time. The most important contribution of anaesthesiology to medicine is the focus on patient safety: hospitals are potentially dangerous environments for patients and every effort has to be made to limit risks both in and outside the operating rooms, in the intensive care departments, and for all other aspects of perioperative medicine for that matter. Only close cooperation with other specialties and mutual respect enables anaesthesiology to take a leading position in patient safety in medicine.

// Quality in medical training programs

Training of medical specialists is a challenge for both trainers and students and is vital for the future. The changes in health care due to the aging of the population, financial restrictions, the increase of costly technologies, concentration of care and progressing specialisation demand a constant fine-tuning and quality improvement of training programs of doctors.

The demand from society that medical specialists should also acquire other competencies than medicine itself such as cooperation, adequate communication, professional behaviour, management principles, science and new insights in effective training methods require a continuous quality improvement cycle to be established in many training institutions. In contrast to the past, quality of training can be quantified by the development and identification of training quality indicators for several domains such as the training institutes, the training staff and the residents.

// Combining accreditation and quality programs

In a number of European countries accreditation and visitation programmes for medical specialist training institutions were designed to decide whether a specific training system meets certain minimal training guidelines determined by a government or a national scientific society. Meeting the minimum training requirements during such a visit allows programme directors to continue training for the specialty, usually for five more years. Understandably there is no guarantee that the quality of the specific training programme is maintained on the same level in between two visits.

Taking into consideration that continuous change is essential nowadays and that ongoing efforts are required to keep a minimum quality level of training of residents, more and more training institutions consider an external accreditation visit, such as the EBA/ESA visitation, a part of a continuous improvement program for their specialist training. A striking example of this is the continuous quality improvement program in some Dutch training institutions for anaesthesiology. The basis for this is the establishment of the level of a number of quality indicators for resident training as part of a strategic plan of the department, following the accreditation visit. By preference the level of these indicators should be convened and agreed upon by both responsible supervisors and residents following mutual agreement of the current level of quality of the various indicators. An annual quality improvement programme for resident training should be monitored for progress, both by supervisors and by residents together as part of a quality and advice cycle.

Experts from an educational centre then evaluate the training institution 1.5 years later using a selection of instruments aimed at evaluating the quality of the training climate, the teaching quality of individual staff, a quick scan interview procedure, the participation by residents of non-specialty training competencies such as communication, cooperation, health advocacy, professional behaviour, participation of teach the teacher training programmes of staff and exit enquiries of residents. These evaluations usually provide a number of recommendations for improvement for training staff and residents of the specialty involved and this adds to adjustment and fine tuning of the current quality improvement program.

Halfway between two external accreditation visits, an audit of the training programme by experts from the hospital’s own team, but outside the training programme itself, may provide feedback on the whole training programme, thus further contributing to the already existing quality improvement efforts. Following a final evaluation with a limited number of instruments as mentioned before, but well ahead of the next accreditation visit, the training programme is ready to be evaluated, and it is also possible to report on the efforts and results of the continuous quality improvement program which has been continuously active since the previous visit.

// Combining National and European accreditation

Above is an example of a combination of an internal continuous quality improvement programme for medical specialist training with an external accreditation programme which beneficially may enforce one another. The EBA/ESA Hospital Visiting and Training Accreditation Programme (HVTAP) may therefore be seen as a powerful quality
stimulant programme which may help residents, supervisors and training programme directors to continuously improve their training. We considered the input of the EBA/ESA accreditation visit of great value in our strategy to excel. The EBA/ESA visit is to be highly recommended to all anaesthesiology-training programmes which have the ambition to improve. This is in line with the declared aim of the HVTAP to have European Centres of Excellence serving as references for national accreditation programmes.

Explanatory notes

National program:
The Dutch training system is based on national guidelines which are minimum standards for every training institution. The quality of training is evaluated by a visitation programme of the Netherlands Society of Anaesthesiology at least every 5 years.

Local quality programme:
The University Medical Centre Utrecht has set up a local quality programme aiming at a continuous quality improvement procedure for all medical specialty training programmes. The strategy of our quality improvement is based on a number of quality indicators of the training institution, of the professional development of supervising staff, of the content of the training program and of the residents according to the quality indicator system by Scherpbier et al. A local three year strategy is translated in annual improvement programmes which are evaluated monthly. Support comes from the hospital which offers a quick scan, including the SETQ (System for Evaluation of Teaching Qualities) or the EFFECT (Evaluation and Feedback for Effective Clinical Teaching), the D-RECT (Dutch Residents Educational Climate Test) and a survey of the teachers status of the supervising staff. This “dOORijk” programme is offered one year after the national visitation and repeated one year before the next national visitation.

2) http://www.umcutrecht.nl/subsite/Medischevervolgopleidingen/kwaliteitenadvies

1. Bilateral recurrent laryngeal nerve section
   A causes complete airway obstruction
   B causes respiratory difficulty
   C causes tetany
   D allows adduction of the vocal cords on inspiration
   E causes dysphagia

2. Early sequelae of near-drowning in sea water include
   A cardiac dysrhythmias
   B haemolysis
   C hypotension
   D atelectasis
   E seizures

3. The use of regional anaesthesia for Caesarian section is appropriate in patients with
   A placenta praevia
   B pre-eclampsia
   C HELLP syndrome
   D mitral valve disease
   E Christmas disease

4. Ventricular fibrillation is likely to be initiated by an electrical stimulus during the
   A PQ interval
   B ascending limb of QRS
   C peak of QRS
   D peak of the T wave
   E interval between the S and T wave

5. In a patient suffering from a thyroid crisis, suitable treatment includes
   A beta adrenergic blockade
   B digoxin
   C corticosteroids
   D intravenous paracetamol
   E intravenous carbimazole

EDAIC Paper B Questions //
DR. SUE HILL // CHAIRMAN PART 1 EDAIC SUBCOMMITTEE

The following are the multiple True/False questions published in the previous issue of this newsletter. The answers and explanations to these questions are given on the following page.

Answers & explanations
Answers & explanations //

DR. SUE HILL // CHAIRMAN PART 1 EDAIC SUBCOMMITTEE

For each question, the answers are given as T = true or F=false. So for example, question 1, part A=false (F), part B=true (T), and so on.

1. FTFFF
   This is an applied anatomy question relevant to head and neck surgery. Bilateral recurrent nerve injury leaves the vocal cords in a near-closed, midline position. This does not lead to complete obstruction although respiration is impaired. Parathyroid surgery is a cause of recurrent laryngeal nerve damage but also hypocalcaemia and tetany, but tetany is not caused by loss of laryngeal nerve function. The recurrent laryngeal nerve does not affect oesophageal function, so dysphagia is not a problem - the problem is with failure to protect the airway.

2. TFTFT
   This is an intensive care question relevant to management of a patient with seawater near-drowning. Seawater has an osmolarity greater than plasma, so pulmonary oedema is a complication and haemolysis is not a problem, very different from near-drowning in fresh-water. Hypoxaemia and CO2 retention can lead to arrhythmias and seizures in both types of drowning. Atelectasis is more a feature of fresh water drowning because it disrupts surfactant function and causes closure of alveoli. Hypotension occurs with both types of drowning due to increased capillary membrane permeability and interstitial oedema.

3. FTFTF
   An obstetric question, in the “special anaesthesia” section of Paper B, relating to contraindications to regional anaesthesia for C-section. Any pathological process affecting coagulation is a contraindication to such a technique so HELLP (haemolysis, elevated liver enzymes and low platelets) syndrome and Christmas disease (haemophilia B) are contraindications. Pre-eclampsia can be associated with low platelets, but not always low enough to make this a contraindication. Placenta praevia used to be considered a relative contraindication, but modern management shows a lower blood loss with regional as opposed to regional techniques.

4. FTTFF
   This is an applied physiology question. The most sensitive period for an additional electrical impulse to trigger VF is during the QRS period, before this it may cause a premature contraction and after this the relative refractory period (S to T) reduces the risk of triggering an arrhythmia. The so-called R-on-T syndrome is not normally a risk for VT unless the patient has an abnormally prolonged QT interval. In such a question, assume the patient is physiologically normal unless told otherwise.

5. TFTTF
   This is an applied pharmacology question relating to medical treatment. Beta-blockers, such as propranolol, reduce tachycardia and hypertension, glucocorticoids prevent peripheral conversion of T4 to T3 so are useful, Carbimazole is first-line treatment as an oral (not intravenous) medication to prevent uptake of iodine. Paracetamol will help in reducing the hyperthermia associated with a thyroid storm.
I was a young resident when I had to work in the outpatient clinic. It was far from the operating theatre, the intensive care, the pain clinic, and radiology even. I knew I would be bored. And I was slowly starting to get bored when a small child walked in with his mother. He came in with a skip, came right up to the doctor’s desk, eyed me up and down and said in a loud clear voice, ‘I am the Cookie Monster’. His parents were just entering so the door was open, and I could hear the laughter coming from next door. The Plastic Surgery Outpatient Clinic was a single room just like ours, and the resident sitting there was a friend of mine. He appeared at the door and said, ‘You must look awfully round and brown from where he stands!’.

That is when I decided to take a look at life from where he stands, and life suddenly got very ‘un-boring’. I saw how children, and then the elderly, and then everyone else can really open up to someone who cares. A little blind girl took my hand after a pre-anaesthetic visit and said she would not let anybody else anaesthetise her. Her mother, curious, asked her how she was going to recognise me. And she said, ‘It is easy, I will give her a code word and ask for it tomorrow when I go for operation’. After which she very seriously whispered the code in my ear, not letting even her mother hear, and I made it my duty to remember it the next time we met.

Years later I was a specialist, I was working in radiology and for once all the problem cases were over by mid-afternoon. Then they said someone was coming for a central catheter, and I was supposed to anaesthetise him. It was only a minor shock to see a classmate, and when I monitored him his heart was beating only 30 times a minute. Following a call, the cardiologists arrived and were starting the procedure of putting an ICD device in. I was just holding his hand and looking at a monitor. ‘You try too hard’, he said. And started asking me questions all about my work as a GP, training, and my thesis. My friend had a weird sad kind of smile, I could not be sure if he was in pain, I looked at the cardiology team and the monitor, and knew I had to keep him there, thinking of anything but himself, so I decided to answer him truthfully when he asked, ‘Your research, which took three and a half years of your life, two hour interviews with hundreds of patients…do you have it in print?’ ‘Wow, I remember thinking, he can think so clearly and form that long a sentence with that heartbeat?’

‘No’ I said, ‘You see I was working so hard and doing it wrong. Afterwards I spent months reading about research done in face-to-face interviews, how you standardise questions, limit the research to a certain subject, decide how many people you need, do the statistics and other essential tasks. Now if any of my residents were going to do research, I would be there for them, and we would get it in print.’ ‘Oh, so you have to learn everything by living? Listen, it is OK to ask for help sometime, as well as giving it. Remember this OK, after I am gone?’ His voice was starting to fail, but...was he smiling?

Long after that moment, when his eyes closed, his grip lost its strength, long after his heart started failing and we did all we could, long after we lost him, I went back to that day in my mind countless times, and wondered at how a dying man could use his last strength trying to teach a friend something so basic and important. And yes, believe me, he did teach, and being at the end of his life he was really entitled. That memory of him is among countless ones I would not want to lose. Now I am part of a team, teaching how to teach. Just give life a chance, give even the slow-starters and late-achievers a chance, they might have interesting tales to tell. And believe me, the journey is never boring! //

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**Technology is based on faith, in contrast to science, which is based on doubt**

(M.D. Altschule, Chest 1986;90:134)
From Cavendish to Morton // Part 2

Our last flash (number 4-part 1) brought the readers to the discovery of hydrogen by Henry Cavendish (1731-1791) and of oxygen by Lavoisier (1734-1794), two extraordinary important developments in the field of chemistry, which opened the door for further advances in the domain of medical drugs, among them anaesthetics.

The real precursor of analgesia-anaesthesia was Sir Humphry Davy (1771-1829) an English complex scientist especially chemist but also physicist. He was introduced as an apprentice at the “apothecary dispensary” of Dr. J.B.Borlase’s practice in Penzance, southern England, becoming a chemist. In the laboratory of the praxis he prepared N₂O as he learned it from Priestley, and decided to inhale it in spite of the fact that this gas was considered highly toxic and lethal. He took the risk and was the first to feel the effects of N₂O inhalation declaring “An agreeable sense of lightness”, which increased to reach a real cheerfulness and the unstoppable necessity to laugh. He remarked also that this gas had the power to remove intense physical pain and used it on himself during the acute inflammation of his wisdom tooth which had to be extracted and was surprised to be relieved. He repeated his experiments in secrecy many times until one night he had to assist a patient while being under the influence of gas inhaling and laughing incessantly. The scene repeated next night and his boss Dr. Borlase caught him in his bedroom with all the equipment he was using for his experiments and was tempted to inhale the gas himself becoming drunk and hilarious like Davy. Borlase recognised the virtues of N₂O and tried to introduce it in his practice but this was not well received by the town’s people and he had to give it up. Davy continued his experiments in the lab of his godfather Dr. Tomkin until one of the bottles exploded and he had to stop, but not for a long time as he was remarked and recommended to Dr. Beddoes who was leading a hospital where he treated patients by inhalation of different gases the “Pneumatic Institute” of Clifton. Davy moved to Clifton and put in practice his N₂O inhalation therapy which led him to exploit the analgesic effects suggesting and trying it in surgery. For his time, he approached most to the realisation of an artificial sleep which of course he could not produce due to the microhydrodynamics of this gas. Davy made an outstanding career as a scientist, was knighted, became president of the “Royal Society” and was decorated by Napoleon. He had numerous other achievements like the discovery of new elements Sodium, Iodine, and Chlorine and imagined the security lamp. Hypnosis was propagated by Mesmer (1737-1815) for the treatment of mostly mental and other functional diseases, but not for anaesthesia. It seems still to work in some special occasions when a genuine hypnotist meets a corresponding medium. I remember reading in “Anesthesiology” some time in the 60 years of the last century, a notice which I consider worth to be mentioned, reporting an anaesthesia by pure hypnosis performed in the US in a highly obese patient (over 200 kg.) which was considered to exceed the possibilities of standard techniques of anaesthesia at the time. Morphine was isolated in 1806 (also quoted are 1803) from the 10 opium alkaloids just a few years after Davy’s experiments with N₂O by Wilhelm Adam Sertuerner a pharmacist in Paderborn (Westphalia, Germany). Morphine was proven to be the strongest analgesic and could and was, more than 150 years later used as analgesic in general anaesthesia, but at the time of its isolation this was forbidden by its respiratory depressing effects for which there was no solution. With the advent of mechanical ventilation, airway maintenance and antidotes, more than 140 years later morphine and morphine-mimetic drugs made a glorious entrance in anaesthesiology.
Another successful technique was performed by Crawford Long (1815-1878) who was a surgeon and pharmacist living in Georgia USA. He had knowledge about Davy’s experiments with N₂O and had the inspiration to recur to Paracelsus’ and Faraday’s hints to use ether instead of N₂O to produce “sleep for surgery”. On the March 30, 1842 he produced anaesthesia for the removal of a neck tumour on one of his patients J.M.Venable. He repeated this experiment on other types of current operations in his practice such as amputations and childbirth having total priority in the field. The first paper he published was in 1849 “Account of the first use of sulphuric ether as an anaesthetic in surgical operations”. He is considered to day as the first real user of ether for surgery in spite of the fact that William T.G. Morton was the first to perform a successful public demonstration.

During the same time William E. Clarke from Rochester, New York (1809-1880) having played with ether recreationally, had the idea of proposing the inhalation of ether vapour to his friend, a young lady Miss Hobbie, for the extraction of a tooth in January 1842. Clarke administered ether and the dentist Elijah Pope made a painless extraction. William T.G. Morton (1819-1868) is the man who is prized and known as the founder of anaesthesia and anaesthesiology by demonstrating and propagating his method explosively throughout the world. But his story is a sad one. Morton was a dentist son of a farmer in Massachusetts he frequented the “Baltimore College of Dental Surgery” in 1849 without graduating, opened with Wells a practice in Hartford. Later he frequented the Harvard Medical School again without graduating. There he had the occasion to listen to lectures given by Charles T. Jackson who taught also on the properties of ethyl-ether and, short time after, used it for the first time for a tooth extraction on September 1846 which was reported in the press. Bigelow, a Boston surgeon, became aware of the event and arranged for a demonstration at the “Massachusetts General Hospital” where Dr. John Collins Warren was in charge of the surgical department and where Wells failed a few years before. Warren was reluctant of the idea but at last accepted to make the trial. In the morning fixed for the demonstration Morton was late on the spot because his glassmaker being late in delivering the new device Morton had designed for the administration of ether. At last he came in and succeeded to put Edward Gilbert Abbott, his patient, to sleep so Warren could remove a tumour from the neck without the patient feeling any pain or remembering the event. It is on this day, October 16, 1846, that is the day we consider the birth date of our specialty. After this event Morton patented his method, had continuing conflicts with Jackson and lived hard days until his death. In the meantime, his method spread quickly throughout the world, a subject to be discussed in the next flash. //

“Neuromuscular blocks are like the slur pedal of a piano. They hide a lot of sins.”
(M. Bookali, Gasnet March 30, 1999)
Poznań is an old Polish city, situated in the west part of Poland, at a crossroads of commercial and cultural exchange from all directions. Poznań is a capital of Great Poland (Wielkopolska), where the history of the Polish state started and where the graves of first Polish kings can be found. From the beginning, Poznań was a dynamic, open and friendly place for visitors and habitants. Joining different cultural impacts, flowing from East and West. Living together with original Polish citizens, German, Italian, Jewish, Greek, Scottish or other immigrants arrived and helped develop the intellectual and spiritual values that form part of the international culture in our city. The life was very attractive in Poznań in 14th -17th centuries, the period of greatest prosperity of the United Kingdom of Poland and Princedom of Lithuania. After historical changes with good and bad times, Poznań again opens its arms to embrace guests from all over the world. The city is actually the informal economic capital of Poland with many universities, cultural institutions and beautiful traditions. Medicine and anaesthesiology in Poznań has beautiful traditions. Heliodor Święcicki, professor of obstetrics and anaesthesiology at Poznań University, presented apparatus of his own construction for the perinatal analgesia during the World Congress in Berlin 1890, at the same time as Lister taught about the importance of aseptics. Together with their colleagues, they promoted this medical discipline in the University of Poznań. In the 1920s and 1930s, Poznań and Lwów were among the most influential centres of development in anaesthesiology.

After World War II, Poznan was half destroyed and bereft of its intellectual human resources due to biological and later economic elimination. But the city began carefully rebuilding itself, and this quickly opened opportunities for education of new groups of society. The Medical Faculty of the University began in year 1949 independently as an Academic School of Medicine. Despite different political rationales and ongoing changes, academic staff of the medical university were continuously focused on good medical education, nurturing universal human values and open contacts with different intellectual and cultural influences, while remaining faithful to Poznań’s history. Anaesthesiology in Poland after the years of World War II developed very dynamically, oriented on English standards of education and German organisation of hospital structures. From the beginning Polish anaesthesiology and anaesthesiology in Poznań was an active part of the world family of anaesthesiologists. Chair and departments of anaesthesiology at the Karol Marcinkowski University of Medical Sciences in Poznań last year celebrated their 60th anniversary. The first head and organiser of academic structures was Prof Wiltold Jurczyk, who celebrated his 80th birthday, and as his successor Prof. Roman Szulc. Both have been active members of and Prof. Jurczyk was co-founder of the European Academy of Anaesthesiology, incorporated later to ESA. In Poznań the Poland Department of the Experimental Anaesthesiology and Museum of the History of Polish Anaesthesiology are both based. I have the honour and pleasure to continue the work of both great ancestors. To my teachers, beside academic professors, and also my elder colleagues without academic degrees but with great experience and warm attitude to patients, being not able to count them here all, because the list could be too long. I met in my professional life many mentors from abroad, with a special place in my memory for Professor Hans Sonntag from Goettingen, whom I admired because of his high appreciation of human dignity and his way of seeing this quality in every human person. In the chair and departments of anaesthesiology of the Karol Marcinkowski University of Medical Sciences there are 110 anaesthesiologists employed along with a great number of nurses, technicians, physiotherapists and administrative personnel. A chair of Anaesthesiology and Intensive Therapy is composed of 6 departments. Clinical departments, with their heads responsible for the administration and clinical work necessary to aid functioning in these 6 separate university hospitals, located in diverse parts of our city. Didactic and scientific problems as well as some clinical problems are discussed together during regular meetings and on the basis during daily practice. Residents of anaesthesiology and intensive therapy are obliged to fulfil a 6-year training program, the same for the whole country and adapted to the standards of ESA/UEMS recommendations. Rotation between hospitals in the city and highly recommended courses and training in other training centres in Poland or in European training centres outside of Poland are documented in the logbook and in regional state offices of the postgraduate medical education. MCQ tests and oral examinations after the practical 6-year training are obligatory. European Diploma of Anaesthesiology and Critical Care I is one possible option for the written form of anaesthesiology exams. Poznań was 3 times accredited as European training centre in anaesthesiology and is again preparing to re-accreditation. In October this year we are organizing the international symposium “Anaesthesia and critical care in brain injuries” (www.anestezjologia2013.pl). Why not come and join us there.

My colleagues in Poznań work hard but still preserve a great joy of life, curiosity for new friends and new visions of the future. We have been guests in many centres abroad and we welcomed many colleagues from different countries. We are waiting now for you. Please come and visit us!
We have many discussions on how to teach students, however, we are taking the first steps in improving the teaching process of our residents. Anaesthesiology and intensive care residency and resident teachers are among the targets of this improvement. The Lithuanian Society of Anaesthesiology and Intensive care has dedicated four doctors from Vilnius and Kaunas Universities to take the Teach the Teacher course, led by professor Gabriel Gurman and organized under the umbrella of ESA. Consecutively the courses designed to train teachers are expected to be started in Lithuania as well.

The courses on Competence Development of Supervisors of Residents initiated by the Anaesthesiology Clinic supported by our University and the European Society of Anaesthesiology (ESA) were held in May. The goal of the courses for instructors in anaesthesiology and other fields is to train the instructors by enriching their theoretical knowledge. This method of teaching is suitable for teaching adults.

Hopefully, the instructors who have completed this course will find it easier to teach young specialists and senior residents to have a contemporary approach towards various clinical cases and their solution methods by employing the theoretical knowledge and accumulated experience. The daily program of the course included presentations of cases, lectures on organisational and professional aspects and lessons on “how to teach”.

The courses were led by Lecturer Vojislava Nesovic (M.D., Cardiothoracic Anaesthesiologist of the Military Medical Academy in Belgrade, Member of the NASC of the ESA, Lecturer of the Teach the Teachers’ course and Coordinator of the Training Programs for Supervisors of Residents), and Lecturer and Program Supervisor Miodrag Milenovic (Sc. D., employed as an Anaesthesiologist in the Emergency Centre of the Clinical Centre of Serbia, Vice-President of the Society of Anaesthesiology and Intensive Care of Serbia, Member of the Educational Committee of the World Federation of Societies of Anaesthesiologists). They were assisted by the following four Lithuanian lecturers: Ieva Norkienė and Saulė Švedienė from Vilnius University, and Arūnas Gelmanas and Andrius Macas from the Lithuanian University of Health Sciences. The additional lecture on how teach and learn how to bring bad news was held by Nedas Jasinskas. The course lectures and practical assignments were of a wide variety ranging from lesson planning and improvement of its quality to giving feedback to the resident.

Teachers from various clinics (anaesthesiology, neurology, cardiology, obstetrics and gynaecology, and intensive care units) participated in the course. The participants were not only doctors of medicine, but also veterinary physicians and teachers of nurses.

This academic year, these were the last courses for supervisors of resident physicians. However, the next academic year will come soon. We hope more of our anaesthesiologists will benefit from courses like this.
Editor's note: With this article, we inaugurate a new rubric, of short presentations of professional topics with general interest for our readers. Doing this we fulfil a need for keeping the ESA members updated in some subjects related to our daily activity. We are indebted to the authors for accepting our invitation to prepare this article for the ESA Newsletter.

Safety in the Post Anaesthesia Care Unit: reality, utopia, or our next goal? //

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Today for most patients, risks directly related to surgery and anaesthesia are low. Nevertheless, a large international European survey (EuSOS) recently pointed out a postoperative mortality rate higher than anticipated, suggesting a major role for postoperative complications [1]. The majority of our patients leave the operating theatre and its protective environment to transit by recovery areas where they can be exposed to various serious adverse events which may affect their outcome. Severe complications may end with unplanned intensive care unit admission or increased length of stay in the hospital. “Minor” events like undermanaged pain control, however, should not be neglected as they may yield to severe pain afterward and delayed postoperative rehabilitation. Without doubt, the safety in the recovery room or Post Anaesthesia Care Unit (PACU) deserves our attention.

// What is the current situation?

Studies reporting incidents in PACU are not only scarce but also quite old. In 1999, Bothner identified 22.1% of minor complications and 0.2% of major complications in PACU [2]. A major study later reported 5% incidents (i.e. 419 cases out of 8372 reports from the Anaesthetic Incident Monitoring Study (AIMS) database) [3]. The incidents occurred mainly in daylight time (90%), in ASA 1-2 patients (75%), all types of surgeries being concerned. Respiratory or airway issues (43%), cardiovascular events (24%) and drug errors (11%) were the most common problems. Among respiratory incidents, respiratory failure was the major issue (18%), mainly related to residual paralysis. Several studies including recent ones suggest that residual curarisation is not unusual in PACU and may concern as many as 40% of the postoperative patients [4]. PACU complications may lead to a patient being managed in the High Dependency Unit or Intensive Care Unit (ICU) (29% of the cases in the observational study of Kluger & Bullock) [3].

// What about guidelines?

Among the various guidelines which rule the practice of modern anaesthesia, practice guidelines exist regarding the safety of post-anaesthesia care [5-7]. They include several topics like PACU functions, facility, monitoring, equipment and drugs, staff, transfer and handover of care, management of patients, discharge from the PACU, and quality control. Some issues need to be highlighted. First, opening 24 hours a day is not the norm for a majority of European hospitals but is recommended except when ICU can substitute [5]. Second, at least two nurses should be present when a patient is present in PACU and an anaesthetist should be immediately available [5-6]. Nurse-bed ratio should be 1:1 for the patients until they have regained airway control, respiratory and cardiovascular stability and are able to communicate [6]. This ratio may increase up to 1:4 with awake or arousable patients [5]. Unfortunately, for most of the hospitals, the economic conditions and the difficulty of recruiting nurses make the application of the aforementioned points difficult to achieve.

// Are there solutions to improve patients’ safety in PACU?

Most of the PACU adverse events and unplanned ICU admissions might be prevented by higher standards of perioperative care. Kluger & Bullock [3] already pointed out important factors to pay attention to, including error of judgement (18%), communication failure (14%) and inadequate pre-operative evaluation (7%). Regarding the later point, several validated scales of risk are available and should be implemented during the preoperative visit. The STOP-BANG score identifies high-risk patients for obstructive sleep apnoea, thereby post-operative oxygen desaturation. The Apfel-score points out high-risk patients for postoperative nausea and vomiting which may favour aspiration. Lee’s revised cardiac risk index predicts perioperative cardiovascular complications. Kalkman’s score identifies patients at risk of severe acute postoperative pain. Filling up those scales during the preoperative evaluation is time consuming but might be worthwhile regarding postoperative benefits. If even only one single PACU incident can be prevented. Patient’s intra-operative management also plays an important role as the choice of

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anaesthetic techniques and drugs will influence postoperative recovery. While long-term effects are not always evident e.g. prevention of chronic post-surgical pain, short-term benefits are highlighted with the development of “fast-track or enhanced rehabilitation programmes” which promote fluids restriction and opioid-sparing analgesic techniques [8]. Benefits may become even more obvious in PACU in terms of patient’s safety. The methods used to reduce the risk of residual weakness are mandatory [9]. The reduction of intraoperative opioid doses not only decreases postoperative nausea but also prevents exacerbated postoperative pain caused by opioid-induced hyperalgesia phenomenon [10]. Preventing severe pain at the emergence of anaesthesia reduces PACU complications related either to the pain itself e.g. confusion, agitation, poor chest expansion, or to the treatment of pain by analgesics titration (heavy sedation, respiratory depression, nausea and vomiting).

Finally, patient handover, e.g. from the anaesthesiologist who has cared for the patient during the surgery to the PACU nurse, is a major aspect of safety in patient care. The communication during handovers is often brief and informal. A recent pilot study seems to show that poor quality of handover is associated to a longer stay in the PACU [11]. The use of a checklist might improve the quality of patient handover by increasing the information handed over [12].

// Conclusion: our future goals

Improvement of the actual situation regarding safety in PACU should remain a priority task. As anaesthesia techniques have changed since the last studies on the topic, the implementation of a novel large observational survey (using ESA clinical trial network) might help to document the incidence, type and causes of actual adverse effects occurring in PACU. Improving the quality of communication between health care providers is another goal. Anaesthesia simulation is now very popular as a valuable tool which allows us to develop both technical and non-technical skills during training sessions [13]. //

References

There is a global concern regarding early childhood exposure to anaesthesia and surgery and subsequent long-term cognitive outcomes. In series of experimental studies, brain development in very young animals seems to be vulnerable to the effects of many commonly used anaesthetic drugs. These preclinical studies have shown that exposure to anaesthetic agents for several hours can later induce programmed cell death, abnormal connections between nerve cells and behaviour changes.

ESA is of course concerned that these effects might also occur in young children after exposure to anaesthesia and surgery. To date there is, however, no convincing evidence that this is the case after a single exposure to anaesthesia and surgery for up to one hour. There is more concern that exposure to multiple surgical procedures under anaesthesia might lead to abnormal brain development, but even here, the currently available data are too sparse to provide firm evidence of an effect on the young brain. A large ongoing international study compares general anaesthesia with spinal anaesthesia for hernia repair in children up to 60 weeks after conception. The results on neurocognitive development will be available in 2018.

ESA has recently decided to be committed to a broad-based European research effort to clarify the situation. It has brought together a task force of European anaesthesiologists and basic scientists with expertise within this field and with the aim to bridge current gaps of knowledge and ultimately find out the clinical relevance within the paediatric population of early experimental data (EuroSTAR - European Safe Tots Anaesthesia Research: www.esahq.org/eurostar). EuroSTAR is chaired jointly by Prof. Cor J. Kalkman (University Medical Center, Utrecht, Netherlands) and Prof. Lars I. Eriksson (Karolinska Institute, Stockholm, Sweden). The task force has set out to coordinate activities between basic scientists and clinical investigators who are actively studying or planning to study the effects of anaesthetic exposure and surgical trauma on the young and developing brain. The resulting
collaborative studies will hopefully answer some of the urgent questions regarding this important topic. The preclinical group, coordinated by Niccolò Terrando (SE) has started its efforts to design collaborative experimental studies and will propose quality criteria for the design and reporting of studies on neurotoxicity in experimental animals.

In the meantime ESA fully endorses the following statement by the International Anesthesia Research Society’s ‘Smart Tots’ initiative (December 2012):

...Each year, millions of young children require surgery and other procedures for serious or life-threatening medical conditions or to improve their quality of life. Anesthetic and sedative drugs are widely used to help ensure the safety, health, and comfort of children undergoing these procedures. However, increasing evidence from research studies suggests the benefits of these agents should be considered in the context of their potential to cause harmful effects.

Previous research in young animals and children has raised concerns that exposure to commonly used anesthetics may produce adverse neurobehavioral effects. However, these studies had limitations that prevent experts from drawing conclusions on whether the harmful effects were due to the anesthesia or to other factors, including surgery, hospitalization, or pre-existing conditions. Furthermore, the findings in children have been mixed, with some studies of infants and young children undergoing anesthesia or sedation finding long-term deficits in learning and behavior while others have not. Clearly, additional research is urgently needed to identify any possible risks to young children. In the absence of conclusive evidence, it would be unethical to withhold sedation and anesthesia when necessary. Instead, healthcare providers should do the following:

• Discuss with parents and other caretakers the risks and benefits of procedures requiring anesthetics or sedatives, as well as the known health risks of not treating certain conditions

• Stay informed of new developments in this area

• Recognize that current anesthetics and sedatives are necessary for infants and children who require surgery or other painful and stressful procedures

(www.smarttots.org)
I have the conviction that the major problem facing young anaesthesiologists, who choose to lead an academic career, is ‘getting published’. It should be admitted that new regulations, ethical concerns, legislation protocols and ever evolving concerns in the field make the development of an academic difficult, in comparison to previous decades.

Today, the fact that we access easily and quickly to specific information makes it clear: we seem to be the last generation checking books to find information in alphabetically designed indices. It is needless to say that the ease and speed of accessing information brought along the inevitable consequences of information pollution. We can observe that the words of ‘fraud, fabrication, plagiarism, duplication, overlapping, unethical’ have made their way into the world of scientific research. Reading about retracted articles, we realise that the information we actually rely on is far from being reliable. This fact leads us to reconsider the question of ‘How to decide what to read?’ This, I believe, is the sole query that makes ‘getting published’ difficult; for it is a MUST to keep unreliable data away from entering the world of science.

The new regulations to be implemented shall unquestionably secure the reliability and quality of the future scientific data.

The ESA Masterclasses offers to young anaesthesiologists the necessary skills and values of being ethical, patient centred, honest and reliable in clinical research. A piece of clinical research will be attractive as long as it is based on these principles; however, it is clear that ‘getting published’ requires strict adherence to the rules of scientific writing not only in terms of presenting the data solely but also in terms of writing and in the use of proper language. In this respect, the two ESA Masterclasses that I attended, Scientific Writing and Clinical Research, were complementary.

These Masterclasses brought colleagues from different countries together. We had different cultures and were of various specialities. We were all at similar ages, at relatively similar degrees of our academic careers and had more or less similar problems. Some of the attendees were seemed to know more about conducting research, and some less, however, this, aside from learning from lecturers themselves, this allowed us to share our knowledge and learn from each other.

At the ESA Masterclass on Clinical Research, we learned how to design a study and my take home message was that ‘a badly designed study is unethical’. No matter how intense the programme was, it was perfectly organised. Both were composed of lectures and workshops. Our lecturers were the real Masters of clinical research, they were fun and encouraging, allowed time for questions during their lectures and one-to-one discussions during workshops. During the workshops we worked in groups and discussed on sample research ideas to design a study. When the study designs were developed, we presented our proposals, and learned how to ask for fund however tough the reviewers were (!). The most effective and informative part was the workshop on our own study designs, which was a real learn-by-doing challenge. Now, I am trying to develop and improve what I have learned, to the best of my ability.

Aside from learning many things, I had the chance of meeting colleagues from different countries and the invaluable experience of meeting and listening to the real Masters. I am obliged to ESA for having confidence in us, the future promising researchers.
CTN Studies: Get Involved! //

The most important and challenging clinical questions are more likely to be answered if several centres join forces!

The ESA Clinical Trials Network (CTN) has been established to facilitate, integrate and support clinical anaesthesiology research on an international level.

Multicentre studies recently selected by the ESA Research Committee:

- **APRICOT**: Anaesthesia PRactice In Children Observational Trial: European prospective multicenter observational study: Epidemiology of severe critical events
  
  **Chief Investigator**: Prof. Walid Habre (Switzerland)

  **Recruitment**: It is planned to recruit at least 25,000 children over a period of two consecutive weeks including weekends and after-hours. The 2-weeks recruitment period will be chosen by each site to occur as from 1 April 2014. We anticipate that a total number about 200 centres will be needed to include between 20 and 200 children over the 2 weeks.

- **POPULAR**: POstAnaesthesia PULmonary complications A fter use of muscle Relaxants in Europe: a Prospective Observational International Multi–center Cohort Study

  **Chief Investigator**: Prof. Manfred Blobner (Germany)

  **Recruitment**: It is planned to recruit approximately 24,000 patients via an estimated 200 centres in Europe. Recruitment is planned to start as of April 2014.

Become an ESA CTN Centre! //

Would your hospital like to join one of these studies as an actively contributing research centre?

**Eligibility**

The ESA CTN is open to all clinicians meeting study protocol criteria. Centres may participate in several studies.

**Process**

The ‘Call for Centres form’, available on the ESA website (www.esahq.org/ctnform), must be filled in on-line. The completion of this form will facilitate the coordination and is mandatory for participation in ESA CTN. ESA Secretariat and Study Chief Investigator will then contact Centres providing them with additional information.

**More information?**

Go to www.esahq.org/research or contact us at research@esahq.org.
ESA BAXTER Prize: Improving patient recovery after general anaesthesia - 2014 //

The European Society of Anaesthesiology (ESA) is pleased to announce that for the first time, an annual Prize in Anaesthesia and Intensive Care Medicine is awarded and sponsored by BAXTER.

The Prize is awarded for a clinical peer-reviewed publication or a laboratory peer-reviewed publication of significant relevance on the following area of interest: **Improving patient recovery after general anaesthesia**. The paper must have been published in the previous calendar year (e.g. award in 2014 for a paper published in 2013). The submission deadline is **1 February 2014, 23:59 CET**.

The paper of highest interest and importance will be rewarded with € 10,000. In the year the Prize is awarded, the winner receives free registration to the Euroanaesthesia Congress to accept the Prize during the Awards Ceremony.

**Guidelines and Eligibility Criteria**

- The applicant must be an ESA active or affiliate member or if there are co-investigators, at least one of these investigators should be an ESA active or affiliate member at the moment of application. Please visit ESA website to apply on-line to become a member.
- Any qualified member of an institution in one of the European countries that is represented in the ESA Council or from which the National Society is an active Society Member of the ESA may apply.
- No proposal which is co-authored by employees of BAXTER is considered. Any financial support from an industry or any other source for the research must be detailed in the application.

**More information?**

Detailed Guidelines and Eligibility Criteria, how to fill in the ESA BAXTER Prize Application Form and the Application Form are available at [www.esahq.org/research](http://www.esahq.org/research). For questions, contact us at research@esahq.org.

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“There are two ways to live our life. One is as though nothing is a miracle. The other is as though everything is a miracle.”

(Albert Einstein, 1921)
ESA DRÄGER Prize in Anaesthesia and Intensive Care Medicine - 2014 //

The European Society of Anaesthesiology (ESA) is pleased to announce that for the eighth time, an annual Prize in Anaesthesia and Intensive Care Medicine is awarded and sponsored by DRÄGER.

The Prize is awarded for a clinical peer-reviewed publication or a laboratory peer-reviewed publication of significant relevance on an intensive care topic. The paper must have been published in the previous calendar year (e.g. award in 2014 for a paper published in 2013). The submission deadline is 1 February 2014, 23:59 CET.

The paper of highest interest and importance will be rewarded with € 10,000.

In the year the Prize is awarded, the winner receives free registration to the Euroanaesthesia Congress to accept the Prize during the Awards Ceremony.

Guidelines and Eligibility Criteria

• The applicant must be an ESA active or affiliate member or if there are co-investigators, at least one of these investigators should be an ESA active or affiliate member at the moment of application. Please visit ESA website to apply on-line to become a member.

• Any qualified member of an institution in one of the European countries that is represented in the ESA Council or from which the National Society is an active Society Member of the ESA may apply.

• Re-applications from a Principal Applicant that have been funded in previous years are accepted after at least a 2-year interval from the previous application (e.g. 2013 winners can only apply again in 2016).

• No proposal which is co-authored by employees of a sponsoring industry is considered. Any financial support from an industry or any other source for the research must be detailed in the application.

More information?

Detailed Guidelines and Eligibility Criteria, how to fill in the ESA DRÄGER Prize Application Form and the Application Form are available at www.esahq.org/research. For questions, contact us at research@esahq.org.
The European Society of Anaesthesiology (ESA) is pleased to announce that for the fourth time, an annual Grant in Anaesthesiology is awarded and sponsored by MAQUET Critical Care (MCC).

MCC’s aim is to support research in a certain focus area every year 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 2014 is Research projects focusing on inhalation anaesthesia and the young child, preferably the neonate.

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.

The submission deadline is 1 February 2014, 23:59 CET.

In the year the Grant is awarded, the winner receives free registration to the Euroanaesthesia Congress to accept the Grant during the Awards Ceremony.

Guidelines and Eligibility Criteria

- The applicant must be an ESA active or affiliate member or if there are co-investigators, at least one of these investigators should be an ESA active or affiliate member at the moment of application. Please visit ESA website to apply on-line to become a member.

- Any qualified member of an institution in one of the European countries that is represented in the ESA Council or from which the National Society is an active Society Member of the ESA may apply.

- Re-applications from a Principal Applicant that have been funded in previous years are accepted after at least a 2-year interval from the previous application (e.g. 2013 winners can only apply again in 2016).

- No proposal which is co-authored by employees of a sponsoring industry is considered. Any financial support from an industry or any other source for the research must be detailed in the application.

More information?

Detailed Guidelines and Eligibility Criteria, how to fill in the ESA MAQUET Prize Application Form and the Application Form are available at www.esahq.org/research. For questions, contact us at research@esahq.org.
ESA Newsletter opens a short story competition for its young readers //

The Newsletter team has decided to start an annual competition for the best short story written by a young European anaesthesiologist. The winner will receive a free registration for Euroanaesthesia2014.

Conditions for participation:

1. age less than 40 years
2. the story must be taken from the professional activity of anaesthesiology, but can be true or fiction
3. the story must contain no more than 800 words

The deadline for sending the manuscript (to gurman@bgu.ac.il): December 31, 2013.

The competition will be held every year.
ESA has gone live with a brand new website! //

The new ESA website has a complete new look and feel! Definitely more attractive and easy to browse through than our previous site, making your visit at www.esahq.org a more pleasant experience.

The new site also contains some added features which will make it a lot easier for you to stay connected and up to date on all ESA happenings.

The new Social Login, for example, allows you to use your existing social network account to sign up as a ‘Registered User’ at the ESA website: using the same login details that you use to access Facebook, Linkedin or Twitter, speeds up the registration process and eliminates the need for you to remember multiple passwords or login details.

Go on-line to discover the new website and help us improve it by sending us your feedback at communication@esahq.org!

The ESA will also be more actively involved in Social Media, so be prepared to read more about us on our social pages:
- Like us on Facebook: www.facebook.com/esahq.org
- Linkedin: http://www.linkedin.com/company/3248444
- Twitter: twitter.com/ESA_HQ
2013

November, 19-21
ESA Masterclass on Scientific Writing
Contact: masterclass@esahq.org  I  www.euroanaesthesia.org I Brussels, Belgium

November, 19-21
Echocardiography for Hemodynamic Monitoring 2013
Contact: sympicus@ulb.ac.be  I  www.intensive.org I Brussels, Belgium

November, 29-30
3rd International Fluid Academy Days (IFAD)
www.fluid-academy.org I Antwerp, Belgium

December, 5-6
Ultrasound for Regional Anaesthesia
Contact: ciaranwazir@gmail.com I London, UK

December, 6-7
13th International Echocardiography Course
Contact: Kathy.vangeel@uzbrussel.be I Antwerp, Belgium

December, 8-11
Update on Renal Replacement Therapy
Contact: sympicus@ulb.ac.be I Rome, Italy

December, 13-17
67th PostGraduate Assembly in Anesthesiology (PGA)
Contact: HQ@nyssa-pga.org I www.nyssa-pga.org I New York, USA

2014

January, 19-24
London Pain Forum Winter Symposium
Contact: ciaranwazir@gmail.com I www.lpfwintersymposium.blogspot.be I Tignes, France

February, 27-March, 3
4th Annual UBC Whistler Anesthesiology Summit
Contact: cpd.info@ubc.ca I Whistler, B.C, Canada

March, 18-21
34th International Symposium on Intensive Care and Emergency Medicine
Contact: sympicus@ulb.ac.be I Brussels, Belgium

March, 28-29
Study in Multidisciplinary Pain Research Meeting - SIMPAR
Contact: info@fedracongressi.com I www.simpar.eu I Rome, Italy

May, 31-June, 3
Euroanaesthesia 2014
Contact: secretariat@esahq.org I www.esahq.org/euroanaesthesia2014 I Stockholm, Sweden

September 17-20
SFAR
Contact: www.sfar.org/evenements/135/congres-national-sfar-2014 I Paris, France

October, 1-4
4th Biannual International Multidisciplinary Pain Congress
Eindhoven, the Netherlands

October, 10-15
ASA 2014
www.asahq.org I New Orleans, U.S.A.

October, 23-25
25th ESCTAIC Congress
Contact: esctaic2014@esctaic.org I http://congress.esctaic.org I Timisoara, Romania

November, 24-28
4th World Congress of Regional Anaesthesia and Pain Therapy
www.wcrapt2014.com I Cape Town, South Africa

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The European Anaesthesiology Congress

Euroanaesthesia
The European Anaesthesiology Congress

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Abstract submission from
Friday 1 November to
Sunday 15 December 2013