Current aggressive IVF treatments put patients at risk

The Netherlands – In-vitro fertilisation (IVF) is an overly aggressive treatment and needlessly exposes childless women to substantial risks of complications and serious discomfort, according to researchers at the University Medical Centre, in Utrecht.

During standard IVF treatment, high drug doses are used to stimulate the ovaries – but these cause menopausal symptoms such as sweating, flushing, depression and loss of libido for two to three weeks. From a study comparing mild and standard IVF treatments, which involved 404 patients, the Utrecht team concluded that lower drug doses are not only as effective as higher doses, but also less unpleasant.

Reporting in The Lancet Bell C J M Fauser and colleagues said: ‘Our findings should encourage more widespread use of mild ovarian stimulation and single embryo transfer in clinical practice. However, adoption of our mild IVF treatment strategy would need to be supported by counselling both patients and health-care providers to redefine IVF success and explain the risks associated with multiple pregnancies.’

The mild version also proved cheaper at €8,333 per pregnancy, compared with €10,745 for standard treatment. The researchers also point out that replacing one embryo in the womb at a time, instead of the usual two embryos, achieved almost the same live birth rate – 44% – over a year, whilst it also dramatically cut the chances of producing twins.

Also writing in The Lancet, IVF specialist Professor William Ledger, of the University of Sheffield, commented that as success rates in IVF have continued to improve, attention has turned to improving the safety of the procedure. ‘Some patients want to complete the procedure as quickly as possible and see twins as the most desirable outcome,’ he added. ‘While 75% of IVF treatment in the UK continues to be paid for by the patients themselves, many couples opt for double embryo transfer because it is much less costly.’

It was pointed out that the standard treatment could produce twins but using the mild treatment to produce a single baby would mean the patient paying for a further treatment cycle.

Multiple births carry a higher risk of complications for mother and babies, including an increased risk of being born prematurely. Replacing one embryo, and freezing another for use in a second attempt if necessary, cut the twin rate to one in 200 births compared with one in eight births when two embryos were replaced at the same time.

Twin births have risen by 66% in Britain from 6,000 a year in 1975 to almost 10,000 a year today, driven by the increase in IVF. One in four IVF pregnancies leads to the birth of twins compared with one in 80 natural pregnancies.

An expert group commissioned by the ‘Home’, the Department of Health and Embryology Authority (HFEA) in the UK recommended last October that tough controls be introduced to cut the number of patients in whom two embryos are replaced. The report is to go out to public consultation next month and the HFEA is due to announce its new policy in the autumn. A spokesman said: ‘We know that multiple births are the single biggest risk for mothers and children.’

The reason is clear – they want to save money by paying doctors at work only a fraction of what they deserve according to the EU norm and Labour Code. Staying by the phone is not work!

Many think wages will remain the same as now and, generally, physicians accepted the changes to their working hours without much discontent. Any salary changes will be soon be known from the new work contracts being prepared in line with the new Labour Code. If adverse, effects will work on doctors and ICUs, operating theatres, orthopaedic and plastic surgery units.

Right wing politicians blame this situation on those who pushed the bill through parliament - the Social Democrats and Communists. Some note that Commissioner Spidla’s draft EU labour regulation will clarify the matter and define what work is to be included in working hours.
Czech Republic authorities force unlawful membership of professional chambers

Hurray! The Czech Republic finally approved a trustworthy government. After ‘merely’ seven months, we made it! What’s not so encouraging is that the new government also doesn’t know how to deal with some perennial problems – those hindrances that have slowed Czech healthcare’s development and reforms for years. A deep need for a circumstance restructured healthcare system has been prevented by problems that began with missing funding and progressed to insufficient insurance legislation - or maybe it was a pure lack of political will to do something.

This time, a new European-size problem emerged – an inability to incorporate EU rules into the Czech Medical Chamber (CMC) and Czech Dental Chamber (CDC) legislations. Czech law requires foreign doctors and dentists wanting to work in this country to become members of Czech professional medical chambers although, under EU legislation, practitioners should need only a certificate from their home country. The requirement for being a chamber member is really absurd – it applies also to those physicians or dentists simply visiting the country, not to mention the fact that all CMC/CDC members must pay membership fees. In other words, foreign doctors staying in the Czech Republic end up as double-members with double-money paid. Which isn’t really too fair. The situation should have been corrected by a revision of professional chambers last year.

Unfortunately, Czech President Klaus vetoed that law, stating there were too many appendices to it that made the whole situation unclear. In the last weeks of January the European Court of Justice ruled that the Czech Republic is breaching EU law by not acknowledging doctors’ diplomas and certificates issued by other Member States. For the moment, Czech Republic must pay court expenses, and soon, the European Commission will decide further steps to be taken against the Republic.

Follow up: www.kcr.cz
http://www.dent.cz/cs/csk

Attracting foreign patients

Czech hospitals maintain a very high standard of medical care, and their charges are more than affordable for foreign patients. However, local hospitals still lag behind in attracting them; foreign patients are just 0.5% of all clients – a dismal situation.

Czech economists think hospital care, based on medical know-how of real specialists, is fertile ground for business here. Unfortunately, the way the healthcare system needs to change first. Patients are not allowed, for example, to pay for above standard health insurance on their own which, some insurance agents claim, leads to extremely low motivation to travel here for treatment. If all treatment costs are fully covered only by State insurance, and there is no prospect of better care covered by private funding, local medical settings simply will not be swimming with foreign clients.

One idea to help secure extra funds for the healthcare system is to combine tourism with healthcare services. Patients could travel to sights, and in their spare time have some minor plastic surgery that was planned beforehand. As of now,” said Michal Veber, Secretary of the Travel Agencies Association, “our tourist agencies do not offer any of this kind of service, although it is very common abroad.”

Former Minister of health, David Rath added: ‘There are buses stuffed with pensioners from Germany and Austria driving regularly to Hungary – because of the quality and low-cost of dental care provided by Hungarian dentists.’

Only for the chosen

Since EU accession in 2004, increasing numbers of wealthy patients have indeed travelled to Western European countries for treatment. Unfortunately, very specific specialists are profiting from that phenomenon. Patients pay cash to orthopaedic specialists, plastic surgeons or reproductive medicine specialists, because they come to CZ to have joints replaced, eyelids reshaped, and in-vitro fertilization is also very popular. Other medical specialists must depend on an income generated only by domestic clients.

The main obstacle for even more patients to come for treatment of different ‘illnesses’ is the fact that foreign health insurers do not pay for planned treatment but only for acute care, and they are also not paying more than local insurers pay for the same treatment for local residents. Such a policy results in lower interest among Czech hospitals to tend foreign patients who do not pay cash, but pay through health insurers.

Another reason might be the language barrier, which means a need for specially trained staff. Probably most foreign patients go to Hospital Na Homolce – where foreigners make up almost 5% of all patients. Among these, 1.2% pay cash.

Nonetheless, numbers of foreigners treated in Czech hospitals are rising very slowly: 2001, foreign patients 4,781 (0.2%); 2005, patients 8,861 (0.4%).

Medical tourism conference details and further thoughts - EH back page (p.20)
Learning English for the English patient

The growing influx of English-speaking people to France has sparked a rise in language classes for French doctors keen to avoid embarrassing linguistic and cultural faux pas.

In 2000, Parisian doctor Marc Bonnel launched his formations a l’anglais, a series of courses aimed at hospital medics and general practitioners. They are designed to promote better use of English, in particular the correct medical terms needed when dealing with English-speaking patients. Most of these are British, but they also include Dutch or Germans, for whom English is their second language rather than French.

A key part of the courses is teaching French doctors what is considered acceptable to patients from different national and social cultures. For example, by French standards, the British are considered more prudish. One doctor, whose practice is close to the Dordogne, an area with a high number of English by French standards, the British are considered more prudish. One doctor, whose practice is close to the Dordogne, an area with a high number of English people, said: ‘If I ask an Englishwoman to undress for an examination, I have to do it very carefully and make sure she understands exactly the reasons why it is necessary. Similarly, a male patient has to understand what is happening if it is necessary to examine his prostate. This is why it is vital to know the language well.

The courses not only help us learn the correct medical terms but also the correct protocols of behaviour. They also help us explain what drugs we prescribe and how the patients should take them.

We practise doctor-patient role-playing, as an English teacher listens and corrects us. We also learn about medical and healthcare systems in the UK and other European countries. Press cuttings in English about medicine are discussed and there is a strong emphasis on grammar and vocabulary.

‘In our profession we are always taking medical training courses to update our skills and practices, but this makes a nice change.’

Dr Bonnel offers 11 courses throughout the year from a number of locations in France, while others are held in London and Malta.

Booming babies

France is one of the few European countries whose population growth comes from births rather than immigration.

According to the country’s statistics agency, INSEE, 367,466 more babies were born here during 2006 than in any year in the past quarter of a century. Over 830,000 babies arrived in that year (the highest number since 1981) taking the French population to 63.4 million.

The fertility rate is now two children per woman, up from 1.92 in 2005. INSEE reports this has been climbing since 1996, but has still not reached 2.1, the rate considered adequate to replace a population in developed countries.

The government says the figures are a victory for its family-friendly healthcare policies, cheap day care, generous postnatal parental leave and a wide range of other social and financial benefits.

National smoking ban begins

From 1 February, France has implemented the first wave of a national smoking ban, with all health and administrative buildings, educational establishments and public transport becoming smoke-free areas. Smoking is also banned in all other workplaces, except in specially designated smoking rooms, which non-smokers would not have to enter for any reason.

Individuals breaking the law will be fined 65 euros. Companies and others who flout the ban will be fined 135 euros.

However, the French government will pay for nicotine substitutes and ‘willpower’ courses to help people who wish to quit the habit.

A hospital spokesman in Périgueux, in the south-west of the country, said: ‘Smoking has been banned for many years in all the hospital’s buildings and people who want a cigarette have had to go outside. We are now stepping up our efforts to encourage those members of our staff who smoke to quit, and explaining and emphasising to patients that it is the single most avoidable cause of death.’

The second part of the ban, which will affect bars, restaurants, hotels, casinos and cafes, will come into force in January 2009.

Bitter pill for pharmacists

Many French pharmacists are falling on hard times after a year of falling revenues. Those most affected are in rural or semi-rural areas, where there is a growing shortage of doctors willing to set up practice or where resident GPs are leaving for the more populous towns.

In one central region of the country, pharmacists reported a drop in sales of almost 7% in 2006. Delegates at a recent regional conference complained: ‘What is the point of having a pharmacy in a village where there is no doctor? Local people have to travel to the nearest town to seek medical attention, so naturally they also buy their medicines there.’

A change in prescribing practice has also hit pharmacists’ profits. They are now required to supply at least 74% of medicines in generic form rather than those made by brand-name drugs companies.

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**Financing the future of European healthcare**

Modern financing approaches, such as public-private partnerships (PPP) and asset finance, are necessary to meet the challenge of affordability in healthcare systems today, writes Mike Tearney, Managing Director, Siemens Financial Services (SFS) GmbH, Munich, Germany, in a guest article for the European Heart Journal.

**The need to use of echocardiography**

As the first pan-European VHD, CVD and diabetes guidelines

The first pan-European VHD, CVD and diabetes guidelines were recently published in the European Heart Journal, in February. They are the result of a joint task force of the European Society of Cardiology (ESC) and the European Association for the Study of Diabetes (EASD), which aimed to provide guidance on the management of VHD, CVD and diabetes in European healthcare systems.

The guidelines cover a wide range of topics, including the management of heart failure, atrial fibrillation, and the prevention and treatment of CVD. They are intended to help healthcare professionals provide the best possible care for their patients, while also ensuring that healthcare systems are sustainable in the long term.

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Variations in urological residencies

Urology is a surgical specialty with a limited number of consultants in Europe (around 134,000). The field is very well organised and active. At a European level, the EAU (European Association of Urology) and EBU (European Board of Urology) are the main senior urologists associations. In terms of residents and trainees in Urology, the ESRU is the sole European organisation fully dedicated to them.

One of the main ESRU objectives is to improve training for young urologists and contribute to the establishment of standards in training, to ensure that an optimal urological service can be offered to the European population.

One of the first steps to individualise the good points of training, is to be able to compare the actual situation of trainees between European countries. Hence, ESRU recently conducted a survey to compare urological residencies, helped by 496 trainees living in 30 European countries.

Stéphane Larré, Chairman of the European Society of Residents in Urology (ESRU) outlines results from a study to be presented at the EAU Congress this March.

Their ages were 22–33 years (average: 28 years) when they began their residencies. Those in Western countries started later than in Eastern countries – especially Denmark, the United Kingdom and Ireland. The number of residents in each department was also very different from country to country, ranging from two to 15 with a mean of six, but there were no differences when comparing Eastern and Western Europe.

Residents had also been trained in a variable number of urological departments, ranging from 1–5 with a mean of 2.7. Many of them (83%) had also completed training in other specialties for a mean period of 21 months.

Residents from Western countries were more likely to have moved for training in another country, and the overall rate of residents who declared moves was 12%. Residents were globally satisfied with their working conditions (70%) and social status (78%), especially in Western countries, but this was associated with less satisfaction in non-professional activities for Western residents (52% vs. 64%). Eastern residents were less likely to be satisfied with salaries than Western residents (5% vs. 19%); the mean salary was also lower. The average hours trainees work in their departments was 67, with many variations (ranging from 24 to 160 hours). This is about 20 hours more than the European Union directives, which established that the maximum must be an average 48 hours weekly in a three-month period, for all doctors, including trainees.

Access to new surgical techniques was less often present in Eastern countries, with no laparoscopic procedures performed in the department of about half of Eastern trainees, compared with one third of Western residents. National courses are also organised in many countries in Europe, and more often in Eastern countries. Many European courses are now offered to residents (mainly with the help of the EAU), but only 43% of trainees had good understanding of English, with a better level in Western countries.

The last aspect of the study was to compare residents’ interest in research. Around 90% of them considered clinical research as essential, with no differences between Eastern and Western residents. Although, Eastern trainees were more interested in fundamental research than Western trainees (50% vs. 40%).

Globally, we observed that there were many differences from one country to another in Europe, but the impact on the training level is still poorly known. It is nonetheless likely that increasing the number of departments where residents are trained, and decreasing the number of residents in each department, might increase experience and hence the global level of trainees.
THE 27th ISICEM

‘Over 230 established and emerging international leaders in intensive care and emergency medicine will provide participants with a state-of-the-art review of the most recent advances in diagnosis, monitoring, and management of critically ill patients,’ Jean-Louis Vincent, Head of the Department of Intensive Care, Erasme Hospital, Free University of Brussels, Belgium, promises the expected 5,000 participants at this year’s International Symposium of Intensive Care and Emergency Medicine (ISICEM).

Among presentations and discussions: Sepsis: New mediators and potential targets for effective therapies for sepsis patients. Ongoing controversies over various management strategies, e.g. corticosteroid use, tight glucose control, activated protein C.

Monitoring: Less-invasive methods for haemodynamic monitoring. Study results, using various techniques to monitor microcirculation – a possible role in resuscitation and ongoing therapy?

Respiratory failure: Insights into the pathogenesis, monitoring and treatment of patients with ARDS, non-invasive ventilation, and causes and prevention of ventilator-induced lung injury.

Disasters: General principles of major disaster preparation in general, as well as specific approaches to pandemics, natural disasters, and terrorist threats.

ICU management: Important facets affecting ICU management, including admission and discharge criteria, long-term outcomes, the benefits and limitations of medical emergency or outreach teams, and the need (or not) for follow-up clinics.

Details of the four-day meeting: www.intensive.org

CURRENT TRENDS IN NEUROLOGICAL CARE

The role of anaesthesia in MRI procedures

In response to increasing demand for anaesthesia procedures that complement MRI procedures, Dräger Medical is developing a new ventilator that will be compatible with field strengths of up to 3-Tesla

In 2006 blood gas analysers and monitors earned manufacturers revenues of around US$360.5 million, and revenues could reach US$470 million in 2013, according to a new market report from Frost & Sullivan (F&S). ‘Laboratory tests that used to take around 30 minutes to be obtained are now a thing of the past, currently manufactured point of care devices yield immediate answers,’ the report’s author, research analyst C R Hema Varshika, explained. That instant bedside capability, along with a rising patient population, is, she believes, the cause of a notable sales boom.

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needed to arrange all supplies and to prepare and check the anaesthesia device, it might easily consume ten hours of physician, nurse, and logistics personnel time. However, the hospital is only allowed to bill for the anaesthesia time, not the actual effort and time required.’

Presently, near the hospital’s MRI suite, the induction room is stocked with MRI compatible accessories, e.g. consumable patient hoses, soda lime canisters, MRI-specific ECG electrodes etc. Stephan Hinz explained. ‘MRI compatibility has to be checked by our anaesthesia nurses in advance. We use a non-MRI-compatible anaesthesia device and patient monitoring in the induction room.’

‘Whereas for adult patients, induction is mostly applied intravenously,’ said Prof Klotz, ‘we often use Sevoflurane for children to avoid venous in-dwelling cannulas, which might cause traumatic situations while the injection is taking place.’

The following steps comprise balanced and/or even intravenous anaesthesia,” Stephan Hinz continued. ‘Leaving the induction room, the patient is placed directly on the MRI table, then connected to the MRI-compatible anaesthesia device, which has been checked and tested in advance. In our hospital, the MRI anaesthesia device stays in the MRI suite. Electrocardiograms (ECG) and partial arterial oxygen saturation (SpO2) patient cables are specified for use in MRI environments.’

So, what would a ventilator need to offer to alleviate problems in the MRI suite – simply more compatibility with the imaging procedures?

The usual patient data is monitored (oxygen, ventilation pressure, tidal volume, carbon dioxide, and anaesthetic agent concentrations). ‘The most important ventilation modes are volume-controlled ventilation for healthy (even claustrophobic) patients and pressure-controlled ventilation for paediatric and critical care patients,’ Prof Klotz recapped. ‘So far, the more advanced ventilation modes, synchronised intermittent mandatory ventilation (SIMV) and pressure support (PS) for spontaneously breathing patients, have seldom been required. We have standardised our patient monitoring throughout the hospital. This is a tough task in the MRI suite because the MR environment requires various sensors, for example for ECG, non-invasive or invasive blood pressure (NIBP, IBP), and SpO2, and a dedicated user philosophy. To reduce the challenge to staff as much as possible, the differences between using a main operating room (OR) device and the MRI-compatible unit should be kept to a minimum. Unfortunately, this does not reflect the current status at our hospital.’

The ventilation and monitoring devices installed in the MRI suite are unique and require a high level of training and support to keep them up and running smoothly, Stephan Hinz pointed out.

Along with that, the anaesthesiologist is only needed if special patient conditions occur during the MRI procedure – for example, overcoming a 10–15 second apnoea phase, Prof Klotz explained. So, he added, mostly, the anaesthetist watches the MRI procedure through safety windows. Therefore, a larger display screen would be advantageous, he said, ‘…since the anaesthesiologist needs to get an angle on the vital curves and patient data provided by the anaesthesia workplace from outside. If the screens are too small for external viewing, an additional screen outside the MRI suite is needed, to display all important information. We currently use hand-written anaesthesia reports in the MRI suite. As soon as our hospital-wide automated record keeping system is installed, we will consider saving the MRI anaesthesia data directly in an electronic patient file.’

Multi-task ventilator testers

Made by TSI GmbH, the battery-operated Certifier FA and Certifier FA Plus ventilator test systems are flow analysers that can be used to test a variety of other medical equipment, e.g. anaesthesia gas delivery machines, insufflators and oxygen concentrators.

Of compact design, the testers are not only for use in hospitals and nursing/care homes but, TSI points out, they are also ideal for the laboratory, biomedical shops, manufacturing, production applications and in field service.

Contact: tsi@tsi.com
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EUROPEAN HOSPITAL Vol 16 Issue 1/07
Vital patient-related data must be documented by emergency medical services, disaster relief units and emergency physicians in service settings, and currently most of this is done manually, on paper. Apart from the human error involved, this practice also makes it difficult to review certain details, or pass data to the admitting hospital or to extract information for research.

Solutions for digitising software and hardware solutions have been introduced to digitise pre-hospital patient data. These systems range from scanning protocols with handheld scanning, to digital pen systems that allow the writing process and viewing move isolated into digital layers and finally, mobile devices such as PDAs and tablet PCs. Making the choice of an answer for mobile data digitisation is mainly determined by cost, logistics, personnel, transfer, store and display the information. Numerous programmes for all kinds of medical care needs are available, but given their enormous variety, the biggest problem is that most hospitals and healthcare providers use different systems, and in most cases even several different ones in the same institution. This makes it difficult to exchange data internally or transfer it to another institution.

Strategic planning and implementation of new emergency/disaster relief units
Redesign of international concepts for disaster scenario management

The Von Bergh Global Medical Consulting group
Martin von Bergh MD PhD MBA, founder and CEO of Global Medical Consulting, is a practicing medical doctor, emergency physician and disaster manager, and an MBA in International Hospital Management. His organisation advises governmental organisations, hospitals, private organisations and industries on emergency and disaster management, and assists in the improvement of emergency medical services as well as disaster preparedness and response.

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By Martin von Bergh

Basic cardiopulmonary resuscitation (CPR), particularly when performed immediately by those witnessing a cardiac or respiratory arrest, definitively saves lives. However, the witnessed cases of ventricular fibrillation (VF) and childhood drowning events. Anecdotally, when queried, many employers agree that having all their employees trained in CPR and the use of an automated external defibrillator (AED) is valuable, in that it creates a `safer workplace' and also benefits the families of that workforce.

However, the problems lie in creating adequate time for a busy, productive workforce to be trained, and securing, scheduling and paying an adequate number of `certified' instructors to do the training of, perhaps, up to thousands of workers. A traditional CPR-AED course takes 3–4 hours, and requires a ratio of one instructor for every five or six workers. This is costly, financial, and productivity obstacles can become enormous – and other expenses must consideration (training equipment, instructor and/or location fees, catering, etc).

Training in under 30 minutes

The concept of teaching CPR and AED use in less than an hour became reality thanks to the methods of compressing efforts of educational researchers, the American Heart Association (AHA) and the Laerdal Corporation (Stavanger, Norway) and using modern digital video disk (DVD) technology and adult learning principles, the 20-minute CPR course `CPR Anytime for Family and Friends' was developed and launched about two years ago. Subsequent research demonstrated that by using this technology adults could learn and perform CPR up to 20 minutes and perform basic CPR as effectively as adults taught during a 3–4 hour traditional course.

During 20 minute training session, the learner is told to open a large textbook-size box, which contains a small, inflatable manikin and a few other small components, including a facemask. The facilitator then plays a video for them to follow. After a quick, guided setup of the equipment (numbering from 5 to even 500, depending on the logistics, video screen size and audio capabilities), simply follow along as the video narrator demonstrates the techniques. First they learn chest compressions, then mouth-to-mouth ventilation and later integrate the two steps at a 30:2 compressions-to-breaths ratio. Then they practice for several more minutes. In fact, cumulatively, the trainees actually do more hands-on practice (almost continuously for about 17 minutes) than those taking traditional courses, because usually the latter must wait for another trainee to finish his or her session with one of the traditional bulky manikins.

Also in the 30-minute course, the facilitator also points out inappropriate hand placement or reinforce that the individual trainees have chosen to do the person who serves as the CPR demonstrator, the course DVD. Nevertheless, they do not need to be `certified' instructors, nor do they need to spend several hours with students. Most importantly, two or three facilitators could easily manage a group of 60. Therefore, any application for use by Emergency Medical Services must be adapted to the needs of medical consumers and medical personnel, which was carefully done when this new mobile emergency protocol application was designed.

World’s smallest meets latest ATS/SpiorStar is the smallest lung function testing system in the world, reports its Finnish manufacturer Medikro. Working just 22 grams, this also became one of the first to satisfy the new and changed requirements for the calculation of lung function testing, meeting the latest ATS/ERS spirometry standards.

The current, globally accepted, spirometry standards were developed jointly by the American Thoracic Society (ATS) and the European Respiratory Society (ERS). Among other changes in the latest version of those standards (released Dec. 2005), the criteria for the reproducibility of tests were amended, and the allowed range of variation was reduced.

The easy to operate SpiorStar lung function testing system can be connected directly to a PC through serial port.

GUESS THE BEST

Traditional or 30-minute CPR & AED training?

Paul E Pepe

American Airlines administration headquarters in Dallas, were studied in a randomised, provider manner. These were compared using blinded evaluations involving both objective measurements and video recordings of performance. The evaluations were conducted both immediately following training and at the critical six-month juncture previously shown to be best correlated with long term retention of skills.

This so-called C-30 course (CPR, choking and defibrillation in 30 minutes) proved not only to be as successful in terms of measured performance, but the results were the same when trainee skills were measured at the six-month time mark, thus also demonstrating excellent retention. In fact, AED use was superior using the five-minute training for this in the 30 minutes course, compared with the much longer traditional AED courses. Moreover, with no interim training to reinforce the initial instructions, 93% of the people evaluated at six months were judged to be operating the AED adequately.

Community-CPR training? The success of the 30-minute CPR Choking-AED course is truly compelling. If an employer, church,
lung function testing system
ERS spirometry standards

a serial interface or USB, delivering reproducible and reliable results, Medikro reports. Together with its corresponding software Spiro2000, SpiroStar can be directly operated with all Windows-based operating systems, and can also be included in database and hospital information systems.

"By satisfying the latest ATS/ERS standards, SpiroStar provides physicians with the assurance that it is conducting dynamic lung function tests according to the latest international scientific requirements. At the same time, the lung function testing system, composed of SpiroStar and Spiro2000, offers a guarantee of reproducible, reliable and easily manageable test results," Medikro says, adding: "Another component of the system is the hygienic, disposable flow transducer. For calibration purposes, a calibrated, specially adapted and easy to operate calibration syringe is available."

Details: www.medikro.com

GE/DGAI prize for research

GE Healthcare and Germany’s DGAI (the country’s society for anaesthesiology and intensive care) are offering their first clinical sciences research prize, worth 60,000 euros. To be funded by GE for the next three years, the award aims to promote comprehension of clinical practice in anaesthesiology, intensive care and emergency medicine and pain therapy, via intensive clinical research.

Applications for the first GE/DGAI research prize closed on 15 February. Now it will be up to the panel of judges to decide on the first winner. The panel includes internationally recognised medical professionals such as Professor Peter M Suter, Vice President of Research at the University of Geneva and Professor D Pierre Coriat, of the C.H.U. Pitit-Salpêtrière, and Chairman of the Dpt. D’Anesthesie-Réanimation in Paris, and is headed by Professor Sten G.E Lindahl of the Karolinska Institute, who is also Head of Research and Education at Karolinska University Hospital, Stockholm.

The award will be presented at this year’s anaesthesiology congress in Hamburg (5-8 May), held by the DGAI. Founded as a medical/scientific society in 1953, today the Society reports it has over 12,000 members and continues to encourage them to work together to scientifically expand and advance anaesthesiology, intensive care medicine, emergency medicine and pain therapies.

Details: www.dgai.de (Infoservice’section)
For use with microscopes

WORLD’S FIRST DIGITAL SLR WITH LIVE VIEW

The new Olympus E-330 micro-imaging system for microscopy includes the world’s first digital SLR camera to show real-time frame images on the LCD, the company reports. The system is based around a 7.5 Megapixel sensor, which together with an array of unique features delivers incredibly sharp and vibrant images directly onto a 2.5 inch high-resolution colour LCD. Other features of the micro-imaging system include a 1.2x adapter, RM-1 multifunction remote control and a multi-cable, which can be linked to either a TV monitor or PC.

The system consists of the world’s first digital Single Lens Reflex (SLR) camera to feature Live View, making it possible to frame images on the large, colour, high-resolution liquid crystal display (LCD). Olympus adds that the camera is easily adaptable for use with any microscope via its 1.2x adapter, and the microscope can also be operated while viewing live images on a TV or PC monitor.

The E-330 camera features the latest generation MOS (Metal Oxide Semiconductor) sensor that produces full-scale 7.5 Megapixel quality imaging during continuous viewing of live microscope images. Ideal for long-term imaging applications, “no touch” image capture can also be achieved by using the multi-function remote control unit, which completely eliminates camera shake and vibration,” Olympus points out. “The newly developed 7.5 Megapixel Live MOS image sensor provides high-sensitivity, high-speed processing while maintaining superior image quality through its high-resolution, Full-Frame Transfer (FFT) Charged Coupled Device (CCD). The advanced sensor also captures microscope images with accurate edge-to-edge detail, displayed in vivid colour on any screen with exceptional clarity. The 100% field of view allows accurate framing and a designated area of the image can be enlarged up to 10x whilst viewing images under macro observation.

The camera presents continuous Live View subject framing via a 2.5 inch 215,000-pixel high-resolution HyperCrystal LCD, which offers many times the contrast of conventional LCD’s and simplifies focusing and framing, the company adds. “This rear-mounted display is designed with advanced swivel capability, providing super clear images over a 160° viewing angle. The larger LCD also means the icons and text on the camera’s menu display are large enough for easy viewing.”

When the camera is switched on, the Dust Reduction System shakes at 35,000 vibrations per second to remove dust and debris from its sensor.

An Auto-Connect USB transfers images and Live images for viewing on a computer monitor. “Multiple slots support CompactFlash Type I and II, MicroDrives or xD-Picture media cards providing users with convenient multiple storage solutions,” Olympus adds. “The E-330 can also be controlled by the optional Olympus cell family imaging software, which enables full camera control in live mode and image acquisition.”

New test to relieve chemotherapy toxicity

Olympus Life and Material Science Europa, GMBH – Diagnostics (Olympus) and Saladax Biomedical Inc. (SBI) are to co-develop a blood test expected to help oncologists to more effectively administer the chemotherapy agent 5-fluorouracil (5-FU) and thus reduce toxicity.

SBI will adapt the first of a line of Personalised Chemotherapy Management (PCM) assays for quantifying the concentration of 5-FU (Rubec/Fufoxide/Adrucil) in cancer patients to the Olympus AU400 clinical chemistry system, while the parties finalise the terms of the non-exclusive multi-year distribution agreement.

Dr Salvatore J Salamone, Chairman and CEO of Saladax, further explained: ‘There is a large body of published clinical evidence that managing 5-FU dosing by measuring blood concentration has a significant positive impact on response to therapy and reduction of toxic side-effects. However, today doctors have no clinical relevant tool by which to get this information. Saladax plans to launch a simple 5-FU test within the year.’

Details: www.olympus-europa.com
A ‘World Health Insurance’

Could International Solidarity Be Achieved to Attain Such a Goal?

In a recently published article, a team from Médecines Sans Frontières has suggested a ‘World Health Insurance’ to help provide healthcare for people in poorer nations (see box). Over 50% of the 42 countries carrying that healthcare burden would be European. We asked Gunter Danner MA PhD to examine the broader implications for these countries if they became legally bound to contribute to such a scheme.

From a Euro centrist’s point of view, true global solidarity and a ‘World Health Insurance’ are rather unusual topics. For innumerable years calls for, rather than more, social protection have been the norm. Consequently, in Western Europe most healthcare systems are permanently battling against shrinking funds and a noticeable decrease in political relevance. But, nonetheless, the WHO has presented the idea of ‘health as a public good’.

Poor states cannot blame rich states for not honouring their obligation to provide assistance, thus leaving poor states with insufficient tax revenue, and rich states can blame poor states - and each other - for not doing enough.

The EU has, however, to find a common understanding on recognition of health as a basic human right. The new entry in the Athens charter on human rights states: ‘The right to health is a fundamental right of all human beings. It shall be exercised without any discrimination of any kind’.

In their article published in Plos Medicine (vol. 3, issue 12, 2006, Pp. 2714), Médecines Sans Frontières (MSF) members Görik Ooms, Katharina Derderian and David Melody questioned: ‘Do we need a World Health Insurance?’ to realise the right to health?

Although the EU’s 2008 setting of recognition that health should be considered a human right has grown, the authors point out that far less attention has been paid to any legal obligation to provide international assistance. They suggest that there are several reasons why many countries avoid their obligation to provide such healthcare assistance: 1. The concept of shared responsibility. Poor states can blame rich states for not honouring their obligation to provide assistance, thus leaving poor states with insufficient tax revenue, and rich states can blame poor states - and each other - for not doing enough.

There is little doubt about the proliferation of the virus and thus the infection. The problems of the 21st century are not just on paper – rich states, ask for heavy contributions. Such contributions will be hard to get in Third World countries.

Nobody, not even Brussels, has suggested a ‘World Health Insurance’ to help provide healthcare for people in poorer nations (see box). Over 50% of the 42 countries carrying that healthcare burden would be European. We asked Gunter Danner MA PhD to examine the broader implications for these countries if they became legally bound to contribute to such a scheme.

Funding

The federal state of Baden-Württemberg funds the research building.

The mathematical models projects at the Centre for Modelling and Simulation in Life Sciences are funded by Heidelberg University\'s Tischka Foundation, EMBL, German Cancer Research Centre (DFKZ), Max Planck Society and the federal state of Baden-Württemberg.

Within the German National Excellence in Science (DFG) programme, Bioquant won the ‘Cellular Networks’ cluster (from molecular mechanisms to quantitative understanding of complex functions). The BMBF and DKFZ fund IDSCancer (System Biology of Signalling in Cancer).

Optical firms such as Leica, Nikon and Olympus, provided specialised microscopy equipment.
A new testing approach has effectively identified patients at the highest risk of cancer relapse after bladder cancer surgery, according to a study published in the February issue of The Lancet Oncology (http://oncology.thelancet.com). Vol 8 Feb 2007 91, ‘Bladder cancer and apoptosis: matters of life and death’). Bladder cancer recurs in many patients after radical cystectomy (bladder and surrounding tissue removal). Conventional prognostic features such as tumour grade, stage, and lymph-node status are not accurate enough to predict outcomes in patients with bladder cancer’, explained Dr Var Lotan, one of the study’s researchers at the Texas Southwestern Medical Centre, Dallas, Texas.

For the study, the team analysed bladder samples, from 226 patients, which had been removed during bladder cancer surgery. Using a tissue profiling technique, the authors tested for four different proteins (P53, Bel-2, caspase-3, and survivin) which have been implicated in causing cancer. When hen expression of all four proteins was altered, the researchers found the patients had a greater risk of developing a recurrence of their bladder cancer — and eventual death from the disease — compared with patients who had no change of expression of these proteins. ‘We found that evaluation of combined apoptotic biomarkers [markers of cell death] status can help identify patients at high risk of recurrence and death from bladder cancer after radical cystectomy, independent of conventional prognostic features,’ said Dr Jose Karam, another member of the research team.

Lead researcher Professor Shahrokh Shariat, the teams lead researcher added, ‘...clinical trials are needed to target bladder cancer in patients with a high number of alterations’, as these patients have poor survival rates with current treatments and might benefit the most from experimental therapy’.

‘Our findings should encourage more widespread use of mild IVF treatment strategy with both patients and health-care professionals’, said Dr Lotan.

The NHS and private health-care providers are to be encouraged to adopt a ‘two-embryo policy’ in the UK, under proposals to be announced by the Department of Health (DoH). The rules were described as a ‘sensible and logical conclusion’ by Dr Lotan, who commented that the DoH failure to produce a clear policy on ‘two-embryo’ practice had previously resulted in patients being ‘on standby’ for work is to be cut from the new work contracts.

The report is to go out to public consultation. A spokesman for the Department of Health said: ‘We will now be able to start considering a range of options to improve the arrangements for patients, helping to dramatically cut the chances of complications for mother and baby — and at a cost of just £10. The DoH reports that the cost of pregnancy is £10 per baby. ‘It was pointed out that the NHS and private health-care providers are to be encouraged to adopt a ‘two-embryo policy’ in the UK, under proposals to be announced by the Department of Health (DoH). The rules were described as a ‘sensible and logical conclusion’ by Dr Lotan, who commented that the DoH failure to produce a clear policy on ‘two-embryo’ practice had previously resulted in patients being ‘on standby’ for work is to be cut from the new work contracts.

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clinical application is justified. These studies will require five or more years of follow-up, depending on sample size, to achieve the number of events necessary to reach statistical power. Because many other markers are rapidly being repeated (e.g., molecular profiling), it would be more efficient to compare within the same studies, to begin to compare their predictive accuracy. Meanwhile, confirmation in large, high-quality, retrospective studies might be warranted; this strategy could allow for the re-screening of the many competing markers, to reduce the number of hypotheses to be tested in prospective studies, and the likelihood of false-positive results.

“The major challenge that urologists, oncologists, pathologists, and general scientists face is to integrate their scientific interests and work together in large, collaborative, prospective studies in order to answer questions of clinical relevance. It is certainly not an easy task, but it is a matter of life or death.”

Contact: Dr Jose Karam, UT Southwestern Medical Centre, Dallas, USA. Phone: 001-214-417-7687

prostatectomy. This ‘soft’ surgical procedure, combined with high quality care, means the Martini patients can be discharged within six days – particularly appreciated by businessmen. Developed and developed by UKE Hamburg, the success of this procedure depends a lot on the surgeon’s experience. Entry is via the abdominal wall, so the nerve bundles running along the prostate gland are preserved. Professor Hartwig Huland, who has been director of the UKE Urology Department since 1992, was one of the inventors of the procedure. He and Dr Markus Graefen perfected it and, to date, they have carried out this operation more than 5,000 times. In addition, the professor’s current studies impressively demonstrate that potency and continence can be maintained in 96% of patients. According to these two chief surgeons, today the surgical removal of the prostate is considered the gold standard for patients with localised prostate cancer. ‘The soft surgical method that we have perfected has proved much more successful than new technologies,’ Professor Huland pointed out.

The clinic also takes an innovative approach to drug-based therapy, which aims to improve potency after surgery. Dr Graefen explained: ‘The precautionary therapy with potency-increasing medication in the particularly vulnerable post-operative phase substantially increases erectile function.’ The clinic obviously also offers all the established therapies that are adapted to fit the health and personal situation of the individual patient. ‘The range of services we offer is unmatched in Germany,’ Dr Graefen confirmed. Details: www.martini-klinik.de
Further diagnostic procedures are therapist clues to the appropriate wound surface. Not all surfaces indicate wound infection. There are greasy white surfaces that are hard to detach from the wound and look like pus. However, this is actually fibrin that has to be removed when treating the wound but which is not a sign of bacterial colonisation or infection. Bacterial colonisation is differentiated as follows: Contamination: Bacteria are present in the wound but they are not multiplying. The granulation tissue appears rosy, the healing process is not affected, the typical wound smell does not develop; this appearance is also found in Colonisation: Here the wound is colonised with germs which can multiply but the patient and wound healing are not yet affected. This is different in Critical colonisation: In this state between colonisation and local infection there is increased exudation in the area. There are no obvious signs of healing and the first signs of infection are present. If granulation tissue is present it appears sensitive. There is an increased production of wound exudate, healing is delayed and pockets may develop as well as discoulouration with surfaces that can be slippery or greasy and smells. Local pain can develop or existing pain may intensify as a sign of an active infection, which is characteristic of Infection: Here we see the classic and systematic signs of infection: Redness, heat, swelling and pain, along with multiplying bacteria. Oedema: The oedema around the wound, its surroundings are sensitive to pain, there is increased secretion of (as the case may be) purulent fluids. The patient may develop a fever and the blood count may show an increased number of leucocytes.

Wound smell Smell is one of the first signs of an infection caused by certain types of bacteria. It is necessary to carry out a microbiological investigation and resistance determination to treat the pathogens systematically. Staphylococci and streptococci — particularly the MRSA strains — initially do not cause specific smells, which makes early identification difficult.

Suggested Microtherapy action: These pathogens cause neither smells nor colourings of the wound cover. As the wounds may have existed for months or even years it is advisable to carry out a Gram and resistance determination to prevent further development of resistance. Pseudomonas aeruginosa is phenotypically resistant to silver — one should use only dressings tested and certified by the manufacturer concerning their effectiveness against this species.

Wound rim Chronic wounds, particularly those found on the lower extremities, point to underlying diseases not apparent or diagnosed for years. Each causes a typical appearance of the rim of a wound so that the therapist can start treatment accordingly.

An irregular, non-horny rim, independent of a warm foot and distended veins, can indicate an ulcer cruris venosum (venous leg ulcer). A regular wound rim with keratosis, independent of a cool, pale to bluish discouloured, and non-oedematous leg, may indicate an ulcus cruris arteriosum (arterial leg ulcer). A regular, slightly raised and horny wound rim that almost looks cut out with warm, rosy but dry skin can be an indication of undiagnosed or insufficiently treated diabetes mellitus.

We purposely did not show the fourth criterion, wound exudate, because there is not an unambiguous correlation with certain underlying diseases and the resulting wound care procedures, which we have only been able to hint at. The important issue is to increase the clinical awareness of the signs that make wound diagnosis possible even at the first contact with the patient. This is then followed up with further diagnostics, particularly with regard to microbial colonisation.

**What wounds tell us**

By Heidi Heinhold

Better records reveal more bugs

Clostridium difficile has killed more patients than MRSA

UK - According to new figures obtained from death certificates by the Office for National Statistics (ONS) deaths involving Clostridium difficile rose by 69% from 3,800 in the 2004-05 period, whilst MRSA increased by 39% to 1,629. (In two hospitals in one city, C. difficile was linked to the deaths of 12 patients in just four weeks and, in another city, in one eight-month period, at least 49 people died after catching C. difficile.)

Although the bacteria were mentioned on the death certificates, the ONS bridge out and does not state what they were the cause of death.

In addition, the apparent increase in cases might be due to greater public awareness of the disease and, as a result, an increase in recording its presence on the certificates, the ONS suggested.

Lord Hunt, the British Health Minister, agreed with this possibility, but said it nonetheless remains ‘...a major challenge for the NHS, and a top priority for government’. However, he added that tough hygiene targets were already begin to see significant reductions in MRSA infections.
How much IT does healthcare really need?

The question is increasingly significant. Information technology (IT) has thrust itself into all corners of life – some argue for better, some for worse, largely because efficient electronic networking cannot happen overnight. Thus gatherings to share experiences are valuable, as seen in the Berliner Klinik IT Forum, a two-day event in January, supported by the Charité Berlin. The theme was: ‘IT as a process enabler – How much IT does healthcare need?’

Subjects aired by some 100 participants included: sensible IT integration, network architecture facility control and IT requirements of hospitals and private practices; what a patient and a partner portal should look like; what is needed for inter-departmental communications; whether a hospital’s entire workflow should be served by one HIS, or whether it would be better to have individual solutions, built on dedicated databases, to fit the needs of specific departments. And, finally, how those choices would affect the tasks and responsibilities of hospital IT staff.

EH reporter Denise Hennig asked Thorsten Matthies, of Hewlett Packard’s Digital Hospital Business Development department, for his thoughts. ‘Today hospital IT is still seen somewhat as an appendage,’ he responded. ‘But information and telecommunications technologies should be regarded as a strategic issue by hospital management. This requires a change of attitude. However, change can only be brought about by a management that focuses on economics and is prepared to take tough decisions and break up ossified structures. The advantage is obvious: the new technologies will help to optimise primary and secondary processes and thus realise savings.’

Those new technologies are not free, he pointed out. Basic investments are required that differ from hospital to hospital, he added. ‘However, if you look at the total costs of a hospital, those investments will have paid off within three to four years because they optimise processes and workflows.’ Since these new technologies need to be operated and further optimised, future IT budgets need to be increased. In Germany, hospitals have taken just a few initial steps on the long road towards the digital hospital. Currently, mostly individual hospital areas – administration, radiology, laboratory – have IT solutions, i.e. they are interfaced, but still isolated solutions. ‘We develop one-stop-shopping infrastructures and look at the hospital as a whole, because ‘We want to get away from niche solutions,’ Thorsten Matthies explained. ‘We look at processes in a hospital and, based on this analysis, develop a seamless and integrated solution. We aim for a centralised IT infrastructure that connects and controls all departments and tasks on one platform, down to the paperless hospital. Implementing such a project takes several years and requires a solid design and close co-operation with everybody concerned – as our project planning and implementation at St. Olavs university hospital, in Trondheim, Norway, illustrates.’

When planning began in 2002 to renovate and update the 100-year-old St Olavs, the installation of state-of-the-art information and telecommunications technologies were included. Partnered by several hard- and software groups (e.g. Cisco) Hewlett Packard implemented an integrated infrastructure for speech, data and video communication, which also serves as a platform for all the hospital’s clinical and administrative applications. More information on this and other hospitals with similar systems can be accessed on www.hp.com (Enterprise section). See also: www.stolav.no
IT introduction is increasingly considered a strategic element, since it is capable of supporting different decision processes at various levels (top management, middle management and professionals) and guiding them towards concrete objectives: cost control and containment, improved efficiency, evaluation and enhancement of service quality. Italy has a specific policy to improve IT implementation, particularly in public administration. Central topics:

- digital management of administrative workflows
- use of digital signature and management of documents workflow (signature, distribution, conservation, etc.)
- the use of only digital documentation (paperless)
- use of electronic smart cards (CIE Electronic Identity Card, CNS National Card for Services)
- development of a national network connecting public administrations.

All public administrations and healthcare structures are shifting towards those objectives, and some actually represent a beacon in IT implementation.

In recent years, Treviso Local Health Authority ULSS 9, in Veneto, has invested in the development of technology projects, in the implementation of ICT prototypes and in the adoption of telemedicine services and applications. This has resulted in considerable improvements for users and providers alike.

Treviso is improving its healthcare services by setting-up telemedicine applications and full digital management of medical documents. Treviso Hospital leads two important, closely connected projects: Health Optimum and EscapeTeleMed-EscAPE. It also manages Near to Needs, an innovative satellite communication project.

Approved and co-funded by the European Community within the delivering and storing clinical documents, and maintaining the privacy and security of healthcare data.

Health Optimum became the ‘Best e-TEN project of 2005’ and will be financed for dissemination, extending the project experience to other specialities and other countries, namely Sweden and Romania.

The satellite platform

Romania is already a Treviso partner in the Near to Needs (telemedICNE via a ´Atelle´to bRidge Italian and RomaniaN Healthcare and TeleHealth Services) project. Co-funded by the European Space Agency (ESA), and important private supporters such as Groupo Veneto Banca, (Veneto Banca and one of its subsidiaries, Banca ItaL, Romania), the Near to Needs project will develop and validate a pre-operational service to support diagnosis, treatment and medical training between two local health authorities in Italy and a specialist opinion is needed (tele radiology).

Application for experimentation, envisaging the following services:

- Laboratory diagnostics through Point of Care Testing (POCT), to conduct tests in the polyclinics, then have the analysis and report carried out in a laboratory in Italy (tele-laboratory); this service will benefit from the Health Optimum experience and, using cardiac markers and a portable ECGs, will allow a quick evaluation of cardiovascular diseases.
- Multi-functional radiology diagnostics (chest etc.) with the possibility of sending the data to Italy if a specialist opinion is needed (tele radiology).
- A tele-counselling position for real time consultations between Treviso and Timisoara specialists, to evaluate and/or discuss difficult cases (virtual referral and tele-counselling) e.g. suspected stroke or head trauma; the teleconsultation will be tested for neurosurgical and cardiology cases.
- An e-learning service to train staff and nurses: for academic purposes videoconference sessions between physicians will be organized and lessons for nurses also managed.

To share clinical information relative to a patient record (tests, radiological images, reports, tele-counselling opinions...) the creation of an electronic patient record (EPR) is envisaged. A system based on the IHE Infrastructure Technical Framework XDS (Extended Data Service) will be used to realise the EPR, while the tele-counselling repository is set up according to the XDS profile architecture.

This will allow physicians in the polyclinic and specialists in the centre of excellence to access a patient’s documents, naturally in accordance with local legislation for personal data protection.

ORBITS PROJECT: FIRST PHASE CONCLUDED

Italy – After five months’ work, the first installation phase of Agfa’s hospital and clinical information system (HIS/CIS) Orbis for the Gruppo Malzoni (Malzoni Group of hospitals) has been completed at the Clinica Medica Malzoni, in Avellino, and staff are already working with the system.

Agfa reports that four Orbis modules (ward & second ward, graphic, medical documentation and order entry & result reporting) have been installed in the hospital’s obstetric-gynaecology department, which has 90 beds in two different sites.

In the second project phase, the Agfa HealthCare HIS will be rolled out to the other hospital wards, the Laboratory Information System and the Picture Archiving and Communication System (PACS) will be interfaced with and Agfa HealthCare’s RIS/PACS (Radiology Information System / Picture Archiving and Communication System) will be implemented.

In the third and final phase, other clinical modules of Orbis are to be implemented.

The Malzoni Hospital Group, one of the largest private healthcare groups in southern Italy, and user of Agfa HealthCare’s CR solutions (Computed Radiography), directly or indirectly controls over 500 in-patient beds and a series of out-patient facilities in the Company region.

Agfa speculates that, apart from the fact that Orbis is already used by 400,000 people daily, in 750 hospital sites throughout Europe, the Malzoni chose the firm as an IT partner due to the conceptual design of the core system of Orbis. It is inherently based on processes, with macro- and micro-workflows and functions that can be tailored to the specific needs of its hospitals. The group now has the possibility of creating control nodes for its key processes, resulting in direct trace-ability and accountability of all decisions and interventions. An additional reason for the hospital group to opt for Orbis is that the core system can be easily connected to all existing departmental systems currently in use in the group.

Apart from full-documentation of medical care, and trace-ability, Antonio Perrone, Managing Director of the Malzoni Group, said: ‘It also enables us to easily analyse the responsibility of individual staff in atten- tion in case of organisational bottlenecks... enabling us to perma- nently fine-tune our current process- es.’

Ruggiero Liatti, Agfa Healthcare Cluster Manager, Italy & Greece, also pointed out: ‘With Orbis, the Malzoni Group will be able to introduce the Electronic Patient Record (EPR) throughout the hospital group.’
Teleradiology workflow

The polyclinic has an antibiotic resistance reader to detect bacteria that cause nosocomial infections – by far the commonest complications affecting hospitalised patients. This agent is part of the dataset that the reader helps with epidemiological studies. The treatment of infections, the Treviso expandable and flexible than the versatile, reliable, seamless, fast, and cost-effective telemedicine services. The satellite will be crucial in providing telecommunications and medical training services, with a view to EStA's future telemedicine programme.

Med-e-Tel will include the World Health Organization's eHealth Co-ordinator, the Acting President of the World Academy of Biomedical Technologies (WABT/QUATI-ICTE/UNESCO) and the Director of Global Healthcare Strategy at industry giant Intel. The ETST (European Telecommunications Standards Institute) Specialist Task Force on Telecare will host a workshop focused on 'User Experience Guidelines for Telecare Services' and a session titled 'The Need for User and Provider Involvement in the Development of Ageing Services Technologies' and conducted by the International Association of Homes and Services for the Ageing (IAHSA), will investigate how technology acts as a condition and driver for economic participation of senior citizens, with European comparative studies providing lessons.

In addition, the Interm living labs (in-house adapted movement) will be highlighted. These have been designed to help demonstrate, test and design building and living technology, to provide maximum independence for the disabled elderly. Representatives from the American Centre for Ageing Services Technologies (CAST) will discuss how emerging technologies can improve life for the aged. A regional (Be-Lux) seminar, coordinated by the Luxembourg CRP-Sante, will look at how new IT tools can improve healthcare performance and quality. Leading healthcare providers and policy makers from the region, as well as firms such as Cisco, Hippocad, IBM, IRIS, Noemalife, will provide market and policy updates and present successful business cases.

At the event, Med-e-Tel, in association with the Luxembourg visitors, offers the chance to see and evaluate actual products, technologies and services, as well as great networking opportunities.

Med-e-Tel 2007

Med-e-Tel – the International Educational and Networking forum for eHealth, Telemedicine and ICT – expects to host IT industry specialists, government representatives, medical providers, payers/insurers and researchers from 50 countries at this 5th conference and exhibition. Supported by the International Society for Telemedicine & eHealth and the European Commission, the organisers report that participants

will include the World Health Organization's eHealth Co-ordinator, the Acting President of the World Academy of Biomedical Technologies (WABT/QUATI-ICTE/UNESCO) and the Director of Global Healthcare Strategy at industry giant Intel.

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At the event, Med-e-Tel, in association with the Luxembourg visitors, offers the chance to see and evaluate actual products, technologies and services, as well as great networking opportunities.
Peter Herrmann: The English parent company caused the turbulence, which, in turn, affected the entire group. The media, particularly the English-language press, covered our story in detail. There were three major issues leading to iSOFT’s troubles: First, we were unable to meet the high expectations the market had placed in us, which forced us to issue profit warnings on the stock exchange. Second, there were delivery delays due to a lack of co-ordination between the systems integrators in England, which obviously pleased our customers. And third, we were optimistic in posting sales regarding licences and got out of sync with the actual time frame of projects implementation.

What this means is that we recorded sales quite early but then – with the delays – had to post losses for a long time, so the overall picture looked skewed. All those factors led to substantial changes within the company – most prominently on management level, with the chairman, John Weston, temporarily also acting as CEO. It was he who brought in a consulting company to develop a restructuring plan, which led to the new iSOFT company strategy.

A crucial part of this strategy is the improved co-operation between individual countries. In the past, iSOFT was a conglomerate of basically autonomous national companies, which all more or less had their own agendas. That will change. We will present ourselves as a unity so that each of us can profit from their own successes and that of the others. Each in point Germany.

Our lab solutions have been very popular for some time; we are the undisputed market leader. Compared with our solutions offered in other countries, the German version is also convincing. In the past, our head office did not acknowledge this, but now the German solution will be implemented internationally. In the end, the centre of competence ‘laboratory’ will be based in Germany.

To identify best practice, other solutions will be evaluated. For example, the German radiology solution has very good support and works well within the group internationally. We also moved competences from other countries and areas that are ahead of their time?

Our vision is still the same: to have a product that’s ahead of its time, so we can roll out in the shortest time possible. We now have a significantly better understanding of the market and understand our mistakes and new plans.

As a matter of fact, Agfa or Siemens tried to counter our Lorenzo solution with their solutions. The idea and design for Lorenzo (an inter-sectoral IT system for healthcare economy) are already a couple of years old. Nonetheless, it is still so innovative that, so far, our competitors haven’t managed to be able to come up with an answer.

Our solutions for administration, clinical & care, radiology and lab are convincing. They offer an unmatched breadth and depth of functions. The competition is still lagging behind. Lorenzo should have hit the market like a bomb. Why hasn’t it? If the product is ahead of its time? That’s not quite correct. Look at the huge success in Europe and also we mentioned quite recently the launch particularly after its launch in Germany. We count leading healthcare facilities among our customers worldwide. But, yes, we could not yet establish Lorenzo as a major contender. Therefore, when restructuring, rationalised all – the philosophy, concept, design

our development centre in India back into individual countries. It turned out to be a mistake that management of the current product range had been moved entirely to India – it was more than the Indians envisaged they could handle particularly because they were also busy with our new development – Lorenzo.

With the company restructuring, the individual countries can again take over and manage systems that are marketed locally. Where iSOFT is continuing to focus on Lorenzo.

Is Lorenzo iSOFT’s answer to your competitors’ systems?

As a matter of fact, we used to call Lorenzo a mid诸侯. But now we repositioned it and the idea was to make it a module so that countries and regions can choose what works for them. We think this will change the structures of the healthcare system. Projects such as Lorenzo benefit from the sheer volume of the NHS programme and enable development. But there are also two sides to this: Such a groundbreaking concept cannot always run smoothly. To avoid dependence on a few companies, the government created several regions and contracted different firms for each region. As soon as something goes wrong, the government can switch the contract to another company in a region, all other companies in that region are also blamed. That’s unfortunately what happened in two regions in which iSOFT participated with Lorenzo. However, we are still very successful in the NHS project.

The core product - areas that are identi- cal worldwide - is handled by an inter- national project management team made up of English German, Dutch and so on. As for adaptation to different systems, in my opinion the major part of the work has to be developed such a system is replicable. In England, a patient’s record, for example, is very similar to that in Germany. Obviously there are differences for example reimbursement systems, or the legal framework for quality assurance. But Lorenzo is a modular sys- tem, which means we have a fixed core around which we build the different modules. For German counties, in the past, we provide a DRG-based reimburse- ment model without having to redesign the entire system.

So, we believe the Lorenzo System can serve as a model for other countries.

Moreover, we want our successful RIS – the market leader in England and Germany – to profit in the long run from the state-of-the-art Lorenzo technology. We will continue to resolutely develop both our radiology system (RadCentre) and our lab system (LabCentre). In addition, we want to position Lorenzo more strongly in markets in which, in the past, our distribution partners took care of our products. In those European coun- tries where we’re not yet represented, we will sell a lot of potential for growth over the next few years – partic- ularly as new healthcare systems and new follow-up products are concerned. All in all, we have ambitious plans and are optimistic that we will realise them successfully.
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MilanoCheckUp. The new medical and healthcare exhibition.

MilanoCheckUp is the new medical and healthcare exhibition that targets companies, professionals and the medical-scientific and healthcare community, organised by Fiera Milano Tech. At a single event of international appeal, visitors will have the opportunity to get up to date on the most innovative technology and participate in the specialised conferences within The Future of Medical Sciences congress. The congress will involve top authorities on numerous clinical-medical specialisations and from the business world. When health and science take the stage, it’s worth being there.

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29-30 May, Prague, Czech Republic
ICNC 8 International scientific nuclear cardiology meeting, with focus on PET and cardiac CT imaging.

According to an as yet undefined ruling of the European Court of Justice, EU patients whose names have been on long waiting lists in their homeland now have a right to be treated in another EU country, and this is to be reimbursed by their national health insurers.

Such cross-border patient numbers are not yet significant, in part because many people prefer to be treated nearer to their homes. However, acute pain and growing cancer markets, and those who have had successful hip ops, for example, in foreign lands have found medical tourism more than worthwhile.

For the private health insurer it holds its breath, as many hospitals financially well off EU and other countries can offer surgical procedures in state-of-the-art units for perhaps 50% less in Western countries. So, even adding in travel costs for patients, the savings on major surgery can be immense.

Currently, for the British health tourist, it is said to have left ahead of France and Germany as the most popular choice; with the highest number of expatriate doctors and hospitals, Belgian costs for private surgical treatment range between 20-50% less than those in the UK (Gastric bypass - £8,000; Hip replacement - £11,800, Belgium £5,000; total knee or hip replacement - UK £10,300 and £9,000, Belgium £5,500 and £4,500 respectively), Others, newer EU member states, e.g. Malta, Estonia and Latvia, are also offering treatment to private patients, and all are reported to have excellent surgical facilities. Yet, they can cost up to 70% less than in other countries (e.g. private hip replacement: £4,000).

One day, might such cost savings also attract our national health insurers? As yet, the concept is still quite novel and needs further research.

Medical tourism and the health insurer
Since 2000, US health insurance premiums for employers rose 73%, and average deductibles rose 72% and out-of-pocket costs rose 143%. In 2004, the average US patient with health insurance paid twice that of other Western countries. Thus a few private health insurers in the USA have already recognized the economic value of what's on offer in Eastern countries and are carving a niche in this market. One, IndiHealth in Raleigh, North Carolina, specialises in sending certain medical cases for treatment to India, China and some to Thailand and Indonesia.

In India/IndiHealth works with the Woodbridge International Hospital, a large Indian pharmaceuticals and biotechnology firm. With modern facilities in the Emerging Markets in India, the Middle East, South Africa and the Far East, Wooden has created a division specifically for inter-national medical tourism including the chauffeured airport pickup, or by life support ambulance, with interpreters to have Complex surgical procedures and many of its doctors have either received their medical training in Western countries or have worked in them.

Woodbridge Hospital states that its services compare 'more favourably with American or European Hospitals', and indeed its Mumbai hospital is one of only 70 hospitals world-wide that has accreditation from Joint Commission International (JCI, USA), the international arm of the Joint Commission on Accreditation of Healthcare Organizations that evaluates quality standards of US hospitals.

The Group also points out that its facilities are not only cheaper than in the USA and other countries, but so are the Indian pharmaceuticals. In addition, the private rooms are more luxurious than most, providing air conditioning, a computer TV, DVD player, en suite bathroom, sofa-bed for a companion, room and laundry service etc.

One US firm is cautiously examining the feasibility of overseas care for its patients, specifically with hospitals that have joint Commission International accreditation or accreditation from The International Standards Organization in Geneva.

The numbers of patients receiving cross-border treatments is too as yet only in the hundreds, but the market is rising up at a remarkable rate.

Suggested hazards in medical tourism
• Surgery followed by lengthy air travel
• Limited malpractice laws to protect patients

In a survey by United Group, 70% of respondents said that they would be willing to spend more money to have their treatments performed in India, provided they had no wider range of treatments available in the USA. The other 30% said they would definitely be willing to consider going abroad to receive their treatment, and the majority of those said they would choose countries in the Far East.

The Group also points out that its members believe that what patients are looking for is not necessarily the best healthcare in the world, but the best possible healthcare at the best possible price.