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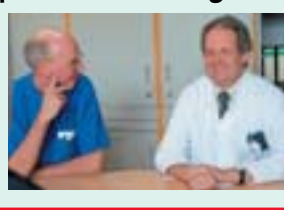
5, 12, 13 Urology

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FEBRUARY/MARCH 2007

Current aggressive IVF treatments put patients at risk

Dutch researchers show health and cost benefits in 'milder' approach

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* Bart 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 risen in recent decades, 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 will 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 conceptions.

An expert group commissioned by the Human Fertilisation 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 Lancet, 2/3/07. 'A mild treatment strategy for in-vitro fertilisation: A randomised non-inferiority trial').

French fundraisers fund geriatric wards

A nationwide fundraising campaign aimed at improving the lives of elderly hospital patients collected €1,750 million last year, beating the 2005 total by more than 17%.

Cash raised by the campaign, called 'Operation + de Vie', will help to fund 363 projects in geriatric wards throughout France. These are implemented with the help of the medical teams concerned and include developing activities for patients, helping to relieve their pain and improving reception facilities for visiting families.

Other projects include buying equipment to provide a hairdressing and beauty salon, supplying special anti-bedsores mattresses, and buying a projector and films for long-stay patients.

* *European Hospital* will feature the potential value of employing a professional fund raising manager to augment investment funds in hospitals. Read about our special managers symposium, to be held at the ECR this March. ECR supplement (centre pull out). Pages 12-13. Also, go to our website: www.european-hospital.com

Vitamin pills increase mortality

Denmark – Vitamins A, E and beta carotene, taken singly or with other supplements, 'significantly increase mortality' according to a review study released by the Cochrane Hepato-Biliary Group* at Copenhagen University Hospital. Their study, published in the *Journal of the American Medical Association* (JAMA), did not find evidence that vitamin C could increase longevity, but did find that selenium tended to reduce the risk of death.

The Copenhagen researchers analysed 68 previous trials of the five antioxidant supplements, involving 232,606 participants, and say their findings contradict those of observational studies that claim antioxidants improve health. 'Considering that 10-20% of the adult population (80-160 million people) in North America and Europe may consume the assessed supplements, the public health consequences may be substantial.'

The team reported that 47 'low-bias risk' trials, with 180,938 participants, were 'best quality'. Based on those low-bias studies, vitamin supplements were found to be associated with a 5% increased risk of mortality. Beta carotene was associated with a 7% risk, vitamin A with a 16% risk and vitamin E with a 4% risk. No increased mortality risk with vitamin C or selenium were seen.

* *The Cochrane* is an international network of experts who carry out systematic reviews of scientific evidence on health interventions.

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New Labour Code causes confusion and anger

Rostislav Kuklik reports on the effect of EU rules on Czech healthcare

The amended version of the new Czech Labour Code stipulates that emergency working hours and overtime in hospitals and social care institutes be altered so that employees are paid no less than they receive for regular working hours. Many strongly oppose this change - including top Czech EU representatives such as MEP Cabrnock (Civil Democratic Party), who said the Code imposes even more regulations than the EU requires. A key issue, he said, is whether or not being 'on standby' for work is to be included in hours worked.

Some hospital directors say it is too early to assess the Code's impact on local wages. Physicians must be reachable by phone, 24/7. However, on standby, they cannot stay in hospital, but must be home to receive emergency calls. *Staying in hospital is work!* That's too expensive, ICU managers say. 'We are sending duty physicians home, and some will also be working in shifts, because

it's cheaper for us.'

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 be mostly felt in 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 Špidla's draft EU labour regulation will clarify the matter and define what work is to be included in working hours.

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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 swarming 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 sightsee, 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, only 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 in their country of origin.

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)

Czech Republic authorities force unlawful membership of professional chambers

Hurrah! 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 circumstantially 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.

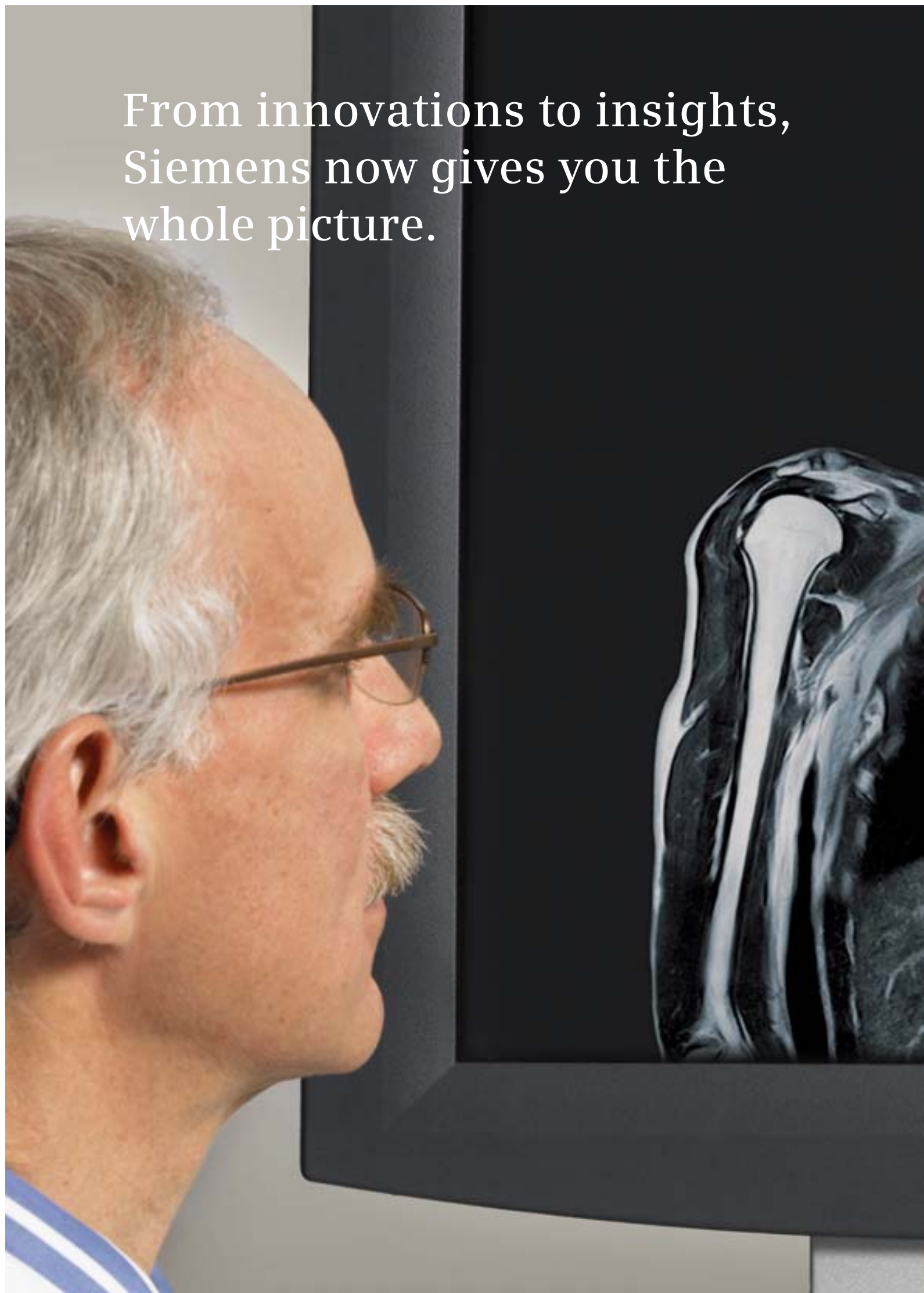
Czech law requires foreign doctors and dentists wanting to work in this country to become members of Czech professional medical chambers although, under EU legislation, practitioners should need only a certificate from their home country. The require-

ment 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 ain'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.lkcr.cz
<http://www.dent.cz/cs/csk>





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 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, 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 post-natal 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 1 January 2008.

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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“Siemens Financial Services (SFS) recently published an international white paper focusing on the financing of European and US healthcare systems. Our aim was to offer professionals in the field some metrics and fresh perspectives on the issue at a time when the minds of many strategists are occupied with the viability and sustainability of national healthcare systems. One of the key conclusions from our study is that flexible capital is absolutely critical to the timely provision of modern healthcare equipment, technology and IT – but that a substantial proportion of capital is currently ‘frozen’ in European healthcare systems because it is not effectively or efficiently deployed.

We defined ‘frozen’ capital as capital funding that is radically out of step with the purposes to which it is being applied, and is therefore not delivering value for money. On this basis, we calculated that the main European economies are tying up some €10 billion or more of capital (see Figure 1). The main cause of this is the old-fashioned practice that dictates that technology and equipment should be *owned*, at a time when the pace of technological change has placed a major question mark over the advantages of actually owning capital equipment. In reality, the two main areas of capital equipment that we study in our report –

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 Treanor, Managing Director, Siemens Financial Services (SFS) GmbH, Munich

major medical devices and IT – are prime candidates to be leased, or acquired through other asset financing techniques.

The report suggests that if this frozen capital were transferred into asset-financing plans, then healthcare financing could start to provide more modern technology and equipment. Such plans would mean that the organisation would be charged an equipment lease/rental and maintenance cost against revenue budgets, which would reduce longer-term outlay because the asset financier would

ing techniques to accelerate the introduction of modern technology to the healthcare industry is just one area highlighted by our in-depth study. We conclude that although some areas of healthcare costs require structural, long-term solutions, others may be addressed in a more immediate fashion with available finance solutions. The private sector (and not just the private medical sector) is already aware that it no longer makes sense to buy depreciating assets outright – and public health authorities should follow their example.

fulness of the MRT images. Patients then can receive the best possible treatment, and the number of patients can be improved.

‘I think it is very important for as many people as possible to benefit from medical progress,’ said Dr Neumaier. ‘It is important to us that we receive the technology and financing from a single source. This particular deal was structured as a hire-purchase arrangement where ownership transfers to us at the end of the financing term. As such, the equipment is immediately on our balance sheet so that we can claim all available tax breaks and allowed depreciation. The customary fast and smooth handling of our financing requests and the option of financing the value-added tax gives my practice much-needed budgetary freedom. As a doctor, this allows me to concentrate even more closely on my patients.’

France: An ‘Operating Lease’ arrangement with upgrade flexibility

The *Centre d’Imagerie Médicale Sainte Marie*, based in Osny, has financed its major equipment purchases through Siemens Financial Services since 1994, spanning MRI scanners, ultrasound, radiology equipment, and more. As an independent imaging centre, obtaining equipment out of capital expenditure would not have been economical. ‘Today, in the private medical sector, the use of asset financing, and particularly operating leases, is becoming increasingly standard,’ said the Centre’s Director, Dr Valentin. ‘We are a specialist organisation, and so it is imperative for us to offer the highest quality imaging capabilities using the very latest equipment. We were the first organisation in France to acquire a multi-slice MRI scanner. But we have no desire now to own this equipment, just to have use of it to provide the services we offer.’

François Yon, Financial Director of the Centre, added: ‘Operating leases are the ideal financing vehicle, especially since we wrap up equipment, maintenance, insurance, and so on into a single 360° arrangement that ensures that we have a reliable fixed monthly outlay. We also remain free to upgrade or change our equipment if – as happens – a technological breakthrough occurs, rather than being burdened with having to get rid of obsolete equipment. This kind of financing is simple to understand, and flexible in the face of change. Also, when compared with other financial methods, it remains competitive.’

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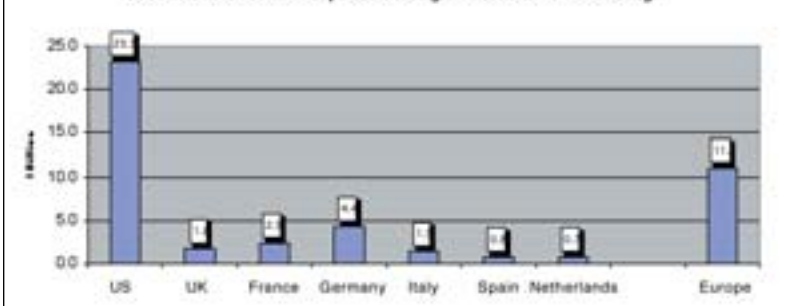
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Figure 1 Capital in Healthcare Systems that could be Freed for Revenue Purposes through Alternative Financing



retain title to the equipment and dispose of it at the end of the lease. At the same time the healthcare provider would enjoy the efficiency benefits of current technology and have the option of refreshing older equipment with modern whenever attractive to do so.

The call for wider usage of asset financing can also meet the demand for costs to be in line with actual equipment utilisation through payment-per-usage structures, where assets are rented or leased on the basis of a fee per unit of utilisation.

Modern financing methods therefore can enable organisations to upgrade to superior new technology at their discretion, without an increase in rental payments or expenditure of scarce capital budget, and can also pass to the financier the risks of disposing of older equipment and of the level of utilisation of the new equipment.

The potential for modern financ-

Two best-practice examples:

Germany: Hire-purchase

The Medical Centre Dr Neumaier and Colleagues, in Regensburg, Germany, offers its patients diagnostic options that extend far beyond traditional methods of treatment. More than almost any other medical specialists, radiologists rely on the latest technological equipment. This is why, as early as five years ago, radiologist Dr Neumaier decided to finance imaging systems through Siemens Financial Services. He has chosen this financing method over and over again.

His most recent investment is the latest generation magnetic resonance tomography (MRT). The Magnetom Trio scanner from Siemens Medical Solutions offers an extremely high magnetic field force (3-Tesla), which produces unprecedented quality and, as a result, assures the diagnostic use-

The first pan-European VHD, CVD and diabetes guidelines

The first, pan-European guidelines to be published on the treatment of valvular heart disease (VHD), diabetes and cardiovascular diseases (CVD) have made a series of new recommendations that experts hope will contribute to improving the outcome for patients.

Published in February, in the *European Society of Cardiology's European Heart Journal* in February, the guidelines for VHD highlight what should be happening according to the best available evidence from clinical trials. Professor Alec Vahanian, chair of the ESC VHD guidelines task force and head of the cardiology department of the Bichat Hospital, in Paris, said a unique feature of the guidelines is the integration of the current practice in Europe and emphasis on particular issues that were not adequately performed in current practice.

The guidelines on diabetes, pre-diabetes and CVD - also published recently in the *EJH* - underline the fact physicians should check for both conditions if they see a patient with one of them. Professor Eberhard Standl, co-chair of the diabetes and CVD guidelines task force, chair of the Diabetes Research Institute in Munich and president-elect

of the International Diabetes Federation of Europe, said the great merit of the guidelines is that they recognise that CVD and diabetes are ‘on the same coin; diabetes on one side, CVD on the other’.

One of the problems for the international experts collaborating to write the VHD guidelines was the lack of evidence on best practice. Prof Vahanian said: ‘Our guidelines are based on evidence that exists and the consensus of all the experts involved in each step of the writing process.’

The VHD guidelines deal with every aspect of treatment, from evaluation to surgery, other therapies and management during pregnancy. Prof Vahanian said one important recommendation concerned the use of stress testing, and recommended this should be used more often, to ensure patients who are not symptomatic receive the right treatment.

The need to use of echocardiography as the key technique to confirm a diagnosis of VHD is also emphasised. (Some countries provide better access to echocardiography facilities for patients, than other countries).

Although VHD occurs most frequently in the elderly, Prof Vahanian pointed

out, the Euro Heart Survey showed many of them were not even considered for surgery, often for unjustified reasons. The guidelines stress the need for precise risk stratification before decisions are made about treatment for elderly patients.

A joint task force of the ESC and the European Association for the Study of Diabetes (EASD) wrote the diabetes, pre-diabetes and CVD guidelines. They believe there is still much to be done to improve treatment of these patients. Among the issues that they highlight is screening for undiagnosed diabetes.

Prof Standl said the team had ‘...not recommended mass screening for asymptomatic diabetes until there is evidence that the prognosis of such patients will improve by early detection and treatment. Indirect evidence suggests that screening might be beneficial, improving possibilities for the prevention of cardiovascular complications.’

Since many patients with CAD may have asymptomatic diabetes, or pre-diabetes, the guidelines recommend that patients should have an oral glucose tolerance test if their diabetic status is unknown. Additionally, every diabetic should be screened for CAD, so they can receive the right treatment.

Variations in urological residencies

Urology is a surgical speciality 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 specialities 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

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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 EAU provides support for residents in urology to travel to another country to complete their training, which is very appreciated. The centres where residents are trained are also very important, and many differences also exist from one centre to another, within the same country. Hence, ESRU will continue its evaluations by focusing on centres more than countries, to highlight the aspect of the training that are the most efficient for increasing trainee levels in Europe.

Details: www.esru.net

More Urology features in EH pages 12 – 13

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'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)*

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Respiratory failure: Insights into the pathogenesis, monitoring and treatment of patients with ARDS, non-invasive ven-

tilation, 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

Currently, to expand and centralise the MRI Department at the University Hospital Schleswig-Holstein in Luebeck, Germany, a new building is being planned. This will include the installation of two 1.5-Tesla MRI systems to cover most routine scans, and one 3-Tesla MRI system. The new MRI Department also plans to install Draeger Medical's new MRI-compatible anaesthesia workstation, which includes all modern ventilation modes (volume and pressure controlled ventilation, SIMV/PS and PS), as well as compliance compensation. A new MRI-compatible patient monitor complements the workstation.

Professor Karl-Friedrich Klotz MD, Vice Director and head physician at the hospital's Anaesthesiology Clinic, and Anaesthesia Nurse Stephan Hinz,

with Sevoflurane during induction and move on to intravenous or balanced anaesthesia. For the recovery phase we prefer Sevoflurane anaesthesia. Neonates and children should be ventilated during anaesthesia by pressure-controlled modes. Neonates weighing less than three kilograms require special attention and qualified equipment. The anaesthesia device currently installed in our MRI suite can

in the MRI suite; this procedure often includes elongating pump tubes. Easy measures, such as safety blankets, provide shielding for these additional devices.'

These intensive-care patients are often ventilated in quite sophisticated ways that must be modified during MRI scans, Prof Klotz pointed out. 'Even pressure-controlled ventilation should be standardised from a therapy standpoint. We have to choose easier modes for device reasons. Intensive care patients are handed over to critical care ward personnel directly after the scan, to be transferred back to the ward.'

MRI patients need treatment at least once every other day, Stephan Hinz said, and sometimes scans can be scheduled three to four days in advance. However, then patients from critical care wards or trauma units often arrive unexpectedly, needing high staff input. 'We have a special kind of



Stephan Hinz (left) and Karl-Friedrich Klotz (right)

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

The role of anaesthesia in MRI procedures

who is responsible for medical practice guidelines, explained that, in the induction room, a standard anaesthesia machine will continue to be used. 'The user interface of the older induction room anaesthesia machine cannot be compared with that of the new device,' Prof Klotz pointed out, 'but at present our personnel is familiar with it. In another step, a Fabius® Tiro could be added here, in order to simplify and unify the operating philosophy.'

Who would need anaesthetic during MRI scans?

High-acuity patients and, faced with confinement in a narrow MRI scanner, claustrophobic patients. Some of the latter, Stephan Hinz pointed out, only need reassurance and mild sedation (Medazolam), whilst others need more complex anaesthetic procedures, e.g. classic volume-controlled ventilation.

Sedation is also needed for neonates and older children treated by paediatricians, said Prof. Klotz. 'For these we begin

only ventilate patients weighing more than five kilograms and does not have compliance compensation, which is advisable. And hand-bagging this very tiny patient through three metre-long hoses without proper compensation information is like flying blind. Hence, we do not usually anaesthetise neonates, but prepare them for MRI scans by sedating them.'

A large number of patients arriving from critical care wards also need anaesthesia in the MRI suite, Stephan Hinz added. 'This group of high acuity patients is comprised of neurology, neurosurgery, and coma patients who require mandatory ventilation, as well as patients with blood clots, aneurysms, and epilepsy. These patients often arrive already connected to, or wearing, other devices, for example invasive blood-pressure measuring devices, pacers, infusions, Catecholamine therapy, and so on. Additional mandatory devices, such as syringe pumps, have to be arranged peripherally

logistical problem related to MRI scans,' he said. 'The MRI anaesthesia device is the only one of its kind in the university hospital. Therefore, not only are there special requirements and aspects of the delicate MRI environment that need attention, but also our staff is not routinely familiar with the user interface of the anaesthesia device. As said, many cases cannot be planned, so trained staff cannot be prescheduled. Therefore, we need to implement time-consuming training for our nurses and anaesthesiologists – over and over again – to have trained personnel available at all times.'

Prof Klotz estimated that, if obtaining an MR image takes six minutes, 30 minutes are needed for the anaesthetic procedure. But currently the MRI unit is in a distant part of the hospital campus, so the physicians and specialised nurses needed to be prepared and support any unscheduled MRI procedure are taken away from their routine hospital work for up to four hours. 'If you add the time

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BLOOD GAS ANALYSERS AND MONITORS

IMMEDIATE BEDSIDE RESULTS INCREASE SALES

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 for the result 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 boost.

The main challenges for manufacturers include each country having its own purchasing system, which will only change when countries adopt uniform laws. The author attributes other problems to the high levels of brand consciousness among hos-

pitals and 'intense competition from local participants'. This, Ms Farshika suggests, can be overcome through innovative products and effective marketing strategies. 'Proactive marketing of technologically advanced and user-friendly products will lead to a rise in market share,' she then predicts.

F&S points out that this analysis - 'The European Blood Gas Analysers and Monitors Market' (M00B - 56) - is part of its Patient Monitoring Subscription, which includes research on: Remote Patient Monitoring and the Strategic Analysis of the European Neurological Monitoring Market.

For a virtual brochure, e-mail Radhika Menon Theodore - Corporate Communications at rmtheodore@frost.com, giving your name, company name, title, phone number, e-address, city, state, and country. (<http://www.patientmonitoring.frost.com>)

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 indwelling cannulae, 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.

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Posters: Deadline for abstract submission: December 15, 2006

ACCIDENTS, EMERGENCIES AND DISASTERS

Out-of-hospital digital documentation

Vital patient-related data must be documented by emergency medical services, disaster relief units and emergency physicians, in out-of-hospital settings, and currently most of this is done entered manually on paper. Apart from being time consuming, this practice also makes it difficult to review certain protocol details, pass on data to the admitting hospitals or to extract information for research.

Lately, numerous soft and hardware solutions have been introduced to digitise pre-hospital patient data. These systems range from scanning in protocols with handwriting-recognition, to

By Martin von Bergh

digital pens that analyse the writing process and translate viewed movements into digital letters, and finally, mobile devices such as PDAs and tablet-PCs.

The success of any solution for mobile data digitisation is mainly determined by software - to process, 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.

To overcome the problem *Orion Health* has developed an application for mobile devices that allows digital entering of data in to emergency protocols and transferring this data into any existing hospital software. This is possible due to a software integration engine that translates incoming data into the format required by a hospital's current applications. Furthermore, the patient data can be stored on a central database to be accessible for certified users, using a web-based integration application named *Concerto*. Later, all stored data can be analysed, statistics can be extracted and reviewing data is easily possible.

To ease data entry as much as possible, the emergency protocol application on the mobile device follows the logical structure of the paper forms

already used in a certain area. Due to its modular configuration it could be easily adjusted to the needs of a variety of Emergency Medical Service providers. To enhance recognition by hospital personnel, the print out could also match the style of the paper version. To maximise efficiency, most data is entered by checking boxes or is automatically received from diagnostic appliances via Bluetooth.

Since this new application runs on mobile hardware solutions, such as Tablet-PCs or PDAs, apart from manual data entry, additional information can be added to the protocol. Digital cameras can capture images and videos of the patient, captured by digital cameras at the emergency site, can be added to the electronic version of the protocol. When under time pressure it can be beneficial to simply audio record medical findings instead of typing them at the site.

After completing the entire emergency protocol, a print out could be created on a mobile printer built in to the ambulance. Then the digital file can be sent either via cell phone network (GPRS) or uploaded directly into the hospital system using Wireless-LAN.

The most important reason to implement modern technology in emergency situations is to improve or ease working procedures. The digitisation of patient data in the out-of-hospital setting can only be an asset if easy to use and of a familiar pattern. Therefore any application for use by Emergency Medical Services must be adapted to the needs of the paramedical and medical personnel, which was carefully done when this new mobile emergency protocol application was designed.

World's smallest meets latest ATS/

SpiroStar is the smallest lung function testing system in the world, reports its Finnish manufacturer Medikro Oy. Weighing 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 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 SpiroStar lung function testing system can be connected directly to a PC through

SpiroStar: The software for this computer-based system is available in 14 languages, and it runs with all available Windows operating system versions



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, with an MBA in International Hospital Management. His organisation advises governmental organisations, hospitals, private practices, and other healthcare providers 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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GUESS THE BEST Traditional or 30-minute CPR & AED training?



Paul E Pepe

Basic cardiopulmonary resuscitation (CPR), particularly when performed immediately by those witnessing a cardiac or respiratory arrest, definitively saves lives - especially in witnessed cases of ventricular fibrillation (VF) and childhood drowning events. Nevertheless, the frequency of bystander CPR still remains mostly low. In turn, survival chances for potentially salvageable patients remain low, even in well-developed, rapidly-responding EMS systems.

Most people believe that learning to perform CPR is very important. However, the inevitable hurdle is getting them to the classroom. Communities that have experienced a relatively high frequency of bystander CPR and accompanying high survival rates for out-of-hospital VF have been those in which healthcare is a major industry, or where CPR training is provided for all students in their school systems. Therefore, widespread CPR training often requires a focus on captured audiences who are required to learn CPR.

Considering this concept, another key strategy to ensure widespread CPR is to require it (or make it easily available) in the general (non-healthcare) workplace. 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 class takes 3-4 hours, and requires a ratio of one instructor for every five or six trainees, so logistic, financial, and productivity obstacles can become enormous - and other expenses need 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 half an hour became a reality thanks to longstanding efforts of educational researchers, the *American Heart Association* (AHA) and the *Laerdal Corporation* (Stavanger, Norway). 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 technique adults could learn CPR successfully within 20 minutes and perform basic CPR as well as those taught during a 3-4 hour traditional course.

During 20 minute training sessions conducted by a 'facilitator', each participant 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 set-up, the trainees (numbering from 5 to even 500, depending on the logistics, video screen size and audio set-up) 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 practise 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 follow the cadence of the person who serves as the CPR demonstrator on the 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 trainees in 30 minutes, compared with the traditional 10 or 12 certified instructors needed for the 3-4 hour course.

Whilst the effectiveness of the AHA 20 minute CPR DVD course has been shown to be just as effective as traditional courses immediately at the end of course, the all important question remained: Could those learned skills be retained long term? Additionally, early pilot studies had not involved the critical skills of choking rescue and AED use. Accordingly, a recent study (comparing traditional 3-4 hour training for CPR, choking and AEDs to a modified half hour session for the same skills) examined both immediate performance of these life-saving skills and comparative performance six months later.

In that study, several hundred subjects, participating from various positions and diverse educational backgrounds, at the

American Airlines administration headquarters in Dallas, were studied in a randomised, prospective manner. Their performances 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 just 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 demonstration of skills, 93% of the people evaluated at six months were judged to be operating the AED adequately.

Community-wide CPR training?

The success of the 30-minute CPR-Choking-AED courses is truly compelling. If an employer, church,



One of the award's initiators: DGAI's new President, Professor Hugo Van Aken, Head of the Anaesthesiology and Surgical Intensive Care Unit at Münster University Hospital

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.
www.dgai.de ('Infoservice' section)

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. Pitié-Salpêtrière, and Chairman of the Dépt. D'Anesthésie-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

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 require-

ments. 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



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By **Paul E Pepe MD MPH**, Professor and Chair, Emergency Medicine, University of Texas, **Lynn P Roppolo MD**, and **Ahamed H Idris MD**

or civic leader wants to host a lunch, or lunches, and supplies the inflatable manikins (available via www.cpranytime.org) to every employee, church member or constituent, the participants will not only return from a half-hour lunch-break knowing how to save a life, they also could take the training kits home and become facilitators for their families and friends. Thus, in the resulting 'multiplier effect', the number of trained lifesavers would grow.

Additionally, due to the sessions' shortness and because few resources are needed for instructors and materials, more frequent re-training could take place to improve skill retention. So, one can envision such sessions being held routinely at the places mentioned as well as other potential mass training venues. A class could be held anywhere if a big video screen and adequate sound system is available.

Long-term results would likely be that more people in a given community would be trained in the latest CPR techniques, subsequently translating into many more lives being saved in coming decades.

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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 multifunction 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 framing and focusing, 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 Europe, 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 (*Rubex/Efudex/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

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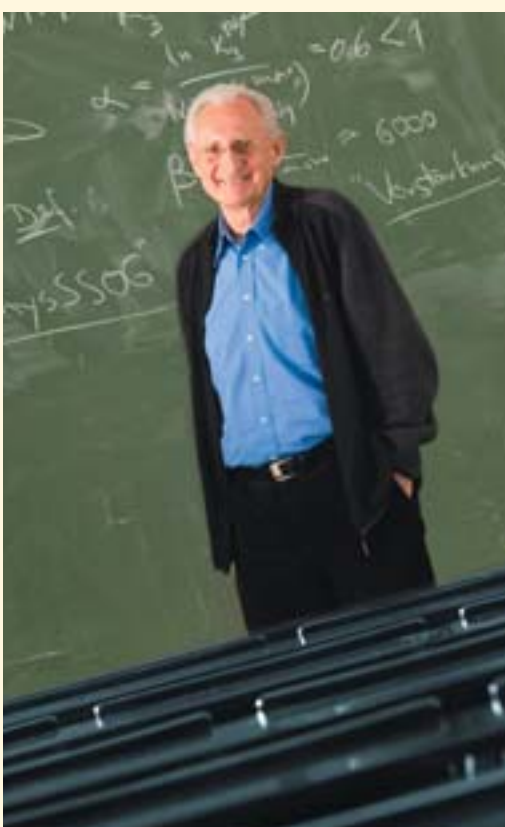
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Since the human genome was mapped 'systems biology' centres have sprung up all over Europe, including **Bioquant** in Heidelberg, Germany.

Systems biology is defined as the quantitative analysis of molecular and cellular biosystems, which involves experts in life sciences, mathematics, physics and chemistry. Their aim is to fully comprehend the complex and dynamic processes in a cell, or organ, and visualise them. This could take 10–20 years.

'Systems biology is a hot topic in science,' said **Professor Jürgen Wolfrum** of the Institute for Physical Chemistry at Heidelberg University and founding director of Bioquant, during an interview with **Meike Lerner** of *European Hospital*. When the human genome was

Seeking life's chemical processes



Before he became founding director of Bioquant in 2005, physicist and physical chemist Prof Jürgen Wolfrum headed a group of 50 scientists and students at Heidelberg University. His many awards include the 1987 the Philip Morris Research Prize, 1993 Max Planck Research Prize, 1999 BMW Scientific Award, and the 2000 Polanyi Medal of the Royal Society of Chemistry

mapped, scientists had access to all information on a molecular level for the first time, the professor explained. 'With this knowledge we can now begin to study the elementary chemical processes of complex molecules – the building blocks of life – this means the entire complex system operating in a cell down to the accumulation of cells into tissue and organs. We want to understand and visualise these quantitative processes – a task that cannot be solved by one discipline alone; this needs joint efforts of all life sciences, chemistry, physics and

mathematics.

'Bioquant offers ideal conditions to tackle this problem. Even the building was designed to facilitate communication between the disciplines. Systems biology is a vast field. The Heidelberg working group will focus on virology and the cellular network. Our concept also encompasses a technology platform, primarily for high-resolution microscope diagnostics and digital image processing. We want to develop the technological foundation to observe complex cellular processes and communication between cells in vivo. We need diagnostic procedures that don't interrupt or disturb those interactions. Light is best suited to achieve this – so, for example, we are working with laser microscopy on a nano scale. Another procedure – the

single molecule technique - allows us to apply fluorescent markers to individual molecules then track them. Finally, there's cryo-electron microscopy, in which frozen cells can be studied on a nano scale. We hope to apply these three methods simultaneously, so we can set off the weaknesses of each individual approach by the strengths of the others.'

The work should reveal how a virus can dock on to a cell, penetrate the membrane and use certain proteins inside the cell to proliferate. 'We are particularly interested in finding out which proteins the virus needs and which genes activate those proteins. With the European Molecular Biology Laboratory (EMBL), we are building an ultra-fast high-throughput microscope to screen the genome and find out which genes are responsible for the proteins that help the virus. Then, one day, we might be able to stop the proliferation of the virus and thus the infection. The results of optical techniques are being combined with mathematical models. Both research approaches – screening the genome and building mathematical models – will yield enormous amounts of data that cannot be handled with normal memory capacities. So we're supported by a *high energy physics* working group, specialised in processing large amounts of data – we are talking about petabyte, which means one million gigabyte.'

European congresses are now being organised to draw the separate systems biology centres together. 'There is little danger of double work in research because the systems biology field is very wide,' Prof Wolfrum reassured, adding that, in this complex, time-consuming research, exchanging results is important. 'The more centres that work in this field, the faster we can put together the pieces of this puzzle. No doubt, the next few years will be thrilling and we'll gain essential new insights into the functioning of our bodies.'

FUNDING

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

The mathematical models projects at the Centre for Modelling and Simulation in Biosciences are funded by Heidelberg University, Klaus Tschira Foundation, EMBL, German Cancer Research Centre (DKFZ), Max Planck Society and the federal state of Baden-Württemberg.

Within the German National Excellence in Science initiative, Bioquant won the 'Cellular Networks' cluster (*From molecular mechanisms to quantitative understanding of complex functions*).

The Federal Ministry for Education and Research (BMBF) supports the Viroquant project under the systems biology initiative ForSys (Systems Biology of Virus-Cell Interactions).

The BMBF and DKFZ fund dSBCancer (System Biology of Signalling in Cancer).

Optical firms such as Leica, Nikon and Olympus, provide specialised microscopy equipment.

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* have 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

Gunter Danner MA PhD, studied history, economics and international relations in Great Britain, South Africa and the USA.

Today, he is personal advisor on socio-political and economic affairs to the CEO of Techniker Krankenkasse, which is Germany's third largest not-for-profit health fund.

In addition, Dr Danner is Deputy Director of the permanent liaison bureau of the joint associations of German statutory social insurance in Brussels. He also regularly lectures on socio-economic subjects, specialising in the international comparison of social security systems in France, Germany, Switzerland and Sweden.

Along with major research on questions arising from EU-developments and enlargement, Dr Danner also participates in PHARE/TACIS projects for social reform in all East European countries, including Russia.



The proposition

In their article published in *Plos Medicine* (vol. 3, issue 12, 2006. Pp.2174), *Médecines Sans Frontières* (MSF) members Gorik Ooms, Katharina Derderian and David Melody questioned: 'Do we need a 'World Health Insurance' to realise the right to health?'

Although international 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 two major 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 means to meet their core obligations. Rich states can blame poor states - and each other - for not doing enough,' the MSF team points out.
2. The notion of 'progressive realisation', i.e. recognition that economic, social, and cultural rights cannot be fully realised in a short period. 'This allows states to claim that they are doing, or have done, everything they can,' the authors suggest.

They then argue that a 'world health insurance' could solve both those problems by defining rights and duties for both rich and poor states. But how could such an insurance scheme work?

Ooms et al. cite the example of the *Global Fund to Fight AIDS, Tuberculosis and Malaria*. The creation of this fund, they say, '...demonstrates the merits of ambitious thinking: the provision of anti-retroviral therapy to people living with AIDS, previously dismissed as unsustainable, became widely accepted as soon as the Global Fund provided a long-term funding perspective. Other health interventions deserve a similar approach'.

The team's suggested framework for a world health insurance involves rich states paying a fair contribution and poor states having the right to assistance for healthcare needs that they cannot finance themselves. The WHO has estimated that a state needs to spend at least \$35 per person per year to finance adequate levels of healthcare. Ooms et al suggest that rich countries should be obliged to assist those countries unable to reach this financial outlay alone.

Their original article can be accessed at: <http://medicine.plosjournals.org/perlserv/?request=get-document&doi=10.1371/journal.pmed.0030530>

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 less, 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. Recent international research has presented the idea of 'health' as a human right, enshrined by international treaties and perhaps some day legislation. However, in practice such rights might be quite difficult to ensure. No insurance, no matter whether statutory or private, can guarantee 'health' to any individual. However, it can ensure that people in need will receive some treatment, irrespective of their own solvency.

Thus the practical value of a health insurance for a sick individual is influenced by, for example, the generosity and decency of the scope of benefits offered, the availability of medical care and the ability of the insured to pay his or her dues as contributions or taxes.

Even throughout the EU this reality shows vast differences. Many systems are almost paper tigers, making illegal co-payments inevitable. Lots of the 27 different healthcare models are under-funded. Therefore, increasing out-of-pocket payments are quite normal. Productivity does not always guarantee quick treatment rather than lengthy waiting lists. Even Central and East European

Countries, with mostly poor public systems, ask for heavy contributions. Backhanders may have to be added on top.

Such contributions will be hard to get in Third World countries. Universal coverage – if possible not just on paper – is thus almost non-existent. The idea of a universal health fund, subsidised by 'rich' countries and allotting funds to those considered 'poor', therefore runs the risk of mixing up different levels of action. Nobody, not even Brussels, has ever insured a Member State. Health insurance is logically aimed at the individual, not the Government. In the eyes of many, paying Governments to do or to leave something has not lived up to expectations as far as the creation of a better quality of life in economically challenged countries is concerned. Consequently, the additional 'burden sharing' of a 'World Health Insurance' (Author's note: *the term 'insurance' is misleading since no insurance principle – social or based on risks assessment – is involved*) might ask the UK for an additional US\$4.4 billion; France for US\$2.6 billion, and Germany for US\$2.9 billion. (It remains an open question, why Britain, with her problematic NHS, should pay roughly the same as the US, or one third more than France or Germany, with their still far more generous systems of healthcare). Given the pressures on their own systems, local voters might not like this idea at all.

On the other hand, the widening gulf between well-to-do coun-

tries and those where most people are forced to live in appalling conditions should not be brushed aside simply for reasons of local populism. Questions to be answered are still perhaps more complicated than just another call for more money to alleviate poverty gaps between Governments. Indeed, by concentrating existing means on health and other basic services of general interest, much might be achieved. Yet, the sometimes tragic political conditions in receiving countries may render this quite difficult (The history of the arms' race among poor countries does not speak in favour of many local Governments). Initially, public awareness in donating countries ought to be changed from the prevailing scepticism to a positive socio-strategic vision. Thus structural development aid, locally provided, double and triple checked against corruption, is of the essence. After all, millions of weary Western taxpayers rather than a few devoted Third World activists must be convinced that indeed more cash is needed and will do some good.

This calls for a well-balanced approach. More basic help and change should be made directly available to the suffering on the spot. Any anonymous global institution telling others what they have to do could add to the problems rather than bring about a solution. At home, a new approach to social issues in so-called 'rich' countries under a growing demographic strain is important. Even here, injustice and poverty are unfortunately rising, albeit less horrifying than elsewhere.

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EH 1/07

UROLOGY

NEW

Test combination predicts high risk of relapse and death in bladder cancer patients

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 Yair 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, Bcl-2, caspase-3, and survivin) which have been implicated in causing cancer. When 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 apoptosis 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'.

In a *Lancet Oncology* 'Reflection and Reaction' link (see website), Dr Francisco Real and Dr Nuria Malats commented that this is the first study in which multiple apoptosis markers have been used together to assess the value in improving accuracy of predicting outcome for patients with bladder cancer. However, they add: 'Although the paper provides important, novel information, the findings do not call for any change in current clinical practice.'

They point out: 'Ideally, these hypotheses should be tested in multicentre prospective studies in the context of either standardised clinical care or therapeutic trials. Even then, the results will need to be independently replicated before

PROSTATE CANCER

Clinic's technique preserves continence and potency in 96% of patients

The Martini Clinic, a private clinic located at the Hamburg-Eppendorf University Hospital (UKE), specialises exclusively in the diagnosis and therapy of one medical condition: prostate cancer.

Modelled on similar clinics in the USA, such an approach is unique in Germany, but has proven a success in just two years. During the first year, 200 patients underwent surgery, generating a turnover of 2.4 million euros. 'Last year, our success continued,' said Dr Michael Moormann, Director of the Martini Clinic. 'We performed 450 surgical interventions.' The clinic met growing demand by increasing its beds from nine to 17.

Martini patients are now international. Along with Germany, they hail from countries such as Greece, Cyprus, Sweden, Austria, Poland, the Ukraine and, increasingly, from Arabic countries. For all of them the facility not only provides high performance medicine and amenities similar to those of a luxury hotel (meals are à la carte), but it is also conveniently within easy reach of Hamburg airport, and offers a special accommodation package for family and friends. Private

Dr Markus Graefen perfected the technique with the professor

Professor Hartwig Huland, one of the inventors of the procedure



The clinic's entrance hall echoes the top class accommodation within

rooms have en suite bathrooms, refrigerators and multimedia terminals with internet access.

More importantly, the nurses have been trained in the care of

prostate cancer patients, and most important of all, the two renowned heads of surgery enjoy an excellent reputation, throughout Europe, for nerve-preserving radical

The 22nd Annual Congress of the European Association of Urology (EAU)

clinical application is justified. These studies will require five years or more 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 reported (e.g., molecular profiling), it would be more efficient to assess them within the same studies, to better compare their predictive accuracy. Meanwhile, confirmation in large, high quality, retrospective studies might be warranted; this strategy could allow for a pre-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

Since 13,000 urologists attended last year's congress in Paris, a similar number is expected in Berlin, making the EAU the second biggest international urology event (after the American Urological Society's congress). 'It began as a European congress, but over the last few years has increasingly developed into a world congress,' explained Professor Dr Udo Jonas (right), Head of Hanover Medical School's Urology Department and EAU Secretary General and this year's

President. 'We expect, for example, a large delegation from Iran. Also, Japan has always been very well represented. With the accession of the Eastern European countries, we gained valuable new discussion partners. The globalisation of medicine has long been a fact. Medicine knows no borders.'

During recent years oncology issues proved particularly popular at the congresses, he said. 'So one of the major areas this year will be prostate cancer diagnosis and therapy. The agenda is

divided into 13 sections, which cover the entire field of urology: andrological urology, female urology, male genital surgery and reconstructive urology to oncological urology, transplant urology and urological research, imaging and pathology – to name a few. The chairperson of each section is responsible for the programme, both in terms of concept and realisation. It is already a tradition that all sections meet during the first day, and the results and evaluations will then be presented and dis-

cussed during the following days.

The organisers point out that, since the EAU congress was last held in Berlin, it has become a particularly attractive venue – for it is now a thriving, modern and exciting city, with both historical and impressive contemporary buildings standing side by side. 'So,' the professor added, 'we are looking forward to being the hosts and are certain that this year's congress will be an enjoyable and enlightening experience for all.' Details: www.eauberlin2007.org



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prostatectomy. This 'soft' surgical procedure, combined with high quality care, means the Martini patients can be discharged within six days – particularly appreciated by businessmen.

Invented 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

Every day, patients are admitted to surgeries, hospitals and outpatient clinics with chronic wounds. Careful inspection gives a wound therapist clues to the appropriate primary care required even before further diagnostic procedures are carried out. So what do the clinical signs and symptoms tell us?

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 exposure to bacteria. 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 discoloration with surfaces that cause intensive, malodorous 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 systemic signs of infection: Redness, heat, swelling and pain, along with multiplying bacteria. Oedemas develop around the wound, its surroundings are sensitive to pain, there is increased

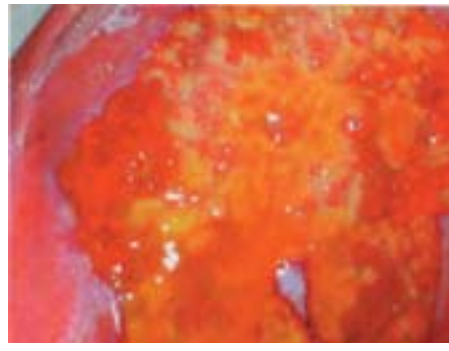
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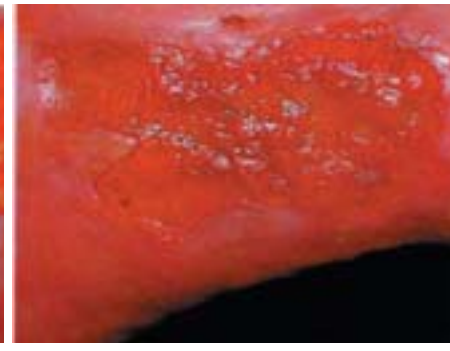
Pseudomonas aeruginosa



Staphylococcus aureus



Infected wound



Contaminated/colonised wound

NUTRITION AND HEALTH



14 million European children are overweight

According to figures released in 2006 by the International Obesity Task Force (IOTF), around 14 million children, aged 7-11 years, are overweight - and three million of these are obese. Each year 400,000 overweight first-graders enter school. Most of the overweight kids live in southern Europe, but northern Europe is catching up: the steepest increases in the number of obese children have been recorded in England and Poland.

The health consequences for these children are well known. They run a significantly higher risk of cardiovascular problems, diabetes or joint disease. Psycho-social problems further exacerbate the situation. Last, but not least, come the economic consequences. According to IOTF estimates, 2-8% of healthcare costs in western European countries are caused by overweight and obesity. A further increase is expected.

When is a child considered overweight?

Internationally, the agreed method to determine of the nutritional status of children is the Body Mass Index [BMI = weight/height² (kg/m²)]. Modern scales and measuring systems, made, for example, by seca, calculate the BMI automatically after height and weight have been determined.

In children and teenagers the BMI is age and sex specific due to changes in the amount of body fat. Consequently, these factors must be taken into account: Sex specific age percentiles were established with the 90th BMI percentile being the cut-off value. This means the BMI of 90% of all children of a certain age lies below this cut-off value. If the BMI is above this 90th percentile, that child is considered overweight; if it is above the 97th percentile the child is considered obese.

Definitions: Obesity or adipositas?

In children, weight fluctuates for many reasons, so an increase is not necessarily problematic. The word adipositas is used when body fat increases to such a degree that it affects a person's health.

The fact that increasing numbers of children are overweight cannot be reduced to a single factor. According to experts contributors to this escalating problem are: food high in fat and energy dense; changing eating habits; overall lack of physical exercise and their social background. Therefore any treatment should apply a multidisciplinary approach and aim at a sustainable lifestyle change.

What wounds tell us

By Heidi Heinhold

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 discoloured, and non-oedematous leg, can indicate an ulcer 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.

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% to 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 pointed out that does not mean they were the actual cause of death.

In addition, this apparent increase in cases might be due to greater public awareness of Clostridium difficile, and so 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 showed that the NHS is beginning to see significant reductions in MRSA infections.

C. difficile, lives up to its 'difficult' name. Alcohol hand rubbing and other measures that combat MRSA appear to have little effect on these bacteria, which produce spores that become airborne, and can survive well on surfaces for some time.

However, vigorous disinfectant cleansing of affected environments and the hands of hospital staff is effective. From the death certificates it was seen that most of them, from both types of bacteria, were of older patients.

Microfiltrex Biofil PES filter cartridges

Patient safety during endoscopy



Despite thorough cleansing, endoscopy tools can be re-contaminated because non-sterile water is used for the final rinse. Biofil PES filters, developed by Microfiltrex (info@porvairfiltration.com) can make that water bacteria-free during an automated endoscope reprocessing (AER) cycle because, the firm reports, they are composed of an asymmetric polyethersulphone membrane that enhances bacterial retention. 'They are manufactured in class 10,000 clean rooms, using FDA approved materials, and validated in accordance with the HIMA guidelines for sterile water provision,' the firm adds. The filters are available as point-of-use capsules or water treatment system cartridge filters suitable for use with most OEM systems.

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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.

Management must take tough decisions and break up ossified structures

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

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IT & TELEMEDICINE

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 *Escape/TeleMed-Escape*. It also manages *Near to Needs*, an innovative satellite communication project.

Approved and co-funded by the European Community within the

eTEN programme, the telemedicine project Health Optimum involves Italy, Spain and Denmark. Its aims are to validate existing application experiences and demonstrate the value of organisational, procedural, technological and medical-legal practices applied in neurosurgical tele-counselling and tele-laboratory - services perfectly extendible to other specialities. This is possible through the significant re-engineering of processes obtained from Escape/TeleMed-Escape projects, which developed a fully digital system of signing, transmitting,



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 specialties and other countries, namely Sweden and Romania.

The satellite platform

Romania is already a Treviso partner in the Near to Needs (telemedicine via sAtellite to bRidge iTalian and rOmaniaN hEalthcare and EDucational Services) project. Co-funded by the European Space Agency (ESA), and important private supporters such as Gruppo Veneto Banca, (Veneto Banca and one of its subsidiaries, Banca Italo Romena), 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

two different geographical areas of the continent: Treviso and Timisoara (Romania). Begun in June 2006, this project will end in June this year.

A healthcare structure is to be created in Timisoara County Hospital and directly connected to the Treviso local health authority. Using telemedicine services when necessary, the structure will provide care for Italian or Romanian employees of Veneto companies in Romania, as well as to Romanian citizens.

After analysis of the user groups and needs, the project coordination chose a telemedicine

• 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.

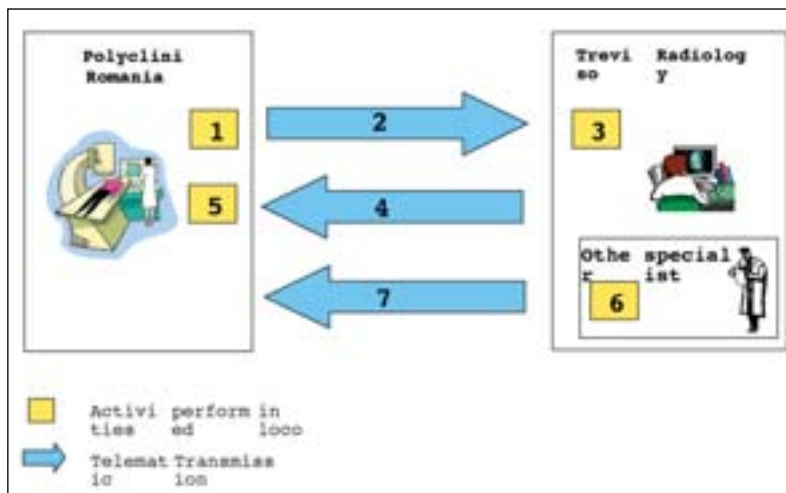
To share clinical information relative to a patient record (tests,

ITALY

The Treviso ULSS 9 experience



By **C Dario**, General Director of Treviso ULSS 9; **S Giovannetti**, IT and Project manager of ULSS 9, and **E Procaccini**, of the Near to Needs project working group



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 ECG, 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).

radiological images, reports, tele-counselling opinions,...) the creation of an electronic patient record (EPR) is envisaged. A system based on the I.H.E. Infrastructure Technical Framework XDS (Extended Data Service) will be used to realise the EPR, while the telecounselling 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.

ORBIS 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 (Master Data & Security, Ward Graphic, Medical Documentation and Order Entry & Result Reporting) were 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 (LIS) of the hospital group will be interfaced 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

Campania region.

Agfa speculates that, apart from the fact that Orbis is already used by 400,000 people daily, in 750 hospital sites throughout Europe, 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 Pernice, Managing Director of the Malzoni Group, said: 'It also enables us to easily analyse the response times and draw our attention in case of organisational bottlenecks.... enabling us to permanently fine-tune our current processes.'

Ruggero Lietti, 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. As well as monitoring those infections, the reader helps with epidemiological studies. The Near to Needs project enables us to:

- promote synergies between different healthcare structures and training systems, cultures and working environments between Italy (an EU member state) and Romania (new EU member state)
- promote the integration and sustainability of ICT in daily healthcare provision and medical/nursing training
- analyse the potential of a satellite platform in healthcare, with a view to ESA's future telemedicine programme
- provide first aid healthcare services thanks to the help of medical and technical personnel in loco
- provide specialist healthcare because qualified personnel are connected remotely
- act as a star centre for network connections with local Romanian Centres of Excellence
- produce a complete electronic patient record (EPR) that can be consulted by the patient's physician, wherever he may be
- carry out epidemiological studies to prevent and safeguard against infectious diseases by introducing new tests and methodologies, following standards recognised at a European and international level.

In conclusion: For new EU members, such as Romania, delivering even basic health care and education to remote, sparsely populated regions has long seemed an almost insurmountable challenge. Today, thanks to the advent of broadband communication links, and advances in compression and image processing technology, telemedicine and tele-education applications are becoming cost-effective solutions.

Satellite communication is an efficient support to broadcast and multi-point communications for medical education and consultation sessions and, in particular, for the Near to Needs project, where an inter-hospital link has to be provided.

The use of telemedicine services should be considered one of the most appropriate service solutions to

- give prompt, effective answers for critical or borderline medical conditions
- provide safe diagnosis supported by specialists in centres of excellence
- overcome geographic limits caused by distance, providing qualified healthcare in a uniform manner and optimising time and patient transfer reduce costs, particularly those related to inappropriate admissions that could be avoided by specialist teleconsultations or to the expected reduction of transfers of borderline patients.

In this context satellite communications could play a crucial role in providing telemedicine services. The satellite connection is actually more versatile, reliable, seamless, fast, expandable and flexible than the terrestrial channel, granting a more efficient workflow in delivering healthcare through telemedicine.

As already proved with the Near to Needs project, and with its past successful experiences, the Treviso healthcare unit always stands at the sharp end of technological innovation.

IT EVENTS

Med-e-Tel – the International Educational and Networking Forum for eHealth, Telemedicine and Health ICT - expects to host IT industry specialists, government representatives, healthcare providers, payers/insurers

Med-e-Tel 2007

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 reports that participants



Conference

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

The ETSI (European Telecommunications Standards Institute) Specialist Task Force on Telecare will host a workshop focused on 'User Experience Guidelines for Telecare Services'.

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 *InHam living labs* (in-house adapted movement) will be highlighted. These have been designed to help demonstrate, test and design specific 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, co-ordinated by the Luxembourg CRP-Santé, 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 asso-



The Luxembourg venue

ciation with Rays of Hope Foundation and HealthSpan International, will also set up a 'funding' roundtable discussion, drawing together those with specific healthcare needs (especially in developing and emerging regions) and sustainable solutions providers (using ICT tools) as well as representatives from finance groups.

The organisers emphasise that Med-e-Tel offers the chance to see and evaluate actual products, technologies and services, as well as great networking opportunities.

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eHealth week Berlin 2007

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Following the success of three previous events the International Forum for Healthcare IT (IteG) expects over 250 specialist exhibitors at its 2007 event.

Aimed at IT managers, healthcare decision-makers, doctors and those responsible for IT in nursing, participation in the ITeG specialist programme is free of charge.

ITeG 2007 is also central in several healthcare IT and telematics events taking place within *eHealth week Berlin*, which aims to promote eHealth discussions and exchange of views to present medium-term solution options for cross-border, interoperable processes and Europe-wide electronic services.

'We are convinced that the bundling of high quality eHealth events at the ITeG provides added value for our specialist visitors, said Dr Wolrad Rube, Chair of VHitG, adding: 'This year we can create a European platform from our national platform.'

Parallel events to IteG:

- Within the EU Presidency of the Council framework, the EU Commission and Federal Ministry for Health (BMG) organised the *eHealth Conference 2007* (www.ehealth2007.de); which will present EU member states eHealth activities, and target those responsible for telematics in governments, health insurance, service provision and user organisation at home and abroad. The eHealth Conference is on the level of European Under-Secretaries of State.

- *Telemed* (www.telemed.de) is directed at scientists in health telematics and telemedicine. Main topics: electronic patient records (EPR), health portals, etc.

- *The KIS Conference of the GMDS organisers* will be involved in workshops.

- *The European Connectathon of the IHE* (Integrating the Healthcare Enterprise) will run in tandem with these events. IHE is an international initiative, in which users and industry work on the interoperability of IT in medicine. At Connectathon almost 140 IT systems from some 300 developers will be tested for compatibility.

The VHitG

The VHitG – the registered association of healthcare IT solutions manufacturers – represents manufacturers whose products are used in over 90% of German hospitals and around 20% of doctors practices and pharmacies. The products include clinical and administrative IT, communications and archive solutions, systems for pharmacists and materials management, laboratories, radiology and other specialist centres, and solutions for a sector-wide communication system.

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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. Next, there were delivery delays due to a lack of co-ordination between the systems integrators in England, which obviously didn't please our customers. And finally, we were a bit overly 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 quite 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. Case in point: Germany. Our lab solutions have been very popular for some time; we are the undisputed market leader. Compared with iSOFT 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. This means that, in the future, 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 chances to prevail within the group internationally.

We also moved competencies from

–everything! We couldn't identify a single fault. What might have been our weak point was the lack of consistent implementation of the entire product strategy – to bring to market exactly what was on paper. We will do that now, but obviously we lost a lot of time and gave our competitors a chance to gain ground.

But in England you have another ace in the hole: iSOFT's Lorenzo is part of the world's biggest IT project – the National Health Service's National Programme for IT (Npfit). Right! Lorenzo's roots are in England and the NHS project was a major driver for us – not surprisingly, since this project will radically change the structures of the healthcare system. Projects such

Will other European countries do the same as the Britain?

Other countries are about to get started, but England is the avant-garde. One reason is that the English healthcare system was not as decentralised as, for example, Germany's. This means the Ministry of Health has more power to implement things, to drive ideas and developments. But, we have to admit that healthcare IT in European countries does not yet rate as high as in Britain. However, if the English model is successfully implemented, I imagine other European countries will follow.

Could other languages cause a problem for Lorenzo?

Not really. Lorenzo was designed for the international healthcare market.

iSOFT Alive and kickin'

New strategy New self-confidence



Once upon a time iSOFT was the software 'wunderkind', with sales hitting the billion-euro mark. Then disaster struck. Money and reputation vanished. But that was once upon a time... today iSOFT is back – with fresh strategies aimed at a happy ending. Daniela Zimmermann, of European Hospital, met with Peter Herrmann (above), Managing Director of iSOFT Deutschland, to discuss old mistakes and new plans

The core product – areas that are identical worldwide – is handled by an international 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 effort to develop 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 system, which means we have a fixed core around which we build the different modules. For Germany, for example, we can provide a DRG-based reimbursement model without having to redesign the entire system.

So, we believe the Lorenzo SolutionCentre has enormous potential. 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 iSOFT more strongly in markets in which, in the past, our distribution partners took care of our products. In those European countries where iSOFT is already well positioned, we see a lot of potential for growth over the next few years – particularly for Lorenzo – as far as follow-up products are concerned. All in all, we have ambitious plans and are optimistic that we will realise them successfully.

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 Indian organisation 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, whilst colleagues in India continue to focus on Lorenzo.

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

As a matter of fact, Agfa or Siemens tried to counter our Lorenzo SolutionCentre with their solutions. The idea and design for Lorenzo (an intersectoral 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 really been 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 England; and also we recorded quite impressive sales shortly after its launch in Germany. We count leading healthcare facilities among our customers and partners. But yes, we could not yet establish Lorenzo as a major contender. Therefore, when restructuring, we scrutinised everything – the philosophy, concept, design

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 with one 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.

MPOWER Aiming for empowerment to age happily at home



The MPOWER project aims to help older people to live independently and well, in their own homes, for as long as possible.

'This objective influences both organisational, reimbursement and technical issues. In this respect the project aims at the easiest part – the provision of technology that enables the other changes,' the organisers explain. 'The project surveys organisational and reimbursement issues – issues that need to be approached by every national and regional authority in near future.' Dr Elly de Heus (above), of the European Association of Homes and Services for the Aging (EAHSA) reports:

"In the MPOWER trials all professionals supporting older people, as well as non-professionals e.g. relatives, friends and neighbours, will be included in an integrated approach in which information is collected and shared on a need-to-know basis. The Proof-of-Concept applications will be tested in the project in Trondheim, Norway and Krakow, Poland. The project focuses on creating

confidence for the older people as well as their relatives. Technology is utilised to support older people and help provide enhanced healthcare services. It includes:

- an individual (medical) plan for patients, which contains relevant information from all stakeholders, including medical information that can be shared between the different treatment and care providers
- communication technology including video-conference, chat and telephone, through TV, mobile phone and apartment communication system
- smart house technology, which helps the target groups to support themselves in daily life and will make it possible to grow older at home, rather than move to a care facility
- biosensors and patient question-

Mpower partners
SINTEF ICT, SP Andersenv 15b, Trondheim, N-7465, Norway (project leader); Norwegian Centre for Dementia Research (NCDR); University of Krakow, Poland; University of Cyprus, Greece; DI, Spain; TBSOL, Spain; Ecomit, Spain; ARC Seibersdorf Research GmbH, Austria; Ericsson, Croatia; EAHSA, Brussels; IAHSa, Washington

naires that provide the capability to continuously monitor the patient

● interoperable information communication between professional care providers that will relieve doctors in hospitals from routine procedures that could easily be done without seeing the patient in person.

MPOWER will deliver an open platform supporting rapid development and deployment of distributed integrated services for the target groups. For this platform – which features distributed and shared care – usability, security and interoperability is of central importance. Biosensors and smart house technologies are integrated; and structured mechanisms are provided for adapting to changes in user context in a distributed, mobile environment supporting various user contexts.

The project will promote the international use of the MPOWER framework through the European Association of Homes and Services for the Aging (EAHSA) in Brussels, in association with the International Association of Homes and Services for the Aging (IAHSA) in Washington DC, USA.

Details: Dr de Heus.
Phone: 00 31 55 576 62 44



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www.hret.org/hret/publications/ihwm.html

26-28 Paris, France
The World Health Care Congress - Europe 2007 www.worldcongress.com

27-30 Cairo, Egypt
Egyptian E-medicine International Conference
www.onlinediabetes.net/emedicine



EVENTS

Nations HealthCareer School of Management MBA International Hospital and Healthcare Management

Start date: 4 May 2007
Deadline for applications: 9 March 2007
www.nations-healthcareer.com

APRIL

11-13 Vienna, Austria
15th International Conference on Health Promoting Hospitals (HPP)
www.univie.ac.at/hpp/vienna2007

13-14 Lisbon, Portugal
Annual European Forum of Medical Associations (EFMA)
The Portuguese Medical Association will host representatives of the leading medical societies.
www.euro.who.int/healthcaredelivery/EFMA/efma

13-14 April Bratislava, Slovak Republic
International Medical Tourism Conference (See feature below)

19-22 Prague, Czech Republic
IHOF Technology www.ihofforum.com

22-24 Beijing, China
China Med 07
19th International Medical Instruments and Equipment Exhibition. www.chinamed.net.cn
E-mail: chinamed@mdc.com.cn

23-24 London, United Kingdom
Reporting Adverse Events
www.smi-online.co.uk

25-28 Santo Domingo, Dominican Republic
Annual Investment & Healthcare Conference Organiser: American Hospital Management Company
www.americanhospitalmanagement.com/

29-2 May, Prague, Czech Republic
ICNC 8 International scientific nuclear cardiology meeting, with additional focus on PET and cardiac CT imaging.

MAY

1-3 Sydney, Australia
CeBIT Australia 2007
Organised by Hanover Fairs Australia.
www.cebit.com.au

15-18 Singapore
HIMSS AsiaPac07 Conference & Exhibition focusing on healthcare IT challenges in the Asia Pacific region, and sponsored by Cerber, Microsoft, Siemens and the Dictaphone-a Division of Nuance Corp. Email for details: himssasiapac@pwevent.com

21-23 Singapore
World Health Care Congress Asia
<https://www.worldcongress.com>

JUNE

9-12 Hamburg, Germany
Heart Failure 2007
Hfsecretariat@escardio.org

18-19 London, United Kingdom
Pharmaceutical Portfolio & Product Life Cycle Managementsmi-online.co.uk

20-22 London, United Kingdom
NHS Confederation Annual Conference & Exhibition
www.nhsconfed.org

24-27 Lisbon, Portugal
Europace 2007 The European Heart Rhythm Association (EHRA), a registered branch of the European Society of Cardiology. Focus: arrhythmias and cardiac pacing in Europe. europace@escardio.org

27-30 Berlin, Germany
CARS 2007 Computer Assisted Radiology and Surgery. www.cars-int.org

27-1 July Glasgow, Scotland
World Congress on Design and Health Organiser: International Academy for Design and Health.
www.designandhealth.com E-mail: academy@designandhealth.com

JULY

2-5 York, United Kingdom
Society of Occupational Medicine Annual Scientific Meeting
www.som-asm.org.uk

SEPTEMBER

26-29 Paris, France
Sepsis 2007 Venue: The Pasteur Institute.
www.sepsisforum.org

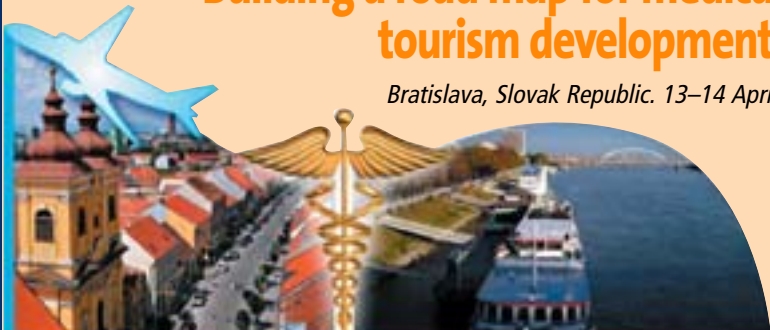
OCTOBER

6-11 Philadelphia, USA
AHIMA 2007
Convention of the American Health Information Management Association. E-mail: info@ahima.org

23-26 Vienna, Austria
2007 World of Health IT conference & exhibition sponsored by HIMSS
Contact: klaidler@himss.org

International Medical Tourism Conference 'Building a road map for medical tourism development'

Bratislava, Slovak Republic. 13-14 April



Sanigest Europe s.r.o., an international healthcare and management consulting company, has organised a two-day international conference to discuss the rapidly growing development of Medical Tourism. 'By 2010 medical tourism is expected to be a \$40-billion business, with over 780 million patients seeking care outside of their principal country of residence,' the conference organiser points out. 'The rapid growth of this industry, and the central role that Eastern Europe is playing in the development of a medical tourism market in the European Union, provides a unique opportunity to bring together governments from around the EU, leading insurance companies, providers participating in the medical tourism market, and patient associations to discuss the current and future expansion of the medical tourism industry. Likewise, the tourism industry in general will also be heavily impacted, bringing more business to hotels, travel agencies, and low cost airlines.'

Sanigest continues: In India alone, medical tourism is expected to generate \$2.2 billion in revenues for providers by the beginning of the next decade. Last year, an estimated 150,000 foreigners visited India for medical procedures, and the number is increasing at the rate of about 15% annually, according to Zakariah Ahmed, a healthcare specialist at the Confederation of Indian Industries. Costa Rica, Argentina, Cuba, Jamaica, South Africa, Jordan, Malaysia, Hungary, Latvia, and Estonia all have entered into this profitable market, and more countries join the list every year.'

'According to Christopher Jones, a faculty research associate at Johns Hopkins University School of Public Health in Baltimore, the growing number of self-

insured patients who decide to travel abroad for treatment are fuelling this trend. "With low-cost air travel, many middle-class people are accepting the promise of a vacation combined with their medical procedures, together, at a fraction of the cost they might otherwise pay." At the same time, patient mobility in the EU implies that people are increasingly able to travel among EU countries for care, with their insurance company in their home country covering the costs. As waiting lists grow in the UK and other Western European countries, patients are increasingly seeking a solution to their problems abroad.

'But by overall the biggest draw to potential customers are the savings, which in some cases could be more than €70,000 after travel arrangements. Surgery prices are much cheaper in foreign countries because of lower costs for manpower, real estate and administrative concerns like insurance, said Vishal Bali, CEO of Wockhardt Hospitals, a Mumbai, India-based company with 10 hospitals in the country. The cost of surgery in India, Thailand, or South Africa can be one-tenth of what it is in the United States or Western Europe, and sometimes even less.

'Some sceptics fear that the quality of care in these developing countries is inferior to what is offered in the United States; however, the hospitals and clinics that cater to the tourist market often are among the best in the world, and many are staffed by physicians trained at major medical centres in the United States and Europe.'

Conference and sponsorship details: <http://www.sanigest.com/MedTourism/index.html>

E-contact: pszilagyoiva@sanigest.com.

According to an as yet undefined ruling of the European Court of Justice, EU patients whose names have been on long waiting lists for surgery 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 their homes. However, acute pain over a long period does change minds, 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 another attraction. Hospitals in the less financially well off EU and other countries can offer surgical procedures in

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 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 services, etc.

In a survey by United Group Programs, an established Florida-based insurer, to examine the benefits of overseas treatments in India and Thailand, the firm found that a heart bypass would cost US\$16,000 in

Huge cost-savings for private insurers

BUT FOR SOME 'HOME IS BEST'

By **Brenda Marsh**, Editor-in-Chief, European Hospital

state-of-the-art units for perhaps 50% less than in many Western countries. So, even adding in travel costs for patients, the savings on major surgery can be immense.

Currently, for the British health tourist, Belgium is said to have leapt ahead of France and Germany as the most popular choice; with the highest number of doctors and hospitals, Belgian costs for private surgical treatment range between 20-50% less than those in the UK (Gastric bypass - UK £11,800, Belgium £5,000; total knee or hip replacement - UK £10,300 and £9,000, Belgium £6,500 and £5,600 respectively). Other, newer EU member states, e.g. Malta, Estonia and Latvia, are also offering surgery to foreign 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 to private insurers.

Medical tourism and the health insurer

Since 2000, US health insurance premiums for employers rose 73%, and average employees' contributions rose 143%. In 2004, the average US patient's hospital bill (US\$6,280) was twice that of other Western countries.

Thus a few private health insurers in the USA have already recognised the economic value of what's on offer in Eastern countries and are carving a niche in this market. One, IndUShealth in Raleigh, North Carolina, specialises in sending certain medical cases for treatment in India, and some to Thailand and Indonesia.

In India IndUShealth works with the Wockhardt Hospitals Group, owned by a large Indian pharmaceuticals and biotechnology firm. With modern facilities in Bangalore, Mumbai, Hyderabad, Nagpur and Calcutta, this group has created a division specifically for international patients, which includes chauffeured airport pickup, or by life support ambulance, with interpreters to hand. These modern hospitals carry out complex surgical procedures and many of the doctors have either received their medical training in Western countries or have worked in them.

Wockhardt Hospitals states that its services compare 'more than 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 numbers of patients receiving insured treatments in the Far East are as yet only in the hundreds, but the market is revving up at a remarkable rate.

Other US firms are cautiously examining the feasibility of overseas care for patients, specifically with hospitals that have Joint Commission International accreditation or accreditation from The International Standards Organization in Geneva.

Suggested hazards in medical tourism:

- Surgery followed by lengthy air travel
- Limited malpractice laws to protect patients
- Frequently, no prior referrals needed from patients' own doctors.

So far, most people (around 65%) who independently seek surgery beyond their own boundaries want dentistry or cosmetic surgery, often due to far lower costs elsewhere. Referrals are obviously vital for cosmetic surgery because would-be patients might suffer underlying psychological problems for which treatment is the better course.

The patients? For some, home is best

In the USA, Mexican workers have been cross-border patients for decades (insured largely via their agricultural associations, though nowadays by more cross-border insurance plans).

Although given a choice of plans by insurers, which include care in the USA, most choose the Mexico-based care plans, and currently around 150,000 Mexicans and their families are covered for healthcare in Mexico. Premiums for plans sold by Blue Shield of California, Health Net of California and the Mexican firm SIMNSA, can be 50% cheaper than traditional US insurance for workers and their employers.

The insurers are said to check that the physicians used are licensed in Mexico and meet any specialty board requirements. In medical emergencies those insured can be treated either side of the US-Mexico border.

Since the majority of the Mexican workers show they prefer to see Mexican doctors in their native land, the same could be assumed for the majority of other nationals.

The future of medical tourism clearly depends on many factors.