

Yesterday's Anaesthesia

Ernest Kern, Jean Lassner, Guy Vourc'h

Three men who joined Général de Gaulle

Preface by Professor Jean-Marie Desmonts

The Social History of Medicine

Glyphe & Biotem éditions

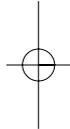
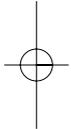
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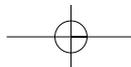


The Social History of Medicine

The Social History of Medicine is a collection dedicated to the study of medicine from a historical and sociological point of view.



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LE PRÉSIDENT DE LA RÉPUBLIQUE

Paris, le 27 mai 2003

Monsieur le Professeur,

Informé de l'hommage que votre famille et vos amis ont souhaité vous rendre à l'occasion de votre quatre-vingt dixième anniversaire, j'ai tenu à m'y associer. J'adresse à mon tour au grand médecin que vous êtes mes vœux les plus chaleureux et toute mon admiration.

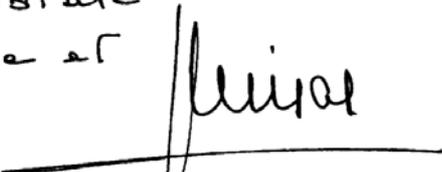
Le maître incontesté dans le champ de l'anesthésie-réanimation, que tous reconnaissent en vous, mérite l'affection profonde et le respect immense dont vos anciens élèves et vos confrères vous ont apporté le témoignage.

Je veux vous assurer également de la reconnaissance des patients, et en particulier de ceux qui ont bénéficié directement de votre attention. Le dévouement dont vous avez toujours fait preuve démontre une fois encore qu'il n'est de grand médecin qui ne soit un grand humaniste.

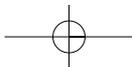
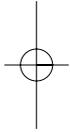
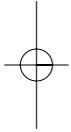
C'est avec raison que la France a reconnu et distingué cette soif de l'engagement qui ne vous a jamais quitté depuis votre plus jeune âge. C'est en son nom que je vous renouvelle mes remerciements.

Je vous prie de croire, Monsieur le Professeur, à l'assurance de mes sentiments les meilleurs.

*Avec ma bien cordiale
fratitudo, mon estime et
mes amitiés,*


Jacques CHIRAC

Professeur Jean LASSNER
Professeur Honoraire de la Faculté
De Cochin - Port-Royal



The President of the Republic

Paris, May 27th, 2003

Dear Professor,

When I heard of the tribute your family and friends wished to pay your ninetieth birthday, I wanted to participate.

Thus I extend to you, great physician that you are, my warmest wishes and assure you of my admiration.

You are recognised by all as the undisputed master in the field of anaesthesia and intensive care. You truly deserve the deep affection and immense respect of both your former students and your colleagues.

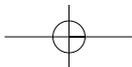
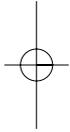
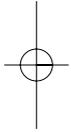
I also wish to assure you of the gratitude of your patients particularly those you have cared for personally. The devotion you have always demonstrated to your patients proves once more that a great physician must also a great humanist.

France has been right to recognise and honour the readiness you have shown, since your youth, to commit yourself. It is in the name of France that I renew my thanks to you.

With my warmest gratitude, esteem, and friendship,
Sincerely yours

Jacques Chirac

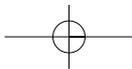
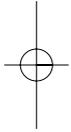
Dr. Jean Lassner
Honorary Professor of the Faculté de Cochin-Port-Royal



***T**he French version of this book was published on the occasion of the 90th anniversary of my father and to commemorate his friends Ernest Kern and Guy Vourc'h.*

This English edition was made possible through the kindness and hard work of the authors whom I would especially like to thank. I would also like to express my regret to the authors whose texts were not able to be translated in time and which hence do not appear in this edition.

Claudine Lassner



The first scientific society devoted to anaesthesia was created by surgeons in 1934. It included only four anaesthesiologists (anaesthetists) out of one hundred members.

During and after World War II, Ernest Kern, Jean Lassner and Guy Vourc'h prepared themselves for the practise of this new discipline.

Kern had joined the Free French forces in Great Britain and had taken advantage of that experience by training and qualifying in the English method of anaesthesia. Upon his return to France, he worked with Merle d'Aubigné at the Hôpital Foch, which had been requisitioned by the military.

Jean Lassner joined the Free French in Saint-Pierre et Miquelon and took advantage of his proximity to Canada to make contact with Canadian anaesthesiologist, from whom he received training. When he returned, while working in the burn unit at the Hôpital Foch, he got to know Ernest Kern.

Guy Vourc'h had been a model soldier with the Free French forces. While still a medical student, he served as part of the 4th Battalion of navy gunners in the Normandy landings. After the war, he finished his studies, left for England on a scholarship to be trained in British methods of anaesthesia, and obtained a Fellowship in the Faculty of Anaesthetists of the Royal College of Surgeons. When he returned, after Kern and Lassner had gone to work at the Hôpital Cochin, he remained as an anaesthesiologist at the Hôpital Foch, which had by then reverted to civilian use.

After 1947, Kern and Lassner organized a hands-on training programme first at the Hôpital Foch and then at the Hôpital

yesterday's anaesthesia

Cochin. These sessions were always quite lively; it was not without a certain degree of trepidation that the youngest members made their first presentation. When it was well received, the author might be invited to publish his text in the *Cahiers d'Anesthésiologie*, the journal founded in 1953 by them – Kern and Lassner – together with Jean Valletta. Its founding was occasioned by a disagreement with the editorial board of the *Revue de la Société Française d'Anesthésie et d'Analgésie*, which at that time was edited by Pierre Huguenard.

The rather deep-seated theoretical differences between the schools of French anaesthesia – on the one hand, those favouring British practises, and, on the other, those favouring the theories set out by Henri Laborit and promulgated by P. Huguenard – eventually led to the dissolution of the *Société française d'anesthésie, d'analgésie et de réanimation* in 1960 which led to the creation of a second society, *L'Association des anesthésiologistes français*.

This quintessentially French event did not fail to arouse ironic comments from our British colleagues. As the years passed and new generations came on the scene, it became clear that this schism was destructive to the development of our discipline.

To this end, Jean Lassner, then president of the *Société française d'anesthésie*, set up a joint commission called the *Union française des anesthésistes réanimateurs* (UFAR). Via this organization we were able in 1981 to use our mediating abilities – C. Rouet, C. Winckler, P. Maestracci, G. François and myself – to reorganize the Societies under the single rubric of the *Société Française d'Anesthésie et de Réanimation*. This new joint organization permitted France to develop scientific societies comparable to those of all other industrialized countries.

Above and beyond this reunifying gesture, Jean Lassner, who was then president of the *Syndicat des anesthésiologistes des Hôpitaux de Paris* and a member of the medical commission of public welfare, prevailed upon Madame Simone Veil, then Minister of Health, to create a national commission on anaesthesiology. This commission, chaired by Lassner's friend Guy



préface

Vourc'h, facilitated the first national investigation into anaesthesia-related deaths.

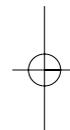
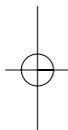
Lassner, a promoter of the use of epidural anaesthesia in obstetrics, organized the first in a series of meetings of the Société d'anesthésie at the Hôpital Cochin. Earlier in his career, he was among the first to be concerned by the role of the *numerus clausus* and the qualifying internship in the diminution of the ranks of anaesthesiologist.

It is hardly necessary to emphasize the enormous contributions that these three men have made to our discipline. This celebratory occasion provides an opportunity to once again express my gratitude to those of you to whom we are paying tribute today.

Jean-Marie Desmonts

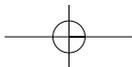
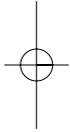
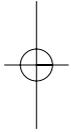
**Professor, Head of the Department of Anesthesiology
and Surgical Intensive Care Unit**

CHU Bichat Claude-Bernard



***Doyen* of the Faculty of Medicine Xavier-Bichat.
President of the SFAR, 1988 - 1989.
Member of the European Academia of Anesthesiologia
Fellow of the Royal College of Anaesthetists**







Yesterday's Anaesthesia

Ernest Kern, Jean Lassner, Guy Vourc'h
De Gaulle's Free French

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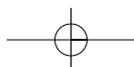
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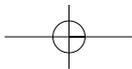
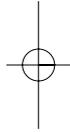
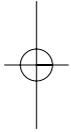
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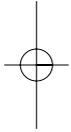
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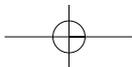
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Appreciations





Ernest Kern

Ernest Kern, a Portrait

Annie Anargyros – Klinger – Kern

Psychanalyst – Paris

Ernest Kern was born in 1908 in Czernowitz, capital of Bucowina, to the east of Polish Galicia. Under the Emperor Francis Joseph, Czernowitz had become the eastern bastion of the Austro-Hungarian empire and German civilisation. It was a cosmopolitan city whose inhabitants – Ukrainians, Romanians, Poles and Jews living peacefully under Austrian rule – spoke Russian, Polish, Romanian, German and Yiddish. This background forged the personality of Ernest Kern.

In some respects Czernowitz resembled Vienna, the distant, prestigious capital. It was an important cultural centre with a German-speaking university, a theatre, libraries, and the birthplace of many writers and poets, the most famous of whom was Paul Celan. Over half its inhabitants were Jews. They lived in freedom and security, enjoyed the same rights as other citizens, a rare situation in Central

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Europe. Convinced that they owed this privilege to the Emperor, the Jews of Czernowitz were staunchly loyal, a state of mind referred to as K and K – Königlich und Kaiserlich, meaning Royal and Imperial – a combination of honesty, strong morals, loyalty, culture and tolerance.

At eighteen, after passing his final school examination, Ernest Kern decided to study medicine. Czernowitz had no medical school and so he, Fanny Ungar and a few other like-minded friends decided to leave for France which recognized the Romanian baccalauréat. In 1933, he passed his final medical examination and married Fanny who had also become a qualified doctor. The couple settled down as general practitioners in Bussières, a small village between Lyon and Saint-Étienne. Working as a doctor in the rural conditions of the day was not easy but they accepted the challenge with enthusiasm and gained the trust of the local population.

After five years of a comfortable existence, Ernest Kern began to feel dissatisfied. His was an unimaginative, unadventurous and very predictable life. As he wrote in his memoirs (*Mes quatre vies*, Paris, Arnette, 1971), he wanted to



Ernest Kern in the operating theatre

appreciations

keep abreast of new medical discoveries and dreamed of other ways of practising medicine..

Then came the tragic events of 1938 – the persecution of Jews in Central Europe and Hitler's annexation of Austria. He and his wife had parents living in Czernowitz which soon toppled to a Romanian regime close to the Hitlerian nightmare. And he had relatives in Vienna too: Robert Beiner, his mother's brother, a lawyer like his grand-father, and Bina and Emmanuel Klinger, his mother's sister and her husband, who were my parents. My uncle Robert managed to escape to Bolivia and returned to Vienna after the war, but it was too late for my parents, Bina and Emmanuel Klinger. Visas were no longer being issued to Jews wanting to leave Austria.

Realizing the danger we were in, Ernest Kern offered to help get me out of the country, at least until he was able to find a solution for my parents. He obtained a German tourist visa for me to visit Switzerland and collected me at Vorarlberg where my parents took me on December 30, 1938. I never saw them again.

I went to live with Ernest Kern and his wife in Bussières and that is how they became my adoptive parents. I am convinced that my cousin saved my life twice over. He saved me from the concentration camp where my parents died in 1943, and he protected me from the trauma that has resulted in depression and a variety of psychic disorders, some extremely severe, for many child survivors of the war whose parents died in deportation. Ernest Kern welcomed me with such kindness, love, and generosity, enveloped me in a climate of such security that retrospectively those years seem relatively carefree. His confidence in life sustains me to this day.

In September 1939, at the outbreak of war, his life took an unforeseen turn. As a doctor he was called up, although not to serve in a fighting unit as he had hoped. In February 1941, he and his wife were forbidden to practise medicine on the grounds that they were Jewish doctors of foreign extraction.

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At the end of 1942, to escape arrest for their Resistance activities, they both left for London and joined the Free French Forces. I was sent into hiding and safety at the Cévenol college of Chambon-sur-Lignon. We were separated until their return in 1945.

Ernest Kern's first contact with modern anaesthesia was in the summer of 1943 when he had the opportunity to watch an operation in London. The anaesthetist worked with equipment he had never seen before. Replacement respiration could be provided when spontaneous breathing was insufficient or inexistent, narcosis could be increased or reduced, and the patient could be brought back to consciousness at the right time. He was fascinated. He studied the principles, the drugs and their handling and managed to get himself posted to a military hospital where he could get practical experience. At the end of May 1944, just before the Allied landings in Normandy, he qualified for the Royal College of Surgeons Anaesthesia diploma.

After the Armistice, his unit was sent to the Black Forest. There he met a colonel, Dr Merle d'Aubigny, who had heard about his special knowledge of anaesthesia and offered him a position in the hospital department he was organizing in Paris. Wearied by the limitations of being a country doctor and longing to apply his newly acquired knowledge of anaesthesia, here was the answer. Ernest Kern's research, his work with patients and his professional ethics all show that he was a man of outstanding intellectual honesty and strict discipline, although his strict ethical code earned him the scornful hostility of certain colleagues with less exacting moral standards. At the top of his scale of values were intellectual curiosity, knowledge, the discovery of new fields of learning and the wish to further scientific progress.

At times his great self-confidence led him into risky undertakings that verged on sheer rashness. Had he not braved very real danger in coming to my rescue at the

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Austrian frontier in December 1938. And again, was it not pure madness in May 1945 to think of going to fetch his mother in Czernowitz from behind the Iron Curtain in the Ukraine. His father was dead, he knew, but his mother had survived the massacre and the deportation of Jews under Romanian and German occupation ; she was alive, poverty-stricken and morally deprived. He decided to bring her back to France at the risk of his life.

The surgical group to which he belonged had been chosen as medical corps for the French sector of occupied Vienna where the Allied forces of occupation were based. With Vienna as his departure point the journey became possible. He obtained a mission order as far as Budapest and set off with his driver in an ambulance. Beyond Budapest, roads were unfit for motor vehicles. More than once he was on the point of abandoning the expedition due to repair difficulties and petrol shortages, but the Russian frontier drew nearer. He crossed the border at nightfall. The soldier on guard believed his story that he was there to repatriate French prisoners and signed the mission order without even looking at it. In Czernowitz, he found his mother and set off on the equally perilous journey back to France. That was how we reunited in Paris after the war.

Ernest Kern began his career as an anaesthetist, his wife Fanny became a Medical Health Inspector and I began my medical studies all at the same time. Those first years were difficult. Hospitals and private clinics knew nothing about closed circuit anaesthesia and were wary of the technique. Practising anaesthesia was something of an athletic performance too. This is what E. Kern wrote in his memoirs: "I did not own a car so I travelled by metro, carrying a heavy anaesthesia appliance in my right hand, a briefcase full of instruments and drugs in my left hand, and a knapsack loaded with bottles of oxygen, nitrogen protoxide and cyclopropane on my back". I have vivid memories of those days of pioneering.

yesterday's anaesthesia

I lived with them in the romantic villa they had rented in Saint-Cloud until 1949; it had a large garden and was totally charming, the perfect setting to start life anew. After the despair and anxiety of separation, people vibrated with the desire to lead intensely active and rewarding lives, a feeling that was as violent as their previous feelings of total disarray and fear. It was also necessary to forget, to make a clean sweep of the unbearable past.

My memory of the welcoming atmosphere in our Saint-Cloud home is very vivid. Ernest Kern's mother, his sister and his brother-in-law came to stay, and a cousin from Vienna spent a year with us. Hardly a day passed without there being some dinner to celebrate meeting up with old wartime comrades who then became friends. At weekends, long-standing friends mingled with other more recent friends; improvised meals were served in the garden, or someone set about organizing a game of bridge. There was that atmosphere of joyous nonchalant hospitality typical of old Russian country houses which Chekhov has described so well...

In his professional life Ernest Kern was a fighter and he attacked his leisure time activities in the same spirit. He was fond of sport and high mountains, skied in all weathers, at great speed and on any kind of slope. He often took me with him, willing me to overcome fright, which sometimes happened to be justified when I followed him down some dangerously steep icy slope. And on our summer mountain expeditions, I would never have mustered the courage to scale a sheer rock face on ropes had my faith in him not been so great. All the same I have never repeated those feats! He was demanding, firm and yet treated me with affection. Thanks to him, I know what it is to feel the unsuspected strength that comes of mastering fatigue and the fear of danger ...

As I have said, Ernest Kern's background taught him tolerance. His kindness and open-minded attitude won him

appreciations



Cochin 1950

Professor Merle d'Aubigné Department. Seated in the first row. From the left: Pr Kern, Postel, Foureux, Cauchoix, Merle d'Aubigné, Benassy, Meary, Lassner, Lelièvre. Second row, standing, third from the left, Dr Zimmer.

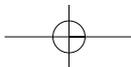
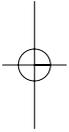
many warm and friendly relationships with colleagues, wartime comrades and his students. Yet in his position as department head he remained authoritative. He was adventurous and willing to take risks, which accounts for his tendency to experiment, innovate and imagine new methods. Material comfort and the money to procure such comfort were the least of his concerns and since wealth was not a priority, he gave money generously.

This portrait of Ernest Kern may seem partial and incomplete, as it probably is. It is the description of a person I have perhaps idealized, coloured by affection, admiration and gratitude. The few negative traits of character which would have shown him in a contradictory, more complex and truer light have faded into the past. Still, I am certain of one thing, which is that today his family, friends and colleagues



yesterday's anaesthesia

remember him as an exceptionally human, open-minded,
kind and generous person.



appreciations



The watchfull presence of the Master



Jean Lassner

Reminiscences

Jean Lassner

Honorary Professor of the Faculty of Medicine
of Cochin – Port-Royal (Paris)

Former Head of Anaesthesia-Intensive Care Department

Founder and Editor of Cahiers d'Anesthésiologie from 1953 to 1970

Honorary Expert to the Higher Court of Appeal

Former President of the International Society
for Clinical and Experimental Hypnosis

President of the French Society of Anaesthesia,
Analgesia and Intensive Care from 1976 to 1978

Founder and First President
of the European Academy of Anaesthesiology

While the practise of anaesthesia began in the middle of the nineteenth century, the actual science of anaesthesia dates back much further. It can be traced back as far as the renaissance of medical knowledge that took place in Salerno during the Middle Ages. This town, founded by the Greeks

yesterday's anaesthesia

and taken over by the Romans and thus falling under the dominion of different rulers, experienced a rare situation: following conquest by the Normans in the Middle Ages, the town enjoyed a high degree of intellectual freedom. Though today an extremely poor province of Italy, Campania was extremely affluent during the Middle Ages. Exchanges with nearby Sicily, which was then under Arab dominion and influence, favoured contact between Muslims and Christians.

During the eighth century, at the time of Pepin the Short, King of France, the medical faculty created in Salerno experienced an extensive influx of Greek science thanks to the arrival of Constantine the African, who brought a large collection of ancient texts from his native Carthage. Constantine translated these texts into Latin.

The teachings on surgery given in Salerno were known throughout Europe thanks to the transcription by Guido d'Arezzo of the lessons of his master, Rogerius Frugardi (Roger of Salerno), which were published in 1170. Documents from this era describe the different compositions of an anaesthetic preparation applied either through a tissue or sponge either placed on the face, generally over the nose, or instilled through the nose. This procedure came to be known as the soporific sponge technique.

As regards surgical practise, an event of cardinal importance was the attribution of legal status to the medical corps by the Emperor Frederick II in 1224; this status was strictly non-ecclesiastic. Furthermore, this status made medical and surgical studies obligatory, with validation by final examinations. Once they had obtained their diploma, students were required to spend a year in practise.

The Arabs were aware of the works of the Ancient Greeks and procured libraries of Greek works, many of which were subsequently brought to Andalusia. At the time of the reconquest, these works were translated into Latin. Chief among the scholars was Gerard of Cremona, a native of Lombardy who arrived in Salerno in 1170. Through his

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knowledge of Arabic, he was able to furnish the western world with Latin translations of some seventy works, including those of the most prominent Arab doctors. The original Greek writings were translated into Arabic and thus found their way into the Christian world via a double translation.

Knowledge of these works arrived not only in Salerno, but subsequently in Montpellier, from where they spread throughout the rest of Europe. Lombardy acted for a long time as a hub through which knowledge was transmitted. It is thought that Hugh of Lucca (Borgognon, Ugo de Lucca 1220), a surgeon in Bologna who took part in the crusades to the Holy Land, was the originator of the soporific sponges used in ancient times and described by Dioscorides. The knowledge was then passed on by William of Salicet, author of a treatise on surgery in 1275, to his disciple Lanfranc, who was forced to leave Milan and moved to Paris in 1295. The School of Salerno was closed in 1810 by order of Napoleon.

Unlike Salerno, medicine in Paris was in the hands of the clergy and Lanfranc, who was married, was not allowed to study at the faculty of medicine. He joined the order of Saint-Cosmas and Saint-Damian, which later became the college of Saint-Cosmas, the surgical school and body. The status of clerk of doctors was a key element in the subsequent development of surgery. A certain degree of independence between surgery and medicine began to appear at this time. This divergence continued to grow until complete rupture occurred following a series of ecclesiastical decisions. In this context, the role of monks in relation to disease had already been criticised by a number of popes several centuries earlier. However, a number of eminent persons continued to perform medical activities. The famous Sainte Hildegard of Bingen dispensed remedies to the sick in the twelfth century to help them resist the devil. Following a number of council decisions forbidding clerics from treating patients by fire (cautery) and iron, it was at the council of Tours in 1163 that the declaration *Ecclesia abhorret a sanguine* rejected outright

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any further affiliation between surgery and learned ecclesiastical medicine. It was perhaps thanks to the influence of the Iberian peninsula that a spirit of tolerance was maintained towards surgery at the school of medicine of Montpellier.

Two further eminent mediaeval French surgeons, Henri de Monfort and Guy de Chauliac, were educated in Montpellier. Guy de Chauliac warned against soporific persisted among surgeons, who had become simple practitioners. The order of Saint-Cosmas and Saint-Damian represented the elite of the profession. For several centuries, this order fiercely resisted scientific and social decline, but did not succeed in gaining the protection of learned doctors despite the brilliant success of certain members, the most well-known of whom was certainly Ambroise Paré. Thanks to the brief and courageous action of the surgeon Felix in treating the anal fistula of Louis XIV, in 1686, the king opened the gateway to surgeons to achieve higher rank. It was not until some fifty years later that the College of Surgery was created by letter of patent by Louis XIV in 1724. The college was only transformed to the Royal Academy of Surgery on 18 December 1731 by Mareschal and Lapeyronie. This academy, like the Faculty of Medicine, disappeared under the Convention on 8 August 1793.

Equal rights and positions for surgeons and doctors came about through a royal declaration on 23 April 1743, engineered by François Rigot and François Lapeyronie, who were the King's First Surgeon and Head of Surgery of the Kingdom.

The accession of surgeons to a social rank practically equal to that of doctors was not restricted to France but also occurred in other European countries. Thus in Great Britain, a number of great surgeons became known, including several Scotsmen, and in particular John Hunter.

In all probability, practical considerations played a part in this change. Kings began to feel concern about the health of their subjects. The population at the time was chiefly rural.

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There were sufficient surgeons to conduct meaningful action, in contrast with the handful of learned doctors. However, another century would elapse before surgeons passed from a bit part to the predominant rank in the medical hierarchy, thanks to two innovations essential for surgery in the nineteenth century: anaesthesia and asepsis.

Thereafter, surgery rapidly achieved recognition as the paradigm of effective medical action, while the horizons of medicine remain very restricted. The salaries of surgeons far outstripped those of doctors. Their attitude towards doctors was completely transformed, and they became condescending, occasionally acting like *nouveaux riches*. When the issue of administration of anaesthetics arose, surgeons clearly preferred to entrust the task to auxiliaries rather than to doctors. To this day, their relationship with anaesthetists continues to be marked by the past. Surgeons had now achieved an important professional, social and economic status, and as the sole masters of the operating theatre, wished to be at the cutting edge of progress. It was the surgeons who contributed most to the development of methods of anaesthesia.

After the First World War, surgeons in France became aware of the distance that had crept between them and their British counterparts. They wished to make up this ground, but without changing their habits. In his précis of surgical anaesthesia, Émile Forgue pronounced in favour of training of anaesthetist-doctors, but felt that career anaesthetists would be perfectly adequate for “well equipped surgical centres” and that “even for hospitals with fewer staff, there is a need for a specialised assistant, who is our most useful collaborator.” He nevertheless states that Professors of surgery have a duty to teach students in university hospitals and concludes on the need for two contradictory obligations: “For the sake of uniformity and safety of operating conditions, (he may) entrust difficult anaesthetic procedures during major operations solely to a habitual, fully trained and

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even specialised assistant; he must not just tolerate, but as the person responsible, encourage the participation of trainees in simple anaesthesia with close supervision, since no amount of theoretical instruction can replace practical experience in this domain." Forgue went on to say that this "habitual, trained and specialised assistant had a duty of attentive and skilful supervision", and that he must be "highly trained", stating without hesitation that he wished to have "well-trained staff". He states with some regret that for anaesthesia using nitrous oxide, the operator must "sacrifice some of his own comfort to the interests of the patient", as Desmarest insisted. Forgue concludes that a surgical nurse, or a nurse acting as an anaesthetist are more valuable than a medical student who is "highly learned but unpractised", so that this "formula of specialised anaesthetist is that towards which we all tend, at least in the major departments, but it involves difficulties... such as organisation, division of work and also budgetary constraints that can create obstacles." Before the Second World War, the practise of anaesthetics was in fact entrusted to auxiliary nurses or externs, and in some cases to *garçons de salle*, or to any other person who happened to be at hand.

My own experience of anaesthesia in Paris began in 1938. It was at this time that I had the opportunity to take part in various activities at the Rothschild Hospital and I was asked to give anaesthesia using the Ombredanne inhaler. Prior instruction was limited to advice about gradually opening the valve and holding the mask firmly in place. Users were hardly concerned about the inside of the chamber into which the anaesthetic was poured (generally Schleich's mixture). I must humbly confess that at that time, I was completely ignorant about the mechanism governing the entry of air and anaesthetic vapour.

Debates about local anaesthesia demonstrated that the majority of surgeons restricted its use to minor procedures, with procaine (Novocaine) being most widely used. There was a device allowing pressurised injection of the local

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anaesthetic in which a syringe was no longer needed: this practise was later adopted in the USSR. Spinal anaesthesia and epidural anaesthesia were used. Novocaine and Percaine were utilised. A subcutaneous injection of ephedrine was often given before lumbar puncture by the surgeon. We feared dire last-minute consequences consisting of acute hypertensive episodes accompanied by vomiting and malaise, occasionally with respiratory depression or arrest. The short-lasting effects of spinal anaesthesia with Novocaine also posed a problem, but at that time surgeons operated swiftly.

Great importance was attached to rectal anaesthesia using avertine (Rectanol). However, this was generally considered as a basic narcotic, which had to be supplemented where necessary. A number of surgeons, in particular Desmarest, attempted supplementary anaesthesia through inhalation of nitrous oxide. Others used ether for induction via the rectal route. A barbiturate was used by Jacquot. Intravenous Evipan began its career for induction, occasionally as the sole anaesthetic given.

However, inhalatory anaesthesia continued to play a predominant role. While Paris long remained faithful to chloroform and Lyon favoured ether, a sort of compromise finally prevailed and Schleich's mixture was widely used, generally being given using the Ombredanne inhaler. Modifications had been made to the Ombredanne inhaler by Thalheimer and Desplats, with carbon dioxide being given for patients with respiratory depression and cyanosis! Regarding the average position of the valve with the Ombredanne mask, the inhaled mixture contained 15.6% oxygen and 4.3% carbon dioxide. By increasing the concentration of the anaesthetic vapour, the volume of oxygen was reduced. Tiffeneau describes Scleich's mixture in the second paragraph of his précis concerning ether, where he states that "ether is occasionally used in the form of Scleich's mixture containing ether-30, chloroform-10 and ethyl chloride-5." For chloroform, Ricard or Fredet devices were generally used.

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Nitrous oxide was given using various devices, the most simple of which consisted of bottles of nitrous oxide, oxygen and carbon dioxide. The patient inhaled pure nitrous oxide, which was replaced with oxygen when cyanosis appeared to be threatening. Carbon dioxide was used to stimulate respiration in the event of an accident. This method of administration alone was indicated by Tiffeneau, who wrote the following about nitrous oxide: "Although a combustible like oxygen, this gas is unsuitable for combustion in living organisms. Its anaesthetic action, like that of other gases (ethylene, acetylene), is never profound; it only produces incomplete subsidence of reflexes and requires inhalation of the pure gas, resulting in a state of asphyxia, the disadvantages of which maybe avoided either by restricting the use of this gas to short-term anaesthesia, or by providing short inhalations of pure oxygen every two or three minutes. For this purpose, a respiratory mask connected to an *ab libitum* supply of nitrous oxide and oxygen in two metal bottles may be used."

Devices fitted with a mixer (Martinaud) and flow-meters were built, but they were considered too cumbersome.

McKesson's device constructed in the United States by Foregger in accordance with the indications of Waters was known only by word of mouth.

Ethyl chloride had been widely used for short operations, being administered via a Camus mask. A flow-meter device had been proposed to facilitate the use of ethyl chloride in longer operations. Despite the increasing number of technical means available, anaesthesia remained the province of surgeons, who were eager to remain dominion, and anaesthesia was practised by doctors only in rare cases. However, certain French surgeons were in favour of training anaesthetist-doctors after the example of the English, but their attitudes remained ambiguous.

In 1934, Professor Robert Monod founded a society named the *Société d'études sur l'anesthésie and l'algésie*

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(The Society for the Study of Anaesthesia and Analgesia). At the first meeting, Monod declared: "The aim of this new society is not to become a society of anaesthetists." The selection of members reflected this principle. Only four anaesthetists figured among the hundred or so members of the new society: Amiot, Chenot, Jacquot and Schlissinger. The latter died the same year, in 1934. The next year, two anaesthetists were elected as members, Drs J. Boureau and Doutrebente. Membership of the society soon rose from one hundred to one hundred and twenty, and one of the few anaesthetists to belong to the society, Dr Bourbon, the accredited assistant of Prof Hartmann, was elected member of honour. Only one of these first Parisian anaesthetist-doctors, Dr Jacques Boureau, is still alive today.

Clearly, renowned surgeons were thankful for the assistance of skilled anaesthetists, whose role was restricted to administration of anaesthesia alone. The anaesthetist rarely saw the patient before and after the operation. Rates were determined by the surgeon. Surgeons summoned anaesthetists and their profession was necessarily itinerant. Anaesthetists working for several surgeons travelled between clinics. Hospital work was unpaid. Practically all anaesthetists were general practitioners and devoted only part of their working time to anaesthesia.

In the absence of any agreement concerning hospital posts, surgeons also began to explore other solutions. In 1936, at an executive meeting of the society, Prof Monod declared that: "Our society has been concerned with the creation in Paris of a post of emergency anaesthetist. A list of anaesthetists will be drawn up indicating their skills in different methods of anaesthesia. This department 'may be attached to the transfusion department'. The inverted commas placed around "department" refer to an obstacle that would later become manifest.

The members of the board requested that the Director General of the Public Hospitals of Paris create hospital posts

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for anaesthetists but did not make any provisions for their training. Together with the Health Department of the Armed Forces, they sought to recruit anaesthetists for military hospitals and ambulances. Since they could not find any anaesthetists amongst serving doctors, they paradoxically concluded on the urgent need to train nurse anaesthetists. It was not until 1939 that they created an initial course in anaesthesia in thirteen lessons at the Pharmacology Department of the Faculty of Medicine of Paris. None of the seven anaesthetists that were full members of the Society of Anaesthetists at that point contributed to these courses, which were given entirely by surgeons. Lavoine is the only anaesthetist to have published monographs on nitrous oxide and cyclopropane, with the main pre-war French publications being written by surgeons: Dupuy de Frenelle, Forgue and Maisonnet. Most anaesthetist-doctors at this time appear to have assumed their position of assistants and servants of the surgeons, being forced to find other medical activities to make ends meet.

Such was the case of Dr Jacques Boureau. Straight as an arrow, thin and with a supple gait and curious eye, Jacques Boureau, born on 9 April 1909, was a handsome man for much of his life. He was happy to talk of his souvenirs. His father, Maurice, had been an extern in the Department of Terrier, who had appreciated his talents as an anaesthetist so much that he kept him as his assistant until the end of his career. Terrier's successor, Antonin Gosset, hung on to this precious collaborator, both for anaesthetic work at the hospital and for private work. Upon the death of Maurice Boureau in 1930, his son Jacques was studying medicine and was an extern at Salpêtrière in Gosset's department. On the advice of his superior, he completed his studies and then took over his father's position. He had the opportunity to see him at work and even to administer anaesthesia himself under his father's watchful eye. Thus, Jacques Boureau received teaching in anaesthesia while other anaesthetist-doctors of his time

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were self-taught by force of circumstance. He completed his medical studies in 1934 and defended his thesis on the subject of tri-bromo-ethanol anaesthesia (Rectanol). After completing his military service between 1933 and 1934, he was mobilised at the outbreak of war as an anaesthetist in a heavy surgical ambulance based at Pont-à-Mousson between September 1939 and August 1940. He then returned to Paris and resumed his activities. In 1941, he became the head of Prof. Delay's laboratory at the Sainte-Anne Hospital and was interested above all in the practise of electroshock therapy, carrying out anaesthesia and electrical therapy at simultaneously. In 1980, he published a monograph, *Modern Sismotherapy under narcosis and curare anaesthesia*, in which he set out the technical methods and modes of application of electroshock therapy. The introduction by Prof. Deniker shows that psychiatrists readily used the anaesthetist to administer electroshock therapy. Boureau had made a speciality of this work, and travelled from clinic to clinic at the behest of psychiatrists. In his monograph, he claims to have performed a hundred thousand procedures involving anaesthesia and electroshock. During this period, he acted as an unpaid assistant in the department of Prof. Gossand, working with Gossand and his patients in private practise. Such was also the case of other assistants in the department, and primarily those of Jacques Hepp.

At the same time Boureau worked as a GP and also practiced for several hours a week as the doctor in charge of the medical section of the Assurances Générales.

During the occupation, he met regularly with other anaesthetists including Mlle Geneviève Delahaye, Marc Maroger and Lavoine to reflect on methods of improving the position of anaesthetists. Their reflections resulted in the creation after the war of the National Syndicate of Anaesthetists-Intensive Care Doctors, of which Boureau would become the first president. He occupied this post for seven years. Boureau then joined Monod in organising an

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international congress of anaesthesia held in Paris in 1951. This meeting was the starting point for efforts resulting in the creation of the World Federation of Societies of Anaesthetists that took place several years later in The Hague. Elected as corresponding member, then full member of the Society of Anaesthesia, he became the President in 1958.

His contemporary, Mlle Delahaye, had more titles than him. She was trained both as a doctor and as a lawyer. She completed her medical studies in Paris, where she was born in 1906. After working as an extern of the Paris Hospitals in 1927 and as an intern in 1930, she was appointed Clinical Assistant/Lecturer and defended her thesis in 1935. She began her activity as an anaesthetist in the department of Prof. Bergerand at Saint-Antoine, later working with Dr Servelle and then Monod in the Thoracic Surgery Department of the Marie-Lannelongue Hospital. She was elected a member of the Society of Anaesthesia in 1937.

With her Joan of Arc fringe, her rapid gait, her stocky silhouette and abrupt gestures, her sensitivity in private relationships was somewhat surprising. She pleaded in favour of modern anaesthesia and teaching of the subject. Paradoxically, however, she supported Dr Amiot, elected candidate of the "Ancients", following the creation in 1958 of the Chair of Anaesthesia at the Faculty of Medicine. This post was finally attributed to John Baumann. Following her appointment as Assistant Anaesthetist to the Paris Hospitals in 1947 and Assistant Doctor in 1957, she became Lecturer of Anaesthesiology, subsequently being appointed Head of Department at la Pitié-Salpêtrière Hospital on 11 January 1965; she continued to occupy this post until her death in 1971. Thanks to her husband, M. Plouvier, advisor at the French Court of Auditors (*Cour des Comptes*), she was able to play a part in developing the regulations concerning the CES diploma in anaesthesia-intensive care (CESAR) created by decree on 22 November 1948. She was Secretary General of the Society of Anaesthesia from 1961 to 1967. In 1969, she

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interceded on behalf of the SFAAR to the interministerial committee in charge of hospital reform in order to obtain full acknowledgement of anaesthesiology and the creation of departments. As with Boureau, the career of Mlle. Delahaye spanned the pre-war period, the occupation and the post-war period. The same was true of most of those active in 1939 within the Anaesthesia Society, who were still present after the *Libération*.

The military collapse in 1940 and the Vichy government, supported by the majority of the clergy, with representatives in the medical field such as Leriche and Carrel, cut France off from England and the United States.

The call to honour of General de Gaulle, the Free French Forces and the Resistance resulted in different attitudes.

The Society's activities were suspended in 1939 and were resumed only in 1946. Its founder and Secretary General, Monod, had been active in the Resistance and had distinguished himself by completing a most dangerous assignment; he had crossed the German lines to carry the urgent request for help for the Parisian insurrection in August 1944 to the headquarters of General Bradley. This message was instrumental in the decision to direct General Leclerc's armoured division to the aid of Paris.

During the war, the Parisian anaesthetist-doctors suffered no direct losses, in contrast with French doctors in general, of whom over one thousand paid with their life for their activities in the Resistance and the Free French Forces.

When General de Gaulle began assembling the Free French forces in Great Britain in June 1940 against all odds, it was necessary to create a health service from scratch. This action centred initially on reconstitution of the Hadfield-Spears surgical ambulance. This ambulance, created in France during the First World War and reconstituted in 1939, had been captured by the Germans in 1940. Thanks to the energy of Lady Spears, it was recreated in England.

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Commanding Doctor Henri Fruchaud, Professor of Surgery at the Medical Faculty of Angers, who had arrived in Great Britain on the same boat as the staff of the old ambulance, was its first commander after having served as Director of the Health Service of the Free French Forces. The ambulance enterprise was also aided by a group of Quakers.

In July and August 1940, only four doctors, one pharmacist, one administrative sub-officer and a medical student returning from Norway rallied to the call of General de Gaulle. These included Dr Henri Debidour, known as Monrad, surgeon and former intern of the Paris Hospitals, two doctors wounded at Dunkirk, Dr Robert Garraud, a Captain with the Medical Corps in active service (known as Jean Ray) and Dr Henri Lebenthal (known as Bristol), a reserve lieutenant doctor, who had joined the Free French Forces while still in hospital. In September 1940, Garraud-Ray replaced Prof. Fruchaud as Director of the Health Department.

Drs Lemanissier, a young married couple, a tuberculosis specialist and a biologist, learned of General de Gaulle's call on 18 June 1940. The husband, having found an opportunity to embark, boarded a coaster bound for England. After bidding his wife farewell, he turned to her a last time. She was in tears on the dock and he cried to her: "Will you not come with me?" She nodded her head and without further reflection he leapt into the water to join her side. After missing this first opportunity to leave, they later embarked on *La Fleur d'Océan* and arrived in Plymouth on 22 June 1940. Louise-Marie Lemanissier was the first female lieutenant doctor in the French army. She was appointed as anaesthetist for the new Hadfield-Spears ambulance. For training, she was authorised to visit various hospitals in London for a period of three weeks. It was her responsibility to assemble the necessary equipment. This was a difficult task since the English had lost most of their medical equipment at Dunkirk

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and their own priority was to re-equip. Furthermore, the anaesthesia equipment in hospital departments did not strike her as being suitable for military campaigns. Since the medical equipment of the French troops fighting in the Norwegian expedition had been brought back to England, she was able to use it. In this way, the first French military anaesthetist-doctor administered ether anaesthesia using the Ombredanne inhaler during the military campaigns in which she took part, including the battle of Bir-Hakeim. After the war, she completely gave up her activities as an anaesthetist to resume her work as a biologist.

In 1938, after completing my studies at the Faculty of Medicine of Vienne and Lausanne, I arrived in France. I had carried out research on major burns victims prompted by a study published by Belgian authors under the title, *The death of burns victims*. They ascribed a major role in death to resorption of a toxin considered to develop in burned tissue. In order to continue this research, I had submitted my project to the administration of the health department of the armed forces and was fortunate in having the opportunity to work at the laboratory of the Rothschild Hospital in the Haematology Department of Prof. Pierre-Paul Lévy.

In 1939, I enlisted and was posted to the Versailles Civil Hospital in unit "Z", intended for the treatment of victims of combat gas. I very quickly applied for a more active posting and was appointed doctor in a unit of foreign "service providers". After the attack of May 1940, we were forced to fall back towards the south west of France. We were informed that if we were captured by the Germans we would be shot. This ensured that was no lagging behind on the long and tiring marches! Finally, after catching a train, we arrived in Albi, where I was demobilised in September 1940. Taking refuge in the Loire department, I met up with a number of people who would soon join the resistance and I managed to find a way of escaping into Spain, from where I was able to make my way to Portugal in June 1941. After learning of the

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call of General de Gaulle after my arrival in Lisbon, I went to offer my services to de Gaulle's representative. Being forced to leave Portugal before receiving a reply, I was able to join my family in the United States, where I renewed my commitment to the Free French Forces.

After the Islands of Saint-Pierre-et-Miquelon joined the Free French Forces on 24 December 1941. The two doctors to the colonial troops at their posts refused to serve the new regime and treat the population. Dr René Le Bas, the doctor of the submarine *Surcouf*, one of the vessels commanded by Admiral Muselier and despatched from Saint-Pierre, took over the medical department of the hospital. He remained in Saint-Pierre until his vessel left, before ultimately being lost in action together with the submarine on 19 February 1942. He was replaced from 9 February to 10 July 1942 by Dr Charles Coucke, a first class doctor in the Free French Navy, former intern of the Lilles Hospitals and previously doctor on board the colonial sloop *Savorgnan de Brazza*.

Dr Coucke requested assistance and as a result, I was posted to Saint-Pierre Miquelon in January 1942, but only arrived there in March, together with my wife, who had also enlisted in the Free French forces. On 5 July 1942, first-class Doctor Monrad (Henri Debidour) arrived in Saint-Pierre as Head Doctor of the hospital. He had served in the Norwegian campaign under the orders of General Bethouard and, having passed through England, had been repatriated to France before being forced to leave very rapidly to join the Free French Forces. Although he had initially joined the Alpine Brigade, it was as a naval doctor that he was sent to the naval base of Saint-Pierre-et-Miquelon. A former hospital intern, he quickly developed very extensive surgical activities. It was agreed that I should be responsible for anaesthesia alongside my various other activities. We had a complete understanding and remained great friends until his death.

On 8 August 1944, Debidour and I left Saint-Pierre et Miquelon for North Africa. Before this territory rallied the

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Free French cause, two doctors from the colonial troops and a civilian contractual doctor, Dr Dunant, had practised there. Before our arrival, the latter had been appointed to take care of medical surveillance of the five hundred inhabitants of the island of Miquelon. For the military doctors, the stay in Saint-Pierre et Miquelon was not only an opportunity to get some rest, after working in trying conditions, but also to earn a little money by treating patients among the local inhabitants.

We had heard about the Beveridge report on public health in England which formed the basis of the British post-war social-security legislation and introduced free consultation. It was agreed that we give medical care to the Saint-Pierre population without asking for consultation fees. However, we added a condition to this measure – all those who were able had to come to see us at the hospital for consultation and home visits were to be reduced to a minimum. By decreeing that medical care would be free, we enhanced the standing of the Free French in the eyes of the population. Moreover, it was useful to show the Canadians who were in support of Maréchal Pétain and looked upon the Free French with distrust, if not total hostility, that their biased view of us was unfounded. This measure of free medical care, new to the island, was approved by the territorial administrator, Alain Savary, a young officer with the Free French, and accepted by Mr Pleven, commissioner of the French national committee for the colonies in London. I submitted a report to him on the subject of this experiment in 1943. However, the well-off minority, essentially composed of merchants and shopkeepers, were vexed by this arrangement and as the Free French had a bad press amongst this section of the population, saw it as a political manoeuvre.

Looking back fifty years later, I realize that my commitment to this policy, without doubt well-intentioned, was not very well thought out. The realities of the egalitarian French social security system need to be considered;

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expenditure exceeds any reasonable budget of state investment in health care. More emphasis should be put on prevention rather than on treatment. In addition, the desire to maintain equality on the health care programme is badly conceived when applied exclusively to a precarious equality – the distribution of the expenses is not calculated according to an individual's revenue. Today, the system is oriented more towards each individual contributing to the expenditure of the state. It is a step in the right direction and must be upheld. This is the reason why politicians in France no longer wanted to finance health care made necessary by the demands or by the constraints of others, which now seems perfectly acceptable. After the Liberation, I suggested to the minister of health that we implement this system in France and the proposition was backed by Dr Debidour who became president of the health committee of the National Assembly. The communist minister was opposed to any measure that would undermine the "revolutionary will" of the people. Fifty years on, my good intentions seem to me to have been a little naive. It is clear that the Social-Security system, instituted by General de Gaulle, is facing huge problems and the National Health Service in Britain is in no better state.

Once at Saint-Pierre, I made contacts in Canada to help further my instruction on the subject of anaesthesia. Dr Wesley Bourne was a great help to me and as an initiation document, I received the text of his lecture of 22 May 1941. Later, on visits to the American naval base at Argentia in Newfoundland I managed to lay my hands on various instruments including a laryngoscope. Reading the *American Naval Medical Bulletin* was extremely beneficial to me.

Within two years, three-hundred major operations have been performed and a nurse-anaesthetist had been trained, Auguste Olano, who was able to practise in metropolitan France after the war. I had the opportunity to use thiopental in many cases, which certainly must have been its first use on French territory.

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It was only years later that I was able to make the most of my experience in anaesthesia. In chronological order, I believe I must have been the second doctor of the Free French forces to be involved in anaesthesia.

The return of the Free French doctors who had experienced the means and procedures used by the allied forces contributed greatly to the modernisation of anaesthesia in France.

The effort of bringing about change did not fail to provoke some antagonism. The reformists were confronted by those who had remained faithful to the old ways. This was true not only for the methods of anaesthesia but also the relationships between surgeons and anaesthetists. The activity of the Society for the Study of Anaesthesia had been re-launched and the first post-war meeting was held on 17 January 1946 under the presidency of Mr Rouvillois. Eleven full members were present. Fourteen full members were elected, among whom; J. Boureau and M. Crantin as well as Miss de Lambert, all three anaesthetists. Two anaesthetists were among the members of the management committee, Messrs Jacquot and Lavoine. Among its one hundred and twenty full members, the Society counted seventeen anaesthetists; Mrs Chevillon, Mrs Crantin, Mrs Delahaye, Mrs de Lambert, Mrs Piot, Mrs Thierry; Messrs Amiot, Boureau, Cara, Doutrebente, Jacquot, Kern, Lavoine, Maroger, Marotte and Simon.

At the annual general meeting of 15 January 1948, the president of the Society Robert Monod said: "We have been accused, not without reason, of having created an academic society with too much emphasis on research and not enough on practise. From this point of view we still have a long way to go for, in spite of the creation of our society, in spite of the journal we publish, it is certain that the situation of anaesthesia in France is not what it is abroad, especially in the Anglo-Saxon countries, and this is deeply regrettable. Obviously, I'm speaking primarily as a surgeon; we realise today that one of the reasons for our slow progress, which

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leaves surgery in France lagging behind other countries, is exactly the fact that the practise of anaesthesia is not what it should be and it has not achieved the degree of perfection attained elsewhere.”

A certain number of surgeons agreed with Monod's view on the slow development of anaesthesia and the need to follow the Anglo-American example. Others were not willing to change their habits and some anaesthetists sided with them, favouring the preservation of the role of surgeon-chief.

One passage from Robert Merle d'Aubigné's memoirs gives us an idea of what it was like in the hospitals. “There was no anaesthesia and no intensive care. Anaesthetics were administered either by an inexperienced nurse or by an intern equally unqualified and often unwilling.”

For his part, right from 1945, Merle d'Aubigné assigned to his service a qualified anaesthetist, Dr Ernest Kern who, like myself, had been part of a very small number of doctors who had served their apprenticeship in anaesthesia during the war.

He became the true initiator of the discipline in France.

Born in 1908 in Romania where his father taught classical languages, he came to France at the age of eighteen. After a high school diploma and a year of PCB (physics, chemistry, biology) in Montpellier, he studied medicine at the faculty in Paris. After receiving French nationality and completing his military service, he settled in the Loire region, in 1933, as a GP. That was where he had his first experience in anaesthesia. Having heard of a new anaesthetic, developed in Germany under the name of Evipan – the precursor of thiopental – he had several opportunities to try it out in dental surgery with some success. However, after a third operation when the patient suffered apnoea, he gave this up. Later, it became clear that stomatology was a contraindication of intravenous anaesthetic, a subject to which he would devote his first book.

Kern was an albino with a pale complexion and delicate skin. He suffered from severe myopia but showed great

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courage in all situations to overcome his handicap. Although rather stocky and a bit clumsy, he loved to go off mountain climbing or hurtling down snowy ski runs. His podgy fingers and an awkwardness caused by myopia didn't stop him from choosing a career that called for great manual skill. Although not helped by his physique, this man was charming and knew how to charm. He enjoyed the company of women and was surrounded by many who stayed by his side right up to his death. His odyssey during the war is exemplary. He was called up in 1939 and demobilized the following year. Forbidden to practise medicine by the racist laws of the Vichy regime, he worked as an accountant and joined the Resistance very early on. In 1943, when his network was betrayed, he went into hiding and managed to cross the Pyrenees. He was captured and imprisoned in Pamplona where he suffered from hunger and lack of privacy in a crowded cell of six. After two months and without explanation, he was transferred to a village in the Lower Pyrenees where he was kept in a hotel under surveillance, then moved to a village in Navarre where the conditions were bearable. He ended up in the Miranda prison camp. He passed himself off as Canadian and, along with most of the refugees from France and those from Britain, was finally liberated. He was sent to Gibraltar and given the choice of signing up with either Giraud or De Gaulle. He opted for the Free French forces and was transported to Great Britain where he got permission to train in anaesthesia and attend the teaching-hospital courses. He went on to take the diploma of anaesthesia (DA) in May 1944. Before learning the results, he was sent to the front in Normandy, after which he took part in the campaign in Alsace and in the occupation of Germany with the First French army for which he was awarded the Military Cross.

During a spell of leave, he visited the surgical university clinic of Heidelberg and advised the head consultant surgeon to promote the training of anaesthetist-doctors.

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It was at around this time that Kern met Merle d'Aubigné who was a member of the medical committee in the Resistance, run by Pastor Vallery-Radot. Merle d'Aubigné hoped to set up a modern unit in Paris for bone and reconstructive surgery and wanted to enlist the services of Kern as his anaesthetist. In his memoirs Kern describes their encounter: "I found myself confronted with a tall, thin, impressive-looking colonel with a keen face, fiery eyes and slightly greying at the temples. The image of an Italian Renaissance condottiere." This surgeon of the Paris Hospitals explained his project to the unknown anaesthetist: "I've been told that you were a specialised anaesthetist in England, that you have been trained in the use of modern equipment and that you introduced it to the First French army. In my service, anaesthetics are administered in a very antiquated way compared with the Anglo-Saxon methods which I was personally able to admire on visits to British and American military hospitals... I'd like these methods to be used in my hospital service."

And Kern concluded, "And that's how, from a five-minute conversation, a fruitful collaboration of more than twenty years began."

Merle d'Aubigné's project would take shape and a national centre for reconstructive surgery was provisionally set up at the Léopold Bellan hospital. That is where I met Kern for the first time and it was the beginning of a long friendship. Kern having started his work there, in 1946 put a notice in the *Presse Médicale* advertising a course in anaesthesia. This was very unusual and did not fail to provoke a reaction from established anaesthetist-doctors who feared that the newcomers might put their situations in danger. Kern wrote: "The information came out in the *Presse Médicale* and I was faced with hostility from my anaesthetist colleagues of the time and with an unusual summons to appear before the Syndicate where several members expressed their opposition to my initiative. I carried on regardless."

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The service of Merle d'Aubigné was very quickly transferred to the Foch hospital, where it was joined with the maxillofacial surgery unit headed by colonel Ginestet.

As I had been on secondment to the head of the Health Service of the military region, and assigned to assist the Colonel (later General) Imbert – appointed chief physician of the Foch hospital – I was able to participate in the training instituted by Kern in this hospital. The practical side dealt with the operating theatres and at the bedside of patients requiring special care. Kern ran the courses in anaesthesia. Since a burn-victim unit had been created at the Foch hospital, my interest in the subject was rekindled and I took charge of the teaching of intensive care. Every week a lesson in anaesthesia and a lesson in intensive care were held and each was followed up by discussion. We covered all the main subjects in one year. Apart from several military doctors assigned to Foch hospital by the army, the interested parties attended as they pleased, to devote a few days to their training. In 1949, the requisition of Foch hospital was lifted and it was taken over by its pre-war founders, who subsequently rented it to the SNCF (French national railway company).

The surgical service was transferred to Cochin hospital where Merle d'Aubigné became the chair of orthopaedics. Kern and I followed – he as assistant-anaesthetist and myself as head of the faculty laboratory.

On 13 January 1949, I became a national corresponding member of the Society for the Study of Anaesthesia and Analgesia, a full member in 1952 and an honorary member in 1982 of what became the SFAR.

The health and social security services of Paris decided, by a decree of 12 November 1947, to create posts for anaesthetists and heads of service in anaesthesia through competitive entry examinations. In fact, two competitions according to qualifications (15 November 1947 and 28 February 1949) were organised to fill thirty assistant posts.

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Only twenty-six posts were filled. Each service, in surgery, specialized disciplines (ENT, stomatology) and maternity had the right to the services of one assistant-anaesthetist. The assistants were appointed for one year and grouped by sectors comprising six posts to cover duty periods. They had to be accepted by a head of service in surgery to take up a posting, without which they remained at the disposal of the administration – chief anaesthetists posts were not created. The initial budgetary provision for a fully structured anaesthesia organisation had been reduced to take into account the reality of the situation. The remuneration was identical to that of assistants in other branches – almost a token – the work was part-time and one could not live on the pay! For their subsistence, the assistant-anaesthetists counted on the private practise of the surgeon head of service and his assistants.

Kern took up his appointment as assistant-anaesthetist to the Paris Hospitals at Cochin in the reconstructive surgery clinic, while continuing to work with Merle d'Aubigné in his private practise. In his memoirs he relates how he was paid at the beginning: "With supreme contempt, the nurse who reigned over the operating theatres would toss me a hundred-franc coin (in old money)... a sum of money she had the habit of giving at the end of each anaesthetic procedure to the auxiliary lad who traditionally held the Ombredanne mask. But the anaesthetic I was using (cyclopropane) had cost me five times as much!"

As for myself, I passed the entrance examination as assistant-anaesthetist to the Paris Hospitals in 1949 and took up my appointment as such in the maternity unit under the direction of Dr J. Grasset, at Foch hospital. My interest in the subject of burn victims took shape again as soon as I came into contact at Foch with a surgeon, Dr Madeleine Zimmer, who had served during the war as captain in the First French army under the command of General de Lattre de Tassigny (Rhine and Danube). An Alsatian, she was an impassioned

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person and a qualified surgeon – which was relatively surprising for a woman in those days. She was tall with rugged features, but hidden beneath her energetic appearance was a heart of gold and a great clarity of mind. At the time when I was still in the army, a mining catastrophe had happened in the Ruhr and the French government, at the request of the Germans, decided to send help. I was assigned to go, and I went with Dr Zimmer, along with some army personnel. We had to treat over one hundred burn victims, some of whom had suffered extremely serious burns. The grateful German government invited us to a wine reception. After the employment minister had delivered a beautiful speech in German, I leant over to Dr Zimmer and whispered, “What do we do if they give us a medal?” To which she retorted quick as a flash, “We clear off!”

After the episode in the Ruhr, Dr Zimmer, with whom I enjoyed a lasting friendship, left her surgery practise to take up a position as physician of the head offices of the French Coal Board. Together, we have been in charge of the burn-unit at Foch hospital, and together we created a mobile team for medical intervention in coal mines and in the oil industry.

When the military part of Foch hospital closed down in 1949, it was decided that a burn-victim treatment centre would be set up at Cochin hospital as soon as circumstances permitted, which was the case a few years later.

Our activities at the Foch hospital burn-victim centre led us to question the efficacy of the treatment, at the time commended by Henri Laborit: the hibernation of burn victims. Let us just say that, to us the opinion expressed by a Paris surgeon, Dr Raymond Vilain, seemed judicious: “better to burn a hibernatd patient than hibernate a burnt one.” Later on, a unit study of a burn-victim treatment room at Cochin hospital found that the metabolic troubles observed in badly burnt patients could be alleviated not by reducing the body temperature but by increasing the ambient temperature to prevent loss of body heat.

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I had obtained my degree in anaesthesia and then qualified in biology. The Medical Association, having acknowledged at the time that these two branches were not exclusive, I was able to set up a clinical laboratory right after I finished my service in the military. When I had to choose between them, I chose anaesthesia and gave up biology. After a brief spell working with gynaecologist-obstetrician Maurice Meyer, I made the acquaintance of a surgeon urologist, Pierre Aboulker, who had just set up in private practise and was looking for an anaesthetist. This encounter led to a long working relationship of twenty-five years, until Aboulker's death in 1969. This courteous and distinguished gentleman was born in Algeria where his cousin José Aboulker had played an important role during the Allied landing and was made a companion in the Order of Liberation.

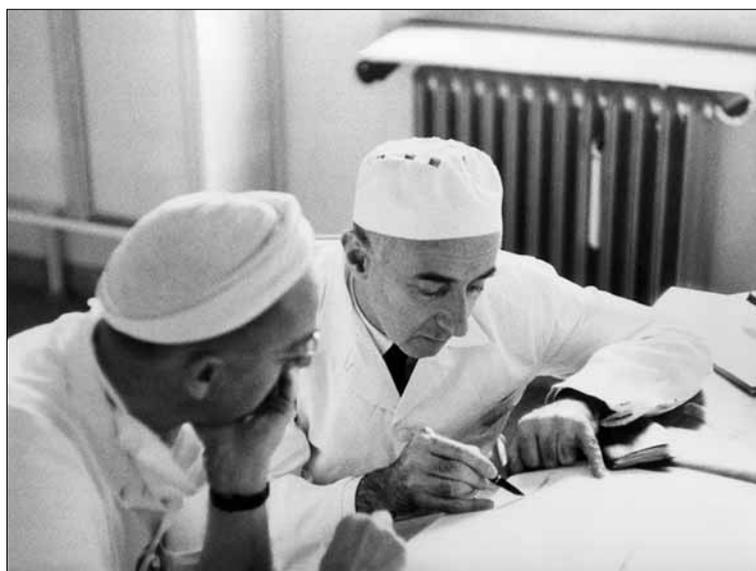
Dr Gouverneur was Head of the urological department at Necker hospital, and I was introduced to him by Dr Aboulker, his assistant. Hospital work was not full time in those days. Dr Aboulker changed service to go to Lariboisière, where I followed, and then to Saint-Louis where he became Head of urology in 1970. Finally, he was appointed professor and succeeded Dr Fey at Cochin. Very soon after, he had built up a successful private practise. He worked at both the Ambroise-Paré clinic in Neuilly and the American hospital.

Cochin hospital is an institution architecturally made up of small pavilions. Attached to it, for administration and latter the faculty, are the maternity wards and, on a university administrative basis, the Saint-Vincent-de-Paul hospital, which has a maternity and paediatric surgery department, as well as the Sainte-Anne psychiatric hospital. Sainte-Anne's at the same time serves the group of psychiatric institutions in the Paris area for surgical treatment of the mentally ill and also has a large neurosurgery and stereotactic surgery installation. For a while, the Longjumeau hospital on the periphery of Paris was grouped with Cochin-Port-Royal.

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Before the creation of university department for anaesthesiology, there were no premises for one in Cochin Hospital. When Dr Kern was appointed Head of Department, he was already quite ill and didn't feel up to entering into lengthy discussions with the administration about this state of affairs. In any case, the anaesthesia services in the various surgical divisions were autonomous entities and there was very little contact between them. The anaesthetists of the hospital departments working in the position of assistants in anaesthesiology, since its creation in 1949, lived within their respective services and in their working relationships with the surgeons. This was how Dr Kern found himself confined to a small office in the reconstructive surgery pavilion.

During the year 1968-69, because of Dr Kern's illness, I accepted the situation and considered myself as his substitute



Pierre Aboulker and Jean Lassner

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with no change in my professional life. I wanted to keep my freedom and considered myself too old to start a new career in the teaching hospitals.

After the turbulence of 1968 and Dr Kern's death in 1969, the organisation of anaesthesiology in the university was in jeopardy and Prof Vourc'h's position was compromised, I finally decided to apply for the post of head of the anaesthesia department of Cochin hospital. Another candidate whom I myself had introduced to the Dean, had already applied.

When my appointment became effective, I resolved to bring some outward signs of "captaincy" to the role of head of department and, to begin with, set up premises within the hospital. The hospital pavilions were like little private realms of the department heads of the various specialities, so I had to find a place outside the establishment. As luck would have it, suitable premises in the cloister of Port-Royal, within the Cochin-Port-Royal hospital grounds, became available and could be converted. The next step was the practical set up and the organisation on a daily basis of cohesion between the anaesthetists in the group of establishments involved. I made a point of this idea of grouping together in a meeting with the anaesthetists once a week. The other meeting was held by the Cochin "Friday Group", which was devoted to teaching and especially discussion.

From the 1970s, the rise of interest in anaesthesia brought an influx of young doctors wanting to train in this branch. They had to learn their trade by practising it and therefore rotate between the surgical services. Since each surgical pavilion had its own little group of anaesthetists, the students had to be taken care of by them. The anaesthetist in charge, generally the one who worked also in private practise with the chief surgeon, had to spend time teaching.

Innovation was needed. I was determined to increase cohesion in the department of anaesthesiology and to replace subordination to the surgeon by cooperation. To do this, it was necessary to shift people who had been accustomed to

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stability. This created problems and a certain amount of friction – a price that had to be paid. Another measure was the participation in teaching by all anaesthetists holding appointments. This too required cooperation on the part of the surgeons. I wanted learning to take the form of an apprenticeship. Each novice in the discipline who had chosen the department for training was interviewed by myself and given the appropriate instructions. The well-being of the patients and the anaesthetist/patient relationship in surgery had to be the main preoccupation. This coincided well with the direction that Kern had taken for the training of his students. I instituted a system of partnership between the students and the qualified anaesthetists in charge of them. I made it clear that, in the case of disagreement, they had to inform me ; otherwise they would be working together for a period of six months. In addition, through concern for the safety of the patients, I decided that, for the first two months of their course, the new comers would only participate as spectators and would assist the anaesthetist in whose charge they were. From then on, every step they took would be under the supervision of their mentor. To work on duty, where they would be on their own, was only for student anaesthetists who had completed their first year of training and with the approbation of the anaesthetist who had been in charge for their first six months. The student would then rotate between the various surgical disciplines to understand their special requirements relating to anaesthesia. Lectures were given in different surgical departments to point out the differences as to anaesthesia. In urology, spinal and epidural anaesthetics were more often applied than in other departments. At the Sainte-Anne hospital, anaesthesia for neurosurgery and anaesthesia for thoracic and pulmonary surgery at Marie-Lannelongue hospital were demonstrated.

One particular problem was intensive care. The general surgery department had finally been reorganised and the intensive-care premises had been taken over. However, a

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surgical intensive-care unit was attached administratively to the departments of surgery with which a working arrangement with the department of anaesthesia was established. In fact, it was the anaesthetists who took charge of the patients. Intensive care units were later installed at the Saint-Vincent-de-Paul hospital for paediatric and at the Sainte-Anne hospital for neurosurgery and medical emergencies.

It took a certain time before physician anaesthetists were appointed to the maternity units. Nurse-anaesthetists working there since the 1950s had been replaced by midwives trained in anaesthesia. Obstetrical anaesthesia and analgesia became a field of great interest mainly thanks to the arrival of Dr Barrier in the department. The same was true for paediatric anaesthesia when Dr Saint-Maurice took charge of it at Saint-Vincent-de-Paul. The rotation of anaesthetists to be trained in these disciplines then became possible. The appointment of Dr Meignan as head of the anaesthesia department at Sainte-Anne contributed to progress in anaesthesia for electro-convulsive therapy.

The work of a physician-anaesthetist included the obligation to stay on duty once a month. This duty service covered all of the Paris Hospitals in the early days. In those days, there were very few anaesthesia machines available. Therefore, the surgeon on duty had to transport the apparatus and the anaesthetist. It happened that surgeons refused to go and pick up the anaesthetist, especially if he lived far away from the hospital which had put in the call. Only about a third of the calls made for the on duty surgeon required the presence of an anaesthetist. It is understandable that the equipment transported by car (including the gas cylinders) was subjected to so much moving around that it was not always in working order. The machine used was a Heidbrink make – dating from 1934 – inherited from American army surplus and it had to be removed from its case and reassembled every time. The hospitals and anaesthetists were able to equip themselves by purchasing American

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surplus appliances which were sold off at low prices. Besides the Heidbrinks, we had Foregger devices, also made in the 1930s. The American syringes and needles were vastly superior to those available in France. Dehydrated (lyophilized) plasma was used widely by the military and became available on the market after the war. Anaesthetists very quickly contributed to the construction of anaesthetic machines and respirators.

In Paris, R. Alluaume was the first to devise a machine, called Pulmotor, for pumping oxygen into the lungs. This apparatus made it possible to regulate the volume insufflated and the frequency of insufflations. Many anaesthetists preferred to respect a minimum of spontaneous respiration during anaesthesia and to assist respiration by compression of the reservoir bag (assisted respiration). The first respirators imposed a controlled respiration. According to some, this deprived the anaesthetist of contact with the patients, according to others, it left them free to perform other tasks. Initially, anaesthetists purchased their own equipment; but soon many private clinics became equipped with state-of-the-art apparatus. The public hospitals followed gradually.

When doctors in charge of resuscitation of the wounded in the army (resuscitators-transfusers) came back to civilian life, they chose either anaesthesia-intensive care or haemobiology/transfusion, which was the case for the majority. To the transfusion centre of Paris at the Saint-Antoine hospital (under Dr André with his colleagues Dausset and Bessis), a national transfusion centre was added at the the initiative of Dr Arnaud Tzanck on Alexandre Cabanel Street. There, desiccation and plasma division was carried out. Dr Tzanck, both a haematologist and a dermatologist, was the inventor of a direct transfusion device – the syringe that bears his name. An engaging character with a ruddy complexion, he was a good musician and had an inborn curiosity. His son, René, later supervised one of the blood banks of the Paris hospitals.

The army created its own institution of transfusion at the Percy hospital in Clamart, under physician-colonel Julliard,

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continuing the work begun by Prof Benhamou in Algiers. Dr Kern had brought back a King anaesthesia machine from England, small in size, which he used in the private clinics where he worked. We were able to acquire flow-meters for the various gases through *Air Liquide*, the manufacturer of oxygen and nitrous oxide.

By putting together the necessary flow-meters, I was able to build an anaesthesia appliance for my own use. It permitted the administration of nitrous oxide and cyclopropane and, obviously, oxygen. The Waters canister was used for the absorption of carbon dioxide. After the introduction of halothane, I added a vaporizer which made the apparatus more difficult to transport – but that soon became unnecessary, when the private clinics became better equipped. The production of French equipment soon began under the acronym AMP (precision medical equipment). An anaesthesia machine came on the market, followed by another perfected by the surgeon Dr Sabourin. At that time, the old-fashioned rubber tubes for infusion were replaced by single-purpose plastic tubings. Perfusion bottles for i.v. drips imported from America were so successful that the Baxter brand name became the synonym of the contents. Its French equivalent, called a “massive solution”, in thin glass phials was not competitive. The elimination of bacterial bodies, destroyed by sterilization, prevented the feverish reaction often seen in the past during perfusions (apyrexia).

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Hospital posts for anaesthetists still remained very few. In 1953, a higher degree in anaesthesiology was created in the Paris Hospitals. The discipline still lacked positions for heads of service. For the higher posts, a competitive examination was held. Dr Kern stood a good chance of being appointed, even more so since Prof. Merle d'Aubigné was on the jury. Deceived by his bad eyesight, he treated the subject

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“Pulmonary hyperventilation under anaesthesia” when it should have been “Pulmonary hypoventilation...”, so he failed this exam and was not appointed. When another chance came up in 1960, he succeeded, but the title was soon to be abolished.

After the teaching hospital reforms in 1958, Kern was nominated in 1962 to the Concours d’agrégation and integrated as full senior lecturer (holder of the agrégation) by the decree of 7 May 1963. He became head of department in anaesthesiology at the Cochin hospital in 1966.

For Kern, teaching was a vocation, “I got great satisfaction out of teaching – I just had to exploit the gift passed on to me by my parents, both of whom were teachers.” The talent Kern had for teaching was demonstrated by his simplification of questions and by the clarity of his lectures. He designed an education programme that he instituted at Léopold-Bellan, and later at Foch and Cochin hospitals. Later, his courses were replaced by weekly lectures followed by discussion, while formal teaching was organised at the Paris faculty of medicine.

Like Sancho Panchez for Don Quixote, he had an unlimited affection for Merle d’Aubigné – that of an assistant for his boss. Their shared passion for mountaineering brought them close together as friends. Their relationship was bound up by their professional mutual respect and remained so until Kern’s death.

In two monographs published by Masson, Kern set out the technical methods and modes of application of Pentothal and curare, whose introduction met with fierce opposition. For Griffith and Johnson, the initiators in 1942, curare (the intocostriane of Squibb plus the d-tubocurarine crystallized by King) seemed at first a simple adjuvant to facilitate abdominal relaxation. The risks inherent in the use of curare were not clearly established. Defenders and opponents held famously controversial debates over its use. For Frankis T. Evans, who summed up the first three years of the English experiment,

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curare represented a great advancement. But he added that it was better to wait in order to determine its use in practise. Kern concluded in his monograph that, "curare is an agent of exceptional value, of which the indications in anaesthesia are numerous." He noted that, "the contraindications of curarization are rare. They are primarily of a technical order; lack of insufflation equipment, absence of a qualified anaesthetist." In his autobiography, however, he recounts an event that could have thrown a different light on the innovation. "When in 1946 I was presenting, for the first time, a paper on controlled respiration to the French Society of Anaesthesia, the chairman of the meeting, an honourable old gentleman, stood up and said: 'God gave man breath, only God has the right to take it away. I deny any man or any anaesthetist this right. Anyone who does so, is committing an act of sacrilege.'" This objection was targeting interference with the vital functions of the body which, according to tradition, the anaesthetist should respect and, in order to protect life, ensure that none of his actions put them in jeopardy. In fact, the introduction of curare brought about a radical change in the attitude of the anaesthetist. Instead of the anaesthetist's full attention being concentrated on the detection of any adverse effects on the respiration or the circulation, they were deliberately stopping the respiration. The study that Kern and I led on the subject of "Flaxedil" (gallamine) was to reveal that this relaxant was considered by some a "cyanogen". The "syringe-pushers" as the adherents to intravenous anaesthesia were derisively called, became (with the introduction of curare) the "bagonists" – a term used scornfully in reference to respiratory assistance.

The interest in induced hypotension, several years after the introduction of curare, added to this trend of increased intervention in vital function. Muscle relaxation did so much to facilitate surgery that surgeons could hardly argue against the value of this new method or the merit of its practitioners, the anaesthetists. In practise, anaesthesia had three compo-

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nents: the hypnotic effect produced by the barbiturate, the muscle relaxation produced by curare, and the effect produced by a substance known as analgesic (pethidine), introduced in 1944 by Neff, a Californian. While the majority of anaesthetists continued to employ nitrogen protoxide, others preferred to use intravenous anaesthesia exclusively.

Just before the Second World War, cyclopropane, a costly and explosive anaesthetic gas, was used in closed respiratory systems, mainly Waters' lime tray and bag. Although rather inconvenient, this method was soon adopted. It allowed anaesthetists to correct the respiratory depression induced by cyclopropane by simply compressing the bag. The same anaesthetic device allowed for the respiratory assistance necessary when using curare.

The introduction of Pentothal (thiopental) did not bring any major change to the field. It presented a few significant advantages over Evipan. Yet the anaesthetic effect produced by Pentothal required repeated intravenous injections, whereas Evipan required only a single injection when administered before ether.

The introduction of a new respiratory agent, halothane, soon brought respiratory anaesthesia back into the limelight.

In 1946, Dr Nadia du Bouchet published her *Manual of Anaesthesia* (Flammarion), the first French language work devoted to anaesthesia after the war. Born in Byelorussia in 1898, she emigrated with her parents to France at the age of two, and completed her medical studies in Paris. Admitted to a non-resident medical studentship in the French hospital system, she obtained her doctorate in 1931. While still completing her studies, she married and had two children. When her husband became seriously ill, she was forced to provide single-handedly for her family's financial needs, and in 1935 moved to the Eure region of France, where she obtained a position as a hygiene inspector. A distinguished physician, she was known above all for her subtlety, her

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courtesy, and her appreciation of music. She demonstrated remarkable insight and resolve in organizing her life. Forced to abandon her career as a result of the racist laws passed under the Vichy regime, she and her two children left France for America in December 1940 and she became a resident in anaesthesiology in New York. In 1943, she was admitted to the Board of Anaesthesiology. She practised in New York until the end of the war, at which time she met Professor Pasteur Vallery-Radot, president of the French Resistance Medical Committee; he invited her to return to Paris to work with Prof de Gaudart d'Allaines. She accepted and organized the department of anaesthesia at Broussais Hospital, where France's first cardiac surgery unit was established. It was there that she took the initiative to organise the training of young anaesthetists.

The Cochin lectures, or the "Cochin Fridays" as they were known, took over from the instruction offered at Foch Hospital in 1946; they were not the only attempts at private anaesthesia teaching in Paris. Besides the training offered at Broussais Hospital, similar courses were organised, first by Pierre Huguenard at Vaugirard Hospital, and then by Claude Guilmet at Saint-Antoine Hospital. The Cochin lectures continued after Kern's death in 1969; I succeeded him, after having replaced him during his long illness. In principle, I had already been integrated into the university hospital system since 1962, and so I stopped my private practise and became the head of the Department of Anaesthesia at Cochin Hospital, a post which I held until my retirement in 1982.

Jean Valletta participated in these teaching efforts. Ernest Kern met him in Montpellier while he was completing what is known as the PCB degree (physics, chemistry and biology). He was born on 5 May 1910 in Tunis to a family of Maltese origin. He was granted British citizenship, thanks to the efforts of his shrewd father, who worked as a physician at the Maltese embassy in Tunis. Those efforts paid off significantly later on. Despite his background, Valletta decided to receive

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a French education. He completed his secondary school education in 1928 in Algiers, then his PCB diploma in Montpellier, and he received his doctorate from the Medical Faculty of Paris in 1930. He completed a non-resident medical studentship in the French hospital system in 1933, and then worked as an intern at Bon-Secours Hospital, where he practised general surgery under the direction of Prof J. Quénu. In 1939, he joined France's first foreign regiment. In 1940, he worked as a surgeon under the direction of Prof Vignes at the Landy Military Hospital in Saint-Ouen. Discharged after the armistice was signed with the Germans, Valletta made it to North Africa in 1942 where he joined the British army. He participated in military campaigns in North Africa and Italy. After the armistice was signed in Italy, he was sent to Tripolitania. He was honourably discharged with the rank of captain in 1946, and was awarded the Africa Star, the Italy Medal and the British Medallion commemorating the Second World War. He returned to Paris and finally became a French citizen. With the help of a scholarship, he was able to complete two years of anaesthesia training at Oxford with Prof R. Macintosh. Upon his return to France, he was hired as an assistant anaesthetist in the Paris Hospitals and returned to work under Prof. Quénu's direction at Cochin Hospital.

Starting in the 1950s, spectators regularly attended and participated in the discussions that always took place during the "Cochin Fridays." Such distinguished guests as Dr. Bonica from the United States, Sir Robert Macintosh from Great Britain and Bernard Halpern, among others, participated in these sessions.

Some of the spectators eventually became professors in their home countries. For example, Karl Steinbereithner became an instructor in Vienna, and Rudolf Frey taught in Heidelberg and later on in Mainz, where I participated in the training programme that he had put in place.

There is one particularly revealing anecdote about Kern's influence in Germany. One day he received a letter from a

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young German asking him for help to begin his anaesthesia training in Paris. In order to obtain the necessary permission, he needed two guarantors, and Kern asked me to be the second. Soon after, Rudolf Frey, a young man, arrived and completed a six-month training course. He then studied at Oxford under the direction of Prof Macintosh, to whom we had recommended him. He completed his education in Boston, in the United States, and upon his return to Heidelberg became the first university-level anaesthetist. Kern's influence certainly paid off. Afterwards, when Frey had become a professor at Mainz, he invited me as a visiting professor in his department where I spent several months. An energetic and friendly man, Rudolf Frey died young by his own hand during a phase of depression.

The lectures organized by Dr. Kern and Dr. du Bouchet, as well as their publications, attracted a large number of physicians to the field of anaesthesia. Nonetheless, the instruction available through private training and university programmes alone would not have been enough to permit the expansion of anaesthesia in France, had it not been for the creation by General de Gaulle of France's social security laws. These laws were part of a political programme pertaining to social relations promoted by the Ministry of Labour and Social Security, an entity put in place upon the establishment of the provisional government in Paris after the Second World War. The first ordinance concerning social security (the health-care system) was passed on 4 October 1945. The first listing of professional medical procedures established by the social security system included reimbursement for anaesthetic procedures conducted by medical doctors. These procedures were known collectively as "closed-circuit anaesthesia", to distinguish them from traditional anaesthetic techniques. Tracheal intubation was classified as a distinct procedure, justifying a supplementary fee. Surgical procedures were reimbursed by a sum including the cost of the procedure and a supplementary fee for the auxiliary administering the

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anaesthetic. This supplementary fee constituted one-tenth of the surgeon's overall fee. If the surgeon was assisted by a physician-anaesthetist (whom he could not reimburse himself, lest he be accused of fee sharing), the social security system paid the anaesthetist a fee equal to one-fifth of the surgeon's fee; the system would then deduct one-tenth of the surgeon's fee for the procedure. Employing an auxiliary-anaesthetist would cost the surgeons less than one-tenth of their fees. As a result surgeons were financially penalised for employing physician-anaesthetists and so the system hardly encouraged surgeons to make use of these specialists.

Finally the system was changed. Doctors understood the advantage offered by the new ways which increased their clientele, yet they remained wary about the regulation of their fees. The syndicate of anaesthetists, in which



Octobre 1988

Sir Robert Macintosh and Jean Lassner

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Dr. Verhaeghe played an important role, fought long and hard in order to replace the original system by a new one that identified anaesthetic procedure as being separate from surgery. In 1948, the Medical Association recognised the new discipline, even though the number of anaesthetists still remained small. As a result, those who wished to do so could declare themselves as exclusive specialists or simply as trained anaesthetists. The latter option allowed them to practise general medicine or another non exclusive speciality alongside anaesthesia. Most doctors in the field preferred to be designated as trained (but not exclusive) anaesthetists, which allowed them to keep their private practise.

Nonetheless, the contractual obligations imposed upon anaesthetists by the hospital system remained problematic.

Anaesthetic or para-anaesthetic procedures are never isolated events. They are always justified by and associated with a surgical or other specialised medical procedure. As a result, anaesthetists came to be regarded as occupying a subordinate position. The competitive examination that the public hospital system had planned to offer department heads for anaesthesia was blocked as a result of opposition by surgeons and by a report presented on this subject to the advisory medical commission. This report concludes that the anaesthetised patient is only partially and temporarily in the care of the anaesthetist. Moreover, the report notes that anaesthetists practise in other hospital departments, run by their own department heads. Any department head for anaesthesia would therefore be the head of a non existent department, without a specific location, without patients, without personnel, and without any autonomous authority. It was impossible at the time to imagine a department under dual direction. The report was aimed more at anaesthetists than at their field. Surgeons did not look upon them as equals. These surgeons, who had once served as hospital interns, considered themselves superior to other doctors and

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especially to anaesthetists, who had not taken (or had not passed) the competitive examination of hospital internship.

In 1958, the university-hospital reform took place, initiated by Prof Robert Debré. His memoirs tell the difficult story of managing this process. Prof Debré asked me on two occasions to inform him about the discipline of anaesthesia. Having determined that his outline configuration of the relations between the different medical departments did not appropriately reflect the role of anaesthesiology, I insisted upon two points. Firstly, clinical needs were going to begin to dominate the field and so anaesthesia would imminently undergo an important expansion. As a result, the strict alignment between the university and the hospital systems was unjustified. Secondly, I thought it was best to separate the tasks of medical care, teaching, and research, few individuals being well suited to all three. A configuration modelled after the British system, where each consultant deals individually with the administration, would allow for greater flexibility. These observations fell on deaf ears.

Nonetheless, it was decided that a period of reflection was necessary to determine the role of anaesthesia. Unfortunately, this period of reflection only led to the creation of a temporary hospital placement for the majority of anaesthetists. As a result, the majority found themselves marginalized and, in a sense, subordinated. Their course of study (the CES degree) were implicitly judged as inferior to those completed by surgeons; the division between hospital medicine and medicine in private general practise could only be detrimental to both. Later on, the creation of a private sector within the hospital system increased the remuneration of a small number of hospital doctors, while excluding the anaesthetists. Their relationship with the surgeons was not on equal standing. As a result the anaesthetists started to favour a kind of anonymity. This affected their personal contact with patients as well as their sense of individual responsibility. Group practise of anaesthesia spread from

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hospitals to private clinics, altering the relations between patients and doctors. The division between anaesthetists with a single affiliation (hospital consultants) and those with double affiliation (university-hospital consultants) created a destructive climate in many university departments of anaesthesia.

The most important gain for the discipline of anaesthesia was the recognition of parity with the other medical disciplines, acquired through the "captaincy" of department heads. By their sheer numbers, anaesthetists played an important role in all administrative matters. The creation of a qualifying internship for all specialists put an end to discrimination against anaesthetists trained through the CES programme by surgeons who had been trained as interns. The establishment of this programme reduced the number of anaesthetists in training and rapidly diminished the number of practising anaesthetists.

The demographic make-up of French anaesthetists, extensively documented by Dr. Pontone, has been most significantly affected by the influx of individuals entering the profession between 1970 and 1980. As a result, there will be an equally massive departure of anaesthetists thirty years later. How will we be able to cope with this reduction in the number of anaesthetists? A reorganisation of the hospital system could, in some sense, avert a major crisis. For the moment, no such plan exists. Will we have to abandon certain procedures, or create a separate training programme for anaesthetists? Or will we have to call on foreign anaesthetists, or employ auxiliaries again to take charge of anaesthetic procedures? This last alternative could be concealed by placing these auxiliaries under the control of a certified anaesthetist. Our current regulations require that a certified "anaesthetist be able to intervene at all times"; it would become necessary to change these regulations in order to allow one anaesthetist "to be in attendance" at two or three procedures at a time.

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Anaesthetists are likely fight to conserve their key role in intensive care.

The recognition of this role was not easily obtained. The conflict between anaesthetists and medical resuscitators has found, if not a permanent solution, at least a compromise that reflects the dominant role of the Department of Surgical Anaesthesia-Intensive Care.

If the number of anaesthetists continues to decline, this role of anaesthetists as resuscitators may become problematic. This is true as well for other functions conducted outside of the operating room.

Fortunately anaesthetists have been able to maintain a directive role in the French mobile-emergency services (the SAMU and the SMUR), even though there is no longer a sufficient number of personnel available in the hospital departments of anaesthesia to meet the operational needs of these services.



Cochin 1964

From left to right: Prof Steg, Prof Robert Debré, René Brouillet, Michel Debré, Prof Aboulker, Prof Lassner.

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Having discussed the individual efforts to provide anaesthesia training since the end of the Second World War, we should now consider the official efforts to create an instructional programme.

It was thanks to the initiative of surgeon Pierre Moulonguet, who occupied the chair of surgical technique at the Medical Faculty of Paris, that the first anaesthesia courses were created in 1947.

After completing his medical studies in Amiens, where he was born in 1890 and where his father taught as a Prof of clinical surgery, Pierre Moulonguet came to Paris where he completed a non-resident medical studentship and then an internship. He began his military service in 1913. Working as an assistant doctor when war was declared in 1914, he served with the mountain infantry and received France's croix de guerre and a military decoration for his bravery. After demobilisation in 1919, he became an assistant anatomist and a laboratory head at the university. He defended his dissertation in 1923, and received the gold medal for exceptional service as a medical intern in 1924. The following year, he joined the staff of the Paris Hospitals, and began a brilliant career: he went on to pass the competitive examination to become a professor in 1929, and was named department head at Tenon Hospital in 1941.

His calm yet firm opposition to the occupying forces and the Vichy regime was apparent in his efforts to help Jean Baumann, a medical assistant targeted by the laws passed against Jews, as well as in his support for his friend Robert Monod. He was appointed to the chair of surgical technique in 1945 and the chair of clinical surgery at Salpêtrière Hospital in 1956.

As early as 1945, he was interested in anaesthesia instruction and during his inaugural lecture he declared, "I

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will also be speaking about anaesthesia: no official training has yet been dedicated to this field in France, in contrast to what is being done abroad. However the creation by my friend Robert Monod of the Society of Anaesthesia and Analgesia has created a forum for studies in this field which, as you know, have been prolific in recent years. Neither of these subjects has yet been sufficiently covered in hospital instruction; doctors proceed to the operating table without any background knowledge. I do not intend to be obsolete. I will therefore speak also about pre- and post-operational examinations, subjects rich in new discoveries, and I will be discussing transfusions, an area which has recently begun to play an important role in surgical procedures.”

Pierre Moulonguet, who died in 1981, took important initiatives in the progress of anaesthesia and his efforts contributed significantly to the development of this discipline in France.

In 1947, while he himself inaugurated the instruction of anaesthesia at the Paris Faculty of Medicine, it was his accredited assistant, Jean Baumann, who carried out a significant part of the work.

Of gruff appearance, Baumann had a sharp mind and was by no means lacking in sense of humour. A well educated man, he was known for forming lasting friendships and for persistently defending his ideas. Baumann was born in Paris on 7 May 1906; he completed his medical studies and obtained his doctorate in 1933. He received a non-resident medical studentship and then an internship in the hospital system, and was named clinic head, and then medical assistant. He was called up to serve in 1939, and returned to his post under Moulonguet's direction after the French defeat in 1940. Despite Moulonguet's efforts to help him keep his post, Baumann was finally forced to abandon his work and escaped France in 1943 by crossing the Pyrenees. After a period of imprisonment in Spain, he arrived in North Africa where he immediately joined the army. He was assigned to

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the French expeditionary corps in Italy and served as a surgeon in an ambulance run by Madame Catroux. Discharged at the end of the war, he returned to France to take up his former position in Moulonguet's department. It was the courses in anaesthesia at the Paris Faculty of Medicine that directed him towards our field.

The first course began on 10 January 1947 and lasted until the end of February. One hundred and twenty-two doctors and medical auxiliaries were enrolled. The programme was followed by a six-month training course with an assistant anaesthetist in the Paris Hospitals. At the end of the training, the doctors had to take an exam; those who passed received a degree in anaesthesia-intensive care. No exam was required for the auxiliaries, although they received a certificate in anaesthesia.

Baumann's attitude toward anaesthetists was ambiguous. In a speech given before the Society of Anaesthesia on 17 June 1948, he spoke about the future role of specialists in a way that could only irritate them. He took the liberty to judge their role and their future. It is true that he defined their role judiciously: "It is their responsibility to examine the patient before the operation and to choose the appropriate type of anaesthetic in consultation with the surgeon, who is to provide him with all of the details of the operation. During the procedure, he is responsible for maintaining the patient's state of analgesia as well as the stability of the patient's vegetative functions. As a result, he also participates in what is termed as intensive care." But he added: "I see no disadvantage in including the necessary intensive care training in the official instruction and competitive examinations intended for anaesthetists. After the operation, the anaesthetist participates in the observation of the patient, which requires knowledge of bronchoaspiration." More specifically, he stated, "It is necessary to establish a rigorous definition of who is legally permitted to administer an anaesthetic. The current situation is frankly anarchical, but it

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is clear that administering anaesthesia is not considered to be a procedure reserved for doctors. Dental surgeons are also legally authorised to induce narcosis.”

It is important to remember that from 1939 to 1945 the army called upon dentists and then pharmacists to serve as anaesthetists.

Up until 1948, Paris hospital regulations called for pharmacy interns to administer anaesthesia during duty hours.

A decree published in the *Journal officiel* on 9 January 1948 can be interpreted as an implicit authorisation to use auxiliary personnel (nurses) to administer anaesthesia under the direction of a surgeon.

Anaesthetists had not yet been accorded the exclusive right to practise anaesthesia. It is true that their numbers were then rather small. The anaesthetists' syndicate only had twenty-three members. “About forty new anaesthetists will probably be trained this year thanks to Moulonguet's course, but we cannot expect with any certainty to maintain that number in the years to come”, Baumann said. Indeed at the time forty doctors completed the course and became qualified anaesthetists. That number slowly rose to fifty and then finally to one hundred entering each year the two post-war decades. The directory published by the French National Syndicate of Anaesthetists-Resuscitators in 1966, created thanks to the efforts of Jean Montagne, lists two thousand such specialists.

The speech that Baumann gave before the Society of Anaesthesia clearly presented the contradictions between the different conceptions of the role of anaesthetists. It is true that doctors wanted to improve the use of anaesthesia during surgical and obstetric procedures. Although they knew that this goal could not be attained without training specialised doctors, they were aware that the number of such doctors, even those who had completed rapid training programs, would still be insufficient for several years to come. The decision was taken to train auxiliary medical personnel, in

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order to improve the existing system; yet the creation of a body of nurses and nurse-anaesthetists counteracted the goal of training doctors for this role. Physician-anaesthetist tended to be confused with nurses, which hardly did much for prestige. Moreover, the future of their financial status was affected, indeed compromised. The relationship, which had yet to be definitively established, between surgeons and anaesthetists suffered for a long time because of this ambivalence. A specialist must, legitimately, be remunerated more generously than an auxiliary. Baumann himself remarked that in smaller medical centres, no qualified doctor could live on what he earned by practising his "speciality" alone.

Baumann sought the chair of thoracic surgery but was not successful. It was partly in order to give him personal recognition that a chair of anaesthesiology was created at the Medical Faculty of Paris in 1957. He received the appointment and Guy Vourc'h was named his *agrégé*. At that point Baumann became director of the Institute of Anaesthesiology created by Moulonguet.

In 1965, Baumann was finally changed to the chair of thoracic surgery at Beaujon Hospital, and Guy Vourc'h succeeded him in the chair of anaesthesiology.

A fervent Catholic, a patriot, and a proud native of Brittany, Vourc'h was a man of invincible courage and great sensitivity who was deeply committed to everything he undertook. His distinctive build and rugged face, as well as his sulky demeanour, were characteristic of his Breton origins. He was a lover of languages and classical authors. Although not generally talkative in company, he adored poetry, and could occasionally be caught reciting his favourite verses out loud. In 1946, he married Brigitte Gayet, a charming woman who was also a trained pharmacist. Vourc'h began medical studies but was forced to stop because of health problems. In 1939, after a year in a sanatorium, he was called up to serve, and was discharged shortly after. His career as a war hero had begun badly.

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Jean Lassner and Jean Baumann

He did not need much encouragement from his parents, who played an important role in the resistance movement in Brittany, in order to join General de Gaulle. He, his brother Jean and a few friends boarded a fishing boat called "La petite Anna", purchased for the occasion, and headed for England. None of them were sailors, and the expedition quickly took a turn for the worse. They ran out of fuel, lost their mast in a storm. For nine days lost at sea without water or provisions, they were rescued, half-dead at that point, by an English cargo boat.

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Guy Vourc'h became a parachutist with the Free French Forces and would later become part of the marine commando under the direction of Commander Kieffer, which was the only French military unit to participate in the Normandy landings in June, 1944. Wounded and sent back to England, he wasted no time before rejoining the military and participated in a night-time raid on Schouven Island. By the end of the war he had earned the rank of captain and was awarded a knighthood of the French Legion of Honour. Returning to civilian life, he completed his medical studies and received his doctorate in medicine in 1949.

A scholarship awarded to him by the British Council permitted him to go to England for his training in anaesthesia and to board at the Royal College of Surgeons. Later on he resided at Middlesex Hospital. He obtained the Diploma of Anaesthesia (DA), and went on to become the first foreigner received as a Fellow of the Faculty of Anaesthetists of the Royal College of Surgeons (FFARCS). Since 1947, this title has been recognised as the highest qualification in the field. Upon the creation of the Royal College of Anaesthetists, the faculty became known as the FRCA.

Having returned to France, he began his career as an anaesthetist in 1951 at Foch Hospital in Suresnes. In 1953, Vourc'h decided to go to the United States, where he worked for six months as an associate at Massachusetts General Hospital in the department of anaesthesiology directed by Prof Harry K. Beecher.

In 1958, Guy Vourc'h was named *agrégé* to the chair of anaesthesiology, and thanks to Moulouguet became involved in the teaching of this discipline. Vourc'h became head of the department of anaesthesiology at Foch Hospital, and in 1965 followed Baumann in the chair of anaesthesiology. His situation in the Paris Hospitals was a particular one, because since 1949 Foch hospital was owned by France's national railway company (SNCF) and so was not technically part of the public hospital system of Paris. Nonetheless, it was he who had

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centralised anaesthesia instruction in Paris upon succeeding Baumann as the head of the Institute of Anaesthesiology.

When the Academy of Medicine decided to create a position in its surgical section for an anaesthetist, Vourc'h was elected to this venerable institution. Unfortunately, around the same time that Vourc'h, the spokesman of our discipline, received this great honour, he lost his voice due to a laryngectomy. Despite his state of health, he never missed a single Tuesday session. With admirable courage, he accepted the terrible constraints of his illness, and after having struggled with and faced death so often throughout his life, he succumbed peacefully.

His respect for the British stance during the war and the appreciation of his training, inspired him to give an Anglo-Saxon approach to his teaching style. He was Editor-in-Chief of the journal of the SFAAR and a member, but never president, of its board of directors, most likely because he was not a man to make compromises. He was nonetheless faced with the difficult task of organising the National Congress of Anaesthesia in the turbulent year of 1968. He was a member of the editorial committee of the *Cahiers d'Anesthésiologie*, a journal in which he published numerous papers. He participated in the Cochin lectures and published more than two hundred papers, focusing specifically on neuro-anaesthesia and neuropharmacology. He was a founding member, and later member of honour, of the European Academy of Anaesthesiology which I created in 1977. He was chosen to preside over the Academy's epidemiological inquiry on accidents related to anaesthesia, and his precision helped generate a study that remains a reference to this day.

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During the 1950s, *Anesthésie-Analgésie*, the journal of the French Society of Anaesthesia and Analgesia published under the editorship of Pierre Huguenard, had adopted a specific

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doctrine advocated by Henri Laborit; several columns of the journal were generally reserved for him. Kern took offence to this and I accepted his proposition to start a journal, the *Cahiers d'Anesthésiologie*, intended as an independent forum in which we would publish the Cochin lectures and colloquia. The independent spirit of the Cahiers played a role by no means insignificant in the development of the discipline.

At a certain point, the discussions concerning the most current methods of treatment took on an impassioned tone, all the more so since the new statistical methods of comparison were generally ignored. A good example of this were the muddled debates surrounding "potentialized" (potentialization means more than addition of two interacting drugs) anaesthesia and artificial hibernation.

In 1947, Kern published two monographs (published by Masson), the first one entitled *Intravenous Anaesthesia with Sodium Pentothal* and the second entitled *Curare in Anaesthesia*. In 1949, appeared J. Dallemagne's book, the *Current Aspects of Anaesthesiology*. It was, in a sense, as a response to these works that Laborit published a little volume in 1951 with Masson Publishers entitled *Facilitating Anaesthesia through Medicinal Synergies*.

With this publication, Henri Laborit, a naval surgeon later to become the father of "artificial hibernation", took to writing books about anaesthesia. He was born in Hanoi in 1914 to a father who was a physician with the colonial troops. His father died when he was only three years old, when his mother was expecting a second child. He studied at the Naval School of Health in Bordeaux and chose to pursue a career in surgery. He passed the competitive examination allowing him to receive a non-resident medical studentship in the Bordeaux Hospitals. During the war he was stationed on the torpedo boat Sirocco and was present at the evacuation of troops from Dunkerque. When the Sirocco was sunk by a German torpedo boat, he was saved by an English sloop that brought him back to Dover. He returned home on 6 June,

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seriously tried by these events, and received the French Military Cross with distinction. He was stationed in Dakar at the very moment when the navy was thwarting General de Gaulle's attempt to land troops. Laborit spent the end of the war in Africa, but by then he believed that "our enemy is no longer the Germans, but the English."

He served as a surgical assistant at the Sainte-Anne de Toulon maritime hospital, where he completed his studies in biology, thanks to the help of pharmacist Pierre Morand. It was at this point that he became interested in biological research. Morand had already developed a method using cholinesterase, and so he and Laborit turned their attention towards pseudo-cholinesterase and attempted to evaluate states of shock by testing capillary permeability. Laborit left at this point for Paris to undergo training at the blood transfusion centre directed by A. Tzanck. He obtained from Jean Gosset the present action of his and Morand's studies at the Academy of Surgery and from Lucien Leger to publish them in the *Presse Médicale*. His career as a doctor in the navy was rather a turbulent one. From the very beginning he was in trouble with the hierarchy – a humoristic report was deemed injurious and sanctioned accordingly. He then tried to quit the navy, but was unable to do so. He decided to take the competitive examination to become a naval surgeon, but failed. Due to conflicts at Sainte-Anne hospital, he requested a transfer and soon left for Lorient. Laborit then spent 1947 and 1948 in Indochina on a hospital ship. Upon his return, he was authorised to take the competitive examination for surgery in Bordeaux, and he passed. He was sent to Sidi-Abdallah-Bizerte.

In the introduction to his book, he comments upon the astounding advances made in the field within just a ten-year period, noting that the era when chloroform and ether were the principal agents used in surgical anaesthesia had not ended long ago. He writes that curare rapidly became widespread thanks to the unbridled enthusiasm of those using

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it, and he adds that administering several anaesthetics successively or simultaneously led to important progress in the field.

His own method, which he named "potentiated anaesthesia", was based on a concept of anaesthesia as a balance between drug effect and the wanted effect. Laborit's idea was to employ various substances acting upon the neurovegetative system in order to create the conditions necessary for weaker anaesthetics to induce a state of narcosis sufficiently profound for major surgery. As a result, anaesthesia would become a relatively minor affair that could be left to auxiliary medical personnel. The essential patient treatment would take place before surgery by physicians, according to Laborit's principles. Of course this idea conformed perfectly to the wishes of surgeons, and Laborit, a surgeon himself, was well received by many of them.

The concept behind potentiated anaesthesia coincides with a notion put forth by Guedel, according to which an individual's sensitivity to anaesthesia varies according to the individual's basal metabolism. Laborit proposed to reduce basal metabolism by using multiple substances acting on the vegetative nervous system. This method also involved lowering the patient's body temperature through another method advocated by Laborit and known as "artificial hibernation." Among the drugs intended to slow down the vegetative nervous system, Laborit recommended first and foremost procaine, the synthetic antihistamines and the derivatives of dibenzoparathiazine, Diparcol (diethazine). Tetraethylammonium bromide also played an important role in this treatment. Morphine was not advised, but vitamin B1 was recommended.

The final chapter of Laborit's book is dedicated to surgical shock and is based on the ideas of René Leriche. In order to prevent surgical shock, it was necessary to lower the patient's basal metabolism in order to place the neurovegetative system in the deepest possible state of rest. In the 19th

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century, Xavier Bichat, who also began as a naval surgeon, defined life as the set of forces which oppose death. Laborit turned this idea on its head by declaring that opposing death means jeopardising life; he advocated non-resistance and always fleeing danger, a stance he adopted as his attitude towards life in general.

Laborit claimed that “This biological surgery has transformed our daily practises; it has provided us with a sense of security unknown just a few years ago; it has already provided us with often spectacular results, and has allowed us to be innovative in ways that could hardly be conceivable for those surgeons who did not grow up with this method”. Laborit did not think it necessary to confirm the effects of the medications on basal metabolism nor his results by statistics. Yet, measuring basal metabolism can be done simply and quickly without any risks. In the end, Laborit’s ideas found more critics among surgeons than among anaesthetists. Jean Gosset declared before the Academy of Surgery: “The major role that Laborit attributes to the vegetative nervous system in the life of the organism is clearly inspired by the ideas of René Leriche. The same is true concerning Laborit’s preference for an understanding of surgical shock as rooted in the nervous system. Keeping with this theory of shock, Laborit rejects from the outset the use of a superficial anaesthetic combined with relaxation which, at the time, had already proven its usefulness; instead he calls for an anaesthesia that blocks all nervous stimuli. The choice of the term potentiated anaesthesia was even criticised by those who agreed with Laborit’s theory; their criticism was based on the fact that potentiated is a pharmacological term, whereas the method Laborit was advocating resulted in additive, and not potentiated effects.”

In the 1950s, there was great debate about potentiated anaesthesia, particularly hibernation. At the time, there were several publications, especially British ones, dealing with statistical procedures for comparing biological variables.

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Fisher's famous book, *The design of experiment* starts with an amusing anecdote in which an English lady swears she can taste the difference of tea that has been poured into the cup before the milk and a cup of tea prepared by pouring the milk first. Fisher asks how one can show whether this woman is telling the truth or is mistaken. In the same way, to see if dice are loaded, one has to compare a string of rolls of the dice in order to determine how often the six comes up. Still, the laws of chance can bring up other numbers, so the question therefore becomes how to determine at what point one can say that the dice are in fact loaded. It was very tempting to apply this statistical principle to the evaluation of medical treatment, and it later became fairly common to do so. Yet while a treatment's worth can be established rapidly when its application substantially changes preceding conditions, when the differences are less marked, this can require larger and larger series of applications or of patients observed.

Random distribution of treatment must be accomplished without either the patient or the doctor knowing if the medication employed is presumed to be active or inert. In cases where the differences are limited, very large series are needed in order to bring them to light. This demonstrates the method's limitations: the combination of a great number of observations and observers, as well as an increasing lapse of time, are required. These inevitable restraints lead to complications that can invalidate the entire study. In other words, what is known today as evidence-based treatment should be handled with care. Clearly, when the superiority of one treatment over another is immediately obvious, this should of course be taken into account. However, when it is a case of subtle, hard-to-establish nuances, then factors like the doctor-patient relationship, the situation, and the conditions in which the treatment has been prescribed and/or followed, can be influential enough to require that great precaution be used before leaping to a conclusion. In any case, when choosing one treatment rather than another, the

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remaining uncertainties inherent to the doctor-patient relationship must be allowed for.

Proponents of Laborit's methods didn't bother with the principles of validation. The success of Laborit's ideas among French anaesthetists can only be explained by its doctrinal contents. Varied and often opposing schools of thought were dividing the profession. Pierre Huguenard's rallying to the "Laboritite" cause has probably convinced a number of anaesthetists.

In the journal *Urgences Médicales, (Medical Emergencies)* in which Catherine Desfemmes published "*Un parcours de cinquante ans: de l'anesthésie à la prévention des risques*" ("A 50-year path: from anaesthesia to risk prevention"), certain key elements of Pierre Huguenard's biography appear. Born in 1924 in Besançon, he was in his second year of medical school in 1944, at the time of the Allied landing in the south of France. He dropped out of medical school at that point to join the Resistance. Once Besançon was liberated from the Nazis, he joined the First French Army, where he served as a surgical medic during the German campaign. Under the command of Dr Lavergne, a native of Algiers, he received instruction in anaesthesia. Demobilised in 1945, he took his third-year medical exams in the city of Nancy. He then decided to pursue his studies in Paris, where his future wife, who had joined the First Army in Algiers as a Red Cross nurse, was receiving training in anaesthesiology in a course organised by Mr Jacquot. It was Jacquot who obtained a position for Huguenard, then in his fourth year of medical school, in Prof Sénèque's department at Vaugirard Hospital. On the strength of his army experience, Huguenard was led to administer anaesthetics. In 1947, he enrolled in the university anaesthesiology course and obtained an M.D. and a degree in anaesthesiology in 1948. He then became an assistant anaesthetist at Vaugirard Hospital. While working on his thesis about gallamine (Flaxedil), he came into contact with Laborit, who had been appointed to Val de Grâce

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hospital in Paris. He contributed to the development of the artificial-hibernation method. Huguenard became an ardent advocate of the "Laboritite" concept. In 1950, thanks to his friendship with Jacquot, then Secretary General of the Society of Anaesthesia, he became assistant editor of the Society's journal. His appointment as editor-in-chief in 1954 enabled him to publish and promulgate Laborit's concepts. It became more and more difficult for those who didn't share those views to obtain access to the discipline's main voice in France. After the reform of the teaching-hospital system, Huguenard took further degrees in anaesthesiology, and began his career in Mrs Delahaye-Plouvier's department at Pitié-Salpêtrière Hospital. In 1964, he was appointed Chief Anaesthetist at Beaujon Hospital. When Henri Mondor Hospital opened in Créteil, he was named chief-anaesthetist there, and he organised the intensive-care unit and the ambulance corps (SAMU). This is when he began to specialise in emergency and trauma medical care. Huguenard's essential contribution to potentiated anaesthesia consisted not only in experimenting various associations of medications in order to determine the best so-called "lytic cocktail" (because they were supposed to dissolve resistance), but above all in a concept that gave anaesthetists the role of "patient's protector", thanks to the aforementioned cocktails. The term "protection" took on tremendous signification, and the "lytic cocktail" had an extraordinary fate. While it had been intended to protect life, it was used to end life in later time. The anaesthetist was thought to protect the patient by preventing the dangerous effects of the operation and of his own reactions. The anaesthetist was taking over the leading role from the surgeon.

For French anaesthetists, other considerations may also have come into play: after following foreign methods, there was one originating from France. Lowering the body's needs to preserve life was a tempting idea. Rather than diminishing it, British reticence to this method added to its appeal in

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France. Students love to surpass their teachers! And lastly, a concept that counselled submission for survival, at a time when the Resistance was being glorified, brought a certain justification to those who had remained aloof, if not fought against it outright.

While Laborit had rejected morphine, P. Huguenard included Dolosal (pethidine) in the basic mixture. This “cocktail” (Phenergan, Largactil, Dolosal) was the forerunner of the combination proposed by De Castro and Mundeleer, pairing fentanyl and a new tranquilliser, dehydrobenzperidol (Droleptan), which had a long career in anaesthesiology.

The first case study of the effects of this new substance, Largactil, on a healthy subject was on 9 November 1951, and I happened to have been involved. Largactil’s international success was the result of the discovery by Delay and Deniker of its anti-psychotic properties. The latter came up with the term neuroleptic (tranquilliser). The first case study of the psycho-affective effect dates to a human experiment that I helped to bring about. It has been described by two out of the four participants, Henri Laborit and Léon Chertok, and has been the subject of contrasting presentations. They met through my intermediary, in order to perform an experience that I had suggested. During this experience, I compared the effect of the Largactil injection on the volunteer (Dr Quarti) to the indifference observed on patients having undergone a prefrontal lobotomy. This comparison was certainly hasty, but Laborit was struck by it, and he subsequently quoted it.

I invited Laborit and Huguenard to come and expose their views at Cochin. Laborit gave a lecture entitled *Physio-pathology of the vegetative nervous system*, which was later published, and Huguenard, *A closer look at artificial hibernation*.

In 1954, Laborit and Huguenard published *Practising hibernato-therapy*. Huguenard summed up his ideas about hibernation as follows: “It hardly matters if the theory is correct or not... What matters is whether or not it works. It

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seems for the moment that it does, insofar as it has caused more cures than it is responsible for deaths." How could he be so sure of this without a comparative study? His talent for presentation was established from the very first publications that introduced potentiated anaesthesia, under the surprising title: *Trials in general anaesthesia without anaesthetics*. His skill for observation allowed him to select from out of 35 different combinations of paired drugs tested in 112 cases the two ones considered appropriate.

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In 1960, the Society of Anaesthesia needed to elect a new treasurer. Pierre Huguenard, Editor-in-Chief of the Society's journal, was convinced that he could get one of his disciples, Dr Jaquenoud, elected easily. But Jacques Boureau, who had been President of the Board of Administration since 1958, supported a different candidate – a pharmacologist, Prof Quevauviller – who in fact won the election. In a letter addressed to every member of the Society, Huguenard immediately announced that he was resigning as editor-in-chief and Secretary General. Then, in a note containing an analysis of the vote, he added, "The Society of Anaesthesia has one hundred and twenty full members, but only fifty-two anaesthetists (58 since February 1960). Only thirty-eight members attended the General Assembly of 17 December 1960, including approximately twenty anaesthetists". Ten anaesthetists out of the twenty or so in attendance decided to take the Society and its president to court for mismanagement, four others (Messrs Campan, Cara, Jolis and Lada) shared in the dissenters' reservations, while only two anaesthetists (E. Simon and J. Verhaeghe) seemed to remain neutral. Other members attending, Mrs Laborit (anaesthetist), Messrs J. Cahn and H. Laborit, were ready, if need be, to join the dissenters. In the opposing ranks, just one anaesthetist (myself) and two non-anaesthetists (Miss Levy, Mr Monod) attempted to defend the board.

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Huguenard and his cohorts then sued the President of the Society, accusing him of not respecting his obligations. Laborit wrote on this point: "Huguenard lost his position as editor-in-chief of the Journal because he supported my ideas". Indeed, the anaesthetists who supported Huguenard almost all believed in potentiated anaesthesia. The dissenters then founded the Association of French Anaesthetists, thereby creating a split in the still-emergent body of anaesthetists. The Association of French Anaesthetists (AAF) supported a specific doctrine. On 16 November 1960, at a round table about anaesthesia, a group of anaesthetists from Lyons distributed a newsletter inviting all anaesthetists to join the AAF.

Both sides defended their positions so passionately that one couldn't help wondering about their motivation. It seems likely that the conflict was exacerbated by a generation gap, as almost all of the younger members had joined the revolt. In addition, there was the refusal to submit to the Anglo-American point of view, which bestowed a patriotic aura on so-called "potentiated" anaesthesia.

The split in the Society of Anaesthesia at least had the positive effect of hastening its transformation into a Society of Anaesthetists, thanks to the surgeons' decision to leave it. A fundamental change in the Society's by-laws reserved the status of full membership for physician anaesthetist. Unfortunately, on the other hand, the split weakened French anaesthetists' standing abroad. A doctrine-based split and animosity between colleagues remained the norm for quite some time. From an international point of view, far from adding to their prestige, the existence of two societies weakened the French position.

In 1961, Mrs Plouvier-Delahaye succeeded Pierre Huguenard as Secretary General of the Society of Anaesthesia. Guy Vourc'h was appointed editor-in-chief of the journal.

Louis Lareng was President of the Society of Anaesthesia from 1964 to 1972. He is the only one of the post-war

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presidents to have remained in office for so long. Appointed as assistant professor in 1961, in 1963 he became the head of the anaesthesia and intensive-care department at Purpan Hospital in Toulouse. Founder of the SAMU (the French mobile-emergency service), under his leadership, anaesthetists began to have a role to play in the emergency room. Promoted from town counsellor to mayor of his village in the Upper Pyrenees, he was eventually elected deputy of the Haute-Garonne – representing the south Toulouse sector of the region – and in 1981 he became a Counsellor General for the region. This jovial, talented southerner shuttled constantly back and forth between Toulouse and Paris. Unflagging, undeterred, he always had some new idea and an enthusiastic and colourful way to describe it. He succeeded me as president of the National Anaesthesiology Commission of the Ministry of Health. Currently retired, he has become one of the leading proponents of tele-medicine, and has been president of the European Society of Tele-Medicine since 1989.

In the early years, at Monod's instigation, a special laboratory had been created by the Public Hospitals of Paris; it was run by Dr Maurice Cara, Monod's anaesthesia assistant. Maurice Cara had intended to become a physicist, before he developed an interest in anaesthesia. After the 1952 polio epidemic in Denmark, which illustrated the usefulness of pulmonary ventilation, several different machines were designed and built to this effect in various Scandinavian countries. The Engström had the best reputation of them all. A few of these devices were imported into France on a precautionary basis, and were delivered to Mr Cara for his testing laboratory. Pulmonary ventilation was adapted by Mr Cara for transporting certain patients, including those afflicted with tetanus and treated by curarisation. Rapid transport of patients to hospital had long been considered the best way to provide treatment. It eventually became apparent that certain ill or wounded patients' chances of survival could be improved greatly with on-the-spot care. This concept lead

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to the organisation of a mobile emergency-care service, the SAMU. Mr Cara was the director of the SAMU in Paris.

Cardio-respiratory intensive care was revamped by Prof Yvonne Noviant. At the end of the war, she came to Foch Hospital still in uniform. I encouraged her to go into anaesthesiology, which she studied under the direction of Kern. She took a first degree in France, then went to continue her studies abroad before beginning a university career which would see her achieve the rank of assistant professor. Department Head at Kremlin-Bicêtre hospital, she continued to practise at Marie-Lannelongue hospital. After several visits to Sweden, she developed cardio-pulmonary resuscitation in France. Elected senator of the European Academy of Anaesthesiology, she was the embodiment of French elegance and refinement in that assembly. She remained true to the memory of Kern and to an open-minded approach to anaesthesiology.

As president of the European section of the World Federation of Societies of Anaesthetists, I could see the disadvantage for France of having two Societies of Anaesthetists. When I became president of the SFAAR, in 1976, I led that Society's attempts to reconcile with the AAF. A tripartite umbrella organisation, the UFAR, regrouping the Society of Anaesthesia, the French Intensive Care Doctors' Association and the National Syndicate of Anaesthetist-Intensive Care Doctors, was constituted. On 18 December 1976, the French Society of Anaesthesia decided to join the UFAR, by a one-vote margin.

My successor as president of the Society was Charles Rouet, who had been one of my first students at Foch Hospital. In 1949, I had been part of the jury for his oral exams in anaesthesia. His experience as a Resistant put him in a favourable light in my eyes, and his decency and commitment turned this initial judgement into one of great esteem, which eventually evolved into close friendship. When it came time for him to start a career, and he found a post in

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Orleans, he spoke to me about his plans for his career. I suggested that he find an ENT surgeon and convince him to practise tonsillectomies on prone, anaesthetised and intubated children. He proceeded to do exactly that, and this revolutionary procedure was the beginning of a flourishing career.

As President of the UFAR, Charles Rouet spared no effort to achieve the fusion of the Society of Anaesthesia and the Association of French Anaesthetists, which did become legally effective in 1981. At that time, the SFAAR was presided by Prof Claude Winckler, a student and a friend of Prof Vourc'h.

In the end it took more than 20 years to re-establish unity amongst French anaesthetists, and for this achievement, Claude Winckler, a charming, efficient and skilful president, deserves our gratitude and congratulations.

The new Society, entitled "*French Anaesthesia and Intensive Care Society*" (SFAR) was the result of that fusion.

During that period, I was able to achieve two cherished goals. The first was the creation in 1977 of "The European Academy of Anaesthesiology", which I presided for four years. From its inception, this Academy united anaesthetists from all over Europe, including the then Eastern-bloc countries: USSR, Czechoslovakia, Poland, Romania, Yugoslavia and the GDR. This was facilitated by my position in the World Federation of Societies of Anaesthesiology, which put me in contact with anaesthetists the world over. My knowledge of French, English, German and Italian were also very useful. The idea in my mind was to promote encounters between European anaesthetists, in order to enable them to get to know each other better and to become familiar with their counterparts' professional lives. Indeed, as far as anaesthesia was concerned, certain questions were being posed back then that existing organisms were not qualified to debate. It must be borne in mind that the official doctrine in the USSR at the time was that local anaesthetic with procaine,

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administered by the surgeon, was the only authorised method. On the other end of the spectrum, in order to cope with the proliferation of new drugs, Prof Robert Macintosh was calling for a several-year-long suspension of pharmacological research in order to allow anaesthetists to properly train in the best use of existing agents.

In addition to organising annual scientific meetings in a different country each year, the Academy also created a European degree in Anaesthesia and Intensive Care (DEA) which was sufficiently well-received as to be adopted, at least in part, by certain Scandinavian countries as their national licensing exam.

Dr Zorab from Bristol was the main proponent of this European degree, and then of a movement to enhance the quality of anaesthetic training throughout Europe.

Prof Vickers of Cardiff was the founder and first editor of the European Journal of Anaesthesiology, a well-respected journal that promulgates European research in this discipline via the European Academy of Anaesthesia. It has become the European journal of reference, as it has brought together the discipline's other associations with a European vocation: the UEMS, and the European Society of Anaesthesiologists.

Prof Otteni, Strasbourgeois at heart, fervent European, and unflaggingly hard worker, contributed greatly to the success of the DEA and the organisation of this exam. Let him be thanked.

They all laboured for the causes of European anaesthesia.

Later on, I created an organisation called the "French Centre of the European Academy of Anaesthesiology", one of whose activities was to organise seminars several times a year to allow some 20 or so European doctors to debate on a given theme. These meetings took place at my home in Dordogne. The sessions were held during the day, and the evenings were reserved for introducing these doctors, and their spouses, to the charms of the Perigord region.

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My very first memory relating to pain is probably imaginary. It isn't really about pain per se, but perhaps about the fear of pain. If indeed it is a true memory, then it took place before I was five, because my mother's sister, who died of the Spanish flu in 1918, appears in it. The scene is as simple as can be: it is set in a lovely garden, in what would seem to be summer. For a reason that is unclear to me now, perhaps I had been frightened by a wasp, I am running towards my aunt, who welcomes me with open arms. This instantly soothes my fear and whatever pain there may be. In chronological order, several passages from books then come to mind: when I was about ten years old, I used to read stories about the Indians' indifference to pain, which gave terrifying details. Several scenes of torture endured without complaint figured in these novels. They brought me both horror and a kind of pleasure as well. Later, when studying Roman history, I learned about the glorious adventure of Mucius Scaevola, hero of the Roman war against the Etruscans. He had sneaked into the enemy camp to attack their leader. Once captured, and in order to impress his adversaries, he put his hand into the fire until it charred. Our Latin teacher's comment about this annoyed me greatly: he specified that Scaevola had put his right hand into the flames, but pointed out that the Roman soldier was left-handed. It was a cheap way to tarnish the glory of his triumph over pain.

At around the time I was reading the Indian stories, I was cruel to a little kitten one day, and I realised that it both made me feel guilty and gave me a certain pleasure as well. Later on, the war and the torture inflicted on prisoners made me reflect upon the lack of literature about sado-masochistic exchanges

In the course of a very pleasant year of my youth spent in a Swiss boarding school, I was granted a privilege by the principal: I could go to her private library and read whatever

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I pleased. Among her volumes was *The Imitation of Christ* by Thomas à Kempis, a 14th-century German contemplative monk. I was also very impressed by the Latin Stoics, Seneca and especially Cicero.

It wasn't until much later that the connections between pain suffered, pain as an object of fear, pain borne bravely and the pleasure in inflicting or even feeling pain appeared to me as the elements of the phenomenon of life that pain is. I was rather put off by the Romantics' attraction to suffering and death. Yet neither could I accept René Leriche's stance rejecting pain as "useless". Pavlov compared martyrs, singing on the way to their deaths, to dogs conditioned to being fed after getting a jolt of electricity and who will eventually begin to salivate as soon as they receive the jolt. This assimilation seemed to me both incorrect and unseemly. The usefulness of pain was a sort of excuse for its reality, whether from the evolutionist or the divine providence perspective.

I only mention the history of my interest in pain in order to justify my first article, which I wrote for the *Cahiers d'Anesthésiologie* in 1953, and which concerned pain. Years later, in England, I met a young doctor who was presenting information concerning the use of morphine-based products. More than her arguments in favour of a wider use of heroine, it was her quick sketch of a project for a palliative-care centre that caught my attention. If the name Cicely Saunders is now preceded by the title "Dame", it is because it was bestowed upon her for her great work, the founding of St Christopher's Hospice, work which has gained followers in many countries. I am proud to have been invited to both the stone-laying and the opening ceremony for this hospice.

The idea of a centre for terminally ill patients, organised to provide comfort and ease pain, i.e., the idea of accompanying the end of life, seemed excellent to me. To my mind, this institution should be combined with a centre for chronic-pain sufferers. The point would be to enable them to adjust to their condition, not in the spirit of fighting pain, but of easing

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it, through a new way of living with one's body. A first step towards associating these two categories of patients had been made at St Christopher's Hospice in London. My intention was to take it one step further in France, not only for practical reasons and the theoretical ones I have outlined above, but also to take into account the horror inspired in many doctors, particularly civil servants with the Ministry of Health, by what they termed a "death ward". And so I set out in search of premises that would suit this type of establishment. By chance, in Neuilly-sur-Seine, a suburb of Paris, I stumbled across a homeopathic hospital that had closed its doors before the war, and that had been requisitioned by the French Army in 1939. It had by then been handed back to the Association of Homeopaths, who still owned it, but it had never been reopened. I went to visit, and discovered a charming, almost rural place, with chickens and roosters roaming the courtyard. I began to negotiate with the owners, and discovered that although there was some disagreement within the Association, a sale did seem possible. Thanks to Mme Nicole de Hauteclouque, who was both a deputy and a friend of mine, I was put in contact with the then mayor of Neuilly, Mr Peretti, president of the National Assembly, who pretended to express an interest in the project. It did not go any further however, as the town of Neuilly expropriated the homeopaths in order to raze the hospital building and turn the grounds into a public park for the people of Neuilly.

My first attempt to create this kind of centre in Paris proper, dating back to 1964, failed for two reasons. The first was the horror inspired by the idea of a "death ward". The second was more circumstantial. The Health Minister of the time, Mr Marcellin, and the director of his cabinet, Dr Robin, offered me a ward in the grounds of Charenton Psychiatric Hospital. A combination of the location itself and its difficult access convinced me to abandon my hopes for a centre there.

Later on, I learned that the surgical clinic of the Augustine convent, located on the rue de la Santé, opposite Cochin

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Hospital, was going to be closed for administrative reasons. Through the establishment's anaesthetist, Dr Desvallées, a former student of mine at the anaesthesia service at Cochin, I was put in contact with the Mother Superior of the convent. She was very open to my plan to turn the clinic into a palliative-care centre for the terminally ill and for chronic-pain sufferers. The nuns whom she consulted however, were against the idea, arguing that such a centre would be too sad!

Considering all the difficulties I was encountering, I decided to ask Prof Robert Debré for advice. He recommended creating an association, and he suggested the name "Centre for the study and treatment of pain". That is precisely what I did in 1964. Prof Debré agreed to join, in order to represent medicine. I solicited the participation of Prof Levy-Solal, as a representative for obstetrics, and Prof Aboulker for surgery. These two respected professionals and personal friends were willing to help out by becoming respectively president and treasurer of the association; Mr Wladimir d'Ormesson, French ambassador, Emmanuel Monick, former governor of the *Banque de France*, Dean Zamansky, who had become a close friend, were also part of the scientific steering committee. In the end, it was in a completely different context that the analgesia clinic at Cochin Hospital came to be. Dr Escoffier-Lambiotte called me to the side of his friend and colleague, Mr Pierre Viansson-Ponté, political journalist with the newspaper *Le Monde*. I attended him in the last phase of his life. After Mr Viansson-Ponté passed away, Dr Escoffier-Lambiotte and his friends on the staff at *Le Monde* made a generous donation in his memory. The Public Hospitals of Paris acceded to my request to invest these funds in establishing a unit at Cochin Hospital for a chronic-pain clinic.

It was the first clinic of its kind in France, and it soon made a name for itself. But space was limited, and it had no beds for hospitalising patients. Through a series of events, we were able to obtain a transfer to Tarnier Hospital, which is attached to Cochin Hospital. The clinic has been open for

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some 15 years now. One of my former students, Dr Jean Bruxelles, has been at the helm since my retirement. The unit cares for more than a thousand patients a year.

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Thanks to my position in the World Federation of Anaesthesiology, I was able to organise a European congress in Paris during my tenure as president of the SFAAR. By putting French anaesthesia in the spotlight, I was able, I hope, to contribute to enhancing its prestige.

At my instigation, Prof Jean-Marie Desmonts, then president of the Society of Anaesthesia, currently Dean of the Bichat-Claude Bernard medical faculty, managed to create a steering committee for the creation of the French College of Anaesthetists-Intensive Care Doctors. This college brought together all of our anaesthesiology organisations (societies and syndicates). This organisation was the first to provide continuing medical training, which has since become "almost" mandatory. At my request, they submitted Paris's successful bid to hold the scientific conference of the European Academy of Anaesthesia in the year 2000. Prof Scherpereel was in charge of that conference, and he decided that it would be held in conjunction with the French Society of Anaesthesia's national congress. One would have hoped that this would have revived French anaesthetists' interest and participation in the Academy's activities!

As president of the SFAR, Prof Scherpereel also managed to obtain that, in 2004, by hosting the World Congress, Paris will once again become the international capital of anaesthesia; and so I send my best wishes to my discipline and to this congress.

The years have gone by, and they have been very full indeed. The way things turn out is often unexpected.

It has been a lesson in humility.

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I warmly thank:

- Professor José Aboulker
- Doctor Jacques Boureau
- Professeur Pierre Huguenard
- Professeur Philippe Monod-Broca
who willingly shared their memories with me.

Dedicated to my wife, Colette, who was sadly not able to read the completed text.

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Guy Vourc'h

Guy Vourc'h, a Portrait

By his son Francois Vourc'h*

Researcher, Urmis, Paris VII University/CNRS

You are asking me to do one of the most difficult things that a son can do: to describe my father. As those who knew Guy Vourc'h can attest, he himself makes the task all the more challenging. To describe him properly, I need to remain fair, avoid both Freudian revenge and glorifying my family, and this is difficult on both sides. On one hand I know nothing of medicine, and on the other he strongly influenced me as a child, fascinating and revolting me at times, and I still do not understand him as well as I would like. Why try to describe him now? As an attempt to set down and make clear

* I am the sole person responsible for the form and contents of this article, and all the footnotes. I would like to thank my nephew Marc-Étienne for kindly translating my texts and footnotes except for some footnotes specific to the english version (all followed my initials FV).

All texts on Guy Vourc'h were translated by Marc-Étienne Schlumberger: meschlum@hotmail.com

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the conversations about his life I had with him in his last years. There were two topics I was very interested in: the Second World War, and the appearance and growth of anaesthesiology in France during the fifties. Perhaps surprisingly, these two topics are more closely linked than it may seem at first glance.

Even without the influence of the horrors of the war, I am convinced his life would have been largely the same otherwise. He would have become a doctor, since that was his major after the baccalaureate. The university was a completely new intellectual environment for him, where he met many students of the *École normale*,¹ and considerably broadened his literary and musical knowledge. Still, he would have become a doctor, if only to follow the family tradition and follow his father's footsteps.

Guy was born in 1919, the eldest of nine children, in a Brittany that was still suffering from the horrors and losses of the First World War.

After the war and surviving a severe head injury suffered at Verdun², his father returned to the village of Plomodiern where he had chosen to live before the war. Both of Guy's parents³ served as role models for him, inspiring by example

1. The *École normale supérieure*, also known as "Ulm", is one of the oldest and most prestigious French *Grande École*. A long list of famous French scholars in sciences, philosophy, literature... were students there. (FV)
2. His second brought him back from the battlefield, then literally dragged out of a pile of bodies judged beyond help by a surgeon who recognised his medical insignia.
3. My grandfather's initial doctoral thesis had for a title : "Healing by faith : medical studies of a few healings at Lourdes". This in the middle of the fights over the separation between Church and State, and it seems he was asked to change his topic, on the night before his examination, by none less than the Archbishop of Bordeaux. To his examiners' great relief, my grandfather defended a completely different thesis the next day, which he'd spent the night writing with the help of some friends from the Naval medical school. His original thesis was finally published in its original form in 1911.

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his iron determination to do what was right and refuse any compromise or easy way out when dealing with “essential” matters, as well as his religion. He was strongly catholic, nearly a Jansenist along the lines of Blaise Pascal, whom he quoted willingly. To him, social and moral order had to coincide, and he remained inflexible and conservative on this topic his whole life.

He studied the classics, both figuratively and literally. First at Plomodiern, then as a boarder in the church run Saint-Yves high school in Quimper until graduation, like his younger brothers did after him. He did not enjoy those years much, and photographs of him during this period show him uncomfortable and sullen. After remarkable scores for his baccalaureate, he studied medicine in Paris where he lived in the *Cité Universitaire*⁴, but was interrupted by a six month stay in a sanatorium, then by his military service.

When the war began, unlike other first year medical students, he refused to be registered then mobilised as a military nurse, and instead volunteered to join the Army. So it was at the officer training school of Fontenay-le-Comte that he heard about the collapse of the French military and the armistice of 1940. He would not accept this defeat and deserted with many friends, intent on reaching England. It took him until October 1940 to reach England, with his brother Jean and four other friends, after an eleven day odyssey on board the ship “*La Petite Anna*”⁵.

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4. The only one in Paris at those times the cité was created, during the 20s, by the famous industrial Emile Deutsch de la Meurthe “to promote exchanges between students from all over the world” (FV)
 5. They left Douarnenez in October 1940 on what they expected would be a short trip, only to be caught in a terrible storm. Guy did not expect to survive and, prey to delirium, began reciting the “prayer for the dying”. He could also have chosen an extract from the only book he brought with him, Plato’s Phedon, the dialogue on Socrates’ death, a wonderful dissertation on the immortality of the soul.

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The four long years that followed were both frustrating as he endlessly awaited the opportunity to go out and fight⁶, and enlightening as he shaped his political opinions, and shared them with his friend Guy Hattu⁷, the nephew of George Bernanos, whom he admired a great deal. The friendship between the two Guy led them to ask to be affected to the same division, in the Kieffer commandos, where they met a third Guy, Guy de Montlaur⁸. They were all present at D-Day, on June sixth 1944, but my father was severely wounded minutes after landing. Passing on command of his Troop Number 1⁹, he watched his friends head off into the battle¹⁰.

His whole family rejected the “*Boche*” occupation, and participated in many ways. In the words of one of the members of a resistance network where the family members who stayed in France participated: “*between 1940 and 1944 the bench at Mass was emptier each time, until in 1944 only a single and feeble woman remained to attend the great Mass at Plomodiern. By then, the family was spread over all the fronts of the War: resistance, Black Africa, Libya, Alger, Italy; the landings in Normandy, Provence, or in Holland; the battles for Alsace, etc. Every time, at least one Vourc’h was there, fighting.*”

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6. Guy Vourc’h was convinced that the next battles would take place in England, and so decided to remain there, unlike his brother Jean who joined Leclerc’s army in Africa. In memory of Jean’s death on the eve of the liberation of Paris in August 1944, my father accepted the role of “Representative of the families of the Compagnons” in the Ordre de la Libération.
 7. Both spent time with the main figures of the paper La France Libre, which was known for opposing De Gaulle.
 8. Guy Hattu became my older brother Jean-Guy’s godfather, and Guy de Montlaur was mine.
 9. The Kieffer commandos were organised in Troops. Though he only held the rank of a sub lieutenant, my father commanded the troop number 1. It was the most severely struck unit on the beach of Ouistreham.
 10. In his book Béret Vert, Phillip Kieffer published a letter Dad sent him from the English hospital he was evacuated to.

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While one of my father's main traits was his abruptness, he should not be interpreted only from that perspective, as doing so would completely hide the other aspect of his intellect: he was interested and aware of all the great philosophical movements, from ancient Rome and Greece to the *Lumières*, and was always ready to argue his opinions, using his extensive reading for reference. He knew Xenophon, Demosthenes, Socrates, Plato, Cicero, etc. inside and out, along with all the literary greats: Montaigne, Pascal, Racine, Corneille, Voltaire¹¹, Renan, but also Villon, Baudelaire¹², Verlaine. As a child and adolescent, the works he referred to were for me source of knowledge and nightmares, fascination and fear (I only managed to understand the quotes from "*sapeur Camembert*" and "*savant Cosinus*"¹³, both of which made him break into gales of laughter).

His knowledge was not a disordered mass of information, full of badly chosen quotes, but true culture, both of the classics and modern works, which he used to build his worldview. His favourite Christian authors were Saint-Augustine, Pascal, Péguy, Bernanos and two men from Brittany, Chateaubriand and Renan, not the rationalist but the one who wrote the Prayer on the Acropolis. These writers show his loyalty to the austere school of thought that reveals the stoic and Christian man through his inner suffering, whose faith drives him to always seek his eternal salvation that can only come from God's final forgiveness. The Greeks, and Demosthenes in particular, taught him to refuse to serve

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11. He used this agnostic writer's *Candide* as a pseudonym for some of his articles, a sign that in spite of being catholic he willingly set himself against the Church, and did not care much for the institution itself, attitudes that were the product of his upbringing and of the War.
 12. While Holland layed in the water, he had named the *Doris* used for the commando raids : "*Heautontimeroumenos : le boureau de soi-même*", as an homage to Baudelaire. He knew many of the poet's works by heart.
 13. Two comic strips very famous in France, published by Georges Colomb, called *Christophe* at the end of the 19th century (FV).

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the conquerors, like the Greek orators who spoke for freedom in front of Phillip of Macedon, or Bernanos's *Carmélites* who would not give in, even in the face of death. The book he loved the most, whose every word and sentence he knew exactly, and upon which he often thought, was *Les mémoires d'outre-tombe*, which honours Christian duty before the hope of divine salvation and, when facing death, before the overwhelming perspectives of eternity.

His vast culture was linked to the image he had of his duties as a doctor and as an educator. He combined strong moral principles, illustrated by his constant references to the Hippocratic oath, with a nearly encyclopaedic knowledge of medicine, the latter was greatly assisted by his phenomenal memory. His memory allowed him to get around his difficulties in mathematics, one of the rare areas where he admitted to being utterly incompetent. Another paradox lies here, for while his whole life he found it difficult to repair a simple electrical outlet, he spent his entire professional life in a completely technological environment. For instance, when discussing his work with people from the Afnor¹⁴, he could quote each and every characteristic of the equipment he used.

His political formation was complicated, and is still rather obscure to me. As a student in Paris before the war, he seems to have been tempted for a short while by the conservative and monarchist right, along the ideas of Charles Mauras. However, like his father, he opposed the Munich accords. He supported the Spanish republicans¹⁵, and rejected both Nazism and Franquism. His political experiences in England were somewhat contradictory: he was a fervent anti-Nazi, but

14. *Association Française de Normalisation* in charge of the promotion of French standardisation at international level, and cooperation with third countries. (FV)

15. To him, as a catholic, only the position taken by Georges Bernanos was valid. When he was in the commandos, he met many men who had participated in the Spanish war, mostly in the International Brigades, and he admired and respected these men a lot.

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also broke with Gaullism, while casting aside his pre-war references. We rarely spoke of politics, but when we did we discussed the major issues of the post World War II world. One of my earliest memories is of him listening to the radio, empathetic and horrified, as people called for help from Budapest as the riots there were violently repressed. He was a vigorous supporter of Pierre Mendes-France¹⁶ and his wish to decolonise Indochina. During the Algerian war, he fervently decried the use of torture but did not, to my knowledge, publicly state his opinion or participate in demonstrations¹⁷. Later, he welcomed the vents of May 1958¹⁸ and the end of the Algerian war, but he forgave the head of Free France upon reading the *Mémoires de guerre*, rather than for De Gaulle's political actions. Besides *Le Monde*, he read few newspapers, sometimes *France Observateur*, or the equivalent of the *Express* at the time. The only periodic he was interested in was *Esprit*¹⁹, which he subscribed to from its beginnings shortly after the war; in it, he particularly enjoyed reading the texts and editorials of Emmanuel Mounier and his successor Jean-Marie Domenach.

After reading the papers you were kind enough to let me see, his opinion of May 1968 and the dreams of utopia around

16. in June 1954, Mendès-France formed a government and immediately negotiated an armistice with Ho Chi Minh, the Vietnamese Communist leader, that ended *la guerre d'Indochine* (FV).

17. He did, however, write a letter of support for the general Paris de la Bollardière, who was denounced in 1957 for protesting against the use of torture. He also blamed De Gaulle for his inaction despite the facts reported by Geneviève Anthonioz-De Gaulle and others.

18. This was one of the few times our entire family went to the Champs Elyseés to see De Gaulle and Coty on parade.

19. The *Revue Esprit* was founded before the war by the philosopher Emmanuel Mounier. After the war Esprit brought together intellectuals from "*La résistance*" against Stalinism and the French colonisation's wars. *France Observateur* and the *Express* were founded latter to inform agaisnt the Algerian war. (FV).

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it seems less hostile and more open than my memories suggest. The best illustration of his opinion about this period can be found in his speech for the 18th French Conference on Anaesthesiology and Reanimation at La Baule²⁰: Péguy, Bernanos, Chateaubriand and Renan were quoted once more to support his statements. While he seemed to find protests against conservatism in universities and politics both legit and necessary, he did not extend this opening to social changes, in particular as to lifestyles. Debates on sexual freedom, abortion, etc. quickly became violent arguments rather than more reasoned discussions among people with differing viewpoints. This topic was another thing that made him break up with many of those near him, in his family or among his colleagues, despite their strong bonds in other areas.

It was in June 1968 that, exceptionally and by pure coincidence, he was at the *Arc de Triomphe* on the Commemoration Day for June 6th 1944, and to his surprise and anger was accused of being a Fascist by nearby students. He expressed his fury at the insult in a remarkable letter to *Le Monde*²¹. In it, his indignation, visceral rage and incomprehension in face of the insult made to the dead are manifest. Overall, he was actively opposed to the social changes taking place, and did not hesitate to show it. He found Sartre's rise to prominence among the figures of May 1968 particularly annoying, as Sartre has "*did have a single day of war to blacken his record.*"

As a teenager, I had little contact with his work, except via often horrifying stories he would gleefully tell his non-doctor dinner guests at the end of the meal (ablation of the bladder instead of an appendectomy, forgetting different tools and bandages, mistaken diagnostics, or even patients, etc.).

20. Published in *Anesthésie Analgésie Réanimation* 1968. Volume XXV, pages CDXXXV-CDXXXIV

21. The letter was republished twenty years later in a report *Le Monde* published about May 1968.

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Sometimes he'd also happily describe his "fisticuffs" – to say the least – with the management or other doctors at the Foch hospital. One of his fellow workers supposedly said: "*I have only two enemies: the taxman and Vourc'h*"; the director of Foch was accused of wanting to run "*a small provincial hospital*" where Dad wanted it to be on the breaking edge.

I have a few other memories left, of frantic days spent getting ready for his aggregation, of setting up a reception desk in a room "won" from part of my maternal grandmother's connected apartment, or of mysterious briefcases, full of anaesthesiology equipment, piles of documents or medicine, that lay in his office. Most of the time, he'd lock himself inside and come out a few hours later, having written, often in a single effort, an article in French or in English, or corrected draft articles and examinations. This last activity at times distressed him, at times made him laugh out loud at the foolish notions he found there²², things all teachers have experienced. I also recall how often he was away on duty at the hospital, sometimes leaving in a hurry, or the nights of medical "discoveries"²³. I only saw him at work once, during a televised presentation. Almost as soon as the show began, he stood up, outraged, because the producers had "stuck" the commentary for another operation on the images, apparently "involuntarily" reproducing Chateaubriand's inversion during his trip from Paris to Jerusalem: the patients' heart was on the right and the doctors seemed very strangely lateralised.

22. Such as a question asked by a student in his last year of anaesthesiology: "According to you, what are the symptoms of an inability to breathe?"

23. In fact, the excuse of a medical emergency was used, in spring 1961, by our parents to hide from children his participation in the plans to defend Paris from the threat of parachutists from Algeria intent on overthrowing the government. "Just a walk" he went on with Jean Lassner... He came back the next morning, very amused – "it was complete chaos" – that he'd had to patrol all night with a pair of shoes shoved in his pockets.

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There were some rare moments of true professional friendship, during the “cheese” dinners at “*54 faubourg Saint-Honore²⁴*”, which I awaited impatiently, enjoying the chance to “rob my favourite Lucullus”. At those parties, I met high dignitaries (or people I believed to be), fellow workers, friends, students and collaborators; also during family meals with some of his students, many of whom were foreigners. My horizons opened with hints of Turkey, Syria, Lebanon.... At times, I found out about them as he related situations in which he behaved in a completely new way: for instance, the memorable party for Foch interns, where as photographs attest he dressed up as a cardinal blessing his flock.

He was also this way when we went to Brittany, always from July 15th to August 15th, when he relaxed away from the stress of his work. He enjoyed boating, fishing for crabs or with a seine, and was friendly and happy to speak with others, his friends or even passing strangers. Except for Germans, of course: one day, a couple came by close to the house at Ty Gard point, and Dad told them about its history, etc. then he asked where they came from, and their innocent answer was “*From Germany*”. “*Murderers always come back to the scene of the crime*” was his response, before he went back into his house and slammed the door shut. Much like Spain under Franco, he refused for a long time to go to Germany “*the focus of his resentment*”. In Brittany, we lived in Menez C’heg, which my grandfather rebuilt out of granite after the “*Boches*” dynamited the old one during the war, or in Ty Gard, which my father restored. Ty Gard was the last remnant of Napoleons’ attempts to keep an eye on the English and, according to rumour, to prevent the “Bretons” from trading with them during the continental blockade. It’s a single room, hanging on top of a cliff, surrounded by water. And finally in Menez Yann, built in the late seventies “deep” in the country, on the sides of the Menez Hom... on the land where, as a

24. Family home in Paris, just in front of the British embassy (FV).

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teenager, Dad liked to spend his afternoons reading and meditating. He always dressed in his fisherman's clothing, pink for Camaret or blue for Douarnenez, clothing that was if possible washed out and patched up, which led a "tourist" to tell her overly curious daughter "*leave those poor people alone*". He rediscovered some of the feel of the world before the War, and loved to tell stories to children and adults, much like his father, a remarkable and at times terrifying storyteller. My childhood was full of korrigans, Mathusalem's nightly visits, the city of Ys, King Gradlon, Saint-Guénole's miracles, the abominable Dahu, the ambiguous Marie Morgane...

I also remember him coming back from conferences set all over the world, enthused by discussions he'd had in Romania or Brazil, sometimes distressed by the foolishness of the people he met. For instance, there was a soviet marshal doctor, wearing a plethora of decorations, who made him tour one of the country's icy cold great hospitals in the middle of the winter, insulting all his subordinates and showing no care for his guest's comfort.

Let us go back to the beginning of his career. He found it difficult to resume his medical studies after so many years of military life. In the course of our discussions, whose transcript you can find in this document, he described his doubts and difficulties: after such a long interruption he was tempted to enrol in the army, where a position awaited him, or to become an administrator for the African colonies. His specialisation in anaesthesia was something of a "default option", but he quickly became aware of the discipline's importance.

Though coming back to France was a shock, he managed to build a "niche" in Foch that did not depend on the vagaries of public health policies. In 1952, anaesthesia still was not viewed as a branch of medicine, and could be given by any nurse who was on hand, as was the case before the War. The emblem of the surgeon was dominant in the notions of medicine, and the anaesthesiologist was there to make the

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patient available – not for the surgical act, but for the surgeon himself.

And this seems to be the keystone of the dispute that would “poison”²⁵ the lives of anaesthesiologists for decades. Roughly speaking, there were two opposed schools of thought, one focussed on the patient and wanted to completely separate anaesthesia from the surgical act, which would make anaesthesia the first stage of an operation. This would also have destroyed the surgeon's absolute power, only the anaesthesiologist could decide when an operation would take place.

The other viewpoint, at least the way my father put it, took the reversed perceptive and based itself on the nature of the intervention that would take place; the objective was to make the patient available to the surgeon for the operation under the best circumstances possible. He made surgeons his allies, his department and students his calling card, to face down his detractors with pride and some self-satisfaction. However, he also demanded that those working with him meet exacting timetables, and perform with care and precision. Here, his fellow workers at Foch can bear witness to his dedication to tracking down and preventing any failure to the rules he established. He wanted a model service and viewed incidents or mistakes as a personal insult. What he would not look over in others during his judicial expertises, he could not accept to see in his domain. Many times, I saw him hang up the telephone, slightly pale, hold his head in his hands and cry out: “How could such a thing have happened in my service?”

The paradox, which the developments at Foch illustrate, was that for the whole to perform well the “head surgeons” had to release their control over the complex structures of the

25. The disagreement between the two schools was very violent and lasted a long time. I am not qualified to discuss the contents and scientific value of each side's arguments, but it is worth noting that this fight only took place in France.

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operating block and be put together in a single place, under the direction of an anaesthesiologist.

It was in this hospital, unburdened by the constraints of public health policies, that he was able to put his ideas into practice. This is how he patiently created the “famous operating block” where he ruled, and was “Mister” for the rest of his career.

And this brings us back to the structure of the medical professions in a hospital, which he described in our conversation.

The other aspect he insisted upon, recalling the first anaesthesias he performed before the War, was that anaesthesia is a fully medical act, for which nurses are not qualified, and that only specialist doctors can perform or be responsible for (thus, at Foch, there was a team of specialised nurses for this purpose). Under no circumstances would he allow a surgeon – even his brother in law Alain Gayet – to take responsibility for this act. One of his leitmotifs was: “*There is no minor anaesthesia.*” And yet many hospitals, and countless private clinics and dental cabinets, did exactly that during the fifties.

When he came back to France, he failed his first examination for an assistantship, as the topic and especially his response were beyond what the examiners understood. This links to another of the issues he cared about, ensuring that the teaching and examination of future anaesthesiologists be done by other anaesthesiologists and for anaesthesiologists. He spent a lot of time on this, but remained active in the applied parts of his work as well. For him, the future of anaesthesia as a specialty in its own right rested on the linkage of practice with education.

A final aspect remains, one that his personality, his stubbornness and convictions made him avoid or set him aside, the acquisition of power. Remaining fixed in the position of the “righteous”, playing on the contradiction between

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creating the structure of a profession and participating in it every day with great skill and subtlety, he pretended to believe that he only had to "*speak the truth*" to make any opposition vanish. He probably did not measure the full implications of his policies, or focussed too much on professional ability as a measure of competence, but he managed to move the system from Ombredanne's mask to computers and computer-assisted observation! Another paradox is that he promoted these technologies....

He was a paradoxical man, apparently cold and distant, inflexible, sometimes abrupt, but he also knew how to be friendly and funny, ready to help those he met to the limits of his ability and knowledge. I also saw him pay close attention and take significant interest in friends and colleagues whose viewpoints he would not have accepted coming from me.

Before I conclude this brief text about my family, I have to mention my mother, who for all her absence in this document was far more crucial than my father in establishing a family structure, showing me that I could live without constant altercations. Very early, she had and shared the perceptiveness of a peaceful and tolerant world where everyone could freely express their own opinions, even on "difficult" moral issues. They met in the mid thirties when the Gayet family came to Plomodiern, and Brigitte was with him first in his thoughts, then in his life. He tried to relearn how to love and live after the horrors of the War, as the world was discovering their true extent; at the end of the war, when he was in the army occupying Germany, he wrote to his wife to be: "*Nothing will be the way it was, I've seen too much of what men can do, and I will never regain the joy I had before the war.*" The regulations for the troops in Germany went so far as to forbid responding to "children's smiles". Brigitte is certainly the one who allowed him to defeat the "spleen" that cast him down so many times. Both shared a deep, abiding faith, though they expressed it differently, but above all they shared a wonderful love. His last days were painful, but Mom faced them, convinced that

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**“The Disturbances of June 6th
at the Arc the Triomphe”**

I am a former captain in the first marine commando battalion, currently a Professor at the faculty of medicine in Paris.

On June 6th, the anniversary of D-Day, I headed towards the Arc de Triomphe to join the ceremony planned exactly at 6 pm to commemorate our friends who died in battle twenty four years ago. I was there by pure chance, for while the memory of my dead friends is still with me, I have rarely had the opportunity to participate in the ceremony.

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Another demonstration, containing members of the CFDT1 clogged up the Champs-Élysées. I was somewhat surprised to see red and black flags as well as student

signs (the one explained the other, perhaps).

My companions and I (about a hundred in all, former commandos and parachutists in the Free French forces) gathered in the corner of the Champs Elysées avenue and raised out our old flags – which, truth to tell, bore the Croix de Lorraine.

They were the same flags that, in 1944, were welcomed with explosions of joy by the villages we freed. Apparently, raising them was an unbearable insult. About a hundred demonstrators, between twenty and twenty-five, and whose dress did not evoke the working class, charged us while calling us fascists and bastards, raising their fists and singing the Internationale.

I'd like to point out, if I may, that if these young people can behave the way they do, it may be because their elders paid a significant price so that they would have the right to do so.

Being called a fascist when, like me, your soul and flesh have suffered from five long years of war against nazism and fascism is hard to bear, especially on the anniversary of the Libération. Many of those whose memory we had gathered to

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honour were communists or socialists. Other students, our comrades, died fighting the same fight, in deportation camps or before the firing squad. They would be as besmirched as we were by these young fool's insults if we were not all bound together by a common purpose that they seemingly cannot imagine.

What followed was predictable : some of the "war veterans" expressed political opinions that were inappropriate under the

circumstances. Almost everyone remained calm, and we managed to finish the ceremony in dignity. Did we deserve to be treated thus ?

For myself, I believe not, for I have not changed.

Le Monde, June 5th 1968

Guy Vourc'h

1. Confédération Française Démocratique du Travail. A socialist French trade union politically active during spring 68 (FV).

they would meet again in the next world, just as they met on the steps of the Madeleine in 1946, when she was a young pharmacist and he was a young officer of the Kieffer commandos, wrapped in glory and mystery.

I can only wish that their so ardently desired rejoining took place in 1998 when, after a terrible disease, Mom left us as well.

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October 1988, Brigitte and Guy Vourc'h



Guy Vourc'h, London 1943

Guy Vourc'h and His Country: Plomodiern “These Men who Set Us Free”

Extracts from the *Revue de la France Libre*,
2nd trimester 1982 p. 9-11*

Those who have met Professor Guy Vourc'h remember a man who knew how to combine greatness and simplicity.

Those who had the fortune to share his professional life will remember the quality of his teaching, his rigorous standards for himself and others, his humanity, his goodness.

But Guy Vourc'h is also part of “*les Vourc'h de Plomodiern*”.

On April 11th, 1982, Easter day, Plomodiern, which lies at the entrance to the Crozon peninsula, where blue houses gather around the granite clocktower, was declared a key center for the Resistance, and set up a plaque honouring Doctor Vourc'h on the walls of the town hall.

That doctor was not Guy, since it was his father, but the whole family deserves recognition for what they did.

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This father, a fervent catholic, a doctor, came from a farming family in Guipavas, was the second youngest among ten siblings and had been a glorious combatant in the First World War, when he was awarded the Legion of Honour at the Invalides in 1916. He was fifty-four in June 1940 when, after a few days in prison brought on by speaking his mind too openly, he started helping young men who wanted to leave and join De Gaulle. He joined an organised Resistance group in April 1941 and created the "Johnny network", a transfer point for information gathered around Brest. The Gestapo destroyed the network, and he managed to escape in 1942. He was in Alger in November 1942 where he met his son Jean, who fought in Leclerc's columns, for the last time. When peace returned, he became a representative then a senator, and worked to preserve the memory of the Resistance.

He was the father of four sons and five daughters, all as ready as he was to give their all to free France:

Guy: Green Beret in the commandos. Landed at Ouistreham;

Jean: 2nd DB – Compagnon de la Libération. Wounded on August 24th at Voisins-le-Bretonneux near Versailles – died August 28th 1944;

Paul: Cadet of the Free France "Fezza-Tunisia class" – 1st DFL – landed at Frejus;

Yves: Green Beret in the commandos – On November 1st, 1944 he took part in the liberation of Flushing (Walcheren island, Holland).

On this day of commemoration, it seems fitting to remember the bonds between Guy Vourc'h and Jean Lassner, bonds that were not only professional.

In 1942, Guy's mother, alone, continued her husband's work in welcoming and assisting Resistance members. In October 1943 a young officer, from the Bir-Hakiem class of the Free French Cadets and recently parachuted into France, came to ask for her help. He was Jean-Claude Camors, the

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head of the Bordeaux Loupiac network and put in charge of ensuring the return of allied pilots who had landed in France. With Marguerite Vourc'h and her son Yves' enthusiastic assistance, he managed to leave Camaret on October 23rd 1943 with the nineteen pilots who had been hiding in the Sainte-Marie chapel at Menez Hom.

Jean-Claude Camors was the friend of another Cadet of Free France, Jean-Claude Diamant-Berger, Colette Lassner's brother. Jean-Claude Diamant-Berger had been in the Fezzan-Tunisia class with Paul Vourc'h.

Jean-Claude Camors, Compagnon de la Libération, captured and killed by the Gestapo in 1943

Jean-Claude Diamant-Berger, parachutist, died for France on the banks of the Orne on July 24th 1944. A poet, he wrote the following text upon learning about Camors' death, his friend and schoolmate. Guy Vourc'h who had become Jean-Claude Diamant-Berger's friend in London, knew the poem by heart and recited it out loud to those who would listen to him:

*It is not our hollow tears
and our regrets and thoughts
that will grant us eternity;
there is no call to cry.
It is not a sad poem
that will bring you back to life
Camors and already you are no longer a memory
but a legend. A Legend and you, where are you?
God knows, Camors
It is not a sad poem
it is not even tears
it is not speech
that can make you live again.
In France and in the World, oh how many rosaries*

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*In France and in the World, oh how many prayers are freed for
you from the chains of human bondage?*

*You are no longer memory
but legend and your death struck our adolescence
like a final axe blow.*

*Who will give us back our youth
and summer in Bewdley and the harmonious Severn
and my all consuming love*

*for that kind young girl; and your beloved heroism Camors, and
the sun sinking besides us when under the tall tree we listened to the
second symphony.*

*It is not a sad poem nor a dream nor nostalgia
But Life, Life beyond the world*

*Why spread death and pain when all of death is held within a
single corpse*

and when all suffering is resolved in his passion.

They broke your bones, they made a martyr of Your Flesh

And I was with them Lord and this blood you bleed is my own.

This is how Guy Vourc'h and Jean Lassner, friends and colleagues, found themselves bound together by the War and the memory of their dead friends, but they only knew this story many years after they first met.

Unpublished Interview of Guy Vourc'h

Made in 1986 by his son Francois*

Once the war was over, I went back to civilian life. I had begun studying medicine before the war. At the time, there was a compulsory surgery traineeship for first year students. At the time, no one liked anaesthesia, and just about anybody gave it: a poorly trained nurse, a local doctor who didn't know anything about it, sometimes the surgeon's driver and, in hospitals, interns or trainees. Interns did all they could to avoid the job. So it was typically the poor trainees who ended up doing it, caught by a passing nurse saying something along the lines of: "*You there, there's a patient who has to put to sleep... Hurry up and do it. The Chief is waiting. Hurry...*"

The only *tool* we had at the time for anaesthesia was Ombredanne's mask. It was a kind of metal sphere with felt inside. We'd fill it with ether, chloroform, or Schleich's mixture (ether, chloroform and ethyl chlorate). When we asked to put patients to sleep, no one had any idea of what was really happening.

We were told:

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“All right, you put the mask on the patient, then you turn the dial: 0, 1, 2... Then from time to time – every minute... every two minutes... You set the dial up one unit. Sometimes the patient coughs or throws up, and you move the dial back down because it could be dangerous. When you’ve reached 8, the highest level, the patient is asleep.”

When the patient wasn't fully asleep, the surgeon would complain:

“What are you waiting for, put that guy to sleep!”

“But sir, the dial is already up to eight...”

Waking up afterwards was horrible: the patient threw up. It was awful. At the time I wasn't aware of the risks to the patient involved in the method I used, because no one had taught me anything about anaesthesia.

In January 1946 I did a first traineeship in surgery. Nothing had changed, we still used Ombredanne's mask. However, the Parisian public health system had bought anaesthetic equipment from the American army. Each surgery had received two modern machines (Heidbrink). But no one knew how to use them!

In June 1946 I took first place at the competitive examination for internships in the Parisian hospitals. I was assigned to Jean-Paul Binet's surgery in Beaujon hospital. I was newly married and we had a baby. I told my boss about my unusual career, medical school before the war, the war, then medical school after the war, and especially mentioned my wife and child. Given my age, I expected to have trouble with an internship, and was mostly looking for a way to make a living for myself and my family.

Jean-Paul Binet then asked: *“Why don't you do anaesthesia? It's a completely new discipline, with a bright future ahead of it. England and America are far more advanced than we are in the discipline. You should try to get funding to go there and learn about anaesthesia.”*

As I failed to express any opinion on the matter, he continued: *“Well, since you're so interested in anaesthesia, I'm*

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putting you in charge of it here.” This new responsibility did nothing to increase my knowledge of anaesthesia. Of course, at the time, I was hardly alone in my ignorance. All the nurses, surgeons and wardens who were asked to put patients to sleep were equally uninformed.

My friend Jacques Boureau’s father told the story of how, when his patients wouldn’t fall asleep, Antonin Gosset would kick him under the table saying “*Boureau, come on! Do something!*” At the time, anaesthesiologists made their living by working for hospital heads in private clinics. When the service had to perform a very difficult operation, the surgeon asked one of the anaesthesiologists working in the city to come and put the patient to sleep, for free, of course!

Moulonguet came back from the United States in 1947, dazzled by the advanced state of anaesthesia: services, departments and specialised doctors, so much so that he promptly organised classes in anaesthesia. The course was at first six months long, then it grew to an entire year. Local anaesthesiologists taught the classes, some of whom did not know about the recent, and mostly English, advances in the discipline. A few of them had served in the War, and so had been in English or American military hospitals.

I attended these classes from the beginning, a few late night theoretical courses at the faculty and applied lessons that were supposed to be done in the hospital or, quite often, in clinics.

The army and later hospitals bought or were given American equipment after the War. The equipment was designed for adults only. Just as laryngoscopes were not designed for children, none of the anaesthetic equipment was either. The first anaesthesiologists to be trained after the war hadn’t had any opportunity to become familiar with epidurals or rachianaesthesias. Since surgeons were trained in these areas, anaesthesiologists ran the risk of significant criticism.

One of the formative events of my career was meeting the very kind anaesthesiologist Dr Amiot. When we first met, he was struck by my likeness to one of his wife’s children, who was

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in the Resistance and had been shot by the Nazis. This is doubtless why he became very fond of me. He gave me the following piece of advice: "*Don't waste your time going to the United States. England is much closer and they are just as good in anaesthesia, because only doctors have been performing it since 1846.*"

When my internship was over in 1949, I wrote to Prof. Adrien at Cambridge, Nobel prize in physiology and a friend of my father-in-law the physiologist René Gayet. I knew him quite well because I had spent a few days with his family in Cambridge when I was on leave. He at once told a friend of his about me, who advised me to ask the *British Council* for funding. Few people were asking for funding at the time, I spoke English, I had English medals, so I was accepted at once and left for England in October 1949.

There were two parts to the English diploma: the first year focussed on basic knowledge, and the second year on the practise of anaesthesiology. I was alone during the first six months, as a boarder at the Royal College of Surgery. The teachers were wonderful, very high level physiologists and remarkable pharmacologists. We had recent pharmacology and physiology textbooks, while the only ones that could be found in France dated from before the war. I was accepted at the first examination. Then Brigitte and the children came over, and Adrien offered to put all of you up while I stayed in London.

I applied for an internship at the *Middlesex Hospital* in London. I was accepted after an interview, and had the opportunity to see what anaesthesiology could be when given by competent doctors to assist highly skilled surgeons. I learned a lot over that year, and passed the second year examination, receiving the English degree for anaesthesiology.

In 1951, I wrote to Moulonguet to tell him about my diploma and ask for a position. He put me in touch with Prof. Cadenat at Saint-Antoine hospital, who did not have an anaesthesiologist. When I arrived, I took in the sorry state of the surgery methods and equipment, and thought to myself: "*I*

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can't work in this environment. It simply cannot be done. I didn't go to England and learn anaesthesia to step back into the Middle Ages!"

I then met an old friend I'd lost from sight, Ms. Chavelet, whom I'd first met when I was an intern. She knew Nedey well, he was a doctor at Foch hospital, and she recommended me to him. The hospital had just opened after being invested by the French army in 1939, then the German army in 1940, then again by the French army in 1944. It was run by the French national railways, but was open to the public. The workspace included a central operating bloc, reanimation rooms, and a polyvalent reanimation service. Their use of physiological and pharmacological knowledge for anaesthesia and reanimation was far ahead of the practises elsewhere in France; this despite many of the practises being commonplace in other countries, England in particular. But the laryngoscopes they used were still the American army's! Fortunately, I had bought supplies in England and had everything I needed.

The working conditions at Foch were similar to those in English hospitals. Mr Chevalier, the energetic director of the hospital, of a new type for France, was largely responsible for the creation of a modern anaesthesia service in Foch.

Dr Faure, an old and very kind man, was the head of the service when I arrived. He had taught histology at Toulouse and had changed disciplines to anaesthesia after the war. He didn't understand it very well, and trusted me to do what was right. The surgeons quickly realised that I understood my work well and since they trusted me, I was the head of the service for all practical purposes.

In 1952, Moulonguet asked me to help him and participate in his classes. I found it easy to translate the courses I had followed in England into French. Therefore I was quickly given educational responsibilities, though the title did not come with any money attached. Soon afterwards Moulonguet told me that anaesthesia assistants for hospitals would soon be

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selected via a competitive examination. The first step that followed the public health care system's acceptance of anaesthesia was the creation of this examination. I entered it in 1952 but failed. I think my answers were too complicated for the examiners to understand! I passed the next year, and once I became an anaesthesia assistant for hospitals, I had to be on call for the Paris public hospitals. I was on top of the list for on call assistants, a position Claude Winkler took over in 1961.

This form of call duty applied to all hospitals. There was an on call surgery resident, who had to bring in the on call surgeon if any problems arose. The surgeon then either allowed the resident to operate, or did so himself. We were on call from 2 pm to 8 am the next morning, and had to do so once every two weeks, as well as one week-end every other month. We stayed at home, close to the telephone, to answer any calls. If the surgeon decided to come in person, the anaesthesiologist was summoned. A car with anaesthesiology equipment was sent by the public health system to collect him. After many years of being on call, we were moved into the reserve, which was rarely called upon.

In 1953 the public health system created a higher rank: associate doctors in anaesthesia. This was the result of a compromise aiming to avoid naming anaesthesiologists as heads of services. I applied for the rank and was accepted.

In 1954 Prof. Moulonguet introduced me to the well-known Dr Harry Beecher when he came to Paris. Beecher asked me come work for him at Boston's Massachusetts General Hospital. It was difficult to pull off due to our three children, but we managed to spend six months in Boston. In the United States hospitals were rich and very well equipped, and the surgeons were very good. Anaesthesia was relatively poor compared to England, however. The American anaesthesiologists had neither the skills nor the style of their British counterparts. They had set ideas and resisted change.

appreciations

For instance, Beecher had decided that curare was dangerous and forbid its use.

While in Boston, I met Keith Sykes, who is now a Professor of anaesthesia in Oxford. Even though we both bemoaned the sorry state of American anaesthesia compared to that in England, my time there was educational and I established a lot of professional contacts, which is always worthwhile.

When I came back to Paris in December 1955, I went back to my responsibilities at Foch and my teaching. That's when Moulonguet told me that the School of Medicine would make his assistant Jean Baumann the head of an anaesthesiology department. At the same time, he told me about a Professorship that was also being created, and that he hoped to give to me! It was quite a surprise, and a great honour. I had to pass an examination, with a jury made of pharmacologists, biologists and surgeons. Even though I am "*the only worthwhile candidate*" Moulonguet warns me that I should keep up appearances and give two classes, one three quarters of an hour long and the other lasting an hour. The examination was done with great care.

And so in 1958, the surgeon Jean Baumann became the first head of a Parisian anaesthesiology department, and I became the first Professor of anaesthesiology in France.

That same year, with De Gaulle back in power and Michel Debré the prime minister, Professor Robert Debré took advantage of the opportunity to change hospital organisation into something closer to the Anglo-Saxon model. Until then all the doctors who worked at a hospital, as well as hospital associates or assistants, were barely paid at all. Being given a position in a hospital brought them fame, and fame made their private clinics more popular. The change introduced full time, fully paid work in hospitals. The first years after the Debré reform saw rapid growth in hospitals. University hospitals were created all over France, with surgeries and what were in effect anaesthesiology services. Some doctors

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who had been assistants for years were given full time positions and awarded honorary doctorates in these hospitals.

Over the following three or four years, many doctors received these positions. Anaesthesiology was finally recognised as a full-blown discipline in France. Before the reform, an anaesthesiologist was only a surgeon's assistant. Now he could become the head of a service, like a surgeon could. He was responsible for teaching his discipline, anaesthesiology in the hospital as well as the care for patients in surgery, and sometimes even for research.

As a Professor of anaesthesiology, I could easily fit into the new system. I could work full time at Foch and be well paid for doing so. Therefore I stayed at Foch while continuing to teach at the university.

In 1965, Dean Cordier died and J. Baumann was named department chair of clinical surgery. He told me: "*You are the one who will replace me.*" But things weren't that easy. Before the Debré reform, Paris had only one faculty of medicine. Both the Dean and the faculty council were important figures. Afterwards, nominations were no longer made by the council but by the ministries of Health and Education. Candidates had to be accepted by three different groups: the consulting medical commission, the faculty council and the university consulting committee.

The decisions of the university consulting committee were made by some fifty Professors from different French university hospitals, who had different specialities. Candidates had to send them a list of their papers and research. I wandered through France for eight days visiting the different members of this committee. At Montpellier I met a pharmacology Professor I had met in 1949 in England when he was studying there with funding from the *British Council*. Since he didn't understand any English, I had been his interpreter for eight days. Overall the committee members welcomed my visit and surprisingly enough all of them voted in my favour!

appreciations

When I replaced Baumann in 1966, I was the head of the anaesthesiology department of the Parisian faculty of medicine, and responsible for the teaching of anaesthesiology in Paris. At the same time, Professor du Cailar was nominated in Montpellier. I was also the director of the anaesthesiology Institute Moulonguet created. This Institute was supposed to deal with any problems in the teaching of anaesthesiology in Paris, where there was only a single faculty. It also was responsible for performing research. Claude Poyard and Ripse were among those working there. After the new medical faculties were created some of the Institute's space was reassigned to another faculty and its laboratory disappeared.

Being at Foch allowed me to train students, at first five or six each year, and later nearly thirty each year. The first ones were Ms. Germain, Gisele Caballero, Élisabeth Beretti, Françoise and Claude Lecharny, Claude Winckler, Madeleine and Jean-François Cavellat, Claude Poyart, Michel Duvelleroy, Paul Glaser, Raymond Nedey, Simon Burztein, Bernadette Trichet, Pierre Viars, Jean-Marie Desmonts, and there were many others!

Very soon, anaesthesiology became a three-year course.

Once they graduated, anaesthesiologists could choose to work privately, or in hospitals. To get a position in a hospital, they had to be accepted by an anaesthesiology department. They then had two possible career options: one was focussed only on work in the hospital, the other added teaching to the mix, and required at least three years' practical experience. A few of the latter become *agrégé non chef de service*, then *chef de service*. The highest rank in the hierarchy is a Professorship, possibly combined with the direction of a department. Anaesthesia now has roughly fifty such positions in university hospitals.

Unfortunately, the doctors named to these positions sometimes have no practical knowledge of anaesthesia. Since they are responsible for teaching and choosing personnel,

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there can be severe consequences on the operation of the department. Part of this change is linked to the twofold orientation of the discipline, as there are both surgery and polyvalent reanimation teams – and the latter form is often preferred by some anaesthesiologists.

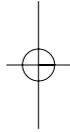
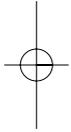
Anaesthesiologists first focussed on reanimation as a separate discipline in 1952 in Denmark during the polio epidemic. Prof. Mollaret at the Claude Bernard hospital and Nedey at Foch used this example to create their own similar departments.

Conflict very quickly appeared, with some doctors saying: “We take care of reanimation, anaesthesiologists are ignorant, you don't have the same degrees we do, we used to be residents, heads of services, etc. while you were just interns.” And anaesthesiologists replied: “We taught you to intube, we have a right to participate in reanimation.”

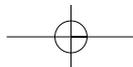
Finally, medical reanimation and surgical reanimation were separated, and the latter was left as the sole province of anaesthesiologists. In this regard, France was far ahead of the rest of world in its view of reanimation. This is why some anaesthesiologists chose to specialise in reanimation, as Glaser did in Paris, or Motin in Lyon. They gave up anaesthesiology, but kept their positions as anaesthesiologists, which had unfortunate consequences on the profession and the teaching of anaesthesiology.

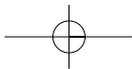
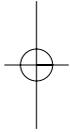
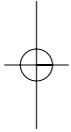
At the same time, the French Anaesthesiology Society was having problems due to a group following some of the less sensible notions of the period. Of course, I never thought those theories had any value!

As to myself, as you know, I enjoy teaching and I truly love my work, anaesthesiology, the way I've always done it, in the operating block, besides and for the patient.



Memories and reflections





54 Years of Friendship

Louise Delègue

Professor, Former Head of Department of Anaesthesia
and Intensive Care – Hôpital Necker-Enfants Malades – Paris

I graduated in medicine shortly after the war and specialised in paediatrics.

In 1948, I asked Prof. Robert Debré for advice and he suggested that I take up paediatric anaesthesia.

Indeed, at that time paediatric surgery had made great strides: a number of malformations such as *esophageal atresia*, imperforated anus or *spina bifida* received surgical treatment.

A surgeon friend of mine introduced me to one of the few anaesthetists practising in Paris at that time: Dr Jean Lassner. He received me in a very friendly manner and invited me to watch him work. I was impressed by his competence in very different methods of anaesthesia and found this new field most interesting. I therefore entered the then very recent course in anaesthesia at the faculty of medicine. I received my

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qualification as anaesthetist in 1952. My hospital career finally brought me to the post of head of service in the *hôpital des enfants-malades* in Paris.

While I had not trained with Dr Lassner, he invited me to the meetings he and Dr Kern had organised at Cochin hospital, famous as the Cochin-Fridays. I was impressed and very interested by the way Dr Lassner guided the discussions.

A number of studies conducted in my department were presented at these meetings and later published in the anaesthesia Journal edited by Drs Kern and Lassner assisted by Dr Valletta, *Cahiers d'Anesthésiologie*. Dr Lassner's invitation and his presentation of our work were most helpful. When Prof. Lassner became head of the department of anaesthesia of Cochin Hospital, after the death of Dr Kern in 1968, my participation in the meetings and publications became even more active. Prof. Lassner drew our attention to the importance of studying the effects of anaesthetics agents in children and not to rely on observations in adults. Thanks to Prof. Lassner's position in the council of Paris hospitals, he was able to promote a number of very helpful changes.

Having known Prof. Lassner for 54 years, I greatly value his friendship. Since he lives permanently in his country place in the Dordogne region, encounters have become rare but this has not diminished our mutual understanding and my gratitude.

A Three-Decade Collaboration

Professor Adolphe Steg

Surgeon – Head of the Department of Urology
CHU Cochin Port-Royal – Paris

Member of the Académie de Médecine
and the Académie de chirurgie

Grand officier of the Légion d'Honneur
And of the Ordre National du Mérite

I first encountered Jean Lassner in 1954, on the staff of my teacher Pierre Aboulker, and we have been collaborating ever since.

Through the years, I have been in a privilege position to fully appreciate, not only his extraordinary merits, but also the impact he has had on French Anaesthesiology.

At a time when anaesthesia was still synonymous with an Ombredanne mask (handled by an inexperienced and terrified young extern) Jean Lassner was developing and relentlessly upgrading modern techniques. He has, in particular, given priority to rachianaesthesia thus making

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urological surgery and notably prostate operations safer.

At a time when surgical-patient reanimation was entrusted to the hands of interns, Jean Lassner was arranging for this to be carried out by anaesthetists and giving them specific training.

In more general terms, he has greatly devoted himself to teaching. Mastering to perfection both English and German, he has always read everything and his knowledge never ceased to impress all those around him. Anaesthetists all over France rushed to him and it can be safely said that Jean Lassner was an admired and respected teacher.

It might be appropriate to insist on a less spectacular, yet highly important aspect, of his activity, his influence on the status of the anaesthetist within the services provided by the hospital. Anaesthetists at this time were, indeed, placed very low on the of hierarchical ladder. Not having emerged, as a rule, the rank of intern, they were not treated as equals among their "colleagues". By setting an example, with his high scientific and technical abilities, sustained by his proud temperament and his sense of self, Jean Lassner has given the discipline a new prestige, and the anaesthetist a new dignity.

We should stress that all this would not have been possible without the trust and esteem of Pierre Aboulker, whose support was unfailing.

As for myself, I had the great fortune – and my patients with me – of benefiting from Jean Lassner's collaboration.

For three decades, I have been allowed to admire his glowing intelligence, his intellectual rigor, his thirst for knowledge, and his tireless dedication to his patients. I have always been astonished by the special care he took to allow his surgical-patients to benefit from medical progress and from the smallest of "details" aimed at making them more comfortable.

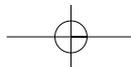
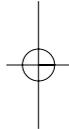
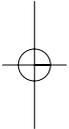
I knew that, with him, the patients were in the "the best of hands" and that I could operate on them with the utmost serenity.

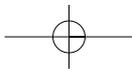
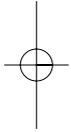


memories and reflections

For all this, but also for his boundless friendship, I would like to express my gratitude to him and to assure him of my respect and devotion.

Paris, October 18, 2002





Eulogy for the Academician

Jean-Paul Binet

Professor, Member of the National Academy of Medicine

Today I have the dangerous honour of making the eulogy of Guy Vourc'h. I know how important this is, and I am filled with the fear of failing in the mission you gave me, of not finding the right words to speak of his unusual destiny, especially since many of you knew him longer and better than I did.

But I have to speak about him, for fear that if I do not we will forget that he was one of those who held to the true things in life.

My dear colleagues,

You didn't know Guy Vourc'h very well; he was, as the folk of Brittany say, a quiet one: he never spoke about himself and when he joined our ranks in 1984 he had already lost his voice. I hope mine can serve to tell you all that he never did. Following tradition, I feel it is my part to tell you as much

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about the man as the doctor, the soldier as much as the anaesthesiologist.

[...]

Some stories are so remarkable they must not be summarised.

Guy Vourc'h was born on March 2nd 1919 in the small town of Plomodiern, which lies in the bay of Douarnenez, opposite Morgat. His father was Antoine Vourc'h, a doctor who had set up his office at the entrance to the Crozon peninsula, was a follower of Marc Sangier, a member of the Sillon, a Christian social movement, a fervent democrat and a somewhat progressive militant. Marguerite and Antoine Vourc'h were tireless workers, very kind and generous people [...] And completely inflexible when dealing with "essential matters".

Guy was the eldest of their nine children. He grew up in a large, busy and happy family where the things that mattered most were God, France and Brittany. Guy was an excellent student, learning Greek and Latin with ease, reading countless books and remembering each one; the one topic he abhorred was mathematics.

After easily obtaining his baccalaureate, he decided to study medicine, in order to become a doctor in Plomodiern and help his father.

He left Brittany for Paris, where he joined Rene Gayet and his family, spent many days with them at Rue Saint-Honoré, met Brigitte who was twelve at the time and decided that she, and she alone would one day become his wife.

After the PCB, he entered his first year of medical studies in 1937. He was interested by the specialities of his father's friends, in particular physiology as it was both Gayet and Monnier's discipline. Anatomy and osteology were key topics for the end of year examination. He studied under Hovelacque. He caught a tuberculous pleuresy at the end of the first year, likely brought on by too much work and stress,

memories and reflections

and was sent to the student sanatorium at Saint-Hilaire-du-Touvet to recover. He was drafted as a nurse at Nantes in September 1939, but requested a position in the infantry student-officer courses at Fontenay-le-Comte, from which he graduated in June 1940.

By then the Germans occupied a significant fraction of France, the armistice had been signed and France split in half. Vourc'h let it be known that he was still intent on fighting, and made his way back home, where he was welcomed with these words: "What, you aren't in England yet!"

[...]

With his friends, Ch. de la Patelliere, a Professor in history and geography, Robert Alaterre, an archivist in the French Embassy of London, and his brother Jean, he was welcomed in London in De Gaulle's name by d'Estienne d'Orves. Jean was sent to Africa, and Robert Alaterre went back to the Vourc'h family in Plomodiern with the first two radio emitters sent from London to the occupied zone. Robert's mission was to keep an eye on Brest's harbour, and the three raid crusiers that were supposed to head there. Guy was first sent to Camberly, then to Bedford, where he was assigned to a radio propaganda service. His final affectation was doubtless influenced by his perfect mastery of English, his extensive culture and his charming voice; however, he had requested to be on the frontlines or parachuted into France when he arrived in England.

We know Guy's frustration at not being allowed to fight from the many letters he wrote, with clumsy codes, to his family. He went so far as to wonder whether, despite the great respect he had for him, the leader of Free France used unsuitable methods in his command. As a matter of fact, he did not suspect that during 1940-1941 the war also needed "clever men" in some key positions: through his parents in Plomodiern, Guy Vourc'h was a key transfer point from Britainny to England. When the "Johny" network was partly destroyed, he finally got what he'd been asking from the

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beginning: a position in a fighting unit, and the unit he was affected to was not just any unit, as he joined the special battalion of marine gunners.

[...]

On June 6th, Guy lead the first of the two marine gunner companies. The one hundred and seventy seven men of the Philippe Kieffer commando were the only Frenchmen in the first wave, and there were two Vourc'h among them, since Yves had joined his older brother.

These men were attached to Lord Lovat's English brigade, their mission was to take Ouistreham at the eastern end of the landing area. The German Navy's best telescope lay in Ouistreham's bunker, and was used to adjust the artillery firing solutions over most of the beaches.

Let us hear Guy speak of the landing in his own words:

"Those fifteen days behind barbed wire, cut off from the outside world, kept hidden before departure, to perfect the attack, using small scale replicas and aerial photographs..."

Leaving on June fifth in a small ship (called an LCIS: Landing Craft Infantry Small), supposed to drop us off in France on the morning of June sixth...

The wild sea that made everyone sick, even the ship's crew...

The grey dawn when we saw the Normandy coast, awash in explosions, and above all the cloud of smoke created a bit before dawn by the Lorraine squad...

The 5,333 ships, all heading south!

But, the perfect landing, at the planned spot, among the dangers hidden under water... landing, rushing down fragile ramps, with forty kilos of munitions on our backs... crossing two hundred meters of bare sand, until we reached the dunes and the Germans... a burning tank on the beach, off to the right. And weapons firing – our first wounded. I was one of them. Four years of training for a few minutes of battle. This too was part of what war was."

He was evacuated to England and recovered there. His wounds bandaged, he rejoined the remnants of his company on August 4th: only twenty-five men were left. With fresh

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troops, he participated in the arduous battles of Bois-de-Vent, and finished the Normandy campaign. In November, he attacked Flessingue on Walachern island, a key point for the allied supply lines going through Anvers. He fought on until Germany's surrender.

Then, he set the time of the War aside. At the end of the War, he was a captain, officer of the Legion of Honour, with many citations on his Croix de Guerre, the Rosette de la Résistance, and most important, the British Military Cross. He never spoke of these things, but helped the families of his brothers in arms through the Society of the Compagnons de la Libération.

He began his life anew. He resumed his medical studies and married Brigitte in 1946. He and his equally heroic brother in law, Alain Gayet, attended one of my conferences for interns. It was quite a pleasure, as he remembered everything, and often questioned the unquestionable.

He scored the highest marks at his very first admission examination, and decided not to prepare for a residency, since he had a family to take care of, with the birth of Catherine, Jean-Guy and Francois. Ivan Bertrand and I advised him to focus on anaesthesia, a specialty that was sorely lacking at the time.

But he still needed to learn it. Unlike the Anglo-Saxon countries, there was no organised teaching of anaesthesia in France: we still relied on Ombredanne's mask and for two years, one must admit that Guy was entirely self-taught. He obtained funding from the British Council to become a resident at London's Middlesex Hospital, where he spent two years (1951-1952), and was the first foreigner to receive the prestigious degree of Fellow from the department of anaesthesia in the Royal College of Surgeons. He began his career in hospitals when he came back to France, and was accepted at Foch hospital. He remained there until his death, thirty-seven years later.

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The traditional summary of his work that he gave to you before joining our ranks is noteworthy because he published regularly, about every eighteen months in every specialty he was responsible for putting patients to sleep. Over the years, he wrote countless teaching papers or specific articles, for digestive, vascular, urological, orthopaedic, cardiac and thoracic surgery, as well as ophthalmology, nose and throat, and neurosurgery. He says his favourite topics were neurosurgery, which led him to study neuropharmacology with Ms. Albe-Fessard, thoracic surgery where he was the first to perfect anaesthetic techniques when using lasers for bronchial or nose and throat pathologies, and renal transplantation surgery, where he collaborated closely with R. Kuss and M. Legrain in their first works on renal homografts among irradiated subjects.

Vourc'h, a Professor in anaesthesia, taught anaesthesia: he put a lot of effort into removing from its theoretical teachings the works with unsound foundations. He forced himself to teach the applied aspects of anaesthesia as well. A professional, he wanted to teach the perfect and easy motions essential to his work. He had understood that to perform anaesthesia properly, all motions had to be efficient from the start, and that there was one and only one good hand position for each action, intubing the trachea, performing a local anaesthesia, or finding a needed or lifesaving vein. He taught all his students, by his example, to abhor approximations and imperfect technique. He was always courteous, often grumpy, at times abrupt or furious in enforcing the permanent perfection he demanded; his well-known stubbornness quickly drove away amateurs and incompetents, which he quickly identified.

He was always in the operating rooms at Foch, from morning until evening and sometimes from evening until morning. Above all, he was always on hand during an operation, when he looked over what was being done, took over, or delegated, depending on the time and situation. For

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years, the only consequence of his endless rushing about was the smoke of his cigarette, always an English one. He managed to sway people. He was the only one at the time who mastered anaesthesia in its totality, every anaesthesia for every specialty and under every circumstance.

[...]

Over the course of his stellar career, he had the good fortune to keep the friendship of his colleagues, in particular Jean Lassner, Yvonne Noviant and Ms. Delegeue. But his greatest joy came from creating the first French school of anaesthesia, with students who later became masters in their own right, such as Pierre Viars and Jean-Marie Desmots in Paris, or Claude Winckler in Rouen. And from all his other students and colleagues, whom he taught and who then went out into Paris and the rest of France. And maybe most of all from those who went back to his home country, such as Le Bourlot, and illustrated the roots of the new French anaesthesia, Foch and Brittany.

In the Vourc'h family, nothing ever seemed to happen.

He suffered from cancer of the tonsils and went through a laryngectomy, and after a long re-education effort, he developed an audible esophageal voice. He accepted and went through the recommended chemotherapy. He also accepted the relapses and metastases, in particular a pneumonectomy for a tumour of the same type found two years later during a check-up. He dealt incredibly well with these two major operations and managed to both continue his work at Foch and to continue his written teaching and publications in the medical press and the anaesthesia journal whose content and style he had always controlled, demanding that all articles be written in perfect French.

He was also one of the most frequent attendees at our Tuesday sessions in the Academy of Medicine, wearing a small scarf hiding his scar.

He realised the cancer was spreading in January 1988. A scanner showed cerebral metastases in March, and he

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serenely chose to spend his last weeks on earth with his family. He wrote letters to a few of us, telling us that his time was over and, thanking us for all our help, encouraged us to pursue with our own projects and continue to do what was right. With the former chaplain of the commandos, who insisted on joining him despite his own illness, he received the sacrament for the sick at the hands of Mgr Pezeril. His light died in early July 1988 and he was buried at his home in Plomodiern at the sides of Antoine, Marguerite, who had finally been awarded the Croix de Guerre and the Médaille de la Resistance, and his brother Jean.

I deeply regret, mister Chancellor, that we cannot reopen the directory of the Compagnons, where men, cities, regiments, planes, ships and even an island are set down in alphabetical order, so that we could add a family to it. We could add in the middle of page 107, following the guidelines set by the general de Gaulle:

Vourc'h of Plomodiern (family)

Inside Resistance (Antoine, Marguerite and their five daughters), 2nd DB (Jean), 1st DFL (Paul), Marine Gunner Commandos (Guy and Yves) of May 9th 1945.

This is where the exceptional destiny of our colleague Vourc'h ends.

After all of this, we no longer need to describe him. Every page of his life shows that he was unusually brave, remarkably stubborn, ready to face any challenge. We also know well the stone block, the menhir, the best of Celts, demanding as much from others as from himself, as opposed to student agitation as to the pathogenic insanities of a school of anaesthesia that, all in all, was very marginal.

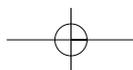
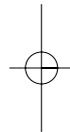
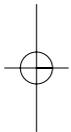
What we don't know as well is that he was a man who was fascinated by French speech and writing, loved the English language and its literature, enjoyed Mozart above all, and in spite of never having cheated in his life, admired the great politician and seducer Chateaubriand above all.

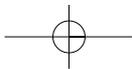
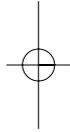
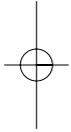


memories and reflections

Oh Guy, there is so much love and honour in all you did, as a son, as a husband, as a father, as one of the first fighters of the first days, as a founder of anaesthesia, as a doctor and as death came for you.

Bull Acad Nat Med, 1989; 173 number 8: 1051-1058, November 21st 1989 meeting. (Extracts).





To the Doctor and to the Honoris Causa

Wolfgang F. Dick

Prof. Dr. Dr.h.c. Wolfgang F. Dick FRCA

Head, Clinic of Anaesthesiology

University Hospital Mainz – Germany

On behalf of the Clinic of Anaesthesiology and the Faculty of Medicine of the University of Mainz it is my great pleasure and honour to give our sincerely felt most cordial, best wishes to the honorary doctor of our Faculty, Professor Jean Lassner, on his 90th birthday.

When Professor Lassner was made an honorary doctor of the Johannes Gutenberg-University Mainz in 1978, he had already established a close working relationship with this institution, and had, in 1968, spent a period of time as a guest Professor at the Institute of Anaesthesiology of this university. In a tribute to Professor Lassner in the journal *Der Anaesthetist*, 27, 1978, my predecessor and teacher, Professor

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Rudolf Frey, acknowledged the importance and great benefit of the advice received from Professor Lassner in the development of the Institute in Mainz, which was reinforced by practical experience gained during a longer stay at his institution in Paris. Professor Lassner's broad spectrum of interests led him to develop additional ties to the University of Mainz: his work on the psychological effects of ketamine and on the psychological aspects of anaesthesiology in general, and hypnosis in particular, brought him together with the former Mainz psychologist, Professor Dietrich Langen, and one of Professor Lassner's major monographs, *Hypnosis and Psychosomatic Medicine* was published by Springer in Heidelberg.

I had the honour and pleasure of first meeting Professor Lassner at the University of Ulm, where he gave a number of inspiring lectures. My appreciation and admiration of Professor Lassner, his outstanding personality, extraordinary intellectual capabilities, his innovative, future-directed, and broad philosophical vision of anaesthesia and the related specialities, have grown steadily throughout the years.

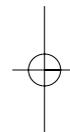
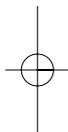
One of Professor Lassner's visions became reality, leading him to the creation and foundation of the European Academy of Anaesthesiology; many publications give evidence of his sustained and tremendous efforts and successes with this body. Professor Lassner's concept of the EAA was to bring together many distinguished people at smaller scientific meetings designed to enable intensive highly focussed scientific work, while avoiding big business meetings with thousands of participants. Working for the EAA, I have been supported by Professor Lassner many times. It was he, who advised me to serve as its honorary secretary for a few years, and later even to stand for election as the president of the Academy. Professor Lassner's concept included the organisation of small workshops, which were held at his home in the Dordogne. Everyone who had the honour of attending these small and extremely effective workshop

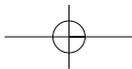
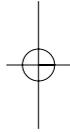
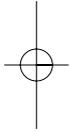


memories and reflections

treasures memories of his most extraordinary and enjoyable hospitality. Although the European Academy of Anaesthesiology has since fused with the larger European Society of Anaesthesiology, it is to be hoped that Professor Lassner's original encompassing vision will nevertheless be kept alive.

I am grateful to have been given the honourable opportunity on this day to extend on behalf of the Department of Anaesthesiology, and the Faculty of Medicine of the University of Mainz my deeply felt best wishes to Professor Lassner, an advisor of the Mainz anaesthesia department, and the creator and developer of an academic institution, which was shaped by his creativity, his innovative thinking, his purely academic orientation.





Jenny Rieuneau and “Ces Messieurs de Port-Royal”

Professor Colette Saint-Marc – Mai Van Dau

Professor Emeritus of the University of Medicine, Rennes

Dear Sir and dear Master – please, allow me to call you that because, although it has not been my privilege to be one of your immediate students and to benefit from your teaching, both at the patient’s bedside and in the operating room, I have always considered you a Master in anaesthesia who became a friend when I met you, in 1966, after I had just passed my agrégation in anaesthesia.

No one can forget that you were, together with N. du Bouchet, E. Kern, G Vourc’h in Paris, a pioneer in modern anaesthesia when it was imported in France from the United States and the United Kingdom after World War II.

I cannot resist associating Jenny Rieuneau with this experience. She was the first to teach anaesthesia in Toulouse in the fifties, a discipline which she had studied in Boston and Montreal.

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Despite her competence and merits and because of her unassuming personality, she remained unfairly unknown

I knew you through your writings and the aura that surrounded you, an aura of courage during the dark. I appreciated the review you had just created, the *Cahiers d'Anesthésiologie*, a most didactic review accessible to all.

After taking up my post in Rennes and my immediate promotion to departmental head responsible for a CES in anaesthesia, I knew you better, and I remember the kind and judicious advice which you gave freely to improve the organization and management of my brand-new department. I appreciated your erudition, your innovative mind, European before its times. You had an easy command of foreign languages which remains extraordinary.

I still remember our conversations in your office at hôpital Port-Royal, overlooking the cloisters, a place full of historic memories and much to your taste, and I cannot help recalling the Messieurs de Port-Royal, their strict convictions as well as their open views of the world.

I am glad to have this opportunity to express my admiration to a truly Renaissance man and to mark my respectful and affectionate gratitude for all that you have brought to me.

Mourir oui, mais quand?

Corrado Manni*

Professor Emeritus of Anaesthesia and Intensive Care
Catholic University of Rome
Member of the European Academy of Anaesthesiology

L'attitude du médecin devant le mourant est devenue un problème pour la médecine moderne du fait que celle-ci peut à présent modifier profondément la phase terminale de la vie.

La réanimation obtient des résultats qui obligent à une redéfinition du concept de la mort. Elle apporte l'espoir de survie et celui d'une vie digne d'être vécue pour nombre de malades en état critique. La ventilation pulmonaire mécanique, la nutrition parentérale, l'hémodialyse, l'assistance circulatoire, la transplantation d'organes permettent de

* Le professeur Manni a fait partie de l'équipe de la clinique Gemelli qui a pris en charge le pape Jean-Paul II, gravement blessé lors de l'attentat du 13 mai 1981 (NDLR).

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prolonger la vie pour des mois ou des années chez des malades exposés de prime abord à une mort prochaine.

Cette possibilité de contrôler l'avenir de la mort, de la retarder ou de la hâter, de programmer le moment ultime de la vie, pose une interrogation nouvelle à laquelle on cherche une réponse. L'objectif du médecin doit être de défendre la vie de l'homme en respectant sa complexité psychosomatique et spirituelle. Le risque est celui d'une technicité qui assujettit l'homme et le met à la merci d'un « pouvoir médical ». La possibilité de retarder, par tous les moyens et tous les coûts, le moment de la mort peut facilement inciter à un acharnement thérapeutique, mais peut aussi se traduire par le souhait d'arrêter les souffrances qui accompagnent la fin de vie en abrégant celle-ci.

On entrevoit la complexité du problème et la difficulté, pour le médecin le plus expérimenté, de trouver une réponse satisfaisante, capable, dans tous les cas, d'éviter de mauvais choix.

En 1959, Mollaret et Goulon ont proposé le terme de « coma dépassé » pour la « mort du système nerveux central ». Cette formule devint vite populaire chez les médecins et a contribué à provoquer la confusion chez certains. Il s'agit d'établir avec certitude la mort sur des critères neurologiques. La mort encéphalique n'est pas un coma, celui-ci étant un état transitoire. Les malades comateux au long cours, à moins de mourir de causes intercurrentes, présentent toujours pendant une période variable en jours et en mois des phases de « réveil », accompagnées de retour d'un contact avec l'environnement. S'il ne se produit pas, le patient se trouve en état végétatif persistant (le syndrome apallique), condition des plus graves, au pronostic incertain, mais pas équivalent de la mort. La mort correspond à la perte irréversible de la capacité d'intégrer et de coordonner les fonctions physiques et mentales. Cette capacité est liée à l'encéphale qui contrôle aussi bien les fonctions végétatives que celles de la relation ce qui permet à l'organisme de conserver l'activité coordonnée,

memories and reflections

c'est-à-dire de conserver l'essence biologique de la vie. La législation italienne en vigueur l'entend dans ce sens et l'érige en critère nécessaire et suffisant pour le constat de la mort.

Le problème de notre société contemporaine est qu'elle refuse la mort. Les médecins sont portés à considérer la mort d'un patient comme un échec, comme preuve d'un traitement insuffisant. L'acharnement thérapeutique résulte de cette fausse conception. Il faut rejeter cette erreur et s'opposer à la «médicalisation» de la fin de vie, si fréquente dans les pays industrialisés.

Cette «médicalisation» commence dès l'entrée du patient à l'hôpital par l'éloignement de la famille. Le malade est isolé, privé de rapports affectifs, dépersonnalisé. L'homme malade «industrialisé» n'a plus d'individualité et se trouve identifié à sa maladie. Dès lors sa mort n'est plus acceptée comme la fin naturelle de la vie, mais comme le résultat d'un échec thérapeutique.

Cette erreur fondamentale transforme les rapports entre malade et médecin, ce dernier ne s'intéressant plus qu'à la maladie. Ce risque est d'autant plus grand qu'augmente, dans les soins, le recours aux moyens techniques et biomédicaux. Cela conduit à la question souvent posée en présence d'un malade atteint d'un cancer avancé: ne faut-il pas recourir à l'euthanasie pour abréger, avec la vie, les souffrances inévitables? Si l'on résiste à cette tentation, peut-on laisser la maladie poursuivre son cours et se limiter à des soins palliatifs?

Celui qui doit prendre la décision ne pourra pas se retrancher dans l'agnosticisme ni renoncer à chercher un code de conduite précis qui doit pourtant tenir compte du cadre clinique et de la situation objective. Celle-ci doit, obligatoirement, être appréciée en fonction de l'évolution de la maladie, bien que les phases terminales ne soient que rarement graduelles, mais plutôt constituées de multiples épisodes aigus. L'un de ces épisodes sera l'élément ultime et décisif de la mort. Pour une affection déterminée, l'incertitude du lendemain persiste quant à la conduite

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médicale: intervenir sans espoir de guérison ou opter pour le soulagement de la douleur. Qui prônerait l'abstention?

En face d'un malade en occlusion intestinale, qui souffre, vomit et ne peut plus s'alimenter, peut-on refuser une éventuelle intervention, même si l'on sait qu'elle n'aura pas de but curatif? Le terme souvent entendu de «traitement symptomatique» est injustement dévalorisant.

Les pronostics chez les malades au «stade terminal» (ou en cours de «maladie terminale»), promis à une mort proche, doivent respecter l'incertitude de l'évolution; trop de maladies restent inconnues à ce jour et c'est souvent grâce aux efforts entrepris pour secourir les mourants que la médecine a pu trouver de nouveaux traitements.

Devant le nombre croissant de malades et face à leurs exigences accrues, notre société a le choix entre deux voies possibles: dans la communication avec les malades et leurs proches, soit les médecins privilégient l'attente de l'amélioration, ce qui risque de conduire à une déception et à une plus grande déchéance; soit les médecins agissent pour augmenter les chances d'amélioration de leur malade. Le juste équilibre ne peut se trouver qu'en une sorte de communion avec le malade.

L'euthanasie sera d'autant moins prise en considération ni demandée que le choix de la solidarité avec les patients en grande difficulté, comme avec les faibles et les marginaux, sera accepté. Cela n'est nullement contraire aux progrès de la science. Espérons que ce progrès aidera à éviter les maladies chroniques qui affligent l'humanité. Cet espoir justifie la recherche et l'oriente vers une stratégie biomédicale. Celle-ci ne doit pas seulement viser à l'allongement de la vie, mais plutôt à la prévention des maladies débilitantes. L'euthanasie ne trouve pas sa place dans cette perspective. Elle apparaît comme une reddition et un échec.

Certes, devant un malade qui souffre, atteint d'une maladie incurable, il ne suffit pas de dire non à la requête de la mort.

memories and reflections

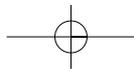
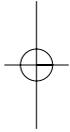
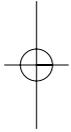
Il est nécessaire de dire oui à la demande d'allègement des souffrances, mais avant tout d'aider à trouver un sens à une vie qui s'éteint lentement.

Pour le médecin chrétien, le premier impératif moral est celui de servir la vie, ce qui veut dire aussi de l'assister à la fin de son accomplissement naturel. L'assistance médicale aux mourants est un moment particulièrement important et délicat qui devra permettre, jusqu'à la mort, à l'homme de se reconnaître vivant.

Traduit de l'italien



Castel Gandolfo, 8 septembre 1988
His Holiness John Paul II, Corrado Manni and Jean Lassner.



The Doyen

Dr Douglas Howat

Former General Secretary of the World Federation
of the Society of Anaesthesiology
Founder Member of the European Academy of Anaesthesiology,
Great-Britain
Fellow of the Royal College of Anaesthetists

It gives me great pleasure to congratulate Professor Jean Lassner on his ninetieth birthday on the occasion of the fiftieth birthday of the Cahiers d'Anesthésiologie, the child which he fathered with Dr Valetta and Dr Kern.

I have known Jean Lassner for ever thirty-five years have the happiest memories of our meetings. It is not my place to recount the many honours which he has received, but I am proud of the small part I have played in presenting him for election to the Faculty of Anaesthetists of the Royal College of Surgeons of England, now the Royal College of Anaesthetists, and for Honorary Membership of The Section of Anaesthetists in Britain. In 1977, when I was president of the Section, he

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came at my invitation to speak at an all-day meeting on anaesthesia in the European Community and, when I was an examiner in our Fellow of the Faculty of Anaesthetists examination, to see how we held it at a time when France was the only other European country to hold a national examination.

I have always appreciated his sense of humour. During a difficult session of the annual general meeting of the World Congress of Anaesthesiologists in Mexico City in 1976, he interrupted the proceedings to announce a break in which he had arranged for all the delegates to be served with tequila and champagne. As I recall, we were actually served with tequila and the subsequent session was even more prolonged and argumentative, which I do not think surprises Jean Lassner!

A happy memory is of the time my wife and I met as Jean's country house in the Dordogne to draft the original constitution of the European Academy of Anaesthesiology. Because at that time the offices were to be in Paris, the constitution had to be written in French as well as in English, and according to French law. With the expert help of Madame Lassner, herself a lawyer, we performed this task, marrying French logic to English empiricism. My wife, who was in the next room, said that all she could hear were our frequent bursts of laughter! When we had finished, Jean asked me to speak to the doctors in Sarlat on the use of epidural analgesia in childbirth in spite of my faltering French!

When His Back Was Getting Painful

Geneviève Barrier-Jacob

Professor Emeritus – Former Head of Department
of Anaesthesia and Intensive Care Unit
CHU Necker-Enfants-Malades – Paris

When I finished my medical studies, my favourite Professor, Pierre Soulié suggested to me to become a cardiologist. At this time cardiology was indeed becoming a revolutionary part of medicine. In spite of his reluctance I decided to study anaesthesiology which to me appeared as the future of surgery. I hesitated as to which the trend to choose inside this speciality. Then, in the summertime on 1960, I was doing a part time summer job in the anaesthesia department in the American Hospital of Neuilly-sur-seine. Two famous obstetricians, Professors Jacques Varangot and Maurice Mayer were working here. Both of them suggested to me a training in a new part of the speciality, perinatal medicine, initiated in USA by the anaesthetist: Virginia Apgar. Both of them had met her at the Presbyterian medical centre in New-

yesterday's anaesthesia

York, which like the American Hospital of Paris was depending on Columbia University where Apgar was Professor of anaesthesia and perinatal medicine. Professor Mayer obtained a travel grant for me (it was easier then than now!) and I flew to New-York city in order to meet Apgar. I was introduced to her by Mike Finster, an excellent french speaking anaesthesiologist. This trip changed my professional life. I discovered a new kind of medicine: she taught me that a newborn can be as anybody else a patient who has to be clinically examined. He must be treated as any patient must be on the basis of a scientific research. The state of the patient must be evaluated objectively following "the Apgar score" she had describe some years before and is still used worldwide.

In the early sixties, in France, anaesthesiology was not an independent speciality: it was depending of surgeons. Only in 1967, thirty years after Great Brittany, it will be individualized as a speciality. In 1961, I had to find an appointment in an obstetrical department. For this, I wrote to the President of the French Society of Obstetric and Gynaecology: his answer was "delivery is a physiologic function and does not require neither anaesthesia nor a specialist in anaesthesiology". Then, in the room, somebody unknown to me stood up and said: "every morning, at home, I perform physiologic actions", and yet, I don't need anaesthesia. But, I don't take the risk of dying of hemorrhagy and death as do parturients in an obstetrical ward. If you accept to come with me, I am the new Chief of the *Maternité Notre-Dame de Bon Secours*. This man was doctor Michel Chartier he became my new boss. We decided to work part-time together and I worked part-time in the American Hospital. We began a modest activity of clinical research in obstetrical analgesia and resuscitation of the newborn. Our collaboration was always friendly and productive. From time to time, I met Professor Lassner in the operating theatre of the American Hospital. For me, he was a commanding figure, a very impressive man, a fearful and

memories and reflections

respected person as a free french during the second world war. Many years later, in 1967, anaesthesia was officially acknowledged as a medical speciality in France. An anaesthesia department was created in Cochin hospital, just before the *joli mois de mai* 1968, when the student agitation was not really propitious to the organization of a new academic department. In 1969, Professor Lassner became the first Chief on the new department of anaesthesia at the University and Hospital Cochin-Port-Royal. During this time, I worked quietly at Notre-Dame de Bon-Secours in an agreeable and free environment.

I returned to New-York for a three months period, during which I became acquainted with Sol Schnider and Stanley James who were among my best friends up to their death and Mike Finster. This team was designing the new obstetrical anaesthesia. It was performing clinical foetal research on pregnant sheep in the basement of the building. The collaboration between pediatricians and anaesthetist was for me fascinating. They were pioneering the resuscitation of the newborn. During this trip, Virginia Apgar invited me to join her in a round trip of conferences she gave, performing in a new city every day. Then, I saw the first case of paraplegia following an epidural analgesia for a normal delivery. This dashed the intention I had to apply this technique during delivery. Coming back to Paris, I rapidly found that it would be difficult for me to do what they was done in New-York. I wrote to Apgar, explaining how troublesome it would be to follow, modestly, his example. She answered me the enclosed letter.

Few weeks later, Professor Lassner wanted to see me. He was building his new anaesthesia department, recruiting collaborators. He offered to me the charge of obstetrical anaesthesia in his department. His program was very clear, and his will very precise. He had a good knowledge of both english and american medical ways of medical practise and research. He was thinking many years ahead of the

yesterday's anaesthesia

majority of his french colleagues, and, above all, the hospital administration. This proposal was of great interest for me, but also a leap in the dark. I hesitated. Professor Lassner was very convincing and found the administrative solution for my appointment. So, I accepted and never regretted to do so. His exceptional intelligence, his strategic instinct, his current trilingual culture and sense of humour seduced me, in spite of his roughness and sometimes severity. To negotiate a research programme with Prof. Lassner was a hard work: he was forcing his collaborators to discuss. He argued every sentence of every anaesthesia record or research programme until it was clear that the project was built on solid basis. Once the project accepted, we were sure that he would help us as much as needed. He was a severe boss, especially when he suffered a back pain. By chance, in this case, we had the support of Ms. Lassner, a good, cleaver and ironic lady who knew how to soften the boss bad temper. She was always ready to help us. I want to show gratitude to Professor Lassner. He taught me the exactness of reasoning, the management of anaesthesia (a single small syringe is enough, he used to say). He was the first to teach me pain relief management, since he was one of the first to practise it in continental Europe at that time. He did not succeed however to convince me that hypnosis was of importance in anaesthesia. Thank you, Mr Lassner. Let's meet in 2013 for your centenary.

memories and reflections

30 Eagle St
 Tenafly,
 New Jersey
 Aug. 24, 1967

Dear Genevieve,

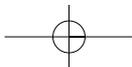
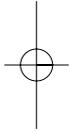
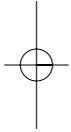
I was simply delighted to receive the personally inscribed book by Jacqueline Caurat - about the Wonderful World of Stamps. It is most imaginative and beautifully printed. France is one of my favorite countries - I have already learned some new facts about your stamps - Please thank Mlle Caurat for her thoughtfulness.

It was great fun meeting you - you encourage me greatly about the progress of Medical Anesthesia in France - especially in Obstetrical anesthesia. Thank you for the volume you gave me of your recent Symposium. You are a true pioneer and I like pioneers! 😊.

Do not get discouraged by those funny people - Obstetricians. They need YOU very much though they may not admit it!

Keep up the good work, and come again soon. Even though you dislike "spinal" because of your own experience, do not overlook block techniques for obstetrics. Do write when you can. Thank You + Best Wishes
 Virginia Apgar

Facsimile of the letter from Virginia Apgar



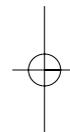
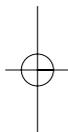


A Family Affair

Michael Vickers

Professor Emeritus, University of Wales College of Medicine,
Cardiff, UK

President, European Academy of Anaesthesiology, 1990-3

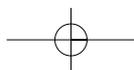


Introduction

Jean Lassner will be remembered and honoured for many things. I would like to recall an enterprise in which his family assisted and which benefited European Anaesthesia as a whole – the founding of the French Centre of the European Academy of Anaesthesiology

The context

The Academy was founded in 1978 and Jean was the first President. So dominating was his influence that, despite the constitutional term of office being restricted to three years (and he drafted the constitution himself!) he was persuaded to



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accept a further three year term. By 1984, six years was up, and his direct influence was beginning to wane. To retain his advice, the senate approved the title of "Founding President" carrying with it a permanent seat on the Executive committee. Whether he felt the need to justify this, or whether he just felt that he was uniquely placed to develop a new (and desirable) activity for the Academy, he initiated the first Academy Seminar in 1985.

The Academy had already exceeded the hopes of its founders in at least one respect: the senior academic anaesthetists from most European countries immediately got to know one another personally. To a large extent, this was due to the small size of the annual meetings and the emphasis on the social side. The seminars successfully built on this great benefit.

The place

The seminars were held at his country home near Sarlat, in the Dordogne valley. To call it merely his country home is to mislead those who never went there. It was a large estate, a castle that had been partly destroyed shortly after the invasion of Normandy in 1944 during the German retreat, and its surrounding buildings and grounds. Jean Lassner bought it after the war and set about restoring the farmhouse and some of the other buildings, which included a mill, a piggery, a dovecote, another cottage, and several barns. To house the seminars he completely restored one of the barns, located about 400 m deep in a wooded area, and equipped it as a meeting room which could be used flexibly but which, on logistic grounds, was laid out as a seminar room for about 18 participants. He named it (and gave it a nameplate) as "The French Centre of the EAA" and endowed it with independent maintenance funding.

Close to it was La Suquette, a two-story cottage with basement, which he restored and converted to serve as sleeping accommodation and a cafeteria for coffee and tea

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breaks. Other sleeping accommodation was provided in the piggery, the mill and in 2-3 bedrooms in the house. When this was insufficient, some participants stayed in small local hotels or in chalets at a nearby campsite.

While the location was idyllic as a holiday retreat there were serious drawbacks for this purpose: the estate was about 5 km from Sarlat, itself only accessible by slow train from Bordeaux, or Souillac (15 km away) on the main line from Paris to Toulouse. This took 4-5 hours and there were a limited number of trains. The nearest regional airport was over an hours' drive and necessitated a change in Paris: not surprisingly, many participants had to travel by car, sometimes a very considerable distance.

The organisation

This was truly a family affair. It would not have been possible to undertake such an enterprise without the wholehearted support and involvement of his wife, the late Colette. The fact that his youngest daughter, Claudine, was an employee of the *Société d'anesthésie française* afforded some administrative support. These two managed the social side, Claudine herself hiring and driving a minibus as required. Lunches were taken by the participants at Madame Delpeyrat's hotel in Carsac whilst the ladies were being taken out for the day to see one or more of the numerous sights for which the region is famous. In the evenings the whole party would dine together, often at one of the many epicurean restaurants for which the region is equally well known.

Jean Lassner selected a suitable international topic and invited a leading figure with a relevant interest to be Chairman. Together they would select the participants to be invited from several countries. These were mostly members of the Academy but some relevant experts outside the membership were invited. Everyone was given an aspect of the matter to prepare and be prepared to lead in the discussion. There were no "passengers".

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There was always at least one senior figure from the pharmaceutical industry or equipment makers: this arose because Jean financed the whole event via sponsorship, apart from the cost of travel to any nearby pick up point. The prospect of accommodation, good food and good company on a topic of interest was enough to compensate for the difficulty of getting there.

The topics

Before I decided to write this piece I circuitously asked Jean if he had any records of the topics and participants. To my surprise and disappointment, there were none. Claudine was slightly more helpful in having some details about the first two. I have been able to fill in several more in outline but am still missing 1990 and 1991, (I any took place) and any that followed 1992. There is thus a sizeable lacuna and I hope that any reader with more information will contact me so that I can complete a full historical record. I would like to know, as a minimum, the title, chairman and as many other participants as possible.

Those I know something about are as follows:

- 1985 Safety of Anaesthesia Equipment;
- 1986 Legal consequences of Anaesthetic Accidents;
- 1987 Teaching and Training in Europe;
- 1988 Automated Anaesthesia Records;
- 1991 Monitoring Standards in Europe;
- 1992 Reflections on the Future of Anaesthesiology in Europe.

One can see that they provided for a useful interchange of opinions and of information about the differing conditions in the various countries represented. Particularly valuable were contributions from Eastern Europe. They could not, however, encompass every European country, for reasons of space. There was a high proportion from France. This was natural: Lassner would be more aware of French experts in the relevant topics and it could also have acted as a recruiting

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aid to persuade more senior French anaesthetists to join the Academy, in which they were under-represented. There was also a tendency to invite those he knew well, of which I was fortunate to be one.

What happened?

Professor Lassner frequently made the point that unless something came out of the discussions, they were of limited value. That “something” meant, in practise, a publication. Since the seminars were conducted in English this inevitably pointed to the responsibility falling on a native English speaker, of whom there might be only two or three present – of which I was one on at least three occasions. To this end the proceedings were taped verbatim, initially on an old reel-to-reel machine. Latterly, another member of the family – granddaughter Miriam – was conscripted to manage the recording process on a more modern machine.

The problem of publication was probably the main reason that the seminars eventually ceased. Commercial companies are not inherently philanthropic organisations. Their sponsorship needs wide professional recognition and they are reluctant to fund events for which they see no likelihood of publicity. Yet their sponsorship was essential: the seminars would not have been a practical proposition if participants had had to meet all the costs involved.

Achieving publication of this sort of material depends on leverage, and we did not have enough. The Academy’s journal (The European Academy of Anaesthesiology) had only just been founded as a quarterly in 1984 and was trying to get established on the basis of good scientific papers, not on rather diffuse opinions. Other primary journals would have taken the same line. Book publishers were disinterested unless comprehensive, fully referenced and edited chapters could be supplied and the topic was thought likely to sell. Unfortunately, the participants were, for the most part,

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unwilling to take on the work involved in producing material for the remote possibility of seeing it published as well as for the seminar. Their presentations were the only material available to work on.

Anyone who has attempted to process verbatim tape recorded presentations followed by long periods of spontaneous discussion of varying relevance to the topic, given in a language foreign to the speaker, will know what a nightmare this is. On only one occasion was this successfully achieved when I managed to put together a small booklet on the 1987 seminar (*Teaching and Training in Europe*), which was published by Laboratoire Jannsen. This earned the sobriquet of "The Little Red Book" (from its cover) and a copy went to each Academician.

By 1992 the Academy itself was publishing small booklets and the broad conclusions of the seminar on "The Future of Anaesthesiology in Europe" were published as an Academy booklet. The only other publication was that on "Automated Records" which I "sold" to Baillière's as a topic in their series *Clinical Anaesthesiology* and persuaded Gavin Kenny, who was an internationally well known for his contributions to the field, to edit. The publication, (*Bailliere's Clinical Anaesthesiology: International Practice and Research*, Vol.4 No.1, "Automated Anaesthesia Records", Bailliere Tindall London, 1990.) was much more comprehensive than the seminar, but its origin was at least acknowledged in the Preface.

Thus, ultimately, there was not a lot to show for all the work that went into this innovation. But that does not detract from the fact that Jean was already retired and had contributed more to the Academy than anyone else. He could easily have "rested on his laurels". Instead, he, Colette and Claudine devoted some seven years at least to furthering the unity of European Anaesthesia. Those who were fortunate to have attended will have happy memories as well as lasting friends and acquaintances in other countries.

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A personal note

At Jean's request, I organised the 1988 seminar and discovered that one of my selected speakers, Michael Fisher, was an amateur pilot and he and his wife flew me in their own four-seater plane to Sarlat/Domme aerodrome. Jean met us and took us back. The day we returned was one of the most perfect days one could imagine; sunny, warm, but not too hot and I said "This is somewhere where I could happily buy a holiday home." Jean never let me forget it and immediately started house hunting for me. My wife and I travelled to see his "finds" every three months for over a year until we found what we could afford and also visualise what we could make of it, a burnt out house with planning permission to rebuild. In 1989 we bought; with his invaluable help we had rebuilt by



Towering over Jean Lassner's realm le « royaume » de Jean Lassner
Trois phantom towers.

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mid 1990, and in 2000 finished paying for that holiday home, a mere 7 km from what is now his permanent home. On every visit we still enjoy his acerbic wit, all thanks to his seminars.

More Than Forty Years Together...

Professor Emeritus Jean-Claude Otteni, FRCA

Former Head of the Department of Anaesthesia
and Surgical Intensive Care

University Hospital Strasbourg – Hautepierre

Secretary Elect of the European Academy of Anaesthesiology,
from 1989 to 1993

Organizer of the Examination Centre for the European Diploma
in Anaesthesiology in Strasbourg, from 1984 to 1996

Dear Professor Lassner, for more than forty years I had the privilege of working with you in various circumstances, such as the “Cochin Hospital meetings”, the *Cahiers*, the “French Society”, and the “European Academy”.

Our encounters started in 1961, in Paris, at the Cochin hospital, during the Friday-afternoon meetings, which you chaired with Ernest Kern, Guy Vourc’h and Jean Valetta. The presentations and the subsequent discussions were regularly published in the *Cahiers*. At that time, I started my two-year military service. I was intensively trained in anaesthesiology

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by Professor Kern, at Cochin hospital, as the military teaching hospital Val-de-Grâce was unable to produce enough anaesthesiologists for the needs of military surgery in Algeria.

After my return to “civilian life”, I took “Anesthesiology and Intensive Care” as the speciality for my professional life. I joined Professor Gauthier-Lafaye, founder of the Department of Anaesthesiology at Strasbourg University Hospital. This provided the possibility to meet you regularly at the scientific meetings of the French Society of Anaesthesiology, held first at the French Academy of Surgery, rue de Seine, and thereafter in our “own” premises, successively rue Saint-Maur and rue Raynouard.

In 1970, you presided in Strasbourg at the National Congress of Anaesthesiology and the first French – German scientific meeting, dedicated to the “multiple trauma patient”.

Later on you enrolled me on to the Editorial Board of the *Cahiers d'Anesthésiologie*.

You invited me also to participate with you in meetings organized by colleagues in German-speaking countries. Over the years we have been the two representatives of French Anaesthesiology. There I had the privilege to appreciate your efforts for the development of our speciality and international friendship. I became aware also of the overwhelming regard in which you were held by the leaders in Anesthesiology throughout Europe.

Therefore it was no surprise when you founded the European Academy, to which of course you recruited me at once.

It was you, together with John Zorab, who suggested that I should set up the first Examination Centre for the European Diploma in Anaesthesiology in Strasbourg. I accepted this promising project for our speciality and for my city, which is a seat for major European institutions. Moreover, the premises for the Centre were particularly convenient: the great dissection room for the examination and the historical

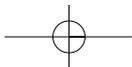
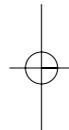
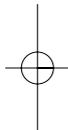


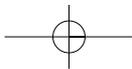
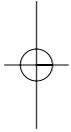
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wine-cellar of the hospital for the reception in honour of the new diplomates. As the number of candidates increased considerably, up to three sessions a year had to be organized. All those who went through the examination in Strasbourg (they are about a thousand) have a pleasant memory of that event.

Progressively other Examination Centres had to be opened. The diploma became the “jewel of the Academy”. Beyond all doubt the Diploma contributes to increase the level of quality and security of our speciality in Europe and elsewhere.

Dear Professor Lassner you enriched greatly my professional life: I thank you warmly!





The Reason that One Must Get up Early

Bill Wren

Founder Member of the European Academia of Anaesthesiology
Dublin – Ireland

The stellar conjunction of these two birthdays resonates with a conjunction in my own life in the early 70's; this took place in the little graveyard of an early Christian church near Dublin, during an interval in a scientific meeting, when the man next to me remarked that a corner of the graveyard reminded him of a similar corner in the little graveyard in his local church in Carsac in which he had told the local priest he would like to be buried; to which the curé responded "Oh, no doctor, that corner would be far too damp during the winter".

This, my first meeting with Jean Lassner, admirably set the tone for a friendship which I have cherished through the years, and, as this was also the occasion on which he first broached the concept of a European Academy of Anaesthesio-

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logy, marked the outset of a close working relationship which was sustained at high intensity for the following twenty years.

While that was a stage in my life in which I was extremely busy with the affairs of my hospital, my Faculty, the post-graduate training programme etc., etc., I rapidly learned that, however high I might consider my output to be, it still did not compare with that of this "older" man, who, having just added the editorship of *Cahiers* to his myriad other responsibilities, maintained at the same time a most remarkable Europe wide correspondence, with a constellation of distinguished anaesthetists throughout the continent, and indeed further afield.

One of the secrets of this performance was revealed to me when, over the succeeding years I was frequently received, with such charm, wit, and unfailing generosity by Madame Colette Lassner as a guest at the Rue Mechain; and, being an early riser, became familiar with the sound of Jean's typewriter coming from his rooftop office at six a.m. Another dividend of those years was, apart from the joy of frequent visits to Paris, that I met the Lassner family, and, not least, the indefatigable M. Claudine Lassner; and, in working meetings in a succession of beautiful places, a large number of distinguished anaesthetists, and remarkable personalities, from all over Europe. This last experience, which unconsciously placed our affairs in a wider European context, was an unexpected benefit of inestimable value to me, and my colleagues in Ireland.

During those years I also watched with admiration how many potential problems were solved, with apparent ease, by Jean's skills at what would now be called "net-working", and the remarkable vision, drive and energy with which he pursued his objective of raising the standard of practise to high uniform level throughout Europe, and of raising the *Cahiers* to it's present level of eminence.

It is therefore a very great privilege to me to be given the opportunity to join with my colleagues throughout Europe in wishing that Jean, and the *Cahiers d'Anesthesiologie*, may have a Very Happy Birthday, and many more of them.

On Ancient, Almost Pre-, History

Monique Lande

Assistant Doctor of Anesthesiology in Hospitals
CHU Cochin Port-Royal – Paris

Having been out of the hospital, surgical and anaesthetic environment for a considerable time, I have chosen to give a perspective from the past...

In the early 1950's surgical services consisted of a Head of Service, who was a Hospital Surgeon, one or two Hospital Assistants and at least two Interns from the Paris Hospitals. Surgical operations, programmed for the morning, finished before mid-day, seldom later. Urgent cases were dealt with locally by the Interns and Assistants through to the end of the day. What one called "emergency hospital cover" started at 6 pm. It was done by a Hospital Surgeon who travelled at night using a car supplied by the AP-HP. The emergency cover finished at 8 o'clock in the morning.

Following the first examinations for Assistants of Anaesthesia for Hospitals in 1948-1950, an anaesthetist assisted the

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surgeon on call. Each team was on call approximately once a fortnight. At that time, there was also a second “surgeon-anaesthetist” team, only called in the event of need, i.e. extremely rarely.

The AP-HP had been able to take advantage of modern American surplus “Heidbrink” anaesthetic apparatus. This apparatus was portable, transported disassembled in a case on castors, together with a vat of lime, an ether tank, a respiratory balloon and two pipes attached to a “Y” piece, whose third opening attached either to a mask or tracheal intubation tube. The tanks of oxygen and nitrous oxide were connected to the apparatus using clamps. It was the first “closed loop” system giving the possibility of working with the respiratory balloon.

On arrival at the operating theatre suite, while the surgeons prepared, the anaesthetist had to assemble the apparatus, examine the patient and to induce the anaesthesia as quickly as possible. Injectable barbiturates soon became available, with “Pentothal” happily replacing “Evipan”. The first curare, the “D-tubocurarine”, started to be used.

The anaesthetist on call was presented with a whole series of challenges:

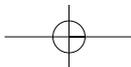
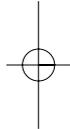
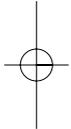
- for the preoperative examination of the patient, often in a state of shock, there was only a stethoscope and an often decrepit defibrillator, and seldom, at the beginning, a laryngoscope. Little by little, each anaesthetist added his own equipment. The anaesthetist then delivered a glucose serum drip or if necessary plasma while waiting for the emergency supply of blood;
- once the intervention was completed, the patient needed to be woken as soon as possible and to have recovered a correct respiratory function;
- the anaesthesia apparatus needed to be disassembled quickly so that it could be taken back by the driver who also removed the tanks of oxygen and nitrous oxide.

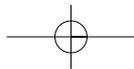
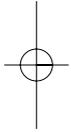


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- you needed to be prepared quickly for the next emergency, which might be in a completely different area of Paris and in a completely different surgical speciality;
- unpleasant surprises could occur. Once, during a caesarean at the Beaujon Hospital, after having conscientiously assembled the apparatus, I realized that it was missing the “Y” piece, which connected the spiral tubes to the mask... I had to ask someone to bring the old “Ombredanne” apparatus which was still in use at that time...

All that is fortunately part of prehistory and the Story of Anesthesiology is 50 years old... which, from the point of view of Cyrius, is not as old as all that!





Unforgettable Meetings!

Tapani Tammisto

Professor Emeritus of Anaesthesiology
Honorary Member of the European Academy of Anaesthesiology
Espoo, Finland

Perhaps it is meaningful to begin by explaining the nature of my relationship to Professor Jean Lassner since by doing so I can give the reader a better chance of understanding why it is precisely these kinds of episodes that have left a permanent and unforgettable mark in my otherwise sclerotic and deteriorating memory.

Finland's first anaesthesia was given with ether in Helsinki on 16 February 1847 (i. e., only some seven weeks later than in Paris) and chloroform was introduced in 1848. However, further development of anaesthesia in Finland was slow and dragged along behind some German and French innovations. Consequently, ether or chloroform given with Julliard's or Ombrédanne's mask or by drip were used almost exclusively until the second World War. Thereafter the development of

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“modern anaesthesia” stopped in Central Europe and was the sole preserve of Anglo-Saxon countries. However, the first anaesthesiological doctoral dissertation *Étude sur la teneur en éther du sang chez l'homme pendant l'anesthésie générale combinée avec la scopolamine-morphine*, defended by Eero Turpeinen at Helsinki University shortly before the main attack of the Allied Forces on the Karelian Isthmus in summer 1944, may be mentioned as a curiosity and as a possible exception to the rule. As a result of this change, the great leaders and mentors of the Finnish pioneers in modern anaesthesia were American or English anaesthesiologists and the connections to other anaesthesiologists were occasional and based mainly on coincidental and concurrent training in the same Anglo-Saxon centres. When these pioneers then started the training in Finland, they naturally transferred their knowledge, methods and routines to their assistants. Moreover, since many of these assistants in training wanted to improve their skills abroad, they made use of the personal contacts created by the former generation. Thus, also the first generation of the anaesthesiologists trained in Finland admired only Anglo-Saxon anaesthesia and found acquaintance and contact with other European centres less important and less interesting.

Unfortunately, I happened to belong to that generation – with the “anomaly” that due to the German origin of my beautiful wife, I was not entirely ignorant of Central European anaesthesiology but had rare contacts with some German anaesthesiologists. Thus already before the foundation of the EAA, I knew Professor Lassner by name, and was aware of his being one of the leading anaesthesiologists in France. I also had some vague impression of his role in the resistance movement during the war. When the EAA was founded 25 years ago, I got to know Jean Lassner as a sovereign, polyglot leader and a skilled politician in European anaesthesiology. The following ten years as a Senator of the EAA naturally deepened my relationship to him and created even a kind of “uncle-son” friendship. Despite that, I would

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not like to describe in my article the characteristics or achievements of Jean Lassner in greater detail, since there are plenty of friends and colleagues who are much better qualified for that purpose. Instead, as already mentioned above, I will write about some occasions on which I came into contact with Jean Lassner and which have made a deep impact on my mind.

Starting in 1970 Professor Karl Hutschenreuter organised in Homburg/Saar very popular post-graduate courses. The courses, which lasted almost one week, were organised every second year. The atmosphere was relaxed and very familiar, partly due to the fact that many of the lecturers were invited more or less repeatedly. Jean Lassner was lecturing there, too. I do not remember the topic of his lecture but I think that it was perhaps his first performance at the courses since he began his lecture by stressing the importance of international cooperation as well as the importance of learning foreign languages and the languages of the neighbouring countries, in particular. Saar as a borderland between France and Germany was naturally an excellent place for these ideas. When explaining the realisation of his ideas in greater detail, Lassner mentioned, e.g., that the best way to learn foreign languages is to learn them in bed. I do not know whether he spoke on the basis of his own experiences or whether the audience had similar experiences but I personally – poor in English but moderately fluent in German – could not have agreed more with him. Though presented as a joke in the midst of serious opinions, and also in view of our present EU, I have later had much use of his statement. Finland was previously, i. e., from 1153 to 1809, the Eastern half of Sweden and then from 1809 to 1917 an autonomous Grand Duchy within the Russian Empire. The language of education was naturally first Latin, then Swedish and only after the 1890s were all teachers required to be able to lecture in Finnish. Thus hundred years ago all educated people were fluent in Swedish. Since Finland's declaration of indepen-

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dency in 1917, the Swedish language has gradually lost its positions and the Swedish-speaking minority has become smaller; hundred years ago it accounted for about 12% of the population and nowadays only for about 6%. Moreover, nowadays many, if not most, of the educated people are communicating in English with their Scandinavian neighbours. Due to the small size of the Swedish-speaking minority, mixed marriages are naturally very common but unfortunately Finnish is often the families' home language since nowadays both spouses are usually fluent in Finnish. In my opinion this is a wrong and disastrous development. On the contrary, all the mixed marriages should have Swedish as their home language since this would prevent the disappearance of the Swedish-speaking minority, would increase Finland's bilingual population and thus preserve our Scandinavian heritage. But many of the Finnish-speaking majority do not think so and the policy in regard to the language spoken seems to belong to the "evergreen" issues in Finland. And it is just in these debates where I have – often with some success – argued my case by using the above statement of Jean Lassner.

Another, for me ever memorable speech given by Jean Lassner dealt with the co-operation between the anaesthesiologist and the surgeon. In his speech, Lassner referred to an obscure complication which had occurred during anaesthesia in his clinic. Later on, when discussing privately the aetiology of the incident, the weeping anaesthesiologist confessed to Professor Lassner that she had got so furious with the surgeon that she had intentionally reduced the inspired oxygen content of the gas mixture. Lassner presented this sad incident as a warning example of tragedies which can happen in very extreme situations when an uncooperative team is forced to work together. Consequently, he emphasised the responsibility of the heads of the departments in avoiding arrangement of dysfunctional teams. This was a shocking and a very important lesson to me since I had been working just in the opposite way. As a young Professor, I had had great

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aversion to the practise of many surgeons to select their own favourites among the anaesthesiologists who – and only who – were allowed to anaesthetise their patients. In my mind this practise had been very unfair, undemocratic, disturbing and even dangerous at a university clinic training future anaesthesiologists and thus responsible for their competence. Now Professor Lassner had forced me to look at “the other side of the coin”. This was very welcome since I had to reflect on the problem, change my previous obstinate attitude and find more individual and flexible solutions to the problem. Though retired seven years ago, I still find that this may be a problem without any good solution, particularly under unfortunate conditions with several difficult mutual relationships between the persons involved. Anyhow, it cannot be denied that this was an ever memorable speech for me.

The 6th European Congress of Anaesthesiology was held in 1982 in London. The congress organisation was brilliant in a splendid and magnificent framework. Princess Margaret was the Patron of the congress. This was very impressive, considering that her grandfather’s grandmother, Queen Victoria, so greatly promoted the acceptance of anaesthesia in a time when the initial prejudices against the use of anaesthesia still were prevailing. In connection with the Opening Ceremonies, Princess Margaret and Jean Lassner appeared together on the stage. Lassner honoured Princess Margaret with a speech emphasising the great contribution of her grandfather’s grandmother to the development of modern anaesthesia. The atmosphere in the auditorium was very solemn and one really could “hear the swish of the wings of history” as the Finnish saying goes. Lassner’s speech was very eloquent and his whole appearance so charming, elegant and cultivated that I was quite overwhelmed, unable to do anything but admire and envy him. Now, having almost reached that age which he had in those days, I admire and envy him even more but the proportions of the feelings may be slightly different – the share of envy is perhaps greater.

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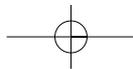
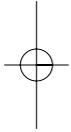
Once – it was perhaps in the spring of the year 1987 – my wife and I were invited to a meeting of the Senate which was held in Lassners' manor house in Dordogne. The visit was quite memorable in every respect. The impressive large traditional house, the beautiful surroundings, the numerous historical monuments, nothing to say about the caves of Lascaux which we, however, for some reason could not see even in replica. One especially memorable detail were the joint breakfasts with vivid and witty discussions and with the "eggs modo Lassner", in particular. They were boiled eggs, very hot and very soft without any coagulation observable even in the white of the egg. I found them very palatable but eating them without spoiling the surroundings required some degree of know-how. Now I must blushing admit that my knowledge in French culture is poor and I do not know whether eggs boiled in this way are quite common in the French cuisine or even essential for a French gourmet. Anyhow, for us Northern Barbarians they were something quite unique, even though most of our Finnish friends find our four-minute eggs much too soft, too. Back home after this wonderful tour, it then happened that we, my wife and I, carelessly boiled our breakfast eggs much less than the normal four minutes. When beginning to eat them both of us gave a cry of delight: "Lassner's eggs!". Well, since neither of us is very punctual, it often happens that the eggs get too soft or too hard. Unfortunately, we have no memorable expression for the too hard eggs but the excessively soft eggs are and will remain "Lassner's eggs", still evoking lively memories of that wonderful journey. Moreover, if somebody of our younger grandchildren or our close friends still does not know the expression, we will tell the story about the famous Professor Jean Lassner, about his manor house in the beautiful surroundings, etc. Thus the personality of Jean Lassner is already known to the third generation in our family. We do hope that the tradition continues.

In the beginning of 1997, the Working Group on Ethics of the EAA had its meeting in London. I was flying back home

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shortly after noon on the following day which happened to be a typical gray and wet winterday in London, with wet snow falling slow but sure. I had been retired for almost two years and had felt myself already somewhat alien at the meeting of the group. Furthermore, I had had personal difficulties towards the end of the previous year. Therefore I was not at my best when I was looking through the hotel window in the morning, and thus decided to set out directly to Heathrow airport without visiting any touristic attractions of London during the morning hours. I, therefore, had a couple of hours spare time at the airport and when sauntering around I came across Jean Lassner. He had spare time, too. But his reason for the spare time – if I understood correctly – was the difficulty to walk the long distances at the airport and not the transient melancholy as was the case with me. This unexpected reunion delighted us, and after having almost reached his gate, we sat down and started chattering. I no longer remember what we were talking about but I do not think that we had any “serious discussions”, rather “small talk but on a high level”. What was substantial for me was the general feeling, not the topics. I believe the warm and pleasant atmosphere was a result of the following: we were not in a hurry, we had no agenda, no solutions were required, there were no other persons present, etc. I can still almost hear his captivating giggling that interrupted the flow of our conversation. His plane left a bit earlier than mine. Looking at him going to the gate, I realised my melancholy had subsided. Landing in Helsinki-Vantaa airport, I felt even better although the weather was more miserable than in London. After this unofficial meeting we have not met again. Should we for some reason no more meet in this world, I am extremely happy that this unplanned meeting at the airport was granted us after the planned one.

May I conclude my memories by sending my best and warmest birthday greetings and a threefold “Long Live!” to the great leader and promoter of the European anaesthesiology, Professor Jean Lassner.



Mixed Memories

Prof. Yvonne Noviant – Mallet

Professor, Former Head
of Department of anaesthesia – Intensive Care Unit
Hôpital Bicêtre – Le Kremlin-Bicêtre

Member of the European Academy of Anaesthesia
Chevalier de la Légion d'honneur – Officier de l'Ordre du Mérite

Chevalier des Palmes académiques
Chevalier du Mérite de l'Ordre souverain de Malte

One cannot recall the events of one's professional life without some nostalgia. In my professional life, as well as in the rest of my life, Jean Lassner is the one who has shown the way. By his example, he demonstrated the importance of keeping a clear mind on our way between the technical world and human suffering.

After the liberation of Paris in 1944, I enlisted in the Army and participated in the military campaigns in Alsace and in Germany. I served in the surgical ambulances that followed the troops as closely as possible. As a medical student, I was

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under the orders of various medical officers, among them Lieutenant E. Kern, in the unit called GCM2. Shortly afterwards, Kern met Merle d'Aubigné and I met R. Sauvage, both at the beginning of a brilliant career as surgeons. Our professional lives were shaped by these encounters.

At my level of medical studies, the volunteers were offered three functions in the military ambulance: assistance to the surgeon during operations, blood transfusion to prepare the wounded for surgery, and anaesthesia.

Depending on the injuries, early operations presented a number of difficulties, especially of chest and lung injuries. I was impressed by the way Dr Kern resolved the problems posed by open chests, paradoxical movements of the lungs and insufficient pulmonary ventilation. Dr Kern lectured in free moments and I was soon convinced that anaesthesia was my field.

In the autumn of 1945, I was appointed to a military hospital in Paris. On arriving to take up my duties, I presented myself to the medical officer in charge: Captain J. Lassner, Assistant to the General in command of the hospital. He was courteous, slightly distant, impressive. Kern was among the physicians at this hospital and he and Lassner organised lectures on anaesthesia and intensive care. A few years later, Merle d'Aubigné became head of an orthopaedic clinic in one of the Paris hospitals, Cochin – Port-Royal, where Kern and Lassner joined him. I managed to pursue my training in anaesthesia there. In due course, Jean Lassner became a friend – less distant than in the beginning and very friendly and attentive. In the following years, I learned to appreciate his talent for shaping the anaesthetists' professional life and for settling the many problems that beset the new discipline – to a great extent thanks to his gift for negotiation.

R. Sauvage asked me to take charge of anaesthesia in his unit of thoracic surgery at Beaujon Hospital in 1950. My predecessor in the post had not wanted to adopt the new

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methods. As soon as I made the decision to take the post, I went to London's Brampton Hospital, highly reputed for its thoracic surgery unit. In later years, I continued to visit foreign hospitals. For French surgeons who had been to England during of after the war years, British anaesthesia had left a deep impression. In postwar France, material conditions were very hard. The very limited anaesthetic equipment available had mostly been left by the American Army.

At Beaujon Hospital and, later, at the Marie-Lannelongue Centre for Thoracic Surgery, I enjoyed an atmosphere of mutual understanding among physicians. The most difficult problem I faced was postoperative respiratory insufficiency. Mechanical pulmonary ventilation was still some years off.

For the younger anaesthetists, the lectures and discussions at Cochin Hospital on Friday afternoon were of great value. Various opinions were expressed on each topic. Anaesthetists from various European countries came to lecture and to participate in the debate. Every session was memorable. R. Kern and J. Lassner served as co-chairmen. When the relationship between surgeons and anaesthetists came under discussion, the co-chairmen's views diverged. Kern considered his surgical chief, Merle d'Aubigné, as his sovereign. Lassner obviously refused the role of vassal and a relationship based on dominance. But his lucid thinking made him accept interdependence between autonomous and equal physicians.

When Debré's reform of the French hospitals gave the doctors full-time employment, the anaesthetists became, nominally at least, the surgeon's equals. At the same time, their relations with their patients became more and more anonymous. Jean Lassner opposed this trend. He considered the relationship between the doctor and his patient to be a privileged one, more important than matters of technical or pharmacological interest. His own way of handling and experiencing this relationship was exemplary. He knew how to listen to a patient, how to speak to him, how to gain his confidence and appease his fears.

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It may be an illusion to aim at such a relationship in surgical units with ever greater numbers of patients and shorter and shorter hospitalisation. It is to be feared that in accepting such conditions, we may lose the core value of our profession.

A Spirit Perpetually Alert

Prof. Em. Dr Karl-Heinz Weiss M.A.

Professor Emeritus, Former Head of Department of Anaesthesiology
University Hospital of Würzburg – Germany

Honorary Member of the European Academy of Anaesthesiology
Kümach (Germany)

Dear M. Lassner,

What more could I wish you than which you already possess so abundantly: sound physical health and the enduring inquisitiveness of your ever so alert and agile mind?

And for the readers of this letter I may perhaps add a few very personal recollections culled from my initial and then later experiences in our shared field of anaesthesiology since quite early in my career I had the good luck to make your acquaintance at the University of Mainz – if was in 1949 – and Rudolf Frey was the link to this encounter.

The Medical Faculty of the University of Mainz was the first in the Federal Republic of Germany to succeed in

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establishing an independent chair for anaesthesiology and filled the position with the most outstanding anaesthesiologist of the time in the country, Prof. Dr Rudolf Frey from the University Clinic of Surgery at Heidelberg. Certainly credit is due the faculty members as a whole, but the far-sightedness and driving force of Prof. G. Brandt, Director of the University Clinic of Surgery, and Prof. G. Kuschinsky, Director of the medical school's Pharmacological Institute, deserve special mention. This all the more since it is widely known that most of the university department heads of surgery had great difficulty in granting not only anaesthesiology its independence along with the young physicians who were prepared to devote their medical future exclusively to it, but also in recognizing its autonomy in the treatment of patients, in research and in training.

I myself profited greatly from the progressive stance of the faculty in Mainz: as a resident in surgery, albeit assigned exclusively to anaesthesiology, I was allowed to work by agreement three days of the week in pharmacology and the four remaining in anaesthesiology. Privileged in this manner I was able to witness the arrival of Prof. Frey from Heidelberg. And I know that you, M Lassner, were involved in consulting the faculty on the choice of R. Frey. I can no longer remember the date of the day in 1959 on which you first participated in the residents' conference held in quite modest chambers (a former apartment in the clinic), but I do remember exactly the anxious expectation arising after R. Frey introduced you as France's foremost anaesthesiologist. In addition, you were one on the first of the many foreign visitors who in the following years visited him and therefore also us.

Initially it was your perfect German, which surprised me, then your unpretentious demeanour, and at the same time a repartee paired with humour and acumen. We young residents were careful in asking you questions or answering yours; the content had to make sense, otherwise there would

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follow your reply which without offending clearly exposed in the deficits of the foregoing.

Those of us just starting in the speciality and revolving around our boss, Prof. Frey, were eager to show the operative disciplines what modern anaesthesiology was capable of achieving, and we were proud of the first internationally pre-eminent visitor whose presence strengthened our self-confidence and gave us the assurance to continue confidently and resolutely on down, the path just started in the new field and thus to establish an exemplary central department of anaesthesiology in the medical school of Mainz.

By your repeated and always stimulating visits, M. Lassner, you accompanied us on thy path. Just one question which at that time secretly occupied me and was concerned with my own future image of myself as an anaesthesiologist wasn't to be answered by your presence: I just was unable to picture myself as a 60-year old administering anaesthesia (as opposed to nowadays we had no such role models then). You do have a 15-years head-start on me, but at that time in spite of all your accomplishments, your academic standing and your leading role in European anaesthesiology I saw you as anything other than an "old" anaesthesiologist. To my relief, a year later I did run into such as these and, moreover, highly respected at that ("consultants") in London; the path I had chosen turned out to be the right one after all.

At the end of 1965, a year after completing my habilitation in Mainz, I accepted the offer of Prof. W. Wachsmuth to set up a department of anaesthesiology in the University Clinic of Surgery at Würzburg. While engaged in this challenging task I was offered the chair for anaesthesiology at the Free University of Berlin. You, M. Lassner, promptly fulfilled my wish when I asked you to visit our new, aspiring department in Würzburg. Just as in Mainz, you participated here too in the residents' conference. Afterward, the two of us then conversed together on the insular and politically precarious

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situation of the divide city of Berlin at that time during the “Cold War”. You quickly agreed with me that if the position in Berlin offered the same framework that Würzburg was supplying-central department of anaesthesiology with an intensive care unit and laboratories – then Würzburg should be given preference. It was at this point that over beyond our professional interests a personal friendship started to develop.

Something that I found especially interesting and exciting in our encounters was that in spite of or perhaps because of the “Iron Curtain” which was dividing the people of Europe into two polar camps, you had already started in a determined and persevering way to transform a personal vision into public reality, on which foresaw a union of anaesthesiologists from all European countries, regardless of the political and national dispositions of the single countries. Your goal was to advance not only the scientific standard and the academic training throughout Europe, but initiate joint scientific meetings as well. Your vision remained pure illusion for many people of that period who refused to follow your lead while others embraced the idea enthusiastically.

In the national speciality societies called upon by you to participate, discussions on the endeavour were soon initiated, in our DGAI as well. To the first preparatory session for a timely establishment of the “European Academy of Anaesthesiology” you invited representatives to Paris on March 12, 1977. The board of the DGAI allowed me as its president and K. Hutschenreuter as the representative of the Professional Association to attend, but just as observers. And we experienced a reaction quite typical for you, actually a penalty: as opposed to the delegates of the other 15 national societies of anaesthesiology who had already pledged their support to establishing the “Academy”, we who were only granted observer status had to sit at a separate table while the erstwhile health minister, Madame Veil, in a short, emphatic address lively advocated the founding of this Academy. Whether the minister recognized the reason for

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our separate seating at the little table or even tried to explain it remains unknown. Following Mme Veil's departure we were allowed to integrate into the "mainstream" table society. We two "sinners" were no less amused than you, M. Lassner. At the opening ceremony of the "European Academy of Anaesthesiology" during the "European Anaesthesiological Meeting" in Paris, on the 5th of September, 1978, full (West German) participation was assured along with the other 22 national societies.

The anaesthesiologists in Germany, who after the devastating world war had established one common scientific society in 1953 and had regularly held meetings together, were separated first professionally and then personally by the calamitous erection of the Wall in 1961. Hereafter, two German anaesthesiological societies came into being and convened independently from one another. Reciprocal visits in the two separate countries were practically no longer possible.

The idea you put into practice, M. Lassner, the birth of the European Academy of Anaesthesiology, led from 1978 on during its annual meetings to personal encounters between anaesthesiologists who had come into positions of responsibility in the 70's and 80's in both German states and who thus became acquainted and began to understand each other. Without knowing what the future would hold, this turned out to be the groundwork for the reunification, which then came as a surprise to everyone. And as a participating contemporary witness it was a great joy for me to experience the quickly reached unanimity taken for nearly granted which arose in the two societies, separated for a decade when the unification of both in the DGAI was mutually decided on and then quickly took place. It was a great honour for the DGAI, M. Lassner, that you, already awarded the highest distinctions of France, various honorary doctorates (including one from the Medical School of Mainz), honorary member of at least a dozen different national scientific societies in Europe, became its honorary member in 1980.

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My dear M. Lassner, now on your 90th birthday you will be looking back on a life rich in many ways, on a life's work characterized by success in a way few people may ever hope to render or to put into practice. Perhaps your inner strength remains a secret even to you. Any attempt to describe and to note everything involved can only remain fragmentary and overlook some essential characteristics. But in spite of this I would like to venture a try now at the end of my letter.

What has most fascinated me about you, whether I was with you at a medical meeting or just at lunch in a Parisian restaurant, is your intellectual presence paired with reassuring calmness which to be sure wouldn't exclude a temperamental reaction: you listen attentively, you skip over topics of no interest, you are self-assured in a modest and agreeable way, aware of your value and your achievements and only smile when a too pointed or submissive reaction to your honourable distinctions is evoked. It is thus that I enjoy your friendship and hope to be able to continue to do so for long to come.

I am grateful to you, living in France and certainly not without reservations after painfully and bitterly experiencing Hitler, for offering us anaesthesiologists in Germany your support, for helping to advance the new field and lead us back into the Western community of common values.

Very sincerely yours.

Such Is Life...

Professor Louis Lareng

Honorary President of Paul Sabatier University – Toulouse
Founding President of SAMU – France
Honorary Chairman of the French Society of Anaesthesia,
Analgesia and Intensive Care
Director of the European Telemedicine Institute
President of the European Society of Telemedicine
President of the National Federation for Civilian Protection
Commander of the Légion d'Honneur
Officer of the National Order of Merit
Decorated by the Ministry of Education

It is with profound emotion that I should like to tell the story of the *Cahiers d'Anesthésiologie* which is closely bound up with that of my friend, Jean Lassner.

E. Kern, J. Valette, G. Vourch and J. Lassner comprised the drafting committee. Reflecting all our vicissitudes, joys and worries, the articles in the *Cahiers d'Anesthésiologie* were

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steeped in the skills and knowledge that paved the way for the safe development of our field.

I highly appreciated the discretion with which this great, yet simple, publication grew in an area that was *complementary to the scope of the Revue d'Anesthésie, d'Analgésie et de Réanimation* for which, as president of the French Society of Anaesthesia, Analgesia and Intensive Care, I long held the position of editor. There were never any differences of opinion about strategies, nor any quarrels over semantics, nor any problems rooted about schools of thought between these two reviews. During the major discussions on “hibernation”, in particular, the *Cahiers d'Anesthésiologie* adopted a rigorous position, while at the same time moving in the direction of progress based on ever better techniques and product pharmacology.

The independence of the anaesthetists, sadly the only doctors at the time to be considered surgical assistants from both a legal and ethical stance, was firmly supported with great diplomacy and determination by the *Cahiers d'Anesthésiologie*. As I belonged to the *Cahiers d'Anesthésiologie* team, I was involved in all these “battles” for independence, together, naturally, with all branches of anaesthesia (societies, reviews, unions). I tried to avoid, albeit often with difficulty, any useless assault on our fellow surgeons. The day the status of Assistant was abolished, I, like everyone else, felt most satisfied.

It was at hôpital Cochin during the weekly anaesthesia study sessions that I assiduously and regularly prepared my forty-five minute and one hour lessons with a view to my *agrégation* – a competitive examination.

Jean Lassner, representing the editing department of the *Cahiers*, called on me to seat on the reading committee in order to cover the various papers on emergency medicine.

Happy Birthday my dear Jean! Our paths cross far too rarely. Whenever we have an opportunity to meet, we have a joyful time. We defend the same human values which, over

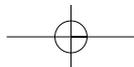
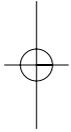
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time, have helped to maintain the humanist features of French and European medicine. I have partaken of family meals with your charming family. Those invitations I was able to take up in The Dordogne revealed that you unflinchingly strive to hone your knowledge in a most relevant manner.

My dear Jean, such is life. No one escapes the passage of time, whatever the moment or place. Your line of conduct has never varied: in a world in which the unity of time has partially replaced the unity of place, it remains a beacon of rectitude and honesty in a human application of medical science.



Left to right: Guy Vourc'h, Louis Lareng, Jean Lassner



The “de Gaulle” of French Anaesthesia

**Professor Michael Rosen C.B.E, LL.D.,
F.R.C.A, F.R.C.O.G, F.R.C.S. (Eng)**

President Royal College of Anaesthetists (1980-1991)
Honorary Member of the *Société française d’anesthésie*

I first met Jean Lassner in 1970 through his enthusiasm and interest in improving obstetric anaesthesia and analgesia in France. In Cardiff, had been the first course on obstetric anaesthesia and analgesia had been established for anaesthetists and obstetricians, and he was strongly interested in this educational venture. I was immediately impressed by his clarity of vision, directness, and total command of the subject, expressed in impeccable English. I was, soon after that, elected to the Council of the Association of Anaesthetists, and known to be strongly in favour of the establishment of an independent Royal College of Anaesthetists (our Faculty of

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Anaesthetists was part of the Royal College of Surgeons of England). In 1975 he invited me to the Port-Royal Hospital to lecture on obstetric anaesthesia. During that visit he introduced me to Claude Sureau who became a friend and an ally in FIGO the international body uniting obstetricians, who helped, with Jean Lassner, to develop stronger bonds between obstetricians and anaesthetists.

During that visit, as we drove down the right bank, I discussed the advantages of the Royal Colleges as professional arbiters of standards, independent of government. I enquired whether such an institution could be of benefit in France and Europe. He immediately understood the implications, broadened the ideas, and commenced wider discussions facilitated by his wonderful expertise and fluency in many languages. We were joined in expanding these ideas by Michael Vickers, and later by John Zorab, which were fully aired at the World Congress in Mexico in 1976. We worked through many titles and structures deciding upon the name "Academy" with its prestigious echo in Europe, and different from the "British College". We drafted the basic laws and rules over the next year and a half and after preliminary meetings, in April 1978 in Paris, the European Academy of Anaesthesiology was founded in the presence of the, then, Minister of Health Madame Simone Weil.

His achievement was enormous in bringing together so many anaesthetists of diverse talents and standards into one international body, and without any particular number of places allocated for any single country. This was a triumph for Jean Lassner, international diplomat and academician extraordinaire!

The format today of the European Academy of Anaesthesiology is almost exactly as that planned in 1976-78. The development of that body into a formidable academic institution over the next 25 years can be mainly attributed to his achievements as the first (and now Life) President. He encouraged everyone to try harder. He enlivened every

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meeting with his intimate clinical insights. He raised every social occasion to heights enhanced by his interesting, pithy, humorous, and incisive speeches – forgetting nobody! His benign influence was everywhere, encouraging Michael Vickers and myself to set up the European Journal of Anaesthesiology. He was, also, totally supportive during my period of office as Treasurer – supportive meaning getting things done!

There have been difficulties. The foundation of the European Society of Anaesthesiology was partly or mainly, due to the European Academy – dissatisfaction with its elite structure. This has turned out, after fractious periods, to have been beneficial. Now at last both organizations together with the European Section of WFSA – CENSA, are working together harmoniously for the benefit of anaesthetists all over Europe – and thanks to Jean Lassner.

I have seen in my lifetime the transformation of French anaesthesia and critical care into world leaders from small beginnings. Jean Lassner was there – a de Gaulle figure – from the beginning. He, together with Guy V'ourch, orchestrated most of the initial anaesthetic academic developments in France with the greatest skill, always continuing to ensure governmental support for our speciality. On the world scene his support for WFSA has been crucial in establishing the “ownership” of world congresses, and the subsequent vital WFSA education programmes essential to the developing world. I plead, in his name, here for all “good” anaesthetists now to help through donations, WFSA continue and expand these programmes.

Of course no man is an island. Without the support of his family he would undoubtedly have been less successful. His hospitality was legion. I recall many dinner parties at 7 Rue Mechain which turned adverse opinion to his side. His wife Colette was a material force in these efforts and a great support in his life's work. His daughter Claudine, too, has been in the forefront of these endeavours. We in the

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European Academy, WFSA, and no doubt the French Society, owe a great deal to their support.

His energy is enormous. It was only in 2000 while I was in Paris attending a planning meeting for the 2004 World Congress meeting that he travelled from Sarlat specially to greet me. As always it was a great occasion to see my old friend, and to get his advice!

What next? After all he's going to be only 90. I and all British anaesthetists, salute him with pleasure. Happy Birthday – and may there be many more!

Memories of a True Story... Or of True History

Yvette Bossé-Jaureguiberry

Chevalier de la Légion d'Honneur
Combattant Volontaire de la Résistance
Saint-Pierre et Miquelon – France

Born in Saint-Pierre et Miquelon, I enlisted in the Free French Naval Forces (FFNF) in June 1942.

Posted to Saint-Pierre-et-Miquelon hospital in July, I was selected by the FFNF doctors, Doctor Henri Debidour, chief surgeon and Doctor Jean Lassner.

During an interview in the office of the doctor in charge, I could see from doctor Lassner's expression that he fully approved of my appointment as an assistant-nurse in the operation room. His glance changed my life.

These doctors impressed us as much by their imposing demeanour as by the feeling of confidence that they inspired.

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When doctor Lassner arrived, the wards of the hôpital Saint-Pierre had to be fully organized or rather reorganized, beginning with the hygienic conditions:

- the isolation of patients suffering from tuberculosis;
- the implementing of treatment by pneumothorax;
- the admission and the full treatment of patients.

Such changes proved successful and numerous youngsters, after several months of treatment could enjoy a normal life again.

The improvement of the lab soon proved fruitful. More complex and trustworthy examinations allowed doctors to apply better adapted treatments. As early as 1943, it was possible to identify the blood group of patients, a very useful datum for blood transfusion...

Doctor Lassner trained a lab assistant, A. Cordon, a gifted male nurse, who was soon able to carry out the usual examinations. I also remember pregnancy tests performed on female rabbits. At that time, this was surprising.

At the intensive care unit, the people who were burnt or wounded, brought by the FFNF corvettes and the speed-boats which patrolled the North Atlantic, were treated in priority.

Doctor Lassner took charge of the still nascent anaesthetic department. Until early 1943, there existed only the chloroform mask (masque d'Ombredanne) for general anaesthetics and rachis anaesthetic, for certain abdominal operations like Caesarean section.

At Doctor Lassner's insistent demand, a qualified nurse, A. Olano, was sent to Canada to become further acquainted with a new path-setting apparatus, producing oxygen and nitrogen protoxyde, to permit respiratory assistance. The patient's comfort was tremendously improved.

The full cooperation of the surgeon and the anaesthetist made the work of all the staff easier.

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Important decisions were taken by the two doctors after studying all the data that could save the patient. Doctor Lassner's authority and his competence in this field were all the more remarkable as he was only twenty-nine.

On the island of Miquelon, a physician under contract, Doctor F. Funan, was responsible for the health of the 600 inhabitants. The overall population of the islands was about 4500 people. To those should be added the 200 military personnel and the crews of the three speed-boats based at Saint-Pierre.

For sixty years, I have regularly been in contact with the Debidour and Lassner families.

I feel for them true admiration and deep affection.

To this day, I retain the memory of having worked within a closely bound group in which everyone had his or her place. The climate of respect and confidence which prevailed in the team, opened up a path full of hope for the girl I then was and left its mark for ever on the woman I was to become.

For all these reasons, I want to thank with all my heart, Professor Jean Lassner as a Doctor, as a man and as a friend.

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From left to right, first row

Noël Yon, Jean Danchise, Dr Jean Lassner, Dr Lise Eliachef, Dr Henri Debidour,
Sœur Odile, Eugène Siosse.

Second row

Martin Hirrigoyen, Amand Cordon, Augusta Quann, Sœur Alain, Edmée Debidour,
Ms. Mc Intyre.

Third row

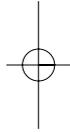
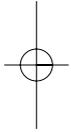
Auguste Olano, Germaine Olaisola, Madeleine Pochic, Céleste Quann, Thérèse
Lebars, Joseph Chartier.

Fourth row

Angèle Boudreau, Yvonne Walsh, Simone Bouvier, Adèle Gens,
Gisèle Servain, Constance Farvacques, Thérèse Derouet, M. Etcheverria.

Fifth row

Ms. Corrouse, Yvette Jaureguiberry, Paule Garzoni, Ms. Letiec,
Louise Corrouse, Gaby Ruault-Cazier, Denise Haran, Mimi Riggs, Louis Hue.



Always Agreeing, Never the Same Opinion

John Zorab

Fellow of the Royal College of Anaesthetists
Founder Member of the European Academy of Anaesthesiology

President of the Examination committee
for the European diploma in Anaesthesiology

Former President of the World Federation
of Societies of Anaesthetists

I first met Professor Lassner at the 4th European Congress of Anaesthesiology in Madrid in 1974. He was already a member of the Executive Committee of WFSA and, when the new Board of the European Regional Section was formed in Madrid, Lassner was elected Secretary and I was elected a Vice Chairman. So began a friendship extending over the subsequent years and one for which I remain profoundly grateful. Without realising it at the time, Lassner was responsible for a major change in my professional life when,

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at the European Congress in Paris in 1978, he resigned from the Executive Committee of WFSA. This created a casual vacancy. I was lucky in being in the right place at the right time and was asked to fill the casual vacancy, so beginning my long association with WFSA. However, this was not the only basis for our friendship. Two years earlier, we had met at the World Congress in Mexico City where Lassner instigated discussions for a European Academy of Anaesthesiology. This led, in 1978, to my becoming a founder member of the Academy. Although Lassner and I by no means agreed on everything, when I first suggested that the Academy should introduce a European Diploma in Anaesthesiology (EDA), Lassner gave me his full support, support that never wavered and, without which, the EDA could not have succeeded. And so our friendship continued. I was privileged to get to know his late wife, Colette and their daughters, Claudine and Elizabeth and it has been a pleasure to count them among my friends and to visit their homes in Paris and in Sarlat. After the Academy meeting in Cardiff in 1990, Lassner came to a luncheon party at my home in Bristol. The room was crowded. I have a treasured photograph of Lassner, who hated to eat standing up, having his lunch on the keyboard of my grand piano! There were occasions when Lassner displayed his wicked sense of humour. On one occasion, I had been invited to attend a meeting of the Portuguese Society. I was also invited to say a few words and the invitation specified that French would be preferred. Although, to Lassner's disappointment, I cannot speak French, I asked a friend to translate my few words into French which I thought I could then read. At the lectern, I was alarmed to see Lassner in the front row. I read my few words in what I thought was passable French. Immediately afterwards, Lassner rose and said, "John would you read your words again, in English, so we can all understand!". I could have strangled him at the time but everyone laughed and our friendship continued. I never attempted to speak French again! Lassner's contribution to European anaesthesiology is legendary. He has not always

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pleased everybody but there will be many like myself who will wish to offer their congratulations on the success of his journal *Cahiers d'Anesthésiologie* and on his 90th birthday. I count myself very fortunate to have enjoyed his friendship for so many years and trust that it will continue for many years to come.

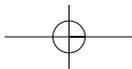
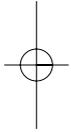
1st June 2002



Septembre 1987

Ms. Simone Veil and Jean Lassner

Opening of the European Congress on Anaesthesia



From a Thesis on the History of a Successful Partnership

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Like many of Professor Jean Lassner's countless students and friends, I have been asked to recall and relate, on the occasion of the celebration of his 90th birthday (which happened to coincide with the 50th anniversary of the publication *Cahiers d'Anesthésiologie*, of which he was one of the three founding members) some of the memorable moments and anecdotes that I shared with him through the years, from our occasional sporadic contacts to our teacher-student relations, and our professional relations and friendship.

First I must mention that I would never have had the honour and pleasure of meeting this exceptional head of the Hôpital Cochin's Department of Anaesthesiology if I had not

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been the pupil of my wonderful teacher, Professor Louise Delègue, from whom I had the good fortune to learn my professional skills at the Hôpital des Enfants-Malades, a children's hospital, in the early 1970s.

At that time, there was a close spirit of cooperation between these hospitals' two departments, and there were frequent scientific society meetings and case presentations. Professor Lassner's charisma, vast medical knowledge, exceptional listening skills, analytical mind, memory, and past experiences as an escapee from Occupied France, and later as a combatant for the Free French Naval Forces – as well as the fact that once, as everyone knows, he was even General Charles de Gaulle's Anaesthetist – impressed us immensely, and me in particular especially as we were only students at the time...

I will always remember one day at Cochin when Professor Daniel C. Moore of Seattle, then considered the virtual "Pope" of loco-regional anaesthesia, had been invited to the hospital, and Professor Lassner, switching effortlessly back and forth between English and French, proved yet again that day how brilliant, witty and kind a host he was.

In the meantime, Professor Lassner had served as Chairman of the Thesis Committee for the CES state specialisation degree in Anaesthesia-Resuscitation, which I earned after defending my dissertation in 1973.

As the years passed, I kept working on a short-term basis in Ms. Delègue's department, and later with Mme Barrier at the hôpital des Enfants-Malades, but my work as an anaesthesiologist was performed almost entirely at the Centre Médical de la Porte de Choisy surgical unit, where I was primarily in charge of Anaesthesia and Intensive Care in Professor Émile Letournel's orthopaedics department. Now a prominent and internationally renowned figure in this speciality, the latter is a native of a very small French territory in North America – an archipelago of which he is particularly proud – Saint-Pierre et Miquelon.

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It so happens that this valiant little country, modest in terms of its size and population, was stoutly patriotic and joined the Free French movement as early as December 1941 through the agency of the corvette *Aconit*, commanded by Lieutenant Levasseur and seconded by Sub-Lieutenant Alain Savary. Both were later decorated as “Compagnons de la Libération”. As a result of that mission with which they were entrusted by Admiral Muselier, young naval officer Alain Savary was appointed as Governor, and later went on to serve as the first Deputy elected to represent Saint-Pierre et Miquelon in the *Assemblée nationale*.

Professor Lassner, a member of the Free French Naval Forces, happened to be on duty there as a doctor and biologist in 1942. His interest in anaesthesiology and Anglo-Saxon techniques, the proximity of these far-away islands with Canada and the American naval base of Argentia in Newfoundland, the very first use of Pentothal on a French territory, and the performance of over 300 major surgical operations, would make him one of the greatest pioneers of anaesthesiology in France and only the second doctor in the Free French Forces to devote his efforts to this major fledgling medical specialty, destined for the incredible future that we are experiencing today.

Professor Lassner's special ties with these distant islands, his need for an immediate surgical operation, his acquaintance with, and choice of, a leading surgeon who was, moreover, a native of the country quite simply provided the occasion, a few years later, for me to enter into close contact with him. The student and anaesthetist that I was at that time were going to be placed in charge of the master – you can easily imagine how anxious I was!

The anaesthesia, operation, and post-operative care went very smoothly and, in the course of the various visits and meetings that we had during that period, our conversations naturally turned to the history of the “Free French” and to World War II.

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I was, indeed, familiar with Professor Lassner's past and knew that he had joined the French Army in 1939, been demobilised in September 1940, became an early member of the Resistance, and escaped from France in June 1941.

In addition, I had very close ties with this period myself, having been born in Paris in 1942, one of the darkest years of the German Occupation. No doubt the subject that I had chosen for my doctoral dissertation – "Several examples of French doctors who were war heroes and members of the Resistance (1939-1945)" – had helped to strengthen our relationship!

As soon as he had completed his convalescence, Professor Lassner sponsored my membership in the Free French Association, and, in particular, the *Amicale des médecins de la France Libre* (a Free-French doctors' association), of which he is an active and loyal member. Finally, under pressure from Professor Lassner and Professor Geneviève Barrier, I was elected as a member of the European Academy of Anaesthesiology, of which the former was one of the principal founding members. Today, that gesture of recognition and great honour have enhanced the esteem, admiration and gratitude of the pupil for his master and, specifically through him, for this outstanding field in which we are fortunate enough to specialise.

The Flamish and French Speaking Community: a Belgian History

Georges Rolly, MD, PhD, FRCA

Emeritus Professor Anaesthesiology. Ghent University – Belgium

*I dedicate this manuscript to Professor Jean Lassner, founding
President of the European Academy of Anaesthesiology.*

At the time of starting my specialisation in anaesthesiology, the techniques were rather simple; few anaesthetic agents were available and the observation of the anaesthetised patient was mainly clinical. This is very well illustrated by a picture, printed in the famous book of R. Smith *Pediatric Anesthesia*, mentioning: “The stethoscope, the anaesthesiologist’s best friend”; it shows the anaesthesiologist listening during the course of anaesthesia, to the pulmonary ventilation and heart beats by means of a stethoscope permanently fixed on the thorax wall. Ventilation was done in many patients

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by manually compressing the bag of the anaesthesia apparatus, in the way of an umbilical cord realising a continuous binding of the anaesthesiologist to the patient. However at that very moment already some respirators existed, either very simple, but also sophisticated ones such as the Engström respirator.

In british practise maintaining spontaneous ventilation was preferred, evidenced by numerous reports on alarming accumulation of CO₂ and appearances of cardiac arrhythmias. On the other hand in continental european practise ventilation was mostly controlled, probably by the scandinavian influence. International literature and particularly the publications of Bendixen mentioned already the occurrence of atelectasis during spontaneous ventilation, but curiously also during controlled ventilation using respirators inducing a too monotonous ventilation, giving origin to the idea of periodic hyperinflations (called "the Boston squeeze"). The interest I had in respiratory function, conducted me to study the alveolar-arterial gradient for oxygen (A-a DO₂) in clinical anaesthesia practise using the Engström respirator, as well as in the physiology laboratory within dogs; this was the topic of my thesis for obtaining the degree of higher education (*agrégé de l'enseignement supérieur*) in anaesthesiology.

In 1969 an independent department of anaesthesiology was created at the Academic Hospital of the Ghent University (with own financial budget, independent secretariat and anaesthesia library), where I was appointed as low grade Professor. Till up then anaesthesia was part of the department of surgery. The charges of a university department are triple: education, research and rendering services. The following are some thoughts on the changes of our speciality, as I saw them during my academic career, while I belonged myself to the second generation of belgian anaesthetists.

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Education

From the beginning on, education consisted of regular courses with examination, leading to a “Certificate of special studies in anaesthesiology” delivered by the Ghent faculty of medicine after two years of study and clinical training after MD graduation. Also an optional course named “Elements of anaesthesiology” was created for the 5th and 6th years medical students. This allowed the future medical doctors to have some knowledge on modern anaesthesia and was also a stimulant for eventual candidates for specialisation in anaesthesiology. Some years later a course on CPR and first aid (10 h) and practise on mannequin (15 h) with obligatory examination was created for the 3rd year (afterwards already 2nd year) medical students, followed very soon by the same course for the young dentists and students in physical medicine. To my great astonishment, all these courses accredited more academic points to the department than the proper anaesthesiology courses, due to the great number of students.

It was also necessary to arrange the postacademic continuing education of the specialist anaesthesiologists. Anaesthesia teaching evenings and symposia on Saturday (often in english language, with speakers from abroad) were organised by the department and had a large attendance, like in Paris the famous JEPU, which I regularly attended.

As anaesthesia practise became gradually more and more complicated, with the growing arrival of new drugs and techniques, the idea of a continuous refreshment of knowledge acquired during the initial training was progressively growing. After contacts with the Boerhave course in Leiden (The Netherlands), the *Fondation européenne en anesthésiologie* (FEEA) was created in 1986 by the Professors J. Spierdijk (Leiden), who was its first president, Ph. Scherpereel (Lille), G. Rolly (Gent), G. Hanegreefs (Antwerpen) and M. Lamy (Liège). The central office had established in advance a complete program of refreshments topics, each of two and a half days duration, first spread over

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five years and later six years. Each course ends with an anonymous evaluation of knowledge. A real european network of regional centres of education was created. This network is actually highly developed and under the influence of the actual president Prof Scherpereel, centres were even opened in South America!

After promotion as full Professor, a chair in anaesthesiology was created at the Ghent university in 1981. Gradually the academic anaesthesia corps could increase in number. After the reform of education in two autonomic regions (flemish and wallone) and a ministry decree, the certificate of special studies in anaesthesiology was reformulated in "Postacademic formation in anaesthesiology". The intense contacts between the seven belgian universities, but especially between the four flemish universities, were the stimulus for the actual obligatory interuniversity course for those in specialist training. A two years duration course was started in 1988, with each year six saturday anaesthesia teaching of seven hours, given on rotation at another university, and obligatory examination with multiple choice questions and possibility for an oral reexamination. In the different teaching institutions and particularly at the universities, complementary courses are given each week, besides the regularly hold staff meetings.

Research

Most of the new drugs, as well intravenous as inhalational agents, lead to several clinical studies. Some are already part of anaesthetic history nowadays (propanidid, gamma OH, methoxyflurane). Taken into account our privileged contact with the belgian company Janssen Pharmaceuticals, it was possible to test the new derivatives of fentanyl very early. In 1976 thanks to the collaboration of Dr B. Kay of Manchester (UK) who did a sabbatical in Ghent, it was possible to utilise for the first time in clinical practise the new intravenous anaesthetic (still with a code name) that was later named

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propofol. As the department had not an own research laboratory, we had to look for technical analyses done in the department itself. A pneumotachography analysing unit allowed the intense study of most of the new respirators. A mass spectrometer gave the possibility to follow continuously and simultaneously all respiratory and anaesthetic gases, allowing to directly show the elements of respiratory physiology and uptake and distribution of inhaled anaesthetics. The prototype of the anaesthetic machine PhysioFlex was analysed in this manner and allowed to have direct data during completely closed circuit anaesthesia; this technique was called computer controlled quantitative anaesthesia. This machine contributed considerably to the diffusion of this technique which was previously mainly archaic and fulfilled the requirements to considerably reduce environmental pollution. Scientific interest of a young staff member Dr M. Struys allowed to develop an intravenous anaesthesia technique by computer target-controlled infusion and is now available on internet as "RUG loop". At the end of my academic career a "living" lung with CO₂ production and O₂ consumption was developed for the analysis under standard conditions of eventual production of compound A with sevoflurane and several soda limes.

Rendering services

It is important for an academic department to be always in the front line for new clinical needs who change continuously. Already 35 years ago we had to adapt our techniques for allowing renal transplantations and avoiding recurarizations. Very soon came the requirements for lung transplantation, where we obtained the first human survival of nine months. Later came the requirements for examinations and laryngeal surgery with laser, leading to the development of high frequency ventilation. Major surgery frequently in older and critical patients, and the steadily increase of the number of anaesthetics asked for more and more staff

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members in our academic hospital where the number of beds increased over than 1000. Keeping a sufficient number of quality anaesthesiologists was always a very difficult task taking into consideration the financial attraction of private practise. A new statute of the hospital, now called university hospital in stead of academic hospital, allowed to nominate more easily new staff members. The last 10 years of my career I had also to take up the functions of medical co-ordinator of the operating theatres, with the mission to increase the output, what brought about several frictions with the surgeons despite the diplomatic approach.

Services to Belgian anaesthesiology

As Belgium is a bilingual (french, flemish) and even tri-lingual (german in some parts) country, the national meetings of the belgian scientific society were in the begining hold in both languages. Later under the influence of several univer-sity Professors the english language was adopted, particularly for the national congresses with participation of foreign speakers. The *Acta Anaesthesiologica Belgica* were also published from 1973 on in english language.

Confronted with the growing complexity of the speciality, it was necessary to increase the duration of training successively from three years (1964) to four years (1979) and finally five years (1987). These changes were always realised in common agreement of the Professors in anaesthesiology and the professional society. The training is continuously assessed by a ministry commission of accreditation in anaes-thesiology, where I have still the honour of being its president. Since 1999, by ministry decree, it is necessary to have an attestation of acceptance by a university to start the speciality and an attestation of specific university courses followed with success. Finally an evaluation of training is done at the ministry commission by an examination of clinical knowledge (three questions of type Diploma European Academy of Anaesthesiology, taken by chance).

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The candidates are examined by three groups of two examiners (one university and one non-university).

Together with the growing complexity of anaesthesiology, monitoring has been developed. One may never underestimate the beneficial influence of continuous pulse oximetry and capnography on the reduction of anaesthetic mortality and morbidity. In 1989, after long discussions, security rules "Belgian Standards for Patient Safety in Anesthesia" were established by a group of anaesthesiologists, wherefrom I was one of the members. Besides the necessary monitoring devices, the continuous attendance of the doctor anaesthesiologist is stipulated, as anaesthetic nurses do not exist in Belgium. Very fast hospitals and anaesthesiologists themselves bought the monitoring equipment, maybe partly to avoid medico-legal actions. To my great regret, the simultaneous anaesthetic activity limited to one table, is not always followed. A well equipped recovery room with appropriate personnel became also a necessity.

The initial training and scientific knowledge differ to a great extent within Europe. After long discussions between members of the national societies, the European Academy of Anaesthesiology was founded in 1978, thanks to the driving force of Professor J. Lassner, who became its first president. Now the first european organisation was born who could stimulate anaesthesiology. I had the honour of organising the 10th annual meeting in Ghent and to serve as senator for eight years. Very soon the examinations of the European Diploma in Anaesthesiology and Intensive Care started and in 1983 the European Journal of Anaesthesiology was born. Several elements have nevertheless made that 15 years later the *European Society of Anesthesia* (ESA) was established, more or less oriented to the organisation of major congresses, creating several tensions in the anaesthesiology world. Fortunately for the unity of our specialisation an approach is made by the creation of a uniform european organisation and the acceptance of the *European Journal of Anaesthesiology* as unique journal of both societies.

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Future of Belgian Anaesthesiology

Like in the rest of the world belgian anaesthesiology has changed, over the last 40 years, from a manual technical speciality to an instrumental speciality, but highly sophisticated and scientifically founded. Structured services of anaesthesia are created and have replaced anaesthetists working on their own. In many places anaesthesiologists are in charge of, or occupy important positions in services of intensive care, emergency admission or pain clinics. The practitioners of the "young" speciality are now already retired and many are close to retirement, what will create in the near future an increased demand for new specialists. By political decision a "numerus clausus" was established not only for family practitioners but also for all specialists, each time for the flemish and french community. It can be predicted that within a short time it will become very difficult to correctly satisfy the demands on the field for our speciality. This will be a very important and troublesome point to solve for our two societies, scientific and professional, if belgian anaesthesiology wants to keep its right place amongst the other medical specialities in the future.

A Great Professor

Ginette Albouze

CES in Nephrology
CES in Anaesthesiology and Intensive Care
Chevalier de l'Ordre du Mérite

Suzanne Py

Degree in Industrial Medicine
CES in Anaesthesiology and Intensive Care
Officier de l'Ordre du Mérite

November 3rd 1953: First we got off at métro République station, on a misty autumn morning, then walked across the tenth arrondissement, over the bridge on the Canal Saint-Martin and finally entered Saint-Louis Hospital through its awesome gates.

We were two young doctors from the provinces: Suzanne Py, from Toulouse, Head of Christian Dior's medical department, a very smart and distinguished young woman with a Dior

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look, yet totally ignorant of the ways and customs of Parisian hospitals. At the entrance, she enquired about the Urology department where she was to meet Professor Lassner.

The concierge answered: "Urology department? Turn left after the entrance".

Suzanne came into a long corridor where patients sat waiting. A head nurse, of considerable tone and figure commanded: "First door on the left and take off your knickers!"

"Well, Madame, I have been warned about Parisian manners but I had no idea that studying anaesthesiology implied that you were to take off your pants! I'm here to learn anaesthesia in Professor's Lassner service."

The nurse replied: "Next floor! This is gynaecology, here!"

Ginete Albouze had an Auvergnat look and came from the very heart of the country...

I introduced myself to Professor Lassner who instantly understood how desperate I was and asked simply: "How do you manage to live in Paris?"

Such was the start of Professor Lassner's glorious team.

Our training began on that very day. Nothing to compare with today, although anaesthesiology is still a "craft" in its noblest sense.

We came up against various difficulties and primitive techniques:

- first and foremost: intubation, as finding the right path was not easy;
- the sterilization of small equipment items, which were boiled in a pan, drips included;
- as the Ombredanne mask had just disappeared, we had new equipment adapted to the new techniques and we found them delectable: the rotameters, the blue bottle of nitrogen protoxyde which was similar to the white bottle of oxygen, the balloon that was to be pressed regularly, sometimes for half an hour,

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- sometimes for hours so that curarized patients could survive.
- the current anaesthetic appliance was one of the first pieces of French equipment developed by the Robert & Carrière Laboratory to which a tank of ether and some cyclopropane were still connected for short term anaesthesia, it was banned if an electric surgical knife was used as it might prove dangerous and cause explosions;
 - besides the equipment, we used a barbiturate called Pentotal, and two types of curarizing products: d-tubocurarine, for longer effects and Flaxédil for operations lasting roughly thirty minutes.

The head-anaesthetist would supervise the observation of patients put to sleep but every morning we were given a course in sleep medicine.

So, every single morning, with endless patience, he would say “so... about the cyanosis” and so on...

Given all these memories and his choices during the Second World War, I was not surprised to hear that he put General de Gaulle to sleep when Professor Aboulker operated on his prostate.

With great patience and deep concern for his students, as his question about my means of living suggested, Jean Lassner was a brilliant teacher who always made a point of speaking clearly and plainly to his students. When he happened to go beyond the field of science, it was to “teach us about life”.

As for me, Gilberte Albouze, I worked with him for three years before I settled in Châteauroux. All through those years, I made frequent incursions into Foch hospital, in Professor Vourc'h's service, and more especially at Marie Lannelongue hospital in Professor Yvonne Noviant's service. I particularly appreciated her love for good craftsmanship, her righteousness, her unwavering calmness so reassuring when the moment was difficult. Not to mention her extreme kindness.

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Life consists of a series of encounters and some are a gift from heaven. Meeting Jean Lassner was one of them. Thanks to his advice and support, I was trained in the service of Professor Noviant whom I thank for her excellent teaching and for introducing me to American hospitals, as early as 1966.

We loved and appreciated Professor Lassner.

Malraux once wrote: "Being a King is silly, it is the making of a kingdom that counts". Jean Lassner initiated anaesthesiology in France and the *Cahiers d'Anesthésiologie* were his kingdom.

From France to Sub-Saharan Francophone Africa Or How to Make an Impact*

Martin Chobli

Professor of Anaesthesia-Intensive Care
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CHU SAMU Cotonou – Republic of Benin

Yves-René Yapobi

Professor of Anaesthesia-Intensive Care
Institute of Cardiology
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It was in September, 1983 in the corridors of the immense Congress Palace in Lille at a conference of French-speaking Association of Anaesthetists-Intensivists, that Professor Scherpereel invited me to present a poster session on the

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practical situation of anaesthesia in my country. In keeping with the rather seductive tendency to catastrophize characteristic of my early career in Africa, I had just described in poignant terms the state of anaesthesia in Benin and in neighboring Togo. During the coffee break, a frail silhouette advanced toward me and said: "Well, my friend, I heard your presentation. It is truthful but should not in any case be taken as reason for discouragement. Here is what I'd like you to understand: offering you a few intubation tubes and vials of halothane won't do much good. On the other hand, I will convince my colleagues to help you organize a real department of anaesthesia in your country, relying for the time being on the nurse-anesthetists in your hospital. Work with what you have, but diligently, always keeping in mind that the primary goal must be the patient's safety. And you will speak to your colleagues in neighboring countries. You'll see, that approach will spread further, and in twenty years, perhaps thirty, you will have made a great deal of progress in Africa. The early days in our own country were not much easier."

Yes, twenty years after this unusual encounter in the dreariness of Northern France, it must be said that Professor Lassner's prophecy was indeed correct. It should be noted that he had had substantial experience in Africa and had established the first medical school in Abidjian, having received on that occasion the Legion of Honor of the Ivory Coast from President Félix Houphouët-Boigny.

Despite major problems in certain countries, the practice of anesthesiology has made appreciable progress in our region. At the time that he offered me this wise counsel, Professor Lassner was already close to the end of his career, if not yet formally retired, and therefore I was never again to have the opportunity to meet him in the corridors of our professional conferences.

Two heavier-set gentlemen accompanied him when he addressed this kind message to me: the late Professor Viars, and Professor Winckler who, a few years later, made me the honor of inviting me to his house in Rouen. The connections with

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Professor Scherpereel, a longtime representative of the World Federation of Societies of Anesthesiology (WFSA) in the African region, have remained close and always cordial. Many other colleagues, too numerous to mention, eventually contributed to strengthening the fabric of this cooperation between France and Africa in our speciality. Thus, to avoid offending anyone, let us say that they are of all ages, both sexes, and are spread almost evenly around the whole of France, with perhaps a slight advantage in favor of those from the regions of the Southwest, Île-de-France and Auvergne.

“Offer someone fish and he will be fed for a day; teach him to fish and he will be fed for life.” Paraphrasing this Chinese proverb, Professor Lassner showed us the path for developing anesthesiology on our continent.

From 1983 to the present, anesthesiology has progressed in ways that are far from negligible. Even with regard to demographics and the necessary medical training for the staff, the wager is being won. Between 1983 and 2001, the number of physician-anesthetists increased from one to ten in Benin, from three to twenty-five in Cameroon, from two to fifteen in Gabon, and from eight to fifty-eight in Ivory Coast. Although these figures may still seem laughable compared to those of France and the larger European nations, it is nonetheless the case that this evolution is contributing in remarkable ways to the improvement of the quality of the practice of anaesthesia available to the populations of our region.

Although in the mid-1980s some physician-anesthetists were trained in larger African cities as a result of the system of specialized inter-university diplomas (DIS), the disappearance of this system favored the training of our specialists in Africa. At present, three medical schools guarantee a rather high quality of training: Abidjan, Cotonou and Dakar with, respectively, thirty-three, twenty-seven and twenty-five physicians enrolled last year. There is also the school of Yaoundé, but for several years it has been suffering from under-enrollment, with only five individuals currently in training. Theoretically, within the next five years,

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Francophone Africa may well be able to welcome a hundred new specialists, a prospect that certainly offers cause for celebration. But in order to train them, one must have access to qualified personnel, and there are few teachers of the highest order available in anesthesiology in French-speaking Africa. To be sure, in this sense as well, progress has been made, but it is minimal. There were only three such teachers in 1983 (Professors Bondurand, N'Dri d'Abidjan and the late Professor Bele Binda in Kinshasa). Today, there are thirteen of us (four in Abidjan, three in Cotonou, two in Yaoundé, and one each in Lomé, Libreville, Dakar and Ouagadougou). Our appreciation of the support of our SFAR colleagues is thus all the more heartfelt with regard to the training of CESAR students accustomed to taking courses from Professors Isabelle Murat, Jean-Pierre Carpentier, Dominique Grimaud, Jean-Marie Saissy, and Jean-Étienne Bazin, to mention only a few. But one of them has been cruelly missing for some time: that is to say, the fragile figure of the late Professor Pascal Adnet who invested so much of himself in the development of our collaboration both as an active member of the nucleus of scientific solidarity represented by SFAR, and as a representative of the World Federation of Societies of Anesthesiology for Francophone Africa. For Africans, deeply religious and attached to symbols as we are, it was taken as a sign from God that he passed away on African soil in October 2000 while engaged in a teaching mission. From now on, providing excellent training for our young physician-anesthetists is a way of honoring his past contributions. These are the people who will create and develop our field.

The improvement of demographics in training anesthetists witnessed a concomitant improvement in the safety of the practice of anaesthesia in our sub-region. If one were to visit the operating rooms of Africa today, one would often find an pulse oximeter, a dynamap there, a small multi-use monitor elsewhere and, in certain cases, even a ventilator in the main operating room. One of the primary objectives of SARANF in the coming

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years is to standardize our equipment and our anaesthesia suites, guided by the search for simple, secure, efficient and reasonably priced equipment. Such equipment is available if one makes the effort to refine the criteria for selecting it. Another conspicuous consequence of the medicalisation of staff in anaesthesia in Africa is to be found in the local and regional development of the practice of anaesthesia. Although epidural anaesthesia is still rarely practiced (especially for obstetric use), a high epidural has, on the other hand, become a frequently utilized technique that offers a great deal more security for patients, as in the use of small-gauge needles and the rational management of deleterious hemodynamic effects. Even though from time to time one may still come across a nerve stimulator in certain African hospitals (such as in Cotonou, Libreville, or Dakar), regional anaesthesia in the extremities is not yet a matter of common practice. On the other hand, however, Professor Murat has developed a wide practice of the penile block to the great relief of many young boys undergoing ritual circumcision.

In the area of general anaesthesia, things are also moving forward but not in such a satisfactory manner. Some teams continue to use “gallamine” as curare and “pethidine” as an analgesic, and it is important to convince them that this practice is no longer up to date. This is far less an economic problem than a question of understanding (relatively unproblematic agents such as Norcuron® and Fentanyl® are available in generic form). Finally, the management of post-operative pain is a crucial problem that warrants particular attention since many patients continue to tear out their hair in pain in post-operative hospital rooms in Africa. Even though the use of PCA and PCEA may seem to be a luxury for us these days, we must encourage the rational use of morphine to ease the suffering of our surgery patients. As we have already stated, there are some positive images, a few timid advances, but also some darker zones in this picture.

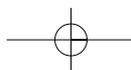
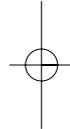
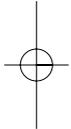
But it is undeniable that anesthesiology in Afrique, engaged as it is in intelligent cooperation, is making progress, and it is a



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pleasure to take note of this in light of this homage to the founders of the Cahiers d'Anesthésiologie which represents the forum in which we Africans have published the greatest volume of articles in our specialty over the course of the past decade.

A happy retirement to Professor Lassner!



An Apprenticeship, a Bible and a Creed

Professor Jacqueline Rendoing
Former Head of the Department of Anaesthesia – Intensive Care Unit
CHU Reims

It is a great pleasure to give homage in his lifetime to a pioneer of anaesthesia and how wonderful to be invited to the Fountain of youth of your 90th year. Having chosen a Parisian retreat, how could one ignore what automatically comes to mind as one gravitates to the places where your fame emerged? Cochin Port-Royal, *rue Méchain*...

What exciting neighbourhood made more vivid by the underlying emotions.

The focal point, amongst the masses of souvenirs, is the *vendredis de Cochin*; solemn meetings of a kind of professional ecumenism, marked by the authority which you and E. Kern shaped. They brought together the pupils of many categories interested in anaesthesia; doctors, medical students, nurses, even wives of surgeons, those who did not hesitate to provide a secure service until their husband could acquire a fully trained anaesthetist.

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What astonishing moments I have experienced from the start of my apprenticeship in this discipline where you were a precursor, both as a teacher and a practitioner! What fervour brought together at the Friday Meetings, the faithful finding a place behind the first row occupied by the "ladies", dominated by the great "redheaded" priestess, Vincent. Still ringing in my memory are the names of Marion Bertreux, Monique Lalande, Odette Mehary. Yvonne Noviant who also has established her retreat in the shade of Cochin, was already an authority.

Cochin, the parish of my postulate did however trouble my conscience as I was arriving from a different chapel close to your sanctuary, via the help of a surgical colleague, a pupil of Quenu. From the start, I found myself under the tutelage of Jean Valletta, the unrivalled champion of "Pento-cu" which he administered in total serenity as reassuring to the patient as to the surgeon. His faith was limited to those two products; he banished all other means of anaesthesia and the use of anaesthetic machines in the operating rooms was limited to delivering oxygen. Consequently, under his tutelage, the Friday meetings that nothing on earth would make him miss, was a source of bewilderment to his pupils.

You can imagine the adventures that occurred by coming into contact with different and more elaborate techniques during my various courses!

The haunting fear of explosion altered the course of my noviciate as I, deliberately, even with stealth, excused myself from the operating rooms using Cycloprane or ether. However, on one occasion under the tutelage of Louis Amyot, an authoritarian and impatient surgeon, made me use ether. The excitatory stage which I could not avoid was so severe that a call for help resulted in the simultaneous appearance of the wife of the surgeon and the head of the Anaesthetic Department (Juliette Chateaufreynaud), one inciting me to increase the concentration of ether, the other to reduce it. The end of this dilemma escapes me but the patient survived – Thank God.

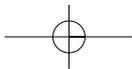
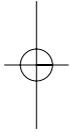
memories and reflections

It is also during my apprenticeship that the *Cahiers d'Anesthésiologie* came to fruition, brought to existence by yourself and your two acolytes – E. Kern et J. Valletta.

Accepted straightaway as the “bible”, it contributed in no small way in maintaining me in orthodoxy in the face of novel theories and practise coming from a rival “chapel” which could have shaken my faith.

Today, dear Master and friend where you are the only remaining member of the founding trinity; bound by strong ties of friendship; please accept my homage based on respect and affection that is your due.

Please also acknowledge my utter gratitude for the help and solidarity with which you surrounded my “revered” teacher, Jean Valletta, during his long ordeal resulting in his early death.



Doubtless an Austrian, but Definitely a Frenchman

Sylvia Fitzal

Department of Anaesthesia and Intensive Care Medicine
Wilhelminenspital – Vienna – Austria
Member of the European Academy of Anaesthesiology

Jean Lassner's roots are in Vienna, the city of his birth, his childhood and his youth. His family, which had been in Austria for far more than a century, belonged to the upper middle-class and held to traditional values. His parents' apartment, where Jean Lassner was born, and the apartments of both sets of grandparents were all located in the same block in the Second District. He grew up across the street from one of Vienna's most famous "green lungs", the beautiful, expansive park called the Prater. It will surprise the visitor who comes here to get to know the district that much is still in its original condition, so that it is easy to feel

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transported back in time to the world of Jean Lassner's youth. Most of the Second District's beautiful houses in Baroque style were spared the destruction of the Second World War. This is also true of the parks, which have fortunately been maintained as green space and not turned into building sites. Even the nearby elementary school that Jean Lassner attended is still standing, in its original appearance.

At first Jean Lassner's life followed well-ordered paths. His father was the director-general of a chemical concern, and his parents were able to provide their children, Jean and his twin sisters, with an outstanding education. It was a highly musical family. His father played the violin, his grandfather the piano, and his aunt was an opera singer. It was natural that attendance at concert, opera and, of course, theatre performances was a regular part of their lives. Very early on, Jean Lassner learned several languages, first of all French, for which he had a private tutor. In the course of a year's stay in a Swiss boarding school he learned Italian and English. He had first-rate teachers and mentors, who influenced him in different ways, as, for example, the director of the Swiss Boarding School, who introduced him to literature, in particular to religious writings, and his teacher of Greek and Latin, who awakened his interest in philosophy, especially the works of Edmund Husserl, which particularly impressed him.

After completing the Gymnasium, Jean Lassner began to study medicine at the University of Vienna. He interrupted these studies briefly to turn his attention to philosophy. For Jean Lassner's 22nd birthday, his revered Professor Husserl held a lecture at the home of Jean's parents.

During his student years he was overtaken by the political chaos which shook the little country, now the Republic of Austria, that was left of the Austro-Hungarian Empire. Like many other innocent people, his family was eventually driven out of the country and strewn to the winds. Those relatives who were still in Austria died during imprisonment and in concentration camps. His parents survived solely due to

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Jean's efforts, who realized the danger in time and got them out of the country. But like many expellees, his family lost all its property.

Obviously, it was impossible for Jean Lassner to complete his medical studies in Vienna. Many years later, in 1948, when he had settled in France and had accepted French citizenship, he obtained his medical degree from the University of Paris. At that point, Lassner had long been actively participating in the early development of modern anaesthesia in France.

France became Jean Lassner's second home country. His love for that country is no accident. While in Paris for a short visit during his Gymnasium years, he experienced a dramatic moment: He tells of walking along the Seine and looking towards the Louvre, which at that moment was bathed in light, and feeling a strong sense of belonging – even more so something akin to obligation – to this city, this country. Jean Lassner has surely fulfilled this obligation!

Despite the terrible memories of Austria, Jean Lassner went out of his way for his colleagues from his native country during his very first contacts with Austrian anaesthetists, becoming their mentor and friend. When the still young Austrian Society of Anaesthesiology was invited to Paris by the French Society of Anaesthesia for a joint conference in the spring of 1955, this provided the setting for the first meeting of the Austrian anaesthetists Otto Mayrhofer, Karl Steinbereithner, and Hans Bergmann with the ex-Austrian Jean Lassner. At this point, Jean Lassner had been active in anaesthesiology for more than 10 years. They met for a gala dinner on the 8th of May in a restaurant at the Eiffel Tower. Oddly enough, on that evening Otto Mayrhofer had, like Jean Lassner so many years before, an unforgettable experience with light – in this case a tremendous fireworks display that rose into the sky on the far side of the Seine to mark the 10th anniversary of the capitulation of the German Army.

The bond with Jean Lassner across all borders continued

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intact, deepened in the course of the years, and led to Lassner's being an ever more frequent guest at Austrian anaesthetist meetings. At the First European Congress of Anaesthesiology, a trilingual meeting (German, English, French) held in 1962, Lassner was the invited speaker on the topic of "Hypnosis in Anaesthesia". This is a topic that Lassner began to be interested in very early, in fact during his medical studies in Vienna, and which he continued to work on for many years.

Lassner was again an invited speaker in Vienna at the Annual Meeting of the Austrian Society of Anaesthesiology in 1969. His topic "*Schmerz und Anästhesiologie*" ("Pain and Anaesthesiology"), which was also published in *Der Anästhesist*, is an impressive medico-philosophical treatise, which one can only recommend to every anaesthetist. During this lecture Jean Lassner also expressed his own pain, felt during his visit to the city of his birth, on remembering the terrible events his family experienced, pain that made him a stranger in his native land.

Thereafter, Lassner was several times a guest lecturer at the international further education courses of the Vienna Anaesthesia Institute, where he dealt with the hot topics of the time and with forward-looking issues such as "The Work of the Anaesthetist Outside the Operating Room" and "The Pain Clinic".

One of the most important aspects of the life's work of Jean Lassner was the establishment of the European Academy of Anaesthesiology. As early as the 3rd Congress of this academic society, Vienna was chosen as the venue for the meeting. This is not least due to the deep and close friendship connecting Jean Lassner especially with Karl Steinbereithner, who organized this congress together with Otto Mayrhofer. Karl Steinbereithner had always been fascinated by the thought of Europeanizing our specialty on a high academic level and he became one of the most fervent advocates and supporters of this institution. His selection as treasurer and

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later as president of the European Academy of Anaesthesiology was for Lassner, who supported it strongly, a logical result of the constant efforts of his friend and intellectual partner, Karl Steinbereithner.

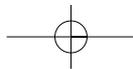
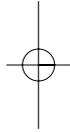
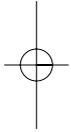
Jean Lassner concerned himself not only with the most important representatives of the field of Austrian anaesthesia, as named here, but also with members of later generations of anaesthesiologists. He supported and assisted many of them, including the author of this article. I am indebted to him for an extremely interesting period as a member of the Senate of the European Academy, for his translations of articles to publish them in the *Cahiers d'Anesthésiologie* as well as for the opportunity to participate in one of his outstanding symposia in the Dordogne.

The field of Austrian anaesthesiology considers Jean Lassner to be one of its most important supporters. As an expression of its thanks for his deep involvement and the close scientific relationships that Jean Lassner maintained with Austrian anaesthetists, the Austrian Society of Anaesthesiology, Resuscitation and Intensive Care Medicine in 1980 conferred on him Honorary Membership.

Everyone who has had the opportunity to hear Jean Lassner as a speaker and in discussions, to have been engaged in conversation with him, to have experienced his lively spirit and sparkling wit, to have admired his foresight and broad vision, continues to be fascinated by an unrivalled personality, as physician, as philosopher, as scientist and teacher, who was always a step ahead of most of the rest of us.

The Austrian Society of Anaesthesiology, Resuscitation and Intensive Care Medicine wishes its supporter, mentor and friend all the very best on the occasion of his 90th birthday.

Ad multos annos!



A Master, a Precursor

**Danièle Fluhr, Jacqueline Jasson, Luc Jeanne,
Jean-Paul Lamas, François Legagneux, Jacques Léoni,
Jean Lirzin, Jean-Paul Morin,
Marie-Louise Talafre-Catteau**

CHU – Cochin Port-Royal (Paris)

Twenty years have passed already since you retired. Now that some of us, your former students, are near retirement ourselves, we would like to say a few words to you on your 90th birthday. By accepting us for speciality training and later offering us posts in the department, you have given us an opportunity to grow richer in ideas and in human and professional experience. We have been privileged to participate, under your guidance, in the functioning and development of the department of anaesthesia and as well as in research, your students in all stages of training achieved their education. Although you were our chief, you were

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always ready to listen and to talk with us whenever one of us was in difficulty, professional or private.

You taught us to be exacting and critical of ourselves and this has been valuable in practise, in preparing papers or simply reading published articles. The staff meetings you held twice a week fostered contact among colleagues and internal discussion. The Friday afternoon lectures gave us opportunity to meet anaesthetists from other hospitals and even from various foreign countries for an exchange of ideas.

Clinical research was the method for dealing with problems of any kind. Whatever the problem, it would be discussed and ways and means of solving it would be examined.

Your strong interest in regional anaesthesia and its teaching led to work on corpses before undertaking actual practise – an approach that was quite unusual at the time. Many foreign specialists in this field came as guest lecturers, giving us the opportunity to discuss matters with them. We were particularly impressed by John Bonica and Daniel Moore. Thanks to you, regional anaesthesia techniques came into use in chronic pain too – a field of particular interest to you.

After launching the European Academy of Anaesthesiology, you encouraged several of us to attend its meetings. The time we spent with you was most fruitful and rewarding. Please accept our sincere thanks.

As Time Goes by, Friendship Lingers on...

Daniela Filipescu, MD, PhD

Chief of Department of Cardiac Anesthesia & Intensive Care
Institute of Cardiovascular Diseases "Prof. Dr.C.C. Iliescu"

Bucharest, Romania

Member Academician of the European Academy of Anaesthesiology

When Claudine Lassner invited me to write a few lines at the anniversary of the *Cahiers d'Anesthésiologie* and of their founder I rejoiced. At last, there was an opportunity to thank the one that contributed to my formation as an anesthesiologist and intensive care specialist, Professor Jean Lassner.

Due to his recommendations, I was accepted in November 1990, in the Department of Professor Jean-Marie Desmonts, and during one year, I completed my formation as young anaesthesiologist at Bichat Hospital. Also, during my stay in Paris I attended the courses of the Institute of Anaesthesio-

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logy (*diplôme interuniversitaire spécialisé*). The knowledge thus accumulated permitted me to sustain the written (1991) and the oral exams (1992) for The European Diploma of Anaesthesiology.

Passing this exam represents for me, even today, the most important professional achievement. This is the international acknowledgement of my professional level in this domain. Without false modesty I must say that I was the first Romanian anaesthesiologist to become member of the Academy by exam. The example was then followed by many other colleagues.

For all this I thank to Professor Jean Lassner.

After my return home I practised in cardiac anaesthesia and in 1995 I became Chief of the Department of Cardiac Anaesthesia & Intensive Care of Fundeni Hospital, the largest center of cardiac surgery in Romania.

I am proud to be educated as an anaesthesiologist in France and I am proud as well that I followed the path opened by my father-in-law, Doctor Zorel Filipescu.

He studied at Foch de Suresnes Hospital between 1957-1958, while he attended the courses of the Institute of Anaesthesiology in Paris. There he met Professor Guy Vourc'h, one of the founders of The French School of Anaesthesiology and Intensive Care. During the 50's, Guy Vourc'h and Raymond Nedey founded at Foch a Department of Anaesthesiology and Intensive Care, uniting their two departments.

Zorel Filipescu, the first Romanian to study this speciality in France became at his return the pioneer of modern anaesthesiology in Romania. He contributed to the formation of the Romanian School of Anaesthesiology that was recognized as a speciality in 1957. Also he organized the first Intensive Care ward at the Emergency Hospital in Bucharest. In 1958 he founded the Circle of Anaesthesiology and Intensive Care which became in 1959 a section of the

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Romanian Society of Surgery and, in 1972 The Romanian Society of Anaesthesiology and Intensive Care (SRATI). Since 1960 Zorel Filipescu was a member of SFAR and AIAREF (International Association of the Anaesthesiologists and Intensivists of French language). Along with the former society he organized in 1978 in Sibiu the annual Symposium of SRATI receiving the visit of over 100 guests, many of them from France. Among those were: M. Goulon, Jean Lassner, Guy Vourc'h. Also in 1978, Dr Zorel Filipescu became a member of the recently created European Academy of Anaesthesiology.

Professor Lassner's family supported not only the development of anaesthesiology in Romania but he also encouraged Romanians in their desire for freedom. These few words are a homage in the honour of this friendship between the Filipescu and the Lassner families.

A very close relation was kept also with Guy Vourc'h's family. During my stay in Plomodiern, in Bretagne, I learned



Guy Vourc'h and Zorel Filipescu in Bucharest

In front of the monument erected to the memory of the French Soldiers who died for Romania

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about the courage and the role that the Vourc'h family played in the French Resistance.

The French Society of Anaesthesiology and Intensive Care (SFAR) keeps as a souvenir a photo of the monument of the French Soldier placed in the central park (Cismigiu) in Bucharest, offered by Zorel Filipescu to Jean Lassner, the president of the Society. In front of that very statue are Guy Vourc'h and Zorel Filipescu.

What is the significance of this monument? It represents a French soldier wounded on the Romanian battle field, watched over by a Romanian nurse that bends warmly to revive and heal him. Over decades her gesture expresses the feelings of a whole nation – the French-Romanian fraternity.

On the front it is written: *“Aux soldats français tombés au champ d'honneur sur le sol Roumain pendant la Grand Guerre 1916-1919”* (“For the French soldiers that died with honour over the Romanian territory during the great war between 1916-1919”).

Now I take the liberty to quote from my father-in-law's speech with the occasion of a Symposium of Emergencies, organized by the MARSA (Midi-Pyrénées-Anesthésie-Réanimateurs SAMU-SMUR) in Toulouse in 1990:

“France and Romania used to be and still remain eternal partners [...] The Latin blood not only flows in our inner core but it connects us [...] The proofs of fraternity were obvious throughout the centuries [...] You certainly do remember that more than a century ago, our Prince Alexandru Ioan Cuza received French support to achieve the union of the two Romanian regions and the independence from Turkish domination. And it was not hazard that the Romanian Kingdom adopted the Napoleon's code as the first law. These are historically well recognized facts. Let's not forget the participation of the French Military Mission under the leadership of General Berthelot in battle on Romanian ground during the First World War. [...] French language was popular then as it is now [...] The language kept us all close together [...] I shall quote from my memory some doctors that after their French studies became very important names in the medical field like Levaditti, Gheorghe

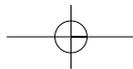
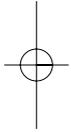
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Marinescu, and Victor Babes. We, the Romanians and the French, exist each of us under a three-color flag, as we live under the same blue sky. Let us never again allow dark clouds over our heads to shadow the joy of togetherness.”

These words are not just a simple proof of a marvelous oratorical talent. They express the feelings of a person strongly, historically connected to France. Let us not forget that during his moments of hardship when one of his sons, Radu Filipescu was arrested and sentenced for 10 years to prison by the communist regime for his daring deed of spreading leaflets against the dictator Ceausescu, he was supported by French people. Among those who helped to his liberation and made the dissident's name well known abroad were: Jean Chirac, Jean Lassner, Pierre Viars...

In the end and also because the *Cahiers d'Anesthésiologie* reached their 50th anniversary, I must remind that they represented for a long time, the only source of medical information for the Romanian anaesthesiologists. This is why after 1990, when Zorel Filipescu succeeded to gather the adequate funding, the Romanian Review of Anaesthesiology and Intensive Care was born as a younger sister of the *Cahiers* which stood as a model.

Long life and happy anniversary for both journals!



Sixty Years Already

Professor Claude Saint-Maurice

Professor, Former Head of the Department of Anaesthesia
and Intensive Care Unit

Hôpital Saint-Vincent-de-Paul (Paris)

Editor in Chief of the *Cahiers d'Anesthésiologie* from 1988 to 1997

Fellow of the Royal College of Anaesthetists

Chairman of Paediatric Anaesthesia – 1990-1995

President of Federation of European Associations
of Paediatric Anaesthesia 1993 – 1997

My first experience of anaesthesia dates back exactly sixty years. It was in January 1943 and I was twelve years old. One day I felt a pain in my right side and had a temperature of over 38°C, which was enough to confine me to bed and wait for the doctor. He called in in the evening, reassuring and smiling. After a careful examination, Doctor L. diagnosed appendicitis. I learned from his diagnosis that my iliac fosse was inflamed and that I needed an operation. Needless to say

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I wasn't overjoyed at the prospect! Still there was one advantage. I would have to stay in bed for two weeks with only one thing to do – hold an ice-pack on my groin to cool my ache and reduce the swelling. Then the surgeon would operate and I'd get an extra two weeks' rest to recover from the operation. I started calculating the amount of books I would be able to read.

And there was more. Before and after the operation, I would be allowed to occupy the only heated room in the flat.

Two weeks later, I went to the clinic where I was to spend the night before the operation. Doctor L. called and told me that he would be the one to put me to sleep. Then in came the surgeon, a tall, thin man with a moustache who looked very serious and hurried. With a broad grin, he told me that I was lucky to be first in line for the operating table early the following morning, which was a good thing. At dawn Doctor L. came to fetch me and suggested we walk together up to the operating theater. On entering the room, I had sudden doubts as a nurse congratulated me on my courage before making me lie down on the operating table. She strapped my arms to the armrests so that I wouldn't fall off when put to sleep. I then saw a strange machine comprised of a metal ball and funnel topped with a crumpled buff-coloured bag. The doctor asked me to breathe deeply and rapidly and to try and inflate the bag. I felt the edge of the funnel pressing down on my nose and it hurt. However, it didn't last long and I very soon got the feeling that I was surrounded by a swarm of buzzing bees. I could hear the doctor urging me to breathe deeply and I felt his hands pressing tightly over my face, then I lost consciousness although I was still aware of metallic noises that sounded like the rattling of cutlery. Then, suddenly I felt cold liquid being poured on my stomach and I started to panic, thinking I'd be operated on without being completely put to sleep. At a certain point, I distinctly heard, "Stalingrad is the beginning of victory but I'm afraid the Germans aren't down on their knees yet." When I woke up,

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shortly after this, I told the surgeon what I had overheard. He looked annoyed and curtly remarked, "we always talk too much!" What I recall from that experience is the reassuring tone of the doctor's voice and how our walking to the operating theater had trivialized the operation itself.

My second experience came nine years later. After a preparatory year in college (PCB) I was starting my first year in medicine. The surgeon who had operated on me had been appointed senior consultant at Bichat hospital. He suggested I join his unit and I immediately accepted his offer with pleasure. An intern took me in hand and advised me to practice intravenous injections. I was then taken in charge by two nurses from the hospital ward who had me come in early mornings to take blood samples for tests. I spent the rest of the mornings in one of the operating theatres, sitting on the steps around the table where the surgeon was at work. Anaesthetics were administered by the nurses or an extern. The equipment was less rudimentary than it had been when I was a child – the masks were now made of rubber, like the balloons and the tube leading to the glass jar was annular. I was informed that this was modern equipment from American army surplus.

I soon began to master the technique of intravenous injection. In the corridors, I came across the intern who was in charge of me and he suggested I administer anaesthetics for curettage operations. He praised the merits of Thiopental, a product injected through the veins, as being "simple, efficient, and safe". The very next day, I found myself in a darkened room in the middle of which stood a gynaecological table with an adjustable lamp that looked more like an office lamp set on a metallic rod than a genuine piece of medical equipment. Before the sixteen-year-old patient who was to undergo curettage entered the room, I made enquiries as to the exact procedure I was to take. He reassured me that I simply dilute the product, fill up a syringe and inject the liquid slowly while the patient was counting. So, she counted up to forty and I was relieved to see that I had

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just enough Thiopental in the syringe before she could say forty one. But then, she stopped breathing and changed colour. The nurse, who had been keeping an eye on me sent out for a cylinder of oxygen, with a mask, tube and balloon. Of course, I was instantly dismissed and realised I had just witnessed a serious anaesthetic accident which, fortunately had no further consequences. I then understood that taking short cuts was no good and decided to get back to my studies in anatomy, histology and the rest.

Nine years later, after two year's military service I was appointed intern in the surgery unit at Auxerre hospital. I intended to specialize in obstetrics and gynaecology but after a hundred or so deliveries with some requiring forceps it became obvious that I wasn't up to it – deliveries put me in an uncontrollable state of anguish!

Later on I met up with Doctor J. Lebis, a friend who had just passed his Certificate in anaesthesia and intensive care and told me with enthusiasm all about his new speciality. He suggested I go to Cochin hospital and meet Doctor Kern in Prof. Merle d'Aubigné's service.

I made an appointment and introduced myself to M. Kern, somewhat apprehensively.

I will never forget his warm welcome.

After questioning me about my studies and degree, nothing worth noting I'm afraid, he enquired about my family and my financial situation and promised he would help me further my career. He explained how the service was run and told me all about the professional requirements which would, today, seem almost unrealistic.

I was immediately charmed by the simplicity and friendliness of the man who in 1962 was the first Professor in anaesthesia and intensive care and "senior consultant" at Cochin hospital.

It is important to remember that in 1960, anaesthetists still depended on the senior consultant of the surgery unit. They were either assistants or *attachés* and were on the surgery

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payroll. This state of dependency could prove more or less unmanageable and varied according to the character and mood of the surgeon. Mr Kern's great advantage was firstly to have been trained in Britain as a genuine anaesthetist and, secondly, to have had the courage to join the few Free French volunteers there. This explains the common mutual respect shared by Prof. Merle D'Aubigné and the future Prof. Kern.

However, as I was to later notice, the surgeon's whimsical personality occasionally led him to react over impulsively, despite his remarkable qualities both as a surgeon and a teacher. Mr Kern invariably played down the unfair remarks he had to endure.

When we first met, Mr Kern insisted I should not content myself with mere technical training but should read as much as possible. I therefore got acquainted with the *Cahiers d'Anesthésiologie*, a journal created in 1953 by E. Kern, J. Lassner and J. Valletta, all three of whom had been Free French volunteers.

Six years after the speciality was first taught in faculty and several hundred doctors had been trained, a higher course in anaesthesia was created and published (*Acta de l'Institut d'Anesthésiologie*, under the direction of Prof. Moulonguet). It enabled students to prepare for the Certificate of Special Studies in Anaesthesia which was to last until its replacement by the qualifying internship (a competitive exam).

Among the twenty three people who taught anaesthesia at that level, ten were not anaesthetists themselves. Yet, some of them were later to become Grade A Professors; E. Kern, J. Lassner and the youngest of them all, Guy Vourc'h, who had been trained in Britain and had survived the war where he had fought in Commander Kieffer's Marines. In 1954, he became a member of the Editing Committee of the *Cahiers d'Anesthésiologie*. That same year, he published his first article in the *Actes de l'Institut d'Anesthésiologie* (n°2; 5-31) that tackled the controversial issue of per-operative hypotension by hexamethonium, which was also the subject chosen by

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E. Kern in his article published by *Les Cahiers*. In 1952, J. Lassner had published, together with Aboulker "The reduction of bleeding through controlled hypotension in pelvic organ surgery" – N° 10/11 *Mémoires de l'Académie de chirurgie*. This technique will be the subject of seventy two observations, forty five of which in pelvic surgery as noted in an article published in the September issue of *Anesthésie Analgésie* Tome 1X N° 3.

For our training, Maud Khan and I joined Mr Kern's team run by Mrs Echter, Hartung, Meary and Vincent-Espinasse. To "test" us, they first trusted us with very simple tasks, then, very quickly allowed us "under close surveillance" to get on with the actual job. Everything new was always explained patiently, without any sign of irritation. I was lucky enough to assist Mr Kern on many occasions and soon realized that his being extremely short-sighted caused him problems when performing certain simple actions such as intravenous injections. Most of the time, he had to feel for the vein and would ask his assistants to help as soon as he thought they were experienced enough. Complying with his demands was already a lesson in itself. We had to explain and justify every single action and specify the type of anaesthesia we would have used had we been alone. The anaesthesia room, which was adjacent to the operating theatre was the very best place to learn. There the patients were anaesthetized and prepared for the operating table. They could be taken down early enough for the trainees to get everything ready and, depending on their qualifications, either take part or observe the anaesthesia and the preparation of the patients. This room was also used for storing medicines, drip solutions and basic equipment such as catheters, tubes, circuits, etc. This methodical training was designed to monitor the trainees and their ability to act alone. When they were ready, they would be put on duty.

Reading through the Acta, I come across names such as Du Cailar, thanks to whom Montpellier University became the

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place where anaesthesia took such prominent importance, P. Jolis, M. Cara, G. Delahaye, Gauthier Lafaye, P. Huguenard, J. Passelecq, L. Lareng, L. Serre, all of whom contributed to the extraordinary vitality of French anaesthesia.

Unfortunately, very soon the “pragmatists”, who were dominant in Britain and the US and favoured a “balanced” type of anaesthesia opposed those who sought to intervene upon the physiological and metabolic alterations caused by “aggression”, most particularly in surgery. Hence, in 1959, J. Bimar, M. Cara, J. du Cailar, M. Sabathié, H. Vignon, R. Deleuze, P. Huguenard, P. Jaquenoud, E. Simon, and J. Chopin, launched a new journal, the *Annales de l'Anesthésiologie Française*, more to compete with the *Anesthésie-Analgésie* the journal of the Anaesthesia Society, than the *Cahiers d'Anesthésiologie*.

This new journal soon became extremely successful and the creation of the Association des anesthésiologistes français was the founding act of a new school of anaesthesia. A fourth journal had already seen the light of day – Laborit's *Aggressologie*.

Yet, the bone of contention is not as serious as it may appear. It is more a question of a clash of strong personalities than the doctrine itself. Both sides have the same common aim, which is to reduce risk in anaesthesia and ensure the safety and comfort of the patient. It is rather the means to achieve the goal that divides them. They all use potentially dangerous techniques which are difficult to handle. Resorting to ganglioplegics to reduce bleeding is no better solution than using neuroplegics or any other mixture bearing the same code name. It would seem, in fact, that the problem lies in the “overuse” of products such as central analgesics and neuroleptics – when used in huge proportions, the latter causes total analgesia without real loss of consciousness, as described by so many patients. Moreover, it becomes necessary to resort to either artificial ventilation that can lead to a simpler post-operative situation in major surgery but

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which is not necessary in most surgical operations, or to the use of the antagonists and thus, obviously, to bad-quality post-operative analgesia and the risk of secondary respiratory depression. For ten years, this mental "bypassing" has affected most of the profession, not to mention the "pragmatists" themselves.

The development of regional anaesthesia favoured by E. Kern and J. Lassner found advocates within both camps. Mr Kern had approved of the anaesthetic techniques used in orthopaedics, namely spinal anaesthesia and intravenous regional anaesthesia of the upper limb and lower limb, the latter being rarely used due to the large amounts of local anaesthetics required. In Urology, Mr Lassner, assisted by E. Guillerat whom he had trained, had selected epidural anaesthesia for his speciality. One of the advantages of epidural anaesthesia being the quality of the post-operative analgesia that may be obtained by reinjection or by a low-concentration drip of lignocaine if necessary.

Messrs Kern and Lassner also did pioneering work in the field of regional anaesthesia. Another leading unit should be added to their two services: Professor Léger's general surgery unit where Mrs Lande, assisted by S and Cl Clot worked together with Nicole Jude.

Besides practical studies in the units, which were the main elements in the training of future specialists, there were two maternity units in which anaesthetics were administered by midwives. They qualified as anaesthesia "assistants" and their one-year training consisted in lectures given at the Faculty of Medicine and training courses in appropriate services. Besides practical training, they took theoretical courses at Cochin hospital. These comprised clinical lectures on anaesthesia and intensive care that dealt with current issues and clinical cases. They were followed by debates often quite "animated" as the protagonists came from different backgrounds. As an example, I would mention the lecture delivered in 1959 by the Reverend Father Oraison who was

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invited to talk about euthanasia. He contributed to the *Cahiers d'Anesthésiologie* a text published in 1960 which is still topical and could very well be reprinted in 2003/4 as still relevant.

The same year, Mr Cara wrote an interesting critical study on artificial respiration equipment which, in most cases, was rented on a daily basis. At Cochin hospital, the orthopedy department of anaesthesia possessed only one single ventilator machines. The same went for the peranaesthetic monitors. There were only three cardioscopes and blood pressure was measured by hand. Heart rates were calculated by feeling the pulse for fifteen seconds, thirty seconds, or one minute. In post-operative care, it was important to observe the "quality" of the pulse, the colouring of connective eye-lids and to auscultate the chest and the heart as well as observe the recolouring of sub-ungual tissue. However, a symposium on the problems raised by the development of anaesthetic equipment was organized. Today, this is still an issue, although seventy percent of the potential offered by the monitors is never really used.

In the sixties, the pharmacopoeia of anaesthesia was reduced to its simplest form. The anaesthetics administered through inhalation included nitrogen protoxid, ether, Vinether and cyclopropane. For intraveinuous injection, thiopental had no rival. As for curares, d-tubocurarine and gallamine, synthesized in France by Bovet, were widely used, and occasionally, Auxoperan, a curare produced by methylating an alkaloid close to d-tubocurarine but which was never really adopted. Two local anaesthetics Lidocaine and tetracaine, were used as regional anaesthetics. New products later became available namely; halothane, gamma-hydroxybutyrique acid, hydroxydione and propanidide. The latter was soon discarded as it caused irritation in the veins in spite of its qualities which were close to those offered by propofol today. And then there was alcuronium, fairly similar to d-tubocurarine. Later, two new morphinated anaesthetics

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derived from pethidine were introduced; dextromoramide and phenoperidine. In the late sixties, only two products were not simple improvements of existing anaesthetics; kétamine and sodium gamma-hydroxybutyrate which, unfortunately only became active after ten minutes. Conversely, ketamine should have been used to create a series of new products used in anaesthesia as happened with benzodiazepines. The use of neuroleptics and phenotiazines could also have helped develop new molecules.

In 1960, anaesthesia, quoted in the Social Security list, was an act that could be performed by any doctor or by a paramedic, under medical supervision. In those days, most anaesthetics were not administered by qualified staff. Although Professors had been appointed as early as 1962, in 1966 anaesthesia became a speciality and new specialists were made Professors. Thus, E. Kern, J. Lassner, P. Huguenard, G. Plouvier-Delahaye, C. Guilmet, J. Passeleq, N. du Bouchet, P. Viars, among others, were appointed as Professors in Paris and new services could be set up. Similarly, new schools were created for paramedics, especially in Saint-Germain-en-Laye, near Paris. Although these schools were independent from the Faculty of Medicine, the director had to be a rank-A Professor, specialized in anaesthesia and intensive care.

When we look back to the past, which is not always positive, it appears that our speciality was exceptionally active right from the very start. The small team who first took up the challenge enabled following generations to develop surgery and intensive care and then to start, first clinical research and secondly scientific research with the success we know today.

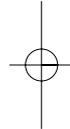
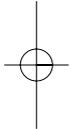
We still have a long way to go if we want to catch up with earlier specialities, especially if we consider radiology which was able to switch from imaging to operational radiology, a change envied by the then incredulous surgeons.

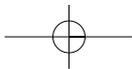
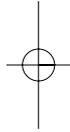
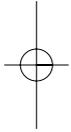
Throughout my twenty-five last years' practice as an anaesthetist, the conditions of diagnosis and therapy have



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completely changed. The number of products available today has increased threefold. Thanks to the development of monitoring, anaesthetists now have at their disposal more equipment, including anaesthesia machines, than even research teams had thirty years ago. This is without doubt due to the revolution in programmable electronic devices. Although there is still more progress to be made, the future will entail ever increasing complexity in the professional environment and will inevitably involve new risks. A future specialist in anaesthesia and intensive care will need to acquire more and more knowledge. In the future, the prospect may be to create specialists within the speciality, as happened for surgeons in the second part of the last century.





Long Live Free Poland*

In the Name of Polish Anaesthesiologist

Professor W. Jurczyk

MD, Ph. D, Sponsor of the Doctorate Honoris Causa

Professor A. Nestorowitz

MD, Ph D., President of the Polish Society of Anaesthesiology

Professor Z. Rondio

MD, Ph D, Editor-in-Chief
of the Polish Review of Anaesthesia – Intensive Care

Professor Jean Lassner has been well known to Polish anaesthesiologist for a great many years, particularly to those who, during the difficult post-war period, had the privilege of

* The title of this homage is excerpted from a phrase pronounced in Polish by Jean Lassner during one of his visits to Poland.

Text translated by Catherine Portuges, Comparative Literature, University of Massachusetts Amherst, USA.

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perfecting their training in France and especially in Paris. Some twenty-five years ago, his great sympathy for the Polish people earned him the complete support of the Polish Society of Anaesthesiology (Professors A. Aronski and W. Jurczyk) on the occasion of the constituent meeting of the European Academy of Anaesthesiology (EAA).

Jean Lassner's contributions have left a defining mark upon the history of anaesthesiology, for not only was he the founder of the E.A.A. which he defended so vigorously, but he also offered his support to a number of national societies, in particular our own. the *Cahiers d'Anesthésiologie*, of which he was a founding member, has long remained a vital source of information about French anaesthesiology for our colleagues.

In recognition of Jean Lassner's efforts to enable our physicians to meet their colleagues from other European countries, the Polish Society of Anaesthesiology elected him as one of its honorary members. Moreover, through the good offices of Professor W. Jurczyk, then Senator of the E.A.A., the University of Posnan conferred upon him the title of Doctor Honoris Causa.

Jean Lassner thus became one of the few foreign Professors of Anaesthesiology on whom this distinction was bestowed in Poland, and the anaesthesiologist of our country owe him a great debt of gratitude for the assistance that he has continuously offered us. It is unfortunate that some of his ideas did not receive the response they so richly deserved. The increased professional and scientific level of European anaesthesiology, particularly thanks to the examination for the European diploma in our speciality, will remain forever linked to his name. For this reason he takes his place among the great pioneers of anaesthesiology.

Dear Professor Lassner, we wish you many more years at the heart of European anaesthesiology.

The *CAHIERS D'ANESTHÉSIOLOGIE* and the Francophone World

Professor Marie-Claire Antakly

Head of the Department of Anaesthetics and Intensive Care
Hôtel-Dieu de France – Beirut – Lebanon

This tribute to Jean Lassner, the great scientist and clinician, almost coincided with the Ninth Meeting of Francophone countries. He was dedicated to advancing and worked tirelessly for this concept of sharing knowledge around the world. He was one of the pioneers of French anaesthesiology and amongst his students were Lebanese doctors, of which I am proud to have been one. Professor Lassner, whom I came to know through his friend Professor E. Kern, was for us a role model and inspired teacher. He always had a visionary approach to the speciality, practising pains management long before the creation of specialist centres for pain.

The *Cahiers d'Anesthésiologie* has always been an invaluable medium in which to follow progress in the dynamic field on

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anaesthesiology and intensive care. The teachings of this great anaesthesiologist formed the solid foundations for this journal.

I wish the *Cahiers d'Anesthésiologie* ever more success and wider distribution. I have had the honour of being a member of the committee for many years and have carefully kept every issue from 1967 to the present day.

I wish Professor Lassner long life and good health – my memories of him are as fresh as ever.



Jean Lassner, 7 May 1993, Faculty of medicine. Paris
80th birthday

Un provincial à Paris

Henri Bricard

Professeur, chef du département d'anesthésie-réanimation,
CHU Caen

Qu'est-ce qui avait bien pu conduire le jeune externe de province que j'étais à « monter » à Paris fin 1964 pour se spécialiser en anesthésiologie ?

Certainement pas son médecin de famille qui ne voyait vraiment pas l'intérêt que pouvait présenter ce « métier de femme ». Il faut dire qu'au fond du bocage normand, éther et chlorure d'éthyle ne semblaient plus avoir de secrets pour lui depuis bien longtemps. Je n'ignorais pas son expérience, moi qui, à l'aube de ma huitième année, pieds et poings liés sur un solide siège en bois, avait eu l'immense privilège de voir disparaître mes amygdales après avoir respiré très fort dans un masque de Camus habilement manipulé par ses soins. Quel souvenir inoubliable d'un de ces passages semestriels de l'oto-rhino-laryngologiste venu de la ville, son *sludder* à la

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main et qui à chaque séance «venait débarrasser» une fois pour toutes de leurs angines une douzaine de jeunes de mon âge qui n'avaient rien demandé à personne... Que de cris et de sang éclaboussé dans la salle à manger du médecin, transformée en salle de surveillance post-interventionnelle et où les «victimes» jonchaient le sol, côte à côte, suçant avec avidité les glaçons distribués à titre antalgique par l'épouse du docteur jusqu'à ce que leur «aptitude à la rue» soit reconnue et qu'ils soient remis aux bons soins de leurs parents respectifs. Qui sait si, une quinzaine d'années plus tard, ce souvenir «cauchemardesque» n'a pas été pour quelque chose dans un choix encore loin d'être évident à cette époque? Peut-être... mais, je pense que ce choix reposait surtout sur l'exemple des quelques rares aînés qui avaient décidé avant moi d'embrasser cette toute nouvelle spécialité de la médecine et qui semblait pleine d'avenir. Tout au long de mon cursus, au bloc opératoire, j'avais eu le loisir de les voir piquer, perfuser, intuber, ventiler dans des spécialités diverses allant de l'orthopédie à la chirurgie thoracique, en passant par la chirurgie digestive et même la neurochirurgie, sans oublier l'efficacité de leurs interventions ici ou là dans l'hôpital et particulièrement aux urgences. Je fus impressionné par leurs solides connaissances médicales et j'enviais la parfaite maîtrise de leurs gestes dans la prise en charge des patients qui leur étaient confiés et ceci, il y a quarante ans, avec des moyens encore bien limités. Merci à eux, par leur exemple, de m'avoir encouragé et soutenu pour me lancer dans une aventure passionnée et qui se révélera chaque jour un peu plus passionnante mais qui aujourd'hui, bientôt arrivera déjà à son terme...

Ainsi, en 1964 ma décision était prise et bien prise et je m'inscrivis alors au certificat d'études spéciales d'anesthésiologie à la faculté de médecine de Paris. Le 4 novembre, comme on me l'avait demandé, je me présentai à sept heures trente dans le service de chirurgie digestive du docteur Hepp à l'hôpital Bichat. C'est dans ce service, sous la houlette des

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docteurs Raymond Alluaume et Françoise Jacquin, que je devais accomplir ma première année de formation. Et pourtant, ce matin-là, je ne pénétrerais pas en salle d'opération! En effet je fus immédiatement invité par mon maître de stage à me rendre au prestigieux hôpital Américain de Neuilly pour y surveiller, le plus attentivement possible, dans sa chambre, une sommité du monde médical parisien qui présentait une hémorragie digestive. Ma mission était de prendre et de noter la pression artérielle et la fréquence cardiaque, de vérifier la perméabilité et la production de la sonde nasogastrique, de relever tout événement anormal et d'informer téléphoniquement de toute aggravation. Un laryngoscope et une sonde d'intubation étaient disponibles au pied du lit, mais j'aurais été bien en peine de les utiliser... Fort heureusement, la journée se passa sans incident. Je dois avouer que mon moral fut très agréablement soutenu par de charmantes infirmières venant régulièrement prendre de «mes» nouvelles mais aussi par les échanges courtois que je pus avoir avec mon célèbre mais non moins sympathique patient. Si cette journée fut longue elle me permit cependant, en moins de douze heures, de faire la connaissance de plusieurs grands noms de la médecine venus s'enquérir de l'état de santé de leur collègue et ami en faisant fi de la pancarte «visites interdites» accrochée à la porte. Difficile pour moi de m'opposer à leur entrée lorsqu'ils avaient décliné leur identité, et je m'éclipsais discrètement dans le couloir à chaque visite après avoir donné quelques nouvelles. Aucun d'entre eux ne quitta la chambre sans avoir tenu à me remercier avant de prendre congé. Malgré tout, vers vingt heures, je fus vivement soulagé d'être relevé de mes fonctions sans que «mon» patient ne se soit aggravé. J'ignorais encore, alors, qu'il ne s'agissait là que d'un premier épisode d'un feuilleton qui ne manquerait pas de se reproduire à l'hôpital américain et ailleurs dans les mois à venir.

Dès le lendemain matin, enfin, je franchis pour la première fois la porte du bloc opératoire flanqué de l'étiquette

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«anesthésiste». La quasi-totalité de mes journées, tout au long de cette première année, se passa dans une des trois salles d'opération d'un des services de chirurgie digestive les plus en renom de la capitale et réalisant quotidiennement toutes les interventions majeures de l'époque orchestrées de main de maître par les soins d'une surveillante chef de bloc remarquablement efficace et à l'autorité reconnue et incontestée par des opérateurs brillants mais néanmoins parfaitement disciplinés. Ceci explique peut-être cela...

Progressivement, mes collègues en formation et moi nous vîmes confier la surveillance d'interventions de plus en plus lourdes, surveillance essentiellement clinique à cette époque, les moyens de monitoring se résumant le plus souvent à un électrocardioscope à une seule piste et parfois à un pulsomètre sonore et lumineux! La ventilation peropératoire était le plus souvent manuelle (les pouces bien parallèles sur le ballon... sans faiblir au fil des heures...). En effet, l'unique «pulsomoteur» artisanal conçu par les soins de notre maître de stage était le plus souvent réservé aux interventions les plus lourdes conduites sous son autorité personnelle. Le service avait une réputation dépassant très largement les frontières de l'hexagone en matière de chirurgie complexe des voies biliaires, c'est dire l'importance de son recrutement et la durée souvent prolongée des interventions lorsqu'il s'agissait de «réparer» des voies biliaires traumatisées ici ou là. Mais c'était aussi la grande époque de la chirurgie de l'hypertension portale et, si la transplantation hépatique n'existait pas, un des futurs pionniers en la matière, chef de clinique à l'époque, «collectionnait», tout au long du nyctémère, anastomoses portocaves et splénorénales... Et nous, nous transfusions en quantité le sang total en flacons de verre que nous allions souvent chercher nous-mêmes au centre de transfusion voisin et, comme ne manquait pas de nous le rappeler F. J., il ne fallait surtout pas oublier le «calcium» pour compenser les effets du citrate. Merci à elle pour les sandwiches qu'elle nous faisait porter quand le

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programme se prolongeait dans des plages additionnelles non rémunérées ni récupérées...

À cette époque, l'arsenal des médicaments de l'anesthésie était limité. Il y avait le thiopental, quelques neuroleptiques (diéthazine, chlorpromazine, dropéridol) mais surtout le gamma hydroxybutyrate de sodium qui se révéla, pour moi, dans le contexte de ces malades fragiles, ictériques, volontiers insuffisants hépatiques et rénaux un médicament pourvu de qualités indiscutables mais qui, malheureusement, n'étaient et ne sont toujours pas reconnues par tous. Les plus anciens se souviendront des querelles de clocher qui agitaient le petit monde de l'anesthésie à l'époque. Les analgésiques se limitaient essentiellement à la morphine et à la péthidine, les curares à la succinylcholine, et à la d-tubocurarine ou la gallamine. Quant aux anesthésiques locaux disponibles, procaïne et lidocaïne, ils étaient utilisés essentiellement en perfusion pour assurer analgésie et protection neurovégétative. Les salles de surveillance post-interventionnelle n'existaient pas et réveil et extubation devaient se faire sur table... parfois il faut bien l'avouer avec quelque retard.

Lorsque malgré tous nos efforts la maîtrise du réveil n'était pas parfaite, il n'était pas rare de faire appel au Dr M. Cara de Necker qui venait livrer avec son camion tôle Citroën un respirateur de type Engström pour ventiler le patient, sous notre surveillance, jusqu'à ce qu'il soit extubable ou transféré en réanimation et cela parfois, malheureusement pouvait durer... un certain temps.

Parallèlement à cette formation pratique à l'hôpital, il y avait la formation théorique dispensée sur deux années, la première année étant essentiellement consacrée aux bases de la physique des fluides, à la physiologie, à la pharmacologie des médicaments de l'anesthésie et aux techniques anesthésiques, la réanimation étant elle plutôt enseignée en seconde année. Les cours magistraux avaient lieu rue de l'École de médecine dans l'amphithéâtre Cruvelhier près de l'Institut d'anesthésiologie et nos maîtres étaient alors les

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Prs Ernest Kern, Jean Lassner, Guy Vourc'h, mais aussi bien d'autres qui ne m'en voudront pas de ne pouvoir les citer tous. Je ne voudrais pas oublier cependant les séances de travaux pratiques à Necker où M. Cara, P. Jolis et M. Poisvert nous disséquaient les appareils d'anesthésie et au terme desquelles manomètres, débitmètres, valves avec ou sans *rebreathing* n'avaient plus de secrets pour nous.

Le passage en seconde année était soumis à la réussite aux épreuves d'un examen théorique et pratique passé en fin de première année. De cet examen dépendait également le choix des sites des gardes qui devaient être obligatoirement et intégralement effectuées au cours de la seconde année pour pouvoir se présenter à l'examen national terminal du CES. Nous reviendrons plus loin sur les conditions dans lesquelles je fus amené à remplir ce contrat de gardes dans la banlieue Nord de la capitale.

La seconde année de formation m'amena à fréquenter plusieurs services. Tout d'abord celui du Pr Mollaret, le saint des saints de la réanimation médicale, à l'hôpital Claude-Bernard sous la houlette de J.-J. Pocard. C'est là où je me familiarisai avec les techniques de réanimation de l'époque et découvris entre autres les patients atteints de tétanos et ventilés sous curares mais aussi avec les toutes premières benzodiazépines. Combien enrichissantes étaient les visites dans le service, «pendu aux basques» des uns et des autres, mais passionnantes aussi les présentations de dossiers en amphithéâtre par le Pr Mollaret lui-même ou les membres de son équipe.

Je retournai ensuite en anesthésie à Lariboisière dans le service de neurochirurgie du Pr Houdard. Mon maître de stage était alors le Dr Geneviève Laborit, femme d'une extrême gentillesse qui me fit découvrir le monde de la protection neurovégétative, de l'hibernothérapie et me confia les recettes de tous ses cocktails destinés à protéger le cerveau. Je ne fus guère «dépaycé» car là aussi le gamma OH (et pour cause) était très largement utilisé. Je me familiarisai

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avec la traumatologie crânienne grave mais aussi avec la neurochirurgie des tumeurs, des malformations vasculaires, la stéréotaxie et bien d'autres choses... Je me souviens encore des matinées où dès sept heures du matin on devait débiter l'hypothermie avec nombre de vessies de glace et surveillance étroite du thermomètre spécialement conçu à cet effet (sans se laisser surprendre et dépasser...). Je fus rapidement mis en charge des explorations radiologiques vasculaires et les opacifications radiologiques de l'aorte par voie postérieure, chez des patients en décubitus ventral, isolé à l'autre bout de l'hôpital, m'ont laissé des souvenirs impérissables.

Au terme de ce passage à Lariboisière, souhaitant me familiariser avec l'anesthésie en chirurgie infantile je partis à l'hôpital Saint-Louis dans le service du Pr Barcat où j'eus la chance de pouvoir travailler sous l'autorité bienveillante du Dr Jeanine Ménard. À l'époque les évaporateurs calibrés d'halogénés n'existaient pas encore ou tout au moins nous n'en disposions pas. Ainsi l'anesthésie était-elle donnée à l'éther ou à l'halothane, voire aux deux en série, grâce à un barbotage savamment dosé et basé essentiellement sur la surveillance clinique, les doigts sur le pouls, le stéthoscope placé sur l'aire précordiale et en permanence aux oreilles, le tout sous ventilation manuelle au ballon. Bienheureux étions-nous les jours où nous pouvions disposer d'un scope. Il n'est pas inutile de rappeler que l'oxymètre de pouls ne sera disponible que vingt années plus tard! Outre cette activité principale en chirurgie infantile, je fus également amené au cours de cette période à faire un peu d'anesthésie « foraine » en ORL, en ophtalmologie, en maternité, bref de quoi goûter un peu à tous les risques du métier!

Quelle chance d'avoir pu bénéficier de cette diversité de formation lorsque je dus effectuer les gardes dont j'ai parlé plus haut. En effet dès la fin de la première année je fus affecté, pour ce contrat obligatoire avec l'AP-HP, à l'hôpital Franco-Musulman à Bobigny. La première difficulté était déjà de pouvoir s'y rendre et l'expérience m'avait rapidement

yesterday's anaesthesia

prouvé que, si je voulais être à l'heure, le moyen le plus sûr, une fois sorti du métro, c'était encore la marche à pied! La garde du week-end commençait le samedi matin à huit heures et se terminait le lundi à la même heure. Quarante-huit heures dans un total isolement pour faire face aux aléas des urgences de toutes sortes (y compris en maternité) avec pour seul recours possible en cas de difficulté, les avis téléphoniques d'un médecin senior «attaché» pour Paris Nord et qui malheureusement ne pouvait guère se déplacer. Un autre médecin était lui «attaché» pour Paris Sud... En ce qui me concerne je n'ai jamais eu le loisir de connaître «mon attaché» au cours de ce semestre de gardes au «Franco». Que d'angoisses parfois... Fort heureusement sans trop de dommage pour les patients. Mais il faut dire que pour cette activité de garde, l'AP-HP nous rémunérait grassement: nous recevions en effet pour 24 heures de garde la somme forfaitaire de neuf francs mais néanmoins majorée de six francs par anesthésie donnée! C'est la panseuse de garde au bloc opératoire qui justifiait de notre activité sur le premier morceau de papier venu. En quittant l'hôpital, à la fin de la garde, il fallait présenter ce «chèque» à la loge du concierge qui nous rémunérait «en liquide» (non imposable) s'il vous plaît. N'était-ce pas Byzance? Fort heureusement au «Franco», la vie en salle de garde à cette époque était particulièrement tonique, ce qui me permet d'avoir conservé de cette période quelques souvenirs mémorables sur lesquels je ne m'étendrai pas.

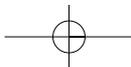
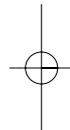
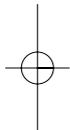
À la fin de la seconde année avait lieu l'examen national terminal du CES d'anesthésiologie. Les épreuves écrites avaient lieu dans la bibliothèque de la faculté, rue de l'École de médecine, où nous devions plancher sur des questions de physiologie, de pharmacologie et d'anesthésie réanimation. Ainsi étaient tombées cette année-là, la pharmacologie de l'atropine, la physiologie du tubule rénal et l'anesthésie-réanimation du patient éthylique chronique! Ayant passé l'obstacle avec succès, j'étais devenu médecin anesthésiste et

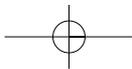
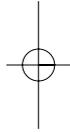
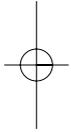


memories and reflections

bon pour un service militaire de seize mois, terminé tout juste pour «embrayer» sur mai 68 et embrasser la carrière d'anesthésiste en qualité d'adjoint du cadre hospitalier temporaire d'anesthésiologie le 1^{er} septembre 1968.

Merci à tous ceux et celles qui au cours de ces deux années m'ont communiqué leur savoir et donné des bases solides pour l'exercice de mon futur métier.





Modern Ventilation Equipment, Yes, but not Any

Jacques Berthier

Anaesthesiologist-Resuscitator
Hôpital Foch, Suresnes

Because I practiced for ten years at the Hôpital Foch with Guy Vourc'h, I wish to add my tribute to the man who trained me.

Starting in October, 1949 when he went to England for a while to do a rotation, I replaced him. Then when he came back, we were all able to benefit from what he had learned. This was important because the war had prevented French professionals from enjoying educational exchanges with other countries. Anaesthesia was a budding new speciality at that time. In Parisian hospitals, the staff anaesthetists worked as itinerant, ambulatory physicians. For instance, in one night we might go from Beaujon to Bicêtre or to the Hôtel-Dieu, and from Tenon to Trousseau. We responded to

yesterday's anaesthesia

many different kinds of emergencies and each hospital had different types of equipment.

After being named *Assistant d'anesthésie des hôpitaux* I was able to fully appreciate how staff were progressing and how the freshly trained anaesthesiologists were recruited.

When I was in Munich in 1957 I had the opportunity to visit a German operating room: in the middle of the room stood the professor's operating table, and, on each side, one table where each of his assistants were operating. The professor could supervise them simultaneously. There was also another operating room, which was barometrically controlled, with a hole in the wall permitting the patient's head to pass through and where the anaesthesiologist was stationed. Therefore in the pressurized operating room the surgeons could open the chest without collapsing the lung, and a pressure change corresponding to 300 meters of altitude was sufficient to keep the lung inflated against the chest wall and these conditions were tolerable to the medical staff. This procedure was quickly abandoned; the respiratory insufficiency after the chest was opened was caused more by paradoxal breathing and the pendular air movement created than by the pneumothorax. Therefore only controlling the patient's breathing by ventilating the patient can prevent what is often dramatic respiratory distress.

Many problems still remained to be resolved in order for thoracic surgery to proceed safely, such as the problem of contralateral seeding. If the infected lung were in a higher position, the secretions, which were rich in Koch bacillus, would fall into the healthy lung. Performing the surgery with the patient on his stomach in prone position was not a viable solution, because that position was inconvenient for both the surgeon and for anaesthesiologist. A double lumen tubing allowed the doctor to ventilate and aspirate the two lungs separately, and represented considerable progress.

Thanks to the Carlens tube, made in Germany by Rusch, the healthy lung could be isolated from the infected lung, to

memories and reflections

properly ventilate and aspirate, even if the other bronchus were open, and doctors were also able then to operate on broncho-pleural fistulas. For reasons which at the time he thought were ethical, Vourc'h refused to use this new tube.

He had always had trouble recognizing that the Germans could create anything good, and it should be noted that the Germans had caused his family to disperse, caused him to go into hiding, caused him and his brothers to emigrate, and finally was responsible for the deaths of many friends as well as his brother Jean who died on the battlefield. What's more, at Hôpital Foch, the director's son, Jacques Chevalier, had just finished his training in otolaryngology in that hospital. (He had been condemned to death, spared because of his youth, and subsequently imprisoned for several years for having demonstrated on November 11, 1940 with the students of Lycée Buffon at the Arc de Triomphe.)

Refusing to use the German probe, Vourc'h proposed to use instead some English tube that was difficult to put in place and to maintain. Afterwards, he became more European and he used it.

By this time Hôpital Foch enjoyed many skilled teams of highly specialized physicians. Having one single group and one single team of anaesthesiologists made exchanges between departments much easier. The level of technical equipment available to us was exceptional and highly successful.

For Vourc'h, knowledge was not only practical; he believed that theoretical knowledge was also important: physiology, pharmacology, and pathology were to be studied. He thought it necessary to speak English. At this time, the anaesthetic books and reviews were printed in English, rarely in French. He insisted on this because he felt that if a doctor could be familiar with the pharmacology of a product, it was more difficult to understand the effects of several drugs used all at once. Hypnosis, pain control, and muscular relaxation were obtained by specific products. The students operating on patients must use only simple, classical methods.

yesterday's anaesthesia

Vourc'h learned from everyone and allowed everyone to learn from him so that surgery and anaesthesia could progress. In Hôpital Foch:

- neurosurgery: Guiot, Rougerie: controlled hypotension—treatment of hydrocephaly;
- plastic surgery: Tessier, Rougerie: treatment of cranio-synostosis;
- maxillo-facial surgery: Ginestet: blind naso-tracheal intubation;
- thoracic surgery: Hertzog, Toty: broncho-pleural fistulas
- obstretic-gynecology: Merger;
- orthopedics: Padovani;
- gastroenterologist: Mouchet;
- urology: Küss; the first kidney transplants.

When we think of Guy Vourc'h, we remember he stood for “la petite Anna”, Free France, the Normandy debarkation, the Kieffer Commando, but he stands especially for Brittany, Plomodiern, the Pointe du Raz, the Crozon Peninsula. When one leaves this protected area one runs the risk of shipwreck, of losing one's mast in the tides, currents and rocks from Raz de Sein and Fromveur.

Anaesthesia, too, has its risks, and to arrive safely one must prepare carefully.

Guy Vourc'h: a great Breton, a brave soldier, a pioneer in anaesthesiology who left a profound impression on his students.

France, I Love Your Tender Symphony

Saint-Pierre et Miquelon – 1942

Colette Lassner[†]

Née Diamant-Berger

Solicitor, Volunteer in the French Force

Like a little village in Normandy, Saint-Pierre goes uphill, stepwise, on a steep hill, taking on soft shades of yellow and pink in the sun. The green of its meadows and the deep blue of the sea are the only bright, burning colours. The wind blowing over the hilltops becomes an infinite moan over the ocean. Human noises from the houses cease. Nothing remains but the grey soil, covered here and there by short, pale grass. White pebbles of various sizes are scattered over the hill. On the top of the will, grey rocks are planted in the soil. The quiet port below rocks its ships at rest. Sailors' Island stretches out languidly, flanked by two rounds, bare islands called Green Island, Isle of Pigeons. In the fog or in the rain, everything becomes grey at Saint-Pierre: the port with its lowing foghorn, the dull, closes houses, the wet ground, the low sky.

yesterday's anaesthesia

Newfoundland vanishes from the narrowed horizon. The outline of Sailors' Island becomes hazy and distant, passers-by, few and far between, hasten their steps on the wharfs and streets of the wet little village. Untiringly, the water continues its mysterious work. Gurgling in its frail springs, stagnant in its small, quiet ponds, this water too makes the soil damp and soft.

The people of Saint-Pierre have their own characteristic way of walking. Their steps are quick and stiff. They move rapidly, displacing as little air as possible. Used to storms, snow and cold, they march on, even in sunshine, as if they were still fighting the harsh onslaught of their long winter. Dogs, on the other hand, quickly forget the severity of the climate. They loll happily in the sun, play and roll on the ground, jump again and again into the icy water to retrieve the stick thrown by their master. There are no trees at Saint-Pierre but there are flowers; the lily of the valley does not flower in May – maybe in June, some yellow iris and some little white flowers with no name and no scent. At night, over the sea, the round moon shines. In the clear cold air, the silent night stands still for a moment. From the masts of a schooner comes a song.

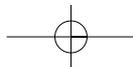
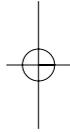
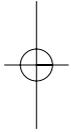
An accordion accompanies the sailor's voice, bantering and sad, and the port listens to the music of the sea. Silence of sweet nights, distant hum of the morning, awakened by the crowing of a cock, murmuring fragrance of a lively day, and when cows moo while frightened young goats remain silent, I love your lively and tender symphony.

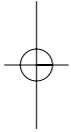
When the sun has sunk into its deep sleep, when the glittering star has risen, shining in happiness to see the moon, when tired men fall silent, their cattle bedded down for the night, the eyes of the houses close one after the other, I listen. Wanderer, passer-by, stay to listen too, listen to the sweet song of the sea.

memories and reflections

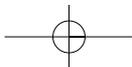


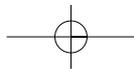
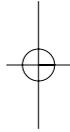
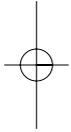
Ms. Lassner, Ms. Couremenos and Mr Lassner





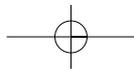
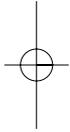
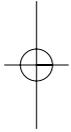
Homages





Dedication of the Général de Gaulle

*L'an à Dostum Jean Larmer
en témoignage d'admiration et d'affection.
Son ami, son compagne
5.5.64 J. de Gaulle.*



homages

Admiral Flohic's Testimony

I met Jean Lassner in May 1942 when he had just begun to serve as head of the Department of Health in the Navy of Saint-Pierre-et-Miquelon. The "corvettes" of the Free French made brief stops there after their work escorting transatlantic convoys. I was then in service aboard the Rosalys. In Saint-Pierre Jean Lassner treated the island dwellers and the Free French sailors who were badly in need due to the extremely harsh conditions under which the corvettes worked until 1944.

We had occasion to meet again when Général de Gaulle was operated on in 1964. I was by then the General's aide-de-camp. It fell to Professor Jean Lassner to anesthetize this illustrious patient, as well as to provide intensive care to him – which I am glad to say he accomplished successfully. Since that time, we have remained close friends, and Jean Lassner accorded me the honor and friendship of bestowing on him the insignia of Grand Officier de l'Ordre national du Mérite. Apart from his participation in the Free French forces, itself a great distinction, his Croix de Commandeur de la Légion d'Honor, his insignia of Grand Officier du Merite, and his Médaille des Évadés were more than fully deserved by his conduct during the War, by his qualities and his international reputation as Professor of anaesthesiology.

*Suz Fours le
12 juin 2002*

H. Flohic

yesterday's anaesthesia

Cryptosensitivity

All those who have known Jean Lassner for a long time, who have been his students, colleagues and correspondents or who have been in his care, all those who have attended his lectures or read his scientific articles, will tell you about his thoroughness, his stringency, his intransigence regarding quality and professional duty. They will also draw your admiration for his scholarliness, the breadth of his knowledge, his teaching skills, his enthusiasm and his stamina at work.

There is no need for me to remind you of all this, so I shall dwell on his inapparent yet genuine kindness, his acute sensitivity, his keen, often caustic sense of humour, his loyalty even as a friend, his integrity even in adversity; he is a Gentleman, a Friend.

Doctor Émile Benassayag

Head of Urological and Surgical Clinic of the Faculty
Assistant at the Hôpitaux de Paris
Consultant Urologist at the Hôpital Cochin, Paris

Much could be said

Congratulations and best wishes from your niece who – thanks to you – became an anaesthesiologist. You taught me to be careful by taking care of others. Thank you for your kindness and affection!

Kathlyn Collet

Anaesthesiologist-Resuscitator. Paris

homages

For my mentor Guy Vourc'h

I am writing a few words to express the friendship and thanks I owe you, as one of the many simple anaesthesiologists you taught. I was a student from your dear country, Brittany, and closer still, from Plomodiern where you were born.

You frightened us all a bit at first, but we quickly got past the outer shell and were reassured when we discovered your openness, generosity, attentiveness and availability. We were happy to work in your service, but us Frenchmen and the foreign students who were delighted by your welcome, at your home, and how you would discreetly help them out, with their financial or housing problems, or anything else.

I respected the great Professor, his degrees, his well-deserved honours, the doctor, the service chief who was a demanding of others as he was of himself, whose judgements were fair, who was generous and cared for his patients. I feel I am one of his spiritual children. You taught us everything, not only the methods of our work but also care and attention to detail, your traits, in examining a problem and in making each motion, because ours is a discipline where mistakes cannot be undone.

You also taught us that technique is not everything, and that beyond the surgical act, the Man remains, in all his aspects: physical, affective and spiritual.

Georges Le Bourlot

Anaesthesiologist-Reanimator, Quimper
English Translation by Marc-Etienne Schlumberger

Brazilian Story

The anniversary of Jean Lassner is the perfect opportunity for me to thank and send my sincere regards to him for having welcomed in his department and guided me throughout my professional career.

National Coordinator of a university movement in Brazil during the military "coup d'état" in 1964, I was arrested, sent to prison and all my civic rights were taken away from me.

yesterday's anaesthesia

I had nevertheless managed to obtain my state Doctorate before leaving Brazil, in very special conditions because after being released from prison I was closely shadowed by the police.

As for many others, my only way out was to leave Brazil and go into exile. I couldn't speak French and knew no one in the university circle. My Brazilian diploma enabled me to prepare my University Doctorate in Paris. I met Professor Jean Lassner upon my arrival in Paris in 1966. Professor Jean Lassner encouraged me to study Anaesthesiology, Reanimation I also had to pass a French State Doctorate, which was required in those days.

As his other students did, I benefited from his advice that was always in line with rigorous medical practice, the respect of patients and flawless ethics towards my colleagues.

I would like to send all my best wishes, to my Mentor, a very strong personality, a man of action, with a rigorous intelligence, who made France my land of exile.

Dr Marie-Laly Meignan

Head of the Department of Anaesthesiology and Reanimation
Saint-Anne Hospital. Paris

The story of an old Citroen

That particular event occurred in spring 1970 in Strasbourg. Professor Jean Pierre Gauthier-Lafaye, famous chairman of the Alsatian school of "Anaesthesie-Reanimation" organized the national congress of the speciality. Indeed in these times, the national congress was provincial.

Among the French personalities, Professor Jean Lassner appeared in good place. Among the nice organizers ("gentils organisateurs") appeared the rare ones and very young residents who had chosen to launch out into a speciality still stammering and little medicalized. I was one of them.

homages

Professor Gauthier-Lafaye had entrusted the delicate mission to me of giving Professor Jean Lassner a good reception. One of my tasks was to drive him from the station to the faculty of medicine where was held the congress. I was at the time the happy owner of an old “deux chevaux Citroen” whose not very aerodynamic silhouette still remains in the memories.

It was even at that time a modest vehicle to transport such a personality. One of its characteristics was the absence of gasoline meter on the dashboard. You imagine what happened. Without any premeditation my car stopped and I had to leave Mr Lassner alone to look for some gasoline. Mr Jean Lassner could show magnanimity. He did not hesitate to comfort me what enabled me to find the gasoline to give again power to my car and to achieve my mission without too much damage.

However my feeling of shame had been so sharp that I never forgot what happened this day and how Professor Jean Lassner could behave as a gentleman.

Renée Krivosic-Horber

Professor, Head of the Department of Anaesthesiology – Intensive Care Unit
Hôpital Roger Salengro. Lille.

How to repair an arm

As I was a young biologist, at the beginning of my career, I had the privilege to meet Professor Jean Lassner and to become his correspondent. This has been a long-lasting collaboration.

His demand for quality and quickness, when waiting for results from our lab, has been a most invaluable stimulus. We have tried our best to meet his requirement and to have our other correspondents benefit from this degree of expectation.

yesterday's anaesthesia

Many times did he express his friendship to us. I cannot forget how quick he organized the reduction of the fracture of my younger son's forearm, and carried it out in less than an hour; moreover, his troncular anaesthesia ensured immobilization without either oedema or pain.

In his constant fight against pain, even on the most trivial occasions, he has taught me – before painless needles were developed – to apply a spray of local anaesthetic to patients before taking any venous sample. This simple action actually showed our solicitude to our patients and has largely contributed to better relationships with them.

And throughout this long story, never has he dropped his strong sense of humour.

At the time when his birthday is about to be celebrated, it is particularly a pleasure for me to thank him publicly for all that I owe him and to assure him of all my friendship and admiration.

Paul Thiaucourt

AEHP, médecin biologiste, Paris

Many are called, but few are chosen

Many are called, but few are chosen.

Many aspire to teach and to be worthy of the title "teacher", but few achieve this aim.

One of the few who, through his honesty, his knowledge and his abilities, indisputably merits this distinction is Prof. Lassner. He had both the capacity and the willingness to teach a considerable number of pupils who, today, can undoubtedly proclaim with great pride that they had the privilege of sitting at the feet of such an exceptional man.

We learnt the science and art of anaesthesia and intensive care from his teachings and his writings, always enlivened by the vivid personal and professional memories of this teacher who, even now, at the wonderful culmination of a long and fruitful career, continues to teach us how to live out our remaining years in this complex and ungrateful world.

At a decisive moment, Prof. Lassner understood the need to bring greater dignity to this discipline of ours, and began the arduous task of setting up the European Academy of Anaesthesiology.

homages

I am sure that, today, many years later, he must feel gratified and amply rewarded for that inspiration which he was able to see translated into a joyous, effective and living reality, thanks to the understanding and unconditional support of a handful of "romantic visionaries", throughout the length and breadth of our European continent, who were taken with his idea and were able to give him full support.

Prof. Lassner, teacher, friend and most worthy gentleman, I believe that many of us have tried, whether successfully or not, I do not know, because it is no easy task to follow your example, your dedication, your capacity for hard work, the dignity which can only be acquired from many long hours given over to serving others, the unknown patients who confidently placed themselves in your hands, the colleagues who came seeking advice, the students who tried to follow in your footsteps, your always understanding friends, the family which you made exemplary in the face of every adversity.

God bless you, and give you every day of your life, the calm assurance that you hold a very special place in all of our hearts, and not just in our minds, which may sometimes be too cold to transmit that warm affection with which we extend to you our very best wishes, now and always.

Barcelona, Spain. September 2. 2002

Miguel Angel Nalda-Felipe

Prof. Emeritus – University of Barcelona

Devotion, abnegation, passion

It was a great honour for me writing this lines for the ninetieth anniversary of my Master the Prof Jean Lassner. This happy occasion remembered me far recollections: my stay in Paris during four years – from 1973 to 1976 – in order to specialize on anaesthesiology, and specially my passing by the department of the Prof Jean Lassner. Despite his many occupations at department, faculty or revue "Les cahiers d'anesthésiologie" he was always looking after his students to give them the best training and the best management with his associates.

yesterday's anaesthesia

He hadn't hesitated on giving me a thesis 's subject on anaesthesiology and intensive care; which accomplishment was impossible before on my country – Tunisia.

He was always concerned with the progression of this work which was very appreciated by the members of the jury on Tunisia. Mr Lassner teaches me devotion, abnegation and over all the love of my work in spite of its difficulties and constraints. He also inspired me through his humility, modesty and generosity. I hope he'll find through this lines the expression of my recognition and respect to this greatest man who is a promoter and a mainstay for anaesthesia and health care not only in France but also in other speaking french lads.

Long life and good health, dear sir.

Professor Abdelmajid Daoud

Professor, head of anaesthesia – Intensive Care unit

President of the Tunisian Society of Anaesthesia and Intensive Care.

Affectionate veneration!

I began my training in anaesthesiology in November 1948, in the department of Professor Merle d'Aubigné, under Drs Kern and Lassner at what was then the military hospital Foch at Suresnes

Had it not been for their encouragement, I would have soon given up; the atmosphere in the operating theaters was too oppressive for me. I passed the examination in anaesthesia successfully in 1949 and later competed for the post of anaesthesia-assistant to the Paris hospitals. My appointment was obtained in November 1951 and I took up my duties first at Port Royal maternity then at that of Baudelocque. In 1961 I went to the maternity service of Lariboisière hospital where I worked until 1965. I resigned that year from the public hospitals and worked with my surgeon-husband and different obstetricians in private establishments. When my husband retired in 1978 we left Paris and went to live in my parent's house on the Mediterranean coast.

homages

During my years in Paris, as well as later on, it has been my good fortune to have the support of Prof. Lassner to whom I turned in search of advise, help and comfort at difficult moments. When my uncle Dr Dupuy de Frenelle became severely ill, i was Prof. Lassner who gave decisive help. Besides solid friendship I feel for him faithful and affectionate veneration.

Doctor Marion Bertreux

Anaesthesiologist. Toulon

An innovator, a friend, a model

Professor Guy Vourc'h knew he had a cancer. Surrounded by friends and family, he fought it with courage and dignity. He took on his last fight with the serenity granted by a true faith and Hope.

The Chief – he deserved the title – was demanding with himself and with his students. Some did not appreciate his, at times grumpy, insistence on rigor:

Those who had the honour of learning anaesthesia from him and came to know him, as I did, are fortunate. They saw him as he truly was: very cultured, loyal and true to his responsibilities, a humanist, generous, sensitive, helping his neighbour with love and without pride.

Professor Claude Winckler

Retired Head of the Department of Anaesthesia-Reanimation, CHU Rouen

Retired President of the Société d'Anesthésie et de Réanimation

English Translation by Marc-Etienne Schlumberger

Austere but charming...

During my period of training in Paris, in the year of 1958, I made the acquaintance of Professor Jean Lassner and Professor Guy Vourc'h and so I had the opportunity of working with their teams. I observed their enthusiasm in stressing the position of Anaesthesiology as a medical discipline in surgical as well as intensive care units.

yesterday's anaesthesia

Professor Lassner has occupied an important position throughout his long career. I had the privilege of being conscious of his great efforts in order to organise the European Academy of Anaesthesiology, whose purposes were:

- to contribute towards the training of anaesthetists highly qualified within the European countries and to encourage anaesthetic research;*
- to establish the European standards for the practise of anaesthesiology.*

Within this objective Professor Lassner organised, under on European plan, several meetings that were considered of the highest level. In 1993 he asked me to organise the 5th Congress of the Academy in Porto. Once again I could observe his enthusiasm and the aptness of his interventions and comments. I was in the presence of a cultivated and learned man.

In 1993 I also had the chance of taking part in a meeting of the Academy on monitoring that took place at Professor Lassner's chateau near Sarlat. This meeting was part of a series of meetings where a restricted number of specialists got together to discuss a fixed theme. During the intervals of the sessions and after a day's work, when we went for a walk in the forest that surrounded his beautiful home, I had the opportunity of being aware of that man's greatness. We touched on various subjects, from his collaboration with the resistance during the war to his literary preferences, which, if I may venture to say, have had an influence on me. Professor Lassner is a man, who although austere, is profoundly human and a personality of a great charm.

Dr Manuel Soares Silva Araujo

Professor, Former Head of Anaesthesiology.

Saint-Antoine Hospital, Porto, Portugal

Member of the European Academy of Anaesthesiology.

homages

Prayer

Lord, in the name of the friends that the War let him choose, we ask you to remember Guy Vourc'h.

We ask you to remember the young Frenchman who, with a brother and four friends who have already joined you, went to England in 1940 on board the "Petite Anna" to answer De Gaulle's call.

We ask you to remember the medical student, determined to cast the unholy Nazis out of France who learned to fight with us.

We ask you to remember the marine commando officer who was the first among us to land on our land, at the tragic and glorious dawn of Ouistreham and who hunted the enemy until Holland despite being wounded.

We ask you to remember the perfect friend who, when peace returned, opened his home and heart to us and so many others.

We ask you to remember the sick man who, fully lucid, fought pain, infirmity and death so long, always trusting in Your will.

For all, in all, from all and himself he demanded authenticity with an absoluteness that hurt him at times, for he was sensitive and charitable.

Imposture angered him because his loyalty, when given, was total.

** Loyalty to Brittany with all his enchanted Celtic soul.*

** Loyalty to his Country, from him to whom being French was all the glory he wished, so great was his image of France's virtues, language, values, genius and destiny.*

** Loyalty to our English allies, who welcomed, trusted, and armed us.*

** Loyalty to a humanism that combined beauty, reason and Christian faith in harmony.*

** Loyalty to his enthusiastic and welcoming family.*



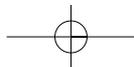
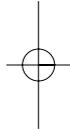
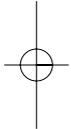
And this is why we pray to You, Lord, for this free, active and fighting family, its members living and dead, and finally for ourselves, with the hope of meeting Guy by Your side among the splendours and joys of Heaven.

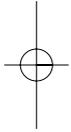
July 5th 1988

Général Jacques Bourdis

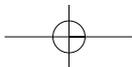
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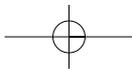
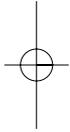
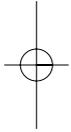
English translation by Marc-Étienne Schlumberger





Epilogue





The Future of Anaesthesiology

Philippe Scherpereel

Professor – Head of Anaesthesia-Intensive Care
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President of the European Foundation of Anaesthesiology Teaching

Member of the European Academy of Anaesthesiology

Fellow of the Royal College of Anaesthetists

President of the French College of Anaesthetists 1994-1998

President of the French Society of Anaesthesia-Intensive Care
1992-1993

When I was asked to write these few lines in homage to Prof Jean Lassner, my immediate reaction was that it would be extremely simple to find an illustration in his life and work that I could recount as a simple witness, given the countless episodes during his activity that deserve to be told and initiatives to be recalled. Like a number of French and European colleagues, it was my honour and privilege to take part in the meetings he organised in Sarlat for the European

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Academy. Each of these meetings, which were attended by some dozen European anaesthetists, provided an opportunity for reflection on an issue concerning the future perspectives of the profession. Each of us was free to express our individual viewpoints and thoughts in a relaxed friendly atmosphere in his beloved Périgord, far from the tumult. Plunged in the thick of action, it is not always easy to step back and reflect on things, and this was one of the great teachings of Prof. Jean Lassner, namely creating such reflection groups, which marked all of those who had the good fortune to take part. It is in this spirit that I wish to make my own contribution to the homage rendered to him, by attempting to outline a dissertation on the future of anaesthetics and intensive care, although the views expressed here are the sole responsibility of their author and do not necessarily reflect the viewpoints of the man in whose honour they have been assembled.

The general theme of this reflection is vast and ambitious, like the future of anaesthetics itself. Three factors appear likely to determine progress in this speciality: new pharmacological discoveries, technological progress and, finally, improved utilisation of resources, particularly, human resources, as a result of a new approach to work organisation and improved training.

New pharmacological discoveries

Progress in the domain of pharmacology has certainly been the most decisive factor over the last fifty years. This progress has resulted in more critical steps forward than in all the previous centuries. The discovery of new families of hypnotic drugs, the development of volatile halogen anaesthetics, morphine anaesthetics and synthetic curares has deeply marked the last half century. In relation to the initial molecules that inaugurated these new therapeutic classes, improvements in both pharmacokinetics and pharmacodynamics have conferred on these drugs used in anaesthesia

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and intensive care a degree of completeness that amply meets efficacy and safety requirements. The more recent discoveries exhibit increasingly slim advantages for increasingly high costs. This is probably the reason why no truly innovative products have appeared in recent years and no truly revolutionary substances are currently marketed.

More worryingly, the key substances of the last decade are successively falling into the public domain, resulting in a boom in generics and a discouraging effect on the pharmaceutical companies who are being forced to turn increasingly towards more lucrative sectors of the pharmacopoeia. Is anaesthesia, long supported by dynamic research activity, set to become the victim of its own success? Must we resign ourselves to existing pharmacological knowledge and to progress in the minor details, or is there hope for the advent of new anaesthetic agents that will bring with them a new approach to the practice of this speciality? A positive reply requires a certain amount of optimism today, and this statement, which is based in most cases purely on hypothesis, appears somewhat haphazard. In the field of inhalatory anaesthesia, xenon may be one of these future pathways heralded by clinical and experimental studies, certain of which are however already dated. Arguments in favour of such progress are provided by the encouraging results obtained during use of this substance and the rising tide of ecological concern, which in the next decade or two may result in outlawing of the use of halogens due to their harmful effects on the working environment and the ozone layer, if they are shown to be significantly responsible. However, the discovery of extensive reserves in sea beds, the development of new and less costly processes for separation and recovery of exhaled xenon, and the widespread use of completely closed respiratory devices could result in a reduction in costs and a marked increase in production, with certain branches of industry showing keen interest. Will this use of xenon be sufficient to revolutionise our speciality? As one who has had

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the opportunity to carry out clinical experimentation, I would have to say clearly not, despite the quality of anaesthesia and post-operative recovery obtained with xenon. Compared with current inhalatory anaesthetic agents, undeniable progress has been made, but it is in fact qualitative, representing a continuation of what already exists rather than a break with the past that constitutes a veritable revolution in practice.

Although the practice of anaesthesia has achieved a certain degree of maturity, marked in particular by a dramatic fall in mortality to around 1/200,000 administrations of anaesthesia, if traditional pharmacology appears to be stagnant at present, from what quarter can we expect significant progress in the coming years? Such progress is necessary, since even if anaesthesia is now less dangerous, it nevertheless remains the cause of perioperative discomfort that includes such conditions as perioperative recall, anxiety and pain and post-operative nausea and vomiting and other adverse effects arising from the lack of specific targets of current anaesthetic agents.

Reduction of the side effects associated with anaesthetic agents will involve a higher degree of selectivity with regard to targets based on more intimate knowledge of the fundamental mechanisms of action of anaesthesia. Although the molecular mechanisms of action of morphine and morphine receptors were only discovered in the 1970s, despite the fact that the analgesic properties of opium and the poppy have been known since ancient times, most anaesthetic agents had been developed and utilised before their mechanism of action was elucidated. It is clear today that pharmacological progress can only come from a better understanding of the molecular and fundamental mechanisms of anaesthesia. Extensive research and important international conferences on the mechanisms of actions of anaesthesia, such as those inaugurated by Raymond Fink in Seattle in 1974, have resulted in advances in our knowledge of the molecular basis of action of anaesthetic agents upon receptors and ion

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channels as well as the intracellular mechanisms of integration. The more our knowledge of such mechanisms improves, the more complex these phenomena appear, and it is evident that many physiological targets are involved in general anaesthesia, and that anaesthetics bind to specific sites on proteins, all of which indicates that it is reasonable to anticipate specificity of action.

In addition to investigation of the molecular mechanisms of action of anaesthetic agents, increasing research efforts must be devoted to genetics in order to determine why certain individuals experience unexpected reactions, with the most well-known example being malignant hyperthermia, but above all, how and why sensitivity to pharmacological agents differs from one individual to another. This knowledge should result in modification of our diagnostic approach, with a better understanding of reactions at sites whose structure is dependent on the genetic make-up of individuals, and of our therapeutic approach, first of all with adaptation of the agents used to known genetic specificities and, much later, modification of the structures in question. We are currently at the gates of science fiction, but it is conceivable that these hypotheses may lead to practical applications sooner or later. This perspective does not apply solely to anaesthesia, and it is clear that in the field of intensive care, genetic therapy and immune therapy hold out great hope, as reflected by the degree of investment in research in these areas, even though the results are as yet disappointing. In this domain as in others, great progress will have been made when we finally begin to understand why it is that individuals differ from one another.

Technological progress

Improvement in the safety of anaesthesia in recent years has been due in large part to progress in monitoring of vital functions, made mandatory by the recommendations of national scientific societies, and in certain cases reinforced by

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legal requirements, as is the case in France. The reliability of new technologies and the quality of materials have resulted in undeniable advances and have contributed to progress, which is now behind us. The advances observed are due more to the clinical application of these technologies than to the discoveries themselves. The techniques of oximetry and capnometry had long been known in principle, but the decisive step involved the transfer from a laboratory technique to mass diffusion to the patient's bedside and the operating theatre. The same was true of haemodynamic monitoring, with constant progress in this field leading to its introduction as a fundamental requisite of patient safety. More recent developments in monitoring of brain function by means of bispectral index electroencephalography (BIS) and the study of evoked potentials are the outcome of a similar approach to technological application rather than of revolutionary inventions. There has been continuous progression in terms of more reliable and efficient equipment. The same is also true of pulmonary ventilation techniques. Numerous exhibitions of equipment formerly used in anaesthesia and intensive care retrace the history and technological progress in this domain that the older members of our fraternity have seen with their own eyes. Because of the quality of ventilation provided and the safety of use associated with the degree of monitoring now installed, modern-day ventilators bear very little resemblance to the devices of old. However, the principles of ventilation remain the same, despite the increasing number of ventilatory modes and the return to initial favour of closed circuits. One recent advance in this domain must be emphasised, namely the appearance of Physio Flex[®], with an entirely new conception of a fully closed-circuit ventilator through the introduction of ventilation chambers, a turbine to generate rapid flow, electronic halogen injectors and an active carbon filter which, thanks to rapid analysers, can deliver inhalation anaesthesia using very precise gas concentrations.



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Following a period marked by the development of invasive techniques, advances in haemodynamic monitoring have deliberately turned towards increasingly less aggressive and more effective methods. The advances set to be introduced in coming years, including some advances such as assay using “chips” at the bedside for ever more sophisticated measurement, are currently under clinical development. Nanotechnologies and implanted microdialysis devices no longer belong solely to the realm of science fiction but have now been introduced into pioneering diagnostic and therapeutic applications, although they are still at the experimental stage. The scope for application of these techniques in almost entirely unexplored domains such as the physiology and pharmacology of the brain is immense. Massive application of computer science to anaesthesia and intensive care is only just beginning and technologies such as computer control, data transfer and artificial intelligence will doubtless result in new breakthroughs. However, are there any grounds for expecting fundamental questioning of the essence of the practice of this speciality? Probably not. The most likely outcome of the new steps in technical progress could paradoxically be greater humanisation of the medical act of the anaesthetist-intensive care specialist who, now freed from ancillary constraints, will be able to devote greater attention to listening to patients and to reflection on the fundamental issues of pathology and disease.

Improved utilisation of resources

While pharmacological and technological progress appear to have come to a standstill, new data concerning work organisation and social protection appear to be most likely to have a bearing on the future of anaesthesiology. Even if we examine the recent past, analysis shows a greater likelihood that progress in terms of training of doctors and nurses, together with the application of standards and recommendations governing good practice, have done more to reduce



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anaesthesia-related morbidity and mortality than pharmacological and technological advances. However, all of the foregoing is closely intermeshed and recommendations could only be implemented as a result of the technological advances that made them possible. This step is now behind us, although training, and in particular further training, must continue to be an essential concern. Key elements that will determine future developments consist of the reduction in funding allocated to healthcare in the economy of industrialised countries, dwindling of human resources and the reduction of working hours. Firstly, all of the three foregoing elements appear destined to have a negative impact on the quality of healthcare with the future being dictated in terms of recession. Although this is a possibility, it is by no means certain. While socio-economic constraints may lead to regression, they may also result in greater effort to find solutions through progress. Such solutions are illustrated by the example of ambulatory anaesthesia. In a country such as the United States, where patients must bear the brunt of health costs either personally or indirectly, ambulatory treatment has proved to be a very effective way of keeping down spending. Clearly, development of ambulatory anaesthesia has been slower in countries such as France, which enjoy a high degree of social protection and where economic pressure on individuals is less marked. Another essential factor for the future is the consumer pressure that is currently being brought to bear on the health care domain. Although negative impact undoubtedly exists, the positive consequences of patient involvement in healthcare delivery are numerous and extensive, and include provision of information to patients, provision of informed consent by patients and the ability to access patient's medical records. Taking greater account of the patient in this way will bring profound changes not only regarding the relationship between doctor and patient, but also on the quality of healthcare.

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In terms of healthcare economy, a broader vision of changes at the worldwide level is required. While the United States is cutting back on healthcare spending, which currently stands at around 14% of the gross domestic product (GDP), the emerging countries and the countries of the former eastern block are experiencing an increase in this percentage from between 4 and 6% of the GDP to a value approaching 9-10%, in line with the countries of the European Union. Within these budgets, a new balance is being struck and money required for expensive healthcare has to come from somewhere, in particular from a reduction in spending on hospitalisation. Among certain economists, there is a strong temptation to equate reduction in healthcare spending with a reduction in healthcare resources, and more specifically with a reduction in the number of doctors, as might have been deduced from the maintenance of limited enrolment numbers for medical students and the announced reduction in the number of specialists in the majority of disciplines. The wide discrepancies in numbers of operations and specialists, not only from one country to another, but also from one region to another within specific countries, could lend some credence to the thesis of these brilliant thinkers, had the lengthening of waiting lists and disparities between life expectancy among different populations not existed to bring them back down to earth. If the demographic perspectives of the speciality in the majority of countries throughout the world, and in France in particular, are not to engender an irrational catastrophic outlook, reflection is clearly required to determine the implications of these perspectives and to institute the measures required to deal with them. Although the situation in France, with fourteen anaesthesiologists per 100,000 inhabitants, is currently slightly higher than the average figure for the European Union, recent demographic studies point ineluctably to a reduction in the number of specialists in this discipline from 8,500 to approximately 6,000 in the next ten years. Based on inequality between the different regions of France, from 6 to

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9/100,000 in the north to 18/100,000 in the south, everything suggests that this difference will persist or even worsen as a result of the attraction of better working conditions coupled with a pleasant climate. Since anaesthesia is a medical act, there is no possibility of introducing palliative measures by replacing medical specialists with non-doctors, except if the principle of unacceptable regression is adopted. Furthermore, I do not feel it is acceptable to turn to massive importation of specialists from other countries, which would result in abolition of the efforts made to train specialists in our country while draining specialists from countries with already worrying medical demographics, principally because of extremely low pay levels. Unbridled authorisation of free circulation of doctors following the entry into the European Union of countries in the former Eastern Block could have disastrous consequences on the healthcare situation in certain of these countries, which is already a major cause of concern. It thus appears necessary to find a solution within France to counter the decline in numbers of anaesthesiologists, of whom there are already too few in certain regions. These specialists will come to be a precious resource in the next few years. In addition to the demographic perspectives, we must consider the consequences of recent legal measures to reduce working hours, and to an even greater extent, the reduction in the working week, and of imposed rest periods after duty periods in the interests of safety for a discipline that is greatly affected by these problems.

Are these problems insurmountable? The only credible solution that may be implemented within a reasonable time frame is reorganisation of work. This has already begun in many places, but it cannot be undertaken without a number of feudal privileges being given up. Such reform concerns both space and time and requires abandonment or reconversion of all structures that are no longer viable due to their size or else redundant and consuming excessive human resources in return for inadequate productivity in terms of

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numbers of medical acts. This requires regrouping, not only where there are shortages, but also where there are relative excesses. Such restructuring must be implemented not only countrywide but also throughout regions and in individual institutions, where grouping together of anaesthesia and intensive care facilities has been far from the universal rule. A practically Copernican revolution is required with regard to scheduling in order to adapt activities to suit the available time and resources rather than the other way round, as was previously the case. Scheduling of operating theatres and departmental timetables are necessities that require rigour and coordination. It will no doubt be necessary to break down a number of taboos in order to answer such essential questions as: why in private practice, are twice as many medical acts performed by half the number of practitioners? Another taboo question also concerns the presence of the anaesthetist and intensive care specialist. Beyond a certain degree of hypocrisy and trade union concerns, on both sides, realities impose themselves even in countries such as Great Britain or Belgium, where the very existence of nurse-anaesthetists has always been refused and vigorously contested.

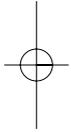
In France we are fortunate enough to have high quality state-enrolled nurse anaesthetists (IADE) in more reasonable numbers than in the Scandinavian countries, where there may be between three and ten times more than medical specialists. Their theoretical and practical training, backed up by a skills diploma, makes them the natural and suitable allies of anaesthetist-intensive care doctors, both in the operating theatre and in the post-operative recovery room and in emergency and intensive care departments. The idea of the anaesthesia team as it exists in the United States has already existed for some time in France. This notion is accompanied by another specific French feature, namely the rediscovery in the United States of peroperative medicine. This medical management of the patient has its advocates even in countries

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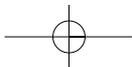
where the role of the anaesthetist has traditionally been limited to the surgical ward. This activity is highly time consuming and certain commentators see current and future difficulties as a potential stumbling block, in contrast with the general tendency. It is here that the notion of perioperative medicine dovetails with that of the anaesthesia team due to the need to share tasks. Extensive reflection is necessary to determine which parts of anaesthesia and intensive care activities require doctors and those that can be entrusted to nursing staff. Evidence-based medicine must be continued in order to demonstrate that this new organisation of healthcare does not lead to consequences harmful for patient safety rather than passive acceptance of the impassioned pleas that have hitherto very been posited as proof.

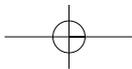
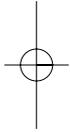
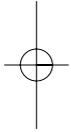
In addition to the benefits patients may hope to gain from this new organisation of healthcare, it should also provide anaesthesiologists with greater work satisfaction and sense of personal achievement.

In conclusion, progress in science and technology will doubtless continue in irregular fashion, as has been the case to date, although the current period appears to be something of a transition period. However, the social and human aspects of our activity are undergoing profound changes, from the point of view of both patients, who are increasingly active participants, and doctors and nurses, who are involved not only as professionals but also as human beings in their relationship with their patients and also in their work relationships. A humanistic conception of anaesthesia and intensive care is required, to which Professor Jean Lassner has contributed enormously through his personal philosophy, his international vision and his reflections on our profession. It is a striking paradox that scientific and technological progress always leads back to human beings and consciousness of our humanity.



Acknowledgements





In alphabetical order

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