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Reply from the authors
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None declared.

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Adoption of the European Diploma in Anaesthesiology as the National Board examination in anaesthesiology and intensive care: 2 yr of experience in Poland

Editor—We present important changes which are occurring in the training of a new generation of anaesthetists educated in Poland—a new member of the European Union (EU). Since many Polish anaesthetists moved temporarily or permanently to the UK and other EU countries, we hope this information will be of interest.3 The labour market in the EU is open. Representatives of medical professions, including physicians trained in anaesthesia, migrate within the EU. The ‘Helsinki Declaration’ regards anaesthesia as a key specialization which ensures the safety of patients.4 We believe that the key issue for realization of this declaration is proper education and evaluation of knowledge of all physicians completing training in anaesthesia in Europe.5 6 This should reduce the occurrence of critical incidences during periopera-

tive care, and also morbidity and mortality of European patients.4 In order to introduce EU requirements in Poland, the decision was made to restructure the educational procedures and the knowledge evaluation system of physicians trained in anaesthesia to meet the requirements set out by the European Society of Anaesthesiology (ESA) and included in the European Diploma in Anaesthesiology (EDA I) exam.

Poland (population 38 million) joined the EU in 2004. At the end of 2009, only 2778 anaesthetists worked in the country, that is, 7 per 100 000 inhabitants, which compares with 8.9 in the UK and 19.9 in Germany.5 By joining the EU, Poland knowingly agreed to assume some responsibilities, and also respect rules and laws that jointly and equally apply to all member states, with an awareness that the quality of health care in the EU is defined by standards and is therefore the same for all, regardless of their place of residence.6 Harmonization should be urgently applied to the field of education, and medical science, to ensure a high standard of skills common to all medical specialists.6 7

Subscribing to this philosophy of a common Europe, the Polish Society for Anaesthesiology and Intensive Therapy presented benefits of adopting the EDA I exam in Poland. A letter of intent declared the proposal to adopt the EDA I examination as the first National Board examination for medical specialists in Poland.8 This was to replace the standard test which was based on the structure of National Boards of Medical Examiners administered in the USA.

As most people prefer to deal with what is known, rather than with what is uncertain and do not like changes that could make an exam more difficult, the declaration of intent to adopt EDA I rules for the State Examination did run into some resistance. The purpose of it may have been misrepresented or misunderstood and some saw no need for change. One can draw parallels with the introduction of the Euro which met with initial resistance but is now legal tender in 16 European countries (total population 322 million).9 Important differences between unification of currency and unification of examination procedures notwithstanding, the social features of both processes are remarkably similar as although the EDA I exam tests knowledge in the field of anaesthesia and intensive care in general, it does not test knowledge in this field in Poland. The same obstacles exist on the path to harmonization that we have seen in the earlier attempts to standardize currency.9

The bulk of primary sources in anaesthesia and intensive care are available only in English. Therefore, candidates sitting for the EDA I exam would have to read English literature recommended by the EDA in the form of a ‘reading list’ posted on the ESA website.10 Those who were hostile towards the exam tried to convince candidates that medicine, including anaesthesia and intensive care, is different in a foreign language and, contrary to common sense, the laws of physics can be different in English and in Polish. We must understand that while physics may be the same regardless of geographical location and language, it is more readily comprehended in one’s native language.
On the basis of a letter from the Chairman of the EDA Committee, and the Minister of Health, the National Consultant who is an anaesthetist nominated by Minister of Health to supervise standards in medical care, training and education, enacted a legal act to empower the National Consultant to select questions from the EDA pool, while allowing the EDA I to serve as the first part of the Boards for anaesthesia and intensive care residents in Poland. The National Consultant appointed a working group, who established a residency curriculum fully compliant with EDA I requirements. The National Consultant website posted selected lectures in Polish, which were presented during a conformity certification session, held 2 weeks before the EDA I exam. During this course, participants had the opportunity to sit a mock exam in accordance with EDA I rules.

The first EDA I exam was run in Poland on October 4, 2008, as the first part of the National Boards in anaesthesiology and intensive care taken by residents. There were 73 candidates, including 72 from Poland. The Polish candidates passed the EDA I exam exceptionally well, and one candidate achieved the highest score in all of Europe. In 2009, 97 candidates sat for the EDA I exam in Poland, representing a 24% increase compared with the previous year.

In conclusion, despite initial difficulties in making the EDA I exam officially recognized in Poland, it is currently popular among candidates, mainly due to its clarity. Requirements posed by the EDA I exam were accepted by candidates primarily due to introduction of a special training programme based on literature guidelines presented by the EDA and the administration of a mock exam which played a key role. Objective promotion of EDA I among health professionals, scientists, and politicians was of fundamental importance in winning support for its adoption as the official exam in Poland.

We consider the process of fundamental changes which were implemented according to UEMS, ESA, and EDA guidelines, into the programme of residents training in anaesthesia and intensive care in Poland, as our practical contribution to enforcement of the contents of the Helsinki Declaration.

**Conflict of interest**

None declared.

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**Postoperative visual loss after plastic surgery: case report and a novel continuous real-time video monitoring system for the eyes during prone surgery**

Editor—Perioperative blindness is a devastating complication, with an incidence ranging from 0.01% to 0.2% and even as high as 4.5% in cardiac surgery. It is most often associated with surgery performed in the prone position. Compressive force on the eyes during prone procedures seems to lead to the development of perioperative blindness. We present a case of perioperative blindness and, in addition, a simple and unique continuous perioperative monitoring system of eye protection and positioning. This may have an impact on the incidence of perioperative blindness, by reducing or eliminating undetected compression of the eyes.

A 62-yr-old male (ASA II) presented for split-thickness skin graft for acne keloiditis. He had no prior medical conditions, although he was suspected of having undiagnosed glucose intolerance based on a preoperative blood glucose of 11.2 mmol litre⁻¹. Anaesthesia was induced with propofol and sufentanil, tracheal intubation was facilitated with rocuronium, and maintained with desflurane. Ventilation was maintained with a tidal volume of 750 ml and a ventilation rate of 8 bpm, which maintained a $\text{P}_{\text{O}_2}$ of $\sim 4.5 – 5$ kPa. A large-bore i.v. was secured along with a radial artery monitoring, before the patient was positioned prone on a Jackson table with a...