

# Vapour

The official E-Newsletter of the  
Indian Society of Anaesthesiologists

## HIGHLIGHTS

### PROFESSIONALISM AND ETHICS IN ANAESTHESIA PRACTICE

*Dr. Ripon Choudhary, Dr. Ridhima Sharma*

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*Dr. Rajesh M.C., Dr. K.V. Deepa, Dr. Rabida C.*

### ETHICS IN ORGAN TRANSPLANT

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# EDITOR'S NOTE



Dear esteemed members,

Warm greetings from Indian Society of Anaesthesiologists (ISA) National Headquarters!

I am happy to present to you the October issue of VAPOUR. As every issue, this issue brings to you glimpses of activities of our vibrant body, the ISA. This issue is based on the theme 'Ethics' and it features articles on various aspects of ethics related to our subject of Anaesthesiology. Traditionally, medical ethics have ruled almost all aspects of our professional lives; be it clinical practice including physician behaviour and decision-making or research. Ethics, professionalism and law are closely related.

The Hippocratic Oath, the Declaration of Geneva and the Declaration of Helsinki were instituted several years back. Today, medical ethics is evolving fast with the times. The developments in human rights have made a huge influence on medical ethics. It is said that the relationship between physicians, their patients and the society has undergone a lot of changes. Many people consider themselves as their primary health care providers (thanks to Google information!) and consider physicians as their instructors or consultants. The modern physicians are now accountable not only to their own selves, their colleagues and the Almighty, but also to the patients and third parties such as hospitals, licensing authorities and the courts of law. [1]

Nonetheless, medical ethics has acquired an amazing importance in the current times. It deserves a slot as a separate subject especially for undergraduates because it is said that basic ethics are taught in the family itself. The first step to this is already laid with the introduction of the Attitude, Ethics, Communication (AETCOM) module in the new Competency based medical education (CBME) curriculum that has been implemented for undergraduate medical education in our nation. The students are needed to acquire competencies related to doctor-patient relationship, cadaver as the first teacher, several issues in bioethics including patient care such as autonomy, decision-making, do not resuscitate and withdrawal of life support. [2] In the postgraduate curriculum, the student is expected to acquire competencies in the ethical and legal aspects of critical care, concept of informed consent and medico-legal aspects of anaesthesia. [3] All this goes to show that the teaching and learning of medical ethics is now receiving due attention.

Newer and more complex ethical issues and dilemmas are now coming up and these are related to patient communication, long working hours, institutional support in malpractice cases, rights of anaesthesiologists and many others. [4] More research on existing ethical problems in the field of Anaesthesiology and appropriate ethical approaches to these problems are needed. Studies and literature emanating from our nation on euthanasia, do-not-resuscitate, withdrawal/withholding treatment are currently limited.

I thank all the authors and my editorial team members who have contributed to this issue of VAPOUR which I am sure will spread the flame of 'research on ethics' in our members in the coming days.  
Adieu till we meet again with the November issue ...  
Long live ISA!

**Dr Sukhminder Jit Singh Bajwa**

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**'VAPOUR'**

(The official newsletter of the ISA National)

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# PROFESSIONALISM AND ETHICS IN ANAESTHESIA PRACTICE



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Roy Porter, a great medical historian penned in his book, “The Greatest Benefit of Mankind”, that the Hippocratic pledge foreshadowed the western conception of a profession as a morally self-regulating discipline committed to helping others, marked by the profession of an oath.[1]The term "profession" has been used since the Middle Ages to refer to a vocation that has many benefits granted by society in exchange for the duty to serve it. Therefore, the term "professionalism" refers to a set of attitudes, values, and behaviours that are expected of medical professionals. fundamentally based on the moral and ethical commitment to honesty, benevolence, cooperation, lifelong learning, and profound regard for other people. Being a professional means that a doctor must completely comprehend that the patient is the most significant person in the unique patient-doctor interaction. In order to do this, the doctor makes an effort to provide the finest care in line with the needs, values, and beliefs of the patient.

The physician's motivation to uphold the highest standards of care, partake in demanding continuing education, actively participate in medical organisations, and pursue clinical advances is greatly influenced by this patient-centredness. Three fundamental principles — the primacy of patient care, patient autonomy, and social justice—as well as ten professional obligations and commitments—professional competence, candor in patient interactions, patient confidentiality preservation, appropriate patient relations, improving care quality and accessibility, distributive justice in relation to resource allocation, scientific knowledge, upholding trust through disclosure of conflicts of interest, and professional responsibilities—are included in a joint Euro-American Physician Charter on Medical Professionalism. [2]

Freeman and Berger address the four fundamental elements of professionalism: humanism (proper doctor-patient relationship); responsibility (priority of patient interests); ethics (integrity, honesty, highest moral standards); and physical and mental well-being of physicians. [3] A commitment to quality, excellence, and selflessness beyond an eight-hour workday is the foundation of professionalism, which is driven by a desire to accomplish goals that are more fulfilling than short-term financial gain. Real respect for patients and other professionals, as well as a strong foundation of education, experience, and skill, are essential components of professionalism.[4]

Establishing and overseeing Continued professional development (CPD) training, and care standards, as well as putting in place procedures to look into and make decisions when professionals become incapacitated, standards aren't met, unfavourable things happen, and corrective action is needed, are additional professional obligations. This task should also be performed by hospital departments and practice groups, nevertheless on a different scale than that of South African Society of Anaesthesiologists (SASA) and the College of Anaesthetists. Furthermore, it is paramount that all professionals should ultimately serve as their own judges.

The practice of Anaesthesiology is governed by practice guidelines, ethical rules, and legislation that establish professional standards and obligations. The National Patients' Rights Charter (2008), [5] the chapters 2/6 and 2/7 of the National Health Act pertaining to informed consent,[6] the various practice guidelines and ethical rules issued by the Health Professions Council of SA (HPCSA)[7] and the SASA are among the guidelines that anaesthesiologists should be familiar with. We are required to abide by these professional rules and obligations since they are significant in real-world situations.

Ethics is the study of what is morally acceptable and unacceptable in the trading of ideas, as well as what is best for individuals and society across the board. It is sufficient to say that social norms regarding ethics are dynamic, susceptible to evolving externalities, and heavily shaped by native social, cultural, and economic factors.

Nonetheless, in order to guarantee ethical practice, the medical profession continues to be subject to stringent legal constraints as well as ethical standards, identical to the legal profession. The American Medical Association (AMA), for instance, mandates that its members abide by the AMA Principles of Medical Ethics in addition to other particular ethical standards.

Ethics and rules established by the Indian Medical Council Act of 1956 govern the conduct of a registered medical graduate. Therefore, rules under the Indian Medical Council Act, particularly the Professional, Etiquette & Ethics Regulations 2002 and its later amendments, must be implemented by qualified physicians. [8]A set of guidelines for the moral practice of anesthesiology were issued by the American Society of Anesthesiologists (ASA) and appraised in 2018. [9] Comparable recommendations for moral behaviour have also been made by the Indian Society of Anaesthesiologists (ISA). [10]

## **Fundamental Principle of Medical Ethics [11]**

### **Non-maleficence:**

**Autonomy:** Do not harm your patients

Coercion is unethical considering the patient is an autonomous being capable of arriving at fully informed decisions regarding their own health care.

### **Justice:**

When providing their services to surgical patients, anaesthesiologists ought to treat them fairly.

**Beneficence:**

Although the concept of beneficence requires medical professionals to constantly act in the best interests of their patients, the tenet of non-maleficence is centered on the principle of "do no harm."

In the unique field of Anaesthesiology, patients are largely unaware of the anaesthesiologist's existence or "behind the curtain" work. Using equipment and machines to provide care for patients is expected while giving anaesthesia. These elements could lead to an ethical conundrum and the marginalisation of patient care. A substantial amount of research demonstrates that not enough has been done to integrate ethical value education into the teaching and learning process in this field.

For greater clarity, ethical issues in Anaesthesiology can be divided into three categories: preoperative, intraoperative, and postoperative.

Effective communication is essential to building a positive rapport and comfort level between the anaesthetist and the patient, as they are typically less acquainted.

**Preoperative Concerns [12]**

The precise amount of information that anaesthesiologists should impart to patients regarding the anaesthetic procedure in order to obtain the patient's "Informed Consent" It frequently happens that the surgeon disapproves of the anaesthetist fully disclosing to the patients all the risks associated with both the surgery and anaesthesia out of concern that the patient might decide not to proceed. A patient may occasionally be posted for an unnecessary surgery. The dilemma in both situations is for the anaesthetist to determine whether to present the patient's true opinion or to persuade oneself that it is not their role to counsel the surgeon.

**Perioperative Concerns**

In the operating room, anaesthesiologists should respect the patients' modesty and show empathy for their feelings. One of the main things that can lead to conflict is the surgeon's tendency to become the "captain of the ship." It is important for anaesthesiologists to act through diplomacy in order to prevent disputes during this time. It is important for anaesthesiologists to maintain their assertiveness and resist other professionals' dominance while providing patient care because their quiet, collected demeanor could be erring over docile.

**Postoperative Concerns**

As a perioperative physician, the anaesthesiologist has more duties during the postoperative phase until the patient has been discharged from the hospital. As inadequate pain relief is a prevalent shortcoming, an overworked anaesthesiologist may depend on the surgeon for postoperative pain relief, which can have ethical ramifications. An all-encompassing prior The principle of do not resuscitate (DNR)[13] may not always apply during anaesthesia. Certain aspects of anaesthetic care might necessitate the suspension of DNR orders during surgical procedures, but the exact nature of such an exception must be tailored to the individual patient and always discussed with them.

**Role of Consent in Ethics and Professionalism**

It is the right of every adult and sound mind to decide what should be done with their own bodies, and any surgeon who operates on a patient without getting their permission qualifies as an assault. Without patient's consent, a medical professional cannot examine, treat, or operate on them unless they commit infringing or an assault. "Cardozo, Benjamin"[14]

The legal term "informed written consent" refers to a patient's independent and informed permission to receive medical or surgical treatment. Proper communication between a doctor and patient regarding all pertinent details of a suggested treatment and any available alternative procedures is a necessary part of informed consent.

## Types of Consent

### Informed Written Consent

The autonomous, informed approval of a patient for undergoing medical or surgical treatment is referred to as "informed written consent" in legal terminology. Informed consent requires proper communication among the treating physician and patient regarding every pertinent detail about the suggested regimen of treatment and all potential alternatives.

### Substitute/Proxy Consent

When consent is given or obtained on behalf of a patient who is incapable of giving informed consent for medical treatment or refusing it, this is known as substitute consent. In the event of a minor, unconscious patient, patient under sedation or anaesthesia, intoxicated patient, emergency situation, or accidental case in which close relatives are not available, this form of consent is acceptable.

### Blanket Consent

It is standard procedure to ask a patient to sign a paper document at the time of the hospitalisation, offering permission for any kind of surgery or procedure without mentioning a specific course of treatment. Since this kind of general consent is illegal, it should be avoided.

### Can Consent be withdrawn?

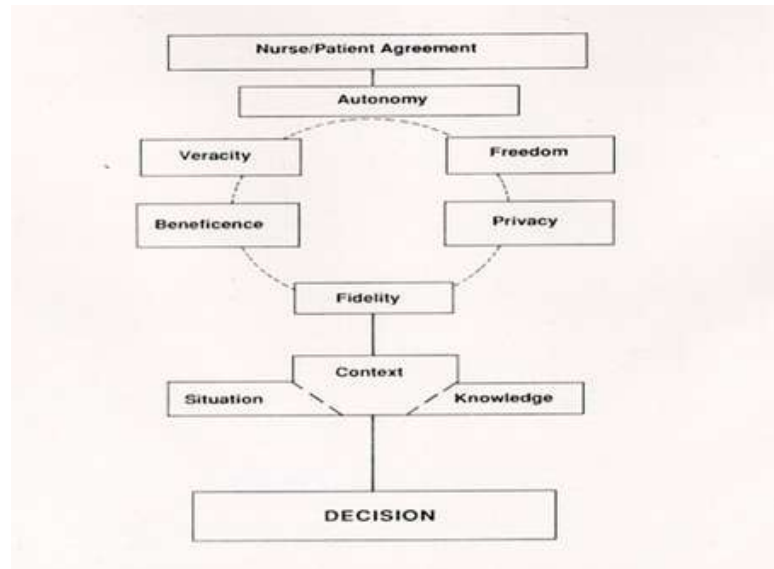
Yes, the patient possesses the right to revoke her consent at any point because it is a voluntary act. If a patient withdraws their consent, a medical professional is not allowed to treat them further.

## Changing Scope of Ethics Committees

Committees are expanding the scope of their activity to include organisational ethics, considering questions regarding:

- Finances
- Administration
- Organisation
- Human Resource

## Husted's Formal Ethical Decision-Making Model [15]



Husted GL, Husted J H. Ethical decision making in nursing. St. Louis (MO), Mosby year book;1991.pp.xi.

## Conclusion

Anaesthesiology became a profession after a remarkable confluence of concepts, occasions, personalities, and influences transformed it from a trade or craft. The creation of formal training programmes and academic departments, the growth of professional societies, and the start of accreditation procedures all contributed to the evolution of professionalism.

Ellison says it all in this quote, which I will end with:

*"The pursuit of something more fulfilling than short-term financial gain is the foundation of professionalism, which also calls for a dedication to excellence, quality, and selflessness that extends beyond an eight-hour workday."*

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# ETHICS IN RESUSCITATION



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The term “ethics” originated from the Greek word “ethos” which means ‘science of morals.’ Out of the many different ethical frameworks, two principles that are relevant to western medicine are utilitarian and deontological ethics.[1] In utilitarian ethics, actions are judged right or wrong based on the balance of their good or bad consequences. But in deontological (duty based) ethics, right intention is more important than the consequences. The clashes between these two ethics are common in resuscitation, critical care, end of life care and triage. But in any given situation, the moral principles should be our priority.

The moral principles described by Beauchamp and Childress are 1) Autonomy: the patient’s moral right to determine 2) Beneficence: for the benefit of the patient 3) Non-maleficence: avoiding harm 4) Justice: balance to first three principles. [2] In resuscitation, the urgency of

cardiopulmonary resuscitation (CPR) and the impaired competence of the patient makes it difficult to come to a conclusive decision. Whenever the treating physician is in doubt on whether to go in with Do Not Attempt Resuscitation(DNAR) or not, CPR should be performed as the default option.[3]

## **Ethics of ‘Doing resuscitation’**

In a study by Krishna CK et al with regards to out-of-hospital cardiac arrest resuscitation outcome in India, 67.5 % of patients did not achieve return of spontaneous circulation (ROSC) and were declared dead.[4] Out of the rest 32.5%, 23.7% patients expired eventually with only 8.8% patients surviving. 2.5% of patients were discharged in a vegetative state. From this, we note that there are three outcomes of resuscitation i.e. survival with good health, death or the comatose state which increases the burden on the family.

Here come the harms of resuscitation which may be unnecessary when the patient's family has limited resources to survive, unsuccessful resuscitation due to the patient's condition being too far advanced or without hope, unkind because of unhappy results, unwise if it is futile, unwanted if it is against the patient's wish. Considering the harms of resuscitation, we must respect the patient's autonomy (advanced directive or living will) and take prior appropriate informed consent.

The two most common forms of consent in resuscitation are presumed consent and proxy consent. Presumed consent uses the concept that a reasonable patient under similar circumstances would consent to resuscitation. Presumed consent using substituted professional judgement [5] and involves speaking to the patient's loved ones that how the patient would view the decision. However, proxy consent involves obtaining consent from surrogates like family member or another person on behalf of the patient. Proxy consent with substituted judgement involves what the proxy thinks the patient would want in such a condition.

### **Ethics behind 'Not doing resuscitation'**

Respecting the patient's autonomy "the rights to die with dignity", the honourable Supreme Court of India legalised passive euthanasia in the year 2018[6] by withdrawing life support or DNAR or DNR (Do Not Resuscitate). Recently in 2023, Supreme Court modified the guidelines to make DNAR more accessible as the attestation by first class judicial magistrate changed to a notary or gazetted officer.[7]

DNAR decisions are considered in three situations; [8] when patient with capacity refuses CPR or a patient without capacity has recorded a refusal to CPR in advance (by advance directives or living will) or when CPR is judged unlikely to be effective where the potential burden of CPR outweighs the benefits. In the latter case, where there is no advance

directive, the decision of DNAR will be taken by the primary medical board by discussing with the family physician if any and the patient's next kin/friend/guardian with intimation to the judicial magistrate first class (JMFC).

In 2020, the Indian Council for Medical Research (ICMR) expert group on DNAR proposed consensus guidelines [9] regarding the instructions, decision of taking DNAR and storage of DNAR forms. The hospitals can set up clinical ethics committee or multidisciplinary teams which can help guide the implementation of DNAR.

Systems, clinicians and the public should consider CPR as conditional therapy. Decision to withholding and termination of CPR should be taken considering the specific local legal, organisational and cultural context. Systems should define criteria for withholding and ensure that are validated locally including considering ineffective CPR (asystole despite 20 minutes of advanced life support), valid advance directives, unwitnessed cardiac arrest with initial non-shockable rhythm where the risk of harm likely outweighs the benefit e.g. absence of ROSC, severe chronic co-morbidity, very poor quality of life prior to cardiac arrest. Criteria that should not alone inform decision-making are pupil size, CPR duration, end tidal carbon dioxide (EtCO<sub>2</sub>) value, co-morbid state, initial lactate value and suicide attempt.[10] The clinician should clearly document the reasons for DNAR. It is recommended that a copy of the DNR form be attached to the patient's case records and it should be integrated with the electronic health records, if available. [9]

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# ETHICS IN ORGAN TRANSPLANTION



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The practice of medicine upholds the importance of ethics from time immemorial. The Hippocratic oath taken by all of us stresses the role of ethics in clinical practice. Ethical considerations play an important role in organ transplantation. Ethics in our practice is an awareness of rights of individuals, for people to be aware of certain rules about what is right and what is wrong and most importantly to have a balance between demand and supply in a logical way. The role of ethics is increasing with the growing numbers of organ transplantation being done globally and with the advent of newer technologies like artificial intelligence (AI) and xenotransplantation.

It is important to bifurcate ethical practices and legal considerations. Ethics in medical practice essentially comprises of four pillars, namely beneficence (doing good), non-maleficence (to do no harm), autonomy (giving the patient the freedom to choose freely, where they are able) and justice (ensuring fairness).

These parameters help in arriving at the best decision for an individual at a given circumstance. The World Health Organization (WHO) has laid out some guiding principles on human organ transplantation which have to be followed globally in order to maintain transparency. In India, the Transplantation of Human Organ (THO) act was passed in 1994 to monitor and streamline organ donation and transplantation activities. The act legalises brain death and sale of organs as illegal. With the acceptance of brain death now, along with kidney transplants, other solid organ transplants can be performed.

In organ transplantations, there are ethical concerns in donors and recipients as well. Furthermore, donors can be living or deceased and needless to say, they have their own sets of considerations and challenges.

In living donors, emphasis lies primarily on the motives of the donor. Altruistic motive of the donors, although cannot be assessed objectively and scientifically, is based on corroborative evidence. Despite this, sale of organs under the pretext of altruism is rampant in our country.

Living donation though safe, is a complex procedure and the responsibility not only lies with the patient requesting donation but also the clinical team performing the procedure. The clinical team must scrupulously apply selection criterion, must ensure follow-up and definite health in the donor. Donors must be aware of the consequences - informed and voluntary consent free of any undue influence or coercion. Gender bias in donation in India, especially spousal donation is very common. A special evaluation, specifically psychosocial evaluation, should be done when the wife is the donor.

The growth of organ transplantation worldwide warrants formation of guidelines that focus not just on quantity but on quality as well. Quality and the outcome measures do not mean graft and patient survival alone, but the transparency of ethics pertinent to the concurrent scenario. In 2008, the Transplantation Society and International society of nephrology convened at Istanbul and a declaration was made which was endorsed by 135 countries. This declaration upholds the ethics in transplantation by defining illegal and unethical organ transplantation. The aim was to prevent exploitation of the poor and powerless donor pool and to prevent organ trafficking. In 2010, the Madrid resolution was passed which formulated guidelines and protocols to face and overcome challenges in transplantation and to enhance accountability of various governments, thus ensuring organ availability

by increasing donor pool and preventing the need for transplantation. Ethics in a deceased donation programme involves the unbiased systematic allocation of organs based on a pre-approved scoring system. No organ should be wasted. There should be a uniform definition of death as there are different definitions according to THO Act and registrations of Birth and Death acts. Despite the existence of THO Act for almost three decades, it has neither reduced commercialisation of organ transplant nor has promoted deceased organ donation especially in India where majority of the population is economically backward and there is lack of application of stringent rules. With the advent of new technologies in regenerative medicine that incorporates cloning, stem cells and tissue engineering, understanding ethics in organ donation becomes prerequisite. Ethics plays an important role in organ transplantation which mandates the formation of governing bodies (transplant ethics committees) at central and state level which can monitor transparency in organ allocation and its surveillance. Redefining brain death and creating awareness to tap the large deceased donor pool can be a way forward to bridge the gap between demand and supply thus curbing illegal organ transplant.

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# ETHICS IN PAIN MANAGEMENT



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Pain management and palliative care play integral roles in enhancing the quality of life for individuals facing serious illness. As medical professionals strive to alleviate suffering, ethical considerations become paramount in guiding decisions related to treatment, medication and end-of life care.

The principles of medical ethics are

## 1. Autonomy and informed consent

Autonomy is the right of an individual to make a free and informed decision. Autonomy, in the context of medical practice, includes the patient's right to full information and to participate in medical decision-making. This includes the right to refuse interventions. But the individual can't insist a particular treatment. Respecting a patient's autonomy is fundamental. In pain management, this involves transparent communication about treatment options, potential risks and expected outcomes. Informed consent ensures that individuals are actively involved in decisions concerning their care.

## 2. Beneficence and Non-Maleficence

The principle of beneficence underscores the obligation to promote well-being. Balancing this with non-maleficence, or the duty to do no harm, requires careful consideration of treatment plans. Striking the right balance ensures that pain is adequately managed without causing undue side-effects.

## 3. Justice

Ensuring fairness in resource allocation is crucial in palliative care. Limited access to certain medications or therapies may raise ethical concerns. Equal distribution of resources is a challenge and healthcare providers need to address it to uphold ethical standards.

Beneficence and non-maleficence do not overweigh autonomy. A patient who is conscious cannot be taken to the intensive

care unit(ICU), even when done in good faith for treatment, against his wishes. Here comes the importance of advance directives. Advance directives in end-of-life care are legal documents that outline a person's preferences for medical treatment if they become unable to communicate. They provide guidance on issues like life support, organ donation and pain management, ensuring that individuals retain control over their healthcare decisions even when they can no longer express them. These directives offer peace of mind and help healthcare providers honour patients' wishes during critical moments during their end-of-life journey.

Advance directives include living wills or health care proxies and they become operational only after the person loses capacity.[1] Advance directive is very useful in preventing futile or inappropriate treatment and the associated suffering and indignity when one's life comes to close.

Then what is an appropriate treatment or what is the duty of a doctor? According to the Indian Council of Medical Research (ICMR), the duty of a healthcare provider is to mitigate suffering, to cure sometimes, to relieve often and to comfort always and there are no exceptions to this. No medical ethics forces you to stretch out the dying process. In cases where the patient is terminally ill and undergoing prolonged treatment in respect of an ailment which is incurable or where there is no hope of being cured, the physician may inform the hospital which, in turn, shall constitute a Hospital Medical Board and discuss with the family physician and the family members and record the minutes of the discussion in writing. During the discussion, the family members shall be appraised of the pros and cons of withdrawal or refusal of further medical treatment to the patient and if they give consent in writing, then the Hospital Medical Board may certify the course of action to be taken. Their decision will be regarded as a preliminary opinion.

The ethical dilemma surrounding opioid use is significant. While opioids are powerful pain relievers, concerns about addiction and misuse raise questions about the appropriate balance between pain relief and potential harm. Stricter regulations and monitoring systems are ethical measures to mitigate these risks. Understanding and respecting diverse cultural perspectives on pain and end-of-life care is essential. Cultural competence in healthcare ensures that ethical decisions are rooted in an appreciation for the individual's values and beliefs.[2]

Palliative care often involves navigating complex decisions about withdrawing or withholding treatment. Ethical considerations in these situations revolve around the patient's wishes, the principle of dignity and providing compassionate support to both patients and their families. [3] Euthanasia is an active process. Euthanasia is the intentional act of killing a dying patient with terminal illness by the direct intervention of a doctor, for the purpose of good of the patient. However, allowing natural death, withholding and withdrawing of life-sustaining treatment to limit harm and suffering in a dying patient should not be construed as euthanasia. Thus, ethically and legally we can withhold or withdraw life-sustaining treatment and provide good quality care and palliation of symptoms.

#### **4. Communication and Honesty**

Maintaining open and honest communication is an ethical imperative. Discussing prognosis, treatment options and potential outcomes fosters trust between healthcare providers, patients and their families. It allows for shared decision-making based on realistic expectations. A collaborative approach involving healthcare professionals, social workers, spiritual counselors and ethicists is essential. This interdisciplinary collaboration ensures that ethical considerations are holistic and encompass the diverse needs of the patient.

In the realm of pain management and palliative care, ethical decision-making is a continuous process that requires a delicate balance between compassion and responsibility. Upholding the principles of autonomy, beneficence, non-maleficence and justice ensures that individuals facing serious illnesses receive care that is not only effective but also aligned with their values and preferences. As the field evolves, an ongoing commitment to ethical reflection and adaptation is crucial to meet the complex challenges of compassionate end-of-life care.

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# HENNING RUBEN: AN INSPIRING BIOGRAPHY

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ISA No. S0468



**Figure 1: Ruben the dance master excellence**

Henning Ruben was born on 20th July 1914 at Copenhagen, the eldest son of an orthodox Jewish family. At age 19 he entered the Royal Dental College in Copenhagen. As a professional dancer and dance teacher (the tango was reputedly his specialty) he toured the halls of Denmark with a well-known singer to earn some extra money as a student (Figures 1, 2).

An accomplished athlete, he represented his country at fencing and was a member of the Danish team that won a bronze medal at the World Championships in Monte Carlo, Monaco in 1939. [1]

Ruben Henning was also a brilliant illusionist and thought reader who was elected a member of the exclusive Danish “Magisk Cirkel”.



**Figure 2: Ruben the inventor par**

This talent was to stand him in good stead later in the crucial years after World War II. Ruben qualified in dentistry in 1938 and started a general dental practice in Copenhagen. He wanted to study medicine as well, and enrolled in the University of Copenhagen Medical School. In 1943, however, when Denmark was occupied by the Nazi regime, his partisan activities required him to leave the country very urgently one night in a fishing boat bound for neutral Sweden. As a refugee in Sweden for nearly 2 years, he continued to work as a dentist, and a magician and thought reader in some of the bigger restaurants.

Returning home to Denmark at the end of the war, he graduated in medicine in 1946, and decided to become an anaesthesiologist.

At that time, anaesthesia was an undeveloped speciality in Denmark but considerably more advanced in Sweden. Ruben desired to study in Sweden but travel and foreign money exchange were a major problem. It was his talents as a magician that came to his rescue and he was able to visit Sweden as an invited guest of the Swedish Society of Illusionists at one of their special performances at the Stockholm Concert Hall. During this visit, he introduced himself to the prominent anaesthetists at Sabbatsberg and St Erick's Hospital. On their recommendation, he was appointed in 1948 to the celebrated Serafimerlasarattat hospital in Stockholm as a neuroanaesthetist. This enabled him to visit leading centres of anaesthesia in the United Kingdom, including Oxford and Liverpool. [2,3]

On his return to Copenhagen in 1949, he was appointed as an anaesthetist at the Gentofte Hospital and the Finsen Institute where he began a programme of research and invention that have an enduring effect on the practice of anaesthesia and resuscitation.

In 1951, he went on deputation to the Department of Anaesthesiology at the University of Iowa to work with the renowned Lucien Morris, inventor of the 'copper kettle' vaporiser. He also met the legendary James Otis Elam and established their collaboration.

In 1953, Ruben was appointed head of department at the Finsen Institute where he developed a lightweight, foot-operated suction apparatus that caught the attention of Dr Holger Hesse, founder of Ambu-Testa, who marketed this device worldwide.

In 1954, Ruben invented a simple automatic constant-rate syringe pump driven by a wind-up alarm clock.

In 1955, he was promoted as Professor of Anaesthesia at the University of Copenhagen. [4]

Ruben then collaborated with a watchmaker to fabricate a unidirectional non- rebreathing valve that had a bobbin moving against a spring. During inspiration or when the bag was squeezed, the spring-loaded bobbin occluded the expiratory limb allowing gas flow to the patient and on expiration, closed the inspiratory limb so that gas could be vented out. It was a low resistance contraption with minimal apparatus dead space. The resuscitation version of the Ruben's valve had no expiratory outlet so that during spontaneous respiration, the patient was able to breathe in atmospheric air. Later editions of the valve substituted the springs and valve discs with silicone membranes and enclosed in a transparent plastic casing and came to be known as the Ambu E valve (Figure 3).



**Figure 3: The Ambu E valve**

A strike by Danish truck drivers the same year led to a shortage of oxygen cylinders. Ruben got a mechanic to weld together four bicycle wheel spokes and inserted the assembly into an anaesthesia bag. When the bag was squeezed, the spokes regained their original shape making it self-inflating. Linked to his non-rebreathing valve and a valved inlet, the assembly enabled manual ventilation without oxygen or power supply. Later versions had a foam filled bag. In 1964, the American Medical Association declared this invention the most significant medical advance in anaesthesia since the past 25 years (Figure 4).

In 1957, training in resuscitation (mouth to mouth) became mandatory in Scandinavian medical schools. Ruben worked to construct

the first manikin, the Ambu Man, for skills training. It had a plaster head and permitted lung inflation only when forward movement of the jaw and backward tilt of the head was accomplished. This manikin proved very popular and in great demand. It was even demonstrated at an international NATO meeting in Copenhagen in 1958.



Figure 4: The Ambu bag RESUSCITATOT

The same year, Ruben joined Elam at Buffalo, New York where he was Professor and Chairman at the Roswell Park Memorial Institute to display his creation. Elam was convinced of its essential teaching value and he accompanied Ruben to a number of cities in the United States to demonstrate it, including the Walter Reed Hospital in Washington. The manikin was modified the next year to protect against cross infection and in 1960 had further mechanisms added for the training of closed chest compressions.[5]

In 1958, Ruben introduced the novel idea of occluding the oesophagus with a blocked inflated tracheal tube to prevent gastric insufflation during ventilation

In 1959, Ruben published his landmark paper titled 'Rescue breathing. A modification' in The Lancet and JAMA, describing his head tilt chin lift manoeuvre to open the airway during resuscitation. He later published X-rays of anaesthetised patients to prove the utility of the technique.[6]

Ruben also advocated for nasal-mouth resuscitation instead of mouth-to-mouth

resuscitation citing that the latter method had higher risk for gastric inflation; this became the norm for practice in Denmark and Central Europe over the next few decades. [7]

Ruben was awarded the Knight of the Order of Dannebrog in 1973. He delivered the prestigious Husfeldt lecture in 1977 and was elected honorary Fellow of the Faculty of Anaesthetists of the Royal College of Surgeons in Ireland and England respectively. He was Chairman of the Danish Association of Anaesthesiology from 1963 to 1965 and member of the European Resuscitation Council in 1994 and the European Society of Intensive Care Medicine in 1997. Ruben died on 04th December 2004 in Copenhagen, Denmark.

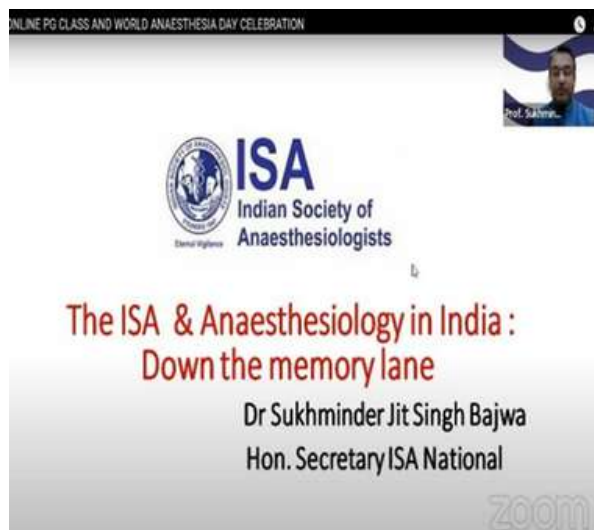
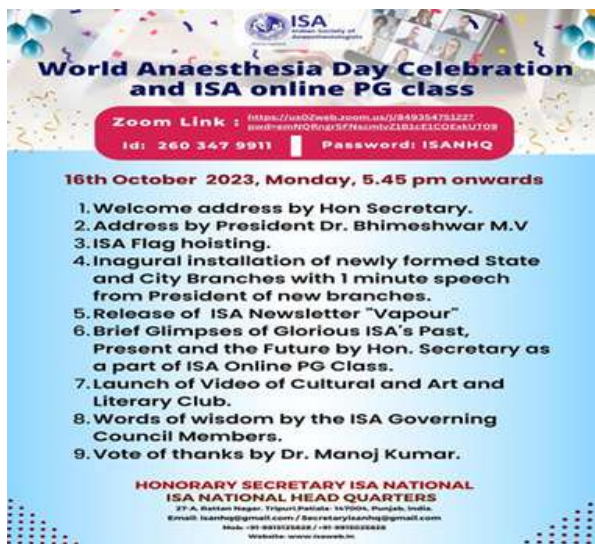
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# WORLD ANAESTHESIA DAY CELEBRATION BY ISA NATIONAL

On October 16, 2023, ISA conducted its online postgraduate (PG) Class and also celebrated the 'World Anaesthesia Day' with its members. ISA President Dr. MV Bhimeshwar and Hon. Secretary Dr. SS Bajwa delivered the welcoming addresses to kick off the show. It was followed by the ISA Flag hoisting. The programme had some remarkable announcements that included the formal inauguration of the newly formed state and city branches and brief speeches by the President/Secretary of the newly formed branches. It was followed by the release of the latest issue (September) of the ISA newsletter, 'Vapour' on the theme 'Opioids' that witnessed the contributions by various anaesthesiologists across the country including editorial board members. Thereafter, as a part of the online PG Class, the Hon. Secretary Dr. Bajwa gave a superlative summary of the ISA's illustrious history, as well as its accomplishments and contributions from the organization's inception to the present. The various academic programs and co-curricular activities conducted by ISA, the roles and activities of its different clubs, upgradation of the official journal 'IJA', the various awards under the ISA banner and the future vision of the society were also highlighted. The videos of the cultural and art & literary clubs created by the various talented anaesthesiologists across the country were also released on this grand occasion. Prior to conclusion, the Governing Council members of ISA shared their experiences and words of wisdom. The other anaesthesiologists also took the opportunity to share their views and opinions on this occasion. The treasurer of ISA, Dr. Manoj Kumar concluded the programme by delivering the vote of thanks.

**Long Live ISA!**





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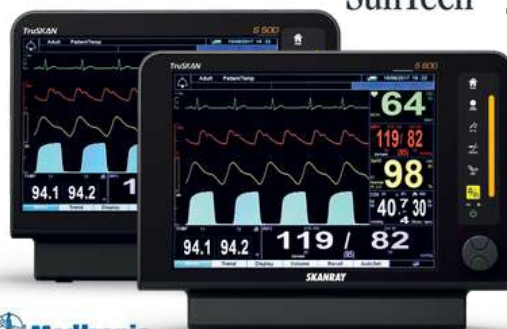


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# Ethics in Research work and Publications:

## A message to postgraduate students



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Research occupies an integral part of the postgraduate (PG) curriculum. As a PG student, one has to carry out work on an assigned research project under the guidance of the designated PG teacher (guide) within a stipulated period and present the results of the research in the form of a thesis. The aim of making the students do this research work is to ignite the flame of scientific enquiry in them, to expose them to research methodology and to make them develop the art of critical analysis of scientific literature.

Nevertheless, one needs to conduct true and robust research. A novel hypothesis, a good study design, appropriate and accurate statistical tests and meticulously collected data can contribute to a good study. It is often observed that the students are full of enthusiasm when the synopsis of the proposed

study is presented, but this enthusiasm diminishes once the data collection starts. Violation of protocols submitted to the ethics committee and the Clinical Trials Registry-India (CTRI), failure of the blinding process in randomised controlled trials, duplication of data, falsification and fabrication of data sometimes come into the fray. The results of such a study thus lose their authenticity and value. It is said that most of the research work done as a part of thesis work culminates in publication. The research papers and the articles that are sent for publication based on such kind of research are never appreciated and get rejected. Most standard journals, nowadays, ask for the 'raw data' during the peer review process and even after publication, the de-identified data may be requested to be shared by the authors.

Nonetheless, the ethics of publication need to be followed. Plagiarism is the biggest villain in the publication system. It means copying of text from someone else's work and concepts without citing the references of the original authors. Copying data or figures without taking permission of the original author/publisher (copyright infringement) also falls under plagiarism. Most commonly, plagiarism occurs due to author ignorance. There is software available to check plagiarism eg- PlagScan, iThenticate, Turnitin. This can be used to avoid plagiarism in the thesis and publications.

Furthermore, to become an author, one has to fulfill certain criteria such as substantial contribution towards conception or design of the work, or the acquisition, interpretation of data or writing of the manuscript. Mere friendship or pressure from peers or seniors that leads to gifting of authorship eg-'I put your name as author in my article; you put mine in yours' is not correct.

Ghost authorship includes entailing a significant contribution to a manuscript without acknowledgment of that contribution. The falsification and fabrication of data are other forms of scientific misconduct. These forms of scientific misconduct are on upswing nowadays. [1,2]

Whatever the circumstances, one should never forget the ethics of research and publications. True and good quality research is always warranted and it will always find its way in good quality scientific forums. True research will always remain etched on the sands of time.

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# CROSSWORD ON ETHICS

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**Professor**

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**HIMS, SRHU, Dehradun**

**ISA no. P1190**

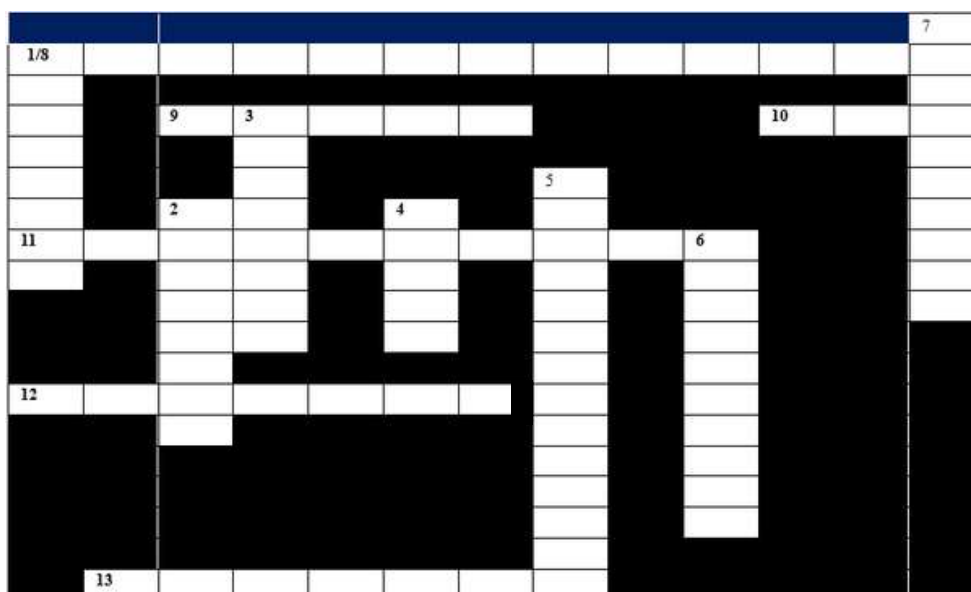


## Down:

1. Which act in 2019 repealed the former Act of 1986 and deals with remedies in cases of disputes qua deficiency of goods/services. (8)
2. Situation's where a person is morally obligated to do two different actions but is unable to do both. (7)
3. Medical Council of India has published a separate section on ..... guidelines. (7)
4. A consent which is taken or obtained on behalf of a patient who is not competent. (5)
5. A Doctrine of 'do no harm' to one's patients. (14)
6. American College of Physicians Ethics Manual states that "Physicians are morally as well as legally accountable and the two may not be ..... " (10)
7. Edmund ..... philosophy of Bioethics states that "ethics is an eminently practical discipline [that] deals with concrete judgments in situations in which action must be taken despite uncertainty." (10)

## Across:

8. The informed consent must be ..... with respect to the patient (13)
9. .... volant, scripta manent means that you cannot trust spoken words, if something is important you need to have a written text. (5)
10. Abbreviation for an effective tool in teaching ethical value education to students. (3)
11. Clinical Establishment (CE) Act and Rules (2012) mandate all clinical establishments to maintain or provide records in what format? (10)
12. .... consent is taken for any type of procedure or surgery without specifying any treatment .(7)
13. Ethics which states that anaesthesiologist should be fair when providing their services to patients. (7)



## SOLUTIONS

### Down:

1. Which act in 2019 repealed the former Act of 1986 and deals with remedies in cases of disputes qua deficiency of goods/services. (8) CONSUMER
2. Situations where a person is morally obligated to do two different actions but is unable to do both. (8) DILEMMAS
3. Medical Council of India has published a separate section on ..... guidelines. (7) ETHICAL
4. A consent which is taken or obtained on behalf of a patient who is not competent. (5) PROXY
5. A Doctrine of 'do no harm' to one's patients. (14) NONMALEFICENCE
6. American College of Physicians Ethics Manual states that "Physicians are morally as well as legally accountable and the two may not be .....". (10) CONCORDANT
7. Edmund ..... philosophy of Bioethics states that "ethics is an eminently practical discipline [that] deals with concrete judgments in situations in which action must be taken despite uncertainty." (10) PELLEGRINO

### Across:

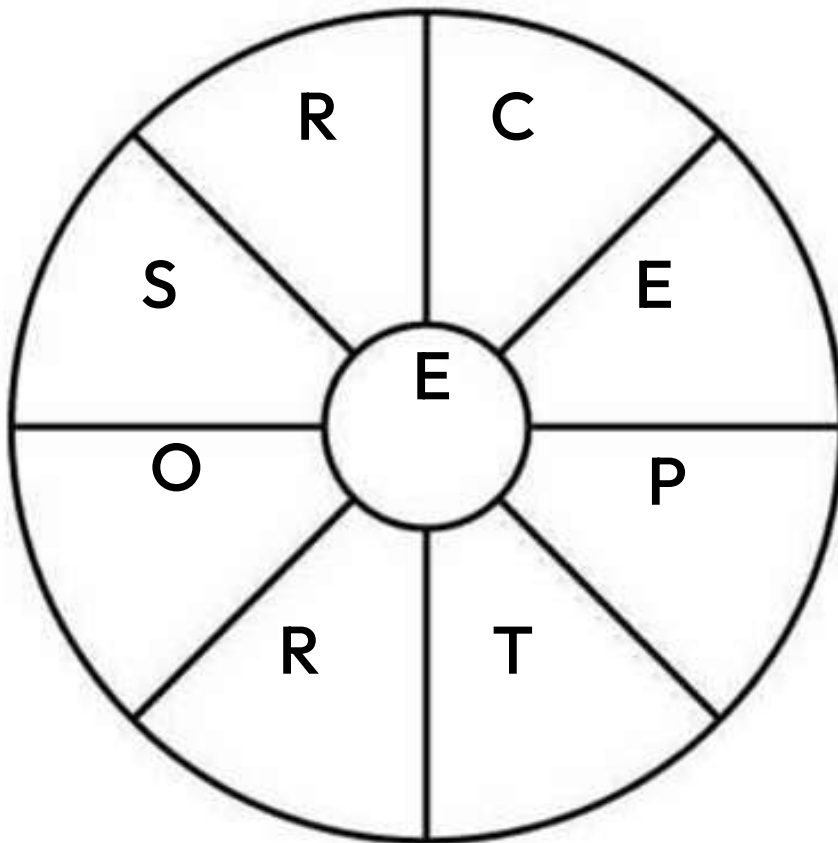
8. The informed consent must be ..... with respect to the patient (13) COMPREHENSIVE
9. .... volant, scripta manent means that you cannot trust spoken words, if something is important you need to have a written text. (5) VERBA
10. Abbreviation for an effective tool in teaching ethical value education to students. (3) PBL - PROBLEM BASED LEARNING
11. Clinical Establishment (CE) Act and Rules (2012) mandate all clinical establishments to maintain or provide records in what format? (10) ELECTRONIC
12. .... consent is taken for any type of procedure or surgery without specifying any treatment. (7) BLANKET
13. Ethics which states that anaesthesiologist should be fair when providing their services to patients. (7) JUSTICE

|                  |                 |                |                |   |                |   |                |   |                |                 |   |                |
|------------------|-----------------|----------------|----------------|---|----------------|---|----------------|---|----------------|-----------------|---|----------------|
|                  |                 |                |                |   |                |   |                |   |                |                 |   | P <sup>7</sup> |
| C <sup>1/8</sup> | O               | M              | P              | R | E              | H | E              | N | S              | I               | V | E              |
| O                |                 |                |                |   |                |   |                |   |                |                 |   | L              |
| N                |                 | V <sup>9</sup> | E <sup>3</sup> | R | B              | A |                |   |                | P <sup>10</sup> | B | L              |
| S                |                 |                | T              |   |                |   |                |   |                |                 |   | E              |
| U                |                 |                | H              |   |                |   | N <sup>5</sup> |   |                |                 |   | G              |
| M                |                 | D <sup>2</sup> | I              |   | P <sup>4</sup> |   | O              |   |                |                 |   | R              |
| E <sup>11</sup>  | L               | I              | C              | T | R              | O | N              | I | C <sup>6</sup> |                 |   | I              |
| R                |                 | L              | A              |   | O              |   | M              |   | O              |                 |   | N              |
|                  |                 | E              | L              |   | X              |   | A              |   | N              |                 |   | O              |
|                  |                 | M              |                |   | Y              |   | L              |   | C              |                 |   |                |
|                  |                 | M              |                |   |                |   | E              |   | O              |                 |   |                |
| B <sup>12</sup>  | L               | A              | N              | K | E              | T | F              |   | R              |                 |   |                |
|                  |                 | S              |                |   |                |   | I              |   | D              |                 |   |                |
|                  |                 |                |                |   |                |   | C              |   | A              |                 |   |                |
|                  |                 |                |                |   |                |   | E              |   | N              |                 |   |                |
|                  |                 |                |                |   |                |   | N              |   | T              |                 |   |                |
|                  |                 |                |                |   |                |   | C              |   |                |                 |   |                |
|                  | J <sup>13</sup> | U              | S              | T | I              | C | E              |   |                |                 |   |                |

# SPIN THE WORD WHEEL

(SEPTEMBER ISSUE)

**Dr. PARUL JINDAL**  
PROFESSOR,  
DEPT OF ANAESTHESIA,  
HIMS, SRHU, DEHRADUN



The centre Letter has to be used in all the words.  
Only 6 to 9 letters words are acceptable

## INTERPRETATION

>20 words ... Pain-free

15-25 Mild pain

12-18 Moderate pain

# ANSWERS TO SPIN THE WORD WHEEL (SEPTEMBER ISSUE)

## WORD: RECEPTORS

- 9 LETTER WORD: RECEPTORS
- 8 LETTER WORDS: erectors, prescore, prestore, receptor, secretor
- 7 LETTER WORDS: copters, erector, porrect, porters, presort, prester, pretors, prosect, receipts, rectors, reports, reposer, rescore, respect, restore, scepter, sceptre, specter, spectre, sporter
- 6 LETTER WORDS; certes, copers, copter, corers, corpse, corset, coster, creeps, crepes, crores, erects, perter, pester, peters, porter, poster, preset, presto, pretor, proser, receipt, rector, rectos, report, repose, resect, resort, respot, rester, retore, retros, ropers, roster, scorer, secret, sector, sorter, stereo, storer, terces, terser, topees, topers, tropes

# Ethical Concerns and Duties of an Anaesthesiologist

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**Assistant Professor**

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**All India Institute Of Medical Science (AIIMS)**

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**ISA No: N-1314**



“...I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice....”. Hippocrates of Kos (460-370 BC) Ethics is defined as a set of knowledge derived while studying the human behaviour in an attempt to explain the moral rules in a more rational, scientific and theoretical way.[1] Under the umbrella of ethical considerations, medical personnel are required to abide by certain codes of conduct based on the four fundamental principles of beneficence, nonmaleficence, autonomy and justice.[2] Ever since its inception, anaesthesiology has seen tremendous growth with increased subspecialties like critical care, pain management and transplant anaesthesia mushrooming under its cover. These subspecialties have dealt with greater involvement in patient healthcare revolving around social, legal, medical and ethical dimensions of healthcare system. Therefore, it becomes imperative to formulate certain codes of conduct in anaesthesia with an intent of safeguarding the rights of patients as well as of the physician involved in their healthcare

In the light of the aforementioned concerns, Indian Society of Anaesthesiologists (ISA) has laid down certain guidelines for ethical conduct by anaesthesiologists during the anaesthesia care of patients which should be followed by all practising anaesthesiologists across the country. [3] These include:

1. Pre-anaesthetic check-up (PAC) is mandatory for any patient undergoing surgery under anaesthesia. It not only helps in building rapport with the patient's and their relatives but also helps in allaying their anxiety regarding the anaesthesia and postoperative period. Proper documentation at the time of PAC plays a major role in successful anaesthetic outcome of many patients. It is also an important document which can be tested in the court of law in medicolegal cases.
2. Ensure that the patient is optimised before elective surgery, the requisite investigations be done and well documented in the PAC records.
3. Proper informed written consent should be taken for anaesthesia after explaining the possible risks and complications.
4. Anaesthesiologist should be actively involved in patient care and management. There is no substitute to vigilant perioperative monitoring.
5. Anaesthesiologist should escort the patient to the post-anaesthesia care unit or intensive care unit and should ensure that proper handover of the particular case be given to the nursing officer in charge for the particular patient.

## **Various Duties of an Anaesthesiologist [4]**

i. Towards the patients:

The anaesthesiologist should respect the doctor-patient relationship and the medical

decisions should be taken in the best interest of the patient. The patients should be involved in the decision-making after carefully explaining the involved risks and benefits. If the patient is not in the capacity to take his/her decision due to age or medical condition, the guardians should be made a part of the decision-making process. Also, the patients are vulnerable under the influence of anaesthesia and it is our responsibility to take care of their dignity and to protect them against any physical misconduct during this period. At all times, patient information and identity should be concealed and patients' consent should be taken before using their medical information for academic and/or research purposes. The patient should be informed regarding the participation of training-physicians and other paramedical staff in their anaesthesia care.

**ii. Towards fellow colleagues:**

Anaesthesiologists should be cooperative and have mutual respect for colleagues from other specialities. In case of a medical emergency, they should help other specialities by prompt action and should have keen interest directed towards improving the quality of patient care. They should not be involved in any financial return from other colleagues which is likely to jeopardise the standard care of the patient.

**iii. Towards work place:**

Anaesthesiologists should be involved in improving the health care by participating in different institutional committees targeted at uplifting the standard of patient care. Periodic survey and audits are helpful in finding the lacunae in the existing system. The institute can work on these shortcomings to improve the healthcare services. Also, it is the shared responsibility of the anaesthesiologist to monitor and ensure proper dispensing of anaesthetic drugs with the potential of being misused or illegally used for non-clinical purposes.

**iv. Towards oneself:**

Anaesthesiologists should remain updated regarding the latest advancements in the speciality which can aid in better patient management. They should strive towards refining their clinical skills and judgement. They should maintain a balance between mental,

physical and emotional health as this can impair their technical skills and decision-making.

**v. Towards the community**

Anaesthesiologists should not be engaged in unethical research practices. They should change their working practices such that it causes minimal damage to the environment.

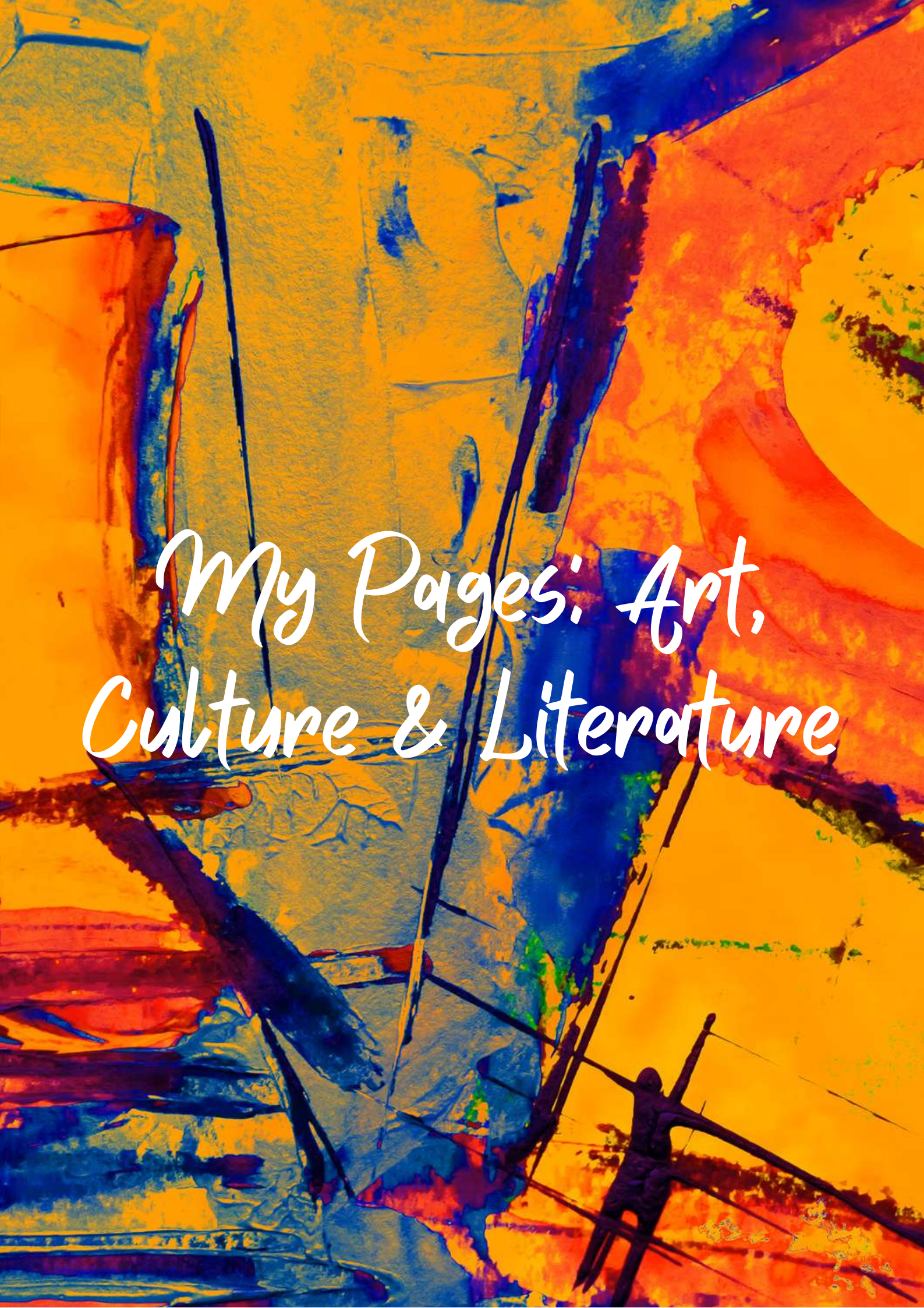
**Teaching ethics to anaesthesia postgraduates**

Ethical education forms an essential component in professional development of anaesthesia postgraduate students. Traditionally these codes of conduct were learnt by observing the senior faculties. However, the growing importance of these aspects in the present world has drawn considerable attention of the respective medical fraternities. Problem-based learning is an interesting tool to teach ethical value education to the students. It has been used in the past to help the student understand these concepts on the basis of different clinical scenarios. Simulation-based teaching is the latest addition to the wide array of teaching methodologies. It has been successfully used for teaching crisis resource management. It is now being used as a relatively newer modality for teaching ethical education to the students in real-time simulated scenario.[5]

Ethics form the fundamental framework for the growth and development of any system. It is essential that these codes of conduct are religiously practised for smooth running of the system. Therefore, all anaesthesiologists should practise the ethical guidelines with the aim of improved patient safety and health care system.

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# *My Pages: Art, Culture & Literature*

# Madhubhani Art

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Dehradun

## “Ethics in anaesthesia with a twist of Madhubani”



# A TRYST WITH DR. GANESH CHOUDHARI

Consultant anaesthesiologist at Shri Markendey Solapur Sahakari  
Rugnalaya, Solapur

Has a Facebook cartoon page named 'Laughing Dose' with more  
than 1,17,000 followers, mostly doctors. Has published a book and  
launched an app on android by the name 'Laughing Dose'.

(ISA No. G 1089)



Hello Dr. Ganesh!

You are a renowned cartoonist medico and have a brand of your own. Malaysian medical school and Abbott India limited have purchased your cartoon pics. It would be interesting to know how you find humour in this profession of anaesthesiology which one considers to be the most serious, tense profession dealing with life-and-death.

1) How did you develop this hobby?

I loved drawing ever since childhood. During my school days, I received around 50 awards in many different drawing competitions. In fact, for a long time I was confused whether I wanted to become a doctor or pursue architecture. Finally, life made me realise that medicine was my chosen career and drawing was my beloved hobby.

2) Since when are you drawing cartoons?

I joined MBBS at Seth GSMC & KEMH, Mumbai. During my second year at the college in 2003, I started drawing cartoons for our college events. I was posting it on WPM board. College events like student sleeping during community medicine lecture, boys 'bird watching' and dog entering library were few of the topics. Mobiles were just introduced during that time and I drew inspiration from how mobile ringtones were disturbing library study hours. Also, I drew a popular cartoon of the whole college including all departments which was released in the college magazine. This all took place when social media was not yet born.

3) Which theme do you usually like to draw?

There is no specific theme I like. I love to draw on current events. I also like themes which make fun of surgeons.

4) Did you undergo any formal training?

During MBBS, I was drawing using my hands but after finishing my postgraduation in anaesthesia I joined an animation course. There I learned more about Photoshop. All the cartoons you see now are drawn on Photoshop. It is really an easy one as once I draw an anaesthesia workstation, there is no longer a need to draw it again and again. Just copy it and paste.

5) How did you get this idea of depicting the current medical scenario in the form of cartoons?

I had seen a few cartoons on doctors / surgeons on internet. Hence I thought I can picturise the operation theatre (OT) scene precisely. So I gave it a try and posted it on Facebook. The response received was immense and it inspired me to draw more.

6) Which are your favourite characters for drawing cartoons?

An angry surgeon and an anaesthesiologist enjoying the mobile phone.

7) How much time do you devote for your passion?

Whenever I get time. Drawing one cartoon usually takes me one to two hours.

8) Which is your favourite cartoon picture till date?

Evolution of anaesthesia.

9) How many drawings have you made till now? Have you considered compiling them and publishing a book?

Around 500 till date. All are available on the Facebook page named 'Laughing Doses'. I have also published a book named 'Laughing Doses' in 2015.

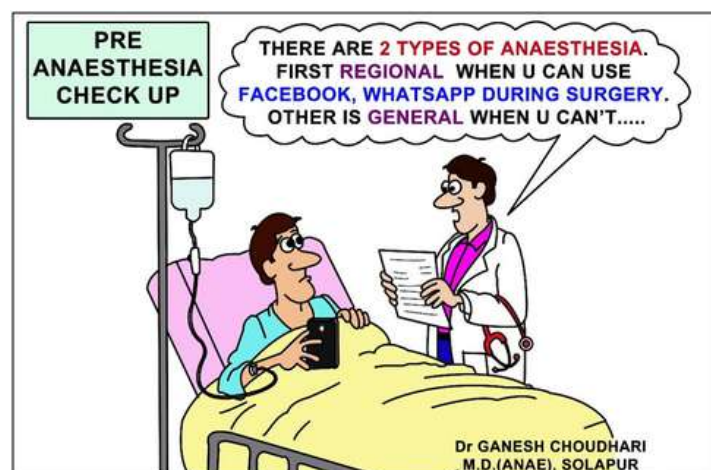
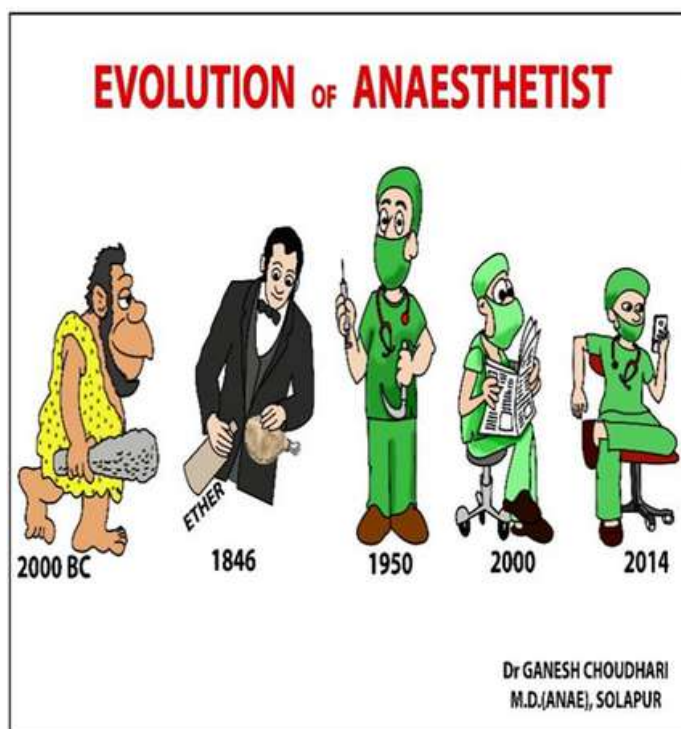
10) Is there any real-life character who has inspired you to draw cartoons?

Yes. My surgeons, obstetrician gynaecologist and orthopaedic surgeon friends working with me inspired me the most. In fact, many themes were suggested by them when something funny happened in the OT. I am really thankful to them for their sporty attitude.

It was indeed very interesting to know that humour can be found in anything and anywhere, which makes life interesting. One should really have a regular 'Laughing dose'.

Thank You.

Editorial team 'VAPOUR'



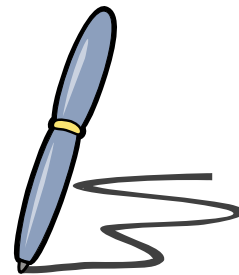
# OBITUARY

## DR. HEMANT KUMAR CHORASIA (ISA NO. H0125)



It is with great sadness that we announce the passing away of Dr. Hemant Kumar Chorasia, a former Professor in the Department of Anaesthesiology at G.R. Medical College in Gwalior, Madhya Pradesh. Dr. Chorasia passed away peacefully on November 18th, 2023 after a brief illness. He received his M.D. in Anaesthesiology in 1985 and began his career as a Lecturer in Anaesthesiology at G.R. Medical College in 1988, retiring as a Professor in 2018. Dr. Chorasia was known for his gentle and kind nature, as well as his extensive knowledge of Anaesthesia. He was highly regarded as a teacher and anaesthetist by his students and colleagues. He was an active member of ISA and served as the Secretary and President of MPISA. Prior to his passing, Dr. H.K. Chorasia made a noble commitment to donate his body for the purpose of teaching and research of medical students. Following his demise, his wife and family members entrusted Dr. Chorasia's remains to G.R. Medical College, Gwalior where he had served the public and students for nearly three decades. Dr. Chorasia is survived by his wife, Mrs. Prabha Chorasia, as well as a son and daughter. His colleagues, students, friends and family members paid tribute to his noble soul and prayed for his eternal peace and Moksha and to provide strength to his bereaved family in this profound loss.

# INVITATION TO CONTRIBUTE



‘Vapour’, the official newsletter of the Indian Society of Anaesthesiologists invites contribution of articles originally written by ISA members (Life and associate). The articles can be in the form of interesting case reports for discussion, articles on topics of current clinical relevance, photo-essays, articles on medicolegal /health/ financial/extracurricular issues of interest to the anaesthesiologists. Original literary works such as poems, funny cartoons or paintings on topics of anaesthesia are also welcome. Information about extraordinary achievements /experiences of ISA members, book publication can be sent.

The articles should be brief and written in font Times New Roman 12-14 size and presented in Microsoft office word document (rtf/doc files). Plagiarism and violation of copyrights should be strictly avoided. The articles should be e-mailed to [isanhqvapour@yahoo.com](mailto:isanhqvapour@yahoo.com) with a covering letter addressed to the Honorary Secretary ISA National.

**Dr Sukhminder Jit Singh Bajwa**

**Honorary Secretary ISA National & Editor-in-Chief**

**VAPOUR**

**(The official newsletter of the ISA National)**

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