the anesthetic agents now in use. The degree to which this is compensated for by alterations in peripheral resistance seems to vary both with the anesthetic and the depth of anesthesia.

(*Burstein, C. L.: Adrenocortical Insufficiency during Surgical Anesthesia.*) Although the establishment of anesthesia results in an increased plasma concentration of 17 hydroxycorticosteroids, the eosinophil count does not decrease significantly. After the effects of anesthesia are dissipated, an eosinopenia develops in most patients studied. The inference drawn is that the traumatic stimuli of surgical intervention are blocked by the anesthetic and become apparent only upon emergence from anesthesia. In patients with natural or iatrogenic hypoadrenalism preparation with adrenal corticoids is stressed.

(*Aviado, D. M., Jr.: Hypotension and Autonomic Nervous System.*) The cardiovascular reflexes are reviewed in terms of reflexes which cause hypotension and those which compensate for the hypotension initiated by any cause. The baroreceptor reflexes arising from the carotid sinus, and the aortic arch, by causing tachycardia and vasoconstriction, are responsible for the return of the blood pressure. In all instances of hypotension, the primary concern is the correction of the initiating cause. When it is not readily removable (high spinal, ganglioplegics) sympathomimetic amines are ideal for bringing about a rise in aortic blood pressure.

(*Zweifach, B. W., and Hershey, S. G.: Protective Mechanisms in Shock.*) Resistance to shock in animals can be induced by pretreatment with autonomic blocking drugs or certain antibiotics and by increasing the tolerance of the host through repeated exposures to sublethal trauma or bacterial endotoxins. Resistance is characterized by the absence of vascular decompensation and pathology in the liver and bowel. However, since "irreversible" shock can be induced in the absence of significant bowel and liver disease it appears that a decisive factor or factors have not yet been identified.

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**EUROPEAN FEDERATION** An European Federation of Anesthesiologists has been founded with the following aims: friendly union of the united societies and their members, exchange of information, study of the duties and interests of anesthesiologists, and discussion of professional problems. The following questions shall be studied by the Federation: legal responsibility of the anesthesiologist, standardization of anesthesia machines and creation of reserves in cases of catastrophies. The board of administration consists of: President: S. Brena (Turin), Vice Presidents: S. Couremenos (Athens); R. Frey (Heidelberg); P. Jaquenoud (Marseilles). General Secretary and Treasurer: G. Bovay (St. Sulpice, Vaud, Switzerland). The Federation will publish "European Anesthesiology" ("Anesthesiologie Européenne"), edited by Dr. P. LaCombe, Issoudon (Indre), France.

**MORAL POSITION** The qualified specialist of anesthesiology is granted all powers for the softening of pain and the procedures of anesthesia—even at the risk that by this treatment the life of the patient might be shortened accidentally. Today there is no more a moral obligation to endure pain as "God's will" since we have relatively safe drugs and specialists conscious of their responsibility. (*Pope Pius XII: Anesthesia and Human Personality, Anaesthetist 6: 197, 1957.*)

This public recognition of our profession from the theological and philosophical point of view helped vitally to fix the moral position of the anesthesiologist in continental Europe.