In this issue:

Primary Trauma Care in Rwanda
Glostavent Field Trial
Smoking amongst the staff members of hospitals in Kigali

What’s in a name?
Guest Editorial

As the WFSA has now reached its half century it is interesting to speculate as to how the founder members might feel it has measured up to their original aspirations, expressed so succinctly in their initial aim “to make available the highest standards of anaesthesia to all peoples of the world”. Exactly how they imagined this would be achieved or how long it was expected to take is not clear. What is clear is that it is proving to be an extremely difficult task which is going to require a formidable effort over a prolonged period if it is ever to be realized.

Undoubtedly the founders would be impressed with the advances in the drugs, techniques and equipment that have occurred over the last 50 years. They would probably also be impressed with the expansion in our specialty, its diversification and the standard of training. However, they would have been disappointed, if not shocked, at the uneven distribution of these great advances which seem to have bypassed some countries almost entirely. They would probably be even more disappointed that, so far, it has proved impossible to correct these huge imbalances.

With so much need in so many countries it is easy to feel overwhelmed at the sheer scale of the task facing WFSA and to dismiss its current contribution as inconsequential.

Nothing, however, could in fact be further from the truth. Indeed the WFSA should be congratulated on the realistic way it is approaching this challenge by deploying the available resources in a most cost-effective way. The WFSA does not have at its disposal vast funds which can be distributed to all in need. However, it does have an asset which in some ways is even more valuable. That is access, via its component societies, to experts who are willing to share their knowledge and experience with colleagues practising in less favourable environments.

The education and publications committees, whose reports appear in this edition, have provided examples of aid which is highly effective despite a strictly controlled budget. This has only been achievable because of close co-operation with the various member societies so that local priorities are met and waste is avoided.

Similarly the WFSA/DfID Glostavent project, which is also reported in this issue, has demonstrated the value of close liaison with colleagues in the developing world to produce an anaesthetic machine which meets their specific requirements.

Yet another WFSA initiative enables recent journals to be distributed to colleagues in the developing world. Subscribers have been invited to send their own journals on a regular basis, once they have read them, direct to colleagues in the developing world. In this way over 300 anaesthetists in 60 countries are now receiving free journals at no cost to WFSA. It has been so successful that a similar scheme is being introduced for up-to-date text books.
These reports should be compulsory reading for all government or aid agencies before they squander vast sums of money in an attempt to see instant solutions without first canvassing local opinion or seeking local advice.

Despite these achievements the WFSA is still unable to meet all the demands on its services. Moreover these demands will undoubtedly increase as more countries join the Federation and seek advice and assistance.

Fortunately anaesthetists all around the world have a long standing tradition of innovation at times of shortage and of mutual help when difficulties occur. Hopefully many readers will appreciate that they are in a position to help their less fortunate colleagues and will want to contribute to the efforts of the WFSA to live up to the aims of the founders.

Some practical suggestions are listed below.

Roger J Eltringham

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Editor Emeritus
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Practical Steps that can help the WFSA achieve its goals
- Volunteer to lecture on a WFSA refresher course
- Sponsor an anaesthetist from the developing world to attend a major congress.
- Invite an overseas visitor to visit your department for a few weeks.
- Twin your department with a department in the developing world for a regular exchange of ideas/personnel.
- Ask your local anaesthetic society or specialist society to sponsor a speaker for a refresher course in the developing world.
- Donate equipment (such as L.M.A’s, E.T tubes, Laryngoscopes)

For any of the above: contact the WFSA office at wfshaq@anaesthesiologists.org.

Join World Anaesthesia and encourage your colleagues to do the same – an application form can be found at the back of this journal.

To donate journals or text books: contact Carol Wilson at carol@world-anaesthesia.org
At the request of the Rwandan Ministry of Health, the WHO Representative for Rwanda, the Rector of Kigali Health Institute (KHI) and professional colleagues in surgery, anaesthesia, and medicine, a PTC foundation course was held in the Kigali Health Institute in December 2005. The package consisted of:

- A two day Primary Trauma Care (PTC) course led by external PTC instructors
- A one day PTC instructors course led by external PTC instructors
- A two day PTC course led and delivered by the newly-trained Rwandan instructors
- The formation of a Rwandan PTC committee to lead and plan future development of PTC in Rwanda.

Participants were drawn from Surgery, Anaesthesia and Medicine at both physician and Clinical Officer grades. For this first course many participants had been pre-selected as possible instructors, and many were already involved in teaching in KHI or in the medical school in Butare. We enjoyed good administrative support from the KHI staff in preparing for the course. An excellent teaching room was provided, complete with teaching aids including digital projection, whiteboard, flipchart, and overhead projection. This was backed up with an excellent skills laboratory with manikins and teaching equipment. Constant secretarial help was available from KHI. Ample refreshments and lunches were provided for the participants and faculty, together with necessary transportation and accommodation for out-of-town participants. In accordance with PTC policy, no per diems were paid to participants nor did the faculty (international or national) receive any fees for their participation.

The course consisted of a mixture of lectures and informal small group teaching based on practical skill stations, scenarios, and workshops. Although the English language is widely understood in Rwanda, most of the participants were more comfortable with French as a working language, so we were glad that the PTC manual and slides were available to us in French – the slides thanks to the hard work of Mr. Etienne Nsereko of KHI. These slides will be a valuable resource in future for use in other Francophone countries.

The faculty were all native English speakers, so the majority of formal lectures were delivered in English, but French slides were used throughout to give maximum understanding. We made it clear from the onset that participants could respond and discuss in either French or English: 2 of the 3 instructors spoke enough French to conduct the small group sessions in French or English as appropriate. This formula appeared to work well.

PTC headquarters provided course manuals in English for all participants, and in addition locally printed French manuals were available for all who preferred them.

As usual on PTC courses, an MCQ examination was given at the beginning and repeated at the end of the course. All participants showed a great improvement. The average mark was 56% in the first test and 88% in the second. These marks would probably have been even higher but for the
fact that we only had the MCQ in English and this made it much more difficult for some of the participants. One student improved her exam result from 41% to 100% and was awarded a book prize for the most improved result. She subsequently became an effective instructor!

**Instructors Course**

At the end of the PTC course, we invited ten of the participants to attend the instructors’ course and then to teach on the second PTC course which immediately followed it. Choices were made on the basis of performance on the course, and on the advice of local knowledge of teaching potential. These choices were made before the final MCQ was administered, and we were very happy to see that the MCQ results supported our decisions.

**PTC Instructors Course**

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Etienne Nserek</td>
<td>Anaes Clinical Officer. Lecturer</td>
<td>KHI/CHK</td>
</tr>
<tr>
<td>Emmanuel Kayibanda</td>
<td>Surg. KFH/CHK</td>
<td></td>
</tr>
<tr>
<td>Sr. Monique Karikirwa</td>
<td>Anaes. Clinical Officer, Butare</td>
<td></td>
</tr>
<tr>
<td>Charles Nyakanga</td>
<td>Surg. KFH</td>
<td></td>
</tr>
<tr>
<td>Christine Ufashingabire</td>
<td>Anaes. Clinical Officer, Lecturer</td>
<td>KHI:CHK</td>
</tr>
<tr>
<td>Paul Kabayiza</td>
<td>Physician. Kanombe Military Hospital,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kigali</td>
<td></td>
</tr>
<tr>
<td>Simeon Bigirimana</td>
<td>Anaesthesiologist. KHI.</td>
<td></td>
</tr>
<tr>
<td>Rampanjato</td>
<td>Anaesthesiologist. CHK (Belg Co-operation/Madagascar)</td>
<td></td>
</tr>
<tr>
<td>Schadrack Nambayisa</td>
<td>Anaesthesiologist.. KHI/CHK</td>
<td></td>
</tr>
<tr>
<td>Alexis Mutangana</td>
<td>Kanombe Military Hospital, Kigali</td>
<td></td>
</tr>
</tbody>
</table>

(KHI = Kigali Health Institute, CHK = Kigali Central Hospital, KFH = King Faisal Hospital)

The course was taught by the overseas PTC faculty and, in addition, Shirley Dobson, a specialist educationalist, who was teaching on a simultaneous KHI “Training of Trainers” course, provided valuable input. The focus was on improving everyone’s teaching skills, whether lecturing to a large group, running a small-group tutorial or discussion, practical skill teaching, or running a scenario session. In micro-teaching, each participant is required to produce after 10 min preparation.
either a section of a formal lecture or 5 minutes of small group interactive teaching. After presenting this in front of their colleagues they are then given feedback on their teaching technique (What went well? What didn’t? Why? What might you do differently next time?)

The faculty were delighted to observe a substantial development of the participants’ teaching skills over the course of the day. This improvement was even more evident on the following day when our Rwandan colleagues took on full responsibility for both organising and running the second PTC course.

A second PTC course, organised by Etienne Nsereko and led entirely by our Rwandan colleagues, immediately followed the Instructors course.

We were delighted at the efficient way in which our Rwandan colleagues applied themselves to organise and run the second PTC course. The overseas faculty members were present as observers, and to help and support in any way on request. Our experience was that, not only was our help not required, but that various elements of the course – timekeeping, organisation of teaching rooms etc, was significantly better than the course we had run ourselves! The MCQ results for the second course were fully comparable with the first course.

Since the end of the course, we have heard that our colleagues are planning their next course at Kanombe Military Hospital.

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**Second PTC Course Participants**

At the close of the second PTC course, the Rwandan faculty and other local people involved met with us to set up a **Rwandan National PTC committee** consisting of:

<table>
<thead>
<tr>
<th>Dr Emmanuel Kayibanda</th>
<th>Surgeon, King Faisal Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Martine Makanga</td>
<td>Paediatric &amp; General Surgeon</td>
</tr>
<tr>
<td>Mr Etienne Nsereko</td>
<td>Anaesthetic Clinical Officer, Lecturer</td>
</tr>
<tr>
<td></td>
<td>KHI</td>
</tr>
<tr>
<td>Dr Paul Kabayiza</td>
<td>Physician, special interest in Trauma, Kanombe Mil.Hosp.</td>
</tr>
<tr>
<td>Dr. Mpanjato</td>
<td>Physician Anaesthetist</td>
</tr>
</tbody>
</table>

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On behalf of PTC we want to say **THANK YOU** to the Rector, Vice-Rector and staff of Kigali Health Institute for their invitation, welcome and professional and personal support.

We would also like to thank:

- KHI for providing excellent teaching facilities at no cost to the PTC Foundation and the World Health Organization for their advice and financial support, and attendance at the awards ceremony.
- The Rwandan Ministry of Health for their help and participation, through KHI and through the attendance of their representative, Dr Andre, at the awards ceremony.
- The Association of Anaesthetists of Great Britain & Ireland for their financial support both for the course and the travel and accommodation costs of Drs. Frossard and Dobson.
- WFSA for its support of Dr. Oluronboba’s fare and accommodation
- Dr. David Oluronboba for his leadership of the course.
- Mr. Etienne Nsereko for his tireless work organising the courses locally, and for translating all the PTC slides into French.
- Dr. Henry Bukwirwa & Mr. Charles Rangira for their support of and through the Anaesthetic dept in Kigali.
- Dr. Jeanne Frossard for conceiving & planning the course, for her liaison role, and for translating all the slides in the instructor manual into French.
A Report on the Field Trials of a Glostavent Anaesthetic Machine

Roger Eltringham  
Project Co-ordinator  
reltringham@btinternet.com

Introduction

The Glostavent was first introduced in 1996 as a versatile anaesthetic machine, capable of functioning in the difficult environments encountered by anaesthetists working in the developing world. These difficulties include sudden interruption in the supplies of electricity or oxygen and poor facilities for the servicing and maintenance of anaesthetic equipment: conditions that render the use of more sophisticated machines impractical.

The Glostavent combines a draw-over anaesthetic circuit, a gas-driven ventilator and an oxygen concentrator. It can continue to function without interruption if either oxygen or electricity fails.

Its performance has been thoroughly appraised in a modern British hospital (Update in Anaesthesia 2003 No. 16 p31-35). The DFID/WFSA project was designed to enable the performance of the Glostavent to be assessed in the more extreme conditions prevailing in much of the developing world.

Design of the Project

The project was initiated in 1999. 21 Glostavents were distributed to 3 countries in sub-Saharan Africa; Mozambique, Malawi and Zambia, for a field trial in a wide variety of conditions so as to allow a thorough assessment to be made.

Dr Roger Eltringham (Gloucester) was appointed overall co-ordinator of the project. To assist him, local co-ordinators were appointed in each country:

Zambia  
Dr Dixon Tembo  
(Wusakile Hospital)

Mozambique  
Drs Val Magni and Teresa Schwalbach  
(Maputo Central Hospital)

Malawi  
Professor Anneke Meursing and Mr Cyril Goddia (Queen Elizabeth Hospital, Blantyre).

The role of the local co-ordinators was:

1. To select hospitals for the field trials of the Glostavents.
2. To arrange training for the anaesthetists in the use of the Glostavents.
3. To select technicians for instruction in the servicing and maintenance of the Glostavents.
4. To keep records of their use and performance.

Progress of the Field Trial

2001  
5 Glostavents delivered to Zambia. Clinical Officers and technicians were given an intensive training course on the operation, servicing and maintenance of the Glostavent.

2002  
8 Glostavents delivered to Mozambique. A similar training course was provided.

2003  
8 Glostavents delivered to Malawi. This part of the field trial was only made possible due to the support of the Dutch Government.

2004  
Further training courses were run in all three countries.

2006  
Final inspection of the Glostavents and assessment of the project. This was carried out by Dr Eltringham and...
Mr Richard Tully, the Chief Engineer of Diamedica, the company that now manufactures the Glostavent

Objectives of the final visit

1. To meet the local project co-ordinators to discuss the results of the trial.
2. To visit the hospitals that are using the Glostavents and inspect the condition of the Glostavents.
3. To meet Clinical Officer anaesthetists and discuss their experiences.
4. To meet the staff of engineering and maintenance departments.
5. To meet government officials in the respective Health Ministries.

1. Meetings with local project co-ordinators

The co-ordinators produced records of the use of the Glostavent in the various hospitals in their respective countries. Problems were discussed and recommendations recorded. The co-ordinators in all three countries emphasised their overall satisfaction with the Glostavents and they all expressed a wish to have the Glostavent as the standard national anaesthetic machine.

2. Inspection of the Glostavents

18 of the 21 Glostavents in the three countries were inspected: it was not possible to personally visit 3 hospitals in the Northern District of Mozambique because of the large distances involved and transport difficulties. However, a meeting was held with Dr Pedro Utui, the anaesthetist responsible for the Glostavents in that district and a comprehensive report on them was obtained.

In each hospital visited, the Glostavents were examined and their function tested in the various modes (e.g. draw-over and continuous flow) and under different conditions (e.g. absence of oxygen, absence of electricity). All were found to be in good working order unless otherwise indicated in the table below. Any faults were corrected by the local technicians working with Mr Tully, so that by the end of the visit all were fully operational.

3. Meeting with Clinical Officer Anaesthetists

Clinical officers attended a 2 day training courses in the anaesthetic departments of the University Teaching Hospital (Lusaka), Maputo Central Hospital and the Queen Elizabeth Hospital, Blantyre.

A series of lectures and tutorials were given in each hospital during which the clinical officers were required to demonstrate their understanding and
## Findings on Inspection of the Glostavents

<table>
<thead>
<tr>
<th>Country</th>
<th>Hospital</th>
<th>Hours of Use</th>
<th>Findings</th>
<th>Action Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zambia</td>
<td>University Teaching Hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glostavent 1</td>
<td>Main Operating Room</td>
<td>1055</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Obstetric Unit</td>
<td>1114</td>
<td>1 wheel missing</td>
<td>Replaced</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Respiratory control faulty</td>
<td>Repaired</td>
</tr>
<tr>
<td>3</td>
<td>Ndola Central Hospital</td>
<td>4940</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Kitwe Hospital</td>
<td>4314</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Mufulira Hospital</td>
<td>2903</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mozambique</td>
<td>Southern Region</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glostavent 6</td>
<td>Maputo General Hospital</td>
<td>1040</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Chicuque Hospital</td>
<td>615</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Manjacaze Hospital</td>
<td>280</td>
<td>Vaporiser dial loose</td>
<td>Vaporiser serviced</td>
</tr>
<tr>
<td>9</td>
<td>Chokwe Hospital</td>
<td>446</td>
<td>Excessive voltage fluctuations preclude use of concentrator</td>
<td>U.P.S. to be replaced</td>
</tr>
<tr>
<td>Malawi</td>
<td>Queen Elizabeth Central Hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glostavent 10</td>
<td>Muxungue Hospital</td>
<td>394</td>
<td>Concentrator switch faulty</td>
<td>Repaired</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Oxygen recycling tube disconnected</td>
<td>Re-attached</td>
</tr>
<tr>
<td>Northern Region</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glostavent 11</td>
<td>Namapa Hospital</td>
<td>300</td>
<td>Faulty gauge on oxygen cylinder</td>
<td>Gauge changed</td>
</tr>
<tr>
<td>12</td>
<td>Angoche Hospital</td>
<td>360</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Niassa Hospital</td>
<td>355</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malawi</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glostavent 14</td>
<td>Main operating room</td>
<td>Unavailable</td>
<td>T piece in ventilator broken.</td>
<td>Repaired</td>
</tr>
<tr>
<td>15</td>
<td>Main operating room</td>
<td>&quot;</td>
<td>Oxygen concentrator fitting broken.</td>
<td>Replaced and new oxygen hose supplied.</td>
</tr>
<tr>
<td>16</td>
<td>Main operating room</td>
<td>&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Eye Hospital</td>
<td>&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Thyolo Hospital</td>
<td>559</td>
<td>U.P.S. units never delivered.</td>
<td>Reported to suppliers.</td>
</tr>
<tr>
<td>19</td>
<td>&quot;</td>
<td>Unavailable</td>
<td>Paediatric circuits missing.</td>
<td>Supplied</td>
</tr>
<tr>
<td>20</td>
<td>&quot;</td>
<td>Unavailable</td>
<td>Cylinders needed medical oxygen adapter.</td>
<td>To be supplied locally.</td>
</tr>
<tr>
<td>Malawi</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glostavent 21</td>
<td>Mlambe Hospital</td>
<td>267</td>
<td>No paediatric circuit</td>
<td>Supplied</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Vaporiser dial stiff</td>
<td>Serviced</td>
</tr>
</tbody>
</table>
manual dexterity with the Glostavent during a wide variety of scenarios. They related their experiences with the Glostavents and made suggestions for possible modifications, which have subsequently been passed on to the manufacturers.

4. Meetings with the staff of Engineering and Maintenance Departments
Meetings were held with the senior technicians responsible for the overall servicing and maintenance of the Glostavents:

Zambia – University Teaching Hospital, Lusaka
Eric Luhana and Ganizani Phiri

Mozambique – Maputo Central Hospital, Mr Helder

Malawi – Queen Elizabeth Hospital, Blantyre
Kenneth Kapatuka and John Gawanika

The basic servicing and maintenance requirements were reviewed, the Glostavents examined, faults identified and repairs effected wherever necessary.

In each of the other hospitals using the Glostavents, similar meetings were held with the local staff. All expressed satisfaction with the performance of the Glostavents under their care.

5. Meeting with government officials of the respective Health Ministries
Interviews took place with representatives of the following Health Ministries:

Zambia
Tsibu Bbuku: Adviser on medical equipment for the Zambian Government.

Mozambique
Dr Aida Libombo – Deputy Minister of Health.
Dr Lina Cunha – Clinical Director, Central Hospital, Maputo.

Malawi
Dr Wesley Sangala – Principle Secretary of Health Ministry, Chairman of Medical Purchasing Board.
Dr Ben Mbwana – Deputy Director, Health Technical Support Services.

All had previously been made aware of the success of the Glostavent and had already been approached by the local project co-ordinators and senior anaesthetists in their respective countries with recommendations for the Glostavent.

Summary
On conclusion of the field trial in 2006, all the objectives of the WFSA/DfID project had been achieved within the allocated budget. The project enabled the performance of the Glostavent to be thoroughly examined under the conditions commonly found in isolated hospitals in some of the poorest countries in the world.

Because of the large number of Glostavents distributed and the prolonged duration of the trial, a great deal of experience was accumulated:

Zambia – 5 Glostavents used for 5 years giving a total of 25 years service.

Mozambique – 8 Glostavents used for 4 years giving a total of 32 years service.

Malawi – 8 Glostavents used for 3 years giving a total of 24 years service.

Experience has been gained, therefore, during many thousands of hours of use: a total of over 80 ‘Glostavent Years’.

The clinical officers kept meticulous records, which were collected and evaluated by the local project co-ordinators in each country. The clinical officers and the engineering and maintenance staff were invited to submit their observations, which are summarised below:

• Simplicity
The most popular feature seemed to be its simplicity. It was considered easy to understand and operate. The recommended pre-operative checks took little time and were easy to perform.

• Versatility
The Glostavent was used both in draw-over mode and, when required for paediatric patients, in continuous flow mode. The conversion from one mode to the other was straightforward.

It was used both as an anaesthetic machine in the operating rooms and as a ventilator in recovery or intensive care units. For example, when three of the four HT-50 ventilators had broken down at the same time in the intensive care unit at the Queen Elizabeth Hospital, Blantyre, Glostavents were transferred from the operating room and used successfully as ventilators for intensive care patients.

Halothane was generally used as the volatile agent in all sites. However, when it is necessary to use an alternative volatile agent, this could be readily achieved by changing the label on the concentrator dial. A clear advantage of the Oxford Miniature Vaporiser over more sophisticated TEC type vaporisers is, therefore, that the same vaporiser can be used for whatever volatile agent is available at the time and it is not necessary for a
separate vaporiser to be purchased for each individual agent.

- **Maintenance and Servicing**

  During the total accumulated service of more than 80 Glostavent years, malfunctions were rare, of a minor nature and easily corrected. Throughout the entire trial period, the local technicians required outside assistance on only one occasion (see Glostavent no.2). At other times they had the necessary equipment and skill to maintain the Glostavents in good working order without the need for outside help. The time and effort expended in training local staff in the maintenance and servicing of the Glostavent was fully justified.

- **Economy**

  Providing oxygen cylinders to remote hospitals in sub-Saharan Africa is both difficult and expensive, as great distances are involved and roads are sometimes impassable. Consequently, large savings were made in all hospitals by using the concentrator on the Glostavent as the prime source of oxygen.

  A most striking example occurred in the intensive care unit at the Queen Elizabeth Hospital, Blantyre. Before the advent of the Glostavent, their requirement was for 35 large oxygen cylinders per month. Since the arrival of the Glostavents, this has fallen to an average of 10 cylinders per month. At a cost of £25 per cylinder, this represents a massive saving of £625 per month.

- **Safety**

  The alarms on both the ventilator and the oxygen concentrator were judged to be clear and easy to interpret. When the concentrator stopped working, due either to excessive variation in voltage or the complete failure of the electricity supply (Glostavent no.9, Chokue Hospital, Mozambique), the anaesthetist was able to continue uninterrupted anaesthesia by using the reserve oxygen cylinders.

  **Suggested Improvements**

  The clinical officers made numerous suggestions for improvements they would like to see. The most common were:

  1. A scavenging system to be added to remove exhaled anaesthetic agents.
  2. A suction apparatus on each machine.
  3. A standard reservoir bag to enable respiratory depth and frequency to be observed.
  4. A self-inflating bag near to the patient for assisting respiration.
  5. An additional outlet for oxygen for use when resuscitating babies after caesarean section.
  6. The disconnect alarm to be made less sensitive.
  7. The oxygen concentrator to be quieter.

  These have been referred to the manufacturers for possible inclusion in later models.

- **Conclusion**

  The Glostavent was shown to be an effective and reliable anaesthetic machine, enabling anaesthetists to provide a safe and economical service despite the extreme difficulties frequently encountered in the developing world.

- **Acknowledgements**

  The contributions of the following to the success of the project are gratefully acknowledged.

  **Initiator**
  Dr Michael Dobson

  **Trustees of the DFID/WFSA Partnership Scheme**
  Dr Michael Rosen & Mr Francis Wirgman

  **Scientific Adviser**
  Dr David Peel

  **Local co-ordinators**
  Dr Dixon Tembo
  Professor Anneke Meursing
  Mr Cyril Goddia
  Dr Valeria Magni
  Dr Teresa Schwalbach

  **Engineer**
  Mr Richard Tully

  **Typist**
  Mrs Debbie Dooley

  Thanks are also due to the many individuals who helped collect the data and to DFID, the WFSA and Dutch Government for their support.

  DFID - The UK Department for International Development
Knowledge and practice with regards smoking amongst the staff members of hospitals in Kigali (Rwanda)

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ABSTRACT
A sample of 135 people was drawn from a population of 600 staff members who were working in hospitals in Kigali in 2003. Responses were received from 122 participants. The proportion of smokers amongst the participants was found to be 12.2% and this proportion was higher than the prevalence of smoking amongst adults in Rwanda (11%) as published in the National Clearing House on Tobacco and Health Program. (Corrao et al.)

1. Background to the Study
The use of tobacco is the single most preventable cause of death and disease in our society (Centre for Disease Control, 1999). Despite the information delivered to increase awareness of the harmfulness of tobacco many people continue to smoke. In 1993 the American Environmental Protection Agency (EPA) published a report on the effects of secondary smoke after an examination of the scientific literature on this subject. Thereafter, the agency decided to classify the secondary smoking of tobacco in Group A of human carcinogen, reserved for the most dangerous products (EPA, 1993).

Exposure to Environment Tobacco Smoke (ETS) increases non-smokers’ risk for lung cancer and heart diseases. Amongst children, ETS is also associated with serious respiratory problems including asthma, pneumonia and bronchitis. The World Health Organization estimated that in the year 2000 about 4 million people died as a result of tobacco related illness (WHO, 2001). Without effective international tobacco control programmes, the death toll may increase.

In Rwanda, the Ministry of Finances has introduced tobacco taxes in an attempt to discourage smoking. The goal of the Rwandan government is to have a tobacco control program in order to reduce disease, disability and death related to tobacco use by promoting cessation of smoking amongst young people and adults and eliminating non-smokers’ exposure to ETS. (Ministry of Health, 2002). Laws have also been introduced to prohibit smoking in a public place.

Studies have shown that tobacco control programmes and efforts are effective. However, they have limited impact on smoking behaviour. Strobi and Latter (1998) in their study on qualified nurse smokers revealed that although there is support for smoking reduction policies, the support is limited and compliance is very low due to lack of programmes supporting smokers’ efforts to quit smoking.

These researchers suggested that future policies should aim at strengthening nurses’ determination to give up smoking as well as securing their support for restrictions to facilitate their changing their smoking behaviour. In a study which was conducted by Tapia-Conyer et al. (1997) aimed at determining the prevalence of cigarette smoking, as well as knowledge, attitudes and information on specific issues concerning smoking, it emerged that despite participants knowledge that tobacco is an addictive drug, that smoking is banned inside health care institutions and that there is significant relationship between smoking and lung cancer, a great number of people continued smoking.

2. Problem Statement
In Rwanda, the Ministry of Health prohibits smoking in any public area but in a large hospital in Kigali some members of staff continue to smoke in the hospital. The question arises whether the smoking behaviour of health workers is due to a lack of knowledge of the tobacco use legislation, the health consequences of tobacco use and of strategies that can be used to give up smoking or whether they continue to smoke despite this knowledge.

3. Purpose and objectives of the study
The purpose of this study was to investigate the prevalence of smoking amongst members of staff in a large urban hospital in Rwanda and to evaluate the staffs’ knowledge and practice regarding tobacco use.

The objectives of this study are to:
- Determine the proportion of smoking staff members
- Establish the extent of the staffs’ knowledge about smoking and its effect on health
- Analyse the reasons given by staff for smoking
- Determine how staff members who smoke make their decisions about quitting smoking.

4. Significance of the Study
The findings in this study will provide information that might be helpful in the planning and evaluation of tobacco cessation programmes in Rwanda. The findings might also be helpful in shaping workshops to be held for the staff on smoking, and in developing health education material such as pamphlets for cigarette smokers.

5. Definition of the terms
Knowledge of smoking: This term covers the extent of staff members’ knowledge of tobacco consumption and its consequences for their health and the environment, as measured by the Kamanzi’s questionnaire (Kamanzi, 2001).

Practice of smoking: This term refers to how regularly staff members consume tobacco, how many cigarettes are smoked per day, and how long they have been smoking. We also sought to determine what influenced them in starting or
continuing to smoke and how they may decide to quit smoking.

Staff members: Any person who is recognized as a staff member in Kigali central hospital, including nurses, doctors and medical auxiliaries, technicians and logistics and administrative workers.

6. Literature review

Tobacco-related diseases are the single most important cause of preventable death in the world: smoking and passive smoking cause twenty major categories of fatal and disabling disease, including lung and other cancers, heart and respiratory disease and tuberculosis (WHO, 2001). They are a number of complex and inter-related factors that predispose people to smoking, although these factors vary (Kamanzi, 2001). Years of research have identified certain factors that commonly play a role in smoking initiation: these include high levels of social acceptability for tobacco product, exposure and vulnerability to tobacco marketing efforts, availability of and ease of access to tobacco, role modelling by others and peer group use (WHO, 1999). The WHO in 2002 stated that among the young, tobacco was perceived as a lifestyle statement and a mark of freedom and sophistication. The adult smokers, on the other hand, believed that smoking was a way of escaping anxiety. The WHO continue to state that every day, 11,000 people die of tobacco related diseases and that most of today’s 1.2 billion smokers started before they were eighteen years old (WHO, 2000). The Health Systems Trust (1999) reported that smoking contributes significantly to the burden of diseases in human society. Smoking directly causes or exacerbates a number of diseases some which have been discussed by Health System Trust (1999) as follows:

- Tobacco is conclusively linked to the development of lung cancer: men who smoke increase their risks of death from lung cancer by more than 22 times and women by 12 times.
- Lung diseases like bronchitis and emphysema may be the direct results of smoking: men who smoke increase their risk of death from bronchitis and emphysema by nearly 10 times, women more than 10 times.
- Smoking is also directly related to cardiovascular diseases: this may manifest itself as a heart attack or angina, a stroke or peripheral vascular diseases.
- Even non-smokers are at risk of smoking-related illnesses if they are exposed to environmental tobacco smoke. Scientific studies also link second hand smoke to heart diseases and serious respiratory problems in children.

The preventable nature of smoking-related diseases places a major responsibility for health promotion on all health professionals (the Journal of Advanced Nursing, 2001). The smoking prevalence amongst health professionals is high in many European countries. In fact, in most European countries, the smoking rate among hospital workers is over 25% but, in the United Kingdom, less than 10% of medical doctors smoke (http://ensh.aphp.fr/coordination/European_guide.doc.). According to Dekker, 30% of medical doctors in France are smokers (Dekker, Caspar et al, 1993) and about 20% of Scandinavian medical doctor are smokers.

According to the WHO, the tobacco “epidemic” is increasingly becoming a major problem with developing countries accounting for up to 80% of global cigarette consumption (Achieng, 2000). The World Health Organisation is targeting African policy-makers in an attempt to counter the marketing campaigns by tobacco multinationals. Smoking prevalence on the continent ranges from between 15% to an approximated high of 67%, largely attributed to intense promotional campaigns by the tobacco industry that target youth in all the countries in the region. Achieng (2000) stated that a recent WHO study conducted in Nairobi revealed a high level of tobacco use: 67% of men and 32% of women were reported smokers, a trend applicable to nearly all African countries.

Tapia-Conyer et al (1997) conducted a survey on cigarette smoking.
knowledge and attitudes among Mexican physicians. The findings of this study revealed that although physicians were well informed of the dangers of cigarette smoking to their health, only 65% were in favour of banning smoking from workplaces and over 10% were not aware that it was forbidden to smoke inside health care facilities. This study revealed the although the percentage of smoking physicians was lower than that of the general population, there was a greater prevalence of smoking among female physicians and the number of cigarettes smoked per day was greater than in the general population regardless of sex. It also emerged in this study that although the participants were aware of the adverse health consequences of smoking cigarettes, this awareness did not influence their behaviour and it was possible to establish that the decision to smoke was independent of what was known about the consequences of smoking on health.

In Africa smoking prevalence is increasing dramatically in most countries both among the adult population and among young people. The current youth smoking rate varies from 17% in Ghana and Nigeria to 24% in South Africa, 37% in Burkina Faso and 58% in Zimbabwe. Tobacco marketing in Africa is aggressive and many children start smoking when as young as eight or nine years old. (http://www.ktl.fi/enyfat/statistics_page.htm). Despite the high incidence of tobacco smoking in African countries, including in Rwanda where 11% of the general population are smokers (Corrao, Guindon, Sharma, & Shokoodi 2000) few published studies on attitudes to smoking have been carried out in Africa.

7. Research Design
A quantitative research approach and a descriptive survey was used in this study aiming at establishing the knowledge and practices of smoking amongst members of staff in a large hospital in Kigali, Rwanda.

Setting
The researcher used one hospital. The hospital that was chosen was the biggest hospital in Kigali, and the researcher had access to a larger population of staff members; doctors, nurses, medical auxiliary staff, technicians, logisticians and administrative staff.

Population and Sample
The hospital had 600 staff members employed in the year 2003. Amongst those staff members were seven categories namely; doctors, nurses, medical auxiliary staff, technicians, logisticians and administrative staff. All these categories of staff were included, smokers and non-smokers. Simple random sampling was used in this study: all staff members employed in the hospital had an equal chance of being selected to participate in this study. The names of all staff members in each category were placed in a basket and randomly were selected until the sample size was reached.

The prevalence of smoking among the staff members in hospital is not known in Rwanda but an estimation of prevalence of smoking among adults (11%) as published in the National Clearing House on Tobacco and Health Program (Corrao & Guindon et al., 2000). The total number of the staff in Kigali is 600 (Administration, 2003). Thus, the sample of 135 represents 22.5% of the whole staff (population).

Data Collection Instrument
Information about staff members was collected through a self – administered questionnaire. This questionnaire was composed of 3 parts, with a series of questions in each part. The first part concerned the demographics data of the participants, the second one their knowledge of smoking and the last was related to their practice of smoking.

The data collection instruments were available in English and French. The original questionnaire was developed by Kamanzi (2001) and permission was obtained from him to adopt and use it.

Data Collection
The questionnaire was distributed along with payment slips in June 2003. Every staff member concerned was requested to fill in the questionnaire within a maximum of two days and then put it in a box located at the main gate of the hospital where they were collected every day by the researcher.

Data Analysis
The data collected was analysed on a computer using Epi info 6 data files. In general the researcher used frequency distributions, counting the number of times various answers were occurring. An attempt was also made to test the significance level of the responses by evaluating the difference between the observed and expected responses.

Ethical Consideration
Permission to conduct research was sought from the Director of the hospital after obtaining ethical approval from the University of Natal, Durban, South Africa. Anonymity of the participants was ensured by not having any identification on the questionnaire. The questionnaires contained a covering letter giving the details of the researcher and information about the research project. Participants were made aware that they had a right to withdraw from the research at any point. Nobody had access to completed questionnaires except the researcher. Participation in the research was voluntary. Returning a completed questionnaire was taken as the participant’s consent to the research.

8. Results
The mean age of the all participants was 30 years old and the maximum was 58 years old (table 1). As shown in the table, most of the participants were young adults. Of the 122 participants, 46 (37.7%) were males and 76 (62.3%) were females.
20% of the males surveyed smoked but only 8% of females were smokers.

Table 2 shows that 27% of the physicians were smokers, 12% of the nurses, 8% of the administrative workers and 14% of the other health professionals.

The fact that tobacco smoke is harmful to non-smokers who are exposed to it was acknowledged by 83% of the participants; only 15.6% of the participants did not believe it to be so while 1.6% were not sure. Useful strategies to quit smoking were known only by 38% of the participants while 62% claimed not to be aware of useful strategies that could help them to give up smoking.

In term of knowledge of major disease caused by tobacco, 54% (67) listed lung cancer and other forms of cancer, 20% (25) listed tuberculosis, 13% (17) heart diseases, 8% (10) bronchitis and 2% (3) brain retardation.

73% of female smokers had started between the age of 17-19 years and 46% of the males had started at the same age. Many of the smokers (47%) have been consuming tobacco for more than 6 years, while a further 40% have been smoking for between 1 and 5 years. Only 2 had been smoking for less than 1 year. A total of 36% of the participants, whether smokers or not, lived with regular smokers whereas 63% of non-smokers live in smoke free-environment. With regard to when people smoke, 60% of those answering the specific question smoked at any time, the 20% smoked in the evening, 13% in the morning.

In term of smoking behaviour, 67% of females use their bedrooms to smoke. In contrast 56% of males smoke anywhere and 33% smoke out of doors.

The most cited reason for smoking was that tobacco was absolute needed (40%), but the pleasure derived from smoking was also scored high (13%). 33% of those surveyed consumed 11-15 cigarettes/day. More than half (54%) of the smokers said they had tried several times to give up smoking. About 65% of the smokers wanted to give up smoking because they feared the health consequences of smoking and the 33% wanted to give up because of the cost of cigarettes.

Table 1 Classification of smokers according their jobs

<table>
<thead>
<tr>
<th>Job</th>
<th>Smokers</th>
<th>Non-smokers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>3</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Nurses</td>
<td>9</td>
<td>68</td>
<td>77</td>
</tr>
<tr>
<td>Others</td>
<td>1</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Secretary</td>
<td>2</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>107</td>
<td>122</td>
</tr>
</tbody>
</table>

Table 3 Distribution of the Respondents Regarding their Smoking Initiation

<table>
<thead>
<tr>
<th>First to give tobacco</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>One of my parent</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Friend</td>
<td>13</td>
<td>48</td>
</tr>
<tr>
<td>Siblings</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Other relatives</td>
<td>10</td>
<td>37</td>
</tr>
<tr>
<td>Boy/Girlfriends</td>
<td>67</td>
<td>55</td>
</tr>
</tbody>
</table>

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The most cited reason for smoking was that tobacco was absolute needed (40%), but the pleasure derived from smoking was also scored high (13%). 33% of those surveyed consumed 11-15 cigarettes/day. More than half (54%) of the smokers said they had tried several times to give up smoking. About 65% of the smokers wanted to give up smoking because they feared the health consequences of smoking and the 33% wanted to give up because of the cost of cigarettes.
9.1 Smoking according to the Sex
We found that 8% of females and 20% of males were cigarette smokers. These results differ from those found in a study performed in Canada on smoking amongst students, where more females (23%) than males (17%) smoked (Spurgeon, 1999). The Rwandan population appears to be more tolerant of males smoking and disapproves of females smoking.

9.2 Knowledge of smoking and smoking behaviour
The harm caused by tobacco is well known, and was recognised by 82% of the participant in this study. This finding is similar to that of a study in South Africa that reported that 87% of the participant in national study agreed on the deleterious health effects of smoking (SA Family practice, 1995).

The major dangers associated with smoking that were acknowledged included cancers (54%), tuberculosis (20%) and heart diseases (13%). The Health Systems Trust (1999) reported that smoking has been linked to lower birth weight and mental retardation in the children of women who smoke during their pregnancies although this does not appear to be widely known.

9.3 Practices of Smoking
In Rwandan culture, older people ask their children to give them tobacco and the cigarette lighters. The young man or woman is expected to smoke the tobacco before giving it to the adult as a sign of respect. The influence of culture was also noted in that 73% of female smokers started smoking between the age of 17-19 years whereas only 46% of males started smoking at that age. We believe that this is also a consequence of the Rwanda culture because females spend more time at home with their old parents who then encourage them to smoke. These findings are similar to those of Blakey and Seaton (1992) who noted that 75% of student nurses who smoke had started prior to the age of 18 years whilst a study conducted in France found that 63% of the smokers in Nord Deux-Sèvres hospital had started smoking before the age of 19 years (Vellemonteix, 1999-2000)

We also found that a large percentage of participants (55%) started smoking due to peer pressure. A similar situation was reported in Hungary where Ursicz's results revealed that the prevalence of smoking among students whose friends smoked (42.6%) was much higher than those whose friends did not smoke (6.8%). According to the WHO (1998) exposure to peers who smoke markedly increases the risk of adolescents starting to smoke.

In this study 27% of the smokers were physicians and 11% were nurses. A similar situation was found in the USA in a 1977 study performed by the Office of Population Census and Surveys (OPCS) when 25% of the medical doctors were found to be smokers. In the UK, 48% of nurses are said to smoke (Corrao et al. 2000) although the study by Tapa-Conyer (1997) found that smoking was less common among physicians than in the general public but was higher

<table>
<thead>
<tr>
<th>Table 4 Decisions about quitting smoking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need to quit smoking?</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 5 Daily Cost of Tobacco</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost (Rwandan Francs)</td>
</tr>
<tr>
<td>20-100</td>
</tr>
<tr>
<td>200-400</td>
</tr>
<tr>
<td>More than 400</td>
</tr>
<tr>
<td>Total</td>
</tr>
<tr>
<td>Minimum</td>
</tr>
<tr>
<td>Maximum</td>
</tr>
<tr>
<td>Mean</td>
</tr>
</tbody>
</table>

RWF 1000 = £1 (GBP), RWF 610 = $1 (US)
among female physicians than in the general public.

9.4 State of second-hand smokers
We found that 36% of our sample lived with a regular smoker, thus increasing the number of the population at risk of adverse consequences of tobacco. The WHO has stated that non-smokers breathe in the same toxic chemicals from tobacco smoke as smokers do, with a similar although smaller effect (WHO, 2000). A study conducted in Brazil by Laranjeira, Pillon and Dunn (2000) about environmental tobacco smoke exposure among non-smoking waiters in restaurant found that exposure to environmental tobacco smoke was the most likely explanation for increase in carbon monoxide levels among non-smoking waiters.

9.5 Smoking and decision making about smoking cessation
We observed that 47% of the participants in our study had tried several times to stop smoking. Singleton (2000), in a study of adults and adolescents in America, found that most prefer to stop smoking on their own although this is not the most effective means to stopping and even brief counselling will markedly increase the chances of success. A study undertaken by Andriaanse et al. (1991) in Northern Ireland amongst nurses smokers showed a strong desire among the smoking sample to quit with 82.5% having attempted to do so an average of five times (Journal of Advanced Nursing, 2001). According to the study conducted by Vellemonteix (2000) in hospitals in France, 57.7% of those surveyed wished to give up smoking. The reasons most frequently cited were the consequences of smoking to their health and the cost of cigarettes.

12.4.4. Reason for Tobacco Consumption
The most commonly stated reason for smoking (40%) was that tobacco was an absolute necessity. They needed it. 33% stated that tobacco gave them pleasure and 13% indicated that tobacco lowered their anxiety levels. Research undertaken by Vellemonteix in hospitals in France reported that 61% of participants smoked because smoking was needed and pleasurable. The findings in this study also revealed that 50% of the participants were spending 200-400 Rwandan francs per day buying cigarette. Although there was no item in the questionnaire asking whether or not cigarettes were reasonably priced, the reason given by 33% of participants for wanting to give up smoking was the cost of cigarettes. This was higher than that found by Vellemonteix where 28% cited the cost of tobacco as one of the reasons for wanting to give up smoking.

Recommendations
A smoking doctor or health care worker sets a bad example. It is not acceptable that hospital workers smoke openly at their workplace in their work clothes. Furthermore, it is the duty of hospitals to provide their patients with a clean environment, specifically air quality. Second-hand smoke is a risk to other patients who may be particularly vulnerable to it. There are many examples of fires in hospitals being caused by careless or negligent use of cigarettes (European network, 2000).

Hospitals should be smoke-free areas and smoking bans must be rigorously enforced.

References
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18. (http://www.ktl.fi/enypat/statistics_page.htm) Statistics on tobacco use among youth in different countries
The Work of the WFSA Education Committee 2005

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The WFSA Education Committee is chaired by Dr Angela Enright (Canada) and currently has members from Australia, Benin, Colombia, Egypt, Israel, Norway, Singapore and the UK. The committee works closely with national and regional anaesthetic societies as well as numerous universities and individual departments of anaesthesia around the world.

Africa

After years of effort on the part of Prof. Adrian Bosenberg, a paediatric training programme has started in Cape Town, South Africa, and has its first international fellow, Dr Zipporah Gathuya, from Kenya. We are grateful to Drager for supporting this project. In Tunis, Tunisia, Dr Mohammad Ben Ammar has also established two Fellowships in paediatric anaesthesia that are supported by Drager. Dr Yahya Siop from Senegal has been the first fellow and has spent six months in Tunis.

Meanwhile, the established collaborative training programme between the American Society of Anaesthesiologists and the WFSA in Accra, Ghana is drawing to an end. Since its inception in 2000, it has trained 15 anaesthetists from Ghana, 2 from Nigeria and 1 from Sierra Leone.

At the University of Assuit in Egypt, an innovative modular training programme for anaesthetists from Africa and the Middle East has been established and is being enthusiastically supported by the Scandinavian Society of Anaesthesia and Intensive Care.

As reported in the last issue of World Anaesthesia News, in Malawi, Mr Cyril Goddia has established an imaginative exchange programme that allows Clinical Officers working in rural areas to spend time in the teaching hospitals at Blantyre and Lilongwe whilst their place is taken by Clinical Officers from those centres.

During the year, the WFSA, in cooperation with national societies supported teaching programmes, Refresher Courses and gave assistance with examinations to Eritrea, Ethiopia, Kenya (where the next All Africa Anaesthesia Congress will be held in 2009), Malawi, Mauritius, Nigeria, Rwanda, Tanzania, Uganda, Zambia and Zimbabwe. Primary Trauma Care courses were held in Mauritius and Rwanda and equipment maintenance courses in Malawi and Rwanda.

In Francophone Africa, the regional SARANF Congress continues to receive support as does the training programme in Benin. Lecturers were also supported to enable them to participate in courses in the Central African Republic, Guinea Conakry, the Ivory Coast and Mali.

Asia

The Bangkok Anaesthesia Training Centre continues to be our longest-established and flagship programme ably led by Prof Thara Tritrakarn. Trainees spend 7 months at the university teaching hospital followed by 3 months in provincial hospitals. Their final month is spent back in Bangkok and there is an exit examination. In 2005, the ninth class included students from Bhutan, Cambodia, Mongolia and Myanmar.

In Vellore, India, Dr Rebecca Jacob has established a paediatric anaesthesia training programme with support from the paediatric section of the Canadian Anesthesiologists Society and CASIEF (the International Relations Fund of the Canadian Anaesthetic Society).

Support was also provided for Drs Casey and Davies (UK) to visit Afghanistan, a country with only 11-12 physician anaesthetists and a population of 28 million, and provide assistance with training and equipment. Dr Davies has since returned to work and teach in Kabul for at least 6 months. Dr Alexandra Bojarska (UK) was supported in spending 2 months teaching in Saidpur, Bangladesh.

With a grant of $5000, the Indian Society of Anaesthesia was able to provide refresher courses for almost 1000 of its members working in rural areas. In Mongolia, Prof Tritrakarn (Thailand) and Drs McDougal and Pescod (Australia) participated in the first WFSA refresher course. With the increasing number of graduates of the Bangkok Training Centre now working in Mongolia, rapid improvements in anaesthetic standards are occurring and the first pain clinic has been established.

Regional anaesthesia and pain management workshops were supported in Pakistan as was the South Asian Congress of Anaesthesia in Sri Lanka.
Central and South America

For many years, Dr. Silvana Cavallieri has run a very successful paediatric anaesthesia training programme in Santiago, Chile. In December, Dr. Marisol Villalobos from Venezuela completed a year’s training in paediatric cardiac anaesthesia and returned home. Further trainees from Honduras have also returned home recently while a Bolivian, Dr. Hugo Begazo has recently joined the programme. The centre has also accepted 2 further trainees from Paraguay for 2006.

Drs. Barreiro from Uruguay and Lille from Mexico were WFSA lecturers at the Ecuadorean Society meeting in Quito. As well as supporting lecturers who visited Guatemala, Honduras, Nicaragua and Paraguay, there are plans to start an obstetric fellowship in Argentina and a pain fellowship in Mexico.

Dr. Ibarra (Colombia) has been running a website in Spanish on the WFSA activities in the region (www.anestesianet.com/wfsa) that links with the CLASA website (www.clasa-anestesia.org) Finally, WFSA helped to fund and facilitate a PTC summit in Santiago, Chile.

Europe and Israel

The training centre established at Beer Sheva in Israel by Dr. Gabriel Gurman continues to flourish and is now being run by Dr. Nathan Weksler. The centre concentrates on educating trainees from East Europe and in 2005 trainees from Bulgaria (4), Macedonia (4), Moldova (1), Romania (2) and Slovakia (2) each spent one month there. In addition, the centre has hosted 4 short term and 2 long term trainees from Kenya.

Dr. Zeev Goldick from Haifa has recently joined the Education Committee and hope to start a similar training centre there. As well as providing assistance for anaesthetists from Eastern Europe, he hopes to offer training to Palestinian anaesthetists.

At Cluj-Napoca in Romania, a training centre was established in 2003 under the direction of Prof. Iurie Acalovschi with the aim of assisting in the training of anaesthetists from Moldova whilst at Basingstoke, UK, Dr James Knight hosts anaesthetists from Slovakia.

A Romanian anaesthetist, Dr. Julia Csajkovszki, attended an obstetric anaesthesia conference in London and then spent time in Belfast as a guest of the Irish College of Anaesthetists. That College also proposes to fund a speaker to visit Eastern Europe in 2006. Finally, Dr. Hans Kirkegaard from Denmark attended a meeting on respiratory support in Krasnoyarsk in Siberia that was attended by 400 local doctors and has established mutually beneficial links with the local society.

Pacific

All our efforts in the South Pacific were focussed on getting speakers and delegates to two important refresher courses: distances are vast and many anaesthetists work in isolation.

The 9th Micronesian Refresher Course was held in the Marshall Islands. Drs. Florian Nuevo and Angelina Gapay from the Philippines were guest speakers. Locums, sponsored by the Philippine and Australian societies were organised so that 29 anaesthetists from Palau, Yap, Pohnpei, Chuuk, Ebeye and Majuro attended the five day meeting and the Micronesian Anaesthesia Society was formed. Dr. Willie Tokon from Palau was elected President.

The Pacific Anaesthesia Society course was held in Raratonga in the Cook Islands. Dr. Harry Aigeeleng from Papua New Guinea and Drs. Sereima Bale and Harry Collins were sponsored to attend by the WFSA. Other speakers were from the USA, Australia, New Zealand, Switzerland and Fiji. Locums were provided by Australia and New Zealand to enable as many Pacific Islanders as possible to attend. Dr. Tia Va’ai from Western Samoa was elected President and Dr. Bataboni Anigafutu from the Solomon Islands was elected Secretary/Treasurer.

Conclusion

As always, the Education Committee has had a busy, demanding but very rewarding year. Much has been done in developing training centres around the world so that trainees can learn in conditions not dissimilar to those in their own country as well as sponsoring lecturers to attend local refresher courses and national meetings.

Although much has been achieved, much remains to be done to achieve the goal of the founding fathers of the WFSA “to make available the highest standards of anaesthesia to all peoples of the world.”
The work of the WFSA Publication Committee

Iain Wilson
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During 2005 – 06, the Publications committee undertook the following activities:

- Two editions of Update in Anaesthesia were published, and translated copies were produced and distributed in French, Russian and Chinese. We were able to provide finance to support a Spanish web version whilst SFAR (the French anaesthetic society) kindly sponsored the French edition. Many thanks to Dr Michel Pinaud, Dr Jing Zhao, Dr Oscar Gonzales and Prof Eduard Nedashkovsky for their kind support and hard work. In India, Mr Anand Bhat of Nicholas Piramal India Ltd, has kindly printed and distributed 7000 copies of each edition of Update free of charge. His company have now changed the nature of their business but it is likely that Baxter in India will continue to support WFSA publications.

- The book and journal donation scheme started by Dr Roger Eltringham has been extended following publicity organised by Dr Berend Mets. It is now administered by Carol Wilson who can be contacted on carol@world-anaesthesia.org. Free subscriptions of “Anaesthesia” and also “Anesthesiology” have been organised for selected teaching centres due to the generosity of the publishers and editorial teams.

- The new web-based tutorial scheme “Tutorial of the Week” which commenced in May 2005 in collaboration with the World Anaesthesia Society has become established. TOTW is generously hosted free of charge on the www.anaesthesiauk.com site. The tutorials are proving very popular and may be accessed either on the web or received by email. TOTW is providing a wider variety of learning and teaching materials as the scheme develops.

- Anaesthesia textbooks have been distributed in Uganda and Malawi with generous help from Oxford University Press, British Airways and the Association of Anaesthetists of Great Britain and Ireland. Recently the International Relations Committee of the AAGBI commissioned 1500 copies of the Oxford Handbook of Anaesthesia specifically for distribution in Africa – an extremely generous project.

- In association with the International Relations Committee of the AAGBI, a second educational resource CDROM was produced and distributed at major meetings and via eTALC (Teaching Aids at Low Cost). The British Journal of Anaesthesia Board have also generously supplied copies of CDROM version of their publications.

- The Publications budget was fully used this year and has been increased to $45,000 for 2006. The committee is very grateful for this generous increase.

Wanted

A specialist registrar or consultant to work at the King Faisal hospital in Kigali, Rwanda. We are looking for someone to help develop the department of anaesthesia and intensive care. The hospital currently has 145 beds but will shortly be expanded to 350 beds.

The appointee will be asked to supervise ICI 1-2 weeks per month and to undertake elective lists and supervise and assist in the training of junior anaesthetists (physicians and anaesthetic officers).

The salary is $4500 per month, more than enough to live comfortably in Rwanda.

If you are interested, contact Betty Khainza at beth@yahoo.com or Bill Casey at wfcasey@doctors.org.uk
Access Statistics for World Anaesthesia Online

Summary (as of 12/1/06)

- Total number of visitors: 319,945 from 156 different countries
- Daily access rate last month: 151.5 visitors / day

(Note: These values exclude visitors using text-only browsers such as Lynx)

Visitors per Month

Accessing the Site

- 37% of the visitors use permanent network connections (e.g. Universities).
- 22% use a temporary connection via a dial-up service (e.g. IAfrica or SatLink)
- The method of access for 41% of visitors could not be resolved
- 84% of visits are for Update in Anaesthesia, 16% for World Anaesthesia newsletter
## Access by Permanent Network Connections: Countries of Origin

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A WFSA Refresher Course and a Primary Trauma Care (PTC) course took place between June 25 and July 1, 2005 in Ulaan Baator (UB) the capital city of Mongolia. The faculty members were Thara Tritrakarn, Professor and Director of Bangkok Anaesthesia Regional Training Centre (BARTC), Thailand and Drs David Pescod and Rob McDougall both from Melbourne, Australia and Dr Doug Wilkinson from the UK. They shared their knowledge with Mongolian colleagues and gave their energy, time and professional experiences to them. Around 40 Mongolian anaesthesiologists from UB city and district hospitals attended the WFSA refresher course and 10 physicians participated in the PTC course. The WFSA courses followed the WFSA precept of “helping people to help themselves” and covered topics such as: anaesthesia in the developing world, technology, crisis management and pain relief.

Drs Rob McDougall and Doug Wilkinson organized the two-day PTC Course. It was the first such course for Mongolian health professionals. The local doctors were very excited about the training methodology such as practical skills sessions and case-based scenario teaching.

The goals of the PTC program were: to teach the basic principles of trauma resuscitation and management, adaptable to the local conditions and equipment.

For Dr. David Pescod, this trip was not the first. He has come several times (2001, 2003) to Mongolia and visited several hospitals at different level of services in UB and the surrounding area and had organised seminars on each trip (WAN Vol 8, No3, November 2005). He is definitely one of the pioneers of anaesthesia facilitation from outside. A group of members of the Mongolian Society of Anaesthesiology are working on the translation of a textbook of anaesthesia for developing countries written by David Pescod. The Mongolian anaesthesia community is looking forward to his next workshop on Obstetric anaesthesia in 2006.

A large team (more than 20 experts) from the Mayo Clinic (led by Prof. Sait Tarhan, Dr. Keiichi Tada and Dr Gurinder M Vasdev) visited Ulaan Baator in 2002 and in 2005. They were introduced to the conditions and level of anaesthesia services and emergency medicine in Mongolia and provided useful medical review courses with the anaesthesiologists and local health authorities on up-to-date evidence based medicine and care.

Prof Jung Un Lee (Korea) started a training program in 2004 and he is focusing on the training of anaesthesiologists from the remote areas. In September 2005 a workshop was held in the north of the country in Khuvsgul district. In spite of the snow and cold, there was a comfortable and friendly atmosphere indoors! He is intending to continue this program.

The WFSA and BARTC, the Bangkok Anaesthesia Regional Training Centre, have trained young anaesthesiologists from Mongolia since 2000. The BARTC graduates (there are 8 of them) are the key persons and innovators in anaesthesia development and training and the main bridge in international relations. Besides the anaesthesia activities, they have made video presentation on paediatric safety, hand washing and paediatric trauma for public education and broadcast on Mongolian television. They have developed short courses for rural doctors on simple anaesthesia, airway care and safety. They have made many changes in clinical practice of anaesthesia including the use of regional anaesthesia in children, which was previously unknown here. They use combined RA and GA in many suitable cases. They have also started the first pain clinic in Mongolia. WFSA and BARTC were gratefully appreciated for training anaesthesiologists for Mongolia.

Roger Eltringham, a vice president of WFSA, and Richard Tully, a medical engineer, visited Mongolia for 2 days in November 2005. They told us about the Glostavent anaesthesia machine as well as lecturing on topics in anaesthesia and postoperative complications as well as WFSA activities throughout the world.

Through the activities of colleagues from the WFSA and the international community we hope that our anaesthesia service is getting more reliable and safer and that the professional knowledge and experience of anaesthesiologists of Mongolia is improving and progressing. We hope that the WFSA will continue to support the MSA and our international relation will be strengthened and continue to flourish.
At a recent meeting of the ASEAN Congress of Anaesthesiologists in Hanoi, Vietnam, in keeping with tradition, the WFSA International choir performed. After polished performances by the Indonesians (a rock opera), the Thais (traditional dancing) and dancing and singing from the Filipinos, Malaysians and Vietnamese, an ad hoc group calling themselves the International WFSA choir, with members from Australia, the UK, USA and France took to the stage.

Led by Prof Stephen Gatt (Australia) (Photo 1) they performed a version of Waltzing Matilda with specially commissioned lyrics. The performance was not uneventful as Berend Metz (Pennsylvania, USA and WFSA Publications Committee) knocked his leg getting up on to the stage and performed in an ever increasing pool of blood. Fortunately, the Vietnamese had remembered what they had heard earlier in a lecture on the management of trauma and were able to control the bleeding without difficulty (Photo 2).

The lyrics of Waltzing Matilda are here and “Gai Me Hoi Suc” means “anaesthesia and resuscitation.”

YOU’LL COME TO ASEAN IN HANOI WITH ME

Once there was a Gas Man
His name was Dr Thang
He came to Surabaya in 2003
And he sang with his friends at the closing ceremony
You’ll come to ASEAN in Hanoi with me.

Gai Me Hoi Suc
Gai Me Hoi Suc
You’ll come to ASEAN in Hanoi with me.
And he sang with his friends at the closing ceremony
You’ll come to ASEAN in Hanoi with me.

Dr Thang has a boss, his name is Professor Thu
In charge of the VSA as it grew and grew
From the office of Viet Duc
Dr Kinh’s emails made the world look
You’ll come to ASEAN in Hanoi with me.

Gai Me Hoi Suc
Gai Me Hoi Suc
You’ll come to ASEAN in Hanoi with me.
And he sang with his friends at the closing ceremony
You’ll come to ASEAN in Hanoi with me.

There are many others in the team
Who made the congress run like a dream?
Thanks to you all for the hospitality
Let’s give a cheer for anaesthesia ASEAN
You’ll come to ASEAN in Hanoi with me.

Gai Me Hoi Suc
Gai Me Hoi Suc
You’ll come to ASEAN in Hanoi with me.
And he sang with his friends at the closing ceremony
You’ll come to ASEAN in Hanoi with me.

Dr Metz has made a full and uneventful recovery and the next meeting of the ASEAN Congress will be in Pattaya, Thailand between 10-13 November 2007.
What’s in a Name: Do we need to change the name of our speciality?

Dr. L.D. Mishra MD
Reader in Anaesthesiology & I/C Division of Neuroanaesthesia, Institute of Medical Sciences, Banaras Hindu University, Varanasi – 221005, INDIA
Email: ldmishra@rediffmail.com

I will begin my deliberations by reminding you of the various names with which our speciality and its practitioners were called until the recent past. Some would call it “Anaesthesia” and others as “Anaesthetics”. Accordingly, we the practitioners of the speciality were called “Anaesthetists”. Some (including even a few anaesthesia colleagues) will go to the extent of calling us “Anaesthetics”, as if we were a bottle of ether or halothane.

On analyzing the cause of this misunderstanding, we came to realize that this can largely be attributed to the words “Anaesthesia, Anaesthetists and Anaesthetics” themselves. These being relatively difficult words to pronounce were also difficult to understand. Yet, at least in part, this was also due to a lack of awareness and probably a lack of interest on the part of the public in our speciality and in us. This can be traced back to our historically less dominant clinical and academic role. I, being a strong proponent of pro-active undergraduate teaching of our speciality, would like to suggest that adequately taught new medical graduates who are well aware of our crucial roles may well act as our ambassadors to the masses including among the members of the medical fraternity.

The word “Anaesthesiology” emphasising that the speciality is concerned with the “science and practice of anaesthesia”, is a more meaningful and respectful name. So is the word “Anaesthesiologists” which refers to the “physicians who practice anaesthesia” after specialising in it. Surely, these appear more appropriate terms. Moreover, the term anaesthesiologist helps to differentiate us from non-physician (non-medical) anaesthetists. It is within this context that I would like to emphasize here that the practice of licensing and permitting non-physicians to work as anaesthetists in some countries (some Scandinavian, Eastern European, Australasian countries and the United States) is detrimental to the cause of anaesthesiology. In my view this trend should be stopped as soon as possible.

On the other hand, we have come to understand that anaesthesiology itself is not a very appropriate term for two main reasons:

1) In itself it is a fairly difficult word to pronounce (and sometimes to understand)

2) It is an incomplete word.

As for the pronunciation, readers who attended the inaugural function of our (ISA) 2003 national conference at Bhubaneswar, will be able to recall the way, the chief guest at the conference, the Chief Minister of Orissa pronounced the word. Although he could speak the word “Anaesthesiology” with some difficulty, yet he could not complete speaking the word “Anaesthesiologists” without stopping at 2-3 places. He pronounced it as “Anaes-thesi-o-logists”, even though the said Chief Minister is highly educated and very conversant in English.

In recent years, the speciality has emerged as a multifaceted clinical discipline occupying a “central role in overall patient care”. Anaesthesiologists are now playing a major role in the pre-, intra- and post-operative care of surgical patients. They work in the intensive care units as intensivists and as key consultants/specialists in the
management of critically ill patients throughout the hospital. Their role in the non-surgical management of chronic and intractable pain is also commendable. Trauma care and the medical management of natural calamities, disasters and other emergency situations are a few other emerging roles for us. As “anaesthesiology” is inadequate to describe our established and emerging roles, we need to consider a more appropriate term for our speciality which gives a more complete meaning to it. This idea is not totally new. There have been serious attempts to highlight the emerging sub-specialities of anaesthesiology and correlate the parent speciality with major subspecialities.3

Here it is worth considering a few other often used terms, such as “Anaesthesiology and critical care,” “Anaesthesiology and Intensive care,” “Anaesthesiology and Re-animation” or “Anaesthesiology and Resuscitation.” These and a few other similar terms have spontaneously come in use during the past few years, but the word “Anaesthesiology” remains a part of all these terms; so does the word “Anaesthesiologists”. To me, as also suggested by Hoellerich4, “acute care medicine” could be a more acceptable and versatile term. Yet, it falls short of the total nature of our speciality as it does not include “chronic pain management”.

In this regard, the term “perioperative, critical and pain medicine” could be a more befitting name for our speciality. It appears long but carries an appropriate and easily understandable meaning. Moreover, it is expected to bring more respectability to our speciality as we all know that “there is a lot in the name”.

It will not be out of place to mention a word of caution here. Just giving a new name to our speciality is not sufficient. We have to excel and perform second to none in the given areas of patient care. We must be adequately trained and experienced in the areas concerned. To meet these objectives, we need to continuously update our undergraduate, postgraduate and super-speciality teaching and training and demonstrate our academic and research potential.5 We may have to consider including mandatory rotations to most medical departments during postgraduate training and the respective super-speciality medical and surgical departments during super-speciality training.

Naturally this is not the end. I do, however, sincerely wish that this will initiate a serious dialogue on the issue and hope that it will not be an endless dialogue.

References


The views expressed in this article are those of the author and not necessarily those of the WFSA or the World Anaesthetic Society.
PROFILE OF ANGELA ENRIGHT
Chair of the Education Committee, WFSA.

Angela Enright was born in Ireland and graduated MB, BCh, BAO from the University College of Dublin in 1970, the same year she also gained a Licentiate of the Royal School of Music in London. After working as an intern and then a senior house officer in paediatrics, Angela moved to Canada and became a licentiate of the Medical Council of Canada in 1973. She was a resident in anaesthesia at the Foothills Hospital in Calgary between 1974 and 1977 when she became a Fellow of the Royal College of Physicians and Surgeon of Canada (FRCPC).

Angela then moved to the University of Saskatchewan in Saskatoon where she was director of residency training (1978-1980) and chief of anaesthesia at the Saskatoon City Hospital (1989-94). She subsequently moved to British Columbia where she became chief of anaesthesia in Victoria (2000-2005). She is currently medical director of anaesthesia for the Vancouver Island Health Authority.

Angela was an examiner in anaesthesia for the Royal College of Physicians & Surgeons of Canada between 1980-86 and was a professor of anaesthesia at the University of Saskatchewan. She is currently a professor in the Division of Medical Sciences at the University of Victoria and Clinical Professor of Anaesthesia at the University of British Columbia.

After serving as president of the Canadian Anesthesiologists’ Society (1994-95), Professor Enright was chair of the Organising Committee of the 2000 World Congress of Anaesthesiologists that was held in Montreal: another successful meeting. She was then invited to be the chair of the Education Committee and a member of the Executive Committee of the WFSA. She is also the chair of the Board of Trustees of the International Education Fund of the Canadian Anesthesiologists' Society (CASIEF). In these roles, she has travelled extensively throughout the developing world as well as managing to work in both Guatemala and Yap in Micronesia.

Angela has gathered many honours throughout her distinguished career from university colours for track and field at University College Dublin (1969) through woman pilot of the year at the Thunder Bay Flying Club (1973) to the Gold Medal for Distinguished Service to Anaesthesia of the Canadian Anesthesiologists’ Society (2003).

Angela is married to Patrick Enright, has had a lifelong interest in music and plays both the cello and piano. She enjoys the outdoors, particularly downhill skiing. She has also been working hard on her linguistic skills seeking to become fluent in both Spanish and French.

I regard it an honour to have got to know Angela and to work with her on the WFSA Education Committee.

Bill Casey (Painswick, UK)

VII Congress of Anaesthesiology (FESACAC 2006)

This Congress will be held in Santo Domingo, Dominican Republic between 7-11 November 2006. Topics to be addressed include:

- Regional Anaesthesia
- Paediatric Anaesthesia
- Medico-legal topics
- Pain management
- Emergencies and Trauma
- Obstetric Anaesthesia and Analgesia
- Cardiovascular Anaesthesia
- Neuroanaesthesia
- Ambulatory Anaesthesia
- Internet: Information and Teaching in Anaesthesiology

The Chairman of the Organising Secretariat is:
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E-mail: sda2000@verizon.net.do, sda_sociedad@yahoo.es
Website: www.fesacacrd2006.com
Kester Brown  
Former President, WFSA

Richard Walsh graduated from Sydney University, Australia in 1974. He undertook his post-graduate training in anaesthesia in Sydney and became a fellow of the Faculty of Anaesthetics in 1980. He had planned to spend some time undertaking further training overseas before seeking a definitive position in Australia but was encouraged to apply for a post as a cardiac anaesthetist at the Royal Prince Alfred Hospital in Sydney.

He was, however, able to travel overseas for three months visiting departments in the USA, UK and Europe where he made many friends and developed a broad vision of world anaesthesia.

Richard has continued to work at the Prince Alfred Hospital and was head of department for fifteen years. During this time, he has helped to train many anaesthetists from overseas chiefly from China, South East Asia and the UK. He has been an invited speaker at many overseas meetings and serves on the board of the Australian Perfusion Group of which he has been chairman.

He gained national prominence in anaesthesia when he became Secretary of the Australian Society of Anaesthetists in 1992, a position he held for 4 years. These were difficult times for anaesthetists as the government tried, unsuccessfully, to limit anaesthetist’s fees. He subsequently became an examiner for the final fellowship of the College of Anaesthetists and in 1988 became a councillor of the Australian and New Zealand College of Anaesthetists. He later held the position of treasurer of the College for six years and was president for two years.

In 1988, he led the successful Australian bid to host the 1996 World Congress of Anaesthesia in Sydney. He then became chairman of the Organising Committee of what turned out to be the largest medical congress to be held in Australia up to that time. The Congress was very successful and was attended by delegates from over 100 countries and speakers from over sixty.

He then became a member of the Finance Committee of the WFSA in 1996 and was appointed deputy treasurer in 1998 and treasurer in 2000, a position he continues to hold.

As well as filling these time-consuming posts, Richard continues to have a heavy “hands on” clinical workload as well as pursuing a number of interests outside anaesthesia. These include tennis, sailing, opera, cooking and history. Richard is married and has three daughters.

Richard Walsh has made and continues to make a great contribution to anaesthesia both in Australia and worldwide.

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5th Annual Meeting  
Asian Society of Paediatric Anaesthesiologists

31 August – 3 September 2006

For more information, contact:  
Dr Rebecca Jacobs  
Christian Medical College, Vellore 362004, Vellore, Tamil Nadu, India

Email: aspacmu@gmail.com  
www.aspa-2000.com
It is with great regret that we record the death of Henning Poulsen in Copenhagen, who died on 10th March, 2005. Poulsen was one of that band of Danish anaesthetists who remained in Copenhagen for much of the war and played an important role in the Danish resistance.

He was born in Copenhagen on 2nd May, 1918 and studied medicine at the University of Copenhagen graduating in 1946. In 1940 he married Gudren and they had three children, two sons and a daughter. In 1947 and 1948 he went to Stockholm to study anaesthesiology at the Karolinska Institute with Torsten Gordh. He also made visits to London and Oxford. On his return to Copenhagen, he worked at the Municipal hospital with Bjørn Ibsen, gaining recognition as a specialist Anaesthesiologist in 1952. In 1953, when the polio epidemic hit Copenhagen and Ibsen became heavily involved, Poulsen was given leave of absence so that he could assist Ibsen at the Blegdams-hospitalet. After that, Ibsen and Poulsen, went their separate ways since, later in 1953, they were told that one of them would have to go to Århus to fill a vacancy at the Municipal hospital there. They discussed this proposal with their respective wives. Ibsen's wife was not keen to go to Århus but, Poulsen's wife, who was a dentist, decided she was would be happy to move. There was no Chair in anaesthesiology in Århus at this time and Poulsen was appointed as Lecturer, a post he held from 1954 until 1975. Nevertheless, in Århus, he continued to make great contributions, particularly in the fields of resuscitation and intensive care.

In 1975, he left Århus to become Director of the Dansk Sygehus Institute - a post her held until 1988. Gudrun died in 1997 but Poulsen remained active and became president of the “Senior Forum”, arranging social meetings and events for retired doctors in North Sealand. During 1964, Poulsen had become interested in the World Federation of Societies of Anaesthesiologists (WFSA). He attended the WFSA 3rd World Congress in Sao Paulo, Brazil where he was elected as the WFSA Treasurer. He held this post for four years and, at the 4th World Congress in 1968 in London, he was elected Chairman of the Executive Committee. Normally a four year appointment, Poulsen was, exceptionally, re-elected to the post at the 5th World Congress in Kyoto in 1972. He was very active on behalf of WFSA during this time. He made teaching visits to the WFSA Training Centre in Caracas and he also visited Africa to assess the need for a similar centre there.

The greatest sorrow of his life was when his daughter died of asthma at the young age of 46. Poulsen had a brother, Gunner, who lived in Canada and with whom he stayed when he attended what proved to be his last World Congress of Anaesthesiology in Montreal in 2000. He leaves his two sons and his sister, also named Gudren.

John Zorab (Bristol, UK)
Professor Dr Jan Crul

Professor dr Joannes Franciscus Crul, known to all as Jan died on 28th April, 2006. He was one of the leading figures in Dutch anaesthesia for many years.

Jan was born in Batavia, now known as Djakarta, in Indonesia. His grammar school education was in Nijmegen but he undertook his medical training in Leiden. He trained in anaesthesiology with Ritsema van Eck in Groningen, later spending a year with Francis Foldes in Philadelphia. He became Chairman of the department of anaesthesia at the Radboud University in Nijmegen in 1957.

At the World Congress of Anaesthesiologists in Kyoto in 1972, he was elected Chairman of the WFSA Statutes and Bylaws Committee. Since the Statutes and Bylaws of WFSA had been originally written in Dutch and were due for a full review, it was a great advantage to have a Dutchman as Chairman. Following eight years as Chairman of the Statutes & Bylaws Committee, Jan was elected to the WFSA Executive Committee at the 7th World Congress in Hamburg in 1980 and then became a Vice President of WFSA.

In 1978, Jan became a founder member of the European Academy of Anaesthesiology (EAA) and delivered a thoughtful paper on “Newer Technologies in Training” at one of the EAA’s seminars in Sarlat, France. His research interests lay in the mechanics of the neuromuscular junction, on which he published many papers. He also had a deep interest in Respiratory Physiology. Through his leadership, Nijmegen developed one of the best training programmes in the Netherlands. He also made important contributions in training anaesthetists from the developing world, particularly Indonesia, Vietnam and Tanzania. He was elected a Fellow of the Royal College of Anaesthetists in 1972. He will be sorely missed.

John Zorab, (Bristol, UK)

Prof. dr. Manuel Soares Silva Araujo

I first met Manuel at the 4th WFSA European Congress of Anaesthesiology in Madrid in 1974. It was a fortunate meeting. We were each accompanied by our wives and it laid the foundations of a long-lasting firm friendship.

After that, I made several visits to Oporto and began to learn of the honoured position Manuel held in the eyes of his colleagues, particularly in the field of anaesthetic training and, of course, in the Portuguese Society. My wife and I were privileged to be guests in his home on several occasions where he and Elena always made us feel very welcome. Indeed, there are few visits among all those I made around Europe and elsewhere that I recall with such affection as those which took me to Oporto.

Manuel became a member of the European Academy in 1982 and was elected to Academician status in 1985. By that time, the European Diploma examination had just started and Manuel gave freely of his time to act as an examiner when it was held in Barcelona in 1991. Subsequently, in 1993, Oporto hosted the Annual Meeting of the Academy under the leadership of Manuel. That was our last professional meeting on Portuguese soil although we continued to meet at various congresses for many years thereafter. Portugal in general, and Oporto in particular will miss Manuel’s wise counsel and I shall miss a very dear friend. We extend our deepest sympathy to Elena.

John Zorab, (Bristol, UK)
Useful Information

World Federation of Societies of Anaesthesiologists (WFSA)
21 Portland Place, London, W1B 1PF
UK
Tel: (+44) 0207 631 8880
Fax: (+44) 0207 631 8882
Email: wfsahq@anaesthesiologists.org

Courses in Anaesthesia for the Developing World
Oxford (UK): July (annually).
Contact: Dr. M. Dobson
Department of Anaesthesia
John Radcliffe Hospital
Headley Way
Headington,
Oxford OX3 9DU
UK
Tel: (+44) 01865 221589
E-mail: michael.dobson@nda.ox.ac.uk

Bristol (UK): December (annually).
Contact: Dr. Claire Jewkes
Department of Anaesthesia
Frenchay Hospital
Bristol BS16 1LE
UK
Tel: (+44) 01179 701212
Email: james.rogers@nbt.nhs.uk

Remote Situations, Difficult Circumstances, Developing Country Anaesthesia
Hobart or Launceston (alternate years), Tasmania, Australia
Contact: Dr Haydn Perndt
Royal Hobart Hospital
GPO Box 1061-L
Hobart, TAS 7001
Australia
Email: haydn.perndt@utas.edu.au

Primary Trauma Care Foundation
An organisation training doctors and nurses in the management of severely injured patients in the District Hospital.
Contact: PTC Foundation
Outeniqua House
313 Woodstock Rd
Oxford, OX2 7NW
UK
Email: ptc@nda.ox.ac.uk

PTC Chairman: Dr Douglas Wilkinson (douglas.wilkinson@nda.ox.ac.uk)
PTC Administrator: Annette (admin@primarytraumacare.org)

Durbin plc
This organisation has bought ECHO and now supplies drugs and equipment to developing countries.
Contact: Durbin plc
Durbin House
180 Northolt Rd
South Harrow
Middx. HA2 0LT
UK
Email: www.durbin.co.uk

Equipment collection and distribution to the developing world
Carelift International Inc.
185 Walnut Street (Floor 22)
Philadelphia P.A. 19103
USA
Tel: (+1) 215 535 3590

Dr. William Rosenblatt
REMEDY
Dept. of Anaesthesia
Yale University School of Medicine
333 Cedar Street, New Haven
CT 06510
USA

Book Aid International
39-41 Coldharbour Lane
Camberwell
London SE5 9NR
UK
Tel: (+44) 020 7733 3577
The organisation is interested in receiving recent complete sets of journals and newish text books. These are collected free and distributed by Rotarians.

Society for Education in Anesthesia
International members are invited to join this Society that promotes techniques and excellence in the teaching of Anesthesia.
520N Northwest Highway
Park Ridge, Illinois 60069-2573
USA
Tel: (847) 825 5586
Fax: (847) 825 5658
Email: sea@asahq.org
Web: www.seahq.org

The TOKTEN Project
Expatriate nationals returning to their country of origin are invited to apply for the post of project expert. Each project is sponsored by the United Nations who would meet the cost of international travel and pay a subsistence allowance ($90/day). Applications should be made to the Minister of Health of the host developing nation.

Technical Assistance at Low Cost (TALC)
A unique charity that supplies low-cost healthcare, training and teaching material to raise the standard of healthcare and reduce poverty worldwide.
Contact: David Moreley
Institute of Child Health
Guilford Street
London WC1N 1EH
UK
Web: www.talcuk.org

Book Aid International
39-41 Coldharbour Lane
Camberwell
London SE5 9NR
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Institute of Child Health
Guilford Street
London WC1N 1EH
UK
Web: www.talcuk.org
Useful Information continued

Douleurs sans Frontieres (DSF).
Goals:
1. To participate, to create or to encourage any structure involved in the treatment of pain and suffering (cancer pain, AIDS, acute pain, etc.)
2. To search for therapeutic methods, to provide training and to propagate knowledge about pain and suffering especially in developing countries.
For further information contact:
Douleurs sans Frontieres
Docteur Alain Serrie
Hôpital Lariboisière
2, rue Ambroise Paré
75010 Paris, France
Tel: (+33) 1 49 95 81 77
Fax: (+33) 1 49 95 69 98
Email: alain.serrie@lrb.ap-hop-paris.fr
or
Docteur Jacques Meynadier
Centre Oscar Lambret
BP 307 - 59020 Lille cedex, France
Tel: (+33) 3 20 29 59 89
Fax: (+33) 3 20 29 59 97
Email: j-meynadier@o-lambret.fr

International Anesthesia Research Society (IARS)
2 Summit Park Drive 140
Cleveland, Ohio 44131
USA
Tel: 216 642 1124
Fax: 216 642 1127
Email: amaggiore@iars.org

The International Committee of the Red Cross (ICRC)
The ICRC acts to help all victims of war and internal violence, attempting to ensure implementation of humanitarian rules restricting armed violence.
Contact: ICRC, Recruitment Division
19 Ave. de la Paix
CH-1202
Geneva
Switzerland or your local society.
Web: http://www.icrc.ch

Overseas Doctors Training Scheme (UK)
Anaesthetists seeking recognised training posts in the UK should apply to the:
Bernard Johnson Adviser
Royal College of Anaesthetists
8 Russell Square
London WC] B 4JX.
UK
Tel: (+44) 020 7637 4104
Email: odts@rcoa.ac.uk

The SOROS Foundation will consider applications from anaesthetists in Eastern and Central Europe for support for limited periods of study in the UK. Applications should be made in advance to the branch office of their country of origin whose address may be obtained from:
The Soros Foundation
400 West 59th Street
New York
NY 10019
USA
Tel: (+1) 212 548 0600
Fax: (+1) 212 548 4600
E-mail: osnews@sorosny.org

Teaching Videos:
The following titles are available at £5 each:
1. Servicing the EMO & Tri-Service vaporisers.
2. The oxygen concentrator
3. The Manley multivent/ Glostavent
4. Servicing the anaesthetic machine
Contact:
Dr. R Eltringham
Gloucestershire Royal Hospital
Gloucester GLI 3NN
UK
Tel: (+44) 01452 394786/394194
Fax: (+44) 01452 394485
E-mail: reltringham@btinternet.com

Job opportunities in the developing world
These are listed in a bimonthly magazine produced by the International Health Exchange and on it’s website.
Contact:
IHE / RedR
1 Great George St
London SW1P 3AA
UK
www.ihe.org.uk

US volunteers wishing to spend periods working in developing countries
Contact:
1. Dr. Lena Dohlman
Health Volunteers Overseas
c/o Washington Station
PO. Box 65157
Washington DC 20035-5157
USA
Tel: (+1) 202 296 0928
Fax: (+1) 202 296 8018
2. Committee Chair
Overseas Teaching Program
American Society of Anesthesiologists
520 N. Northwest Highway
Park Ridge, IL 60068-2573
USA

World Anaesthesia
This organisation works to improve standards of anaesthesia throughout the world. In conjunction with the WFSA, it produces two publications, World Anaesthesia News and Update in Anaesthesia* (an add-on textbook) published twice-yearly. The annual subscription is £35, or $65. For further information
Contact:
Dr. Iain Wilson
World Anaesthesia Society
Association of Anaesthetists of Great Britain & Ireland
21 Portland Place
London W1B 1PY
UK
E-mail: carol@world-anaesthesia.org
www.world-anaesthesia.org
* also available at:
www.nda.ox.ac.uk/wfsa

Association for International Development of Anaesthesia (A.I.D.A.)
Contact:
Professor Stanley Samuels
Department of Anesthesia
Stanford University Medical Centre
Stanford
California
USA
Tel: (+1) 415 723 6411
Fax: (+1) 415 723 8544
Email: Samuels@Ireland.stanford.edu

Commonwealth Medical Awards
Available to citizens of Commonwealth countries for limited periods of postgraduate study within the UK. Applications should be addressed to:
Medical Awards Administrator
Commonwealth Scholarship Commission
36 Gordon Square
London WC1H 1PE
UK

Medecins Sans Frontieres (MSF)
offers assistance to populations in distress, to victims of natural and man-made disasters and to victims of armed conflict. They require volunteers for both long and short-term projects. If you are interested in obtaining more information, contact them at:
MSF
64-74 Saffron Hill
London ECIN 8QX
UK
Tel: (+44) 020 7404 6600
Email: office-ldn@london.msf.org
or
11 East 26th St.
Suite 1904
New York NY 10010
USA
Tel: (+1) 212 679 6800.
Email: www.msf.org or www.uk.msf.org

WHO Liaison Officer
Dr M Dobson
Nuffield Department of Anaesthetics
The John Radcliffe Hospital
Headington
Oxford OX3 9DU
UK
Tel: (+44) 01865 221589/741166
Fax: (+44) 01865 221593/453266.
E-mail: michael.dobson@nda.ox.ac.uk

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Email: wfcasey@doctors.org.uk

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Sumographics
67 Sullivan Road
Exeter
Devon EX2 5RB
UK
Tel: (+44) 01392 669098
E-mail: info@sumographics.co.uk
www.sumographics.co.uk
# Anaesthetic websites to try

## Resources

**Anaesthesia & Critical Care Resources on the Internet**
- www2.eur.nl/cgi-bin/accri.pl

**Anaesthesia UK**
- www.anesthesiaweb.com

**Anesthesia Web**
- www.anesthesiaweb.com/

**Anesthesia International**
- www.geocities.com/anestint

**Armenian Society of Anaesthesiologists**
- http://freenet.am/~armanest

**Ask Medline**

**Bandolier (Evidence-based Medicine)**
- www.j2.ox.ac.uk/bandolier

**Cyber Medical College**
- www.cybermedicalcollege.com

**Developing Anaesthesia (Australia)**
- www.developinganaesthesia.org

**Gasboys (& gasgirls)**
- http://gasboys.net

**Illustrated Regional Anesthesia**
- www.nysora.com or http://depts.washington.edu/anesth/regional/welcome/html

**Indian Anaesthetists Forum**
- www.theiaforum.org

**Primary Trauma Care Foundation**
- www.primarytraumacare.org

**Society for Education in Anaesthesia**
- www.seahq.org

**The Trauma Organisation**
- www.trauma.org/

**Virtual Anaesthetic Machine**
- www.vam.anest.ufl.edu

**Virtual Anaesthesia Textbook**
- www.virtual.anaesthsia-textbook.com

**Virtual Libraries and Museums**
- www.www.nda.ox.ac.uk/Pages/BooksFrame.html

**World Anaesthesia Online**
- www.world.anaesthesia.org

## Journals:

**Anaesthesia**
- www.blackwell-science.com/ana

**Anaesthesia and Analgesia**
- www.anesthesia-analgesia.org

**Anaesthesia and Intensive Care**
- www.aaic.net.au

**Anesthesiology**
- www.anesthesiology.org

**British Journal of Anaesthesia**
- www.bja.oupjournals.org

**British Medical Journal**
- www.bmj.com

**NEJM**
- www.nejm.org

Blackwell, the publishers of numerous anaesthetic and pain journals including the BJAA and Acta Anaesthesiologica Scandinavica are available free of charge to those working in developing countries at www.blackwell-science.com/anaesthesia.asp

## Associations:

**American Society of Anesthesiologists (ASA)**
- www.asahq.org

**Association of Anaesthetists of Great Britain & Ireland**
- www.aagbi.org

**Australian Society of Anesthetists**
- www.asa.org.au

**Douleurs Sans Frontieres**
- www.douleurs-sans-frontieres.org

**European Academy of Anaesthesiology**
- www.eaa euro-anaesthesiology.org/

**International Anesthesia Research Society**
- www.iars.org

**International Society for Anesthetic Pharmacology (ISAP)**
- www.isaponline.org

**International Society for the Study of Pain**
- www.iasp-pain.org

**International Trauma Anaesthesia & Critical Care Society**
- www.itaccs.com

**National Confidential Enquiry into Patient Outcome and Death**
- www.ncepod.org.uk

**Obstetric Anaesthetists Association**
- www.oaa-anaes.ac.uk

**Royal College of Anaesthetists**
- www.rcpa.ac.uk/

**Society for Ambulatory Anaesthesia**
- www.sambahq.org

**Society for Critical Care Medicine**
- www.sccm.org

**Society for Computing and Technology in Anaesthesia**
- www.scata.org.uk

**South African Society of Anaesthesiologists**
- www.sasaweb.com

**World Federation of Societies of Anaesthesiologists**
- www.anesthesiologists.org

The Editor would be delighted to hear of other sites that might be of interest and to learn of any site addresses that are incorrect or no longer functioning.
# World Anaesthesia Society

## Application Form

**Are you a new member or renewing your subscription:**  
New ☐  Renewing ☐

**If renewing, how do you usually pay:**  
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The current subscription is £35 (or equivalent $65, €50). If you have a UK bank account, please complete the attached standing order mandate and forward to your bank.

If you live outside the UK and are able to pay, please complete the credit card details on the form.

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**Particular interests:**
(e.g. subspecialities of anaesthesia/care of the critically ill, education, distance learning, appropriate research, writing, disaster relief, conflict situations, medical missionary, long term secular):

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**Availability:**
Are you happy to answer enquiries relevant to your experience?  Yes [ ] No [ ]
Are you able to write for WA publications?  Yes [ ] No [ ]
Are you available for working visits abroad?  < 1 month / 1 to 6 months / longer term
How much notice do you require?  2 weeks / 2 months / 6 months / > 6 months

**Credit/Debit Card Payment:**
I wish to pay by:  Visa / Delta / Eurocard / Mastercard
I authorise you to debit my account annually with the amount of:  £35
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**Please return this form to:**
Dr Karen Henderson, Treasurer, WAS, Association of Anaesthetists of Great Britain & Ireland, 21 Portland Place, London, W1B 1PY, UK.