In this issue:

Tribute to Professor Dorothy ffoulkes-Crabbe

An Epitaph for Di-ethyl Ether

An Elective in Anaesthesia
A resurgence of draw over anaesthesia

Although the draw-over technique is now seldom used in hospitals with full facilities and plentiful resources, it is nevertheless enjoying resurgence in popularity among those anaesthetists practising in difficult environments and with the military.

This is not surprising considering the poor record of the latest ultra-sophisticated anaesthetic machines in hospitals without access to the technical expertise needed to service, calibrate and maintain them and in situations in which the supplies of oxygen or electricity are unreliable. These expensive machines and accompanying electronic monitors are not designed for these conditions in which they are totally useless. They are generally discarded at the first fault and immediately consigned to the graveyard of anaesthetic apparatus which is such a familiar feature of hospitals in parts of Africa and Asia.

Although these conditions are so widespread in Africa and Asia, the requirements of the anaesthetists there have been largely ignored by equipment manufacturers and aid agencies as if they don’t exist or are unimportant.

Attempts to standardize equipment such as CE marking have been of no relevance in rural Africa. The anaesthetist working in isolation without oxygen is not impressed to be told that, although his new expensive anaesthetic machine cannot function, nevertheless it possesses a CE mark. This situation has been going on for far too long and it must be accepted that anaesthetic machines designed for difficult environments need to meet much more exacting standards.

However, in recent years there have been encouraging signs that that the plight of colleagues in difficult environments is being taken more seriously. W.F.S.A. Refresher courses, equipment workshops in Canada, Uganda and Australia and A.A.G.B.I. seminars for developing world anaesthetists are examples of changing emphasis.

There have also been great improvements in draw over equipment resulting in enhanced performance and, consequently, renewed interest in this technique. Most of these improvements have been at the instigation of anaesthetists who themselves work with limited facilities in difficult environments. They have first hand experience of the unique problems faced in these conditions and know that they can only be overcome by equipment which is purpose built to do so.

Now that suitable equipment is readily available it is to be hoped that aid agencies and other donors will respond to the pleas of the local anaesthetic staff and supply the equipment that is requested locally rather than impose unsuitable equipment for their own convenience or the benefit of other...
About 25 years ago, as a registrar in anaesthetics at King’s College Hospital, Denmark Hill, London, I was first introduced to a great persona in the world of inhalation anaesthesia: Di-Ethyl Ether.

The occasion was another registrar’s imminent departure to work in Nepal. I forget her name, but I remember that she had been informed that ether was the mainstay of general anaesthesia in that country and as she had never used it, she felt that some experience with the agent was required, in the teaching environment of Dulwich Hospital (a satellite of King’s). She decided that the patients on her morning list would be anaesthetised with ether.

How times have changed! How much that is implicit in those simple words above has vanished from the everyday experience and training, the freedom of practice of anaesthetists today. All in less than the span of one professional career.

The notion that something done in Nepal could as well be done in England, that some equivalence might exist between the two, in training, practice or equipment. That a registrar could chose a method of anaesthesia and a different patient breathing system, found in standard texts and renowned for its safety, of his or her own free will. That ether, once the everyday agent in western practice could be found and that a consultant would be around to supervise with expert eye.

Alas, even then in 1983, things went badly wrong. Perversely she chose exactly the wrong occasion (a packed minor gynae list) to try out ether, but things would probably still have gone wrong.

The patients would not go to sleep, they would not stay asleep, they would not wake up, the surgeon could not use diathermy, the theatre staff all developed headaches, the scavenging did not connect with the breathing valve, the recovery staff could not go home, everyone was vomiting post-op, the administration lodged a complaint about the smell wafting down the corridor, the visitors were complaining, the list over-ran and afternoon list was partly cancelled. A ward sister, a patient on the list, made an official complaint. All surgeons were speechless with rage – one benefit at least.

I don’t know about the (hastily) departing registrar, but the lesson I learned that day was that ether has its role in the science of inducing insensibility but shifting a lot of minor gynae cases is not part of it.

I next came across our venerable friend in Africa, some three years later. Ether was there provided in wonderful large brown bottles with foil-wrapped cork stoppers under screw caps, embossed with the name of the sugar factory in Durban, South Africa where they were made, a product of the sugar cane business. You needed a corkscrew to get in. Opening a bottle felt like an occasion.

I learned about dehydrating alcohol with concentrated sulphuric acid which could be re-used indefinitely. As Malawi also produced sugar, I naively explored the business of the country becoming self-sufficient in volatile agents.

Queen Elizabeth Central Hospital, Blantyre, Malawi, had EMO and PAC vaporisers to administer the agent, but no one ever used ether at that hospital. The EMO’s were already museum pieces and, by a quirk of timing, my arrival coincided with the delivery of the Malawi Anaesthetic Machine, which used the PAC vapouriser. The ether, of several years vintage, was sitting on the shelf, apparently waiting for the random conjunction of a means and a person to give it. There was no expiry date. Perhaps it did not expire. So, here was my chance to
welcome ether, in a friendlier environment than Dulwich Hospital.

There were two situations where my new friend excelled in patient response; indeed saved lives: caesarean section and the very sick patient. We had plenty of both and the ether bottles were soon standing empty – we had to return the empties in order to get full ones; that was the system.

By what mysterious process ether causes both the post-gravid uterus and the adrenal glands to be squeezed I do not know and now, with ether's demise, the secret will go to grave. We will never know. But squeezed they do get and the result, (marvellous to behold for the anxious anaesthetist) which is the pallid, tightly clenched, formerly haemorrhaging flab and a mother with bounding pulse and puffing-billy minute volume of 10+ litres can only be seen during ether anaesthesia. This is Etherisation (still accepted by my spell checker). Ketamine comes nowhere near. As regards the other Dulwich ether woes, all was well: the nurses complained of headaches but when I said it was a pure ethanol hydrocarbon they were happy, no one vomited in recovery, mothers were comfortable and administrators were yet to discover where the operating theatre was, so we were safe.

Then the ether ran out. This was the problem with ether: one C/section used up to 200 ml and with about 3 GA C/sections (plus other needfuls) a day, we were running through the stock in the Central Medical Stores fast. We were re-supplied from time to time, until about 1995, and then it stopped altogether.

I went round to the stores and had the following conversation with the Chief Pharmacist:

Chief Pharmacist: CMS does not stock ether.

Me: Yes, that's true, you are out of stock. Please order some more.

CP: CMS has never stocked ether.

Me (offering embossed brown bottle): This bottle came from CMS. It contained ether.

CP: There is no label to prove that. (The label had been washed off).

Me: The writing on the bottle shows the factory in SA where they make it.

CP: They also make alcohol. Maybe it's an alcohol bottle.

Me: Smell the contents, it smells of ether.

CP: It might be toxic for me to smell that.

Me: Ether is not toxic; we give it to all our patients.

CP: I don't know the smell of ether.

I smelled the bottle for him. It smelled of nothing. Someone had been using it as a water bottle.

I tried again to order through the conventional channels. The Chief Pharmacist was in New York, at a management seminar on the privatization of drug procurement. When he returned, he sent me an invoice for the cost of the ether, as obtained from the same factory whose name and contact details I had given, plus 12% commission for his department's services. The Central Medical Stores had been privatized following the recommendations of a recent DFID funded workshop, he explained. The Business Action Plan of the Workshop said that he had to make a profit.

He sat back and waited for his money. As far as he was concerned, in his newly privatized store, he had done his job. Now he was a Manager. He outsourced.

Reluctant to diminish our Departmental slush fund in support of the now-despised Chalker-Blair doctrine, we bought ether through our own agent, an enterprising Medical Assistant who brought it up from the factory by bus in 25 litre drums. We kept it in an underground room. One day it rained, the room filled with water and all the drums came floating up.

The problem with ether had thus become how and where to get it – suppliers would not supply it and procurers would not procure it. I now have the sad duty to report that this has become the world-wide terminal condition of my 160-year-old friend. A severe attack of non-availability, metastasising to all parts. I went to Nepal recently. No ether. I went back to Malawi last month – on a hands-up of 30 people, no one used it and most had never used it. Indonesia is probably the world's largest remaining user. But in Surabaya it went from being used in 20% of cases in 1999 to 3.5% in 2001. The interloper? Not halothane but isoflurane.

Somewhere from Tanzania, or remotest Gulu, Uganda perhaps, we may hear a faint bleating: "Reports of my death have been greatly exaggerated". But I fear that sometime very soon, probably in the next 5 years, the last ether anaesthetic ever to be given will be given from the last bottle taken from an empty shelf and the pharmacist will say, without a flicker, "We never stocked ether here." The record will be lost.

So please, can someone – whoever has this great honour, the one who will give W.T.G. Morton the closure he needs – an anaesthetist who may not even know at the time that HE or SHE was the ONE – please record for posterity the date and the time, take a picture – even if the vaporiser is empty – of this momentous event for the Annals of Anaesthesia.

Lest we forget; we were well served.
The winter seasons and cold weather brings to mind the story of baby Jesus wrapped up in swaddling clothes in a manger and the long silent and cold night. Although baby Jesus did not have general anaesthesia and surgery, he was prevented from having hypothermia. It is well known that general anaesthetics, with or without the effects of surgery, may have important complications related to interference with thermoregulation resulting in hypothermia in the operating theatre. Temperature regulation: monitoring the operating room (OR) environment and patients, especially neonates coming for operation, is therefore mandatory. An OR environmental temperature of 22-24°C which is comfortable for the surgical team may be too low for neonates, therefore a thermoneutral environment of 28-30°C is required to maintain normothermia in them.

Hypothermia has many deleterious consequences amongst which are increased oxygen consumption, apathy, metabolic acidosis, apnoea, ventricular fibrillation and difficult reversal of neuromuscular blockade. Although, the radiant heat from the OR lights helps to prevent heat loss and to maintain normothermia, it is often necessary to use warming blankets, hot air convection systems and Gamgee gauze in babies but these may not be readily available in resource poor environments.

In our theatres, we usually improvise with cotton gauze and drapes [Figure 1 & 2]. These can be pre-warmed, even without an oven, by placing them on top of a warm sterilizing unit before the neonate arrives. After
Education

routinely skin preparation, this is then used to wrap up the baby on the operation table while exposing only the area for operation. Final draping is then performed as required for the operation. Temperature monitoring can be achieved using a simple thermometer intraoperatively. Supplemental warming can be provided by using warm infusions and blood as required or using warmed up bags of infusion fluid as hot water bottles. Heat loss using these simple methods is effectively reduced intraoperatively. There is also an adequate maintenance of a normal and stable body temperature trend and no associated over heating or burns.

Swaddling is the art of snugly wrapping a baby in a blanket or some kind of fabric for warmth and security. It is commonly used in homes and non-hospital setting by mothers and it dates back to before the birth of Jesus Christ. Swaddling, as performed in our theatre is a user friendly technique, cheap and easily available. Materials for swaddling can be cotton wool and cotton fabrics. It’s application requires no training and can be applied even by non-medical staff. There are no risks of electrical shocks or burns and it is not dependent on electricity therefore can be used in rural settings.

Although, forced-air warming units are very effective, they are costly and the disposable blankets available may not be easily affordable in resource poor environments. Furthermore, the hoses of forced-air warming units are potential sites for bacterial colonization because they are difficult to clean. The airstreams from forced air warming units have also been shown to carry pathogenic organisms. In contrast, cotton fabrics used for draping are very affordable, they are easy to wash and sterile and so have little or no risk for causing infection when handled properly.

Ideally, temperature needs to be closely monitored regularly throughout the course of anaesthesia and surgery. Swaddling of a baby may be continued postoperative to prevent disturbance by the startle reflex when recovering from anaesthesia. The baby feels more secure because swaddling simulates the position and confinement of the baby in the womb, as well as helping to reduce pain and stress. The muscle and joint position sensors which are at rest and are quiet, helps in calming the baby.

In conclusion, we need to remember that hypothermia can be prevented in neonates using the simple technique and traditional method of swaddling borrowed from revisiting the manger during Christmas. It has a very low risk of complications, does not depend on electricity and does not require any formal training.

REFERENCES:
It is sad to watch an excellent health delivery service slowly disintegrate. That is what has happened in Zimbabwe.

In 1980 at Independence from Britain, health care at least in Zimbabwean cities was functioning, available to all, and working to standards as good as many parts of the West. Nurses and doctors were enthusiastic and hard working and students were being well trained to high standards.

Over the next years facilities for health care opened up throughout the Country and many doctors were working in rural areas. Then from the mid 90s the hospital services began to deteriorate with ever increasing speed especially in the last year. Now the once free government hospitals only admit the sick after a substantial down payment, after which the relatives will have to access various essentials such as drugs. They may also have to provide clean bed linen and food. Only some wards are open and many toilets are blocked. There are student nurses but a minimum of trained nurses on duty.

Why is this? The basic reason is economic. With the highest rate of inflation in the world there is little money to spend on essentials and salaries, let alone maintenance. Windows remain broken and plugs unscrewed from their sockets are not replaced. Nurses' salaries went up and up, but in real terms went down and down. Towards the end of 2008, nurses stopped reporting for duty because their salaries would no longer pay the bus fares to get to work. On November 18th 2008, Hospital staff at the main hospital in Harare, Zimbabwe's capital city, staged a demonstration to draw attention not only to salaries, but also the absence of so many essentials such as drugs and other basic equipment. The riot police were called out and the planned march did not manage to get far beyond the hospital grounds. A 4 hour protest was held in the hospital grounds.

The riot police finally attacked and some staff were beaten up. The protesters tried to bring their grievances to the authorities, but neither the Minister of Health nor Secretary for Health, seemed able to take any serious action. Leadership from Government was non existent.

The situation reached its lowest ebb after this with all staff on strike. Some doctors remained willing to support an emergency service, but with no other staff, nurses, cleaners, laundry, pharmacy it was impossible. The nurses who left the ICU in the main Parirenyatwa Hospital walked out locking the door behind them and taking the keys. At this point, patients requiring emergency Caesarean Sections either died at home or somehow got to Mission or District Hospitals, often many kilometres away. One gynaecologist led the move to set up an emergency maternity service in Harare. At a meeting of the Zimbabwe Association of Doctors for Human Rights on November 29th a resolution was passed to try to set up basic primary care service using volunteers. I am pleased to report that the Harare Dept of Anaesthetics never failed to provide emergency anaesthesia when it was possible to use theatres.

The situation in Zimbabwe's second town, Bulawayo, was even worse. At the main hospital, Mpilo, most drugs and disposables had to be provided by the patients relatives, who frequently could not access sufficient funds, oxygen supplies in the main theatres broke down, as did the freezing system in the mortuary. This later was particularly disastrous. At one time the mortuary was housing 269 bodies, many of which were not collected because of the high cost of funerals.

Urgent communication with the Ministry of Health only resulted in a secretary being asked to ring round the Embassies for help. Again Anaesthesia did not collapse thanks to one local consultant, two foreign nationals, who might or...
might not be willing to work, some nurse anaesthetists, and a handful of interns.

Narcotics were unavailable in both cities for more than a year. In Harare paracetamol suppositories were used for post operative analgesia, with poor results, and in Bulawayo ketamine drips, with the patients monitored in ICU.

In addition to the problems in the hospitals, a cholera outbreak has raged throughout the country from mid 2008 with to date 4000 deaths. Excellent attempts have been made to tell people how to avoid infection. But in some areas of greater Harare, there is inadequate water supply or none at all, and sewage is running down the street.

Frequent electricity cuts making boiling of water difficult. So it is not surprising that the epidemic is still uncontrolled.

Fortunately 2009 has seen an improvement in the hospitals in parallel with some long awaited political changes. Most staff still remaining in the country are back on duty with salary payments in January of US $ 100 across the board. NGOs, Embassies, and other well wishers have provided drugs and other essentials and even a few elective lists are starting up again. It is good to be able to report that despite the problems both Government, and University Departments of Anaesthesia have continued to provide a service, thanks to a few dedicated individuals including Nurse Anaesthetists. The Zimbabwe Anaesthetic Association celebrated its fiftieth anniversary in 2008 with its usual excellent two day Congress. But sadly although training has continued for medical students, nurse anaesthetists, interns, and specialist registrars the quality has dropped.

Anaesthesia is essentially a practical subject. With minimal surgery being done theory replaces ‘hands on’ training. Young doctors have voted with their feet and this year there were no applicants to start the 3 year specialist M.Med training.

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**Announcements**

The 4th All African Anaesthetic Congress is to be held at the Kenyata International Conference Centre in Nairobi, Kenya between 12-17 September 2009. Further information and registration details can be found at [www.aaackenya2009.org](http://www.aaackenya2009.org)

We are sorry to report the death of Dr Carlos Parsloe, a former president of the WFSA (1984-88). A profile of him was published in World Anaesthesia News, Volume 10, No1 in March 2008.

The Oxford/Kampala course will take place in Kampala between 1 - 6 November 2009. For further information contact Dr Mike Dobson at [michael.dobson@nda.ac.uk](mailto:michael.dobson@nda.ac.uk)
It’s what all medical students look forward to, the clinical elective. Two months almost anywhere in the world gaining hands on experience in a branch of medicine that we’re interested in, no exams, no log books, just great experience in exciting places. For many it’s their first extended trip abroad and the excitement is palpable as the time approaches. Even for a mature student following an action-packed ‘gap decade’ I just couldn’t wait to get there.

Ethiopia is the only African country never to have been colonised and its 80 million inhabitants continue to face considerable challenges in terms of health. The population is spread over vast swathes of beautiful highland terrain but the combination of difficult and lengthy access to health care services, poverty and health behaviour results in many patients presenting to hospital late.

I was based at ‘Jimma University Specialized Hospital’ a 300 bed tertiary referral centre situated in Oromia province about an 8 hour drive south west of Addis Ababa. The hospital is situated out of town, on a hill side amongst trees next to the Jimma University campus and queuing patients, staff and students enjoy the company of monkeys and lots of large squawking birds as they go about their business.

Besides the overall aim of gaining insight into health care in a developing country, the main aim of the elective was to pursue my interest in anaesthesia and gain as much practical experience as possible. I was interested in both anaesthetic education and anaesthetic practice particularly in the obstetric department, as well as the wider role of the anaesthetist including intensive care and emergency medicine.

Times are changing for anaesthetic provision in Ethiopia. Since the early 1970’s when the World Health Organisation and the Ethiopian Ministry of Health set up the first school of anaesthesia for nurses, almost all anaesthetic care has been provided by the 300 nurse graduates of this institution. The school recruited existing nurses and gave an additional two years training providing the graduates with an advanced diploma in anaesthesia. 2003 saw the introduction of a new B.Sc. Degree in Anaesthesia, a four year course designed to equip individuals with the scientific and medical basis as well as the practical experience necessary to work independently as anaesthetists throughout Ethiopia. It also aims to address the deficit in numbers whilst retaining these professionally trained staff in the country. Anaesthesia is not a popular speciality choice for junior doctors, and there are currently only 14 medical anaesthesiologists working in the whole of Ethiopia. In Jimma, the first graduates entered the work force in the summer of 2008 not long before I arrived, and I was fortunate enough to spend my elective working closely with two of them.

In order to gain a place on the course students graduating from high school in the natural sciences apply to the health and medicine faculty. Depending on their grade point averages, students then have a series of courses they can apply for including medicine, pharmacy, dentistry, health officer training, laboratory technology, anaesthesia, nursing and environmental health.
Students rank the courses in terms of preference although decisions are ultimately made by the Ministry of Health who allocate students to courses where often demand for places exceeds availability. There are no interviews. While I was there I asked 23 2nd year students where they ranked anaesthesia on their university application forms and why, and also what they knew about anaesthesia before applying. 69% of the cohort had put anaesthesia in second place or lower in their order of preference and there was a universal lack of knowledge regarding the role of the anaesthetist prior to starting the course, although this is changing as the course has filled and applicants talk to enthusiastic graduates and current students. Once on the course students cover a broad range of topics. The first two years involve generic modules where students study alongside other healthcare professional undergraduates. In the first year this includes modules such as biochemistry, anatomy and physiology, and the second year focuses more on the clinical modules such as medicine, surgery, paediatrics and Obstetrics and Gynaecology. The third and fourth years involve a series of anaesthetic specific modules covering many aspects of anaesthesia along with practical exposure. Graduates are required to have performed over 200 major general anaesthetic procedures with tracheal intubation and over 15 paediatric, obstetric, emergency and regional anaesthesia cases before graduating.

There were 31 students in the first cohort that began in Jimma in 2004 and in September 2008, 22 of them entered the workforce as practicing anaesthetists. Of the other 9, 4 were asked to leave in the first 2 years and the remaining 5 were required to re-sit a year and they will graduate in the class of 2009. There are approximately 20 students currently studying in each of the subsequent years. Once qualified, the graduates are assigned posts throughout Ethiopia. The majority are sent to work in the regional health centres where they will be largely responsible for all the anaesthetic care of patients in those institutions. Some of the graduates remain in the teaching hospitals and referrals centres where they immediately begin independent practice and in some cases have already become involved in mentoring and lecturing their juniors.

I met four graduates in Jimma, where I spent the majority of my time assisting two of them in both the main and obstetric operating theatres. Main theatres performed a range of intermediate operations including orthopaedic, gynaecological and general surgical procedures. My focus was to learn about the machines, anaesthetic techniques, and the pharmacology of anaesthetic agents and gain practical skills such as tracheal intubation. Pre-operative assessments were rare due to the emergency nature of much of the surgery and theatre lists that changed like the wind. I found the graduates intelligent, proud and motivated and to my relatively untrained eye they appeared entirely competent and extremely knowledgeable and I learnt a lot from them. They talked a lot about anaesthetics, resource issues, inter-professional relationships and their futures, sharing many concerns and challenges with anaesthetists I have spoken to from the UK. It seems their main concerns are the lack of rungs on their career ladder, a deliberate but necessary aspect of the qualification designed to keep the staff in the country. From an outsider’s perspective, it seems there must be a balance between attracting quality applicants and catering for their inevitable desire to progress if the course will serve its purpose of raising standards of anaesthetic care.

In the obstetric theatre, as well as assisting in many anaesthetics for obstetric procedures, I also carried out an obstetric anaesthetic audit in order to try and determine the contribution of anaesthesia used for caesarean sections to maternal death and identify any possible contributing factors.

Ethiopia has one of the worst maternal mortality rates in the world although despite recognition of this, tackling maternal mortality remains a difficult task due to its complex nature. The majority of both maternal and perinatal deaths are due to obstructed labour with or without ruptured uterus. Not long after I arrived in the obstetric department there were six uterine ruptures in one 24 hour period. Other common causes of death include the hypertensive disorders of pregnancy, anaemia and hypovolaemia and sepsis, and a proportion of deaths are due to anaesthesia.
The rationale for this part of my elective was that almost all anaesthetic related maternal deaths are due to complications of general anaesthesia, and in Ethiopia general anaesthetics are given routinely for all obstetric surgical procedures including caesarean sections despite the availability of spinal anaesthesia in some centres. The reasons for this may include lack of equipment, or familiarity with the technique and the emergency nature of many of the operations depending on the centre. The reasons for anaesthetic related death i.e. intubation failure, lack of support or experience, aspiration and anaphylaxis all need to be addressed if the anaesthetic proportion of the maternal deaths are to be minimised, at least until spinal anaesthesia is more commonly used.

Despite a short study period of only 4 months there were 3 maternal deaths, all of which were due to ‘uterine rupture’ and none of which were attributed directly to the anaesthetic. Although this may reflect the relative scarcity of anaesthetic related death, previous research and ICU records suggested deaths do occur due to aspiration of gastric contents for example and may be in the region of one per year. The anaesthetic records also showed no use of antacid premedication in any of the cases. 155 of the 166 cases were emergencies.

Having arrived home and having had a chance to reflect on my experience in Ethiopia, I think it would have been tough for me to find a more enjoyable and educational elective. It helps knowing what you want to do after graduation, as the time flies and it’s great to have a focus. Working with the anaesthetic graduates was an education, a privilege and lots of fun, and despite some data issues the obstetric audit was a valuable exercise. Ethiopia can be a challenging place to work and travel, although there is definitely truth in the old adage that you get out what you put in. A trip to the Simnean Mountains on the way home is a must!

The moral imperative to provide overseas aid is easy to find. The UN “Universal Declaration of Human Rights” is one example. Article 25 supports the “right” of everyone access healthcare. I wish to discuss some of the ethical issues that arise in providing overseas aid. It is unrealistic to expect the resolution of all ethical conflicts and my aim is promote discussion and reflection. There often is no correct answer to ethical dilemmas. I will concentrate on the contribution we, as anaesthetists, can make after addressing some of the general ethical considerations of aid.

Firstly, if we accept the right to access healthcare, with whom does the corresponding responsibility lie? Is it governments, ours and/or that of country to be aided? Is it NGOs, international organisations such as the WHO or the UN, medical societies such as the WFSA or individuals?

An important concept is that of dignity and respect for the population to be helped. Through involving the local community in the entire aid process, they retain autonomy and when we know what they want and need, the most appropriate aid package can be provided. I would suggest that that working in this way with the recipient community is not paternalism.

What is defined as aid? Again this can be referred back to the community. Do they want an improved infrastructure, food, clean water, urban planning, public health projects such as vaccination or acute medical care for the victims of natural disasters or military conflict? Alongside specific outcomes the dignity and autonomy of the local population must be respected. By supplying support and education as well as practical assistance, our contribution is magnified and enduring and maintains the respect of the community. Remember that is better to give a man a fishing rod than a fish.

For my part, my contributions might include anaesthetising patients, teaching, providing educational material, providing financial support or simply staying at home and covering the duties of others who are travelling and teaching.
A powerful motivation for providing aid is a personal moral code to “do good.” As one with specialist skills and the opportunity to help others, is it my responsibility to do so? There might be other motives such as a love of travel, medical tourism, research interests, or invitations from colleagues or pharmaceutical companies.

The questions of justice and resource allocation arise in several aspects of aid including the issue of waste. The efficacy of aid can be reduced by a lack of coordination between aid programmes, poor planning, incompatible supplies, excessive salaries for expatriates, corruption and so on.

Two philosophical views may appear to conflict: that of utilitarianism, “the greatest good for the greatest number” and that of autonomy with the potential of the best health for the individual. Should resources, always limited, be spent on projects to give benefit to as many people as possible or can I, as an anaesthetist, justify treating one patient at a time while knowing that many others could benefit from the same individual care? When combined with teaching local anaesthesia providers my one-on-one care is probably helping to improve other people’s health as the country’s health service develops. I trust that concurrent with my work, public health projects are being undertaken. Meanwhile, I exercise beneficence for those individuals under my direct care.

Is anyone disadvantaged or harmed by aid work? Perhaps I do not need to travel to provide aid. Are Australia’s indigenous populations being ignored and harmed while I provide aid to the populations of other countries? Doctors and other health professional travelling to Western countries to train may decide to stay there. This medical “brain drain” is disadvantaging the health services in their country of origin.

The benefits of overseas aid work extend to those who are the “helpers”. Many who return from aid missions say it was them who learnt the most and express their humility. The educational aspect of overseas work may benefit trainees and, in addition, they may provide support and encouragement to their peers. By encouraging and supporting trainees in aid work, a new cohort of anaesthetists will become aware of further career opportunities.

We may witness, poverty, abuse, corruption and the consequences of warfare and torture as well as experiencing different values of life, health and death in different cultures and societies. This can be very disturbing.

Providing aid may involve moral conflicts and challenges and provoke feelings of helplessness and pointlessness. Camus offers a response to this in his novel “The Plague”.

Examples of specific ethical decisions and confrontations that might arise when providing overseas aid might include; what is achievable in my time, am I compromising my standards, is using out-of-date medication or poorly serviced equipment justifiable, how do I deal with requests for preferential treatment from those in positions of authority, how do I deal with witnessing deaths that would have been easily preventable at home or with decisions made by the family or community rather than the patient themselves.

Coordinated aid programmes incorporating local education and support that are providing outcomes desired by the communities to which they are provided are the most ethical ways to contribute to increasing global access to sustainable health care.

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Background
Some years ago, when I worked at Gloucestershire Royal Hospital, I formed a friendship with Dr Arturo Segovia (AS) then an honorary SHO and now President of the organising committee of the Paraguayan Anaesthetic Congress. As this was the first national/international Congress organised in Paraguay after a gap of 7-8 years, our participation was more than welcomed by our Paraguayan hosts.

The Link
After being invited to Paraguay, I contacted 3 other colleagues and good friends, who were equally interested in teaching and lecturing in the UK and abroad.

The UK-based anaesthetists involved were:
1. Dr. Iljaz Hodzovic(IH), Senior Lecturer at the University of Wales College of Medicine Cardiff and Consultant Anaesthetist at the Royal Gwent Hospital, Newport
2. Dr. Cristobal Rincon Aznar(CR), Consultant Anaesthetist, Maelor General Hospital, Wrexham
3. Dr. Rafael Blanco Davila(RB), Consultant Anaesthetist, Lewisham General Hospital, London
4. Myself: Dr. Bazil Ateleanu(BA), Consultant Anaesthetist, University Hospital of Wales, Cardiff

Planning
We discussed potential topics, the timing of the Congress and our travel arrangements with Dr Segovia who also arranged our accommodation in Paraguay. We decided that we would have a symposium consisting of two days of lectures and workshops preceding the international congress at which we would lecture on different topics.

We left a cold and rainy London in the evening of 21st of March and travelled on TAM (Brazilian airline) from London to Asuncion via Sao Paulo. Both outbound and inbound flights were overnight flights of approximately 18 hours each. Despite having checked in our luggage directly to Asuncion, we discovered that, incredibly, most of our presents for our host in Paraguay, contained in a non-locked bag, were stolen. Interestingly, the anaesthetic presents (bougies, books etc.) were left untouched.

On a hot Sunday morning we arrived at the Silvio Pettirossi Airport in Asuncion, where AS was waiting for us. We stayed at the Hotel Guarani in the centre of the city where the congress was also held. At the time of our visit, the President of Ecuador was visiting Paraguay and was staying in the same hotel.

Paraguay
Paraguay is a land-locked country bordering Brazil, Argentina and Bolivia. Most of the present (reduced) territory is due to the disastrous consequences of losing the War of the Triple Alliance in 1870. On more than 400 000 sq.km live around 6 million people (i.e. in more than 1 and a half Britain’s territory lives the population of Wales). More than 60% of the country is the impenetrable Chaco, a combination of marshes and shrub forests.

The country is one of the poorest in South American countries. The infrastructure is underdeveloped; there are no motorways and no railways. More than 80% of the population speaks Guarani and Guarani is one of the official national languages (together with Spanish). The majority of the people are mixed race, Paraguay was one of the first countries in the world to encourage the mixed marriages between Spanish colonists and the indigenous Guarani population.

First days
After an unforgettable reception at Arturo’s house, where we met his wife and his 4 children and we were first faced with the huge asados (plates of meat) washed down with beer and serenaded by guitar music played by another WFSA veteran, Dr. Oscar Gonzalez Allen. The next day we faced our first challenge: facing the local anaesthetic 5-a-side football team. Even if we lost at football, we gained new friends and this friendly, informal and welcoming atmosphere was to continue throughout our stay in Paraguay.
“Charlas”

On Tuesday the 24th of March we started our Refresher Course with 2 lectures/workshops (“charlas” in Paraguay), delivered by CR and IH.

CR presented the UK guidelines for management of the Difficult Airway. Paraguay does not have national guidelines for Difficult Airway management (or for any other anaesthetic management or emergency), so CR`s presentation (in Spanish, his native language) was extremely well received. After his original success, CR reinvented himself as a translator, helping IH`s presentation of “The role of bougie in the management of the difficult airway”. At the present moment, only a small minority of Paraguayan anaesthetists are using bougies and fibrescopes are rare. There is no Difficult Airway Trolley in the main operating suites.

Both workshops were very interactive and lasted about 1 hour each, to the delight of the approximately 50 participants invited to the elegant auditorium of the Sanatorium Migoni, one of the best private hospitals in Asuncion. On Wednesday the 25th of March we continued our Symposium with 2 other lectures delivered by RB and BA in another very elegant private hospital.

RB lectured about ultrasound-guided peripheral nerve blockade (US PNB). Again in Spanish, he explained the main physical principals of ultrasound, the indications for US PNB, the advantages over nerve-stimulator techniques and showed video clips of a multitude of personal blocks. He finished by showing an absolutely amusing epidural video clip. At the moment, there is no expertise in US PNB in Paraguay. All blocks are performed using nerve stimulators. A lot of operations are performed under blocks only +/- sedation.

SRB continued as translator for the 2nd topic of the day: Eye Blocks, delivered by myself (BA). After a hiccupping computer-related start, I described the anatomy of the eye, the main principles of eye blocks and their indications and contraindications and I finished showing video clips of the main eye blocks.

At the moment, no Paraguayan anaesthetist uses sub-tenon block. This technique was perceived by the local audience as being cumbersome and very invasive. A lot of anaesthetists use different approaches for peribulbar blocks and a minority still perform retrobulbar blocks.

Congress

Having finished our Refresher Course, we continued as lecturers at the International Congress, held between 26-28 March at the Hotel Guarani in Asuncion. The venue was up to the task, the lecture theatre was spacious, airy and cool, the IT support was impeccable, translation and later parallel translation was available. There was an impressive South American participation, with speakers from Argentina, Brazil, Uruguay, and Chile. The standard of the presentations was consistently high. A continuous trade exhibition was held in the foyer of the hotel.

IH started with a brilliant lecture regarding Assessment of Difficult Airway. He also demonstrated a few recent airway management devices available in the UK with a possible role in the management of the difficult airway. It was obvious that main diagnostic tests were known but the airway aids were never seen before in Paraguay. We donated about 10-20 bougies to the local doctors.

CR continued with a presentation in Spanish of Cardiopulmonary Exercise Testing (CPET) and its role in diagnosing and managing difficult patients for elective surgery.
The necessary machine was not available in Paraguay and the cost of over £60,000 was considered prohibitive.

In the afternoon, RB did a real “tour-de-force” by demonstrating on a live model all the relevant US PNB in a modified workshop scenario. He scanned the relevant anatomical regions and explained in detail the actual technique of performing PNB under direct vision with the help of US.

I (BA) started the last lecture of the day by acknowledging the contribution of Drs. Segovia, Ayala and Gonzalez and the important moral and financial support received from AAGBI and WFSA. I even thanked the organising committee for inviting us in Paraguay – in Guarani! I then finished in force with a detailed dissertation: Anaesthesia for Liver Resections. It included the history of this operation, relevant anatomy and terminology, techniques and main anaesthetic principles.

There were a lot of questions at the end and considerable interest from neighbouring countries was shown with a view to inviting us to lecture again in the future.

Social
On Saturday evening we were invited at a party at the home to Dr. Ignacio Caceres. We were entertained with live music and another tasty asado was served by impeccably dressed waiters and Dr. Caceres’s family spent a lot of time with us. The following day, we visited “the jewels of Paraguay”, the mighty Iguazu Falls (the biggest waterfall in the world) and the Itaipu hydrocentral, again the biggest in the world. Despite the almost unbearable heat, the incredible images of the Iguazu Falls will stay with us forever.

Hospital Visit
I dedicated most of Monday 30th of March to an extensive visit of several public and private hospitals. There is a big discrepancy between these 2 categories. Despite having in almost every theatre, reasonable or even brand new anaesthetic machines, there was an obvious lack of disposables in the state hospitals. Patients are invited to buy anaesthetic or intensive care drugs and equipment. The private hospitals are at a western level. There are far more state hospitals than private ones.

There are about 20-25 residents per year of training. Residency in Anaesthesia lasts 3 years. It was not very clear if there is a formal exam (or not) at the completion of this training. Every resident does a lot of on-calls (12/month) and they are genuinely very busy (more than 30 blocks/day!). A senior anaesthetist would be expected to be resident on-call at least once a week and there is no limit on the maximum number of hours that can be worked. All anaesthetists are expected to work a full day after being on-call the previous night. A normal day would last from 7am to 4pm, but may be longer.

There are about 200 anaesthetists in Paraguay and the vast majority work in Asuncion, with less than 10 in the rest of the country. Every theatre is covered by a resident anaesthetist. Fewer senior anaesthetists supervise the theatre suite (i.e. in the University Hospital there were 10 theatres with 10 residents and 3 seniors).

As to subspecialties, there is no liver or heart transplant service in Paraguay although a live donor transplant service appears to be imminent.

Even as complaints in relation to clinical practice start to appear, few anaesthetists have medical malpractice insurance (like MDU or MPS in the UK). None of junior doctors we spoke to had insurance.

Conclusion
We had a wonderful time in Paraguay and we met many delightful people there. Our thanks are going to Drs. Segovia, Gonzalez, Ayala and Caceres. As a result of the exceptional success we had in Paraguay we unanimously decided to create the BARACRIL Group (from the first initials of our names) with the aim of facilitating, teaching and lecturing in Anaesthesia and Intensive Care in a non-profit charitable fashion in the developing countries.

After this brilliant experience, BARACRIL Group looks optimistically to the next teaching programme in the developing world. We already had several invitations and there is a fair chance we will be teaching in 2010 in Ukraine.

We would like to use this opportunity to thank The International Relations Committee of The Association of Anaesthetists of Great Britain and Ireland for all their moral and financial support.
Mercy Ships, a global charity founded in 1978, uses hospital ships to deliver free world-class health care to developing nations. Mercy Ships follows the example of Jesus as a compassionate response to the world in need.

Mercy Ships currently has volunteer positions available for Anaesthetists during our field service in West Africa. Our Anaesthetists need to be capable of managing their own cases with minimal or no supervision. Case loads will include some difficult airway management – including fibre-optics, potential ICU cover, and pediatric anesthesia. Minimum two-week commitment.

Mercy Ships also needs to fill the Anaesthetic Team Leader position: Consultant Anaesthetist preferably with experience in team leadership and experience in both paediatrics and ICU. Case loads will include difficult airway management – including fibre-optics, ICU management, and paediatric anaesthesia. Minimum six-month commitment.

For more information on how you can volunteer, please email crowthed@mercyships.org or visit our website www.mercyships.org
Report of Second Anaesthesia Conference held in Monrovia from November 5-7, 2008

Submitted on behalf of LANA by J. Garrison Kerwillain

Background information
As you may be aware, the Liberian civil war devastated every aspect of our society and the health sector was no exception. Anaesthesia was particularly affected: the last batch of anaesthetists trained at John F. Kennedy Medical Centre graduated in 1983 and during the civil war many anaesthetists fled the country. When the war subsided, the Phebe Hospital resumed training of anaesthetists but on a very small scale, not more than three students at a time. This disruption in the training of nurse-anaesthetists has created serious problems in the provision of surgical services. Some health institutions do not have any trained anaesthetist at all. Some surgeons, in extreme emergency cases, have to take the risks of administering anaesthesia while simultaneously operating.

A recent report from data collected during the last Liberian Anaesthesia Conference of November 2007 by the Liberian Association of Nurse-Anaesthetists (LANA) revealed that there are only twenty-five trained anaesthetists currently practicing throughout the country.

The conference held in November 2008 had three major objectives:

• To support the Liberian nurse-anaesthetists since, in most cases, they are working independently in the absence of an anaesthesiologist.
• To act as a single voice so that their appeals to central government for improvement in facilities and services can be more forceful.
• To organize themselves as a professional body providing a quality services to their patients.

The second nurse-anaesthetists Conference was held in Monrovia at the John F. Kennedy Medical Centre, National AIDS and STIs Control Program Centre from Wednesday November 5 to Friday November 7th, 2008.

The conference was organized by Dr. Keith Thomson of Mercy Ships Africa with Dr. Jim Tomarken and Dr. Stella Eguma of John F. Kennedy Medical Centre along with the leadership of the Liberia Association of Nurse-Anaesthetists. The conference was facilitated by five international anaesthesiologists and one anaesthesiologist assigned at the John F. Kennedy Medical Centre. Dr. Tomarken co-ordinated the training activities and arranged catering services and accommodation over the three days.

The facilitators were:
1. Dr. Keith Thomson
2. Dr. Michael Dockery
3. Dr. Sarah
4. Dr. Alexandria Bajarska
5. Dr. Anuraag Guleria
6. Dr. Stella Eguma

There were twenty-nine participants: 21 certified Nurse-anaesthetists, 6 students in Anaesthesia School from Phebe Training Program, 1 pharmacy student from the University of Liberia Medical College, a journalist from a local radio station, King FM who came to cover the event, and a nursing student.

The conference began with an opening ceremony which was attended by all the participants, the facilitators, the Deputy Minister of Health for Preventive and Curative Services at the Ministry of Health and Social Welfare, Dr. Moses Pewu, the General Administrator for John F. Kennedy, Mrs. Wannie Scott McDonald, Dr. Stella Eguma, and a World Bank hired Anaesthesiologist and others. Dr. Jim Tomarken of John F. Kennedy gave the welcoming remarks in which he expressed appreciation for the training team presence in Liberia in recognition of the need for development in anaesthesia education in Liberia following a protracted civil war which devastated the country.

This was followed by a brief overview of the conference by Dr. Keith Thomson. The presentation highlighted anaesthetic activities around the world, morbidity and mortality rates and strategies to improve anaesthesia services thus reducing anaesthesia related deaths in. He is indeed a veteran in holding conference of this nature around the world.
A special statement was delivered by Mr. J. Garrison Kerwillain, President of the Liberia Association of Nurse-Anaesthetists (LANA) in which he sincerely and humbly appealed to the Government of Liberia through Deputy Minister Moses Pewu to urgently recognize and improve anaesthesia services in Liberia.

He stressed the need for training as there are only twenty-six trained nurse-anaesthetists currently practicing in the country. He lamented that the last batch of anaesthetists trained by the government of Liberia qualified in 1983. He made several recommendations to the Government among which are the followings:

- That the Ministry of Health & Social Welfare recognise the need for the services of nurse-anaesthetists in the Liberia
- Increase/adjust the salary of nurse-anaesthetists as they are not only nurses but nurses with specialty training
- Provide needed anaesthesia drugs and supplies as well as equipment on a regular and sustainable basis
- Resume training of anaesthetists as soon as possible since there is now a physician anaesthesiologist, Dr. Stella Eguma from Nigeria working in the country.

In response, Dr. Pewu of the Ministry of Health & Social Welfare promised to take the Association’s recommendations to the proper Authorities at the Ministry of Health & Social Welfare for discussion and redress. He further called on any anaesthetists who are not employed, to contact his office for possible assistance in facilitating the process.

Thereafter, active training began with Dr. Keith Thomson presenting on the topic: obstetric haemorrhage, its aetiology, signs, symptoms and complications. The lecture was followed by a questions and answer period. The second lecturer was Dr. Michael Dockery who spoke on maternal hypertension, pre-eclampsia and eclampsia; its aetiology, incidence, signs and symptoms, complications and management. The third lecturer, Dr. Alex Bojarska presented on blood transfusion, its indications, associated factors, complications and management.

After a pause for lunch, the session resumed with a discussion on the topic of professionalism in anaesthesia. The discussion was led by participants who were placed in small groups to discuss subtropics such as:

- Building a better team
- Qualities of a good leader
- Being a good role model
- How to acquire basic knowledge and skills

Then a quiz was then held and prizes awarded to winners.

On day 2, lecturers presented the following topics:

1. Paediatric anaesthesia with emphasis on anatomical differences, drug dosage, equipment and monitoring
2. Resuscitation of the newborn with emphasis on resuscitation protocols. Each participant took it in turn to do a demonstration while others watched.
3. Complications of anaesthesia with emphasis on causes and how to prevent them.
4. Fluid Management
5. Case reports with reference to pre- and post-operative assessment
6. Anaesthesia record keeping

Day three started with another quiz and prizes were awarded to the winners. Then lectures were delivered on

- Trauma and its management
- Post-operative pain management
- Anaesthesia in patient with medical disease.

The final session reiterated the need for the anaesthetist to take responsibility caring for their patients to ensure anaesthesia related deaths or complication are significantly reduced.

A formal closing ceremony was held with the speeches of appreciations from the both the local facilitators and the members to the international six man team of lecturers.
Report on the W.F.S.A. Refresher Courses held in Malawi and Rwanda March 2009

Malawi

A W.F.S.A. refresher course was held at the Queen Elizabeth Central Hospital in Blantyre on March 17th-19th 2009 and was attended by 24 clinical officer anaesthetists from all parts of the country.

The lecture team consisted of Lena Dohlman of Harvard University, USA and Robert Axe, Jen Pearce and Roger Eltringham from U.K. The inclusion of Jen, who is not an anaesthetist but a nurse specializing in emergency care and resuscitation of paediatric patients, proved extremely successful as hers were subjects in which few appeared confident and her lecture handouts were in great demand at the end of the course.

The subjects covered had been requested in advance by the local organizers and included obstetrics, paediatrics, trauma management, anaesthesia in difficult environments, head injuries and care of equipment. Formal lectures were interspersed with case discussions on practical problems commonly seen locally, tutorials on equipment, and workshop sessions on emergency airway management and resuscitation. Each day ended with an open forum in which questions on any subject were invited for the visiting team.

In addition to the WFSA lecturers, Richard Tully, an engineer from Diamedica accompanied the team and was available to give practical instruction on the testing, operation and maintenance of anaesthetic equipment including the Glostavent which is now being used in 90% of District hospitals in Malawi. He also worked closely with the local equipment team of Kenneth Kapatuka and John Gawanika in the servicing, maintenance and repair of anaesthetic machines in the local hospitals. Before leaving Malawi he also visited isolated hospitals in the periphery of the country to commission new Glostavents and train the users.

The course concluded with a fiercely contested quiz followed by the award of prizes for the winners and the distribution of W.F.S.A. certificates.

Summary

Our thanks are due to Cyril Goddia and his team for their hard work in making all the arrangements to enable the course to run smoothly despite the heavy work load they share. The level of enthusiasm shown by the local delegates was a credit to the existing teaching program in Malawi and to the input by the Scotland Malawi project under Catriona Connelly. The repair and maintenance service for anaesthetic equipment run by Kenneth Kapatuka and John Gawanika is functioning smoothly and should be an example to the rest of Africa. The long awaited program for the training of physician anaesthetists is now a reality. It is hoped that under the expert guidance of Professor Gregor Pollack that this will expand over the next few years in order to produce a physician led service in Malawi.

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Dr Robert Axe
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On Sunday March 22nd the WFSA team flew from Blantyre to Kigali to repeat the course at the Kigali University Hospital. Although it was nearly midnight before we arrived nevertheless we were met at the airport by the new chief of anaesthesia, Dr Willy Kiviri, who escorted us to the Gorilla Hotel.

Despite the heavy clinical load and the chronic staff shortage at the hospital over fifty delegates were able to attend some or all of the course.

The content of the course was almost identical to that used in Malawi but with an even greater emphasis on practical problems and their solution as this had proved so popular. Richard Tully again provided practical advice throughout the duration of the course on the care, servicing and maintenance of anaesthetic machines.

The audience for this course was drawn from a much more varied background and included a combination of experienced consultants, trainees, nurse anaesthetists and clinical officer anaesthetists, for most of whom French was their first language. As a consequence the lectures had to be slightly modified and adapted with the aid of carefully prepared overheads.

It rapidly became obvious that the delegates had a good grounding in anaesthesia and had no difficulty following the proceedings. Their enthusiasm and thirst for knowledge was almost palpable and the morale of the whole department seems to have risen dramatically over the past few years. It is difficult to pinpoint the reasons for this change but the effect of the Canadian teaching program and the arrival of Dr Willy Kiviri have clearly both been important contributory factors.

In addition to their enthusiasm for clinical work in the operating rooms and intensive care unit, several anaesthetists expressed a wish to become involved in research projects. Two members of staff have already submitted papers on their experience with the Glostavent for presentation at the forthcoming All Africa Congress in September. Another group are studying the potential savings of introducing oxygen concentrators to the paediatric wards and the WFSA team were able to meet the hospital director and offer help and advice for this project.

The course ended, as before, with a quiz with the distribution of prizes and the WFSA certificates of attendance. The anaesthetic department at Kigali professed great satisfaction with the WFSA visit and expressed the wish for further visits to be made in the future. The secretary of the Rwanda Society of Anaesthesiology was apparently so impressed that he delayed our departure so that he could pay the WFSA subscription in person as a sign of continuing good faith.

Recommendations for the future

At the conclusion of both courses the audiences were asked if they had any requests for the future. The following suggestions were made;

1. The courses should be repeated at regular intervals and the present format retained.

2. The duration of future courses should be extended to five days.

3. Printed handouts of all lectures should be available for the delegates to take away.

4. More time should be set aside for practical instruction in the operation, care and maintenance of anaesthesia equipment.

5. The range of topics should be increased to include ICU subjects, common regional blocks and fluid and electrolyte management.

My own view is that both centres are making such encouraging progress that future courses could justifiably be supported by WFSA.
Profile of Ailun Luo

Dr Ailun Luo qualified as a doctor at the Shanghai First University in 1961. After spending 8 years in the Dept of Surgery at the Peking University Medical Centre (PUMC) she transferred her allegiance to the department of anaesthesia in 1969, a decision which was to have a profound influence on the practice of anaesthesia, not only in China but in many other parts of the world.

She made rapid progress in her new specialty at the PUMC, completing the comprehensive training program there and was subsequently appointed a consultant in the same institution in 1980. In 1991 she was appointed as full professor and chief of the anaesthesia department.

Throughout the forty six years of her medical career Dr Luo has been guided by the PUMC principle of “strictness, constant improvement, diligence and devotion.” These guidelines appear to have provided the inspiration for an outstandingly productive career characterized by innovations in the fields of teaching, clinical practice and research.

Her main fields of interest have included endocrine tumour management, the peri-operative protection of vital organs and measurement of anaesthetic depth. She has been in the forefront of the introduction into China of the Post Anaesthesia Care Unit, the management of chronic pain and the development of a diagnostic system for malignant hyperthermia. She has published in excess of 100 papers and 3 academic monographs. She has been particularly active in anaesthesia education and was awarded the “excellent educational worker of moral education” by the Chinese Academy of Medical Science. She actively promoted the Chinese translations of “Anaesthesia and Analgesia” and “Update in Anaesthesia” which have contributed to the advancement of anaesthesia throughout mainland China. She has organized and hosted international congresses in China and has been much sought after as a contributor at National Society meetings throughout the world.

Her career spanned a period of great political change in China beginning at a time when contact with the outside world was minimal. She recognized the advantages of maintaining links with anaesthetists in other countries and sharing knowledge and she sympathised with the aims of the WFSA to “make available the highest standards of anaesthesia to all peoples of the world.”

Her tenure as the chairman of the Chinese Society of Anaesthesia has seen the introduction of important projects involving quality control and continuing medical education. It also saw the successful application of the Society to become a full and very welcome member of the WFSA.

Dr Luo has been the recipient of many distinguished awards including “Excellent Department Director of PUMC,” “Advanced Worker of Beijing,” and in the U.K. Honorary Fellow of the Royal College of Anaesthetists. She has had an exemplary career, has represented China throughout the World and has been a credit to her country and to the specialty of anaesthesia.

Visit to Nairobi to discuss the All African Anaesthetic Congress

En route from Kigali to London, I spent Saturday March 28th in Nairobi discussing progress and arrangements for the All Africa Congress. Although Dr Kabatu, the principle organiser, was unavailable, I was able to have a long discussion with Dr Dave Otieno who appears to be satisfied with the progress being made and had no particular worries. Although he didn’t go into detail he assured me that there has been wide interest, with a good number of registrants already, both for the Congress and for the trade exhibition. It might be worth WFSA asking for more details in a week or two to confirm this, in case he was being over optimistic but he did appear business like and confident.

I encouraged him to carry on with the good work but one area that does worry me is the price of Nairobi hotels. I wondered if the WFSA is planning any bursaries of the type we used for World Congresses to enable delegates from poorer regions to attend.
Jannicke Mellin-Olsen, the current chair of the World Federation of Societies of Anaesthesiologists Education Committee has had a varied career. She is Norwegian and after qualifying from Trondheim University and completing her internship, she spent some time in General Practice and Clinical Pathology in Trondheim. She was the first female doctor to complete military training and served as a Senior Medical Officer (major) with Norwegian forces in UNIFIL – UN Peace Keeping Forces in Lebanon. She has also worked with the Red Cross in Peshawar, Pakistan and in Belgrade, Serbia.

She did her anaesthetic training in Trondheim University Hospital and is now working full time in Asker and Bærum Hospital on the outskirts of Oslo as a consultant anaesthesiologist.

Between 1997 and 2001 she was Director of the Norwegian Air Ambulance/Global Medical support that also undertakes aero-medical transfers world wide. She also was the Medical Director of MedAire Ltd for 10 years. The company HQ is based in Phoenix, Arizona and the European division operates internationally out of Farnborough Airport, UK. This company is most famous for its support at in-flight medical emergencies on commercial airlines, but provides medical support in all remote locations. She has also been involved in other international medical activities.

Closer to home, she has been the president of the European Board of Anaesthesiology (UEMS - the EU Organisation for medical specialities) since 2007, and she is the National Council member of the European Society of Anaesthesiology. In addition, she is on the Board of the Scandinavian Society of Anaesthesiology and Intensive Care Medicine and has served as President of the Norwegian Society of Anaesthesiology. She is currently the chair of the group of all medical speciality societies in Norway. She is involved in various Disaster Medicine Boards. In 2004, she joined the WFSA Education Committee. Reflecting her military past, she has also served as Vice-President of the Norwegian Society of UN veterans, a member on the Board of Nordic Blue Berets and as Founder and President of the Trondheim Union of UN veterans.

She has published extensively in Scandinavian and other international journals, received many awards reflecting her military and humanitarian work and has completed a diploma in Public Health Science at the University of Gothenburg, Sweden.

In her spare time, if there is any, she enjoys international travel, cross-country skiing and marathon running: she is the Norwegian female champion in her age group.
For the past ten years each edition of World Anaesthesia News has carried profiles of individuals who have made a significant impact on the practice of anaesthesia. The subjects of all previous profiles have been consultant anaesthetists, many of whom came from prestigious institutions and have been renowned throughout the world because of their specialist knowledge or expertise.

However, even the most skilful anaesthetist is dependent on reliable support staff who are often unknown and unrecognised yet who dedicate their careers to our specialty. It is impossible to name them all but as a tribute to these dedicated individuals and as a reminder of the debt we owe to them we are featuring in this edition the profile of Kenneth Kapatuka, a clinical officer from Malawi whose contribution to the practice of safe anaesthesia, like that of so many of his colleagues, has been outstanding.

Kenneth was born in 1966 at the Malingunde mission hospital in Malawi. He received his primary education at Nkhoma Demonstration School and the William Murray Secondary School near Blantyre, before attending the Malamulo School of Medical Sciences. He obtained the certificate of clinical medicine and began work at the Queen Elizabeth Central Hospital in Blantyre in 1986.

Inspired by the work of Professor Paul Fenton, who was chief of the anaesthesia department at the time, he decided on a career in anaesthesia, and in 1988 he qualified as an anaesthetic clinical officer at the Malawi School of Anaesthesia in Blantyre.

In 2001 he attended a course on the repair and maintenance of anaesthetic equipment organized by Henry Bukwirwa of Mbarara University Hospital in Uganda. This was to have a profound effect on his career as it sparked an interest in this important but frequently neglected aspect of anaesthesia. Under the guidance of Cyril Goddia, an equipment maintenance unit was established at the QECH in Blantyre and Kenneth, along with his partner John Gawanika, was appointed to run it. Theirs has proved to be an outstanding partnership and the unit has been a resounding success. It has become an example to other countries of the importance of proper care and attention to anaesthesia equipment.

In 2003, at the suggestion of Prof. Anneke Meursing, then president of the WFSA, Kenneth visited the UK where he was introduced to the Glostavent anaesthetic machine for the first time. He attended courses on the maintenance of this machine organized by Dr David Peel of Ashdown Consultants and Ian Revell of Penlon. When models began to arrive in Malawi, Kenneth was in an ideal position to service and maintain them. His knowledge and expertise have grown to the extent that he now travels all over the country commissioning new machines, ensuring that they are in good working order and that the anaesthetists are able to use them safely. This aspect of his work entails a great deal of time and travel as they are now in over 90% of district hospitals in Malawi.

His careful attention to detail and conscientious approach have meant that his services have been in great demand, not only in Malawi but also in other countries.

His advice is constantly being sought and it was only after consulting him that the Rwandan anaesthetists decided which type of anaesthetic machine they should buy.

His opinion is also sought when difficulties arise with any sort of anaesthetic equipment in distant institutions.

In 2004 he was appointed senior tutor at the Malawi School of Anaesthesia, a position he holds to this day. In addition to his clinical practice and engineering duties he has become an accomplished speaker and his services are in great demand by congress organizers. In 2005 he presented a paper on the teaching of maintenance and repair of anaesthesia machines at the All Africa Anaesthesia Congress in Harmermet, Tunisia. In 2008 he was invited to present his experiences at the World Congress of Anaesthesia in Cape Town. He has recently been invited to present his experiences at the AAACongress in Nairobi in 2009.

In addition to equipment maintenance Kenneth is a busy clinical anaesthetist with a wide range of interests. He has attended courses in paediatric anaesthesia, regional anaesthesia and intensive care. He is currently working at the Queen Elizabeth Hospital the major teaching and referral hospital in Malawi. He is married to Rose and they are blessed with two sons, Ronald aged twelve and Arthur aged 9. Outside his busy job he likes to relax with his family and enjoys chess and reading.

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A Tribute to Professor Dorothy J O ffoulkes-Crabbe FFARCS, FWACS, FMCA

(Retired Professor of Anaesthesia, College of Medicine, University of Lagos) (1st January 1934 – 24th December 2008)

The Department of Anaesthesia, College of Medicine University of Lagos and the Lagos University Teaching Hospital as well as the entire membership of the Nigerian Society of Anaesthetists announce the death of Prof DJ ffoulkes-Crabbe popularly known as ‘Mama Anaesthesia’ on the 24th of December at her home in Accra, Ghana.

Mama joined the staff of the College of Medicine, University of Lagos and the Lagos University Teaching Hospital as a lecturer/consultant in 1968 and became a Professor of Anaesthesia in 1978. She retired in 1999.

During this time, Mama trained generations of anaesthetists for the Fellowship programme and over 150 anaesthetists for the Postgraduate Diploma programme. She was instrumental to the commencement of the 3 year training programme for anaesthetic technicians in 1983 which has since produced numerous highly trained professionals.

Prof ffoulkes-Crabbe was a brilliant academic, an articulate teacher, a compassionate clinician and an eloquent speaker. She was an inspiration to junior specialists by her exemplary dedication to the profession, strong leadership qualities, embarrassingly high level of confidence which was tempered by her warm compassionate nature, amiable character and motherly attitude. She brought creativity and imagination into the operating rooms and would sing and dance when escorting a totally enchanted child smoothly through the depths of anaesthesia. There was always something new to learn from her.

Mama was totally committed to the development of anaesthesia in the West African sub-region and training of anaesthetists became one of her utmost priorities. She served in numerous positions in the anaesthetic community: Chairman of the Faculty of Anaesthesia, West African College of Surgeons, the 16th and only female president of the West African College of Surgeons (1991-1993) and Editor-in-chief of the African Journal of Anaesthesia and Intensive Care. She was a founding member of the Nigerian Society of Anaesthetists (1992), the Ghana Anaesthetic Society (1996) and the Ghana College of Physicians and Surgeons.

Her contributions to anaesthesia were not limited to the sub-region as she served on the Education Committee of the World Federation of Societies of Anaesthesiologists (WFSA) and was also the first Chairman of the African Section of the WFSA. She was in many ways the ‘mother of modern anaesthesia’ in Nigeria and West Africa.

She was and is indeed a legend and will never be forgotten. Her story and doctrine will reverberate through generations of future anaesthetists. She will be sadly missed.

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President WFSA (2000-2004)
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It was with great regret that we heard of the passing of Dorothy ffoulkes-Crabbe just before Christmas. She was one of the most outstanding woman doctors in Africa and in the world of anaesthesia.

I first met Dorothy ffoulkes Crabbe at the Third Asian-Australasian Congress in Canberra in 1970 where she was the sole African representative.

Dorothy was originally from Ghana, educated in England and graduated from the Royal Free Medical School in London and then trained in anaesthesia. She returned to neighboring Nigeria where she became Professor of Anaesthesia in Lagos at a time when anaesthesia was in its infancy as a specialty in Africa.

I met her again at Port Harcourt, Nigeria when I attended the West African Anaesthesia congress in 1989 while I was chairman of the WFSA Education Committee. She was obviously a dominant figure in West African anaesthesia and gave an outstanding keynote oration, both the content and the presentation which was one of the most polished I ever heard during my anaesthetic career. Drs John Broadfield and Gordon Paterson from UK and I stayed on to conduct a course for the young doctors. They were an enthusiastic group. At that time Nigeria seemed to be well off with anaesthetists, having about 200 but in proportion to the population of a hundred million the numbers were grossly inadequate — 1:500,000.

During a visit to the Port Harcourt Hospital I saw a half built building — the money had run out, a child with the largest heart which I had ever seen and the cleanest hospital I encountered on my numerous visits around the world.

After the course I travelled to Lagos with Dorothy by “Land Flight”. This was some experience — a Peugeot carrying about seven passengers travelling much of the time at 120 kph. We covered 700km in seven hours and that included a 20 minute stop and a section of 40 km where we had to travel slowly because of the large potholes on the road — some were over a metre across. Dorothy saved our lives as at one point the driver lost concentration and was rapidly approaching a truck from behind without any sign of trying to pass it. She alerted the driver in no uncertain terms! On the trip she bought some of the largest snails I have ever seen — 15-20cm shells. She disapproved of smoking in confined spaces and berated one poor fellow who lit a cigarette in the van. She was a dominant personality and made her views known when necessary.

While attending the World Congress in The Hague in 1992 she became a member of the WFSA Education Committee. At that congress I found out a unique aspect of her personality. I introduced her to a Finn and then a paediatric anaesthetist from Beijing. She greeted both in their own language. I was amazed and asked her how many languages she spoke. A little of many she replied and told me why. When she was a medical student in London the Turkish-Greek conflict in Cyprus had led to Turkish refugees coming to London. When the women were having babies they knew no English and the staff did not speak Turkish leading to a very frightening situation for the mothers. She then decided to try to learn a least a few words of as many languages as she could so that when she returned to Africa she would at least be able to greet sick people who came off ships needing hospitalization in a familiar language. Only once after that did I introduce her to someone she could not greet and she soon rectified that situation. This ability to communicate at all levels was something that made her stand out.

Another feature was her warm greeting to anyone she met and the way she treated her old trainees and anyone special as if they were part of her family.

In 1996 a delegation of Africans attending the World Congress of Anaesthesia in Sydney approached the Executive with a request to set up an African Regional Section of WFSA. Because of my African background I was asked to meet with them and deal with the issue. We met and decided that it was appropriate. A subsequent meeting was arranged after approval was given to go ahead so that a steering committee could be elected. There were three nominations. After one round of voting Dorothy ffoulkes-Crabbe was tied with Hannes Loots from South Africa. Something unusual then occurred. Hannes said we should not proceed to another vote as he would defer to Dorothy. The following year the first African Congress was held in Harare, at the instigation of Ruth Hutchinson, another outstanding lady anaesthetist in Africa. The African Regional Section was formally established and the elections were held during the congress. Dorothy ffoulkes-Crabbe became the first Chair. Then another amazing thing happened. The first committee was elected — three whites from South Africa and Zimbabwe, three East Africans and one from Mauritius. Laurie Marks from Zimbabwe then said he would stand down to make way for a French speaking West African delegate from Benin, Martin Chobli, to provide a better representation on the committee. Dorothy was perplexed.

The Third Asian-Australasian Congress in Canberra 1970...
She turned to me because I had been involved in setting up the organization and its constitution saying we hadn’t anything in the constitution to deal with such situations. I told her to forget the constitution and accept such a generous offer which was obviously in the interests of the region. So Dorothy was a player in two of the most unusual goodwill occurrences in world anaesthesia politics.

On one occasion in the 1990s she was an invited overseas visitor to the Australian Society of Anaesthetists Annual Scientific Congress.

In 1998 I attended a conference of the East African Society of Anaesthesiologists in Kampala. As there were relatively few anaesthetists in East Africa, medical assistant anaesthetists who provide most of the anaesthesia in many of the smaller hospitals also attended. Dorothy ffoulkes-Crabbe was also there. She felt very strongly that the trainee doctor anaesthetists were being rather neglected so the two of us spent an afternoon with them. She expounded the importance of their role as physician anaesthetists in Africa to them and I tried to help them with some practical tips and how to teach. They were very appreciative.

Regrettably I lost touch with her after she retired. She had a very distinguished career and although communication was sometimes difficult with Nigeria she was a role model and inspiration to many in our field.

She was a devout Christian and did not hesitate to call for prayers before meetings which she chaired regardless of the religious constituency of the committee. All religions believe in God or a higher being.

Her passing is the loss of a dear friend, a warm hearted lady and a great leader.

---

**AN ODE TO MAMA, PROF D. ffOULKES-CRABBE**

Oh! Death, where is thy sting?
Our Mama came, saw and conquered without fear
She was a scion of Anaesthesia
Not only in the West African sub-region
But, nay in the African continent and beyond
Death, where is thy sting?

Mama was a pillar in the Anaesthesia family
She indeed was a teacher of teachers
I remember those days as a Resident
When exams almost made me a dissident
Mama was always at hand, to put me right
When I was wrong in her sight
Always squeezing my ears
Saying - ‘the Basics’, remember!
Death, where is thy sting?

In death, our Mama remained an asset
For her, nothing mattered again, for her consent
For the rest of us her acolytes
We will surely miss her in our closets
But we trust in the Lord always
To make her, in His bosom rest in perfect peace
Oh! Death, indeed, where is thy sting?
Adieu, our dear Mama ffoulkes-Crabbe.

Brig Gen ’Shina Ogunbiyi FWACS,
Commander, UNAMID Level II Hospital, Sector West
El-Geneina, Darfur-Sudan.
** Faculty Secretary, Faculty of Anaesthesia, WACS (2007-2009)**
Useful Information

World Federation of Societies of Anaesthesiologists (WFSA)
21 Portland Place, London, W1B 1PY
United Kingdom
Tel: (+44) 0207 631 8880
Fax: (+44) 0207 631 8882
E-mail: wfsahq@anaesthesiologists.org
Website: www.anaesthesiologist.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
United Kingdom
Tel: (+44) 01865 221589
E-mail: michael.dobson@nda.ox.ac.uk

Bristol (UK): December (annually).
Contact: Dr. James Rogers
Department of Anaesthesia
Frenchay Hospital
Bristol BS16 ILE
United Kingdom
Tel: (+44) 01179 701212
E-mail: james.rogers@nbt.nhs.uk

‘Global Outreach Course’
Nova Scotia
Canada
For more information contact
Dr Tim Coonan at tjcoonan.gmail.com

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
E-mail: 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
United Kingdom
E-mail: ptc@nda.ox.ac.uk

PTC Chairman:
Dr Douglas Wilkinson
douglas.wilkinson@nda.ox.ac.uk

PTC Administrator: Annette Clack
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
United Kingdom
E-mail: admin@primarytraumacare.org

Equipment collection and distribution to the developing world
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185 Walnut Street (Floor 22)
Philadelphia PA. 19103
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Dr. William Rosenblatt
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Yale University School of Medicine
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CT 06510
USA

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The organisation is interested in receiving recent complete sets of journals and newish text books. These are collected free and distributed by Rotarians.

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E-mail: sea@asahq.org
Web: www.seahq.org

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This organisation has bought ECHO and now supplies drugs and equipment to developing countries.
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E-mail: www.durbin.co.uk

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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 WCIN 1EH
United Kingdom
Web: www.talcuk.org

Doulleurs 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:
Doulleurs 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
E-mail: alain_serrie@hrlb.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
E-mail: j-meynadier@o-lambret.fr

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.

International Anesthesia Research Society (IARS)

2 Summit Park Drive 140
Cleveland, Ohio 44131
USA
Tel: 216 642 1124
Fax: 216 642 1127
E-mail: 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.
E-mail: 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 WCB 4JX.
United Kingdom
Tel: (+44) 020 7637 4104
E-mail: 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
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Contact:
Dr. R Eltringham
Gloucestershire Royal Hospital
Gloucester GLI 3NN
United Kingdom
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 its website.

Contact:
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1 Great George St.
London SW1P 3AA
United Kingdom
www.ihe.org.uk
US volunteers wishing to spend periods working in developing countries
Contact either:
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
or
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, €50 or $60. For further information
Contact:
Mrs Busola Adesanya-Yusuf
World Anaesthesia Society
Association of Anaesthetists of Great Britain & Ireland
21 Portland Place
London W1B 1PY
United Kingdom
E-mail: busola@aagbi.org
or
E-mail: carol@world-anaesthesia.org
Website: www.world-anaesthesia.org
* also available at: www.nda.ox.ac.uk/wfsa

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
United Kingdom

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
United Kingdom
Tel: (+44) 020 7404 6600
E-mail: office-ldn@london.msf.org
or
11 East 26th St.
Suite 1904
New York NY 10010
USA
Tel: (+1) 212 679 6800.
E-mail: 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
United Kingdom
Tel: (+44) 01865 221589 / 741166
Fax: (+44) 01865 221593 / 453266.
E-mail: michael.dobson@nda.ox.ac.uk

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- Support anaesthesia and the education of anaesthetists in the developing world through training, material and equipment.
- Act as an advocate in dealings with governments and agencies involved in anaesthesia and resuscitation overseas.
- Maintain a network of appropriately trained and experienced anaesthetists in order to assist members and advise those intending to work in the developing world.

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