This piece should perhaps come under the title “What’s New in Your WFSA.” And after the warm welcome that I and other WFSA officers received in San Francisco at ASA’s annual meeting, it is more than apparent that this is a shared endeavor. For more than 50 years, ASA has been a valued contributor to our World Federation, not just through the annual fees that it pays to support our work (around $2.50 per year for each ASA registered member) but through the active contribution of individual anesthesiologists such as Mark Lema M.D., Ph.D., Berend Mets, M.B.,Ch.B., Vinod Malhotra, M.D., Adrian Gelb, M.B.,B.Ch., Charles Otto, M.D., Quentin Fisher, M.D., Roger Moore, M.D., Steve Howard, M.D., Robert Peterfreund, M.D., Ph.D., Douglas Bacon, M.D., M.A., Krystof Kuczkowski, M.D., Mark Newton, M.D., Constantine Sarantopoulos, M.D., Ph.D. and others. Volunteering is in the DNA of the WFSA; if we were to give it a monetary value, it would contribute at least $2 million each year to supporting our mission “to unite anaesthesiologists around the world for the betterment of patient care,” and yet the value to those (often less-well-resourced) anesthesiologists and their patients is, of course, without monetary equivalent and is what makes your $2.50 such a sound investment.

The most obvious change in the secretariat of the WFSA is the appointment of a CEO (that’s me), but this is simply the expression of a conviction among the leadership (past and present) that the WFSA has both a duty and an obligation to do more for anesthesia in poor countries and that it is well placed to do so. What other organization in this area of medicine brings together more than 120 national societies and hundreds of thousands of medical professionals in pursuit of shared objectives?

Visit our refreshed website at www.wfsahq.org (we think you might prefer this to “anaesthesiologists.org” for spelling, typo and tongue-twister reasons) and you will already get a sense of new beginnings. Educational assets such as “Anaesthesia Tutorial of the Week” and “Update in Anaesthesia” are displayed more prominently and accessed more easily; and access to fellowships and research opportunities for anesthesiologists from lower-income countries likewise. Look again and I hope very much that a shift in focus from “who we are” to “what we do” will become apparent. Increasingly, our programmatic areas (Education and Training, Safety and Quality, Innovation and Research, Working Together) will come to the fore as we demonstrate activity and impact and do more to display the change that WFSA makes to health outcomes in some of the world’s poorest countries. It is no coincidence that these program areas will sound familiar, we do what we – what you – all do best, but I believe it is time for the WFSA to make more noise about what it does and explain its work in a way that is more accessible to a wider audience.

Let me give just one example of why we should all feel passionately about the work of our WFSA. Since 1996, some 64 fellows have been trained at the Bangkok Anaesthetic Regional Training Centre (BARTC) in Thailand, which is just one of the 13 different fellowship programs currently offered through the WFSA. Sixty-two are now working as anesthesiologists in their home countries (a return rate of more than 96 percent), giving us between three and four anesthesiologists returning from their 12-month-long training to their national health systems each
year. On the reasonable assumption that each anesthesiologist cares for 500 patients per year (it’s probably higher), then the cumulative number of cases attended by WFSA BARTC fellows would have reached some 270,000 by the end of 2013 – giving a training-cost-per-patient case of less than $2.50 ... and the return on that investment just keeps getting better.

So as a newcomer, I would hope that “new” is not to say that we change all that we do, but to say that we really ought to do more and ensure that we are as efficient and as effective as possible. It is to say that safe anesthesia is an essential part of safe surgery, that perioperative mortality rates should be considered alongside other health indicators in global decision-making, that a response to road traffic accidents ranks alongside the outstanding global response to HIV/AIDS, tuberculosis and malaria ... It is to say that anesthesiology matters.

With more than 230 million major surgeries taking place around the world each year, the stakes are already high, and yet we know that 2 billion people are without access to emergency and essential surgery, and 34 million anesthetics are delivered annually in low-income countries without the standard safety equipment needed or a trained provider in attendance. In these same countries, as many as 90 percent of anesthesia departments do not have the equipment to provide a safe pediatric anesthetic. Surgical intervention, if available globally, could treat 11 percent of the global burden of disease. This requires access to safe, quality and appropriate anesthesia and can be delivered at a cost that is similar to more widely publicised (and better-funded) health interventions such as immunization. Our Federation vows to involve anesthesiologists in this global effort – not a new vow, but a vow worth renewing.

If you would like to get involved in the work of the WFSA, please visit [www.wfsahq.org](http://www.wfsahq.org) for more information.

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**Perioperative Do-Not-Resuscitate Orders**

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> responsibility for deciding when conditions are suitable to reactivate the DNR order.

  For anesthesiologists who believe caring for a patient with an active do-not-resuscitate order violates their conscience or impairs their professional judgment, it is ethically acceptable for them to refuse to deliver anesthesia to patients with active DNR orders, provided the patients or their surrogates are assisted in arranging for alternative care.

  In emergency situations when there is insufficient time to ponder these issues without causing additional suffering, morbidity and possibly mortality, the anesthesiologist may proceed in a manner that is most consistent with the patient’s goals and values as expressed by the patient or his or her surrogate.10

**References:**

1. Schoendorf v. Society of New York Hospital, 211 NY 125, 105 NE 92 (1914).