Global Burden of Surgical Disease

The Third International Medical Development Symposium

The College held its third triennial International Medical Development Symposium on 26-28 September. Specialists and leaders in global surgery and anaesthesia attended from North America, Europe, Asia and the Pacific to address the global unmet burden of surgical disease.

This was the first time that a global surgery and anaesthesia meeting of this scale had been held in this region of the world. It was an outstanding success, with the meeting agreeing to advocate for a World Health Agenda to reduce the Global Burden of Surgical Disease, and ensure that essential and emergency surgery and safe anaesthesia are seen as a basic human right.

This Symposium was jointly convened with the Australian Society of Anaesthetists, the Alliance for Surgery and Anaesthesia Presence (ASAP), the Harvard-based humanitarian surgery initiative and the International Society of Surgery. The meeting brought together surgeons, anaesthetists and other specialists, donors and policy makers, to discuss the global challenges facing surgery and anaesthesia.

Visiting speakers included Professor Eddy Rahardjo from Airlangga University, Surabaya, and Dr Ian Norton from the National Critical Care Trauma Response Centre, who spoke about disaster response, and Mr Pedro Monzon Barata (Cuban Ambassador to Australia), who spoke about the Cuban Medical Training Program.

Dr Kelly McQueen (ASAP) gave the College Triennial Lecture on the chronic unmet need of essential and emergency surgery and safe anaesthesia, and Dr Rich Gosselin (University of California) gave a stimulating presentation on the health economics of surgical intervention. Lord Tangi o Vaonukonuka (Tonga) spoke about aid effectiveness and local leadership in the Pacific.

The program also included presentations and discussion on workforce development, minimum standards, non-communicable diseases and trauma, including a talk by Dr Manjul Joshipura from the World Health Organisation (WHO) in Geneva on the WHO Global Alliance for Care of the Injured.

The first day focused on the global needs for surgery and anaesthesia, and on the second day, the meeting looked at strategies to respond to, and reduce the burden of surgical disease.

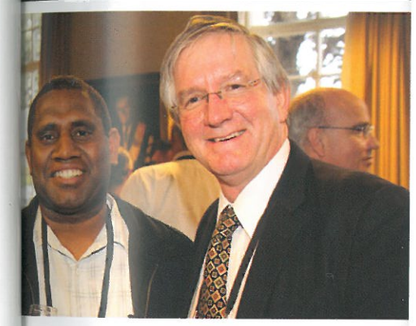
The conference addressed such topics as the measuring of unmet surgical need, the safety of surgery in low and middle income countries (LMIC), essential surgical care, and the role of organisations in training, support, advocacy, and research. The meeting highlighted that globally there is a high proportion of unmet, but potentially surgically-treatable pathology, resulting in death, deformity and disability.

In the past two decades (1995-2014) the Millennium Development Goals made no specific mention of disease, deformity and disability that can be corrected or reduced by surgery.

Yet the evidence supports the fact that the unmet burden of disease is significant.

The populations inhabiting the world's richest nations undergo 60 per cent of global surgical procedures whilst those living in LMICs receive only 3.5 per cent of the surgery.

Currently two billion of the world's population do not have access to emergency and essential surgical care. Those in need of emergency or essential surgery have no therapeutic alternative to a surgical procedure, which normally requires some form of anaesthesia.



David Watters and Kiki Maoate chair the panel discussions. Below: Richard Leona and John Batten at the Cocktail reception. Inset: Warne Baravilala presents.

There remain 74,000 operating theatres without a pulse oximeter; something that Lifebox, an anaesthetic Non-Government Organisation backed by the World Federation Society of Anaesthesiologists, is seeking to address, as highlighted by Canadian anaesthetist, Dr Angela Enright.

Surgical mortality audits will be critical to getting emergency and essential surgery and safe anaesthesia on the global health agenda. There has been significant collaboration and momentum since the meeting to advocate for perioperative mortality, an indicator of the safety and quality of surgery and anaesthesia, to be included as a basic health indicator similar to maternal and infant mortality.

Support for the development of surgical capacity in developing countries continues to be a priority, in order to address the workforce, facilities and resources required to deliver an emergency and essential surgical and anaesthetic service.

Prior to the meeting we hosted workshops on the Global Initiative for Emergency and Essential Surgical Care (GIEESC) and how to manage contaminated wounds in disaster settings. The outcome of these workshops will inform future Surgical News articles.

The Symposium speakers spoke on ways of measuring the unmet burden of surgical disease and the cost-effectiveness of surgical treatments. Surgical care has often been perceived to be expensive, but in reality can be delivered for $11-30 per Disability Adjusted Life Year (DALY) which is a similar cost to measles vaccination, providing bed nets for malaria prophylaxis or Vitamin A supplementation.

Surgery cannot be carried out without anaesthesia. The next stage is to advocate for safe, if minimum, standards for anaesthesia and surgery, together with the measurement of outcomes, particularly perioperative mortality.

It will be such advocacy for surgical and anaesthetic services with the ministries of health in our region that will turn our discussions into something of on-going value in addressing the global burden of surgical disease.

David Watters and Kiki Maoate