Improving access to safe anaesthesia

Interview with Jannicke Mellin-Olsen, President, World Federation of Societies of Anaesthesiologists

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Eight years on from the Helsinki Declaration on Patient Safety in Anaesthesiology what would the report card say?

It has been a surprise how much it has spread beyond Europe, illustrating that the anaesthesiology world and our partners see the need to improve safety for our patients. The map says it all (https://iii.hm/noi). But a signature does not mean improvement per se, it must be followed up by committed actions.

What are your priorities as President of the World Federation of Societies of Anaesthesiologists (WFSA)?

The WFSA mission is to unite anaesthesiologists around the world to improve patient care and access to safe anaesthesia and perioperative medicine. I have noticed that in high-, middle- and low-income countries, we are driven by the same goal—we want to help our patients. Five out of seven billion people in this world do not have access to safe, timely and affordable anaesthesia and surgery. This must be changed, and we anaesthesiologists cannot expect anyone other than ourselves to drive that change. We must lead by creating awareness of the situation, advocate, set standards and educate.

The WFSA's global workforce survey highlighted the lack of anaesthesia in many parts of the world:

How can this gap be closed? It must be a combination of workforce expansion, education, investing in facilities and equipment, including anaesthesia drugs, and improving the living and working situation to reduce emigration and more. We need to help policy makers and decision makers understand that they must provide sustainable plans for scale-up.

How is the WFSA working on the interim goal of at least 5 specialist physician anaesthesia providers per 100K population? The Lancet Commission on Global Surgery (thelancet.com/commissions/global-surgery) estimated that there should be at least 20 surgeons + obstetricians + anaesthesiologists per 100K. We estimated that of those, a bare minimum of 5 must be anaesthesiologists to lead and educate in addition to some direct patient care. The WFSA is working on many fronts. We are now developing a Training Framework, we do training ourselves—for instance the SAFE Courses and all our training centres, we have developed the WHO-WFSA Standards for Safe Anaesthesia, we work with governments on National Surgical, Obstetric and Anaesthesia Plans and more.

What work is being undertaken to define and map non-physician anaesthesia providers as well as infrastructure and

equipment? Non-physician anaesthesia providers are also counted in our Workforce Study, which will be repeated during the coming two years.

What's behind the WFSA campaign #KetamineisMedicine?

Where there are limited resources, like when there is no oxygen, no electricity or no equipment and limited training, ketamine is often the only available anaesthetic. China has called for international scheduling, as Chinese ketamine has been used as a recreational drug in neighbouring countries. They have been supported by some other countries where there is illicit use of ketamine. The morphine experience taught us that when medicines are scheduled, the medical usage is dramatically reduced, although countries are supposed to ensure that they are available for medical purposes. An example is when India enacted the Narcotic Drugs and Psychotropic Substances Act in November 1985 (Mohan and Bansal 2005). So many bureaucratic restrictions were put in place that doctors stopped taking morphine from the pharmacies, who in turn, stopped stocking it, and the manufacturers stopped producing a medicine nobody bought. The use of medicinal morphine dropped by 97%. There is no reason to believe that it would be different for ketamine, which would be a disaster for patients.

The WFSA raised concerns about the recommendation on FiO_2 in the World Health Organization guidelines to prevent surgical site infections—has this been amended?

Our concerns were twofold—one is that even in high-income settings, it is very difficult to maintain a level of FiO_2 0,8 during the whole perioperative period, so it does not make sense to recommend it. The other is of course, the effect of a high FiO_2 on lungs with atelectasis and other problems. The WHO took our input seriously but have not been willing to change the recommendation yet. However, since these discussions started, one of the papers by Schietroma has been retracted, so they have now excluded all his papers previously included in their reviews, and the strength of evidence changed. Therefore, they have decided to reconvene the Guidelines Development Group and expand it with more anaesthesiologists. We are also now involved in a Dutch study looking into the actual practice of perioperative FiO_2 administration throughout the world.

What is holding back gender equity in anaesthesiology and how can this be improved?

The same factors as in other fields of medicine and in society in general. It is a multifaceted problem: Medicine should be gender balanced, to meet the patient mass which is 50/50. Yet, medicine as a profession is being feminised. Hence, we need to investigate factors preventing men to apply to medical school. But the increased female workforce is not reflected in leadership positions and academics. The reasons are multiple, so the measures must be multiple: as it is now, there is a positive discrimination in the way that people have a tendency to select and appoint people who resemble themselves. When the "selectors" are white, middle-aged men, they tend to recruit other white middle-aged men. Therefore, there must be a mechanism to actively identify people that "are different" but not sacrificing quality. Quotas have also been used with success in my country, but it is controversial. Role models and good mentors (not necessarily of your own gender) are also important.

> "Five out of seven billion people in this world do not have access to safe, timely and affordable anaesthesia and surgery"

What is meant by critical emergency medicine (Böttiger et al. 2018)? What are the basic principles of CREM?

There has been and is some controversy regarding "emergency medicine" in Europe and beyond. Anaesthesiologists view emergency medicine as one of the pillars in our speciality, and the European Board of Anaesthesiology and the European Society of Anaesthesiology have not been supportive of a basic speciality in emergency medicine. Yet, "our" emergency medicine represents only the critical part—ten percent of what the speciality claims, while 90% of their speciality is totally something else. We argue that those most critical patients are better served by a team approach where we contribute what we are good at, supporting airways and circulation in those critical patients.

Who should manage the airway in an emergency outside the hospital and inside?

Basic airway management—jaw thrust and mask and bag ventilation should be a basic competence of all health workers. Advanced airway management should not be defined by designation, but by competence. Health systems are different, so one cannot transplant one system to another. But in times where for instance laryngeal mask is replacing endotracheal intubation, it should not be spread on too many professions as it will be difficult to obtain and maintain that competence. Therefore, as a rule inside the hospital it should be that anaesthesia personnel are in charge. Outside the hospital, the trend is that intubation is being replaced by subglottic airways, and that is probably a good trend. ■

References

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