Continuing transition in surgical care

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The presentations that constituted the "Symposium on Ambulatory Surgery," held as part of the annual meeting of the Canadian Association of General Surgeons at the annual meeting of the Royal College of Physicians and Surgeons of Canada in September 1996, are well summarized by MacFarlane in this issue (page 259). The symposium also addressed same day admission surgery.

All of us are faced with the necessity of decreasing costs while trying to maintain quality of care and the volume of surgery. Elimination of patient-stay costs offers a solution, and the symposium's first presenter, Dr. Douglas Sinclair, discussed the practicalities.

For ambulatory and short stay surgery programs to succeed, all those concerned must change their habits. There are specific areas of change for surgeons. Medical student and resident teaching, traditionally done with inpatients, must adapt to the outpatient setting. In his presentation, Dr. Rudy Danzinger pointed out the planning necessary to make the transition. Discussing the proposed surgery with patients and their families and obtaining informed consent must now be done in the office. Preoperative and postoperative documentation and instruction sheets should be given to all patients. Dr. Julius Stoller's presentation, "Patient preparation," covered this topic thoroughly.

In "Practice — breast," Dr. Gayle Higgins addressed the infrequency of technical failures, particularly with respect to the management of drains, and the occasional failure to control pain and nausea in outpatients who undergo surgery for breast cancer (modified radical mastectomy, quadrant resection with node dissection and complicated open biopsy) and therefore require admission.

Central to the increased volume of outpatient and same day admission surgery is the preoperative clinic, where laboratory testing, clinical evaluation and teaching are done. Dr. Andrus Voitk explained the important part the preadmission clinic plays in preparing the patient. In the preoperative clinic, written general instructions with regard to anesthesia must be given to all patients, as well as instructions for their specific surgery. When patients are ready to leave the Day Surgery Unit, they should be given written and verbal instructions from the surgeon for their particular procedure and followed up by phone after 24 hours (at the Royal Victoria Hospital in Montreal, a day surgery nurse calls all patients at home the day after the operation.)

Voitk is to be congratulated on achieving a 95% rate of outpatient laparoscopic cholecystectomies on healthy patients, and his suggestion to use comparisons of individual surgeon's practice habits to effect institutional change should be supported.

Most patients and their families are worried when they hear that their surgery will be done on an outpatient basis. However, once the patients actually have the procedure, most report that they find it more acceptable than in-hospital surgery. Fear of the unknown is a general phenomenon, but as more and more people have outpatient and short stay procedures, it will become accepted as the norm.

Voitk highlighted the fact that a 6-hour postoperative observation period is long enough to identify those who will need admission, and our experience at the Royal Victoria Hospital parallels that of Dr. Mark Taylor of Winnipeg, who reported no increase in readmissions or complications when traditional inpatient procedures were moved to day surgery and same day admission procedures.

In summary, the habits of health care professionals, especially surgeons, and the organization of the surgical service, must change. Day surgery, same day admission surgery and short stay surgery can replace many of the traditional inpatient operations.

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