Inpatient today — outpatient tomorrow?

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Descriptions of "the funding crisis" that faces the provincial health care ministries abound in our daily newspapers and surgical journals. In many instances, physicians and surgeons are feeling more disenfranchised than ever by a rapidly changing health care system that they seem unable to influence in the best interests of their patients, the system itself and their professional satisfaction. It is with a sense of refreshment that I reviewed the article by Voitk entitled "Establishing outpatient cholecystectomy as a hospital routine," which appears in this issue (page 284).

Faced with the challenge of doing more with less, Voitk and his 3 colleagues undertook to change the management of a population of surgical patients. These 4 general surgeons, practising in a nonteaching hospital, fostered a profound change in the delivery of surgical services from traditional inpatient management to outpatient (i.e., same day discharge) management, with substantial economic benefit to the hospital in which they worked and with no apparent ill effects (readmission, emergency department visit) on their patients. What I believe started as an "internal review" (preliminary study) by a surgical group resulted in a total system change for the institution. More than ever, the senior surgeon in this group realized, as did the hospital administration, that the whole institution had to speak and act on this one issue (outpatient cholecystectomy) with a single voice and mode of action. Total commitment to this goal from the allied health professionals in the preadmission clinic to the nurses in the recovery room is required for this effort to be successful. A remarkable achievement of 95% of patients managed by outpatient laparoscopic cholecystectomy creates for all of us, as general surgeons, a new benchmark in surgery for which we should all strive. This occurred regardless of age, sex and, for the most part, the presence of comorbid conditions. Failure to "measure up," based on the widely available data from the Canadian Institute of Health Information of hospital surgical activity will be put in front of groups and individual surgeons. The previous argument of many surgeons simply stating "my patients are different" will no longer be respected by health administrators, provincial authorities, government health officials and surgical colleagues. The burden, as they say, is for each of us to prove it! This would seem even more applicable to teaching hospitals in our provinces. One of the mandates of our teaching hospitals is to lead the change process and engender this attitude in our trainees. If our patients are truly different and need "additional care," show me the data.

What is truly commendable about this significant change in the delivery of surgical care by Voitk and colleagues is that it was done with the surgeons leading the way. The need for change came about because of external forces, the unique solution was a voluntary, internal one. I believe this is the challenge that faces all surgical specialties in Canada. If we do not lead this change to provide guidance and ensure quality patient outcomes, it will assuredly be forced on us with less optimal results.

There are words here for hospital administrators who do work closely with their surgical colleagues to effect the very nature of surgical practice. These 4 committed surgeons have engineered a profound change in their own surgical practice patterns with personal and, in most cases, tangible economic sacrifices (it costs an individual surgical office *more* to participate in such a program). The hospital or institution is the major financial benefactor (substantial reduction in length of hospital stay, which is inevitably linked to the bottom line), assuming no change or better outcomes in patients so treated. It is incumbent on the hospital to recognize these efforts by tangible means. It was the convergence of technology (laparoscopic surgery) and

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an economic crisis that were the main factors leading to this change. The economic crisis has abated somewhat, yet the need for technology is ever present and extends into all areas of surgery so that we may all benefit. Those who foster genuine change in the system need to see a reward for their efforts. This reward can take on many forms — service recognition awards, purchase of operative technology, transfer of a share of "saved" (actually costs avoided) resources to other areas needed within the same surgical portfolio (e.g., better support for general ambulatory care).

The final chapter has not yet been written in the area of "inpatient today — outpatient tomorrow." I believe that we need to study more accurately the outcomes from both patient and economic perspectives to realize the true impact of many of these conversions in surgical practice. Surgeons must realize that the traditional "surgical bed" is no longer the cherished unit it once was. Access to the operating room, advanced technology and ambulatory care (preadmission clinics, etc.) are the future for successful outcomes as we realistically "do more with less." It will mean the collaborative efforts of surgeons, health care administrators, anesthetists, family physicians, epidemiologists and many others. I say "bring it on!"

SESAP Critique / Critique SESAP

Item 2

Avoidance of premature debridement in frostbite is essential. Surgical debridement or early amputation prior to clear demarcation and mummification greatly increases the risk of infection and will result in increased tissue loss. Demarcation of nonviable tissue may take two to three months and early, active physiotherapy and functional splinting should be underway both before and as an adjunct to eventual operation.

For patients who develop vasospastic syndromes as a sequel to frostbite, late regional sympathectomy has been proposed to treat chronic symptoms. In addition, late distal sympathectomy at the level of the digital arteries may be useful for relief of debilitating vasospastic states with pain, cold sensitivity, and trophic changes.

Systemic anticoagulation is not useful in frostbite injury. The intrinsic muscles of the hand may be particularly sensitive to severe frostbite; varying degrees of fibrosis of the muscle bellies have been attributed to local ischemia. In extreme cases, late release of fibrosed muscles and joint contractures may be required but this is not considered until a rigorous rehabilitation program is completed.

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References

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