

## “Who says there is a deficiency in care?”

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In the article “Outpatient cholecystectomy: home visit versus telephone follow-up” (page 39), Fallis and Scurrah address a concern that is shared by some of our colleagues and patients: whether care provided today is as good as it was before the introduction of outpatient laparoscopic surgery. Further, whether surgical practice changes have been dictated by reduced funding of hospitals rather than by the standard of excellence in patient care.

There is a fundamental, incorrect perception that patients are missing out on care; care that they would normally receive if they were admitted to hospital versus no care when if they were discharged the same day after outpatient surgery.

Physicians and other health care personnel have warned that care must be maintained for patients who are undergoing increasingly complicated surgery with same day discharge from hospital. Their message is that patients are deprived of some aspect of their care and that an alternative care plan needs to be in place since the health care providers are in a default position. This is the subliminal message that is promulgated by nursing administrators, usually, and by some physicians, yet they don't define the issue as I have outlined it.

Without clearly defining any deficiency in care, Fallis and Scurrah have addressed the perceived deficiency with arms' length care/follow-up by comparing the efficacy of telephone follow-

up versus a home visit after same day laparoscopic cholecystectomy. The nearest we get to a positive outcome from either the telephone call or the home visit is a subjective feeling from the patients of improved esteem. Although the patients may have improved self esteem, leading to fewer complaints and possibly legal suits when they are talked to, this was not a primary measure in the study. What was measured were concern scores and nursing intervention, neither of which differed between the home visit or the telephone call groups.

What underpins all of these extra activities after hospital discharge is the notion of the default position in care and the desire on the part of health care professionals to fill this void. As yet, we have no measure of any deficiency in health care, which begs the question, Is there a deficiency in health care, and if there is, what is it? If a deficiency does exist, then we can adopt measures to overcome it. There is an increasing amount of literature reporting the use of telephone interviews as support for various clinical jurisdictions. Fallis has previously published on the use of the telephone interview in an attempt to improve postoperative patient care after hospital discharge.<sup>1</sup>

To surgeons performing outpatient laparoscopic surgery, the additional follow-up suggested by others is a mystery. They know that outpatient laparoscopic surgery works and wonder what all the fuss is about.

Perhaps it is the surgeons' fault for not taking the time to explain how the current surgical management of gallstones has evolved through a series of steps, each based on the care of hundreds of patients.

The first step was the observation that laparoscopic cholecystectomy is as safe as open cholecystectomy in most patients. All patients are warned that an open operation may be required if the laparoscopic approach is not feasible. The second step was the observation that patients recover much more rapidly after laparoscopic surgery than after an open procedure. Early ambulation as a consequence of minimal postoperative pain allows patients to be discharged sooner than the traditional several days after in-hospital cholecystectomy. The final step was the realization that for most patients admission to hospital is redundant.

This sequence of events has been paralleled by changes in the management of the nonperforated appendix by laparoscopic appendectomy. The duration of postoperative care in many patients is only a few hours, so a much reduced stay is required for the majority. Similarly, patients who have tension-free hernia repairs do not require hospital admission since the majority of such patients are pain free. This underscores the fact that the main reason for admission to hospital after operation is to control pain in patients who otherwise have no significant physiologic disruption. As pain management teams become more

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common, surgery other than laparoscopic surgery will be manageable in the home care situation.

As Fallis and Scurrah suggest that providing a crisis call number to a patient at the time of discharge would be useful, giving that patient an increased comfort level. Telephone advice other than for the patient to go to the emergency room for any worrying symptoms could be inappropriate and dangerous, since the telephone helper is not necessarily familiar with the patient or experienced in postoperative management. To avoid potential medicolegal issues arising out of bad advice, a structured interview was used in the current study. Although this may avoid medicolegal issues resulting from inappropriate advice, the authors do not demonstrate any improvement in actual care, in terms of the level of patient concern or nursing intervention. Unfortunately, only in an interview where there is a free exchange of information and advice can the anxious patient be reassured.

Is there anything, in addition to a crisis call number, be it telephone interview or home visit, that serves patients any better?

The study described by Fallis and Scurrah had the power to determine if further care was needed after discharge, but no control group was added. A control group receiving neither home visit nor telephone interview could have been included in the 48-hour post-discharge survey. If this cohort had identified a deficiency in care it would have been a unique observation, and a corrective strategy could be adopted. Alternatively, the control group could indicate what surgeons believe, that there is no deficiency in care. Until this is proved, we are left wondering whether patients should simply use common sense and rely on the information given to them by their surgeon before operation and the nurse who gives advice on self-help and provides an advice sheet before discharge.

This paper did not purport to demonstrate a need for follow-up after discharge but it did confirm what practising surgeons would expect, that there was no deficiency in care as a result of "same-day home" laparoscopic cholecystectomy. The single complication of a biloma identified in the study was not picked up by interview because the patient pre-

sented on the third postoperative day, care was not compromised and the patient was satisfactorily treated with a good outcome.

Every patient is advised to contact the surgeon or go to the emergency room if there are difficulties. As surgeons we know that outpatient cholecystectomy works well for the majority of patients. Patients are never denied hospital care if it is needed, the rare complications are efficaciously managed and outcomes are no worse than in hospitalized patients.

In short, as part of the surgical fraternity we need to be more vocal because we do not see any deficiency in care. Outpatient laparoscopic surgery is a leap forward in the management of gallstones. We need to inform our patients and colleagues better. We need to shout the message out louder.

#### Reference

1. Chewitt MD, Fallis WM, Suski MC. The surgical hotline. Bridging the gap between hospital and home. *J Nurs Admin* 1997;27(12):42-9.



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