Editorial

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The more I meet and work with international colleagues the more I feel that we face many common problems.

It seems that **wherever we work and whichever** healthcare system we work in, that we have common ground around issues of finance, hospital-related harm including infections and the introduction of new techniques. Successful ambulatory surgery can make sound financial sense although payment systems in some countries do not promote ambulatory surgery and may even prejudice against it. Minimising the length of hospital stay reduces the risk or exposure to hospital related infections and so reduces patient harm. However one area where we all have a responsibility relates to the introduction of new techniques or new technology in our practice. The recent metal on metal hip joint scare is a timely reminder of that responsibility. Innovation in healthcare has improved the quality of life for many but we must all ensure the evidence is incontrovertible before we introduce new techniques.

In this edition we have articles from across the globe and from a variety of specialists.

From the UK we have articles on the management of incisional hernias – demonstrating that laparoscopic repair reduces length of stay and another looking at patients' perception of risk around the time of surgery. From Australia we have a comparison of patients undergoing assessment for endoscopy procedures by telephone or in a dedicated clinic setting. It is interesting to note that there was no difference between the two groups – perhaps this this sign of the modern 'mobile phone' culture. From Germany we have two articles. The first provides an explanation of the funding system which appears to promote inpatient rather than ambulatory care through perverse financial incentives. The other looks at a comparison between hospital and office based surgery. To round things off my Editor in Chief colleague Beverly Philip describes the funding and management of ambulatory surgery in the USA.