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Promoting ambulatory surgery – grounds for contention?

(Doubts and questions)

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1st International Congress on Ambulatory Surgery

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A. The patient asks for ambulatory surgery

The argument that the patients ask for ambulatory surgery can be questioned on grounds of different observations:

1. It is a common experience in the daily practice of most of us that patients rarely ask spontaneously for ambulatory surgery.

Morgan M and Beech R
Variations in lengths of stay and rates of day case surgery: implications for the efficiency of surgical management
'Given the choice, many patients in Britain would probably currently prefer inpatient admission for intermediate surgical procedures, although choosing day case treatment for minor excisions.'
J Epidemiol Commun Health 1990; **44:** 90–105

Kirby RM
Day case surgery
'We have undertaken a survey of 101 patients undergoing either inguinal hernia repair or surgery to varicose veins. Each patient was given a questionnaire on the evening after operation containing a simple question: "Would you like to be going home on the evening of surgery?" Of 44 patients having varicose vein surgery, 25 replied "no" and 19 replied "yes". More importantly, however, of 57 patients who had an inguinal hernia repair 52 replied "no" and five replied "yes", a ratio of 10 to 1 against the idea of discharge on the same evening.'
Lancet 1991; **338:** 1529

Johnson I
Day case tonsillectomy – a public demand?
'This study not only raises the question regarding the public's knowledge of complications, but in the time of the Patient's Charter asks if the public actually wants day-case tonsillectomy.'
J Laryngol Otol 1993; **107:** 765

2. If the doctor proposes ambulatory treatment, a not negligible number of patients refuse.

Davies B and Tyers A
Do patients like day case cataract surgery?
'This is a selected group of patients in that some patients are not offered day surgery because of medical or other reasons and of those who are offered day surgery 30% declined.'
Br J Ophthalmol 1992; **76:** 262–3

3. In choosing ambulatory surgery it is most of the time the doctors' opinion, and not the patients' opinion about ambulatory surgery, that is decisive.

Lowe K, Gregory D et al.
Suitability for day case cataract surgery
'It is the authors' experience that patients who are offered a choice of day case or inpatient management often ask which their doctor would recommend.'
Eye 1992; **6**: 506–9

Morgan M and Beech R
Variations in lengths of stay and rates of day case

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surgery: implications for the efficiency of surgical management
'Clinical barriers limiting the adoption of day case surgery or short stay policies may also arise if surgeons do not regard such forms of management as having any clinical advantages.'
J Epidemiol Commun Health 1990; **44**: 90–105

4. The results of patient satisfaction measurements are highly variable.

Pica-Surey W
Ambulatory surgery – hospital based vs freestanding
'Few researchers, however, have studied patient satisfaction with ambulatory surgery and the findings of the studies reported are inconsistent.'
AORN J 1993; **57**: 1119–27

Duncan P, Cohen M et al.
The Canadian four-centre study of anaesthetic outcomes: III. Are anaesthetic complications predictable in day surgical practice?
'In spite of the widespread development of ambulatory surgery, there has been relatively little critical evaluation of the outcome of this service. Randomization of subjects between inpatient and outpatient facilities has essentially not occurred.'
Can J Anaesthesia 1992; **39**: 440–8

Morgan M and Beech R
Variations in lengths of stay and rates of day case surgery: implications for the efficiency of surgical management.
'The majority of patients express a high level of satisfaction, although several studies showed that a significant proportion of patients undergoing day case surgery for inguinal hernia repair and varicose veins would have preferred inpatient care.'

'Similarly, a significant proportion of the cholecystectomy patients (reviewed by Reder et al.) would have preferred a longer period of hospital care. However, the reasons for this preference and the strength of the preference are rarely described.'

'There is also the question of the trade offs that patients are willing to make where there are waiting lists for surgery. For example, the choice between a shorter length of stay and an early operation, or a longer length of stay and a greater waiting time (or between immediate day case surgery and waiting for inpatient care), may result in a preference for the more immediate care option.'
J Epidemiol Commun Health 1990; **44**: 90–105

5. It can be observed that patients prefer inpatient surgery without co-payment to one day surgery with (even minor) co-payment. Along similar lines of thinking it has been published that even insurance policies that offer relatively lower out-of-pocket payments for ambulatory surgery do not increase the probability that surgery will be done in the ambulatory setting.

Pauly M and Erder M
Insurance incentives for ambulatory surgery
'The results indicate that insurance policies that offer relatively lower out-of-pocket payments for ambulatory surgery do not increase the probability that surgery will be done in the ambulatory setting.'
Health Services Research 1993, **27**: 813–39

Many reasons can be enumerated to explain why a substantial number of patients do not prefer surgery in the ambulatory setting:

- additional discomfort in the ambulatory organization of preoperative assessment
- additional patient load in the organization of his own postoperative care (GP, home nurses, pharmacist...)
- traffic jams at the critical hours of the day
- patient reserves in taking responsibility for the supervision of their own postoperative care or that of their children.

Voepel-Lewis T, Andrea C et al.
Parent perceptions of paediatric ambulatory surgery: using family feedback for programme evaluation
'Eighty-two families (25%) in the sample perceived the outpatient experience as being very stressful.'
J Post Anesthesia Nursing 1992; **7**: 106–14

Callanan V, Capper R et al.
Daycase adenoidectomy, parental opinions and concerns
'Parents worried about: their child bleeding at home (53%); bleeding on the way (40%); vomiting at home (39%); vomiting on the way home (35%) and not knowing if their child was sick during the night (44%).'
J Laryngol Otol 1994; **108**: 470–3

Schloss M, Tan A et al.
Outpatient tonsillectomy and adenoidectomy: complications and recommendations
'Most revealing, however, were the parents' feelings about their child's first postoperative night. While 60% of the parents reported being somewhat worried if their child was hospitalized for the first night following surgery, 25% were relieved, apparently being reassured by the knowledge that inpatient care was being provided for their child. Conversely, 20% reported that having to care for their child at home would "terrify" them, with an additional 58% experiencing some worry over this possibility. Only 4% of parents felt significant relief due to being able to care for the child in the home environment.'
Int J Ped Otorhinolaryngol 1994; **30**: 115–22

While A and Wilcox V
Paediatric day surgery: day case unit admission compared with general paediatric ward admission
'The findings of this small exploratory study concur with those of Caring for Children in the Health Services Organization (CCHS) (1991) that day case admissions must be carefully planned if they are not to cause unnecessary stress for children and their families.'
J Advanced Nursing 1994; **19**: 52–7

B. Ambulatory surgery results in a better quality of care

The quality of ambulatory surgery is documented to be good and not to be worse than the quality of the same type of surgery in the inpatient setting. This is, however, not the same as saying that ambulatory surgery leads to a better quality of care. Several comments can be made on this point:

1. In many countries comprehensive, reliable and accessible measured data on the quality of inpatient care do not exist. However, the situation is even worse in the ambulatory setting. Statements about quality are often based on impressions and/or opinions, not on facts or measurements.

Osborne G and Rudkin G
Outcome after day care surgery in a major teaching hospital
'There have been few comprehensive published studies of outcome after day care surgery. More comprehensive outcome studies are required to confirm that the potential advantages of day surgery are realized in practice.'
Anaesth Intens Care 1993; **21**: 822–7

Warner M, Shields S, et al.
Major morbidity and mortality within 1 month of ambulatory surgery and anaesthesia
'The determination of appropriate candidate selection criteria for ambulatory anaesthesia and surgery in older or less healthy patients is difficult because of a lack of ambulatory outcome data extending beyond the first 24–48 postoperative hours.'

'Reports of ambulatory surgical outcomes that include only the initial postoperative period may underestimate the actual incidence of surgical and anaesthetic-related complications.'
JAMA 1993; **270**: 1437–41

Yozzo J
Is it feasible to track infections in an ambulatory surgery centre?
'The ambulatory surgery centre (ASC) at Northern Westchester Hospital has approximately 55 surgeons performing an average total of 300 surgical procedures every month. After many months of identifying and evaluating infection tracking methods, we were unable to ascertain an infection rate for all patients who visited our ASC. Obtaining a statistically significant response was difficult, leading to questions about each method's validity.'
J Post Anesth Nursing 1989; **4**: 255–8

Michaels J, Reece-Smith H et al.
Case-control study of patient satisfaction with day case and inpatient inguinal hernia repair
'Lack of information about outcome, including less easily measured results such as patient satisfaction, may give a misleading impression and some form of audit of outcome should be carried out.'

'Six patients reported wound problems, five of which were unknown to the hospital.'
J Roy Coll Surg Edin 1992; **37**: 99–100

2. The argument of the reduction of the risk for hospital acquired infection is of minor relevance in the debate since ambulatory surgery patients in general do not belong to any of the risk groups for hospital infections (indwelling catheters, mechanical ventilation, immunosuppression).

3. Many patients mention more postoperative discomfort than they expected.

Oberle K, Allen M et al.
Follow-up of same day surgery patients
Percentage of patients with severe postoperative pain:

Procedure	*Postoperative day*			
	0	*1*	*2*	*3*
Arthroscopy	29.4	27.6	11.8	5.9
Bunionectomy	53.3	46.7	16.7	6.7
Cataract extraction	15.2	3.0	3.0	NA
Laparoscopy	33.3	29.0	16.1	3.2
Mammoplasty	54.3	31.4	14.3	8.6
Submucosal resection	24.2	39.4	24.2	9.1
Tubal ligation	62.5	15.6	8.4	9.4
Other major procedures	40.6	43.7	18.7	6.2
Other minor procedures	20.6	14.7	11.8	14.7

NA, not applicable.

AORN J 1994; **59**: 1016–25

Astfalk W, Warth H et al.
Day case surgery in childhood from the parents' point of view
'Nevertheless, a total of 40 children (16.8%) have unpleasant or strong memories of the pain they experienced.'
Eur J Pediatr Surg 1991; **1**: 323–7

Duncan P, Cohen M et al.
The Canadian four-centre study of anaesthetic outcomes: III. Are anaesthetic complications predictable in day surgical practice?
'Even with the limitations of the telephone survey, it is disturbing that so many patients reported sore throat, nausea, headache and backache.'
Can J Anaesth 1992; **39:** 440–8

Voepel-Lewis T, Andrea C et al.
Parent perceptions of paediatric ambulatory surgery: using family feedback for programme evaluation
'Thirty-seven of the respondents (12%) felt that their children experienced more postoperative pain than expected. Families of children in the otorhinolaryngology sample perceived significantly more pain than expected than did other families. More postoperative nausea and vomiting than expected was perceived by 33 families (10.4%). The orthopaedic sample perceived significantly more nausea and vomiting than the overall sample.
J Post Anesth Nursing 1992; **7**: 106–14

Levin P, Stanziola A et al.
Postoperative hospital retention following ambulatory surgery in a hospital-based programme
'The main finding of the present study is that 9.5% of patients undergoing surgery at a hospital-based ambulatory surgery centre were retained in hospital postoperatively for observation or complications. This is much higher than reported in earlier studies.'
Qual Assur Utiliz Rev 1990; **5**: 90–4

Philip B
Patients' assessment of ambulatory anaesthesia and surgery
'Although our respondents were discharged on the day of surgery, full recovery required additional days at home. This finding, while not new, is contrary to the popular expectation by patients and surgeons of "street fitness" after "in-and-out surgery". Sixty-two per cent of our patients did not resume normal activities the next day, but instead required an average of 3 additional days.'
J Clin Anesth 1992; **4**: 355–8

4. Taking patient satisfaction as an outcome measure, the quality of ambulatory surgery is of varying levels.

Duncan P, Cohen M et al.
The Canadian four-centre study of anaesthetic outcomes: III. Are anaesthetic complications predictable in day surgical practice?
'While the low response rate (36%) to the telephone interviews created a sampling bias, the high rate of patient dissatisfaction among those reached is disconcerting.'
Can J Anaesth 1992; **39**: 440–8

Michaels J, Reece-Smith H et al.
Case-control study of patient satisfaction with day case and inpatient inguinal hernia repair
'Nearly half of the patients felt that they were discharged too early and the majority would prefer inpatient treatment.'
J Roy Coll Surg Edin 1992; **37**: 99–100

Pineault R, Contandriopoulos A-P et al.
Randomized clinical trial of one-day surgery. Patient satisfaction, clinical outcomes and costs
Patient perception of the appropriateness of length of stay by surgical procedure and mode of care (n = 182):

Surgical Procedure	*Mode of care*		
	One-day (%)	*Inpatient (%)*	χ^2
Total for all procedures	100.0	100.0	
Too short	55.9	21.3	22.8*
Appropriate	44.1	78.7	
Tubal ligation	100.0	100.0	
Too short	51.6	20.0	6.6*
Appropriate	48.4	80.0	
Hernia repair	100.0	100.0	
Too short	59.4	25.8	7.3*
Appropriate	40.6	74.2	
Meniscectomy	100.0	100.0	
Too short	56.7	17.9	9.3*
Appropriate	43.3	82.1	

*= $P \leq 0.01$.

Patient preference for alternative mode of care by surgical procedure and mode of care (n = 182):

Surgical Procedure	*Mode of care*		
	One-day (%)	*Inpatient (%)*	χ^2
Total for all procedures	100.0	100.0	
Same mode	50.5	86.5	26.3*
Alternative mode	48.4	13.5	
Undecided†	1.1	–	
Tubal ligation	100.0	100.0	
Same mode	56.7	93.8	10.8*
Alternative mode	46.3	6.7	
Undecided†	1.0	–	
Hernia repair	100.0	100.0	
Same mode	53.1	77.5	4.09‡
Alternative mode	46.9	22.5	
Meniscectomy	100.0	100.0	
Same mode	43.3	89.3	23.54*
Alternative mode	56.7	10.7	

*$P \leq 0.01$. †not included in analysis; ‡$P \leq 0.05$.

Med Care 1985; **23**: 171–82

While A and Wilcox V
Paediatric day surgery: day case unit admission compared with general paediatric ward admission
'The care offered in the day case unit was found to be woefully deficient in many areas.'
J Adv Nursing 1994; **19**: 52–7

C. Ambulatory surgery saves money

In spite of all arguing on patient preferences and quality improvement the real argument for the development and promotion of ambulatory surgery is the claim that it saves money. This claim has not been proved. Observations can even be made that suggest an opposite effect:

1. In the USA, where ambulatory surgery is promoted more than in any other country, healthcare expenditures are growing at a faster pace than in any other country (see Figure 1).

2. No comprehensive study on the macro-economical effects of the introduction of ambulatory surgery exists. Most studies are fragmentary and do not measure all cost elements.

Kitz D, Slusarz-Ladden C et al.
Hospital resources used for inpatient and ambulatory surgery

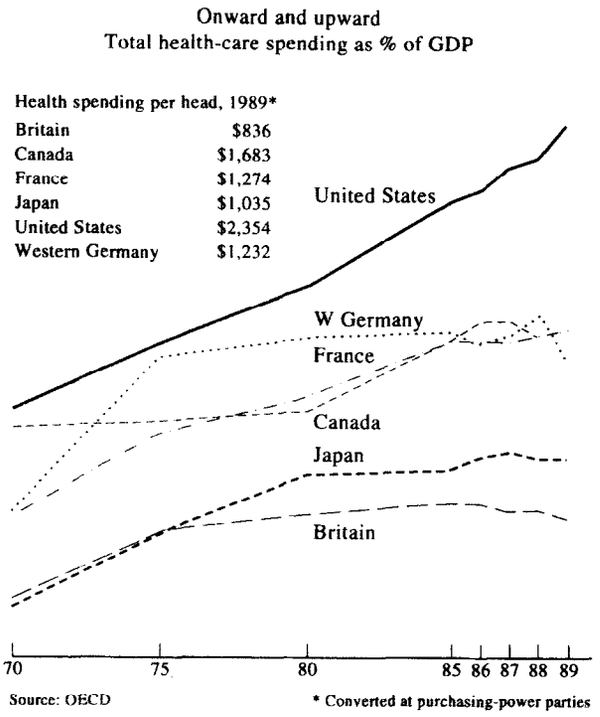

Figure 1. Onward and upward. Total health-care spending as % of GDP

'Costs for other components of care, such as pharmaceuticals and overnight hospital stay, were not available for the period included in this study.'
Anesthesiol 1988; **69**: 383–6

Almost all studies neglect transferred costs.

Detmer D
Ambulatory surgery. A more cost-effective treatment strategy?
'Of course, some of these cost reductions resulted from the transfer of expenditures from the healthcare system to other caregivers, such as the patient's family.'
Arch Surg 1994; **129**: 123–7

Schwartz W and Mendelson D
Hospital cost containment in the 1980s. Hard lessons learned and prospects for the 1990s
'Our calculations include only changes in expenditures for acute care in hospitals and do not indicate the overall effect of these changes on system-wide expenditures for healthcare. When care is transferred to free-standing ambulatory care facilities and physicians' offices, the resulting costs partially offset the savings accomplished in hospital-based care. Because there are not readily available measures of care shifted to settings outside the hospital, we have been unable to calculate the net savings to society.'
New Engl J Med 1991; **324**: 1037–42

Morgan M and Beech R
Variations in lengths of stay and rates of day case surgery: implications for the efficiency of surgical management
'Reductions in lengths of stay and the substitution of day case surgery for inpatient admission reduces hospital costs per case. However, there are questions of the precise cost savings achieved and the existence of any "knock on" effects, or costs transferred to other caring bodies, such as district nurses, general practitioners and home helps. Finally, there may be social costs (or savings) linked to the time patients and their families are absent from work.'
J Epidemiol Commun Health 1990; **44**: 90–105

These transferred costs can, however, be substantial.

Stott N
Day case surgery generates no increased workload for community based staff. True or false?
'Garraway et al. reported a study in Edinburgh, involving 163 practitioners and 498 patients, in which they investigated the impact of day surgery on general practitioners' workload: one in four practitioners mentioned increased workload and the possibility of additional late house calls as disadvantages of the scheme.'

Ruckley et al. studied 117 Edinburgh patients discharged home the same day after surgery for varicose veins or hernia: a quarter of the nurses said that day surgery had increased their workload significantly. Average levels of contact time (including travelling) in the 3 week follow-up period were 186 min (ward patients), 204 min (convalescent patients) and 325 min (day care patients). This is a clear indication of the greater demands on district nurses when day surgery is involved.'

'Nothing is more erosive to morale than assumptions that transferred costs are trivial when doctors and community nurses know they are being called for postoperative complications or concerns. Patients should expect an excellent proactive postoperative service at home.'
BMJ 1992; **304**: 825–6

Schloss M, Tan A et al.
Outpatient tonsillectomy and adenoidectomy: complications and recommendations
'The effect on family life-style as the result of a surgical procedure and postoperative care of the child can be seen and hypothesized from the data presented. The indirect cost of providing primary postoperative care at home, including parental loss of time from work, the anxiety resulting from the operation and concern over providing in-home post-surgical attention are revealed in the study findings.'
Int J Ped Otorhinolaryngol 1994; **30**: 115–22

Michaels J, Reece-Smith H et al.
Case-control study of patient satisfaction with day case and inpatient inguinal hernia repair
'Although there was no objective difference in recovery, nearly half of the patients felt that they were discharged too early and the majority would prefer inpatient treatment. Day case patients required significantly more medical attention after discharge.'
J Roy Coll Surg Edin 1992; **37**: 99–100

3. Apart from their fragmentary nature most published reports show two fundamental methodological flaws. They use charges as a measure for cost and/or they use average inpatient cost as a measure for the cost of selected patient groups.

Evans R and Robinson G
Surgical day care: measurements of the economic payoff
'Previous research on this question had not adequately-addressed the issue of cost savings because it tended to rely either on hospital per diem comparisons or on comparison of charges.'
CMA J 1980; **123**: 873–80

Pauly M and Erder M
Insurance incentives for ambulatory surgery
'In 1987, short-term, general community hospitals in the US performed 2 041 455 surgical operations(...). It has been estimated that one-third of hospital costs are related to surgery(...). Since the average charge for each inpatient day was $530 in 1987 (AHA, 1988), a shift of one inpatient surgery to outpatient in 1987 would have yielded for each inpatient day a saving of $530 in hospital charges. Assuming that each shift of surgery to outpatient surgery saves at least one inpatient day, the annual savings from a 20% shift to outpatient surgery would have resulted in savings of at least $21 million in hospital charges alone.'
Health Serv Res 1993; **27**: 813–39

Van den Oever R et al.
Comparison of the average hospital bill for inguinal hernia repair – inpatient vs outpatient (amounts in Belgian francs)

	Inpatient	*Outpatient*	*Difference*
Surgery	7111	7115	−4
Anaesthesia	2329	2420	−91
Lab medicine	2775	2550	225
Medical imaging	1119	–	1119
Intensive care	124	–	124
Emergency	129	–	129
Pharmaceuticals	1982	–	1982
Medical surveillance	2517	1200	1317
Stay	20 169	2572	17 597
Total	38 255	15 857	22 398

Adjusted comparison of the average hospital bill for inguinal hernia repair – inpatient vs outpatient (amounts in Belgian francs)

	Inpatient	*Outpatient*	*Difference*
Surgery	7111	7115	−4
Anaesthesia	2329	2420	−91
Lab medicine	2775	2550	225
Medical imaging	1119	–	1119
Intensive care	124	–	124
Emergency	129	–	129
Medical surveillance	2517	1200	1317
Total	16 104	13 285	2819

Het Belgisch Ziekenhuis 1992; **211**: 28–31

4. Data have been published in which increases in outpatient expenditures tend to offset the savings in inpatient care.

Schwartz W and Mendelson D
Hospital cost containment in the 1980s. Hard lessons learned and prospects for the 1990s
'If the increase in the number of visits for ambulatory care were equal (in the period 1990–1995) to that in 1987 and 1988, much or all of the savings from cutbacks in inpatient care would be offset.'

'Our findings suggest that the era of easy reductions in the number of inpatient days, with the associated attenuation of rising costs, is largely over. If further reductions in inpatient days are accompanied by an increase in the amount of ambulatory care similar to that during the past few years, the net savings will probably be negligible.'
New Engl J Med 1991; **324**: 1037–42

5. Factors exist which may lead to an increase in healthcare expenditures upon a large-scale development of ambulatory surgery facilities.

(a) For hospitals a large part of the fixed and overhead costs remain when beds are closed but services are maintained.

Morgan M and Beech R
Variations in lengths of stay and rates of day case surgery: implications for the efficiency of surgical management
'These small savings stem from the assumption that hospital overhead costs will remain fixed, and with the exception of nursing costs, the costs associated with the treatment of patients will be unchanged.'
J Epidemiol Commun Health 1990; **44**: 90–105

Detmer D
Ambulatory surgery. A more cost-effective treatment strategy?
'An old but unsubstantiated hospital rule of thumb says that an empty bed costs 80% as much as a full bed.'
Arch Surg 1994; **129**: 123–7

(b) Another factor: the hospital outpatient setting has a much more limited history of cost-containment efforts.

Sulvetta M
Achieving cost control in the hospital outpatient department (OPD)
'The hospital outpatient setting has a much more limited history of cost-containment efforts. Given the relatively short history of attempts to control OPD costs, there has been minimal incentive for providers to control outpatient costs. As a result, Medicare sometimes pays more for an OPD procedure than it does for the same procedure performed on an inpatient basis.'
Health Care Fin Rev 1991; Ann Suppl: 95–107

(c) The risk for doubling and relative under-use utilization of capital investment.

Detmer D
Ambulatory surgery. A more cost-effective treatment strategy?
'The newly built free-standing ambulatory surgery centres (FASCs) are also changing in terms of appearance and function. In addition to surgical facilities, these centres may incorporate imaging services, laboratories, electrocardiography services and radiation therapy; they often offer some type of hotel accommodation to provide for the short-term stay of patients and families. As such, these facilities have begun to resemble "mini-hospitals" and are moving away from their identity as simply FASCs. In light of an excess of hospital beds in the US, development of these more complex FASCs could further boost the aggregate costs of the American healthcare system.'
Arch Surg 1994; **129**: 123–7

(d) A factor that may increase expenditure is an increase in the intensity – and consequently also the cost – of inpatient care, of patient throughput and of the number of services delivered.

Haworth E and Balarajan R
Day surgery: does it add to or replace inpatient surgery?
'This study has shown that for all the operative procedures investigated (mastectomy, cystoscopy and inguinal hernia repair in patients aged 15–44) increasing day surgery rates have been superimposed on a steady or increasing inpatient rate.'

'Additional day surgery per se or that which represents a shift from outpatient rather than inpatient care would, instead of saving funds, be more costly.'
BMJ 1987; **294**: 133–5

Detmer D
Ambulatory surgery. A more cost-effective treatment strategy?
'Although the adoption of ambulatory surgery will decrease the costs per case, it will also lead to greater throughput of patients and thus to greater total costs and possible budget overspending. This so-called efficiency trap is one of the reasons hospital administrators and physicians in European countries have been reluctant to adopt ambulatory surgery.'
Arch Surg 1994; **129**: 123–7

(e) Supply creates demand. The development of minimally invasive diagnostic and surgical techniques confirms the truth of this observation. *

Pauly M and Erder M
Insurance incentives for ambulatory surgery
'The lower user price of outpatient surgery might also, however, create an incentive to increase the use of outpatient surgeries. If the rate of substitution from inpatient surgeries is low relative to the rate of increase in utilization of outpatient surgeries, total utilization of surgeries may increase and charges for surgery may rise.'
Health Serv Res 1993; **27**: 813–39

6. The number of warnings against blind and unconditional belief in the cost savings capacity of ambulatory surgery is growing. Ever more, conscientious authors, although defending ambulatory surgery with enthusiasm, ask for rigorous cost-efficiency evaluations.

White P and Smith I
Impact of newer drugs and techniques on the quality of ambulatory anaesthesia
'As new biomedical technology is introduced to facilitate the perioperative management of patients(...), evidence that these systems enhance our ability to continue to provide high-quality, cost-effective healthcare will assume increasing importance. Limitations in healthcare resources necessitate a careful re-evaluation of our clinical practices with respect to choice of drugs, supplies, equipment and even discharge criteria.'

'Ambulatory anaesthesia and surgery will continue to increase because of the potential cost savings for patients undergoing elective operations on an outpatient basis. However, the challenge we face will be to continue to provide high-quality anaesthesia care at a reduced cost. A careful examination of commonly accepted (but unproven) clinical practice patterns will be necessary to meet this challenge.'
J Clin Anesth 1993; **5** (Suppl 1): 3S–13S

These are some comments and some observations which aim to inspire a more critical attitude towards the common statements that patients ask for ambu-

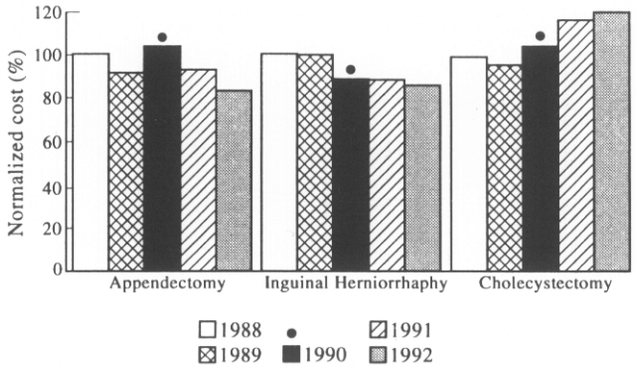

Figure 2. Inpatient expenditures per 1000 enrollees for selected procedures: appendectomy, inguinal herniorrhaphy and cholecystectomy (1988 = 100):

*Examples in Figures 2 and 3 adapted form Legoretta et al., *JAMA* 1993; **270**: 1429-32.

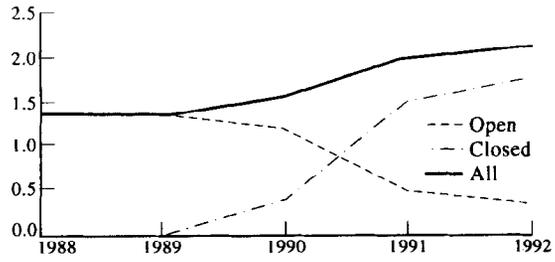

Figure 3. Evolution in the number of cholecystectomies in a south-eastern Pennsylvania HMO (per 1000 enrollees).

latory surgery, that ambulatory surgery is better and that it is cheaper. Space does not allow detailed discussion about:

The nurse, who is lacking the more satisfying relationship that can be built up with the patient in the inpatient setting.

Astfalk W, Warth H et al.
Day case surgery in childhood from the parents' point of view
'In our times, since today fateful occurrences have lost their natural significance, most persons have lost the ideological motivation to assimilate such situations and even the motivation to assimilate is systematically destroyed by our mass media. In the past, this task was assumed by nurses who had preserved a natural empathy for the psyche of fearful parents without necessarily needing to learn each act of comfort. Today, new directions must be sought. Undoubtedly, supportive accompaniment is necessary, a responsibility also for medical insurance and social institutions.'
Eur J Pediatr Surg 1991, **1**: 323–7

The surgeon, who worries about the increasing workload.

Morgan M, Beech R et al.
Surgeons' views of day surgery: is there a consensus among providers?
'Problems of workload or case mix were identified as "very important" constraints by 22% of consultants with positive attitudes. This involved a concern with the increased workload if day surgery formed an addition to inpatient care, or a concern about the balance of their workload if day surgery formed a substitute for inpatient care, as this would increase the proportion of routine procedures undertaken and result in a loss of inpatient beds.'
J Publ Health Med 1992; **14**: 192–8

and about the vagueness of his juridical statute in the outpatient setting.

Forceville X, Oxeda C et al.
Peut-on éviter la faute pénale en réalisant une anesthésie ambulatoire?
'Beaucoup d'anesthésistes ignorent qu'en pratiquant une anesthésie en ambulatoire, ils commettent souvent une faute pénale.'
Cahiers d'Anesthésiol 1991; **39**: 427–33

Fritz K
Ambulantes operieren. Einführung: wirtschaftliche und rechtliche Aspekte, Möglichkeiten und Grenzen
'Bei den rechtlichen Aspekten steht das Spannungsverhältnis zwischen der Wirtschaftlichkeit ärztlicher Leistungen und den Anforderungen des Haftungsrechtes an die Sorgfaltspflicht im Vordergrund. Dabei gilt in der Rechtsprechung der Grundsatz, dass der Arzt immer dann, wenn zwei gleich wirksame Behandlungsmöglichkeiten zur Verfügung stehen, diejenige wählen muss, die mit den geringeren Risiken belastet ist. Dies bedeutet, dass die ambulante Durchführung eines Eingriffes kein grösseres Risiko haben darf als die stationäre.'
Chirurg BDC 1993; **32**: 77–80

The health policymaker who worries about quality, accessibility and equity when he reads:

Schwartz W and Mendelson D
Hospital cost containment in the 1980s. Hard lessons learned and prospects for the 1990s
'Most notably, between 1982 and 1988 the number of inpatient days used by Medicare patients fell by 41%, whereas the number of days used by non-Medicare patients fell by only 15%.'
New Engl J Med 1991; **324**: 1037–42

Note
The editors would welcome any referenced responses to the questions raised in this article.