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Editorial

Decision making partners: cost and outcome

The practice of ambulatory surgery was documented in 1909 by J. H. Nicoll of Glasgow (Scotland). He informed the British Medical Association of 8988 operations that had been performed on day surgery patients between the years 1899 and 1909 at the Glasgow Hospital for Sick Children.[1] Surgical outcomes were equally successful for day-surgery and hospitalized patients. Nicolls said, "The treatment of a large number of the cases at present treated indoor constitute a waste of the resources... we keep similar cases in adults too long in bed". He based his report on patient outcome; although he referred to "a waste of the resources", cost at that time was not a factor.

In 1916, Ralph Waters opened a Down-Town Anesthesia Clinic in Sioux City, Iowa (USA) for dental cases and minor surgery. Waters reported, "As to the satisfaction of my patients, I think I can say this: There are none who have found fault with our work... nor fail to tell their friends about it".[2] Patient satisfaction influenced his decisions; cost at that time was not a factor.

The Phoenix Surgicenter, a freestanding ambulatory surgical facility, opened its doors in 1970 in Phoenix, Arizona (USA). A plaque in its lobby proclaimed , "Dedicated to the principle that high-quality outpatient surgical care can be provided in a caring, personal environment, in a freestanding ambulatory facility at a lower cost than other alternatives". The message of Nicoll and Waters had been heard; cost is now considered a factor.

The last 20 years has been a time of remarkable change in clinical medicine, but no aspect has proved to have a more profound influence on the delivery of healthcare than the development of ambulatory surgery. Physicians and patients have come to realize that hospitalization is not the only method of providing quality care; day-surgery has proved itself to be cost-effective, safe and convenient to the patient, the patient's family and the physician.

Today, largely because of a thrust towards cost containment, ambulatory surgery has been substituted for more traditional hospital surgery in ever-increasing numbers. By the end of this decade, it is expected that over 70% of all elective procedures in the USA will be performed on an ambulatory surgical basis. Similar patterns are expected throughout many other areas of the world.

Whereas originally ambulatory surgery meant short procedures on healthy patients, we are currently seeing more patients with significant health problems, more geriatric patients, and with the improvement of surgical techniques and instrumentation, a continually expanding list of acceptable procedures. Now that ambulatory surgery has matured with some little changes and fine tuning, it is necessary and desirable that emphasis on the medical aspect of ambulatory surgery replaces emphasis on more technical and administrative matters that have characterized this specialized area during its initial growth phase.

In the 21st century we will face increasing pressure from government, industry and healthcare payors to perform more significant ambulatory surgical procedures on patients who have a health problem. Because of past successes, we must not allow ourselves to be lulled into a state of complacency. Cost cannot be the only driving force in our decision-making process. We must continually reassess patient and procedure selection, appropriate laboratory and diagnostic testing and safe discharge criteria. Every day-surgery facility must gather outcome data and develop an action plan based upon documented results.

Clearly, cost containment is becoming the order of the day. We are challenged by and will be continually challenged to merge excellence of care with low cost. Extrinsic pressures must never cause us to lose sight of the fact that ambulatory surgery patients have special needs and present special challenges. There is a panorama of vital issues in

ambulatory surgery that need to be addressed continually, including preoperative evaluation, selection of anesthesia drugs and techniques, appropriate surgical procedures, pain management, postanesthesia care challenges and a large number of administrative demands. We must have outcome data that will allow appropriate decisions to be made.

References

1 Nicoll JS. The surgery of infancy. *Br Med J* 1909; **2**: 753
2 Waters RM. The down-town anesthesia clinic. *Am J Surg* 1919; **33** (Suppl): 71

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