ELSEVIER

Ambulatory Surgery 7 (1999) 183–186

Ambulatory Surgery

www.elsevier.com/locate/ambsur

James H. Nicoll Memorial Lecture. 3rd International Congress on Ambulatory Surgery, Venice, April 26, 1999

# Ambulatory surgery: an organisational and cultural revolution, a social and political challenge

Claude De Lathouwer

*Nouvelle Clinique de la Basilique, Avenue du Duc Jean, 71–73, 1083 Brussels, Belgium*

Received 26 April 1999; accepted 5 May 1999

I cannot remember the name of the rabbi who called out—maybe it was in fact Woody Allen: 'Does anyone have a question, because I have the answer'.

No doubt this question seems at first glance a paradox or absurd humour. Could one actually imagine solving a problem before having stated it? Of course not.

But could one imagine an answer to a non-question? No more.

To a formulated question, an answer is possible, probable and maybe even certain. The answer is more certain than the question. The questioning is therefore undoubtedly the most hazardous and essential moment of the answer.

Why this rather philosophical introduction and how does this concern our subject?

All present here already know the answer: The answer is ambulatory surgery. But ambulatory surgery is the answer to what, to which questions?

Nowadays the paternity of modern ambulatory surgery is classically attributed to James Henderson Nicoll a surgeon from Glasgow which, as every Scot knows, is in Scotland.

In 1909, Nicoll published an article in the British Medical Journal about his experience with 8988 operations performed as day surgery cases [1].

What do we know about this experience that related to a wide range of operations performed on children, almost half of them less than 3-years-old and a fair number of them less than 1 year.

Which problems was the development of this important healthcare practice supposed to solve? Nicoll explained it in his article: 'Infants and young children in a ward are noisy and not infrequently malodorous. Children rest more quietly and fare better in the arms of a mother of average intelligence than anywhere else'. Finally, the Scottish surgeon continues: 'I have no alternative to the opinion that the treatment of a large number of the cases at present treated as inpatients constitutes a waste of the resources of a children's hospital or a children's ward'.

Taking into account his experience with children, Nicoll estimated that, as far as the adults are concerned, various operations and particularly cures of hernia, lead to hospitalisations that, according to him, were too long and could be reduced to... less than a week.

Unfortunately we don't know much—if anything—about the possible means, and in particular about the organisational model implemented by Nicoll. All that Nicoll tells us, is that the children were operated in the out-patient department and went home in their mother's arms. The mothers were given nursing advice and apparently, everything went well.

When he gave this presentation, at a meeting of the British Medical Association, most of his distinguished colleagues participating in the debate entirely agreed with him and claimed that they shared the same practice.

Under these circumstances, it is at the very least curious that no report whatsoever has reached us relat-

*E-mail address:* e.delathouwer@baas.be (C. De Lathouwer)


PII: S0966-6532(99)00019-0

ing to these practices and their authors from the 50 or 60 years that followed. Not only from Scotland, but elsewhere.

It would appear in fact that modern ambulatory surgery was reinvented about 30 years ago.

At that time, a few programmes were successfully implemented in a small number of North American hospitals which all suffered from a lack of hospital beds. But most certainly the creation by J. Ford and W. Reed of the first freestanding centre with four operating theatres, the Surgicenter of Phoenix, has been the strongest incentive for the development of modern ambulatory surgery [2,3].

Indeed, by leaving the cocoon of the traditional hospital environment, ambulatory surgery fitted in from the start with a resolutely new context. It was not a matter any more of somehow adapting existing hospital procedures in an attempt to shorten traditional hospitalisation. By becoming independent, ambulatory surgery outside hospitals compelled its pioneers to a new, specific thorough re-think, both conceptual and systematic, of this kind of patient care, in all its aspects.

Whatever the original stimulus may have been, J. Ford and W. Reed had at the same time to convince—which surely was not easy—the political world, the health authorities, the social security organisms, the insurers, the banks, the physicians and of course the patients. Indeed substantial personal financial risks had to be taken at last.

Without any doubt ambulatory surgery owes a significant part of its specificity and of its image power to the whole enterprise and to its happy outcome. The exemplary implementation and success of the project of J. Ford and W. Reed stimulated many others to follow their example.

They have probably also contributed in an efficient way to making ambulatory programmes operational in many hospitals.

Now ambulatory surgery has evolved considerably since Nicoll. Nowadays it is considered to be an accepted concept with several aspects aimed at all population groups and at all medical specialities.

From an architectural aspect: various architectural models range from a more or less substantial integration into the traditional hospital structure, to an increasing autonomy and even to a complete independence from it.

From a medical aspect: ambulatory surgery imposes choices: selection of eligible operations, selection of suitable patients, selection of surgical techniques and implemented anaesthetic means. Neither technological progress nor new molecules have made the advent of ambulatory surgery possible—Nicoll, 1909, testifies to the fact—but clearly this progress and these molecules—and all those to come—have led to a significant increase of the number of indications.

From an economic aspect: I shall come back to this later on.

From a qualitative aspect: the search for global quality in traditional hospitals is impeded by various parameters: the many players involved, geographical dispersion of sites, variable complexity and length of patient care chains. Under these conditions, with concerns for efficiency, the quality approach usually concentrates on selective targets in patient care chains. Conversely, in the unit or the centre of ambulatory surgery, the parameters are: units of time, place and action. The staff is small and characterised by its great cohesion. The care chains are short. The process of taking charge is homogeneous. Both its validity and its quality can easily be managed and controlled. Modern ambulatory surgery is really a great step forward in the process of implementing global quality in the hospital.

Although architectural, medical, economic and qualitative aspects certainly are remarkable characteristics of ambulatory surgery, the essential point is actually elsewhere.

In fact, ambulatory surgery is above all defined as an organisational concept. Organisation is really the core of the concept. Every administrative or medical eventuality needs to be anticipated, has to follow clearly established procedures. The organisation must be formalised in an organisational model, a chart, standardised documents to which all of the participants need to adhere. Oral and written information among the various players is essential at every stage. Any improvisation may compromise the safety of the patients and prevent their returning home at the scheduled time. However, if organisation is its most remarkable element, this is not so much because of the organisation itself, but because of its absolute emphasis on the patient. The organisation is the focus of the concept, the patient is the focus of the organisation.

However, some will point out: 'But does not the same apply to the traditional hospital'? In a traditional hospital, the patient is certainly central to diagnostic and therapeutic preoccupations but not to the organisation. Indeed, the physician and the nursing staff are at the centre of the organisation. The time the inactive patient spends in his bed, is not one of these parameters to which the administrator, the physician or the staff pay much attention. The hospitalised patient orbits the periphery of the medical services that take care of him at more or less widely spaced intervals depending on their own availability. Regularly providing information to the patient and, possibly, to his environment, so essential in ambulatory surgery, is too often uncertain. 'Don't worry about anything, we take care of everything'.

The order of organisational priorities is reversed in an ambulatory surgery unit. This substantive organisational revolution is even more: it is indeed a genuine cultural revolution.

For the past 30 years an increasing number of us have committed ourselves to promoting a better recognition and extension of the practice of modern ambulatory surgery. With determination, sometimes even with passion. The contexts are sometimes as difficult as those which J. Ford and W. Reed had to confront in their time, maybe even more so. Why? What questions do we wish to answer?

Ambulatory surgery is much appreciated by the patient—how could it be otherwise in a system where he really is the focus of all preoccupations.

Ambulatory surgery is much appreciated by the staff because of the excellent working conditions. It yields better quality management. Finally, it is economical. This last aspect is usually put before the other arguments. That is also why I mention it at the end of the list to clearly indicate that other arguments exist that are equally substantial to justify our commitment to ambulatory surgery.

Through all this, it is clear that the economic aspect takes a critical place in the present context.

We know very well that health costs weigh ever more heavily and unbearably on public and private finance. The problem is world-wide. It applies to rich and poor countries, countries suffering from too many or too few hospital beds, and this whatever the social security system, be it state provided or liberal. Moreover, the perspectives are not encouraging: constant and expensive development of sophisticated techniques, increased patient requirements, plethora of supplies for health care, ageing population, occurrence of new pathologies,…

As Woody Allen puts it: 'It is better to have money than not to have it, be it for financial reasons'. But money is also required for healthcare. The survival of our social security systems depends upon it and the preservation of quality care accessible to all at an affordable cost constitutes a major social challenge.

Lacking in resources, the authorities typically react with authoritarian actions aimed at limiting the access to health care financed by the Community. This has other consequences: difficult access to sophisticated and expensive techniques, decreased quality of health care, stagnation and degradation of hospital equipment, medicine at two speeds, increased financial contribution by the patients, de facto exclusion from social security benefits of certain categories of people.

These regulatory measures usually lead hospitals, providers of health care and patients to generate perverted compensation mechanisms which, at the economic level, reduce the capacity to efficiently limit cost increases.

But most intolerable is clearly the social and medical deterioration of the poorest and most vulnerable population categories. Because funds are said to be lacking. Because in fact important resources are wasted without real justification.

History teaches us that economic and social misery brings about social disorder, social conflicts, rise of extremisms, exacerbation of antagonisms, rejection of others. It sometimes ends in damaging national balances and consequently intentional relations.

But it is not at all necessary to recall history; are we not witnessing this today in many places around the world and especially in our western countries?

You could ask me whether all this is not a bit exaggerated? Maybe, but anyway, access to quality health care as a whole for our fellow-citizens is a major right in our societies which needs absolutely to be preserved. It is out of the question to waste it through lack of imagination or determination. Each contribution to more social justice deserves consideration. And this is what we demand from our project.

In the hospital sector which is the principal source of health care expenses, ambulatory surgery is probably the only really innovative approach. It does not consist of managing shortage, but of making better use of available resources by modifying the modus operandi. Ambulatory surgery is not a stopgap measure at times of restrictions, but is clearly the best choice for more than half of the operations that require a typical hospital environment. As it affects such a large scale market for operations, a very impressive savings potential seems feasible. Precious resources that are presently wasted without real necessity could be preserved to meet needs that are far more acute.

From all this, I'll conclude that the commitment to ambulatory surgery is presently of a clearly ethical nature. It reflects elementary social ethics.

In the end, the result seems beyond doubt. Who still questions the importance and the legitimacy of ambulatory surgery nowadays? Who still hesitates to predict the generalisation of this practice? Can we doubt that, if presently a new hospital network had to be created from scratch on a national scale, the sanitary authorities would conceive it so that globally 50% of the operations would automatically be performed in ambulatory surgery units and centres especially conceived to that effect: units and centres characterised by a light structure, performing and productive organisation, a rapid turnover. At the same time, traditional hospital services would significantly reduce their bed capacity, but increase their technical density and their endowment in qualified personnel.

As all our countries have hospitals, the necessity to adapt and to transform traditional hospital is probably the major obstacle to the development of ambulatory surgery. And this more so as the hospital park is larger. The hospital is in fact both a centre and a power stake. To touch its structure and the arrangements of every kind that rule it inevitably leads to strong resistance and opposition.

But do we have a choice? And if ambulatory surgery is an alternative to traditional hospitalisation, is there a credible alternative to ambulatory surgery?

'One should never make projects, especially for the future'. I quote the French humorist Jean Amadou. Should that stop us? In order to answer the difficult challenges that our societies are faced with regarding social security and public health, one has today to:

1. Update the nature and the importance of what is needed as a result of modern techniques and new modes of patient care management,
2. Adapt hospital structures to these redefined needs in order to optimise the use of available resources,
3. Implement policies that provide efficient incentives to all stakeholders: hospitals, physicians and patients.

If, no doubt, in the end ambulatory surgery will develop as it should, the real question is: how fast and under which conditions. Therefore, which loss of time and resources should one still bear? The answer largely depends on the determination of the policy makers and their capacity to efficiently manage this matter.

Saving money requires clear thinking. And the latter is often missing. This does not relate to political power only. Let me tell you a short anecdote. From the 13th until the 15th September 1995 a world congress on an important surgical topic was held in Kiel in Germany. The international participants had the choice among numerous simultaneous sessions in various rooms of variable size. I had been invited to chair a session on ambulatory surgery and I was allotted the smallest room. In the largest room, the speakers tackled far more important questions: organ transplantation. A brief survey of surgical activity in Belgium displays a few hundred operations of this type. On the other hand, hundreds... of thousands of operations qualify to be treated by ambulatory surgery, but it is, of course, only ambulatory surgery.

Oh yes, let me tell you the name of this congress: 1st World Congress on Surgical Efficiency and Economy.

What can we propose or wish or dream? Maybe the politicians could take the initiative to organise a big, straightforward and open debate, that would gather all the most involved field workers and experts, and no longer only the usual lobbies and political partners. What would be the general framework for such a debate? The main objective is obviously to deliver high quality health care for all at a reasonable cost. The most appropriate policies and the most suitable means would be sought and discussed. Each stakeholder should be heard and find his legitimate claims satisfied: the goverment, the hospitals, the physicians, and the patients of course.

It is out of the question to set traditional hospital activity against day hospitalisation. Each type of structure must be able to fulfil its mission alongside one other. Ambulatory surgery will not develop unless the necessary means are made available. Moreover, if the hospital must be transformed, in exchange it will have to benefit from adequate means in order to assume its heaviest missions to the very best. To reform the hospital, not to penalise it.

One should also identify and treat the questions and concerns that are often unformulated by certain decision-makers:

1. Does ambulatory surgery create a transfer of patients or an additional market?
2. Will the development of ambulatory surgery not lead to the creation of a new treatment network—an additional competitor—which could possibly worsen a potential hospital over-capacity?
3. Doesn't ambulatory surgery lead to a financial transfer from the hospital to the patient, the family, and the extra-mural services?

Physicians and patients may also fear certain adverse effects in the future: what will happen to our liberty to choose the mode of hospitalisation?

Don't these questions seem legitimate and judicious to you? Probably yes, and many answers are already available. But, as I said at the beginning of this lecture, they could only be so, if politicians are sufficiently sensible to ask us these questions.

Perhaps they judge the situation not serious enough to require handling in the way we recommend.

Let me end then with a final anecdote: "A Minister of Social Affairs and a Minister of Health fall together from the 50th floor of a building. When they reach the level of the first floor. they congratulate each other by saying: until here, everything has gone well". Of course, at that moment everything is still possible but soon somebody inevitably will have to pay the bill, financially, socially and politically.

Ladies, gentlemen and politicians, please note that on an international and on a national level, the IAAS and its national associations are at your disposal: somewhere between the ground floor and the 50th floor.

## References

[1] Nicoll JH. The surgery of infancy. Br J Med 1909;2:753–75.
[2] Ford JL, Reed WA. The surgicenter: an innovation in the delivery of medical care. Ariz Med 1969;26:801–4.
[3] Reed WA, Ford JL. Development of an independent outpatient surgical center. Int Anesthesiol Clin 1976;14(2):113–30.