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Short communication

The paradox of ambulatory surgery in the third world

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The introduction of ambulatory surgery in Europe is attributed to Nicoll [1]. It would be better to say 'ambulatory surgery in modern times and in western societies', for ambulatory surgery has existed for centuries in Europe and has been practiced in the third world for thousands of years. Circumcision is always ambulatory and, just to give one remarkable example, Kisii craniotomy and craniectomy are also ambulatory [2]. In terms of the long history of surgery, hospital based operations have been the novelty rather than ambulatory surgery. Hospital based operations had bad statistics for a long time principally but not solely because of hospitalism.

In the third world, where the cleavage between rich and poor is so great, there are two different sets of circumstances in relation to ambulatory surgery.

One set applies to the poor or to situations pertaining to poverty. The patient may be sent home immediately after an operation because he has no money to pay for the bed or the hospital is so full that there is no bed for him, no half bed for him, no space under or between the beds.

There are no surveys and no data that would readily quantify this situation. My personal experience, gained in Eastern Africa, where I have operated in more than a hundred hospitals, is that in some hospitals most of the operations which would be performed on a day surgery basis in a modern western day surgery unit are similarly ambulatory in nature. Other hospitals refuse to perform even the most minor procedures unless the patient remains in the hospital. Institutions belonging to the latter category may adopt this policy either out of ignorance or because they cannot fill the beds.

In the private hospitals which cater for the prosperous, the situation is different. These are the hospitals in which prima facie ambulatory surgery should have taken root exactly in the manner in which it has in developed countries. Indeed day surgery units have been established in many private hospitals. In the African situation they have not succeeded and I am informed by my Asian patients that there are difficulties with ambulatory surgery also on the subcontinent of India.

To illustrate the situation when the roads are bad, traffic jams gigantic, where there are power cuts, where there may be no water, where there is no reliance on telephones and where security is poor, one should not advocate ambulatory surgery. Hence it is not necessarily the quality of surgery or anesthesia which is lacking: it is the environment which is not conducive.

For day surgery the paradox is that whereas the leading hospitals are ready for widening the scope of ambulatory surgery, the privileged clientele is not. At the same time the poor limp home, are carried by relatives, are helped into buses or, yes, tied onto donkeys, because they have no choice. Ambulatory surgery, day surgery is all that is available to them.

The perceptions of the developed world, even the terminology, do not necessarily apply to poor countries. Surgery in Africa has never been as hospital based as it was in Europe or America.

References

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