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Editorial

The time has come to promote true day surgery

Greed and threats are powerful forces for change. They are difficult to resist. Those who succumb hide their real motives for change behind a farrago of false justifications. But greed and threats have no part in the practice of medicine. They should be an anathema to health care professionals overarched by the Hippocratic oath. But doctors and healthcare managers are human and, as such, are prone to human frailties. Thus the original concept of day surgery is increasingly being distorted; in the private sector by greed and in the public sector by threats. Income and political targets, respectively, are increasingly dominating the quality of patient care and some of the fundamental benefits of true day surgery. This is evidenced in the move from day surgery to office-based surgery on the one hand and to 23-h stay surgery on the other.

The development of office-based surgery in the USA has come about purely for the financial benefit of surgeons. It allows them to collect both the operation and facility fees. Shrinking incomes as a result of being squeezed by health insurers or healthcare management organisations and increased fees charged by day unit facilities might well have driven them in this direction. But is it better for patients? Perhaps overall it is cheaper, yet this may be at the cost of safety. The back-up and resuscitation facilities in an office seldom match those of a good hospital attached or freestanding day unit. In the UK dental office-based general anaesthesia will be banned from 2001 because of the comparatively higher morbidity and mortality compared to dental anaesthesia in a hospital. But it must never be assumed that surgery under local anaesthesia, with or without sedation; is devoid of complications. In all but the most minor cases, problems may occur due to the local anasthetic or unexpected surgical pathology that require assistance or equipment beyond that of an office facility. To minimise these risks an office facility ought to be equipped and staffed to the level of a day unit. Then de facto it becomes a freestanding day unit. Yet in the USA there is now a growing Association for Office Based Anaesthetists separate from the Society of Ambulatory Anaesthetists.

Twenty-three-hour surgery has developed in the USA to maximise the profits of freestanding day units. The 23-h stay format has allowed these units to cream off straightforward short stay inpatient cases from inpatient hospitals. As a camouflage for the real motive these cases are still referred to as day or ambulatory cases. A similar sleight of hand is increasingly being used in the National Health Service in the UK. Targets are set for day surgery procedures. Hospitals that cannot reach these, either because consultants are unwilling to follow the disciplines of day surgery or adequate day surgery facilities are not provided, have taken to the definition of a day case as up to a 23-h stay in order to reach their targets and thus avoid financial penalties. On neither side of the Atlantic is there a cogent economic case for 23-h stay facilities. In the USA the overnight facilities attached to free-standing day units add to the already over provided inpatient facilities and drive up the unit cost in established inpatient hospitals. In the UK 23-h stays become an excuse for not undertaking true day surgery, i.e. admission, operation and discharge during the same working day. The cost savings of a move from inpatient to true day surgery are reduced, as is the quality of treatment for patients who, in the in the majority, prefer to go home to recover rather than stay in hospital.

There are certainly a group of patients at present that may require a 23-h stay for surgical or anaesthetic reasons. It might include those having bilateral inguinal hernia repair, carotid endarterectomy, aortic aneurysm stenting, thyroidectomy or middle ear surgery. With new techniques and improved day surgery management, some of these procedures are already being performed on a day basis. Indeed a period using a 23-h stay for a particular procedure as it is developed to be moved from full inpatient care to day surgery is often useful. Some patients with conditions suitable for day surgery, but ASA 3 or 4, may also benefit from an overnight inpatient admission. Social preclusion from day surgery is no reason for a 23-h inpatient stay. All these patients require is a hospital hotel with no nursing or

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medical staff. But is there a need for a 23-h stay unit and should patients remaining in hospital be managed in a day unit? In the context of elective surgery there can be no economic justification for subdividing inpatient beds into units catering for different lengths of stay. This will only lead to inflexibility. There will be times when one area is underused whilst another is full and cannot cope and vice versa. For cost effective management the less subdivisions in a hospital the better. The hospital of the future should be ring fenced in three areas only, namely emergency care, elective inpatient care and ambulatory care. The 23-h elective surgical cases should be managed as elective inpatients, which they are, and not as day cases in the day unit, which they are not. In fact a 23-h unit attached to a day unit can reduce the rate of true day surgery because of the ease of admission to such a facility. One hospital in the UK undertook a good percentage of laparoscopic cholecystectomies on a true day basis with good outcomes. It then developed a 23-h stay unit and the number of true day case cholecystectomies fell.

Over 80% of all elective surgery can be undertaken safely and with high patient satisfaction rates on a true day basis. A move to 23-h day surgery is economically retrograde and a move to office-based surgery a regression towards operating on the kitchen table. Major and minor complications may arise after day surgery performed in the best of units. All personnel practising office-based surgery and anaesthesia should be made aware of these problems. The obvious move should be from inpatient surgery (including 1 night stays) to true day surgery and from day surgery to non-surgical outpatient treatment. This has overall benefits to both patients and global health economics. Greed and political or healthcare management threats must not be allowed to cause a diversion to less satisfactory, higher risk or more costly approaches to treatment.

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