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J. of Ambulatory Surgery 10 (2003) 53

Ambulatory
Surgery

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Editorial

More ambulatory surgery—Is it worth doing?

Worldwide, we are seeing ever-mounting interest and pressure to increase the percentage of procedures performed as ambulatory surgery. Is it worth it? We need to assess the value of such an approach, and for ambulatory surgery, two indicators of value are quality and cost. Do we lose quality in exchange for increasing productivity? Do we actually reduce the use of resources?

Several papers in this volume look at these questions. Martin López et al. studied the development of ambulatory surgery in their hospital. They noted the increase in percentage of ambulatory surgery from 22% in 1994 to 53% in 2001, caring for over 15 000 patients. During those years, the medical complexity of their DSU patients also increased, as measured by percentage of patients who were ASA Status ≥ 2 . How does one assess whether this growth resulted in the maintenance of quality of care provided to the patients? One of the central indicators of quality in ambulatory surgery is whether the patients indeed can go home. Martin López et al. reviewed both early admissions (patients not discharged) and late admissions (patients re-admitted) in their population. They found that there had been no increase in the admission rates over that time, staying at around 1.6%. This is a very respectable admission rate, and the authors should be congratulated for this indicator of stable quality care.

How can we generalize the lesson shown here, and even go one step further? If we are to know how well we are doing, it is imperative that we collect outcomes data in each of our facilities. This is especially important message for our colleagues who are in the early stages of setting up an ambulatory surgery program, who should integrate this activity from the very beginning as a fundamental management function. First, we need to know about significant undesired events, also known as critical incidents. An example is reintubation of a patient in the PACU. These occurrences should be rare, and each incident should be analyzed. However, we must also develop a program of ongoing continuous quality improvement. This addresses the expected, common minor adverse outcomes associated with am-

bulatory anesthesia and surgery. An example is the rate of vomiting. We need to review these data regularly to assess ongoing the quality of our care. Optimally, these data should be collected by procedure and by practitioner—anesthesiologist, surgeon and nurse. We all contribute to these outcomes. The individual data should be given to each practitioner, in a secure fashion, to allow them to evaluate their care and improve their practices.

The second half of “is it worth doing?” is the question of economics. Increasing the percentage of operations done as ambulatory surgery should save the healthcare system money, and allow us to care for more patients with the same amount of resources. Theoretically, but does it happen? In this issue Lemos et al. studied two groups of patients who were scheduled to undergo tubal ligation at their hospital. All were candidates for ambulatory surgery, but half-received inpatient and half ambulatory care. The authors measured the costs, and found that there was an average actual saving of 62% for each procedure performed as an outpatient. Furthermore, they extrapolated these measured savings to project the money saved if all such procedures at their hospital that year had been done as ambulatory surgery. Their answer, for just 181 procedures, was an impressive €107 372.82.

We could extrapolate further to the conversion of all conservatively appropriate operations to be done as ambulatory surgery. The savings to each country's healthcare system would be truly enormous. We should bring similar cost data, with demonstrations that quality of care is indeed maintained, to our countries' Health Ministers, to enthusiastically encourage the use of ambulatory surgery for the benefit of our patients.

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