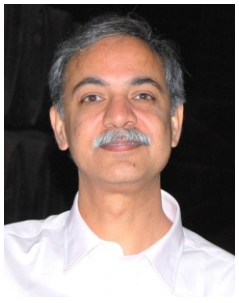
One Day Surgery Times

Volume 8 no. 6 Issue: June 2015

A monthly publication of **O**ne **D**ay **S**urgery India Private Limited Free for Distribution

www.onedaysurgeryindia.com

European and Mid-Term IAAS Congress of Ambulatory Surgery,
Paris, France
28-29, January, 2016
www.afca-iaas2016.org



DAY SURGERY "MY PERSONAL JOURNEY"

Dr. Hugh Bartholomeuz
Secretary, Australian Day Surgery Council.

Continued from last issue.....

My own experience expanded from simple multiple skin cancer excisions to involve all reconstructive procedures including Breast Reductions, Abdominoplasties, Liposuction, Facelifts, and some Breast Reconstructions. We were regulated by law to have written agreements from the local private and public hospitals to allow admission of any patients that were not suitable for discharge on the day of surgery. In the first five years of this operation the number of patients transferred to other facilities was only a staggering three. The centre had become accepted within the local region as the first multi-disciplinary day surgery and patients and medical practitioners alike chose the facility in preference to the local private hospital.

After ten years of operation and a throughput of approximately two thousand patients per year, the centre became too small for the increasing demand of surgical procedures. I therefore bought 700sq metres of freehold space within a local new medical centre and designed and built a new two theatre complex. Our challenge was to retain the homely atmosphere of our previous centre within what was now a very modern building. By using the same quality standards and "family" approach to our patients, we have been able to achieve this goal and have increased our surgical throughput.

During this time the number of day procedure centres has grown to over 270 freestanding units within Australia. Most of these centres are still owned by medical practitioners and they have varying profit sharing structures dependent upon the investment protocols of their surgeons. Most of the centres are in the capital cities and large regional centres. Some are multi-disciplinary but a number have been established specifically for disciplines such as Ophthalmology, Otolaryngology, Gastroenterology and Plastic and Reconstructive Surgery. All centres are financially viable and some, I believe, generate earnings before income tax of approximately 20% of their gross turnover. All centres must have a State Government license to operate and a Commonwealth Government provider number to enable them to be reimbursed by the Private Health Funds for procedures that are performed within their facility. Each centre must negotiate on a yearly basis with each of over twenty Private Health Funds operating within Australia. Approximately 50% of the Australian population are privately insured and, like other countries in the world, waiting lists for surgery at the public hospitals are exceedingly long. In this environment, even uninsured patients elect to pay for private day surgery treatment.

All centres have strict quality control guidelines and must be accredited by one of three agencies. The major agencies for accreditation are the ACHS (Australian Council for Healthcare Standards) and ISO9001 (International Standards Organisation for Day Surgery). To qualify for accreditation, surveys are conducted by both organisations at regular intervals and certificates of accreditation issued to each facility. As well as this, each state government performs their own licensing inspections on a regular basis and in some states, a Quality and Complaints Council has also been established. This council also requires regular data from each day procedure centre. The burden of all three regulators on the finances of each centre has become extraordinarily significant.

The peak body for day surgery management in Australia is the Australian Day Surgery Council. It has been legally constituted by the Royal Australasian College of Surgeons, Australian and New Zealand College of Anaesthetists, and the Australasian Society of Anaesthetists. A six member central committee is appointed by these bodies and it co-opts representatives from twenty other associations who have an interest in day surgery. Foremost among these is the Australian Day Surgery Nurses Association and the Australian Day Hospital Association. The Australian Day Surgery Council elects two representatives to sit on the International Association of Ambulatory Surgery. Currently these representatives are Dr Lindsay Roberts and I. Lindsay has recently retired from the Executive Committee of the Association where he served two years as the International Association President. I have been recently elected onto the Executive and have also been chartered with the responsibility of being the President of the Organising Committee for the International Association of Ambulatory Surgery Conference in Brisbane in 2009. This is the first time that the conference has been held in the Southern Hemisphere.

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When I reflect on my association with Day Surgery over the last twelve years, I am extremely humbled by the thought that I may have in some small way contributed to the success of Day Surgery within Australia. I see the future of Day Procedure Centres lying in extension toward 23 hour care and becoming teaching centres of excellence for medical and nursing undergraduates and surgical registrars. Because of the success of many individual day surgeries, it is my view that the corporate sector will begin to show an interest in acquiring these profitable centres. All in all, the future is certainly bright for Day Surgery in Australia.

Development of Outpatient Laparoscopic Surgery in Hong Kong

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Abbreviations: Laparoscopic cholecystectomy: LC; Endoscopic totally extraperitoneal inguinal hernioplasty: TEP; Day Surgery Centre: DSC; Pre-anaesthetic clinic: PAC.

INTRODUCTION:

Since the introduction of laparoscopic surgery in the late 1980s and early 1990s, it has soon become the standard treatment for a variety of diseases. In recent studies, some of the laparoscopic procedures have been evaluated as a safe and effective outpatient procedure (1, 2). In Hong Kong, we have been practising outpatient laparoscopic cholecystectomy (LC) and outpatient endoscopic totally extraperitoneal inguinal hernioplasty (TEP) since 2000 and 2001, respectively (2-4). Now they have become our standard treatments for selected patients with symptomatic gallstone diseases and groin hernias. Unlike other western countries, advocating outpatient procedures in Hong Kong is not cost-driven but patient-driven. Patients in Hong Kong have a drive to receive a high standard of surgical service and alternative treatments for surgical diseases.

OUTPATIENT LAPAROSCOPIC CHOLECYSTECTOMY (LC):

Since 2000, we have been routinely performed outpatient LC in selected groups of patients with symptomatic gallstone diseases. Patients of American Society of Anaesthesiologists (ASA) risk classification I or II, less than 70 years of full perioperative details were explained. They would be given the date of operation and written instructions concerning the preparation, admission and highlights of procedures. Patients were admitted at 7:30 am on the day of operation.

Outpatient LC was defined as operations performed on patients who could be discharged before 6:00 pm on the day of operation. We adopted the standard four-port technique using 12 mmHg of CO_2 pneumoperitoneum, and intraoperative cholangiography was not routinely used. Gastric tube and Foley catheter were not used. More than 95% of the patients were operated by two experienced specialist surgeons (YWK, LH) and the remaining 5% of the cases was performed by higher surgical trainees under supervision. Patients were then transferred to Day Surgery Centre for close observation.

Results:

In 2000, the successful outpatient LC rate was only 72.7%, among which 8% was overnight stay and the conversion rate was 9.1% (4). The successful rate gradually increased to 100% in 2004 (Table 1) and no conversion was noted. The incidence of postoperative nausea and vomiting was low. Pain control was also excellent. So far there have been no major complications encountered except mild wound infections. Nearly all patients returned to their preoperative activities-of-daily-living by two weeks.

Pre-anaesthetic clinic (PAC):

The establishment of PAC was a major milestone in the development of outpatient LC. It allowed early assessment by the anaesthesiologist, preoperative counseling by nursing staff and routine investigations before operation. It has been shown that PAC significantly reduced patients' anxiety (5), contributing to a potential favourable impact on outcomes. As in the earlier phase of outpatient LC, the overnight stay rate was 8% and almost all of the patients stayed overnight due to psychosocial reasons (2).

Day Surgery Centre (DSC):

Another milestone for outpatient LC was the establishment of DSC. It provided a place for patients to relax before operation and for close observation after operation. Nursing staffs were trained for early recognition of potential complications.

To Be Continued.....

Printed by: Dr. T. Naresh Row, **Published by:** Dr. T. Naresh Row, **Owned by**: Dr. T. Naresh Row, **Printed at**: Gemini Printing Press, 33/A, Kanbai wadi, Khadilkar Road, C.P. Tank, 1st fl., Opp. Pooja Cards, Mumbai-400 004. **Published at** One Day Surgery Center, 15, Sadguru sadan, Babulnath Road, Mumbai-400 007. **Editor:** Dr. T. Naresh Row