

The Indian Association of Day Surgery was conceptualised 2 years ago by a few like minded surgeons, who were interested in day surgery. They got together with the sole purpose of furthering the concept of day surgery in the country by increasing the awareness among the patients, creating training facilities for the surgeons and working with government agencies to help them make policies which will be beneficial to all.

Paucity of funds has been the main deterrent in achieving your goals, but it is hoped that the perseverance and devotion of a few dedicated surgeons will extensively establish Ambulatory surgery in India.

CONCLUSION

A developing nation like India, with a large part of its population living below the poverty line, would benefit tremendously by popularising the concept of Day surgery. There is little doubt that, like anywhere in the world, Day surgery will be the Future of Modern Surgery in India too.

cma

PARALLEL SESSION 1
AMBULATORY SURGERY QUALITY IMPROVEMENT
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CQI. PATIENTS AND PROFESSIONALS PERCEPTION OF DAY SURGERY

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"La mejora continua" es una pequeña frase que encierra un gran significado para la labor diaria de los profesionales sanitarios. Efectivamente es necesario mejorar continuamente para satisfacer las necesidades y expectativas de nuestros pacientes y para nuestra propia realización personal y profesional, como sanitarios.

La importante revolución que ha supuesto la CMA en el abordaje de determinados problemas quirúrgicos, está produciendo un importantísimo efecto en la distribución de recursos y en la percepción que los pacientes y familiares tienen ante un proceso de esta naturaleza. En dicho proceso, el protagonismo reside en dos actores fundamentales e imprescindibles, los pacientes y los profesionales que les atienden. Para mejorar, dentro de un sistema de gestión de la calidad, no podemos

obviar las opiniones que unos y otros tienen sobre la Unidad y su actividad, y por tanto el nivel de satisfacción que tanto los pacientes como los profesionales presentan en relación con la misma.

Por ello es necesario establecer métodos de evaluación de la satisfacción de ambos actores. Los resultados nos permitirán profundizar en el proceso de mejora continua de la asistencia que prestamos en nuestra Unidad, unidos a otras herramientas de mejora de la calidad.

Vamos, por tanto, a analizar algunos aspectos básicos que pueden ayudarnos a conocer cual es la percepción, que de la UCMA, tienen de un lado los pacientes y de otro los profesionales que en ella trabajan.

1. Evaluar la satisfacción de los pacientes.

Un principio de calidad mundialmente aceptado y perfectamente válido en el sector sanitario, nos dice que el cliente es quien debe establecer el nivel de calidad de los productos o servicios, y que eso siempre lo hace en función del grado de satisfacción obtenido en el cumplimiento de sus necesidades y expectativas. De ahí que exista calidad si el cliente lo dice y el grado de calidad alcanzado es el que el cliente manifiesta. La satisfacción del cliente debe conseguirse en todas las facetas que pueda llegar a percibir, no deriva solo del resultado final alcanzado puesto que un solo fallo en la cadena puede hacer percibir una mala calidad en la prestación del servicio recibido, y el no cumplimiento del objetivo perseguido por la calidad.

En la Unidad de Cirugía Mayor Ambulatoria el cliente es el enfermo o paciente, y las premisas antes manifestadas mantienen todo su valor. Una magnífica cirugía aplicada al paciente con un resultado extraordinario en cuanto a la curación del mismo, puede ser percibida como un auténtico desastre si en el trascurso de la atención recibida algún factor, que no tiene porque ser estrictamente sanitario, ha producido la sensación en el paciente de fallo en la organización y que la asistencia recibida, en su conjunto, deja algo o mucho que desear.

Cuando procedamos a medir o evaluar la satisfacción de los pacientes, debemos establecer una serie de variables o parámetros relacionados con los diversos aspectos que el paciente puede detectar y que para los responsables de calidad de la UCMA sean fáciles de medir. Estos suelen coincidir con los motivos de queja mas habitualmente recogidos.

- Variables o parámetros cuantitativos relacionados con el acceso a los servicios sanitarios.
 - Tiempos de espera o demoras en la cita previa.
 - Tiempos de espera o demoras en la admisión o retrasos en las pruebas.
 - Anulaciones de citas.
 - Continuidad de los cuidados.
- Variables o parámetros cualitativos relacionados con el diagnóstico y el tratamiento.

- Percepción sobre el progreso en el diagnóstico y tratamiento de la enfermedad.
- Percepción sobre los resultados terapéuticos. Esperados o inesperados.
- Competencia profesional percibida. Suficiencia o insuficiencia.

- Variables o parámetros cualitativos relacionados con la comunicación con el enfermo y familiares.

- Suficiencia de la información transmitida.
- Coherencia de las informaciones transmitidas
- Nivel de satisfacción sobre la confiabilidad e intimidad.
- Percepción sobre el trato en lo referente a cortesía, amabilidad, etc.
- Comodidad en las instalaciones. Hostelería, restauración, limpieza, ruidos, telefonía, entretenimiento, etc.

Mediremos la satisfacción de los pacientes mediante la elaboración de un cuestionario que contemple todas las variables antes mencionadas y aquellas que creamos necesario introducir según las características propias de la Unidad y de los pacientes a los que atendamos. Para elaborar el cuestionario tendremos en cuenta los siguientes aspectos:

- Sobre el cuestionario:

- Con una introducción que lo justifique.
- Debe ser corto para no cansar al que responde.

- Sobre el tipo de preguntas:

- Lo suficientemente importantes como para analizar y detectar las necesidades de los pacientes.
- Concisas para no complicar en la respuesta.
- Entendibles, de modo que eviten cualquier tipo de ambigüedad.
- Únicas, no permitiendo que aparezca más de una cuestión en cada pregunta.

- Sobre el tipo de respuestas:

- Formato check-list. Con respuesta afirmativa o negativa, tiene la ventaja de proporcionar un alto grado de simplicidad a quien responde.
- Formato Likert. Permite al paciente, mediante un sistema de escala, responder en grado variable. Tiene la ventaja de conceder al paciente más libertad en la respuesta y aumentar la fiabilidad de la percepción que tienen los pacientes sobre el servicio evaluado.

2. Evaluar la satisfacción de los profesionales.

La satisfacción de los clientes o pacientes es fundamental en un modelo de gestión de la calidad total, pero esta es solamente uno de los dos pilares básicos en los que se apoya un proceso de mejora continua. El otro pilar es la satisfacción de los profesionales. Un modelo de gestión de la calidad total está orientado a obtener el máximo grado de satisfacción de los profesiona-

les que trabajan para la organización.

Obtener el máximo grado de satisfacción del personal de la organización tendrá como consecuencia la creación de un clima adecuado de trabajo, disminuyendo las incidencias imputables a este, y consiguiendo que sientan satisfechas sus necesidades y expectativas profesionales.

Los profesionales de la UCMA son los encargados directos de prestar el servicio sanitario a los pacientes, por lo que su adecuada motivación y estímulo permitirá obtener el máximo rendimiento de su trabajo, teniendo como referente la búsqueda de la máxima eficiencia y eficacia, y por tanto la excelencia como persona y como integrante de un equipo de trabajo. En ese sentido entendemos que la búsqueda de la excelencia es un objetivo permanente, siempre presente, y motor del proceso de mejora continua de la calidad.

Es conveniente medir la percepción de los profesionales mediante una encuesta que los consulte sobre aspectos fundamentales de la estrategia que se sigue, sobre el papel de la dirección de la Unidad y del Centro Sanitario en la que se ubique, sobre la credibilidad de los logros obtenidos, sobre la política de personal de la empresa y la medida en que esta ha logrado sus objetivos de motivación de los profesionales, etc. Esta medida directa de la satisfacción de los profesionales, unida a la atención que se presta a las quejas y sugerencias que se planteen por los mismos, viene complementada con otros sistemas de medición indirectos de la satisfacción del personal.

- Sistemas de medición directa.

- Percepción de los profesionales sobre la propia organización
 - Política y estrategia de la organización
 - Papel de la dirección
 - Políticas de personal y motivación
 - Comunicación dentro de la organización
 - Planificación de la carrera profesional
 - Plan de formación
 - Percepción de la valoración de la organización

- Sistemas de medición indirecta.

- Existencia de medidas activas de fomento de la satisfacción
 - Estabilidad en el empleo
 - Sugerencias admitidas por la dirección
 - Premios no monetarios
 - Ambiente laboral agradable
- Sistemas de medición pasiva
 - Bajas por enfermedad
 - Absentismo
 - Bajas voluntarias

La metodología seguida para la elaboración de encuestas de evaluación de la satisfacción de los pacientes, es válida para la confección de encuestas dirigidas a conocer el grado de satisfacción de los profesionales sanitarios.

MEASURING THE QUALITY OF PROCESS AND OUTCOME: IAAS CLINICAL INDICATORS

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Continuous quality surveillance by regularly updated, reliable and valid data is the basis for improvement and delivery of a high quality of health care. The IAAS indicators are *one of the key elements in the process of quality assessment* and with *standards of good clinical practice* they represent essential parts of core components for surveillance of day surgery quality including:

- *Selection of important and relevant aspects of health to be surveyed*

Selection of the aspects may be based on frequency or seriousness of the health problem

- *Setting targets of quality*

Targets of quality are set as realistic standards of good clinical practice and are based on available literature and best evidence. Grading of evidence is based on a scientifically approved method.

- *Selection of relevant indicators*

Indicators are selected in relation to a specific problem to be monitored and are applied as part of a professional analysis and interpretation. They act as strategic parameters enabling surveillance of important aspects of the output from the health care system with respect to structure (organization, resources, competence levels, quality of technology, equipment and facilities), process (extent to which evidence based procedures related with the process of treatment are practiced) or outcome (change in health as a result of a treatment, survival, physical or psychological changes, complications, patient satisfaction).

The indicators are needed to clarify to what extent the targets have been achieved. They represent variables easy to measure and to understand.

- *Collecting data to measure quality by the indicators*

The most important sources of data are from clinical databases, patient files and central registers of health

- *Analysis of data to assess and compare present quality*

The local standard of quality is compared to the Standards of good clinical practice as previously defined. Differences may express random variations or true failure in quality. To avoid erroneous conclusions, data analysis is performed by statisticians and/or epidemiologists

- *Adjustment of procedures to meet the documented lack of quality*

Failures in quality are met with interventions like feedback, audit, clinical guidelines, teaching

and training or changes in structure and organisation.

In 2003 the following Clinical Indicators were approved by the General Assembly of the International Association for Ambulatory Surgery as universal clinical indicators for ambulatory surgery. The indicators that have been derived from the Australian and French Clinical Indicators are:

- Cancellation of booked procedures.

1. Failure to attend the day surgery centre/unit due to:

Acute medical condition.

Decision of the patient

Organisational reasons.

Other reason (to be explained)

2. Cancellation of the booked procedure after arrival at the day surgery centre/unit.

Pre-existing medical condition.

Acute medical condition.

Organisational reasons.

Other reason (to be explained)

- Unplanned return to the operation room on the same day.

- Unplanned overnight admission.

Surgical reason(s)

Anaesthetic/medical reason(s)

Social/administrative reason(s)

- Unplanned return of the patient to an ambulatory surgery unit or hospital.

< 24 hours

> 24 hours and < 28 days

- Unplanned readmission of the patient to an ambulatory surgery unit or hospital

< 24 hours

>24 hours and < 28 days

The IAAS indicators relate to the control of patient flow and to the result of treatment reflecting quality both in the dimension of process and outcome. Control of patient flow is one of the main issues in highly organised day surgery units whether they be public or private, free standing or within hospitals. The procedures of day surgery are predictable and controllable, being well defined, relatively short and uniform and expected to have very low morbidity rates. In the chain of events from first contact to final recovery at home unplanned deviations such as cancellation of surgery or reoperation, overnight admission or unplanned return contacts to day surgery unit or hospital all reflect different aspects of quality failure.

CANCELLATION OF BOOKED PROCEDURES

The indicator refers both to patients failing to arrive and cancellation after arrival. The indicator is based on comparative rates of cancellation and addresses the process of patient care. The reasons may be related to the patient or to the organisation. The patient may suffer from acute intercurrent illness or from unrecognised concurrent medical problems adding risk to otherwise safe

procedures. The selection of the patient may have been inappropriate, the instruction to the patient misinterpreted or the patient may simply have changed his mind. These reasons may be unavoidable or they may be obviated favourably by adjustments of the procedures of selection, pre-operative assessment, booking and instruction.

UNPLANNED RETURN TO THE OPERATION ROOM ON THE SAME DAY

Unplanned return to the operation room on the same day. The indicator reflects possible unexpected complications emerging after the initial surgical procedure. The reasons may be related to anaesthesia, surgery or unrecognised pre-existing pathology and may result in un-planned re-entry to the operating room for a further procedure.

UNPLANNED OVERNIGHT ADMISSION

The indicator reflects possible inappropriate practice in anaesthesia or surgery or in the selection of patients for day surgery procedures. Recovery from anaesthesia may be delayed, unexpected morbidity may have occurred due to unrecognised medical conditions, in-experienced surgeons or anaesthetists or poor patient selection; either physical unfit or with unrecognised mitigating social circumstances.

UNPLANNED RETURN/READMISSION OF THE PATIENT TO AN AMBULATORY SURGERY UNIT OR HOSPITAL

The indicators reflect unexpected return contacts within 24 hours or within 28 days due to a problem that relates to the procedure, be it medical, surgical or anaesthesiological. The contact may be short and managed on an out-patient basis or may necessitate re-admission. All related contacts including those to other institutions than that of the initial procedure are considered.

The indicators relating to unplanned return to the operation room, *unplanned overnight admission and unplanned return/readmission of the patient are all based on comparative rates and in the strictest sense addresses the process of patient care but indirectly the indicators all reflect aspects of the outcome of care. Failure of quality may call for changes in structure and organisation and interventions both in patient selection and assessment, audit, in clinical guidelines, in teaching and training of implicated health personnel, anaesthetists, surgeons and nurses.*

Mortality rate and infection have been considered inappropriate for use. Death as an outcome measure that can be related to the day surgical procedure is extremely rare be it in the day surgery centre or later after discharge. Such a rare occurrence impedes the use of death as a practical clinical indicator unless large sample size is available and interventions to improve quality may take years to show an effect. Infection rates as measures of outcome of care seem to be sensible indica-

tors. Unfortunately data are likely to be misleading because a large number of cases are likely not to be known to the day surgery centre. Quality programs focusing on infection rates in selected procedures with long term follow up by telephone calls or questionnaires may deliver the necessary data for quality assessment in this area.

As day surgery expands and includes more extensive procedures in patients of increasing age and with more serious coexisting diseases, the greater are the demands to continuous quality improvement in all of its three dimensions: structure, process and outcome. But measurement of quality by indicators never stands alone. Centre differences in organisation, in patient population and in the surgical procedures, are all likely to have an impact on outcome. Before application of the universal indicators, each centre should specify its own Standards of good clinical practice to meet local conditions. Standard program for surveillance of quality, documenting the quality of the health care system is the basis not only for continuous quality improvement but also for a rational control of health care economy and distribution of resources.

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BENCHMARKS FOR AMBULATORY SURGERY

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This presentation will review data developed as part of a quarterly project measuring certain outcomes that the Federated Ambulatory Surgery Association has been conducting for more than five years. This data provides insight into how ambulatory surgery centers (ASCs) in the United States operate. It can also be used to assess differences between the United States experience and that of other areas.

PROJECT METHODOLOGY

Approximately 1,500 FASA-member ASCs are sent a quarterly response form seeking information on 29 parameters. Those that choose to participate complete the form and return by fax. Approximately 400 ASCs respond quarterly, although few respond to all queries. In the most recent quarter the number of respondents varies from 140 to 399. Data is compiled, analyzed and a quarterly report prepared. In addition to the national data the quarterly report includes data by type

of ASC – multi-specialty, single-specialty and specific specialties -- ophthalmology, gastrointestinal and orthopedics. Participating ASCs receive their results and the quarterly report.

RESULTS

The presentation will include a discussion of key results. For example, overall results show that ambulatory surgery is safe; with a median complication rate of 1.38 per 1,000 patient encounters and a median transfer rate to a hospital for overnight care of 0.64 per 1,000 patient encounter. ASCs pride themselves on efficiency and this would seem warranted as 50% of ASCs have an average operating room time per encounter of 50 minutes or less. This, of course varies, with the average operating room time per encounter in orthopedics being 58.50 minutes and ophthalmology being 31 minutes. One point touted by ASCs is that surgery is started on time. This is reflected in the data with the median percentage of cases starting on time being 84%. Additional detail on the above factors and data on staffing, documentation, patient satisfaction and cancellation rates will be discussed during the presentation.

It should be noted that because of legal and reimbursement issues within the United States this data is only from ASCs that are operated independently of a hospital.

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EVIDENCE BASED QUALITY IN AMBULATORY SURGERY

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Evidence-based medicine (EBM) is defined as an approach to practice and teaching that is established on systematic literature review. The correct use of evidence is related to its strength, graduated following 4 levels:

1. level A: evidence supported by wide controlled, randomized, meta-analyzed trials (standard level for therapy guidelines)
2. level B: evidence supported by properly designed, randomized trials
3. level C: evidence supported by properly designed, non-randomized trials or multicenter, multitime case control studies
4. level D: evidence based on simple experts advice, based on clinical experience descriptive studies or reports evidence-based surgery fits into the context of EBM.

The origin of both is located into the history of the USA medicine, and coincides with public reports published in the 30s (A study on hospital efficiency, by E. Codman; Two reports on costs, access and quality of care, by the Commission on Medical Education and the Committee on the costs of Medical Care). Evidence based quality in medicine should consider both what care should be applied and how this care should be implemented in order to be as efficacious, cost effective and patient satisfying as possible.

Following the classical Donabedian approach, quality evaluation in medical care should consider the structures, the processes and the outcome. Extending the perspective to ISO 9000, quality evaluation in Ambulatory Surgery should also consider both the evidence in the literature that describes patient requirements and satisfaction following AS, and the cost-effectiveness of the care process itself.

About structures, the evidence that should be searched for basically refers to the organization models for ambulatory surgery (dedicated versus mixed inpatient/outpatient facilities). On this subject, where as prospective, randomized and controlled studies are lacking, some descriptive studies can be found that indicate dedicated outpatient facilities to be superior than mixed inpatient/outpatient facilities in providing preoperative information and, in general terms, in satisfying patients expectations (evidence of level C-D).

Evidence on processes involves a wider field, and encompasses the whole process of care, from preoperative selection to the follow-up. On this subject, clinical studies are numerous, focusing on different aspects, and their results not easy to synthesize and often inconclusive. The only study published so far that took in consideration the ambulatory process of care in an inclusive perspective is a study by Collopy, in 1999. Collopy examined the ambulatory process of care under an inclusive perspective in a study that explored the activity of 240 Australian DS units during three months and monitored activities by the ACHCS quality indicators, analyzing a total of 380.000 patients. Results showed that the majority of organizational defects are allocated at the beginning of the process: the total number of organizational defects enlightened by indicators was 9.486, 80% of them taking place in the preoperative phase. This study underlined the role anaesthesiologists play in selecting patients (so avoiding late cancellations), and also showed that ACHCS quality indicators have high responsive power (i.e. high ability to induce improvement actions), as 64% of the facilities involved in the study, once results became known, took corrective actions such as conceiving preoperative information leaflets, or anticipating anaesthesia consultation to 3-5 days before surgery (evidence of level C).

Evidence on outcome varies considerably,

when assuming ambulatory surgery outcome as its appropriateness, as its level of safety or as its rate of minor complications. When reviewing literature to evaluate outcome in ambulatory surgery in terms of appropriateness, it is astonishing how abundant positive reports are on ambulatory surgery itself, and how scarce comparative studies are. In other words, it clearly appears that, so far, suitability of operations for ambulatory surgery has been established in the majority of cases only following expert advice, i.e. only on the base of evidence of level D. Considering the outcome of ambulatory surgery as its level of safety, many reports in the literature show that mortality and major complications are exceptions in this field. About minor complications, evidence from the literature is of level C-D.

The most investigated fields are cardiovascular and respiratory adverse events, elderly patients, postoperative pain and postoperative nausea and vomiting (PONV). Minor cardiovascular and respiratory complications appear to be correlated to the preoperative conditions, age, obesity and asthma. Elderly patients are at higher risk of cardiovascular events than younger, but at lower risk of many peri-operative events, such as PONV.

Many studies have showed that, after ambulatory surgery, pain is frequent, not rarely severe, influenced by the duration and the kind of surgery, associated with high values of BMI, often perceived as invalidating and interfering for more than one week with normal activities. PONV results to be a strong predictor for prolonged hospital stay, to be influenced by anaesthesia technique and surgery, and to be associated to female sex, obesity, motion sickness history, intensity of pain and condition of not smoking.

Evidence on patient requirements is of level C-D; randomized trials are absent, but many descriptive studies have been published and analyzed, showing that main patient requirements focus on adequate pre-operative information and adequate post-operative pain relief. In conclusion, some basic points in ambulatory surgery organization and quality are evidence-based. Anyway, due to the lack of randomized trials, evidence from the literature is of low degree (C-D level). Probably, EBM is not the best tool to define the principles for a quality-based practice in ambulatory surgery, and this is not surprising when considering ambulatory surgery to be 20% clinics and 80% organization. Organization theories and management principles offer new perspectives, from which some input can be derived. Their fundamentals are:

1. keep your process under control
2. investigate and satisfy your patients requirements.
3. use a management style based on staff motivation and development of competencies.

OPTIMIZING COSTS AND QUALITY IN AMBULATORY SURGERY

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COST

Total costs of procedures

Total costs were calculated in a multicenter study for 7 tracer operations including all pre- and postoperative work. The results of two tracer operations are shown in fig.1.

	Hospital laparotomy	Hospital endoscopic	Day clinic endoscopic
Cholecystectomy	5294.-	3869.-	1601.-
Adnexectomy	4753.-	2711.-	1415.-

Fig. 1. Total cost per case (in Euro, Eichhorn and Eversmeyer 1999)

These results show that endoscopic procedures are less expensive than open laparotomies, and that ambulatory procedures cost less than inpatient treatment.

Calculated costs for fee schedules

- RBRVS in the USA exists since 1992. It is well established and gives relative values for the physician's work, for practice expense and for malpractice expense.

- Tarmed (Switzerland) is in effect since 2002. It lists the physician's work, the technical expense and takes into consideration the type of operating room (OR).

- DRGs are used in many countries. Depending upon each country the DRGs are calculated either for inpatient treatment or for outpatient/ambulatory treatment, the latter sometimes at lower fees.

Operating costs of day clinic

Smaller surgical units like day or "praxis" clinics can determine total running costs for the surgical unit (including costs of operating room (OR)) plus doctor's fees.

The total costs of the surgical unit should be calculated as costs/day or even better as costs per working hour in the operating room = hOR

In our gynaecological praxis clinic the operating costs in 2003 were 306,- Euro/hOR plus 129,- Euro/hOR fees for one surgeon. This amounts to 435 Euro/hOR plus fees for anaesthesia. The individual costs of each procedure can then be calculated on the basis of costs/minOR.

As these fees for procedures are only based upon time of occupation of the operating room they should be adjusted to the number of surgeons/hOR and, with the help of a relative value scale, to further parameters like special training of the surgeon, difficulty of performance etc. as it is done with RBRVS.

QUALITY

The following methods have been widely accepted to measure quality:

- Complication rate (quality assessment of outcome)
- Days of disability (time off work)
- Patient satisfaction

The most effective way to answer these questions is to use a patient questionnaire (PQ).

In Germany the quality assessment system AQS has proven to be an effective instrument for quality assurance in ambulatory surgery. For each procedure it uses diagnoses (ICD-10), type of procedure (OPS.), and complications judged by a) the surgeon, b) the anaesthesiologist and c) the patient (anonymous, separate questionnaire). It also offers to every participating day clinic a benchmarking for complication rates for every procedure and yearly reports on institutional performance, all at reasonable prices.

OPTIMIZING COSTS AND QUALITY

In order to optimize we must know the goals that we want to aim at. Below are listed possible goals and their probable favourites:

Goal	Favoured by
- high quality of work	- patient, physician
- low costs for procedure	- patient, insurance company, clinic owner
- high patient satisfaction	- patient, physician
- high income of doctors	- physician
- "inexpensive" public health	- governmental politics

From the patient's point of view the goals are:

- The problem of the patient shall be resolved quickly, if possible permanently.
- The function of organs should be restored as soon as possible (short disability).
- A low complication rate will increase the chance of fast recuperation.
- Results should cosmetically be acceptable.
- The patients should feel at ease in the surgical unit and possibly at home.

As the patient is the most important person during ambulatory surgery a patient questionnaire should be used to judge the outcome of procedures and management.

CONCLUSION

For many individuals the goals of "good" medicine will be: optimal medical cure in short time at fair prices.

But the goal for ambulatory surgery must not necessarily be the highest quality possible, because this may be linked to a higher complication rate or to higher prices. Medium quality at low complication rates and low costs may be preferable for many patients especially if they have to pay for themselves.

National insurance systems generally aim at the lowest prices. These, however, may force the doctors to produce low or medium quality or push

treatment from the ambulatory into the inpatient sector - at higher costs for the insurance system.

The goal of ambulatory surgery should not be high income of the surgeon, however.

An action list will be presented.



PARALLEL SESSION 2
CURRENT ISSUES IN PEDIATRIC AMBULATORY ANESTHESIA (CHILDREN IN AS)
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HOW TO AVOID LAST-MINUTE CANCELLATION

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The high safety record of pediatric anesthesia today is due in large part to the role of the anesthesiologist as the perioperative physician who bears the ultimate responsibility of ensuring that the child is properly evaluated and medically fit to undergo anesthesia and surgery. Early evaluation of the patient, and communication with the surgeon and referring pediatrician will ensure that most problems are solved ahead of the day of surgery, and therefore prevent the inconvenience and expense of last minute cancellations on the day of scheduled surgery.

THE FORMER PREMATURE INFANT (EX-PREEMIE)

The premature infant is not a suitable candidate for ambulatory surgery because of potential immaturity of respiratory center. Several studies have reported a high incidence of postoperative apnea in these infants. The age at which a former premature infant attains physiologic maturity and no longer presents an increased risk for postoperative apnea remains controversial, and is best considered individually. It is generally considered that infants younger than 50-55 weeks postconceptual age (PCA), extremely premature, anemic and/or have preoperative history of apnea are at greatest risk; and should not be scheduled for out-patient surgery.