Outpatient Surgery in Day Clinics*

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SUMMARY

The results of outpatient surgery performed in a day clinic (unattached operating-theatre unit) on 5 321 patients in the period 1965 - 1971 by general practitioners and consultant surgeons are outlined and discussed. The types of surgery which can be undertaken are outlined and the dangers and precautions are analysed. Circumcision, contrary to expectation, provided the highest morbidity rate, whereas tonsillectomy proved to be an ideal outpatient procedure. The socio-economic and psychological implications are also discussed. In the light of the results obtained, combined with a survey of experience of British writers, the author makes a plea for more extensive use of day clinics for minor surgery.

S. Afr. Med. J., **45**, 1395 (1971).

When we advise surgery we usually explain to our patient the need for it and whether it is urgent or not. Often the duration of the resultant incapacity will be discussed. Rarely, however, do we enlighten the patient as to the cost involved, and seldom will he have a say in deciding to which hospital he will be admitted.

'May I stay with my child?' asks an anxious mother. 'No, dear, he must be admitted the night before, I will remove his tonsils the following day and unless you are prepared to book a private room for yourself, I'm afraid your child will have to spend the night before the operation alone in hospital.' We are discreetly silent about the fact that our own child was admitted a short while preoperatively, as an outpatient for the same operation and brought home a few hours postoperatively. Furthermore, I shall remain silent on the subject of the psychological trauma *my* child was spared by not being separated from its parent and most important of all, no mention is made about the 3 days of ward fees I saved. Also, dear parent, excuse my choosing the easy way out in the case of your child, but it will save me a lot of bother having your child tucked away for 3 days, even though I know the operation is a potentially hazardous but relatively minor procedure.

The interview is now completed and arrangements are duly made.

How often is this interview made every day in every consulting room by consultant and general practitioner alike? If this is medically, psychologically and economically the best arrangement for the patient then it should continue; but how many of us have ever questioned this time-honoured ingrained procedure? Is it tradition rather than good sense that dictates our present habits and is it not as well to consider these critically?

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THE DISADVANTAGES

These have been adequately illustrated in the introduction. However, some other points need to be mentioned. Is it necessary for a qualified sister to look after a patient who is scheduled for a minor operation the following day, when she is already overburdened looking after ill patients requiring the special skill she has been trained for? Is it necessary to fill a hospital bed with a patient booked for a circumcision the following day? Is it necessary to expose these patients to 24 hours of contact with contaminated hospital wards? Are we so over-supplied with hospital beds and nursing staff that we can afford such luxuries? Must we insist on defying the first principles of surgery by creating factors predisposing to sepsis and deep-vein thrombosis? Finally, must we put our patients to excessive expenditure for our own convenience when we can offer equal facilities at lower cost, by a little more exertion on our part regarding aftercare?

THE ALTERNATIVE

The alternatives we seek will be evident from reviewing the literature as well as from my personal experience.

Firstly I quote from the outstanding work of J. Alexander Williams:[1] 'I believe we must explore the possibilities of reducing unnecessary and unessential hospital expenditure, by not admitting to hospital patients who can equally well be treated as outpatients.' He continues: 'Is a simple hernia repair more painful, more difficult, or more dangerous than many dental extractions? I think not, yet tradition dictates that hernia cases remain in hospital.' He goes on to list procedures which have proved suitable for outpatient surgery, viz: hernia (both femoral, inguinal and umbilical), breast segmental excision, fissurotomy or polypectomy, node biopsy, skin and subcutaneous lesions and saphenofemoral ligation. In my opinion a special point relating to breast surgery is to arrange for mastectomy within 48 hours on the rare occasion where an unsuspected carcinoma is found, rather than subject *all* patients to the mental trauma of knowing that they might wake up having had their breast removed.

Arden and Lunn[2] add the following procedures to outpatient surgery: carpal tunnel syndrome, ganglia, De Quervain's syndrome and 'trigger finger'.

Calwell[3] lists a host of procedures suitable for day patients; he quotes from a paper read by J. H. Nicoll[4]

of Glasgow at a meeting of the British Medical Association in 1909, in which Nicoll presents an account of 7 329 operations he had performed on outpatients at the Royal Glasgow Hospital for Sick Children. These included 610 operations for talipes, 406 for hare-lip and cleft palate, 36 for spina bifida, 165 for mastoid disease and 220 for hernia. The results were as good as those in children treated as inpatients.

Fullerton[5] was so impressed with Nicoll's results that he stated: 'Personally I have no hesitation in operating on hare-lip, cases of cleft palate, knock-knees and bow-legs, enlarged tonsils, adenoids, naevi, tuberculous joints in the upper extremity, glands, tumours, and cysts in the neck and many other conditions requiring surgical intervention (on outpatients)'.

What about our own results? In the period 1965 - 1971, 5 321 patients requiring general anaesthetic were operated on as day patients. The table gives a breakdown of procedures performed.

TABLE I. OPERATIONS PERFORMED IN A DAY CLINIC 1965 - 1971

Procedure	No. of cases
Hernias—umbilical and inguinal (adults and children)	143
Haemorrhoidectomy (Lord's procedure)	58
Anal stretch for fissure	94
Circumcision	58
Varicose veins (Trendelenberg and strip)	9
Simple tumours of breast	112
Diagnostic dilatation and curettage	236
Curettage for incomplete abortion	183
Insertion of intra-uterine contraceptive device	12
Bartholin's abscess and cyst	48
Trachelorraphy	38
Posterior vaginal repair	6
Tonsil dissection and adenoidectomy	2 297
Tonsil dissection (adults)	164
Myringotomy	827
Cautery of nose for epistaxis	13
Submucosal resection	8
Turbinectomy	3
Antral washouts	56
Foreign bodies in ears and nose	28
Antrostomies	24
Fractures and dislocations	142
Carpal tunnel	28
Ganglionectomy	43
Manipulation under anaesthesia	23
Extensive lacerations, digital amputations, and minor plastic repairs	368
Excision of moles and other superficial tumours	286
Node biopsies	14

These procedures were undertaken at a day clinic in Randburg and performed by a total of 19 operators including general practitioners and consultants. Anaesthetics were administered by specialist anaesthetists throughout. The day clinic used, complied fully (in respect of equipment) with the requirements set out in notice No. R1071 of the *Government Gazette* of 25 June 1971 and in retrospect the author feels that these requirements should be regarded as the basic minimum and should not be considered as sufficient to prevent accidents.

Complications

1. **Haemorrhage:** Strangely enough, the procedure which caused most complications was circumcision; no less than 6 patients had to be redone because of haemorrhage, i.e. 10%, and in all cases haemorrhage was evident within the first 2 hours postoperatively. Tonsillectomy resulted in 3 postoperative haemorrhages evident in the first 4 hours and 1 haemorrhage on the 5th day.

2. **Sepsis:** Sepsis was not noted in any patient.

3. **Deep-vein thrombosis and pulmonary embolus:** No cases occurred.

4. **Respiratory complications:** Nil.

Why the Low Morbidity?

These results speak for themselves but it would be prudent to try to evaluate the reasons for this low complication rate.

1. **Selection of patients:** This was left to the individual operator and in view of the fact that the procedure was to be performed in a day clinic, practitioners probably made doubly sure about the fitness of their patients for surgery; by the same token, extra care was probably taken in respect of haemostasis.

2. **Anaesthesia:** For the same reason anaesthetists took more than the usual superficial interest in their patient and as a routine examined the patient pre-operatively, as well as ensuring that the patient was wide awake before leaving the operating theatre. This is rather more important than might appear at first glance, as many anaesthetists in nursing homes will entrust deeply unconscious patients to recovery staff who are not fully on the alert.

3. **Treatment and supervision:** In view of the smaller numbers of patients treated, all aspects of treatment and supervision are optimal, and in many respects superior to what can be offered in a crowded nursing home.

4. **Time of operation:** Operations were performed (except in emergencies) from 0700 - 1000 in the mornings and checked by the operator before discharge in the late afternoon.

The Doctor's Duty Postoperatively

In addition to the immediate duties outlined above, the operator should be willing to visit his patient and make sure that his deputizing arrangements are adequate and that the patient is aware of them.

Advantages to the Patient and Community

Safe minor surgery in a day clinic situated geographically within easy reach of a patient population makes it a simple matter for parents and relatives to ultilize this facility. The avoidance of parental separation from a child in times of stress cannot be overemphasized.

The saving in costs to the patient, the increased productivity of nursing staff and the better utilization of our limited number of hospital beds and staff for patients who do require overnight facilities, are of prime importance in our present socio-economic environment.

CONCLUSION

The concept of day clinics for outpatient surgery should be vigorously explored and encouraged by both the profession and government.

REFERENCES

1. Alexander Williams, J. (1969): Brit. Med. J., **1**, 174.
2. Arden, G. P. and Lunn, J. A. (1969): *Ibid.*, **1**, 377.
3. Calwell, H. G. (1969): *Ibid.*, **1**, 378.
4. Nicoll, J. H. (1909): *Ibid.*, **2**, 753.
5. Fullerton, A. (1913): *Ibid.*, **1**, 470.