Quill on Scalpel
Plume et scalpel

O.R. time — not beds

Jonathan L. Meakins, MD

Sadly, budget constraints are not a new phenomenon in the Canadian health care system, and they appear to be getting worse, precipitating hospital closures and mergers and demanding that those medical specialists who practise exclusively within hospitals make changes in their practice patterns or habits such that total costs are dramatically reduced. In the framework of global budgeting, the standard practice in Canada, there is no revenue side; therefore, any savings have to be accrued through changes in practice to lower costs, rather than an increase in income to hospital and physician. In the United States, where there are multiple payers, dramatic changes in practice can be imposed on very short notice because of the revenue stream. This was witnessed most notably with the introduction of DRGs (diagnosis related groups) in the early 1980s and the sudden impact on the length of stay.

In many respects, present day surgeons and anesthetists are faced with making some of these same draconian changes. However, the way in which we should implement changes in practice is not apparent because the hospitals target departments to change their approach rather than addressing each individual surgeon. It is difficult to persuade large groups of independent professionals to alter their approach to a patient problem that for years they have managed in a certain fashion. In recent years these changes have become apparent and include what we now consider pretty standard approaches to patient care: preadmission, same-day admission, early discharge and day surgery. These approaches were previously thought to be impossible for many procedures, such as cholecystectomy. The next stage in change is that of incorporating increases in operating room efficiency, utilization of home intravenous drug administration and home care, where, for example, drains are managed by visiting nurses, as well as a variety of step-down units in the community so that convalescence from major surgical procedures can be managed in less expensive environments.

Many of these ideas have already been implemented or are in progress. Where do we go next? Sugeons complain endlessly about budget restrictions, often without even questioning how they collectively contribute to higher costs, through choice of antibiotic or other drugs, parenteral rather than oral medication, parenteral rather than enteral nutrition, and even the choice of anesthesia or methods by which an operative procedure might shorten hospital stay. Kehlet has shown that it is possible to discharge octogenarians 2 to 3 days after colon surgery by using a combination of general and pre-emptive epidural anesthesia, early enteral feeding, laparoscopic technique and anti-inflammatory drugs.[1]

In this light, the question asked by Willard and Blair in this issue (pages 213 to 217) as to whether pre-emptive anesthesia might speed the recovery of their patients with appendicitis is germane. It is unusual for this journal to publish a negative study, particularly one in which design problems may have contributed to the negative results. We owe the authors an apology, since the manuscript was lost in the editorial process. By the time the details were sorted out, no changes in design were possible. We have accepted the article despite the small number of patients, the short duration of the study and the failure to resolve the issue of whether or not local anesthesia might function pre-emptively, because it asks a very good question. The *Canadian Journal of Surgery* wishes to highlight the need for surgeons and their anesthetists and nursing colleagues to focus on the next stage of how our clinical practice must evolve so that we can provide the same level of care at a lower cost. We must design clinical programs to focus not only on high-quality patient-centred outcome but also on the need to manage problems clinically and effectively as well as efficiently. For surgeons, O.R. time, not beds, is the key, and how we organize our activities to transfer resources from the ward to the operating room will be crucial to our ability to maintain service to our community.

The question posed by Willard and Blair is the kind of question we need to pursue in order to define ways to hasten recovery and reduce hospital use while maintaining patient flow.

Reference

1. Bardram L, Funch-Jensen P, Jensen P, Crawford ME, Kehlet H. Recovery after laparoscopic colonic surgery with epidural analgesia, and early oral nutrition and mobilisation. *Lancet* 1995;345(8952):763-4.

Surgeon-in-Chief, Royal Victoria Hospital, McGill University, Montreal, Que. Coeditor, Canadian Journal of Surgery

Correspondence to: *Dr. Jonathan L. Meakins, Room S10.36, Royal Victoria Hospital, 687 Pine Ave. W, Montreal QC``H3A`1A1*

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