

Social and Economical implications of Short Stay Procedures in a General Practitioners perspective

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Dear Colleagues,

It was in the beginning of this year my department at the Ghent University, which is General Practice and Primary Care, under presidency of Prof. Jan De Maeseener, was asked to present here, on the occasion of your annual meeting, a GP's point of view on the phenomenon of shortening hospitalization time and growing importance of day care medical procedures. We want to thank to Belgian Society of Anaesthesia and Resuscitation for this opportunity.

In short, this presentation will deal with some general introduction items on day care, it will present to you a definition of modern primary care and focus on some aspects of it that are relevant to this meeting. I want to show you the importance of guidelines in Primary care and make a first move towards a possible future interdisciplinary guideline on peri-operative management of the ambulatory patient. Although there is very little information to be found in international literature I would like you to show some published data on primary care and day care surgery, in an international (unfortunately exclusively British) context and a Belgian context. All this before formulating conclusions.

The relative number of short stay procedures (including day surgery) is growing. This is a consequence of different findings :

Firstly : economical : overall cost of a surgical procedure can be reduced by greater cost effectiveness and so by reducing length of stay to a necessary minimum. Studies show that there is no cost-shift to primary care, because depending on the performed procedure costs generated by primary care in the perioperative phase are minimal.

Secondly : social : the majority of patients are satisfied with services received as a day patient but research emphasises on the condition that they need to be well informed at all stages of their care. And thirdly a medical-technical finding that the evolution in anaesthetical and surgical techniques was and will be fundamental in the development of short stay procedures.

But GPs are not happy with some aspects of health care organisation in Belgium. We have a feeling that hospital care could develop itself unlimited with a huge governmental support. Subventions are mainly canalised towards institutions and buildings : hospitals, nursery homes, palliative care units, day clinics etc... Investments in structural primary care, financially as well as organisationally, are very low. This is in strong contrast with other European countries.

And we notice the same on an lower scale. Although the task definition of day care and primary care are obviously complementary, there is little or no involvement of primary care representation in the set-up or direction of day care centres. Even when such representation is very present like there are GP associations all over the country. And when day care centres are co-operating with primary care we find a large diversity in intensity and modalities this co-operation is realised.

Day surgery really seems to have a very promising future but it has to take into account some important recent evolutions in primary care. That's why I want to present you a contemporary definition of primary care. Wonca Europe, the European part of the World Organisation of Family doctors, published in 2002 a very complete well reasoned definition of General Practice and Family Medicine but it is too extensive for today's purpose. So I selected a definition published in the brand new Oxford textbook of Primary care. That's how it goes :

'Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health needs, developing a sustained partnership with patients and participating in the context of family and community.'

This definition establishes that primary care is a function, not merely a specialty, within a health-care system. Different health care professionals (nurses, doctors assistants, mental health special-

Voordracht congres Anesthesie op zaterdag 27 november, Albert Hall, Brussel.

ists) can contribute to this function, but supervision and co-ordination is organised by the family physician or general practitioner.

Some of the aspects mentioned in this definition are worth taking into account when defining the GPs role in a day surgery procedure. I want to emphasise on 'integrated', 'sustained partnership' and 'participating in the context'.

GPs concentrate on integrated aspects of care that are not related to a certain age, or to a certain organ system. As specialty care increasingly controls tinier parts of a human body, it may lose control over the connexion between these tiny parts and a global human body and mind. A family physician surveys a wide array of orthopaedic, thyroid, cardiovascular and gynaecological problems, paediatric and oncological problems, physical, psycho-relational and social problems. This explains why a GP should preferably be involved in choosing between treatment options, choosing between day care and hospital care, in preparation and post-operative care or in one word in the process of a day care centre.

Primary care is based on a sustained partnership between doctor and patient. We try to establish a long term relationship with a relatively limited number of patients, often suffering multiple chronic diseases with their ups and downs : this relationship is non-episodic offering intensive care in the ill periods alternating with easy access care and control in the not-ill periods. It's a kind of care based on a mutual commitment from doctor to patient and from patient to doctor.

We try to gather information about one person in a broad way. Primary care workers are context specialists, resulting in an individual patient-centred approach, taking into account one's individual history and individual responding pattern in various situations. These responding patterns are based on each patients' individual beliefs, fears, expectations and needs.

GP's training during two years is more and more emphasising on identifying these patient beliefs and fears and exploring his expectations and needs.

In our contemporary definition we find these items showing why GPs' involvement may offer added value in successfully running through a day surgery procedure and why GPs can share in the tasks like information, indication, planning and organisation, communication, discharge, postoperative care and follow-up.

For some 20 years now, problem based guidelines are published for practising family medicine.

These guidelines or 'standards' offer in well described clinical situations a solid base for quality care, according to contemporary scientific insight. They are 'evidence based'.

By publishing and promoting these guidelines, some problems at least can be dealt with in a uniform and consistent way.

These guidelines are permanently updated.

It is certainly worth considering to make a new guideline on day care procedures with clear task description of primary care workers and day clinic staff in the pre-, per- and postoperative care.

The development of such a guideline could be based on what we call the 'functional care'-model, guaranteeing the right care at the right time and place, provided by the right person at the right price. The daycare procedure should be entirely described and taken up in consensus avoiding conflict between care-providers. The guideline should emphasise on the '5 Cs': continuity, complementarity, coordination, communication and context. The latter, context, we discussed already, so let's focus on the other Cs.

It should be clear who is responsible for which part of the procedure. At all stages patients must know who to consult in case a problem occurs and this should be made clear by another C, communication.

In other words, agreements should to be made on coordination, in a home as in a hospital situation.

And these agreements should preferably be based upon a mutual respect for each others professional competences with a dose of self-criticism and a spirit of team work.

To achieve these aim, contemporary medical student education emphasizes on teaching communication, being a cornerstone of our professional activity.

This communication is of utmost importance when organizing a day surgery procedure. There has to be a skilful doctor-patient communication exploring patients ideas, concerns and expectations and giving all necessary information on the planned procedure. Also interprofessional communication is important and causes still big difficulty in daily practise. We dealt with clear guidelines already but explicit communication with an immediate discharge letter formally transposes responsibility of care to the primary care level and in this way it has an different function than a hospitalisation report which may follow afterwards.

GPs may be afraid of an extra burden caused by further development of daycare procedures. So

let's focus on the demand upon primary care workers.

Very, very little research on this domain has been done, excepted in the United Kingdom where these studies could be found showing no important surcharge of workload in primary care. The study which was published in 1997 in the *Annals of the Royal College of Surgeons in England*, showed that in 1500 daycare procedures, 329 GP consultations were needed, of which only 51 during the first 24 hours. Reasons were pain in most cases, other reasons included most of the times administration acts for work etc.

In the same study actions performed by GPs were observed. Drug prescription, advice and reassurance were the most frequently performed ones.

Another English study, published one year later shows a comparison in workload in function of number of hospitalisation days. In a mixed array of surgical procedures, performed both in daycare and with hospitalisation, the workload for primary care, here presented as average contact rate (number of contacts/patient) is low, with a little more work even for people who had been hospitalized for 2 or more days. This may be due to a more complex surgical procedure, which required more hospitalized days and more complex postoperative care.

In Belgian context I found one, not published, study, from the Roeselare region. It shows us results of a attempt of making a daycare guideline for local family doctors and daycare units.

Data were collected during 2001-2002, in three hospitals in cooperation with two GP associations.

The aims of the locally developed guideline were :

1. speeding up information transfer
2. improving information quality and
3. affirmation of the GP involvement in a daycare surgical procedure.

A preparative protocol was developed as well as a discharge protocol, as a result of several meetings of anesthesiologists and surgeons and a GPs' representation.

Implementation of the guidelines and the achieving of the presented aims was evaluated by indicators such as :

1. quality measurement by DCU nurse : proportion of available information through GP on a patient who could be prepared in primary care
2. quality measurement by anaesthesiologist on the completeness of this information

3. presence of discharge documents at the moment of leaving the hospital
4. by GP ; time interval between discharge and moment of contact between GP and patient
5. global satisfaction of GP on the procedure, using a standard rating scale.

Further study data : like I told you, three daycare units, 32 GP, evaluating 318 daycare surgery procedures. Sex distribution was OK and age distribution very large : from 1 to 87 years. Different surgery disciplines were involved in this study.

I want to highlight some of the results of this study.

A clear guideline tells us that a patient who has to undergo a daycare surgery procedure, and belongs to class I and II of the American Society of Anaesthesiology classification is to be sent to his GP to be informed on and examined before the procedure. This referral took place in only 50 to 60 % of the cases.

On the moment of hospital admission, the morning of the procedure, only 66 % of preoperative files are complete, conform the protocol. Files of patients seen by their GP were complete only in 81 % of the cases.

The guideline points out that patient should get in touch with his GP after discharge from the hospital. He or she should be instructed so when leaving the DCU.

Only 80 % does so, and the average time needed to establish such a contact is 4 days.

In one third of the cases the contact was a telephone call or merely the delivery of the immediate discharge letter.

In 25 % readmission at the hospital was needed : this proportion is, in an international context (I refer to the british study) too big to merely cover complications and must include routine postoperative care.

In conclusion I want to emphasize on the added value primary care can provide when planning a day care surgery procedure, but we need a clear care-protocol, based on consensus among the professionals involved and a constant 'evaluation and improvement' – procedure to assure maximal implementation. To be able to take up these responsibilities primary care will have to organise itself, as well as DCUs do. This requires a structured health care system in which, like hospital care is now, also primary care is organisationally supported by the government and in which co-operation between structures is promoted and encouraged.

Thanks for your attention and I'll be pleased to answer possible questions.