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Editorial

Major Ambulatory Surgery: Where We Are and Where Are We Going☆

Cirugía mayor ambulatoria: dónde estamos y adónde vamos

In the late 1950s, centers dedicated to major ambulatory surgery (MAS) were first established in Vancouver and later in Washington and California.[1] The first totally independent center (''Surgicenter'') was inaugurated in February 1970 in Phoenix (Arizona), conceived by 2 anesthesiologists, Wallace Reed and John Ford, for ambulatory interventions without the participation of traditional hospitals.[2] That day, they performed 5 ambulatory interventions, 4 of them with general anesthesia. In 2011, more than 5300 centers in the US carried out more than 23 million interventions without hospitalization.

In October 1990, 20 years later, a multidisciplinary, autonomous and integrated non-hospitalization unit was opened at the Hospital de Viladecans in Spain.[3]

The International Association for Ambulatory Surgery (IAAS) was founded in 1995, coinciding with its first international congress (third European) in Brussels. The founding members had begun the publication of the *Ambulatory Surgery* journal in 1993, which is currently available at www.iaas-med.com. In addition, the IAAS organizes a biennially medical congress.[4]

In addition to the IAAS was the then-newly created Spanish Association of Major Ambulatory Surgery (*Asociación Española de Cirugía Mayor Ambulatoria*, ASEMAS), which was preparing its second national congress in Seville. The first had been in Barcelona in 1992, organized by the Hospital de Viladecans. ASEMAS, which has been holding congresses and meetings between congresses every year, created its own journal.[3] The congress of 2017 was the 13th national congress that, simultaneously, was the 6th Iberian congress, which is an international congress organized in collaboration with the Portuguese Association of Ambulatory Surgery (Associação Portuguesa de Cirurgia Ambulatoria) and is the result of an interesting symbiosis between both associations.

In Spain, according to data from the Ministry of Health, Social Services and Equality, the percentage of outpatient surgery of the total of number of operations went from 10.4% in 1997 to 16.3% in 2000, which is an increase of 5.9%.[5] In 2001, the development of MAS units by Spanish autonomous communities was very unequal,[3] although this has now been surpassed, with only minor differences among the regions. In Catalonia, there was an increase in ambulatory surgery activity and a decrease in surgery with hospitalization in the period from 2001 to 2011.[6] In 2014, the Ministry recognized 763 hospitals (345 public and 418 private), with 4352 operating rooms, 434 of which are dedicated to MAS. Between 2010 and 2014, 2 148 895 surgeries with hospital admission and 1 281 903 outpatient surgeries were performed, which represents an outpatient rate of 37.36%. Not all of these interventions correspond to General Surgery, but to all services that perform interventions under this modality.[7]

If we analyze the data of our specialty, the rate of ambulatory surgery has varied from 27.86% in 2010 to 30.14% in 2014.[8] We have the infrastructures and the support of professional organizations, but the increase in ambulatory activity in 4 yrs has only been just over 2%, which must make us take pause.

First, we must consider how we account for MAS. The classic idea of the patient admitted early in the morning and released the same day has given way to other modalities. Many of these patients are involved in afternoon surgery programs, which are the current competition for established MAS programs, as they consume the same resources as MAS units with the added costs of the overnight stay. It is necessary to unify criteria when we speak of MAS and, therefore, to unify the language. Under the heading of MAS, different autonomous communities include procedures as diverse as minor surgery, MAS, prolonged-recovery surgery (23-h surgery, overnight surgery) or short-stay surgery. It is necessary for

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hospitals and institutional computer systems to have the ability to discriminate between each of these surgical management modalities. Only then will we know the reality of our healthcare indicators.

Secondly, we must think whether the current service portfolio is definitive, or whether we should include new processes. It seems clear that laparoscopic cholecystectomy and thyroid surgery, esophageal hiatus surgery or breast surgery will spark discussion in the future, but does the system really support MAS? What benefits do surgeons obtain when performing these surgeries on an outpatient basis over those who prefer to perform them with hospitalization? Is the current service portfolio inalterable, or should new procedures be included? Does this inclusion involve any unnecessary risk?

Third, we must assess the contribution of other actors. The participation of primary care is testimonial, and we continue to make the ''day after'' phone call to calm our consciences and ensure that we do not abandon our patients to their fate. Home hospitalization units treat complex patients at home, training and involving family members in their care. Would it not be possible to train surgical home hospitalization units to be able to treat more processes and empty hospital beds that are being occupied unnecessarily? Although some centers have already taken the initiative, this is a postoperative follow-up model that should be developed.

Fourth, today it is not necessary to discuss the importance of MAS in healthcare management. Indicators, such as the rate of ambulatory treatment, say a lot about the overall function of a medical center as well as the national healthcare system in general.[9] Do we perceive the interest of healthcare administrators?

Fifth, registries for MAS activity records continue to be deficient. Do we have a proper registration system available for ambulatory activity? Do we use that information to compare ourselves with other units? Do we all know our rate of ambulatory treatment, our substitution rate, our rate of complications or re-hospitalizations? Do we care about their evolution over time?

And, sixth, should the staff of MAS units be specific? Or, on the contrary, should MAS units be transversal, where each division performs certain operations?

This century, the evolution of MAS should be as follows: continue doing well what we already do well, include new processes with home support, and improve our computer systems to integrate concepts of continuous improvement. Similar to what occurred when the MAS programs were initiated, the motivating factor will be differential funding favoring this surgical treatment modality over traditional surgery with hospitalization.

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