# Systematic surveillance

ONE of the most striking and important changes in general practice since the second world war has been the change of emphasis of many consultations. Throughout the nineteenth century and up until 1939 the vast majority of consultations were initiated by patients. Going to the doctor was seen as a patient's decision: the idea of the doctor sending for patients or seeing patients on a regular basis was hardly recognized.

Starting with antenatal care and then rapidly spreading to child care surveillance, geriatric surveillance, and contraception, an entirely new system has begun to emerge. Increasingly doctors are choosing to send appointments *before* there is illness, usually for some form of preventive medicine. In some practices a doctor-initiated consultation has become the second or third commonest reason for a patient seeing a doctor at all.

A second and quite separate trend has been the gradual emergence of chronic as opposed to acute illnesses in general practice. Slowly improving standards of living and nutrition, coupled with the introduction of antibiotics in the 1940s and widespread immunization, have made many of the common children's diseases such as measles both less common and much less severe. As a result, proportionately more consultations are taking place for behavioural problems and chronic disease. The problems of the chronically handicapped loom larger and larger because of the greater number of handicapped children surviving, the recognition of chronic disorders of childhood, such as asthma, and the rising number of the elderly in the population.

Gradually it is coming to be recognized that patient-initiated consultations are not adequate for long-term supervision of patients with chronic handicaps and the concept of regular monitoring is being introduced. Blood pressure checks, peak flow checks, and testing blood levels for serum anticonvulsants have all become part and parcel of the everyday management of hypertension, asthma, and epilepsy, and are likely to remain so. The trend towards miniaturization with such aids as the mini peak flow meter is probably only a start to a whole new range of devices which will enable general practitioners to measure the progress of chronic diseases more and more accurately in the future.

Surveillance, however, is achieved only at a price. If the doctor takes the initiative and sends reminders to defaulters, an image that 'big brother is watching' is soon created.

### *Practice management*

The concept of systematic surveillance of chronic handicaps, whether in children, adults, or the elderly, coupled with systematic monitoring of relevant age groups—girls for rubella, women for cervical smears—is throwing a new responsibility on doctors for practice management.

Age/sex registers, simple diagnostic registers, and secretarial systems which can comfortably cope with these new arrangements are needed more than ever before. Practical preventive medicine is not possible without them.

The first so-called revolution in general practice took place in practice organization and paradoxically the wheel is coming full circle: the implementation of systematic surveillance for the handicapped and for preventive medicine may now depend as much on good practice organization and records as on medical skills.

# Day care surgery

FROM the patient's point of view, much of the inconvenience and disturbance associated with routine surgery lies as much in going into hospital for a week or so as in having the operation itself. For women the disturbance of leaving the home and family can be so great that it can often deter them from accepting elective surgery at all. The case for day care surgery arises partly from these considerations and partly from pressure to save money in a health service in which demand is poured like a quart into a pint pot of financial resources.

Cochrane (1972) has underlined the intellectual necessity, if doctors are to take decisions rationally, to demonstrate that one form of management is superior to another, or at least cheaper, if it is to be preferred in future.

There have been several reports of the safety of day care surgery, but most of these have come from enthusiasts and very few have been controlled.

Prescott and colleagues (1979) from Edinburgh have now reported an important prospective trial comparing the outcome of surgical treatment for varicose veins and inguinal hernia in three groups of patients, all over 100 in number, who were admitted either to a teaching hospital for two days or to a convalescent hospital for two days, or were discharged home on the same day of operation; or in other words, had day care.

Previous studies have tended to concentrate on the absence of complications in patients treated through day care and have not sought for positive advantages of such a system. This study, in which a research nurse saw all the patients at least twice and there was thorough follow-up, found that there were statistically significant differences in how patients slept on the first postoperative night, with 56 per cent sleeping well at home and only 21 per cent on the wards.

However, the majority of patients requiring tablets for pain during the first 24 hours after an operation showed a significantly reduced requirement for them in ward care, although in some individual cases tablets requested were not received.

By seven days postoperatively a statistically significant difference was found in help with washing: almost a fifth (19 per cent) of patients receiving ward care needed help compared with only four per cent and nine per cent of those in convalescent and day care groups. This is further confirmation of the growing suspicion among general practitioners that hospital care may breed dependence and inhibit patients from assuming responsibility for themselves at the optimum point.

More important still was the statistically significant difference found in the follow-up clinic in the proportion of patients who had returned to their main social activities—74 per cent of day care patients having done so, compared with only 68 per cent and 58 per cent of the ward and convalescent groups.

In terms of the percentage of patients off work, day care patients returned to work more quickly after both hernia and varicose vein operations than the ward and convalescent groups.

It only remains to show the extent of the impact of extra work created by day care surgery on the domiciliary services. In Prescott's study, the general practitioners accepted the increased clinical responsibility and home visits with fairly good grace, and the district nurses who put in between three and five hours contact time (including travelling) in the three-week follow-up period were still able to provide a service which even including the ambulance costs showed a total saving to the health service of £30 for day care compared with ward care based on a 48-hour admission. (Longer stays are commonplace and the saving in day care compared with a seven-day stay in a surgical unit is about £100.)

Many thousands of patients are currently on surgical waiting lists for a relatively small number of operations. Hernia repair, varicose veins, dilatation and curettage, and piles are obvious examples; and vasectomy, sterilization, and several orthopaedic conditions are common. The Lane Committee (1974) strongly urged the increase in day care abortion, since in that condition there is overwhelming evidence that delay is not merely inconvenient for the patient but greatly adds to the rate at which complications occur.

As a general principle, day care surgery is gaining ground. It fits the general trend of providing the maximum amount of care possible in the patient's home and it is reassuring to patients and relatives. It is beginning to look as if day care is not merely a cheaper alternative, but may well have substantial benefits for patients, promoting mobility and assisting rehabilitation and return to work.

Nevertheless, vast numbers of operations are still being carried out in expensive hospital beds for routine surgery of this kind. It is not often that there is a development in health care which is apparently welcomed by patients, acceptable to general practitioners, technically possible by specialists, saves hospital beds, and is actually cheaper.

For general practitioner members of district management teams, district and local medical committees, the question now perhaps should be: "Why not here too?"

## References

Cochrane, A. L. (1972). *Effectiveness and Efficiency.* Rock Carling Fellowship 1971. Oxford: Nuffield Provincial Hospitals Trust.

Committee on the Working of the Abortion Act (1974). Lane Report. Cmnd 5579. London: HMSO.

Prescott, R. J., Ruckley, C. V. Garraway, W. M. *et al.* (1979). Functional assessment of patients undergoing day-care surgery for varicose veins or hernia: results from a randomised controlled trial. *Health Bulletin,* **39**, 82-88.

Waller, J., Adler, M., Creese, A. & Thorne, S. (1978). *Early Discharge from Hospital for Patients with Hernia or Varicose Veins.* London: HMSO.