Position Papers

Pre-admission clinics in anaesthesia

The new name, Canadian Anesthesiologists' Society, was approved in June 1998 and resulted in the adoption of terminology devoid of diphthongs. The changes in nomenclature are being phased in to coincide with the printing of all new editions of the Society's publications.

The purpose of this paper is to examine the place of pre-admission clinics in the Canadian health care system and the role of anaesthetists in their operation. The paper will address a number of issues related to the operation of such clinics and is based on the views of a number of Canadian anaesthetists. Since these clinics are relatively new, particularly in the Canadian context, review of the literature was not very helpful; consequently, most of the information on which this paper is based was obtained by personal communication.

The impetus to develop pre-admission clinics derived from an increased use of day surgery and admission of patients for major surgery on the day of operation. While the rationale for such practices was initially financial, it seems that patients actually benefit from a shorter exposure to the hospital environment. Admission to hospital on the day of surgery is now recognized as a means by which costs can be reduced and patient satisfaction increased.

Structure of Clinics

If patients are to be admitted to hospital shortly before surgery, it is essential that as much preoperative preparation as possible is performed on an out-patient basis. This preparation involves a wide range of activities. An anaesthetist must have the opportunity to evaluate the patient and discuss anaesthetic management. Consultation with other physicians may be necessary. Evaluation and instruction by nurses is always required. The services of other professionals, such as physiotherapists, occupational therapists or respiratory technologists may also be necessary. Old charts must be obtained and appropriate investigations carried out. Finally, discharge planning must also be attended to. In a pre-admission clinic, most of the above functions can be accomplished in a calm and thorough manner, thereby not only providing patients with comprehensive evaluation and instruction, but also avoiding last-minute delays or cancellations on the day of surgery.

Since a variety of pre-admission tasks must be accomplished, a multi-disciplinary clinic is required. In order to provide access to the necessary personnel and facilities, the clinic is usually part of the hospital where the procedure is to be done. Nursing staff coordinate the clinic with clerical help. Patients are scheduled at times when ancillary staff, who are needed for their care, are present. The medical direction of the clinic should be accomplished by anaesthetists, since all patients must have a pre-anaesthesia evaluation before surgery and most of the questions and problems that arise in this evaluation can be resolved only by an anaesthetist. An anaesthetist should be present much of the time that the clinic is in operation, but may not interview all the patients.

The pre-anaesthesia evaluation follows a protocol which specifies both the individuals who must meet the patient and the tasks which must be performed. The clinic coordinator makes sure that all the relevant data, including lab work, results of other investigations, old charts, questionnaires etc., are available. The patient is then interviewed by a nurse and/or an anaesthetist, depending on the patient's needs. By the end of the visit, all necessary investigations should be arranged or complete, and the patient should have a clear understanding of what to expect with regard to surgery, anaesthesia, and hospital stay. The visit should take place close to the time of surgery, but there must be time before the day of surgery to deal with any problems encountered.

In most cases, the anaesthetist who supervises the pre-anaesthesia evaluation in the clinic will not provide the anaesthetic on the day of surgery. This situation requires that the patient has had the opportunity to discuss the options for anaesthesia and realises that the final decision regarding anaesthesia techniques will be made with the anaesthetist at the time of surgery. The pre-admission anaesthesia evaluation will provide the anaesthetist on the day of surgery with much useful information regarding the patient's condition. Nevertheless, the decision whether to proceed on the day of surgery cannot be delegated. Although one of the objects of the clinic is to avoid lengthy

delays at the OR door, the anaesthetist must take time to ensure that the patient is fit for the proposed procedure and understands and consents to the intended anaesthetic technique.

Financing of Clinics

Given that pre-admission clinics can improve the quality of care, are they cost effective and how should they be financed? Operating room time is extremely expensive, therefore, if the existence of a clinic results in avoidance of delays and cancellations, money should be saved. This saving is difficult to quantify. Nevertheless, the savings associated with reducing every patient's hospital stay by one day is easy to calculate. The costs of existing clinics are less than $100 per patient. Since daily hospital care costs over $600 in large institutions, we have a net saving per patient of over $500 if one day's care is avoided. Thus, provided hospitals close a number of beds and associated facilities proportionate to the reduction in lengths of stay, hospitals with a reasonable volume of in-patient surgery will be able to operate clinics within their existing budgets and still save money.

The financing of physician services is more problematical. In most provinces, provision of a pre-operative history is considered the responsibility of the surgeon and is paid for by the surgical fee. Similarly, the pre-anaesthetic evaluation is paid as part of the anaesthesia fee, and there is usually no payment for routine evaluations. Pre-operative anaesthesia consultations are remunerated, but must meet strict criteria, which would not apply to most patients in a pre-admission clinic. Because evaluation in a pre-admission clinic represents a new service which does not relieve the anaesthetist at the time of surgery of any of his or her legal responsibilities, such evaluation should receive funding from sources outside those allocated for existing anaesthesia services. This problem has been recognised in some jurisdictions, where a sessional fee is paid to participating anaesthetists. Ideally, the cost of these fees would be added to any existing global budget for physician services, since the service is new and is primarily intended to reduce the overall cost of medical care.

It has been suggested that anaesthetists' services in these clinics be remunerated by the hospitals from savings that accrue from reduced patient stays. While this may be feasible in the short term, we must remember that Canadian hospitals are not funded on a "per case" basis. If hospitals require fewer beds for a given volume of work, their budgets will be reduced accordingly. Eventually, there will no longer be any excess with which to fund anaesthetists. Provincial departments of health must recognise that this clinic work is a new service which reduces overall costs while improving the quality of care. The best way for governments to confirm and maintain this recognition is to pay for it as they do for other physician services.

Conclusion

Anaesthetists are uniquely qualified to participate in pre-admission clinics and many Canadian anaesthetists have already played a leading role in their development and direction. These clinics improve the quality of anaesthetic care by assuring that the patient is better informed and more thoroughly evaluated than is possible in today's increasingly rushed and stressful hospital environment. Medical-legal problems related to consent will diminish when patients have more opportunity to discuss their concerns. Work in the operating room will proceed with fewer delays and cancellations and be less stressful for all concerned.

In conclusion, there is compelling evidence that the development for pre-admission clinics has the potential to benefit Canadians both medically and financially. The Canadian Anaesthetists' Society supports the involvement of its members in this service as an essential part of modern anaesthesia practice.