

Procedure cancellation on the day of surgery should be a rare occurrence. Operating theatres are an expensive resource that needs to be efficiently utilised. The practical consequences of last-minute surgery cancellation and the psychological impact on patients should be unacceptable in a modern health care system. A lot of factors can affect the smooth progress of a patient through the process from booking of a case through to discharge from the recovery room. All are important, as the system is only as strong as its weakest link, for example, a relatively inexpensive factor such as the employment of porters to bring patients to the theatre suite can impact on the ability of expensive medical and nursing teams to facilitate surgery. Much effort has been expended to address this conundrum. For example, preoperative assessment clinics can decrease the likelihood of last-minute cancellations for medical reasons. This facilitates early identification of co-morbidities, improves and allows time for dialogue between specialist teams and gives adequate time for pharmacological or non-pharmacological interventions. They can also decrease costs and morbidity, and shorten hospital stay, and not surprisingly many Hong Kong hospitals are currently developing such services. The development of patient care plans such as for those with diabetes or persons undergoing a particular type of surgery can simplify management and reduce confusion over what is appropriate preparation. Likewise teams can be issued with guidelines on preoperative investigations. None of these is particularly difficult to achieve with some local modifications, as they have been tried and tested in other countries. However, they require cooperation between surgeons, anaesthetists, and physicians, as well as support from the hospital administration.

Local audits, such as that described in the interesting article by Chiu et al¹ in this issue of the *Hong Kong Medical Journal*, are extremely useful as they allow us to benchmark performance against internationally accepted standards, and based on such findings, attempt to improve practice. Whilst the

particular hospital reported in Chiu et al's audit is a busy tertiary referral teaching centre, its data may not be applicable Hong Kong wide. Nevertheless, similar results are likely to accrue in many of our hospitals and we should encourage every operating theatre service to carry out their own audits into factors that might possibly impact their efficiency.

Interestingly the major issue addressed by Chiu et al¹ was facility factors, particularly lack of available operating room time. Since public hospitals in Hong Kong employ their staff to run a set of operating theatres for elective work, there needs to be a cut-off time when elective surgery should be completed and an appropriate period allowed for recovery from anaesthesia and for post-anaesthesia care. This time requirement should comply with whatever is needed to allow a smooth running service. Audits of individual hospitals and operating team work practices should facilitate reasonably accurate prediction of the surgical and anaesthetic times necessary for any particular procedure carried out by a given team. It should then be relatively easy to determine what is achievable within allocated surgical sessions and plan on that basis. OVERRUNS will be inevitable, as complications and unexpected events can still occur, but based on statistical analysis provisions can also be made for these eventualities. Operation lists should be prepared a week in advance, so that resources can be directed accordingly. This would also make it easier to manage surgery that is known to take longer than a standard 8-hour session and is inevitable, particularly in a tertiary referral centre. Nursing time, portering, and all parts of the chain could then be strengthened.

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Reference

1. Chiu CH, Lee A, Chui PT. Cancellation of elective operations on the day of intended surgery in a Hong Kong hospital: point prevalence and reasons. *Hong Kong Med J* 2012;18:5-10.