Outpatient Surgery in Zhongshan Ophthalmic Center: Promise and Problems

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To the Editor: The Chinese government is actively advocating medical reform, aiming at reducing medical costs, and improving service quality. As to ophthalmology, transition from traditional hospitalized surgery to a predominant outpatient mode could be a solution. Zhongshan Ophthalmic Center (ZOC) is one of the largest and leading ophthalmic centers in China, where over 65,000 surgeries are performed annually. ZOC is now working on the transition toward outpatient surgery mode, improving both performance and efficiency.

Except for orbit surgeries and rare serious systemic conditions, outpatient surgery is the standard practice in developed countries. In the USA, 99% ophthalmic surgeries are performed in an outpatient setting.[1] Obviously, outpatient surgery is associated with a shorter waiting list, a lower cost, a shorter hospital stay, and reduced investment in medical facilities and personnel. Surprisingly, it also comes with less postoperative complications, better visual prognosis, and patient compliance.[2] Therefore, transition to outpatient surgery seems an appropriate choice.

We have been working on this transition over the past 3–4 years through various challenging situations. First, we have many complicated cases referred nationally and we used to spend more time with each case when the patient is hospitalized. While outpatient mode allows us to handle more patients, it also makes doctors avoid accepting complicated cases, as simple cases in large quantity are associated with better financial reward. Second, patient compliance becomes an issue. Patients with lower level of education have difficulty to understand surgery-related care.[3] The problem is magnified when total communication time is reduced between doctors/nurses and patients in the outpatient setting. Some financially restricted patients are intentionally lost to follow-up. Third, unlike the developed countries, China does not have a mature social support system. There are very few community workers and volunteers to help patients postoperatively, either inside a hospital or at offsite locations. Fourth, a supplementary support system needs to be established, and sample components include ophthalmology care navigator, both on-site and off-site; a concise but detailed instruction booklet for each surgical procedure for patients to take home; 24/7 telephone consultation support; emergency “green path”. Fifth, volunteers and social workers with certain medical knowledge and familiar with hospital settings and resources can be very helpful. If possible, hospitals could negotiate contracts with off-site hotels and commercial transportation to provide affordable service for the patients. Last, insurance companies and government need to update the insurance policies to encourage the operation of the outpatient settings; financial stimulus for outpatient surgery from administration could help facilitate this transition. For the financial challenged patients, the government and hospitals could work together to provide financial aid, and in some cases, free humane service for emergent surgeries.

In conclusion, we have achieved encouraging clinical outcomes in the ophthalmology care. The concerns and solutions proposed here require a systemic reform involving the government, insurance companies, hospitals, and social support. We hope that the experience from ZOC can help understanding and facilitating the
transition, and ultimately improving the quality and efficiency of the medical service, benefiting more patients nationwide.

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There are no conflicts of interest.

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