nearest kidney transplant unit as many potential donors as are available. In doing this doctors will need to enlarge their vision from concern for the patients under their own care to include other patients who may otherwise die.

From this survey it seems that a sustained campaign is required to improve the communication between doctors and nurses caring for potential donors and those working in kidney transplant units. These measures may be taken on a regional basis, as described for six large Liverpool hospitals by Sells and Heal.[4] National approval and support for such local schemes by the Department of Health and Social Security would be valuable and appears to be indicated.

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Hospital Topics

A Year in the Life of a Surgical Day Unit

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Outpatient surgery has been practised for a very long time. At a B.M.A. meeting in 1909 Nichol[1] reported on over 7,000 children operated on as outpatients at the Royal Glasgow Hospital for Sick Children during the decade 1899 to 1909. These included patients with hernia, harelip, and cleft palate, talipes, spina bifida, and tuberculous glands. One has some misgivings about the home conditions in Glasgow in the nineteenth century. Surprisingly, Nichol's account does not seem to have stimulated much interest in the practice, and little more was published until 1955, when Farquharson[2] described a series of 600 cases of hernia operated on under local anaesthesia and sent home the same day. These were done over a period of six years, averaging 100 a year. Subsequently, further series were recorded by Lawrie,[3] mainly of children, and by Stephens and Dudley,[4] Aldridge,[5] and Williams.[6] Most of the patients suffered from hernia and all were admitted to a surgical ward for the day and operated on at the beginning of a routine list. These arrangements inevitably put an extra burden on the ward staff and limited the number of patients that could be dealt with in this way.

The advantages of an entirely separate unit for day cases are considerable and were well described by Calnan and Martin.[7] An existing hut at Hammersmith Hospital was converted, providing a theatre unit and a small recovery ward, with the usual offices. Space was restricted, however, so that the number of patients dealt with was comparatively small—750 a year.

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This is an account of the work done in a somewhat larger unit in Coventry during 1971. It shows the much greater turnover that can be achieved with extra accommodation.

Present Unit

The possibility of a surgical day unit had been considered in Coventry for some years but no room for it could be found. Then in June 1969 the new district hospital was opened at Walsgrave and the bed situation was dramatically improved. We were fortunate in having a former maternity ward at Gulson Hospital in which the labour wards had been converted into an excellent theatre unit. The ward consisted of five rooms, each containing four beds, plus the usual supporting offices. It was thought that 12 beds would be sufficient, so these were provided in three of the rooms, leaving other rooms for a general purpose room, sister's office, secretary's office, patients' waiting room, etc. Only minor structural alterations were required and it was opened as a surgical day unit in March 1970. The unit has been in full use since 1 January 1971.

Nursing staff consist of one sister, one staff nurse, and two assistant nurses in the ward and one sister and three assistant nurses in the theatre, with the loan of a sister or staff nurse from the main theatres as required. Since my retirement I have had the overall responsibility for the running of the unit with the help of a full-time medical secretary. This is desirable and probably essential to ensure its full potential and to make adjustments in the programme. But clearly success depends ultimately on the keenness and devotion of the nursing and secretarial staff, and in both this unit has been fortunate indeed. General administration, preoperative investigations, and liaison with general practitioners and district nurses are all much the same as those described by Calnan and Martin[7] and are not repeated here. The

TABLR I—*Timetable of Work carried out in the Surgical Day Unit*

	Monday	Tuesday	Wednesday	Thursday	Friday
Morning	Dermatology, plastic surgery,* sclerocompression	Urology†	General surgery†	Orthopaedic surgery†	E.N.T. or dental surgery†
Afternoon	Minor ops.,* sclerocompression	Radiotherapy	Minor ops.,* sclerocompression	E.N.T.†	Sclerocompression

*Local anaesthesia
†General anaesthesia.

unit is open from 8 a.m. to 5 p.m. Monday to Friday and the timetable of work is as shown in Table I. The four sclerocompression sessions coincide with the operating lists done under local anaesthesia, when the ward staff are available to help. The work is shared between two consultants and two general practitioners.

Of the three lists done under local anaesthesia one is shared by the dermatologist (skin biopsies, pigmented moles, papillomata) and the plastic surgeon (excision of small scars, moles, papillomata, and sebaceous cysts). The two minor operating lists are done by preregistration house surgeons, who are under supervision in their early days, and consist almost entirely of sebaceous cysts and other superficial lesions. A total of 580 patients were dealt with on these three lists during 1971. The other six lists were done under general anaesthesia and were divided between general surgery, urology, orthopaedic surgery, and E.N.T. surgery. The radiotherapy cases were all inpatients and are excluded from this report. The senior anaesthetist, Dr. H. Rex Marrett, has for many years been interested in short anaesthetics with speedy recovery, and the registrars in anaesthesia are well versed in his technique. Each of three consultants and three registrars give the anaesthetics for one list a week. The numbers of cases dealt with in each specialty are shown in Table II.

A break-down of conditions dealt with in each of the various specialties is given in Table III. The urological cases were almost all cystoscopies, either diagnostic or for follow-up after cystodiathermy of vesical papillomata. "Ganglion" appears to be regarded in Coventry as an orthopaedic problem, while ingrowing toenail is equally divided between orthopaedic and general surgeons. The large number of fractured noses requiring manipulation is not a reflection of any undue violence in this city; most of them were the result of boxing or Rugby football injuries.

TABLE II—*Cases managed in each Specialty during* 1971

General surgery	438
E.N.T.	579
Urology	561
Orthopaedic surgery	225
Dental surgery	89
Plastic surgery and minor operations under local anaesthesia	580
Total	2,472

TABLE III—*Conditions dealt with according to Specialty*

General surgery:	
Varicose veins (mainly saphenofemoral ligation)	195
Cysts and lipomata	94
Ingrowing toenail	48
Anal fissure	38
Biopsies	35
Hernia	15
Vasectomy	14
E.N.T.:	
Myringotomy	221
Antral wash-out	130
Fractured nose	95
Turbinal diathermy	92
Ear toilet etc.	41
Orthopaedic surgery:	
Ganglion	67
Ingrowing toenail	48
Carpal tunnel syndrome	35
de Quervain's syndrome	21
Toes and others	57

In general surgery the type of case dealt with has been influenced by the number of hospital beds. Since the day unit was opened a few months after a considerable increase in hospital beds had been provided by the new district hospital at Walsgrave adults with hernia and children have been fairly easily accommodated as inpatients, so that the emphasis as regards day cases has been on varicose veins. In Coventry as elsewhere the standard treatment has for many years been flush saphenofemoral ligation and stripping; a not altogether satisfactory procedure and often a lengthy one. Fegan's method of sclerocompression has been practised somewhat sporadically and only to a limited extent. It has been clearly shown[8 9] that the best results are obtained by developing this treatment in a special clinic, and the day unit offered a great opportunity to do this.

Over 800 new cases were treated by sclerocompression during the year. In some 400 of these patients this was the only treatment given; the others had had previous surgery, usually saphenofemoral ligation with short-saphenous ligation where necessary. The waiting list for varicose vein operations, which was nearly 600 in 1970, is now under 50, and there should be no difficulty in keeping it under control by treatment in the day unit alone.

Comment

A surgical day unit can thus be shown to be of great value both to patients and to the hospital. The patient is helped by the reduction in the waiting time for most minor and "intermediate" operations; the commonly felt anxiety about the loss of independence involved by admission to hospital is removed; the prompt return home lessens the emotional reaction to operation and encourages a quicker recovery and a shorter convalescence; and for children and for mothers of small children the disruption of the family routine is averted.

The advantages to the hospital are more tangible. Firstly, the programme of a day unit can be elastic and adjusted from time to time to give help to any specialty with a current difficulty. In Coventry two main causes of anxiety were the long waiting lists for varicose vein operations and E.N.T. surgery. Varicose veins have now ceased to be a problem, and the impact of two E.N.T. lists a week has helped considerably to reduce this waiting list. There may develop a need for additional help in general surgery —for adult hernia or vasectomy, for example—or for urology or gynaecology. There is already a tendency to increase the number of children operated on for hernia in this unit.

Secondly, the economic benefit is considerable. Roughly 2,000 patients were operated on under general anaesthesia, and it seems reasonable to assume that each of these patients, if admitted, would have occupied a bed for three days. With an 80% occupancy the resulting 6,000 bed days would have needed 20 beds. This was the number of beds in the original ward, so there has been no appreciable saving in hospital beds. The cost of maintaining these 20 beds for a year, however, would have been about £70,000, whereas the total cost of the day unit for the year was less than £30,000; and this included the cost of all those patients not requiring general anaesthesia—the minor operations and sclerocompression.

Thirdly, and most important, is the saving of nursing staff. The nursing complement of a ward of 20 to 30 beds is about 16, whereas the total nursing strength of this day unit has been eight, four of whom work in the theatre. Morevoer, these nurses are nearly all married women who can manage a five-day week from 8 a.m. to 4 or 5 p.m. but who would not easily be available for other hospital work. Any hospital with wards closed on account of shortage of nurses would do well to consider converting one ward into a surgical day unit.

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