Prevention of pain is better than relief (6). In the selection of operative procedures, the amount of postoperative pain should be taken into account. For example, endovenous obliteration of varicose veins requires the extra investment of the necessary device and disposable catheters, but advantages as less postoperative discomfort and faster return to normal activities, as compared to conventional stripping, have been documented (7).

Preoperative education of the patient is important, surgeons should not only explain exactly what they are planning on doing (give procedural information), but also provide their patients with sensory information, i.e., information about possible unpleasant feelings postoperatively (8). Only combined sensory-procedural information gives the most benefit in reducing pain. During the operation, everything should be done to lessen postoperative pain; hence the use of nerve blocks and/or infiltration of wound edges are highly recommended. Also, pain management at home deserves attention to detail.

Clinical indicators:
It is recommended that units for Ambulatory Surgery use clinical indicators to monitor the overall quality of procedures. The International Association for Ambulatory Surgery (IAAS) advises the continuous registration of:
1) Cancellation of booked procedures, either failure of the patient to attend the day surgery unit (‘no show’ or ‘do not attend, DNA’) or after arrival of the patient, due to medical or organisational reasons,
2) Unplanned return to the operating room on the same day,
3) Unplanned overnight admission and
4) Unplanned return to the hospital after discharge home.
These indicators might be compared by data from other units or from the literature (benchmarking!) and might provoke the adaptation of certain procedures, when unsatisfactory results are obtained (9).

Professionals, unite! The Dutch experience:
Ambulatory surgery, in the Netherlands rather differently defined as a surgical procedure with a post-operatively required nursing time of at least 2 hours (up to a maximum of 8), is by now well established. The first units were founded in the seventies of the last century. In the beginning, incentives didn’t come from the government but from local hospital managers who visited ambulatory surgical centres in the UK and the USA. From 1985 onwards day surgery expanded tremendously partly due to a greater awareness of doctors and patients, but also due to a government-induced reduction of the number of hospital beds, also leading to the fusion of many smaller hospitals with large ones. At this moment, departments for ambulatory surgery are present in almost all hospitals, even in university hospitals: a few years ago, three university hospitals (Amsterdam, Groningen and Rotterdam) reopened their completely rebuild units for day surgery. In addition to these in-hospital units, many free-standing ambulatory surgery centres have been established. In 2004, 49 percent of all operative procedures were performed on an ambulatory basis, and this figure is expected to increase to 65 percent in the years to come. The data of the IAAS international survey on ambulatory surgery from the Netherlands are quite comparable with those from other countries like the United Kingdom, with minor exceptions only (10).

But of course, the accumulated data of all hospitals in a country don’t tell the whole story: there might be huge differences in the amount of procedures performed between hospitals.
This issue was investigated by Kroneman et al in 2003, who tried to was established in Brussels, Belgium. The Dutch Association was one link the number of certain procedures performed (curettage, of its founding members. One of the major challenges of IAAS is to cataract surgery and laparoscopic cholecystectomy) to available maintain a high quality of ambulatory surgery, and to improve the hospital-dependent variables as hospital size, number of beds development of ambulatory surgery all over the world. To do so, available (a relative shortage of beds would promote ambulatory IAAS initiates the organisation of an International Congress every 2 surgery?), number of GP’s (less burden on social network?), age of years. The next congress will be organised in Amsterdam, the popula the in explaining the results found, and it was concluded that more journal Ambulatory Surgery. Membership of IAAS is available for all detailed data on physician partnership and hospital National Associations for Ambulatory Surgery. circumstances are needed to do so.

To promote the understanding of people active in ambulatory surgery: both problems are not easily solved. But a much more important issue than volume and types of surgery, IAAS documented all national definitions, with translations procedures performed is quality improvement of day surgery. In in English, of the words day surgery, office-based surgery, extended procedures performed, IAAS initiates from time to time (preferably publication of a National Standard for Ambulatory Surgery. The every two year, but this seems to be too frequent due to the labour-development of this standard was initiated by the government, intensity of the task) the collection of national data, not from who asked the Dutch Normalisation Institute (NEN, Delft, the member countries only: provided the availability of a reliable Netherlands) to organise things. All parties involved in ambulatory contact, every country might participate. The core-issue was the surgeon (departments for ambulatory surgery, patients/consumers, selection of a basket of 20 procedures, suitable to cover all anaesthetists, surgeons, insurance companies, government) were essential aspects of day surgery. Procedures in the final basket invited to contribute to the composition of a protocol for included not only hernias and varicose veins, but also laparoscopic ambulatory surgery. The Dutch Association was supposed to cholecystectomy and laparoscopic-assisted vaginal represent all departments for ambulatory surgery. The Standard hysterectomy. The collected data were first published in 1998 (12), focuses on the patient passing through the process of day surgery, the second set in 2000 (10), a third survey of this kind will be An essential step in this process was strict requirements to be met. published soon. These surveys document the variability in the For example, in the guidelines, preoperative assessment has been number of procedures performed, and stimulate the discussion of given an important place. The role of the consulting nurse and the reason and outcome, for example during the annual meeting of anaesthetist was clearly defined. But likewise the representatives of the representatives of all member countries, where delegates after the patients/consumers appreciated the fact that it was agreed by reporting their local data discuss the obstacles present. No country all participants that in at least 80 percent of cases the waiting-time is perfect yet, or maybe ever will be perfect! Obstacles almost for a scheduled appointment with a consultant should not exceed always focus on problems with reimbursement of the procedures 15 minutes. The updated version of this National Standard is now in performed, and/or lack of interest of the medical profession in the process of evaluation. Once accepted every department for ambulatory surgery: both problems are not easily solved. ambulatory surgery has the choice to use it or not. But certification of the unit might become difficult when the Standard is completely It might be concluded that IAAS played and will continue to play a significant role in the promotion of Ambulatory surgery (14).

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To promote the understanding of people active in ambulatory surgery: both problems are not easily solved. But a much more important issue than volume and types of surgery, IAAS documented all national definitions, with translations of the words day surgery, office-based surgery, extended surgery, IAAS documented all national definitions, with translations procedures performed is quality improvement of day surgery. In in English, of the words day surgery, office-based surgery, extended procedures performed, IAAS initiates from time to time (preferably publication of a National Standard for Ambulatory Surgery. The every two year, but this seems to be too frequent due to the labour-development of this standard was initiated by the government, intensity of the task) the collection of national data, not from who asked the Dutch Normalisation Institute (NEN, Delft, the member countries only: provided the availability of a reliable Netherlands) to organise things. All parties involved in ambulatory contact, every country might participate. The core-issue was the surgeon (departments for ambulatory surgery, patients/consumers, selection of a basket of 20 procedures, suitable to cover all anaesthetists, surgeons, insurance companies, government) were essential aspects of day surgery. Procedures in the final basket invited to contribute to the composition of a protocol for included not only hernias and varicose veins, but also laparoscopic ambulatory surgery. The Dutch Association was supposed to cholecystectomy and laparoscopic-assisted vaginal represent all departments for ambulatory surgery. The Standard hysterectomy. The collected data were first published in 1998 (12), focuses on the patient passing through the process of day surgery, the second set in 2000 (10), a third survey of this kind will be An essential step in this process was strict requirements to be met. published soon. These surveys document the variability in the For example, in the guidelines, preoperative assessment has been number of procedures performed, and stimulate the discussion of given an important place. The role of the consulting nurse and the reason and outcome, for example during the annual meeting of anaesthetist was clearly defined. But likewise the representatives of the representatives of all member countries, where delegates after the patients/consumers appreciated the fact that it was agreed by reporting their local data discuss the obstacles present. No country all participants that in at least 80 percent of cases the waiting-time is perfect yet, or maybe ever will be perfect! Obstacles almost for a scheduled appointment with a consultant should not exceed always focus on problems with reimbursement of the procedures 15 minutes. The updated version of this National Standard is now in performed, and/or lack of interest of the medical profession in the process of evaluation. Once accepted every department for ambulatory surgery: both problems are not easily solved. ambulatory surgery has the choice to use it or not. But certification of the unit might become difficult when the Standard is completely It might be concluded that IAAS played and will continue to play a significant role in the promotion of Ambulatory surgery (14).