Editorial

Is the standard operating times system applicable to ophthalmology in the public health system?∗

¿Es el sistema tiempos quirúrgicos estándar (TQE) aplicable a la oftalmología actual del sistema sanitario público?

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The existence of surgery waiting lists (SWL) for obtaining access to various health services and more specifically surgical operations, gives rise to the necessity of establishing patient classification systems to determine the efficiency or performance of surgical activities (operating room time of use vis-à-vis available time), in order to determine the cause of delays in health services which may affect the principle of equity underlying our health system.

The most widely used patient classification systems in our environment (groups based on different diagnostic variants) apply the use of resources as unit of measure for classifying patients in homogeneous groups. In some cases, these systems can provide estimates on the severity of the diseases of said patients. However, these current systems are not too useful for assessing surgical performance,1 as they include a broad range of patients according to the duration of the surgical operation.

In order to resolve the patient classification problems in SWL, in 2006 the Health Service of Madrid (SERMAS) developed a standard surgical time grouping system (STG) which has the aim of enhancing clinical consistency and homogeneity as regards the required operating room time for carrying out each intervention.2

The STG system groups of the most usual surgical operations and classifies SWL patients in standard or optimum time operating room usage, i.e. it is based on the time an expert surgeon will take to perform each operation.

The initial phase of the development of STG groups began with the analysis of SWL patients in the SERMAS, classified according to the International Classification of Diseases (Review 9, Clinical Modification) (CIE-9-MC) with 2 fields for diagnostic and 2 for procedure to define the disease. Subsequently, a group of experts in each specialty defined the “STG Groups” in which the SWL classified their specialty, assigning to each group an STG or optimum time for the operation. STG groups should be limited, fully detailed (able to classify all the records in the waiting lists) and exclusive (each patient can be included in only one STG group). In addition, idle time was defined (the time required for preparing the operating room for the next intervention) for each of the STG groups; the highest STG time, established in 7 h, which constitutes a standard surgery session and the “weight of the intervention” related to

∗ Please cite this article as: Sánchez-Sánchez C, Won-Kim HR, Sales-Sanz M. ¿Es el sistema tiempos quirúrgicos estándar (TQE) aplicable a la oftalmología actual del sistema sanitario público? Arch Soc Esp Oftalmol. 2015;90:53–54.

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the retribution for each operation in an extraordinary working day.\textsuperscript{3}

Said system was validated in 2008, finding a high correlation ($r = 0.86$) between the actual operation times in each group and the time periods established by the experts.

The first review of said classification system was carried out in 2010–2011, increasing the details and the number of defined groups as well as a number of associations between procedures. However, despite these modifications, the validity of the system vis-à-vis the previous version was not improved, probably due to the quality of the encoding.\textsuperscript{2}

In ophthalmology, 29 STG groups has been defined for adults and 24 for children. In adults, the 24 STG groups correspond to isolated procedures, 4 to combined procedures and a final STG for the “remainder” (records which are unclassified due to having nonspecific code or belonging to infrequent diseases). As for children, 18 isolated procedures were included, 1 group for associated procedures and another group for the remainder.

Once implemented, the classification of patients with the STG system produces a number of advantages and some drawbacks. From the efficiency viewpoint, the most important advantage is that the standardization criteria have enhanced the knowledge of SWL management in a hospital (inclusion and exclusion from said lists depending on the available operating room time of a given specialty) and the complexity of the processes included therein. In addition, as there are comparable groups in what concerns surgical performance, it is possible to determine which departments are more efficient within the health system.

Another significant advantage for our specialty is that we no longer depend on the “operating room performance” as an indicator (percentage of operating room occupation time by a patient vis-à-vis the overall available time). In ophthalmology, where most of surgeries are carried out on an outpatient basis and many are quite short, operating room performance does not reflect true performance because it does not take into account the idle times which account for a high percentage when there are many interventions to be carried out in a single day.

The main, widely criticized drawback of this classification system is that the STG concept refers to optimum times for each intervention without taking into account that the largest number of operations are carried out in public hospitals that include teaching objectives which increase the duration of operations, with the ensuing influence on efficiency standards. In addition, it tends to penalize departments which perform associated surgeries because, even though they use up less resources and take full advantage of the operating room time, are not considered as an STG group, therefore underestimating the duration of an operation because it is considered as a single procedure.

If we consider that students become part of the medical training system and that the efficiency thereof is diminished to facilitate said training, perhaps and despite the current economic climate in which costs have reached top priority in the health industry it may be worthwhile to place a value on the reduced efficiency of said system in order to develop a model which values human resources training along with economic profitability.

On the other hand, it would be necessary to simplify the system because, despite the apparently easy classification of STG groups in diagnostics and clearly established procedures described in the CIE-9-MC, in order to achieve optimum classification it is necessary to have the assistance of administrative personnel as well as medical staff. This cooperation would increase the administrative workload for physicians who would have to fill in more forms in daily practice for the classification to meet quality standards, and this increases their already overburdened workload in order to meet surgical performance criteria which frequently do not match the reality of the treated disease.

Accordingly, even though the STG system is a useful instrument for hospital management and an efficient method for assessing operating room performance, it must continue evolving in order to adapt to the actual circumstances of operating rooms.

REFERENCES