Editorial

Everything has been thought of before

The 20th century should be viewed as the time when ambulatory surgery became viable, when it slowly came into acceptance, when we realized that hospitalization was not the only method of providing quality care, and when within its last decade we have seen the number of ambulatory surgical procedures in the United States exceeding the number of inpatient procedures[1]. We should no longer try to determine why this has happened; physicians and the public are now accepting ambulatory surgery. Ambulatory surgical care has proven itself to be cost effective, safe and convenient to the patient, the patient's family and the physician.

Even though ambulatory surgery was successfully performed during the early 1900s, there were few reports in the literature. Beginning in the 1960s, improvements in anaesthesia allowed for a significant increase in the numbers of ambulatory surgical procedures. In the 1970s hospitals began to support ambulatory surgery to allow for more beds to accommodate sicker patients in need of inpatient care.

Ambulatory surgery was first documented in 1909 when JH Nicoll of Glasgow informed the British Medical Association that 8988 operations on outpatients were performed at the Glasgow Royal Hospital for Sick Children[2]. Surgical results were as successful for outpatients as for inpatients. In 1916 Ralph Waters opened the Down-Town Anesthesia Clinic in Sioux City, Iowa (USA) for dental cases and minor surgery[3]. Within two years he enlarged the facility, moving into an office building in which 50 physicians and dentists had their offices. In 1937 Gertrude Herzfeld of Edinburgh reported on more than 1000 hernia repairs performed on children; many of these were done on an ambulatory basis using general anaesthesia[4]. In the late 1950s, a shortage of hospital beds in Canada provided the impetus for expanding outpatient surgical facilities in that country.

In the United States in the mid 1960s hospital ambulatory programmes were started at the University of California at Los Angeles and at George Washington University (Washington, DC). In 1970, the Phoenix Surgicenter (Phoenix, Arizona) opened its doors. A plaque in its lobby proclaims, "Dedicated to the principle that high-quality outpatient surgical care can be provided in a caring, personal environment, in a free-standing ambulatory facility at a lower cost than other alternatives." The free-standing ambulatory surgery programme had officially been launched; ambulatory surgery was rediscovered.

Whereas originally ambulatory surgery meant short procedures on American Society of Anesthesiologists physical status 1 or 2 patients, we are currently seeing more physical status 3 patients, more geriatric patients, and because of improved surgical techniques and instrumentation, a continually expanding list of acceptable procedures. As we view the future, less complicated procedures will be performed in physicians' offices, while more complicated surgeries will shift to the ambulatory setting. Add to this innovative methods of postoperative care (i.e. medical motels, home healthcare nursing, free-standing surgical recovery centres), and there is little doubt that the increasing complexity of procedures performed in an ambulatory setting will continue into the 21st century.

Developments that account for the recent rediscovery and growth of ambulatory surgery include: improved anaesthetic drugs, growing public interest in participating in personal healthcare, growing acceptance by surgeons, endorsement and encouragement by industry and health insurers, and the demonstrated safety of surgery in the ambulatory environment[5]. As ambulatory surgery continues to grow, we must never lose sight of a most important ingredient to ensure patient safety and overall quality of care in ambulatory surgery: careful selection of the patient and the surgical procedure.

In this issue, Gail Durant provides valuable insight into the growth of ambulatory surgery in the non-hospital setting, in the excellent article, 'Expanding the scope of ambulatory surgery in the United States' (pp. 173–178). The fact that the hospital is still a most important player in ambulatory surgery delivery should not be lost. However, as the surgical pie is being further divided more procedures are moving away from the hospital

setting to other outpatient sites. This shift in total ambulatory surgical activity is clear when one realizes that hospitals in the United States controlled slightly over 70% of ambulatory surgery in 1990 compared to nearly 90% in 1984.

Hospitals have always had an important role in ambulatory surgery. Free-standing surgery centres, on the other hand, as relatively new entrants, have grown and positioned themselves as strong competitors to hospital-based care. As a result, within a short span of time, we have noted an increased participation of hospitals in the free-standing arena, an increase in the number of free-standing centres owned and managed by hospital corporate chains, and an increase in the number of physicians' office-based surgery suites.

Achieving more cost-effective care has been a significant stimulus in the development of ambulatory surgery. However, unless the hospital bed the outpatient would have used is left empty, the healthcare system as a whole experiences greater costs because the system has effectively been enlarged. Thus, true savings from ambulatory surgery can only come from a global effort to contain, if not shrink, the healthcare system. Such appropriate initiatives include a greater reduction in inpatient surgical caseloads through bed closures, conversion of some acute care beds for chronic care, control of possibly excessive ambulatory surgery utilization, and a moratorium, or at least a reduction in, future facility expansion[5]. Nonetheless, it is incumbent on each of us to make selection decisions that put as much surgery as possible in the ambulatory setting without compromising quality of care.

Free-standing ambulatory surgical facilities may not be for everyone nor may they be the ideal method for every country. Being a medical director since the mid-1970s of a hospital ambulatory surgical programme that has cared for over 175 000 patients, I feel that hospital programmes with good planning can provide efficiencies that are the equivalent of free-standing facilities with the added security of support from all hospital services. The key to a successful hospital facility is to maintain separation of the outpatient from the inpatient whenever possible: registration areas, waiting rooms, holding areas, and postanaesthesia care are some examples. Physicians, nurses and ancillary personnel should never lose sight of the importance of taking care of the healthy ambulatory surgery patient; ambulatory cases should be scheduled as the first cases in every operating room theatre. Ambulatory surgery patients are not second class citizens compared to neurosurgical or cardiovascular inpatients.

Under healthcare reform that is being proposed in the United States it is likely that reimbursement for ambulatory procedures will be the same whether they are performed in a hospital or a free-standing facility. The advantage of cost-effectiveness will no longer be on the side of the free-standing facility. Hospitals will learn to compete; hospitals will have to become cost effective if they are to survive, whether it be their outpatient or their inpatient programmes.

To provide cost-effective care with satisfactory outcomes, in addition to the facility where surgery is performed, we must continually assess the importance of selection of appropriate surgical procedures, patients, patient preparation, equipment, technology, choice of anaesthetic, postanaesthesia care and discharge criteria. I am an advocate of ambulatory surgery and I feel that when a programme is properly thought out and implemented, ambulatory surgery can be performed to the satisfaction of the patient, patient's family and physician in either a hospital-based or free-standing facility.

Everything has been thought of before, Goethe suggested; the challenge is to continually improve, learning from our past experiences. And so it must be with ambulatory surgery.

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References

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