Ambulatory Surgery 1993; **1**: 204

Standards for ambulatory and office-based surgery

In an era of major change in health care delivery, the issue of standards of care emerges almost immediately because standards provide a means of measuring both utilization and quality of care. How and by whom standards are defined, as well as evaluation of adherence to them is an important issue. How and by whom they can be modified is yet another concern. Finally, the whole question of whether standards are necessary has been raised.

Implicit in any discussion of standards in health care is the assumption of their communal good; this is a difficult value to refute. Moreover, standards are an integral part of quality, an obviously desirable communal objective. The issue of who defines and evaluates compliance with established standards at once assumes some degree of urgency. One could argue that standards, once established, lead to a more algorithmic medical practice, obviating creativity and limiting physician choice. The apparent trade-off of individual freedom for community benefit with quality as the outcome measure is, for now perhaps, a more philosophical than real threat. In any case, this issue must be considered lest the quality of care revert to a mean rather than an ongoing pursuit of excellence.

Standards are established so that facilities can achieve accreditation or quality of care is assured. For the former, certifying bodies exist; each has similar points covered often with interpretation differences. Not infrequently, these differences are predicated on the population served (e.g. ASA 1 or 2, young, healthy elective cases) and not on a universal total population standard. Clearly, an assessment of patient risk is an integral part of any standard-setting exercise along with appropriateness of site and indications for the procedure. Preoperative evaluation and preparation for, and type of, anaesthesia are important issues. Age and the presence of chronic illness are factors to consider for both could increase risk. It is reasonable to match necessary preoperative testing to type of anaesthesia proposed and patient's health status. Such relationships have been established and variance from them could result in an unnecessarily poor outcome.

Standards are established to recognize or screen for a risk, allowing for preemptive management. The effectiveness of this risk assessment can be determined from the number of patients admitted after ambulatory surgery because of problems with preexisting disease conditions. Risk, complexity of procedure and anatomic site should be considered when deciding where a procedure should be done. Despite the growth of ambulatory surgery it is not appropriate for all cases. Some procedures require inpatient facilities, while others can be done in offices. Whether a procedure can be done in a specific site is different from whether it should be done there. This is a quality issue related to standards, and disagreements are frequently contentious.

Indications for the procedure should be documented in the medical record. Physicians as a group can define indications and adherence to them is expected. Lack of documentation – a critical problem – raises issues of quality of care.

Standards should be relevant to decreasing risk and minimizing cost without sacrificing quality or patient safety. Institution- and site-specific standards related to physiologic assessment, intra- and post-procedure monitoring, discharge criteria and postoperative instructions are clearly part of quality care and need to be in place and available for evaluation. Standards must be designed to give the highest yield of useful data to assure a quality outcome that can be identified and measured. The objective of standard setting is the assurance of quality care. When standards are implemented a high quality outcome is more likely.

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Accepted: August 1993

0966–6532/93/040204–01