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Editorial

Office-based surgery: learn from experience, not from mistakes

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And the Lord God caused a deep sleep to fall upon Adam and he slept. And he took his rib and closed his flesh in its place.

Does the book of Genesis, in fact, report the first case of ambulatory surgery? A successful outcome: without the need for patient selection criteria—there was only Adam; without the need for physician privileges—the only physician granted himself privileges in both anesthesia and surgery.

During the 20th century, the time during which ambulatory surgery rose to its place of prominence, we learned that a successful outcome by itself is not sufficient reason to continue; we learned of the need for appropriate patient and procedure selection criteria, credentialing of physicians and facilities meeting regulatory standards of care (i.e. national society, governmental and accreditation organizations).

Ambulatory (day) surgery in the US is now the tail that wags the dog. There are three main settings where day surgery is performed: hospital, freestanding and physicians office. Initially motivated, in the mid 1960s, by a shortage of hospital beds, now driven by a need to contain costs, ambulatory surgical care through improvements in technology and anesthetic drugs and techniques is fast approaching 70% of all surgical procedures. Many other countries have been moving in a similar direction, and if it has not already occurred, will soon reach a similar percentage of surgical patient care.

Procedures once considered too complex (i.e. procedure length, invasiveness, patient physical status, etc.) to be performed without overnight hospitalization, are now scheduled in hospital or freestanding ambulatory facilities. Paralleling this growth in day surgery procedures, there has been an increasing number of less complicated surgeries performed in physicians' offices. From 1984 to 1990 office-based surgery grew from 400000 procedures to approximately 1.2 million per year. Whereas currently close to 10% of all surgeries in the US are performed in an office setting, the SMG Marketing Group (Chicago, IL) estimates an increase to 14% by the year 2001. Growth will be driven by patient convenience, physician convenience and cost. These factors are as current today as they were in 1916 when Ralph Waters (considered by many as the father of the specialty of anesthesiology in the USA) in detailing the opening of his "down-town anesthesia clinic" wrote of convenience to physicians and patients, cost-effectiveness, physician independence from the hospital and the need for careful physical examination of the patient [1].

Porterfield and Franklin in reporting 16 years of office outpatient surgery (13000 procedures under local anesthesia with or without sedation, 5038 under general anesthesia) stated, "if general anesthesia is to be used in an office facility, the service of a trained, competent and compassionate anesthesiologist should be enlisted. This person must be delegated the responsibility for final selection of patients, including a veto power over the surgeons' selection. Only in this manner can a safe and effective environment exist for the benefit of patients" [2]. Far better than veto power is having open channels of communication, establishing mutual respect among surgeons, anesthesiologists and nursing staff-an understanding that all are working toward a common goal of patient safety.

Continued growth as projected by SMG will depend upon the ability of office-based surgery to meet the following criteria [3]: deliver high quality care, establish internal peer review procedures for quality assurance

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and utilization, gain accreditation from a national organization and obtain adequate reimbursement for facility expenses.

In addition to consumer and payer acceptance, continued growth is further dependent upon technological advances that will allow new and more complex procedures to be performed or shifted to the office setting. Who defines 'complex' cannot be left to the eye of the beholder; there is a need to establish independent guidelines. The patient who is scheduled for an office procedure, by virtue of location of care alone, will view the procedure as 'less threatening and less risky'. It is our responsibility to see that there is no increased risk by maintaining similar standards of care, similar standards of patient safety, regardless of whether a procedure is performed in a hospital, a freestanding facility or in a physician's office.

As we move toward the 21st century, preparations are in place for the projected growth of office surgery: (1) guidelines have been established by the American College of Surgeons which match intensity of anesthesia care provided (local, local with sedation and general/major regional block) with facility equipment and drug needs; (2) the American Society of Anesthesiologists with input from the Society for Ambulatory Anesthesia (SAMBA) is in the process of establishing guidelines for anesthesiologists; (3) there are three independent national organizations which can provide accreditation; (4) three states have passed regulations governing office-based surgery; and (5) a Society for Office-Based Anesthesia (SOBA) was formed in 1996.

At its Mid-Year Meeting 1997, SAMBA, a leader in ambulatory anesthesia education, citing office-based surgery as the fastest growing segment of all surgery, presented a full day conference on office-based anesthesia. Two of the presenters at that meeting have articles in this Journal issue. Both Lydia A. Conlay's 'The history of office-based anaesthesia', and Ian Smith's, 'Office-based anaesthesia: the UK perspective' recognize the need for guidelines; the importance of patient and procedure selection; the value of collecting outcome data; and the need for a trained staff.

We should learn not from the mistakes we make, but from the experience we have gained in managing the ambulatory surgical patient. There are no short cuts; office-based surgery is but an extension of ambulatory surgery. The surgical and anesthetic care provided in a physician's office must be equal to that provided in a hospital or free-standing ambulatory facility. Surgeons, anesthesiologists and nurses must work together to provide a safe environment for all patients.

Everything has been thought of before, Goethe suggested. The challenge is to continually improve, to avoid mistakes by learning from our past experiences. So it has been with ambulatory surgery, and so it must be with office-based surgery.

References

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