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Evolution in ambulatory surgery: unispeciality perspective

When establishing an office-based outpatient surgical unit, the unispeciality practitioner should be cognizant that constraining himself to performing only minimally invasive surgery is probably unrealistic. The surgeon must determine the full range of the procedures that are safely performed by members of his speciality in the outpatient setting, and gear his facility accordingly. Otherwise, the temptation will be to expand to accommodate these procedures without the proper policies and procedures in place.

There are pros, cons and issues to be faced when one contemplates construction of an ambulatory surgery unit. The issues and relative advantages and disadvantages impact the unispeciality practitioner in a much more personal way than they impact participants in a multispeciality unit.

Pros

Factors in favour of establishing a unispeciality unit include:

1. Greater surgeon control of the atmosphere and the ambience of the facility;
2. Greater surgeon control of the logistics of the care delivered, instrumentation, supplies, etc.;
3. Patient privacy and confidentiality (this may be speciality-dependent and is particularly meaningful relative to aesthetic surgery); and
4. As a potential profit centre – to enhance overall practice revenue.

Cons

The disadvantages of a unispeciality centre include:

1. Greater responsibility accrues to the owner/surgeon for all aspects of care – including anaesthesia and the nursing activities surrounding the surgical procedure;
2. An increase in liability relative to the increase in responsibility;
3. An increase in financial risk resulting from an era of patchy reimbursement of unispeciality facility services, lack of economies of scale that are inherent in multispeciality and large group-owned units and the need to meet high fixed costs, thus limiting discretionary time away from the practice;
4. A decrease in 'visibility' of the surgeon at hospitals and other health care facilities where other practitioners meet and see one another on a day-to-day basis. This may adversely impact the physician's referral sources: 'Out of sight, out of mind'.

Issues

The issues confronting the unispeciality surgical unit are really no different from the issues confronting the multispeciality unit or the hospital-based unit. It is simply that there are often fewer resources available to the solo unispeciality practitioner and less manpower with which to address the following issues:

1. Physical plant setup (meeting stringent building codes for surgery centres);
2. Capital for equipment;
3. Staffing and personnel;
4. Regulatory issues, including Occupational Safety and Health Agency (OSHA) and toxic waste management;
5. Credentialling;
6. Ongoing quality control and quality assurance;
7. Accreditation and certification;
8. Licensing.

The primary issue to be addressed by any practitioner, administrator or management team in any surgical centre setting should be continuous quality assessment and quality control (QA/QC). The concept of total quality management serves as a platform from which to address all issues that may impact a patient care delivery system. A well written policy and procedure manual serves as a template for the ambulatory surgery centre. Established policies and procedures become the bases for invoking controls, verification procedures and validations that carry out the QA/QC mission. This is a fluid exercise and never ceases.

All outpatient surgery centres should be subject to peer review and accreditation. These controls on utilization and standards serve the best interests of patients and providers alike.

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Potential solutions to pros, cons, issues, etc.

The solo practitioner is probably ill advised in today's practice climate to implement an outpatient surgery unit. However, for large single-speciality groups and multispeciality groups, the prospect of incorporating an ambulatory surgery unit into the practice setting becomes more attractive. The formula for establishing a successful outpatient surgery centre begins with shared risk.

Another group concept that is only now beginning to surface as a viable sponsor of the ambulatory surgery centre is the 'similar speciality' consortium – for example, plastic surgery, ear, nose and throat and ophthalmology or orthopaedics, hand surgery and neurosurgery or general surgery, gynaecology and urology. Hospital/physician joint ventures in outpatient surgery units are not applicable to unispeciality or 'similar speciality' modes, and, given the tenuous nature of these relationships – both from a regulatory and practical perspective – I believe they should not be recommended to individual practitioners.

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