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Editorial

Procedure selection guidelines: the time is now to prepare for the 21st century

With the development of rapid emergence anesthetics, with new surgical techniques and technology, ambulatory surgical procedures have moved far beyond selection guidelines of the early 1970's. Restriction on length of procedure or the need to be minimally invasive appear to have evaporated.

Who could have imagined that in the 1990's ambulatory facilities would be performing laparoscopic cholecystectomies and hysterectomies; lumbar and cervical microdiskectomies; anterior cruciate ligament repairs and shoulder stabilizations. What doors will be opened by the use of Magnetic Resonance Imaging operating rooms? Who among us is visionary enough to predict technologies that will be available and types of ambulatory procedures that will be performed in the next century?

Typically, each year ambulatory surgical procedure lists expand as we continue to discover we have not yet reached beyond the boundaries of acceptability; boundaries for which guidelines have not been established. Facilities must develop and adapt their own selection process to the continually evolving ambulatory surgery setting. Decisions must be based not only upon physical status of the patient or invasiveness of the surgical procedure, but must also take into consideration where the procedure will be performed: an ambulatory setting within the hospital; a freestanding facility that could be a distance from the hospital; a totally separated and possibly even isolated physician's office surgery setting. Regardless of the type of ambulatory facility, the underlying goal must be to maintain quality and safety. Past accomplishments must not lull us into a state of complacency.

Acceptable procedures for a given ambulatory facility should be established by an evolutionary process. On a periodic basis, the medical director with a committee made up of those physicians who use the facility must decide which procedures and which patients are appropriate for that particular facility, given the availability of equipment, staff and their capabilities, the ability and reliability of a given surgeon, and medical condition of the patient.

Although the length of a surgical procedure is generally not a contraindication; we have availability of short-acting fast emergence anesthetics. Longer procedures and those procedures ending late in the workday may be associated with an increased risk of overnight observation. Not a problem in a hospital ambulatory facility; not a problem in a freestanding facility that has extended recovery care; but a potential problem for a physician's office setting.

Procedures can be performed in an ambulatory setting if it is expected the patient will be sufficiently stable in the post operative period to be managed at home by nonmedical personnel or in time by themselves. Relative contraindications include procedures associated with significant blood loss or large fluid shift, large and difficult wounds at risk for bleeding, infection or other complications, delayed complications such as airway edema, inability to void, or difficulty with oral intake.

As we approach the 21st century, there will be increasing pressure from government, industry and healthcare payors to perform more complex ambulatory surgical procedures, to manage increasing numbers of patients with health problems. We will be continually challenged to merge excellence of care with lowering of cost. Future challenges may be as great, if not greater, than those faced in past years.

Selection criteria today are still being made by blending available information, clinical judgement, and intuition. We must rely upon outcome studies that not only address surgical procedure, patient physical status, anesthetic management, post anesthesia care, rate of unanticipated admission, patient and family satisfaction with the ambulatory surgery experience, but are also site specific. The time is now to prepare for the 21st century.

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