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Editorial

After-care: the changing look of recovery care

James H. Nicoll, in 1909, related his experience with 8988 outpatient surgical procedures (included, in addition to the usual childhood operations, were cleft-lip and palate repair, elevation of depressed birth fracture of the skull, pyloromyotomy, debridement of mastoid empyema) performed at the Glasgow Royal Hospital for Sick Children. His pioneering report to the British Medical Association included commentary on after-care. "That sucklings and young infants should remain with their mothers after operation... Even when the child is 'bottle-fed' separation from the mother is harmful... (for this reason). For seven years I have had a small house near the Glasgow Children's Hospital for the accommodation of young infants and their mothers. The mothers are catered for, and themselves nurse their infants. My experience of the cases so treated has been such as to make me confident... that no children's hospital can be considered complete which has not, in the hospital itself or hard by, accommodation for a certain number of nursing mothers whose infants require operation."

In the United States (USA), by the year 2005, it is predicted 82% of all surgeries will be performed as ambulatory surgical procedures, and of that number 24% will be managed in office settings. We are beginning to see and will continue to see patients with significant health problems; longer and more invasive surgical procedures testing the outer limits of acceptability. To meet the post-procedure needs of these two groupings as well as patients with inadequate social back-up, a number of innovative and extended after-care options are becoming more available. Rebecca Twersky, Society for Ambulatory Anesthesia (SAMBA) past-president, sees after-care as bridging "the gap between traditional inpatient length of stay and extended postsurgical recovery care in the outpatient settings." The modern evolution of extended after-care includes 23 h recovery, hospital hotels, home health care, and freestanding recovery centers.

1. Twenty three hour recovery

Over the past 20 years, in an attempt to provide after-care yet maintain outpatient status, hospitals in the USA have consolidated underutilized beds and developed 23 h guest services with limited or no nursing care; a family member or friend remaining with the patient. At the Methodist Medical Center of Illinois (Peoria, IL, USA) where I was medical director of the department of ambulatory surgery, we developed an in-hospital 12 room facility in 1978, referring to it as a hospital hotel. It was available for patients who did not require skilled medical/nursing care, had no one to provide home care, or resided a distance from readily available healthcare. During the same time frame hospitals also created 'observation beds' for patients who might need some degree of nursing/medical care for less than 24 h. Routine nursing care was provided; charges, although not always reimbursed, were often based upon an hourly rate.

2 Hospital hotels

Started in the mid-1980s, in close proximity to a hospital, hotel-like facilities might be devoted entirely to after-care or an existing hotel might provide designated rooms at lower cost, improved ambiance and comfort. Medical/nursing services might or might not be offered.

3. Home health care

Following a major procedure (i.e. vaginal hysterectomy) performed as the first case of the morning, the patient would be observed in the regular postanesthesia care unit until late afternoon at which time the patient would return home in an ambulance; a nurse would be in attendance or a nurse would visit the patient at home to provide necessary care.

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4. Freestanding recovery centers

The most recent approach to providing extended care for patients who need pain management, nursing care or physician consultation, are recovery centers. Recovery centers are usually part of a freestanding ambulatory surgical center (FASC). In spite of the support of patients, physicians, healthcare plans and the business community, regulatory constraints have limited the growth of recovery centers, particularly those seeking to provide 24–72 h of after-care; opposition is mainly from hospital associations. Currently more than 10% of 2500 FASC's in the USA have extended recovery care; that percentage will continue to increase for those centers providing after-care have reported a 6.5% increase in surgical volume and a high level of consumer satisfaction.

There is no doubt that more complex procedures will continue to shift to the ambulatory setting. Innovative approaches to postoperative care will provide a means for this transition to take place. Innovation is encouraged, but there is a need for outcome studies that assess safety, quality, and cost.

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