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Editorial

Office-based surgery: how should the International Association for Ambulatory Surgery proceed?

Bernard Wetchler has recently written a timely editorial on office-based surgery (OBS) in this journal and his sage advice should be heeded, that office personnel should not learn from their mistakes but rather from their experience gained in managing ambulatory surgical patients [1]. Indeed several publications on OBS have now appeared and it would seem that this sub-speciality is expanding rapidly within the USA [2–4].

Fortunately many of these articles have stressed the need for patient safety and although scientific evidence is minimal most would agree that OBS should never be performed solely for financial gain. But where does the International Association for Ambulatory Surgery (IAAS) stand as regards OBS should its affiliated countries turn to it for advice?

One of the prime objectives of the IAAS, founded in 1995, was the safe expansion of international ambulatory surgery. So far this Association has not established any guidelines on the subject of OBS and it would now appear prudent to consider this aspect of healthcare as a matter of some urgency. For instance there is a need to insist that ongoing quality assurance programmes should be routinely practised in every establishment conducting OBS.

Whitwam has also indicated that with the development of minimally-invasive surgery (MIS) anaesthetic techniques should also be reviewed. [5] In future monitored anaesthetic care (MAC) will flourish and anaesthetists may not remain the sole administrators of anaesthesia within ambulatory units and offices. Indeed if surgeons, radiologists, endoscopists and nurses become single-handed operators there will be a need for further training and supervision. To say that this increased work-load would be acceptable for already busy anaesthetic departments would be a gross understatement. However, if OBS was to spread across Europe ancillary assistance would have to be recruited to monitor and resuscitate day cases undergoing procedures in remote hospital departments or offices. Unlike several recognised training centres for MIS, the practice of sedation is at present uncontrolled and there are no specialist training facilities. The IAAS will need to advise on the siting of such centres, the formulation of appropriate sedo-analgesic protocols and a decision will also have to be taken as to whether nurses who perform the bulk of day case sedation should remain attached to anaesthetic departments. As one informed observer remarked 'here is a potential time-bomb situation just waiting to explode'. Hopefully the IAAS will consider these aspects of OBS and issue instructions accordingly.

Major and minor complications may arise after ambulatory surgery performed even in the best of units and all personnel involved in OBS should be aware of these problems [6]. They should therefore check that their premises, equipment, resuscitation skills and staff are equal to the demands made upon them. A recent editorial on British anaesthesia for electro-convulsant therapy may be relevant to the question of OBS [7]. Of the 40 hospitals studied the percentage of ECT patients having no pre-treatment medical assessment was 73%, no ECG monitoring (19%), no blood pressure recordings (46%), no trained assistance for the anaesthetist (49%) and no trained recovery nurses within the immediate recovery area (70%). Furthermore no defibrillation facilities were available in 11% of the ECT units studied. Clearly these standards are unacceptable and who is to say that such activities would not extend to innovative programmes of European office-based surgery? If safety is to be the prime goal in OBS then those involved in this sub-speciality should have a high index of suspicion and they will need to be aware that there is a wide variation in the interpretation of medical and nursing practices within different countries. With this in mind the IAAS should be seen to support safe OBS treatment and it ought to ensure that state, national and international guidelines are established and adhered to.

Previous UK experience of office dental surgery performed under anaesthesia has received much attention. Such practices were not without incident and during 1979 there were 11 deaths recorded in the dental chair for non-emergency surgery. The Wylie Report (1981) deplored the practice of a single person acting as both the operator and the anaesthetist [8] and the later Poswillo Report (1990) stressed that office-based dental anaesthesia should be deemed a post-graduate subject

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serviced only be accrediated anaesthetists [9]. Clearly there is a pressing need for the IAAS to educate and inform as many OBS practitioners as possible that such practices are not as simple as they may at first appear and that the cost of medical litigation could be disastrous for doctors, nurses and managers alike.

So how should the IAAS advise its members on the safety and acceptability of OBS? Every country should produce their own accreditation standards and as a first step OBS personnel should liase with their National Associations for Ambulatory Surgery. Furthermore as a starting point the IAAS executive could constructively debate Smith's excellent OBS paper which appeared in this journal [10]. Briefly he has outlined and modified the Poswillo Report recommendations concerning the use of general anaesthesia in OBS. For instance the use of general anaesthesia should be avoided if at all possible and the same standard in respect of personnel, premises and equipment should apply irrespective of where general anaesthesia is administered. In addition anaesthetic training should include specific experience in office-based anaesthesia. Furthermore, Smith has made other recommendations and these include the use of sedation by non-anaesthetists, minimal monitoring standards and resuscitation facilities. Finally he has listed the drugs essential for emergency situations. Certainly these guidelines could form the basis of an interesting debate at the forthcoming IAAS Congress in Venice on 25–28th April 1999.

In conclusion the expansion of OBS in the USA may yet sweep across Europe. The IAAS should be prepared for this eventuality. The surgeon's office is a hostile environment for the administration of general anaesthesia or sedation and it goes without saying that trained staff should be immediately available to meet any emergencies which will inevitably occur. In future if OBS is to succeed then appropriate programmes of quality assurance, research and education must be established as a top priority. All the multidisciplinary staff working in ambulatory surgery units and offices should be involved in these programmes and perhaps the IAAS through its own journal and international congresses could co-ordinate this complex exercise. In the meantime past experience should be heeded and countries establishing programmes of ambulatory surgery will require appropriate assistance and sound advice. At this point in time surely these countries should, in the first instance, be encourage to develop ambulatory surgery and then only after considerable experience they may wish to debate whether or not their own healthcare systems should embark on programmes of OBS.

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