Certification for Office-Based Plastic Surgery

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ABSTRACT

Office-based and freestanding ambulatory surgical facilities have become commonplace and the surgeries they perform more elaborate. Accreditation of all outpatient surgical facilities is necessary to maintain a standard of care that safeguards the patient and reduces liability for the physician. The accreditation entities that currently dominate the industry include JCAHO (Joint Commission for Accreditation of Hospital Organizations), the American Osteopathic Association's HFAP (Healthcare Facilities Accreditation Program), and AAAASF (American Association for Accreditation of Ambulatory Surgery Facilities). All of these accrediting bodies provide standards of operation that maintain a level of care and improve patient safety. We will examine the impact of certification in the safe operation of outpatient surgical facilities

KEYWORDS: Accreditation, certification, classification of facilities

Crawford Long, a dentist, first used ether for pulling teeth. It wasn't until the discovery of ether as a general anesthetic in 1847 by Dr. John Collins Warren that surgery could reliably be performed with an unconscious and pain-free patient. The success of that particular case led to use of ether as a general anesthetic for all applicable procedures. All this occurred within a few days in the Boston area.¹

In 1910, Dr. Ernest Codman first proposed a system by which a hospital would track a patient long enough to establish a treatment that was effective. If the treatment was not effective, the hospital would then attempt to understand why and modify their methods so that similar patients could be treated successfully in the future.

This simple principle resulted in the American College of Surgeons (ACS), the Joint Commission for Accreditation of Hospital Organizations (JCAHO), and the homogenization of standards of care for hospital, psychiatric, and dental facilities.²

The first freestanding day-surgery center was started in the late 1960s in Phoenix, Arizona, right

across the street from St. Joseph's Hospital. Dr. Ford and his crew of anesthesiologists developed the first outpatient day-surgery center. Hospitals were initially opposed to freestanding surgery centers. After some time, the substantial savings in time and money that freestanding outpatient surgery facilities provided their users became obvious, and freestanding surgery centers have flourished ever since. Insurance companies gradually not only accepted but even insisted on it. Today, outpatient surgery is ubiquitous for elective surgical procedures, and the hospital is mostly limited to those patients who have a serious illness or are high risk or whose insurance provider has contracts with hospitals and thus insists on all their members having surgery at a particular site. Currently, dentists and oral surgeons perform millions of procedures in an outpatient office-based setting.

The most prevalent source of accreditation for plastic surgery outpatient surgical facilities is the American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF).

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CLASSIFICATION TYPES

Outpatient surgical facilities are classified as A, B, or C.

A *type A* facility is defined as a facility where procedures are performed under local and or topical anesthesia.

A *type B* facility is defined as a facility where procedures are performed under intravenous or parenteral sedation, regional anesthesia, analgesia or dissociative drugs (excluding propofol) without the use of intubation, laryngeal mask or inhalation general anesthesia.

A *type C* facility is defined as a facility where procedures are performed using propofol, spinal or epidural anesthesia, endotracheal intubation, laryngeal mask airway or inhalation anesthesia by an anesthesiologist, certified registered nurse anesthetist (CRNA), or under the direction of an anesthesiologist.

Although the classification covers all types of facilities, it does not provide standardized methods by which local anesthesia and intravenous sedation should be administered other than to require heart rate, blood pressure, and pulse oximetry monitoring. Type C surgery centers rely on anesthesiologists to follow adequate guidelines in the administration of general anesthesia, however type B (and A) facilities must rely on the training and experience in sedation techniques of the operating surgeon. That may vary.

Certification of facilities is as important as board certification is for surgeons. The requirements for certification of outpatient surgical facilities are similar for the Joint Commission for Accreditation of Hospital Organizations (JCAHO), AAAASF, and the Healthcare Facilities Accreditation Program (HFAP). They will all inspect and certify compliance with the following:

- General environment
- Operating room environment
- Facility safety
- Handling of blood and medications
- Medical records
- Peer review and quality control
- Personnel

- Governance
- Americans with Disabilities Act (ADA) compliance

TRENDS IN CURRENT TRAINING

Most modern training programs are in a multidiscipline setting where surgeons depend on the anesthesiology department to determine the type and level of anesthesia that will be delivered to the surgeon's patient. This approach results in a reduced exposure for the surgeon to intravenous sedation techniques, and this results in a lesser likelihood that a surgeon will choose sedation once in private practice.

These training trends are resulting in the extinction of safe and reliable sedation methods for anesthetizing our elective surgery patients. This is a negative development as evidenced by the repeated published studies that find that morbidity and mortality can be reduced for patients undergoing outpatient surgery with the administration of sedation instead of general anesthesia.

Physicians and other practitioners routinely use conscious sedation in their surgery centers and offices. Generally, sedation is administered by the physician or under direct physician supervision. The administration of conscious sedation does not always require an anesthesiologist, and current techniques for the administration of conscious sedation are not regulated by any of the existing accrediting bodies.

It is possible that a standardized protocol for sedation procedures should be required for outpatient surgery facilities. Standardized practices would facilitate the monitoring of such centers, increase oversight, and maximize safety for their patients.

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