

REPORT OF THE SPECIAL COMMITTEE ON OUTPATIENT (OFFICE-BASED) SURGERY

Executive Summary

The Federation of State Medical Boards is a national non-profit organization whose membership includes all medical licensing and disciplinary boards in the United States and its territories. The Federation acts as a collective voice for its 70 member medical boards in promoting high standards for medical licensure and practice. At the Federation's April 2001 Annual Meeting, a resolution was presented by the Arizona Board of Osteopathic Examiners in Medicine and Surgery and approved by the House of Delegates requesting that the Federation establish a committee to evaluate problems associated with outpatient surgery and make recommendations as to the best method of regulating such practices.

In response, a Special Committee was appointed by Federation President George J. Van Komen, MD, in April 2001 and charged to develop recommendations to assist state medical boards in oversight of unregulated office-based surgery and educate licensees as to appropriate standards for office-based surgery. Special Committee members were carefully selected to represent physicians practicing outpatient surgery in regulated and unregulated settings, state medical boards and the public. Robert del Junco, MD, was appointed to chair the committee.

The Committee acknowledged at the outset that outpatient surgery in many settings was already regulated by an array of state agencies and accrediting organizations; however, surgeries performed in office-based settings were increasing and were, in most states, currently unregulated. Proposing guidelines for oversight of office-based surgery (see "Definitions") would involve addressing a multitude of complicated issues beyond basic questions about facilities, equipment and appropriate procedures. In particular, the Committee was divided on whether to exclude specific minor surgery from the guidelines, but opted to leave the issue of what threshold to apply in this regard up to the discretion of individual medical boards.

At its initial meeting in June 2001, the Committee reviewed statistics verifying the growing number of surgical procedures being performed in physicians' offices; surveyed existing state policies, regulations and statutes relating to office-based surgery; reviewed accreditation requirements from recognized accreditation organizations; and examined standards and guidelines relating to outpatient/office-based surgery from several medical professional groups.

Prior to the second meeting of the Committee in August 2001, the Committee reviewed materials from a number of outside entities, including the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC), the Institute for Medical Quality (IMQ), the American Society of Anesthesiologists (ASA), the American Association of Nurse Anesthetists (AANA), the American College of Surgeons (ACS), the American Academy of Dermatology (AAD), the American Medical Association (AMA), the American Osteopathic Association (AOA), the Anesthesia Patient Safety Foundation (APSF) and the Health Care Financing Administration (HCFA). The Committee agreed unanimously that input from these and other organizations was critical to successful completion of the committee charge and the ultimate acceptance of its recommendations by policymakers, regulators and practitioners.

At the August meeting, the Special Committee drafted model guidelines and identified three pathways that state medical boards can adopt separately or in combination for oversight of office-based surgery in unregulated settings. The three pathways are:

- Adoption of FSMB Model Guidelines
- Requiring accreditation by a recognized national or state accrediting organization
- Development of individual state standards

A state medical board following the first pathway would adopt the model guidelines recommended in the Special Committee report. These model guidelines are not intended to be all-inclusive, but outline basic policies and procedures that should be in place to ensure public protection in office-based surgery settings. The guidelines are divided into four sections: Administration, Quality of Care, Clinical, and Miscellaneous.

| Section | Issues Addressed |
|--------------------|---|
| 1. Administration | Governance Patients' Rights |
| 2. Quality of Care | Personnel Credentialing Patient Evaluation Informed Consent Medical Records Discharge Emergency & Transfer Protocols Reporting Requirements Peer Review |
| 3. Clinical | Anesthesia Monitoring Surgical Services Ancillary Services Facilities and Equipment |
| 4. Miscellaneous | Liposuction Laser Surgery Advertising |

The second pathway provides for accreditation by a nationally recognized accrediting organization in lieu of, or in conjunction with, specific state standards. Under the third pathway, a state could adopt individualized standards.

After a draft of the Special Committee Report was approved by the Federation Board of Directors in October 2001, the report was distributed to member medical boards and other interested parties with provisions for a 45-day comment period. Comments were considered by the Committee during two meetings in January 2002. At that time, the Committee agreed to name the report *The Report of the Special Committee on Outpatient (Office-based) Surgery*. A final draft was approved by the Board of Directors in February 2002 for adoption as Federation policy by the House of Delegates at the Federation Annual Meeting in April 2002.

Introduction and Charge

Before modern advances in anesthesia and medical technology, surgery was almost totally hospital-dependent.¹ As concerns about health care costs mounted during the 1970s, rapid advances in anesthesia, innovations in surgical techniques and technologic advances in equipment made surgery outside the hospital setting, or outpatient surgery, a more viable option for physicians and patients. A 1999 professional journal reported that, "In 1979, less than 10% of all surgeries were done as outpatient procedures. By 1987, almost 40% of 25 million operations done in America were done as outpatient procedures; by 1995, more than 50% were outpatient procedures. Currently, in the United States, more operations are done as outpatient (65%) than as inpatient (35%). It is estimated that, by the turn of the century, almost 70% of the anticipated 36 million operations performed in America will be done as

outpatient procedures... It is estimated that 15% to 20% of all outpatient operations are being done as office-based surgeries.”²

Ironically, as surgical procedures moved from hospitals to outpatient settings and subsequently to office-based settings, the logical transfer of the oversight function did not follow. While recognized national accrediting organizations accredit a large percentage of outpatient and ambulatory surgical centers today, most office-based surgery remains unregulated. Physician offices typically are not subject to the same state and federal licensing requirements as hospitals and other health care facilities, making it relatively easy to open an office-based surgical practice. In addition, some office-based procedures are not covered by health insurance plans and thus avoid another source of oversight afforded by third-party payers.

In the early 1990s, several untoward medical incidents in office-based surgery settings brought public attention to the lack of oversight and prompted Congressional hearings. Although the hearings highlighted the growing movement of surgical procedures to unregulated settings and exposed the unfortunate consequences of lack of oversight, no significant public policy changes emerged in response to the hearings. Surgery in office-based settings continued to increase through the mid-1990s when state governments began to discuss the need for standards to protect the public from inadequately trained practitioners, ill-equipped facilities, and preventable anesthesia-related incidents. Thus, patient safety emerged as the driving factor in seeking to set standards for office-based surgery.

Under the auspice of the FSMB, the Special Committee on Outpatient (Office-based) Surgery was formed to develop recommendations to assist medical boards in the oversight of office-based surgery and to educate those physicians as to appropriate standards of care. The Special Committee agreed that unregulated office-based settings should adhere to professional standards or accepted accrediting organization guidelines.

Pathways for the Oversight of Office-Based Surgery

The Special Committee on Outpatient (Office-based) Surgery has identified and recommends that state medical boards adopt (separately or in combination) the following three pathways for oversight of office-based surgery in currently unregulated settings:

- FSMB Model Guidelines;
- national accrediting organization standards; and/or
- individual state standards.

It is recommended that state medical boards consult with legal counsel prior to adopting guidelines, rules or regulations, national accreditation organization standards, individual states’ standards or publishing a position statement. Such counsel is intended to assure that the board’s action does not exceed its jurisdictional authority, restrict the practice of health care practitioners in a manner that is inconsistent with state law, or encroach upon the regulatory authority of other state health care regulatory authorities.

Section I. FSMB Model Guidelines

These guidelines are not all-inclusive, but outline the basic policies and procedures which physicians performing office-based surgery should have in place. The decision to mandate these policies is solely the decision of individual states. When adopting guidelines, state medical boards should establish by affirmative statement the threshold at which the guidelines will apply. Such a threshold may relate to the size of the practice, types of procedures performed, the level and type of anesthesia employed, and other practice-related specifications. Outpatient surgery facilities already regulated by a state agency are excluded from the guidelines.

1. Administration

Office-based surgical practices should be administered in a manner to ensure high-quality health services while recognizing basic patient rights.

1A. Governance. All office-based surgical practices should have policies describing organizational structure, including lines of authority, responsibilities, accountability and supervision of personnel. All such practices should have a medical director or governing body that establishes policy and is responsible for the activities of the facility and its staff. In solo practices, the physician may serve in this capacity. Administrative policies should be implemented so as to provide quality health care in a safe environment and ensure that the facility and personnel are adequate and appropriate for the type of procedures performed. Policies and procedures governing the orderly conduct of the facility should be in writing and should be reviewed annually. All applicable state and federal laws and regulations, local laws and codes must be observed.

1B. Patients' Rights. Patients should be treated with respect, consideration and dignity. The patient has the right to privacy and confidentiality. Patients, or a designated person when appropriate, should be provided information concerning the patient's diagnosis, evaluation, treatment options and prognosis. Patients should be given the opportunity to participate in decisions involving their health care when such participation is not contraindicated. Patients have the right to refuse any diagnostic procedure or treatment and be advised of the medical consequences of that refusal. Patients have the right to request information about a physician's professional liability coverage. Patients have a right to obtain a copy of their personal medical records. Facilities must comply with all state and federal statutes and regulations relating to patients' rights.

2. Quality of Care

Office-based surgical practices should develop a system of quality assessment that effectively and efficiently strives for continuous quality improvement.

2A. Personnel. All health care practitioners should have appropriate licensure or certification and the necessary training and skills to deliver the services provided by the facility. All personnel assisting in the provision of health care services must be appropriately trained, qualified and supervised and sufficient in number to provide appropriate care. Functional responsibilities of all health care practitioners and personnel should be defined and delineated. Policies and procedures for oversight of healthcare practitioners and personnel should be in place. Clinical information relevant to patient care should be kept confidential and secure. At least one person with training in advanced resuscitative techniques (e.g., ACLS or PALS) should be immediately available until all patients are discharged. All medical personnel, at a minimum, should maintain training in basic cardiopulmonary resuscitation.

2B. Credentialing. Credentials, including delineation of privileges, of all health care practitioners should be established by written policy, periodically verified and maintained on file.

2C. Patient Evaluation. A history and physical examination should be performed by the surgeon or his/her designee. The history should be current and reassessed by the surgeon on the day of the procedure. Pre-operative evaluation should consist of reviewing the patient history, conducting a physical exam,

providing for diagnostic testing and specialist consultation, developing a plan of anesthesia care, acquainting the patient or the responsible adult with the proposed plan, and discussing the risks and benefits of the surgery and alternative methods or treatments. Intra-operative evaluation should include continuous clinical observation and vigilant anesthesia monitoring. At least one person with training in advanced resuscitative techniques (e.g., ACLS or PALS) should be immediately available until all patients are discharged. Careful consideration should be given prior to providing services to infants and children.

The condition of the patient, specific morbidities that complicate operative and anesthetic management, the specific intrinsic risks involved, and the invasiveness of the planned procedure should be considered in evaluating a patient for office-based surgery. Nothing relieves the surgeon of the responsibility to make a medical determination of the proper surgical forum.

2D. Informed Consent. Informed consent for the nature and objectives of the anesthesia planned and surgery to be performed should be in writing and obtained from patients before the procedure is performed. Informed consent should only be obtained after a discussion of the risks, benefits and alternatives and should be documented in the medical record.

2E. Medical Records. A legible, complete, comprehensive and accurate medical record must be maintained for each patient. A record should include a recent history, physical examination and any pertinent progress notes, operative reports, laboratory reports and X-ray reports, as well as communication with other medical personnel. Records should highlight allergies and untoward drug reactions. Specific policies should be established to address retention of active records, retirement of inactive records, timely entry of data in records and release of information contained in records. All information relevant to a patient should be readily available to authorized health care practitioners any time the office facility is open to patients or in the event that a patient is transferred due to surgical complications. Patient information should be treated as confidential and protected from loss, tampering, alteration, destruction and unauthorized or inadvertent disclosure. Records should be organized in a consistent manner that facilitates continuity of care. Discussions with patients concerning the necessity, appropriateness and risks of proposed surgery, as well as discussion of treatment alternatives, should be incorporated into a patient's medical record as well as documentation of executed informed consent.

2F. Discharge. Discharging patients is the responsibility of the surgeon and/or the individual responsible for anesthesia care and should only occur when patients have met specific physician-defined criteria. Such criteria should be in writing and include stable vital signs, responsiveness and orientation, ability to move voluntarily, controlled pain and minimal nausea and vomiting. Written instructions and an emergency phone number should be provided to the patient. If sedation, regional block, or general anesthesia has been used, patients must leave with a responsible adult who has been instructed with regard to the patient's care.

2G. Emergency & Transfer Protocols. Written policies must be in place to ensure necessary personnel, equipment and procedures to handle medical and other emergencies that may arise in connection with services provided. At a minimum, there should be written protocols for handling emergency situations, including medical emergencies and internal and external disasters.

All personnel should be appropriately trained in emergency protocols. Adequate equipment for cardiopulmonary resuscitation should be immediately available.

There should be written protocols in place for the timely and safe transfer of patients to a pre-specified alternate care facility within a reasonable proximity when extended or emergency services are needed. Protocols must include a written transfer agreement with a reasonably convenient hospital(s) or all physicians performing surgery should have admitting privileges at such facility.

2H. Reporting Requirements. Reporting should be structured in a manner to consistently encourage a free flow of information. A state agency should be designated to receive incident reports resulting from office-based surgery. Any incident following surgery or administration of anesthesia in an office-based

setting that results in patient death within 30 days, unscheduled transport of patients to a hospital for observation or treatment for a period in excess of 24 hours, or unscheduled hospital admission of patients within 72 hours of discharge after office-based surgery should be required to be reported. Reporting requirements should be consistent with all relevant confidentiality laws and other regulations.

2I. Peer Review. Written procedures for credible peer review to determine the appropriateness of clinical decision-making and the overall quality of care should be established.

3. Clinical

Office-based surgery should be provided by qualified health care professionals in an environment that ensures patient safety.

3A. Anesthesia. The level of anesthesia used should be appropriate for the patient, the surgical procedure, the clinical setting, the education and training of the personnel and the equipment available. The choice of specific anesthesia agents and techniques should focus on providing an anesthetic that will be effective, appropriate and will respond to the specific needs of patients while also ensuring rapid recovery to normal function with maximum efforts to control post-operative pain, nausea or other side affects.

An individual administering anesthesia should be licensed, qualified and working within his/her scope of practice. In those cases in which a non-physician administers the anesthesia, the individual must be under the supervision of an anesthesiologist or the operating physician, unless state law permits otherwise.

All health care practitioners who administer anesthesia or supervise the administration of anesthesia should maintain current training in advanced resuscitation techniques (ACLS or PALS). Medical personnel, at a minimum, should maintain training in basic cardiopulmonary resuscitation.

The anesthesia provider should be physically present during the intra-operative period and be available until the patient has been discharged from anesthesia care. Procedures to be undertaken should be within the scope of practice of the health care practitioners and the capabilities of the facility. The procedure should be of a duration and degree of complexity that will permit patients to recover and be discharged in less than 24 hours or the maximum time allowed by state law, if applicable. Patients who have pre-existing medical or other conditions who may be at particular risk for complications should be referred to a facility appropriate for the procedure and the administration of anesthesia.

Patient care should be individualized according to patient needs and type of surgery performed. The health care practitioner administering the anesthesia, or supervising the administration should: perform a pre-anesthetic examination and evaluation, develop the anesthesia plan, assure that qualified practitioners participate, remain physically present or immediately available for diagnosis, treatment and management of anesthesia-related complications or emergencies; and assure provision of indicated post-anesthesia care. Patient assessment should occur throughout the pre-, peri-, and post-procedure phases. The assessment should address not only physical and functional status, but also physiological and cognitive status and should be documented in the medical record. The surgical procedure and anesthesia should be properly documented in the medical record.

3B. Monitoring. Monitoring equipment should be appropriate for the type of anesthesia and nature of the facility. There should be sufficient space to accommodate all necessary equipment and personnel and to allow for expeditious access to patients and all monitoring equipment.

Continuous clinical observation and vigilance are the basis of safe anesthesia care. Physiologic monitoring of patients should be appropriate for the type of anesthesia and individual patient needs, including continuous monitoring or assessment of ventilation, oxygenation, cardiovascular status, body temperature, neuromuscular function and status and patient positioning.

At a minimum, provisions should be made for a reliable source of oxygen, suction, resuscitation equipment and emergency drugs. In locations where anesthesia is administered, there should be appropriate anesthesia apparatus and equipment to allow appropriate monitoring of patients. All equipment should be maintained, tested and inspected according to the manufacturer's specifications. Back-up power sufficient to ensure patient protection in the event of an emergency should be available.

When anesthesia services are provided to infants and children, the required equipment, medications and resuscitative capabilities should be appropriately sized for children.

3C. Surgical Services. Surgical procedures should be performed only by appropriate health care practitioners who are licensed in the state in which he/she is practicing. Procedures to be undertaken should be within the scope of practice, training and expertise of the health care practitioners and the capabilities of the facilities. The procedure should be of a duration and degree of complexity that will permit patients to recover and be discharged from the facility in less than 24 hours or the maximum time allowed by state law, if applicable. Patients who have pre-existing medical or other conditions that may be at particular risk for complications should be referred to an appropriate facility for the procedure and administration of anesthesia.

3D. Ancillary Services. Provisions should be made for appropriate ancillary services on site or in another predetermined location. Ancillary services should be provided in a safe and effective manner in accordance with accepted ethical professional practice and statutory requirements. These services include, but are not limited to, pharmacy, laboratory, pathology, radiology, occupational health and other associated services.

3E. Facilities & Equipment. All office-based surgical facilities must comply with applicable federal, state and local laws and codes and regulations. Provisions must be made to accommodate disabled individuals in compliance with the Americans with Disabilities Act of 1990 (42 USC 12101 et. seq.). The facility should be clean and properly maintained and have adequate lighting and ventilation. The space allocated for a particular function or service should be adequate for the activities performed. The facility should be equipped with the appropriate medical equipment, supplies and pharmacological agents which are required in order to provide anesthesia, recovery services, cardiopulmonary resuscitation and other emergency services. All equipment used in patient care, testing or emergency situations should be inspected, maintained and tested on a regular basis and according to manufacturers' specifications. The facility should have appropriate fire-fighting equipment, signage, emergency power capabilities and lighting, and an evacuation plan. The facility should have the necessary personnel, equipment, and procedures to handle medical and other emergencies that may arise in connection with services provided. Appropriate emergency equipment and supplies should be readily accessible to all patient service areas. Hazards that might lead to slipping, falling, electrical shock, burns, poisoning or other trauma should be eliminated.

Procedures should be implemented to minimize the sources and transmission of infections and maintain a sanitary environment. A system should be in place to identify, manage, handle, transport, treat and dispose of hazardous materials and wastes, whether solid, liquid or gas. Smoking is prohibited in surgical areas. The facility must comply with federal and state laws and regulations regarding protection of the health and safety of employees.

4. Miscellaneous

Issues relating to oversight of office-based surgery will evolve as new technologies and procedures affect public demand. Two current issues are liposuction and laser surgery for which national guidelines are currently under discussion. Specific regulations relating to these issues should be defined by the individual medical boards along with protections from false, misleading, or deceptive information.

4A. Liposuction. Liposuction procedures should be performed by physicians with appropriate training following national professional guidelines. Procedures provided should be within the scope of practice of the health care practitioner and capabilities of the facility. Procedures should be of a duration and degree of

complexity that will allow patients to be discharged from the facility within a reasonable time period. States should be advised that national guidelines for liposuction are still in an evolutionary phase. At the time of this report, the American Society for Dermatologic Surgery (ASDS), the American Academy of Dermatology (AAD), the American Society for Aesthetic Plastic Surgery (ASAPS) and the American Academy of Cosmetic Surgery/American Society of Liposuction Surgery have issued formal guidelines.

4B. Laser Surgery. Written policies and procedures should be established, including, but not limited to, laser safety, education and training. In those cases in which a non-physician performs laser surgery, the individual should be under the direct supervision of a licensed physician unless state law permits otherwise. Evidence of safety inspection and preventative maintenance for equipment should be current and available. Policies should ensure a safe environment for laser surgery.

4C. Advertising. No practitioner should disseminate or cause the dissemination of any advertisement or advertising which is in any way false, deceptive or misleading related to office-based surgery. False, deceptive or misleading advertising should be grounds for disciplinary action by the practitioner's regulatory board. The American Medical Association Council on Ethical and Judicial Affairs addressed physician advertising and publicity in their Opinion E-5.02, updated in 1996.

Section II. National Accrediting Organization Models

Accreditation is an evaluation process that examines the quality of services provided in a particular surgical setting or facility compared to nationally established standards assumed to be indicative of quality care. Accreditation is for a specific period of time. Several nationally recognized organizations accredit ambulatory/outpatient surgery facilities; such accreditation certifies that the facility meets the organization's national standards.

In requiring accreditation as a model, the state defers the setting of standards to accreditation organizations, thus avoiding the necessity for development of independent state standards. The accrediting organizations should be responsible to and receive permits for accreditation from the appropriate state agency. Thresholds for requiring accreditation should be established by the state agency. Accreditation organizations apply standards in a variety of ways. How standards are organized and described varies by organization; however, generally they address the same basic list of parameters addressed in other states by rule/regulation and/or statute. These parameters include those outlined in Section 1 (FSMB model).

A state should assess the types of unregulated outpatient surgery performed in their state and the types of surgical facilities being utilized in determining if requiring accreditation is a valid option.

Currently accreditation of outpatient surgery facilities is conducted by a number of recognized national and state accrediting bodies. (See *Directory of Organizations, Section VI)

Section III. Individualized State Regulatory Model

A number of national medical professional organizations, as well as the above-referenced national accrediting bodies, have published standards applicable to office-based surgery. State regulatory agencies may choose to adopt some combination of national medical professional organization standards, recommendations from this report, and national accrediting standards to construct an individualized state regulatory model.

Section IV. Definitions

Accreditation Organization

A public or private organization that is approved to issue certificates of accreditation to outpatient settings. Some nationally recognized accrediting agencies include: American Association for Accreditation of

Ambulatory Surgery Facilities (AAAASF), Accreditation Association for Ambulatory Health Care (AAAHC), the American Osteopathic Association Healthcare Facilities Accreditation Program (HFAP) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Ambulatory Surgery Center

Used in this report to mean a licensed and accredited freestanding or hospital-based facility with an organized professional staff that provides surgical services to patients who do not require an inpatient bed.

Deep Sedation/Analgesia

A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients often require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

General Anesthesia

A drug-induced loss of consciousness during which patients are not arousable even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive- pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.⁴

Health Care Practitioner

A physician, dentist, podiatrist or other licensed health care professional.

Minimal Sedation (Anxiolysis)

A drug-induced state during which a patient responds normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are usually not affected.⁵

Moderate Sedation/Analgesia (Conscious Sedation)

A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are usually required to maintain a patent airway, and spontaneous ventilation is usually adequate. Cardiovascular function is usually maintained.⁶

Monitoring

The continual clinical observation of patients and the use of instruments to measure, display and record the values of certain physiologic variables such as pulse, oxygen saturation, level of consciousness, blood pressure and respiration.

Office-Based Surgery

Used in this report to describe surgery and other procedures performed in the office of a licensed physician.

Outpatient Surgery

A broad term used in this report to describe surgery performed in any regulated or unregulated free-standing or hospital-based facility, clinic or office that is organized for the purpose of providing care to patients with the expectation that they will not be admitted to the hospital.

Outpatient Surgery Facility

Used in this report to describe any facility, clinic, office, licensed ambulatory surgical center or hospital where outpatient surgery and/or other procedures are performed.

Physician

A doctor holding an MD or DO degree licensed to practice medicine.

Surgery

For the purposes of this report, surgery includes, but is not limited to, the excision or resection, partial or complete, destruction, incision or other structural alteration of human tissue by any means (including through the use of lasers) performed upon the body of a living human for the purpose of preserving health, diagnosing or curing disease, repairing injury, correcting deformity or defects, prolonging life, relieving suffering, or for aesthetic, reconstructive or cosmetic purposes, to include, but not limited to: incision or curettage of tissue or an organ; suture or other repair of tissue or organ, including a closed or an open reduction of a fracture; extraction of tissue, including premature extraction of the products of conception from the uterus; and, insertion of natural or artificial implants.

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Section VI. Directory of Organizations

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| <p>Accreditation Association for Ambulatory Health Care, Inc. *</p> <p>3201 Old Glenview Road, #300 Wilmette, IL 60091 (847) 853-6060 (Phone) (847) 853-9028 (Fax) e-mail: info@aaahc.org Web site: www.aaahc.org</p> | <p>American Academy of Cosmetic Surgery</p> <p>737 N. Michigan Ave., Suite 820 Chicago, IL 60611 (312) 981-6760 (Phone) (312) 981-6787 (Fax) Web site: www.cosmeticsurgery.org</p> | <p>American Academy of Dermatology</p> <p>P.O. Box 4014 930 N. Meacham Road Schaumburg, IL 60168-4014 (847) 330-0230 (Phone) (847) 330-0050 (Fax) Web site: www.aad.org</p> |
| <p>American Academy of Facial Plastic and Reconstructive Surgery</p> <p>310 S. Henry Street Alexandria, VA 22314 (703) 299-9291 (Phone) (703) 299-8384 (Fax)</p> | <p>American Academy of Ophthalmology</p> <p>655 Beach Street San Francisco, CA 94109 (415) 561-8500 (Phone) (415) 561-8533 (Fax) Web site: www.aao.org</p> | <p>American Academy of Otolaryngology</p> <p>One Prince Street Alexandria, VA 22314-3357 (703) 836-4444 Web site: www.entnet.org</p> |
| <p>American Association for Accreditation of Ambulatory Surgery Facilities, Inc. *</p> <p>1202 Allanson Road Mundelein, IL 60060 (847) 949-6958 (Phone) (847) 566-4580 (Fax) e-mail: aaaasf@sprynet.com Web site: www.aaaasf.org</p> | <p>American Association of Nurse Anesthetists</p> <p>222 South Prospect Avenue Park Ridge, IL 60068 (847) 692-7050 (Phone) (847) 692-6968 (Fax) Web site: www.aana.com</p> | <p>American College of Obstetricians and Gynecologists</p> <p>409 12th Street, S.W. Washington, DC 20090-6920 (202) 638-5577 (Phone) Web site: www.acog.org</p> |
| <p>American College of Surgeons</p> <p>633 North Saint Clair Street</p> | <p>American Medical Association</p> <p>515 North State Street</p> | <p>American Society of Anesthesiologists</p> <p>520 N. Northwest Highway</p> |

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2 Pandit, p.271-272.

3 American Society of Anesthesiologists, *Considerations for Anesthesiologists in Setting Up and Maintaining a Safe Anesthesia Environment*, 2000, p.16.

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7 The New York *Clinical Guidelines for Office-Based Surgery* are in litigation: New York State Association of Nurse Anesthetists v. Dr. Antonia C. Novello, New York State Department of Health and the New York State Public Health Council.

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