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Reconceptualizing the Preoperative Process

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In the last 10 to 15 years in Australian hospitals, the generally accepted "model of care" for elective surgical patients has changed, so that centralized preoperative assessment services led by anesthetists have become widespread.

While clinical practice has changed, the conceptual model for the preoperative process remains unclear.

The traditional model is based on a single channel of information flow and decision-making, starting at the surgeon's decision to operate. Subsequent stakeholders (including the anesthetist and hospital-based services) are seen as reactive to this process. Thus they function as "gatekeepers" or "checks and barriers," interrupting or diverting the patient care process when necessary. This model may no longer be an appropriate way of conceptualizing the preoperative process.

The increased complexity of medical comorbidities in surgical patients, the greater attention to the patient's personal needs and preferences, and the more proactive involvement of the hospital in planning surgical care processes make a different "model" of the preoperative process necessary. A new model **(Figure, next page)** was developed in 2007 and has been accepted by the State (New South Wales) Department of Health.

This model conceptualizes the preoperative assessment process as including 4 distinct groups of process factors (the surgical/procedural requirements, the patient's medical comorbidities, the patient's personal preferences, and the hospital requirements). The preoperative process acts to resolve these different factors into a perioperative management plan, which is then communicated to all those involved in patient care during the surgical episode.

This new model has proved useful to support the redesign of clinical and information management processes, to improve system efficiency, and to allow staff to develop a more appropriate understanding of their role in the perioperative process.

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