Who Owns Deep Sedation?

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Emergency physicians may be surprised to learn that their established deep sedation practice of past years is suddenly at risk because of an unusual privileging statement developed exclusively by anesthesiologists, wherein they propose to unilaterally regulate the deep sedation practice of all other specialties.1 This action capitalizes on recent confusing guidelines from the Center for Medicare & Medicaid Services (CMS).2 No new scientific evidence has triggered this controversial new chapter on deep sedation, and neither of the key documents are evidence based or cite any original research.1,2 Physicians, hospital administrators, and regulators need to be clear on what CMS has actually specified (compared with the anesthesia interpretation) and the broad ramifications of this calculated effort by one specialty to unilaterally dictate the scope of practice in a field long considered multidisciplinary.

ANESTHESIOLOGISTS GRANTING DEEP SEDATION PRIVILEGES TO “NONANESTHESIOLOGISTS”

The new 9-page policy from the American Society of Anesthesiologists (ASA), titled “Statement of Granting Privileges for Deep Sedation to Non-Anesthesiologist Sedation Practitioners,”3 declares that “anesthesiologist participation in all deep sedation is the best means to achieve the safest care,” and proceeds to outline how anesthesia chiefs should exclusively regulate local deep sedation practice by all other specialties.1 For emergency physicians and other nonanesthesiologists to receive deep sedation privileges, the ASA would first require a formal training program that includes, among other things, a written “knowledge-based test” on ASA policies and guidelines, and supervised “clinical experience on no less than 35 patients” to demonstrate competency in airway management. Residency or fellowship training would excuse one from the formal training program only if completed within the last 2 years and if accompanied by a supporting letter from one’s program director. Deep sedation privileges would then be granted on “a time-limited basis,” with ongoing maintenance requirements at the discretion of one’s anesthesia service—but requiring periodic reassessment of competence in airway management and continuing medical education “in the delivery of anesthesia services.” And this is just to sedate adults; separate credentialing mechanism would be required for children (again, with no evidence in support of such a change). Finally, they would require maintenance of advanced cardiac life support (ACLS) and pediatric advanced life support, or other such “certificate” attesting code skills.1 The ASA’s cited motivation for this action is patient safety; however, they provide no evidence to support any contention that sedation is currently unsafe or that there exists a problem that requires solving.1

The ASA’s credentialing requirements may be appropriate for practitioners with no experience or training in sedation but are unnecessary and counterproductive for a specialty already well qualified in the technique, such as emergency medicine. The sedation skills of the various specialties are far from homogenous, and the phrase “nonanesthesiologists” conveys the oversimplified and misleading message that anesthesiologists possess safe sedation skills, whereas all others do not. Emergency medicine residency and fellowship core curricula amply cover deep sedation’s requisite skills of advanced airway management, rescue and resuscitation, monitoring, and sedation pharmacology. Deep sedation is performed as part of routine, daily emergency medicine practice to humanely facilitate a variety of painful or anxiety-inducing procedures, particularly in children. Emergency physicians have a superb and well-established track record of safe deep sedation3-6 and are research leaders in this field.4-13 There is no evidence to suggest that emergency physician–led deep sedation is anything other than exceedingly safe. As affirmed by CMS, “. . . emergency medicine–trained physicians have very specific skill sets to manage airways and ventilation that is [sic] necessary to provide patient rescue. Therefore, these practitioners are uniquely qualified to provide all levels of analgesia/sedation and anesthesia (moderate to deep to general).”14

SHOULD ONE SPECIALTY DICTATE SCOPE OF PRACTICE FOR ANOTHER?

This effort by a single specialty to assert control over a well-established multidisciplinary field appears unprecedented. There are many areas of medicine in which a particular clinical scenario falls within the scope of practice of 2 or more different specialties (eg, carotid stenosis with vascular surgery and interventional radiology, skin surgery with dermatologists and...
plastic surgeons), but in none of them has the house of medicine endorsed the principle that one specialty can dictate the specific proper procedures and qualifications to the other. It is not difficult to imagine progress-thwarting situations that would arise if one specialty could prevent another from developing a different, and better, approach to a clinical problem. What if ophthalmology declared that any specialists wishing to perform ophthalmoscopy or slit lamp examination must first receive their formal certification and then pass the ongoing continuing medical education developed by that specialty? What if surgeons had been able to stipulate the training, credentials, and practices of interventional radiologists who developed a new way to drain abdominal abscesses? What if cardiothoracic surgeons had attempted to regulate and limit when and how cardiologists could perform angioplasty and place stents? What if emergency physicians or intensivists, as experts in resuscitation, suddenly announced that they would thenceforth supervise and credential all other specialists who wish to resuscitate critical patients, and none could do so without their review and approval?

Imagine if anesthesiologists had possessed such absolute authority over sedation 2 decades ago, when anesthesiologists were strongly opposed to the use of ketamine in the emergency department (ED). Emergency physicians would not have had access to what quickly became the first-line sedative for painful procedures in children. Anesthesia “oversight” at that time would have led to millions of children receiving less effective agents or physical restraint to accomplish their procedures while increasing the risk of harm. We have reviewed elsewhere how permitting one specialty excessive authority over a multidisciplinary field results in nonuniform care, hinders innovation, stifles interspecialty dialogue, and foments acrimony. Providing one discipline total control means that other specialties lose their voice; when leadership is neither collaborative nor benevolent, it can create barriers to effective and appropriate patient care.

ASA POLICY REVERSAL ON DEEP SEDATION

The ASA strategy to assume jurisdiction over deep sedation represents a substantial policy reversal on the part of that specialty. The multidisciplinary nature of deep sedation has been widely accepted for more than a quarter of a century and remains unquestioned in the most current sets of prominent sedation guidelines. The Joint Commission (TJC) respects the appropriateness of deep sedation by a variety of specialists and grants each institution the responsibility to govern such practice according to local needs and resources. In 2002, the ASA published detailed guidelines for sedation (including deep sedation) by nonanesthesiologists, explicitly acknowledging that multiple types of practitioners can and do regularly perform this intervention.

Subsequently, and without explanation or evidence, the ASA rejected the well-ingrained paradigm of deep sedation as multidisciplinary, declaring in 2004 that propofol (the most common deep sedation agent) should be “administered only by persons trained in the administration of general anesthesia.” In 2006, they asserted that deep sedation by any agent should be similarly restricted. These sweeping pronouncements puzzled emergency physicians because they were so obviously contrary to the reality of emergency medicine daily sedation needs and practice. The ASA cited no new scientific evidence to support this complete change in position and took this action without collaboration or input by other specialties.

In a signal that their deep sedation about-face was based on more than just patient safety, the ASA president in 2007 accused other deep sedation practitioners of being “poachers,” implying that these sedation cases were being improperly taken from anesthesiologists. The chair of the ASA’S Committee on Non-Anesthesiologist Privileging echoed this sense of encroached turf, saying that “some of the issues involved are surely financial.” To emergency physicians, it is peculiar that anesthesiologists might consider our sedations “poached” because these are our patients in our department.

Anesthesia’s recent change of direction seems to have been provoked not by emergency physicians reducing fractures with propofol, but rather by gastroenterologists who started providing deep sedation during elective colonoscopies and billing for the service. Unlike the ED, the endoscopy suite processes a stream of well-insured, healthy patients needing straightforward sedation during scheduled business hours, amounting to a multibillion-dollar revenue source.

An interesting confirmation that these guidelines are not driven by scientific evidence is that the European Society of Anaesthesiology recently released their own guidelines for propofol sedation by nonanesthesiologists. The need for anesthesia regulatory oversight is not even suggested, in conflict with the ASA position.

SEDATION ORGANIZATION UNDER AN “ANESTHESIA SERVICE”

In 2009, the ASA achieved a lobbying victory in their quest to oversee all sedation when CMS issued “revised hospital anesthesia interpretive guidelines.” This document stipulates 2 dramatic departures from TJC standards. First, all sedation provided in a hospital must be organized under a single “anesthesia service” (which is not mandated to be anesthesia but in most circumstances probably would be). In contrast, TJC specifies only that each hospital name a person or committee to oversee hospital-wide sedation practices, and this is left to hospital choice rather than thrust on anesthesia solely. Second, CMS inexplicably abandons the universally accepted paradigm of sedation as a continuum with sequential stages and instead dichotomizes the process into “analgesia/sedation” (which includes minimal and moderate sedation) and “anesthesia” (which includes deep sedation and general anesthesia). Such a reclassification contradicts both TJC standards and a quarter century of sedation guidelines and clinical practice.
requirements could include “distinctions among medical physicians, the letter acknowledged that privileging treatment for highly qualified practitioners such as emergency specific criteria appropriate for deep sedation privileging.” And meant that “facilities and medical staffs will use our statement as verbatim, the ASA president’s letter qualified that they really the language of their complex policy intended to be adopted their clarifying letter states that they are just suggestions.31

IMPLEMENTING SUCH LOCAL OVERSIGHT MANDATES A LITANY OF ONEROUS requirements for nonanesthesiologists, discussed earlier.1

HOW TO PROCEED AT YOUR HOSPITAL

The summation of these multiple statements and actions is one of confusion for emergency physicians and hospitals. CMS has affirmed the sedation skills of emergency physicians and the validity of our formal sedation guidelines yet paradoxically left oversight of our sedation practice in the hands of each hospital’s anesthesia service.2 The unilaterally developed ASA vision1 for anesthesia/sedation in surgical services, etc.”14 Finally, in contrast to the ASA strategy of sedation requirements determined solely by their single discipline, CMS says that “… hospitals are encouraged to develop the anesthesia services policies in collaboration with other hospital disciplines . . .”14

In response to emergency medicine concerns, in January 2011 the ASA president wrote a letter of clarification to ACEP, attempting to downplay their privileging statement.31 Despite the language of their complex policy intended to be adopted verbatim, the ASA president’s letter qualified that they really meant that “facilities and medical staffs will use our statement as a starting point when they consider how to establish institution-specific criteria appropriate for deep sedation privileging.” And although no mention is made in the statement of any different treatment for highly qualified practitioners such as emergency physicians, the letter acknowledged that privileging requirements could include “distinctions among medical specialties.”31

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Take a Stand on Multidisciplinary Versus Single Discipline Sedation Policymaking

CMS has mandated that ultimately each hospital’s medical staff is responsible for policy creation and implementation, whether delegated or not. Thus, every medical staff group must decide whether they want local sedation practice patterns developed in a collaborative, multidisciplinary fashion (the preferred approach recommended by CMS14) or a single anesthesia chief to decide all policy without consultation or discussion. If the latter, what is the mechanism for recourse when this individual’s decisions deviate from nationally accepted practice patterns and norms or the weight of scientific evidence? In either case, CMS will still hold the medical staff responsible for the results, so if the latter course is chosen another layer of review will have to be undertaken to be sure the policy is defensible to CMS and TJC.14

Evaluate the Economic Implications of the ASA Initiative

Each medical staff group must also carefully consider the implementation costs. The expansive ASA vision for deep sedation privileging entails what would almost certainly require multiday training sessions, essentially an altogether new “life support”-style course such as ACLS or pediatric advanced life support. And how will local anesthesiology groups find time to supervise the airway management of at least 35 patients per practitioner for each of the specialties requesting sedation credentialing? Who will cover these added expenses? Will they be passed on to patients?

Continue Current Practice as the Best Solution

We suggest that the likely best solution for all of this confusion and complexity is to return to what we were all doing before: governing local sedation with a multidisciplinary hospital-wide sedation committee, as specified by TJC.23 It can be called an anesthesia service to satisfy CMS but should remain a collaborative effort. According to the CMS revision accepting use of multiple sedation guidelines within a hospital, if a specialty has such established national guidelines, then they should be adopted verbatim14; if there are none, the committee will have to create them for that group of providers. The ASA statement for deep sedation privileging2 as written cannot apply in blanket fashion for all providers but may provide elements worth adopting on a case-by-case basis, particularly for specialists with little or no formal sedation training.

In this issue, the ACEP has issued a policy statement clarifying that it is “the authoritative body for the establishment of guidelines for sedation of patients in the emergency setting” and affirming that deep sedation (including propofol) is within the realm of emergency medicine practice.52 Separately in this issue, Mallory et al8 describe a strong safety profile in a sample of 25,433 pediatric propofol sedations administered by

Lobby for Retraction or Modification of the ASA Document

To accurately reflect the CMS position on emergency physician skills, the ASA document needs to be either retracted or modified to formally exempt us. Some anesthesia service chiefs will be practical and reasonable, but others may choose to proceed to implement the ASA statement regardless. This lack of clarity based on these conflicting documents has no doubt already fomented unproductive interdepartmental battles, in which unfortunately the outcomes often hinge on politics and turf rather than the strength of the underlying evidence or the benefit to patients.
emergency physicians, more evidence of the safety of our practice.

CONCLUSION
Procedural sedation at all levels is and always has been multidisciplinary, and its leadership belongs not to a single specialty but rather to all with the demonstrated skills and commitment to administer it safely. Emergency medicine has been at the forefront of safe deep sedation practice, and non–evidence-based efforts by another specialty to dictate our scope of practice should be vigorously opposed.

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REFERENCES
Request for Abstracts for ACEP’s Research Forum (non-moderated)

Researchers have a unique opportunity to showcase emergency medicine research published or presented in other specialties’ journals or meetings in the past year. This is an excellent venue to share outstanding emergency medicine research from competing meetings or journals.

ACEPs Research Forum is providing emergency medicine researchers with another opportunity this year to present scientific emergency medicine research at the 2011 conference, which will be held October 15-16, 2011 in conjunction with Scientific Assembly in San Francisco, CA.

Abstracts from emergency physicians who have presented or published in non-emergency medicine specialty meetings or journals within the past 12 months will be considered. Case reports or subject reviews are not considered original research. These abstracts will be accepted on a space-available basis as non-moderated posters. If accepted the presenter is obligated to be available to discuss their poster(s) with Research Forum attendees.

Please submit your research abstract(s) to the academic affairs department by Friday, August 26, 2011 at academicaffairs@acep.org, or by fax at 972-580-2816. Notifications will be sent by September 16, 2011. For questions, please call 800-798-1822, ext. 3291.