
THE WALL STREET JOURNAL

The Informed Patient: Hospitals Move to Curb Anesthesia Risk --- New Guidelines Require Training For Surgeons Who Give Sedation Without an Anesthesiologist

By Laura Landro
1,261 words
9 August 2006
The Wall Street Journal
D1
English
(Copyright (c) 2006, Dow Jones & Company, Inc.)

WITH MOUNTING CONCERN about risks from short-acting sedatives used in outpatient surgical procedures, **hospitals** are adopting strict new policies for the safe administration of the drugs, including new training to help doctors and nurses better respond when things go wrong.

Thanks in part to advances over the past few years in so-called conscious sedation, nearly 70% of surgical procedures are now performed in hospital outpatient departments, surgical centers and doctor's offices. With the latest sedating drugs, including fentanyl and Versed, doctors can now perform operations ranging from tummy tucks to cardiac catheterizations without the need for general anesthesia or an overnight hospital stay.

All this has helped boost demand for anesthesiologists and nurse anesthetists to administer the drugs -- demand they cannot always meet at busy **hospitals** and surgical centers. So more surgeons, gastroenterologists and other providers are pushing **hospitals** for the right to administer their own sedation. At the same time, some insurers are declining claims for anesthesiologist services during outpatient procedures such as colonoscopies.

The downside, safety experts warn, is that powerful sedatives are more often being administered by medical professionals who aren't adequately trained in anesthesia and safety practices, increasing the risks of respiratory complications, cardiac arrest, brain damage and even death. The University HealthSystem Consortium, which includes 95 of the nation's largest academic medical centers, says data presented at a recent meeting suggest there may be potentially 1,690 incidents a year nationwide related to sedation -- ranging from an overdose of drugs to a procedure that is started before a patient is adequately sedated.

Training and licensing standards vary from state to state. So to minimize risk, **hospitals** are adopting strict new credentialing programs for anyone who administers anesthesia, with recertification every two years. **Hospitals** are also conducting mock drills to test response in a sedation emergency and instituting stricter policies for monitoring patients.

"Advances in pharmacology have given us medicines that now permit much better patient comfort than ever before, but they also carry risks," says James Allen, professor of clinical internal medicine at the Ohio State University Medical Center and a member of a task force developing sedation guidelines for the UHC. "Because these drugs can cause more sedation than anticipated, the challenge is making sure the doctor not only has the skills to administer them but recognizes when there's a problem and knows how to deal with it."

UHC, which issued "best practice" recommendations for moderate sedation last year, is finalizing new recommendations for deep sedation, which will be issued this fall. Among its recommendations: that so-called rescue drugs to reverse the effects of sedatives be kept in the operating room, and that providers who administer deep sedation be trained in advanced life support, critical-care monitoring, and inserting breathing tubes.

The American Society of Anesthesiologists, which establishes practice guidelines for non-anesthesiologists used by UHC and others, is reviewing its policies on training and credentials for deep sedation, according to Orin Guidry, the group's president and an anesthesiologist at the Ochsner Clinic Foundation in New Orleans. At minimum, he says, any medical professional administering sedation "ought to be able to deal with sedation one level deeper than the one they intended to accomplish," says Dr. Guidry.

Conscious sedation involves sedative drugs that lower the level of consciousness, but don't put a patient completely under as with general anesthesia; patients can usually breathe on their own and recover more quickly. Under moderate sedation, which may be used for simpler procedures such as dental surgery,

patients can respond to verbal commands or light touch. While in deep sedation, used for more-involved procedures, patients can't be easily aroused and may need extra oxygen.

The most commonly recommended sedation drugs include fentanyl and Versed. A newer drug, propofol, is gaining popularity for colonoscopies and other procedures because it works quickly, deeply sedates patients and lets them recover faster. While there are drugs that can be given to reverse the effects of Versed and fentanyl, there is no antidote to reverse propofol.

Because individuals react differently to sedatives -- depending on factors such as age, weight, and use of alcohol or drugs -- it isn't always clear how deeply a patient will be sedated. Thus, a doctor or nurse experienced in administering moderate sedation, for example, may not be prepared to rescue a patient who slips into a deeper state or has trouble breathing. Patients who snore, are obese, have short necks or excessive facial hair (which makes it hard to seal a facial mask) may be at added risk for breathing complications.

Patients need to ask what type of sedation will be used for their procedure, whether there will be someone licensed to administer anesthesia if there is no anesthesiologist or nurse anesthetist present, and what equipment is in the room in the event of an overdose, such as rescue drugs and defibrillators, says Ellen Flynn, director of quality and accreditation at UHC.

With little or no regulation of procedures in surgical centers and doctors' offices in most states, patients may feel safer in a hospital. But even then, providers aren't always adequately trained for emergencies or don't have the necessary rescue equipment on hand, warns John Blenko, assistant professor of anesthesiology at the University of Maryland School of Medicine and a member of the UHC task forces on moderate and deep sedation guidelines.

In a survey of its members three years ago, the consortium found that 42% of **hospitals** don't require providers to have life-support training, even if a cardiac arrest team may not be available for more than five minutes. Only half of providers allowed to administer moderate sedation were trained in recognizing high-risk airways, or even basic airway management.

The nonprofit Joint Commission on Accreditation of Healthcare Organizations has required for the past few years that **hospitals** have clear policies for administering moderate and deep sedation, and that staffers have appropriate credentials to manage whatever level of sedation occurs. Still, in a survey two years ago, JCHAO found that 18% of **hospitals** weren't adhering to those standards. Robert Wise, the group's vice president for standards, says rapid growth in outpatient surgeries has raised "new concerns that the people who may not be qualified are using agents like propofol that they are more likely to get in trouble with."

Karen Domino, associate anesthesiology professor at the University of Washington in Seattle and chairwoman of ASA's committee on professional liability, notes that in an analysis in the journal *Anesthesiology* earlier this year, more than 40% of malpractice claims associated with sedative use monitored by an anesthesiologist involved death or brain damage. That rate is similar to general anesthesia claims -- and nearly half could have been prevented by better monitoring. "It serves to emphasize that sedative drugs can be very tricky, even with the care of an anesthesiologist," Dr. Domino says. "Patients may think it is safer than general anesthesia, but sometimes things just don't go well."

Email me at informedpatient@wsj.com.

Under Sedation

Questions to ask before surgery:

- What kind of anesthesia will I receive, and what are the risks?
- Will I be in moderate or deep sedation?
- How will blood pressure, pulse and oxygen levels be monitored?
- Will there be a qualified individual monitoring vital signs?
- What emergency procedures and rescue drugs are in place in case there's a complication?

Document J000000020060809e2890002a