Sedation: it is better to be safe than sorry

Editor—We recently came across an editorial in the *British Journal of Anaesthesia* entitled ‘Is sedation by non-anaesthetists really safe?’ written by Drs Webb and Hunter.¹ This topic is becoming more and more at the forefront in our specialty. After spending many years as an anaesthesiologist and taking care (hands on) of patients, including neonates and patients up to 106 yr old, using all types of anaesthetic techniques and agents, we personally cannot understand why any patient would want or allow a non-anaesthesiologist to anaesthetize them. The authors² of the editorial attempt to point out the pros and cons of the situations and to a great extent, we agree with them, but the fact remains an anaesthesiologist should be the one sedating patients, not someone else. Gastroenterologists love to use propofol when they perform their endoscopies, but when the patients get into trouble, cannot ventilate or oxygenate because the level of sedation is too deep, cannot follow commands, become hypotensive and apnoeic, who does the gastroenterologist ultimately call? An anaesthesiologist.

Conscious sedation is a tricky technique because the person administering the sedative is actually walking a ‘fine line’. The agent propofol is the drug most widely used and it is very easy to place a patient into a ‘deep’ sedation level, because of its narrow therapeutic index. A non-anaesthesiologist is less likely to recognize the varying levels of sedation and what to watch out for at each level. Moreover, if the patient stops breathing and needs to be rescued with tracheal intubation, does a non-anaesthesiologist know how to proceed? In fact, the propofol package insert states… ‘to be administered by those trained in general anesthesia’. Because propofol is the drug most physicians use for sedation during endoscopies, cardioversions, cardiac electrophysiology procedures, these patients must be monitored with EKGs, arterial pressure, pulse oximetry, and capnography. Non-anaesthesiologists may conveniently omit the use of these monitors. Hospitals and administration always look at the cost to them, but overlook the safety of the patient.

The controversy on whether or not a non-anaesthesiologist can administer propofol for sedation for various procedures is progressing even further. A more recent article published in the *BJA* October issue 2013³ suggests emergency room physicians to administer propofol as one i.v. bolus (1 mg kg⁻¹) to their patients and supplement when necessary. The authors² of the article concluded that propofol was safe in their series of patients when they gave it, even though they identified a ‘sentinel’ adverse event rate of 1.1%. Although they claim no adverse outcome, even 1.1% is too much. The authors now want to lower the dose to 0.5 mg kg⁻¹. If the ultimate goal is patient safety, then an anaesthesiologist is preferable because of their training and experience in administration of propofol, not ancillary physicians or non-physicians.

As we stated before, the authors of the editorial¹ point towards an anaesthesiologist to provide ‘sedation’ and we totally agree. The entire matter of who should provide ‘sedation’ and administer the drug, propofol, has recently escalated into the media (newspapers). An article was released into the *Wall Street Journal* (on September 26, 2013) indicating that a robot can be used to deliver sedation and therefore an anaesthesiologist is not needed in the procedural room. This technology will make money for the company, but what about the safety of the patient and the high quality of professional care provided by an anaesthesiologist?

One would think that anaesthesiologists would not want a ‘robot’ taking their place in an operating theatre anaesthetizing patients. The ‘robot’ is only to be used in ‘good risk’ patients. What about other patients who are not ‘good risk’? Gastroenterologists and other physicians need to then learn how to correctly assign proper ASA classification. The final question arises, why do men and women go to medical school? The altruistic reason is to learn how to take care of human beings in a compassionate manner with their God-given hands and minds. With robots, the practice of true medicine has depreciated to a great extent. Hats off to the authors¹ of the *BJA* editorial, to advocate for an anaesthesiologist to provide ‘conscience sedation’ to patients.

As we move towards the future, our professional speciality will only survive if we as anaesthesiologist remain the ‘Gold Standard’.

Declaration of interest

None declared.

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Utility of the N-terminal pro B-type natriuretic peptide biomarker to stratify patients undergoing emergency surgery

Editor—Searching for a biomarker that is both accurate and simple to use often results in compromise. We read with interest the study by Forzi and colleagues¹ assessing the role of N-terminal pro B-type natriuretic peptide (NT-proBNP) in identifying patients at high risk of adverse outcomes in emergency surgery and congratulate the authors on conducting a pragmatic study that reflects everyday practice.

However, we have concerns that using a universal preoperative NT-proBNP cut-off value of 725 pg ml⁻¹ as predictive of non-fatal MI, acute heart failure, or all-cause mortality,