

Office-based anesthesia in Belgium ?

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Abstract : For many years, office based anesthesia (OBA), has been considerably increasing in the US. This type of practice is starting to develop in Belgium. On the other side of the atlantic, legislation concerning this practice is becoming more and more precise, whereas the same isn't true in our country. It seems therefore opportune to try and define the different points of view. This article will define the position of the legislator, insurance companies and finally, of the professional organizations. OBA practice is developing insidiously here, and we should therefore ask ourselves serious questions regarding the legal repercussions that it could have.

To conclude, we can say that if for a couple of years, the US have started to legislate and propose guidelines, as well as creating special accreditation organizations to inspect and advise the offices, the same is not the case in Belgium. The OBA phenomenon arrived much later here and is really at its very beginnings, but it seems however important to anticipate and clearly regulate this practice in our country.

Key words : OBA ; guidelines ; rules ; practice.

INTRODUCTION

For many years, office based anesthesia, has considerably increased in the US. This type of practice is starting to develop in Belgium. On the other side of the Atlantic Ocean, legislation concerning this practice is becoming more and more detailed which is not the case in Belgium yet. It seems therefore desirable to try to define the position of the legislator, insurance companies and finally the professional organizations with respect to the feasibility of out-patient anesthesia in Belgium.

Although the majority of anesthetic procedures are performed in hospitals, they can also be carried out in a medical emergency department or in a doctors office.

The type of anesthesia for such procedures is not only local or topic, but may also include sedation, regional and general anesthesia.

Performing anesthesia outside a hospital setting is not new. The first case reports already appeared in Iowa 100 years ago, when Wauters performed anesthesia in his private office. In the US

the estimated amount of surgical acts performed outside the hospital has increased considerably these last few decades, growing from approximately 400000 procedures in 1984 to 8,3 million in 2000.

While during the 80's, transfer of surgical activity was noticed from the hospital to ambulatory surgery, and this for economical reasons, during the 90's such transfers took place to doctors consulting rooms.

In office based anesthesia (OBA), the ultimate stage of outpatient surgery, the cost for insurance companies and for the patient has been reduced considerably in comparison with in-patient surgery. The improvement of the various techniques either surgical (less invasive methods) or anesthesiological (drugs with short lasting activity, adequate monitoring of depth of anesthesia, adequate analgesia) has enabled the development of OBA.

If insurance companies have found great interest in this, it is also the case for the patient and surgeon while additionally avoiding the administrative burden of the hospital.

OBA practice is developing insidiously in Belgium, and we should therefore be considered regarding its possible legal repercussions.

THE SITUATION IN THE US

In the US, some medico-legal problems related to OBA practice, have led to regulations first in the state of Texas, later on in New-Jersey and Florida.

A study assembling data of 35 different insurance companies representing 50% of medical activity in the US throughout 2001, revealed 14 complaints related to OBA, out of a total of

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5480 complaints (dental damage not included). Patients were all nearly exclusively ASA I or ASA II with an average age of 45 years. Respiratory complications were responsible for 50% of the complaints while 25% were drug related. It was also shown that when a serious problem occurred in OBA it was more often fatal than in hospital practice.

At present, the ASA has published guidelines governing OBA. Unfortunately, to date there is no federal law in the US covering this kind of practice. Taking the state of Colorado, for example, the guidelines sustain that only ASA I and II patients should be accepted in OBA and exceptionally ASA III patients if their medical condition is stable. Excluded are some types of procedures such as intracranial, intrathoracic, intra-abdominal (except for laparoscopy) surgeries (> 4 hours), vascular surgery involving important vessels, vital or emergency procedures and procedures with important anticipated blood loss (> 4%). The selection is made under the joint responsibility of the anesthesiologist and the surgeon.

Certain frequently performed procedures, are detailed precisely. For example, liposuction, often performed in OBA but not without certain risks, is precisely regulated. A maximum of 5% of the total fat weight can be removed but should be limited to 1/3 of this maximum if this procedure is combined with another. Drug dosages are also limited to a maximum of 5 mg/kg of lidocaine and 5 mg/kg for epinephrine, the latter being used as a vasoconstrictor.

A preoperative visit with the anesthesiologist is compulsory. Informed consent is necessary and if the patient is at risk of complications, the procedure should be redirected to a hospital. The hospital is obliged to give full power in the form of a license and there must be written agreement with a hospital to deal with any possible complication. In addition, a written agreement should also exist with a medical center covering the transfer of a patient with a possible complication while for cardiopulmonary emergencies written guidelines should be available.

Surgeons, anesthesiologists and interns, should be prepared to get experienced in Basic Life Support and at least one person present should be accredited to Advanced Life Support.

Medical records should be classified and never destroyed or altered. Anesthesia should be performed by a specialist, by a nurse specialised in anesthesia practice or by an intern supervised by an anesthesiologist. Minimum monitoring is mandatory with respect to patient's oxygenation, ventilation, circulation and temperature which should continu-

ously be evaluated. The presence of the anesthesiologist in the room throughout the duration of any type of anesthesia is compulsory. Minimum equipment is required in the medical consulting rooms including electricity, suction, oxygen, drugs and emergency material. If the procedure is performed on a pediatric patient, the material and drug dosages should be adapted. If inhalation anesthesia is chosen an anesthesia machine with a breathing system is obligatory.

«Explosive and combustive» anesthetic products are prohibited. Postoperative surveillance is compulsory and patient's discharge is under the responsibility of the anesthesiologist. Moreover, to treat a malignant hyperthermia event, at least 36 vials of Dantrolene should be available in the operating rooms.

Furthermore, recent guidelines recommend that medical offices performing surgery, should obtain accreditation from a specific organisation. At this stage, three organisations exist to ensure the safety of medical offices. To do so, they have developed specific standards, perform inspections and advice offices which demand help.

THE SITUATION IN BELGIUM

The situation in Belgium is to this day extremely nebulous, and needs to be clarified. Several organisations have already made statements or have answered questions about the feasibility of performing anesthetic procedures in private offices.

The Medical Association Council : J. Coppine has stated that «the place where general anesthesia is performed is dependent on qualified personnel and on the technical equipment necessary for the proper execution of an anesthesia and of its eventual complications».«Deontologically, this could be performed outside a care unit, as long as these recommendations apply».«It seems nonetheless preferable, that such operations should be performed in a care unit, in the interest and safety of the patient».

These recommendations can be found in the official journal of the Association published on the 18/09/1976.

Another precision was added on the 14/11/1998 stipulating that «the anesthesiologist is not entitled to perform anesthesia if not all the safety conditions are fulfilled, with regard to the preparation of the patient, as well as the presence of necessary help and technical equipment».

The professional association APSAR stated that «anesthesia is a medical specialisation solely reserved to anesthesiologists, with the exception of certain treatments in dentistry, stomatology and ophthalmology, as well as esthetic surgery which does not give right to INAMI-RIZIV reimbursement».

The APSAR has not given yet its final opinion on OBA. In fact, it is not opposed to OBA as long as the competence and security conditions are fulfilled.

The INAMI-RIZIV stipulated that there is no specific financial reimbursement but :

- Fees for general anesthetics can be paid only if these procedures were performed inside a hospital (section 3, article 12 , paragraph 3.5).
- Any act conducted above or equal to K120 or N200 has to be done in a C unit (hospital or ambulatory surgery care unit) in order to be reimbursed.
- Reference to a general practitioner performing an anesthesia, has disappeared from the reimbursement list.
- Local anesthesia performed by surgeons is no longer reimbursed as such (even if the operation is superior to N200).
- Fees for anesthesia which is not performed by an anesthesiologist can no longer be honored.

However, these restrictions can be interpreted (Collinet, inspector at INAMI-RIZIV), in the sense that nothing can stop an anesthesia from being reimbursed in OBA if regional anesthesia or a sedative technique is performed and the operation has a code inferior or equal to K120 or N200.

Insurance companies covering civil responsibility consider anesthesia within the highest insurance rating, which is category 6. An extra premium up to 250€/year is asked for if the act is performed in a private office. The response of an insurance company covering civil responsibilities to the question «if there is extra premium subscription and/or is the practitioner insured to carry out ‘anesthetic procedures’ in his private consulting room such as :

- Sedation (eg. colonoscopy)
- Regional anesthesia (eg. therapeutical epidurals)
- General anesthesia (eg. dental extractions)».

is as follows : «information taken to the insurer, we can confirm that the coverage of private practice implies that any anesthesia performed by the insured within the scope of the «art of healing» either in a private office or in a clinic, is covered, as long as the matter of the legal exercise of medicine

is followed. Moreover, the insurer notes that any treatment known to be dangerous in consideration of actual scientific knowledge, is not covered. On these terms, this particular insurance company confirms that anesthesia performed in a medical office is covered in the framework of the above mentioned contract».

CONCLUSION

Whereas the US have started to legislate and propose guidelines, as well as creating special accreditation organizations to inspect and advise the offices, there is no parallel evolution yet in Belgium. The OBA phenomenon arrived much later here and is really at its very beginnings, but it seems however important to anticipate and clearly regulate this practice.

At present, if anesthesia is performed according to the usual rules, consisting of sedation or regional anesthesia, for operations with a code inferior or equal to K120 or N200, if the security conditions are adequate and anesthesia is performed by an anesthesiologist, there is nothing to prevent this type of anesthesia from being performed in a consulting room. Up to now, there is no jurisprudence covering important complications and the question arises as to whether or not a court of justice could rule in case of accident.

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