The December 2010 issue of the European Journal of Anaesthesiology published the so called : “European Society of Gastrointestinal Endoscopy, European Society of Gastroenterology and Endoscopy Nurses and Associates, and the European Society of Anaesthesiology Guideline : Non-anaesthesiologist administration of propofol for gastro-intestinal (GI) endoscopy”.

These Guidelines were signed by fourteen co-authors (among them are only two anesthesiologists) and the NAAP (Non-A naesthesiologist Administration of Propofol) task force members. ESA was approached by the European Society of Gastrointestinal Endoscopy (ESGE) to endorse these guidelines. Accepting that the shortage of anesthesiologists in Europe does not allow the administration of sedation to all requested GI endoscopic procedures by an anesthesiologist, the rationale of the ESA Board was that it would be preferable to collaborate with trained professionals to administer sedation with propofol, following these guidelines, rather than allow the current situation to continue. The ESA proclaims to have a look at the real world of the sedation procedures in Europe. Admittedly, there are not enough anesthesiologists to administer all sedations. Unfortunately in Europe or particularly in Belgium, we have no clear idea on the exact number of propofol sedations performed by non-anesthesiologists.

The SARB board was extremely surprised after reading these guidelines. We have the feeling that the manuscript has been written by GI practitioners using mostly references outside the anesthesiology literature. There is an increasing complexity of GI endoscopic techniques, requiring immobility during a prolonged time. Aged and sick patients are often candidates for these procedures. With an unpredictable amount of propofol given, deep sedation frequently turns into general anesthesia. This can lead to unexpected situations and subsequent attitudes.

If the guidelines recommend that a NAAP person is exclusively in charge of sedation care, they do not define that the caregiver who is in charge of the NAAP sedation is a doctor, a nurse or a technician. Up to now in Belgium, anesthesia is delivered exclusively by doctors. Europe is not a uniform continent with many different realities of health care and anesthesia facilities. What is required as a minimum to allow NAAP in providing sedation cannot be applied to all countries. Why does ESA not follow the ASA recommendations that propofol could be given by anesthesia trained personnel only. ASA has urged successfully the FDA to deny the petition of the gastroenterologists in the US.

Moreover, the guidelines recommend that the first human cases of NAAP performed by the caregiver could be supervised by a non anesthesiologist person who has obtained previous experience of at least 300 NAAP cases without any other detail with respect to the education programme. The guidelines also state that the NAAP caregiver could be autonomous after 30 cases without any reference or evaluation ! In Belgium, to become an anesthesiologist, a medical doctor has to follow 5 years of training, to pass university examinations and to succeed a final evaluation by the Flemish or French agreement commission.

The guidelines recommend that a complete evaluation pre-procedure should be done in order to exclude patients with difficult airway, other conditions at risk for airway obstruction and ASA class > 2. For these patients, the primary involvement of an anesthesiologist is simply suggested ! The SARB board has concerns regarding the individual who is going to perform the pre-evaluation of the patients and who is going to select the patients requiring an anesthesiologist or simply a “NAAP” person !

Finally, the guidelines propose not to monitor ECG or CO₂ in all cases and recommend but do not oblige SpO₂ monitoring ! The authors recommend, not in a clear way, that an anaesthesiologist should be available to help or rescue a patient if some complications appear ! The SARB does not understand how an anesthesiology department can provide pre-anesthesia screening and an “on-call” anesthesiologist to rescue the NAAP team, often far from the operating theatre, in case of cardiac resuscitation, without managing the patient undergoing a GI procedure under sedation ?

Guidelines have political, economical, professional and medico-legal implications. It seems that no consideration was given to these implications in various European countries. In Belgium, there are a number of anesthesiologists administering propofol and managing sedation cases. This raises the question about the interaction of the ESA with the National Societies. It would have been much better to circulate the proposed guidelines within the societies and individuals and ask for their input before publishing these guidelines.

The implicit approval by ESA Board of this document, its publication and implementation is a drawback in the History and Future of Anesthesiology in Europe ! Delegation of tasks to a “sedation-provider” in GI
endoscopy suite due to the reduced number of anesthesiologists in Europe constitutes an extremely dangerous precedent in Europe and another erosion of our profession. After these first ESA-NAAP guidelines, we cannot exclude the possibility that the same situation will be applied in future to radiology, neuroradiology, eye surgery and other procedures suitable to be performed under “Non-anesthesiologist sedation”.

The SARB does not support these ESA-NAAP guidelines in Belgium. Intravenous propofol administration for sedation is always a risk of loss of consciousness and to cross the frontier from conscious sedation to anesthesia. Since our first days of residency, we learned that light sedation can easily progress to a deeper level of unconsciousness and that the limits between deep sedation and general anaesthesia are not clear. The SARB refuses to sell our medical specialty to a new NAAP technician or nurse profession lacking complete control and supervision by an anesthesiologist. The SARB board declares that in Belgium, specifically trained nurses to manage a patient under sedation must be educated and trained under our complete control and supervision. Clearly, basic and advanced life support and previous experience in intensive care medicine do not provide enough skills to manage an anesthetic procedure.

During the last few decades in Europe and certainly in Belgium, there was an exponential increase in medical diagnostic and treatment procedures of all kind which do not require general anesthesia but on the other hand, are very uncomfortable and unpleasant. They require adequate analgesia or sedation. For this reason, a working group will start to write the Belgian requirements to educate specialised nursing caregivers dedicated to help the Belgian anesthesiologist.

In 2011, together with the BSAR-APSAR, we plan to edit a revision of our safety standards which will include the description of these requirements to guaranty the most secured help for the anesthetist during all the procedures and especially those outside the OR. As usual, before publishing our new Belgian Safety Standard recommendations for anesthesia and sedation, both associations will circulate the preliminary draft on their websites. Subsequently we will analyse and discuss your remarks and comments.

Thanks in advance for working with us to improve our profession towards an improved care for our patients.

Luc Barvais, MD PhD
SARB President
In the name of all the SARB board members:

Jan Poelaert, MD PhD, SARB Vice President
Eugène Vandermeers, MD PhD, General Secretary
Luc Herregods, MD, SARB Treasurer
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Vincent Bonhomme, MD PhD
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