Clinical Practice Statement:

Propofol and Other Sedating Agents Can Be Safely Used by Emergency Physicians without an Anesthesiologist Present (2/17/2012)

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Clinical Policy Statement:
It is the position of the American Academy of Emergency Medicine that emergency physicians must be permitted by hospital bylaws and credentialing procedures to utilize propofol (and other sedating agents) for the induction of procedural sedation, without an anesthesiologist present.

Summary:
A large body of research supports the assertion that propofol and other sedating agents, such as etomidate and ketamine, can be safely used by emergency physicians (EPs) without an anesthesiologist present. Propofol is particularly useful for inducing sedation and amnesia for patients undergoing brief painful procedures in emergency departments (EDs). Propofol has advantages over older sedative/amnestic agents such as benzodiazepines, which have longer half lives and potentially adverse risk/benefit ratios. Medical decisions must be made on a patient-by-patient basis, and benzodiazepines may be appropriate for some patients. However, emergency physicians' access to propofol must not be constrained by needless administrative or regulatory barriers.

In its updated regulatory bulletin of January 14, 2011[1] (1/14/11), the Centers for Medicare and Medicaid Services (CMS) revised and clarified some inaccurate or incomplete information contained in its prior document of December 11, 2009[2] (12/11/09). On 1/14/11, CMS unambiguously recognized that EPs are capable of providing procedural sedation services with propofol in EDs in a safe and effective manner. The updated CMS bulletin of 1/14/11 also incorporated previously overlooked, extensive scientific findings from the emergency medicine literature that were not considered by CMS in 2009. CMS also clearly stated that procedural sedation is a core competency of EPs, who typically possess the necessary skills and equipment to recognize and intervene in order to preserve patient safety with airway maneuvers, if moderate sedation becomes deep sedation (with blunted respiratory drive and/or loss of airway protective reflexes). The fact that there is no "reversal" agent for propofol (unlike benzodiazepines) was deemed irrelevant. CMS clearly communicated its desire for EPs to utilize propofol, stating, "…ED physicians have very specific skill sets to manage airway and ventilation that is necessary to provide all levels of analgesia and anesthesia." See Appendix 1 for more detail about these bulletins.

Background:
Procedural sedation is the technique of administration of sedative and/or dissociative agents, with or without analgesics, to produce an altered state of consciousness[3]. Procedural sedation is a

core competency for EPs, taught in all emergency medicine (EM) residency programs[4,5]. Procedural sedation is commonly indicated for patients with painful emergent traumatic conditions such as extremity fracture/dislocations, and for patients with medical conditions that require brief, painful procedures. Examples include synchronized cardioversion for unstable tachycardias, and incision and drainage of abscesses in areas not amenable to local anesthesia.

Emergencies requiring procedural sedation do not respect any schedule. Anesthesiologists are a scarce or unavailable resource for EPs during evenings and weekends. Anesthesiologists must also provide operative and obstetrical anesthesia. Patients in EDs deserve not to be relegated to waiting for an anesthesiologist, when time is of the essence, and when anesthesiologists cannot be counted upon to respond rapidly.