

## ***STATE MEDICAL BOARD OF OHIO - POSITION PAPER***

### **USE OF ANESTHESIA IN THE OFFICE SETTING**

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The economics of the managed care environment has significantly increased the number of surgeries performed under local anesthesia, with or without conscious sedation, in the office setting. The American Society of Anesthesiologists reported a three-fold increase in office surgery from 1989 to 1990, with the number increasing from 400,000 to 1.2 million per year. The State Medical Board's concern is for the safety of patients and the quality of care when anesthesia is administered in the office setting. The purpose of this position paper is to offer some guidelines for the use of anesthesia in settings other than hospitals or ambulatory surgical facilities regulated by the Department of Health.

#### Types of Anesthesia

Pharmacologically induced general anesthesia is intended to render the patient unconscious and nonreactive to pain and emotional stress. Unconscious sedation (deep sedation) is a pharmacologically induced depressed level of consciousness retaining a response to strong stimuli, but which may further lead to loss of airway reflexes. The use of general anesthesia and unconscious sedation is only appropriate in either hospitals or ambulatory surgical facilities. Conscious sedation is a minimally depressed level of consciousness in which the patient will respond purposefully to verbal stimuli. Anesthesia has progressed beyond conscious sedation if reflex withdrawal to painful stimuli is the only response which can be elicited. Regional anesthesia produces insensibility of a part of the body by interrupting the sensory nerve conductivity from that region of the body. Major conduction anesthesia (spinal, subarachnoid, caudal, epidural, peridural, saddle blockade and Bier blocks), although technically regional anesthesia, carries much higher risks of complications than peripheral or local regional anesthesia; it also may require very rapid conversion to general anesthesia. Therefore, major conduction anesthesia must be used only where and under the same conditions general anesthesia can be used. Some types of regional anesthesia, such as digital blocks and local anesthetics, are appropriate in the office setting.

The use of conscious sedation may be appropriate in the office setting, if the following guidelines are observed. Failure to abide by the guidelines could be construed as a departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, in violation of Section 4731.22(B)(6), Ohio Revised Code.

#### **Guidelines for Conscious Sedation in the Office Setting:**

The Ramsay sedation scale is useful for measuring and documenting the level of sedation. Under this system, a sedated patient is classified on a six-point scale:

- Level 1: Anxious, agitated or restless
- Level 2: Cooperative, oriented, tranquil
- Level 3: Drowsy but responds to commands
- Level 4: Asleep but exhibits a brisk response to a stimuli
- Level 5: Asleep and exhibits a sluggish response to a stimuli
- Level 6: Asleep with no response to stimuli

A patient at Ramsay Level 2 or 3 is ready for a procedure. Levels 5 and 6 constitute the onset of general anesthesia which goes beyond the desirable limits of conscious sedation.

Pharmacopoeia: New potent drugs continue to increase the anesthetic pharmacopoeia. There is no universally safe and effective dosing regime for attaining conscious sedation. A protocol should be developed for the use of these drugs. Ultra short acting barbiturates, such as ketamine and propofol, must be used with utmost caution in the office setting. Pharmacological antagonists, such as naloxone hydrochloride and flumazenil, must be available for use.

The Pre-Op Evaluation: Patients with significant cardiopulmonary and/or neurologically compromised status must be considered for the hospital setting. A focused physical examination must be performed and at least the following factors should be taken into consideration when deciding whether anesthesia in the office setting is appropriate:

1. Abnormalities of major organ systems.
2. Previous adverse experience with sedation/analgesia, as well as regional and general anesthesia.
3. Current medications and drug allergies.
4. Times and nature of the last oral intake.
5. History of tobacco, alcohol or substance use or abuse.

The patient should be informed of the benefits, risks and limitations associated with conscious sedation and possible alternatives. Informed consent must be clearly documented.

Equipment: The following is necessary for conscious sedation: oxygen (wall source or portable tanks), suction sources (wall source or portable), emergency cardiac medications, nasal oxygen cannulas (simple and nonrebreathing oxygen masks), ambu bag and assorted masks, oral and nasal airways, endotracheal tubes and stylet, laryngoscopes (at least two), continuous pulse oximeter, continuous electrocardiograph, blood pressure monitor, temperature monitor, intravenous access and method to summon additional help.

Personnel: Individuals administering medications for anesthesia should have appropriate clinical pharmacological training and must be legally authorized to administer anesthesia.<sup>1</sup> A designated qualified individual must be exclusively assigned to monitor the patient; when conscious sedation is being used, this should be the same person who is administering the anesthetic agents. An individual must be readily available who is experienced in airway management and advanced cardiac life support.

Monitoring during procedure:

1. Level of conscious sedation - Verbal commands should be used to evaluate the depth of sedation according to the Ramsay Sedation Scale. This would allow adverse drug reactions or sedation that has progressed beyond the desired level to be diagnosed and treated in a timely manner to avoid cardiovascular decompensation and cerebral hypoxia.
2. Pulmonary ventilation - Hypoxemia is detected much earlier with the use of a pulse oximeter than with clinical assessment. Therefore, the use of a pulse oximeter is highly recommended during the procedure. Although supplemental oxygen may be used to treat mild early hypoxemia, it must be recognized that such use may delay the detection of an underlying serious problem causing the hypoxia.
3. Blood pressure should be monitored regularly at intervals of five to ten minutes during the procedure.
4. Continuous use of electrocardiography is recommended in patients with a history of cardiovascular compromised state or predisposing factors for cardiovascular disease.

Records: All medications, the dosage and time of administration should be recorded. Vital signs, blood pressure and respiratory rate should be recorded every five to ten minutes. Patients with cardiovascular compromise or predisposing factors for cardiovascular disease should have continuous cardiac monitoring which should be documented in the record.

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<sup>1</sup>Allopathic and osteopathic physicians may administer anesthesia. Podiatrists are authorized to administer or to supervise the administration of local anesthesia and conscious sedation in the office setting within the scope of practice of podiatry. Certified Registered Nurse Anesthetists are authorized by Ohio Revised Code Sections 4731.35 and 4723.43 to provide anesthesia with the supervision and in the immediate presence of a physician or podiatrist. Ohio Revised Code Section 4731.36 permits a dentist to administer anesthesia. Physician Assistants are permitted to administer local anesthetics (such as digital blocks) in connection with the care and suturing of minor lacerations only, but are otherwise not authorized to administer, monitor or maintain an anesthetic (See, Section 4730.03(E), Ohio Revised Code).

Following the Procedure: Vital signs should be checked every five to ten minutes for a minimum of 30 minutes following the last IV sedation dose. If the patient is progressing normally, vital signs can then be checked every fifteen minutes until the patient returns to the pre-procedural state.

Discharge Criteria: Discharge criteria should address the following issues:

1. Vital signs and oxygen saturation levels are stable
2. All reflexes are completely recovered
3. The patient is alert and can sit unaided
4. The patient can walk with assistance
5. Nausea and dizziness are minimal
6. Hydration is adequate
7. The patient is being discharged into the care of a competent adult

The patient should be given written post-op instructions and a 24 hour emergency contact number upon discharge.

*This policy or position statement is only a guideline and should not be interpreted as being all inclusive or exclusive. The Board will review possible violations of the Medical Practices Act and/or rules promulgated hereunder on a case by case basis.*

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