

## The sedation issue: accumulating data while failing to advance towards a solution?

Key words: Sedation. Sedation. Efficacy. Security. Efficiency.

Dear Editor,

After reading the monographic issue of April 2018 of *REED* that was devoted to sedation in digestive endoscopy, I was compelled to share the following reflections:

1. Nearly all sections (editorial, originals, special article and letters to the editor) showed that the endoscopist-anesthesiologist rivalry remains the main focus since the almost forgotten editorial of January 2005 (1). This antagonism has had a number of effects, including a skyrocketed implementation of "endoscopic" sedation at Spanish units, which is a benefit that can be generalized to the entire patient population. However, there is no doubt that it may also compromise endoscopy results for a given patient in a given center at a given moment.
2. More or less explicitly, original papers (2-5) are primarily or exclusively aimed at demonstrating the safety of propofol administered by an endoscopist. The effort to accumulate such data, always favoring endoscopists, is no less surprising as it means playing the match away in the anesthesiologists' ballpark, where sedation by endoscopists has always been questioned.
3. For each individual endoscopist, prejudice and, above all, postjudice (personal experience that is neither quantifiable nor analyzable) strongly tips the scales for or against "anesthetic" sedation.
4. Finding a solution seems very difficult since both opposing groups rightfully, though maybe wrongly, claim, regardless of accumulated data, that their stance is most beneficial to patients. They never consider that both may be mistaken and that active, integrated cooperation on their part might be the way forward to provide maximum benefit.

The goal of any medical intervention is threefold and hierarchical: a) to prevent and/or cure disease and/or its complica-

tions (= efficacy); b) to reduce clinical complications (= safety) without compromising point a); c) to reduce economic cost (= efficiency) without compromising points a) and b). However, in the field of endoscopic sedation, the overall mindset does not seem to comply with this universal order of priorities (only questionable in special situations) by prioritizing safety over efficacy. In the 21<sup>st</sup> century this is not the only endoscopic area where the simplistic *primum non nocere* still reigns. Another example, also in the field of sedation, is emergency therapeutic upper endoscopy. Here, the risk of bronchoaspiration "contraindicates" sedation to the detriment of a successful endoscopic hemostasis, foreign body withdrawal or food impaction removal.

The anesthesiologists' strategy of focusing on safety has been partly countered by endoscopists using the hierarchically lower efficiency factor. Thus, why not move the struggle to the battlefield of efficacy? This is likely due to the fact that anesthesiologists take it for granted. Furthermore, endoscopists have assumed that being officially certified guarantees their complete competence in all aspects and scenarios included in the accredited specialty. Nothing could be farther from the truth! Accumulating lots of experience is not necessary to acknowledge the dispersion that exists amongst anesthesiologists regarding their attitude and aptitude on endoscopic sedation, which ultimately leads endoscopists to think that there are "better" and "worse" anesthesiologists. This is in quotations marks in order to highlight the fact that qualification criteria are mostly subjective. Between parentheses, I would add that a quality I deem necessary for an anesthesiologist to fit in the "better" category is their ability to understand that there are "better" and "worse" endoscopists, and integrate this among the many variables that should inform their decisions and actions. Logically, repeat experiences with anesthesiologists with a "worse" attitude and/or ability to sedate patients will lead to endoscopists rejecting "anesthetic" sedation and favor "endoscopic" sedation. However, the opposite is also logical under contrary conditions.

In my opinion, a definitive solution lies not in our hands but in the hands of anesthesiologists. First, they should assume the reality of "endoscopic" sedation; not only its proven efficacy, safety and efficiency but also both the legal and deontologically legitimate status. Rather than opposing this procedure, they should actively contribute to its implementation and optimization. Then, they should also promote among themselves (during their MIR specialty program and beyond) the necessary training to administer sedation

to patients undergoing endoscopy with maximum quality standards in all potential clinical scenarios. Of course, they would rely on our active contribution by facilitating their rotation in our units. Only afterwards would it be possible to establish, both anesthesiologists and endoscopists together, the role of “anesthetic” sedation, in which no doubt persist.

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