it would be higher with propofol. As would gastroenterologist and nursing personnel satisfaction because of increased throughput in the facility and less struggling with patients insufficiently sedated during the procedure who then sleep for hours afterward. I think only those who pay for anesthesiologists’ services might be less satisfied.

To carry Orkin and Duncan’s metaphor along further, to save money, why not instead prune anesthesia services from cataract surgery performed with topical anesthesia? That procedure seems to me to be less stressful than teeth cleaning by a dental hygienist. Cataract-induced discomfort is far under that of a colonoscopy. Or, as one patient told me: “I’ve had more painful haircuts than that cataract operation.”

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References


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In Reply:

Dr. Gerson raises timely issues: there may be alternative bases on which to support the provision of a given healthcare service, and people may differ in how they value different services. Certainly, enhanced patient satisfaction, among a wider set of criteria, could be used to support an expansion of healthcare services, such as anesthesiologist involvement in colonoscopy sedation, as he suggests.

Although the demand for services is infinite, societal resources are finite, if not overstretched. Budgetary limitations in every country prompt difficult choices about which services to provide. Decisions principally reflect judgments about medical necessity, generally based on demonstrated benefit (e.g., efficacy and effectiveness) and, increasingly, perceived value (i.e., cost effectiveness) in effecting population health. Dr. Gerson perhaps unwittingly acknowledges this critical point when he notes, “I think only those who pay for anesthesiologists’ services [for colonoscopy sedation] might be less satisfied.”

Underlying the urgency of U.S. healthcare reform is the need to increase value in our feast-and-famine healthcare system; although first in per-capita healthcare spending, we have mediocre comparative population health rankings that have declined over three decades; one-sixth of our population without health insurance, and uncontrolled healthcare costs that are an important factor in personal, corporate, and governmental bankruptcies. The lack of association between anesthesiologist involvement in colonoscopy sedation in the Canadian province of Ontario and patient acuity in the study by Alharbi et al. indicates that the service is not a medical necessity and, thus, has low value. As we noted in our editorial, fragmentary evidence suggests that the same phenomenon prevails in the United States. Hence, we remain confident that anesthesiologist involvement in colonoscopy sedation in the absence of medical indication (e.g., severe comorbidity) is a low-value service that is ripe for pruning as healthcare reform progresses.

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