Management of sedation in critically ill patients remains one of the more challenging and contentious areas of practice in intensive care. The reasons for this include: the large number of studies performed using different methods of assessment; the variety of agents available; absence of consensus on a preferred sedation regimen; and contradictory results emerging from studies comparing different agents in terms of both quality of sedation and cost efficacy. Pharmacological data from drug studies in healthy subjects are unlikely to be applicable in critical illness, and many studies of sedative agents in intensive care are still performed in stable postoperative patients, not in those with multiple organ failure. The etomidate story provides an important moral in this respect. Few studies have examined changes in drug metabolism and clearance during the evolution of critical illness, the significance of inter-individual differences in drug handling, effect of changes in endothelial permeability or blood–brain barrier function or the interplay between disease and drugs in influencing cerebral function. In part, this is a consequence of the heterogeneity of the intensive care population and the logistic difficulties of conducting research in an unpredictable clinical environment. The net result is wide diversity of clinical practice and the predominance of opinion over fact.

One way of encouraging a more uniform approach to sedation in critically ill patients would be to agree a common terminology for describing depth of sedation and the patient's apparent level of comfort. However, there are instead a large number of methods for describing depth of sedation. The first was the scale described by Ramsay and colleagues, and this has been followed by many others, often with a proprietary label referring to the originating institution. The diversity of methods suggests both a clinical need and dissatisfaction with existing methods. Why should this be?

The need for a method for describing sedation is easy to understand. Poor quality sedation and analgesia in critically ill patients would be regarded by many as unkind and potentially unsafe, and yet personal experience suggests that there are substantial cultural differences in the provision of 'comfort care' between intensive care units at an international level. For example, the use of physical restraints or complete exclusion of relatives from the bedside would be regarded as unacceptable in some ICUs, and yet are standard practice in others. These differences would be easier to explore given a common method for defining clinical end-points. Conversely, oversedation with drugs also has many undesirable effects, and is more difficult to detect and avoid than undersedation, in that an oversedated patient may look comfortable and well cared for, while the adverse effects of deep sedation are more subtle and may not be noticed by an inexperienced attendant. A sedation scale has the advantage that oversedation is documented and can be used to trigger changes in drug dose.

The proliferation of different methods for measuring sedation is open to several interpretations. The most obvious tension is between simple but subjective clinical bedside methods and more complex systems using innovative techniques to improve objectivity, accuracy and reliability. So far, none has found universal favour, and the more complex methods may lack reproducibility. Is it reasonable to suggest that what is required is evidence that measuring sedation makes a difference to clinical outcome, rather than emphasizing differences between methods?

In this issue of the journal, the article by Detriche and colleagues describes the clinical benefit of introducing a simple five-point sedation assessment tool to the ICU. This article strengthens the argument that the clinical application of simple scoring systems may be helpful. What is important is not so much the precise method of measurement (such as that devised by Ramsay and colleagues and subsequently modified in this and other studies) as the fact that the method has been used to change the management of sedation. It is the translation from measurement to effective action which counts.

How can this be achieved? The first element must be to emphasize the importance of proper management of pain, anxiety and sleep for critically ill patients. This is easier to state than to achieve, partly because it is among the more mundane and less glamorous tasks for the critical care clinician and therefore easy to overlook, and also because deeply sedated patients are less demanding in terms of physical management and emotional needs. The aims of sedation need to be defined clearly so that appropriate care
is given—not all comfort care is drug-related. Here we would take a different view from that expressed by Detrice and colleagues in their discussion when they imply that sedation is a necessary part of mechanical ventilation. The indication for sedation is not the need for mechanical ventilation but to relieve anxiety associated with the illness and therapy. Experience tells us that some patients require heavy sedation to tolerate mechanical ventilation while others require none and are very comfortable. The assumption that sedatives are required is a major contributor to the tendency to oversedate patients admitted to the ICU.

The second element is to link assessment of sedation to specific actions, such as to increase, reduce or continue unchanged the sedative drug infusion rate. This requires collaborative development by medical and nursing staff of simple guidelines which become an integral part of clinical practice, in the same way that vasoactive drugs may be adjusted to arterial pressure, or $F_{\text{O}_2}$ to $P_{\text{A}_2}$. This approach has been shown to allow effective sedation with long-acting agents without a negative effect on weaning times. Similarly, a sedation guideline developed by a consensus process through the UK Intensive Care Society, which deliberately does not mention specific drugs, has been shown to have a significant effect on total sedative use and hence sedation costs without impairing patient outcome.

The use of clinical guidelines is an important issue in the current environment. Evidence of effectiveness is limited, but their introduction into clinical practice seems inevitable and is supported by most. It is interesting that in an area as difficult and controversial as sedation in the ICU, the use of clinical guidelines based on a simple scale seems to have a beneficial effect on clinical practice.

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