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State of Utah
Department of Commerce
Division of Occupational and Professional Licensing

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To: Health and Human Services Interim Committee

From: Division of Occupational and Professional Licensing (DOPL)
Utah Department of Commerce

Subject: Sunset Review Recommendations – Sunset Date July 1, 2022
Anesthesia, Sedation, and Unprofessional Conduct
Sections of Code that Sunset: **26-1-40 and various Title 58 sections**

Section 26-1-40 defines the Department of Health's responsibilities to create and maintain a database of deaths and adverse events from the administration of sedation or anesthesia in outpatient settings and non-emergency departments, and creates certain reporting requirements and whistleblower protections. The Department of Health is reporting separately to the HHS Interim Committee on this Section. *See Utah Department of Health's Report dated October 13, 2021: Sunset Review of Anesthesia Adverse Events.*

The following Sections in Title 58, Occupations and Professions were enacted with and are scheduled to sunset along with Section 26-1-40. These sections each provide that it is unprofessional conduct for a practitioner licensed under that chapter to administer sedation or anesthesia intravenously to a patient in an outpatient setting that is not an emergency department without: (1) obtaining certain specific consent from the patient; (2) reporting any adverse event under **Section 26-1-40**; and (3) having access to an advanced cardiac life support crash cart:

a. **58-5a-502** (Podiatric Physician)
b. **58-31b-502.5** (Nurse)
c. **58-67-502.5** (Physician and Surgeon - M.D.)
d. **58-68-502.5** (Osteopathic Physician and Surgeon - D.O.)
e. **58-69-502.5** (Dentist)

To date, DOPL has no record of complaints submitted against a practitioner for violation of these unprofessional conduct provisions, and DOPL has not taken an administrative action against a practitioner for violation of these provisions. However, as stated in the Department

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of Health's *Sunset Review of Anesthesia Adverse Events* report, although there have been 14 submitted reports, there is concern from the DOH workgroup that there is underreporting, and they have suggested continuing the program for another 4 years and exploring adverse events related to anesthesia through other data sources.

DOPL itself has provided outreach and training on these statutory requirements at meetings and scheduled training for the affected health care provider groups, to ensure better awareness of the statutory requirements. DOPL believes that engaging in further outreach is warranted.

Accordingly, DOPL supports the Department of Health's recommendation to continue with the program for another 4 years to continue to collect and assess data and conduct educational outreach efforts, and recommends reauthorization of each of these Title 58 unprofessional conduct sections for a corresponding period.

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