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Advocating Before the California Dental Board - Sacramento

The Dental Board of California (DBC) met on October 13, 2016. On the agenda was a discussion of their Pediatric Anesthesia Study (PAS) in light of recent office-based dental anesthesia deaths and the passage of AB-2235, otherwise known as "Caleb's Law." They incorporated in part the recommendations from the various stakeholders such as the California Society of Anesthesiologists, AAP-CA, American Society of Dentist Anesthesiologists, California Dental Association, and the California Society of Oral & Maxillofacial Surgeons.

The DBC Subcommittee on Pediatric Dental Sedation came up with the following preliminary recommendations: 1) The DBC should continue to research the collection of high quality pediatric outcomes data for informed decision making. 2) Update the existing definitions of sedation and anesthesia for consistency with medicine. 3) They also recommended a restructuring of their existing dental moderate sedation and general anesthesia permit system. It should be mentioned that the DBC Subcommittee consists only of an oral surgeon and a board-appointed attorney.

From the Pediatric Anesthesia Subcommittee came recommendations for a proposed revision of their sedation permit system briefly reviewed here:

For general anesthesia, there would be a new permit requirement for patients under 7 years of age. In addition to Advanced Cardiac Life Support (ACLS) or equivalent training, those administering sedation and anesthesia to children younger than 13 years old would require Pediatric Advanced Life Support (PALS).

Currently, in terms of personnel needed for general anesthesia, two staff members are required in addition to the dental practitioner. At least one person must be trained and solely tasked in monitoring and resuscitation of sedated patients.

A point of contention here is the definition of who this "qualified person" in charge of monitoring and maintaining the patient's airway and respiratory status would be, as

there is no formal education requirement for dental assistants, not even a high school diploma. After 6 months of working in a dental office, a dental assistant may take a Dental Sedation Assistant (DSA) Course approved by the DBC. This course must be a minimum of 110 hours that must include 40 hours of didactic, 32 hours of combined laboratory and preclinical instruction and 38 hours of clinical instruction. These DSA courses are based on a 36-hour online course called the Dental Anesthesia Assistant National Certification Exam (DAANCE) developed by the American Association of Oral and Maxillofacial Surgeons. Currently each course provider will not train anyone except employees of the provider. Currently only 37 DSA certified assistants are in CA, a "dental sedation assistant" may directly administer the medications for general anesthesia and resuscitation as outlined in PALS and ACLS as well as remove IV lines.

Currently, monitoring parameters include pulse oximetry, precordial stethoscope, cardiac monitoring, and capnography – all monitors specified by the American Society of Anesthesiologists for physician and dentist anesthesiologists or CRNA's to use in general anesthesia settings.

A periodic, live-patient office inspection is required for all permit holders, yet evaluation of the dental assistants charged with anesthesia monitoring and medication administration is not specified in the inspection process.

For patients 13 years old and older, including adults, there is a proposed moderate sedation permit to replace the existing "conscious sedation" permit, which covers all routes of sedative medication administration -- oral, intravenous, intranasal, and intramuscular.

In terms of personnel, there must be one staff member in addition to the dentist trained in the monitoring and resuscitation of sedated patients. The equipment is the same as above, except for capnography, where feasible.

The education requirement includes a board-approved course of instruction consistent with ADA guidelines and practitioner with ACLS certification (60 hours didactic, 20 supervised, live-patient demonstrations).

In addition to the existing oral conscious sedation permits, there is a proposed pediatric minimal sedation permit for patients under age 7 years old for oral medication only. This can be a single sedative agent given in addition with nitrous oxide and oxygen that is unlikely to produce an unintended state of moderation sedation. At least one staff member is required to be trained in the monitoring and resuscitation of sedated pediatric patients. An office inspection is NOT required.

Surprisingly, our AAP-CA recommended moratorium on the single operator-anesthetist general anesthesia practice (surgeon performs the dental surgery AND performs the general anesthesia simultaneously), as practiced by most oral surgeons, was not addressed by the DBC subcommittee. While the DBC required compliance with the

ADA guidelines, they did not recommend complying with the well-established AAP-American Academy of Pediatric Dentistry (AAPD) "Guidelines for Monitoring and Management of Pediatric Patients Before, During, and After Sedation for Diagnostic and Therapeutic Procedures: Update 2016" as we have recommended, nor did they incorporate all of the suggestions of the California Society of Anesthesiologists -- in particular the qualifications of the "sole monitor" and eliminating the operator-anesthetist model.

The discrepancy lies in the interpretation of the staff assistants. What the AAP, CSA, dentist anesthesiologists, as well as other patient safety advocates refer to as the "single operator-anesthetist" is considered by the oral maxillofacial surgeons and select dentists as the "team approach." The team is the oral surgeon, a dental assistant assisting with the dental procedure, and a second dental assistant in charge of maintaining the patient's airway and monitoring their respiratory status. Since dental assistants do not have any formal education requirements, even perhaps a high school diploma, it is difficult to argue they possess the necessary qualifications to manage a pediatric airway or monitor a patient under general anesthesia – tasks ordinarily delegated to licensed and trained professionals with 3 or more years of clinical training.

While a dental assistant may now take PALS, the PALS course is intended to save a life through recognition of the signs and symptoms of shock and impending cardiovascular collapse. It is based on a premise that a child could be responsive and breathing spontaneously. In general anesthesia, a patient is *intentionally* rendered patient unconscious with depressed respiratory drive, PALS simply does nothing to prepare a clinician to rescue a patient from airway collapse and central nervous system depression due to general anesthetic agents. Second, the PALS requirement of being able to demonstrate intubation on a mannequin does not confer competency on this critically important skill. PALS is not a replacement for formal anesthesia training in any way or form.

Now to have a dental assistant with limited training monitor and maintain a pediatric airway under the supervision of an oral surgeon with less than 6 months of formal general anesthesia training (current dental education standards for oral surgeons), is both shortsighted and woefully inadequate.

After the Subcommittee presented their findings and permit recommendations, the public was invited to speak. Representatives from the following organizations were each given 5 minutes: CA Dental Association, CA Society of Oral Maxillofacial Surgeons, CA Society of Pediatric Dentistry, CA Academy of General Dentistry, CA Society of Dentist Anesthesiologists, California Society of Anesthesiologists, and the AAP-CA. Also in attendance was Dr. Annie Kaplan, Caleb's aunt of Caleb's Law.

As Dr. Poage, representing the California Society of Anesthesiologists, got up to speak, I realized that I would be speaking last. I enjoyed the opportunity to listen intently to the other speakers and hear what they had to say. Like last time, the AAP-CA forwarded a

letter of comments in advance of the meeting. As my turn approached, I felt my heart begin to race. I noticed it and went back to listening to Dr. Poage and just as suddenly, I noticed that my heart was no longer racing. With that, I got up to approach the DBC.

I once again thanked the DBC for the opportunity to speak on behalf of the AAP-CA. I reviewed our talking points and addressed certain comments made by DBC members to other speakers. For example, Huong Le, DDS, MA of the DBC stated that after she reviewed the list of pediatric deaths during a specific time period, she discounted some as not relevant and concluded that only 3 children had actually died related in the office setting. This did not include several children that have died since the DBC began working on their PAS. I reminded them what Dr. Zakowski of the California Society of Anesthesiologists stated in front of the DBC in August -- that there was no way to track how many near misses had occurred, nor with what frequency. I reminded them that there was no report listing any of those patients that sustained an adverse outcome, such as anoxic brain injury. I also recommended that the PALS requirement be for the hands-on course, not the online version.

Next, I moved to my closing statements. How can we tell the parents of one more healthy child that goes into a dental office for a routine procedure and dies while under dental anesthesia that we were unwilling to do anything proactive to prevent that tragedy. With that, I respectfully requested the DBC to urge all dentists and oral maxillofacial surgeons in CA to comply with the AAP-AAPD Guidelines on Pediatric Sedation as mentioned above, to follow the California Society of Anesthesiologists recommendations -- in particular the qualifications of the sole monitor -- and once again, asked for an immediate and full moratorium on the single operator-anesthetist model for specific types of sedation and general anesthesia.

Not one more healthy California child should suffer a potentially preventable death in a dental chair, if anything can be done to prevent it… Not one more.

View the NBC editorial here.

Late breaking update related to this article. In Alberta, Canada, a 4-year-old girl recently suffered brain damage related to pediatric anesthesia in a dental office. On October 28, 2016, the Alberta Dental Association and College decided to “immediately suspend” the practice of allowing one dentist to provide deep sedation or general anesthesia while also providing dental treatment. Read about it here.

Related articles previously published in Peds@CA2 eNews

AB-2235 (Thurmond) CA Dental Board Pediatric Anesthesia Study Report - **Part 1**

AB-2235 (Thurmond) CA Dental Board Pediatric Anesthesia Study Report - **Part 2**