April 4, 2017

The Honorable Rudy Salas  
Chair, Assembly Business and Professions Committee  
State Capitol, Room 2188  
Sacramento, CA 95814  
Fax: (916) 319-2132

Dear Chairman Salas:

As a board-certified pediatric dentist and nationally-recognized expert in oral sedation of children, I have spent my professional career performing, researching, and teaching the principles of oral sedation and monitoring to a multitude of residents and colleagues. My career path primarily involved care of children in hospital settings. As such, I have often witnessed the intervention by well-trained and accomplished professionals in rescuing children who slipped into an emergent condition wherein inappropriate care could have been the worst of adverse outcomes.

Along with my physician anesthesiologist colleague, Charles Cote MD, we jointly developed the Guidelines for Monitoring and Management of Pediatric Patients Before, During, and After Sedation for Diagnostic and Therapeutic Procedures: Update 2016. The full spectrum of sedation and anesthesia care is addressed in detail and may aid in facilitating practical policymaking and regulations with the primary goal of increasing pediatric patient safety.

With specific concern to the provision of deep sedation and general anesthesia for children, both Dr. Cote and I firmly agree that for the minimum level of safety in delivering these levels of anesthesia involves a dental team of operator-assistant professionals and additionally, the presence of a separately licensed and anesthesia trained dentist, physician anesthesiologist, certified registered nurse anesthetist, or oral surgeon with appropriate pediatric (i.e., specifically, children less than 6 years of age) anesthesia-training. The operator-anesthesia model, wherein the operating dentist or oral surgeon is simultaneously directing the deep sedation or general anesthesia care AND involved in the conduct of the surgery, is inadequate, outdated according to medical standards, and below the expectations for safety that the public deserves.

Our Guidelines are intended to reflect this requirement, and if a child is not bilaterally communicative with the dentist (i.e., not in minimal and moderate sedation), there must be another qualified, licensed and trained individual present to monitor complex patient parameters using capnography, pulse oximetry, and electrocardiography. This qualified person must be able to understand the subtleties of patient monitoring, is knowledgeable in differential diagnosis of emergent patient algorithms, and can intervene providing appropriate rescue. Rescue in these situations includes timely resuscitative procedures, advanced airway management, and administration of medications to possibly prevent significant outcomes of brain damage and/or mortality. When seconds count, a dental assistant or hygienist trained either by the oral surgeon/dentist or in a survey-type continuing education course on emergencies, is unlikely to respond rapidly and effectively, it at all, compared to a
dedicated, licensed and trained competent individual with experiences in rescue procedures in pediatric anesthesia delivery.

The notion that a dental assistant can safely fulfill this role in an isolated emergent event, even with the current time-based cycles of Pediatric Advanced Life Support (PALS) certification and/or "dental sedation assistant" training, is naïve and unrealistic. PALS training is focused on the resuscitation of a pediatric patient from various forms of shock, not necessarily anesthesia induced cardio-respiratory depression. A dental assistant, without formal and standardized medical training in pediatric anesthesiology is not an equivalent surrogate to an independent anesthesia provider. We also have to consider the interpersonal and hierarchical issues associated with an office-based environment that may be fraught with biases and seemingly discordant relationships that could impede appropriate interventions.

Dr. Cote has already published definitive studies where inadequate training and the absence of a true, qualified anesthesia provider have resulted in serious injury and even death in pediatric dental settings. Additionally, one study I authored in 2006 and published in Pediatric Dentistry pointed to the likelihood of adverse sedation events occurring in the post-operative and recovery phase of dental appointments.¹ A single operator-anesthetist delegating general anesthesia recovery duties and discharge to a minimally trained dental assistant, while the surgeon is attending to another patient, may further increase this likelihood. PALS training or even specific dental assistant anesthesia training regimens do not authorize these individuals to determine safe discharge from an anesthesia provider's supervision.

Dr. Cote and I understand that California is considering legislation to mandate a separate anesthesia provider for deep sedation and general anesthesia delivered in dental office settings for pediatric patients under 13 years of age. Given the gold standard medical model of independent operator and anesthesia provider, the expectations of the public, and the increasing scrutiny by many non-dental professionals, I feel it is a needed step in the right direction to move beyond the current archaic dental model of anesthesia delivery. To call for proposed studies or evidence explaining why a separate anesthesia provider model is safer is disingenuous and unethical. Medicine has already established the far-reaching implications and safety of this model.

As an individual, I would strongly support any proposed legislation that would increase the safety of administering sedation and anesthesia to children in any outpatient setting. I strongly believe the safest, most ethical, and humane action is for the California State Dental Board to require a licensed, general anesthesia permit holder to be present, in addition to the dentist and his/her dental staff, whenever a deep sedation or general anesthesia procedure is targeted and used in delivering invasive dental care for children under age 7 or for appropriate special needs patients. I would also urge the California Dental Board to modify and use the definitions of sedation and general anesthesia found in the American Academy of Pediatrics/American Academy of Pediatric Dentistry’s guidelines on sedation (referenced above; it can be found on the American Academy of Pediatric Dentistry’s website under Policies – www.aapd.org). Thank you for your time and consideration.
Sincerely,

Stephen Wilson MA, DMD, PhD
Professor, Pediatric Dentistry (retired)

Cc: The Honorable Tony Thurmond
Members of the Assembly Business and Professions Committee
Le Ondra Clark Harvey, Chief Consultant, Assembly Business and Professions Committee
Bill Lewis, Consultant, Assembly Republican Caucus
Neil P. Clark, Consultant, Assembly Democratic Caucus
Darci Sears, Office of Assembly Speaker