IS DENTAL ANESTHESIA SAFE?

OR........HOW SAFE IS DENTAL ANESTHESIA?
IS OFFICE DENTAL ANESTHESIA SAFE?

ARE DENTAL BOARD’S RESPONSIBLE?

STATE DENTAL BOARD

OFFICE DENTAL ANESTHESIA

MORTALITY

ARE DENTAL BOARDS IN BULLSEYE?
Junior’s Story
Drugged to death, in a Dallas dental chair

By Brooks Egerton | Staff Writer  Published December 9, 2015
Elusive Numbers
We asked for death totals, but most states weren’t counting

By Brooks Egerton | Staff Writer | Published December 9, 2015

Since 2010, Texas has received at least 85 death reports. Projected out to the whole U.S. population, that’s a little over 1,000 deaths.

For every Texas dental patient who died, about six more were hospitalized and survived.

All but three states require dentists to report some deaths, our investigation found. When we requested numbers, however, a majority told us they didn’t know and didn’t have a good way to count.

Texas’ dental board, like others around the country, doesn’t require dentists to disclose restrictions they face. We found that some restrictions, including the suspension of Riehs’ sedation permits, didn’t appear on the board’s own site for months.

The board had granted him permission to dispense sedation cocktails years earlier without exercising its right to inspect his methods. It has no record of ever conducting such an inspection on any dentist, an agency spokeswoman told us.

Voting members of the body are appointed by the governor. By law, a majority are dentists.

Dr. Douglas Terry, a Houston dentist and patient-safety advocate, attended a board meeting last year to urge truth-in-advertising reforms. “It appears,” he said, “that you are protecting bad players.”
Texas Teeth

A report aired on April 26, 2016, by KVUE in Austin, Texas-based ABC television affiliate, investigated dental deaths in the state. They found "at least 86" instances in Texas of patients who "died shortly following dental procedures from 2010 to 2015."

According to the report, the Texas State Board of Dental Examiners rarely disciplined dentists involved in such negative outcomes. Texas state law prohibits the board from giving any details about deaths unless the dentist has been disciplined.

The state's Sunset Advisory Commission recently criticized the Board of Dental Examiners, concluding it "lacks the authority and resources to routinely inspect the offices of dentists providing some anesthesia services and does not require written emergency action plans for any dentist administering anesthesia."

A representative for the board, meanwhile, noted that it did not have the funding for that level of oversight.

February 2017

Marjorie Ann Stiegler, M.D.

Striving to improve medical decisions and physician leadership, one post at a time.

Why are kids dying at the dentist?
My purpose is simply to raise awareness of the issue of confusion for patients, who have the right to understand the training and roles of the people caring for them as well as the risks of anesthesia. That is the basis of the “informed consent” process, which is at the heart of shared medical decision making. A common theme emerging from these recent deaths is that parents felt they were not fully informed. But without question, patients deserve to be fully informed. If you go to the emergency room, you may see a nurse practitioner (NP) or physician assistant (PA) instead of a physician. If you have surgery, an NP or PA may be performing portions of the procedure. There is nothing wrong with the variety of clinicians in healthcare. Certainly, all clinical professionals have experienced or will experience adverse patient outcomes over their careers, and this does not necessarily imply that errors were made.

Patients simply have a right to know. And, they have a right to demand safety standards for anesthesiology that reflect the standards of anesthesiologists, equally applied in all states.

**Dental Sedation Responsible For At Least 31 Child Deaths Over 15 Years**

By Harry Bradford

One of children’s greatest fears has long been the dentist. But maybe it’s the parents who should be afraid.

Dental sedation, or the practice of using drugs to relax or knock out a patient prior to a procedure, may be far more dangerous than people realize, accounting for at least 31 child deaths over the past 15 years, according to The Daily Mail reports. Since 2007, 18,000 dentists across the country have taken weekend-long courses in oral sedation to gain training in techniques that can cost patients tens of thousands of dollars extra in bills per year; but some say the hotel-conference style seminars give a false sense of security.

“This is something that is being presented to the practitioners, the dental community, as a very easy thing to do,” Dr. Robert Kaminski, a dental anesthesiologist from suburban Detroit, told ABC News. “Nothing could be further from the truth.”
But the dangers of anesthesia aren't limited to the field of dentistry alone. A 2011 paper published by the German Medical Association found that deaths related to anesthesia are on the rise, with one in 20 dying within a year of being treated with general anesthesia worldwide, TIME reports.

Still, the extra cash that comes from dental sedation may cause some dentists to overlook the risk. A dentist with DOCS Education, a company offering training in dental sedation, wrote that the practice can put "as much as half a million extra in your pocket at retirement." Its website even features a shopping cart.

Parents too may underestimate the dangers of oral sedation. The parents of Raven Maria Blanco, for example, warn others not to assume a dentist "knows what he's doing." They started a foundation in their daughter's name to raise awareness of oral sedative use in pediatric dentistry after she died from a dose "three times the average range" for her age, 8 at the time.

Other examples of dentists improperly using anesthesia include New Jersey dentist Patrick Bangboyde was under investigation earlier this year after the death of two children under his care, including a 3-year-old. Meanwhile, Dr. Stephen Stein of Denver was found to have reused anesthesia syringes on patients several days in a row, The Denver Post reports.
The highly publicized deaths of two children who died after an in-office dental procedure performed by a dentist and an oral surgeon, respectively, have many questioning whether national guidelines or individual state dental board requirements need to be strengthened when it comes to administering general anesthesia to a pediatric population. The cause of both fatalities is suspected by some to be related to anesthesia.

The educational and training requirements to administer sedation and anesthesia are regulated by individual state dental boards,” said dentist anesthesiologist Joel M. Weaver, DDS, PhD, a spokesman for the American Dental Association (ADA) and emeritus professor at the Ohio State University, in Columbus. Dr. Weaver is a past president of the American Society of Dentist Anesthesiologists, American Dental Board of Anesthesiology and American Dental Society of Anesthesiology, which are the three major organizations for anesthesiology in dentistry.

“Because sedating children is very different from sedating adults,” Dr. Weaver said, “many state dental boards require the dentist who sedates a child 12 years and younger to qualify for a special moderate sedation or anesthesia permit.”

CRNAs: Barriers, and No Pediatric Guidelines

According to Juan Quintana, DNP, MHS, CRNA, president of the American Association of Nurse Anesthetists (AANA), in the state of Texas there are many practice barriers that prevent certified registered nurse anesthetists (CRNAs) from providing anesthesia in a dental office. “If these restrictions were removed, dentists would be more likely to hire CRNAs to administer anesthesia to dental patients rather than perform both the oral surgery and the anesthesia themselves,” Dr. Quintana said. “From my experience as a CRNA, our standard of practice is to assess and evaluate the patient before the procedure and stay with our patient throughout their procedure. CRNAs monitor vital signs, adjust the anesthetic drugs as needed and remain vigilant in case of an emergency. Patients’ safety is our No. 1 priority.”

The AANA does not have specific guidelines or recommendations for a dental office or pediatric dentistry. More generally, however, the association publishes “Standards for Office Based Anesthesia Practice.” Dr. Quintana said, “These standards identify the minimum policies that should be in place, elements of the preanesthesia assessment, monitoring requirements, an assessment checklist of minimum elements for providing anesthesia, and an anesthesia equipment and supplies checklist.”

The AANA also has a document titled “Non-anesthesia Provider Procedural Sedation and Analgesia” for policy development at a facility. “Specifically, this document provides sedation considerations for special populations, including pediatrics,” said Dr. Quintana, who has been a CRNA for nearly 20 years and currently serves as president of Sleepy Anesthesia, an anesthesia practice headquartered in Winnsboro, Texas, which serves several hospitals in the Lone Star State.
Dr. Herlich said ASA’s guidelines are the same for any location: a dental office, a physician’s office, an outpatient surgery center, even a hospital operating room. “We advocate for physician-led, team-based anesthesia care, using standard monitoring for patient care,” Dr. Herlich said.

Standard monitoring for moderate and deep sedation and general anesthesia consists of the ability to monitor heart rate, heart rhythm, blood pressure, oxygen saturation and “of course, a way to quantify the patient’s respiration,” he said. “In loose terms, this quantifying means capnography.”

Dr. Herlich said there is no mandate by any authoritative body to require an anesthesiologist on-site when anesthesia is given.

In other words, dentists can perform sedation and anesthesia themselves, without the need for a physician anesthesiologist, as long as the dentist has met the requirements of his or her own state dental board. “We cannot impose our standards to a dental board or dental office,” Dr. Herlich said.

As for a single provider handling both anesthesia and the procedure itself, “it depends on the situation, because there are people that are trained to do both, such as emergency physicians,” Dr. Herlich said. Variations in state policies and rules also “are all over the map.”

Dr. Herlich, a physician anesthesiologist and dentist, as well as a professor of anesthesiaology at the University of Pittsburgh School of Medicine, said the specialty of oral surgery “has incredibly high standards and follows the same guidelines as ASA, step by step.”

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Dying at the Dentist: Lawmakers calling for action after anesthesia related deaths

by April Molina, News 4 San Antonio | Monday, October 31st 2016

Error loading media: File could not be played
On the heels of this unexpected death and other dental anesthesia related deaths in Texas, lawmakers are taking a close look at what they can do, and also why the TSBDE has not done more already.

"I just want to be really clear to the dental board and I realize you work for them, but this is really your last chance, either you guys come up with some quality recommendations or we're acting," said State Senator Van Taylor at a recent Sunset Advisory Commission Meeting.

Taylor was one of a several legislators who were very vocal about the need for a safe environment for dental anesthesia in Texas.

"We do need to take action, we need to make sure that our regulations as well as our board emphasizes safety in regards to dental anesthesia," said State Senator Charles Schwertner.

TSBDE Executive Director, Kelly Parker, who has been with the board since September of 2015, said currently the statute is vague, and that as a result dental office inspections are not being done prior to the state issuing permits for anesthesia.

When pressed, Parker said the state does have the authority to do some pre-permit inspections.

Vancouver mother's warning after son dies from dentist visit

Nina Mehlhaf, KGW  4:27 PM, PCT March 17, 2017

VANCOUVER, Wash. -- A 4-year-old Vancouver boy died after what seemed like a routine dentist visit last week, and the Washington Department of Health is investigating the death.

Mykel Peterson was put under with anesthesia to fill a cavity, but never woke up. The dental office where it happened, Must Love Kids, was closed Monday, March 13. An employee who came to the door, told KGW it was out of support for employees and the boy's family after what happened Friday, March 10.

The health department has 170 days to complete the investigation.

"They're going to turn over every stone," said department spokesman David Johnson.

The Clark County Medical Examiner said the cause of death is pending until toxicology results are finalized in 6-8 weeks.
DENTAL ANESTHESIA DEATHS . . . GENERAL ANESTHESIA FOR PEDIATRIC PATIENTS IN DENTAL OFFICES

RICHARD NOVAK, M.D.

Richard Novak, MD is a Stanford physician board-certified in anesthesiology and internal medicine. Dr. Novak is an Adjunct Clinical Associate Professor in the Department of Anesthesiology.
REAL ANESTHESIA STATISTIC

HOW DOES DENTAL ANESTHESIA SAFETY COMPARE TO OTHERS?
Figure 1  Pediatric dental deaths by anesthesia provider and age categories. Values within each anesthesia provider category represent the number of deaths by age categories. The largest number of deaths was associated with anesthesia providers who were classified as either a general or pediatric dentists. Within this provider category, the largest proportion of children was within the 2–5 year old age group.

Figure 2  Pediatric dental deaths by anesthesia provider and facility type. Values within each anesthesia provider category represent the number of deaths by facility type. With the exception of anesthesiologists, the largest number of deaths across all anesthesia provider type occurred in office facilities.
Pediatric Anesthesia

ORIGINAL ARTICLE

Trends in death associated with pediatric dental sedation and general anesthesia

Helen H. Lee¹, Peter Milgrom², Helene Starks³ & Wylie Burke³

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2 Department of Oral Health Sciences. University of Washington. Seattle, WA, USA
3 Department of Bioethics and Humanities, University of Washington, Seattle, WA, USA

Keywords
anesthesia; patient safety; child; conscious sedation/adverse effects; dental anxiety/drug therapy; treatment outcome

Summary
Background: Inadequate access to oral health care places children at risk of caries. Disease severity and inability to cooperate often result in treatment with general anesthesia (GA). Sedation is increasingly popular and viewed as lower risk than GA in community settings. Currently, few data are available to quantify pediatric morbidity and mortality related to dental anesthesia.

Objective: Summarize dental anesthesia-related pediatric deaths described in media reports.

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Total Without ¹⁹ | 157/61,929,408 |
Total             | 239/91,904,887 |
Published Mortality Rates in Dentistry Associated with Anesthesia

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Published Mortality Rates in Dentistry

It is stated on this website that roughly 1 death occurs in every 400,000 cases where anesthesia is used in dental offices. The description below is an explanation of how this number was calculated.

Numerous studies have been done over the years to determine outpatient anesthesia mortality rates in dentistry. Statistics range from 1 death in every 162,000 cases [1] to 1 in every 1.733 million cases [16], where anesthesia is used in dental offices, depending on which study is looked at. In some studies no deaths occur and for obvious reasons is not included as an upper bound. Compilation and analysis of data by various authors in the United Kingdom, Canada, and the United States seems to indicate that death occurs in dental offices where anesthesia is used somewhere in the range of 1 death in every 229,730 cases to 1 death in every 835,000 cases. [1-16, 21-23]

Note this does not fully include all dental surgeries such as the ones that occur in a hospital setting. In some cases this figure includes general anesthesia, sedation, and local anesthesia that was given. In other cases local anesthesia and/or sedation may be omitted from the number. Emphasis was made to filter out dentistry procedures that occurred in a hospital. Further note this data incorporates all possible types of dental procedures. This number is calculated from surveys from 1955 to 2013 which found a total of 239 deaths for an estimated 91,904,667 people given anesthesia in dental offices. [1-16, 21-23]
Tonsillectomy-related fatalities are not common; they occur in the "1 in every 30,000 range," says physician Richard Rosenfeld, director of the Institute for Advanced Otolaryngology at New York Methodist Hospital in Brooklyn.

About 530,000 tonsillectomies a year are done on children younger than 15, down considerably from 30 years ago when the number peaked at around 1.5 million, Rosenfeld says.
Speakers for today:
Dr. Dan Gesek – Past Chair of CDEL, Past President Florida Dental Board
Dr. James Nickman – President AAPD
Dr. T.J. Tejera - Florida Dental Board
Dr. Antwan Treadway – Georgia Dental Board
Dr. Art Jee – Maryland Dental Board

AADB
American Association of Dental Boards