Concerned Virginia Dentist Anesthesiologists
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Virginia Board of Dentistry
Perimeter Center
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Delivered via E-mail transmission to Sandra Reen, Executive Director, at denbd@dhp.virginia.gov

Dear Ms. Reen, Dr. Catchings, and the Virginia Dental Board:

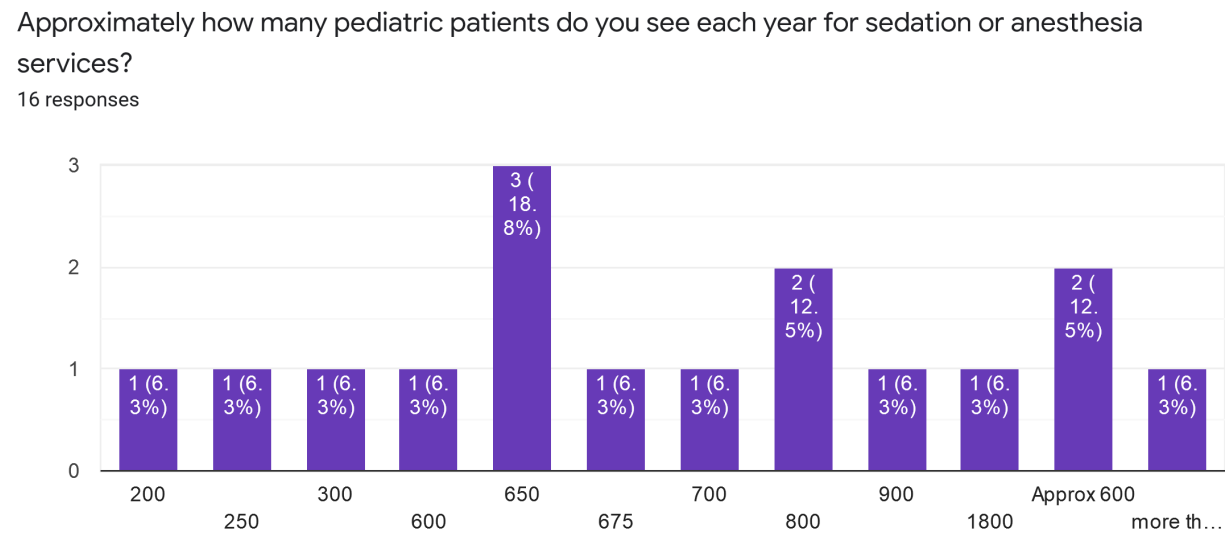
We are writing this letter in response to the August 2020 Virginia Dental Board Briefs, which announced Dr. Catchings's request that the Board staff prepare language to restrict pediatric sedation and treatment to the hospital for a specified age range. A review of the March minutes shows that this motion was adopted. Although specifics of this proposed regulation have not yet been released, it appears that the intent is to introduce a minimum age for treatment of children in the dental office. While it is understandable that the Board would like to end tragedies such as the recent death of a child in Abingdon, VA and the death of a child in Chantilly, VA, there are concerns with the manner in which this may be undertaken. Before voicing these concerns, we believe it prudent to also commend the Board for taking action to protect the children of our Commonwealth. We too wish to see an environment in which no child is harmed by sedation and anesthesia in the dental office.

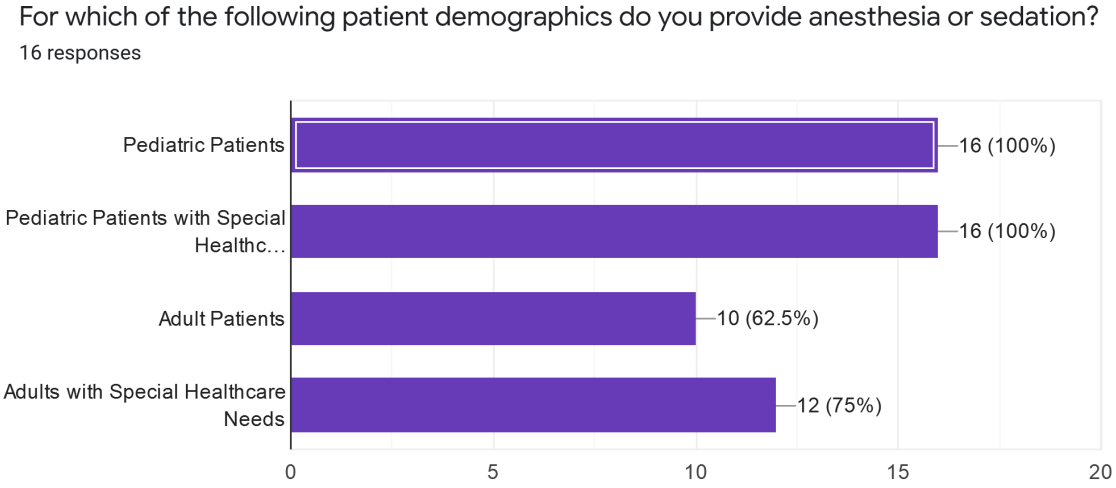
One way to achieve this ideal, of course, would be to eliminate sedation and anesthesia for children in the dental office and relegate such treatments to the hospital. Doing so has several major concerns in our opinion. These concerns are that it restricts access to care, it places a large economic burden on certain patients and their families as well as the tax payer, it removes the ability of the licensed expert to make appropriate decisions for their patient, and it does not promote patient safety—it simply eliminates a service to a certain patient population. We will elucidate the rationale behind each of these concerns below:

Access to Care

Relegating pediatric sedation and anesthesia to the inpatient hospital will severely hamper the ability for dentists in the Commonwealth to see pediatric patients. Today's environment is far different from the past. We are seeing a rising rate of dental caries among children. This may be due to the general public's concern over fluoridation, an increase in access to refined sugars in the diet, increasing income inequality and erosion of the socioeconomic status of the middle class, and cultural changes in regards to ad lib feeding for infants and toddlers as well as changes in child rearing. All these factors are increasing the need for full mouth dental rehabilitations and the need for pharmacologic means of managing behavior.

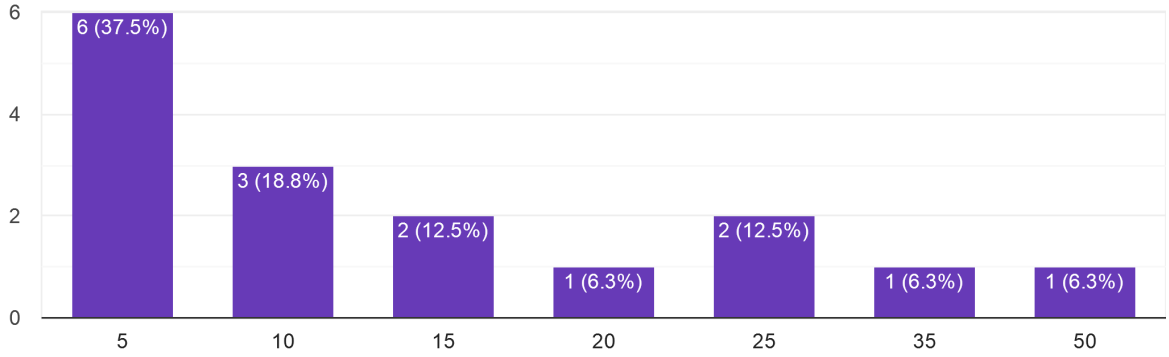
A preliminary survey (the survey is ongoing with 16 respondents currently) of dentist anesthesiologists who are currently licensed or were recently licensed in Virginia reveals that the average dentist anesthesiologist is seeing about 700 children each year. A vast majority of these children are under the age of 7, receiving full mouth dental rehabilitations due to extensive dental caries and generalized severe early childhood caries. By comparison, many dentists, especially in rural Virginia, are having difficulty maintaining scheduled operating room time at their local hospitals. To use an example, Coastal Pediatric Dental & Anesthesia has two pediatric dentists with privileges at both the hospital and two ambulatory surgical centers affiliated with that hospital. Together they can see, at most, 70 patients (if every case is treated as planned, which is rarely true) a year with their assigned block times.





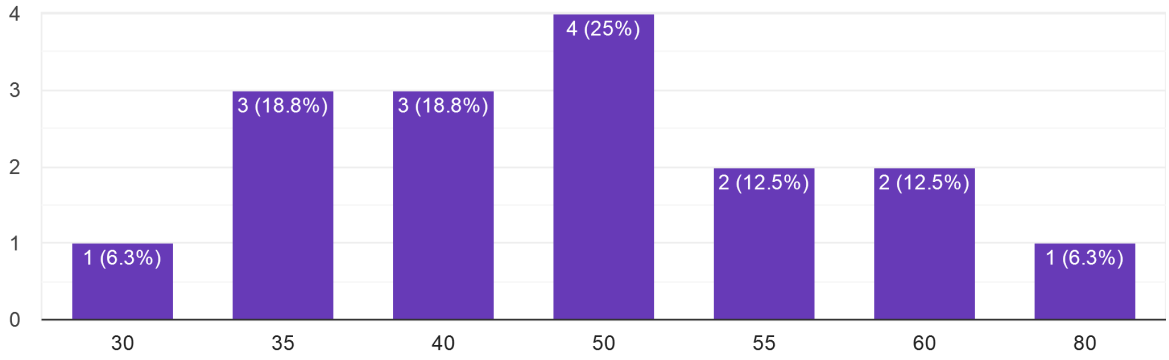
Approximately what percentage of your pediatric patient population (for sedation and anesthesia) is under the age of 3?

16 responses



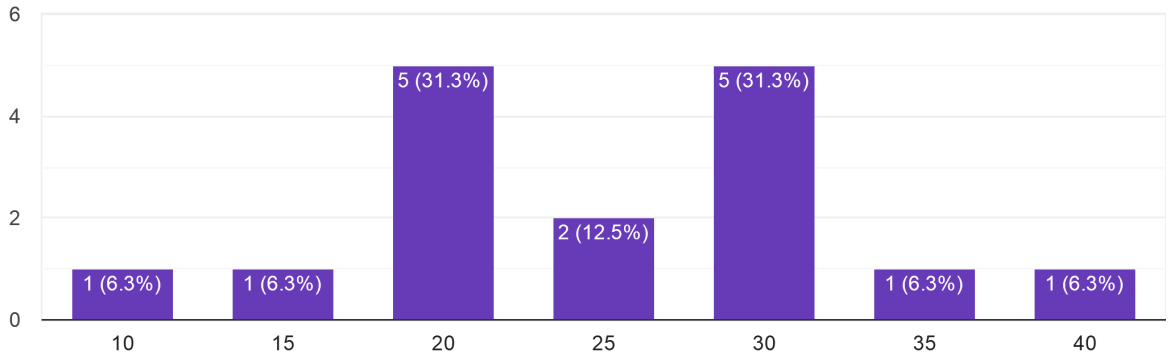
Approximately what percentage of your pediatric patient population (for sedation and anesthesia) is age 3 - 5?

16 responses



Approximately what percentage of your pediatric patient population (for sedation and anesthesia) is age 5-7?

16 responses



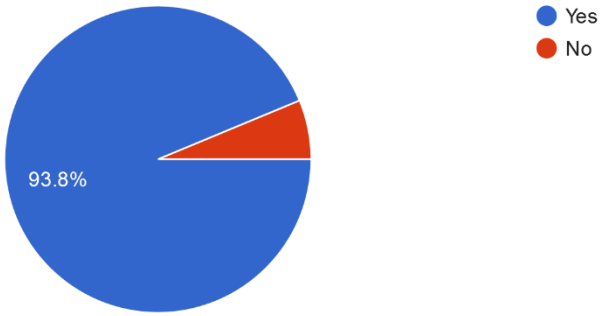
Limiting pediatric sedation and anesthesia to the inpatient hospital will cause severe constraints on the number of patients that can be seen. Even limiting such procedures to hospitals and ambulatory surgical centers would mean significantly increased waiting times for treatment and many children simply not getting care.

Economic Burden

It is well established that the children that grow up in a lower socioeconomic family are at high risk for dental caries. Because of this fact, many children needing sedation and anesthesia services are often on the Smiles for Children Program (Medicaid). In addition, with the impact of the Coronavirus and the expansion of the Medicaid program, more and more children are falling into the aforementioned categories. The same survey of dental anesthesia providers revealed that all respondents currently practicing in Virginia participate as in network providers for the Smiles for Children Program.

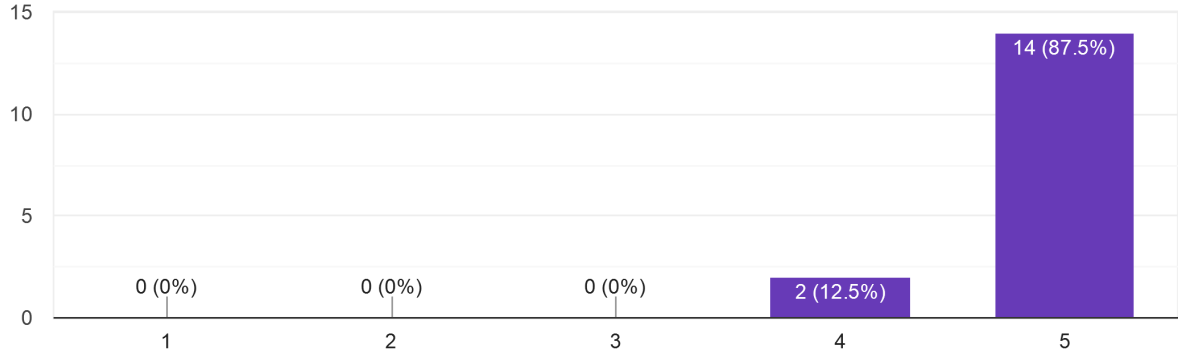
Do you participate in the Virginia Smiles for Children Program (Medicaid / Dentaquest)?

16 responses



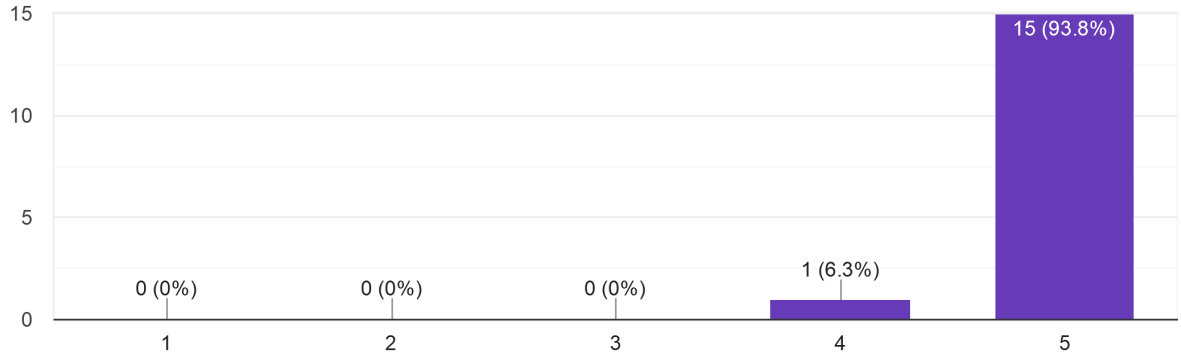
A majority of my pediatric patients are seeking full mouth dental rehabilitation for severe dental caries.

16 responses



Many of the children I treat that have severe early childhood caries / rampant caries are of low socioeconomic status.

16 responses



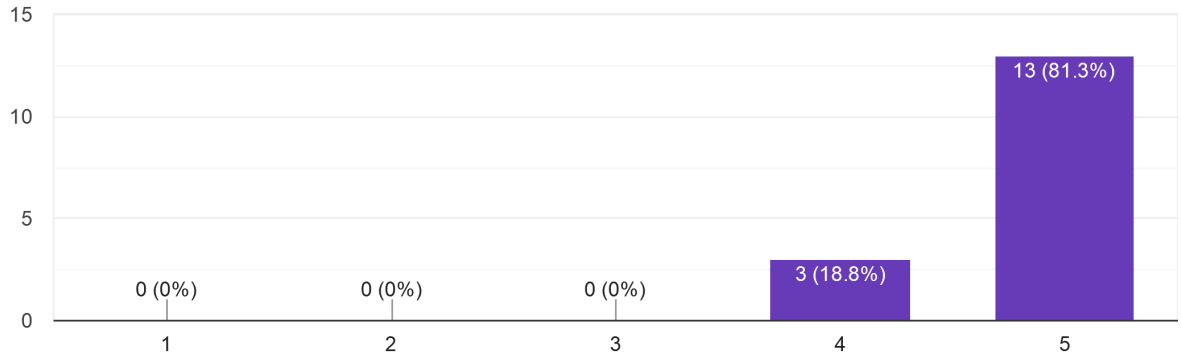
We also know that there is a tremendous cost savings to providing anesthesia outside of the hospital. Wilson et al. found that hospital facility fees were an average of $20 per minute in 2004 (Wilson, 2004). Additionally, Rashewsky et al. found that office based general anesthesia in the ASA I preschool age child saved, on average, $5000 per case (Rashewky, Parameswaran, Sloan, Ferguson, & Epstein, 2012). While this may not directly impact the Medicaid patient and their family, it certainly has an impact on the tax payer and Virginia Department of Medical Assistance Services (DMAS) resources.

A related issue that is not often discussed is that many medical insurances refuse to cover pediatric dental services in the hospital. While Virginia Law (38.2-3418.12) stipulates that such coverage must be provided for children under the age of 5, this often comes with the automatic denial for

children 5 and over. There is often also the argument that these procedures can medically be provided under local anesthesia only, and are therefore not medically necessary. (The counterpoint to this argument is that many medical procedures may also be performed in this fashion, such as a knee or hip replacement, but that does not mean that such a procedure, performed under anesthesia, is not medically necessary.) This often causes parents to seek care in the dental office because they can save tens of thousands of dollars on hospital facility fees and anesthesia professional services. This is without consideration to the cost of the dental care itself.

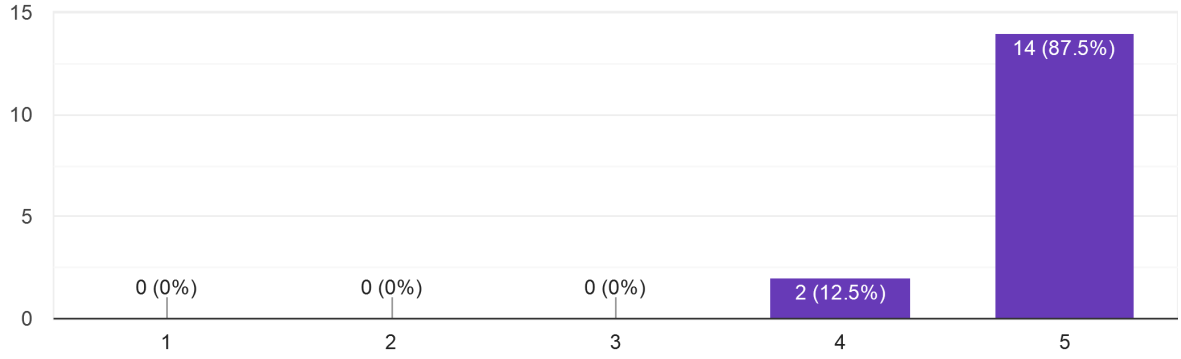
Fee for service and private insurance patients often proceed with care in the dental office because they are either denied medical coverage or it is cost prohibitive to be treated at the hospital.

16 responses



Many of the children I treat would not be able to successfully have their dental disease treated without the expertise of a anesthesia provider.

16 responses



Anesthesia Providers / General Anesthesia & Sedation Licensure

The moto of the American Society of Anesthesiologists is “Vigilance.” As anesthesia providers our responsibility is to risk stratify the patient and help the patient (or their family) determine the acceptable risk AND advocate for the patient when they are under anesthesia. Dentists in Virginia receive a special permit to be able to provide these services. This permit grants the license to make such assessments and provide the treatment based on those assessments. Simply restricting an age group to have such treatment in the hospital restricts the expert from doing so.

Allow me to use a hypothetical to illustrate this issue. Many elderly patients have comorbid conditions that may make them at risk for complications of anesthesia and sedation, including local anesthesia. Such conditions might include a history of coronary artery disease, pulmonary disease, cerebrovascular disease. Because of this, should we make a regulation that all individuals over an arbitrary age, say 70, should not have any form of sedation or anesthesia (perhaps including local anesthesia) unless they are in the hospital where equipment such as percutaneous coronary intervention or diagnostic lab tests (such as cardiac enzymes) would be immediately available. While a majority of dentists would not support such a sweeping regulation, some individuals that treat only pediatric patients might agree that this advances safety in this population. This is likely because these same individuals may not have the comfort or level of expertise in treating this population of patients.

In respect to this argument, please see the American Academy of Pediatric Dentistry’s Policy for Selecting Anesthesia Providers for the Delivery of Office-Based Deep Sedation / General Anesthesia. (The American Academy of Pediatric Dentistry, 2018) Here is a figure from the document showing the training of specific anesthesia providers.

Table. ANESTHESIA EDUCATION AND TRAINING COMPARISON

Anesthesia provider	Permitted to function independent of supervision by anesthesiologist	Minimum duration of program required for certification	Min. # of DS/GA cases	Min. # of pediatric cases	Definition of pediatric patient	Min. # of DS/GA cases involving patients with SHCN	National examination/ certification organization
Certified anesthesiologist assistant[5]	No	24 months	400 GA cases	50	0-18	N/A	National Commission for Certification of Anesthesiologist Assistants
Certified registered nurse anesthetist[6]	In some states	24 months	25/400	< 2 yrs: 10 2-12 yrs: 30	≤12 yrs	N/A	National Board of Certification and Recertification for Nurse Anesthetists
Dentist anesthesiologist[7]	N/A	36 months	800	125	≤7 yrs	75	American Dental Board Anesthesiology and/or National Dental Board of Anesthesiology
Medical anesthesiologist[8]	N/A	48 months	N/A	100	≤12 yrs	N/A	American Board of Anesthesiology
Pediatric medical anesthesiologist[9]	N/A	12 month-fellowship following medical anesthesiology residency	N/A	N/A	N/A	N/A	American Board of Anesthesiology (Pediatric Anesthesiology Examination[10])
Oral and maxillofacial surgeon[11]	N/A	Five months anesthesia service supplemented by OMFS service * 48 months	300	50	≤18 yrs	N/A	National Dental Board of Anesthesiology for anesthesia certification American Board of Oral and Maxillofacial Surgery for surgery certification

DS/GA= Deep sedation/General anesthesia. SHCN= Special health care needs. OMFS= Oral and maxillofacial surgery.

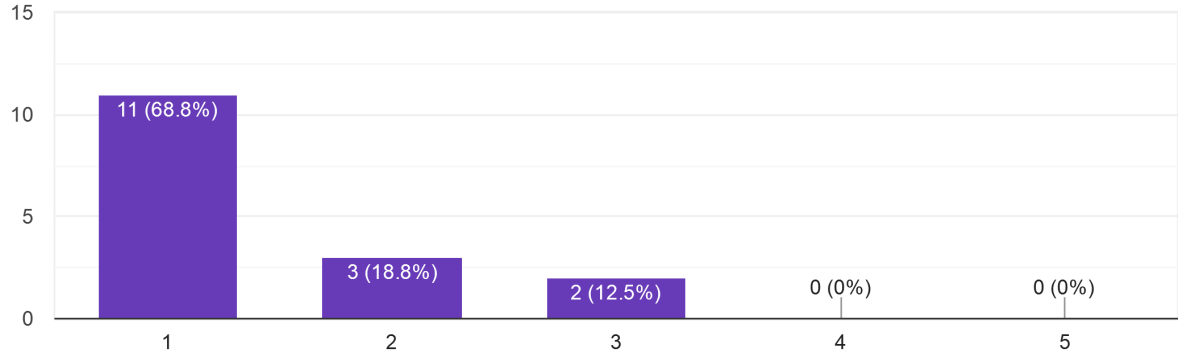
* During the oral and maxillofacial surgery training program, a resident's assignment to the department of anesthesiology "must be for a minimum of five months, should be consecutive and one of these months should be dedicated to pediatric anesthesia".[11] This anesthesia experience is supplemented throughout the training program to ensure competence in deep sedation/general anesthesia on adult and pediatric patients.

Promoting Patient Safety

Dr. Robert Campbell established a standard of care and a record of patient safety here in Virginia when he published "Pediatric Dental Surgery Under General Anesthesia: Uncooperative Children" in Anesthesia Progress (Campbell, Shetty, Shetty, Pope, & Campbell, 2018). In Campbell et al.'s review they treated 351 consecutive pediatric patients, all without any major anesthesia complications. The reported overall complication rate was 1.1%. While we agree that any mortality in the dental office is a tragedy, broad regulations regarding restrictions by age were widely regarded as ineffective by the Dentist Anesthesiologists surveyed.

Patients under the age of 3 should not receive sedation and / or anesthesia outside of the hospital.

16 responses



Patients under the age of 5 should not receive sedation and / or anesthesia outside of the hospital.

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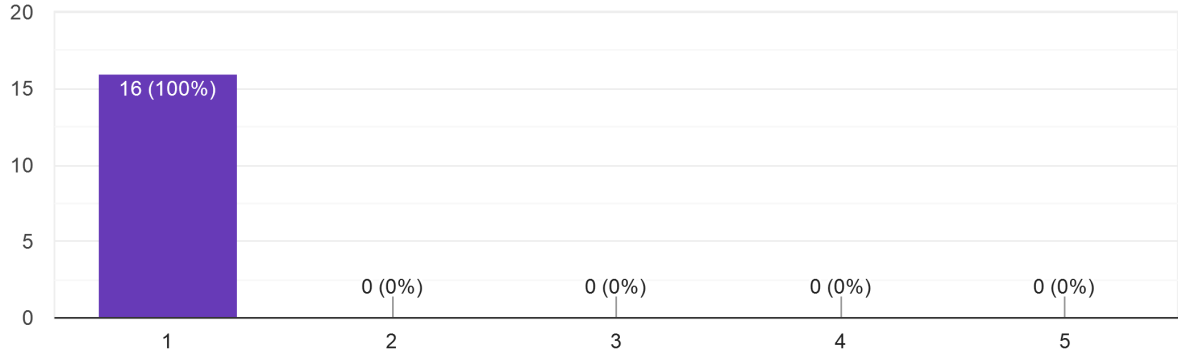
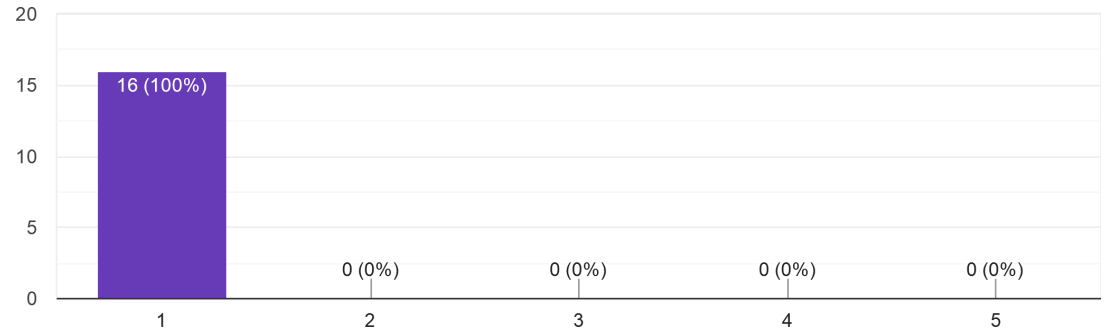


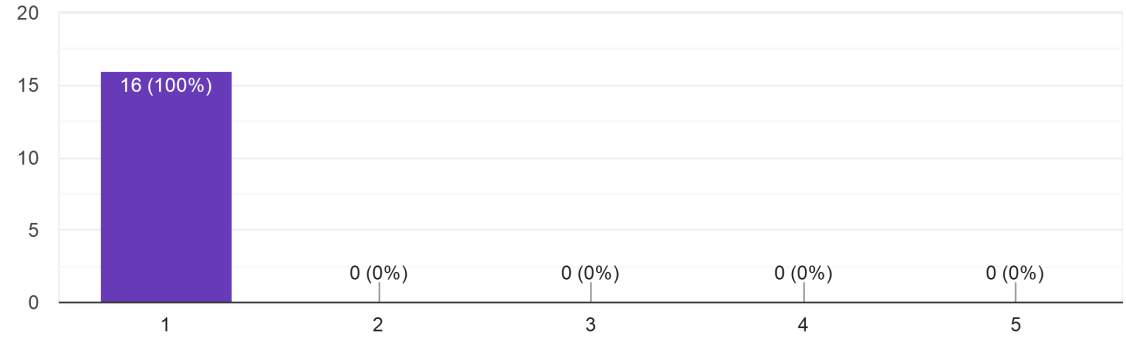
Patients under the age of 7 should not receive sedation and / or anesthesia outside of the hospital.

16 responses



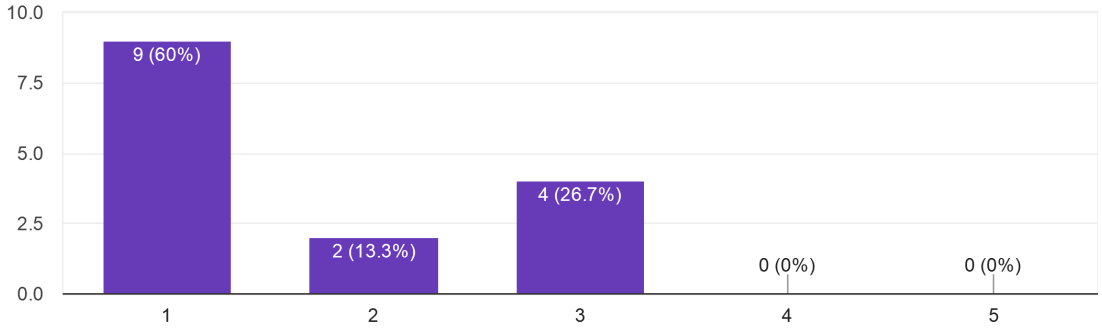
Pediatric patients for general anesthesia should be seen only in the hospital.

16 responses



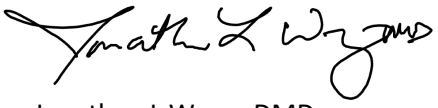
I believe that a lower age limit (whatever that limit might be) will help protect patients.

15 responses



As demonstrated in the preliminary data from the survey, dentist anesthesiologists in Virginia feel that there are much more effective ways of enhancing patient safety in regard to anesthesia and sedation. Again, it cannot be downplayed that tragedies have occurred here in the Commonwealth, but the only way to improve safety for the public is to rely on data and advice from a committee of anesthesia providers who are experts in the given field—in this case, those practicing pediatric anesthesia and sedation for dental care.

Respectfully on Behalf of the Fifteen other Respondents,



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Diplomate, American Dental Board of Anesthesiology

Diplomate, National Dental Board of Anesthesiology

Works Cited

Campbell, R., Shetty, N. S., Shetty, K. S., Pope, H. L., & Campbell, J. R. (2018). Pediatric Dental Surgery Under General Anesthesia: Uncooperative Children. *Anesthesia Progress*, 225-230.

Rashewky, S., Parameswaran, A., Sloan, C., Ferguson, F., & Epstein, R. (2012). Time and Cost Analysis: Pediatric Dental Rehabilitation with General Anesthesia in the Office and the Hospital Settings. *Anesthesia Progress*, 147-153.

The American Academy of Pediatric Dentistry. (2018). Policy for Selecting Anesthesia Providers for the Delivery of Office-Based Deep Sedation/GeneralAnesthesia. In *The Reference Manual of Pediatric Dentistry* (pp. 151 - 153). Chicago.

Wilson, S. (2004). Pharmacological management of the pediatric dental patient. *Pediatric Dentistry*, 131-136.