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Governor Phil Bryant

State of Mississippi

PO Box 139

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Dear Governor Bryant:

I write to you about a grave concern of mine regarding the Mississippi Board of Dental Examiners and general anesthesia (on pediatric patients) in dental offices.

This is a long and complicated story, and I have been involved in this matter deeply for over four months.

This is the background: In the last few years a number of “corporate” dental practices in the state, (practices owned by a corporation, usually based outside of Mississippi) have decided, for a number of reasons, to perform general anesthesia on pediatric patients in their offices. There are a number of reasons for this change.

1. Most of the dentists in these practices are general dentists and unable to obtain privileges in local hospitals to perform dentistry under general anesthesia. In order to avoid referring these patients to advanced practice specialists (pediatric dentists) and losing money, they have decided to perform general anesthesia in their offices.
2. Although these practices “claim” that they wish to save insurers (especially Medicaid) and parents money by avoiding ambulatory surgical center and hospital fees, this has not been factually documented. That is not, I submit, the real reason for office general anesthesia.
3. They claim it is a “kinder and gentler” way for a child to have anesthesia, but this is untrue as often, because of anesthesia restraints in the offices, these children receive unnecessary injections and less sedation and expert care than would occur in a hospital/ASC setting. The procedure is often more traumatic in an office setting.

In order to perform these operations in their offices, these practices have employed the services of truly itinerant “dentist anesthesiologists” who fly into the state with their anesthesia equipment and medications. These “dentist anesthesiologists” have dental licenses in Mississippi from the Board.

However, the American Dental Association does not recognize “dentist anesthesiologist” as a specialty of dentistry. The dentist anesthesiologists are trying to get specialty status, but, to date, they have not obtained this.

I have grave concerns about this practice, and I’ve been joined by the Mississippi Association of Pediatric Dentists, the Mississippi Association of Pediatricians, the Mississippi Association of Nurse Anesthetists in lengthy monthly public discussions with the Board about this practice. To date, they’ve held four open meetings for discussions, and these have included countless statements from these representatives and me about the many problems associated with the unsound safety practices of this type of office anesthesia as it currently exists.

The Board now requires that the dentist performing the procedures have a” general anesthesia permit.” They have very dubious requirements for this permit and have not clarified them, but, to date, are still allowing dentists *without* this permit to have general anesthesia performed in their offices by these itinerant “dentist anesthesiologists.”

To date, as there is no recognized “dentist anesthesiologist” certification, the Board hasn’t defined who these practitioners are, or what their training must be. In general, the ones who have flown into the state appear to have the proper training.

However, there is no control over the safety and proper functioning of their machines, monitors, or medications. They load them on a commercial airplane where they probably bounce around in cargo or overhead compartments. I even believe that some of them *might be* transporting controlled substances across state lines, which is certainly a DEA violation.

In order to properly and safely perform general anesthesia in an office, one needs the following preparations *at a minimum*:

1. An operating dentist with a general anesthesia permit, which requires, according to the Board, an *undefined amount of training in general anesthesia.*
2. A licensed anesthesia provider who can demonstrate education, training, and certification in anesthesia. (The Board has no specific qualifications on this.)
3. Stringent policies and procedures regarding the conduct of surgery and general anesthesia. (The Board has no policies and procedures about this practice.)
4. Periodic inspections of the facility. (I submit the Board is not qualified to perform these inspections.)
5. Periodic inspections of all equipment and the safe use and storage of medications.
6. A written “transfer agreement” to a hospital in case of an emergency.
7. A fully-equipped recovery room with qualified personnel. (The dental offices doing this now do without recovery rooms or qualified nurses.)
8. *National certification* by an office-based surgery certification program. These associations, which serve as JCHO and Medicare inspections are the AAAASF (American Association for Accreditation of Ambulatory Surgery Facilities) or the AAAHC (the Accreditation Association for Ambulatory Health Care). These are bi-yearly inspections using *national safety standards*.
9. A qualified *registered nurse* to assist the anesthesiologist in the operatory to assist, especially in case of an emergency. To date, we have reports of receptionists and/or dental assistants performing this job.
10. *Stationary* equipment that belongs to the operatory and is not brought in, uninspected, for surgeries.
11. ACLS and PALS certification for all dentists, anesthesiologists, and nurses.
12. Emergency protocols. (The Board has no rules on this.)
13. Preoperative evaluation, in person or by phone, by the anesthesiologist, *prior* to the day of surgery. Any child with an ASA category greater than II should not be performed in an office. (The Board has no regulations on this.)
14. Appropriate equipment that is mandatory includes—airway management tools, BP, capnography, oxygen saturation, suction, defibrillator, EKG, intravenous equipment, an anesthesia machine with vaporizers, Ambu bag. This equipment must be age-appropriate. (The Board has no specific regulations on this.)
15. Necessary medications include sedatives, anesthetics, epinephrine, atropine, succinylcholine, lidocaine, bicarbonate, and dantrolene (for treatment of malignant hyperthermia) if anesthetic gases or succinylcholine is used. These medications should be inspected, stored, dated according to national standards, and should remain in the office, not transported into the office. (The Board has no specific regulations on this.)
16. Dental assistants, dental hygienists, office staff are to perform within their qualifications, and are not to be used as nurses, recovery personnel, or general anesthesia assistants. (The Board, at the last meeting, seemed to believe that these personnel *could* perform some medical tasks.)
17. The exact equipment, qualified personnel, procedures, policies, etc. that are available in an ASC or hospital *must* be identical in an office operatory.
18. In addition, the dental regulations might be read to prevent MD anesthesiologists and CRNA’s from performing anesthesia in dental offices, as the Board has opined, “We have no jurisdiction over these other practitioners.”
19. ***Informed consent***, **including the offering of referral to a dentist who can perform this procedure in an ASC or hospital.**

In our discussions with the Dental Board, we have tried to impress on them that the *identical* standards that are required in an ASC and hospital *must* be incorporated into office surgery. I, personally, see no reason why it can’t be performed safely in an office, but it must have exactly the same standards. Additionally, I have no objections to properly qualified “dentist anesthesiologists” (if properly qualified and certified according to education, training, and certification by the Board) performing in a stationary operatory.

I have proposed, in letters and in speeches before the Board, that the Board form a Select Committee composed of MD anesthesiologists, nurse anesthetists, “dental anesthesiologists,” pediatricians, pediatric dentists, general dentists, oral surgeons, etc. to rewrite the outdated portions of the Mississippi Dental Act to conform with current *national* practices and standards. (One of the most serious problems I’ve had with working with the Board is that it is composed entirely of general dentists, and, surprisingly, has no specialists with experience in office anesthesia.)

This committee could quickly come with recommendations to the Board that would be non-discriminatory, safe, current, and would reflect the highest anesthesia safety concerns we must have for Mississippi’s children.

I believe the Board does not wish to change the statute because of potential Legislative interference. However, I do not fully understand their hesitance.

I had a conversation with an officer of the Mississippi Association of Pediatrics who visited the meetings once. In a telephone conversation afterwards, he said to me, “This is my first meeting, but I’m astounded. It just doesn’t seem that the Board is concerned about the poorest and most vulnerable patients, our children.”

Of importance, the Board voted over two months ago to notify dentists that general anesthesia cannot be done in offices unless they have general anesthesia permits. By December 7, 2018 this notification had not occurred, (Dr. Conway said yesterday, “It is being done today.”) and they continue to have general anesthesia performed in their offices in *defiance of regulations*. The Board is seemingly unconcerned and will not yet discipline these dentists, although they have received formal complaints about them. Additionally, the Board has yet to send their removal of one of the FAQs about general anesthesia to the Occupational Board.

Governor, I have “no dog in this hunt.” I have performed over 10,000 pediatric dental anesthetics, more than anyone in the state. I am nearing retirement. I don’t care about the money. I don’t care about any “turf wars.” I care only about insuring that Mississippi’s (mostly Medicaid and African-American) pediatric patients receive the highest level of anesthesia care in dentists’ offices.

I submit that the Board of Dental Examiners *doesn’t* wish to have the highest safety standards, has ignored, with malice and disdain, testimony of experts in the field, has obfuscated and lied about what they have announced and voted on in public meetings, and seems more concerned about allowing these unsafe practices and sorely outdated regulations to continue (and to continue the flow of money into dentists’ coffers) than they are concerned about safety, thereby demonstrating their contempt for our state’s experts’ safety concerns and recommendations.

The press and literature are full of articles about dental office general anesthesia and sedation deaths, especially those of children. **No one should die in a dentist’s office due to anesthesia. No child should die in a dentist’s office due to anesthesia.** I submit that the Board has not lived up to its *raison d’etre,* which is to protect the citizens of Mississippi, especially its smallest and most vulnerable, regarding the administration of general anesthesia in dental offices.

At this point, Governor, I feel like I and my pediatric, anesthesia and pediatric dentistry colleagues have done all we can. We feel the Board, at this point, is *untrustworthy* regarding this subject. Some members have demonstrated contempt, sexism, disdain and, frankly, ignorance regarding general anesthesia and safety concerns. The Board president, Frank Conaway, DMD, has been especially truculent, petulant, obstructionistic, profoundly sexist towards the majority of female experts, and has been derelict in his duties as required to act after being directed by majority votes of the Board. Mark Donald, DMD, has been especially concerned and helpful to my group. The remainder of the Board has acted bored and unconcerned with the entire subject, acting as if all the experts’ concerns are nothing more than a nuisance. The outcome, I predict, if things continue as they are now, will soon, sadly, **be a pediatric death—a completely unnecessary death.**

I know that all of the experts who have been concerned and testified will not let this subject die a slow death with the Board.

I am asking you, with your powers, to become involved in this issue. I will continue, however, preaching my safety concerns even if nothing changes. I intend to contact Medicaid, state private insurance companies, the state Insurance Commissioner, the Department of Public Health, the Mississippi State Medical Association, the Mississippi Dental Association, the chairmen of Medicaid and public health in both houses of the Legislature, and will write columns to the Clarion Ledger, the state medical and dental journals, the Northside Sun, other state newspapers, and television and radio stations. As a very proud practitioner of anesthesia for over thirty years with the majority of my practice limited to pediatric anesthesia, and as a physician board-certified in anesthesia, internal medicine and critical care medicine, I believe it my professional duty to do all I can to insure the highest anesthesia safety standards available, and to warn the Mississippi public of unsafe anesthesia practices wherever I find them, including general dentists’ offices.

Sincerely,

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Cc:

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