ADA'S SEDATION AND ANESTHESIA GUIDELINES PASS: WILL THEY BE UNIVERSALLY ACCEPTED?

The American Dental Association's newly revised "Guidelines for the Use of Sedation and General Anesthesia by Dentists" and "Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students" overwhelmingly passed the ADA's 2007 House of Delegates by more than 92%. What was formerly defined as "anxiolysis" is now "minimal sedation." Minimal sedation includes nitrous oxide-oxygen alone, or enteral minimal sedation alone, or a combination of the two. It is limited by the administration of no more than the maximum recommended dose for unmonitored home use of a single enteral sedative, with the possibility of giving another half-maximum dose later in the procedure, if needed, when the original effect begins to wane. There was little controversy associated with the minimal sedation guidelines. The par-enteral moderate sedation guidelines, formerly called "parenteral conscious sedation," and the deep sedation/general anesthesia practice guidelines had only minor changes and were not significantly debated at several preliminary open discussion meetings preceding the House vote.

The only controversial section of the new guidelines involved a new entity called "moderate enteral sedation," for which there had been no teaching or practice guidelines in the past. Because the old guidelines did not address this area, they merely cautioned against administering multiple doses of oral sedatives because of an increased risk for producing a level of sedation deeper than what the dentist intended. Moderate enteral sedation necessitates more training than needed for administering minimal enteral sedation because the dentist could be giving more than the maximum recommended dose contained in the FDA-approved labeling for unmonitored home use. It typically involves titration of an enteral sedative to an endpoint that may be a little deeper than that attained with minimal sedation, yet this level still must provide a margin of safety wide enough to make it "unlikely" that the patient will drift into deep sedation.

The ADA's experts in sedation education believed that the following course content could adequately teach the necessary principles for dentists to administer enteral moderate sedation safely:

1. 24 Hours of didactic training.
2. Observation of at least 10 enteral moderate sedation cases, including at least 3 actual hands-on cases with no more than 5 students per teacher in an adequately equipped clinical facility, including the rescue of a patient from deep sedation.

3. Advanced cardiac life support training (typically 2 days) or an acceptable sedation emergency course with emphasis on airway management and ventilation.

4. Basic life support for the healthcare provider that includes training in positive pressure ventilation with a bag-valve-mask.

5. For additional safety, the course director must certify the competency of each dentist. A dentist cannot just sign up for the competency course, leave early, and still pass the course.

6. Finally, these are minimal teaching standards. Because the course director must certify the competency of each participant, additional hours may be required for teachers and their students to meet this requirement.

The total number of hours and experiences in moderate enteral sedation are considerably more than the "mere 24 hours" of training that some dentists erroneously proclaim is the weak link in the guidelines. While these dentists argue that the didactic hours for moderate enteral sedation are too low or that the number of moderate enteral sedation cases observed or actually participated in by the student are too few, others have said that the new guidelines are much too rigorous. Who is right? The truthful answer is that we do not know for certain at this point. What we do know is that the educators believe that the guidelines are reasonable in all areas and that we should give them a chance to prove it.

It is your editor's hope that when moderate enteral sedation courses are developed, the ADA community will receive feedback on whether competency can be attained with the recommended hours or whether they should be increased or reduced. Until then, I recommend that all dentists, dental organizations, state dental boards, and legislators universally accept the ADA guidelines as an integral part of their rules and regulations. The guidelines will surely change over the years as new technologies, techniques, drugs, and standards evolve. If the term "According to the Current ADA Guidelines" is written into the dental board's rules, they would not have to be reworded every time the guidelines are updated.

We must realize that no additional amount of required hours of training or continuing education or stricter dental board rules will totally eliminate human errors or their dire consequences. Poor outcomes do not necessarily mean that the guidelines and rules are faulty or that they must be immediately changed. My hope is that universal acceptance of the ADA guidelines will lead to reasonable rules to increase the margin of safety for our patients without unnecessarily overregulating our profession.

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