WHAT IS THE STANDARD OF CARE FOR ANESTHESIA? WHO DETERMINES IT?

Your editor is certainly not a lawyer, but he has provided expert testimony on numerous occasions. The plaintiff's dental malpractice attorney or a dental board prosecutor first must attempt to identify the appropriate standard of care and then must try to demonstrate that the standard of care was breached. The defense attorney often attempts to establish a different version of the standard of care and then tries to show that the dentist's practice met that standard. Experts on both sides provide testimony that often helps define the standard of care. They then offer their own opinions as to whether or not the dentist met that standard. But what is the true standard of care, and who determines it?

The standard of care is often defined as the level at which average, prudent, similarly qualified providers in a given community would have managed the patient's care under the same or similar circumstances. In the past, when there were significant differences in how dentistry was practiced in different communities, experts typically were obtained from the same community as the venue of the case. However, improved communication and the development of national practice guidelines and practice parameters by various medical and dental societies have all but erased many of those community differences. Thus, experts from one area of the country often are used to establish the standard of care in other geographic areas.

The key to accurately and fairly determining the standard of care is for the expert to be a true expert—one with a very broad base of knowledge and experience, who is tolerant of acceptable alternative practices. Finding a true expert can be a difficult task because there are so many different yet very acceptable ways to attain the desired outcome. For instance, one expert sedation provider may be comfortable doing intravenous moderate sedation for a full mouth extraction of teeth, stating that general anesthesia is not necessary, and that it adds too much risk for minimal benefit, whereas another provider may believe that deep sedation or general anesthesia with an intermittent propofol bolus technique provides the best opportunity for a positive experience with minimal additional risk to the patient, and still another may believe that an open airway anesthetic adds significantly more risk to the procedure, and that an endotracheal intubation is the only safe way to manage such a case. A highly respected expert hospital anesthesiologist is more likely to testify that in his experience, it is unsafe and therefore below

the standard of care to do a multiple extraction under general anesthesia without an endotracheal tube to protect the patient from possible upper airway obstruction, laryngospasm with subsequent negative pressure pulmonary edema, and aspiration of teeth, blood, and vomit. On the other hand, an equally highly respected private practicing office-oriented dentist anesthesiologist might argue strongly that intubation requires a much deeper level of general anesthesia than is necessary with an open airway technique, and that intubation increases the risk for laryngeal trauma, airway edema, postanesthesia croup in children, and laryngospasm following extubation. Therefore, it is possible that if any of these three "expert" practitioners were to provide his own very narrow interpretation of the standard of care for office sedation or anesthesia for a full mouth extraction of teeth, his biases may unfairly influence the expert testimony, to the detriment of the potentially innocent defendant. True experts all have their own particular biases, but they understand and are willing to acknowledge publicly that many alternative techniques, methods, drugs, and so forth, are perfectly acceptable, when properly performed or administered, even if they personally do not use them.

I do not define the standard of care as only what I personally do or would do under similar circumstances, although it is hoped that my practices fall within the boundaries of accepted standards of care within our profession. For instance, I personally recommend against using a steel needle butterfly for the patient's intravenous lifeline during deep sedation and general anesthesia, because it offers a much greater likelihood of infiltration compared with a flexible intravenous catheter, which is used universally in all hospital operating rooms. If intravenous access were lost at the time of an anesthetic emergency, the patient's safety would be placed in significant jeopardy. Nevertheless, approximately 50% of oral surgeons still use steel needles for their IVs¹; therefore, I would argue reluctantly that the use of a steel IV needle is within the standard of care in oral surgery, even though it is not acceptable for my own personal standards.

I have heard a dentist testify as an expert that it is the standard of care for every patient with any type of medical condition such as hypertension or coronary artery disease to have a medical consultation before any dental procedure is performed, because this is always done in the hospital general practice dental residency program that he heads. This definitely is not the standard of care in dentistry or medicine, as is evidenced by the 2007 guidelines for evaluation of patients with cardiovascular disease for noncardiac sur-

gery.² I have heard oral surgeons testify that it is below the standard of care to use intravenous diazepam instead of midazolam or halothane instead of sevoflurane or oral triazolam because it does not have an FDA indication for dental sedation. Undoubtedly, some experts have a reputation of stating as fact whatever the attorney wants them to say to benefit their client; however, others are well-meaning practitioners who are flattered to be considered experts, but who do not realize that their views are far too narrow for them to be a true expert.

I find it interesting how quickly the perceived standard of care changes. Guidelines developed by various organizations change every few years, whenever the committees who developed them subsequently meet again. Guidelines are supposed to guide practitioners to sound practice and are not supposed to be rigidly interpreted as the standard of care, making any deviation instantly substandard. This modern approach is emphasized specifically in the current Advanced Cardiac Life Support guidelines and in the guidelines for antibiotic prophylaxis for patients with heart disease and orthopedic implants, for whom the dentist's professional judgment is especially important in making final treatment decisions.

Dentists are, by the nature of our training, perfectionists, and it is not unusual for us to think in terms of black and white. Dentists know that if one accurately completes each small step in a complex procedure, the result almost always will be reproducibly excellent. This is what makes dentists superb practitioners in an-

esthesiology. Unfortunately, lack of acceptance of alternate routes to the same end frequently makes dentists poor expert witnesses. The bottom line is that the standard of care is determined by the profession and is disseminated through advanced educational programs, scientific publications, continuing education courses, and organizational guidelines and parameters of care, which, when taken in total, define the boundaries for each standard. For those who venture into the realm of providing expert testimony, it is hoped that you will choose your words carefully and do your homework on acceptable alternative methods. Finally, you must not get caught up in the competition to be on the winning side. Your testimony should be the same, no matter which lawyer asks for your expert opinion.

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