IMPROVING THE QUALITY AND FAIRNESS OF SEDATION AND ANESTHESIA EVALUATIONS

Most state dental boards require an in-office peer review to assure that a dentist seeking a moderate sedation or general anesthesia permit is practicing within the standard of care. Typically the dentists must not only perform a sedation or anesthetic to show the evaluators their use of monitoring and drug administration technique, but they must also demonstrate their equipment, medications, and knowledge to manage emergencies that might arise. The evaluators' report is accepted by the dental board since most of them do not have sufficient training to critically judge their quality and fairness.

Finding volunteer evaluators is often difficult since dentists seeking a permit typically start their practices in July, the busiest practice season for many evaluators. Additionally, with little or no compensation for their time and travel and considering the economic impact of taking a day off to do the evaluation, it is understandable why volunteering for this professional self-regulating duty is not popular. Consequently, a state anesthesia chairperson may have to accept any dentist with an anesthesia permit to be an evaluator despite their having no special evaluator training. Unfortunately, a poorly executed evaluation can result in a multitude of problems with the perceived or actual lack of quality and fairness by perhaps a well-meaning evaluator who may be a competent practitioner but who is not prepared to be an evaluator. Contrary to the rigorous training that the Commission on Dental Accreditation mandates for their site visitors, sedation and anesthesia evaluators often enter blindly into the evaluator's role, believing that their clinical training will make them good evaluators. A capable evaluator must be trained to accept that there are a variety of drugs and techniques that are all within the standard of care, even though their own personal bias might be, for instance, that an open airway general anesthesia technique is risky and unacceptable in their own office.

Anesthesia educators make excellent evaluators because they have a broad-based knowledge of sedation and anesthesia and have the teaching experience to formulate proper questions and fairly evaluate answers, even though they may prefer providing the care in a certain manner. Private practicing dentists may have a different perspective and contribute to the diversity of the evaluation team. A team of academic and private practitioners is ideal. Requiring at least one evaluator to have the same type of practice as the examinee, as exists in California rules, is highly recommended.

Because any evaluation may be flawed, an in-depth written evaluator's report must be scrutinized by a properly balanced committee of knowledgeable arbitrators, perhaps a combination of oral surgeons, dentist anesthesiologists, and moderate sedationists from both academia and private practice, before an examinee is officially failed. Several decades ago when the American Dental Society of Anesthesiology (ADSA) Fellowship oral exam was being given, one examiner voted to fail a candidate because he did not know how to use rectal Brevital. He was overruled by the exam committee because none of them had ever used it and considered it an outdated technique. ADSA examiners then developed standardized questions and agreed on various acceptable and unacceptable answers before subsequent examinations. Thus, they became self-trained evaluators. In another example of an unfair office evaluation, a moderate sedation-trained dentist failed because he did not have succinylcholine and would not give it when asked how to treat an oversedated patient with laryngospasm. The evaluator did not appreciate the difference between dentists with moderate sedation training and those like himself with general anesthesia training. Those who are intimately familiar with the 2007 American Dental Association "Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students" know that succinylcholine is not part of an intravenous moderate sedation course nor should a moderate sedationist even have it. They are taught to call for help, suction the airway, apply positive pressure oxygen by facemask using the triple jaw maneuver, and to reverse the sedative agents. Not having flumazenil and naloxone or not verbalizing how to use them for benzodiazepine and opioid reversal would be legitimate reasons for failing, but not because the moderate sedationist did not have succinylcholine.

The clinical skill of a dentist with moderate sedation training is easy to evaluate because he/she personally provides the sedation and monitors the patient throughout the appointment while also doing the dentistry. Likewise, the clinical skill of a dentist anesthesiologist who provides only the anesthesia is easy to assess because he/she also personally provides the anesthesia. However, when the operating dentist uses a dental assistant or a certified registered nurse anesthetist (CRNA) to manage the airway and monitor the patient during deep sedation or general anesthesia, it is difficult for the examinee to actually demonstrate his/her own anesthetic skill. The evaluation is actually of the entire team instead of just the dentist. If the team changes personnel, the new team should ideally be evaluated again, but that would not be very practical. While evaluation of the anesthesia team is a valid

concept, the operator-anesthetist dentist should have the option of providing only the anesthesia to demonstrate their own anesthetic skills while their partner does the dental procedure. Unfortunately, in another unfair evaluation, the operator-anesthetist who also sometimes supervises a CRNA for more difficult cases decided to personally provide only the anesthesia to demonstrate his own anesthesia skills, but he was failed by the evaluator, who was also a neighborhood competitor, for not practicing as an operator anesthetist for examination of the anesthesia team and because he felt that the operatory was too small, despite the lack of standards for the minimal size of dental office operatories.

In order to help improve the quality and fairness of the evaluation process, the following are suggested:

1. Evaluators must first receive training by anesthesia-trained educators to develop reasonable questions and discuss the range of acceptable and unacceptable responses.
2. Evaluators must understand that they are observers in the office and must remain professional, even if the examinee struggles for an answer. There is no place for shouting, badgering, belittling, or arguing with the examinee.
3. The evaluation must be made by at least two evaluators, preferably representing both academic and private practices, with at least one having a practice similar to that of the dentist being examined.
4. Evaluators must not be from the same area of the city or be direct competitors with the examinee to prevent the perception that a conflict of interest exists between the evaluator and the examinee. With proper notice, examinees must have the opportunity to disqualify any evaluator with whom he/she is uncomfortable.
5. Close friends or business partners must not evaluate each other. Not only would that appear to be a conflict of interest, but the lack of objectivity may also detract from the quality of the evaluation. It only takes one highly publicized incident of nepotism or cronyism for the public to demand radical reforms in the evaluation system that might be very difficult to manage.
6. Negative evaluations must be written in detail so that the specific points that were missed or substandard can easily be judged for quality and fairness by a peer-review committee, consisting of dentists with varied backgrounds in sedation and general anesthesia, eg, an oral surgeon, a dentist anesthesiologist, a moderate sedation-trained dentist, and a pediatric dentist.
7. Evaluations of dentist anesthesiologists and others who provide mobile anesthesia services must only take place when the mobile anesthesiologist is actually present in an office with their mobile facility in place. It is illogical and unfair to expect an office to have all of the drugs, monitors, and equipment permanently installed, even when there is no one present to use them until the mobile anesthesiologist transforms that office into a mini-operating room with his/her own mobile facility.
8. It is reasonable for dentists to be reevaluated, perhaps every 5 years, to ensure that they have kept up with changes in knowledge, technology, and standards of care. A reevaluation at any time is also reasonable based on complaints or following a poor outcome. It is impractical and unreasonable to mandate a new evaluation whenever a different supervised anesthesia team member replaces one who participated in a previous evaluation. It is also impractical and unreasonable to require mobile sedationists or dentist anesthesiologists to be evaluated in each office where they set up their mobile facility, so long as they provide the same level of monitoring and care at each office that was provided in their original evaluation. Ohio rules, for example, include this provision.
9. All evaluated dentists should provide feedback to the state anesthesia chairperson, anesthesia peer review committee, and the dental board without the fear of prejudice during subsequent evaluations, so that the quality and fairness can be improved.
10. Evaluators must understand their responsibility to be thorough and to point out all deficiencies. If, for instance, the record-keeping system is woefully deficient but is not discovered by the evaluators, during a subsequent dental board inquiry or malpractice litigation, the dentist is at great risk of being charged with substandard documentation even though he may have recently passed the dental board evaluation, which should have included keeping adequate anesthesia records. Any resulting publicity surrounding the perception of a dental board's very superficial, low-quality evaluation process could result in a diminution of the public's confidence in our profession's commitment to self-regulation.

High-quality, unbiased, and nondiscriminatory evaluations increase the safety of our collective practices and provide evidence to dental boards, legislators, and the public that our system works, and that mandatory accreditation of offices and practitioners by nationally-recognized organizations is not necessary. Sedationists and general anesthesia-trained dentists are encouraged to become trained evaluators to improve the quality, fairness, and long-term viability of our evaluation process.

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