American Society of Dentist Anesthesiologists finally recognized as American Dental Association’s 10th Recognized Dental Specialty by the National Commission on Recognition of Dental Specialties and Certifying Boards
Dentistry’s Newest Specialty: Anesthesiology for Dentistry

On March 11, 2019, the American Dental Association’s National Commission on Recognition of Dental Specialties and Certifying Boards (NCRDSCB) voted to recognize the new specialty of Dental Anesthesiology, joining nine other ADA-recognized dental specialties. Thirty-nine years after the founding of the American Society of Dentist Anesthesiologists, with the expressed purpose of specialty recognition, and 25 years after the first application for the specialty was submitted to the ADA by this specialty-sponsoring organization, dentist anesthesiologists now officially join the ranks of the two other long-accepted recognized anesthesia specialists, physician anesthesiologists and veterinarian anesthesiologists. Also included in the process was the recognition of the American Dental Board of Anesthesiology (ADBA) as the new specialty’s official certifying board which was founded in 1994. The specialty designation by the ADA follows previous specialty recognition by the American Board of Dental Specialties.

The NCRDSCB was established by the ADA to enhance the specialty recognition program in accordance with the ADA Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists. It is designed to help dentists excel throughout their careers, and for the public to ascertain the importance of educationally qualified and board certified dental specialists. Former ADA president, Dr. Charles H. Norman III, chaired the 19-member commission which was created in 2017 by a vote of the ADA House of Delegates to prevent perceived or actual bias of the specialty recognition process within the ADA House of Delegates. Thus, in line with the ethical standards of the ADA, dentist anesthesiologists can now inform the profession and the public of their anesthesia specialty status and board certification as Diplomates of the ADBA.

Dentist Anesthesiologist residency training programs have been accredited by the ADA’s Commission on Dental Accreditation (CODA) for more than a decade and are currently 36 months in duration following dental school, with 24 of those months exclusively dedicated to administration of clinical anesthesia, including 6 months of anesthesia just for dental patients. Of those 24 months, a minimum of one full year at the resident level of responsibility must be on a rotation in hospital department of anesthesiology, which is more than twice the duration of a hospital anesthesia rotation in any other dental specialty program according to current CODA accreditation standards.

Dentist anesthesiologists must complete a minimum of 800 cases of deep sedation/general anesthesia with a minimum of 300 endotracheal intubations, including 50 nasal intubations and 25 other advanced airway techniques. Because dentist anesthesiologist specialists frequently manage small children and patients with special needs who often require extensive dental procedures, dentist anesthesiologists are required to provide anesthesia for at least 125 children aged 7 years or younger and for at least 75 patients with special needs. Also, sharing the airway with an operating dentist who may be performing all types of restorative and surgical dental procedures requires special anesthetic skills and techniques unique to dentistry, so an optimal level of safety is enhanced during the required 100 dental anesthetics supervised by dentist anesthesiologist faculty members to teach these specific skills.
The requirements for nasal intubations, advanced airway placements, patients with special needs and cases with dentist anesthesiologist faculty supervision are all unique compared to any other medical or dental residency training program. The required 125 anesthetics for young children even exceeds those of physician anesthesiologist residency standards which require 100 anesthetics for children younger than 12 years. Additionally, dentist anesthesiologists must complete at least 4 months of rotations on hospital medical services such as cardiology, physical medicine, internal medicine and emergency medicine. Their anesthesia residency program must also have a curriculum plan including structured didactic instruction in addition to the extensive clinical experience designed to achieve the program’s competency requirements. Physical diagnosis and evaluation, behavioral medicine, methods of anxiety and pain control, and management of anesthetic complications and emergencies are just a few of the areas included in the rigorous didactic curriculum.

With their comprehensive accredited training in the art and science of anesthesiology for dentistry, the public can be assured that dentist anesthesia specialists will be able to provide safe and cost-effective control of anxiety and pain for dentistry, whether they practice in a fixed facility or as a mobile facility where they transform any dental office into a fully equipped mini-operating room with their ultra-modern portable anesthesia equipment that complies with national standards for safe ambulatory anesthesia. The greater demand for the delivery of increasingly more complex dental procedures by operating dentists has fueled a similar demand for a separate dentist anesthesia specialist to concentrate solely on providing the anesthetic. Recognition of the new anesthesia specialty will increase the number of residency programs and fully-trained graduates to meet that demand for board-certified dentist anesthesiologists.

March 11, 2019
Dr. James Tom
President

RE: Approval of Recognition of Specialty Status for Dental Anesthesiology

Dear Dr. Tom,

At its March 11, 2019 meeting, the National Commission on Recognition of Dental Specialties and Certifying Boards considered the American Society of Dentist Anesthesiologists application to recognize dental anesthesiology as a dental specialty.

I am pleased to inform you that the National Commission determined that the Requirements for Recognition have been met and adopted a resolution recognizing dental anesthesiology as a dental specialty.

The director of the National Commission will be in contact with you concerning next steps.

On behalf of the National Commission, I wish you congratulations.

Sincerely,

[Signature]

Charles E. Norman, III DDS
Chair
National Commission on Recognition of Dental Specialties and Certifying Boards

“I am pleased to inform you that the National Commission determined that the Requirements for Recognition have been met and adopted a resolution recognizing dental anesthesiology as a dental specialty.”
“Who am I in my professional life?”

Who am I? It is a question all of us have asked at different points in our lives. With deep reflection, we may have seen glimpses of an answer. Who am I in my professional life? For all of us dentist anesthesiologists, there always seemed an asterisk was appended to our answer. Clearly, we are dental specialists. We know that. We have all had at least two to three years of structured, formal, even accredited, post-graduate training. We obtained specialized recognition from state dental boards to administer general anesthesia outside the operating room - the only service in dental practice that a general dental license does not automatically allow one to provide. It is the only aspect of dental practice that routinely places the dentist in a life and death situation with our patients. We are experts in pharmacology, physiology and medicine. Yes. All of that. Our client dentists and patients all realize we are specialists. Our medical colleagues all realize we are specialists. Res Ipse Loquitur – The facts speak for themselves.

But, there was always an asterisk appended to our answer. Our national organization, the American Dental Association, never recognized us as specialists. And unlike Medicine, where the American Medical Association does not wield tremendous clout, the ADA has an outsized role in national and state dental affairs. How many times have we seen meetings of all the dental specialty groups, i.e., the other 9 ADA-recognized specialties, and we were not at the table? Four applications all approved at just about every level, except, of course, the ADA House of Delegates. There is no doubt that the ADA-recognized specialty of Oral & Maxillofacial Surgery made every effort, frequently wrongful and untruthful, to block us in the ADA House. The only place they could since, well, Res Ipse Loquitur. With Oral & Maxillofacial Surgery’s superior numbers, money and influence, it was a classic case of politics taking precedence over doing what the process said was the right thing to do.

While OMS is large, we are small. But with truth, justice and the American way on our side, just like Superman/Superwoman, we were not to be deterred.

Who gave the ADA the privilege of determining who is a dental specialty anyway? After our 4th application failed while passing every other ADA level of evaluation – again – we were done with the ADA. We would never file an application with the ADA again. Obviously to us, this was an organization that was deeply flawed, at least on this aspect of dental practice. So, our answer was the American Board of Dental Specialties, a new organization to recognize dental specialties, modeled after the American Board of Medical Specialties. We fought for recognition of what we knew was right. Dental Anesthesiology was a specialty of dentistry. When state dental boards did not recognize the ABDS, we won court case after court case. And it became clear to the ADA that……………… their specialty recognition process was flawed!! Really. Really? Yes. Our little group of 300+ women and men were able to affect change in the ADA, not from within, where we were not wanted, but proving that the power of an organization that represents about two-thirds of all dentists had systems that were corruptible. So, the National Commission was formed. No House of Delegates that our opponents could unfairly influence. No doubt the politics were still there. But, it was contained. And, today, we became ADA specialists. Not dental specialists. We have been that for a long, long time. But now our national professional organization’s recognition of what was obvious.
I thank the Commission for their recognition. I have to say, though, that as I sat in Dr. James Tom’s office awaiting the call, the only thing that came to mind is, “Too little, too late.” Total anticlimax. I know for our younger dentist anesthesiologists, this is a seminal moment. And it is!! I am happy. Truly I am. We will have a seat at the table. It is vitally important for us and for the dental profession to have finally cemented the truth that anesthesiology in all its nuances is the practice of dentistry, as it is the practice of veterinary and human medicine. But the joy in ADA recognition, after writing the last two applications and knowing that all the previous applications were such a waste of effort and money for our small group, is lost on me. I know that those of us who have been in the battles over the decades can relate. But I digress.

Now that this milestone is behind us, what does it mean? I asked at the beginning, “Who am I in my professional life?” I must ask that question anew. And I know the answer. We always took the high road with the ADA and the other specialties as we always fought our battles with facts and science, knowing we had right on our side. And we must take the high road still. It is the only way for us. It is in our DNA. To our Oral & Maxillofacial Surgery colleagues who fought us every step of the way, we have always said we have more in common than we do at odds. We both are the only general anesthesia providers in dentistry. What can we, the specialty of Dental Anesthesiology, do for your specialty to improve the safety of general anesthesia in dental offices? We have offered time and time again to help in training OMS residents. We still want to help. And what can you teach us from your long, storied history of providing general anesthesia in dental offices? Will you work with us, finally, to stop dental boards from limiting mobile anesthesia practice in state dental board rules and regulations? To our pediatric dentists, periodontists and general practitioners who we partner with to provide sedation education, what more can we do for you? To our other dental specialists who are not now providing sedation, we want to help train you to provide this service if it is applicable in your practice. Contrary to what others have said at ADA House of Delegates battles, we want as many dentists as possible to experience the benefits that safe sedation can have for their patients. And where you need a specialist for more complicated cases and patients, we will be there for you to provide safe sedation or general anesthesia, just as you utilize your other dental specialists for those other difficult cases. I am happy that the National Commission has recognized us as ADA specialists. The main reason is that, as an academic anesthesiologist for my whole career, it is my fervent hope that all dental schools will establish Departments of Dental Anesthesiology within their walls. It is in this way that dentist anesthesiologists can make the greatest impact on dentistry for everyone within our profession and for our patients.

The past is the past. We only move forward from here. We must remember who we are. Anesthesiology is a specialty that helps. We help dentists be able to do what they do. We help patients be able to tolerate that. And now, we will help the ADA, generalists and all specialists alike, to make sedation and general anesthesia practice safe, fair and accessible for the patients we serve. Congratulations to all of you who have worked so very, very hard over the years to make this a reality. A very special, warm thank you to Dr. John Yagiela, author of the first three applications, who left us too early to savor this moment. To our younger members, join the leadership. Make your mark. We now count on you to take over for us. You will sit at the ADA table of specialists. Make the most of it by doing as we have tried to do. Always remember that our needs are secondary. Remember that we serve our patients. We serve our profession. Within the American Dental Association.
Reflections of Dr. Christine Quinn, DDS MS, on the eve of March 11th, 2019

(As submitted to the ASDA Newsletter on March 10th, 2019 at approximately 21:30 hours)

Here we are on the eve of possible recognition of Dental Anesthesiology as the 10th ADA Specialty. This certainly is a time of reflection. As Dr. Weaver has pointed out – this journey started back in 1953 with the founding of the American Dental Society of Anesthesiology (ADSA) whose specific purpose was achieving specialty recognition of Dental Anesthesiology. After it became clear that the ADSA was not interested in gaining specialty recognition the American Society of Dentist Anesthesiologists (ASDA) began its efforts. It has been 25 years since our first application. This has been a long journey that many have put their blood, sweat and tears into trying to achieve professional recognition of our discipline. At times we felt like Sisyphus but we appear to have reached the top of the hill.

I know what specialty recognition means to me. It has been 30 years since I completed my residency (yes, I am that old) and recognition of our discipline has always been looming on the horizon. I remember when I was completing my program I was told during my exit interview that I was making a mistake in being a dentist anesthesiologist, that I should be an oral surgeon because there was no future in dental anesthesia. I believe that I have proved them to be wrong. But at this juncture I believe that we need professional recognition in order to cement anesthesiology as the practice of dentistry and to support future dentist anesthesiologists.

I asked some of my former residents what specialty means to them and their responses tell me that we have a great future. I believe Dr. Amanda Okundaye (2008) really summed it up with her response to me. She said, “Validation, credibility and responsibility.” I believe responsibility is one of the most important words in that group. She further stated what that means to her, “The responsibility to uphold standards as the specialist in our field, the responsibility to hold our colleagues to practice at the highest level of care, and the responsibility to know the history of the specialty and to inform those new to this privilege of being a specialist.”

Dr. Jason Brady (2012) told me “recognition will ensure consistent practices in the US in regards to best practices and parameters of care.” Dr. Lenny Naftalin (2002) who has been in practice almost 20 years said to me “I have this eternal optimism that I can’t imagine that the vote won’t go our way”.

Dr. Andrea Fonner (2009) said, ”Specialty recognition is the acknowledgment of the hard work, dedication and perseverance of our mentors. It will be the end of a very long journey for those before us and the beginning of a very long journey for the rest of us. ….We are the leaders of anesthesia in dentistry. It’s about time that dentistry figured that out.”

Recent graduate Dr. Kris Mendoza (2018) said, “…being recognized as a specialty leads to an even higher standard of anesthesia care for our patients. I am excited to help further the conversation of anesthesia in dentistry and hope that this leads to growth in a much needed field in dentistry.”

I am very proud of my former residents and so pleased to hear their optimism about the strong future for our specialty. They understand where we have been and the bright future waiting for them.

It has been such a long road and we have finally reached our destination. I wish that Dr. John Yagiela was here to enjoy this moment in our shared history. Specialty recognition consumed a huge portion of his professional life. I, for one, will be visiting his grave to tell him that we are finally officially recognized as the specialists we have always been.
Evolution of the American Board of Dental Specialties

The American Dental Association has historically been the only available pathway for a discipline to gain specialty recognition in dentistry. The ADA specialty recognition process was, in my opinion, a fatally flawed system. It allowed politics to unjustly sway votes required for recognition and deny applications that had demonstrated compliance with every requirement. Opponents would frequently criticize the application on points not related to the criteria. These distractions worked. Opponents quoted concerns on how the specialty would affect all of dentistry if it was passed while the true concern was how it would affect them. In my opinion, they didn’t spend enough time considering what would happen if we did not pass. Nobody challenged the ADA’s exclusivity for specialty recognition until after the 2012 denial of the ASDA’s application for specialty recognition. Up until 2012 the ASDA submitted 4 applications for recognition, all of which met the ADA criteria, only to be rejected each time by a political House of Delegates. After these 4 failed applications to achieve recognition with the ADA, the ASDA Board of Directors contemplated a very basic question. “What authority does the ADA have to determine who is a specialty?” and more importantly, that we are NOT a specialty. The simple answer is: None. State Boards accept the ADA’s opinion of who is a specialty and take it at face value. This exclusive acceptance of the ADA process has proven to be very expensive for some State Boards.

After the defeat of the ASDA’s application in 2012, the ASDA collaborated with other specialties and formed the American Board of Dental Specialties (ABDS) to recognize specialties based on diplomate boards rather than an application by a Society voted on by a political body. This process is similar to what is done in medicine. Simultaneously, a successful lawsuit was filed against the Texas State Board of Dental Examiners challenging their blind acceptance of the ADA’s position on specialty recognition and automatic rejection of any other specialty. Equally concerning to the ADA is the precedent that was set by the ruling and the uncertainty of what can happen next. While the ADA can determine specialties, States cannot legally reject other bona fide specialties simply because the ADA does not recognize them.

This decision has forced 2 major changes at the ADA. First, the ADA passed Resolution 65H-2016 which no longer considers it unethical to advertise as a specialist not recognized by the ADA. More importantly the ADA passed Resolution 30H-2017 that changed their recognition process by creating a new Commission. Notably one of the principles of the newly formed Commission was “The process must serve to reduce potential bias or conflicts of interest, or the perception of bias or conflicts of interest, in the decision-making process.” A change that most certainly would not have come about without the formation of the ABDS. The ADA formed the National Commission on Recognition of Dental Specialties and Certifying Boards (NCRDCB) AND removed the ADA House of Delegates from the recognition process. The House of Delegates maintains control of the requirements for specialty recognition. Time will tell if this move will have future antitrust implications. The House of Delegates has already changed the requirements to mandate programs be accredited by the Commission on Dental Accreditation. There is some irony in requiring CODA accreditation before applying to the NCRDCB for specialty recognition. This could have the unintended consequence of negating a Society’s need to apply to the NCRDCB. A single lawsuit by a discipline with a CODA accredited program would likely win a constitutional challenge to a state restricting their right to advertise as a
specialty. This could effectively make CODA the de facto determinant of specialties at the ADA. This could also put more pressure on CODA which has oversight by the United States Department of Education. I expect CODA will soon see more applications and perhaps even a legal challenge should they deny a discipline accreditation.

Today the NCRDSCB approved anesthesia as a specialty! We are now the first and only specialty recognized by the ABDS and the ADA. This doesn’t mean we don’t need the ABDS any more. In fact, I think it reinforces our move to form the ABDS and continue to support it. Both the ABDS and the ADA recognition processes require recertification of specialties. The changes we saw today were a direct consequence of forming the ABDS. We need to make sure the process stays apolitical.
The Road Ahead as ADA Recognized Specialists

With today’s historic vote by the National Commission, Dentist Anesthesiologists have taken yet another step forward in advancing the profession of dentistry and the care it delivers to our patients. The process is still very much a work in progress as now the NCRDSCB must convene and review our complementary certifying board, the American Dental Board of Anesthesiology, for recognition. We will keep membership and ADBA Diplomates updated and informed as to the progress of that application process. However, the formal step of ADA recognition our specialty has been attained.

As ADA recognized specialists, we have a certain mandate to fulfill. Just recently, the ADA included in their “Principles of Ethics and Code of Professional Conduct” the following language regarding the obligation to treat patients with special healthcare needs:

4.A.1. PATIENTS WITH DISABILITIES OR BLOODBORNE PATHOGENS. As is the case with all patients, when considering the treatment of patients with a physical, intellectual or developmental disability or disabilities, including patients infected with Human Immunodeficiency Virus, Hepatitis B Virus, Hepatitis C Virus or another bloodborne pathogen, or are otherwise medically compromised, the individual dentist should determine if he or she has the need of another’s skills, knowledge, equipment or expertise, and if so, consultation or referral pursuant to Section 2.B hereof is indicated. Decisions regarding the type of dental treatment provided, or referrals made or suggested, should be made on the same basis as they are made with other patients. The dentist should also determine, after consultation with the patient’s physician, if appropriate, if the patient’s health status would be significantly compromised by the provision of dental treatment.

Dentist Anesthesiologists officially become consultants in the care for the patients at the margins of typical dental practice, and our mission in the coming years is to promulgate and disseminate our services to the far reaches of the dental profession. Are we ready to push dentistry from seeing itself as largely a profession of healthcare convenience and discretionary spending to a basic healthcare tenet of necessity and management of chronic or acute conditions for specialized populations? A reckoning has arrived where we are indeed ADA recognized dental specialists that provide a unique service and level of care that no other provider can offer at our level. And along with this, any notions of perceived encroachment of our field fade as we raise the standards of dental anesthesiology.

The road ahead is filled with obligation and much opportunity. We will need individuals to populate seats at various committees and organizations to promote safe and readily available advanced anesthesia and sedation services in dental settings. A demand for education and research both within the profession as well as outside of our community of dentists will continually arise as we move forward with our intended goals. Each and every member will be encouraged to participate in an outcomes database to track and quantify the value and safety of our clinical expertise, and further, to provide ample evidence for practice change. Earnest and collaborative efforts into producing model legislation and reasonable practice standards for a variety of sedation and anesthesia providers must be initiated and renewed. And perhaps most difficult of all in this immediate period, we must work
towards a path of reconciliation with organizations and individuals who are unable to envision a progression towards improved care of our patients.

Of the qualities our Society must retain is the undying spirit of challenging the status quo. We are a Society borne from conflict and embody a willingness to challenge overwhelming forces of complacency. If there’s anything that has defined our existence these past 40 years, it will be our members’ readiness to heed the call for battle when it comes to patient care and safety, driving the standards of care to greater heights, and ensuring sedation and anesthesia firmly serves the betterment of the profession. We cannot let the attainment of ADA Specialty recognition defeat us and our responsibility to ensure establishing the safest standards of care for patients.

Granted, the size of the ASDA is relatively small amongst other anesthesiology groups in existence, yet we have made quite an impact on the course of dentistry and anesthesia for many years in both individual and community effort. In the same spirit, anywhere dentist anesthesiologists venture, we must serve as ambassadors and mayors to our surrounding practice community. The road ahead compels us to be gracious and diplomatic stewards of those who support or question our practice and values.

Congratulations to all of our members, supporters, and future dentist anesthesiologists. We’ve endured quite a few setbacks over the years, and we’ve lost precious leaders and individuals along the way. We’ve spent countless hours and monies to achieve change in a profession supremely resistant to change. More hard work and effort is ahead of us, and I encourage each one of our members to stay involved and involve others in our mission. See you all in Chicago!
Presidents of the ASDA

2017 – 2019 Dr. James Tom
2015 – 2017 Dr. Steve Nguyen
2013 - 2015 Dr. Mark Saxen
2011 - 2013 Dr. Michael Mashni
2009 - 2011 Dr. Christine Quinn
2007 - 2009 Dr. Joel Weaver
2005 - 2007 Dr. Anthony Caputo
2003 - 2005 Dr. Steven Ganzberg
2001 - 2003 Dr. Bryan Henderson
1999 - 2001 Dr. John Yagiela

1997 - 1999 Dr. John Leyman
1995 - 1997 Dr. James Snyder
1993 - 1995 Dr. Ralph Epstein
1991 - 1993 Dr. James Chancellor
1989 - 1991 Dr. Ron Davies
1988 - 1989 Dr. Russell Seheult
1986 - 1988 Dr. William MacDonnell
1984 - 1986 Dr. Michael Higgins
1982 - 1984 Dr. Joseph Giovannitti
1980 - 1982 Dr. Larry Trapp
My Thoughts on the Specialty Effort

Dr. John A. Yagiela

ASDA 25th Anniversary History and Reflections, 2005

The history of the ASDA’s efforts cannot begin without initial consideration of the stillborn attempt by the ADSA to develop a specialty in anesthesiology for dentistry. In the inaugural publication of the American Dental Society of Anesthesiology (April 15, 1954), then President William B. Kinney wrote, “We hold the future of anesthesiology in dentistry in the palms of our hands, and it is up to us to handle this precious privilege gently, deftly, and surely if we are to succeed in establishing the practice of anesthesiology as a definite recognized specialty in dentistry.” During the years 1984 to 1991, the ADSA committed a great deal of time and resources to developing a board examination, incorporating a boarding organization, and preparing a specialty application in anesthesiology. In October 1991, however, the Board of Directors decided to discontinue sponsorship of specialty development. This decision was the direct result of efforts by the American Association of Oral and Maxillofacial Surgeons (AAOMS) to stop the pursuit of a specialty. The AAOMS initiated a campaign for its members who also belonged to the ADSA to oppose efforts at specialty formation. Since approximately 70% of the ADSA membership consists of oral and maxillofacial surgeons, the ADSA Board of Directors felt that pursuit of a specialty would be neither feasible nor in the best interests of the society. In order to preserve the broad spectrum of anesthesia interests in the ADSA membership, the 1996 House of Delegates voted for the society to remain neutral on the issue of the specialty.

When the ADSA decided in October 1991 to discontinue pursuit of a specialty in anesthesiology for dentistry, the ASDA immediately assumed the role of the sponsoring organization and continued the effort toward specialty development. Quite fortuitously, in 1990 I had been appointed for a 5-year term to the ADA’s Committee on Specialty Recognition (Committee G) and, separately, to the ADA’s Anesthesiology Steering Committee.

Membership in these committees gave me strong insight into the specialty recognition process and how the ADA dealt with matters pertaining to anesthesia in dentistry. In the fall of 1992 I was invited to a meeting of the ASDA’s Specialty Application Committee (SAC).

It was clear from that meeting that the ASDA had progressed much further in one year than the ADSA had the previous eight years in developing an application for submission to the ADA. It was also clear that major problems had to be resolved before a viable application could be developed. One problem was the definition of what constitutes a specialist in anesthesia for dentistry. Core differences existed among the committee members – some wanted to limit specialist recognition to dentists who only provided anesthesia services for other dentists, others wanted to include the delivery of anesthesia for non-dental services, and still others wanted to include the oral surgery model as an acceptable specialty practice alternative. Another problem was that the ASDA was using an outdated application form, which had been revised in several important ways to make the application requirements more difficult to meet. Lastly, the application reflected multiple authorship, leading to disjoint styles, areas of redundancy, missing subjects, and a lack of continuous rigor in answering the questions posed in the application. In early 1993, I was appointed to SAC and charged with developing the final draft of the document. The application was submitted on June 1 of that year.
The first hurdle for the application was Committee G. I was appropriately excused from the meeting. It was a wonderful affirmation of anesthesia in dentistry and SAC’s efforts when Committee G strongly endorsed the application as meeting all criteria.

The next hurdle, the Council on Dental Education (CDEL now with the addition of licensure to the committee’s name), initially determined that the application failed to meet criteria 2 and 3 pertaining to scope of practice and need and demand. Providing the Council an effective rebuttal and a vigorous defense by Committee G of their review of the application caused the Council to reverse itself. A second hurdle arose with our attempt to get the backing of the Academy of General Dentistry (AGD). Jim Chancellor and Ralph Epstein, then President of the ASDA, spearheaded this effort on behalf of the ASDA. The AGD, interested in ensuring access to education in sedation for its members set up a meeting to discuss issues pertaining to anxiety and pain control in dentistry. The ASDA was not invited because AAOMS said they would not attend if we were invited. A lot of misinformation had also been disseminated by our opponents stating that we wished to limit other dentists from providing sedation. In my April 27, 2004 letter to President-Elect Luke Matranga of the AGD, I affirmed the supportive role ASDA wished to play for other dentists and referred him to the ASDA’s recently passed policy statement affirming the right of other dentists to provide sedation and anesthesia services for which they were trained. Happily, AGD extended an invitation for us to attend; AAOMS also attended. In a vigorous debate with the president of AAOMS at the June 3 meeting, he accidentally acknowledged AAOMS’ role in providing information to the American Society of Anesthesiologists of programs where dentists were receiving training in general anesthesia, a role that directly led to the loss of training opportunities for dentists other than oral surgeons. A long-lasting outcome of the June 3rd meeting was the decision by AGD to support our application effort.

The summer of 1994 was filled with our collective efforts to address an avalanche of position papers and letters by our opponents decrying the specialty effort in particular and dentist anesthesiologists in general. An example was Ron Davies’ responses to an article and a letter in the Journal of the California Dental Association by John Lytle, who questioned the safety, affordability, and necessity of dentist anesthesiologists’ services. Many others, including

Many others, including ASDA members, referring doctors, other dentists and patients also wrote letters in support of the application. Collectively, we more than held our own.

With the affirmation of our application by the ADA Board of Trustees, we went to New Orleans with high hopes of success. This led to elation after the Reference Committee hearing, where our collective efforts ensured that the strong majority of comments were in our favor, and the content of those comments was also superior. Thus, there was a visceral shock when the Reference Committee’s vote was to refer the application for further study. It could not have happened if the Committee had been unbiased. Confirmation was provided by oral surgeon Herbert Dolinsky, who confronted a half dozen ASDA members by saying that (1) he was in charge of the AAOMS’ effort to stop the application, (2) the ADA system is corrupt, (3) AAOMS controls it, and (4) how dare be so naive as to think that the application would be judged by its merits. We cost AAOMS a lot of money to defeat an application that had no chance of approval. The 2 to 1 negative vote by the House of Delegates was a forgone conclusion.

Efforts to improve the application and, especially our political effort, within the ADA began immediately. It also became clear that we needed legal help to push ADA institutions to avoid partisan placement on important committees. This was underscored when Dolinsky was appointed to chair the Reference Committee in 1996, when AAOMS thought our next application would be heard. One major way to improve the application was to demonstrate that the ASDA could develop an independent board of anesthesia for dentistry. Because of the cessation by the ADSA to develop a specialty program, the name “American
Dental Board of Anesthesiology” became available. Ralph Epstein, Mike Higgins, Jim Snyder and Jim Chancellor were able to secure it for use. Strong debate occurred over who would be eligible for specialty status, including those who would qualify for grandfather status. These discussions, though heated at times, were necessary for the ASDA to define itself and the ADBA.

Ultimately compromise was achieved and the ADBA was established. The ADBA for formally established in December 12, 1994, and it adopted its own constitution and bylaws in March 1996. An important side benefit was the development of accreditation standards for advanced specialty programs in anesthesiology for dentistry, an effort spearheaded by Joe Giovannitti.

Under the leadership of Ralph Epstein, the ASDA undertook in the spring of 1996 a prospective practice study of ADBA members. This study documented the number and type of anesthetic procedures provided by dentist anesthesiologists. The need for these services was demonstrated by two studies supported by the ADSA’s Anesthesia Research Foundation and conducted by Raymond Dionne and colleagues, one involving the general population and the other examining special-needs patients. With these studies and the successful establishment of the ADBA, the second specialty application was a significant improvement over the first. It was submitted on January 1, 1997.

To ensure a fairer political process, the ASDA consulted with a Chicago law firm to work with the ADA legal department so that the ADA understood the breadth and depth of our concerns. Two beneficial outcomes were a Reference Committee that was balanced, and the ability to request attendance to district caucus meetings at the ADA annual session. Less naïve about the political process, ASDA leadership and supporting members became more active earlier in the process. So too did our opposition. A particular problem, as with the first application, was the ability of AAOMS to secure the support of ADA presidential candidates. It became clear that the heavy financial support given these candidates by AAOMS was crucial to support. It also meant that Tim Rose, a periodontist who as a former trustee voted in favor of our application, switched to become a strong opponent. He was successful in removing the American Academy of Periodontology as a supporting organization for ASDA’s efforts. As Rose was a popular individual and won the presidential election, his opposition was effective. At the one meeting where I had a chance to discuss the issue with him, it was clear that his strong opposition was without a rational basis insofar as the application was concerned.

As before, this application won positive votes from Committee G, CDEL, and the Trustees. A big win occurred when the Reference Committee on Dental Education and Related Matters voted to approve the application as well. During the morning round of district meetings, between the Reference Committee hearing and the House session, I was able to provide brief presentations to some of the district caucuses. This had a significant effect, because delegates could hear our story firsthand, not just the comments by their oral surgery colleagues. Interestingly, I was suddenly “disinvited” to the remaining caucuses in the afternoon once the impact of our presentations became clear to the AAOMS leadership. The House vote was agonizingly close. If four people had changed their vote, we would have won. Even ADA President Gary Rainwater (from Texas) argued for its passage.

In the aftermath of the 1997 defeat, the ASDA leadership considered several avenues: reapplication; legal remedies; seeking specialty status outside the ADA. All of these options were explored. After thoughtful consideration of the issue, the ASDA House directed the Board to seek specialty recognition a third time. The third application, the strongest yet, especially on the issue of need and demand, was submitted July 1, 1998. By this time, it was clear that passage through the House had little to do with the application itself. It was also clear that the AAOMS leadership had been shocked by the closeness of the previous vote. Accordingly, they were going to take no chances with the House. This time, the goal was to defeat the application at every step of the process. AAOMS was
able to get two avid opponents of the application on the CDEL. One, Ronald Marks, was past-president of AAOMS, and the other, Herbert Dolinsky, has already been mentioned. John Leyman, in his letter to CDEL chair Donald Demke requested that both individuals be recused from any discussion and voting on the application. His warning of their inherent unfairness was not acted upon.

Once again, Committee G strongly endorsed the application. However, CDEL voted to oppose the application on requirements 3 and 4. The CDEL stated that changes in training of other specialists meant that anesthesiology could be readily subsumed by these other specialties and that there was no compelling evidence of need and demand for our services not adequately met by other dentists. These conclusions were unsupportable having been based on misinformation provided by AAOMS operatives. The ASDA, with the help of specialties such as pediatric dentistry and periodontology, was able to marshal real data and cogent arguments demonstrating that the CDEL had been badly misled by several of its members. That this campaign was orchestrated by AAOMS subsequently came to light and led to public action against these same individuals. Ralph Epstein, Jim Chancellor and I met with the CDEL on April 17, 1998. As chair of the specialty committee, I presented written arguments buttressed by a Powerpoint presentation. There were no questions, and the CDEL reversed itself, possibly in part on advice of counsel.

AAOMS was very successful in influencing the ADA Trustees, who voted 10 to 9 against the application for the first time. We learned subsequently that AAOMS arguments were strongly presented but that our response to the CDEL was not included. Once again, trustees running for the office of ADA president were turned against the specialty application and proved the difference in the vote.

The ASDA prevailed at the Reference Committee hearing; however, I was excluded from the majority of district caucuses. In half of those where I gained admittance, there were orchestrated efforts to silence me, belittle the ASDA, or limit discussion to such issues as dentist anesthesiologists’ support of independent dental hygiene practice! Our third application was defeated in the House by 22 votes.

Was the specialty worth the time, effort, and cost? What did we gain and what did we lose? My personal view is that the effort transformed the ASDA from a largely unknown society on the fringe of dentistry into a recognized, well-established entity. The ASDA now has a place at the ADA table; our views pertaining to anesthesia are increasingly given weight, and we have a recognized presence on Committee H. Even the term dentist anesthesiologist became accepted by the ADA through this process. Accreditation of our programs, which at this moment looks like it will happen, would never have been considered had we not gone through the crucible of the 1990s. The ASDA has redefined itself by focusing on anesthesia for dentistry; we have a credible board in the ADBA, and we are supporting our training programs in substantial ways. Our continuing education efforts have grown well beyond our annual sessions. Yes, the specialty effort was worth it.

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John Yagiela
Leonard M. Monheim
Distinguished Service Award

The American Society of Dentist Anesthesiologists has identified a need to recognize dentists who have made outstanding contributions to the discipline of anesthesiology, benefiting the dental profession. This Distinguished Service Award is named in honor of Leonard M. Monheim, D.D.S., whose many contributions to the art and science of anesthesiology and visionary leadership helped lay the foundation for a specialty in anesthesiology for dentistry. Dr. Monheim established the first autonomous Department of Anesthesiology within a dental school (University of Pittsburgh School of Dental Medicine) in 1949 and served as the only anesthesiologist for the University of Pittsburgh Medical Center for nearly twenty years. Also in 1949, he initiated the first postdoctoral training program in anesthesiology for dentists. His prolific teaching and writings in the discipline of dental anesthesiology provided a strong educational foundation for all dentists rotating on his anesthesia service and he published the first modern textbook on general anesthesia specifically for dentistry. It is only fitting that the ASDA honor this man’s contributions to our discipline and dentistry.

Past & Current Leonard M. Monheim Distinguished Service Award Recipients

- Dr. Larry Trapp 1999
- Dr. Ralph Epstein 2000
- Dr. John Yagiela 2001
- Dr. Joe Giovannitti 2002
- Dr. Joel Weaver 2003
- Dr. Ray Dionne 2005
- Dr. James Chancellor 2006
- Dr. C. Richard Bennett 2007
- Professor Yuzuru Kaneko 2008
- Dr. William A. MacDonnell 2009
- Dr. Daniel A. Haas 2010
- Dr. Michael Higgins 2011
- Dr. James Phero 2012
- Dr. Steven Ganzberg 2013
- Dr. Christine Quinn 2014
- Dr. Stanley Malamed 2015
- Dr. Morton Rosenberg 2016
- Dr. James Snyder 2017
- Dr. Lee Lichtenstein 2018
- Dr. Michael Mashni 2019
ASDA President Jimmy Tom is scheduled to present Monday May 20, 2019

Dental and Medical Sedation: Is it really all that different? Collaboration among the specialties

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The American Society of Dentists Anesthesiologists newsletter publishes stories of interest to members of the Society. Please contact Executive Director, Erin Baker, if you would like to submit an article, idea, letter or case-report for consideration. One to two member and/or resident submissions will be considered in each monthly newsletter.

Submission Guidelines

We welcome submission of items of interest to society members. Items including letters to the members, referenced scientific articles, case reports, opinion articles, component, legislative and residency news, along with book/media and product reviews will be considered for publication. All submissions must contain the name, professional degree(s), and contact information of the author(s). Scientific articles, case reports and opinion articles should also contain a photograph of the author. Items can be submitted electronically via email to Ebaker@asdhq.org.