N.J. Dental Society of Anesthesiology Newsletter

SCIENTIA OMNEM

DOLOREM VINCIT

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Fall 1994

Our fall meeting will be held once more at the Grand Marquis caterers on Route 9 South in Old Bridge, NJ. The date is October 12, and our speaker will be Dr. Carl Roger Fleser from Cincinnati, Ohio. Dr. Fleser is both a dentist and pharmacist. He graduated from Ohio State University with a degree in pharmacy, and subsequently continued at that school to receive his D.D.S. degree. He completed 2 years of training in anesthesiology at Children's Hospital in Columbus and is presently a Staff Attending at St. Luke's Medical Center. He proposes to discuss the following topics at our meeting.

- ➢Obesity and Anesthetic Complications
- ➢Updated NPO Status and Aspiration Prophylaxis
- ➢Review of Old and New Antiemetics
- ➢Review of Inhalation Agents
- ➢New Parenteral Agents for Anesthesia
- ➢Office Emergencies

We expect a good turnout of our membership. This may prove to be a historic meeting of sorts, not only because of the scientific presentation, but also for the significance of some political decisions that might be considered. The latter are in response to concerns expressed at our spring meeting about the proposed specialty status of anesthesiology in dentistry. *(See Editorial).* This discussion has led to deliberation as to the reasonableness for amending, once again, the Constitution and Bylaws of the ADSA. Your Executive Board will be responsive to your wishes on this matter.

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The accommodations at the Grand Marquis have been well-received in the past, and our speaker is well-qualified to lecture on anesthesiology and related subjects. This course is approved for 35 N.J. anesthesia credit points and 7 hours of continuing education credits.

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EDITORIAL

The subject of dental anesthesiology as a specialty appears to be the prime subject of interest that is dividing our organization. However, and I do not wish to minimize the merits of a specialty status, but a more distressing spectacle is the appearance of subterfuge and duplicity exhibited by recent actions of the Board of Directors. Allow me to be more specific.

1) Every member, including members of the board, is entitled to their personal opinion about the appropriateness of a specialty status for dental anesthesiology. However, in view of the overwhelming expression of the membership against such a specialty, and the previous announcement of the board that the specialty status would not be pursued, I consider it both immoral and undemocratic for the Board to publicly announce itself in favor of specialty recognition without an indication of assent by the membership. If the leadership is so certain that a specialty status is important, then it has been lax or inept in convincing the membership.

2) The ADSA Board and *Pulse* are presently extolling statements by a "founding president" in favor of "establishing the practice of anesthesiology as a definite recognized specialty in dentistry." The unbiased story might have included that this prophet, at a later date in pursuing his own self interests, nearly led the society into financial ruin. Programs and policies should be judged on their merit. Time may prove these policies to be good or bad, but the voice of the membership should not be ignominiously ignored.

3) However, the **most** egregious insult to the membership was included in our newly adopted Constitution and Bylaws. Chapter IV Section 80 gives the Board of Directors **absolute** power of veto over the House of Delegates, society policies, ethics, and charters of component societies. Allow me to quote from paragraph C. "It shall have the power to veto all legislation enacted by the House of Delegates until such time as that body is composed of delegates from twenty-five (25) active, chartered component societies of the Society as provided in Article IV of the **Constitution**, and defined in Chapter II, Section 30 of the **Bylaws**....."

Although 30 states (including Ontario) are represented by our membership, we are considered to have only 22 component societies. This special compacting of our membership denies the House of Delegates the position of a Speaker, and makes all actions of the delegates, **except amendments to the Constitution and Bylaws,** vulnerable to veto by the Board of Directors. I really doubt that this concept of domination was in the minds of our founders. *I WONDER HOW OUR PRESENT MEMBERSHIP FEELS ABOUT THIS ! ?*

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Conscious sedation was discussed in a guest editorial in *Pediatric Dentistry* - May/ June 1994 Volume 16 Number 3 by Dr. Stephen Wilson who is an Associate Professor and Director of the postgraduate pediatric dentistry program and research at the Ohio State University/ Children's Hospital in Columbus, Ohio. The subject of conscious sedation came up at an advisory committee meeting of the Federal Drug Administration, and it was obvious from the reports from our medical colleagues that there was a growing disparity in the guidelines of the medical and dental profession regarding conscious sedation.

As Dr. Wilson tried to define "conscious" sedation for himself, he realized that there was not yet an acceptable standard for determining that condition. He, rightfully, considered the sedated sleeping child who can be awakened by a gentle nudge, and the one who has to be pinched strongly, as well as the one who shows a reflex action to the stimulus of the needle puncture. And then, what about the non-medicated toddler who is a deep sleeper and difficult to arouse? Can this be "conscious" sedation? His conclusions are that more **research and education** are needed, and that the guidelines for pediatric sedation in medicine and dentistry should be the same and include some form of monitoring.

From my point of view, conscious sedation can be considered part of the continuum of general anesthesia. The degree of sedation should be determined by the needs of the patient and the dentist. However, the dentist must understand the effect of the drugs being administered. Patients undergoing sedation (as well as general anesthesia) must be continuously monitored by appropriate observation and apparatus. The dentist must have sufficient training and experience so that these levels of consciousness can be recognized and controlled.

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FINAL REMINISCENCES

(In our last newsletter, I discussed the decline in the use of general anesthesia in the dental office.)

What brought about this radical departure from the use of general anesthesia by persons who had conscientiously sought advanced training and exhibited a high degree of proficiency? I believe that the extreme increases in professional liability insurance rates were the primary cause of dentists downgrading the administration of general anesthesia. The cost of such coverage became prohibitive for those of us who were unable or unwilling to pass on these costs directly to the patient. General anesthesia seemed ideal for the frightened and handicapped patient, but Medicaid reimbursement was an embarrassment. Most every handicapped child was eligible, and parents expected full treatment as an entitlement. The insurance companies, which were taking a big slice of the health care dollar, would scarcely consider general anesthesia as a reimbursable item unless it was associated with surgery, and then there was only a token payment.

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The problem of liability exposure has permeated many facets of our society, and it is difficult to see any relief in sight considering the predominance of lawyers in our legislative bodies. Perhaps, we will have to hit rock bottom before we come to our senses, but I hope not. *(Now, in 1994, we're beginning to see more public recognition of the problem.)*

I suppose that these flashbacks would be incomplete if I did not mention hypnosis, electrical anesthesia, acupuncture, and audio analgesia. Each of these appear on the scene periodically as the latest miracle technique for control of pain. They recede and then reappear in the panorama of pain control and, though often disappointing in their total results, they do add, in some small part, to our knowledge and technique. Often, the time involved and the questionable predictability of success with any one patient is such that those of us who have become the referral of last resort are reluctant to expose that patient to another episode where there might be failure in treatment.

I have searched the recesses of my recall to present this story. I hope that others of you may wish to add to my observations and experiences. I have tried to see the forest as well as the trees, knowing that there are many niches that I was unable to peer into. I hope that we can continue to maintain and develop further our interest in anesthesiology and pain control for the benefit of our patients and dentistry.

The End

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