Thanks, but no thanks

Have the Academy's sedation guidelines saved lives? We don't know and probably never will. The piece of the puzzle that's missing is any sort of evaluation of the direct effects of the guidelines on patient care.

Some data do suggest that the guidelines have influenced practice. Three surveys, one in the *Application for Continued Recognition as a Specialty in Dentistry*[1] another, in *Behavioral Management for the Pediatric Dental Patient — Current Issues and Implications for the Future, A Conference/Workshop,* [2] and a third, in this issue of the journal, indicate that more pediatric dentists are decreasing their use of sedation than are increasing (although most are doing about the same). Some practitioners may have decided that compliance with the guidelines is just not worth it. Other explanations are that the "bulge" of pediatric dentists are aging and tend to do less sedation anyway because they are more comfortable managing children, or that increased malpractice premiums and state laws make sedation a service that isn't cost-effective.

Despite the lack of clinical data, this summer the American Academy of Pediatrics in conjunction with the American Society of Anesthesiologists, published revised guidelines [3] that tightened controls on pediatric sedation. These guidelines are aimed at *all* health providers who sedate children and, although not stated explicitly, they are directed at those providers who continue to ignore safety and monitoring recommendations contained in the 1985 guidelines.

Although the document claims that there has been a marked increase in the use of sedatives in a variety of settings, including dental offices, available data suggest the opposite for pediatric dentistry. The dental citations listed in the report and presumably used to arrive at the modifications are largely outdated and provide no justification for changing the 1985 guidelines for dentistry. A recent study cited in the report, by Acs et al., [4] and published in *Pediatric Dentistry,* actually says that overall, pediatric dental sedation is decreasing in the opinion of program directors ! Dr. Milton Houpt's study in this issue is an ideal snapshot of pediatric sedation because it is directly comparable to data on pediatric dentistry's *pre-Guidelines* behavior. The overwhelming evidence, at least for pediatric dentists, is that sedation is decreasing.

No dentist served on the AAP committee or acted as an official consultant; the Academy had the opportunity to comment, but had no voice in the final document as it had in 1985. The absence of pediatric dentistry at the table is evident in the lack of contemporary data in the references of the document, but even more so in the changed recommendations contained in the new guidelines. It's clear that those around the table had little understanding of how pediatric dentists sedate children.

These new guidelines will affect your life significantly, but probably not the lives of your patients, if you believe, as I do, that the 1985 guidelines provide the necessary safety measures to minimize risk to acceptable levels. The most significant change is that now, when nitrous oxide is used in conjunction with any other depressant medication, deep sedation guidelines apply. You'll need an electrocardiograph, defibrillators, and a third person in the operatory whose sole responsibility is to monitor the child. This change won't just stop reckless sedations, it'll stop all sedations! If this becomes the standard for what many of us do routinely, who will want to or can afford to comply?

Another change in the guidelines is the mention of a specific drug — nitrous oxide — and the recommendation or "encouragement" to use pulse oximetry with

ASA I and II patients under nitrous oxide. We have little randomized trial data to argue for or against this recommendation, but what about the thousands of nitrous oxide cases done safely every day in this country in dental offices? Pulse oximetry for nitrous oxide isn't a smoke alarm, it's building the fire house next door! A dentist on the panel would have provided the necessary guidance in this area.

Will these changes save lives? Perhaps they will, but they will also drive more conscientious practitioners from sedation and this will mean that many children who would have been treated, won't be, except under general anesthesia.

My response to these guidelines is ***thanks, but no thanks***. Thanks for your efforts for children, but no thanks to a set of guidelines that aren't backed by data and which don't reflect changes which will make my practice safer. My advice to practitioners and what I believe our leadership will advise is that we continue to use the 1985 guidelines which we've found safe and effective when followed conscientiously. Institutions will not accept these new guidelines lock, stock, and barrel, but will let individual disciplines modify them to create specific variations which maximize safety, maintain cost-effectiveness, and ensure quality service for the child patient. For many hospitals, dentistry led the way in developing sedation guidelines for children.

A part of any change so major as this is the collection of data and evaluation of the current state of practice. Our membership can provide the data necessary to show safe and effective sedation. Our AAPD Education Foundation has supported studies of TMD and fluorosis using practitioners to assist in the research . What better to focus our efforts on than a procedure so uniquely our own and so vital to the care of so many children?

It seems to me that these guidelines move in the wrong direction. Twenty years ago, same day outpatient surgery under general anesthesia was rare and a one or two night stay was the rule, even for elective procedures on ASA I and II patients. Review of morbidity and mortality statistics (with a little push from those paying the bills) helped change the system, with a tremendous savings in health care dollars and no real change in morbidity and mortality. I believe an accurate assessment of the use of sedation by pediatric dentists would confirm that what was good in 1985 is still good today.

1. American Academy of Pediatric Dentistry, Committee to Develop an Application for Continued Recognition of Pediatric Dentistry as a Specialty in Dentistry: Application for Continued Recognition as a Specialty in Dentistry. Chicago: AAPD, 1989.
2. American Academy of Pediatric Dentistry Educational Foundation: Behavior Management for the Pediatric Dental Patient, Current Issues and Implication for the Future, A Conference Workshop. September 30 — October 2, 1988, Iowa City, Iowa. Chicago: AAPD, 1989.
3. American Academy of Pediatrics, Committee on Drugs: Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures. Pediatrics 89:1110-15, 1992.
4. Acs, G et al: Current teaching of restraint and sedation in pediatric dentistry: a survey of program directors. Pediatr Dent 12: 364-67, 1990.