Mary A. Delsol, DDS – Testimony

Good afternoon. My name is Mary Delsol. I have practiced oral and maxillofacial surgery for 30 years, and have served as President of the American Board of Oral and Maxillofacial Surgery, the testing body for specialty board certification.
As you all know, the Dental Board recently issued recommendations that call for the presence of a second anesthesia permit holder during office procedures, in addition to the surgeon and at least two highly-trained assistants, for pediatric procedures.

If this level of staffing was genuinely necessary in order to ensure a safe outcome, my colleagues and I would absolutely agree. But the truth is far different. Oral and maxillofacial surgeons are already extensively trained and licensed to administer anesthesia during procedures, and have a profoundly strong safety record.

The current OMS Anesthesia Care Team Model calls for the use of ALL of the following patient safety monitors: heart rhythm, blood pressure, pulse oximetry, airway auscultation, and continuous end-tidal carbon dioxide monitoring. Our Anesthesia Care Team consists of a minimum of 3 individuals certified in Basic Life Support and trained in monitoring and in basic emergency airway management for deep sedation/general anesthesia. One team member is dedicated to monitoring the patient and the airway and has no additional duties involving the surgical procedure. The supervising OMS must maintain Advanced Cardiac Life Support certification every 2 years and must complete 24 hours of graduate level continuing education specific to anesthesia every 2 years.

It's important to know that the Anesthesia Care Team Model differs from traditional anesthesia delivery for most surgeries. For example, with a knee surgery, the doctor is positioned at the leg and the anesthesiologist is at the head. An oral surgeon is positioned at the head and at the airway. We can observe and manage the airway quickly in response to changes in the monitors or alerts from the anesthesia assistant. In addition, the level of anesthesia for our surgeries is much lighter because we use local anesthesia, so the patient continues to breathe on their own and a breathing tube is not necessary. We can discontinue our surgical procedure in a matter of seconds to address any issues.

Under this model of care, the safety record for intravenous moderate and deep sedation/general anesthesia administration in the **OMS office is unmatched by anything in medicine.** Statistical evaluation of this fact is undeniable. **And, the Dental Board study confirmed this.**

I chose this profession in order to help people live healthier lives. As a mother, I cannot fathom the heartache of losing a child, but as a surgeon, I must rely on reason and rationale. On this basis, I cannot imagine turning patients away for weeks or months to arrange for a second anesthesia provider, or to double or triple the cost. Oral and maxillofacial surgeons have a long record of delivering safe and effective anesthesia for hundreds of thousands of patients. Any death is a tragedy. Emotionally, we want to react. Logically, we should analyze the facts and respond accordingly.

For that reason, I would ask that you take great care in considering the facts, including the Dental Board's recommendations to examine the effects of new legislation or regulation on access to care prior to implementation of any changes to current statute. While well-intentioned, making this adjustment to our safe model of care would significantly harm access to important dental services to children across California.

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