OPINION // OPEN FORUM

California doesn't ensure the safe use of sedation on kids at the dentist. As an anesthesiologist, I'm worried

Helen Lee
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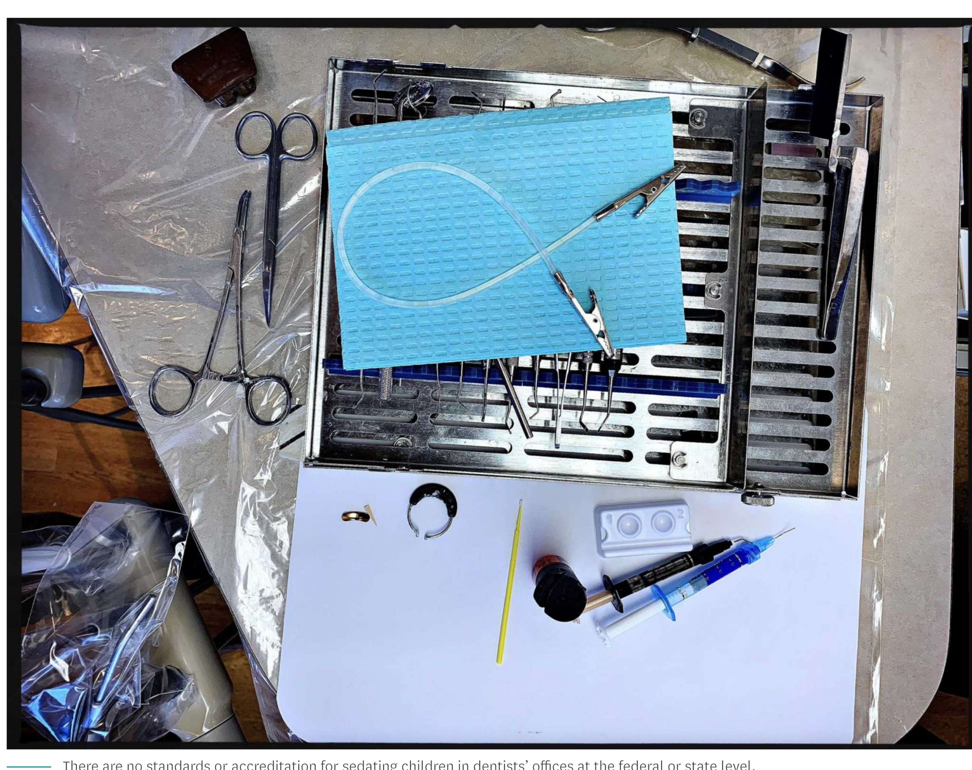

There are no standards or accreditation for sedating children in dentists' offices at the federal or state level.
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In 2015, Caleb Sears, a 6-year-old from Albany, died after being put under general anesthesia for a tooth extraction. Caleb's death prompted Caleb's Law, which, beginning in 2017, requires the California State Dental Board to collect and study data related to such tragedies.

In the five years since Caleb's Law took effect, data collection on the use of general anesthesia in dental procedures in the state has improved, an important step in safeguarding the health of California's children. But as an anesthesiologist who has studied the use of sedation on children, I know the law doesn't go far enough. California, and the country, need to ensure the safety of all anesthesia use on children by all dental health practitioners, including general and pediatric dentists.

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To minimize the pain, anxiety and trauma that children can experience during severe dental decay treatment, including routine cavity fillings, dentists are increasingly offering in-office sedation. Unlike local anesthesia, where a person remains fully conscious during the procedure, sedation, another type of anesthesia, offers more variance and can be categorized as mild, moderate or deep. Dentists are only allowed to administer deep sedation or general anesthesia if they have specialized training or must have an anesthesiologist brought in to help. With the right equipment, protocol and training in place, sedating a patient, even a young one, is a very safe procedure. The problem, however, is there's little oversight or federal regulation of dental offices, which makes it difficult to ensure quality and safety, particularly with mild and moderate sedation.

There is no way to know how often deaths like Caleb's occur because there is no systematic data collection of pediatric dental complications in the United States. To study the phenomenon, I reviewed several decades of media reports. My colleagues and I found that deaths were more common among those 2 to 5 years old who were sedated in the office. The few published studies of poor pediatric dental outcomes also suggest that deaths and other serious complications occur in greatest proportions with general dentists as the sedation provider, in the office setting, with young children and with insufficient monitoring.

In order to participate in Medicare and Medicaid reimbursement, hospitals and ambulatory surgery centers must obtain accreditation from the Joint Commission, a nonprofit body that accredits more than 22,000 U.S. health care organizations and programs. But office settings, of dental or any provider, are not held to the same standards as a hospital. In medicine at least, when children are sedated in an office setting, it's still under the supervision of an anesthesiologist or physician, whose licenses require them to have extensive training. In dentistry, however, if the sedation is mild or moderate, the person sedating a child can have widely variable training and experience from state to state.

In the absence of a mandatory standardized national accreditation body for dental offices that provide sedation, each state regulates licensing for pediatric dental sedation differently. For example, just 16 states require training specific to children, whose anatomy and drug responses differ from adults. Only 20 states require providers to be certified in Pediatric Life Support, a child-specific resuscitation certification. California requires basic life support training but not Pediatric Life Support.

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We already know what safe dental sedation should look like. In 2019, the American Academy of Pediatrics and American Academy of Pediatric Dentistry collaborated on guidelines for monitoring and management of young patients. But guidelines are recommendations, and providers aren't required to follow them. What we need is a national standard for pediatric dental sedation. This could be achieved through state licensing requirements. In 2020, the pediatric dentistry academy developed an accreditation process for office-based pediatric dental sedation with the American Association for Accreditation of Ambulatory Surgery Facilities, but it's not mandated or widespread.

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So what should be done? Nationally, the health care system can improve quality and safety of sedation by tracking and learning from bad outcomes, just as Caleb's Law has mandated for general anesthesia in California. State dental boards already collect this data but there is no mechanism to share it across states. Providers, payers, patients, malpractice insurers, dental organizations and policy makers need to agree upon a national standard for data collection and create task forces to study it so the system can improve.

Until parents can be certain that their state's laws ensure the safety of sedation practices in dental office settings, they will need to ask their child's dentist whether or not they have the pediatric accreditation.

To be sure, dental offices should not be prohibited from offering sedation — children need more, not less, access to qualified dental providers. Anesthesia is an important clinical service that enables children to get treatment without trauma. Many families spent critical months trying to find a provider willing to sedate their child. By the time many of these families find care, cavities have worsened and multiplied and more invasive procedures are necessary. But all children deserve the same standard of safe, quality care.

Teeth are part of the body and dentistry should be fully integrated into our health care system. Dental anesthesia, including sedation, should make it safer for children to visit their dentist. With standardized regulation, accreditation and oversight, parents and their children can be certain that it will.

Helen Lee is an associate professor in the Department of Anesthesiology at the University of Illinois at Chicago and a public voices fellow with the OpEd Project.

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