

# The History of the Specialty of Dental Anesthesiology

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Anesthesiology has been the practice of dentistry since dentists Horace Wells (1844) and William T. G. Morton (1846) first discovered the miracle of anesthesia for painless surgery by administering nitrous oxide and diethyl ether, respectively. Fortunately for the good of mankind, Dr Morton administered it for a patient of the chief of surgery at Massachusetts General Hospital, John Collins Warren, MD, who was a dean at the Harvard Medical School and a primary founder of the *New England Journal of Medicine and Surgery*. Dr Warren was absolutely amazed that Dr Morton kept his patient quietly asleep during the operation instead of having to listen to the painful screaming that always accompanied all surgery at that time. It was reported that he famously said of Morton's demonstration, "Gentlemen, this is no humbug." Dr Warren made certain that this most important discovery was published and made available to all doctors around the world. Both the American Dental Association (ADA) (1864) and the American Medical Association (1870) gave credit to Dr Wells as the discoverer of anesthesia,<sup>1</sup> but Dr Morton's successful public demonstration was especially significant for changing dentistry and medicine forever because of Dr Warren's powerful endorsement and lofty position he held in the worldwide medical community.

For the next 100 years, physicians and dentists together advanced the practice of anesthesiology. Physicians often taught the art and science of anesthesiology to dentists, and dentists, such as Jay Heidbrink, DDS, likewise taught it to many physicians. For instance, Dr Heidbrink was the chief anesthetist at Minneapolis General Hospital and hired famed anesthesiologist Arthur Guedel, MD, to his hospital medical staff.

## AMERICAN DENTAL SOCIETY OF ANESTHESIOLOGY

As the American Society of Anesthesiologists became a more powerful advocate for physician anesthesiologists

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in the early 1950s, several dentists, including Drs William Kinney, Daniel Lynch, and Leonard Monheim, decided to gather interested dentists in Pittsburgh to discuss the formation of an anesthesia society for dentists. Then, on August 30, 1953, at the ADA Annual Meeting in Cleveland, Drs Kinney, Lynch, Monheim, Jay Mervis, and Morgan Allison founded the American Dental Society of Anesthesiology (ADSA), with Drs Monheim and Allison as co-chairs.<sup>2</sup>

On February 6, 1954, at the ADA Chicago midwinter meeting, Dr Kinney was elected as president, Dr Allison as president-elect, Dr Harcourt Stebbins as vice president, and Dr Mervis as secretary-treasurer. Dr Kinney<sup>2</sup> stated in the ADSA's first newsletter, "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." He<sup>2</sup> also wrote that "we are pledged to build a strong, well respected society of dentist-anesthesiologists which can be the spokesman for anesthesiology in dentistry and which will set the high standards necessary for the specialty of anesthesiology to attain its rightful status." Thus, the primary reason that the ADSA was founded was for dental anesthesiology to be recognized by the ADA as a specialty. Because Dr Lynch was a prominent oral surgeon and president of the ADA, he supported the ADSA's position on anesthesiology at the ADA House of Delegates (HOD). They voted to establish a new section on anesthesiology at the 1955 annual session in San Francisco by amending Chapter 13 of the ADA Bylaws.<sup>3</sup> The section on anesthesiology was the 12th section of the Scientific Sections of the ADA and was the first step at that time toward the possible recognition of anesthesiology as a specialty of dentistry.

## ADSA'S AMERICAN DENTAL COLLEGE OF ANESTHESIOLOGY

As another move toward a specialty, the American Dental College of Anesthesiology was created as an

affiliate of the ADSA to provide for certification of training and competency in general anesthesia. Dr John Cotton was elected chairman of the board of governors, and Dr Peter King became secretary of the college. In 1956, a certifying exam was developed and administered, but because of “technical and procedural problems” that were undoubtedly politically based, the exam was declared null and void, and the college was soon rescinded.<sup>3</sup>

### ADSA FELLOW IN GENERAL ANESTHESIA

As an alternative to the college for meeting the perceived need for a specialty in anesthesiology, the ADSA created a new category of membership in 1964, the Fellowship in General Anesthesia, instead of promoting recognition of the specialty of anesthesiology. Despite significant opposed views, Dr Joseph Osterloh was the driving force behind acceptance of this new special category. At its annual meeting in 1965, the ADSA Board of Directors interviewed and passed 3 members to be Fellows in General Anesthesia of the ADSA and continued the annual fellowship interview process until 1975, when the board approved a formalized oral examination to become part of the evaluation of each fellowship candidate. The fellowship certificate was a major impetus for increased membership and activity of the ADSA,<sup>3</sup> especially among oral surgeons, but it did not serve as a specialty designation.

### ADSA SPECIALTY APPLICATION DEVELOPED, BUT NOT SUBMITTED

Despite a seemingly harmonious relationship between dentistry and physician anesthesiology, many residency positions in the 1980s that were once held by non-oral surgery resident dentists were no longer made available to our profession. Thus, an earnest discussion of the need for a specialty of anesthesiology within dentistry began again in the late 1970s. In 1981, the ADSA Board of Directors created a committee to look into the feasibility of applying to the ADA for specialty recognition and the creation of a certifying board. In 1982, the ADSA’s version of the American Dental Board of Anesthesiology (ADBA) was formed with its slate of officers, including Dr Daniel Laskin as the first president. Other board members included oral surgeons Drs Frank McCarthy and Robert Campbell and dentist anesthesiologists Drs James Phero, Morton Rosenberg, and Joel Weaver. Dr Norman Trieger was added to the board in 1987 so that oral surgeons would retain the majority vote. The board was incorporated in 1983, and

the first meeting of the new board was in October 1984. The ADBA worked with a well-known college educational testing service to assist in developing a written certifying examination. The ADSA, under the guidance of Dr Trieger, prepared an application for specialty status that was expected to be submitted to the ADA in 1990.<sup>4</sup>

However, in 1988 and again in 1989, the American Association of Oral and Maxillofacial Surgeons passed resolutions strongly opposing the ADSA’s establishment of the specialty of dental anesthesiology and its corresponding certifying board. With 71% of the ADSA’s members at that time also being members of the American Association of Oral and Maxillofacial Surgeons, the threat of losing the majority of its membership forced the ADSA Board of Directors in 1991 to permanently withhold the submission of the specialty application to the ADA. When the ADBA’s corporate certification of continuing existence in the State of Illinois was not renewed, it also faded into obscurity along with the ADSA’s nonapplication. Subsequently, to preserve the organization, the ADSA affirmed its neutrality on the specialty issue and redirected its efforts toward further enhancing continuing education in the areas of sedation and anesthesia, and that has remained its focus.

### AMERICAN SOCIETY OF DENTIST ANESTHESIOLOGISTS

The American Society of Dentist Anesthesiologists (ASDA) was founded on February 16, 1980, by dentist anesthesiologists Drs James Chancellor, Ralph Epstein, James Snyder, John Leyman, and Lois Jacobs, with all 17 initial members having completed the required minimum of 2 years of hospital anesthesiology residency training. Their goals were to make available to dental patients the full spectrum of anesthesia care, to train dentists in the full spectrum of anesthesia for dentistry, to establish more advanced continuing education programs in anesthesiology for dentists, and, especially, to pursue the development of a specialty of anesthesiology for the entire profession of dentistry. Dr Larry Trapp was the first ASDA president.

Initially the ASDA contributed its great expertise to assist the ADSA in its specialty attempt by gaining appointments to leadership positions in the ADSA, contributing to its continuing education courses, and publishing research in *Anesthesia Progress*. The contributions to the ADSA made by the relatively small group of dentist anesthesiologists were tremendous. From 1985 through 1993, ASDA dentist anesthesiologist members provided 61% of the ADSA’s lectures and 37% of its

lecturers. However, in October 1991, when the ASDA permanently halted its specialty effort, the ASDA immediately picked up the specialty torch and charged ahead to develop its own ADA specialty application.

### ASDA-AFFILIATED ADBA

On December 22, 1994, in the state of Illinois, Drs Ralph Epstein, James Snyder, James Chancellor, and Michael Higgins incorporated the ASDA-sponsored specialty board, the ADBA, exclusively for dentist anesthesiologists, thus giving new life to the discarded name of the ASDA's previously dissolved specialty board. They selected 9 ASDA members who were subsequently elected by the ASDA membership as the ADBA Board of Directors, including Drs Joel Weaver (president), Larry Trapp (vice president), James Chancellor (secretary), Richard Finder (treasurer), Joseph Giovannitti, Robert Peskin, Ralph Epstein, John Leyman, and John Yagiela. They created both written and oral examinations based on scientifically and educationally sound principles and with valid, reliable, and calibrated testing methods. Advertisements for qualified dentists to apply for ADBA grandfathering were published in the *Journal of the American Dental Association* and *Anesthesia Progress*, but the *Journal of Oral and Maxillofacial Surgery* declined publication. Several decades later, the ADBA was recognized by the American Board of Dental Specialties (ABDS) as the legitimate dental specialty board for anesthesiology in dentistry. As of this date, the ADBA has also applied to be the ADA's officially recognized board of the ASDA's newly recognized ADA specialty of dental anesthesiology.

### AMERICAN BOARD OF DENTAL SPECIALTIES

For decades, the profession of dentistry trusted the ADA HOD to be its gatekeeper in the recognition of dental specialties and their associated specialty boards. However, because of perceived or actual bias and conflict of interest in the specialty recognition process that was later acknowledged by the ADA HOD in 2017, the ABDS was created as an alternative to the ADA HOD process. The ABDS mimics the process of the American Board of Medical Specialties, which is an independent organization of specialty experts in their respective medical fields.

The ABDS is an independent organization of dental specialty boards with shared goals and standards related to certification of dental specialists. The mission of the ABDS is to encourage the further development of the

profession of dentistry through independent, unbiased recognition of specialty certifying boards, to improve the quality of care, and ultimately to protect the public. The ABDS was created and predicated on the principle that an organization independent of any professional trade association or self-interest group is required for the objective evaluation and determination of specialty areas in dentistry by careful evaluation of their specialty boards. Accordingly, the objective of the ABDS is to provide fair, equitable, and evidence-based processes for evaluating and recognizing dental certifying boards, their certification requirements, and their respective areas of practice as specialty areas in dentistry to allow an impartial mechanism for state regulators to recognize legitimate dental specialists, even if the ADA does not. The public is assured that the dental specialty boards recognized by the ABDS and the diplomates of those boards are legitimate board-certified specialists.

### ASDA SPECIALTY APPLICATIONS

The ASDA's first specialty application was edited by a team headed by Dr John Yagiela, and after he tirelessly spent months perfecting the final draft, the application was submitted to the ADA in June 1993. Favorable votes were attained in all the required specialty process steps formulated by the ADA HOD, ie, Specialty Recognition Committee G of the ADA Council on Dental Education and Licensure, the entire Council on Dental Education and Licensure, the ADA Board of Trustees, and the ADA HOD Reference Committee on Dental Education. However, the 1994 ADA HOD nevertheless voted not to approve the application. Not dissuaded, 2 other, different applications, based on ever-changing ADA HOD criteria and again edited by Dr Yagiela, passed all the required ADA steps, but the ADA HOD voted them down in 1997 and 1999. In 2012, under the editorship of Dr Steven Ganzberg, this same application process was repeated based on the ADA HOD's even more complex approval criteria. As with the 3 previous applications, it passed the scrutiny of all the ADA's required steps, but ultimately failed the ADA HOD vote for the fourth time.

### ACCREDITATION BY THE ADA COMMISSION ON DENTAL ACCREDITATION

Following the first 3 negative specialty votes by the ADA HOD, the ASDA placed more emphasis on gaining accreditation by the ADA's Commission on Dental Accreditation (CODA) for its ten 2-year residency programs. Having previously been told on

multiple occasions by CODA that it would not accredit nonspecialty programs, with the noted exceptions of general practice dental residencies, dental hygiene, dental assisting, and dental laboratory technician programs, ASDA submitted another accreditation request in January 2001.

Initially the request was on the verge of again being tossed aside when the CODA “public member,” Dr Lanier E. Byrd, PhD, who later became vice president of academic affairs at St Phillips College in San Antonio, reasoned that the public may already believe many programs are accredited.<sup>5</sup> His logic was that if the public assumes that the training program of the dentist anesthesiologist is accredited by CODA, why shouldn’t it be accredited by CODA? He was reportedly astounded by those with opposing views and immediately questioned why 2- to 3-year dental anesthesia residency programs so absolutely vital to the life or death of dental patients were not worthy of accreditation to ensure the safety of the public, which is a main purpose of CODA. Certainly, if CODA accredits the training of the child’s pediatric dentist, the training of the child’s certified dental assistant, and the training of the certified laboratory technician who made the child’s oral appliance, why shouldn’t CODA accredit the training of the child’s dentist anesthesiologist who provides general anesthesia in the office?

To their credit, the majority of CODA members, especially the pediatric dentist member Dr Dennis McTigue, according to Dr Byrd’s recollection, agreed as they began to see the obvious logic of Dr Byrd’s position. After several years of vigorous political maneuvering, including CODA needing to change its mission statement to be able to effect this change (approved January 2001), CODA finally voted to accept new categories for accreditation of programs in dental education disciplines in August 2002.<sup>6</sup> Following ASDA’s application for accreditation of dental anesthesiology residencies, CODA approved the application in January 2005. In August 2005, the standards for accreditation were approved, which then allowed programs to apply for accreditation. It took several more years for individual residency programs to create and submit their accreditation applications and for the residency program evaluations to begin. Dental anesthesiology residencies finally began attaining CODA accreditation in the summer of 2008, starting at the University of Pittsburgh School of Dental Medicine and, soon after, The Ohio State University College of Dentistry. Having just completed the 27-month anesthesia residency at The Ohio State University, Jarom Heaton, DDS, MS, became the first dentist anesthesiologist to graduate from a CODA-accredited anesthesiology residency on September 30, 2008.

CODA accreditation of residency programs in dental anesthesiology was a critical step in giving increased visibility and credibility to the recognition of the specialty. In 2016, the ASDA’s application to CODA to significantly increase both the clinical and academic requirements and the duration of its residencies from 2 to 3 years was passed. The required 3-year residency further increased the anesthesia training gap between dentist anesthesiologists and all other dental practitioners, which also added credibility to the specialty of dental anesthesiology.

### LEGAL CHALLENGES FOR FREEDOM OF SPEECH IN ADVERTISING

A number of legal challenges of state dental board regulations developed in the recent past. In *North Carolina Board of Dental Examiners v Federal Trade Commission* (FTC) (*North Carolina Board of Dental Examiners v Federal Trade Commission*, 574 U.S. [2015]), the FTC charged that organized dentistry, not the state, appoints the dental board members, who may regulate and unfairly limit competition and limit truthful advertising and specialty designation because of self-interest. On February 25, 2015, the US Supreme Court agreed that the lower court’s restraint of trade conclusion “does not question the good faith of state (dental board) officers but rather is an assessment of the structural risk of market participants’ confusing their own interests with the State’s policy goals.” In *Kiser v Kamdar/Ohio Dental Board* (*Kiser v Kamdar*, 831 F. 3d 784 [6th Cir. 2016]), an endodontist specialist challenged the dental board rule, based on the ADA Principles of Ethics and Code of Professional Conduct, that a specialist who advertises as specialist was also prohibited from advertising nonspecialty dental procedures being done. The US Court of Appeals for the Sixth Circuit opined in 2016 that specialist training does not diminish all general dentistry skills, and therefore the board’s rule, based on the ADA’s document, was a violation of freedom of speech.

In *Borgner (American Academy of Implant Dentistry [AAID] v Florida Board of Dental Examiners* [2002], *Borgner v Brooks*, 284 F. 3d 1204, 1210 [11th Cir. 2002]), the US Supreme Court upheld the lower court decision that the American Board of Oral Implantology/Implant Dentistry was a legitimate credential and that the rule, based on the ADA Principles of Ethics and Code of Professional Conduct, preventing diplomates of their board from advertising board credentials without also stating that the board was not recognized by the dental board and the ADA was actually more confusing to the public. The rule implied that the board credentials are

bogus, which they obviously were not. A similar ruling in Florida (*Ducoin FJ v Viamonte Ros, Second Judicial Cir., Florida, #2003 CA 696* [2009]) in 2009 in the Second Judicial Court Circuit indicated that the AAID's constitutional rights in the 1st and 14th Amendments were violated by advertising restrictions. Another similar ruling occurred in 2010, in *AAID v California Dental Board (Potts v Stiger, CIV-s-03-348 USDC, Eastern District of California* [2010]), where truthful advertising of a legitimate board was judged by the US District Court, Eastern District of California, to not be harmful to the public. Finally, in 2017, a similar outcome occurred with the Texas Board of Dental Examiners and Texas Society of Oral and Maxillofacial Surgeons versus the national associations of implant dentistry, oral medicine, and orofacial pain and ASDA (*AAID v Parker, 860 F. 3d 300 [5th Cir. 2017]*). Testimony included a dentist anesthesiologist who stated that the dental board advertising rules for dentist anesthesiologists forced his advertisement to be false and misleading to the public because it had to include a statement that he was a general dentist, when the truth was that he did absolutely nothing that general dentists do, and that general dentists are not permitted in Texas to provide the only procedures that he does, general anesthesia. The federal judge ruled in the US Court of Appeals, Fifth District, that the “plaintiffs have a Constitutional right of commercial free speech.”

### FTC INFLUENCE ON ADA HOD DETERMINING SPECIALTY

The ADA Principles of Ethics and Code of Professional Conduct places restrictions on the specialty and board certification credentials that an ethical dentist can advertise. Because state dental boards incorporate them into enforceable state rules and laws, the FTC has shown interest in whether the ADA improperly restrains trade and violates freedom of speech. Although this author was not privy to the secret deliberations within the closed sessions of the ADA HOD at the ADA Annual Meeting in 2017 regarding the position of the FTC and the implications of the above legal judgements, there were many significant procedural changes made at that time. The ADA HOD relinquished its absolute power to grant specialty recognition to a 19-member National Commission on Recognition of Dental Specialties and Certifying Boards (NCRDSCB) in order to reduce perceived or actual bias and conflict of interest in the specialty recognition process. Additionally, it modified the ADA Principles of Ethics and Code of Professional Conduct to acknowledge as ethical conduct a dentist who advertises as a specialist in a non-ADA-

recognized specialty, if that specialty is recognized by the dentist's state/jurisdiction licensing board. It also accepted as ethical conduct a dental specialist who advertises as a specialist, but who also desires to provide nonspecialty general dental procedures, so long as the specialist does not advertise as “practice limited to” the specialty. Prior to these changes, it was unethical and usually illegal based on state dental board rules for a specialist to advertise as a specialist and still provide nonspecialty procedures.

### DENTAL ANESTHESIOLOGY SPECIALTY RECOGNIZED BY THE ADA NCRDSCB

In 2018, the ADA Board of Trustees, led by ADA President Dr Joseph Crowley, appointed 9 general dentists to the new NCRDSCB. Another 9 specialists, representing each of the 9 ADA-recognized specialties, joined the new commission, as well as a 19th nondentist public member. Former ADA President Dr Charles H. Norman III was elected president of the commission. Considering the remarkable changes in the ADA that had taken place to form the NCRDSCB, and despite the perceived or actual bias and conflict of interest in the previous 4 specialty attempts, the ASDA submitted an updated fifth specialty application in 2018, again edited by Dr Ganzberg and his committee. Although the ADA specialty criteria had not changed since the 2012 application, considerable time was invested in updating this application, because the CODA-accredited anesthesiology residency programs had changed from 2 to 3 years in duration and the CODA sedation-training standards in undergraduate and postgraduate dental programs, to which comparisons had to be made with dental anesthesiology standards within the application, had also changed. A subcommittee of the NCRDSCB scrutinized the application and judged that it again met all the ADA standards for specialty recognition, identically to the 4 previous applications. After evaluating the comments following a 60-day general public comment period, the NCRDSCB met, and on March 11, 2019, it notified ASDA President Dr James Tom and Dr Steven Ganzberg, along with officers Drs Cynthia Fukami, Zak Messieha, and Lenny Naftalin, that the commission had voted in favor of the new specialty of dental anesthesiology. A two-thirds majority was needed to pass the resolution, compared to a simple majority in the ADA HOD for the previous 4 negative votes. Thus the 67-year-old quest for the ADA to recognize the specialty of dental anesthesiology finally resulted in victory for dentist anesthesiologists and, importantly, for the entire dental profession and the public.



The first ADDBA diplomate certificate, awarded to Dr Larry Trapp.

## WHAT IS THE TRAINING OF DENTIST ANESTHESIOLOGIST SPECIALISTS?

CODA-accredited dental anesthesiology residencies are currently 36 months in duration following dental school, with 24 of those months dedicated exclusively to administration of clinical anesthesiology, including 6 months of anesthesiology just for dental patients. In practice, at least 30 months of clinical anesthesiology training is currently realized. Of those 24 required months, a minimum of 1 full year at the resident level of responsibility must be on a rotation in a hospital department of anesthesiology, which is more than twice the duration of a hospital anesthesia rotation for 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 perform-

ing all types of restorative and surgical dental procedures requires special anesthetic skills and techniques unique to dentistry. Thus, an optimal level of safety training is enhanced by 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 with any other medical or dental residency training program. The required 125 anesthetics for children age 7 years and younger exceed even 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, or 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.

**American Dental Board of Anesthesiology Past Presidents**

<i>Year</i>	<i>President</i>
2017–2019	Dr Kyle Kramer
2015–2017	Dr Lenny Naftalin
2014–2015	Dr Brian Chanpong
2013–2014	Dr Ralph Epstein
2011–2013	Dr Steven Ganzberg
2010–2011	Dr Cynthia Fukami
2009–2010	Dr Joseph Giovannitti
2008–2009	Dr John Yagiela
2007–2008	Dr Chad Stoker
2005–2007	Dr Joseph Seay
2001–2005	Dr Mark Saxen
2000–2001	Dr Joel Weaver
1999–2000	Dr James Chancellor
1995–1999	Dr Joel Weaver
1994–1995	Dr Ralph Epstein

With their comprehensive accredited training in the art and science of anesthesiology for dentistry, the public can be assured that dentist anesthesiologist 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 a dental office into a fully equipped mini–operating room with their ultramodern portable anesthesia equipment and monitors for safe ambulatory anesthesia.

### THE FUTURE IMPLICATIONS OF SPECIALTY RECOGNITION

Dentist anesthesiologists are expert consultants and will be available for consultation or referral for complex procedures or for difficult, challenging patients, just like all other specialists in dentistry. With their special expertise in anesthetizing small children, pediatric dentists who work with a dentist anesthesiologist can operate more efficiently and economically in the comfort and familiarity of their own offices with their own dental equipment and assistants without the additional facility fee expenses and scheduling unpredictability of hospital operating rooms or ambulatory surgery centers.

Trends in advanced dental education recently published by the ADA<sup>7</sup> demonstrated that following specialty recognition of oral and maxillofacial radiology, its total enrollment increased 9 times, and the number of its programs doubled. As more dental schools realize the tremendous advantages of dental anesthesiology residency programs supporting all of their dental programs, including departments of oral and maxillofacial surgery, a similar increase in the number of programs and total enrollment will likely

**American Society of Dentist Anesthesiologists Past Presidents**

<i>Year</i>	<i>President</i>
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 Scheult
1986–1988	Dr William MacDonnell
1984–1986	Dr Michael Higgins
1982–1984	Dr Joseph Giovannitti
1980–1982	Dr Larry Trapp

result. Dental schools that have full-time dentist anesthesiologist specialists and an affiliated dental anesthesiology residency benefit from having true experts to teach local anesthesia, pharmacology, management of medical emergencies, and minimal and moderate sedation to all predoctoral and graduate students. Additionally, these dentist anesthesiologist specialists can participate in the teaching and supervision of the clinical administration of deep sedation and general anesthesia to oral and maxillofacial surgery residents, as well as providing all levels of sedation and anesthesia, including nasally intubated general anesthesia, for major dental procedures such as full mouth rehabilitation, multiple dental implant placement, and some orthognathic surgery procedures done within a school's anesthesia-ready ambulatory clinic.

The greater demand for the delivery of increasingly more complex dental procedures by operating dentists has fueled a similar demand for a separate dentist anesthesiologist specialist who can concentrate solely on providing the anesthetic during those complex procedures. Recognition of the new anesthesia specialty will increase the number of residency programs and fully trained graduates to meet that increased demand for board-certified dentist anesthesiologist specialists. However, just as with other specialists, dentist anesthesiologists are consultants and do not limit other practitioners from doing any procedure, including sedation, that they are trained and licensed to do. Specialties have never taken away anything from any dentist. They only add to the betterment of the profession. The decades-old political controversy of

whether dental anesthesia should be recognized as a specialty by the ADA is now over. It is time for everyone to embrace the specialty of dental anesthesiology and move forward together for the sake of the profession as well as the best interests of the public we serve.

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