

Training Matters: Why Competency Should Guide Office-Based Pediatric Anesthesia Policy

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Background: Pediatric office-based deep sedation and general anesthesia policy should prioritize patient safety and preserve access to care. Debate has focused on whether universal staffing requirements—imposing a separate anesthesia provider—should supersede differences in practitioner education, training, and demonstrated competency.

Findings: Oral and maxillofacial surgery residency provides extensive hospital-based anesthesia education, longitudinal experience with deep sedation and general anesthesia in a surgeon-directed anesthesia team model, airway management, and emergency care. Oral and maxillofacial surgery practice is reinforced by a specialty-wide safety infrastructure incorporating office evaluation, anesthesia-assistant education, simulation, emergency preparedness, adverse-event reporting, and continuing education. Available utilization and adverse-event data demonstrate that including a separate anesthesia provider does not improve pediatric anesthesia safety.

Conclusions and relevance: Pediatric dental anesthesia policy should recognize differences in specialty-specific training and professional competency rather than impose uniform staffing models. A competency-based approach supports patient safety and preserves access to care, while appropriately accommodating the demonstrated safety of the surgeon-directed anesthesia team model practiced by oral and maxillofacial surgeons.

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Key Points

Question Should American Dental Association's pediatric office anesthesia staffing policy reflect practitioner competency or require a separate anesthesia provider?

Findings Observational evidence fails to demonstrate greater safety with separate anesthesia providers. Oral and maxillofacial surgeons receive extensive anesthesia training and demonstrated competency using the surgeon-directed anesthesia team model.

Meaning American Dental Association staffing policy should account for practitioner competency, safety systems, patient factors, and access to care, allowing oral and maxillofacial surgeons to continue their current anesthesia practices without a separate anesthesia provider.

Few issues command greater consensus within health care than the obligation to protect children receiving anesthesia. Oral and maxillofacial surgeons, pediatric dentists, dentist anesthesiologists, physician anesthesiologists, pediatricians, nurses, regulators, and policymakers all share a common objective: ensuring that every child has access to safe, high-quality anesthesia care. The debate surrounding office-based pediatric deep sedation and general anesthesia is therefore not a disagreement about whether patient safety should be the highest priority. Rather, it is a disagreement about what factors most influence safe anesthesia delivery and how those factors should be reflected in professional guidelines and regulatory policy. Pediatric anesthesia policy should recognize differences in professional competency rather than impose uniform staffing models. A competency-based approach supports patient safety and preserves access to care while appropriately accommodating the surgeon-directed oral and maxillofacial surgery (OMS) anesthesia team model.

Current Debate

The most recent catalyst for this discussion is the American Dental Association's (ADA's) development of the Guidelines for the Use of Sedation and General Anesthesia by Dentists for Pediatric Patients. These guidelines were initiated following the 2025 ADA Dental Anesthesia Provider Summit¹ and subsequent direction from the ADA House of Delegates to develop pediatric-specific guidance for dentists. This effort represented an important milestone, reflecting organized dentistry's desire to develop guidance under its own governance rather than relying on guidelines devel-

oped by outside organizations. As the American Association of Oral and Maxillofacial Surgeons (AAOMS) noted in its comments to the ADA Council on Dental Education and Licensure, the ADA recognized that continued incorporation of external guidelines could bind the association to future revisions over which it exercised neither authorship nor governance.

Although the proposed guidelines address numerous aspects of pediatric anesthesia, discussion has centered largely on personnel requirements for deep sedation and general anesthesia. Organizations including the American Academy of Pediatrics and American Academy of Pediatric Dentistry have advocated for models requiring a separate anesthesia provider dedicated solely to anesthetic management during pediatric deep sedation or general anesthesia. In the absence of data, representatives of these organizations have expressed concern that the surgeon-directed OMS anesthesia care team model does not provide an adequate margin of safety for pediatric patients.

AAOMS leaders reached a different conclusion. For decades, oral and maxillofacial surgeons have safely delivered office-based anesthesia through a surgeon-directed team model founded on competency derived from extensive residency-based anesthesia education, trained anesthesia assistants, rigorous office evaluation, continual emergency preparedness, continuing educational opportunities, and ongoing quality improvement.

AAOMS does not oppose the use of a separate anesthesia provider when appropriate for the education and experience of the practitioner or the needs of the individual patient. However, AAOMS maintains that practitioners who complete comprehensive anesthesia education and demonstrate competency through formal residency training and lifelong continuing education, should not be subject to identical personnel requirements as practitioners whose educational pathways were designed to achieve different competencies. The OMS anesthesia team model practiced in compliance with such stringent requirements aligns with the AAOMS mission to ensure patients' access to safe and effective care.

Competency Determines Safe Staffing

Across health care, identical procedures are frequently performed under different personnel models depending upon the education, residency training, and demonstrated competency of the licensed professional providing care. This principle is so well-established that it often goes unnoticed. Yet, it forms the foundation of modern credentialing, hospital privileging, specialty certification, and health care regulation.

Emergency physicians routinely administer procedural sedation while directing interdisciplinary emergency department teams. Trauma surgeons simultaneously manage operative care and complex resuscitation. Interventional cardiologists, interventional radiologists, and gastroenterologists perform procedures requiring varying levels of sedation, depending upon institutional credentialing and patient factors. The determining factor is not the procedure alone; it is the competency of the practitioner performing it.

The question before organized dentistry, therefore, is not whether deep sedation and general anesthesia are complex—they unquestionably are. The question is whether every practitioner who performs those services receives equivalent anesthesia education. The answer is no. Consequently, it should not be surprising that different educational pathways appropriately support different anesthesia delivery models.

OMS Education and the Safety Infrastructure

Within dentistry, OMS occupies a unique position with respect to anesthesia education. Accreditation standards established by the Commission on Dental Accreditation (CODA) require OMS residency programs to provide 4 to 6 years of hospital-based surgical education, including a dedicated anesthesia and medicine rotation of at least 32 weeks, with a minimum of 20 consecutive weeks assigned to an anesthesiology service under the direct supervision of physician anesthesiologists.² During this period, OMS residents function, not as students, but as integral members of the anesthesia service. OMS residents participate in preoperative evaluation, anesthetic planning, airway management, induction and emergence, physiologic monitoring, postoperative recovery, and management of anesthetic complications involving pediatric and adult patients.

Training as a member of the medical anesthesia service forms the basis for ongoing OMS resident anesthesia training. Importantly, this dedicated anesthesia rotation represents only one component of OMS anesthesia education. Throughout the remainder of residency, anesthesia continues to be integrated into daily surgical practice. Residents repeatedly administer deep sedation and general anesthesia while managing ambulatory surgical patients, facial trauma, medically complex patients, emergency cases, and patients requiring advanced airway management. This longitudinal educational experience reinforces technical proficiency while cultivating clinical judgment regarding patient selection, procedural risk, anesthetic planning, and recognition of evolving physiologic compromise.

The educational objective is therefore broader than learning to administer anesthetic medications. OMS residency prepares surgeons to integrate surgical decision-making, anesthetic management, airway control, and emergency response into a coordinated model of patient care. The surgeon-directed anesthesia team is not a substitute for anesthesia education; rather, it is the product of that education.

This educational pathway differs substantially from those of other dental specialties, whose residency programs emphasize different professional competencies.

Pediatric dentistry residency programs, for example, focus on comprehensive oral health care for infants, children, adolescents, and patients with special health care needs.

Their curricula emphasize behavior guidance, restorative care, growth and development, interceptive treatment, and management of medically complex pediatric patients.

Although moderate sedation is addressed within pediatric dentistry education, training in deep sedation and general anesthesia should not be characterized as a core component of the specialty's educational mission. Even training in moderate sedation is often limited. The available evidence underscores this distinction. A 2024 CODA survey³ found that nearly one-half of pediatric dentistry residency programs reported no clinical experience with intravenous moderate sedation, much less with deep sedation or general anesthesia. Moreover, current CODA standards require experience with 50 sedation cases beyond nitrous oxide, but do not specify the level of sedation or require comprehensive competency in office-based deep sedation or general anesthesia.⁴ Thus, completion of a pediatric dentistry residency should not be equated with comprehensive training or demonstrated competency in the independent provision of deep sedation or general anesthesia. Nor should such training be construed as establishing the expertise necessary to dictate clinical anesthesia guidelines or policy governing procedures in which the individual lacks formal training, clinical experience, and demonstrated competency.

These differences should not be viewed as evidence that one specialty is inherently superior to another. Rather, they illustrate a fundamental principle of graduate professional education: specialties are designed to achieve different competencies. Just as pediatric dentists possess expertise in child development and behavior management that extends beyond the education of most oral and maxillofacial surgeons, oral and maxillofacial surgeons complete educational pathways intentionally designed to develop competency in hospital-based and office-based deep sedation and general anesthesia integrated with surgical care.

Differences in educational preparation appropriately support differences in clinical practice (Table 1).

Table 1. EDUCATIONAL PREPARATION FOR DEEP SEDATION AND GENERAL ANESTHESIA ACROSS DENTAL TRAINING PATHWAYS

Educational Element	Oral and Maxillofacial Surgery ²	Pediatric Dentistry ⁴	General Dentistry
Predoctoral dental education	✓	✓	✓
CODA-accredited residency required for specialty practice	4-6 years	2-3 years	Not applicable
Dedicated hospital anesthesia rotation	≥32 weeks (≥20 consecutive weeks)	No	No
Functions as anesthesia resident	Yes	No	No
Longitudinal administration of deep sedation/general anesthesia throughout residency	Yes	No	No
Extensive airway management training	Yes	Limited	Limited
Hospital operating room anesthesia experience	Extensive	Limited	None
Trauma and emergency airway management	Extensive	Limited	None
Primary educational objective	Integrated surgery and anesthesia	Comprehensive pediatric oral health care	Comprehensive general dental care

Abbreviation: CODA, Commission on Dental Accreditation. Adapted from CODA accreditation standards.

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Oral and Maxillofacial Surgeons Go Beyond Education Alone

While OMS residency training fully establishes the foundations to administer deep sedation and general anesthesia for pediatric patients utilizing the OMS team-based model, it represents only the beginning of the OMS approach to patient safety (Table 2).

Best clinical practice emerges from systems that reinforce appropriate decision-making, standardize best practices, identify latent hazards, promote continual learning, and prepare teams to respond effectively when unexpected events occur. High-reliability organizations—including commercial aviation, nuclear power, and increasingly health care—have demonstrated that sustained safety depends upon the interaction of education, standardized processes, teamwork, simulation, measurement, and continuous quality improvement.

Over the past several decades, AAOMS has systematically developed such a framework for office-based anesthesia.

Unlike many professional organizations whose primary educational activities focus on continuing education alone, AAOMS has created an integrated patient safety infrastructure encompassing residency education, office accreditation, team training, emergency

preparedness, adverse-event analysis, and continuous performance improvement. These initiatives were not developed independently. Rather, they function as complementary components of a comprehensive safety system intended to strengthen every phase of office anesthesia care.

Among the most distinctive elements of this infrastructure is the AAOMS Office Anesthesia Evaluation Program,⁵ a peer-review process through which qualified oral and maxillofacial surgeons evaluate office anesthesia practices against nationally recognized standards. The program extends beyond regulatory compliance by emphasizing continual quality improvement, emergency preparedness, equipment readiness, documentation, patient monitoring, and adherence to evidence-based anesthesia practices. Through periodic evaluation and peer-to-peer education, the Office Anesthesia Evaluation program reinforces a culture of accountability and lifelong learning that extends well beyond residency training, so much so that it has been adopted for use by several state dental boards for their own office evaluation processes.

Patient safety similarly depends upon the competency of every member of the anesthesia team. Recognizing this principle, AAOMS established the Dental Anesthesia Assistant National Certification

Table 2. COMPONENTS OF THE AAOMS OFFICE ANESTHESIA SAFETY INFRASTRUCTURE

Safety Initiative	Primary Purpose
CODA-accredited OMS residency education	Comprehensive anesthesia competency
Office Anesthesia Evaluation (OAE) Program	Peer review and office quality assessment
Parameters of care	Specialty-wide clinical standards
DAANCE	Evaluation of standardized anesthesia assistant education using psychometrically valid examination
National Simulation Program	Crisis resource management and emergency preparedness
Quarterly mock emergency drills	Team performance and rehearsal of rare events
DAIRS	Adverse-event reporting and continuous quality improvement
Continuing education	Maintenance of competency
Capnography advocacy	Enhanced physiologic monitoring
PALS certification	Pediatric emergency preparedness

Abbreviations: AAOMS, American Association of Oral and Maxillofacial Surgeons; CODA, Commission on Dental Accreditation; DAANCE, Dental Anesthesia Assistant National Certification Examination; DAIRS, Dental Anesthesia Incident Reporting System; OMS, oral and maxillofacial surgery; PALS, pediatric advanced life support.

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Examination⁶ to provide a competency standard for anesthesia assistants participating in office-based anesthesia care. The examination assesses assistants on the skill gained through formal and practical experience, testing on principles including patient monitoring, anesthetic pharmacology, airway management, recognition of physiologic deterioration, emergency response, and effective communication within the anesthesia team. Although anesthesia assistants do not replace the judgment or responsibility of the operating surgeon, this standardization credential further strengthens the collective ability of the team to anticipate, recognize, and respond to evolving clinical situations.

AAOMS has also emphasized continual emergency preparedness through simulation-based education and regular mock emergency drills.⁷ Simulation allows entire office teams to rehearse crisis management,

refine communication, clarify team roles, and improve performance under conditions that closely approximate real clinical emergencies. These educational strategies mirror those increasingly adopted throughout medicine as components of high-reliability patient safety programs.

Further, AAOMS has embraced continuous quality improvement through systematic evaluation of anesthesia outcomes. The Dental Anesthesia Incident Reporting System⁸ encourages reporting and analysis of adverse events and near misses to identify opportunities for improvement before rare complications become recurring problems. This approach reflects a fundamental principle of contemporary patient safety: organizations learn not only from catastrophic outcomes but also from near misses, process failures, and opportunities to strengthen systems before patient harm occurs.

Additional initiatives—including advocacy for routine capnography during moderate, deep sedation and general anesthesia; regularly updated parameters of care; the anesthesia assistants review course, anesthesia update, hands-on emergency drills, and other continuing education opportunities developed and offered by AAOMS; pediatric advanced life support certification; office emergency protocols; and quarterly mock emergency drills—further reinforce a culture in which patient safety is viewed not as a static achievement but as a process of continual improvement.

Collectively, these initiatives distinguish the OMS model from a simplistic characterization of “one surgeon and 2 assistants.” Rather, the surgeon-directed anesthesia team model represents the visible component of a much larger patient safety system built over decades through investment in education, peer review, team training, simulation, quality improvement, and continual reassessment of clinical practice. The resulting framework reflects a central principle of modern health care: sustained excellence in patient safety depends not upon any single individual or staffing configuration but upon resilient systems that support consistently safe care.

What Does Evidence Show?

Randomized comparisons of pediatric dental anesthesia staffing models are not ethically feasible. Available evidence therefore consists primarily of claims data, state reviews, adverse event analyses, and quality-improvement reporting, each with important limitations (Table 3). One of the most important observations is that oral and maxillofacial surgeons provide the majority of office-based deep sedation and general anesthesia in dentistry. According to FAIR Health claims data, oral and maxillofacial surgeons performed

Table 3. SUMMARY OF AVAILABLE EVIDENCE RELEVANT TO THE OMS OFFICE-BASED ANESTHESIA MODEL

Evidence Source	Principal Findings
FAIR Health claims data ⁹	OMSs perform the majority of dental deep sedation/general anesthesia procedures, and specifically pediatric cases, in the United States.
California Dental Board Pediatric Anesthesia Study ¹⁰	Serious adverse events and deaths occurred across multiple provider types; available summaries identify one OMS-associated pediatric deep sedation/general anesthesia death during the review period.
Texas Blue Ribbon Panel ¹¹	Pediatric anesthesia-related deaths/permanent injuries involved multiple provider models; none involved OMSs during the study period.
Publicly reported pediatric anesthesia cases (Table 4)	Serious adverse events have occurred with and without separate anesthesia providers.

Abbreviation: OMS, oral and maxillofacial surgery.

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approximately 77 percent of privately insured dental intravenous moderate sedation and deep sedation/general anesthesia procedures from 2018 to 2025.⁹ Among children ages 1 to 12, oral and maxillofacial surgeons provided approximately 64 percent of privately insured deep sedation/general anesthesia services; Medicaid data show a similar majority role.

These utilization data are important because they provide essential context for interpreting adverse events. A specialty performing the majority of pediatric office-based anesthesia may be expected to account for a proportionate number of serious complications if all delivery models carried equivalent risk. Instead, available data suggest the opposite, with a greater number of pediatric deaths associated with practitioners who are not oral and maxillofacial surgeons. More broadly, the data suggest that serious adverse events have occurred across multiple provider types and anesthesia delivery models, including models utilizing separate anesthesia providers. Separate non-OMS anesthesia providers are associated with a disproportionately higher number of deaths in spite of the fact

that oral and maxillofacial surgeons provide the majority of anesthesia care, per the available data.

The California Dental Board's pediatric anesthesia study¹⁰ reviewed pediatric anesthesia-related adverse events over a 10-year period. Subsequent analyses identified multiple sedation-related deaths and permanent injuries involving various dental providers. One deep sedation/general anesthesia-related death involved an oral and maxillofacial surgeon, whereas several serious adverse events and deaths occurred in non-OMS practices utilizing separate anesthesia providers. Likewise, the Texas State Board of Dental Examiners' Blue Ribbon Panel¹¹ identified 4 pediatric sedation-related deaths or permanent injuries between 2017 and 2021; none involved an oral and maxillofacial surgeon, while 2 occurred during care provided by pediatric dentists utilizing separate physician anesthesia providers.

AAOMS reviewed publicly reported pediatric dental anesthesia deaths of children aged 0 to 12, from 2002 through 2026 (Table 4). Although media reports are an imperfect source of scientific evidence and should be interpreted cautiously, they demonstrated that serious adverse events have occurred across multiple provider types and that several involved independently licensed anesthesia providers rather than surgeon-directed OMS teams.

Table 4 documents 41 anesthesia-related deaths reported in dental offices distributed among 15 states. When the dental provider type was known ($n = 36$), there were 2 (5.6%) deaths in OMS provider settings, but there were 34 (94.4%) deaths in non-OMS provider settings. When the anesthesia provider was known ($n = 38$), 17 (44.7%) deaths occurred in non-OMS settings in the presence of a separate anesthesia provider. These data demonstrate a separate anesthesia provider does not ensure enhanced safety. Requiring an additional anesthesia provider in OMS settings will increase costs and decrease access with no measurable increase in safety.

None of these data suggest that any anesthesia delivery model is risk free. Every pediatric anesthesia-related death represents a profound tragedy for the patient, family, and health care professionals involved. The appropriate conclusion is therefore not that one specialty has achieved perfection, but rather that the available evidence does not demonstrate that the presence of a separate anesthesia provider prevents serious adverse events.

More strikingly, while the availability of a separate anesthesia provider may be one strategy to address serious adverse events for lesser trained professionals, the data do not suggest such correlation for the oral and maxillofacial surgeon highly trained in anesthesia delivery. In fact, the rarity of OMS-related anesthesia incidents in comparison to incidents related to other practitioners suggests that training—not number of providers—might offer the strongest correlation to

Table 4. PUBLICLY REPORTED DEATHS OF CHILDREN AGED 0-12 YEARS, 2002-2026

Year	State	Age	Provider Type	Separate Anesth. Provider
2002	AZ	4	General dentist	No
2005	CA	4	General dentist	Yes - MD/DO
2006	TX	2	General dentist	No
2006	IL	5	Pediatric dentist	No
2006	FL	10	General dentist	Yes - DDS/DMD - General
2007	VA	8	General dentist	No
2009	TX	1	Unknown	Yes - MD/DO
2009	FL	9	General dentist	No
2010	OK	4	Pediatric dentist	Yes - CRNA
2010	FL	5	Pediatric dentist	No
2010	GA	5	General dentist	No
2010	VA	6	Pediatric dentist	Unknown
2011	CA	3	Unknown - non-OMS	No
2011	CA	9	Unknown	No
2011	CA	4	Unknown	Yes - MD/DO
2012	NJ	3	General dentist	No
2012	TX	10	Pediatric dentist	No
2013	HI	3	General dentist	No
2013	TX	4	General dentist	No
2013	CA	11	General dentist	Yes - MD/DO
2015	CA	6	OMS	No
2015	CA	3	Pediatric dentist	No
2015	CA	3	Unknown	No
2016	CA	3	General dentist	Yes - DDS/DMD - DA
2016	TX	4	General dentist	No
2016	TX	1	General dentist	Yes - MD/DO
2017	AZ	2	General dentist	Yes - DDS/DMD - DA
2017	CA	3	General dentist	Yes - MD/DO
2017	WA	4	Pediatric dentist	Yes - MD/DO
2017	Unknown	4	Pediatric dentist	Unknown
2017	AZ	4	General dentist	No
2019	CA	4	General dentist	No
2021	KS	3	Pediatric dentist	Yes - CRNA
2021	WI	7	General dentist	No
2022	SC	3	Pediatric dentist	Yes - MD/DO and CRNA
2024	OR	4	Pediatric dentist	Yes - MD/DO
2025	NC	2	Pediatric dentist	Yes - MD/DO and CRNA
2025	CA	9	General dentist	Yes - DDS/DMD - DA
2025	OK	Unknown	Pediatric dentist	Yes - MD/DO
2026	TX	4	Pediatric dentist	No
2026	VA	12	OMS	Unknown

Note: Data limitation: The information presented in Table 4 was compiled from publicly available sources. Because media reports and other public sources vary in the level of detail provided, certain data elements could not be identified or independently verified. These fields are designated as "Unknown." This designation reflects a limitation of the available source material and should not be interpreted as a finding that the information does not exist.

Abbreviation: OMS, oral and maxillofacial surgery.

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preventing serious incidents. This is underscored further when considering the percentage of services performed by each practitioner. Complications also appear to arise from other factors, including patient selection, airway management, emergency preparedness, communication, underlying medical conditions, and noncompliance with existing regulation.

Patient Safety and Access Are Complementary

Discussions regarding pediatric office anesthesia frequently frame patient safety and access to care as competing priorities. In reality, they are closely intertwined. Delayed treatment of painful dental disease

may result in repeated emergency department visits, progressive infection, nutritional compromise, repeated antibiotic exposure, avoidable hospitalizations, and diminished quality of life. Policies that unnecessarily restrict access to appropriately trained providers therefore carry their own patient safety implications.

This consideration is particularly relevant for children requiring extensive dental treatment, patients with special health care needs, and families living in rural or underserved communities. Access to hospital operating rooms and ambulatory surgical facilities remains constrained in many regions of the United States, and shortages of physician anesthesiologists and other anesthesia professionals continue to challenge timely access to care. Oral and maxillofacial surgeons play an important role in addressing these needs through office-based anesthesia delivered within appropriately equipped facilities by teams specifically trained for that purpose. Frequently, brief surgical interventions under moderate or deep sedation/general anesthesia in the OMS office prevent progression of illness, the need for more extensive surgical and medical management, and serious complications.

AAOMS does not oppose the use of separate anesthesia providers. Rather, AAOMS supports matching anesthesia delivery models to practitioner education, clinical competency, patient characteristics, and procedural complexity. This competency-based approach allows multiple safe models of care to coexist while preserving access for patients who might otherwise experience significant delays in treatment.

Patient safety and access should not be viewed as competing objectives. When office-based anesthesia is delivered by appropriately trained oral and maxillofacial surgeons operating within a comprehensive safety system, available evidence suggests strongly that these goals are advanced simultaneously.

Ensuring Safe Anesthesia Care for Children

Every organization participating in the current discussion shares the same aspiration: ensuring that children receive the safest possible anesthesia care. The differences lie not in that objective but in how best to achieve it.

Throughout health care, staffing models have not been determined by the procedure alone. Instead, staffing models have long reflected differences in education, residency training, competency, and demonstrated performance. OMS represents one example of this broader principle. The oral and maxillofacial surgeon-directed anesthesia model is founded upon extensive hospital-based anesthesia education, rein-

forced by a comprehensive specialty-wide safety infrastructure, and supported by decades of office-based clinical experience and continuous quality improvement. While no anesthesia delivery model is without risk, the available evidence does not support a universal personnel requirement that disregards meaningful differences in professional education and competency.

As organized dentistry continues to refine pediatric anesthesia policy, future decisions should remain grounded in evidence rather than assumptions, encourage transparent reporting and collaborative research, and recognize the diversity of educational pathways within the profession. AAOMS welcomes continued collaboration with all organizations committed to advancing patient safety. Through rigorous science, open dialogue, and continuous quality improvement, the profession can continue to strengthen both the safety and accessibility of office-based anesthesia for the children and families it serves.

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