

*History and Reflections for the
Twenty-fifth Anniversary Celebration*

ASDA

**American Society of
Dentist Anesthesiologists**

Marriott at McDowell Mountains

Scottsdale, Arizona

April 15-16, 2005

**RECOLLECTIONS FOR THE 25TH ANNIVERSARY
AMERICAN SOCIETY OF DENTIST ANESTHESIOLOGISTS**

Table of Contents

1. ASDA 25th Anniversary; An Overview – Jim Chancellor
2. The Birth of the ASDA – Larry Trapp
3. Initial Strategy for Specialty Recognition Utilizing the ADSA (1984-93)
– Bill MacDonnell
4. My Thoughts on the Specialty Effort (1993-99) – John Yagiela
5. Professional Growth of the ASDA – Jim Chancellor
6. The American Dental Board of Anesthesiology 1995-2005 – Mark Saxen
7. The Quest for Accreditation of Postdoctoral Training in Dental Anesthesiology
- Jim Chancellor
8. List of Presidents
9. Reflections of Presidents
 - a. 1980-82 – Larry Trapp (see “The Birth of the ASDA”)
 - b. 1982-84 – Joe Giovannitti
 - c. 1986-88 – Bill MacDonnell
 - d. 1989-91 – Ron Davies
 - e. 1991-93 – Jim Chancellor
 - f. 1993-95 – Ralph Epstein
 - g. 1995-97 – Jim Snyder
 - h. 1997-99 – John Leyman
 - i. 1999-2001 – John Yagiela
 - j. 2001-03 – Bryan Henderson
 - k. 2003-05 – Steve Ganzberg

American Society of Dentist Anesthesiologists
25th Anniversary; A Brief Overview
Dr. James Chancellor

“The American Society of Dentist Anesthesiologists (ASDA) was founded in Chicago, Illinois, on February 16, 1980. Seventeen dentists with two or more years of postdoctoral training in anesthesiology met to discuss ways that they might establish and advanced program for continuing education in pain and anxiety control and pursue the development of a specialty of anesthesiology in dentistry. At that meeting, it was decided to form a new society with these goals, and the ASDA was born.”

The above introduction was taken from all three specialty applications as part of Requirement 1. I was fortunate to attend that first meeting at the invitation of Ed Roberts who was a dental colleague practicing anesthesiology in Houston at the time. I had no idea of the importance of that meeting or who many of these dentists were. I was a neophyte among mentors with a better understanding of anesthesiology’s real position in dentistry and the health care community at large. With leadership from Larry Trapp and Ron Davies, the small group emerged and grew slowly because of the dearth of programs and graduates. As with the beginnings of most societies there was minimal organizational structure, no dues structure and few records of its humble beginnings. The primary requirement for active membership was two or more years of postdoctoral anesthesiology training.

Until that time, I had been quite content with membership in the American Dental Society of Anesthesiology (ADSA) and periodically attended their annual meetings. It was comforting to know there were other dentists with anesthesiology training, although most of them limited their practice to anesthesiology in hospitals with a very few venturing out into offices. State laws in those days, didn’t address the differences between dentist and physician anesthesiologists. Thus depending on need, hospital anesthesia positions were available to qualified dentists.

Over the next eleven years, the ASDA grew very slowly in size because of the limited numbers of dentists with at least two years of anesthesia training. Initially, dentist anesthesiologists may have found ADSA because of its higher profile and journal and then discovered ASDA. ASDA officers paid their own meeting expenses and met rather informally at the same time as the ADSA. Believe it or not, the organization was essentially a one-man show, the President, with most business accomplished at the annual meeting. Most of the focus in those early days was the recognition of a dental specialty with primary sponsorship provided by the ADSA. This relationship was very symbiotic prior to 1991 because of the ADSA Board of Directors’ increased willingness to press forward in the development of a specialty application.

In October 1991, the ADSA Board realized they were no closer to submitting a specialty application to the ADA than they had been five years earlier. Additionally, the American Association of Oral and Maxillofacial Surgeons (AAOMS) continued putting political pressure on the ADSA through its House of Delegates and an organized effort to reduce membership support by asking oral surgeons to discontinue their membership. Ultimately, the ADSA Board of Directors realized the divisive nature of this single issue and at their October 1991 Board meeting voted to discontinue sponsorship of specialty recognition to save their organization.

Of equal importance, on June 28, 1991, the Anesthesia Residency Review Committee (ARRC) of the Accreditation Council for Graduate Medical Education (ACGME) sent a memo to all medical program directors threatening loss of program accreditation if dentists were rostered as anesthesia residents. The inability to continue rostering dentists as residents meant a significant loss of federal funding to medical program directors. Ultimately, ARRC agreed that dentists could participate in medical anesthesia rotations of up to 12 months but were not to be considered residents. This one action essentially stopped medical programs from continuing to train dentists in anesthesiology. As a discipline, we became an orphan with no source of accredited postdoctoral training.

All of this and more occurred during my two-year tenure as ASDA President (1991-1993). At the next annual meeting in the spring of 1992, the ASDA leadership decided to submit our own application for specialty recognition to the ADA. It was a group effort to gather the necessary information to address the requirements stipulated by the ADA. By February of 1993, we still lacked a talented editor to coordinate and finish the project. Then at the Loma Linda meeting that year, I was encouraged by John Leyman to speak with John Yagiela regarding our problem. Fortunately for this organization, John volunteered to take on the responsibility of gathering additional substantive information and completing the application for submission by June 1993. John ultimately spent the better part of a month completing the editing and final writing of our first request for specialty recognition. This was a major undertaking and to John Yagiela we are eternally grateful.

Surprisingly, that first application was reviewed and approved by the ADA Council on Dental Education and their Committee on Specialty Recognition (Committee G). This was the first such application, since endodontics was recognized as a dental specialty in 1963, to achieve this level of approval. Unfortunately, the political tenor of the 1994 ADA House of Delegates was overwhelmingly opposed to recognition of a new specialty regardless of the merit.

During the time of submission and subsequent denial of our first application, Ralph Epstein was our President (1993-1995). It was decided to continue on the quest for specialty recognition and to redouble our efforts. Many of us became politically involved to gain the support of the ADA, our state constituent societies, and various recognized specialty organizations. In this regard, a great deal was accomplished by only a dozen or so dedicated members and a worthy cause. John Yagiela again was asked to edit the second specialty application to conform to new and more stringent requirements. Once

again after due diligence, the Council on Dental Education recommended approval of anesthesiology as a dental specialty. In Washington D.C., the 1997 ADA House of Delegates came within 5 votes of approving anesthesiology as a dental specialty!

With such a close vote, there were still enough resources and energy left for a third attempt at specialty recognition. It was decided to submit another application by June 1, 1998 prior to another ADA moratorium intended to provide time for extensive revisions to the specialty application requirements and process. Unfortunately, the majority of the 1999 ADA House of Delegates in Hawaii judged that the ASDA application met only 5 out of 6 mandatory requirements for specialty recognition. The majority of the House did not feel there was sufficient “need or demand” for anesthesiology as a dental specialty. This too, was a very close vote (by a 23 votes majority).

The subsequent significant revisions to the ADA specialty application requirements, the enormous resources and energy requirements, and the need to improve other membership benefits precluded another specialty application submission in the near future. In looking back on the entire specialty recognition effort, we gained a great deal as an organization. The application efforts over the seven years from 1992-1999 helped us come together as an organization to meet the needs of dentist anesthesiologists. We developed the American Dental Board of Anesthesiology in response to our members’ needs. We improved continuing education for members and developed annual certifying board review courses for residents and members. We became cosponsors of Anesthesia Progress. Our credibility within organized dentistry is higher than it’s ever been. As an organization, we have our own representative on the Council on Dental Education & Licensure’s Anesthesia Committee (Committee H). We participate in the development of revisions to all ADA anesthesia related policies. We continue to thrive as office based anesthesia providers in many of the more populous states.

After the 1999 ADA House of Delegates, leadership within the ASDA took a slightly different approach to improving the field of anesthesiology within dentistry. In January 2001, John Yagiela as then ASDA President submitted a request to the Commission on Dental Accreditation (CDA) asking for accreditation of postdoctoral training in dental anesthesia. This would provide independent oversight and standardization of our postdoctoral training programs. Of all disciplines within dentistry, postdoctoral training in anesthesiology surely merits accreditation oversight to protect the public and ensure the highest standards of education. Despite continued and considerable political opposition from various specialty organizations (American Association of Orthodontics, American Association of Oral and Maxillofacial Surgeons, and American Academy of Oral and Maxillofacial Pathologists) and the ADA and its House of Delegates, the majority of Commissioners were receptive to the concept and developed over a period of 3 years an application process to judge the merits of accrediting postdoctoral training programs in areas of general dentistry not recognized by the ADA House of Delegates or its Council on Dental Education & Licensure. This was a huge step for the Commission. In October 2004 (prior to the ADA House of Delegates Annual Session), the ASDA formally submitted a “revised application” for accreditation of postdoctoral training in anesthesiology for dentistry. The merits of this endeavor are: establishment of Standards

for Advance Education in Dental Anesthesiology; standardization of postdoctoral training for office based anesthesia in dentistry; accreditation oversight by an agency recognized by the US Department of Education; increased opportunity to contribute more to dental education and research regarding dental anesthesiology; and potential qualification for federal funding for postdoctoral programs. In January 2005 the Commission on Dental Accreditation approved the ASDA's request for accreditation of postdoctoral programs. This was a significant milestone in the development of our discipline within dentistry.

Another effort by ASDA leadership is the establishment of a separate permanent fund to develop and focus efforts to provide resources for elevating dental anesthesia education and research eventually leading to specialty recognition. Enhancement of anesthesia education and research within dentistry by itself is a noble cause. Ultimately, however, specialty recognition is necessary for advancement. Interestingly, anesthesia education and research is the focus of the current Requirement 4 of the ADA Requirements of Specialty Recognition. The future of any discipline depends upon its resources to fund research and education activities. A discipline cannot live from hand to mouth and expect to survive long term. It must reinvest for the future, providing for the needs of those who will come behind us. Probably the biggest opportunity for significant growth of this corpus of resources will be through "planned giving" from members' estates. This is a cause deserving of everyone's support. When we get it up and running, I hope that you will seriously consider giving back to the discipline that has provided so much for the profession, the public and our families.

The Birth of the American Society of Dentist Anesthesiologists Dr. Larry Trapp

The American Dental Society of Anesthesiology (ADSA) was a welcome find as I started my anesthesia training in 1975. I was looking for colleagues that had similar training and professional interests. I enthusiastically joined the ADSA, attended the annual meetings (which were invariably held in Chicago *in February*) and began reading its journal Anesthesia Progress. At the end of my first year of anesthesia residency, I signed up for and passed the ADSA's "Fellowship Examination." After completing my anesthesia residency, I became a faculty member in the anesthesia department where I trained. Over the next two years, I came to appreciate that the ADSA was, in most respects, directed at providing continuing education for the Oral Surgery specialist functioning as the operator-anesthetist. My dentist anesthesiologist colleague and co-resident, Dr. Ron Davies, and I got very bored attending many programs on the use of Brevital® (methohexital) and we could not find substantive programs on the pharmacology of general anesthetics, nasal intubation, advances in anesthesia machines, etc. By the annual ADSA meeting in 1980, Ron and I had concluded that the ADSA was not, and would never become, the professional "home" we were seeking. But what choice did we have?

After attending yet more lectures that were unsatisfying, Dr. Davies and I decided to invite all the two-or-more-year-trained dentist anesthesiologists to a meeting (in our hotel room as I recall) to discuss our collective future. I am told that seventeen dentists were in attendance. During this meeting, it became clear to me that most of those present had a similar perspective. As we discussed the subject, the group came to believe that the only solution was to start a new society for the benefit of those trained more extensively in anesthesiology. After discussions of great length, it was decided to design the new society for dentists who had received two or more years of anesthesia training in part because that was the length of training required to be board-eligible in medical anesthesia. It was agreed that I would be president, Ron Davies would be vice-president, Bill MacDonnell would be program chairman, and Dave Anderson would be in charge of publications. I left this meeting with the understanding that the new society would be supplemental to the ADSA and all would choose to be members of both societies. Leaders and past-presidents of the ADSA quickly let me know that they disapproved of the formation of our new society.

The name American Society of Dentist Anesthesiologists (ASDA) was adopted either at the first meeting or shortly afterward and we immediately confronted many issues and realities. The society had no money and professional liability insurance coverage for the dentist anesthesiologist was proving to be ephemeral. Responsibility for handling a problem usually went to the member who lived closest to the individuals or institution that held the solution. The members made donations to raise money for society

expenditures. For many years, attendees paid for the costs of meetings with personal resources (e.g. airfare, hotel, meals). The early society members were *incredibly* generous with both time and money. They were also *very* dedicated.

A variety of legal and legislative challenges faced dentist anesthesiologists from Florida to Oklahoma to Wyoming. The ASDA members once again generously donated money to help their colleagues wage legal or legislative battles that we all knew could cross state lines. The society was in many ways a support group for individual dentist anesthesiologists facing many types of challenges to their professional practices.

Throughout this difficult and tumultuous time, the membership grew little in numbers but grew enormously in the feelings of camaraderie and mutual respect. I cannot list their names in this small article, but I place great value on my relationships with these pioneers of dental anesthesiology.

**“Initial Strategy for Specialty Recognition Utilizing
the American Dental Society of Anesthesiology”
Dr. Bill MacDonnell**

In the late 1980s, the leadership of the American Dental Society of Anesthesiology (ADSA) recognized the problems of the ever reducing anesthesiology residency positions for dentists. Universities and hospitals were having their incomes reduced by both the government and medical insurance carriers. At the same time, American medical students were becoming increasingly more interested in careers in anesthesiology. These issues resulted in a dramatic reduction nationwide in dental anesthesia resident positions and dental anesthesia training programs. In an effort to assure that the dental profession would continue to have dentists with anesthesia training, the ADSA committed its resources to fund and support dental anesthesiology training programs in various parts of the country. This was a large financial undertaking by the ADSA.

ADSA initiated the specialty application process for the recognition of anesthesiology as a specialty of the American Dental Association. The ADSA appointed Dr. Norman Treiger, a past President of ADSA and an oral and maxillofacial surgeon at Montefiore Hospital in New York, as chair of the ADSA Specialty Application Committee. The ADSA contracted with Educational Testing Service to develop the necessary certifying examination in dental anesthesiology. In 1991 the American Dental Society of Anesthesiology's reserves were almost depleted as a result of the financial support of the anesthesiology residency training programs. This, combined with increasing political opposition within ADSA for these efforts, led to withdrawal of support for the specialty application effort.

Shortly after ADSA announced that it would not be pursuing specialty recognition of anesthesiology from the American Dental Association, the American Society of Dentists Anesthesiologists' (ASDA) President Jim Chancellor was advised by Mike Higgins and Bill MacDonnell that the ASDA should take the leadership role in specialty recognition and submit the application to the American Dental Association for the recognition of Anesthesiology as a dental specialty. It was President Chancellor who made the decision to have ASDA submit its own specialty application to the ADA for the recognition of anesthesiology as a dental specialty. He appointed Higgins and MacDonnell as the co-chairs of the ASDA Specialty Application Committee. It was decided that the ASDA application would be prepared for submission to the ADA Council on Education for approval of the 1994 ADA House of Delegates.

The first committee meeting was in Chicago in the fall of 1992 with the following attendees: Jim Chancellor, Ralph Epstein, Joe Giovannitti, Mike Higgins, Lois Jacobs, John Leyman, Lee Lichenstein, Bill MacDonnell, Russ Paravecchio, Bob Peskin, Jim Phero, Sal Squatrito (Connecticut Periodontist), Jim Snyder, and Larry Trapp. Jim Phero

recommended that the ASDA hire a coordinator for the application process. The committee voted to go ahead with the specialty application. There was no published “guidelines” for the ADA Specialty Application.

The committee started the application process by assigning committee members in teams to address each of the five ADA Criteria for Specialty Recognition:

The Sponsoring Organization: The recognition requirements specify: “In order for an area to be recognized as a specialty, it must be represented by a sponsoring organization whose membership is reflective of the special area of dental practice and recognized by the profession at large for its contribution to the art and science of the discipline.”

Criterion I: A specialty must be a distinct and well-defined field which requires unique knowledge and skills beyond those commonly possessed by general practitioners.

Criterion II: The scope of the specialty shall not be coincidental with or readily subsumed within the scope of other specialties.

Criterion III: In order to be recognized as a specialty, substantial public need and demand for services which cannot be adequately met by general practitioners or specialists in other areas must be documented.

Criterion IV: A specialty must incorporate some aspects of clinical practice, i.e., individuals in the specialty must provide health services to the public.

Criterion V: Formal advanced education programs of at least two (2) years beyond the predoctoral curriculum must exist to provide the special knowledge and skills required for the practice of the specialty.

The committee teams were given an assignment to address their “ADA Specialty Recognition Criterion” and to report back to the committee. The long process began. Dr. Trieger gave the committee the ADSA draft specialty application. The committee started to meet on weekends about every eight weeks alternating the meeting location between both Chicago and Dallas. All the committee members paid for their own expenses during the application process. The two day meetings were long and there were many lengthy “discussions” over definitions and other important issues. Both Mike Higgins and Joe Giovannitti coordinated the local arrangements and opened their homes to the committee members after the long days of deliberation.

The ASDA leadership was not too naive to realize that in addition to the submission of the specialty application there was also the political side of the application process which

had to be addressed. This despite the fact that Committee G and the Council by tradition are considered to be apolitical.

The ADA Board of Trustees and the House of Delegates were another matter. As with any organization, politics were to play a significant part of the process. ASDA members were encouraged to become active in their local and state dental societies. They were actively meeting and getting to know their local delegates and alternate delegates. The ADA House of Delegates had more than eight hundred delegates and alternate delegates. The ADA Board of Trustees had sixteen trustees, two vice presidents, secretary, president elect, speaker, and president. The ASDA developed mailing lists to ADA delegates and Board members. Ron Davies created a gold campaign button supporting anesthesia. ASDA members were assigned to each Trustee District and asked to be able to meet with each delegation in the home district and at caucuses at the 1994 ADA Meeting. Each ADA House member was sent multiple mailings asking for support of the recognition of anesthesiology. It was a monumental task that the dentist anesthesiologists nationwide addressed with an enormous all out effort.

The formal application process had been advancing for about a year when Jim Chancellor invited John Yagiela to join the committee in the spring of 1993. Fortunately, he had been serving on Committee G of the Council on Dental Education. His background and knowledge gave the ASDA Specialty Application Committee great insight into what the ADA was looking for in a specialty application. Review of the draft application revealed the need for major revisions and expansions to meet the five ADA criteria. John Yagiela is an amazingly dedicated person who has the ability to work countless hours and with great attention to detail. He took the draft application and refined and expanded the application into a masterpiece. The ASDA Specialty Application was so good that the ADA Council on Education in its report to the 1994 ADA House of Delegates made the following recommendation to the House of Delegates in Resolution 11: **Resolved, that the American Society of Dentist Anesthesiologists' request for the recognition of dental anesthesiology as a dental specialty be approved.**

In less than fourteen years this small organization, the American Society of Dentist Anesthesiologists, founded (1980) in Chicago by Larry Trapp and a very small group of dentist anesthesiologists had accomplished the unheard of by submitting and application to the American Dental Association for the specialty recognition of anesthesiology and had gained acceptance by the ADA Council on Education. Without the influence of politics on the specialty recognition process, anesthesiology would be a recognized ADA Specialty.

My Thoughts on the Specialty Effort

Dr. John A. Yagiela

The history of the ASDA's efforts cannot begin without initial consideration of the stillborn attempt by the ADSA to develop a specialty in anesthesiology for dentistry. In the inaugural publication of the American Dental Society of Anesthesiology (April 15, 1954), then President William B. Kinney wrote, "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." During the years 1984 to 1991, the ADSA committed a great deal of time and resources to developing a board examination, incorporating a boarding organization, and preparing a specialty application in anesthesiology. In October 1991, however, the Board of Directors decided to discontinue sponsorship of specialty development. This decision was the direct result of efforts by the American Association of Oral and Maxillofacial Surgeons (AAOMS) to stop the pursuit of a specialty. The AAOMS initiated a campaign for its members who also belonged to the ADSA to oppose efforts at specialty formation. Since approximately 70% of the ADSA membership consists of oral and maxillofacial surgeons, the ADSA Board of Directors felt that pursuit of a specialty would be neither feasible nor in the best interests of the society. In order to preserve the broad spectrum of anesthesia interests in the ADSA membership, the 1996 House of Delegates voted for the society to remain neutral on the issue of the specialty.

When the ADSA decided in October 1991 to discontinue pursuit of a specialty in anesthesiology for dentistry, the ASDA immediately assumed the role of the sponsoring organization and continued the effort toward specialty development. Quite fortuitously, in 1990 I had been appointed for a 5-year term to the ADA's Committee on Specialty Recognition (Committee G) and, separately, to the ADA's Anesthesiology Steering Committee. Membership in these committees gave me strong insight into the specialty recognition process and how the ADA dealt with matters pertaining to anesthesia in dentistry. In the fall of 1992 I was invited to a meeting of the ASDA's Specialty Application Committee (SAC). It was clear from that meeting that the ASDA had progressed much further in one year than the ADSA had the previous eight years in developing an application for submission to the ADA. It was also clear that major problems had to be resolved before a viable application could be developed. One problem was the definition of what constitutes a specialist in anesthesia for dentistry. Core differences existed among the committee members – some wanted to limit specialist recognition to dentists who only provided anesthesia services for other dentists, others wanted to include the delivery of anesthesia for non-dental services, and still others wanted to include the oral surgery model as an acceptable specialty practice alternative. Another problem was that the ASDA was using an outdated application form, which had been revised in several important ways to make the application requirements more

difficult to meet. Lastly, the application reflected multiple authorship, leading to disjoint styles, areas of redundancy, missing subjects, and a lack of continuous rigor in answering the questions posed in the application. In early 1993, I was appointed to SAC and charged with developing the final draft of the document. The application was submitted on June 1 of that year.

The first hurdle for the application was Committee G. I was appropriately excused from the meeting. It was a wonderful affirmation of anesthesia in dentistry and SAC's efforts when Committee G strongly endorsed the application as meeting all criteria. The next hurdle, the Council on Dental Education (CDEL now with the addition of licensure to the committee's name), initially determined that the application failed to meet criteria 2 and 3 pertaining to scope of practice and need and demand. Providing the Council an effective rebuttal and a vigorous defense by Committee G of their review of the application caused the Council to reverse itself. A second hurdle arose with our attempt to get the backing of the Academy of General Dentistry (AGD). Jim Chancellor and Ralph Epstein, then President of the ASDA, spearheaded this effort on behalf of the ASDA. The AGD, interested in ensuring access to education in sedation for its members set up a meeting to discuss issues pertaining to anxiety and pain control in dentistry. The ASDA was not invited because AAOMS said they would not attend if we were invited. A lot of misinformation had also been disseminated by our opponents stating that we wished to limit other dentists from providing sedation. In my April 27, 2004 letter to President-Elect Luke Matranga of the AGD, I affirmed the supportive role ASDA wished to play for other dentists and referred him to the ASDA's recently passed policy statement affirming the right of other dentists to provide sedation and anesthesia services for which they were trained. Happily, AGD extended an invitation for us to attend; AAOMS also attended. In a vigorous debate with the president of AAOMS at the June 3 meeting, he accidentally acknowledged AAOMS' role in providing information to the American Society of Anesthesiologists of programs where dentists were receiving training in general anesthesia, a role that directly led to the loss of training opportunities for dentists other than oral surgeons. A long-lasting outcome of the June 3rd meeting was the decision by AGD to support our application effort.

The summer of 1994 was filled with our collective efforts to address an avalanche of position papers and letters by our opponents decrying the specialty effort in particular and dentist anesthesiologists in general. An example was Ron Davies' responses to an article and a letter in the Journal of the California Dental Association by John Lytle, who questioned the safety, affordability, and necessity of dentist anesthesiologists' services. Many others, including ASDA members, referring doctors, other dentists and patients also wrote letters in support of the application. Collectively, we more than held our own.

With the affirmation of our application by the ADA Board of Trustees, we went to New Orleans with high hopes of success. This led to elation after the Reference Committee hearing, where our collective efforts ensured that the strong majority of comments were in our favor, and the content of those comments was also superior. Thus, there was a visceral shock when the Reference Committee's vote was to refer the application for further study. It could not have happened if the Committee had been unbiased.

Confirmation was provided by oral surgeon Herbert Dolinsky, who confronted a half dozen ASDA members by saying that (1) he was in charge of the AAOMS' effort to stop the application, (2) the ADA system is corrupt, (3) AAOMS controls it, and (4) how dare be so naive as to think that the application would be judged by its merits. We cost AAOMS a lot of money to defeat an application that had no chance of approval. The 2 to 1 negative vote by the House of Delegates was a forgone conclusion.

Efforts to improve the application and, especially our political effort, within the ADA began immediately. It also became clear that we needed legal help to push ADA institutions to avoid partisan placement on important committees. This was underscored when Dolinsky was appointed to chair the Reference Committee in 1996, when AAOMS thought our next application would be heard. One major way to improve the application was to demonstrate that the ASDA could develop an independent board of anesthesia for dentistry. Because of the cessation by the ADSA to develop a specialty program, the name "American Dental Board of Anesthesiology" became available. Ralph Epstein, Mike Higgins, Jim Snyder and Jim Chancellor were able to secure it for use. Strong debate occurred over who would be eligible for specialty status, including those who would qualify for grandfather status. These discussions, though heated at times, were necessary for the ASDA to define itself and the ADBA. Ultimately compromise was achieved and the ADBA was established. The ADBA for formally established in December 12, 1994, and it adopted its own constitution and bylaws in March 1996. An important side benefit was the development of accreditation standards for advanced specialty programs in anesthesiology for dentistry, an effort spearheaded by Joe Giovannitti.

Under the leadership of Ralph Epstein, the ASDA undertook in the spring of 1996 a prospective practice study of ADBA members. This study documented the number and type of anesthetic procedures provided by dentist anesthesiologists. The need for these services was demonstrated by two studies supported by the ADSA's Anesthesia Research Foundation and conducted by Raymond Dionne and colleagues, one involving the general population and the other examining special-needs patients. With these studies and the successful establishment of the ADBA, the second specialty application was a significant improvement over the first. It was submitted on January 1, 1997.

To ensure a fairer political process, the ASDA consulted with a Chicago law firm to work with the ADA legal department so that the ADA understood the breadth and depth of our concerns. Two beneficial outcomes were a Reference Committee that was balanced, and the ability to request attendance to district caucus meetings at the ADA annual session. Less naïve about the political process, ASDA leadership and supporting members became more active earlier in the process. So too did our opposition. A particular problem, as with the first application, was the ability of AAOMS to secure the support of ADA presidential candidates. It became clear that the heavy financial support given these candidates by AAOMS was crucial to this support. It also meant that Tim Rose, a periodontist who as a former trustee voted in favor of our application, switched to become a strong opponent. He was successful in removing the American Academy of Periodontology as a supporting organization for ASDA's efforts. As Rose was a popular

individual and won the presidential election, his opposition was effective. At the one meeting where I had a chance to discuss the issue with him, it was clear that his strong opposition was without a rational basis insofar as the application was concerned.

As before, this application won positive votes from Committee G, CDEL, and the Trustees. A big win occurred when the Reference Committee on Dental Education and Related Matters voted to approve the application as well. During the morning round of district meetings, between the Reference Committee hearing and the House session, I was able to provide brief presentations to some of the district caucuses. This had a significant effect, because delegates could hear our story firsthand, not just the comments by their oral surgery colleagues. Interestingly, I was suddenly “disinvited” to the remaining caucuses in the afternoon once the impact of our presentations became clear to the AAOMS leadership. The House vote was agonizingly close. If four people had changed their vote, we would have won. Even ADA President Gary Rainwater (from Texas) argued for its passage.

In the aftermath of the 1997 defeat, the ASDA leadership considered several avenues: reapplication; legal remedies; seeking specialty status outside the ADA. All of these options were explored. After thoughtful consideration of the issue, the ASDA House directed the Board to seek specialty recognition a third time. The third application, the strongest yet, especially on the issue of need and demand, was submitted July 1, 1998. By this time, it was clear that passage through the House had little to do with the application itself. It was also clear that the AAOMS leadership had been shocked by the closeness of the previous vote. Accordingly, they were going to take no chances with the House. This time, the goal was to defeat the application at every step of the process. AAOMS was able to get two avid opponents of the application on the CDEL. One, Ronald Marks, was past-president of AAOMS, and the other, Herbert Dolinsky, has already been mentioned. John Leyman, in his letter to CDEL chair Donald Demke requested that both individuals be recused from any discussion and voting on the application. His warning of their inherent unfairness was not acted upon.

Once again, Committee G strongly endorsed the application. However, CDEL voted to oppose the application on requirements 3 and 4. The CDEL stated that changes in training of other specialists meant that anesthesiology could be readily subsumed by these other specialties and that there was no compelling evidence of need and demand for our services not adequately met by other dentists. These conclusions were unsupportable having been based on misinformation provided by AAOMS operatives. The ASDA, with the help of specialties such as pediatric dentistry and periodontology, was able to marshal real data and cogent arguments demonstrating that the CDEL had been badly misled by several of its members. That this campaign was orchestrated by AAOMS subsequently came to light and led to public action against these same individuals. Ralph Epstein, Jim Chancellor and I met with the CDEL on April 17, 1998. As chair of the specialty committee, I presented written arguments buttressed by a Powerpoint presentation. There were no questions, and the CDEL reversed itself, possibly in part on advice of counsel.

AAOMS was very successful in influencing the ADA Trustees, who voted 10 to 9 against the application for the first time. We learned subsequently that AAOMS arguments were

strongly presented but that our response to the CDEL was not included. Once again, trustees running for the office of ADA president were turned against the specialty application and proved the difference in the vote.

The ASDA prevailed at the Reference Committee hearing; however, I was excluded from the majority of district caucuses. In half of those where I gained admittance, there were orchestrated efforts to silence me, belittle the ASDA, or limit discussion to such issues as dentist anesthesiologists' support of independent dental hygiene practice! Our third application was defeated in the House by 22 votes.

Was the specialty worth the time, effort, and cost? What did we gain and what did we lose? My personal view is that the effort transformed the ASDA from a largely unknown society on the fringe of dentistry into a recognized, well-established entity. The ASDA now has a place at the ADA table; our views pertaining to anesthesia are increasingly given weight, and we have a recognized presence on Committee H. Even the term *dentist anesthesiologist* became accepted by the ADA through this process. Accreditation of our programs, which at this moment looks like it will happen, would never have been considered had we not gone through the crucible of the 1990s. The ASDA has redefined itself by focusing on anesthesiology for dentistry; we have a credible board in the ADBA, and we are supporting our training programs in substantial ways. Our continuing education efforts have grown well beyond our annual sessions. Yes, the specialty effort was worth it.

**Professional Growth of
The American Society of Dentist Anesthesiologists
Dr. James Chancellor**

Considering our humble beginnings 25 years ago, the ASDA has grown into a nationally known and respected organization. The first 10 years of existence represents our “childhood” when we took our first steps. The next 15 years could be characterized as our “rebellious teen-age years” when we challenged authority and ultimately came to understand the realities of dental politics as it relates to dental anesthesiology. Hopefully, we’ve gained from this experience the wisdom to eventually achieve specialty recognition by organized dentistry.

In the beginning, virtually all dentists trained in general anesthesia received their postdoctoral training from medical programs around the country. The lone exception to this generalization was the University of Pittsburgh dental anesthesia training program. Medical training opportunities for dentists were regional, depending on the demand for training by physicians and the resource needs of various accredited programs within medicine.

Anesthesiology programs had operating rooms that needed full time coverage and faculty that seldom wanted to spend nights on-call in the hospital supervising residents. Interestingly, anesthesiology at that time was not always viewed by physician graduates as a particularly exciting specialty. Additionally, unfilled residency positions represented a loss of significant federal dollars that supported anesthesiology specialty training. Consequently, dentists requesting training in anesthesia were generally allowed to participate as residents because of the federal dollars allocated for each filled residency position. There seemed to exist a *lessez-faire* attitude within medical anesthesiology. Dentistry was aware and appreciated this training but did not seem to recognize the need for any active involvement in providing it within the profession.

Something happened in the 1970s and 1980s to change organized medical anesthesiology’s view of training dentists to the same level as physician anesthesiologists. The dentists we’ve known personally that trained from 1960-1990 received virtually the same educational experience as their physician colleagues. On completing training, many continued to teach full or part time within those programs as anesthesia staff. The relationship seemed symbiotic for all. Oftentimes, these dentists abandoned traditional dental practice, providing the same full range of anesthesia services in hospitals as provided by physicians. This was probably possible because of the increased demand for anesthesia services in many hospitals at that time and the decreased supply of physician specialists.

Dentists desiring to provide anesthesia in hospitals began to increasingly encounter political opposition from competing physician anesthesiologists, insurance companies,

and hospital administrators. Since these dentists were essentially alone in their quest to practice anesthesia in the traditional hospital setting, they found themselves compelled to resort the legal system to challenge perceived restraint of trade issues.

It was probably these individual legal challenges in combination with the larger concern regarding the rise of independent practice of the certified registered nurse anesthetists that caused organized medical anesthesiology to focus on addressing these competing interests outside of medicine.

On June 28, 1991, the Anesthesia Residency Review Committee (ARRC) of the Accreditation Council for Graduate Medical Education (ACGME) sent a memo to all medical program directors threatening loss of program accreditation if dentists were rostered as anesthesia residents. The inability to continue rostering dentists as residents meant a significant loss of federal funding to medical program directors. Ultimately, ARRC agreed that dentists could participate in medical anesthesia “rotations of up to 12 months” but were not to be considered residents. This one action essentially stopped medical programs from continuing to train dentists in anesthesiology. This was one of two seminal events in 1991 that galvanized the ASDA into pursuing specialty recognition. The other event was the American Dental Society of Anesthesiology’s (ADSA) Board of Directors vote in October 1991 to cease all efforts for specialty recognition within dentistry.

The year 1991 marked the transition for ASDA from a small fledgling organization, working within the larger ADSA encouraging pursuit of specialty recognition, to a more independent organization representing the interests of those dentists with two or more years of postdoctoral training in anesthesiology. The political reality was that anesthesiology as a discipline in dentistry was an orphan. Only the ASDA was willing to pledge the necessary resources and energy to gain legitimacy within dentistry. This endeavor helped transform ASDA into a dental organization that truly focused on the anesthesia needs within dentistry.

In the years ahead, the ASDA would grow in stature and credibility while maturing by focusing organizational efforts on meeting the requirements for specialty recognition established by the American Dental Association. At the time, I don’t believe we were aware that the American Dental Association’s Requirements for Specialty Recognition would function as a “road map” for the rapid growth of ASDA as the premier dental organization representing anesthesiology in dentistry. The quest to fulfill each specialty criteria compelled the ASDA leadership to identify and focus on achieving those criteria judged as fundamental to the development of any discipline within organized dentistry. Ultimately, the ASDA benefited immensely from going through the specialty recognition process. Though each of our three specialty applications was never approved by the ADA House of Delegates, as an organization we continued to become politically stronger because of our specialty efforts. These efforts established strong relationships with recognized dental specialties, the Academy of General Dentistry, dental education and other organizations seeking specialty recognition. As a result we have matured much faster than previously recognized dental disciplines, even though we probably have fewer

than one hundred fifty active (dues paying) members nationwide. True, we've been unsuccessful in our ultimate goal of specialty recognition. However, we have gained much insight in the quest and will continue developing long-term strategies that will ultimately yield a recognized dental specialty in anesthesiology. Among these strategies was the recent ADA Commission on Dental Accreditation acceptance of our request for accreditation of postdoctoral training in dental anesthesiology and the establishment of a permanent corpus of funding for the enhancement of dental anesthesiology research and education. With continued focused efforts, it won't be long before we see our ultimate goals achieved.

The American Dental Board of Anesthesiology 1995-2005

Dr. Mark Saxen

The American Dental Board of Anesthesiology (ADBA) was founded by the American Society of Dentist Anesthesiologists in 1994 for the purpose of advancing the art and science of anesthesiology in dentistry. The ADBA was incorporated in Illinois by Drs. Epstein, Snyder and Higgins. An ad hoc committee was appointed by Dr. Ralph Epstein to develop a framework for the new certifying board to function and define its duties. New board members were elected by the ASDA House of delegates at their 1995 annual session with staggered terms to allow only a third of the members to rotate off the board annually. It was felt this would provide better continuity. Formal transfer of the Board from the founding members to the ASDA took place Sept 13, 1995.

At the first meeting of the Board of Directors in August 1995, the need for a suitable examination process and definition of Diplomate status was addressed. A new Constitution and Bylaws was adopted and officers elected. The Board took its role very seriously in that they realized dentists seeking ADBA Diplomate status would represent the highest level of training in anesthesiology available to dentists. Five major responsibilities were defined that would shape the efforts of the Board for years to come:

1. Establishing the qualifications for Diplomate status of the ADBA
2. Determining the eligibility of applicants seeking Diplomate status
3. Examination of candidates seeking Diplomate status
4. Conferring Diplomate status on successful candidates
5. Establishing criteria for maintenance of Diplomate status

Once fulfilled, the Board took on two additional but equally important responsibilities: establishing standards for postdoctoral anesthesia training programs for dentists and to function as the accreditation body for these programs, if necessary. As an apolitical organization with the necessary resources, it was felt the Board would be the ideal organization to fulfill these responsibilities.

The following are highlights from the years that followed:

August 1995:

- Dr. Joel Weaver elected as first president of the ADBA; Dr. Trapp elected Vice President; Dr. Chancellor elected as Secretary; and Dr. Finder elected Treasurer
- Criteria for Diplomate status, grandfathering was established. The Board recognized the completion of a dedicated formal hospital anesthesiology training program as the defining feature of all grandfathered candidates.
- The two-step process of Diplomate testing was adopted. All candidates would be required to successfully complete a written exam, and subsequent oral exam, to qualify for Diplomate status.

March 1996

- First Diplomate certificates conferred during convocation in Washington, D.C.
- Criteria for renewal of Diplomate status adopted

March 1997

- Establishment of Standards for Dental Anesthesiology Training Programs

October 1998

- Convened a workshop of existing dental program directors to gather input regarding standards for advanced education in dental anesthesiology

March 1999

- Revisions to the *Standards For Advanced Education Programs in Dental Anesthesiology* as discussed at the Workshop of Program Directors in San Francisco, CA in October, 1998
- Dr. James Chancellor became new President with rotation of Dr. Weaver off the ADBA Board and Dr. Peskin became Secretary

March 2001

- Written examination was comprehensively reviewed and overhauled. Question analysis on all Diplomates taking exam since inception performed. Approximately 30% of questions were renewed, rewritten or replaced.
- Certificate renewal mechanisms created and established.
- Protocol developed for annual review of written exams by biometrician

March 2002

- Development of a written In-Service examination
- Mechanism for annual renewal of written examination questions developed

August 2003

- First Mock written board exam given to residents at Second Annual Review Course in Los Angeles

April 2004

- Self-auditing mechanism created for the Written Board . Each year, questions are drawn from the written examination and mixed with new questions as an abbreviated version of the actual written exam given to Diplomates. ADBA Board of Directors take this exam to maintain familiarity with the relevancy and rigor of the exam being given to candidates.
- Mock written Board exam created for residents

August 2004

- Mock Oral and written Boards provided to residents at the Annual Review Course. Examiners are videotaped for critique by peers on Board.

September 2004

- Creation of a mechanism for annual renewal of oral board procedures. Diplomates review videotapes of mock boards and critique examiners for consistency and clarity while examining candidates.
- Revised criteria for Continuing Education requirements for Diplomate Renewal
- Creation of Core Curriculum criteria for Dental Anesthesia training programs
- Extension of provisional accreditation for current residency programs

Current focus: With mechanisms for maintaining strong oral and written examinations in place, the Board was ready to focus its attention to Dental Anesthesia Residency Program Accreditation. However with the January 2005 approval of the ASDA application for accreditation of postdoctoral dental anesthesiology training programs by the Commission on Dental Accreditation (CDA), the ADBA will formally cease these activities. The Board will continue to build a strong relationship with program directors and residents. It will also continue to provide input into the development and subsequent revisions of the new standards for advanced education by the CDA.

**The Quest for Accreditation of Postdoctoral Training
in Dental Anesthesiology
Dr. James Chancellor**

After three unsuccessful and exhausting attempts for anesthesiology to be recognized a dental specialty by the American Dental Association (ADA), the American Society of Dentist Anesthesiologists (ASDA) decided further specialty recognition efforts at this time were futile. The ADA and its House of Delegates were tiring of the specialty recognition efforts of at least five different organizations over the span of 15 years, starting with implantology's multiple attempts in the late 1980s. In 1994, dental anesthesiology was the first discipline to be approved by the ADA Council on Dental Education (CDE) since endodontics was approved in 1963. Despite positive recommendations for specialty recognition from three different CDE reviews, three different ADA Houses of Delegates were unwilling to recognize us as a dental specialty.

After the October 1999 rejection of the ASDA's request for specialty recognition, ASDA leadership began identifying and investigating alternatives for achieving some of the goals normally attendant to specialty recognition. Accreditation of postdoctoral training programs was one of the issues identified. Contact was made with a nationally recognized authority in accreditation, Michael Hamm. His services were retained and a request was made for an in-depth investigation as to how to proceed with accrediting our own programs through the U.S. Department of Education. Mr. Hamm's report was never released to the general membership because of the sensitive nature of its findings. However, it provided the basis for the ASDA's decision to request accreditation from the ADA Commission on Dental Accreditation as a primary choice over establishing our own accreditation process. The costs and other resources necessary to achieve recognition by the U.S. Department of Education were immense for such a small organization.

Consequently in January 2001, John Yagiela, as President of the ASDA, formally submitted a letter requesting the Commission on Dental Accreditation consider accrediting postdoctoral training in dental anesthesiology. Interestingly, a majority on the Commission seemed to embrace the concept, causing quite a controversy with the 2001 ADA House of Delegates. As expected, older specialties such as orthodontics, oral and maxillofacial surgery, and oral and maxillofacial pathology were adamantly opposed to the new concept. The Chair of the Commission, Dr. Eric Hovland, dean of the LSU School of Dentistry, established an ad hoc committee to investigate the request and possibly establish requirements for possible future requests from other disciplines. That committee came back to the Commission with recommendations for accreditation requirements, which were then approved for distribution to "communities of interest." Written and oral testimony was received and the Commission approved the concept and requirements at their August 2002 meeting and promptly received three requests/applications for accreditations that specifically addressed those accreditation

requirements. A few months later in October 2002, the ADA House requested a moratorium on any applications for accreditation and directed the adopted CODA accreditation requirements be strengthened and clearly differentiated from existing ADA requirements for specialty recognition. The Commission understood the differences between their recently adopted accreditation requirements and the specialty requirements, even if the ADA House did not. However, the Commission yielded to the ADA House request for more input from the profession.

At this point, it is helpful to understand the composition and mission of the Commission. It is a separate and distinct agency that has the responsibility for accreditation of all dental and allied dental healthcare programs in the United States. The Commission is the only dental accrediting agency recognized by the U.S. Department of Education but it was established and is supported financially by the ADA. It is constantly upgrading accreditation requirements and advancing standards in dental education in all areas where it has chosen to do so. It is composed of commissioners representing the nine existing dental specialties, a GPR/AEGD commissioner, 4 ADA commissioners, 4 dental examiner commissioners, 4 dental education commissioners, 4 public member commissioners, a dental lab commissioner, a dental hygiene commissioner and a dental assistant commissioner. It has various committees making recommendations to the full Commission for action. Additionally it has Review Committees for predoctoral and postdoctoral dental education as well as the allied dental health education. These review committees supervise accreditation reviews and make recommendations for changes in accreditation standards under their purview.

As mentioned above, the Commission delayed any action on pending accreditation requests and requested further testimony intended to “strengthen” these requirements. The Commission informed the three organizations requesting accreditation of their programs based on previously approved requirements to take back their requests. All organizations except ASDA accepted the return of their requests. Dr. Bryan Henderson, then ASDA President, told the Commission that our request was still active and that we would “amend” it as needed should any new requirement(s) be developed. This new review of already accepted accreditation requirements took over a year to complete. Additionally, during this time the Commission established a more formalized process for accepting these requests, which was CODA’s main reason for returning initial requests for accreditation mentioned above. At their August 2004 meeting, the Commission accepted the newly revised accreditation “elements” and the process for accepting requests.

At that point, the ASDA developed and submitted a revised request documenting that our application met all the “elements” (instead of requirements) recently established. There was an urgent need to submit this “revised request” for accreditation before the 2004 ADA House met in Orlando to preempt any resolutions passed by the House to halt or delay our accreditation request. A great deal of thanks to John Yagiela for answering the call once again, accepting editorship of our latest “amended” request and submitting it a few days before the 2004 ADA House met. Then Chair of the Commission, Dr. Ken Kalkwarf, dean of the University of Texas Dental School in San Antonio, immediately

appointed an ad hoc committee to review this request. Prior to the closing of the 2004 ADA House, one additional accreditation request was submitted by the American Academy of Oral Medicine. As expected that ADA House asked the Commission to delay any action on any requests received and to change their rules to allow the ADA Council on Dental Education & Licensure (CDE&L) the responsibility for approving any new areas of general dentistry prior to the Commission accepting any requests for accreditation of these areas. By necessity, this proposed CDE&L acceptance process would need the final approval of the ADA House of Delegates. This would be a no win situation as with specialty recognition.

At their January 2005 meeting in Chicago, the Commission first addressed 2004 ADA House resolutions #72 and #84 mentioned above. After extensive discussion, they voted to inform the 2005 House that the Commission needed to maintain its autonomy regarding accreditation issues and fully appreciated the House concerns. The Commission then heard their ad hoc committee reports on the ASDA and AAOM requests for accreditation of postdoctoral programs. Most discussion came from several commissioners that seemed opposed to accepting the ad hoc committees report recommending the Commission proceed with accreditation of programs in anesthesiology and oral medicine. At this point, ADA legal counsel reminded the Commission that their discussion should focus on whether these requests met each and every “element” for granting accreditation and not extraneous concerns. The Commission voted 25 to 3 to approve both requests for accreditation on separate votes for each area. Clearly, the vast majority of Commissioners rose above the politics and considered what was in the best interests of the public and dental education. Only the Commissioners for oral and maxillofacial surgery, oral and maxillofacial pathology and orthodontics voted against our request of accreditation.

The next step was the appointment of an ad hoc committee by the Commission Chair, Dr. Morris Robbins. The ASDA was asked for its recommendations for this committee. As a result, Drs. John Yagiela, James Phero and James Chancellor were appointed to this ad hoc committee along with Commissioners Cyril Meyerowitz, Commissioner for General Dentistry and Steven Adair, Ad Hoc Committee Chair and Commissioner for Pediatric Dentistry. The ad hoc committee will develop/draft “*Accreditation Standards for Dental Anesthesiology Programs*.” Hopefully that can be accomplished in time for the Commission’s August 2005 meeting. The Commission will need to approve the distribution of these Standards to all “communities of interest,” including oral and written testimony at the ADA and ADEA annual sessions. The ad hoc committee will then review all testimony and make the necessary modifications and resubmit to the full Commission for their final approval, probably in August 2006 or January 2007 – an 18-24 months process. At that point, all postdoctoral programs will have the opportunity to request accreditation review. Fortunately, during the last 12 months of this process, anesthesiology programs can be making any necessary modifications to their programs in preparation for submission of their individual accreditation requests.

In the time since this last CODA meeting, I’ve taken time to reflect on the Commission’s decision. The overwhelming support we received from 25 of the Commissioners,

including all 4 ADA Commissioners, was truly amazing. It took 4 years to get to this point and there's no "turning back" for the Commission now. We owe so very much to John Yagiela for developing and editing both requests for accreditation (2002 and 2004). At times, I know he was extremely frustrated by all the politics and delays caused by the different ADA Houses. We also owe much to those members and "friends" who networked and contacted key Commissioners over the 4 years to bring this effort to fruition. Believe me: we had a lot of help in this ongoing effort. Additionally, there were new Commissioners being added every year over the 4 years requiring additional efforts to continually educate on this issue. Also, the American Academy of Oral Medicine did much to advocate acceptance of our request, as did we did for theirs. It was truly a joint effort and we thank Dr. Craig Miller for his tireless efforts. Finally, we owe thanks to the Academy of General Dentistry and American Academy of Pediatric Dentistry for their continued support for both our three specialty applications and our two requests for accreditation. These two organizations never wavered in their continued support over the last 14 years! I personally want to thank John Yagiela, Bryan Henderson, and Steve Ganzberg and their respective Boards of Directors for their continued support of this accreditation effort.

In conclusion, we have so much to celebrate in our 25th year of existence! As an organization, our continuing efforts have lifted anesthesiology in dentistry from one based on historical traditions to a discipline "officially" based on current science and education. Anesthesiology for and by dentists has, in a sense, been officially "recognized" by the ADA's Commission on Dental Accreditation. Our postdoctoral programs should have access to federal funding to support infrastructure needs as well as faculty salaries and resident stipends, but this is a new paradigm. Hopefully, some of our training programs will be able to focus on educating our future anesthesiology educators through grants and federal funding. Access to rotations on medical anesthesia and other specialty services will be enhanced because of accreditation. All of this should stimulate development of more training programs in different parts of the country, turning out more residents to eventually practice in all 50 states. The ASDA has done more in the first 25 years of its existence to enhance our discipline than any other organization in dentistry! With continuing effort, the next 25 years should see the recognition of a dental specialty in anesthesiology by the ADA House of Delegates.

Presidents
American Society of Dentist Anesthesiologists

1980-1982 – Dr. Larry Trapp
1982-1984 – Dr. Joseph Giovannitti
1984-1986 – Dr. Mike Higgins
1986-1988 – Dr. Bill MacDonnell
1988-1989 – Dr. Russell Seheult
1989-1991 – Dr. Ron Davies
1991-1993 – Dr. James Chancellor
1993-1995 – Dr. Ralph Epstein
1995-1997 – Dr. James Snyder
1997-1999 – Dr. John Leyman
1999-2001 – Dr. John Yagiela
2001-2003 – Dr. Bryan Henderson
2003-2005 – Dr. Steven Ganzberg

Reflections of ASDA Presidency 1982-84

Dr. Joe Giovannitti

It seems like only yesterday when, in 1982, I embarked on a new career move from Pittsburgh to Dallas and began my term as president of ASDA. The ASDA was still very new and we were all trying to figure out what purpose we were trying to serve. Meetings were held in conjunction with ADSA since many of us were actively involved with them and we could attend their scientific session. It seemed pointless at the time to have our own scientific session, since there were only a handful of us and we seemed to always be having a scientific session of sorts in someone's hotel room or at a bar or restaurant. The thing that I recall most from my tenure as president was at that time the ADSA formed something called the American Dental Board of Anesthesiology (ADBA). That action seemed to mean that the ADSA had responded to our concerns for a greater voice and recognition within their group, and that they were priming for pursuit of specialty status. We were all so excited that we had been heard and hopeful that things would progress rapidly. I remember thinking that specialty status would be here within the next 5-10 years. I even went so far at our House of Delegates to question the need for continuing with the ASDA since what we wanted seemed to be so easily within our grasp. How naïve we all were! That is what I remember most from those times, how hopeful and idealistic and pure we were. I know that I, for one, took things at face value, people at their word, and had an eternal optimism. Things have certainly changed in the last 25 years. We have gone from a small group of dreamers to a very real and strong organization with a major voice in dentistry and anesthesia. I am proud to be associated with the best group of men and women that I have ever known.

Reflections of ASDA Presidency 1986-88

Dr. Bill MacDonnell

The major issue facing the ASDA during 1986-1988 was malpractice insurance for our members and the dentists for whom they provided anesthesia. ASDA was caught in the middle of major changes in dental malpractice insurance simultaneous with becoming established as an organization in the early 1980's. In the late 1970's malpractice insurance rates for dentists were reasonable (1979 Class I local anesthesia \$450; Class II IV/IM Sedation \$800; Class III: general anesthesia/OMFS \$2200). The early 1980's saw dramatic premium rate increases for dental malpractice coverage. At the time there were several other dental malpractice carriers Aetna, St. Paul, Medical Protective, etc. providing coverage in different parts of the country. The major dental malpractice carrier, the ADA endorsed Professional Protector Plan which was insured by Chubb and administered by Poe Insurance Company, was started in 1969. In 1984 the ADA switched carriers to CNA. The malpractice losses and numbers of suits escalated dramatically and several carriers dropped out of the dental malpractice sector, including Chubb, Aetna and St. Paul. The physicians groups started their own captive companies. Dental societies started their own malpractice companies such as TDIC, The Dentists Insurance Company started by the California Dental Association and EDIC, Eastern Dentists Insurance Company started by the Massachusetts Dental Society. Nationwide malpractice coverage was changing from occurrence to claims made coverage.

The withdrawal of several carriers that were friendly to dentist anesthesiologists placed ASDA members in a very difficult situation. For some unknown reason, the ADA Endorsed Professional Protector Plan in the early 1980's had an anesthesia option that would allow their insured to use a dentist anesthesiologist for six cases at a fee of \$50/case. Once the dentist did six cases he/she had to increase their coverage to Class II or III. Yet, if they treated the patient in the hospital there was no change in classification. Dentist anesthesiologists asked the Professional Protector Plan for an answer as to why those dentists using dentist anesthesiologists had to have their malpractice classification changed. As the same time, the ADA Council on Insurance was asked the same question. There was no answer.

Dr. Salvatore Squatrito, a Connecticut periodontist, who knew ADA politics, suggested a letter writing campaign to the ADA Council on Insurance asking them to address this issue. The ASDA organized and thousands of letters from all over the country were sent to the ADA asking for a change in the Professional Protector Plan Policy regarding dentist anesthesiologists. The Connecticut State Dental Association submitted Resolution 63 to the 1985 ADA House of Delegates which became a First District Resolution: **Resolved, that the ADA Board of Trustees direct the Council on Insurance to investigate and report back equitable ways to provide dental malpractice insurance**

for dentists utilizing the services of an anesthesiologists who are independent contractors, and be it further resolved that the Council on Insurance report back to the 1986 House of Delegates.

The thousands of letters sent to the ADA Council on Insurance were overwhelming. The secretary of the ADA Council asked us to stop our letters because his staff spent all their time responding to our letters. The ADA scheduled a large session at the ADA Annual Meeting devoted to malpractice issues. Several ASDA members spoke at the meeting, including Michael Higgins, Lois Jacobs, Bill MacDonnell, and Russ Paravecchio. The ADA brought out all the important players for the meeting. Walter Wisniewski, J.D. a vice president at Poe was a big gun for the ADA. Walter was to become an important dentist anesthesiologist supporter. A deal was made with the ADA and Resolution 63 was referred to the Council. The Professional Protector Plan started to track all cases done by dentist anesthesiologists. That tracking was to last for more than ten years. The six case limitation was removed and the ADA Professional Protector Plan supported dentist anesthesiologists. Walter Wisniewski reminded us that the ASDA was to the ADA like a flea was to an elephant. The most important result of this ASDA effort was that the ASDA did get the ADA to change its malpractice policy with regard to dentist anesthesiologists. That flea got the elephant to change its ways.

**Reflections on the Early Years of Practice
and ASDA Presidency 1989-91
Dr. Ronald Davies**

As a founding member and officer, I had strong opinions regarding how ASDA should fight the significant forces in California and throughout the nation. These adversaries tried to literally stop the practice of mobile anesthesia services utilizing dental boards, medical boards, insurance companies and even personal threats. It seemed like a never-ending battle. Oral surgeons tried to limit us to a single office location or have every office evaluated through the dental board. Additionally, they even lodged a complaint with the California Dental Board alleging I was practicing medicine without a license. I finally hired an attorney, hoping to put a stop to the harassment. After many hearings, I received a letter from the dental board stating that I was in fact practicing dentistry and not medicine - a small but significant step. I also continued to work with the California legislature passing general and intravenous sedation bills favorable to the practice of dental anesthesia.

It was extremely difficult if not impossible to obtain insurance to practice in multiple offices during those first years. No insurance carrier would insure us in California for many years. The usual reason given was “we have no statistics on which to base a premium” unlike existing data for operator-anesthetists. Oral surgeons were heavily involved with the insurance councils in California. Premiums in California were the same as for physicians (very high). The Catch 22 at the time was the California Dental Association said I could call myself a dentist anesthesiologist as long as I only provided the anesthesia. The carriers wouldn’t sell me a policy unless I was an operator-anesthetist. Fortunately my father-in-law was President of Farmer’s Insurance and was instrumental in writing a policy that allowed me to practice until CNA finally insured the dentist anesthesiologist. Additionally without the hard work of Bill MacDonnell and others, nationally available malpractice insurance would never have happened. The availability of national carriers allowed us time to educate TDIC, gaining coverage in 1990 after 10 long years.

By the time I became president of the ASDA, we had implemented the strategy of encouraging the American Dental Society of Anesthesiology to seek specialty recognition because of their perceived image within organized dentistry and their tremendous resources. The specialty recognition effort seemed to be going well during my tenure.

As ASDA President, I recognized our small membership was a significant problem for many reasons. In an effort to increase membership, I contacted all of the existing residencies, sending letters to faculty and residents encouraging membership. Additionally, I contacted former members. The effort increased active dues paying members by 20, which was significant at the time since many still were not paying their

fair share. I created a program in dbase that organized and tracked membership and handled the mailings. I created four newsletters per year for two years by organizing, editing, printing, stuffing and mailing 100 each time to keep the members informed of various state and national issues. These efforts to organize and communicate with members were critical. My term saw the establishment of the “Purpose and Goals” of the ASDA, the first membership survey of practice type, malpractice carrier and actual safety records. I observed the establishment of the Dental Anesthesia Department at Loma Linda University.

After my presidency, I’ve served on the ADBA, helping get the fledgling organization established. I helped establish the California Society of Dentist Anesthesiologists, writing its Constitution & Bylaws and serving two terms as their first President.

Looking back, it was a difficult time. I don’t think of my service as beginning or ending with my presidency and I would encourage all members to stay engaged. As a small organization, we still enjoy a close camaraderie, working together for the common good. It was truly an honor and privilege to serve this great organization.

Reflections of ASDA Presidency 1991-93

Dr. James Chancellor

I assumed presidency of the American Society of Dentist Anesthesiologists in the spring of 1991 in Washington D.C., following Ron Davies' tenure. I had hoped for a quiet two years. However on June 28, 1991, the Anesthesia Residency Review Committee (ARRC) of the Accreditation Council for Graduate Medical Education (ACGME) sent a memo to all medical program directors threatening loss of program accreditation if dentists were rostered as anesthesia residents. The inability to continue rostering dentists as residents meant a significant loss of federal funding to medical program directors for any residency positions filled by dentists, not to mention devastating effects of loss of accreditation. Ultimately after lengthy communications with the ADA, ARRC agreed that dentists could "participate" in medical anesthesia "rotations" for up to 12 months but were not to be considered residents. This one action essentially stopped medical programs from continuing to train dentists in anesthesiology. As a discipline, we became an orphan with no source of accredited postdoctoral training. Neither dentistry nor medicine was concerned about postdoctoral general anesthesia training for dentists other than oral and maxillofacial surgeons.

Additionally in October 1991, our specialty application efforts through the American Dental Society of Anesthesiology (ADSA) came to a screeching halt. The ADSA Board realized they were no closer to submitting a specialty application to the ADA than they had been five years earlier. The American Association of Oral and Maxillofacial Surgeons (AAOMS) had continued putting political pressure on the ADSA through the ADSA House of Delegates and organizing an effort to reduce membership support (through dues) by asking oral surgeons to discontinue their membership. Ultimately, the ADSA Board of Directors realized the divisive nature of this single issue and at their October 1991 Board meeting in Seattle, WA voted to discontinue sponsorship of specialty recognition to save their organization.

All of this and more occurred during my two-year tenure as ASDA President. At the next annual meeting in the spring of 1992 in San Antonio, TX, the ASDA leadership and members present decided to submit our own application for specialty recognition to the ADA. This was a very bold step considering the size of our organization. It was a group effort of less than two dozen members to gather the necessary information to address the requirements stipulated by the ADA. By the Annual Session in Toronto in the spring of 1993, we still lacked a talented editor to coordinate and finish the project. Then at the Loma Linda meeting that year, I was encouraged by John Leyman to speak with John Yagiela regarding our problem. Fortunately for this organization, John volunteered to take on the responsibility of gathering additional substantive information and completing the application for submission by June 1993. John ultimately spent the better part of a

month writing the final version of our first request for specialty recognition. This was a major undertaking and to John Yagiela the ASDA is eternally grateful.

It's been an honor and privilege to serve as your ASDA President. With the support of my Board of Directors and the gentle prodding and vision of previous leadership, ASDA was able to accomplish much of substance that set this small organization on the path to enhance our discipline within dentistry. Over the last 25 years, I've thoroughly enjoyed the camaraderie and networking at ASDA annual meetings and CE courses. I'm looking forward to the next 25 years.

Reflections of ASDA Presidency 1993-95

Dr. Ralph Epstein

During my tenure as president of the ASDA, 1993-1995, the officers, directors and many other ASDA members spent most of their time developing our first application for specialty recognition. The multitude of phone calls, faxed documents, mailings and meetings took a great deal of time away from our families and practices. Our ability to develop such a respected application was the surprise of many within the dental community. The camaraderie that existed between us is something I will always cherish, and never forget.

As with many ASDA members who were involved and devoted to the specialty effort, my family, staff and patients felt that they were a part of the process. When I greeted my patients and asked how they were, their first question to me was, “what is happening with the specialty application.” Ten years later, I still have patients asking me about our specialty effort. Their reactions are disbelief that the ADA has yet to recognize anesthesia as a specialty.

Of course there were many unforgettable recollections of the specialty process, but two of my most memorable memories are:

- The call I received from Judy Nix at the ADA informing me that Committee G and Council on Dental Education approved our application. Immediately following this call was my call to the author of our application, John Yagiela. Because of the time change from New York to California, I was John’s wake up call that morning. I can still hear John’s exuberant response to the incredible news. For some time after that, John and I joked about what was more earth shattering (surprising), my call with the news of the specialty application or the earthquake that occurred at about the same time.
- During the debate on our application, at the House of Delegates in New Orleans, there were two speeches given by pediatric dentists that stirred those in attendance. Doctors Lois Jackson and Larry Lipton talked from the heart and articulated in such an incredible way the response to the application requirement we lived with for so many months, “*need and demand*” for a specialty of anesthesiology in dentistry. If there was any question as to whether we were doing the right thing, by applying for specialty status, those two speeches by our dental colleagues, who had nothing to gain, were the ultimate proof that we had taken the correct course.

Because of the experiences that occurred, and the friendships that were either initiated or strengthened at that time I will always consider those two years to be some of the most

rewarding years of my life. Thank you to ASDA for the wonderful privilege and honor of being president during this seminal time in our history.

Reflections of ASDA Presidency 1995-97

James Snyder

Listed below are some of the accomplishments of my two year tenure as President of the ASDA.

- Foundation for the American Dental Board of Anesthesiology
- Developed financial structure for board and registered the corporations
- Development of validated test of knowledge to verify experts in dental anesthesiology

- Developed the criteria for residency in Dental Anesthesiology
- Convened first meeting of all existing dental anesthesia residency heads and accredited existing programs

- Developed and installed the modern Constitution and By-Laws of the ASDA

- Application to ADA for specialty (#2); lead the successful application through committee G, ADA BOT, and Reference Committee but not the ADA HOD including thousands of calls, letters and solicitations by many, many ASDA members

- Formation of regular meeting of anesthesia interest groups – ultimately leading to ADA Committee ‘H’ (and ending the decades old ‘Anesthesia Steering Committee’)

- Created the Monheim Award

Reflections of ASDA Presidency 1997-99

John Leyman

You can imagine my pride when I received the ADSA Award for graduating seniors at UOP in 1978. Mind you, I had no special talent for anesthesia. We did not have any clinical training beyond nitrous oxide and local anesthesia, and I am sure the honor was bestowed upon me because I had been accepted into 2 different anesthesia programs and had the luxury to choose which to attend.

My first real involvement with the ADSA was when I took the Fellowship Exam, in Chicago, in February 1980. I flew with the 2 residents from Harbor General on a redeye flight and spent the day in Chicago. While I don't recall a lot about the exam, I do remember having Ted Jastak and Stan Malamed as examiners. One of the other examiners must have been impressed with my training because he invited me to the evening reception for the examiners. I felt a bit awkward, and received several stares telling me I was out of my place, but my new friend took me around and introduced me to all of the people there. Nowhere to be found were the people like me, those dentists who had trained for 2 years in an anesthesiology residency.

I didn't have to wait long to find them, or more appropriately, they found me. I was nearing completion of training and heard about a new society for 2-year-trained dentist anesthesiologists. This group was being called the ASDA and the spearheads were 2 fellows from Southern California, Larry Trapp and Ron Davies. I had met Larry when I interviewed at Harbor General and Ron while I was wandering around the California Dental Association Spring Meeting and saw him, with his anesthesia equipment, teaching CPR to dentists. I talked to him for a while, and he even had me help teach the class.

I didn't make the first meeting of the ASDA, but since 1982 I have missed only one (Boston, 1984). By attending the meetings I was able to meet some of the people that were "larger than life," and found many if not all of them to be friendly and as passionate about anesthesia as I was. It was common in the early years for everyone to "talk shop." Often it was about the patients we treated. It was as if we were attending a family reunion, and talk inevitably turns to ailments and medicine, except we would talk about our difficult and interesting cases instead of our own ailments. Over the years this type of talk decreased and the reunion of friends at the annual meeting was spent in an update of our practices without the bragging and rhetoric of the early years.

We did not face many major issues back then, even if we did not realize it at the time. Oh, we had issues to deal with, but compared with later years they now seem relatively minor. Most of the contentious issues ones were regarding specialty and membership requirements, with one big difference between the two— all of us wanted to achieve specialty status but the disagreement was on how to best achieve it. We were very naïve but collectively had a lot of energy.

Every year at the annual meeting, a nucleus of the same people were in attendance. This core group of 25 or 30 people collectively made up ASDA House of Delegates and set policy on a yearly basis. We were all more or less friends, and we could leave an emotionally charged and heated debate in the meeting room while we had lunch as friends, and then return to the meeting to further debate. This ability to debate as friends was later lost (sadly), and some of the resultant hard feelings are still around today. One of the duties of the House of Delegates was to elect officers yearly. I had served on committees and as program director, but I had always resisted serving in the elected leadership because I did not see myself as having the necessary conviction to be president of the ASDA. It was just after the 1993 ASDA meeting that I realized that perhaps I could run for a society office. I had been overheard by two friends defending a position of mine in a debate, and they emphatically told me that I needed to represent the Society.

In 1993 I was elected Vice-President, which meant I would be President-Elect in 1995 and President in 1997. These were the Specialty Years, with our effort beginning in earnest in 1991 or 1992. Much volunteer time was spent evaluating information and plotting strategy for the next several years. The most intense time for me was the two-year period I spent as President from 1997-1999. During those years I spent a lot of time working for the ASDA, with our near singular mission to attain specialty status. We came close in 1997, not because I was President, but because I was surrounded by many talented individuals and could count on them for help. I am grateful to Larry Trapp and Dave Anderson for helping me through those years at work, and my wife Paula and children John and Alissa, who often felt husbandless and fatherless, at home. It was only after my tenure as President did I realize how much of my “regular” life I had missed.

The ASDA is different today than it was 20 and 25 years ago. Not better, or worse, just different. We have grown in numbers, and I no longer know everyone that attends the meetings the way I was able to in the past. We have come to accept the fact that specialty status will not be had for many years, and maybe even not in some of our lifetimes. Despite this devastating blow, most of us have settled comfortably into our practices. Along the years we have seen people come and go, but I can look forward to the seeing the same core group every year. Perhaps this is why I still look forward to our meeting every year with eager anticipation. I am also pleased to see the ranks of new members swell, for they are the ASDA leaders of the present and the future.

Reflections of ASDA Presidency 1999-2001

Dr. John A. Yagiela

My presidency ran from 3/99 to 3/01. The principal issue during my term was the continuing effort by the ASDA to gain specialty recognition for anesthesiology in dentistry. As the editor of the specialty application, chair of the specialty committee, and president of the society, I was intimately involved in most activities pertaining to both the application process and the political effort. With this third attempt in one decade to win recognition, an all-out effort was made to prevail against an increasingly sophisticated and well-financed opposition. A number of individuals played pivotal roles. Jim Chancellor continued to provide a leading role in developing and carrying out strategies pertaining to the ADA House and trustee districts; Jim Snyder contributed numerous "Plain Truths" of distilled acerbity, philosophy, and wit. Virtually all of the board of directors and numerous other individuals contributed much of their time to this heroic, if unsuccessful, attempt. The ASDA as a whole financed the effort through a self-imposed assessment.

The third application was submitted in 1998. In contrast to previous applications, this application, the best of the three, was not approved by the Council on Dental Education and Licensure. Opponents to specialty recognition had managed to place several highly influential members on the Council, and they were successful in overturning all previous reviews of the application, including that of their own committee charged with carefully reviewing the application. A vigorous effort – scientific, political, and legal – was undertaken to reverse this decision, and at the Council meeting of April 17, 2000, we were able to convince the Council after our written and verbal presentation, to rescind their decision and approve the application. A secondary outcome was the subsequent discovery of malfeasance by our opponents on the Council, which we referred to the Council on Ethics, Bylaws and Judicial Affairs and eventually led to the public censure of one of our opponents.

Despite our best effort, the ASDA application for specialty recognition was narrowly defeated at the October 1999 annual meeting of the ADA, held in Honolulu. Believing that we had done the best we could given the political realities of the ADA, the board directed its efforts to explore other avenues to specialty recognition. A number of strategy meetings were held internally and with outside individuals and organizations, and several possibilities were identified. The best of these appeared to involve a special request to the Commission on Dental Accreditation to accredit our programs. Although this action would be independent of specialty recognition, if successful it would provide some of the benefits of specialty status. One of my last official duties was to petition the Commission, which I did in January 2001. It is with a goodly amount of satisfaction that our collective effort to gain accreditation status for our programs is now coming to fruition.

A final accomplishment during my term was the initiation of the Dental Anesthesiology Research Group of the International Association for Dental Research. In 1999 Professor Yuzuru Kaneko, then chair of the Department of Anesthesiology at Tokyo Dental College, approached me about starting a new research group within the IADR. I agreed and together we petitioned the IADR to consider its establishment. Our application was successful, and the first organizational meeting was held at the annual IADR meeting in April 2000. Professor Kaneko was elected the founding president and I president elect. Although not directly linked to the specialty effort, promotion of research in the discipline is now an ongoing process and one that bodes well for anesthesiology in dentistry.

Reflections of ASDA Presidency 2001-03

Dr. Bryan Henderson

The ASDA organization is a great collection of members who are strong in their individual beliefs on anesthesia and its utilization in Dentistry. As a past President, it was an honor to serve this body of knowledge and passion for our profession. I attended my first ASDA meeting in Cherry Hill, NJ in 1988 as a resident. Other than missing a few years for back surgery, I have attending all the annual meetings. I have watched this group grow and become more focused on its mission.

When I first became involved on the Board, specialty was the overriding effort. By the time I was President, the focus had become accreditation of anesthesia programs. I refused to withdraw an application to CODA after the ADA stalled them, though no action was taken. We missed an opportunity to aggressively pursue specialty and I was not going to miss out on this opportunity for accreditation should it be needed. I am proud to see the ADA recognizing the need for accreditation of our programs but am still strongly disappointed that there is no “need or demand” for a specialty with the ADA. In this regard as a past leader I am disappointed in my efforts while in office. I feel certain that as time goes on maybe specialty may again be our focus securing a solid place in Dentistry. We have a long road still ahead.

Our members benefit greatly not only by having excellent CE opportunities but the vast expertise of our members and the ability to network among them while at a meeting or by our internet are invaluable. I would encourage the new members to become more involved and take advantage of this. To the senior members and prior leaders I thank you for the efforts and great length that they have brought the society along. I recall many extra expenses that each of you all incurred to just define what a Dentist Anesthesiologist is and our bylaws. I'm proud to be a member of a group that is dedicated to a true Dentist Anesthesiologist and not diluted by a large number of dentists that just have an interest in giving sedatives.

The American Society of Dentist Anesthesiologists in 2005

Dr. Steven Ganzberg, President 2003 – 2005

As we celebrate the 25th Anniversary of the ASDA, we have much to be proud of as a society of dental professionals. The last two years have seen tremendous growth in the ASDA as an organization and Anesthesiology as a special area of dental practice. The ASDA has always engendered tremendous brainpower and forward thinking for Anesthesiology for Dentistry. Our small numbers, however, have generally made it difficult to effectively organize our efforts in our three main areas of focus: Education, Research and Patient Care. Arguably the greatest advance in the past 25 years has been in the area of Education with our successful effort to accredit Dental Anesthesiology Residency Programs through the Commission on Dental Accreditation. It is through the tireless efforts of the few that devoted tremendous time and energy, and the many who offered any support they could, that this milestone is becoming a reality. The implications of this process have yet to be seen, but will surely benefit the dental profession and, most importantly, the patients we serve.

In the general area of Education, the ASDA has made great strides in the last two years. All of our ongoing meetings are now planned a full year in advance with the following years' Annual Scientific Session agenda distributed at the current Annual Session. This allows members to better plan for our meetings and also to appreciate the excellent program that has been arranged. The Scientific Session has expanded from seven hours to 12 hours. A Morbidity and Mortality Conference has been added to all meetings. When possible, an aspect of practice management is included in the agenda. Speakers are recruited nationally from the ranks of dentist and physician anesthesiologists, other general and specialist dentists and physicians, and basic science researchers. In addition to the Annual Session, there is now a permanent Dental Anesthesiology Review Course held for two days in September of every year. We are embarking on an Oral Sedation Course for general dentists and other interested professionals. We are most proud, however, of the high quality of our educational efforts which set a standard for Anesthesiology in Dentistry. This has not been lost on national groups such as the American Dental Association, the American Association of Dental Examiners and other organizations that routinely call on the ASDA to help guide policy and direction in the area of Anesthesiology for Dentistry.

In the area of Research, ASDA has funded two projects recently to help examine aspects of Anesthesiology for Dentistry practice. Dr. Simon Prior of Ohio State University has received a \$7500 grant to develop a web based program to examine all aspects of dentist anesthesiologist practice patterns including urgencies and emergencies that occur in office and other practice sites. Dr. Sean Boynes of University of Pittsburgh has received a smaller grant to study dentists' perceptions of their sedation education in dental school. In the past few months, we have initiated a tax-exempt ASDA Education and Research Development Fund which we envision as a mechanism for increasing research in the area as well as other efforts deemed beneficial to our special area of practice.

Patient Care remains one of the greatest strength's of our field. Through the efforts of dentist anesthesiologists across the country, numerous pre-cooperative children, mentally and physically challenged individuals, medically compromised and simply extremely anxious or frankly phobic dental patients are able to receive very cost effective dental care under general anesthesia or sedation in the offices of private dentists or in ambulatory surgery centers and hospitals. Our new and improved web site now includes an easy way for patients and doctors to find a dentist anesthesiologist in their area. In order to continue to promote ASDA's efforts in patient care, the need for member recruitment is critical. The ASDA now sends a welcome letter and anesthesiology textbook to all incoming dental anesthesiology residents. We are attempting to contact all recently graduated dentist anesthesiologists to highlight the benefits of ASDA to themselves personally and to their field in general.

It is through the efforts of the officers, the Board of Directors and every ASDA member through the House of Delegates, that all of these advances have become a reality. In truth, it is again the efforts of the few, with the support of the many, which have allowed these developments to occur. Probably the biggest change in our organizational structure was to hire a permanent Executive Director, Ms. Brigitte Bandy, to help run this increasingly complex organization. I can attest to the dedication Brigitte brings to her job by the near daily emails that find us working for the betterment of your organization. What would we do without her??!!

As we stand on the threshold of 25 years of dedication and commitment, we should be extremely proud of our place in the dental profession, which continues to grow. It is truly impressive what a small, dedicated group of professionals, whose worthy mission is focused on the greater good for our patients and profession, can do to make a tremendous difference against formidable odds. There is so much thanks to go around for all the hard work of the past presidents and Board of Directors, my Board, of particular note during my tenure Drs. John Yagiela and Jim Chancellor, and so many others who devoted their time and effort so selflessly to further the goals of our organization. The future of Anesthesiology for Dentistry and the ASDA has never been brighter. I look forward to the years ahead as further advances and recognition come our way.