PROGRESS REPORT ON THE 2021 VALIDITY AND RELIABILITY STUDY OF THE ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS IN DENTAL ANESTHESIOLOGY

Background: The Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology (Appendix 1) was adopted by the Commission on Dental Accreditation at its January 25, 2007 meeting for immediate implementation.

According to the Commission’s Policy on Assessing the Validity and Reliability of the Accreditation Standards, “the validity and reliability of accreditation standards will be assessed after they have been in effect for a period of time equal to the minimum academic length of the accredited program plus three years.” Thus, the validity and reliability of the standards for a one-year program will be assessed after four (4) years. Significant revisions were made to the Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology in 2012 and 2015. Therefore, the validity and reliability study for Advanced Dental Education Programs in Dental Anesthesiology was initiated in the Spring of 2021.

At its Summer 2021 meeting, the Review Committee on Advanced Education in General Dentistry, General Practice Residency, Dental Anesthesiology, Oral Medicine, and Orofacial Pain (AGDOO RC) conducted an initial review of the results of the validity and reliability survey, as well as written comments gathered (Appendix 2). As a result of initial analysis and discussion of the validity and reliability survey data and written comments, the AGDOO RC concluded that further study of the survey data and review of the Accreditation Standards is warranted, in particular data and comments related to the minimum number of clinical procedures that must be obtained by residents and curriculum content in pain associated with the head and neck regions. In addition, the AGDOO RC believed that the newly formed Review Committee on Dental Anesthesiology, which will conduct its first meeting in Winter 2022, should further study the data and identify dental anesthesiology Accreditation Standards which may warrant revision. At its August 5, 2021 meeting, the Commission agreed and directed further review and analysis of the study to the Review Committee on Dental Anesthesiology to identify Accreditation Standards, if any, which warrant revision with a report for consideration by the Commission in Winter 2022.

Summary: At this meeting, the Dental Anesthesiology Review Committee (DentAnes RC) is requested to review the survey data and the written comments gathered through the Validity and Reliability Study for Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology to identify Accreditation Standards, if any, which warrant revision. If proposed changes are made to the Accreditation Standards, the Commission may wish to circulate the proposed revisions for a period of public comment.

Recommendation:

Prepared by: Ms. Peggy Soeldner
Commission on Dental Accreditation

Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology
Accreditation Standards For Advanced Dental Education Programs in Dental Anesthesiology

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## Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology

### Document Revision History

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Mission Statement of the Commission on Dental Accreditation

The Commission on Dental Accreditation serves the public and profession by developing and implementing accreditation standards that promote and monitor the continuous quality and improvement of dental education programs.

Commission on Dental Accreditation
Adopted: August 5, 2016
Accreditation Status Definitions

Programs That Are Fully Operational

Approval (without reporting requirements): An accreditation classification granted to an educational program indicating that the program achieves or exceeds the basic requirements for accreditation.

Approval (with reporting requirements): An accreditation classification granted to an educational program indicating that specific deficiencies or weaknesses exist in one or more areas of the program. Evidence of compliance with the cited standards or policies must be demonstrated within a timeframe not to exceed eighteen (18) months if the program is between one and two years in length or two years if the program is at least two years in length. If the deficiencies are not corrected within the specified time period, accreditation will be withdrawn, unless the Commission extends the period for achieving compliance for good cause. Identification of new deficiencies during the reporting time period will not result in a modification of the specified deadline for compliance with prior deficiencies.

Circumstances under which an extension for good cause would be granted include, but are not limited to:

- sudden changes in institutional commitment;
- natural disaster which affects affiliated agreements between institutions; faculty support; or facilities;
- changes in institutional accreditation;
- interruption of an educational program due to unforeseen circumstances that take faculty, administrators or students away from the program.

Revised: 8/17; 2/16; 5/12; 1/99; Reaffirmed: 8/13; 8/10, 7/05; Adopted: 1/98

Programs That Are Not Fully Operational

A program which has not enrolled and graduated at least one class of students/residents and does not have students/residents enrolled in each year of the program is defined by the Commission as not fully operational. The accreditation classification granted by the Commission on Dental Accreditation to programs which are not fully operational is “initial accreditation.” When initial accreditation status is granted to a developing education program, it is in effect through the projected enrollment date. However, if enrollment of the first class is delayed for two consecutive years following the projected enrollment date, the program’s accreditation will be discontinued, and the institution must reapply for initial accreditation and update pertinent information on program development. Following this, the Commission will reconsider granting initial accreditation status.

Initial Accreditation is the accreditation classification granted to any dental, advanced dental or allied dental education program which is not yet fully operational. This accreditation classification provides evidence to educational institutions, licensing bodies, government or other

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granting agencies that, at the time of initial evaluation(s), the developing education program has the potential for meeting the standards set forth in the requirements for an accredited educational program for the specific occupational area. The classification “initial accreditation” is granted based upon one or more site evaluation visit(s).
Introduction

This document constitutes the standards by which the Commission on Dental Accreditation and its site visitors evaluate Advanced Dental Education Programs in Dental Anesthesiology for accreditation purposes. It also serves as a program development guide for institutions that wish to establish new programs or improve existing programs.

The standards identify those aspects of program structure and operation that the Commission regards as essential to program quality and achievement of program goals. They specify the minimum acceptable requirements for programs and provide guidance regarding alternative and preferred methods of meeting standards.

Although the standards are comprehensive and applicable to all institutions that offer advanced dental education programs in dental anesthesiology, the Commission recognizes that methods of achieving standards may vary according to the size, type, and resources of sponsoring institutions. Innovation and experimentation with alternative ways of providing required training are encouraged, assuming standards are met and compliance can be demonstrated. The Commission has an obligation to the public, the profession and the prospective resident to assure that programs accredited as Advanced Dental Education Programs in Dental Anesthesiology provide an identifiable and characteristic core of required training and experience.
Goals

Advanced Dental Education Programs in Dental Anesthesiology are educational programs designed to train the dental resident, in the most comprehensive manner, to use pharmacologic and non-pharmacologic methods to manage anxiety and pain of adults, children, and patients with special care needs undergoing dental, maxillofacial and adjunctive procedures, as well as to be qualified in the diagnosis and non-surgical treatment of acute orofacial pain and to participate in the management of patients with chronic orofacial pain.

The goals of these programs should include preparation of the graduate to:
1. Deliver anxiety and pain control services for emergency and comprehensive multidisciplinary oral health care.
2. Plan and provide anesthesia-related care for the full range of dental patients, including patients with special needs.
3. Manage the delivery of oral health care by applying concepts of patient and practice management and quality improvement that are responsive to a dynamic health care environment.
4. Function effectively within the hospital, dental office, ambulatory surgery center, and other health care environments.
5. Function effectively within interdisciplinary health care teams.
6. Apply scientific principles to learning and anesthesia-related oral health care. This includes using critical thinking, evidence- or outcomes-based clinical decision-making, and technology-based information retrieval systems.
7. Utilize the values of professional ethics, lifelong learning, patient-centered care, adaptability, and acceptance of cultural diversity in professional practice.
Definitions of Terms

Key terms used in this document (i.e., must, should, could, and may) were selected carefully and indicate the relative weight that the Commission attaches to each statement. The definition of these words as used in the Standards follows:

**Anxiety and Pain Control:** Includes the following: analgesia; local anesthesia; minimal, moderate, and deep sedation; and general anesthesia as defined in the American Dental Association’s “Guidelines for the Use of Sedation and General Anesthesia by Dentists.”

**Competencies:** Written statements describing the levels of knowledge, skills, and values expected of residents completing the program.

**Competent:** The level of knowledge, skills, and values required by residents to perform independently an aspect of dental practice after completing the program.

**Examples of evidence to demonstrate compliance include:** Desirable condition, practice or documentation indicating the freedom or liberty to follow a suggested alternative.

**In-Depth:** A thorough knowledge of concepts and theories for the purpose of critical analysis and the synthesis of more complete understanding.

**Intent:** Intent statements are presented to provide clarification to the advanced dental education programs in dental anesthesiology in the application of and in connection with compliance with the Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology. The statements of intent set forth some of the reasons and purposes for the particular Standards. As such, these statements are not exclusive or exhaustive. Other purposes may apply.

**Interdisciplinary:** Including dentistry and other health care professions.

**May or Could:** Indicates freedom or liberty to follow a suggested alternative.

**Multidisciplinary:** Including all disciplines within the profession of dentistry.

**Must:** Indicates an imperative or duty; an essential or indispensable item; mandatory.

**Outpatient Anesthesia for Dentistry:** The administration of anesthesia services to patients who are discharged from anesthetic care within the same treatment day (same-day surgery) from a facility where only procedures within the scope of dental practice are carried out.
Patients with special needs: Those patients whose medical, physical, psychological, cognitive or social situations make it necessary to modify normal dental routines in order to provide dental treatment for that individual. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairment, complex medical conditions, significant physical limitations, and/or other vulnerable populations.

Should: Indicates a method to achieve the standard; highly desirable, but not mandatory.

Sponsor: The institution which has the overall administrative control and responsibility for the conduct of the program.

Resident: The individual enrolled in a Commission on Dental Accreditation-accredited advanced dental education program.
STANDARD 1 – INSTITUTIONAL AND PROGRAM EFFECTIVENESS

1-1 The program must be sponsored or co-sponsored by either a United States-based hospital, or educational institution or health care organization that is affiliated with an accredited hospital. Each sponsoring and co-sponsoring institution must be accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS).

United States military programs not sponsored or co-sponsored by military medical treatment facilities, United States-based educational institutions, hospitals or health care organizations accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS) must demonstrate successful achievement of Service-specific organizational inspection criteria.

Examples of evidence to demonstrate compliance may include:
- Accreditation certificate or current official listing of accredited institutions
- Evidence of successful achievement of Service-specific organizational inspection criteria

1-2 The sponsoring institution must ensure that support from entities outside of the institution does not compromise the teaching, clinical and research components of the program.

Examples of Evidence to demonstrate compliance may include:
- Written agreement(s)
- Contract(s)/Agreement(s) between the institution/program and sponsor(s) related to facilities, funding, and faculty financial support

1-3 The authority and final responsibility for curriculum development and approval, resident selection, faculty selection, and administrative matters must rest within the sponsoring institution.

1-4 The financial resources must be sufficient to support the program’s stated purpose/mission and goals and objectives.

Examples of evidence to demonstrate compliance may include:
- Program budgetary records
Budget information for previous, current and ensuing fiscal year

1-5 Arrangements with all sites not owned by the sponsoring institution where educational activity occurs must be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved. **Intent:** Sites where educational activity occurs include any dental practice setting (e.g. private offices, mobile dentistry, mobile dental provider, etc.). The items that are covered in agreements do not have to be contained in a single document. They may be included in multiple agreements, both formal and informal (e.g., addenda and letters of mutual understanding).

**Examples of evidence to demonstrate compliance may include:**
Written agreements

1-6 The institutional staff bylaws, rules, and regulations of sponsoring, co-sponsoring or affiliated health care institutions must ensure that dentists are eligible for staff membership and privileges including the right to:

a) Vote and hold office; 
b) Serve on institutional staff committees; and 
c) Admit, manage, and discharge patients.

**Examples of evidence to demonstrate compliance may include:**
All institutional bylaws related to a, b, and c 
Copy of institutional committee structure and/or roster of membership by dental faculty

1-7 Dental residents must be appointed to the staff of the sponsoring, co-sponsoring or affiliated health care institution and enjoy the same privileges and responsibilities provided residents in other professional education programs.

**Examples of evidence to demonstrate compliance may include:**
Institutional staff roster 
Related institutional bylaws

**Intent:** Residents are to be appointed to at least one of the above noted institutions.

1-8 The program must develop a mission statement and supporting written overall program goals and objectives that emphasize:
a) anesthesia for dentistry,
b) resident education, and
c) patient care.

and include training residents to provide dental anesthesia care in office-based and hospital settings.

**Intent:** The “program” refers to the Dental Anesthesiology Residency that is responsible for training residents within the context of providing patient care. The overall goals and objectives for resident education are intended to describe general outcomes of the residency training program rather than specific learning objectives for areas of residency training as described in Standard 2-1 and 2-2. Specific learning objectives for residents are intended to be described as competency requirements and included in the response to Standards 2-1 and 2-2. An example of overall goals can be found in the Goals section on page 8 of this document.

**Examples of evidence to demonstrate compliance may include:**
Mission statement and supporting written program goals and objectives

1-9 The program must have a formal and ongoing outcomes assessment process that regularly evaluates the degree to which the program’s written goals and objectives are being met.

**Intent:** The intent of the outcomes assessment process is to collect data about the degree to which the overall goals and objectives described in response to Standard 1-8 are being met and make program improvements based on an analysis of those data.

The outcomes process developed should include each of the following steps:
1. development of clear, measurable goals and objectives consistent with the program's purpose/mission;
2. implementation of procedures for evaluating the extent to which the goals and objectives are met;
3. collection of data in an ongoing and systematic manner;
4. analysis of the data collected and sharing of the results with appropriate audiences;
5. identification and implementation of corrective actions to strengthen the program; and
6. review of the assessment plan, revision as appropriate, and continuation of the cyclical process.

**Examples of evidence to demonstrate compliance may include:**
Mission statement and supporting written goals and objectives
Outcomes assessment plan and measures
Outcomes results
Annual review of outcomes results
Meeting minutes where outcomes are discussed
Decisions based on outcomes results

**Ethics and Professionalism**

1-10 The program **must** ensure that residents are able to demonstrate the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management.

**Intent:** Residents should know how to draw on a range of resources such as professional codes, regulatory law, and ethical theories to guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern.
STANDARD 2 – EDUCATIONAL PROGRAM

Curriculum Content

2-1  The program must list the written competency requirements that describe the intended outcomes of residents’ education such that residents completing the program in dental anesthesiology receive training and experience in providing anesthesia care in the most comprehensive manner using pharmacologic and non-pharmacologic methods to manage anxiety and pain in adult and child dental patients, including patients with special needs.

**Intent:** The program is expected to develop specific competency-statements that describe what the resident will be able to do upon completion of the program. These statements should describe the resident’s abilities rather than educational experiences the residents may participate in. These competency statements are to be circulated to program faculty and staff and made available to applicants of the program.

**Examples of evidence to demonstrate compliance may include:**
Written competency requirements

2-2  Upon completion of training, the resident must be:

a)  Able to demonstrate in-depth knowledge of the anatomy and physiology of the human body and its response to the various pharmacologic agents used in anxiety and pain control;
b)  Able to demonstrate in-depth knowledge of the pathophysiology and clinical medicine related to disease of the human body and effects of various pharmacological agents used in anxiety and pain control when these conditions are present;
c)  Competent in evaluating, selecting and determining the potential response and risk associated with various forms of anxiety and pain control modalities based on patients’ physiological and psychological factors;
d)  Competent in patient preparation for sedation/anesthesia, including pre-operative and post-operative instructions and informed consent/assent;
e)  Competent in the use of anesthesia-related equipment for the delivery of anesthesia, patient monitoring, and emergency management;
f)  Competent in the administration of local anesthesia, sedation, and general anesthesia, as well as in psychological management and behavior modification as they relate to anxiety and pain control in dentistry;
g) Competent in managing perioperative emergencies and complications related to anxiety and pain control procedures, including the immediate establishment of an airway and maintenance of ventilation and circulation;

h) Competent in the diagnosis and non-surgical treatment of acute pain related to the head and neck region;

i) Familiar with the diagnosis and treatment of chronic pain related to the head and neck region; and

j) Able to demonstrate in-depth knowledge of current literature pertaining to dental anesthesiology.

**Intent:** The program’s specific competency requirements and the didactic and clinical training and experiences in each area described above are expected to be at a level of skill and complexity beyond that accomplished in pre-doctoral training and consistent with preparing the dentist to utilize anxiety and pain control methods safely in the most comprehensive manner as set forth in the specific standards contained in this document.

**Examples of evidence to demonstrate compliance may include:**
- Written competency requirements
- Didactic coursework, including lecture schedules and assigned reading
- Case review conferences
- Records of resident clinical activity including procedures performed in each area described above
- Resident logs
- Patient records in accordance with the Health Insurance Portability and Accountability Act (HIPAA) standards
- Resident evaluations

The program **must** have a written curriculum plan including structured didactic instruction and clinical experience designed to achieve the program’s written competency requirements.

**Intent:** The program is expected to organize the didactic and clinical educational experience into a formal written curriculum plan.

For each specific competency statement described, the program is expected to develop educational experiences designed to enable the resident to acquire the skills, knowledge and values necessary in that area. The program is expected to organize these didactic and clinical educational experiences into a formal written curriculum plan.

**Examples of evidence to demonstrate compliance may include:**
Formal written curriculum plan with educational experiences tied to specific competency requirements
Didactic schedules
Clinical schedules
Didactic Components

2-4 Didactic instruction at an advanced and in-depth level beyond that of the pre-doctoral dental curriculum must be provided and include:

a) Applied biomedical sciences foundational to dental anesthesiology,

**Intent:** Instruction should include physiology, pharmacology, anatomy, biochemistry, pathology, physics, pathophysiology, and clinical medicine as it applies to anesthesiology. The instruction should be sufficiently broad to provide for a thorough understanding of the body processes related to anxiety and pain control. Instruction should also provide an understanding of the mechanisms of drug action and interaction, as well as information about the properties of drugs used.

b) Physical diagnosis and evaluation,

**Intent:** This instruction should include taking, recording and interpreting a complete medical history and physical examination, and understanding the indications for and interpretations of diagnostic procedures and laboratory studies.

c) Behavioral medicine,

**Intent:** This instruction should include psychological components of human behavior as related to the management of anxiety and pain.

d) Methods of anxiety and pain control,

**Intent:** This instruction should include a detailed review of all methods of anxiety and pain control and pertinent topics (e.g., anesthesia delivery devices, monitoring equipment, airway management adjuncts, and perioperative management of patients).

e) Complications and emergencies,

**Intent:** This instruction should include recognition, diagnosis, and management of anesthesia-related perioperative complications and emergencies.

f) Pain management, and

Dental Anesthesiology Standards
**Intent:** This instruction should include information on pain mechanisms and on the evaluation and management of acute and chronic orofacial pain.

g) Critical evaluation of literature.

**Intent:** This instruction should include an understanding of scientific literature pertaining to dental anesthesiology and the development of critical evaluation skills, including an understanding of relevant research and statistical methodology.

**Clinical Components**

2-5 The program **must** ensure the availability of adequate patient experiences in both number and variety that afford all residents the opportunity to achieve the program’s stated goals and competency requirements in dental anesthesiology.

**Examples of evidence to demonstrate compliance may include:**
Records of resident clinical activity, including specific details of the variety, type, and quantity of cases treated and procedures performed

2-6 The following list represents the minimum clinical experiences that **must** be obtained by each resident in the program at the completion of training:

a) Eight hundred (800) total cases of deep sedation/general anesthesia to include the following:
   (1) Three hundred (300) intubated general anesthetics of which at least fifty (50) are nasal intubations and twenty-five (25) incorporate advanced airway management techniques. No more than ten (10) of the twenty five (25) advanced airway technique requirements can be blind nasal intubations.
   (2) One hundred and twenty five (125) children age seven (7) and under, and
   (3) Seventy five (75) patients with special needs,

b) Clinical experiences sufficient to meet the competency requirements (described in Standard 2-1 and 2-2) in managing ambulatory patients, geriatric patients, patients with physical status ASA III or greater, and patients requiring moderate sedation; and

c) Exposure to the management of patients with chronic orofacial pain.
**Intent:** The resident should be competent in the various methods of sedation and anesthesia for a variety of diagnostic and therapeutic procedures in the office or ambulatory care setting and the operating room. The resident should gain clinical experience in current monitoring procedures, fluid therapy, acute pain management and operating room safety. Instruction and experience in advanced airway management techniques are important parts of the training program and may include but are not limited to the following devices and techniques: blind nasal intubation, bougie, fiberoptic intubation, intubating laryngeal mask airway (LMA), light wand, and video laryngoscopes.

**General Anesthesia Experience/Anesthesia Service**

2-7 At a minimum, a total of twenty-four (24) months over a thirty-six (36) month period **must** be devoted exclusively to clinical training in anesthesiology, of which a minimum of six (6) months are devoted to dental anesthesiology.

**Examples of evidence to demonstrate compliance may include:**
- Anesthesia rotation schedules
- Records of resident clinical activity

2-8 Residents **must** be assigned full-time for a minimum of twelve (12) months over a thirty-six (36) month period to a hospital anesthesia service that provides trauma and/or emergency surgical care.

**Intent:** This service should be under the direction of an anesthesiologist with a full time commitment, and each resident should participate in all of the usual duties and responsibilities of anesthesiology residents, including preanesthetic patient evaluation, administration of anesthesia in the operating room on a daily scheduled basis, postanesthetic patient management, and emergency call.

**Outpatient Anesthesia for Dentistry**

2-9 At the completion of the program, each resident **must** have the following experiences in the administration of the full spectrum of anesthesia service for same-day surgery dental patients:
1. At least one hundred (100) cases of the experiences listed in Standard 2-6 in outpatient anesthesia for dentistry that are supervised by dentist anesthesiologists.

2. Experience as the provider of supervised anesthesia care.

**Intent:** Adequate experience in the unique aspects of dental anesthesia care with and without the use of an anesthesia machine and operating room facilities should be provided. Supervising dentist anesthesiologists shall have completed a CODA-accredited dental anesthesiology residency program or a two-year anesthesiology residency for dentists consistent with or equivalent to the training program described in Standard 2. A one-year anesthesiology residency for dentists completed prior to July 1993 is acceptable provided that continuous significant practice of general anesthesia in the previous two years is documented.

**Examples of evidence to demonstrate compliance may include:**
- Anesthesia rotation schedules
- Records of resident clinical activity
- Schedules of dental anesthesia faculty

**Medicine Rotations**

2-10 Residents **must** participate in at least four (4) months of clinical rotations from the following list. If more than one rotation is selected, each **must** be at least one month in length.

- a) Cardiology,
- b) Emergency medicine,
- c) General/internal medicine,
- d) Intensive care,
- e) Pain medicine,
- f) Pediatrics,
- g) Pre-anesthetic assessment clinic (max. one [1] month), and
- h) Pulmonary medicine.

**Intent:** The dental anesthesia resident should have a strong foundation in clinical medicine that can be achieved through rotations in the above-mentioned areas. When the resident entering the program has minimal clinical medicine experience, the program director should attempt to increase the time in these rotations beyond the minimum number of months required. The goal is to give the resident experience in medical evaluation and long-term management of patients. Therefore, only one month of the four
months of this requirement may be met in the pre-anesthetic assessment clinic, although longer periods of time may be arranged as desired.

Examples of evidence to demonstrate compliance may include:
Description and schedule of rotations

2-11 Each assigned rotation or experience must have:

a) Written objectives that are developed in cooperation with the department chairperson, service chief, or facility director to which the residents are assigned;
b) Resident supervision by designated faculty who are familiar with the objectives of the rotation or experience; and
c) Evaluations performed by designated faculty.

Intent: This standard applies to all assigned rotations or experiences, whether they take place in the sponsoring institution or a major or minor activity site. Supplemental activities are exempt.

Examples of evidence to demonstrate compliance may include:
Written objectives of rotations
Description and schedule of rotations
Resident evaluation reports

2-12 Residents must be competent to request and respond to requests for consultations from dentists, physicians, and other health care providers.

Intent: Programs are expected to define the educational goals or competency statements in this area. Residents should be able to interact appropriately with other health care providers.

Examples of evidence to demonstrate compliance may include:
Consultation records or patient records
Written competency requirements
Resident evaluations

2-13 The program must provide instruction and clinical experience in physical evaluation and medical risk assessment, including:

a) Taking, recording, and interpreting a complete medical history;
b) Understanding the indications of and interpretations of laboratory studies and other techniques used in physical diagnosis and preoperative evaluation;

c) Interpreting the physical evaluation performed by a physician with an understanding of the process, terms, and techniques employed; and

d) Using the techniques of physical examination (i.e., inspection, palpation, percussion, and auscultation).

**Intent:** It is intended that medical risk assessment be conducted during formal instruction as well as during in-patient, same-day surgery, and ambulatory patient care. The program is expected to define the type of documentation of physical evaluation and medical risk assessment that is required to be entered into inpatient and ambulatory care records. The program is expected to ensure that such data are being recorded.

**Examples of evidence to demonstrate compliance may include:**
Course outlines
Patient records
Resident evaluations
Record review policy
Documentation of record review

**Other Components**

2-14 The program **must** provide residents with an understanding of rules, regulations, and credentialing processes pertaining to facilities where anesthesia care is provided.

**Intent:** Information about the credentialing processes involved in hospitals, free-standing surgical centers, and private offices should be provided.

**Examples of evidence to demonstrate compliance may include:**
Didactic schedules

2-15 Residents **must** be given assignments that require critical review of relevant scientific literature.

**Intent:** Residents are expected to have the ability to critically review relevant literature as a foundation for lifelong learning and adapting to changes in oral health care.

**Examples of evidence to demonstrate compliance may include:**
Evidence of experiences requiring literature review

2-16 The program **must** conduct and involve residents in a structured system of continuous quality improvement for patient care.
**Intent:** Programs are expected to involve residents in enough quality improvement activities to understand the process and contribute to patient care improvement.

**Examples of evidence to demonstrate compliance may include:**
Description of quality improvement process including the role of residents in that process
Quality improvement plan and reports

**Program Length**

2-17 The duration of a dental anesthesiology program must be a minimum of thirty six (36) months of full-time formal training.

**Examples of evidence to demonstrate compliance may include:**
Program schedules
Written curriculum plan

2-18 Where a program for part-time residents exists, it must be started and completed within a single institution and designed so that the total curriculum can be completed in a period of time not to exceed twice the duration of the program for full-time residents.

**Intent:** Part-time residents may be enrolled, provided the educational experiences are the same as those acquired by full-time residents and the total time spent is the same.

**Examples of evidence to demonstrate compliance may include:**
Description of the part-time program
Documentation of how the part-time residents will achieve similar experiences and skills as full-time residents
Program schedules

**Evaluation**

2-19 The program’s resident evaluation system must assure that, through the director and faculty, each program:

a) Periodically, but at least twice annually, evaluates and documents the resident’s progress towards achieving the program’s written competency requirements and minimum anesthesia case requirements using appropriate written criteria and procedures;
b) Provides residents with an assessment of their performance after each evaluation; where deficiencies are noted, corrective actions must be taken; and
c) Maintains a personal record of evaluation for each resident which is accessible to the resident and available for review during site visits.

**Intent:** While the program may employ evaluation methods that measure a resident’s skills or behavior at a given time, it is expected that the program will, in addition, evaluate the degree to which the resident is making progress toward achieving the specific competency and anesthesia case requirements described in response to Standards 2-1, 2-2, and 2-6.

**Examples of evidence to demonstrate compliance may include:**
- Written evaluation criteria and process
- Resident evaluations
- Resident case logs
- Personal record of evaluation for each resident
- Evidence that corrective actions have been taken
STANDARD 3 – FACULTY AND STAFF

3-1 The program must be administered by a director with at least a forty percent (40%) appointment in the sponsoring or co-sponsoring institution and have authority and responsibility for all aspects of the program.

**Intent:** The program director’s responsibilities include:
1. program administration;
2. development and implementation of the curriculum plan;
3. ongoing evaluation of program content, faculty teaching and resident performance;
4. evaluation of resident training and supervision in affiliated institutions and off-services rotations;
5. maintenance of records related to the educational program; and
6. Resident selection.

It is expected that program directors will devote sufficient time to accomplish the assigned duties and responsibilities. In programs where the program director assigns some duties to other individuals, it is expected that the program will develop a formal plan for such assignments that includes:
1. what duties are assigned;
2. to whom they are assigned; and
3. what systems of communication are in place between the program director and individuals who have been assigned responsibilities.

In those programs where applicants are assigned centrally, responsibility for selection of residents may be delegated to a designee.

**Examples of evidence to demonstrate compliance may include:**
- Program director’s job description
- Job description of individuals who have been assigned some of the program director’s job responsibilities
- Formal plan for assignment of program director’s job responsibilities as described above
- Program records

3-2 The program director must be board certified in dental anesthesia. Program directors appointed after January 1, 2020, who have not previously served as program directors, must be board certified in dental anesthesia. The program director must have
completed a CODA-accredited 36-month anesthesiology residency for dentists consistent with or equivalent to the training program described in Standard 2 of these Accreditation Standards. A two-year anesthesiology residency for dentists completed prior to July 1, 2018 is acceptable. A one-year anesthesiology residency for dentists completed prior to July 1993 is acceptable.

**Intent:** The anesthesiology residency is intended to be a continuous, structured residency program devoted exclusively to anesthesiology.

**Examples of Evidence to demonstrate compliance may include:**
Certificate of completion of anesthesiology residency
Copy of board certification certificate
Letter from board attesting to current/active board certification

3-3 All sites where educational activity occurs must be staffed by faculty who are qualified by education and/or clinical experience in the curriculum areas for which they are responsible and have collective competence in all areas of dental anesthesiology included in the program.

**Intent:** Faculty should have current knowledge at an appropriate level for the curriculum areas for which they are responsible. The faculty, collectively, should have competence in all areas of dental anesthesiology covered in the program.

The program is expected to develop criteria and qualifications that would enable a faculty member to be responsible for a particular area of dental anesthesiology if that faculty member is not trained in dental anesthesiology. The program is expected to evaluate non-discipline specific faculty members who will be responsible for a particular area and document that they meet the program’s criteria and qualifications.

Whenever possible, programs should avail themselves of discipline-specific faculty as trained consultants for the development of a mission and curriculum, and for teaching.

**Examples of evidence to demonstrate compliance may include:**
Full and part-time faculty rosters
Program and faculty schedules
Completed BioSketch of faculty members
Written criteria used to certify a non-discipline specific faculty member as responsible for teaching an area of dental anesthesiology

Dental Anesthesiology Standards
-30-
Program documentation that non-discipline specific faculty members are responsible for teaching an area of dental anesthesiology.

Program documentation that faculty members are responsible for a particular teaching area.

3-4 The number and time commitment of the faculty must be sufficient to provide didactic and clinical instruction to meet curriculum competency requirements and provide supervision of all treatment provided by residents.

**Examples of evidence to demonstrate compliance may include:**
Faculty roster
Clinical and didactic schedules

3-5 A formally defined evaluation process must exist that ensures measurement of the performance of faculty members annually.

**Intent:** The written annual performance evaluations should be shared with the faculty members.

**Examples of evidence to demonstrate compliance may include:**
Faculty files
Performance appraisals

3-6 A faculty member must be present in the clinical care area for consultation, supervision and active teaching when residents are treating patients.

**Examples of evidence to demonstrate compliance may include:**
Faculty clinic schedules

3-7 The program must show evidence of an ongoing faculty development process.

**Intent:** Ongoing faculty development is a requirement to improve teaching and learning, to foster curricular change, to enhance retention and job satisfaction of faculty, and to maintain the vitality of academic dentistry as the wellspring of a learned profession.

**Examples of evidence to demonstrate compliance may include:**
Participation in development activities related to teaching, learning, and assessment
Attendance at regional and national meetings that address contemporary issues in education and patient care
Mentored experiences for new faculty
Scholarly productivity
Presentations at regional and national meetings
Examples of curriculum innovation
Maintenance of existing and development of new and/or emerging clinical skills
Documented understanding of relevant aspects of teaching methodology
Curriculum design and development
Curriculum evaluation
Resident assessment
Cultural Competency
Ability to work with residents of varying ages and backgrounds
Use of technology in didactic and clinical components of the curriculum
Evidence of participation in continuing education activities

3-8 At each site where educational activity occurs, adequate support staff, including allied dental personnel and clerical staff, must be consistently available to allow for efficient administration of the program.

*Intent:* The program should determine the number and participation of allied support and clerical staff to meet the educational and experiential goals and objectives.

Examples of evidence to demonstrate compliance may include:
Staff schedules

3-9 The program must provide ongoing faculty calibration at all sites where educational activity occurs.

*Intent:* Faculty calibration should be defined by the program.

Examples of evidence to demonstrate compliance may include:
Methods used to calibrate faculty as defined by the program
Attendance of faculty meetings where calibration is discussed
Mentored experiences for new faculty
Participation in program assessment
Standardization of assessment of resident
Maintenance of existing and development of new and/or emerging clinical skills
Documented understanding of relevant aspects of teaching methodology
Curriculum design, development and evaluation
Evidence of the ability to work with residents of varying ages and backgrounds
Evidence that rotation goals and objectives have been shared
STANDARD 4 – EDUCATIONAL SUPPORT SERVICES

4-1 The sponsoring institution **must** provide adequate learning resources to support the goals and objectives of the program.

*Intent:* Appropriate information resources should be readily available and include access to electronic databases, biomedical textbooks, dental journals, the internet and other learning resources. Lecture and seminar rooms and study areas for residents should be available.

**Examples of evidence to demonstrate compliance may include:**
Description of resources

Selection of Residents

4-2 Applicants **must** have one of the following qualifications to be eligible to enter the advanced dental education program in dental anesthesiology:

a. Graduates from a predoctoral dental education program accredited by the Commission on Dental Accreditation;

b. Graduates from a predoctoral dental education program in Canada accredited by the Commission on Dental Accreditation of Canada; and

c. Graduates from an international dental school with equivalent educational background and standing as determined by the institution and program.

4-3 Specific written criteria, policies, and procedures **must** be followed when admitting residents.

*Intent:* Written non-discriminatory policies are to be followed in selecting residents. These policies should make clear the methods and criteria used in recruiting and selecting residents and how applicants are informed of their status throughout the selection process.

**Examples of evidence to demonstrate compliance may include:**
Written criteria, policies, and procedures

4-4 Admission of residents with advanced standing **must** be based on the same standards of achievement required by residents regularly enrolled in the program. Residents with
advanced standing **must** receive an appropriate curriculum that results in the same standards of competence required by residents regularly enrolled in the program.

**Intent:** Advanced standing refers to applicants that may be considered for admission to a training program whose curriculum has been modified after taking into account the applicant’s past experience. Examples include transfer from a similar program at another institution, completion of training at a non-CODA accredited program, or documented practice experience in the given discipline. Acceptance of advanced standing residents will not result in an increase of the program’s approved number of enrollees. Applicants for advanced standing are expected to fulfill all of the admission requirements mandated for residents in the conventional program and be held to the same academic standards. Advanced standing residents, to be certified for completion, are expected to demonstrate the same standards of competence as those in the conventional program.

**Examples of evidence to demonstrate compliance may include:**
- Written policies and procedures on advanced standing
- Results of appropriate qualifying examinations
- Course equivalency or other measures to demonstrate equal scope and level of knowledge

**4-5**

The program’s description of the educational experience to be provided **must** be available to program applicants and include:

a) A description of the educational experience to be provided
b) A list of competencies of residency training
c) A description of the nature of assignments to other departments or institutions

**Intent:** Programs are expected to make their lists of competency requirements developed in response to Standards 2-1 and 2-2 available to all applicants to the program. This includes applicants who may not personally visit the program and applicants who are deciding which programs for which to apply. Materials available to applicants who visit the program in person will not satisfy this requirement. A means of making this information available to individuals who do not visit the program is to be developed.

**Examples of evidence to demonstrate compliance may include:**
- Program brochure, application documents or website content
- Description of system for making information available to applicants who do not visit the program
Due Process

4-6 There must be specific written due-process policies and procedures for adjudication of academic and disciplinary complaints that parallel those established by the sponsoring institution.

**Intent:** Adjudication procedures should include institutional policy that provides due process for all individuals who may potentially be involved when actions are contemplated or initiated that could result in dismissal of a resident. Residents should be provided with written information that affirms their obligations and responsibilities to the institution, the program and the faculty. The program information provided to the residents should include, but not necessarily be limited to, information about tuition, stipend or other compensation, vacation and sick leave, practice privileges and other activity outside the educational program, professional liability coverage, due-process policy, and current accreditation status of the program.

**Examples of evidence to demonstrate compliance may include:**
Written policy statements and/or resident contract

Health Services

4-7 Resident, faculty, and appropriate support staff must be encouraged to be immunized against and/or tested for infectious diseases, such as mumps, measles, rubella, and hepatitis B, prior to contact with patients and/or infectious objects or materials, in an effort to minimize the risk of patients and dental personnel.

**Examples of evidence to demonstrate compliance may include:**
Immunization policy and procedure documents
STANDARD 5 - FACILITIES AND RESOURCES

5-1 Institutional facilities and resources **must** be adequate to provide the didactic and clinical experiences and opportunities required to fulfill the needs of the educational program as specified in these Standards. Equipment and supplies for use in managing medical emergencies **must** be readily accessible and functional.

*Intent:* The facilities and resources (e.g., support/secretarial staff, allied personnel, and/or technical staff) should permit the attainment of program competency requirements. To ensure health and safety for patients, residents, faculty, and staff, the physical facilities and equipment should effectively accommodate the educational and patient care programs. Equipment and supplies for delivery of all forms of anesthesia care for dental patients should be readily accessible and functional. There should be a space properly equipped for monitoring patients’ recovery from general anesthesia and sedation.

5-2 In cases where off-campus locations are used in residency clinical education, the facilities, equipment, staffing, and supplies **must** be available in accord with all applicable accrediting bodies and state rules and regulations.

**Examples of evidence to demonstrate compliance may include:**
Certifications of current compliance/accreditation by appropriate governmental/accrediting agencies

5-3 All residents and those faculty utilizing general anesthesia or moderate sedation in the direct provision of patient care **must** be continuously recognized/certified in advanced cardiovascular life support (ACLS) and pediatric advanced life support (PALS).

**Examples of evidence to demonstrate compliance may include:**
Certification/recognition records demonstrating advanced cardiovascular life support training or summary log of certification/recognition maintained by the program

5-4 All other faculty (not included in Standard 5-3) and support staff involved in the direct provision of patient care **must** be continuously recognized/certified in basic life support for health care providers.

**Examples of evidence to demonstrate compliance may include:**
Certification/recognition records demonstrating basic life support training or summary log of certification/recognition maintained by the program

5-5 Secretarial and clerical assistance must be sufficient to permit efficient operation of the program.

**Intent:** The intent is to ensure operations of the program are managed in an efficient and expeditious manner without placing undue hardship on the faculty and residents in the program.

**Examples of evidence to demonstrate compliance may include:**
Staff schedules

5-6 The program must document its compliance with the institution’s policy and applicable regulations of local, state, and federal agencies, including, but not limited to, radiation hygiene and protection, ionizing radiation, hazardous materials, and blood-borne and infectious diseases. Policies must be provided to all residents, faculty, and appropriate support staff and be continuously monitored for compliance. Additionally, policies on blood-borne and infectious diseases must be made available to applicants for admission and to patients.

**Intent:** The policies on blood-borne and infectious diseases must be made available to applicants for admission and patients should a request to review the policy be made.

**Examples of evidence to demonstrate compliance may include:**
Infection and biohazard control policies
Radiation policy

5-7 The program’s policies must ensure that the confidentially of information pertaining to the health status of each individual patient is strictly maintained.

**Examples of evidence to demonstrate compliance may include:**
Confidentiality policy
HIPAA policy
STANDARD 6 – RESEARCH

6-1 Residents must engage in at least one (1) month of scholarly activity and present their results in a scientific/educational forum.

Intent: One (1) month of scholarly activity could be gained in one (1) block or in smaller segments. Scholarly activity may include a hypothesis-driven research project, formal case review or review of literature. Options for advanced academic degrees are highly desirable.
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology Programs

Final Results
INTRODUCTION

At its Winter 2021 meeting, the Commission on Dental Accreditation (CODA) directed that a validity and reliability study be conducted for the Advanced Dental Education Programs in Dental Anesthesiology accreditation standards. The 2021 Accreditation Standards Validity and Reliability Survey - Dental Anesthesiology Programs was designed and implemented as a result of this decision.

CODA, in conjunction with the ADA Health Policy Institute (HPI), designed the survey instrument used for this study (see Appendix). The survey was sent electronically by HPI to a diverse array of groups, including:

- Members of the American Society of Dentist Anesthesiologists
- Recent graduates of CODA-accredited dental anesthesiology programs
- Deans of dental schools in the United States
- Chief administrative officers of the dental service of institutions sponsoring accredited Dental Anesthesiology programs
- Chief administrative officers of the dental service of institutions sponsoring accredited Advanced Education in General Dentistry, General Practice Residency, Oral Medicine, and Orofacial Pain programs
- Directors of accredited Dental Anesthesiology programs
- Directors of accredited Advanced Education in General Dentistry, General Practice Residency, Oral Medicine, and Orofacial Pain programs
- CODA site visitors for Dental Anesthesiology programs
- CODA site visitors for Advanced Education in General Dentistry, General Practice Residency, Oral Medicine, and Orofacial Pain programs
- Presidents of state dental societies
- Chief executive officers of the Federal Dental Services
- Executive directors of state boards of dentistry and clinical testing agencies
- Executive directors of the following national dental organizations:
  - American Association of Public Health Dentistry
  - American Association of Endodontists
  - American Academy of Oral & Maxillofacial Pathology
  - American Association of Oral and Maxillofacial Surgeons
  - American Association of Orthodontists
  - American Academy of Pediatric Dentistry
  - American Academy of Periodontology
  - American Academy of Oral & Maxillofacial Radiology
  - American College of Prosthodontists
  - American Society of Dentist Anesthesiologists
  - American Academy of Oral Medicine
  - American Academy of Orofacial Pain
  - American Board of Dental Public Health
  - American Board of Endodontics
  - American Board of Oral and Maxillofacial Pathology
  - American Board of Oral and Maxillofacial Surgery
  - American Board of Orthodontics
  - American Board of Pediatric Dentistry
  - American Board of Periodontology
  - American Board of Oral and Maxillofacial Radiology
  - American Board of Prosthodontics
  - American Dental Board of Anesthesiology
  - National Dental Board of Anesthesiology
  - American Board of Oral Medicine
  - American Board of Orofacial Pain
  - American Board of General Dentistry
Progress Report on Validity and Reliability Study for Dental Anesthesiology
DentAnes RC
CODA Winter 2022

- American Association of Dental Boards
- Academy of General Dentistry
- American Dental Education Association
- American Student Dental Association
- American Dental Association
A total of 1,138 individuals were invited by email to complete the online survey on April 22, 2021. In order to increase the response rate, follow-up mailings were administered to all non-respondents on May 3 and May 12. Data collection ended on May 18, yielding 291 responses, for an overall adjusted response rate of 25.8% (excluding 11 individuals whose email addresses were undeliverable). A breakdown of responses by category is found on the next page.

### Number of Recipients, Number that Opened Survey, Number of Responses, Unadjusted Response Rate and Abandon Rate by Recipient Category

<table>
<thead>
<tr>
<th>Category</th>
<th>Sent Survey</th>
<th>Opened Survey</th>
<th>Number of Responses</th>
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<td><strong>Total</strong></td>
<td><strong>1,138</strong></td>
<td><strong>455</strong></td>
<td><strong>291</strong></td>
<td><strong>25.6%</strong></td>
<td><strong>36.0%</strong></td>
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1 The Abandon Rate is calculated by subtracting the Number of Responses form the number that Opened Survey, then dividing that result by the number that Opened Survey. It signifies the percentage of survey recipients who accessed the online survey but did not complete it.

The survey had an abandonment rate of 36.0%, meaning that more than one out of every 3 recipients who opened the online survey did not complete it (while nearly two-thirds of recipients who opened the online survey did complete it). The incomplete responses of those who abandoned the survey are not included in this report. It is worth noting that abandonment rates of 20% or higher in an online survey may signify issues to consider with the survey instrument, such as whether the length is appropriate, the difficulty of the questions, whether or not a programming glitch may be present, and the relevance of the survey topic to the recipients.
NOTES TO THE READER

Respondents were asked to rate each criterion in the survey using the following rating scale:

- **Too demanding** = Criterion is relevant to type of program but too demanding for programs and/or residents
- **Sufficiently demanding** = Criterion is relevant to type of program and sufficiently demanding for programs and/or residents
- **Not demanding** = Criterion is relevant but not demanding enough for programs and/or residents
- **Not relevant** = Criterion not relevant to type of program, regardless of how demanding it is for programs and/or residents
- **No opinion** = No opinion on this criterion

The tables in this report provide frequency distributions for each question in the survey overall and by type of respondent. Please note that the respondent categories are based on the samples from which the individuals were drawn. Since many respondents were found in more than one sample, a hierarchy was established to determine the most appropriate category in which to place these individuals. For instance, if an individual appeared in both the dental anesthesiology site visitor and program director samples, that person would be assigned to the program director category.

The report is divided into two main sections: frequencies for the survey questions, and a list of open-ended responses. Each standard is numbered in the frequencies so that it can be cross-referenced with the copy of the survey in the Appendix in order to view the complete wording of the standard.

Although redactions have been made where comments identify a respondent or an educational institution, they are otherwise presented in the report as entered on the survey by respondents; misspellings and typographical errors have **not** been corrected.
Executive Summary – Dental Anesthesiologists

The survey was sent to a 387 dental anesthesiologists in the United States, using membership lists from the American Society of Dentist Anesthesiologists and lists of graduates from accredited dental anesthesiology programs. A total of 128 recipients opened the survey; 63 completed it, yielding a response rate of 16.3% (and a survey abandon rate of 50.8%).

Among all 95 individual “must” statements from the dental anesthesia education program accreditation standards listed in the survey, between 55.6% and 98.4% of the 63 dental anesthesiologists who responded indicated the standards were “Sufficiently demanding.”

The standards that were identified as “Too demanding” by the highest percentage (20.6%) of dental anesthesiologists who completed the survey were:

- Upon completion of training, the resident must be competent in the diagnosis and non-surgical treatment of acute pain related to the head and neck region. (Standard 2-2)
- Residents must engage in at least one (1) month of scholarly activity and present their results in a scientific/educational forum. (Standard 6-1)

The standards that were identified as “Not demanding” by the highest percentage (20.6%) of dental anesthesiologists who completed the survey were part of Standard 2-6 (The following statements represent the minimum clinical experiences that must be obtained by each resident in the program at the completion of training; a. Eight hundred (800) total cases of deep sedation/general anesthesia to include the following):

- 1. Three hundred (300) intubated general anesthetics of which at least fifty (50) are nasal intubations and twenty-five (25) incorporate advanced airway management techniques. No more than ten (10) of the twenty-five (25) advanced airway techniques can be blind nasal intubations. (27.0%)
- 2. One hundred and twenty five (125) children age seven (7) and under, and; (31.8%)

Two standards were identified as “Not relevant” by 11.1% of the dental anesthesiologists who responded to the survey:

- c. Exposure to the management of patients with chronic orofacial pain. (Standard 2-6)
- Where a program for part-time residents exists, it must be started and completed within a single institution and designed so that the total curriculum can be completed in a period of time not to exceed twice the duration of the program for full-time residents. (Standard 2-18)

The three standards with the most dental anesthesiologists having no opinion were:

- United States military programs not sponsored or co-sponsored by military medical treatment facilities, United States-based educational institutions, hospitals or health care organizations accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS) must demonstrate successful achievement of Service-specific organizational inspection criteria. (In Standard 1-1) 20.6%
- Where a program for part-time residents exists, it must be started and completed within a single institution and designed so that the total curriculum can be completed in a period of time not to exceed twice the duration of the program for full-time residents. (Standard 2-18) 20.6%
- The program must be administered by a director with at least a forty percent (40%) appointment in the sponsoring or co-sponsoring institution and have authority and responsibility for all aspects of the program. (Standard 3-1) 15.9%
Executive Summary – Directors of Dental Anesthesiology Education Programs

The survey was sent to eight directors of dental anesthesiology education programs. A total of seven recipients opened and completed the survey, yielding a response rate of 87.5%. Once opened, no program directors abandoned the survey.

Among all 95 individual “must” statements from the dental anesthesiology education program accreditation standards listed in the survey, between 28.6% and 100.0% of the seven dental anesthesiology program directors who responded indicated the standards were “Sufficiently demanding.”

The standards that were identified as “Too demanding” by two dental anesthesiology program directors (28.6%) were:

- i. Upon completion of training, the resident must be familiar with the diagnosis and treatment of chronic pain related to the head and neck region; and; (Standard 2-2)
- a2. One hundred and twenty five (125) children age seven (7) and under, and; (Standard 2-6)

The standards that were identified as “Not demanding” by the highest percentage (42.9%) of dental anesthesiology program directors who completed the survey were part of Standard 2-6 (The following statements represent the minimum clinical experiences that must be obtained by each resident in the program at the completion of training; a. Eight hundred (800) total cases of deep sedation/general anesthesia to include the following:)

- a1. Three hundred (300) intubated general anesthetics of which at least fifty (50) are nasal intubations and twenty-five (25) incorporate advanced airway management techniques. No more than ten (10) of the twenty-five (25) advanced airway techniques can be blind nasal intubations.
- a3. Seventy-five (75) patients with special needs.

Three standards, all in Standard 2, were identified as “Not relevant” by two or more dental anesthesiology program directors who completed the survey:

- Where a program for part-time residents exists, it must be started and completed within a single institution and designed so that the total curriculum can be completed in a period of time not to exceed twice the duration of the program for full-time residents. (Standard 2-18) 42.9%
- i. Upon completion of training, the resident must be familiar with the diagnosis and treatment of chronic pain related to the head and neck region; and; (Standard 2-2) 28.6%
- c. Exposure to the management of patients with chronic orofacial pain. (Standard 2-6) 28.6%

No more than one dental anesthesiology program director had no opinion on any standard.
Executive Summary – Directors of Other Education Programs

The survey was sent to 281 directors of advanced education in general dentistry, general practice residency, oral medicine, and orofacial pain programs. A total of 151 recipients opened the survey, and 105 completed the survey, yielding a response rate of 37.4% (and an abandoned rate of 30.5%).

Among all 95 individual “must” statements from the dental anesthesiology program accreditation standards listed in the survey, between 62.9% and 92.4% of the 105 other program directors who responded indicated the standards were “Sufficiently demanding.”

No standards were identified as “Too demanding” by more than 9% of the 105 other program directors who completed the survey.

The three standards that were identified as “Not demanding” by highest percentage of other program directors who completed the survey were:

- The program must be administered by a director with at least a forty percent (40%) appointment in the sponsoring or co-sponsoring institution and have authority and responsibility for all aspects of the program. (Standard 3-1) 21.9%
- Applicants must have one of the following qualifications to be eligible to enter the advanced dental education program in dental anesthesiology:
  - Graduates from a predoctoral dental education program accredited by the Commission on Dental Accreditation;
  - Graduates from a predoctoral dental education program in Canada accredited by the Commission on Dental Accreditation of Canada; and
  - Graduates from an International dental school with equivalent educational background and standing as determined by the institution and program. (Standard 4-2) 18.1%
- The program’s resident evaluation system must assure that, through the director and faculty, each program: Periodically, but at least twice annually, evaluates and documents the resident’s progress towards achieving the program’s written competency requirements and minimum anesthesia case requirements using appropriate written criteria and procedures; (Standard 2-19) 18.1%

No standards were identified as “Not relevant” by more than 3% of the 105 other program directors who completed the survey.

The four standards for which 20% or more of the respondents in this group had no opinion were part of Standard 2-6 (The following statements represent the minimum clinical experiences that must be obtained by each resident in the program at the completion of training:).

- a. Eight hundred (800) total cases of deep sedation/general anesthesia to include the following: 21.0%
  - a1. Three hundred (300) intubated general anesthetics of which at least fifty (50) are nasal intubations and twenty-five (25) incorporate advanced airway management techniques. No more than ten (10) of the twenty-five (25) advanced airway techniques can be blind nasal intubations. 20.0%
  - a2. One hundred and twenty five (125) children age seven (7) and under, and; 21.9%
  - a3. Seventy-five (75) patients with special needs. 20.0%
Executive Summary – Chief Administrative Officers and Dental School Deans

The survey was sent to six chief administrative officers (CAOs) of institutions sponsoring accredited dental anesthesiology education programs, 169 CAOs of institutions sponsoring accredited advanced education in general dentistry, general practice residency, oral medicine, and orofacial pain programs, and 67 deans of dental schools accredited by CODA. A total of 100 recipients opened the survey; 62 completed the survey, yielding a response rate of 25.6% (and a survey abandon rate of 38.0%).

Among all 95 individual “must” statements from the dental anesthesiology education program accreditation standards listed in the survey, between 66.1% and 96.8% of CAOs and dental school deans who responded indicated the standards were “Sufficiently demanding.”

No standards were identified as “Too demanding” by more than 9% of the 62 CAOs and dental school deans who completed the survey.

The two standards that were identified as “Not demanding” by the highest percentage of the 62 CAOs and dental school deans who completed the survey were:

- The program must be administered by a director with at least a forty percent (40%) appointment in the sponsoring or co-sponsoring institution and have authority and responsibility for all aspects of the program. (Standard 3-1) 24.2%
- Residents must engage in at least one (1) month of scholarly activity and present their results in a scientific/educational forum. (Standard 6-1) 19.4%

No standards were identified as “Not relevant” by more than 5% of the 62 CAOs and dental school deans who completed the survey.

More than 10% of respondents in this group had no opinion on six parts of Standard 2:

- The first four were part of Standard 2-6 (The following statements represent the minimum clinical experiences that must be obtained by each resident in the program at the completion of training):
  - a. Eight hundred (800) total cases of deep sedation/general anesthesia to include the following: 16.1%
  - a.1. Three hundred (300) intubated general anesthetics of which at least fifty (50) are nasal intubations and twenty-five (25) incorporate advanced airway management techniques. No more than ten (10) of the twenty-five (25) advanced airway techniques can be blind nasal intubations. 14.5%
  - a.2. One hundred and twenty five (125) children age seven (7) and under, and; 12.9%
  - a.3. Seventy-five (75) patients with special needs. 14.5%
- 1. At the completion of the program, each resident must have the following experiences in the administration of the full spectrum of anesthesia service for same-day surgery dental patients: At least one hundred (100) cases of the experiences listed in Standard 2-6 in outpatient anesthesia for dentistry that are supervised by dentist anesthesiologists. (Standard 2-9) 12.9%
- Where a program for part-time residents exists, it must be started and completed within a single institution and designed so that the total curriculum can be completed in a period of time not to exceed twice the duration of the program for full-time residents. (Standard 2-18) 11.3%
Executive Summary –Dental Anesthesiology Education Program Site Visitors

The survey was sent to 12 dental anesthesiology education program site visitors. A total of 10 recipients opened the survey, and 7 completed it, yielding a response rate of 58.3% (and a survey abandon rate of 30.0%).

Among all 95 individual “must” statements from the dental anesthesiology education program accreditation standards listed in the survey, between 57.1% and 100.0% of the seven dental anesthesiology site visitors who responded indicated the standards were “Sufficiently demanding.”

The standard with the largest percentage of dental anesthesiology site visitors selecting “Too demanding” (28.6%) was: The institutional staff bylaws, rules, and regulations of sponsoring, co-sponsoring or affiliated health care institutions must ensure that dentists are eligible for staff membership and privileges including the right to: c. Admit, manage and discharge patients. (Standard 1-6)

The standards that were identified as “Not demanding” by the highest percentage (42.9%) of dental anesthesiology site visitors who completed the survey were:

- The program must develop a mission statement and supporting written overall program goals and objectives that emphasize: c. Patient care and include training residents to provide dental anesthesia care in office-based and hospital settings. (Standard 1-8)
- Three parts of Standard 2-6 (The following statements represent the minimum clinical experiences that must be obtained by each resident in the program at the completion of training; a. Eight hundred (800) total cases of deep sedation/general anesthesia to include the following:).
  - 1. Three hundred (300) intubated general anesthetics of which at least fifty (50) are nasal intubations and twenty-five (25) incorporate advanced airway management techniques. No more than ten (10) of the twenty-five (25) advanced airway techniques can be blind nasal intubations.
  - 2. One hundred and twenty five (125) children age seven (7) and under, and;
  - 3. Seventy-five (75) patients with special needs.
- The program must be administered by a director with at least a forty percent (40%) appointment in the sponsoring or co-sponsoring institution and have authority and responsibility for all aspects of the program. (Standard 3-1)

The two standards that were identified as “Not relevant” by the highest percentage (28.6%) of the dental anesthesiology site visitors who completed the survey were:

- Where a program for part-time residents exists, it must be started and completed within a single institution and designed so that the total curriculum can be completed in a period of time not to exceed twice the duration of the program for full-time residents. (Standard 2-18)
- Residents with advanced standing must receive an appropriate curriculum that results in the same standards of competence required by residents regularly enrolled in the program. (Standard 4-4)

The only standard where any dental anesthesiology site visitors had no opinion was: United States military programs not sponsored or co-sponsored by military medical treatment facilities, United States-based educational institutions, hospitals or health care organizations accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS) must demonstrate successful achievement of Service-specific organizational inspection criteria. (Standard 1-1) 28.6%
Executive Summary – Other Program Site Visitors

The survey was sent to 63 site visitors of advanced education in general dentistry, general practice residency, oral medicine, and orofacial pain programs. A total of 33 recipients opened the survey, and 28 completed it, yielding a response rate of 44.0% (and a survey abandon rate of 15.2%).

Among all 95 individual “must” statements from the dental anesthesiology education program accreditation standards listed in the survey, between 60.7% and 89.3% of the 28 other site visitors who responded indicated the standards were “Sufficiently demanding.”

The two standards with the largest percentage of other site visitors selecting “Too demanding” (10.7% each) were part of Standard 2-6 (The following statements represent the minimum clinical experiences that must be obtained by each resident in the program at the completion of training;).

- a. Eight hundred (800) total cases of deep sedation/general anesthesia to include the following:
- a3. Seventy-five (75) patients with special needs.

The standards that were identified as “Not demanding” by the highest percentage of other site visitors who completed the survey were:
- The program must be administered by a director with at least a forty percent (40%) appointment in the sponsoring or co-sponsoring institution and have authority and responsibility for all aspects of the program. (Standard 3-1) 28.6%
- Residents must engage in at least one (1) month of scholarly activity and present their results in a scientific/educational forum. (Standard 6-1) 28.6%
- The program’s resident evaluation system must assure that, through the director and faculty, each program: Periodically, but at least twice annually, evaluates and documents the resident’s progress towards achieving the program’s written competency requirements and minimum anesthesia case requirements using appropriate written criteria and procedures; (Standard 2-19) 21.4%

No more than 8% of other site visitors who responded to the survey identified any standard as “Not relevant.”

The standard with the highest percentage of other site visitors who had no opinion was: Where a program for part-time residents exists, it must be started and completed within a single institution and designed so that the total curriculum can be completed in a period of time not to exceed twice the duration of the program for full-time residents. (Standard 2-18) 17.9%
Executive Summary – Leaders of National Dental Organizations

The survey was sent to the executive directors of five clinical testing agencies and 30 national dental organizations, as well as four chiefs of federal dental services. Of the 39 total recipients in this group, nine opened the survey, and seven completed the survey, yielding a response rate of 17.9% (and a survey abandon rate of 22.2%).

Among all 95 individual “must” statements from the dental anesthesiology education program accreditation standards listed in the survey, between 57.1% and 100.0% of the seven leaders of national dental organizations who responded indicated the standards were “Sufficiently demanding.”

No standard was identified as “Too demanding” by more than one of the seven leaders of national dental organizations (14.3%) who completed the survey.

The standard that were identified as “Not demanding” by the highest percentage of leaders of national dental organizations who completed the survey was: The program must be administered by a director with at least a forty percent (40%) appointment in the sponsoring or co-sponsoring institution and have authority and responsibility for all aspects of the program. (Standard 3-1) 28.6%

No standard was identified as “Not relevant” by more than one of the seven leaders of national dental organizations (14.3%) who completed the survey.

28.6% of respondents in this group had no opinion on six standards:

- The first three were part of Standard 2-6 (The following statements represent the minimum clinical experiences that must be obtained by each resident in the program at the completion of training):
  - a. Eight hundred (800) total cases of deep sedation/general anesthesia to include the following:
    - a1. Three hundred (300) intubated general anesthetics of which at least fifty (50) are nasal intubations and twenty-five (25) incorporate advanced airway management techniques. No more than ten (10) of the twenty-five (25) advanced airway techniques can be blind nasal intubations.
    - a2. One hundred and twenty five (125) children age seven (7) and under;
- At the completion of the program, each resident must have the following experiences in the administration of the full spectrum of anesthesia service for same-day surgery dental patients: Experience as the provider of supervised anesthesia care. (Standard 2-9)
- The program must provide residents with an understanding of rules, regulations, and credentialing processes pertaining to facilities where anesthesia care is provided. (Standard 2-14)
- The program director must have completed a CODA-accredited 36-month anesthesiology residency for dentists consistent with or equivalent to the training program described in Standard 2 of these Accreditation Standards. (A two-year anesthesiology residency for dentists completed prior to July 1, 2018 is acceptable. A one-year anesthesiology residency for dentists completed prior to July 1993 is acceptable.) (Standard 3-2)
Executive Summary – Leaders of State Dental Organizations

The survey was sent to the executive directors of state dental boards and presidents of state dental societies (53 in each group). Of the 106 total recipients in this group, 17 opened the survey, and 12 completed the survey, yielding a response rate of 11.3% (and a survey abandon rate of 29.4%).

Among all 95 individual “must” statements from the dental anesthesiology education program accreditation standards listed in the survey, between 58.3% and 100.0% of the 12 leaders of state dental organizations who responded indicated the standards were “Sufficiently demanding.”

The standard that was identified as “Too demanding” by the largest percentage (16.7%) of state dental organization leaders who responded to the survey was: The program director must be board certified in dental anesthesiology; program directors appointed after January 1, 2020, who have not previously served as program directors, must be board certified in dental anesthesiology. (Standard 3-2)

The two standards that were identified as “Not demanding” by the highest percentage (25.0%) of state dental organization leaders who responded to the survey were:
- At a minimum, a total of twenty-four (24) months over a thirty-six (36) month period must be devoted exclusively to clinical training in anesthesia, of which a minimum of six (6) months are devoted to dental anesthesiology. (Standard 2-7)
- The program must be administered by a director with at least a forty percent (40%) appointment in the sponsoring or co-sponsoring institution and have authority and responsibility for all aspects of the program. (Standard 3-1)

No standard was identified as “Not relevant” by more than one of the 12 leaders of state dental organizations (8.3%) who completed the survey.

25.0% of respondents in this group had no opinion on six standards:
- b. Clinical experiences sufficient to meet the competency requirements (described in Standard 2-1 and 2-2) in managing ambulatory patients, geriatric patients, patients with physical status ASA III or greater, and patients requiring moderate sedation; (Standard 2-6)
- At the completion of the program, each resident must have the following experiences in the administration of the full spectrum of anesthesia service for same-day surgery dental patients: At least one hundred (100) cases of the experiences listed in Standard 2-6 in outpatient anesthesia for dentistry that are supervised by dentist anesthesiologists. (Standard 2-9)
- Residents must participate in at least four (4) months of clinical rotations from the following list:
  - Cardiology
  - Emergency medicine
  - General/ internal medicine
  - Intensive care
  - Pain medicine
  - Pediatrics
  - Pre-anesthetic assessment clinic (max. one [1] month), and
  - Pulmonary medicine (Standard 2-10)
- If more than one rotation is selected [from the list in Question 24], each must be at least one month in length. (Standard 2-10)
- The duration of a dental anesthesiology program must be a minimum of thirty six (36) months of full-time formal training. (Standard 2-17)
- The program must show evidence of an ongoing faculty development process. (Standard 3-7)
Advanced Dental Education Programs in Dental Anesthesiology
Accreditation Standards
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

STANDARD 1: INSTITUTIONAL AND PROGRAM EFFECTIVENESS

(ST1-1.1) 1. The program must be sponsored or co-sponsored by either a United States-based hospital, or educational institution or health care organization that is affiliated with an accredited hospital.

<table>
<thead>
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<th>Field</th>
<th>Dental Anesthesiologist</th>
<th>PD. DentAnes</th>
<th>PD. Other</th>
<th>Dean/CAO</th>
<th>SV. DentAnes</th>
<th>SV. Other</th>
<th>Nat'l Org</th>
<th>State Org</th>
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<td>87.3% 55</td>
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<td>86.7% 81</td>
<td>85.7% 55</td>
<td>85.7% 6</td>
<td>85.7% 24</td>
<td>85.7% 8</td>
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<tr>
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<td>1.6% 1</td>
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<td>106</td>
<td>62</td>
<td>7</td>
<td>28</td>
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</table>

(ST1-1.2) 2. Each sponsoring and co-sponsoring institution must be accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS).
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(ST1-1.3) 3. United States military programs not sponsored or co-sponsored by military medical treatment facilities, United States-based educational institutions, hospitals or health care organizations accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS) must demonstrate successful achievement of Service-specific organizational inspection criteria.

<table>
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<tr>
<th>Field</th>
<th>Dental Anesthesiologist</th>
<th>PD-DentAnes</th>
<th>PD-Other</th>
<th>Dean/CAO</th>
<th>SV-DentAnes</th>
<th>SV-Other</th>
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<th>State Org</th>
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<td>1.6%</td>
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<tr>
<td>Sufficiently demanding</td>
<td>68.3%</td>
<td>43%</td>
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<td>62</td>
<td>7</td>
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(ST1-2) 4. The sponsoring institution must ensure that support from entities outside of the institution does not compromise the teaching, clinical and research components of the program.

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<thead>
<tr>
<th>Field</th>
<th>Dental Anesthesiologist</th>
<th>PD-DentAnes</th>
<th>PD-Other</th>
<th>Dean/CAO</th>
<th>SV-DentAnes</th>
<th>SV-Other</th>
<th>Nat’l Org</th>
<th>State Org</th>
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<td>1.0%</td>
<td>1.6%</td>
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<td>53%</td>
<td>83.8%</td>
<td>91.9%</td>
<td>87.1%</td>
<td>66%</td>
<td>71.4%</td>
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<tr>
<td>Not demanding</td>
<td>7.9%</td>
<td>28.6%</td>
<td>15.2%</td>
<td>9.7%</td>
<td>14.3%</td>
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<tr>
<td>Total</td>
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2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(ST1-3) 5. The authority and final responsibility for curriculum development and approval, resident selection, faculty selection, and administrative matters must rest within the sponsoring institution.

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(ST1-4) 6. The financial resources must be sufficient to support the program’s stated purpose/mission and goals and objectives.

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(ST1-5) 7. Arrangements with all sites not owned by the sponsoring institution where educational activity occurs must be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved.

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(ST1-6) 8. The institutional staff bylaws, rules, and regulations of sponsoring, co-sponsoring or affiliated health care institutions must ensure that dentists are eligible for staff membership and privileges including the right to:

a. Vote and hold office:

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2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(continued, ST1-6) 8. The institutional staff bylaws, rules, and regulations of sponsoring, co-sponsoring or affiliated health care institutions must ensure that dentists are eligible for staff membership and privileges including the right to:

b. Serve on institutional staff committees; and

c. Admit, manage and discharge patients.

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2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(ST1-7) 9. Dental residents must be appointed to the staff of the sponsoring, co-sponsoring or affiliated health care institution and enjoy the same privileges and responsibilities provided residents in other professional education programs.
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(ST1-8) 10. The program must develop a mission statement and supporting written overall program goals and objectives that emphasize:

a. Anesthesia for dentistry;

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b. Resident education; and

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c. Patient care and include training residents to provide dental anesthesia care in office-based and hospital settings.
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2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(ST1-9) 11. The program must have a formal and ongoing outcomes assessment process that regularly evaluates the degree to which the program’s written goals and objectives are being met.

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Ethics and Professionalism

(ST1.11) 12. The program must ensure that residents are able to demonstrate the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management.

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Page 1500
Appendix 2
Subpage 23
Progress Report on Validity and Reliability Study for Dental Anesthesiology
DentAnes RC
CODA Winter 2022
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

STANDARD 2 - EDUCATIONAL PROGRAM

Curriculum Content

(ST2-1) 13. The program must list the written competency requirements that describe the intended outcomes of residents' education such that residents completing the program in dental anesthesiology receive training and experience in providing anesthesia care in the most comprehensive manner using pharmacologic and non-pharmacologic methods to manage anxiety and pain in adult and child dental patients, including patients with special needs.

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2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(ST2-2) 14. Upon completion of training, the resident must be:

a. able to demonstrate in-depth knowledge of the anatomy and physiology of the human body and its response to the various pharmacologic agents used in anxiety and pain control;

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b. able to demonstrate in-depth knowledge of the pathophysiology and clinical medicine related to disease of the human body and effects of various pharmacological agents used in anxiety and pain control when these conditions are present;
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(continued, ST2-2) 14. Upon completion of training, the resident must be:

c. competent in evaluating, selecting and determining the potential response and risk associated with various forms of anxiety and pain control modalities based on patients’ physiological and psychological factors;

d. competent in patient preparation for sedation/anesthesia, including pre-operative and post-operative instructions and informed consent/assent;

e. competent in the use of anesthesia-related equipment for the delivery of anesthesia, patient monitoring, and emergency management;

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Data compiled by DentAnes RC for CODA Winter 2022
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(continued, ST2-2) 14. Upon completion of training, the resident must be:

f. competent in the administration of local anesthesia, sedation, and general anesthesia, as well as in psychological management and behavior modification as they relate to anxiety and pain control in dentistry;

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g. competent in managing perioperative emergencies and complications related to anxiety and pain control procedures, including the immediate establishment of an airway and maintenance of ventilation and circulation;

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2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(continued, ST2-2) 14. Upon completion of training, the resident must be:

h. competent in the diagnosis and non-surgical treatment of acute pain related to the head and neck region;

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i. familiar with the diagnosis and treatment of chronic pain related to the head and neck region; and

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2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(continued, ST2-2) 14. Upon completion of training, the resident must be:

j. able to demonstrate in-depth knowledge of current literature pertaining to dental anesthesiology.

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(ST2-3) 15. The program must have a written curriculum plan including structured didactic instruction and clinical experience designed to achieve the program’s written competency requirements.

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<td>93.5% 58</td>
<td>85.7% 6</td>
<td>95.7% 24</td>
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2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

Didactic Components

(ST2-4) 16. Didactic instruction at an advanced and in-depth level beyond that of the pre-doctoral dental curriculum must be provided and include:

a. Applied biomedical sciences foundational to dental anesthesiology;

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Progress Report on Validity and Reliability Study for Dental Anesthesiology

2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(continued, ST2-4) 16. Didactic instruction at an advanced and in-depth level beyond that of the pre-doctoral dental curriculum must be provided and include:

d. Methods of anxiety and pain control;

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e. Complications and emergencies;

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f. Pain management; and
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(continued, ST2-4) 16. Didactic instruction at an advanced and in-depth level beyond that of the pre-doctoral dental curriculum must be provided and include:

g. Critical evaluation of literature.
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

STANDARD 2 - EDUCATIONAL PROGRAM (continued)

Clinical Components

(ST2-5) 17. The program must ensure the availability of adequate patient experiences in both number and variety that afford all residents the opportunity to achieve the program’s stated goals and competency requirements in dental anesthesiology.

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</table>

(ST2-6a) 18. The following statements represent the minimum clinical experiences that must be obtained by each resident in the program at the completion of training:

a. Eight hundred (800) total cases of deep sedation/general anesthesia to include the following:

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<thead>
<tr>
<th>Field</th>
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<th>SV-Other</th>
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<td>5.7%</td>
<td>8.1%</td>
<td>0.0%</td>
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<td>85.7%</td>
<td>6.9%</td>
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<td>44.0%</td>
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<tr>
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<td>5.7%</td>
<td>4.8%</td>
<td>3.0%</td>
<td>28.6%</td>
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<td>21.0%</td>
<td>18.1%</td>
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<td>82.0%</td>
<td>7.0%</td>
<td>28.0%</td>
<td>33.3%</td>
<td>4.0%</td>
</tr>
</tbody>
</table>
(continued, ST2-6a) 18. The following statements represent the minimum clinical experiences that must be obtained by each resident in the program at the completion of training:

1. Three hundred (300) intubated general anesthetics of which at least fifty (50) are nasal intubations and twenty-five (25) incorporate advanced airway management techniques. No more than ten (10) of the twenty-five (25) advanced airway techniques can be blind nasal intubations.

<table>
<thead>
<tr>
<th>Field</th>
<th>Dental Anesthesiologist</th>
<th>PD-DentAnes</th>
<th>PD-Other</th>
<th>Dean/CAO</th>
<th>SV-DentAnes</th>
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<tr>
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<td>66.7% 70</td>
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<td>57.1% 4</td>
<td>71.4% 20</td>
<td>57.1% 8</td>
<td>65.7% 8</td>
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<td>28.6% 2</td>
<td>33.3% 4</td>
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<td>165 82</td>
<td>7 28 7</td>
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<td></td>
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</table>

2. One hundred and twenty five (125) children age seven (7) and under, and
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(continued, ST2-6a) 18. The following statements represent the minimum clinical experiences that must be obtained by each resident in the program at the completion of training:

3. Seventy-five (75) patients with special needs.

b. Clinical experiences sufficient to meet the competency requirements (described in Standard 2-1 and 2-2) in managing ambulatory patients, geriatric patients, patients with physical status ASA III or greater, and patients requiring moderate sedation;

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<th>Field</th>
<th>Dental Anesthesiologist</th>
<th>PD-DentAnes</th>
<th>PD-Other</th>
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<th>SV-DentAnes</th>
<th>SV-Other</th>
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<tr>
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<td>53</td>
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<td>17.9%</td>
<td>17.9%</td>
<td>17.9%</td>
<td>0%</td>
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<td></td>
</tr>
<tr>
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<td>8</td>
<td>3%</td>
<td>42.9%</td>
<td>11.3%</td>
<td>42.9%</td>
<td>17.9%</td>
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<td>Total</td>
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<td>7</td>
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</table>
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(continued, ST2-6a) 18. The following statements represent the minimum clinical experiences that must be obtained by each resident in the program at the completion of training:

c. Exposure to the management of patients with chronic orofacial pain.

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<th>Field</th>
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<th>Dean/CAO</th>
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<td>14.3% 1</td>
<td>3.8% 1</td>
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<td>67.9% 19</td>
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</table>
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

General Anesthesia Experience/Anesthesia Service

(ST2-7) 19. At a minimum, a total of twenty-four (24) months over a thirty-six (36) month period must be devoted exclusively to clinical training in anesthesiology, of which a minimum of six (6) months are devoted to dental anesthesiology.

<table>
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<th>Field</th>
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<td>78.1% 82</td>
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<td>71.4% 8</td>
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<td>13.3% 14</td>
<td>8.1% 5</td>
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<td>62</td>
<td>7</td>
<td>28</td>
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</table>

(ST2-8) 20. Residents must be assigned full-time for a minimum of twelve (12) months over a thirty six (36) month period to a hospital anesthesia service that provides trauma and/or emergency surgical care.

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<tr>
<th>Field</th>
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<th>PD-DentAnes</th>
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<td>0.0% 0</td>
<td>0.0% 0</td>
</tr>
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<td>78.6% 22</td>
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<td>83.3% 10</td>
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<td>12</td>
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</table>
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

Outpatient Anesthesia for Dentistry

(ST2-9) 21. At the completion of the program, each resident must have the following experiences in the administration of the full spectrum of anesthesia service for same-day surgery dental patients:

a. At least one hundred (100) cases of the experiences listed in Standard 2-6 in outpatient anesthesia for dentistry that are supervised by dentist anesthesiologists.

<table>
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<tr>
<th>Field</th>
<th>Dental Anesthesiologist</th>
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<td>72.4%</td>
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<td>71.4%</td>
<td>67.9%</td>
<td>85.7%</td>
</tr>
<tr>
<td>Not demanding</td>
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<td>8.6%</td>
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<td>28</td>
<td>7</td>
<td>12</td>
</tr>
</tbody>
</table>

b. Experience as the provider of supervised anesthesia care.
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

**Medicine Rotations**

(ST2-10.1) 22. Residents must participate in at least four (4) months of clinical rotations from the following list:

- Cardiology
- Emergency medicine
- General/internal medicine
- Intensive care
- Pain medicine
- Pediatrics
- Pre-anesthetic assessment clinic (max. one [1] month)
- Pulmonary medicine

<table>
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<th>PD-Other</th>
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<td>97.1%</td>
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<td>14.3%</td>
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(ST2-10.2) 23. If more than one rotation is selected [from the above list], each must be at least one month in length.
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(ST2-11) 24. Each assigned rotation or experience must have:

a. Written objectives that are developed in cooperation with the department chairperson, service chief, or facility director to which the residents are assigned;

b. Resident supervision by designated faculty who are familiar with the objectives of the rotation or experience; and

c. Evaluations performed by designated faculty.
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

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(ST2-12) 25. Residents must be competent to request and respond to requests for consultations from dentists, physicians, and other health care providers.

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(ST2-13) 26. The program must provide instruction and clinical experience in physical evaluation and medical risk assessment, including:

a. Taking, recording, and interpreting a complete medical history;
### 2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

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b. Understanding the indications of and interpretations of laboratory studies and other techniques used in physical diagnosis and preoperative evaluation;
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(continued, ST2-13) 26. The program must provide instruction and clinical experience in physical evaluation and medical risk assessment, including:

c. Interpreting the physical evaluation performed by a physician with an understanding of the process, terms, and techniques employed; and

d. Using the techniques of physical examination (i.e., inspection, palpation, percussion, and auscultation).
Other Components

(ST2-14) 27. The program must provide residents with an understanding of rules, regulations, and credentialing processes pertaining to facilities where anesthesia care is provided.

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(ST2-15) 28. Residents must be given assignments that require critical review of relevant scientific literature.

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(ST2-16) 29. The program must conduct and involve residents in a structured system of continuous quality improvement for patient care.
### 2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

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2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

Program Length

(ST2-17) 30. The duration of a dental anesthesiology program must be a minimum of thirty six (36) months of full-time formal training.

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(ST2-18) 31. Where a program for part-time residents exists, it must be started and completed within a single institution and designed so that the total curriculum can be completed in a period of time not to exceed twice the duration of the program for full-time residents.

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2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

Evaluation

(ST2-19) 32. The program's resident evaluation system must assure that, through the director and faculty, each program:

a. Periodically, but at least twice annually, evaluates and documents the resident's progress towards achieving the program's written competency requirements and minimum anesthesia case requirements using appropriate written criteria and procedures;

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b. Provides residents with an assessment of their performance after each evaluation; where deficiencies are noted, corrective actions must be taken; and

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2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(continued, ST2-19) 32. The program's resident evaluation system must assure that, through the director and faculty, each program:

c. Maintains a personal record of evaluation for each resident which is accessible to the resident and available for review during site visits.

<table>
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STANDARD 3 - FACULTY AND STAFF

(ST3-1) 33. The program must be administered by a director with at least a forty percent (40%) appointment in the sponsoring or co-sponsoring institution and have authority and responsibility for all aspects of the program.

(ST3-2.1) 34. The program director must be board certified in dental anesthesiology; program directors appointed after January 1, 2020, who have not previously served as program directors, must be board certified in dental anesthesiology.
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(ST3-2.2) 35. The program director must have completed a CODA-accredited 36-month anesthesiology residency for dentists consistent with or equivalent to the training program described in Standard 2 of these Accreditation Standards. (A two-year anesthesiology residency for dentists completed prior to July 1, 2018 is acceptable. A one-year anesthesiology residency for dentists completed prior to July 1993 is acceptable.)

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(ST3-3) 36. All sites where educational activity occurs must be staffed by faculty who are qualified by education and/or clinical experience in the curriculum areas for which they are responsible and have collective competence in all areas of dental anesthesiology included in the program.

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2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(ST3-4) 37. The number and time commitment of the faculty must be sufficient to provide didactic and clinical instruction to meet curriculum competency requirements and provide supervision of all treatment provided by residents.

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2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(ST3-5) 38. A formally defined evaluation process must exist that ensures measurement of the performance of faculty members annually.

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(ST3-6) 39. A faculty member must be present in the clinical care area for consultation, supervision and active teaching when residents are treating patients.

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(ST3-7) 40. The program must show evidence of an ongoing faculty development process.
### 2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

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2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(ST3-8) 41. At each site where educational activity occurs, adequate support staff, including allied dental personnel and clerical staff, must be consistently available to allow for efficient administration of the program.

<table>
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</table>

(ST3-9) 42. The program must provide ongoing faculty calibration at all sites where educational activity occurs.

<table>
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<th>Field</th>
<th>Dental Anesthesiologist</th>
<th>PD-DentAnes</th>
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<th>SV-DentAnes</th>
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<th>State Org</th>
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<td>0.0% 0</td>
<td>14.3% 1</td>
<td>0.0% 0</td>
</tr>
<tr>
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<tr>
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</table>
STANDARD 4 - EDUCATIONAL SUPPORT SERVICES

(ST4-1) 43. The sponsoring institution must provide adequate learning resources to support the goals and objectives of the program.

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<th>Dental Anesthesiologist</th>
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<th>SV-DentAnes</th>
<th>SV-Other</th>
<th>Nat’l Org</th>
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<tbody>
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<td>0.0%</td>
<td>0.0%</td>
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<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
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<td>95.2%</td>
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</tr>
<tr>
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<tr>
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</table>

Selection of Residents

(ST4-2) 44. Applicants must have one of the following qualifications to be eligible to enter the advanced dental education program in dental anesthesiology:

- Graduates from a predoctoral dental education program accredited by the Commission on Dental Accreditation;
- Graduates from a predoctoral dental education program in Canada accredited by the Commission on Dental Accreditation of Canada; and
- Graduates from an International dental school with equivalent educational background and standing as determined by the institution and program.
### 2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

#### (ST4-3) 45. Specific written criteria, policies and procedures must be followed when admitting residents.

<table>
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<tr>
<th>Field</th>
<th>Dental Anesthesiologist</th>
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<th>PD-Other</th>
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<th>SV-DentAnes</th>
<th>SV-Other</th>
<th>Nat’l Org</th>
<th>State Org</th>
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<td>0% 0</td>
<td>0% 0</td>
<td>0% 0</td>
</tr>
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<td>85.7% 6</td>
<td>84.8% 88</td>
<td>91.3% 57</td>
<td>100% 7</td>
<td>85.7% 24</td>
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<td>0% 0</td>
<td>0% 0</td>
<td>0% 0</td>
<td>0% 0</td>
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<td>Total</td>
<td>63 7</td>
<td>105 62</td>
<td>7 26</td>
<td>7 12</td>
<td></td>
<td></td>
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</table>

#### (ST4-4.1) 46. Admission of students/residents with advanced standing must be based on the same standards of achievement required by residents regularly enrolled in the program.

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<th>Nat’l Org</th>
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<td>0% 0</td>
<td>0% 0</td>
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<td>84.1% 53</td>
<td>57.1% 4</td>
<td>80.0% 84</td>
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<td>85.7% 6</td>
<td>82.1% 23</td>
<td>100% 91.7</td>
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<td>14.3% 1</td>
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<td>14.3% 4</td>
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<td>14.3% 1</td>
<td>0% 0</td>
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</tr>
<tr>
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<td>5.7% 6</td>
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<td>8.3% 1</td>
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<tr>
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<td>105 62</td>
<td>7 28</td>
<td>7 12</td>
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#### (ST4-4.2) 47. Residents with advanced standing must receive an appropriate curriculum that results in the same standards of competence required by residents regularly enrolled in the program.

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<th>SV-Other</th>
<th>Nat’l Org</th>
<th>State Org</th>
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<td>85.7% 54</td>
<td>57.1% 4</td>
<td>81.0% 85</td>
<td>90.3% 56</td>
<td>71.4% 5</td>
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</tbody>
</table>
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(ST4-5) 48. The program's description of the educational experience to be provided must be available to program applicants and include:

a. A description of the educational experience to be provided;

<table>
<thead>
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<th>Field</th>
<th>Dental Anesthesiologist</th>
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<td>86%</td>
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<td>0%</td>
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<tr>
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<td>82</td>
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b. A list of competencies of residency training; and

<table>
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<th>PD-DentAnes</th>
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</tr>
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</table>

c. A description of the nature of assignments to other departments or institutions.
### 2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

<table>
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<th>PD-Other</th>
<th>Dean/CAO</th>
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<th>State Org</th>
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</table>
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

**Due Process**

(ST4-6) 49. There must be specific written due process policies and procedures for adjudication of academic and disciplinary complaints that parallel those established by the sponsoring institution.

<table>
<thead>
<tr>
<th>Field</th>
<th>Dental Anesthesiologist</th>
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</tbody>
</table>

**Health Services**

(ST4-7) 50. Resident, faculty, and appropriate support staff must be encouraged to be immunized against and/or tested for infectious diseases, such as mumps, measles, rubella, and hepatitis B, prior to contact with patients and/or infectious objects or materials, in an effort to minimize the risk of patients and dental personnel.

<table>
<thead>
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<th>Field</th>
<th>Dental Anesthesiologist</th>
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<th>Nat’l Org</th>
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</tbody>
</table>
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

STANDARD 5 - FACILITIES AND RESOURCES

(ST5-1.1) 51. Institutional facilities and resources must be adequate to provide the didactic and clinical experiences and opportunities required to fulfill the needs of the educational program as specified in these Standards.

<table>
<thead>
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<th>Field</th>
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</table>

(ST5-1.2) 52. Equipment and supplies for use in managing medical emergencies must be readily accessible and functional.
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(ST5-2) 53. In cases where off-campus locations are used in residency clinical education, the facilities, equipment, staffing, and supplies must be available in accord with all applicable accrediting bodies and state rules and regulations.

<table>
<thead>
<tr>
<th>Field</th>
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2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(ST5-3) 54. All residents and those faculty utilizing general anesthesia or moderate sedation in the direct provision of patient care must be continuously recognized/certified in advanced cardiovascular life support (ACLS) and pediatric advanced life support (PALS).

<table>
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<th>PD-Other</th>
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<td>28%</td>
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(ST5-4) 55. All other faculty (not included in Question 56) and support staff involved in the direct provision of patient care must be continuously recognized/certified in basic life support for health care providers.

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<td>12%</td>
<td>7%</td>
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</table>

(ST5-5) 56. Secretarial and clerical assistance must be sufficient to permit efficient operation of the program.
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(ST5-6.1) 57. The program must document its compliance with the institution’s policy and applicable regulations of local, state, and federal agencies, including, but not limited to, radiation hygiene and protection, ionizing radiation, hazardous materials, and blood-borne and infectious diseases.

(ST5-6.2) 58. Policies must be provided to all residents, faculty, and appropriate support staff and be continuously monitored for compliance.
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(ST5-6.3) 59. Additionally, policies on blood-borne and infectious diseases must be made available to applicants for admission and to patients.

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<td><strong>26</strong></td>
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(ST5-7) 60. The program’s policies must ensure that the confidentiality of information pertaining to the health status of each individual patient is strictly maintained.

<table>
<thead>
<tr>
<th>Field</th>
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2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

**STANDARD 6 - RESEARCH**

(ST6) 61. Residents must engage in at least one (1) month of scholarly activity and present their results in a scientific/educational forum.

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<th>PD-Other</th>
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</table>
Responses to Open-ended Questions
Standard 1 – Institutional and Program Effectiveness

Questions 1-6 (Standards 1-1 to 1-4)

(Optional) You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below. Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).

Dental Anesthesiologist

I do not think that the sponsoring hospital needs to set the curriculum, they do not necessarily understand the starting points or end points for dentist anesthesiologists.

Military institutions should be held to exactly the same standards as non-Military institutions.

Dean/CAO

4. Not sure of the purpose of this but I interpreted it to mean that outside forces could not exert substantial influence over what is best for the program. This needs to be more clear. At the end of the day, if financial support comes from outside the sponsoring institution, then the program is going to do what is dictated by that group. Even if it is not in the best interest of the program.

Standard One question 1: There are accrediting agencies that can have an office meet the standards of CMS. For example, there could well be a site/office that would have AAAHC accreditation. That would be a viable source for sponsoring a dental residency program.

Nat'l Org

#5 - The authority and final responsibility for curriculum development and approval, resident selection, faculty selection, and administrative matters must rest within the sponsoring institution --- I believe that there should be minimal standards set forth that the sponsoring institution must follow and thus not have exclusive or final authority as noted in this standard.

Program Director-DentAnes

No comments

Program Director-Other

2. Not every program deals with Medicaid. Medicaid should be irrelevant.

3. If the Program is just to teach active duty personnel the basics of field medicine (in anesthesia), I think it would be acceptable. If the purpose to accredit them as anesthesiologists, I think there should be some affiliation with a hospital or US educational organization.
4. Is not specific as to what constitutes compromise and who will make that determination.

I believe that military programs should be connected to military hospitals can achieve the standards of this residency.

Military institutions can be evaluated by the same accrediting bodies in my opinion. Responsibility for resident recruitment and curriculum development should lie with the program director.

**Questions 1-6 (Standards 1-1 to 1-4) - continued**

(Optional) You indicated that one or more of the standards on this page was “Too demanding”, “Not demanding”, or “Not relevant”. Please identify the standard(s) by question number and explain the rating(s) in the space below. Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).

**State Org**

#3 - I do not believe that simply demonstrating the successful achievement of Service-specific organizational inspection criteria is enough to assure the quality of the education received.

5. I think that curriculum development is something CODA should express more control over. I worked with a DA that did not feel confident hiring associates that graduated from one specific program. Their graduates were consistently not up to what he deemed to be standard competency.

**Site Visitor-DentAnes**

No comments

**Site Visitor-Other**

Std 1.1 - I believe that it is possible for a dental anesthesia program to exist at an educational institution that is not affiliated with a hospital.
Questions 7-12 (Standards 1-5 to 1-9)

(Optional) You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below. Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).

**Dental Anesthesiologist**

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<tr>
<th>Question</th>
<th>Rating</th>
<th>Explanation</th>
</tr>
</thead>
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<td>8a.</td>
<td>I don't think the ability to vote or hold an office within an institution is a necessity for sponsoring a dental residency program.</td>
<td></td>
</tr>
<tr>
<td>8a.</td>
<td>This should apply to some faculty but many faculty members would be considered part-time based on time spent under the sponsoring institution, making a voting requirement too demanding to expect.</td>
<td></td>
</tr>
<tr>
<td>8c.</td>
<td>Most hospitals will not allow for the anesthesia dept to admit patients, rather they would be admitted to a hospitality service, therefore not relevant.</td>
<td></td>
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</tbody>
</table>

Admit and discharge are handled by different departments- typically internal medicine, surgery and PACU.

Admitting patients is beyond the scope of our field. The recommendation to do so is appropriate, but to admit patients is a responsibility that belongs to the primary team.

It is not necessary to be able to admit patients to the hospital. Although important for OMS, even physician anesthesiologists do not admit patients. And any other dental specialist can not admit. Regarding Standard 7, this is fine if a "mobile practice" is considered ONE site as it is for AAAHC accreditation. The actual office where the mobile practice goes should NOT be considered "a site".

Not all physicians have hospital admitting privileges, let alone dentists. Hospitals usually have their primary care doctors as medical officers to admit patients. Dental anesthesiologists should not be required to have admitting privileges.

Outcome assessments which includes a resident's performance and ethical standards should be a requirement throughout the residency, which is why I feel this is not demanding.

The program needs to have annual assessment exams and practicals to ensure quality teaching and curriculum. Residents must be kept on track.

The requirement for the facility to allow dentists to admit patients would in theory be nice, but many prohibit dentists other than OMFS from admitting without a hospitalist.

voting and/or holding office while aspirational are not necessarily relevant to the strength of a dental anesthesiology residency

**Dean/CAO**

8. Dentist Anesthesiologists rarely admit or discharge patients. Not relevant 10c. Many hospital programs essentially use DA residents as cheap CRNA's and they do not want them providing care in true dental outpatient settings such as a pediatric office etc. This needs to be clearly delineated and a specified number of cases applied for outpatient, non-hospital based care.

8a. Does not seem to be important.

Anesthesiology is for a person, irrelevant whether limited to dentistry or not.
Most dentists do not have the medical knowledge to accept that much responsibility to admit and discharge at this level. Co-managing would be the best option for patient and provider safety. Having a relationship with medical providers would be a good pattern of practice.

**Nat'l Org**

*No comments*

**Questions 7-12 (Standards 1-5 to 1-9) - continued**

(Optional) You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below. Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).

**Program Director-DentAnes**

*No comments*

**Program Director-Other**

8c - In my opinion, a dental anesthesia resident is part of an interdisciplinary team. With that being stated, the patient's core team leader will be a physician or dentist who will be responsible for admitting, managing and discharging a patient.

Does not seem reasonable to appoint residents as "staff"; I may be misunderstanding the usage but no residents in any of our programs are appointed as "staff", only instructors are appointed as staff.

General dentists provide anesthesia for dental work so I'm trying to see how you would write a goal to be specific for this program and not be broad as in for an AEGD or GPR even.

I do not see why a mission statement should be required.

Not every site utilized by a program is used for the same purpose, therefore, if a resident goes to an outside site, they may not need the same credentials as other residents at that site, only for the purpose of their utilization of that site.

Question 8:Difficult to change by-laws at affiliate hospitals. Recommend at Sponsoring or co-sponsoring only.

Right to admit patients when we have hospitalist and interventionalist might be too demanding

The duration of the program would not make it practical for the student to take part in committee activity or hold office at the institution. Admitting and discharging patients would not be a normal activity for an anesthesiologist.

**State Org**

*No comments*

**Site Visitor-DentAnes**
#10. Office based anesthesia care should be mandated not just emphasized. #12. Ethics are impossible to regulate.

10.a.: Ideally an overall emphasis on anesthesiology for dentistry is not relevant and is covered by c. Anesthesiology is anesthesiology no matter what body part is the target of surgical or other intervention. We could stress exposure primarily to anatomical targets other than teeth overall.

8.c. Dental anesthesia residents typically do not have admitting or discharge privileges.

Questions 7-12 (Standards 1-5 to 1-9) - continued

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Site Visitor-Other

Beyond the scope of dentists in some hospital systems to admit patients.

While entirely appropriate to allow dentists to be privileged to admit patients, an easier path would be to coordinate with the anesthesiology department or the ED for admitting to give potential faculty the option if they'd like to pursue hospital privileges for admitting.
Standard 1 Comments

(Optional) Please use the space below to enter any comments you have related to Standard 1 - Institutional and Program Effectiveness.

Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).

Dental Anesthesiologist

The training programs should have comprehensive anesthesia training in all types of medical cases with some emphasis on treating outpatient dental patients in an office-based setting. The dentist anesthesia should be competent in a operating room managing most types of anesthesia for medical patients undergoing surgery. The DA should also have experience managing medical/surgical intensive care patients, as well as rotations in internal medicine and cardiology.

Dean/CAO

Not sure if voting and holding office is that important

No additional comments

Nat'l Org

No comments

Program Director-DentAnes

No comments

Program Director-Other

All statements of the requirements seem very appropriate.

Dentist do not have the medical training to manage medically compromised patients or patients that need admit due to complications from a general anesthesia procedure

I agree with the 12 statements and they should be implemented into program

I am not aware if there is a research requirement in the DA program?

Look solid

Ongoing verified Continuing Education of Program Directors and Attendings of both the program and the sponsoring facility should be in place to insure that the quality of the program remains focused and relevant in future years. This could be done in a non-threatening online learning environment produced by instructional designers where course content and knowledge requirements could be managed by the CODA governing body.

State Org

No comments
Site Visitor-DentAnes

No comments

Standard 1 Comments - continued

(Optional) Please use the space below to enter any comments you have related to Standard 1 - Institutional and Program Effectiveness.

Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).

Site Visitor-Other

An excellent survey - very appropriate!

 Mostly Boiler Plate

Shouldn't there be a standard that addresses the type of credential the residents earn? (i.e. Certificate, or degree)

Std 1.8.c - I think requiring hospitals to give admitting privileges will reduce the number of hospitals willing to affiliate with the programs.

The program must have a mission that is supported by the goals and objectives.
Standard 2 – Educational Program

Questions 13-14 (Standards 2-1 to 2-2)

(Optional) You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below. Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).

Dental Anesthesiologist

14h. We are not facial pain specialists and the wording of this implies that we should be able to diagnose and non-surgically treat acute head and neck pain. I do not believe this should be a requirement. I think the wording regarding acute pain should be similar to the wording used in 14i regarding chronic pain.

Ability to demonstrate knowledge of current literature should not be limited to dental anesthesiology, but rather expanded to anesthesiology in general, as the disciplines are largely intertwined.

Anesthesia is not for the treatment of chronic pain.

Chronic head and neck pain diagnosis and treatment: Chronic management belongs to other healthcare providers.

Chronic head and neck pain has its own specialty, Orofacial pain.

Chronic pain of the head and neck is more apropos to an Oral Facial Pain Dental residency or chronic pain medical fellowship for long term care of chronic head and neck pain. Acute pain of the head and neck region is a valuable skill that may be learned during residency but shouldn't be required for anesthetic management of most patients.

Competency in the diagnosis and non-surgical treatment of acute pain in the head and neck region could be considered outside the scope of dental anesthesiology.

H. and I. - oral facial pain rotations involving the acute/chronic diagnosis and treatment are not relevant to an anesthesiology program. Time is better spent in direct anesthesiology training. If residents interested in furthering their oral facial pain knowledge, there are programs already established to support that interest.

I am concerned with 14a and b. In-depth is very subjective. I think it should say "in depth knowledge comparable to a physician anesthesiology resident as applicable to anesthesia for dentistry, of the....."

I am not aware of any DA who manages acute or chronic pain of the head and neck as a part of their practice. Perhaps my experience is too limited. Nevertheless, I think this requirement falls outside the bounds of typical clinical practice.

i. Understanding the diagnosis and treatment should only be required as to how it would pertain to anesthetic management, but residents should not be expected to be able to make diagnoses or know treatment algorithms for these chronic conditions.

Most residents will not treat ASA 4 or do complex surgeries after graduation, thus a complete understanding of every disease process in relation to anesthesia is not necessary.
Questions 13-14 (Standards 2-1 to 2-2) - continued

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Dean/CAO

14. h. and 14.i. The training provided in other programs covers these two topics - Oral Medicine and Orofacial Pain. Do not believe it wise require this crossover training for Dental Anesthesiology. Familiarity with the diagnosis and treatment of chronic pain would not adequately prepare trainees to address the needs of the patient population being managed.

I would not expect all anesthesia providers to cross over in the dental specialty of facial pain. This would cases to refer out. It would not prevent a provider from gaining those skills, but not necessary for all providers.

There is an entire recently recognized specialty dedicated to pain acute and chronic. h should read similar to i

Nat'l Org

No comments

Program Director-DentAnes

Chronic orofacial pain falls into the scope of another specialty. Having exposure to chronic pain is not a competency and should be optional for a program to offer exposure but should not be a standard with equal weight as the other standards.

I don't believe Standard 2-14 H and I are relevant any longer now that Orofacial Pain is a recognized specialty. The overwhelming majority of dentist anesthesiologists are providing clinical anesthesia to patients, not diagnosing and treating acute or chronic pain of the head and neck.

Since there is now a specialty in Head and Neck Pain, this stand should read: "competent in managing (sedating or anesthetizing) patients for dental procedures who present with chronic pain of the head and neck."

Standard 14 i. (Familiar with dx and tx of chronic pain related to head and neck region) I believe that area of clinical expertise is covered best by the emerging specialty of OroFacial Pain. [redacted] I have found it the need to include exposure or familiarity with Chronic Head and Neck Pain an awkward fit to the curriculum of a dental anesthesiology residency. It also takes away time from subjects and experience more directly relevant to DA resident btraining.

Program Director-Other

Surgical tx of acute pain falls within the domain of oral surgery and chronic pain within the domain of oral medicine OR orofacial pain speciality

These criteria would require training beyond that offered in the program.
They are not training to be pain experts. Acute pain is one thing, but expecting them to be experts in chronic pain is quite another.

**Questions 13-14 (Standards 2-1 to 2-2) – continued**

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**State Org**

Evaluation and treatment of acute and chronic pain is relevant to all dentists and should not be considered part of advanced specialty training.

I don’t believe in #h that the provider needs in depth knowledge but general knowledge of these conditions

**Site Visitor-DentAnes**

13.f.: "...in dentistry." is not relevant. 13.j.: Dentist anesthesiologists do not practice "dental anesthesiology," a term that implies anesthetizing teeth for tooth procedures. Dentist anesthesiologists practice "Anesthesiology," period, and may or may not limit themselves to tooth procedures.

**Site Visitor-Other**

h. too demanding because it is unrealistic to require competence in all possible aspects of acute pain-this is also the realm of neurology, otolaryngology, orofacial pain, etc.

numeral i describes the OFP programs overall goals - a specialty on its own. Perhaps "familiar" is not the best qualifier
Questions 15-16 (Standards 2-3 to 2-4)

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Dental Anesthesiologist

Again, term in-depth is too vague. See previous comment.

Behavioral medicine is outside our scope.

Dean/CAO

D pain control and F pain management are the same and redundant in my opinion

Nat'l Org

No comments

Program Director-DentAnes

I don't think this is relevant to dental anesthesiology

Program Director-Other

Adequate requirement for development professional skills

Again, acute pain is different from chronic

State Org

No comments

Site Visitor-DentAnes

16.a.: Again, dentist anesthesiologists practice "Anesthesiology," not tooth limited or dental anesthesiology. Eliminate; "...dental..."

Site Visitor-Other

No comments
Questions 17-18 (Standards 2-5 to 2-6)

(Optional) You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

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Dental Anesthesiologist

18.a2-3. The majority of dental anesthesia is utilized for the pediatric and special needs population. Given the unique challenges both demographics may present I do not feel that 15% (pediatric) or 9% (special needs) of total cases is sufficient to provide experience in treating these populations.

300 intubated cases is a low number. 50 nasal intubations is very low as well. At a minimum, these numbers could be doubled.

As stated previously, exposure to management of patients with chronic orofacial pain is not relevant to an anesthesiology program. Time is best spent in the exposure and management of anesthesiology cases.

c. I think we should have exposure to management of patients with chronic pain, but limiting this to orofacial pain I don't believe makes sense.

Cases should be increased to a minimum of 1000 and preferably 1200. minimum of 600 should be intubated.

In my opinion 800 cases is far too low and was probably better suited for times when dental anesthesiology residency programs were two years duration. I think 1000-1200 cases is certainly easily attainable over a three year program.

It is challenging to obtain advanced airway techniques such as fiberoptic intubations.

Minimum number of nasally intubated, pediatric, and special needs cases are too low.

not all residency programs have adequate access to patients with chronic orofacial pain; when I was program director at one of the CODA-accredited institutions, I always found it difficult satisfying this standard.

Number of cases should be higher, particularly pediatric cases

The educational program requirements have not included mention, suggestion or requirement for anesthesiology residents to engage in clinical simulation-based training during their residency. This form of education is a foundational aspect of all physician anesthesiology residency programs and is an essential element of training beyond didactic presentation of anesthetic management, perioperative emergencies et cetera. It is the bridge to clinical experiences and without simulation or medical emergencies, there is no way to guarantee that residents gain enough experiences managing emergencies to be deemed "able."

There should be a higher number of pediatric cases required in residency due to the high demand of anesthesia for pediatric patients undergoing dental rehab. This may be biased by my practice, however I feel like most DAs primarily work with pediatric patients and therefore should have more experience in this area.

Upwards of 200 pediatric cases should be required before practicing solo in the private practice without hospital support.
We should be required to do far more than 300 intubated GA's. This is a very low number in my opinion. Same goes for only 50 nasal intubations. As DAs, this is our wheel house. 50 is not enough to develop true expertise. In addition, "advanced airway" management should not include the use of video laryngoscopes. Video laryngoscopes are an important tool and we should have to use them. However, in my opinion, they represent a separate category. Nasal fiberoptic intubations should be mandatory, perhaps 25. These are in important skill for the DA.

**Questions 17-18 (Standards 2-5 to 2-6) - continued**

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**Dean/CAO**

18.c. Same as the response to 14. h. and 14. i.

I believe exposure should be equivalent to that of an MD anesthesiologist

No sure all anesthesia providers would also be experts in orofacial pain.

**Nat'l Org**

*No comments*

**Program Director-DentAnes**

18. a. 3. The requirement for patients with Special Needs should be increased. The Special Needs population is highly variable in terms of co-morbidities, intrinsic anatomic and physiologic deficits as well as negative behavioral presentation. 75 patients over a three year curriculum is too few for residents to reliably achieve competence in the anesthetic management of this patient population. I believe this requirement should be increased to equal the 125 cases required for pediatric patients.

18. c. Exposure to the management of patients with Chronic Orofacial Pain. This is unnecessary as OroFacial Pain is on the verge of becoming a recognized specialty. Having residents observe management of OFP patients does not enhance their anesthesia education and takes up program time that could better utilized in other areas.

exposure to orofacial is not a competency and falls into the scope of an entirely different specialty and therefore should not be included here The pediatric cases can be challenging because sometimes a patient will be 8 or 9 years of age chronologically but present with medical issues that render them frail compared to a 5 or 6 year old patient. There have been many challenging cases involving children ages 8-12 that "don't count for CODA." A subcategory should be created to allow programs to achieve perhaps a maximum of 25 of the 125 pediatric cases with children in this age category of 8-12.

The advanced airway section should be reevaluated by the new reference committee for dental anesthesiology. The section on chronic orofacial pain should also be evaluated by the reference committee. Since there is a new specialty of orofacial pain this is not needed on dental anesthesiology
We need more requirements.

**Questions 17-18 (Standards 2-5 to 2-6) - continued**

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**Program Director-Other**

18 a 3. They should do more special needs patients. The residents have to get comfortable dealing with this type of patient. A total of 75 means only 25 a year, not an impressive amount.

300 cases for a 3 year period may be too challenging (100 cases/year, 20 cases/week, 4 cases/day) I'd average it at 2 cases/day. Or average the whole year at 75 cases.

Criterion is relevant but locking into a specific number may prove very difficult. I know with my residents I am unable to predict the ratio. I tell them I can always give an equivalent experience but the needs and complexity will vary from year to year.

Getting 75 cases of deep sedation/general anesthesia on special needs patients seems daunting. I can't imagine every program could meet that requirement.

I have no way of know what the appropriate # of cases should be in the above standard

Mix of sedation cases should have more nasal intubations, since the bulk of dental anesthesia cases require a nasal intubation also more cases with special needs cases should be performed for the same rational.

Seems like a high number, not sure if there is the demand for such a high number

Special needs patients will comprise many of their future patients therefore the number of completed cases should be higher. More than just exposure to patients with chronic facial pain.

**State Org**

17. Perhaps this can address a reasonable distribution of mobile, surgical center, and hospital based treatment. 18. I love seeing rigorous and specific quantities of various treatments. I just cannot judge the correct number in the given time because I have not attended a DA program.

As stated before, the management of acute and chronic orofacial pain is the purview of all dentists and therefore not relevant to this specialty.

**Site Visitor-DentAnes**

Should have more special needs and better definition.

18.a.2. Pediatric experiences should be increased to a minimum of 200
I recommend a higher number of nasal intubations (18a1), and a defined number (maybe 20?) of management of patients with chronic orofacial pain (18c).

17. Again, dentists do not provide tooth-only services in anesthesiology. The specialty should be iterated as "Anesthesiology," period. Dentists have been providing anesthesiology longer than any other profession, since DEC 1844.

#18. All of the case numbers in "a." should be increased by 50% as minimums.

**Questions 17-18 (Standards 2-5 to 2-6) - continued**

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**Site Visitor-Other**

Again qualify "exposure", have 10 patients, one rotation?

c. patients with chronic orofacial pain are not well-served by an anesthesiologist who only has an exposure to them during training. It should be made more demanding or eliminated.

In my opinion, the number of mandatory cases seems excessive.

The use of specific numerical minimum goals to demonstrate proficiency or competence does not address the resident's success or lack of success in an educational clinical experience. It just gives the residents a ceiling for clinical experiences of any quality. Once the numerical goal has been achieved, there is no reason for the resident to continue to attempt to challenge himself or herself with more challenging cases of the same type. And, what is to be done if the program is unable for whatever reason to give the resident enough cases to reach the goal?
Questions 19-24 (Standards 2-7 to 2-11)

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Dental Anesthesiologist

100 cases supervised by a dentist anesthesiologist is a very minimal number given the fact the rest of their profession will be dedicated solely to dental cases. We should be doing far more than 100 cases directly with a dentist anesthesiologist seeing as how this is a dental anesthesiology residency.

30 months of GA experience and 18 months in the hospital OR

Designated faculty work with numerous residents each day and who they work with changes on a daily basis. It can make it difficult for them to provide meaningful feedback.

I believe that our resident programs should include was much a a pay-1 internship year as our physician colleagues, meaning they need to have closer to 8+ months of clinical medical rotations and this will include a requirement for residents to complete 4 pgy years to attain specialty certification, an internship year PGY-1 and 3 Clinical Anesthesiology Resident training years (CA1-CA3) [redacted]. We should not be behind our physician colleagues, we should be in step and at the same level as they are. Otherwise, and likely still, there will be contention and discourse between our training pathways and "ability" to be the anesthesiologists that we claim to be.

One month is not necessary in some fields. Focus should be on pediatrics, cardiology and internal medicine.

Possible difficulty in finding hospital support for trauma anesthesia

Supervision of care does not beee to be performed by dentist anesthesiologists, physician anesthesiologist are acceptable

The educational value of certain rotations will vary by hospital and by department. Some rotations will not have any added value after 2 weeks. It should be left to the head of the residency program to determine the best utilization of the institutional resources, based on resident feedback, to best determine how long each rotation should be. A 4 week rotation may be suggested but I wouldnt advise making it a minimum length of rotation

There should be minimum months devoted specifically to the private practice models. There should be a minimum 1 month intensive care required.

with the expansion of training programs to 36 months, it would have been reasonable to expand the hospital-based anesthesia exposure to 18 months

Why is this less than the requirement for Oral and Maxillofacial Surgery resident education? There can only be one standard / requirement for competency.
Questions 19-24 (Standards 2-7 to 2-11) - continued

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Dean/CAO

20 FT is too demanding don't see why it cant be part-time 21B what is "experience" doesn't say anything 22 Four months not enough 23 two week rotations should be find

Dental anesthesiology rotation should be more than 6 month.

I do know it seems that hospital systems may not allow dentist the opportunities to train. If that becomes an issue, then it becomes a problem and alternate means of medical training will need to be addressed by CODA

Nat'l Org

#22 - good idea, but not relevant for dental anesthesia

Program Director-DentAnes

#22, the maximum of one month on pre-anesthetic assessment clinic should be eliminated #23, the one month minimum should be eliminated. This will allow for a greater experience if so desired by the program

21. a. The vast majority of cases classified as "outpatient anesthesia for dentistry that are supervised by dentist anesthesiologists" are general anesthetics provided in the dental office environment. This is by far the most common clinical setting in which dentist anesthesiologists practice and is the environment in which the vast majority of DA residents will practice upon graduation. The office based environment is very distinct from the hospital based OR or ASU which comprise most of the clinical experience of DA residents. In order to be safe and competent in the remote dental office based setting residents should be required to experience more than a minimum of one hundred of these cases over a three year program. I would raise this requirement to a minimum of two hundred (200) cases.

The length of time on a medical anesthesia service is not the issue. The issue is that many hospital based programs emphasize (rightly so) that patient care comes first, resident education second, and everything else is tertiary. The problem is that there is NO CODA standard to point to in support of protected, academic time for all residents to receive didactic training at once. Several DA programs have accomplished the equivalent of 2 days (or 4 half days) per month of protected time where all residents are pulled from patient care for their education. The [redacted] anesthesia program (Medical) is a pioneering example of this practice that promotes resident wellness but taking 2 full days each month and taking all residents out of the OR, clinics, and rotations for learning.
**Questions 19-24 (Standards 2-7 to 2-11) - continued**

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**Program Director-Other**

19. 12 months not 6 months of Dental Anesthesia

100 OPD cases are not enough.

21a. Supervision specifically by a dentist anesthesiologist may be tough as there aren't a ton of them available I would imagine. Might consider expanding who can provide this specific oversight (CRNA, etc).

22 and 23 My opinion is that setting one month as the standard in the hope that sufficient exposure, knowledge and understanding has been gained leaves too much to chance and the vagaries of patient scheduling. However, I realize it is not possible to cover all possible situations in a rotation. I do not have a solution to offer at this time.

23 rotations of only one month is not sufficient to expose residents to pathology and management of medical conditions

I cannot comment on exact # of procedures or # of hours in a specific discipline

**State Org**

19. Is six too minimal a demand for DA specific training?

Question 19 - 6 months of dental anesthesiology cases in a program designed to create graduates who can only work in dentistry sounds too little. Question 20 -

**Site Visitor-DentAnes**

I recommend a higher minimum time devoted to dental anesthesiology, perhaps 8 -12 months (19). I recommend removing maximum time limit for pre-anesthetic assessment clinic (22). I think minimal of 2 weeks is sufficient for some rotations, with the exception of pre-anesthetic assessment clinic, which should be a minimal of 1 month (23).

19. Same issue, "dental anesthesiology" is a non sequitur, it does not follow from what is actually done by anesthesiologists that happen to be dentists. CODA got it right in 21.a.: with: "...anesthesia for dentistry..." But, please, it is not dental or tooth anesthesiology; in fact, one does not even have to specifically anesthetize the teeth if a GA is being run as the entire CNS is the target of the specialty of Anesthesiology.

21. Should be at least 500. This is what 95% of graduates will be doing.
Questions 19-24 (Standards 2-7 to 2-11) - continued

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Site Visitor-Other

21.a. See previous comments on specific numerical targets. 21.b. Nebulous. What does this mean in specific terms. 22. This is unclear. Does that mean the resident has to do rotations in all e areas? 23. This clears up #22. some, both should be reworked to make the standard understandable.

22, 23; rotations should be proscribed because for instance 4 months of pediatrics will not give adequate training.
Questions 25-32 (Standards 2-12 to 2-19)

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Dental Anesthesiologist

30. Time should be allowed for vacation during each year and should allow for informal study time as well.

31. There should not be part-time residents. To become proficient in anesthesiology, one must be immersed in it.

in some institutions, 24 months of anesthesia training coupled with a well-structured general practice residency or pediatric dental residency will achieve competency and help satisfy many of the previously cited standards; I believe post-doctoral training beyond the dental school curriculum is more crucial to the development of a competent dentist anesthesiologist than 36 months of training where there was no post-doctoral institutional exposure prior to training.

Part time programs should not be allowed. Period.

Part time residents should not be allowed. This isn't a specialty that can be learned on a part time basis.

There are not and should never be a part time residency to become an anesthesiology. Such a program would not provide the rigor or intensity of all anesthesiology training programs for physicians and dentists in the USA.

Dean/CAO

Is there any other residency, especially one that truly deals with life and death care, that allows part-time training? What justification could there be for a part-time experience? Does the ASA offer such an experience for their medical residency? This seems absurd.

Should occur at a higher frequency.

Nat'l Org

#30 - 36 months is a very long time; a shorter period may be adequate.

Program Director-DentAnes

Residents are continuously evaluated. To demand an artificial timeline is too demanding especially since they are continuously evaluated. You don't let bad habits become ingrained because you only evaluate on a half yearly basis.
Questions 25-32 (Standards 2-12 to 2-19) - continued

(Optional) You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

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Program Director-Other

#31 - Length of part-time is too long. Concerned that will reduce effectiveness of learning. #32 - Evaluations should be evenly spaced each quarter.

#31 No part-time program #32a quarterly evaluations

31 32a

32a. evaluations should be at minimum, quarterly to ensure that goals are being met and re-evaluated. twice a year is not enough.

32a. Evaluations should be at least Quarterly.

At least initially, I believe a review every 6 months is too long. Should be every 3 months at the most during the first year.

I believe evaluations should be more than 2 x per year. After each rotation and quarterly

More frequent assessment should be required

Quarterly reviews

This program should be no more than 2 years or 24 months. I don't see the justification for 3 years.

State Org

No comments

Site Visitor-DentAnes

#31. A part time program is difficult to justify today.

Site Visitor-Other

26c-if a resident can do a thorough H & P, it would be assumed that they can interpret one and this standard seems unnecessary. 31- don't see the need for a part-time anesthesia residency

AEGD/GPR programs have evaluations at least 3 times annually. 6 months is a long time to go if someone is not performing adequately.

CQI should include program improvement as well. Resident evals should be done at least 3 times per year, vice 2.
### Standard 2 Comments

(Optional) Please use the space below to enter any comments you have related to Standard 2 - Educational Program.

*Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).*

**Dental Anesthesiologist**

<table>
<thead>
<tr>
<th>26b should include more than laboratory studies. Include cardiac and pulmonary studies</th>
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A problem exists with respect to the examinations administered by the American Dental Board of Anesthesiology and the current requirements. Dentist anesthesiologists are expected (by the examining board) to have experience and knowledge in areas of anesthesia for major oral and maxillofacial surgical procedures (ie. orthognathic surgery) which is not provided by some of the current residency training programs. Ideally a minimum of 25 cases of major oral and maxillofacial anesthesia would be set to bridge the gap between training programs and what is expected of the board that certifies dentist anesthesiologists.  [Name redacted]

[redacted] I would comment that the concept of a part time Dental Anesthesia residency program would not provide the continuity that the pedagogic/educational process demands specially in such critical and demanding specialty such as it is anesthesia.

I believe 800 anesthetics and 125 pediatric cases is too few in number for 3 years. The pediatric volume should be increased to 250 and the number of general anesthetics should be a minimum of 1000. Much of our business in the private sector involves pediatric patients. I had done over 500 pediatric patients in my residency.

I think Dental Anesthesiology could really benefit from more medical school exposure, similar to how many oral surgery programs have integrated in with the associated institution medical schools.

It is my opinion that 60-75 “on-site call” experiences should mandatory to achieve CODA standard. On-call experience cannot be replicated and tests the resident’s true anesthesia competence of all aspects of their institutions education program.

Rigidly structuring dental anesthesiology residencies as 36 months in duration, potentially creates funding issues in certain institutions if the program prefers first-year residents to have entered the training program after having had some other clinical experience (a GPR, another residency, or multiple years of practice beyond dental school); for example, certain [redacted] DA residencies will not receive full GME funding for a PGY-4 (or beyond) resident when the PGY-1 (and -2) year(s) were spent in a GPR or pediatric dental training program; the conundrum exists because not all dental schools provide adequate knowledge and skills for a recent graduate to thrive as a first-year dental anesthesiology resident.

See earlier comments with regard to program length and need for us to match our physician colleagues. We are providing the same level of anesthesia care to our patients while in residency and afterword as attending practitioners. There is no solid argument that I am aware of which can convincingly state that we need less training than they, especially with the amount of pediatric anesthesia care our specialty provides, wherein a physician would require a 5th year of post-graduate training to fellowship in pediatric anesthesia.
Dean/CAO

This is appropriate.

Nat'l Org

No comments

Standard 2 Comments-continued

(Optional) Please use the space below to enter any comments you have related to Standard 2 - Educational Program.

Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).

Program Director-DentAnes

31: Part time residents should be eliminated from this type of specialty training

Program Director-Other

31 part-time residency experience has the potential to dilute the training experience as well as increase drop-out rate of residents

All statements seem very appropriate.

Constant communication with their medical counterparts should be available during their time as residents not only for the purposes of the dental anesthesiologist's education but to better train our medical counterparts in aspects of treatment modalities and patient groups that they might otherwise be unaware of in their medical training.

State Org

No comments

Site Visitor-DentAnes

It is important to publicize that Dentist Anesthesiologists are trained to complete H&P's, just as OMS residents are.

Site Visitor-Other

24 months should be considered for program length.
Standard 3 – Faculty and Staff

Questions 33-42 (Standards 3-1 to 3-9)

(Optional) You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

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Dental Anesthesiologist

Being board certified is not relevant to a program director. A program should support the advancement of a program director should they decide to pursue becoming board certified, however, it should not be a requirement. What is most important is the completion at a CODA approved dental anesthesiology program and job history as it relates to dental anesthesiology as well as their competence in anesthesiology and teaching.

I believe that the program director needs to be a full time faculty employee of the sponsoring or co-sponsoring institution and 40% is insufficient.

No one should be grandfathered in as a program director. Everyone should be board certified. (Furthermore, brand new graduates should not be program directors! but that's a separate issue....) Experience is the most valuable teacher in anesthesia. This is why we require residents to do over 800 cases. To spend 36 months. And still, no one believes a resident is fully formed. We are still new. If you believe Malcolm Gladwell, it takes 10,000 repetitions to become an expert at something. This is roughly a decade of experience as a DA. This is all a way of saying that experience is the most important factor. No one should be given a free pass because of their prior position. Someone who is experienced and qualified should be able to pass a board examination. If they cannot, what business do they have teaching those who are training to become board certified? If they do not WANT to, what business do they have in an academic environment at all? All program directors should be board certified at a minimum.

Physician anesthesiologist are adequate program directors and faculty

Program director should be ADBA certified and no mention of duration of program is necessary. Only that they be ADBA certified.

Program Directors should have a minimum of two years of training, as was available at the time of their training. No one year trained faculty should be Program Director

question 34: program directors must be board certified in dental anesthesiology... period. program directors appointed prior to January 1, 2020, who have not previously served as program directors, must be board certified in dental anesthesiology as well question 39: not all medical anesthesiology attendings are characterized as faculty within the dental anesthesiology training program, but oftentimes provide consultation, supervision and active teaching when residents are treating patients

The director should be equal to or more than 50% appointed with the institution
Questions 33-42 (Standards 3-1 to 3-9) - continued

(Optional) You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

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Dean/CAO

33. I believe the Program Director must be appointed within the sponsoring or co-sponsoring institution at least sixty percent (60%).

40% time and effort seems inadequate to ensure the quality of the educational program; this time is less than all other accredited programs (within those standards that specify a time commitment)

All faculty more than 50% need to be board certified. In addition to the full time program director, the teaching staff must have at least one full time equivalent dental anesthesiologist as defined by the institution per each authorized senior resident position. One of the teaching staff who is not the program director must be at least half-time faculty as defined by the institution.

Anesthesiology involves daily life and death care. How can a Program Director be part-time yet still be committed and sufficiently involved ith this training and care. There is a huge difference in safety of patient care - the risk of death is real - when compared to General Dentistry, Endodontics, etc.. If OMFS Program Directors are full-time, then Anesthesiology Program Directors should be also.

Calibration? of Boarded dental anesthesiologists?

Q35......for directors who graduated in less than 36mo programs in the past - should there not be a practice requirement since graduation to assure continued competency?

The program director must be full time. There should be specific requirement for other faculty both in total number and percent FTE to the program. Programs should not be run by a bunch of part time people. At the end of the day, Dental Anesthesiology is not ever going to become a meaningful specialty if they do not hire and retain true academic faculty. That means those with full time commitment to academic practice. Not part time private practitioners who drop by to cover cases. Dentistry does not need a specialty of anesthesiology if all we produce are a bunch of practitioners who provide anesthesia care. We have an entire specialty of medical anesthesiology to do that. We need committed educators to move the specialty forward. OR, it will die.

There are many people who could be program directors that are outstanding. The board certification for PD would leave many individuals out that are excellent at administration. Just because you have board certification would not necessary make you a good program director. I do believe that you could have the program director not be board certified but be an excellent administrator and educator. I do believe that some supervision in the clinical area is best served by someone with experience and a preference for those clinical duties would be some board certification based on the same criteria of 36 months, 24 months, and 12 months.
Questions 33-42 (Standards 3-1 to 3-9) - continued

(Optional) You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

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Program Director-DentAnes

34. This statement should specifically state the American Dental Board of Anesthesiology because this is the specific Board that is recognized by the National Commission on Recognition of Dental Specialties and Certifying Boards. 41: This is not relevant to anesthesiology programs because residents do rotate through operating rooms at VA hospital where there is no allied dental personnel and clerical staff.

38. Since a great deal of training is done by MD anesthesiologists outside the pervue of the dental anesthesia program it is too demanding to ask the Anesthesia Department to be subject to the standard. They may or may not have their own evaluation system in their own timeline. 42. Since many of the DA and/or MDs were trained it is hard to calibrate the training. You can only give them the objectives of the training program. How they go about it, is based on their own training.

A program director should be on staff more than 50% of the time. Ideally with protected time to administer the program.

Standard 3-34: There are many people who are not board certified who are qualified to be program directors. There are not many people who want to be in education. I think that we are limiting the number of qualified candidates who may want to be a program director, but will not meet the criteria. With only eight US programs, we should allow as many qualified people as possible to become program directors.

Questions 33-42 (Standards 3-1 to 3-9) - continued

(Optional) You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

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Program Director-Other

#33 - Program director should be 100%. #38 - Faculty should be evaluated two times per year - every 6 months.

2 years with experience should be adequate for qualification as a director of the program. Otherwise the candidates for this position will be limited and with lack of experience.

33. The program director should be available at least 50% of the time, if not more.

33. The program must be administered by a director with at least a forty percent (40%) appointment in the sponsoring or co-sponsoring institution and have authority and responsibility for all aspects of the program. *My suggestion is at least 60% to have authority and responsibility for all aspects of the program.

A program director should spend at least 50% of his time with the program.

Director should have > 40%

From my experience, a Director should be onsite a minimum of 50% of the time.

I feel that the program director should have at least a 50% appointment or more due to the fact that instruction becomes too varied without directional leadership presentation for the majority of the treatment time available. This may be offset by more online feedback of daily teaching and evaluation metrics by which content, participation, testing and outcomes may be assessed and reviewed however this still would represent a substantial time involvement of the program director and could not be performed at a 40% or maybe even a 50% level of participation and review

Standard 35. Add “or equivalent “.

The PD needs to be held to the same current standard as residents being trained.

who have not previously served as program directors WHY?

State Org

33. 40% commitment by program directors seems low for proper administration and continuity of education.

Question 33 - A director present only two days a week does not seem sufficient to be in charge of a graduate program.
Questions 33-42 (Standards 3-1 to 3-9) - continued

(Optional) You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

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Site Visitor-DentAnes

#33. Program directors should be required to be full time (minimum 80%).

33. My opinion is that this should be at least 51%, although I am not privy to the realities of implementing this opinion.
34. Same thing as previously, "dental" is a highly inappropriate descriptor of anesthesiology for dentistry. Even the ADA has the terminology optimized; see the ADA News article about Delta Dental 02 April 2021.

It should be more specific to state that the program director must be certified by the ADBA, the recognized certifying board.

Site Visitor-Other

41. The faculty development standard is problematic across all types of programs. If the faculty are current, credentialed, and meeting State CE requirements, I don't think this standard adds anything other than a burden to the programs.

Residents toward the end of the program and becoming ready to graduate should not need direct oversight.
Standard 3 Comments

St3comm (Optional) Please use the space below to enter any comments you have related to Standard 3 - Faculty and Staff.

*Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).*

**Dental Anesthesiologist**

Being a board eligible director will suffice

Creating more restrictions on potential future faculty and staff will only create more staff shortages.

**Dean/CAO**

Peculiar expectation of a specialty with high risk of negative outcomes. Faculty time devoted to the education and monitoring of resident progress cannot fulfill obligations with a 40% time commitment.

**Nat'l Org**

No comments

**Program Director-DentAnes**

No comments

**Program Director-Other**

The program must be administered by a director with one hundred percent (100%) appointment in the sponsoring or co-sponsoring institution and have authority and responsibility for all aspects of the program.

All statements seem very appropriate.

**State Org**

No comments

**Site Visitor-DentAnes**

No comments

**Site Visitor-Other**

3-1...Program Director should be 100% Appointment at the sponsoring or co-sponsoring institution. PD should be able to practice Den Anes 20% of full time appointment (1 day per week or 2 1/2 days per week...and be involved with research 1 day per week) Basically the PD should be with residents 60% of the time clinically and 40% of the time involved with academic activities that will enhance his/her ability to lead the program.
Standard 4 – Educational Support Services

Questions 43-50 (Standards 4-1 to 4-7)

You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

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Dental Anesthesiologist

Advanced standing should not be allowed

[redacted]. Some of the internationally trained dentist were very well prepared but must were not. Must international graduates do not have the same basic sciences courses nor the academic demand required to level to the required knowledge for such a demanding speciality as it is Dental Anesthesiology. The National Dental Boards used to be a great gauge when there was a numerical score since you could numerically determine the academic level in basic sciences however now days is a pass or fail which makes it difficult to assess. [redacted].

not all dental schools provide adequate knowledge and skills for a recent graduate to directly enter a year dental anesthesiology residency; in certain instances, additional post-doctoral training beyond dental school (such as a GPR or pediatric dental residency) would be desirable

Only domestic/Canadian graduates should be allowed

questions 46 & 47: I have not had experience with residents seeking matriculation into the program with advanced stahding question 50: COVID-19 immunization should a requirement

Resident selection should be at the discretion of the program director, based on the opinions of interviewing faculty. Written criteria are not required.

US and Canada only

Dean/CAO

50. Add COVID-19

It is almost impossible to determine international students real background. This will be another back door to get an USA license.

It is impossible to establish whether an international dental school has provided "equivalent educational background". Most hospital programs make it very difficult to credential those with this type of training and many dental boards will not license dentists with this type of training. To accept someone into a program when there is significant limitations on their ability to ever practice is wrong. Just don't accept them to start with.

Nat'l Org

No comments
Questions 43-50 (Standards 4-1 to 4-7) - continued

You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

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Program Director-DentAnes

Applicants should be selected from pre-doctoral institutions that are accredited by independent accrediting agencies such as CODA (U.S.) or CODA (Canada). Allowing programs or institutions to independently evaluate the curricula of international dental schools in the resident selection process makes it more likely that poorly prepared applicants will enter DA residency programs.

Should add COVID vaccine and flu shot to this list

Program Director-Other

#44 - Need to have a more thorough process of evaluating graduates of international dental schools.

"Graduates from an International dental school with equivalent educational background and standing as determined by the institution and program" : considering the significant differences of the educational level among the international dental schools (particularly OMFS/anesthesiology), such eligibility should be carefully selected.

50 this should be mandatory

Foreign graduates should be vetted thru accredited US dental schools prior to admission to a dental anesthesia program.

Graduates from CODA or CDAC only

Graduates from International dental schools should pass a standardized minimal assessment tool

I believe only CODA accreditation is appropriate for this particular specialty in order to serve the intended special needs population in the US.

immunization should be required for patient safety

Potentially add COVID vaccination?

Require immunizations to be mandatory to protect staff and patients.

Should only accept graduates of ADA accredited schools. My experience has shown that the level of international education varies considerably.

Standard 50. Required, not encouraged

State Org

**Questions 43-50 (Standards 4-1 to 4-7)**

You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

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**Site Visitor-DentAnes**

It is impossible for a program to determine that an international dental school's training is equivalent to a US school.

It would be difficult to admit an advanced standing resident today.

**Site Visitor-Other**

46. Are there any addition criteria for admission to Advanced Standing? Seems to me there should be. 49. What does "parallel" mean? Shouldn't they be the same? 50. Shouldn't this list other communicable diseases, like Covid-19 that can be immunized against?

International dentists must demonstrate that they have credentials to obtain a license in the USA ie have completed the alternate pathway for licensure in the US.

The international standing should be standardized and not left to the program.
Standard 4 Comments

(Optional) Please use the space below to enter any comments you have related to Standard 4 - Educational Support Services.

Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).

Dental Anesthesiologist

It is my understanding that there is implicit or true bias against advanced standing graduated applicants who are enrolled or have completed prior residency training due to the financial impact this has on GME funding of these residents throughout their 36 months of training. This creates a real problem for advancement of our society as residents with prior post-graduate experience in a hospital-based training program or work will bring significant preparation and value to the program as they integrate with their affiliate hospitals and physician faculty colleagues. To deny them residency or diminish the competitiveness of their application package is unethical and ultimately hurts our specialty in the long run. Such practices need specific policy statements against such bias.

Dean/CAO
No comments

Nat'l Org
No comments

Program Director-DentAnes
No comments

Program Director-Other

Include a requirement for a COVID-19 vaccination.

International Doctors may not be eligible to practice in many states without an US degree.. Needs to be defined well at the beginning. They may train but may not be able to practice

State Org
No comments

Site Visitor-DentAnes

Immunization against SAR-COV-2 should be included in the list on question 50

Site Visitor-Other

What about COVID vaccination?

would ad flu and Covid-19 we are encouraging not requiring so include it.
Standard 5 – Facilities and Resources

Questions 51-60 (Standards 5-1 to 5-7)

(Optional) You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below. 

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Dental Anesthesiologist

52 should say "medical and anesthetic emergencies" not just medical.  53.  Should say "all applicable accrediting bodies AND/OR state rules and regulations" as this is better for mobile practices.

53. All documents state that we must be in compliance with all regulations, yet dental offices and clinic practices often do not adhere to these standards, nor are they taught in training.

All FACULTY should have current ACLS and PALS certification

All instructors MUST be BLS/ACLS/PALS certified.

policies on radiation hygiene? Come on, this is a waste of time. It's important but do we want programs wasting time on nonsense like this?

This should be available and reviewed with enrolled residents, not required to provide to applicants, in my opinion.

Dean/CAO

54. As written, this standard is sufficiently demanding for all enrolled residents. It is too demanding for faculty in that there may be those who specialized in pediatric anesthesia and do not supervise adult anesthesia and vice versa.

PALS is not relevant if the faculty overseeing the particular care is not ever overseeing anesthesia for children.

Nat'l Org

No comments

Program Director-DentAnes

60. Since the implementation of HIPPA regulations nationally, this standard is irrelevant.

Program Director-Other

#55 - Should be ACLS not BLS.

55 ACLS should be minimum
Additionally, policies on blood-borne and infectious diseases must be made available to applicants for admission and to patients - too demanding to make them available to all applicants and patients.

For this residency, I think all faculty and staff involved in patient care should have ACLS or PALS in addition to BLS.

Ideally at least two auxiliary staff (dental anesthesia assistants, nurses, etc.) should be ACLS certified, two in case one is out on any given day.

Questions 51-60 (Standards 5-1 to 5-7) - continued

(Optional) You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant”. Please identify the standard(s) by question number and explain the rating(s) in the space below.

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State Org

No comments

Site Visitor-DentAnes

There may be some attendings that never treat children. They should not be required to have PALS. Wording it as ACLS and/or PALS as appropriate makes sense.

Site Visitor-Other

58. What policies? Does this include regulations?
Standard 5 Comments

(Optional) Please use the space below to enter any comments you have related to Standard 5 - Facilities and Resources.

Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).

Dental Anesthesiologist
No comments

Dean/CAO

Q55.....is "not included in Q56" correct or should it be Q54?

Nat’l Org
No comments

Program Director-DentAnes

If a. hospital is accredited by the joint commission and/or CMS then this is redundant and assumed to be true. If the program is dental school based, then perhaps compliance must be demonstrated, but for a hospital based program, the entire standard could just be summarized with a joint commission certificate.

Program Director-Other

All statements seem very appropriate.

State Org
No comments

Site Visitor-DentAnes
No comments

Site Visitor-Other
No comments
Standard 6 - Research

Question 61 (Standard 6)

(Optional) You indicated that Question 61 was "Too demanding", "Not demanding", or "Not relevant". Please explain the rating in the space below.

Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).

Dental Anesthesiologist

I month of research should be optional and not required.

Need one month of full time dedicated for the scholarly activity. Not a sufficient time to engage in scholarly activity to present in a scientific journal while fully on schedule

One month of a 36 month program for scholarly activity is too long. It would be better to describe what constitutes qualifying "scholarly activity" without a minimum dedication of time.

One month of scholarly activity that is presented in an educational forum is reasonable. Clinical research with IRB approval leading to publication is not. Not all residents are “researchers” and are of the opinion that “research” is heavily encouraged (mandated) in order to bring certain times of grant dollars to the program. Often research projects take much more time than the 30 day minimum, thus taking time away from much needed study time given the heavier didactic load an anesthesia residency has comparatively to other dental residencies.

Presentation not necessary

There are few actual research opportunities in many residency programs

three to four weeks would work out better for residents.

Dean/CAO

61 one month of research is useless. This is not a well written standard. The idea is the product not the time. Research is a vital component of the program and there ought to be something written re. "sufficient time" to conduct scholarly activity leading to presentation at a scientific forum. If your intent, on the other hand is to guarantee that the programs reserve this time for this purpose, than perhaps not so bad. needs clarification, to ensure programs don't claim that directors cannot say that " patient demand necessitate the resident be in clinical care 100% of the time."

It should be more than one month

One month is too limited a time to produce credible research. It needs to be over many months throughout the program. Saying one month provides excuses for not devoting sufficient time to a research project. It takes time to even put the project together, go through an IRB. And most projects are done throughout the year to patients being treated. It is impossible to do this in a month.

seems minimal

the standard should be directed towards the quality and impact of scholarly activity, not a quantitative measure
This is too minor a requirement. In this field, in particular, a higher level of scholarship than this is essential for the future advancement of the discipline.

**Question 61 (Standard 6) - continued**

(Optional) You indicated that Question 61 was "Too demanding", "Not demanding", or "Not relevant". Please explain the rating in the space below.

*Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).*

**Nat'l Org**  
*No comments*

**Program Director-DentAnes**

61: This standard needs to be reworded as it is too restrictive. Programs need to have the liberty to have their residents take part in scholarly activity without stipulating 1 month. The standard should state types of scholarly activity that are acceptable, i.e. case reports, senior presentations to the anesthesia department, lectures to predoctoral students, articles in anesthesia journals, etc.

**Program Director-Other**

to vague, one month.

**State Org**

One month does not seem to be adequate to gain experience in evidence-based research, completion of a project and presentation at a meeting. Need more time.

#61 - clinical relevance of a mandatory research period is dubious.

**Site Visitor-DentAnes**

*No comments*

**Site Visitor-Other**

Very vague - is this one continuous month, or a total of one month distributed over the program? What does scholarly activity mean?

In my 2 year residency, I had to publish a Thesis based upon research I conducted, if I wanted my degree. It is unclear whether or nor these residencies will offer degrees or certificates, or both, and what the minimum research Standard would be for each credential.

This is a throw-away unless there is some ongoing or sustained research component.
One month of research is inadequate.

6-1...one month is not sufficient for a meaningful research experience. The research experience should be maintained throughout the entire 36 month program culminating in significant results to present/publish.
Standard 6 Comments

(Optional) Please use the space below to enter any comments you have related to Standard 6 - Research.

Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).

Dental Anesthesiologist

Research should be not be mandated part of regular curriculum. Opportunity for those residents interested in research should have additional time budgeted from normal schedule/curriculum to achieve desired, qualified research projects as long as all other standards are met.

while the language used within this standard is sufficiently demanding, there are programs that do not further define the forum to include presentation at a national meeting or publication in a peer-reviewed journal; simply presenting care reports within the confines of the hospital dental and/or anesthesiology departments does not adequately demonstrate competency in this standard; the term "forum should be more specifically defined to include presentation at a national meeting or publication in a peer-reviewed journal

Dean/CAO

each resident should get a masters degree and one publication in the medical or dental literature

This is too minor a requirement. In this field, in particular, a higher level of scholarship than this is essential for the future advancement of the discipline.

Nat'l Org

No comments

Program Director-DentAnes

No comments

Program Director-Other

A general, if not exclusive commitment to Evidence Based Learning and Peer reviewed article review should govern the research.

A requirement for a literature review research paper on a particular topic of dental anesthesiology would be a good exercise for residents.

#61 research in program should be optional

State Org

No comments

Site Visitor-DentAnes

No comments

Site Visitor-Other

No comments
(Optional) Any other comments? Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).

Dental Anesthesiologist

Can't stress enough the importance of the “On-call” experience. All medical/physician anesthesiologists take call as part of their programs to test and apply their anesthesia knowledge. As true specialists of anesthesia for dentistry, residents what do not participate in 60-75 on-call experiences in their time as dental anesthesia residents are at a disadvantage. They lose respect from other anesthesia professionals and the lacking experience will be a disservice to their future patients.

I never thought anesthesiology would be allowed to be a recognized specialty in dentistry. Dirty politics was finally defeated. I may never live to see it, but I hope for a day when every US dental school has a residency, and dentist anesthesiologists practice with their physician colleagues in every hospital system.

Should have a mobile component and an optional operator anesthesia component.

There is a severe lack of dental anesthesiologists that wish to be faculty and staff in institutions and dental schools due to the severe discrepancy of income and lifestyle. There should be a concerted effort to bring more people to the forefront by decreasing barriers to entry to undertake such a noble task of teaching.

There needs to be a minimum requirement for time spent in the dental office providing anesthesia. In my opinion, it scares me that residents can graduate a dental anesthesia program and never have a mobile aspect to their training! Most DAs after graduation do not work in institutional settings.

We have a bright future ahead, should we take the necessary and important steps not to set ourself up for equality in training and ability of our future graduates. This will require use to keep pressing forward until we are in step and at the same level of post-graduate training as our physician colleagues. Leave no room for argument, perceived or true, in the knowledge, skills, abilities and experiences of our graduates into this incredible specialty of dentistry, anesthesiology.

Dean/CAO

Having board certification tied to membership in another organization is problematic as it seems too internal a process. The thought was that once the ADA certified dental anesthesia as a specialty, that all would need to go through some process. This process seemed tied to being a member of a specific group and that seems too self-serving. If grandfathering was to be done, then other historic criteria of equivalent nature should be permitted the grandfathering. People would for various reasons were not in a specific organization left some people would lived through the time when dental anesthesia was a difficult due to various dental board restrictions on dental anesthesia providers. I would suggest that the National Board of Anesthesia members be allowed to grandfathered to clean up some of the historic biases. This would be a very few exceptions and would seem the right thing to do as dental begins a new history of providers of anesthesia.

This survey was much too long!

Why is CODA doing this specialty?
Other comments - continued

Nat'l Org
No comments

Program Director-DentAnes

No comments

Program Director-Other

All statements and proposed requirements seem very appropriate.

Consistent with standards for other accredited programs. Reads well. Unambiguous.

Thank you to CODA for taking the time and effort to put forth standards and guidelines to promote better dental education for the provider and to ultimately provide better treatment outcomes for the patient.

This has been a long time in the making, but is well thought out and formulated. Thanks for the opportunity to participate in the 'genesis' of this specialty area of dentistry.

This program must be held to the same basic CODA standards as any other dental specialty program.

State Org

I am not a DA and have humbly performed only 300 moderate pediatric sedations. A school of thought that I applied every day was something not presented in my sedation courses. Rather, this training came from avalanche safety training. The study of heuristics addresses the pressures that can influence a doctor to start a case despite red flags. Heuristics can help a provider recognize these traps before they get into trouble. I think it is also important to emphasize ethics. There have been occasional concerns about pressure by GP's placed on DA's to start cases that the DA may not be comfortable with. There have also been occasional concerns about the pressure to start another case when the patient recovering may benefit from additional direct monitoring. Thank you for taking the time to review my feedback.

Site Visitor-DentAnes

Thank you for reaching out. "Dental" Anesthesiology should be changed. There are indeed dentists that administer anesthesia for non-dental cases or dental cases in addition to non-dental parameters, such as facial fractures (that may be in an edentulous patient by the way) and a fractured leg. We are simply "Anesthesiologists, as recognized by multiple non-CODA entities. Call me anytime. [Name redacted]

Site Visitor-Other

Great survey - best wishes and thanks for what you do!
Appendix

Survey Instrument
Validity and Reliability Surveys - DentAnes

Start of Block: INTRODUCTION

Q2
To begin, click the "Next" button below. Please note that the "Next" button will allow you to move from one page to the next.

Please complete all questions either by selecting the appropriate response or typing your answer in the appropriate field.

If at any point you need to pause the survey and return to it at a later time, simply complete the page you are on and go to the next page, then close your browser. You can return to your survey with your answers saved by clicking the link in your email invitation.

When you reach the end of the survey, click "Finish" to submit your responses.
Q71 Listed in this survey are the accreditation standards by which the Commission on Dental Accreditation and its site visitors evaluate Dental Anesthesiology programs for accreditation purposes. (The complete standards for Dental Anesthesiology programs are available here.)

For each "must" statement in the standards, please select the option that most closely reflects your opinion in terms of the relevance of the criterion to the Dental Anesthesiology educational program.

Please be aware that, while every effort has been made to present the standards in their original wording, certain modifications to the presentation and arrangement have been made in order to incorporate the standards into the survey design.

Please note that certain standards have multiple items to be rated.

End of Block: INTRODUCTION

Start of Block: STANDARD 1 - Q1-12

Q123
For each "must" statement, please select the option that most closely reflects your opinion in terms of the relevance of the criterion to the Dental Anesthesiology educational program.

Too demanding = Criterion is relevant to type of program but too demanding for programs and/or residents
Sufficiently demanding = Criterion is relevant to type of program and sufficiently demanding for programs and/or residents
Not demanding = Criterion is relevant but not demanding enough for programs and/or residents
Not relevant = Criterion not relevant to type of program, regardless of how demanding it is for programs and/or residents
No opinion = No opinion on this criterion

Q128 STANDARD 1 - INSTITUTIONAL AND PROGRAM EFFECTIVENESS
ST1-1.1 1. The program must be sponsored or co-sponsored by either a United States-based hospital, or educational institution or health care organization that is affiliated with an accredited hospital.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

ST1-1.2 2. Each sponsoring and co-sponsoring institution must be accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS).

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

ST1-1.3 3. United States military programs not sponsored or co-sponsored by military medical treatment facilities, United States-based educational institutions, hospitals or health care organizations accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization
recognized by the Centers for Medicare and Medicaid Services (CMS) must demonstrate successful achievement of Service-specific organizational inspection criteria.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

ST1-2 4. The sponsoring institution must ensure that support from entities outside of the institution does not compromise the teaching, clinical and research components of the program.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
ST1-3 5. The authority and final responsibility for curriculum development and approval, resident selection, faculty selection, and administrative matters must rest within the sponsoring institution.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

Q1_6comm (Optional) You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).

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ST1-4 6. The financial resources must be sufficient to support the program’s stated purpose/mission and goals and objectives.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

________________________________________________________________

X
Q84
For each "must" statement, please select the option that most closely reflects your opinion in terms of the relevance of the criterion to the Dental Anesthesiology educational program.

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Not demanding = Criterion is relevant but not demanding enough for programs and/or residents
Not relevant =Criterion not relevant to type of program, regardless of how demanding it is for programs and/or residents
No opinion = No opinion on this criterion

Q139 STANDARD 1 - INSTITUTIONAL AND PROGRAM EFFECTIVENESS (continued)

ST1-5 7. Arrangements with all sites not owned by the sponsoring institution where educational activity occurs must be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
ST1-6 8. The institutional staff bylaws, rules, and regulations of sponsoring, co-sponsoring or affiliated health care institutions must ensure that dentists are eligible for staff membership and privileges including the right to:

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<th>No opinion</th>
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<tbody>
<tr>
<td>a. Vote and hold office;</td>
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<td>b. Serve on institutional staff committees; and</td>
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<td>c. Admit, manage and discharge patients.</td>
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</table>

ST1-7 9. Dental residents must be appointed to the staff of the sponsoring, co-sponsoring or affiliated health care institution and enjoy the same privileges and responsibilities provided residents in other professional education programs.

- [ ] Too demanding
- [ ] Sufficiently demanding
- [ ] Not demanding
- [ ] Not relevant
- [ ] No opinion
ST1-8 10. The program must develop a mission statement and supporting written overall program goals and objectives that emphasize:

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<tbody>
<tr>
<td>a. Anesthesia for dentistry;</td>
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<td>b. Resident education; and</td>
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<td>c. Patient care and include training residents to provide dental anesthesia care in office-based and hospital settings.</td>
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ST1-9 11. The program must have a formal and ongoing outcomes assessment process that regularly evaluates the degree to which the program’s written goals and objectives are being met.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

Q154 Ethics and Professionalism
ST1.11 12. The program must ensure that residents are able to demonstrate the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

Q7_12comm (Optional) You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).

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St1comm (Optional) Please use the space below to enter any comments you have related to Standard 1 - Institutional and Program Effectiveness.

Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).

________________________________________________________________
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Q38
For each "must" statement, please select the option that most closely reflects your opinion in terms of the relevance of the criterion to the Dental Anesthesiology educational program.

Too demanding = Criterion is relevant to type of program but too demanding for programs and/or residents
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Not demanding = Criterion is relevant but not demanding enough for programs and/or residents
Not relevant = Criterion not relevant to type of program, regardless of how demanding it is for programs and/or residents
No opinion = No opinion on this criterion

Q140 STANDARD 2 - EDUCATIONAL PROGRAM
Curriculum Content

ST2-1 13. The program must list the written competency requirements that describe the intended outcomes of residents' education such that residents completing the program in dental anesthesiology receive training and experience in providing anesthesia care in the most comprehensive manner using pharmacologic and non-
pharmacologic methods to manage anxiety and pain in adult and child dental patients, including patients with special needs.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
ST2-2 14. Upon completion of training, the resident must be:
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<th>Sufficiently demanding</th>
<th>Not demanding</th>
<th>Not relevant</th>
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<td>b.</td>
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<td>c.</td>
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- a. able to demonstrate in-depth knowledge of the anatomy and physiology of the human body and its response to the various pharmacologic agents used in anxiety and pain control;

- b. able to demonstrate in-depth knowledge of the pathophysiology and clinical medicine related to disease of the human body and effects of various pharmacological agents used in anxiety and pain control when these conditions are present;

- c. competent in evaluating, selecting and determining the potential response and risk associated with various forms of anxiety and pain control modalities based on patients’ physiological and psychological factors;
d. competent in patient preparation for sedation/anesthesia, including pre-operative and post-operative instructions and informed consent/assent;

e. competent in the use of anesthesia-related equipment for the delivery of anesthesia, patient monitoring, and emergency management;

f. competent in the administration of local anesthesia, sedation, and general anesthesia, as well as in psychological management and behavior modification as they relate to anxiety and pain control in dentistry;
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Q13-14comm (Optional) You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

*Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).*
Q155
For each "must" statement, please select the option that most closely reflects your opinion in terms of the relevance of the criterion to the Dental Anesthesiology educational program.

Too demanding = Criterion is relevant to type of program but too demanding for programs and/or residents
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Not demanding = Criterion is relevant but not demanding enough for programs and/or residents
Not relevant = Criterion not relevant to type of program, regardless of how demanding it is for programs and/or residents
No opinion = No opinion on this criterion

Q156 STANDARD 2 - EDUCATIONAL PROGRAM (continued)
Curriculum Content (continued)

ST2-3 15. The program must have a written curriculum plan including structured didactic instruction and clinical experience designed to achieve the program's written competency requirements.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

Q126 Didactic Components

X->
Q159.16. Didactic instruction at an advanced and in-depth level beyond that of the pre-doctoral dental curriculum must be provided and include:

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<tr>
<td>a. Applied biomedical sciences foundational to dental anesthesiology,</td>
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<td>b. Physical diagnosis and evaluation;</td>
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<td>c. Behavioral medicine;</td>
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<td>d. Methods of anxiety and pain control;</td>
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<td>e. Complications and emergencies;</td>
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<td>f. Pain management, and</td>
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<td>g. Critical evaluation of literature.</td>
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Q15-16comm (Optional) You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

*Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).*
Q124
For each "must" statement, please select the option that most closely reflects your opinion in terms of the relevance of the criterion to the Dental Anesthesiology educational program.

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Not relevant = Criterion not relevant to type of program, regardless of how demanding it is for programs and/or residents
No opinion = No opinion on this criterion

Q160 STANDARD 2 - EDUCATIONAL PROGRAM (continued)
Clinical Components

ST2-5 17. The program must ensure the availability of adequate patient experiences in both number and variety that afford all residents the opportunity to achieve the program's stated goals and competency requirements in dental anesthesiology.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
ST2-6a 18. The following statements represent the minimum clinical experiences that must be obtained by each resident in the program at the completion of training:
### Too demanding | Sufficiently demanding | Not demanding | Not relevant | No opinion
--- | --- | --- | --- | ---
a. Eight hundred (800) total cases of deep sedation/general anesthesia to include the following:

1. Three hundred (300) intubated general anesthetics of which at least fifty (50) are nasal intubations and twenty-five (25) incorporate advanced airway management techniques. No more than ten (10) of the twenty-five (25) advanced airway techniques can be blind nasal intubations.

2. One hundred and twenty five (125) children age seven (7) and under, and

3. Seventy-five (75) patients with special needs.
b. Clinical experiences sufficient to meet the competency requirements (described in Standard 2-1 and 2-2) in managing ambulatory patients, geriatric patients, patients with physical status ASA III or greater, and patients requiring moderate sedation;

c. Exposure to the management of patients with chronic orofacial pain.

Q17_18comm (Optional) You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).
Q162
For each "must" statement, please select the option that most closely reflects your opinion in terms of the relevance of the criterion to the Dental Anesthesiology educational program.

Too demanding = Criterion is relevant to type of program but too demanding for programs and/or residents
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Not relevant = Criterion not relevant to type of program, regardless of how demanding it is for programs and/or residents
No opinion = No opinion on this criterion

Q163 STANDARD 2 - EDUCATIONAL PROGRAM (continued)

General Anesthesia Experience/Anesthesia Service

ST2-7 19. At a minimum, a total of twenty-four (24) months over a thirty-six (36) month period must be devoted exclusively to clinical training in anesthesiology, of which a minimum of six (6) months are devoted to dental anesthesia.

○ Too demanding
○ Sufficiently demanding
○ Not demanding
○ Not relevant
○ No opinion
ST2-8 20. Residents must be assigned full-time for a minimum of twelve (12) months over a thirty six (36) month period to a hospital anesthesia service that provides trauma and/or emergency surgical care.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

Q167 Outpatient Anesthesia for Dentistry

ST2-9 21. At the completion of the program, each resident must have the following experiences in the administration of the full spectrum of anesthesia service for same-day surgery dental patients:

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<th>Sufficiently demanding</th>
<th>Not demanding</th>
<th>Not relevant</th>
<th>No opinion</th>
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<tr>
<td>a. At least one hundred (100) cases of the experiences listed in Standard 2-6 in outpatient anesthesia for dentistry that are supervised by dentist anesthesiologists.</td>
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<td>b. Experience as the provider of supervised anesthesia care.</td>
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Q127 Medicine Rotations

ST2-10.1 22. Residents must participate in at least four (4) months of clinical rotations from the following list: Cardiology, Emergency medicine, General/internal medicine, Intensive care, Pain medicine, Pediatrics, Pre-anesthetic assessment clinic (max. one [1] month), Pulmonary medicine.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

ST2-10.2 23. If more than one rotation is selected [from the list in Question 24], each must be at least one month in length.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
Q173 24. Each assigned rotation or experience must have:

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<th>standard</th>
<th>Too demanding</th>
<th>Sufficiently demanding</th>
<th>Not demanding</th>
<th>Not relevant</th>
<th>No opinion</th>
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<tr>
<td>a. Written objectives that are developed in cooperation with the department chairperson, service chief, or facility director to which the residents are assigned;</td>
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<td>b. Resident supervision by designated faculty who are familiar with the objectives of the rotation or experience; and</td>
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<td>c. Evaluations performed by designated faculty.</td>
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Q21-24comm (Optional) You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).
Q171
For each "must" statement, please select the option that most closely reflects your opinion in terms of the relevance of the criterion to the Dental Anesthesiology educational program.

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Not relevant = Criterion not relevant to type of program, regardless of how demanding it is for programs and/or residents
No opinion = No opinion on this criterion

Q172 STANDARD 2 - EDUCATIONAL PROGRAM (continued)

ST2-12 25. Residents must be competent to request and respond to requests for consultations from dentists, physicians, and other health care providers.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
ST2-13 26. The program must provide instruction and clinical experience in physical evaluation and medical risk assessment, including:
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<tr>
<td>a. Taking, recording, and interpreting a complete medical history;</td>
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<td>b. Understanding the indications of and interpretations of laboratory studies and other techniques used in physical diagnosis and preoperative evaluation;</td>
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<tr>
<td>c. Interpreting the physical evaluation performed by a physician with an understanding of the process, terms, and techniques employed; and</td>
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</table>
d. Using the techniques of physical examination (i.e., inspection, palpation, percussion, and auscultation).

Q179 Other Components

ST2-14 27. The program must provide residents with an understanding of rules, regulations, and credentialing processes pertaining to facilities where anesthesia care is provided.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
ST2-15 28. Residents must be given assignments that require critical review of relevant scientific literature.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

ST2-16 29. The program must conduct and involve residents in a structured system of continuous quality improvement for patient care.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

Q182 Program Length
ST2-17 30. The duration of a dental anesthesiology program must be a minimum of thirty six (36) months of full-time formal training.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

---

ST2-18 31. Where a program for part-time residents exists, it must be started and completed within a single institution and designed so that the total curriculum can be completed in a period of time not to exceed twice the duration of the program for full-time residents.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

---

Q185 Evaluation
ST2-19 32. The program's resident evaluation system must assure that, through the director and faculty, each program:
### Progress Report on Validity and Reliability Study for Dental Anesthesiology

#### DentAnes RC
CODA Winter 2022

<table>
<thead>
<tr>
<th></th>
<th>Too demanding</th>
<th>Sufficiently demanding</th>
<th>Not demanding</th>
<th>Not relevant</th>
<th>No opinion</th>
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<tbody>
<tr>
<td>a. Periodically, but at least twice annually, evaluates and documents the resident’s progress towards achieving the program’s written competency requirements and minimum anesthesia case requirements using appropriate written criteria and procedures;</td>
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<tr>
<td>b. Provides residents with an assessment of their performance after each evaluation; where deficiencies are noted, corrective actions must be taken; and</td>
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</tbody>
</table>
c. Maintains a personal record of evaluation for each resident which is accessible to the resident and available for review during site visits.

Q25-32comm (Optional) You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below. Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).

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St2comm (Optional) Please use the space below to enter any comments you have related to Standard 2 - Educational Program. Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).

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Q46
For each "must" statement, please select the option that most closely reflects your opinion in terms of the relevance of the criterion to the Dental Anesthesiology educational program.

Too demanding = Criterion is relevant to type of program but too demanding for programs and/or residents
Sufficiently demanding = Criterion is relevant to type of program and sufficiently demanding for programs and/or residents
Not demanding = Criterion is relevant but not demanding enough for programs and/or residents
Not relevant = Criterion not relevant to type of program, regardless of how demanding it is for programs and/or residents
No opinion = No opinion on this criterion

Q141 STANDARD 3 - FACULTY AND STAFF

ST3-1 33. The program must be administered by a director with at least a forty percent (40%) appointment in the sponsoring or co-sponsoring institution and have authority and responsibility for all aspects of the program.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
ST3-2.1 34. The program director must be board certified in dental anesthesiology; program directors appointed after January 1, 2020, who have not previously served as program directors, must be board certified in dental anesthesiology.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

ST3-2.2 35. The program director must have completed a CODA-accredited 36-month anesthesiology residency for dentists consistent with or equivalent to the training program described in Standard 2 of these Accreditation Standards. (A two-year anesthesiology residency for dentists completed prior to July 1, 2018 is acceptable. A one-year anesthesiology residency for dentists completed prior to July 1993 is acceptable.)

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
ST3-3 36. All sites where educational activity occurs must be staffed by faculty who are qualified by education and/or clinical experience in the curriculum areas for which they are responsible and have collective competence in all areas of dental anesthesiology included in the program.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

ST3-4 37. The number and time commitment of the faculty must be sufficient to provide didactic and clinical instruction to meet curriculum competency requirements and provide supervision of all treatment provided by residents.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
ST3-5 38. A formally defined evaluation process must exist that ensures measurement of the performance of faculty members annually.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

---------------------------------------------------------------

ST3-6 39. A faculty member must be present in the clinical care area for consultation, supervision and active teaching when residents are treating patients.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

---------------------------------------------------------------
ST3-7 40. The program must show evidence of an ongoing faculty development process.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

ST3-8 41. At each site where educational activity occurs, adequate support staff, including allied dental personnel and clerical staff, must be consistently available to allow for efficient administration of the program.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
ST3-9 42. The program must provide ongoing faculty calibration at all sites where educational activity occurs.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

Q33_42comm (Optional) You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.
Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).

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St3comm (Optional) Please use the space below to enter any comments you have related to Standard 3 - Faculty and Staff.
Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).

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End of Block: STANDARD 3 - Q33-42

Start of Block: STANDARD 4 - Q43-50

Q73
For each "must" statement, please select the option that most closely reflects your opinion in terms of the relevance of the criterion to the Dental Anesthesiology educational program.

Too demanding = Criterion is relevant to type of program but too demanding for programs and/or residents
Sufficiently demanding = Criterion is relevant to type of program and sufficiently demanding for programs and/or residents
Not demanding = Criterion is relevant but not demanding enough for programs and/or residents
Not relevant = Criterion not relevant to type of program, regardless of how demanding it is for programs and/or residents
No opinion = No opinion on this criterion

Q142 STANDARD 4 - EDUCATIONAL SUPPORT SERVICES

ST4-1 43. The sponsoring institution must provide adequate learning resources to support the goals and objectives of the program.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

Q192 Selection of Residents
ST4-2 44. Applicants must have one of the following qualifications to be eligible to enter the advanced dental education program in dental anesthesiology: Graduates from a predoctoral dental education program accredited by the Commission on Dental Accreditation; Graduates from a predoctoral dental education program in Canada accredited by the Commission on Dental Accreditation of Canada; and Graduates from an International dental school with equivalent educational background and standing as determined by the institution and program.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

Q44comm (Optional) Please specify the element(s) of Question 44 that was Too Demanding, Not Demanding, or Not Relevant, and describe the reason for the rating. Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).
ST4-3 45. Specific written criteria, policies and procedures must be followed when admitting residents.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

ST4-4.1 46. Admission of students/residents with advanced standing must be based on the same standards of achievement required by residents regularly enrolled in the program.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
ST4-4.2 47. Residents with advanced standing must receive an appropriate curriculum that results in the same standards of competence required by residents regularly enrolled in the program.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

ST4-5 48. The program's description of the educational experience to be provided must be available to program applicants and include:

<table>
<thead>
<tr>
<th>Too demanding</th>
<th>Sufficiently demanding</th>
<th>Not demanding</th>
<th>Not relevant</th>
<th>No opinion</th>
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<tbody>
<tr>
<td>a. A description of the educational experience to be provided;</td>
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<tr>
<td>b. A list of competencies of residency training; and</td>
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<td>c. A description of the nature of assignments to other departments or institutions.</td>
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</table>
Q276 Due Process

ST4-6 49. There must be specific written due process policies and procedures for adjudication of academic and disciplinary complaints that parallel those established by the sponsoring institution.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

Q194 Health Services

ST4-7 50. Resident, faculty, and appropriate support staff must be encouraged to be immunized against and/or tested for infectious diseases, such as mumps, measles, rubella, and hepatitis B, prior to contact with patients and/or infectious objects or materials, in an effort to minimize the risk of patients and dental personnel.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
Q43Q45-50comm (Optional) You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).

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St4comm (Optional) Please use the space below to enter any comments you have related to Standard 4 - Educational Support Services.

Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).

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End of Block: STANDARD 4 - Q43-50

Start of Block: STANDARD 5 - Q51-60

Q268

For each "must" statement, please select the option that most closely reflects your opinion in terms of the relevance of the criterion to the Dental Anesthesiology educational program.

Too demanding = Criterion is relevant to type of program but too demanding for programs and/or residents
Sufficiently demanding = Criterion is relevant to type of program and sufficiently demanding for programs and/or residents
Not demanding = Criterion is relevant but not demanding enough for programs and/or residents
Not relevant = Criterion not relevant to type of program, regardless of how demanding it is for programs and/or residents
No opinion = No opinion on this criterion
Q118 STANDARD 5 - FACILITIES AND RESOURCES

ST5-1.1 51. Institutional facilities and resources must be adequate to provide the didactic and clinical experiences and opportunities required to fulfill the needs of the educational program as specified in these Standards.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

ST5-1.2 52. Equipment and supplies for use in managing medical emergencies must be readily accessible and functional.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
ST5-2 53. In cases where off-campus locations are used in residency clinical education, the facilities, equipment, staffing, and supplies must be available in accord with all applicable accrediting bodies and state rules and regulations.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

ST5-3 54. All residents and those faculty utilizing general anesthesia or moderate sedation in the direct provision of patient care must be continuously recognized/certified in advanced cardiovascular life support (ACLS) and pediatric advanced life support (PALS).

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
ST5-4 55. All other faculty (not included in Question 56) and support staff involved in the direct provision of patient care must be continuously recognized/certified in basic life support for health care providers.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

ST5-5 56. Secretarial and clerical assistance must be sufficient to permit efficient operation of the program.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
ST5-6.1 57. The program must document its compliance with the institution’s policy and applicable regulations of local, state, and federal agencies, including, but not limited to, radiation hygiene and protection, ionizing radiation, hazardous materials, and blood-borne and infectious diseases.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

ST5-6.2 58. Policies must be provided to all residents, faculty, and appropriate support staff and be continuously monitored for compliance.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
ST5-6.3 59. Additionally, policies on blood-borne and infectious diseases must be made available to applicants for admission and to patients.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

ST5-7 60. The program’s policies must ensure that the confidentiality of information pertaining to the health status of each individual patient is strictly maintained.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

Q51-60comm (Optional) You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).
St5comm (Optional) Please use the space below to enter any comments you have related to Standard 5 - Facilities and Resources. 
Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).

End of Block: STANDARD 5 - Q51-60

Start of Block: STANDARD 6 - Q61

Q143

For each "must" statement, please select the option that most closely reflects your opinion in terms of the relevance of the criterion to the Dental Anesthesiology educational program.

Too demanding = Criterion is relevant to type of program but too demanding for programs and/or residents
Sufficiently demanding = Criterion is relevant to type of program and sufficiently demanding for programs and/or residents
Not demanding = Criterion is relevant but not demanding enough for programs and/or residents
Not relevant = Criterion not relevant to type of program, regardless of how demanding it is for programs and/or residents
No opinion = No opinion on this criterion

Q143 STANDARD 6 - RESEARCH
ST6 61. Residents must engage in at least one (1) month of scholarly activity and present their results in a scientific/educational forum.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

Q61 (Optional) You indicated that Question 61 was "Too demanding", "Not demanding", or "Not relevant". Please explain the rating in the space below.

Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).

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St6comm (Optional) Please use the space below to enter any comments you have related to Standard 6 - Research.

Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).

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Q114 (Optional) Any other comments?  
*Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).*

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Q115 *Thank you for your assistance with this research project.*

*Please click "Finish" to complete the survey.*
CONSIDERATION OF PROPOSED REVISION TO ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS IN DENTAL ANESTHESIOLOGY RELATED TO PATIENTS WITH SPECIAL NEEDS

Background: On June 22, 2021, the Commission on Dental Accreditation (CODA) received a request from the American Dental Association’s Council on Dental Education and Licensure (CDEL) to consider revising the Accreditation Standards to require graduates to be competent in treating patients with special needs. The Council on Dental Education and Licensure’s request is found in Appendix 1.

At its Summer 2021 meeting, the Review Committee on Advanced Education in General Dentistry, General Practice Residency, Dental Anesthesiology, Oral Medicine, and Orofacial Pain (AGDOO RC) considered the request for proposed revision to the Accreditation Standards for Advanced Education in General Dentistry, General Practice Residency, Dental Anesthesiology, and Orofacial Pain submitted by the Council on Dental Education and Licensure. The AGDOO RC believed that the Accreditation Standards for each of the disciplines under its purview should be further studied to determine whether modification of existing Standards or development of new Standard(s) related to patients with special needs is warranted. Further, the AGDOO RC recommended that the new Review Committees on Dental Anesthesiology, which will conduct its first meeting in Winter 2022, further study its specific Accreditation Standards with a report to the Commission at its Winter 2022 meeting. At its August 5, 2021 meeting, the Commission agreed and directed the new Dental Anesthesiology Review Committee to further study the Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology to determine whether modification of existing Standards or development of new Standard(s) related to patients with special needs is warranted with a report to the Commission at its Winter 2022 meeting.

Summary: The Dental Anesthesiology Review Committee (DentAnes RC) is requested to further study the proposed revision to the Accreditation Standards (Appendix 1) submitted by the Council on Dental Education and Licensure. If proposed changes are made to the Accreditation Standards, the Commission may wish to circulate the proposed revisions for a period of public comment.

Recommendation:

Prepared by: Ms. Peggy Soeldner
June 22, 2021

Dr. Jeffery Hicks  
Chair  
Commission on Dental Accreditation  
211 East Chicago Avenue  
Chicago, Illinois 60611

Dear Doctor Hicks:

Over the past year, the ADA Council on Dental Education and Licensure has studied ADA House of Delegates Resolution 100H-2020 Special Needs Dentistry, part of which calls for the Council to address actionable strategies to strengthen training in treating patients with special needs at the predoctoral and advanced dental education levels.

In considering the resolution, the Council conducted a survey of the appropriate communities of interest to gather data on the current state of special needs dentistry education. The Council then considered the survey results and strategies that could be considered for enhancing pre-doctoral and advanced dental training via the Accreditation Standards for Dental Education Programs and Accreditation Standards for Advanced Dental Education Programs.

The Council reviewed and supported recently adopted Standard 2-25 of the Accreditation Standards for Dental Education Programs concluding that the Standard appropriately addresses the scope and depth of predoctoral dental education related to special needs dentistry. However, the Council believed that the intent statement which complements Standard 2-25 could be strengthened to ensure consistent interpretation and application of the standard by dental education faculty and accreditation site visitors. Accordingly, the Council urges CODA to consider revision of the Standard 2-25 intent statement to provide further clarification and additional guidance to programs and accreditation site visitors.

The Council also reviewed the Accreditation Standards for Advanced Dental Education Programs in General Dentistry, General Practice Residency, Dental Anesthesiology, Pediatric Dentistry, Periodontics, Orthodontics and Dentofacial Orthopedics, Orofacial Pain, and Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics which call for students to receive training in managing and/or treating patients with special needs. The Council noted that depending on the document, residents may be required to achieve competency in assessing, diagnosing, and planning and/or managing and/or providing, and/or examining and/or treating patients with special needs and/or disabilities. In reviewing these standards, the Council concluded that although the standards in the relevant advanced dental education programs address special needs dentistry education, the Commission should consider further strengthening the standards to require all graduates to be competent in treating patients with special needs. Accordingly, the Council urges the Commission to consider further revision of these Accreditation Standards to require graduates to be competent in treating patients with special needs and to strengthen the standards in other areas such as curriculum, resident evaluation, facilities and patient care to better support the special needs patient population.
The Council will be transmitting its response to Resolution 100H-2020 to the 2021 House of Delegates. The report will note this request to the Commission to amend the Accreditation Standards for Dental Education Programs and Advanced Dental Education Programs as noted above.

On behalf of the Council, I thank you for the opportunity to comment on this important matter.

Sincerely,

Jacqueline Plemons, DDS, MS
Chair
Council on Dental Education and Licensure

cc: Dr. Anthony J. Ziebert, senior vice-president, Education and Professional Affairs
    Dr. Sherin Tooks, director, Commission on Dental Accreditation
    Ms. Karen M. Hart, director, Council on Dental Education and Licensure
REPORT ON DENTAL ANESTHESIOLOGY ANNUAL SURVEY CURRICULUM SECTION

**Background:** At its Winter 2015 meeting, the Commission directed that each Review Committee review a draft of its discipline-specific Annual Survey Curriculum Section during the Winter meeting in the year the Survey will be distributed. The Commission further suggested that each Review Committee review aggregate data of its discipline-specific Annual Survey Curriculum Section, as an informational report, when the materials are available following data collection and analysis. The Commission noted that all survey data is considered confidential at the programmatic level.

The Curriculum Section of the Commission’s Annual Survey is conducted for dental anesthesia programs in alternate years. The most recent Curriculum Section was conducted in August/September 2020.

At its Summer 2020 meeting, the Commission on Dental Accreditation approved revisions to the Annual Survey Curriculum Section for implementation in Fall 2022. The approved Curriculum Section of the Annual Survey for dental anesthesia programs can be found in Appendix 1.

**Summary:** The Review Committee on Dental Anesthesiology (DentAnes RC) is requested to review the draft Curriculum Section of the Annual Survey of its discipline-specific Annual Survey (Appendix 1).

**Recommendation:**

Prepared by: Ms. Peggy Soeldner
Start of Block: DentAnes Curriculum (Q21-26)

**Part II - Dental Anesthesiology Curriculum Section**

*Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.*

21. What percentage of time did residents spend in each of the following areas during the 2017-18 2021-22 residency year? Column must add up to 100%. Do not enter percent signs.
<table>
<thead>
<tr>
<th>First Year</th>
<th>Second Year</th>
<th>Third Year</th>
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</thead>
<tbody>
<tr>
<td>a. Anesthesia for ambulatory dental procedures provided in a dental clinic or in a facility outside the hospital operating rooms including office-based venues (Standards 2-6; 2-7; and 2-9)</td>
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<tr>
<td>b. Anesthesia for dental inpatient or same-day surgery within the hospital operating rooms</td>
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<td>c. Rotation/assignments to other services (Standard 2-10)</td>
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<td>d. Didactics: conferences/seminars (Standards 2-1; 2-2; 2-3; 2-4)</td>
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<td>e. Teaching <em>(Standard 2-15)</em></td>
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<td>f. Investigative work <em>(Standard 6-1)</em></td>
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<td>g. Other, please specify <em>(Standards 2-12 and 2-13)</em></td>
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<td>Total</td>
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22. Please indicate the number of clock hours residents spent in lectures, seminars or formal courses when on the medical/dental service during the 2017-18 2021-22 residency year. *(Standards 2-2 and 2-3)*
<table>
<thead>
<tr>
<th>First Year Clock Hours</th>
<th>Second Year Clock Hours</th>
<th>Third Year Clock Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Applied biomedical sciences <em>(Standard 2-4 a)</em></td>
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<tr>
<td>b. Physical diagnosis and evaluation <em>(Standard 2-4 b)</em></td>
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<tr>
<td>c. Behavioral medicine <em>(Standard 2-4 c)</em></td>
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<tr>
<td>d. Techniques of anxiety and pain control <em>(Standard 2-4 d)</em></td>
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<tr>
<td>e. Complications and emergencies <em>(Standard 2-4 e)</em></td>
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<td>f. Pain management <em>(Standard 2-4 f)</em></td>
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</tbody>
</table>
g. Critical evaluation of literature
   (Standard 2-4 g)
23. Please indicate the number of weeks residents spent on the following clinical rotations/assignments during the 2017-18 2021-22 residency year.
<table>
<thead>
<tr>
<th>First Year: Number of weeks</th>
<th>Second Year: Number of weeks</th>
<th>Third Year: Number of weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Cardiology (Standard 2-10 a)</td>
<td></td>
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<tr>
<td>b. Emergency medicine (Standard 2-10 b)</td>
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<tr>
<td>c. General/Internal medicine (Standard 2-10 c)</td>
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<tr>
<td>d. Intensive care (Standard 2-10 d)</td>
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<tr>
<td>e. Pain clinic/service (Standard 2-10 e)</td>
<td></td>
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<tr>
<td>f. Pediatrics (Standard 2-10 f)</td>
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<tr>
<td>g. Other, please specify (Standard 2-10 g)</td>
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<td>h. Other, please specify (Standard 2-10 h)</td>
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<tr>
<td>i. Other, please specify</td>
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Use this space to enter comments or clarifications for your answers on this page.

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Part II - Dental Anesthesiology Curriculum Section (continued)

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

24. Please provide the number of cases/procedures the 2018 2022 graduates completed/performed throughout the entire three-year residency program.
<table>
<thead>
<tr>
<th></th>
<th>Highest number</th>
<th>Lowest number</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Deep sedation/general anesthesia cases <em>(Standard 2-6 a)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Intubated general anesthetics cases <em>(Standard 2-6 a.1)</em></td>
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<td></td>
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<tr>
<td>c. Nasal intubations <em>(Standard 2-6 a.1)</em></td>
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<tr>
<td>d. Advanced airway management techniques <em>(Standard 2-6 a.1)</em></td>
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<td></td>
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<tr>
<td>e. Cases of children age 7 and under <em>(Standard 2-6 a.2)</em></td>
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<tr>
<td>f. Patients with special needs <em>(Standard 2-6 a.3)</em></td>
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<tr>
<td>g. Ambulatory patients</td>
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<tr>
<td>h. Patients over age 65</td>
<td>(Standard 2-6 b)</td>
<td></td>
</tr>
<tr>
<td>i. Patients with physical status ASA III or greater</td>
<td>(Standard 2-6 b)</td>
<td></td>
</tr>
<tr>
<td>j. Patients requiring moderate sedation</td>
<td>(Standard 2-6 b)</td>
<td></td>
</tr>
<tr>
<td>k. Patients with chronic orofacial pain</td>
<td>(Standard 2-6 c)</td>
<td></td>
</tr>
</tbody>
</table>

25. How many months, over their entire three-year residency, do the residents devote exclusively to clinical training in anesthesiology?  *(Standard 2-7)*

________________________________________________________________

26. How many months, over their entire three-year residency, are the residents assigned to a hospital anesthesia service that provides trauma and/or emergency surgical care?  *(Standard 2-8)*

________________________________________________________________
Use this space to enter comments or clarifications for your answers on this page.

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End of Block: DentAnes Curriculum (Q21-26)