NZSSD AGM August 16th 2018

President's report.

1. IV course 45 people. Very well received.
2. Capno getting closer next year. General response is now positive
3. Oral sedation courses x 2 Auck and CHC had 23, and 18 attendees. All interested in Capno and safety and guidelines updates. Paul Templer has stepped down from these. Don Macalister has stepped in.
4. DA's course being developed by Nick and Rohit.
5. Sim course available with Anaesthetist and manikin simulation. Lester Settle running one in CHCH.
6. Greg Mahoney update. Decision made not to pursue through legal channels for defamation. He has been advised to not reply to our correspondence by his legal advisors. The treasurer advised us to go through Aphra which is the Oz equivalent of DCNZ. GS decided to not pursue.

   Another formal complaint has been made to Australian sedation society about Greg Mahoney for his inappropriate comments regarding one of our member's staff's physical appearance. No response as yet.

7. Call for interest for a TCI propofol course coming soon.
8. And for interest in a Midazolam with Fentanyl course too.
9. SST refresh is now available to those who's SST has expired. We have some free ones. First in first served.
10. Members were sent details of SST login available for half price. Limited uptake.
11. Next IV hypnovel course dates to be determined shortly.
12. Website continues to improve.

New Zealand Society for Anaesthesia & Sedation in Dentistry Incorporated
Statement of Financial Position
As at 31 March 2018

	2018 $	2017 $
CURRENT ASSETS		
ASB - 00 Account	69,299	65,540
ASB - 50 Account	17,027	20,011
ASB - 51 Account	68,112	66,827
Taxation	-	54
Accounts Receivable	4,875	6,040
Prepayments	7,200	-
Total Current Assets	166,512	158,473
NON-CURRENT ASSETS		
Fixed Assets as per Schedule	5,746	4,021
TOTAL ASSETS	172,258	162,494
CURRENT LIABILITIES		
GST Due for payment	9,936	5,132
Taxation	20	-
Accounts Payable	4,213	5,760
Total Current Liabilities	14,169	10,892
TOTAL LIABILITIES	14,169	10,892
NET ASSETS	158,089	151,602
Represented by;		
Retained Earnings	158,089	151,602
TOTAL EQUITY	158,089	151,602

The Financial Statements have not been audited. The accompanying notes form part of these Financial Statements and should be read in conjunction with the reports contained herein.

Chairperson _____ Treasurer _____

Date:

NOTE: Read in conjunction with the Disclaimer of Liability and Notes to the Financial Statements.

B

NZ SOCIETY FOR SEDATION IN DENTISTRY

AGM of NZ Society for Sedation in Dentistry held at Auckland, 5.15PM TO 6.30PM on THURSDAY 10TH AUGUST 2017, EPSOM ROOM 3, LEVEL 4, STY CITY.

Attendees: Graham Shaw, Graeme Christie, Don Macalister, Nick Stretton, Alex McIntosh, Tom Kool, Gary Winter, Paul Reeve, Berwick Taylor, Lester Settle, Steve Pawley

1. Apologies

2. Confirmation of Minutes of 2016 AGM
Proposed - Graeme Christie Seconded - Graham Shaw

3. Matters arising from minutes

4. Correspondence
   - Usual regarding courses including overseas people wanted to be certificated.

5. President's report. Graham Shaw
   - Attached

6. Secretary's report. Graeme Christie
   - Usual regarding courses including overseas people wanted to be certificated.

7. Treasurer's report. Tania Stuart
   - Annual fee $50 –
   - Total funds available to the society as at 8/8/17

Current Account: $31,377 Business Saver: $20,016 Saver Plus Account: $67,183
Proposed - Graeme Christie Seconded – Alex McIntosh

8. Election of Officers.
Current Committee
President. Graham Shaw;
Treasurer. Tania Stuart;
Secretary. Graeme Christie;

Committee members
- Don Macalister
- David Chrisp
- Paul Templar
- Nick Stretton

Proposed - Alex McIntosh Seconded – Berwick Taylor

9. General business
- "Letter to Greg Mahoney and Australian Sedation Society". Proposed action to be discussed by the membership. Reply letter approved.
Proposed - Graham Shaw Seconded – Don Macalister

10. Next AGM - NZDA - Venue and date to be advised

10/8/17

NZ SOCIETY FOR SEDATION IN DENTISTRY

AGM of NZ Society for Sedation in Dentistry to be held at Wellington 5.15pm Thursday 27 October 2016

Present: Graham Shaw, Graeme Christie, Don Macalister, Nick Stretton, Yuan Yan, Berwick Taylor, Paul Reeve, David Stewart, David McKelvey

1. Apologies - Tania Stuart-Beck

2. Confirmation of Minutes of 2015 AGM
Proposed - Graeme Christie Seconded - David McKelvey

3. Matters arising from minutes
Capnography
Oral Sedation Course's

4. Correspondence
- Usual regarding courses including overseas people wanted to be certificated.
- NZDA and DCNC re guidelines for sedation.

5. President's report. Graham Shaw

6. Secretary's report.
- Usual regarding courses including overseas people wanted to be certificated.
- TV3

7. Treasurer's report.
- Annual fee $50.00 -
- Total funds available to the society as at 31/03/16

Current Account: $47,078 Business Saver: $19,930 Saver plus: $65,325

8. Election of Officers.
Current Committee

President. Graham Shaw;	Proposed: Graeme Christie	Seconded: David McKelvey
Treasurer. Tania Stuart;	Proposed: David McKelvey	Seconded: Paul Reeves
Secretary. Graeme Christie;	Proposed: Paul Reeves	Seconded: David Stewart

Committee members
- Don Macalister
- David Chrisp
- Paul Templar
- Nick Stretton

Proposed - Graham Shaw Seconded - Graeme Christie

9. General business
- Resus levels
- Cannulising – Berwick Taylor noted as a barrier for many.
- New members keen to teach, identify.

10. Next AGM - NZDA - Venue and date to be advised

Signed as a true and fair record

Graeme Christie – Secretary
Date: 27.10.16
graeme@dent.co.nz
Ph +64 21 318882

27/10/16

PRESIDENTS REPORT NZSSD OCTOBER 27TH 2016.

Another extremely busy year.

Advisory roles to NZDA for COP for Sedation. GS TK DM DC. Ratified.

Advisory roles for DCNZ for practice standard for sedation. Don Macalister and Nick Stretton

GS GC and TS also invited for a round table discussion regarding the guidelines.

On going submissions to DCNZ for this. Mainly concerning capnography, and the introduction of 2 yearly training and what this will be.

Liaison with Emcare regarding what a suitable program would be.

They suggest a specific dental sedation modular course involving specific IV sedation scenarios with manikin simulation.

Don Macalister and Dave Chrisp are going to Australia for a 2 day recertification course for IV sedation run in gold coast to see what they do. We will look at submitting something to NZDA and DCNZ after this. It will be run by a third party provider like Emcare or similar.

Recent contact from SST regarding the next 2 year update which is ready now.

They have also offered a 6 hour simulation training for 5 people at a time, and will consider coming to NZ if we have say 3 days booked in a row.

Dental assistants could be part of this, and make it a team scenario? Not sure, but ideally...

SST also to be part of this 2 yearly recertification.

SST is now an integral part of the IV sedation course.

45 dentists and 13 nurses at this year's course.

Oral sedation roadshow x 5. Auck, CHCH, Napier, Queenstown, Wellington. GS, Tania, Nick, Paul. Arranged by NZDA to explain new requirements for Oral sedation.

Looking at a dedicated capnography course for next year with NZDA. Industry suppliers to be involved with sponsorship hopefully.

GS

Presidents Report NZSSD 2017.

The society has been active in teaching the IV sedation course with 40 attendees this year and 8 auxillary staff attending too which we strongly encourage.

SST remains a requirement for the course qualification and the feedback is very positive about this.

We will look to offer SST to the membership as an excellent adjunct to IV sedation skills. It can be renewed 2 yearly.

The website has been updated and sorted so its doing what it was meant to do.

Also the list for "find a sedation dentist" is open to all members to be added in if they wish.

David Chrisp and Don Macalister attended the Australian course for IV emergency management in the Gold Coast at the end of last year. With a view to introducing a similar course here to replace the NZRC course that is the current requirement for sedation. Our view is that the core advanced course has too much irrelevant medical content for what we intend the course to cover.

Our view is that the Sedation requirement should be a course directly applicable to dental sedation.

The plan is to develop and get approval for this course from NZDA and DCNZ as a 2 yearly requirement for sedationists.

Plans are developing for an "advanced' sedation course to introduce fentanyl as an adjunct.

Depending on demand there may also be an advanced TCI Propofol course with BIS monitoring also.

Tania and Graeme will offer their reports next as well.

Graham Shaw

28 July 2017

NZSSD

To: President, Secretary, Treasurer, Board of Australian Society for Dental Anaesthesia, Mr Greg Mahoney, President of NZDA, Chairman of DCNZ, President Australian dental Association, President Australian dental Board.

Dear Sirs/Madams,

It was brought to my attention by an attendee of the 'Pediatric Sedation outside of the operating room' conference in San Francisco, September 10-11 2016 that Mr Mahoney made several incorrect statements about sedation and sedation training in New Zealand.

After further information was obtained I wish to bring the following points to your attention.

Incorrect statements by Mr Mahoney.

1. "An example of an unregulated profession (in sedation) is New Zealand (a small democratic country in the south pacific)"
2. "After 3 days of training dentists can perform remifentanil/propofol sedations ie spontaneously ventilated general anaesthetics. I am yet to find someone outside New Zealand who thinks this is a good idea. (New Zealand Society of Sedation in Dentistry, 2016)"
3. "New Zealand Society of Sedation in Dentistry. (2016, July 30). *New Zealand Society of Sedation in Dentistry*. Retrieved from dentalsedation.co.nz/dental-sedation-courses/"

The above statements are not only untrue, but fictitious.

1. Dental sedation is regulated by the NZDA code of practice for sedation, and the DCNZ Practice standard for sedation.
2. There is no course and never has been a course that teaches remifentanil/propofol sedation in New Zealand.
3. The New Society for Sedation in Dentistry has never been involved with a remifentanil/propofol course, or advertised one. The quoted web page is non-existant/fictitious.
4. The 3 practitioners in New Zealand using TCI propofol/remifentanyl sedation with BIS monitoring have extensive training and experience, and can testify that there is no resemblance to "spontaneously ventilated general anaesthetics" with this technique. It is a lighter sedation technique than most hypnovel sedations.

As a society representing NZ dental sedationists, we request the following actions be taken forthwith.

1. Mr Mahoney discloses any other times and places he has delivered this talk.
2. Mr Mahoney personally and in his role as President of the ASDA, writes a formal apology to the New Zealand Society for Sedation in Dentistry acknowledging his statements were not properly researched, inaccurate and factually incorrect.

3. A retraction of his statements and acknowledgement that his talk was not properly researched, inaccurate and factually incorrect.
4. A statement affirming that NZ is well regulated, and provides very good sedation training and has an impeccable safety record with IV sedation.
5. That Mr Mahoney resign his position as president of the ASDA.

That this apology, retraction and resignation is approved by NZDA and NZSSD and then sent to all attendees of the conference in San Francisco, and all attendees of other courses that he has delivered this talk who may mistakenly have thought that Mr Mahoney had properly researched his content before presenting it.

Yours sincerely

Graham Shaw B.D.S

President NZSSD.

Negotiating the Regulatory Minefield for Better Outcomes for Practitioners and the Public.

Dr Greg Mahoney
President for the Australian Society of Dental Anaesthesiology

Introduction

This is not a presentation with specific learning outcomes but rather it will outline a case for standardised regulation and provide a guide on how to get the best outcomes. It does not seek to tell paediatric sedationists how to do their work ... I'll leave that to others. The presentation will have a North American focus but will draw on the global experience.

Why have regulation?

Indeed we are well trained professionals with high professional standards and who have the best interest of our patients. An example of an unregulated profession (in sedation) is New Zealand (a small democratic country in the south pacific). After 3 days of training dentist can perform remifentanyl/profopol sedations ie spontaneously ventilated general anaesthetics. I am yet to find someone outside New Zealand who thinks that this is a good idea. (New Zealand Society of Sedation in Dentistry, 2016)

Moving to North America we find headlines of numerous deaths of children in particular following or during dental treatment where a sedative is used. Invariably, the findings following such cases point to deficiencies in training, equipment and protocols. (Mason, 2014) (Lee HH, 2013) (Krippaehne JA, 1992) (Bradfort, 2012) (Webster, Mason, & Shafer, 2016) (Horeczko & Mahmoud, 2016)

Furthermore, a regulation and policy vacuum can lead to unacceptable practices by groups or individuals who can survive and thrive because they haven't killed anyone...yet.

So what happen when regulations are non-existent or poor?

Quite simply, regulations will be imposed by regulators be it government or an over reaching professional body (dental/medical board equivalent). This happened in the both the UK and Australia following deaths in dental surgery.

In the UK, this lead to the Poswillo Report (1990) which recommended one drug sedations yet failed to mandate a requirement for oxygen in the dental surgery. (Poswillo, 1999)

In Australia, it lead

- to restrictions;
- better monitoring;
- better mentoring;
- a more formalised training process with an emphasis on knowing candidates limitations; and
- it lead to Dr Doug Stewart.

Situation, in Australia this has meant that there is/ are;

- fewer cases of morbidity and mortality,
- a motivated well training workforce which is actively seeking opportunities to maintain and enhance their skills
- a recognised and accepted process of review, and
- a process should something go wrong.

So what?

You may be comfortable with your processes and procedures but is the dentist in the next town meeting an acceptable "standard" and could his poor practises impact on your ability to practice? Absolutely, if not through imposed regulation then it will be market forces and perceptions. Furthermore, who is to say that your procedures and protocol would withstand scrutiny? Indeed recent article are calling for improved consensus. (Horeczko & Mahmoud, 2016)

Regulation vs Policy

Regulation implies some legally binding process through a legislative process while policy is a document authored by the stakeholders. A regulation may refer to a policy.

So how do we achieve an Outcome that will work for all?

1. Be proactive
2. Have strong leadership
3. Establish Credibility within the profession and public
4. Establish consensus within the profession
    a. In US, there are a number of professional and semi-professional bodies/ groups working. (Anaesthetists, anaesthesiologists, ASDA, ADSA, DOCs, Paediatric dentists and general dentists). The process must be inclusive.
    b. Be flexible
    c. Recognise the skill set and limitations of each group, and
    d. Establish standards of care

Standards of Care

It should be a Joint statement/ policy/guideline

What should it include?

- Definitions
    - Analgesia
    - Sedation
    - General
- Aims
- Patient Preparation
- Patient assessment
- Staffing
    - How many?
    - Who?
- Facilities and equipment
- Monitoring
- Training
    - Paediatric sedation

- Conscious (light) IV sedation
- Deep sedation
- General anaesthetic
- Oral sedation
    - polypharmacology
- Post-op care (Australian and New Zealand College of Anaesthetists, 2014) (Hosey, 2002)

What format?

There is an escalating level of committing on how the standard of care is framed. Typically, standards of care start at the lowest level then go out to community for consultation before the next phase.

Statement, is just that; a statement by the authors which they believe to be the appropriate standard of care.

A guideline is tool for members of the consensus group to assist them in provide an appropriate standard of care.

A policy document is a binding standard on the members.

The standard of care is a working document and should be under a defined review process and language can play an important part in establishing and improving the standard. For example, the words "may and could" imply that it is a nice to have process or piece of equipment while "must" is more definite and leave no margin for interpretation.

What happens when this process fails?

Invariably if the process fails it's through the lack of consensus among the stakeholders. This is best avoided through:

- A process of commitment by these stakeholders to get the best outcomes, therefore binding those stakeholders to an outcome. A failure of the process then becomes their failure. However, if is not inclusive of all the stakeholders in the first place then the process is open to criticism.
- Strong and accepted leadership during the process, this may not be a dental anaesthesiologist. A useful and skilled mediator may be the ADA at a national and state level or a state dental board representative.

Conclusion

Regulation or a binding policy provides the framework to achieve a better outcome for the patients and practitioners. Within the US context, the wide range of skills and techniques of practitioners in sedation makes it particularly challenging.

New Zealand Society of Sedation in Dentistry. (2016, July 30). *New Zealand Society of Sedation in Dentistry*. Retrieved from dentalsedation.co.nz/dental-sedation-courses/

Australian and New Zealand College of Anaesthetists. (2014). *Guidelines on Sedation and/or Anaalgesia for Diagnostic and interventional Medical, Dental or Surgical Procedures.* Melbourne: ANZCA.

Bradfort, H. (2012, July 14). *Dental Sedation Responsible for at least 31 Child Deaths over 15 Years*. Retrieved from Huffington Post: http://www.huffingtonpost.com.au/entry/dental-sedation-child-deaths_n_1671604

Horeczko, T., & Mahmoud, M. A. (2016). The sedation mindset: philosophy, science, and practice. *Current Opinion in Anesthesia; 29* , S48-S55.

Hosey, M. (2002). Managing anxious children: the use of conscious sedation in paediatric sedation. *Int J Paedatr Dent; 12 (5)*, 359-72.

Krippaehne JA, M. M. (1992). Morbidity and mortality from pharmacosedation and general anesthesia in the dental office. *J Oral and Maxillo Surg; 50 (7)*, 691-698.

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Mason, K. e. (2014). *Pediatric Sedation Outside of the Operating Room.* New York : Springer.

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Webster, C. S., Mason, K. P., & Shafer, S. L. (2016). Threats to safety during sedation outside of the operating room and the death of Michael Jackson. *Current Opinion in Anesthesia ; 29 (2)*, S36-S37.