

1 COMMONWEALTH OF VIRGINIA
2 DEPARTMENT OF HEALTH PROFESSION
3 VIRGINIA BOARD OF DENTISTRY

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7 IN RE: PUBLIC HEARING

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13 JANUARY 22, 2004
14 FIFTH FLOOR, CONFERENCE ROOM 1
15 6606 WEST BROAD STREET
16 RICHMOND, VIRGINIA 23230
17 8:45 A.M.

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| 4 | Robert H. Keller, DDS | 23, 37 |
| 5 | James E. Krochmal, DDS | 33 |

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1 MS. LEVITIN: Good morning. I am
2 Trudy Levitin, President of the Board of Dentistry.
3 This is a public hearing to receive comments on two
4 sets of proposed regulations. We will first receive
5 any public comment on the fast-track proposal to
6 restrict home-study continuing education hours to
7 five per year.

8 The proposed fast-track amendment
9 was published in the January 12th, 2004 Register of
10 Regulations. A copy of the proposed regulation may
11 be found on the back table or in the agenda package.

12 At this time, I will call on
13 persons who have signed up to comment. As I call
14 your name, please come forward and tell us your name
15 and where you are from.

16 The first speaker is Ed Griggs --
17 Dr. Ed Griggs.

18 DR. GRIGGS: Is that on the
19 sedation or the fast-track?

20 MS. LEVITIN: They gave me the
21 wrong one. I'm sorry.

22 MS. REEN: There is no one signed
23 up at all.

24 MS. LEVITIN: Oh, okay. Are there
25 any persons who wish to speak, at this time, on the

1 fast-track regulations? I want to remind everyone
2 that written comments on the fast-track regulation
3 may be received through March 13, 2004 and should be
4 directed to Sandra Reen, Executive Director of the
5 Board. Unless the fast-track process is suspended,
6 the regulation will become final and effective on
7 April 1, 2004.

8 We will next receive any public
9 comment on the proposed amendments to clarify
10 certain portions of the regulations and amendments
11 to the practice of sedation and anesthesia.

12 The proposed amendments were
13 published in the December 29th, 2003 Register of
14 Regulations. A copy of the proposed regulations may
15 be found on the back table or in the agenda package.

16 At this time I will call on persons
17 who have signed up to comment. As I call your name,
18 please come forward and tell us your name and where
19 you are from. On sedation and anesthesia; Dr. Ed
20 Griggs. Did we get it right this time?

21 NOTE: Laughter.

22 DR. GRIGGS: I've got my letter. I
23 have copies for the Board. First of all I'd like
24 you to know that I was sorry to see this table
25 disappear.

1 NOTE: Laughter.

2 DR. GRIGGS: But I will try to get
3 through. My name is Dr. Ed Griggs. I'm a dentist
4 in Richmond, practicing in the Midlothian area, and
5 I live in the Bon Air area of Richmond. I've passed
6 out copies of my letter. I'll probably read it word
7 for word, and I apologize for that in advance but I
8 want to make sure that I don't leave out any of my
9 comments.

10 I'd like to thank you today for the
11 opportunity to speak about the sedation issue. I,
12 too, am in favor of regulations that address doctor
13 and staff training, emergency equipment, and patient
14 safety. I believe that it is important to have
15 definitive regulations that will set the standard by
16 which all dentists who employ conscious sedation
17 will need to adhere. This will foster the proper
18 perception that the public interest will be served
19 by providing a safe environment to treat the very
20 anxious and fearful patients who need dental
21 treatment under conscious sedation.

22 I employ it in my own practice -- I
23 employ my own practice the Enteral/Inhalation method
24 of sedation. I do not now nor do I wish to do so in
25 the future employ the Parental Method or the IV

1 Sedation Method. I have been practicing dentistry
2 for 23 years, and early in my career I was cautioned
3 by two prominent oral surgeons not to accept the
4 risk of treating patients with IV sedation because
5 they clearly thought it was beyond the scope of
6 practice for the typical general practitioner. I
7 have followed their advice and have not regretted
8 that decision, but I have observed many patients who
9 needlessly suffered pain, apprehension and,
10 ultimately, their refusal to be treated because
11 their dentistry had to be performed or attempted to
12 be performed without sedation. It is for this type
13 of patient that I was pleased to discover the
14 benefits of oral conscious sedation.

15 I have employed this method in my
16 practice for the past two years. My training has
17 taken place through courses offered by the Dental
18 Organization for Conscious Sedation, otherwise known
19 as DOCS, which provided a sedation method which was
20 safe and effective. Patients could now be treated
21 with an oral medication that provided sedation,
22 comfort and amnesia. DOCS, also, insisted that
23 there be proper monitoring of the patient and
24 training for the staff as well. As you are well
25 aware of, oral conscious sedation has been

1 unregulated and there have been many ways to
2 administer various oral medications. Often these
3 methods were passed on from one practitioner to
4 another without any monitoring or safety equipment
5 in place.

6 DOCS has standardized the practice
7 of Oral Conscious Sedation using the
8 Enteral/Inhalation protocol.

9 I have read the proposed
10 regulations and the supporting documentation and
11 would like to speak to several concerns that I have
12 regarding these regulations. First of all I am
13 concerned about the wording in the document that
14 addresses the methods of conscious sedation under
15 one broad heading of conscious sedation.

16 I feel that the Inhalation/Enteral
17 methods are much different than the Parental methods
18 and should be treated as such. As the insurance
19 companies demonstrated by their rating with higher
20 malpractice rates for practitioners who employ the
21 Parental Sedation in their practices, there is an
22 increased risk with this method. As such, the
23 training and emergency equipment needed may be
24 different for the Inhalation/Enteral methods as
25 there would be less risk to the patient.

1 Further, I would not wish to signal
2 the insurance companies that the Board feels that
3 the Inhalation/Enteral and Parental methods of
4 sedation pose the same risk to the patient. The
5 idea behind the regulations is to standardize the
6 sedation education, training, and emergency
7 protocols, not to stop the practice of oral
8 conscious sedation. If our dental malpractice
9 insurance is rated the same for Enteral sedation as
10 with Parental sedation, then many general
11 practitioners, myself included, would be forced to
12 stop its practice. This would be a serious blow to
13 public health.

14 The wording of your regulations,
15 the ADA document, Part III, Section 1, the General
16 Principles, subsection A-1 deals with these terms as
17 Inhalation, Enteral or Enteral/Inhalation Combined
18 and Parental as separate entities. Structuring your
19 guidelines this way may reduce potential confusion.

20 The second item -- I don't know how
21 you officially refer to these 18 VAC -- is there a
22 way?

23 MS. REEN: If you refer to the last
24 three numbers, we'll be able to find it.

25 DR. GRIGGS: 60 21 20, thank you.

1 Section B addresses training requirements for
2 conscious sedation by any method that would imply
3 that Enteral was being lumped together with the
4 Parental methods. Section C, specifically,
5 addresses a training requirement for the Enteral
6 method of sedation only.

7 When I read this this was somewhat
8 confusing to me in terms of how it was structured,
9 but I would like to comment about the 40-hour
10 requirement for the Enteral method.

11 Again, DOCS already teaches two
12 comprehensive courses that address the
13 enteral/inhalation method of conscious sedation. I
14 would encourage the Board to inquire further and to
15 attend the 20-hour course which is a more intensive
16 course to investigate the possibility of using this
17 course in lieu of the 40-hour course. If the Board
18 cannot accept an invitation to attend the course,
19 due to conflict of interest or potential conflict of
20 interest, then I would highly recommend that the
21 Board pay to send a representative to see for itself
22 what is being taught.

23 I have brought with me the teaching
24 manual that is used in the course. It's a rather
25 large massive document. It's here for your perusal

1 if you'd like to so examine it during the break I'll
2 be happy to stay and allow you to do that. I am not
3 prepared to leave it, however, because I rely on
4 that manual and use it almost with every sedation.
5 I feel that this organization produces a course that
6 would satisfy the educational requirements without
7 overburdening the practitioner. A 40-hour course
8 could suggest a week long course. This would be a
9 burden on most practitioners to forego an entire
10 week in the practice for CE course. Typically, I'm
11 aware of parental courses lasting that long, but I
12 am unaware of week long courses in oral conscious
13 sedation.

14 Item three, regarding 60 20 120,
15 Section E, Emergency equipment. I would recommend
16 that the Board consider substituting the combitube
17 airway in lieu of the laryngoscope and endotracheal
18 tubes. The purpose of this equipment is to secure
19 an airway in a timely manner. As stated in the
20 enclosed documentation -- and I don't know that that
21 made it to you. I'm sorry.

22 I have documentation addressing the
23 combitube. This airway provides for "blind
24 intubation made easy" as there is no need for
25 visualization of the airway. It provides an airway

1 whether it is placed in the trachea or in the
2 esophagus. During my anesthesia rotation in my
3 General Practice Residency at McGuire VA Medical
4 Center here in town, I attempted to place an
5 endotracheal tube in a surgical patient and I can
6 tell you it was not easy and that was under
7 supervision. And it was not easy.

8 I would suggest to you that the
9 typical trained dentist is going to cause more harm
10 to the patient than good if they're asked to place
11 endotracheal tubes in a sedated patient that is
12 having an emergency episode. I would ask that you
13 keep the laryngoscope and endotracheal tubes in the
14 offices of the oral surgeons who have been more
15 highly trained in these procedures, and that we not
16 ask the general dentist to use them. I would like
17 you to give the general dentist a fool proof way to
18 help the patient and not to hurt him. And I think
19 the combitube would satisfy those requirements.

20 The second recommendation regarding
21 emergency equipment that the Board should consider
22 using under this section would be to have the office
23 have an AED, and Automated Electronic Defibrillator.
24 Yes, this is an expensive item, but as anyone who
25 has renewed even the Basic Life Support

1 certification already knows this is now considered
2 part of the chain of survival. And if you're not
3 familiar with the chain of survival, basically, you
4 identify the patient as having a problem, you call
5 911, you ask somebody to bring you the AED. So this
6 is under basic life support.

7 In the ACLS course, training in the
8 use of the AED was already part of the necessary
9 protocols to achieve certification. And if it's
10 already being taught in the BLS classes how much
11 more important is it to have a device such as this
12 in an office that is utilizing sedation.
13 Respiratory arrest is a risk with sedation. If you
14 have respiratory arrest it's safe to assume that
15 cardiac arrest could follow, and it's been clearly
16 demonstrated or documented that successful
17 resuscitation is greatly enhanced the sooner that an
18 AED is brought to the patient.

19 Item four, under the same
20 regulation, Section E or perhaps in Section F,
21 Monitoring Equipment, there is no mention of
22 monitoring the patient during the time that the
23 sedation is being employed. I assume that this
24 might be an oversight since even with the
25 Inhalation/Anxiolysis section it does at least

1 address Blood Pressure monitoring.

2 I would very strongly recommend
3 that the Board consider regulations, which would
4 include a requirement to monitor the patient with
5 Pulse Oximetry and Blood Pressure Monitoring
6 equipment that is used in the treatment room to
7 monitor the patient throughout the sedation
8 procedure. It is very easy for the patient, who is
9 undergoing a sedation, to reposition his or her head
10 and occlude the airway. When the airway is occluded
11 the patient is no longer breathing, and the oxygen
12 level starts to drop. The machine monitors the
13 oxygen levels. As the oxygen levels begins to drop
14 an alarm will sound once its dropped below a certain
15 level. Almost, without question, every sedation
16 I've ever done, the alarm has sounded because the
17 airway has been occluded, and I was not aware of it.
18 With the Pulse Oximetry I am aware of that patient's
19 airway. I'm aware of their oxygen saturation. I
20 know, without a doubt, that I have a problem. It's
21 not a serious problem, it just means that I have to
22 readjust their head, open the airway, have them take
23 a few breaths, oxygen saturation increases, and
24 safety is maintained.

25 In the good old days, and I

1 mentioned earlier, the good old days of winging it
2 when there were no safe protocols combining
3 medications I was clueless as to whether the
4 patient's airway may have been occluded. I was
5 clueless if the patient's saturation level of oxygen
6 had dropped, and now I'm not. Unfortunately if you
7 impose regulations that have no Pulse Oximetry
8 anyone following the Board's regulations will also
9 be clueless as to whether they have a problem.

10 So, I would encourage you to insert
11 a regulation that would require the Pulse Oximetry
12 and Blood Pressure Monitoring equipment. The one
13 that I use in my office prints a script. It prints
14 out all the data at periotic intervals so I have
15 documentation as to the safety that I have rendered
16 for that patient. Not all the monitoring equipment
17 has the print out. That would be the Board's
18 decision whether you would want to insert that
19 requirement as well.

20 But I do feel that this is an
21 essential piece of equipment in the conscious
22 sedation practice doing the enteral method and
23 certainly the Parental method. And I don't believe
24 it's noticed for the Parental method either. So,
25 what I'm here to do is to address the enteral

1 inhalation method, but if you don't insert the
2 regulation for that method at least insert it for
3 the Parental method because the risk for the patient
4 it much higher with an IV sedation protocol.

5 I would like to thank the Board for
6 its time and would welcome any questions.

7 MS. LEVITIN: As to Number Four you
8 said E or F there was no mention of monitoring a
9 patient, but when I look under F it talks about
10 monitoring a patient under conscious sedation. It
11 talks about the treatment team for conscious
12 sedation shall consist of the operating dentist and
13 a second person to assist, monitor and observe the
14 patient.

15 Number Two, monitoring of the
16 patient under conscious sedation is to take place
17 continuously during the dental procedure. Did you
18 not see that?

19 DR. GRIGGS: Oh, absolutely. I saw
20 it, but it didn't appear to go far enough.

21 Can I have that reference again,
22 please?

23 MS. LEVITIN: Yes, it's on Page 66,
24 at the very bottom.

25 MS. REEN: He doesn't have it as

1 Page 66. Page 46.

2 DR. GRIGGS: Okay. Let me get my
3 bearings here. To answer your question, I did read
4 that. And I'm not saying that there is no mention
5 of monitoring.

6 MS. LEVITIN: Oh, I thought that's
7 what you were saying.

8 DR. GRIGGS: No. My point was that
9 under the monitoring section there is no mention of
10 Pulse Oximetry. For instance, when you go --

11 DR. LINK: If you look on the
12 previous page, Page 23, there is a mention of the
13 Pulse Oximetry.

14 DR. GRIGGS: Okay. Could you give
15 me the page number?

16 MS. REEN: It's your Page 23 in your
17 book.

18 DR. GRIGGS: I did see that and
19 that's really what I was assuming there, and I may
20 be wrong here. The document I had showed that as
21 being under the deep sedation section, general
22 anesthesia. It says under Section E, Emergency
23 Equipment and Techniques; a dentist who administers
24 deep sedation/general anesthesia shall be proficient
25 in handling emergencies and complications related to

1 pain control procedures, etcetera, etcetera, items
2 one through nine, which is the Pulse Oximetry
3 references.

4 So, I did see it in the deep
5 sedation section, but I did not see it in the
6 subsequent section.

7 DR. LINK: I think it's just flip
8 flopped or something.

9 DR. GRIGGS: Well, deep sedation in
10 addition to the Pulse Oximetry, also, has the EKG
11 monitor which would be appropriate I think for deep
12 sedation.

13 DR. TAYLOR: Dr. Griggs, tell me,
14 you mentioned Page Two, paragraph one, about the
15 malpractice insurance. You've, obviously, checked
16 into this.

17 What can you tell me about this?

18 DR. GRIGGS: Well, I haven't
19 checked into it as such, but, you know, I know that
20 IV Sedation/Parental Approach is a rated procedure
21 and you do have to pay higher malpractice rates. To
22 me it's not worth it to pay those rates to do oral
23 sedation. I have not -- that's just my own personal
24 bias, but I would just like it to be really clear in
25 the regulations that the enteral/inhalation is

1 different. And I'm talking about --

2 DR. TAYLOR: A financial
3 difference?

4 DR. GRIGGS: I don't know what the
5 difference is, because I do not employ that method
6 but I do know that you take a step up in the
7 malpractice insurance.

8 MS. LEVITIN: Anybody else like to
9 comment.

10 DR. ZIMMET: I'm not familiar with
11 the combitube, is that routine?

12 DR. GRIGGS: In fact, I've got one
13 in the car and I meant to bring it up and forgot to
14 do it. If -- I have a handout I can circulate.

15 DR. ZIMMET: I mean, if it's so
16 easy why wouldn't all oral surgeons offices use it
17 instead of regular sedation?

18 DR. GRIGGS: I don't know how to
19 answer that. The combitube actually has two tubes;
20 one tube is for ventilating the lungs, the other
21 tube is to plug the esophagus.

22 So, the basic technique is you
23 shove it down the throat. Okay. And you have the
24 two tubes that are sticking out. You immediately go
25 to your first tube, assuming that you've put it in

1 correctly, and you put the oxygen mask to that
2 entrance and you ventilate. If the chest rises,
3 then you've done it correct and everything is fine.
4 If the chest does not rise it means you're in the
5 wrong tube and then you just take it and switch it
6 to the evasive tube, which means now you can,
7 without repositing the tube, without wasting any
8 time -- you're going to ventilate one or the other.
9 You ventilate the first one, if you're wrong you
10 move your oxygen to the second tube and you
11 ventilate and you see the chest rise.

12 So, it is almost -- it's a great
13 invention. I'm sorry I didn't invent it myself, but
14 it should make it far easier and far quicker to
15 intubate a patient.

16 DR. LINK: I thought the new ADA
17 guidelines basically were going towards the state of
18 the patient and getting away from the enteral and
19 parental method and that sort of thing.

20 DR. GRIGGS: Well, the guidelines
21 that I had were the guidelines that were on the
22 website, the ADA Guidelines 2002, and they,
23 basically, break down for training purposes the
24 three entities as separate entities. They may be
25 moving in that direction.

1 DR. LINK: I think they are.

2 DR. GRIGGS: And I don't have privy
3 to that.

4 DR. LINK: I think that's when we
5 started looking at it that way. I'll double check.

6 DR. GRIGGS: I had looked and I
7 didn't bring my copy of the ADA Guidelines, Part
8 Three, Continuing Education, the first section and
9 that's the reference that I mentioned in the
10 handout. It does address, for training purposes,
11 addresses it as three separate entities.

12 DR. GOKLI: This documentation on
13 conscious sedation, General Organization for
14 Conscious Sedation, what is their accreditation --

15 DR. GRIGGS: I don't know what
16 their accreditation is. They are a private
17 organization to foster, basically, what the
18 protocols that allow sedation in a safe environment,
19 and they have -- they're based in Philadelphia. And
20 I don't present to speak for that organization. I
21 am a member of the organization, but I don't -- I'm
22 not on staff. I don't speak for them. But they do
23 have staff members who will be happy to come down
24 and address the Board if the Board is so inclined
25 and that is a possibility. I did my first with them

1 in October of 2000 and did a subsequent term. My
2 present training is a 20 hour course last year.

3 If the Board would like to see the
4 training manual, a list of the documentations, if
5 anyone has an interest in seeing it, but, you know,
6 I think if you look at the break downs of the
7 document there's a lot of sections dealing with
8 pharmacology, drug choice protocols, case histories.
9 It's fairly insensitive.

10 It, also, provides a sedation on
11 live patients, that group as a whole. And
12 furthermore the follow up, it's a two and a half day
13 course and the last morning of the last day the
14 patients come back and, basically, resite their
15 experiences that they've had with the sedation
16 method.

17 MS. LEVITIN: Thank you for your
18 comments.

19 Are there any other questions at
20 this point?

21 That's the only person's name I
22 have on the sign in sheet.

23 Is there anyone else who wishes to
24 speak?

25 DR. KELLER: I got here, kind of,

1 late. I went to another building.

2 What are we talking about right

3 now? What is the subject?

4 MS. LEVITIN: Right now, actually,

5 we're speaking on proposed amendments to clarify

6 certain portions of the regulations and amendments

7 on sedation an anesthesia.

8 DR. KELLER: You're not talking

9 about general anesthesia?

10 MS. LEVITIN: We're talking about

11 all kinds of anesthesia.

12 DR. KELLER: All right. I'm Robert

13 H. Keller, dentist. I have been a dentist for 40

14 years and have a good-sized practice. And ever

15 since this problem came up, coming down here this is

16 the fourth trip I've had to come before different

17 State Boards on the same subject. The last three

18 times -- mainly I'm speaking about IV sedation and

19 nitrous oxide analgesic.

20 And at tonight's State Bill meeting

21 I hold 100, at least 100 dentist there about nitrous

22 oxide and IV sedation. On the subject of needing

23 CPR, needing further regulations, and the whole

24 thing was turned down.

25 The group I talked with thought it

1 was not needed, but it has come up before the State
2 Board three times. Now, I use -- I trained -- I had
3 three years residency in the Navy, then general
4 anesthesia, dentistry general anesthesia in the Navy
5 when I was there, because the physician operated
6 through general anesthesia aboard the ship. So, I
7 did that residency.

8 I did a tour down at the Children's
9 Hospital in Miami, and I've been around the wheel on
10 this thing. And, I, for the life of me, I can't
11 find anyone who has had any trouble with this
12 needing all these exceptions and rules. They've
13 been turned down before, and now here it is again.
14 And I would like to know who keeps bringing this
15 thing up, why we have to be regulated almost as much
16 as people with general anesthesia.

17 Does anybody on the Board use
18 Nitrous Oxide or IV sedation? Because I'm sure when
19 I started practicing there were dentist who didn't
20 use Novocain. They said, the first thing, "I don't
21 use Novocain because it slows me down." Well, okay.
22 And then Xylocaine was coming in, and "Maybe we'll
23 not use that because that might hurt the patients,"
24 And I heard that. And when I started using nitrous
25 oxide, in Fredericksburg, that was going to kill

1 everybody. That was what I've heard among the
2 dentist. And IV sedation, and I heard that.

3 I finally quit using IV sedation
4 not because I had anything against it but because I
5 just didn't seem like it fit into my way of
6 operating. But I have nothing against it. I talked
7 to Dr. Flippawhich (phonetic), who's a professor
8 down at the Medical College for 25 years. He said
9 he can't understand why all this problems that seem
10 to be coming up every year wanting to change the
11 regulations.

12 So, I've used nitrous oxide at
13 least 38 years. And I've never seen anything, any
14 reaction, any heart stop, any kind of problem with
15 it. And I do patients or did patients in Mary
16 Washington Hospital, Fredericksburg, Virginia. And
17 I did have a patient who had a heart stop, but it
18 was on general anesthesia and I had an
19 anesthesiologist who was running the program and I
20 was doing the operating. And it was a lot of
21 circumstance because of that, but we didn't use CPR
22 then. We forced oxygen and he banged on her chest
23 until she finally started up again.

24 Most of the CPR used by laymen are
25 out here in the field some where trying to get

1 something started, but I have three articles in the
2 Richmond paper about CPR. And it's not very
3 flattering. Most rescuers don't want to use it in
4 the field because of the Aids and TB and other
5 problems they might get involved with. And they're
6 having a hard time getting people to use it. And
7 the other thing is, according to the Richmond paper,
8 this is a recent one, it came out in January, they
9 recommend using a phaso constrictor which everybody
10 keeps in their office or should keep in their
11 office, rather than CPR.

12 And then there's another article
13 about this device that they've come up with that
14 does better work than the CPR type method. CPR is
15 good for laymen. It's good for people who -- a
16 drowning victim, but I don't see a whole lot of use
17 in the office. And the other point I'd like to make
18 is there's a lot of people out here that are not
19 physically able to give CPR. I can't give CPR
20 because of the fact that I'm afraid I might have a
21 stroke. I already had one. So I don't see that
22 that should be forced on people.

23 There are other methods, and I
24 don't see the need for CPR to be tied to the dental
25 license. And we have to pay a fee every year, which

1 it cost probably \$1,500 a day for a dentist to go
2 out and take these courses. And I live 80 miles
3 from here, in North Cumberland County. It takes me
4 over two hours to get here, and two hours back. And
5 I had to drive all the way to Richmond to get a
6 course. But I feel like that we should reconsider
7 any kind of change in the law on nitrous oxide.
8 Particularly I talked to Dr. Freeman in
9 Fredericksburg the other day. He said he's used it
10 almost as long as I have and never seen a reaction.
11 And we can't figure out why we're brought under
12 these rules.

13 There's no explanation of why
14 there's a need for this. It's just written. And
15 the Board is putting a lot more pressure on it. We
16 only have 240 days a year to practice. And that's
17 about all. I figured it out, and you're increasing
18 the cost in practice and you're not doing public
19 safety. There's no public safety. Now I had a
20 lecture by a cardiologist who said a patient that
21 would have a heart attack was probably better off
22 under nitrous oxide than they would be any other way
23 because nitrous oxide would relieve a lot of the
24 pain that occurs with heart attack. And at least
25 they're getting at least 2 milliliters of oxygen a

1 minute through the machine. These machines are set
2 so you can't turn the oxygen off to a patient. So
3 if properly used you cannot suffocate a patient. In
4 fact we don't believe -- I don't believe we will
5 breath 2 milliliters of oxygen a minute ordinarily.

6 So, we've got to understand that
7 this keeps coming up. I don't know where it comes
8 from and why we keep bringing this in. We, sort of,
9 get drug in with general anesthesia. That's general
10 anesthesia, and I agree with you on that. And we
11 don't agree that controlling nitrous oxide and the
12 way we're controlling general anesthesia and putting
13 it under the same kind of regulations. And it ought
14 to be -- the evidence here ought to be that three
15 other Boards have examined us over a period of years
16 and have put it aside.

17 MS. LEVITIN: Thank you for the
18 comments.

19 DR. LINK: Just to clarify, we're
20 not changing anything on nitrous oxide at all.
21 Those are the same regulations. We're rearranging
22 some of the stuff on general anesthesia. The reason
23 we have to do this is the ADA Guidelines have
24 changed, and therefore we have to change our
25 regulations to keep up with the current guidelines

1 because the ADA --

2 DR. KELLER: Well, now, in this
3 paper I got, recently, you showed a lot of changes
4 in nitrous oxide.

5 DR. LINK: I don't think we've
6 changed nitrous oxide at all.

7 DR. KELLER: Well, you've got
8 these, all these taking CPR.

9 DR. LINK: That's always been
10 there.

11 DR. KELLER: And you've got us
12 taking 40 hours of --

13 DR. LINK: No. No. That's
14 something different. That's something totally
15 different. That's conscious sedation. That's -- if
16 you have not had any generalized training and you're
17 a general dentist and you want to go into conscious
18 sedation/oral medication, that's where the 40 hours
19 comes in.

20 DR. KELLER: Well, what about the
21 12 hours by 2005?

22 DR. LINK: That is for those who
23 administer conscious sedation. That's conscious
24 sedation, no way affecting nitrous oxide. Now I
25 just want to clarify --

1 DR. KELLER: Well, what is your
2 definition of conscious sedation?

3 DR. LINK: I can show you pages
4 where it's located.

5 MS. REEN: I would just like to
6 point out to the Board members that, apparently, we
7 have left out Pages 20 and 21 out of your book. And
8 I will go and retrieve that.

9 DR. LINK: Conscious sedation, the
10 definition is on Page 45 -- Page 3, check Page 3
11 under definitions. Nitrous oxide, which is on Page
12 2, now flip over the page and you will have the
13 answer to your license, which everyone who has
14 testified before the committee has said it would be
15 under nitrous oxide.

16 DR. KELLER: What about CPR?

17 DR. LINK: That's currently in
18 regulation now.

19 MS. YEATTS: I don't think it's
20 required for nitrous oxide.

21 DR. LINK: It's required for all
22 practicing dentist.

23 DR. KELLER: Not as far as I know.
24 The American Heart Association --

25 MS. YEATTS: I think it was

1 required for those that are administering conscious
2 sedation for -- and it's not just CPR.

3 DR. LINK: It should be required.

4 MS. YEATTS: It's not required in
5 CPR.

6 DR. KELLER: Tell me why you should
7 have CPR?

8 We've got people out here that
9 don't know the difference between a stroke, and you
10 certainly wouldn't apply the same --

11 DR. LINK: If you have an adverse
12 reaction to anything, we need to know the basis on
13 how to -- our job here is to protect the public,
14 sir. And we need to protect the public. If you're
15 going to put somebody under general
16 anesthesia/conscious sedation we feel as the Board
17 that we need to protect the public in requiring our
18 licensees to have CPR.

19 DR. KELLER: But you're not
20 protecting the public.

21 DR. LINK: How are we not
22 protecting the public?

23 DR. KELLER: Because I think the
24 things that you're addressing that CPR will not take
25 care of.

1 DR. LINK: Well, we feel for
2 nitrous oxide it will. For somebody that's doing
3 conscious sedation you need a little more
4 advanced -- well, even if the patient doesn't have
5 nitrous oxide, say a patient has a heart attack in
6 the office, if you have no training -- you were
7 required to have this in dental school. At least I
8 was.

9 DR. KELLER: I've had CPR courses
10 but what I'm trying to say is that I don't see that
11 CPR, running down and paying the money to get a CPR
12 course to check off the list has much benefit to the
13 dentist.

14 DR. LINK: I would just like to say
15 that I appreciate your bringing your views before
16 us. We're here to receive comment. It's not a
17 debate.

18 DR. KELLER: Okay.

19 DR. LINK: We've already made some
20 decisions and we would like to hear from whoever
21 would like to speak to the decisions we've made.
22 But we're not here to debate why we've done all this
23 right at this time. We want to give everybody a
24 chance to speak and we appreciate you bringing your
25 concern to this forum.

1 DR. KELLER: My concern is -- part
2 of my concern is requiring as part of our license to
3 the American Heart Association, and I don't feel it
4 would be a safety benefit of any kind. I think a
5 person on nitrous oxide would be in much better
6 shape because they can be ventilated with oxygen
7 continuously and if you don't use nitrous oxide you
8 probably should take the course in the situation.

9 MS. LEVITIN: We thank you for your
10 comment.

11 DR. KELLER: Okay.

12 MS. LEVITIN: Is there anyone else
13 who would like to speak?

14 Please state your name and where
15 you are from.

16 DR. KROCHMAL: I'm James Krochmal.
17 I'm an oral surgeon in Norfolk, Virginia. I just
18 wanted to comment quickly, and I don't represent
19 anybody but myself in practicing oral maxillofacial
20 surgery. I wanted to comment quickly on Page, my
21 Page 61, Section B, the classifications for
22 conscious sedation section, speaking as an oral and
23 maxillofacial surgeon we're training to provide
24 assessment in the history of physicals on our
25 patients and most of us maintain that privilege

1 through hospitals.

2 My concern is that we may be tying
3 oral and maxillofacial surgery community by limiting
4 our abilities to not treat the Sedation Class 4 and
5 5 patients. Most of us, practically, when we see
6 these type of patients in our practices certainly
7 request a consultation with the physician on their
8 ability to withstand even light sedation or low
9 plain anesthesia for that matter.

10 But I think we should leave it
11 practically between the oral and maxillofacial
12 surgeon and physician whether that particular
13 patient is capable to withstand treatment in the
14 office. More often than not, in my experience, even
15 Class 4 patients that are reasonably stable can be
16 treated more safely or as safely in our office than
17 a stay in the hospital, so, if you take the proper
18 precautions. And sedation on a sick patient,
19 anxious patient, is a benefit more than it is a
20 hinderance as long as you're practicing safe oral
21 surgery.

22 So, that's my concern. It's just
23 the classification of the patient. And I would
24 request, as a practicing oral and maxillofacial
25 surgeon in Virginia, that we don't limit the oral

1 surgeons from that or tie their hands down, and
2 leave it to their discretion. That was my concern.

3 MS. LEVITIN: Any questions? Would
4 anybody else like to speak?

5 Next.

6 DR. CRABTREE: Mark Crabtree from
7 Martinsville, Virginia. This particular provision
8 here on -- my understanding is, basically, begins
9 with conscious sedation and anesthesia issues. And,
10 of course, a lot of other little things tacked in
11 there.

12 And I just wanted to speak to one;
13 dropping of the requirement of a very simple
14 examination to assure that the practitioner has read
15 and understood the laws of the Commonwealth of
16 Virginia. I oppose removing that small requirement.
17 I think that you go to get your driver's license in
18 the State of Virginia you have to take an
19 examination by computer to insure that you
20 understand the laws of driving on the highway.

21 I think the laws of the
22 Commonwealth of Virginia are very important to know
23 for the practitioners that are practicing here, to
24 know and understand what you require of them. And
25 to remove that one time effort to assure that they

1 have read and understood that versus certifying that
2 they have read the regulations, does not assure the
3 public that they do indeed know the laws and rules
4 of practicing in the State of Virginia.

5 MS. LEVITIN: Thank you for your
6 comments. Would anybody else like to speak?

7 If not, I want to remind everyone
8 that any comments or new proposals may be received
9 by February 27th, 2004 and should be directed to
10 Sandra Reen, Executive Director of the Board. All
11 written or electronic will, also, be considered to
12 the Board for adoption on it's final regulations at
13 it's meeting scheduled for April the 9th, 2004.
14 This concludes our hearing.

15 MS. REEN: Ms. Levitin, I would
16 like to announce that the regulatory legislative
17 committee will be meeting prior to the April board
18 meeting to review comments and address the comments
19 that have been made. And that meeting is scheduled
20 for February the 27th at 8:30 a.m. in the morning.
21 And it takes place here.

22 MS. LEVITIN: Is that a Friday?

23 MS. REEN: Yes, ma'am. It is a
24 Friday.

25 DR. KELLER: Ma'am, I didn't

1 realize you were going to close the meeting. I

2 wanted to talk about continuing education.

3 MS. REEN: Sir, do you wish to

4 address the proposed regulation, the fast-track

5 proposal?

6 DR. KELLER: The continuing

7 education that you're reducing to only five hours of

8 home study.

9 MS. LEVITIN: Go right ahead.

10 DR. KELLER: All right. I've had

11 some personal experience with this. I didn't think

12 much about it except when the Board finally passed

13 it it was agreed that we would have continuing

14 education. And I have been reminded by Board

15 members in the past that we had this and so it has

16 always been in the back of my mind. In 1999 I had

17 to use this 15 hours because of my parents who live

18 in Bristol. I had to drive because my mother was

19 sick, almost 30,000 miles in the car trying to take

20 care of her and my father, also, was sick.

21 And during those times about all I

22 had time for was to practice and take home study

23 courses. And that was two years. When we had 9/11

24 I had it all planned to go to the State Board

25 Meeting and the State Dental Meeting and as a result

1 of that they cancelled it and I had to call back.

2 And so I picked up 15 hours of home study.

3 The other time was I was sick and
4 got involved, and I had to pick up some home study
5 there. And the one other time that I had to use one
6 study course. And I would like to go to the dental
7 meetings, but, I'll be frank with you, some of these
8 courses you take at some of these meetings are often
9 dog and pony shows with the idea that they've got a
10 salesman out in the hall and he's trying to sell you
11 products.

12 I know I took one course at a State
13 Dental Meeting this year, and I figured out it would
14 cost me almost \$2,000 just to buy the products that
15 he was, sort of, selling. He gave us a list. We
16 have a situation that's been working, and I don't
17 see a whole lot of use in changing it. A lot of
18 people use these journals and send in -- American
19 Dental Association -- to get some hours that way.
20 There's all kinds of ways, but these courses we take
21 a lot of times, golf games and boat rides, are not
22 as good as I think some of the home study courses
23 are. Some of the home study courses I've got I
24 still remember the information. I have a book. I
25 took a test. Believe me, I learned it, and I tell

1 you one thing.

2 It's, sort of, refreshing sometimes
3 that we can sit down at your own leisure and study
4 something.

5 And I tell you folks, when you go
6 in these rooms and they start the slide show, and
7 you scribble down these notes and you go home and
8 you lay them down and you rest, and I guarantee you
9 that we can't read these notes sometimes two weeks
10 later. And sometimes you don't even remember what
11 the show was about. So, I feel that I've got a book
12 that I can always go back and review if I need to
13 that particular subject. And I feel that I've taken
14 my test on it. I feel like the home study courses
15 are good. And you work at doing them.

16 And there's people in this state
17 that go out and they can't go run down an ADA
18 Certified Course. We had a couple professors at
19 MCV, in Denmark and Sweden, and people doing
20 research -- one fellow just threw his hands up. He
21 was doing research. He was the kind of researcher
22 we have -- health, and he just gave up his license
23 because he was going out of the country. And you've
24 got, sort of, a thing there about service people,
25 but service people are not the only ones that go out

1 of this country. There's missionaries and they
2 don't like to get behind. And there's all kinds of
3 folks that are going places and doing things that
4 are involved in other things and would like to keep
5 their license. And so I don't feel that there's a
6 need to change this. It seems to be all about
7 money.

8 MS. LEVITIN: Thank you. All
9 right. We will start the meeting -- we will have a
10 very short break.

11

12 NOTE: Public hearing concluded.

13