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DEPARTMENT OF HEALTH PROFESSION
VIRGINIA BOARD OF DENTISTRY

IN RE: PUBLIC HEARING

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

BOARD MEMBERS:

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

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

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

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

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

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

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

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

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

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

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

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

NOTE: Laughter.

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

NOTE: Laughter.

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. GRIGGS: 60 21 20, thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

address Blood Pressure monitoring.

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

In the good old days, and I

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

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

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

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

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

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

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

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

Can I have that reference again, please?

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

MS. REEN: He doesn't have it as

Page 66. Page 46.

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

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

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

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

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

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

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

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

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

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

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

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

What can you tell me about this?

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

different. And I'm talking about --

DR. TAYLOR: A financial difference?

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

MS. LEVITIN: Anybody else like to comment.

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

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

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

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

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

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

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

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

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

DR. LINK: I think they are.

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

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

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

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

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

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

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

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

MS. LEVITIN: Thank you for your comments.

Are there any other questions at this point?

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

Is there anyone else who wishes to speak?

DR. KELLER: I got here, kind of,

late. I went to another building.

What are we talking about right now? What is the subject?

MS. LEVITIN: Right now, actually, we're speaking on proposed amendments to clarify certain portions of the regulations and amendments on sedation an anesthesia.

DR. KELLER: You're not talking about general anesthesia?

MS. LEVITIN: We're talking about all kinds of anesthesia.

DR. KELLER: All right. I'm Robert H. Keller, dentist. I have been a dentist for 40 years and have a good-sized practice. And ever since this problem came up, coming down here this is the fourth trip I've had to come before different State Boards on the same subject. The last three times -- mainly I'm speaking about IV sedation and nitrous oxide analgesic.

And at tonight's State Bill meeting I hold 100, at least 100 dentist there about nitrous oxide and IV sedation. On the subject of needing CPR, needing further regulations, and the whole thing was turned down.

The group I talked with thought it

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. LEVITIN: Thank you for the comments.

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

because the ADA --

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

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

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

DR. LINK: That's always been there.

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

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

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

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

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

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

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

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

DR. KELLER: What about CPR?

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

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

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

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

MS. YEATTS: I think it was

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

DR. LINK: It should be required.

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

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

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

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

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

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

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

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

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

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

DR. KELLER: Okay.

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

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

MS. LEVITIN: We thank you for your comment.

DR. KELLER: Okay.

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

Please state your name and where you are from.

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

through hospitals.

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

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

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

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

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

Next.

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

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

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

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

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

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

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

MS. LEVITIN: Is that a Friday?

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

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

realize you were going to close the meeting. I wanted to talk about continuing education.

MS. REEN: Sir, do you wish to address the proposed regulation, the fast-track proposal?

DR. KELLER: The continuing education that you're reducing to only five hours of home study.

MS. LEVITIN: Go right ahead.

DR. KELLER: All right. I've had some personal experience with this. I didn't think much about it except when the Board finally passed it it was agreed that we would have continuing education. And I have been reminded by Board members in the past that we had this and so it has always been in the back of my mind. In 1999 I had to use this 15 hours because of my parents who live in Bristol. I had to drive because my mother was sick, almost 30,000 miles in the car trying to take care of her and my father, also, was sick.

And during those times about all I had time for was to practice and take home study courses. And that was two years. When we had 9/11 I had it all planned to go to the State Board Meeting and the State Dental Meeting and as a result

of that they cancelled it and I had to call back. And so I picked up 15 hours of home study.

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

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

you one thing.

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

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

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

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

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

NOTE: Public hearing concluded.