1 VIRGINIA BOARD OF DENTISTRY
REGULATORY ADVISORY PANEL
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6 OPEN FORUM
7 ON CONTROLLED SUBSTANCES, SEDATION AND
8 ANESTHESIA REGULATIONS
9
10 Perimeter Center
9960 Mayland Drive
11 Richmond, Virginia
12 December 1, 2017
13 1:45 p.m.
14
15 BOARD MEMBERS:
16 John M. Alexander, DDS
17 Sandra K. Reen, Executive Director
18 David Sarrett, DDS
19 Malinda Husson, DDS
20 Carol R. Russek, JD
21 Jacques Riviere, DDS
22 Elaine J. Yeatts
23 Sheila M. Beard
24
25

1 TRANSCRIPT OF PROCEEDINGS
2
3 MR. ALEXANDER: Good afternoon everyone.
4 Welcome and thank everyone for coming. We're looking
5 forward to input from everyone.
6 ATTENDEE: Can't hear.
7 MR. ALEXANDER: Do I have to repeat that
8 again?
9 Welcome everyone. Thank everyone for
10 coming, and we certainly look forward to all the
11 input from the audience for this forum.
12 Before we get started, I would like Sandy
13 Reen to read you evacuation notes.
14 MS. REEN: In the event of a fire or other
15 emergency requiring the evacuation of the building,
16 alarms will sound. When the alarm sounds, leave the
17 room immediately following any instructions given by
18 security staff. To exit this room, go out of either
19 of the two doors -- three doors to my left. Turn to
20 the hallway that goes immediately outside that door
21 and turn left to the emergency exit door and proceed
22 to the back of the parking lot to the fence and wait
23 for instructions from security personnel.
24 If you need assistance exiting this room,
25 please let me know, and I'll make sure security

1 personnel are aware of your needs. Thank you.
2 MR. ALEXANDER: Okay, I would like the
3 people up here in front to introduce themselves
4 starting on the right-hand side.
5 MS. BEARD: Shiela Beard, Board Staff.
6 MS. YEATTS: Elaine Yeatts, Policy Analyst
7 for the Department.
8 MR. RIVIERE: Jacques Riviere, retired oral
9 surgeon.
10 MS. REEN: Sandy Reen, Executive Director
11 of the Board.
12 MR. ALEXANDER: John Alexander, board
13 member.
14 DR. SARRETT: David Sarrett, general
15 dentist, dean of D.C. School of Dentistry.
16 DR. HUSSON: Malinda Husson, pediatric
17 dentist and anesthesiologist in private practice,
18 Richmond, Virginia.
19 DR. RUSSEK: Carol Russek, citizen member
20 of the Board of Dentistry.
21 MR. ALEXANDER: I think we can get started.
22 This is an opportunity for us to hear you and your
23 concerns concerning the Anesthesia Regulations of the
24 Board of Dentistry of Virginia. You can come up here
25 and sit in that chair. You have approximately five

1 minutes to tell us your concerns. This is not a time
2 for us to discuss with you. We will be discussing
3 what you say at this point a little later on in the
4 afternoon. So Ms. Reen ...
5 MS. REEN: Ms. Beard is getting the sign-in
6 sheet now.
7 MR. ALEXANDER: When you come up here, just
8 give us your name, and if you have a specialty or
9 general dentistry or nursing, whatever it is, just
10 let us know what you're speaking for and whether you
11 represent a specific organization or not.
12 Okay, I'm going to call the first one on
13 the list, and it's Amanda Kerns?
14 MS. KERNS: And I'm going to waive the
15 right to talk. I'm just going to listen for a while
16 if that's okay, Mr. Alexander.
17 MR. ALEXANDER: If at the end you feel like
18 you want to say something, you're welcome to.
19 Jon Shneidman.
20 MR. SHNEIDMAN: I do have a question, sir.
21 As a general dentist, I do a lot of oral surgery. As
22 a general dentist, I do a fair amount of oral
23 surgery, and I'd like to know what the Board's policy
24 is on giving narcotic pain medication post-op?
25 Specifically, I've been kind of told

1 through the grapevine that we are not to give
2 Percocet anymore and we're to limit the amount of
3 Percocet. Well, I don't even give Percocet anymore.
4 I'm giving Vicodin and Norco, but I want the Board's
5 input on what's considered appropriate treatment when
6 you're taking out multiple teeth.
7   Also, I see a lot of emergency patients who
8 are in pain. And as you know, because of the
9 epidemic, the opioid overdose epidemic, what standard
10 of care does the Board expect us to follow? I want
11 your guidance on what is considered reasonable to
12 give somebody who comes in, has abscess teeth or
13 needs multiple extractions.
14   Because, like I say, my guidance is I'm not
15 giving out Percocet anymore. I'm going to Norco and
16 Vicodin, and I'm limiting the number that I'm giving.
17 Before I was giving like 20, 20 Percocet out and I'm
18 not doing that anymore. I want your input into what
19 is considered by the Board of Dentistry the standard
20 of care concerning that issue.
21   MR. ALEXANDER: I appreciate your question.
22 This is a forum so we're not going to be able to
23 discuss that with you, especially this is a forum on
24 anesthesia. We do have new regulations on opioids,
25 and if you read that, it is pretty clear what you

1 need to do in giving patients medications for
2 postoperative pain and so forth. So I think if you
3 follow those guidelines...
4 If you have any specific questions, you can
5 contact the Board and we'll be able to discuss that
6 with you.
7 MR. SHNEIDMAN: Thank you very much, sir.
8 MR. ALEXANDER: Do you have anything to say
9 about anesthesia?
10 MR. SHNEIDMAN: No, that was all I wanted
11 to say.
12 MR. ALEXANDER: Al Stenger.
13 DR. STENGER: Good afternoon. I'm Al
14 Stenger, as you've heard. I am a general dentist
15 here in Richmond, Virginia, and I practice with two
16 other dentists.
17 I've come to comment on the implications of
18 the sedation regulations on access to care for people
19 that have disabilities. Some background. Our dental
20 practice has provided care to people with
21 disabilities for some 40 years since James Schrader
22 started this practice in the 1970s. Currently we
23 average over 50 adult special needs patient visits
24 per month. These visits range from preventive care
25 to basic restorative and surgical care.

1 Some special needs patients can receive
2 care with simple attention to their needs; others
3 need various levels of sedation, as you can imagine.
4 We provide a range of services in this area. Even
5 going to the operating room with general anesthesia
6 is required to complete their needed dental care.
7 We have concerns in three areas we'd like
8 the Board to consider. They all involve access to
9 care.
10 No. 1: The current regulations make it
11 difficult to provide cost-effective preventive
12 services under mild sedation if this routine service
13 cannot be provided by a dental hygienist under
14 general supervision. Many of these patients simply
15 need a bump in their routine benzodiazepine
16 medication prior to their visit or maybe need a low
17 dose benzodiazepine to lower their anxiety level.
18 We'd like clarification from the Board as
19 to whether this is considered mild sedation and
20 whether a dental hygienist can deliver the care under
21 this circumstance under general supervision with a
22 dentist present in the building, not in the room.
23 As you can imagine, if this is not
24 possible, then the cost of delivering routine
25 preventive care to patients who need a very mild form

1 of benzolysis will be elevated by raising the cost of
2 accessing this care to a population who generally can
3 least afford it.
4 As you can imagine, a lot of these people
5 need to come three and four times a year to maintain
6 their health.
7 No. 2: Regarding monitoring of patients
8 with disabilities undergoing moderate conscious
9 sedation, there are some considerations we'd like the
10 Board to think about. When a special needs patient
11 needs a level of sedation such that monitoring with
12 standard BP pulse ox monitoring equipment is
13 indicated, that doesn't necessarily mean that
14 monitoring is simple or straightforward.
15 Many times we can provide appropriate
16 dental care with sedation while the patient still
17 moves their hands and arms uncontrollably. Sometimes
18 their head also moves from time to time, but we can
19 still deliver appropriate care.
20 The problem comes when managing the
21 monitoring takes more efforts than managing the
22 patient or the procedure. We're wondering how many
23 hands it will take to stabilize the patient who is
24 moving a little, stabilize the monitor, thinking in
25 terms of capnography here, and deliver the dental

1 care. There is only so much room available at the
2 patient's head.
3 We would ask the Board to consider that the
4 monitoring requirements might make it necessary to
5 take these patients to the operating room where
6 general anesthetic would be required.
7 It's our opinion this would expose many of
8 these patients to unnecessary medical risk, as well
9 as elevate the cost of care to levels that will limit
10 access to care.
11 No. 3: Our experience is that many people
12 with disabilities have a very difficult time
13 accessing dental care, especially in a dental office
14 in their local community. We believe this to be the
15 case because of the stories they tell us. We don't
16 have any empirical evidence to share with you all,
17 but we do have a concern that the sedation
18 regulations are not helping.
19 We believe many special needs patients
20 could safely and appropriately receive most of their
21 dental care, particularly routine dental care,
22 preventive services in the dentist office near their
23 home.
24 We believe those who need very mild
25 sedation are facing barriers, some of which are due

1 to regulation, sedation regulations.
2 In sum, we'd like the Board to consider
3 what impact these regulations have on access to care
4 for people with disabilities. We believe that our
5 society should work to integrate people with
6 disabilities fully into our communities, including
7 being able to receive cost-effective routine
8 preventive dental care at a general dental office
9 nearby.
10 I thank you all for your consideration of
11 these matters.
12 MR. ALEXANDER: Thank you very much.
13 Okay, Stuart Broth.
14 MR. BROTH: I have no comment at this time.
15 MR. ALEXANDER: Lisa -- Carl Atkins.
16 MR. ATKINS: I also have no comment at this
17 time. I reserve the right to talk later.
18 MR. ALEXANDER: Certainly, if you'd like at
19 the end.
20 Lisa Turner.
21 MS. TURNER: I have no comment at this
22 time.
23 MR. ALEXANDER: Benita Miller.
24 MS. MILLER: I'll be quick.
25 MR. ALEXANDER: Take your time.

1 MS. MILLER: I just want to thank this
2 panel and the Board for having an open forum and
3 working towards making the regulations as clear as
4 they can be, because we as dentists want to do the
5 best we can for our patients and comply with the law
6 as best we can. So thank you for doing that. I just
7 wanted to say that.
8 I do have a question under the minimal
9 sedation. It's just a little confusing in terms of
10 the role of the hygienist. So it would be on Page 6
11 18VAC -- well, 280 "Administration of Minimal
12 Sedation", letter C, "Delegation of Administration",
13 and then under that D, "Dental hygienist with the
14 training required only for administration of nitrous
15 oxide/oxygen with the dentist present in the
16 operatory."
17 So I'm a little unclear, because on Page 5,
18 it allows the hygienist to administer nitrous oxide
19 under indirect supervision. So in other words, the
20 dentist is in the office but not in the operatory.
21 But then on Page 6, it's saying the dentist must be
22 in the operatory. So to me that conflicts with what
23 we already have in place in 5.
24 And then item -- under C, item or No. 3, it
25 says "If minimal sedation is self-administered by or

1 to a patient 13 years of age or older before arrival
2 at the dental office or treatment facility, the
3 dentist may only use the personnel listed in
4 Subdivision 1 of this subsection to administer local
5 anesthesia."
6 So I guess my question is: Can a hygienist
7 give local anesthesia to a minimally sedated patient?
8 I mean, I know you can't answer that but that's just
9 a point of clarity.
10 And I think that was the main -- the two
11 main points.
12 MR. ALEXANDER: The question is: Can a
13 hygienist give local anesthesia for minimal sedation?
14 MS. MILLER: Yes.
15 And then sort of subsequent to that, you
16 know, is it -- since nitrous oxide can be used as a
17 way to provide minimal sedation and hygienists are
18 allowed to treat a patient under the influence of
19 nitrous oxide, if a patient had taken, say, a very
20 low dose of a Benzodiazepine and, again, they were
21 minimally sedated, is a hygienist allowed to clean
22 that person's teeth, clean that patient's teeth with
23 the dentist in the office but not necessarily in the
24 operatory? I guess my hope would be, yes, that would
25 be the case.

1 And that's all I have to comment on.
2 MR. ALEXANDER: Sort of the same question
3 about the dentist having to actually be there?
4 MS. MILLER: Correct. That's it.
5 MR. ALEXANDER: Thank you very much.
6 Tom Padgett.
7 MR. PADGETT: I'm going to waive my right
8 to speak.
9 MR. ALEXANDER: Cathy Harrison.
10 MS. HARRISON: No comment at this time.
11 MR. ALEXANDER: Michele Satterlund.
12 MS. SATTERLUND: Good afternoon. Michele
13 Sutherland on behalf of the Virginia Association of
14 Nurse Anesthetists. I'm a lobbyist for McGuireWoods
15 Consulting.
16 First of all, I want to thank you all for
17 having us here this afternoon. We applaud your
18 efforts to take a look at the Anesthesia regulations
19 and find out if there are opportunities to make them
20 simpler, more efficient and more in compliance with
21 the statutory requirement.
22 So I have two comments actually, specific
23 to CRNAs in the Anesthesia regulations. The first
24 deals with the terms that are used in describing the
25 relationship between the dentist and the CRNA.

1 In the regulations, the term is used
2 "medical direction and indirect supervision." I
3 think back when these regulations were written, those
4 were the terms used in the code. Those are no longer
5 the terms used in the code and there's no definition
6 of what those mean. So our comment would first be to
7 eliminate that language.
8 And because the code already mandates
9 supervision for CRNAs, whether that's via physician,
10 podiatrist or a dentist, we would say it's
11 unnecessary to have any descriptor related to the
12 CRNAs. So just to avoid confusion, eliminate those
13 terms.
14 MS. BEARD: This is her handout.
15 MS. SATTERLUND: I'm sorry, I apologize. I
16 know there is an echo. Is this echoing to all of
17 you?
18 MR. ALEXANDER: That's fine.
19 MS. SATTERLUND: We have submitted
20 comments, that I don't know if they've been passed
21 around, but I have written detail about the exact
22 regulatory provisions that I'm discussing here.
23 The second concern I want to bring up, and
24 this is 290, 291 and 301, and I didn't write 301, but
25 each of these sections says that in accordance with

1 the statutory requirement, and I think the enabling
2 legislation was passed in 2012, that no dentist may
3 administer anesthesia or sedation unless the dentist
4 has a permit.
5 And then that section of the regulations is
6 in keeping with the code requirement, but what's
7 confusing them is if you go later into those same
8 regulatory requirements, it says that a dentist
9 without a permit may use an anesthesiologist or a
10 qualified dentist in a dental office.
11 And the code is very precise and
12 unambiguous, and I feel that that allowance, that
13 exception is contrary to what the code allows. The
14 code says, "The Board shall require any dentist who
15 provides or administers sedation or anesthesia in a
16 dental office to obtain either a conscious/moderate
17 sedation permit or a deep general anesthesia permit."
18 Interestingly, the code makes the
19 distinction between provide and administer. I looked
20 up in the dictionary what provide means. It means to
21 make available. Administer means to apply. So when
22 I read this, the General Assembly intended that that
23 requirement to be served in two different instances
24 and makes no exception for allowing another
25 anesthesia provider to practice in the dental office

1 unless that dentist has a permit.
2 So our recommendation, if you read our
3 comments, is just to follow the statutory
4 requirement, use the words that are used in the
5 statute, provide rather than employ, which is what
6 the regulations use, and cause confusion.
7 Do you have any questions? Was that clear,
8 what we're trying to explain here?
9 MR. ALEXANDER: I think so, but I think we
10 should read this over and look at that carefully.
11 MS. SATTERLUND: Thank you. And if you
12 have any questions, I am here to serve as a resource,
13 and I appreciate your time this afternoon.
14 MR. ALEXANDER: Thank you very much.
15 That's the end of the list that I have
16 here. You don't have to be on the list if you really
17 need to say something in this, for this. Any input?
18 MR. GLAZIER: Thank you all for having this
19 open forum today and for your time. My name is
20 Thomas Glazier. I am a periodontist in private
21 practice here in Richmond, Virginia.
22 I'm asking the Board to provide a little
23 clarification in the language. If you look at
24 Page 3, it should be under the "General Provisions"
25 part under "Pediatric Patients", which is stated in

1 several areas of this regulation, that "No sedating
2 medication shall be prescribed for or administered to
3 a patient 12 years of age or younger prior to his
4 arrival of the dentist office or treatment facility."
5 I would like a little clarification in the
6 language. The way I read this, it says, "No sedating
7 medication shall be prescribed for." If you just
8 ignore the administer part, which makes sense to me,
9 but what does not make sense is how you prescribe for
10 a patient 12 years of age, period. The way this
11 reads, it sounds like you can't prescribe to them
12 until they get to the dental office, which just does
13 not make sense the way I'm reading this.
14 MR. ALEXANDER: This is one of those
15 sentences you have to read a couple times.
16 MR. GLAZIER: Sure, absolutely.
17 MR. ALEXANDER: We'll certainly look at
18 that and make it so there's no question.
19 MR. GLAZIER: On that same note, if you
20 look further on Page 9 under VAC60-21-291 under
21 No. 3, there is a distinction here between the age of
22 13 years of age or older, which is a clear-cutoff to
23 me that they are 13 years, zero days old. Whereas,
24 under the next part, it again refers to a patient 12
25 years of age or younger. So what I'm wondering is

1 where does a person stand if they're 12 and a half
2 years old?
3 MR. ALEXANDER: Good point.
4 MR. GLAZIER: Lastly under the
5 administration of nitrous oxide, on Page 6 under
6 "Discharge Requirements" and, again, this is just the
7 administration of nitrous oxide under postoperative
8 instructions, it says that "They shall be given
9 verbally and in writing." Does this apply to routine
10 hygiene appointments with the use of nitrous oxide
11 being administered by a qualified dental hygienist?
12 DR. SARRETT: Tom, what section is that?
13 MR. GLAZIER: So it would be under
14 18VAC60-21-279 "Administration of local and of only
15 inhalational analgesia nitrous oxide." And then that
16 would be under letter G, "Discharge Requirements"
17 No. 2.
18 So I understand that verbally but in
19 writing is my question for appointments that say or
20 just routine recall appointments utilizing nitrous
21 oxide. Thank you all for your time.
22 MR. ALEXANDER: Thank you very much.
23 MR. GLAZIER: Have a great day.
24 MR. ALEXANDER: Dr. Pirok.
25 DR. PIROK: Good afternoon. I am a

1 practicing oral surgeon in Saluda, Virginia, and I'm
2 here to advocate. I am a member of the Community
3 Service Boards and member of the Association of
4 Community Service Boards, and I'm speaking about the
5 CSBs, not for them.
6 There are approximately 30,000 staff
7 members, and we are by statute commissioned to be
8 concerned about mental health, intellectual and
9 developmental disabilities and substance abuse.
10 My first advocacy is for the revived
11 program. The revive program is a combination of the
12 Health Department and the Community Service Boards,
13 and this revive program advocates that lay people
14 prepare themselves to deal with overdoses that may or
15 may not occur in the office or near the office. With
16 3,000 hygienists, approximately, and 6,000 dentists,
17 that could be a formidable force to be available to
18 correct an overdose, particularly with the opioids.
19 Approximately six dental patients die a day in
20 Virginia from overdoses.
21 Now, you may say how is that, but everybody
22 needs a dentist. It's universal, and so I would
23 visualize the people dying from overdoses of opioids
24 would be dental patients.
25 I recommend careful and continued

1 preparation for emergencies in the dental office.
2 And I see this as one aspect of it.
3 General anesthesia and IV sedation should
4 be used by the provider only if it is the last
5 resort, such as the care of children, and not be a
6 provider moneymaker.
7 I recommend that the provider attest on the
8 anesthesia record that no other alternative pain
9 control option was available and that active
10 promotion of IV or inhalation treatment did not
11 occur.
12 Postoperatively, only minimum amounts of
13 opioid medication be prescribed unless the patient
14 clearly has a medical indication for those agents.
15 I also advocate that the medical history be
16 expanded to include mental health and chemical
17 dependency questions to aid the provider in
18 supporting prevention. 80 percent of the heroin
19 overdoses were first alcoholics, and we as dentists
20 can make, through our inquiries, an assessment as to
21 whether chemical dependency exist in that dental
22 patient. I thank you.
23 MR. ALEXANDER: Thank you.
24 Okay, yes.
25 DR. WONG: Hello, my name is Jonathan Wong.

1 I am a dentist anesthesiologist, and I want to talk
2 just more in generalities regarding preoperative,
3 perioperative, postoperative vital signs and some of
4 the monitoring techniques that we use.
5 Really the argument on a national level and
6 local level has been about access to care versus
7 patient safety.
8 Now, with the latest ADA guidelines that
9 came out in 2016, the ADA has moved much more
10 aggressively to mirror the American Society of
11 Anesthesiologist guidelines, which I think should be
12 applauded, because most anesthesia providers, whether
13 that's a nurse anesthetist, dental anesthesiologist
14 or MD or DO anesthesiologist, use that as the gold
15 standard.
16 Where there is a lack of those guidelines
17 tends to be in the minimal sedation realm, because
18 that's something that is more or less unique to
19 dentistry.
20 Having said that, the ADA's guidelines
21 recommend using a maximum recommended dose for oral
22 medications. And those maximum recommended doses are
23 doses that are allowed for patients to take without
24 any monitoring. So with those ADA guidelines, they
25 recommend that pulse ox may be a beneficial

1 monitoring device for that minimal sedation scenario.
2 And I believe that that's warranted and recommended
3 because one of the major tenets of all of this is
4 that patients may go into a deeper level of sedation
5 than originally intended.
6 Now, with the new 2016 guidelines, the old
7 terminology of being able to rescue one level deeper
8 than what was intended to be delivered is now gone.
9 And I think that's a good idea because anything that
10 we do, whether it's oral sedation, IV moderate
11 sedation, has the ability even as a single agent to
12 get us as deep as general anesthesia. And that's
13 kind of where that links to the opioid crisis.
14 For example, someone can use simply just
15 narcotic and get themselves to the point that they
16 are basically in general anesthesia and needing an
17 airway rescue and that's how they overdose.
18 So having said that, I think that those
19 things are good things. I think the new educational
20 guidelines that require you to be able to rescue
21 deeper levels at all levels is a very important thing
22 to enforce.
23 So, for example, moderate sedation permits
24 should probably not be obtained as they were in the
25 past with just oral sedation experiences. And that

1 has been reflected in the new update to the 2016
2 educational guidelines that show that a practitioner
3 must be able to show IV or IO competency and access.
4 Having said that, I'm going to focus now
5 more on vital signs, which you guys have been asking
6 about. Capnography is a very important part of what
7 anesthesiologists monitor. And we can argue that
8 will things like --
9 MR. ALEXANDER: Dr. Wong, we want a
10 clarification of the last statement.
11 DR. WONG: Okay. I'm sorry, before I went
12 into the vital signs?
13 MR. ALEXANDER: Yes.
14 DR. WONG: So in the 2016 educational --
15 DR. SARRETT: Earlier in your comments you
16 said the requirements to be able to rescue one level
17 deeper were removed but then you said that they are
18 in the educational guidelines. I'm just looking.
19 DR. WONG: Yes, I'm sorry. One level deep,
20 the old guidelines used to say you had to be able to
21 rescue one level deeper.
22 DR. SARRETT: Which guidelines?
23 DR. WONG: The old educational guidelines
24 on sedation from the ADA.
25 DR. SARRETT: The educational guidelines.

1 DR. WONG: Educational guidelines, and they
2 have removed that. Now it says that you should be
3 able to rescue from any aspect of complication that
4 might arise from your sedation. So if you're, say, a
5 moderate sedation provider, you should be able to
6 rescue someone who goes into deep sedation or even
7 general anesthesia. So you need to at least have the
8 training to appropriately use a bag mask, an LMA or
9 endotracheal tube to rescue that person.
10 Before it was, oh, if you're doing minimal
11 sedation, you should be able to rescue someone with
12 basically a jaw thrust in case they went to moderate
13 sedation. So that's where that has changed.
14 MR. ALEXANDER: That's changed for good.
15 DR. WONG: It is a good change, and I
16 recommend in my opinion that we mirror that, and the
17 Board has always done that, kind of mirrored what the
18 updates were with the ADA recommendations or
19 guidelines were.
20 MR. ALEXANDER: Okay.
21 DR. WONG: Any other questions about that?
22 MR. ALEXANDER: I'm sorry.
23 DR. WONG: No, please. I know I covered a
24 lot in that. Any other questions about that?
25 DR. SARRETT: I just wasn't sure if you

1 were in favor or not in favor.
2 DR. WONG: Definitely in favor. Definitely
3 in favor of it. Thank you.
4 As far as vital signs monitoring, our
5 regulations are a bit nebulous, and people have asked
6 what exactly should we be monitoring for each of the
7 levels of anesthesia or during the perioperative
8 period, the intraoperative period and the
9 postoperative period. And I don't know what the
10 right answer is for that. I think it is very, very
11 patient dependent, but at the same time we need to
12 stress patient safety.
13 So by prescribing basic things like the
14 standard ASA or American Society of Anesthesiologist
15 monitoring is probably a good thing, which includes
16 capnography. However, the question then really
17 becomes pre-op.
18 I see a lot of special needs children and
19 adults who are extremely combative, sometimes
20 wouldn't even get out of the car. Are you going to
21 be able to get preoperative vitals signs on them?
22 No. We do a preoperative exam, often in the car,
23 listening to their lungs, trying to look in their
24 mouth. We're not going to get any better than that.
25 I'm not going to get a blood pressure on them.

1 Oftentimes I can't get a reliable pulse ox
2 reading because the kid is doing this or throwing it
3 across the car or not even letting me touch him. So
4 that would severely hamper our access to care for
5 those patients. However, intraoperatively,
6 absolutely everything should be monitored, including
7 capnography.
8 One gentleman, not to be disrespectful,
9 said, look, it's more equipment; it's more that you
10 have to have area for. It's really a nasal cannula
11 or a small little gas sampling line that hooks to a
12 nasal hook. It's not that much more difficult. It
13 is an added expense but it is something in our
14 current regulations you have to have available anyway
15 so why not use it.
16 The next part of things becomes the
17 postoperative period, and this can be rather
18 difficult, because if we say all monitoring must be
19 performed, sometimes blood pressure monitoring on
20 young kids as they're waking up is not very accurate
21 and it's also not very beneficial. The reason being
22 that the kids are moving around so we are not getting
23 an accurate blood pressure; it's making them more
24 agitated by squeezing their arm repeatedly.
25 And the final thing is that these children,

1 especially at that age, are very rate dependent,
2 meaning that their blood pressure is based on their
3 current heart rate. So if we're monitoring pulse ox
4 and therefore heart rate and we're monitoring that in
5 the immediate postoperative period, we really don't
6 need to be monitoring those additional criteria once
7 they've met kind of what we call phase one discharge
8 criteria, meaning that they don't need the one-on-one
9 relationship with the anesthesiologist anymore. At
10 that point they go to my RN often. At that point we
11 really don't need quite as much, I hate to say
12 invasive because it is noninvasive, but that type of
13 monitoring still.
14   The final thing that we have also noticed
15 in here is it also said that those should be
16 monitored until discharge, but it's not clear whether
17 that's discharge criteria being met or the patient
18 actually being discharged from the office. Because
19 sometimes discharge criteria is met.
20   In my patient population, Medicaid and
21 Medicaid cabs, sometimes we'll wait three hours for
22 the Medicaid cab to show up. That means I have to
23 have my RN sit with them for three hours when I could
24 have, you know, a dental assistant sitting with them
25 after they no longer need any monitoring.

1 In fact, at this point they are often
2 playing games in the waiting room, eating a Popsicle
3 and everything, yet still I have my RN telling them
4 hold still because I need to get additional vitals
5 and everything. Those things we are not sure.
6 MR. ALEXANDER: Basically you want us to
7 look at the monitoring and to be sure that it's
8 clear, and obviously when you have a patient that's
9 not cooperative, you know, you are going to have to
10 use your own judgment.
11 DR. WONG: Absolutely. And I think that a
12 lot of that is just using good judgment from a
13 provider. The problem is that sometimes it's
14 cumbersome. Sometimes people need those regulations
15 in place to make sure that they are doing what's
16 appropriate.
17 MR. ALEXANDER: Well, thank you very much.
18 DR. WONG: I appreciate your time.
19 MR. ALEXANDER: Excellent points.
20 We have time for anymore input from the --
21 DR. STENGER: Is it appropriate I can ask
22 the gentleman a question? One of the things we
23 struggle with is the definitions of moderate rate --
24 MS. REEN: Dr. Stenger, we can't hear you.
25 DR. STENGER: One of the things that we --

1 and it's become clear, you know, with the comment I
2 just heard. One of the things we really struggle
3 with is the definition of this mild, moderate deep
4 sedation. And where we're having trouble, you know,
5 is the patient that's moving around that we can still
6 do treatment on. You know, we may consider it
7 moderate sedation because of the medication we gave
8 them but they're still pretty resistive, and we don't
9 necessarily want to bring them any deeper. You know,
10 if we are going to bring them deeper, we are going to
11 take them to the OR. So this is where we have our
12 issues with the capnography and even all the
13 monitoring.
14 So if the previous gentleman, I understand
15 what he's saying, you know, if you are willing to put
16 that person into a deeper level, a deeper state, then
17 of course monitoring becomes easy. But what we're
18 trying to do is work with the public and with the
19 limitations that they have financially and with our
20 ability to safely treat them at a lower level of
21 sedation. I mean, heck, it may even be considered
22 mild sedation. A lot of these folks are on chronic
23 benzos and they are resistant to medications and they
24 are moving around quite frankly.
25 So where we're struggling is as the

1 regulations become more -- you know, I know you're
2 trying to clarify, but as they become a little bit
3 more strict, they are really making it difficult for
4 us to do what we have done for 40 years safely for a
5 large population of disabled folks in our office.
6 Maybe that's the way the state wants us to go and the
7 public. Maybe that's the right way to go, but I
8 don't know. I don't think it's going to improve
9 access to care. And I know the gentleman mentioned
10 that was an issue.
11 So I don't know if it's better to clarify
12 the -- I mean the bottom line, experienced doctors,
13 we know what we're doing. We've been doing it for a
14 long time. I know you guys see a lot of folks who
15 have had trouble, and it would help to clarify, but I
16 don't want to -- caught in all the clarifications and
17 all the safety, I don't want to see us back to the
18 days where people with disabilities are taking to the
19 operating room routinely for easy basic dental care.
20 Thank you.
21 MR. ALEXANDER: Appreciate your comments.
22 DR. WONG: Mind if I reply to that?
23 MR. ALEXANDER: Sure. This is the last
24 one, though.
25 DR. WONG: Just as a quick reply to that.

1 One of the first things is defining those different
2 levels of sedation. And the American Society of
3 Anesthesiologists has defined that very well. And
4 the new ADA guidelines for the use of sedation and
5 general anesthesia by dentists actually does define
6 that very specifically.
7 So going back to looking at that, I think
8 that we do get some answers there and perhaps it's
9 just a matter of adopting that specifically.
10 Now, movement itself does not determine the
11 level of sedation. It's purposeful movement. It is
12 actual intent for a behavior. So moderate sedation
13 when it's performed, just repeated verbal stimuli or
14 even just regular verbal stimuli should elicit a
15 response that is purposeful from that patient. So if
16 I say Dr. Alexander, you would say oh, what? And
17 that is moderate sedation.
18 Now, if I have to tap you multiple times
19 and give you multiple verbal stimuli, that's deep
20 sedation. If you don't respond to tactile stimuli,
21 that's general anesthesia. It's not based on
22 movement. Because even under general anesthesia, if
23 I don't use local and I prick someone's hand and I
24 have not paralyzed them, they will withdraw and move
25 from it, and that will happen as a spinal reflex. So

1 therefore it is not the movement that determines
2 these things. It's actually as the new ADA
3 guidelines recommend.
4 Now, in regard to access to care,
5 completely agree, and that's where we were talking
6 about that balance of patient safety and access to
7 care. And oftentimes, yes, people can be treated,
8 especially special needs patients, with either oral
9 sedation, oral conscious sedation or IV moderate
10 sedation. Yet sometimes they don't and aren't able
11 to do that. That doesn't necessarily mean they have
12 to go to the OR.
13 For example, in my facility, we have this
14 happen all the time. Patients are appointed to go to
15 the OR. Their medical insurance doesn't cover it.
16 They come in and they say I was quoted a $12,000 bill
17 to go in my area CHKD's Ambulatory Surgery Center.
18 They come into us. Our facility is a category one
19 med gas certified facility, so we are allowed to do
20 general anesthesia. We're certified the same as one
21 of these ambulatory surgical centers; yet they pay
22 1,200 bucks, sometimes less than that if they have
23 insurance.
24 I mean, one of these patients came in and
25 was quoted yesterday I think $5,000 to do all the

1 work, went through, had two insurances, and ended up
2 paying I think 300. Same thing with Medicaid. So
3 the access to care is possible. It's there. It's
4 just changing the way we think about things, and
5 sometimes that's, you know, updating standards.
6 The American Society of Anesthesiologists
7 dealt with this in the '80s and '90s. We, as
8 anesthesiologists, morbidity and mortality from
9 anesthesia was high, and they had to change the way
10 they thought and what the standard should be. And
11 what they did is they went to the airline industry
12 and started looking at safety checks. And those
13 safety checks helped improve anesthesia from being
14 one of the most dangerous procedures in the hospital
15 to one of the safest.
16 And I think doing the same thing on the
17 dental side of anesthesia is important. And I think
18 that we do have to balance both of them, but patient
19 safety should always be paramount.
20 MR. ALEXANDER: Absolutely, thank you.
21 Any other?
22 MS. CARNEY: Hi, good afternoon. I am
23 Jacqueline Carney. I am a pediatric dentist and also
24 dental anesthesiologist. I also submitted the
25 petition for clarification about the guidelines that

1 were proposed on sedation and anesthesia.
2 I think I have the impression that if we
3 have patients that aren't cooperative for the vital
4 signs that are listed to be obtained, that merely
5 documenting that in our records is sufficient
6 representation of our attempt to meet the guidelines
7 that are listed. And I would hope that that would be
8 taken into consideration by all of the practitioners
9 and by all of the people on the Board of Dentistry
10 for a case that were to come forward.
11 My concerns with the petition that I
12 submitted is that based on the current writings, I
13 can't tell what vital signs you would like for me to
14 obtain during each of the three important parts of a
15 sedation or anesthesia. In my mind, there is a
16 perioperative period before we provide any treatment
17 to the patient -- or a preoperative period before we
18 provide treatment, a perioperative period where we
19 are providing treatment and then a postoperative
20 period.
21 And in many of the paragraphs that were
22 written about each of the stages, minimal sedation,
23 moderate sedation, deep sedation, and general
24 anesthesia, the criteria changed. And in some of
25 those categories, they aren't even listed. Pre-op

1 has one set, post-op has a different set and nothing
2 is listed for the perioperative period.
3 I want to be able to get the vital signs
4 because that helps keep the patient safe, but I also
5 want to meet the criteria, and I can't do that with
6 the way it's currently described.
7 I have the same concerns that Dr. Wong
8 brought up about the statement of staff remaining
9 with the patient until discharge. It's not uncommon
10 at all in our practice that the patient clinically
11 has met discharge criteria and despite our repeated
12 statements to the parents that they don't leave the
13 office, they're out running errands or they have gone
14 to pick up four other children from school.
15 And I have an assistant that right now is
16 stuck with the patient who is back to baseline, but
17 because I don't know what the Board is really asking
18 of me and my staff with the current definitions, I
19 don't know whether or not I can allow that staff
20 member to move on to other things.
21 Additionally, one other point that I
22 haven't heard mentioned today is the vital signs for
23 the blood pressure to be obtained for nitrous oxide
24 before and after, and I haven't been able to find any
25 other state that has that requirement. I can't find

1 literature either to support the need for that.
2 Blood pressure tends to be the most
3 unreliable vital sign that you can obtain
4 particularly in a patient that is anxious, which is
5 an indication for the use of the nitrous oxide. So
6 I'm hoping that that can be taken into consideration
7 as well. It is a very difficult vital sign to get on
8 an anxious pediatric patient at any point of the care
9 process.
10 I appreciate the time you guys are giving
11 to all of this to help us understand better what it
12 is you believe we should be doing so that we can meet
13 those guidelines and criteria. Thank you.
14 MR. ALEXANDER: Thank you. Appreciate your
15 comments and the material that you submitted to us a
16 while ago.
17 Any other comments from the audience?
18 Okay, I think at this time if there's nothing
19 further, I think we can take a little break and in a
20 couple minutes we'll come back and begin the portion
21 where the actual RAP or the Regulatory Committee will
22 address some of these issues and discuss this whole
23 change and try to make things a little clearer. And
24 that's mainly what we would like to do.
25 We would like to let you know that we do

1 listen to you, and we like to make things easier for
2 you and understandable. Somebody said it, obviously
3 patient safety is paramount. We'll come back in
4 about ten minutes.
5 (Thereupon, the proceedings concluded at
6 2:41 p.m.)
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1 CERTIFICATE OF REPORTER

2

3 I, Lois B. Boyle, RMR, do hereby certify
4 that I reported verbatim the proceedings for the
5 Public Hearing for the Virginia Board of Dentistry,
6 Regulatory Advisory Panel on December 1, 2017 at
7 Virginia Board of Dentistry, Department of Health
8 Professions, Perimeter Center, 9960 Mayland Drive,
9 Richmond, Virginia.
10 I further certify that the foregoing is a
11 true, accurate and complete transcript of said
12 proceedings.
13 Given under my hand this 18th day of
14 December at Newport News, Virginia.
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21 ________________________________
22 Lois B. Boyle
Notary Registration No. 203748
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