STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

R.I. DEPARTMENT OF HEALTH

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PUBLIC HEARING IN RE:

RULES AND REGULATIONS FOR
DENTISTS, DENTAL HYGIENISTS and
DENTAL ASSISTANTS

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R.I. DEPARTMENT OF HEALTH
3 CAPITOL HILL
PROVIDENCE, RI 02908
SEPTEMBER 11, 2018
10:00 A.M.

BEFORE: SULLIVAN ROBERTS, HEARING OFFICER

M.E. HALL COURT REPORTING

108 WALNUT STREET

WARWICK, RI 02888

(401) 461-3331

E X H I B I T S

(COMMENCED AT 10:04 A.M.)

HEARING OFFICER ROBERTS: Welcome. We are here today regarding a public hearing concerning the Rules and Regulations for Dentists, Dental Hygienists and Dental Assistants. This hearing is being conducted under the provisions of Rhode Island General Laws 23-17 and 42-35. Today is Tuesday, September 11, 2018. My name is Sullivan Roberts, Rules Coordinator for the Rhode Island Department of Health, also known as RIDOH, and I will be the Hearing Officer for today's proceeding.

Before we start, and to prevent any interruption of the proceedings, at this time, I would like to ask those of you with cell phones, pagers and watch alarms to turn them off or set them to vibrate.

(PAUSE)

HEARING OFFICER ROBERTS: The purpose of the hearing today is to afford interested parties an opportunity to comment on the proposed Regulations, allow as many people as possible to be heard and to ensure that an

accurate record of all comments is obtained.

This hearing is intended for your participation only and is not intended to provide a forum or discuss being, debating, arguing or otherwise having any dialogue on the Regulations before us with RIDOH personnel as part of this public hearing. If you would like to speak, the procedure we will use is as follows: Please register to speak at the rear of the room. Speakers will be taken in order of registration. Up to five minutes will be allowed for your presentation, unless the lack of speakers allows for additional time. Any interruptions due to the Stenographer's need to clarify your testimony will not count against your allotted time. If you are reading off of a prepared document such as a paper copy or electronic version of your testimony, we politely request that you speak clearly and at a unhurried pace so the Stenographer can appropriately capture your testimony in its entirety.

I will indicate when you have one minute of time remaining. If you are

unable to complete your testimony in the time allotted, you may have an opportunity to speak if any time is remaining after the other speakers who have signed up complete their testimony. When you are called, come to the podium, identify yourself by name and affiliation, if any. Please spell your name and give the full name of your organization, if you used an acronym, such as NASA. Make your presentation and make sure you conclude in the allotted time of five minutes. If you have a written copy of your statement, we would appreciate if you could provide it for the record. If you read from an electronic version of your testimony, we would appreciate if you could provide a hard copy or e-mail us your testimony.

In accordance with the requirements of the Administrative Procedures Act, additional written comments on these proposed amendments will be accepted by Monday, September 17, 2018. After the conclusion of the public comment period, RIDOH has four options under State law.

The first option is to file the Regulations as posted with the Secretary of State.

The second option is to file with minor technical changes such as correcting spelling, punctuation, et cetera.

The third option is to make non-technical changes in what you see before you today, which would be addressed in RIDOH's concise explanatory statement filed with the final Regulations and could also necessitate a new public hearing and associated public notice posting.

And the fourth option is not file the proposed Regulations, in which case the current Regulations would remain in effect. Unless specified by law or regulation or at the discretion of RIDOH, once filed, the Regulations become effective 20 days after filing and have the force of law upon that date.

Are there any questions on how the public hearing will be conducted today?

(PAUSE)

HEARING OFFICER ROBERTS: At this time, for the record, we will have a presentation of exhibits. The first exhibit is the Notice of Proposed Rule Making posted on the Rhode Island Secretary of State's web site on August 15, 2018.

(EXHIBIT 1, NOTICE OF PUBLIC HEARING, MARKED)

HEARING OFFICER ROBERTS: The second exhibit is a copy of the proposed Regulations with provisions indicated also posted to the Rhode Island Secretary of State's web site on August 15, 2018.

(EXHIBIT 2, PROPOSED REGULATIONS, MARKED)

HEARING OFFICER ROBERTS: The third exhibit is a copy of the existing Rules and Regulations Pertaining to Dentists, Dental Hygienists and Dental Assistants, last filed with the Rhode Island Secretary of State in June of 2017.

(EXHIBIT 3, EXISTING REGULATIONS, MARKED)

HEARING OFFICER ROBERTS: The fourth exhibit is a copy of Rhode Island General Laws 5-31.1-4 and 5-31.1-5, the enabling statutes for these Regulations.

(EXHIBIT 4, RIGL 5-31.1-4 AND 5-31.1-5, MARKED)

HEARING OFFICER ROBERTS: The fifth and final exhibit is a copy of the e-mail dated August 10, 2018 from the Office of Regulatory Reform to Sullivan Roberts confirming that RIDOH was authorized to move forward with promulgation of these Regulations.

(EXHIBIT 5, OFFICE OF REGULATORY REFORM LETTER, MARKED)

HEARING OFFICER ROBERTS: At this time, I would like to call the first speaker. Charles J. Cote.

DR. COTE: So, my name is Charles J. Cote, I'm a Board certified pediatrician and pediatrician anesthesiologist. I have been the primary author of the American Academy of Pediatrics Association Guidelines since the first publication in 1985 and every

iteration since then, so I feel very qualified to be able to address issues in this proposed legislation that attempt to quote from our AAP Guideline.

During the intervening years, I became aware of the adverse drug reports from the Food and Drug Administration, and through the Freedom of Information Act, I requested those reports. Obtained about 700. We also got reports from the United States Pharmacopeia and a survey that we sent to members of the Academy of Pediatrics. Two anesthesiologists, one ER physician and one ICU physician debated the causes of the adverse health problems and we ended up with 95 cases where we felt we could agree on what happened. And of those 95 cases, 60 had death or neurologic injury as the end point and 29 of these were related to dental care. 80 percent of these children seem to present with a desaturation, meaning that they turn blue and should have been able to be rescued, but the practitioners involved did not have the necessary skills to rescue the child.

Interestingly, there was a

three-fold greater instance of cardiac arrest associated with these non-hospital events compared with hospital events with a 93 percent mortality. So, when something went wrong in the dental office setting, the outcomes were dismal. Parenthetically, eleven of these dentists were described as oral surgeons, although we really couldn't tell what their true education or training was. I can say had I known that this dentistry was going to be so highly represented, I would have invited an oral surgeon or pediatric dentist or both to help us analyze the data.

I have grave concerns about the current bill, because at the beginning it states that this bill is consistent with the guidelines of the American Academy of Pediatrics, and I take, I have a lot of concerns about that, because it clearly does not have anything at all related to the Academy of Pediatrics. And I have detailed a whole bunch of different areas where this is a problem, but we don't have time to talk about that.

What I'm concerned about, though, is this independent practice of an oral surgeons who can direct sedation with a dental assistant, who's, the dental anesthesia assistant certification exam DANCE, D-A-N-C-E, which is fulfilled by taking 36 hours of an Internet course and taking an examination. In these 36 hours, they are supposed to learn basic science, how to evaluate and prepare patients, understand anesthetic drugs and anesthetic techniques, anesthesia, anesthesia equipment and monitoring and office anesthesia emergencies. It took me three years to learn that, and yet, these people are expected to learn this in 36 hours of Internet time.

The other thing that's of interest, there doesn't seem to be any educational requirements for these DANCE-trained individuals. It doesn't even say they have to have a high school certificate. It appears that they have on-the-job training with an oral maxillofacial surgeon, and then they take this test, and then they are DANCE certified. So, it says that, in their

guideline, that there has to be either basic life support or CPR certified, and it doesn't mention PAL certified; and if they are going to be taking care of children, obviously I think they need to be PAL certified.

I think you know all know that when something hatches, push comes to shove, you want to have medically trained people there to assist with the emergency; and these individuals have no real life experience that could provide them with the medical knowledge to assist an oral surgeon with any life-threatening emergency, such as a child who stopped breathing due to the effects of the medication. The child developed spasms of the muscle of the voice box. Seizure from a local anesthetic. Drug overdose or allergic reaction or other medical emergencies that can arise. These can happen in anybody's hands. Certainly I have had these happen to myself over the years. Is there a timer?

HEARING OFFICER ROBERTS: Yes.

DR. COTE: How much time do I have left?

HEARING OFFICER ROBERTS: That was your five minutes.

DR. COTE: You didn't give me a warner.

HEARING OFFICER ROBERTS: If you're unable to complete your testimony in the time allotted, you may have an opportunity to speak after the other speakers who are signed up complete their testimony. Thank you. The next speaker is Cynthia Johnson.

MS. JOHNSON: Good morning. Good morning, I'm Cynthia Johnson. I am a professor at the Community College of Rhode Island, and I am speaking to the 2.9 Public Health Dental Hygiene Practice Act. The reason why I'm speaking on this is because in the new guidelines it has spoken about not having the courses come from an accredited institution. CCRI and myself and a few of the faculty were contacted by the Department of Health once this Practice Act was put into place last, excuse me, summer of 2017. So, when we were contacted, we were asked to create some courses based upon the Practice Act. One was medical

emergencies. Another was infection control. Another was being investigated for risk management. With the -- we met several times with Dr. Zwetchkenbaum, and we had come up with two courses that we were going to run, which was the medical emergencies for the public health dental hygienist and also the infection control for the public health dental hygienist. These classes are web-based courses. They run for five weeks; and from the feedback we have gotten from the people that took the course, and it was very positive; and I do have their evaluations with me here today.

The reason why I'm speaking upon this is because now they are trying to make these courses come from a non-accredited site. We were told back in April that the risk management course could be taken or another course in the Rhode Island Dental Association. So, myself and several of the dental hygienists took that course. I, myself, am a public dental hygienist. I also met with Dr. Zwetchkenbaum and made another course, the risk management course. The risk management course

that I have created, again, is on line. It's web-based. It run for five weeks, and it goes over the all the collaborative agreement and all of the tool kit they will need to become dental public health hygienists. One of the web sites that I could go to become a public health hygienist and take the risk management course I went to and I noted that there was some information that was lacking in those particular web sites as well as the course that I took with the Rhode Island Dental Association in May. I have many people, health hygienists, that have come to me that took that course and wanting more guidance. I was happy to give them that guidance within that; but within the risk management course that we offer at CCRI, we incorporated all of those questions and answers.

Also, within the risk management course at CCRI, we incorporated a business management plan as well and we also reviewed the rules and regulations of the public health dental hygienists, which were very confusing for some of the people in this program in the

courses that we teach. From our courses and from our evaluations, it has been noted that every dental hygienist that took the course felt that they had gained something. They had felt that they had changed their practices within our course work and had gained better knowledge within our courses that we taught.

So, I am here today seeking support from the Department of Health, from Dr. Zwetchkenbaum, from the Board to keep these courses to be an accredited course, knowing all the work and the consciousness that our college puts forth in teaching our courses in general and also with these public health hygiene courses, we offer a lot of support to our the students, and we offer a lot of guidance to our students within these courses. Even once they go out and they receive these credentialing, they still come back and I'm still answering their questions, which if they take some other courses, they might not receive that support. I am asking for the continued support of the Board and the Department of Health considering that you had come to us first within these

courses. Thank you so much.

HEARING OFFICER ROBERTS: Thank you. The next speaker is Julie Galleshaw.

MS. GALLESHAW: Hi, can you hear me?

AUDIENCE: Yes.

MS. GALLESHAW: All right. I, first, would like to introduce myself. I'm Julie Galleshaw, J-U-L-I-E, G-A-L-L-E-S-H-A-W, professor of dental health at the Community College of Rhode Island. I am also a newly licensed public health dental hygienist. I would like to specifically speak to Section 2.9.1, qualifications within the draft pertaining to 2.9, the Public Health Dental Hygiene Practice. I was at the original meeting of the draft as a public member. I took part in several meetings in which lengthy discussion took place on the specifics of this particular section of the Regulations. The final version that was submitted has been changed by this Department in format, punctuation and intent.

I am here because I feel these

changes have taken away the intent of producing safe and competent public health dental hygienists for the community. The Department and Board are here to ensure that all dental professionals practicing in the State of Rhode Island meet the requirements for licensure to protect the public. With that said, the new version in front of us today has been changed from its original draft; and in my opinion, not upholding the standard of creating a competent public health dental hygienist. The first error and change made by the Department of Health was the change in placement of the colon. The colon was to be after the words public health fundamentals, colon. In order to start the enumeration of the courses to be taken to meet the educational requirements and not placed after the word insurance. I am submitting with this statement the original documents draft and the corrected version as evidence of what needs to be corrected to regain the original documents intent of what qualifications need to be met in order to obtain a public health dental hygiene license.

The second change made by the Department of Health is in Section 2.9.1B1-B after the word accreditation, the words, comma, or by the program appointed by the Board or the Department were added. I feel the Department of Health has overstepped its authority by placing these words and superceding the Board. The Board in all areas of the Rules and Regulations is the determining entity for course approval for the Department and not the Department itself. Nor is the word Department defined in these Rules and Regulations to mean the Department of Health, specifically to dentistry. Nor is it stated anywhere else in these Rules and Regulations the Department is to be able to approve any course for licensure or license renewal. If the intent of whomever added these words was to reflect that the Board, as defined in these Rules and Regulations, has the ability to approve a course, then I recommend that the words or an and accredited course approved by the Board be the only submission in words not, comma, or by a program or approved by the Department. That

those words be removed and replaced by this statement or and an accredited course approved by the Board.

I submit the following sections within these Rules and Regulations that specifically state that it is by approval of the Board and not the Department. Examples throughout these Rules and Regulations is evident in the following sections: Section 2.4.6 A-3. Section 2.4.6, B, F and G. Sections 2.7.5 C and Section 2.8.4 D.

It is with great hope that this committee will do its diligence and correct these errors. Respectfully submitted. Thank you.

HEARING OFFICER ROBERTS: Thank you. The next speaker is Russell Chin.

DR. CHIN: My name is Russell Chin, C-H-I-N. I'm a general dentist in Rhode Island, and I'm here as a private dentist. I would like to make some recommendations to the Rules that we are talking about.

First one is 2.10.3, Number 4. I want to strike, "plus medication." Number 5,

insert the word, "sedative." Number 13, I want to strike "activation" and insert "detailing." Number 14, I want to strike "entirely." Continuing on to 2.11.1C, the word "when" should be inserted, and "where" removed. On Section 2.11.3 B1, the word "dentist" should be inserted and "dental" strike. On B-3, I want to include or insert "CERP or PACE," P-A-C-E, approval. On C2, the word "moderate" needs to be stricken and "minimal" inserted on the first line and on the second line of C2 again the word "minimal" inserted and "moderate" stricken. On C3, insert "CERP or PACE approve". And on C5 remove "entirely" Continuing to D2, insert "or equivalent". And D3, I'm adding a whole line, "a current certification of advanced cardiac life support." Going down to E1C, insert "or equivalent." On G3, insert "and PALS," P-A-L-S. On 2.11.4A, 1C, strike "minimal sedation"? On B1, insert the word "and" and strike "or." Continuing on to C3, insert "and" and strike "or." On C3B, insert "calibrated." On D3, insert "and" and strike "or." On E2,

insert "successful completion of a on-site office evaluation performed by a Board member and a Board memoranda appointed by an advisory consultant." On 2.11.7A, first line, insert the word "calibrated." On 2.11.9, C1, B, insert "ACLS and PALS, if needed," and strike, "BLS." Going out to D2B, insert "and." On C, insert "DANCE," D-A-N-C-E. Going on to 5C, insert with "BLS" and on Number 7, insert "and PALS." Number 8, insert "PALS if treating children." Section 2.13.2, A1, remove "the American Dental Association."

(INTERRUPTED BY TIMER)

HEARING OFFICER ROBERTS: Thank you. Your allotted time is up. If you are unable to complete your testimony in the time allotted, you may have an opportunity if any time is available. The next speaker is Steve Brown.

DR. BROWN: Good morning. I'm Dr. Steve Brown. I'm an oral surgeon in the State of Rhode Island, and I am -- today I'm representing the Rhode Island Society of Oral and Maxillofacial Surgery. Generally, we are

thankful for the Board for putting such an effort into these new Regulations. I think they are long overdue. It's been a process that I know has taken a few years for this to happen. These new and Rules and Regulations are consistent with the new ADA policy as well as the American Association of Pediatric Dentists and most recent AMS Guidelines for Sedation and Anesthesia by Dentists. The new Regulations significantly increase the educational requirement for the administration of minimal and moderate sedation for the adult patients by dentists. Deep sedation and general anesthesia administration are reserved for oral and maxillofacial surgeons, dental anesthesiologists, medical anesthesiologists or licensed practitioners with equivalent training approved by the Board. These new Regulations significantly encompass anesthesia services provided by dental anesthesiologists and acknowledges the vital service they for identification to the public.

The administration of sedation and anesthesia to pediatric patients has been

separated and the requirements to administer these services to pediatric patients has been strengthened. This is because the physiological and anatomical make-up of pediatric patients is much different than the adult, and additional training and simulation is required. Office inspections have been streamlined. Office inspections for moderate deep and general anesthesia are being conducted by a team. Post permits and portable dental facility permits will address the need for dental anesthesiologists.

Having said that there are a number of typographical errors, omissions, problems with the Regulations as they are now written, and I would recommend, and I, we agree with most of what Dr. Chin had stated. These need to be corrected, and I think another meeting of the -- such as this needs to be done so that we can all look at these Regulations and agree. I think the most glaring example of a problem is Section 2-11.3, Section E, Number 1. Applicants for individual anesthesia permits and general anesthesia and deep

sedation must meet the following criteria: The word one must be removed. It says have fulfilled one of the following educational training requirements. The first two, A and B, are correct; but the third, C, having completed a Board approved simulation course that uses high fidelity simulation is not appropriate. That section needs to be removed. There are other examples, and I think Dr. Chin made a good statement as to those problems.

I think another thing that the Board should look at are the definitions exactly of what a qualified dentist is and what a qualified provider. Maybe we ought to put examples of each. I think in the Regulation it's not clear as to what practitioner can do and what his responsibilities are. There are other problems with these that we will submit in writing, but generally, we concur with these new Regulations. Thank you.

HEARING OFFICER ROBERTS: Thank you.

HEARING OFFICER ROBERTS: The next speaker is William A. McDonald.

DR. McDONALD: Good morning. My name is William McDonald. I am a dentist anesthesiologist. I'm a Providence College graduate. And I practice dental anesthesia, mobile anesthesia in Connecticut. I have been on the facility at the University of Connecticut Medical School and Dental School for many years. I teach sedation, general anesthesia and medical emergencies to medical and dental students; and over the years, I have provided anesthesia for more than 200 dentists in Connecticut, Massachusetts and Rhode Island -- I'm sorry, Connecticut, Massachusetts and New York. Last year I provided anesthesia for dental patients in more than 60 offices.

I came this morning because I'm very concerned about the safety that is being jeopardized in these proposed Regulations. Also, it appears that there's a limit of access to care for patients in Rhode Island because of these Regulations. Also, the dentist anesthesiologists are having great difficulty in being inspected. And also, general practitioners and non-oral surgeons would have

difficulty in getting permits so that they could have anesthesia provided for their patients.

Most importantly, the thing that should be addressed is that, for children, there should be a separate, trained anesthesia provider, whether it is a physician anesthesiologist or an oral surgeon, nurse anesthetist or dental anesthesiologist. The Academy of Pediatric Dentistry and the American Academy of Pediatric Dentistry both make that recommendation. CODA states that for oral surgery training, children are considered 18 and under; so, everyplace that children are mentioned in this document it should be 18. There should be a separate person trained to do the anesthesia. Oral surgeons have five months of anesthesia training during their programs. They are supposed to do 50 cases of deep sedation with general anesthesia during their training for eight children 18 and under. Dentist anesthesiologists have 36 months of training and they have to treat 125 children ages seven and under. Dentist

anesthesiologists practice like physician anesthesiologists where one person provides the surgery and one person provides the dentistry. The oral surgeons in general practice doing two things at once. Is there a hospital in Rhode Island that would let a physician or surgeon do surgery and anesthesia at the same time? I doubt that. Dr. Cote mentioned the issue of the DANCE where somebody has 36 hours of training administering anesthesia. Michael Jackson, as we all know, died as the result of the administration of Propofol. That was administered by a Board certified cardiologist.

In Rhode Island, the DANCE assistant appears to be able to administer opioids such as Fentanyl. In New Haven last month -- there were a hundred overdoses in New Haven Green as a result of Fentanyl. Is there any hospital in Rhode Island that would allow somebody with 36 hours of training to administer Propofol or an anesthetic agent? For the record, no dentist assistants in Connecticut are allowed to administer any anesthetic or medications. Is there really a

need for a host permit? If the anesthesia provider has an anesthesia permit, the facility is permitted, why would you have to have an anesthesia host permit? Why would there have to be an agreement between that dental office and the hospital? Would Rhode Island Hospital or any other hospital in the state turn down a patient in medical emergency? Why should a dentist have to have a hospital appointment? In one point, nitrous oxide is considered an inhalant, therefore, dental assistants may not be able to do that. I think that has to be readdressed. In the wording for inspections, it states surgery. If a general dentist office to be inspected, fillings, root canals, cleanings are not considered as being surgery.

I worked, as I said, in 60 different offices last year. Would I have to be inspected 60 different times? We have had difficulty in Connecticut where those people that control the inspections have made it very difficult for non-oral surgeons to be inspected. A dentist anesthesiologist was told there was no one who could do inspections for

him. A periodontist's office was cancelled at the last minute. Reschedule has taken more than eight months to get inspected.

And then the question of the evaluators. Oral surgeons have five months of training. Dental anesthesiologists have six months of training. Those trained in moderate station have to do 20 cases. Also, in this comment it talks about nitrous oxide analgesia. That term hasn't been used in 40 years. There are no CODA approved nitrous oxide analgesic courses, so the terminology has to be corrected.

HEARING OFFICER ROBERTS: Your allotted time is up. If you are unable to complete your testimony in the time allotted, you may have an opportunity to speak if any time is remaining after the other speakers who have signed up complete their testimony. The next speaker is Sam Zwetchkenbaum.

DR. ZWETCHKENBAUM: Good morning. I'm Sam Zwetchkenbaum, Z-W-E-T-C-H-K-E-N-B-A-U-M, dental director in the oral health program. The following changes

are recommended to the Regulations. Number one, public health dental hygiene education provider, Section 2.9.1B, B, changed to successful completion of the following courses within 24 months prior to license issuance. Public health fundamentals, colon, CBC guidelines, inspection control, comma, risk management for practice in a public health setting and management of medical emergencies, comma, which are offered by an educational institution with a program accredited by the Commission on Dental Accreditation, comma, or a program approved by the Board or the Department. Rationale, the current course available is excellent, however, similar to most continuing education is not subject to CODA approval or evaluation. Fully closing the door to any other opportunities such as can be provided through other Rhode Island resources inhibits the ability of other able organizations to enter this area. For example, for courses in medical emergencies or infection control, Brown School of Medicine, RIC College of Nursing or Salve Regina may wish to be a

provider. For a course in risk management, organizations with significant experience such as Rhode Island Dental Association, Eastern Dentists Insurance Company and other malpractice carriers offer comprehensive training in areas truly in their wheelhouse. Allowing these additional opportunities to be reviewed as alternatives makes sense.

Number two, dental radiology education provider. Section 2.10.3A, 11, lists as non-delegable procedures exposures of radiographs without successful completion of a course in dental radiography which is offered by an education institution with a program accredited by the Commission on Dental Accreditation and which fulfills institutional requirements as set forth in RIGL 40-20-1. Recommended changes to the dental Regulations. Exposures of radiographs without successful completion of a course in dental radiography, which complies with Commission on Dental Accreditation Standards for radiological techniques and safeguards in dentistry and approved by the Board or the Department and

which fulfills institutional requirements as set forth in the Rules and Regulations for Diagnostic X-rays and an Associated Imaging Systems in the Healing Arts. Rationale, the current available course similar to most continuing education is not subject to CODA evaluation or approval. Opening the door to opportunities that can be provided through additional resources would increase opportunities for future dental assistants. Assuring the course meets CODA standards would allow conformance with necessary training components. Other states provide a mechanism of board approval of radiology programs based on guidelines established by the board. North Carolina, almost ten times larger in population than Rhode Island, has over 50 sites approved by their board to provide radiology training. In Massachusetts, their board assures that programs based in their career and tech centers comply with CODA standards and thereby approves them.

Number three, inclusion of WREB, W-R-E-B, as one of the acceptable Dental Board

exams. Recommend change 2.5.A.1C from having, successfully passed the ADEX exam, including the periodontal examination portion, within five years from the date of application for licensure in Rhode Island. 2, have successfully passed the ADEX or Western Regional Examination Board, WREB exam, including the periodontal examination portion within five years from the date of application for licensure in Rhode Island. Rationale, WREB is accepted at multiple Northeast states and offered at several of the largest regional dental schools, including Tufts Dental. Faculty from Tufts find the examination to be of high quality and regularly subject to evaluation. Unique to WREB is the CTP or Comprehensive Treatment Planning exam which tests fundamental and vital skills. Including WREB as an acceptable examination increases likelihood for recent graduates to apply for positions in Rhode Island.

HEARING OFFICER ROBERTS: Are there any other persons present who would like to continue their testimony or make a statement

concerning their proposed Regulations?

Mr. Cote?

DR. COTE: I promise to take less than five minutes. Dr. Charles Cote, C-O-T-E. So, it's astonishing to me that these DANCE certified individuals are allowed to fulfill the position of an independent observer to assist the oral surgeon with general anesthesia and deep sedation. And it's astonishing to me that dental hygienists require three years of training and over 4,000 hours of training to become a dental hygienist but you can become DANCE certified and assist with medical emergencies with 36 hours of Internet training and no practical hands-on experience. So, I'm going to finish, on Page -- to summarize, the AAP and CAPD, American Academy of Pediatric Dentistry Guidelines, is very specific. If the intended level of sedation is minimal sedation, you must have the skills to rescue a patient from moderate sedation. If your intended level of sedation is moderate, you must have the skills to rescue from deep sedation; and if your

intended level of sedation is deep, you must have the skills to rescue from a state of general anesthesia, because we all know that a patient may easily progress from one to the other. The independent observer wording in the Academy of Pediatrics document is that the independent observer whose only responsibility is to continuously monitor the patient is required. That's for deep sedation. This individual must, at a minimum, be trained in PALS and capable of assisting with any medical emergencies. And that's the key phrase, and capable of assisting with an emergency.

The single provider model where the oral surgeon is performing the procedure and directing the anesthetic sedation at the same time is fraught with danger because when something goes wrong with this practice model, there's no other skilled medical or dental professional present to assist with managing the patient and rescuing the patient.

Caleb's Law in California was proposed because of the death of a five-year-old in an oral surgeon's office. His

aunt, Annie, sent me the office records. It was clear that this particular individual was not skilled in rescuing the patient and did not have anybody in the office who could assist him with the rescue of this five-year-old child. When Caleb's oxygen levels dropped and he stopped breathing, he apparently panicked. No reversal agents were given. No oral devices were placed to clear the obstructed airway. He could not perform basic bag-mask ventilation. He attempted intubation and knocked out a number of teeth, and he even attempted a surgical airway from the side of the neck, but he didn't understand the anatomy of the airway. By the time 911 arrived, Caleb was pulseless.

So, if there had been an extra skilled anesthesia trained person there, this would have been something that we see every day and would have been very easily taken care of. But in this situation, obviously, they failed to rescue Caleb; and had they had that person there, I wouldn't be talking to you about Caleb's Law. This is an extreme example of why skilled anesthesia providers must be present,

but it's particular important in a non-hospital environment; because when something happens to me in the hospital setting, we press that code button and help is coming out of the woodwork in seconds. When something happens in an office setting, the only backup is 911 and that may I take five to 20 minutes for them to arrive; and that's why one practitioner cannot and should not perform two services at the same time.

I guess I would ask each of you if you would ever get on a commercial airline flight where there was a polite and no copilot. Well, instead of the copilot, we are going to substitute with the flight attendant, and she or he is going to fulfill the role of the copilot. Obviously, that's very wrong. If something happened, they certainly wouldn't be able to assist the pilot with an emergency. It's kind of like that GEICO ad, oh, yes, that's a giant cavity. We can't do anything about it. We are just here to tell you that there's something wrong.

I think what this legislation is

doing is it's asking you to cardify into law and support this very dangerous, solo practice where they are providing both anesthesia and doing the procedure at the same time. There's nowhere in medicine where this kind of practice is allowed except perhaps in the emergency room where there's an urgent procedure that's going to take a few minutes. And in that situation, they have skilled nurses who are trained to deal with medical emergencies on a daily basis, and they fulfill that role as the independent observer.

A DANCE certified person is, does not have those kind of skills. They could even be a high school dropout. There's no requirement for education, as far as I could tell, when I looked at that document. So, think about if you would ever allow yourself, your child or your grandchild to be put at that kind of a risk. Think about that. Thank you very much.

HEARING OFFICER ROBERTS: Thank you. Mr. Chin?

DR. CHIN: Continuing on, on

Section 2.13.2, 1A strike the American Dental Association. 1B, strike American Dental Association. 2.13.2C, 1A, strike American Dental Association. B, strike American Dental Association. In Section 2.15.1, strike three entirely and strike 4 entirely. And going back to 2.2 H, strike American Dental Association. In Section 2.3A, 30C, strike C entirely. Number 31, insert "director" after mobile dental facility. And 32 insert "permit holder." 37, strike "non" on the first line for nonfacility. On 2.4.3 on the second line, insert CDA and DA. And 2.4.5A, 1A, insert "dental". And 2.46, Number 3, insert "or Canadian dental school" and strike "or its designated agency approved by the Board." In 2.4.7A.2, insert "U.S. CODA or Canadian dental school." On 4, insert "equivalent" on Line 2 and strike "organizations." On 5, insert "for immediate past five years." On 2.5A1, C1, insert "equivalent" on the first line as well as "equivalent" on the second line and on the third line strike "similar." And going down to 3, strike "a clinical exam," insert "an

equivalent clinical exam." On 2.6B, that should be stricken or modified to July 1. On 2.7.2A, 3, insert the word "equivalent." On 2.7.3A, 2, insert CODA. Section 4, insert the word "equivalent" and strike out the word "organizations", and on 5, insert "in the past five years." Section 2.7.4B, 4, insert "equivalent" on the first line and on the second line insert "equivalent" and strike "similar." On 2.8.4D, insert "ACLS" and strike "basic life support, BLS." On 2.9.1B, 1B, strike "or program approved by the Dental Board or the Department." 2.92C, 1, insert "CODA." On 3, insert "equivalent." Strike out "organizations." On 2.9.3A, 6F, insert "contact the MBO director or PDO director." On B, "can provide emergency dental referral or propofol referral." Thank you.

HEARING OFFICER ROBERTS: Mr. McDonald?

DR. McDONALD: William McDonald again. Just to continue, the question of the inspections talks about surgery and the issue is if the inspection were done in a non-oral

SURGEON'S office, a general practitioner that's not considered surgery, so this terminology has to be readdressed. The next question is does each office have to be inspected, and the other issue is does a patient have to be put to sleep in each office. In my case, I would have to be inspected 60 times to put 60 patients asleep. How many people do you have to put to sleep that demonstrate that you're safe at doing that? The other question is, is the host permit. The question is why would there have to be an agreement between any office, physician office, dental office that Rhode Island Hospital would accept their patients? I don't understand that or the fact that there is a need to have the dentists be on the hospital staff. How many, how many Rhode Island dentists are on hospital staff? The other issue is with the dentists anesthesiologists, it appears they have to have a portable individual anesthesia permit. There has to be a facility permit, and do they have to have an individual anesthesia permit also? The question is that being redundant? The facility

host permit, what's the advantage to that other than limiting access to care and restraint of trade. It really makes it very difficult for the host. I see no reason to have that. The other thing I did mention before is there are no CODA approved nitrous oxide analgesia courses. The term nitrous oxide analgesia hasn't been used in more than 40 years in dental education. On Page 38, Number 2, it should read "be a candidate or hold a diplomatic status of the American Board of Anesthesiology. The oral surgeons also refer to candidates in the line before that. And under 2.13 A1, 3, Page 53, why should any nitrous oxide anesthesia machine in a dental office be able to administer a hypoxic mixture -- in other words, give a hundred percent nitrous oxide. There's no reason to have that. It mentions the fact that if a machine can deliver less than 25 percent oxygen, you have to have an in-line oxygen analyzer. That would mean the machine could give a 100 percent nitrous oxide, which is obviously a hypoxic mixture.

I also notice in the Regulations there's no mention for nitrous oxide systems to have either the appropriate pin index safety system or diameter index safety system. Thank you.

HEARING OFFICER ROBERTS: Are there any other persons presented who would like to make a statement concerning the proposed Regulations? Please just state and spell your name for the record.

DR. BROWN: Steve Brown, S-T-E-V-E-N, Brown, B-R-O-W-N. I just wanted to add in the very last section where we talk about continuing education, what's considered continuing education. The very last section, Section 7 says cardiopulmonary information resuscitation afford the person three hours of continuing education. I would hope that the Board would add in there as well ACLS training and PALS training to apply toward to an individual's annual or bi-annual continuing education requirements. Thank you.

HEARING OFFICER ROBERTS: Thank you. Are there any other persons present?

THE WITNESS: Hello, my name is Ray English, the third. I'm a new oral surgeon in Rhode Island. I recently completed my training and have come back to Rhode Island because I'm a native of this state. The crisis in Rhode Island is not dental anesthesia but access to care. And one of the reasons for this is that Rhode Island has made it difficult for dentist specialists to practice here due to reimbursement issues; and my fear is that if we continue to restrict our ability to practice, that's only going to exacerbate the problem. So, I'm thankful to the Board for putting together new Regulations that increase training because that's important, but I would keep access to care in mind when we finalize these Regulations because that's what matters. When a patient comes to our office with an acute dental abscess, it is important to treat them in a timely manner. The hospital system cannot accommodate all of our dental needs. Thank you and that's it.

HEARING OFFICER ROBERTS: Thank you. Are there any other persons...

DR. Hello. My name is doctor McCardi, and I'm a Board certified dental anesthesiologist who's been practicing in Rhode Island since 2007. Graduate of Boston University, University of Southern California and Mt. Sinai Hospital where I did my anesthesiology residence. Since 2008, I have been staff anesthesia at Franciscan Children's Hospital in Brighton, Massachusetts. I have held clinical appointments at the dental schools, Boston University, Tufts University and Harvard University providing didactic and clinical instruction. All right. Where was I? So, I have provided didactic and clinical instruction regarding sedation and general anesthesia for pediatric residents, dental residents, periodontal residents and continue education courses for private practice dentists since 2007. I have maintained a mobile office-based anesthesia practice originating in Massachusetts and Rhode Island. And the practice has grown to cover four states, including New Hampshire and Maine and encompassing four anesthesiologists, all dental

anesthesiologist providers.

In 2018, to give you an idea of our patient volume, we have conducted over 2400 general anesthetics. Over the last eleven years, we have zero instances of morbidity and mortality. And while an inherent risks exist for any provider at any level of sedation or general anesthesia, adherence to known standards of care often mitigate risks to an appropriate level.

For any football fans out there, we all know Coach Parcells. And his saying of you're only as good as your last game. One thing that Parcells did was surrounded himself with a talent that was experienced and qualified in an expense of our new friend, Bill Belichick.

I followed the Rhode Island dental anesthesia regulation process since late 2015. What I cannot follow is the logic of ignoring aspects of the American Society of Anesthesiology, the American Academy of Pediatrics or the American Academy of Pediatric Dentistry and the parameters of care regarding

the qualifications of collaborative professionals, ignoring standards of care regarding utilization of the separate licensed anesthesia professional or filing to surround oneself with staff that are truly qualified and experienced and not just certified by a private organization. Any panel of advisory consultants should include a diverse group of providers with various degrees of sedation and anesthesia training.

We had an anesthesia committee set up for these Regulations and I'm not going to make any contention comments, but I believe there are people in this room that will state that was an infective committee, and I'm sure they will by right. Aside from that, you know, the panel itself should be led by professionals who have completed formal anesthesia training, whether it be an MD or a DO, a DDS or a DMD like some of the members here in this room, or CRNs, who are also dedicated towards putting the public well-being of the profession ahead of their own agenda along with primarily the welfare and the public safety of our patients.

And I don't think that's happened with this document. I really don't.

Aside from that, you know, there's no question we have concerned professionals willing and able to provide their time and efforts to improve safety, access to care with the benefit of the patients and the profession in mind. Charles Cote is end-all authority on any of these national regulations, and he came down today to speak, and I think, honestly, we have a meeting. I understand there's time constraints, but to tap out on five minutes, which I understand is part of the process, I'm sure, if asked, he would donate his time. Bill McDonald came from Connecticut. We know Mark Rosenberg has done so. There's others that would gladly do it. I think when we make regulations that, while I agree with Dr. English, access to care is an issue and so is safety. I think it's hard to put one above the other, much like the practice of anesthesia itself. It's most in hindsight, and we have to remember that with some foresight.

Following today's testimony, I hope

the Department of Health urges the Dental Board to revise numerous aspects of this proposed Regulations. Although I'm sure everyone is eager to complete what's been a long process with a great deal of effort on all parts, it's far more important to make sure those Regulations are capable of their intention. I hope it's clear that the currently proposed draft needs a great deal of revision, and I think there's people in this room and people involved in the process up to this point that are capable of that, and I hope that it's done. Thank you for your time.

HEARING OFFICER ROBERTS: Thank you. Are there any other persons present who would like to make a statement concerning the proposed Regulations?

(PAUSE)

HEARING OFFICER ROBERTS: Thank you all for your attendance and for the information you have observed, and this hearing is now closed. Thank you.

(HEARING CLOSED AT 11:10 A.M.)

C E R T I F I C A T E

I, Mary Ellen Hall, hereby certify that the foregoing is a true, accurate and complete transcript's of my notes taken at the above-entitled public hearing.

IN WITNESS WHEREOF, I have hereunto set my hand this 24th day of September, 2018.

_____
MARY ELLEN HALL, NOTARY PUBLIC/
CERTIFIED COURT REPORTER

JOB DATE: SEPTEMBDER 11, 2018