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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

* * * * *

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

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1 (COMMENCED AT 10:04 A.M.)

2 HEARING OFFICER ROBERTS:

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

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

19 (PAUSE)

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

1 accurate record of all comments is obtained.

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

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

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

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

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

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

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

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

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

24 (PAUSE)

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

7 (EXHIBIT 1, NOTICE OF PUBLIC
8 HEARING, MARKED)

9
10 HEARING OFFICER ROBERTS: The
11 second exhibit is a copy of the proposed
12 Regulations with provisions indicated also
13 posted to the Rhode Island Secretary of State's
14 web site on August 15, 2018.

15 (EXHIBIT 2, PROPOSED
16 REGULATIONS, MARKED)

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

23 (EXHIBIT 3, EXISTING
24 REGULATIONS, MARKED)

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

5 (EXHIBIT 4, RIGL 5-31.1-4 AND
6 5-31.1-5, MARKED)

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

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

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

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

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

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

24 Interestingly, there was a

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

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

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

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

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

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

22 HEARING OFFICER ROBERTS: Yes.

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

1 HEARING OFFICER ROBERTS: That
2 was your five minutes.

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

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

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

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

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

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

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

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

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

1 courses. Thank you so much.

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

4 MS. GALLESHAW: Hi, can you hear
5 me?

6 AUDIENCE: Yes.

7 MS. GALLESHAW: All right. I,
8 first, would like to introduce myself. I'm
9 Julie Galleshaw, J-U-L-I-E, G-A-L-L-E-S-H-A-W,
10 professor of dental health at the Community
11 College of Rhode Island. I am also a newly
12 licensed public health dental hygienist. I
13 would like to specifically speak to Section
14 2.9.1, qualifications within the draft
15 pertaining to 2.9, the Public Health Dental
16 Hygiene Practice. I was at the original
17 meeting of the draft as a public member. I
18 took part in several meetings in which lengthy
19 discussion took place on the specifics of this
20 particular section of the Regulations. The
21 final version that was submitted has been
22 changed by this Department in format,
23 punctuation and intent.

24 I am here because I feel these

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

1 The second change made by the
2 Department of Health is in Section 2.9.1B1-B
3 after the word accreditation, the words, comma,
4 or by the program appointed by the Board or the
5 Department were added. I feel the Department
6 of Health has overstepped its authority by
7 placing these words and superceding the Board.
8 The Board in all areas of the Rules and
9 Regulations is the determining entity for
10 course approval for the Department and not the
11 Department itself. Nor is the word Department
12 defined in these Rules and Regulations to mean
13 the Department of Health, specifically to
14 dentistry. Nor is it stated anywhere else in
15 these Rules and Regulations the Department is
16 to be able to approve any course for licensure
17 or license renewal. If the intent of whomever
18 added these words was to reflect that the
19 Board, as defined in these Rules and
20 Regulations, has the ability to approve a
21 course, then I recommend that the words or an
22 and accredited course approved by the Board be
23 the only submission in words not, comma, or by
24 a program or approved by the Department. That

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

4 I submit the following sections
5 within these Rules and Regulations that
6 specifically state that it is by approval of
7 the Board and not the Department. Examples
8 throughout these Rules and Regulations is
9 evident in the following sections: Section
10 2.4.6 A-3. Section 2.4.6, B, F and G.
11 Sections 2.7.5 C and Section 2.8.4 D.

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

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

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

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

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

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

(INTERRUPTED BY TIMER)

13
 14 HEARING OFFICER ROBERTS: Thank
 15 you. Your allotted time is up. If you are
 16 unable to complete your testimony in the time
 17 allotted, you may have an opportunity if any
 18 time is available. The next speaker is Steve
 19 Brown.

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

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

23 The administration of sedation
24 and anesthesia to pediatric patients has been

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

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

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

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

21 HEARING OFFICER ROBERTS: Thank
22 you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 concerning their proposed Regulations?

2 Mr. Cote?

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

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

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

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

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

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

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

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

24 I think what this legislation is

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

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

22 HEARING OFFICER ROBERTS: Thank
23 you. Mr. Chin?

24 DR. CHIN: Continuing on, on

1 Section 2.13.2, 1A strike the American Dental
2 Association. 1B, strike American Dental
3 Association. 2.13.2C, 1A, strike American
4 Dental Association. B, strike American Dental
5 Association. In Section 2.15.1, strike three
6 entirely and strike 4 entirely. And going back
7 to 2.2 H, strike American Dental Association.
8 In Section 2.3A, 30C, strike C entirely.
9 Number 31, insert "director" after mobile
10 dental facility. And 32 insert "permit
11 holder." 37, strike "non" on the first line
12 for nonfacility. On 2.4.3 on the second line,
13 insert CDA and DA. And 2.4.5A, 1A, insert
14 "dental". And 2.46, Number 3, insert "or
15 Canadian dental school" and strike "or its
16 designated agency approved by the Board." In
17 2.4.7A.2, insert "U.S. CODA or Canadian dental
18 school." On 4, insert "equivalent" on Line 2
19 and strike "organizations." On 5, insert "for
20 immediate past five years." On 2.5A1, C1,
21 insert "equivalent" on the first line as well
22 as "equivalent" on the second line and on the
23 third line strike "similar." And going down to
24 3, strike "a clinical exam," insert "an

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

19 HEARING OFFICER ROBERTS:

20 Mr. McDonald?

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

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

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

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

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

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

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

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

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

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

1 anesthesiologist providers.

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

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

18 I followed the Rhode Island
19 dental anesthesia regulation process since late
20 2015. What I cannot follow is the logic of
21 ignoring aspects of the American Society of
22 Anesthesiology, the American Academy of
23 Pediatrics or the American Academy of Pediatric
24 Dentistry and the parameters of care regarding

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

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

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

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

24 Following today's testimony, I hope

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

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

18 (PAUSE)

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

23 (HEARING CLOSED AT 11:10 A.M.)
24

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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

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