NEVADA STATE BOARD

of

DENTAL EXAMINERS

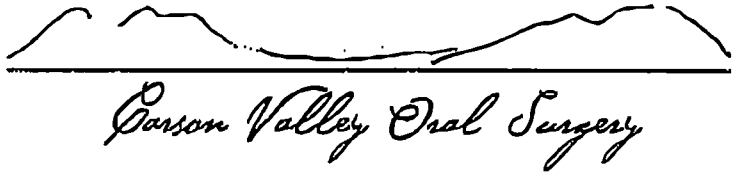
Anesthesia Subcommittee Meeting

March 11, 2016

3:30 p.m.

ADDITIONAL ITEMS

PUBLIC BOOK



Edward Gray, DMD, MD

March 3, 2016

Ms. Angelica Bejar
Public Information & Travel Administrator
Nevada State Board of Dental Examiners
6010 S Rainbow Boulevard Building A Suite 1
Las Vegas, NV 89118

Attention: Anesthesia Committee

Subject: Newly proposed anesthesia regulation changes.

Dear Ms. Bejar, and Committee Members,

At our anesthesia subcommittee telephone conference on Tuesday, December 15, 2015, there was a request for input from the subcommittee members concerning the proposed anesthesia regulation changes. As I am new to this committee, I am not sure what beneficial comments that I can make at this time.

There is certainly a lot that I do not understand about this process and the reason for these changes. As far as I know, there have not been problems in the State of Nevada with general dentists who are utilizing the Conscious Sedation guidelines listed in NAC 631.2211. Because there have not been significant adverse events that place the general public in the State of Nevada at risk, I am not exactly certain why these changes are needed.

Conscious Sedation is a very well understood term, universally understood among dentists. Changing the term Conscious Sedation and splitting it into the terms, Minimal and Moderate Sedation, seems like an unnecessary splitting of hairs from my view point.

Concerning changing NAC 631.004 and requiring additional permits, I believe the Board should really seriously consider this significant change, which would require a "sedation permit" for the utilization of 'minimal and moderate' sedation. This would induce an increase in workload to the Board and the anesthesia and sedation examiners. A need to increase present personnel will increase costs to the Board.

Concerning, NAC 631.2233: Recommendations of inspectors. Under subsection 1, if a licensee is undergoing an inspection for the administration of general anesthesia or deep sedation and receives a failing grade, the statute states the inspector needs to inform the Board no later than within 72 hours. I feel that if a general anesthesia or IV sedation provider fails the site and/or provider evaluation, the Board should be notified immediately, and the licensee should be informed that they must stop providing these services immediately.

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NAC 631.2235, subsection 6. This indicates a re-inspection one year after a failing exam. I believe this time requirement should be shortened. Re-inspection should be available to the provider sooner than one year. I know as an examiner, I would be more than happy to return whenever they feel they are ready to undergo their re-evaluation. The re-evaluation could be limited to one additional re-evaluation. For an Oral and Maxillofacial surgeon certainly a one year moratorium could mean bankruptcy.

Continuing with this issue, the State of Nevada is quite gracious in completing these site and anesthesia evaluations at no charge, but if the examiner needs to return to the office, there should be a charge for re-evaluation. (California increased its fee for the exam to $1,500.)

Lastly, I would like to make one final comment that was not discussed at our telephone consultation. While we are currently changing terminology that no longer includes the term conscious sedation and we are increasing regulations to ensure public safety for problems that are theoretical, I feel strongly that the Board is not addressing a public safety issue that is real and has resulted in three deaths in the State of Nevada. That is the issue with itinerant (fly in and fly out) oral surgeons. I am discussing oral surgeons who do not live in the community, do not see patients regularly in his or her office, but fly in to complete a day or two of surgery, then leave. These particular surgeons cannot properly vet the patients.

Prior to IV sedation or general anesthesia, a patient should be seen by the treating surgeon or at least by a partner or associate of similar training. A complete and thorough history and physical should be completed by that person. Any additional information that the surgeon would require, whether it be from cardiology, pulmonology, nephrology, endocrinology, etc. should be obtained and evaluated. When the patient then arrives for surgery, he or she should have been properly vetted, proper pre-operative evaluations should have been completed to insure that the patient is cared for in as safe a manner as possible. The team working with the surgeon should also have had proper training in handling emergency events. (In my office we do that twice per year). All members of the team should know where each and every item needed in an emergency is located and how to get that item and put it together efficiently. How do you do this when you are in an office once per month?

In addition, the provider or an immediate partner/associate of similar training should be available to see patients who are experiencing postoperative problems, whether that problem be the night after surgery, a week later, a month later, or six months later. Post-operative problems should not be left until the surgeon is once again in the area. Post-operative problems should not be pushed off onto providers who are always available in the community.

This particular practice model, with surgeons who have not properly vetted patients and are simply arriving in a community to complete a day or two of surgery before they are gone once again, is not a safe situation for the public in our state. This problem is real, and has resulted in real morbidity and mortality. As we are in the process of rewriting anesthesia and sedation regulations, we should use this moment to address this issue.

Regards,

Edward Gray DMD, MD

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