KENTUCKY BOARD OF DENTISTRY

SPECIAL MEETING AGENDA #1 AND #2

DATE: TUESDAY, MARCH 29, 2011

TIME: 9:00 A.M.

PLACE: OFFICE OF THE KENTUCKY BOARD OF DENTISTRY

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APPEARANCES

BOARD MEMBERS PRESENT
C. MARK FORT, D.M.D.
JULIE MCKEE, D.M.D.
ADAM K. RICH, D.M.D.
ROBERT B. ZENA, D.M.D.
SUSAN M. KING, D.M.D.
MARY ANN BURCH, R.D.H.
ALLAN D. FRANCIS
FONDA ROBINSON, D.M.D.

STAFF MEMBERS PRESENT
BRIAN K. BISHOP, EXECUTIVE DIRECTOR
WILLIAM A. BAUSCH, GENERAL COUNSEL
LISA TURNER, EXECUTIVE STAFF ADVISOR

OTHERS PRESENT
WILLIAM J. MOORHEAD, D.M.D.
RICHARD PAPE, D.M.D.
SHEILA SCHUSTER, PH.D.
JOHN GAITHER
TRICIA SHACKELFORD
ELISA PAPE, D.M.D.
STEVEN RHODES, D.M.D.
JAMES HARGAN, D.M.D.



KENTUCKY BOARD OF DENTISTRY
SPECIAL MEETING 1 AND 2

DR. FORT: I would like to call to order the Special Meeting Number 1.

MS. TURNER: Roll call?

DR. FORT: Yes, Lisa, would you please do roll call.

MS. TURNER: Dr. Greg Vance. And I failed to call Dr. Greg Vance at the public comments hearing, too. He is absent.

Dr. Julie McKee?

DR. MCKEE: Here.

MS. TURNER: Dr. Katherine King.

(NOT PRESENT.)

MS. TURNER: Dr. Rich?

DR. RICH: Present.

MS. TURNER: Dr. Zena?

DR. ZENA: Here.

MS. TURNER: Allan Francis?

MR. FRANCIS: Here.

MS. TURNER: Dr. Fort?

DR. FORT: Present.

MS. TURNER: Mary Ann Burch?

MS. BURCH: Here.



MS. TURNER: Dr. Susan King?

DR. S. KING: Present.

MS. TURNER: Dr. Robinson?

DR. ROBINSON: Here.

MS. TURNER: Dr. Daughtery?

(NOT PRESENT.)

MS. TURNER: Dr. Fort, you have the quorum.

DR. FORT: Thank you. All right.

So this meeting is to consider the comments presented at the public hearing on KR -- 201 KR -- KAR 8:550, "Sedation and Anesthesia."

Let's do four first. Consideration of approval of the credential's committee report, just so we can -- I'm sorry. I caught you off guard. I didn't tell you, but I actually did read ahead.

MS. BURCH: Okay. The credential committee met yesterday --

DR. FORT: Okay. We will wait. I'm sorry. I just jumped ahead. I'm sorry.

Okay. Let's do comments. So when we go through the comments, Brian --

MR. BISHOP: Go ahead. I can do that.

DR. FORT: Would you just lead us through the comments that were made, and we will

have our discussion.
MR. BISHOP: I will.
DR. FORT: And thank you very much.
MR. BISHOP: Yes, sir. I'm ready to direct traffic.
DR. FORT: Thank you, and let's go.
MR. BISHOP: The first comment we have was from Dr. Fred Look. That was the one that I read into the record.
His proposed solution was to encourage the board to add EKG monitoring and AED availability to the regulations for everyone administering moderate sedation. It is time for the Kentucky Board of Dentistry to step up and be a leader and do the right thing.
Let me ask a question of Dr. Moorhead. This seems very similar to the change that the KDA work group proposed. You put permissive language in there or language in it that would require a defibrillator or an AED.
DR. MOORHEAD: But not an EKG. That's the difference.
MR. BISHOP: Okay. Either a defibrillator -- maybe -- I am sorry.
DR. MOORHEAD: A defibrillator or an



automated external defibrillator.
MR. BISHOP: Okay. What other kind -- just because I don't know -- is there?
DR. MOORHEAD: That's the only kind of defibrillators. And then the other thing is that there should be a rhythm strip EKG present.
MR. BISHOP: Okay. So by allowing a defibrillator or an AED --
DR. MOORHEAD: An AED has a built-in -- you can't see it, but it has a EKG built in. So it can evaluate a life-threatening rhythm and deliver a shock.
MR. BISHOP: Yeah. And some of them do have displays on them where you can see if it's V-fib or V-tach or whatever it is. An actual defibrillator --
DR. MOORHEAD: An actual defibrillator would require an EKG, and that's the paddles.
MR. BISHOP: Yeah. Okay. So my question was, if a defibrillator or AED would address, at least in part, his comment because he is requesting here that we do either an EKG monitoring, he says, and AED available. You guys made it a little more permissive, and it was either/or.
DR. MOORHEAD: And the reason for the



rationale that we -- of the compromise we made was that an AED does have on it the ability to check for a shockable rhythm.
MR. BISHOP: Okay. So I just want to be sure we have the difference here. It looks like what Dr. Look is asking for is that we require an EKG and an AED be available, where the KDA sedation work group said you either have to have a defibrillator or an AED.
DR. FORT: Okay. I have a question, Dr. Moorhead. Why would you have not included an -- and this is only so you have a chance to talk. Why would you have not included an EKG in your recommendations?
DR. MOORHEAD: Do I need to be up there (indicating)?
DR. FORT: It would be nice.
DR. MOORHEAD: Okay. Personally, I have an EKG in my office. I have done IV sedation now for about a year and a half. I've done oral sedation for about 10 years. Of the people on my work group, I was the only one that had done oral sedation.
For people that do not have experience with an EKG, to put one there without expertise, if you



don't use it for a while, there is a learning curve. And there was some argument on whether there would -- if it's there and you don't understand it -- whether there is a legal liability.
So that was one argument. Knowing that argument, I contacted those three experts I mentioned earlier -- Malmed, Hawkins and Becker -- and I asked is there a cookbook for me that you can go by for these practitioners that might have an EKG forced on them?
Is there something that can say if you do a preop EKG and you see this, you need to do this? And if it was okay on the preop EKG but if you're getting to the procedure that's stressful and you see this, you should do this? And there is nothing like that. And what's more, because of legal liabilities, there's not going to be something like that. They want you to take CE courses, et cetera, to learn that. But it's not a quick course. It takes a while to do that.
DR. FORT: Okay.
DR. MOORHEAD: And dentists are not cardiologists.
DR. FORT: The past statute did not have EKGs in it.

DR. MOORHEAD: Or AEDs.
DR. FORT: Or AEDs.
DR. MOORHEAD: Correct.
DR. FORT: Okay. AEDs probably weren't even around when that one was written.
Now, at the risk of confirming my ignorance, what about pulse oximeters? How close do they get to that particular --
DR. MOORHEAD: Well, pulse oximeters were required under the old regulation for what is now called moderate sedation.
DR. FORT: Okay.
DR. MOORHEAD: They were even required for the non permitted oral sedation provider. They -- the biggest issue to do with sedation, especially moderate sedation, is maintaining an airway. And all the training is primarily geared toward knowing how to maintain that airway.
Same thing to do with minimal sedation for pediatric because on pedos, it is easier to lose that airway. So that's why our recommendations are different from minimal sedation for pedos, and the pulse oximeter is to address that airway.
DR. FORT: Okay. So they would not be considered interchangeable?



DR. MOORHEAD: Not directly, no.
DR. FORT: You wouldn't gain the same information from a pulse oximeter as you would from an EKG?
DR. MOORHEAD: Correct.
DR. FORT: Okay. All right.
DR. ZENA: I have a comment. Why do we want to make -- and this is just something to think about. If we're going to write laws, why do we want to make language where technology is moving so fast that eventually these pieces of equipment that we're talking about become obsolete?
So why not include language that's more general to where we don't have to argue about an AED or an EKG or pulse oximeter? All we do is describe what problems that we want to be able to address if there's an issue. You see what I am saying?
So we get out of this EKG and AED problem by excluding those specific pieces of equipment and more address the actual problems themselves so that they have the ability to check for a shockable rhythm, they can maintain an airway and deliver a shock or whatever. But we don't have to tie the law to a specific piece of an equipment. You know, I've got a problem with all that.



MR. BISHOP: That's a great question and a great comment. In the regulatory world, they're always looking for something specific because that's going to be inspection criteria. And if we don't give a dentist the heads-up on it, we expect to find either an AED or an EKG.
And when you write regs, although this has been what has felt like a 20-year process, regs will only last probably about five years or so at best, and then we'll be right back in this middle of this again, looking at all the updates.
MS. BURCH: I thought it only had to be reviewed every two years.
MR. BISHOP: Well, they'll probably be reviewed every two years. But, typically, an agency doesn't have to make a change for about five or so.
MS. BURCH: Okay.
DR. MOORHEAD: And may I speak to that last one too? Even the American Dental Association's sedation recommendation uses those terms, too, because they're universally recognized terms, and I would suppose -- I would presume that it eliminates ambiguity.
DR. FORT: I mean, even if you were to throw something in like -- you know, a minimum



equipment requirement or, you know, something like that might be proactive. But we're not to that.
Okay. So the way we proceed through this --
DR. ZENA: I'm sorry. I missed that.
DR. FORT: If you were to say, like, a minimum level of equipment, armamentarium, would include to kind of catch where you were going with that.
So, yeah, I mean, I am with you on that. I don't know if we can do it, but I am with you.
MR. BISHOP: You have to be careful how general you get because you have to remember, MacGyver used a computer screen and two silver candlesticks, and if you leave it too far open, you really open Pandora's box where you're not accomplishing what you want, because there is always --
DR. ZENA: If you're too specific, on the other hand, then you've got a problem with technology.
MR. BISHOP: Sure. So --
DR. FORT: The way we'll proceed through this is that we make a motion to accept, reject --
MR. BISHOP: This comment.
DR. FORT: Or, yeah, accept or reject

this comment.
MR. BISHOP: And the specific comment that you're considering is --
DR. RICH: Can we reject this comment --
MR. BISHOP: We can do either part.
DR. RICH: -- and accept somebody's else later --
MR. BISHOP: Certainly.
DR. RICH: -- with the intent of --
MR. BISHOP: Certainly. Yeah.
DR. RICH: Okay. I vote that we reject the comment.
MR. BISHOP: Okay.
DR. FORT: Second?
MR. FRANCIS: What comment are we rejecting?
MR. BISHOP: It's the one from -- by Dr. Fred Look. I'm sorry.
DR. FORT: He wanted to add EKG monitoring and AED to --
DR. S. KING: I second it.
DR. FORT: Okay. Dr. Susan King seconds it. Any --
DR. RICH: Dr. Fort, you already seconded it.



DR. FORT: Huh? Who did?
DR. RICH: You did.
DR. FORT: No, I said I need a second.
DR. RICH: Oh, okay. I thought you said second.
DR. FORT: Okay. I will just bail you out if we really get in trouble.
Any additional discussion? All in favor?
BOARD MEMBERS: Aye.
DR. FORT: Any opposed?
BOARD MEMBERS: (No response.)
DR. FORT: Okay. Dr. Look has been taken care of.
The next one?
MR. BISHOP: Because they are kind of intertwined, I guess we can take a minute. Let's -- would it be okay if we go with the anesthesiologist group because it kind of tied in with some of the stuff that Dr. Moorhead had too.
So let's look at the comments by, first, the Kentucky Association Nurse Anesthetists with Sheila Schuster.
MS. SCHUSTER: Mr. Gaither.
MR. BISHOP: Oh, I'm sorry. Yes.
DR. FORT: Thank you, Dr. Moorhead.



MS. SCHUSTER: I figured you really wanted to hear from a CRNA, not a psychologist.
MR. BISHOP: No. I'll need your services once we are done.
DR. FORT: Go ahead.
MR. BISHOP: Well, we are. He is having a sidebar with Dr. --
MR. GAITHER: I'm sorry. I was just talking about -- I was just asking a question for a last name. Is it okay if I do that for one second?
MR. BISHOP: Sure. Sure. It's all fun and games when the guns come out.
MR. FRANCIS: Let me ask a very quick question: Are you currently providing CRNA services to the dentistry in the State of Kentucky right now?
MR. GAITHER: That's a good question. In the past, with your guidelines up until now, yes, we have been providing that. However, with the current regulation that you have, there's a little bit of ambiguity. And the question that we ask is, under your current regs, are we allowed to practice like that?
So that's why we asked for an advisory opinion from your board. So in the past we were, but currently, we're not really sure. So that is why we



had these issues, and we're discussing with you-all today.
MR. BAUSCH: Okay. And I have the drafted advisory that ties somewhat into a segue from the emergency regs. So if we understand what we are currently doing and make sure those are clearly defined and that's where we want to be, then the new regulations and the old regs would then be a consistent scene. But I think your question is what can we do now before the old regs come on so we understand our current regulatory scheme, then we go forward.
MR. GAITHER: Okay.
MR. BAUSCH: And that was issued -- a request was issued, and I have a draft that obviously I can't circulate until the Board grants authority that they either like it, don't like it, or want to change.
MR. GAITHER: Right. Right.
MR. BURCH: But that kind of gives us a stepping off point from emergency regs to old regs; so -- Dr. Fort, with your permission, I'll be glad to try to explain what has transpired here.
MR. FRANCIS: Well, we need to because obviously, you know, if we are providing services

and all of the sudden, you know, we are in limbo around here and you can't do anything, we need to figure that out.

DR. FORT: Okay. Let's define the problem before we go to the solution. Let's just try to not completely stir up the waters.

MR. BURCH: There were two specific questions. And one is, are we, as the dental board, through the E regs limiting CRNAs? Are we in some manner limiting what they can and cannot do?

And secondly, there was -- under Section 9, it listed the educational settings that were required and the CRNA education level that is being allowed to provide sedation. We're not intending to not include them.

But for clarity's sake, if CRNAs are going to be able to provide sedation, then whether or not we just need to say yes, they are, even though we didn't in the E regs list it -- and then if that's the determination, then the next step is under the new regulatory provisions, do you want to include the CRNA educational levels as qualifications for sedation?

DR. FORT: The first comment that they made on section -- on the one that refers to Section



9 --

MR. BURCH: I gave all of mine out; so I --

DR. FORT: I've got more. Well, I thought I did. That's fine. Maybe, I don't.

The first comment -- and what we'll do with theirs is do it by part.

MR. FRANCIS: Okay. Section 9?

DR. FORT: Yeah. We're going to do Section 9, this first half of page two.

What I see here is -- he's made cross-outs of provided proof and successful completion of, which is redundant to number four at the top, and then the addition of D.

And the way I understand this, if a dentist wants to give sedation, he can find himself going to a board-approved nurse anesthetist school, and that would be okay. This has absolutely nothing to do with nurse -- nurse -- one of those people (indicating).

MR. BISHOP: I think you're right.

DR. FORT: Okay.

MR. BISHOP: When I spent some time with Dave Nicholas over at the administrative regs the other day -- Section 21 and 22 referenced back to



this Section 9 as what folks must have. As it related to CRNAs, we were kind of referencing a black hole. So there were kind of two options.

Number one, I think your interpretation of Section 9 is correct. A dentist could have any of those levels of education. When you look at that along with Section 21 and 22, we needed to put the CRNA education in there to reference what the board looks at from a CRNA perspective; that this is what the Board of Nursing considered to be a CRNA, someone who has completed these types of courses.

So that addition, I think, is appropriate and kind of helps us reference an actual process rather than the black hole that we kind of created.

MRS. SHACKELFORD: And I will interject. My comments are not -- don't track this language completely. And I would defer -- I think that the language that they have proposed is more appropriate than the language that I proposed. So I would suggest that the Board go with the language proposed by the association.

DR. FORT: Okay. All right. So with regard to Section 9, I'll enter in a motion to accept or reject these comments.

DR. RICH: I motion we accept.



DR. S. KING: Could we have more discussion?

DR. FORT: We certainly can.

DR. S. KING: Are we going to identify the comments? Can we get more specific about what we're accepting?

DR. RICH: D.

MR. FRANCIS: D.

DR. S. KING: Just the D, educational requirements; is that all?

DR. FORT: Right now, just this part right here.

DR. S. KING: Just the educational --

DR. FORT: D.

DR. S. KING: Okay. I'm with you. I'm just double-checking.

DR. FORT: Okay. Any additional discussion?

MS. BURCH: As a suggestion -- I had just written in my own notes that the dentist applicant could have any of the following. I don't know whether that makes it any more clearer. They wouldn't have to have all, but they could have any of those.

MRS. SHACKELFORD: They're "or's."

MR. BISHOP: Well, yeah. There is "or's" between each one of them. So, yes, that takes care of it, yes.
MS. BURCH: It does the same thing. Okay.
DR. FORT: Okay. All in favor?
DR. RICH: Aye.
DR. E. PAPE: Oh, I'm sorry. I just need --
DR. MOORHEAD: Is it appropriate to ask a question?
DR. FORT: I'll entertain, yes.
DR. MOORHEAD: Do you want to ask it?
DR. E. PAPE: Oh, me?
DR. MOORHEAD: Yeah.
DR. E. PAPE: I don't know if this is the -- hi, Elisa Pape, periodontist. I'm on the KDA sedation work force.
I don't know if this is the section that we would need to put this in here, but I just want to bring this up. As licensed dentists in the State of Kentucky with hygienists in our office, we, as dentists, are responsible to make sure that our hygienists' licenses are current, active, and in good standing.



So I feel like we need to have some verbiage within this -- if we are to go with this -- in here that would say that we need to make sure the CRNA working in our office has an active, current license that is in good standing with the Board of Nursing.
DR. RICH: I think that comes up in 21, doesn't it? I mean, that --
MR. BISHOP: Well, there are two things we have to be very careful as we tread on here.
Number one, our laws are very specific, that says, "that a hygienist may only work under a dentist." And so we can make those transitions fairly appropriately. I think if we can put some language in there that could require a policy by every dental office using an outside practitioner that they have that.
But for us to make a rule, if you will, that says they have to have that, kind of gets into that murky area of treading on toes. What I'm talking here is from board to board. I don't think it's a bad idea as a matter of policy that every dentist who utilizes any professional, do that. Do you have any insights on that?
DR. FORT: If they're not currently licensed -- down here under number three, which we



are not to yet, then they don't fit that bill.
MR. BISHOP: That's exactly right.
DR. FORT: I mean, if you're not licensed, you're no longer a -- you know, you are only a dentist as long as you are --
MR. BISHOP: And I want to be careful for us not to put the dentist in the box of, if -- let's say there's been a lapse in the CRNA license, for whatever reason, and they administer those services, I want that to be a CRNA Board of Nursing problem, not a Kentucky Board of Dentistry dentist problem; so --
MRS. SHACKELFORD: Well, I think if you are going to do that, you have to do it for the anesthesiologist as well as the CRNA.
MR. BISHOP: Right. Everybody.
DR. FORT: Ms. Schuster.
MS. SCHUSTER: Sheila Schuster, with the Kentucky Association of Nurse Anesthetists.
DR. FORT: See, it's hard to say, isn't it?
MS. SCHUSTER: And I practiced for six months before I started working with them.
Let's remember -- and this is where the ambiguity came from originally -- that we're talking



about training that the dentist gets. There's no licensure here because there are no other professionals here. CRNA education that is referred to here does not refer to CRNAs as professionals.
This is all education that the dentist would have to get in order to get the permit. So, you know, I think the issue of licensure of another profession may come up someplace else, but it would not be under Section 9.
And that's why we suggested that you insert a dentist applicant at the very outset up there because it was so confusing about who was getting the permit. Because when you first read it, it looks like there's an anesthesiologist; then there's two dental qualifications and no CRNA. So we are talking about the dentist here getting the permit. Thank you.
DR. FORT: So if a dentist -- to go on and expand, if there was a CRNA that decided he wanted to become a dentist, and he had completed that education, or she -- he or she -- and then became a licensed dentist, they would -- because of that education, they would qualify as a sedation dentist.
MR. BISHOP: And, actually, we do have

one of those in the state.
MS. SCHUSTER: So it's not a hypothetical.
MR. BISHOP: It is not a hypothetical.
DR. FORT: Okay. A vote. A vote. All in favor?
MR. FRANCIS: Aye.
DR. FORT: Do you know what we are voting on?
MS. BURCH: Yes.
DR. FORT: Okay.
DR. S. KING: Section 9.
DR. FORT: All in favor?
BOARD MEMBERS: Aye.
DR. FORT: Any opposed?
BOARD MEMBERS: (No response.)
DR. FORT: Thank you. We will approve that portion of the comment.
Now, we are going to move down to --
Brian, I'm sorry. I jumped in on your toes there.
MR. BISHOP: That's okay.
DR, FORT: I am sorry. I can't answer your Words With Friends right now.
MR. BISHOP: Really? You are so far



behind now, you should probably go ahead and quit.
I guess the next place for us to stop on the train is with Section 21. I wanted to let you know that when these questions starting popping up, I went ahead and went upstairs to the Board of Nursing. I tried to get some research because I was hearing a lot of CRNAs can't do this. They can only do it here. They can't work there.
Nathan Goldman is the general counsel upstairs along -- and Charlotte Vinson is the executive director. Our regulations and the proposed changes that we're looking at are all perfectly in concert with what the Board of Nursing has promulgated through that regulatory process with the CRNAs.
It is my understanding, from having talked to them, that a CRNA is as independent a practitioner as any license holder sitting in this room; that in a hospital setting, there is some permissive language where they can work in conjunction with an anesthesiologist, but that is not a mandate. That was all set up for rural providers when the enabling legislation and regulations were passed, I think.
MR. GAITHER: Correct.
MR. BISHOP: And you probably know this history better than I do, but I am giving you what I



know.
So earlier, we had a question of liability. I posed that very same question to Nathan Goldman because I wanted to know -- there are some specialty nurses that have to work only with a collaborative agreement with the physician. This is not one of those groups. They are as independent as anybody here.
So obviously from a liability, standpoint -- if something goes wrong with sedation in your office and you are working with a CRNA, a good attorney is going to sue everybody in the room. Okay? But inevitably that liability runs to the licensed independent practitioner providing those services.
Is that accurate?
MR. GAITHER: That's correct.
MR. BISHOP: Okay. So although everybody is probably going to get sued, it was the opinion of the general counsel at the Board of Nursing, their executive director -- and then when I spent some time talking with Ms. Schuster and John over the weekend, everybody seemed to be in agreement there. And I think that we are on solid legal footing, and Bill has looked at that.
So, initially, the idea that I thought we had



and I think when Dr. Moorhead and I talked, we were saying the same thing and meaning two different things. He was saying that we wanted people to be able to practice at the level to which the dentist was permitted. And I was hearing him say we wanted people to practice at the level to which the facility was certified.
We really have two different animals here. One is that Dr. Rich may take the education and training and become permitted to provide those services as they relate to anesthesia for his patients.
The second critter is that the dentist who wants nothing to do with putting people out but wants to have those services available. And with that, we've created an animal in the regulation where you could have your facility permitted, where you have all the toys in the toy box appropriately, but you contract with a CRNA, an anesthesiologist, or another dentist who has had that appropriate training to come in and provide those services.
Now, I want to be sure we understand there are two very distinct critters here.
So when we look at Section 21 and Section 22, I think we are considering those comments in light of the second option. Okay? You have the facility

permit. Your facility has been inspected. You have all of the toys in the toy box that are correct. You are not providing those services. But on a case-by-case basis, as you need it, you are bringing in a CRNA, an anesthesiologist, or another dentist to provide those services.

MR. BURCH: Can you put those back up? The one with the red line.

MR. BISHOP: So as we consider where we are going to go with Section 21 -- I think that's what we have to decide is, do we want the dentist to have to have the education at the same level as people he is going to be contracting with, or do we just want the dentist to be able to go, "Hey, I don't want any part of that. I want to hire a professional to come in who does that voodoo that they do"?

MR. FRANCIS: Is the CRNA certified by the state?

MR. BISHOP: A CRNA is licensed by the Board of Nursing.

DR. S. KING: So I am going to ask you a very simple question. And I just don't know the answer to this. Are nurses permitted to diagnose?

MR. GAITHER: Under certain criteria, we



have nursing diagnoses. We don't practice medicine. We practice nursing. So we don't pretend to be doctors in any way, shape, form, or fashion. We're nurses.

So we do not practice the art of medicine. We do not diagnose certain medical conditions. We will give an opinion about -- if a patient comes into your office to have a procedure, and we think that they have underlying medical conditions -- COPD, CHF, certain things like that -- then we're going to be trained and educated to help identify those types of issues and make sure the patient is safe for the anesthetic. However, we are not going to specifically diagnose that condition, as a physician provider.

DR. S. KING: Are there events that occur during an anesthesia procedure which would require diagnosis?

MR. GAITHER: Possibly. A good example, it's just like -- you were talking about the monitoring-type capabilities with the pulse oximetry or with your rhythm monitoring devices, whether it's an EKG, whether it's a monitoring defibrillator with a three-lead strip.

If, during a procedure, the anesthetist --



whether it's an anesthesiologist, a dentist who's trained to provide the sedation, or a CRNA -- recognizes a change in the rhythm strip or a drop in the pulse oximetry -- or the pulse oximetry, you also get a heart rhythm. You don't get an interpretation, but you get a regularity of the rhythm.

If, for some reason, that regularity changes and goes from a regular rhythm to what's irregular, that may be possibly an atrial fib, yes, we can identify that and intervene in those situations.

MRS. SHACKELFORD: And if I could interject to answer that question a little further. I think that it all comes to the scope of practice of your licensure category.

Physician assistants have to work in conjunction with a physician. A nurse practitioner does not.

A nurse practitioner can function and see patients and diagnose patients and even prescribe certain medications under the scope of practice of their licensure without any collaboration with a physician. So I think it depends on what the licensure category of the professional that you are working with is.



So to pair it with what he is saying or expand upon what Mr. Gaither just said is there are certain diagnoses he can make because that's within the scope of practice of his licence. He can't go beyond that --

MR. FRANCIS: That makes perfect sense.

MRS. SHACKELFORD: -- beyond what his training is to diagnose things that are beyond his scope of practice in his licensure category. But certainly within his training, he is qualified to make diagnoses and treat accordingly.

DR. FORT: So you can make diagnosis of a seizure?

MR. GAITHER: Yes.

DR. FORT: And prescribe and actually push antiseizure medication?

MR. GAITHER: Correct.

DR. ZENA: I have a comment I would like to make. First off, I agree with --

MRS. SHACKELFORD: Mrs. Shackelford.

DR. ZENA: -- with the attorney. For clarity's sake, I like the language of what they've put in here, but I think we need to interject another word as the licensed certified registered nurse anesthetist, rather than just certified

registered nurse. This way we know they're under the jurisdiction of the Board of Nursing.

Somebody could be a certified registered nurse anesthetist that's retired or whatever and decided to moonlight in a dental office. So just for clarity's sake and to make sure that everybody is registered, we don't have to worry about that person being licensed. We just interject the word "license" in front of every one of those -- that wordage that's as presented here.

MRS. SHACKELFORD: And we need to do that with anesthesiologists --

MR. BISHOP: Let's build on that. Why don't we take paren one, if we are going to follow what Dr. Zena has here or has proposed, and say "A treating dentist who desires to allow a licensed individual, whether it be a, one, physician anesthesiologist, two, a certified registered nurse anesthetist or, three, another dentist, who holds an anesthesia or sedation permit to administer anesthesia sedation of to a patient" -- blah, blah, blah, blah.

That way we can enumerate them, and we can put it in the beginning that all of them have to be currently licensed.



MR. FRANCIS: I think we can just move it back to the board that they fall under their jurisdiction.

MR. BISHOP: Yeah.

DR. FORT: Does that work? Are we allowed to do that?

MR. BISHOP: Yeah, we can do that.

DR. FORT: I mean, because we are accepting and rejecting comments -- I mean --

MR. FRANCIS: That's modifying.

MR. BISHOP: Well, if they would be so inclined to -- actually, with the comments you can kind of modify it the way you want it, but they may be willing to say, yes, we would like -- that's the language that we would like or -- now, we'll know what he'll know. I mean, that's why Mr. Gaither is here; so --

DR. FORT: Mr. Gaither, do you have a comment?

MR. GAITHER: No, sir. We do not.

DR. FORT: Yes, ma'am. Feel free.

MS. BURCH: Okay. I -- just out of curiosity or my own education, do most CRNAs sedate patients without an EKG?

MR. GAITHER: No.



MS. BURCH: Thank you.

MR. GAITHER: We do in some settings. But across the board, if you look at most of the practice settings -- CRNAs work -- and as I said earlier, in a variety of states, we will follow the state's guidelines for that particular facility. If the state says that you have to have certain monitoring devices for this type of procedure in your facility, then we follow those guidelines.

So if it says we do not need to have that, if it's a little bit of Versed for a procedure or something like that, then we're not going to do that. We are not going to monitor that. We wouldn't have to have the monitor for that.

So if that answers your question -- I hope it does. We do in some situations, most settings, but not all.

DR. FORT: Dr. Moorhead.

DR. MOORHEAD: But to clarify, would you say that if you were going to do deep sedation, you would definitely have a -- at least a three-lead -- a rhythm strip, three-lead EKG? But if you were doing moderate sedation, you would not necessarily have it?

MR. GAITHER: If the facility -- if that



was part of the facility's guidelines, we would follow whatever the facility guideline says. Personally, my comfort level is, if I am doing deep sedation, yes, I would prefer to have that monitoring device in place. Yes, sir.

DR. MOORHEAD: But for moderate?

MR. GAITHER: Moderate -- it would be nice, but, again, we fall back -- if we had a pulse oximeter, we might be able to go with that.

DR. ROBINSON: But it also depended on the condition of the patient, though.

MR. GAITHER: Yes, it would definitely depend on the condition of the patient.

DR. HARGAN: My only question was --

DR. FORT: Name?

DR. HARGAN: -- but I think it just got answered.

THE COURT REPORTER: Wait. Wait. I need your name.

DR. HARGAN: I'm sorry. I'm James Hargan. I am a private practice oral and maxillofacial surgeon. I am representing myself. But my question was going to be -- you know, if there were no regulations and you had your box with you, would you leave your EKG at home, if you were

going to go out to facility and do some work?
MR. GAITHER: No.
DR. HARGAN: That was my only question.
MR. GAITHER: No. Our national organization, the AANA, provides very specific practice, policy guidelines for office-based anesthesia procedures.
DR. HARGAN: As does ours.
MR. GAITHER: Yes. And it's, like I say, patient safety is always a key issue. I don't think you are going to find any CRNA that wants to get themselves -- or any anesthesia provider, CRNA, anesthesiologist, licensed dentist -- that wants to get themself in any kind of problem with the patient. So I think we are going to use the monitoring and sedation technique that we are comfortable with using. I don't think we are going to do anything that's unsafe.
DR. FORT: I know you're not.
MR. GAITHER: Especially when you're watching us.
DR. RICH: My comments -- I'm pretty happy with the Section 21 as he has written it out.
On part three down there is the only place I have a comment. Where it says, "in an ambulatory



care center or hospital," can we expand that to say, "any facility certified to deliver administration of deep or general anesthesia" or something along that line -- as long as it is a facility, not just ambulatory care center or hospital, but any facility that is up to snuff with our guidelines as far as what's required?
MR. BISHOP: I can't think of a problem. Can you think of any?
MR. GAITHER: Office-based anesthesia practice that may not be certified as an ambulatory surgical center. There are a lot of providers that do office-based only.
MS. SCHUSTER: But isn't that what this board is trying to issue permits for?
MR. BISHOP: Yeah. But we'll be permitting the ones that aren't in an ambulatory care center or hospital. I think what we wanted to be sure that included with parenthesis three was that dentists can go to a hospital or an ambulatory care center and do that. The facility permitting section of the regulation allows for them to do it in their office, if they are permitted.
DR. RICH: Okay. So it doesn't disclude (phonetic) that?



MR. BISHOP: No, no, no. Parenthesis three just makes it more inclusive.
DR. FORT: Where are you going with this? Because in number two, it says, "the facility of a treating dentist." Are you trying to expand that, like, to a facility, you know, like Joe's Sedation Clinic that's -- you know, and you can go there, or are you trying to get --
DR. RICH: Well, I think that's covered as an ambulatory care center. Yes or no?
DR. FORT: Well, I mean, I don't know. Is that what you're asking?
DR. RICH: Well, I --
DR. FORT: Like, if you've got the facility -- if Adam Rich has got the facility, can I go there?
DR. RICH: That's what I was going to say.
DR. FORT: But that's -- yeah. And is the way this is written, is it that way?
MS. SCHUSTER: But, again, my question is: Doesn't Section 9 cover that? Isn't that what this board wants to do, is to control the permit level of the dentists' offices?
DR. FORT: We want to control permit



level of the facilities certainly.
MS. SCHUSTER: Okay.
DR. FORT: And the facility is tied to the dentist that owns it, but in number two that you have presented in the comment -- and I am just trying to decide if -- where we want to go with this.
Do we want to be able to do -- do I, as a practicing dentist, who has no sedation -- I don't have any dreams of doing sedation -- could I go to a permitted facility, not an ambulatory care, not a hospital, but a permitted facility, take you with me and perform dentistry while you have a patient sedated?
DR. RICH: Or even another doctor's office? I mean --
DR. FORT: Another dentist's office.
DR. RICH: Another dentist's office, yeah.
DR. FORT: Yes. Yes, that's the question --
DR. RICH: Someone else's dental office.
DR. FORT: Is that where we want to be?
MRS. SHACKELFORD: Isn't that covered under Section 1 of that Section 21?

DR. FORT: Is it?
MRS. SHACKELFORD: Well, it's a specific practice location which complies with --
MR. GAITHER: Section 9.
MRS. SHACKELFORD: -- Section 9.
MR. BISHOP: I think you're right.
MRS. SHACKELFORD: My understanding about number three was that was just to clarify that the dental board could not in any way regulate an ambulatory care center or a hospital. But only -- the only thing that the dental board can regulate is dental practices. That was my understanding of why 23 is in there.
DR. FORT: I agree with that.
And Bill brings up a point that with me, if I want to go to Adam's place and work, I have to register with the board, that that's a place that I'm going to go.
MR. BISHOP: Right. Okay.
MR. BAUSCH: That's covered under our general rule but --
DR. FORT: That's under general rules, but I would probably have missed that.
MR. BISHOP: Yeah. Okay.
MR. GAITHER: And on the other hand, as



an anesthesia provider, whether it's CRNA or other provider, you would have to have credentialing agreement with that individual facility before -- you couldn't just take me as your personal CRNA to where -- whoever's facility. I would have to be credentialed, licensed to practice at that individual facility.
MR. BISHOP: By the Board of Nursing.
MS. BURCH: Through the Nursing Board.
MR. FRANCIS: By the Board of Nursing.
MR. GAITHER: Well, I would be licensed by the Board of Nursing to provide care; however, the individual facility would have to credential me to be able to provide services at that facility.
MR. FRANCIS: Oh.
DR. FORT: That's under number three, but in an individual dentist office, you're not going to get -- you're credentialed only by your certificate.
MR. GAITHER: Correct. But you're allowing me to come into your practice.
Say, for instance, that if you hire me to do dental services in your office and you have a patient that you would like to take over to Dr. Rich's office to do it, Dr. Rich, since it's his



facility -- I cannot just follow you over there and do the services without Dr. Rich's permission. Dr. Rich would have to allow you to allow me to do those services at his facility.
DR. FORT: Right.
MR. BAUSCH: And without Dr. Rich's facility being in compliance with the needs of the sedation that you're doing.
MR. GAITHER: Correct.
DR. RICH: And Dr. Rich does not have to be present?
MR. GAITHER: No.
DR. ZENA: I have a question for you in that regard. Are you required by the Board of Nursing -- you're licensed -- you can go to a dentist's office that alleges that they have a permit for their facility to do general anesthesia, do you have to have them produce documentation to that effect, or is it your responsibility to see that they really have it, or you just --
MR. GAITHER: It's my responsibility.
The Board of Nursing does not require me to do that; however, it's my responsibility as a provider to make sure that if I'm going to practice at that facility giving different levels of sedation or



anesthesia, I have to be aware that that facility has the credentials and the equipment available, and the facility itself is --
DR. ZENA: By law or just by your fear of malpractice -- your malpractice insurance carrier?
MR. GAITHER: I can lose my license. If the board finds out that I'm practicing at a facility, I can lose my license.
DR. ZENA: So that's already been specified by the Board of Nursing anyway. Okay.
MR. BAUSCH: And, Dr. Zena, I think you're getting to the issue of the board's oversight of a dental office in order to be capable of providing that type of sedation. In order to be able to look at the -- and the board's jurisdiction over the dentist, having the board --
DR. ZENA: "The board," meaning the dental board.
MR. BAUSCH: -- the dental board. He might get in trouble with the nursing, but in order for the dental board to oversee the facility and inspect and make sure, that's where we're heading -- we're looking at facility inspection. That way if the facility is not up to speed, somehow he misses

it, the dentist still has responsibility for what occurs in their office.

DR. FORT: I was getting ready to ask for this -- go ahead.

DR. R. PAPE: Rich Pape, dentist practicing in Kentucky in Louisville, and is on the KDA work group.

Since we're talking about facility inspection, one of the things that I just thought of today that we didn't even really consider in terms of itinerant anesthesia, it doesn't matter whether it's a nurse, physician, or another dentist, we kind of assumed -- in the old regs -- kind of assumed that you just had everything set in place, but people who practice itinerant anesthesia tend to pick up their stuff and leave.

So they bring in their monitor. They bring in their drugs. It's usually not a set place. So one of the things you're going to have to consider when you're finalizing these regs, in terms of inspection, is that you're going to have to inspect an office. It's going to be scheduled. And the CRNA or dentist or whoever is applying anesthesia will have to be there as well.

Dr. Pointer or whoever is not going to be able



to do a surprise inspection because aside from looking at the size of the operatory and making sure all the gas lines are there, all the other equipment may be gone if they're practicing itinerate anesthesia. So just something to consider.

DR. FORT: I guess what I understand is -- to certify, everything has to be there.

MR. BISHOP: Well, the answer to both of your comments is yes. I mean, Dr. Pape is right in that when the dentist calls to schedule their facility inspection, for their facility permit, then the CRNAs would bring all their -- could bring all their toys in, have it all set up. We go in and do the inspection. Yes, you had everything you need. Subsequent inspections would have to -- we would have to know at that time who owns the toy box, you know.

DR. ZENA: What difference does it make if the toys aren't there, if the patient is not there?

MR. BISHOP: Well, that's exactly right. So long as there is not a sedated patient there, the toys can be anywhere.

But we just have to know that when there is a patient that would be eligible for sedation, we're



going to have sedation that everybody is in the right place; so -- and that's going to be more on it from a complaint-driven scenario because we do get complaints on sedation occasionally. And when we go in and look at that facility -- you know, who had the toys at the time.

DR. S. KING: So what happens if you bring an equipment box that has this inventory, and the next nurse anesthetist has a different set of equipment?

MR. BISHOP: Well, what I hear him saying is, though, they're going to, for lack of a better term -- they're going to bow to whatever our regulatory standard is for that facility. So if we require two pink ones and three brown ones, he's going to have two pink ones and three brown ones --

DR. FORT: I guess I was under the impression that -- and Bob brings up a good point -- but I was under the impression that that facility was equipped, you know, all the time.

Yes, ma'am.

DR. E. PAPE: Elisa Pape, KDA Sedation Work Force.

At that point, would the board possibly consider having two different facility inspection



levels or two different facility permits? One for a standing facility, and one for the mobile anesthesiologist?

MS. BURCH: Would it make a difference to the patient which one it was? I mean, we're looking at the safety of the patient. It seems like they'd have to --

DR. E. PAPE: No, because you're still going to have two red ones and two red ones over here. And two blue ones and two -- you just know that this one that's going to be a -- the mobile, that would have to be a scheduled inspection you would not be able to do. I'm just making suggestions.

MR. BAUSCH: We just had an inspection where -- it's been a little while back so nobody knows who it is. But the patient was sedated, but there was no reversal drugs on the premises, and so we did do a surprise inspection. So, you know, those cases do come up. So the standards of what's there at the time of sedation --

MRS. SHACKELFORD: I think you're violating your facility license if you don't have the equipment that you've said that you were going to have when the initial inspection was done.

That's -- I think that's more of an issue of violating the license that you have. Once you've got the license, you're certifying that you will have the equipment that is present at the time that you get your license every time you sedate a patient.

DR. FORT: Yeah.

Dr. Moorhead, I'd like to invite you -- you have -- when -- to comment on the dentist -- I think in your proposed regulation, which we're -- it's intertwined, but I would like to invite you to comment on -- about the dentist level of sedation. It's -- that's the first part that Brian talked about, but I believe this is intertwined as far as the facility and the dentist level -- the dentist certificate of -- I don't even know how to say it.

DR. MOORHEAD: Certification.

DR. FORT: Certification for level of sedation.

Do you follow my question?

DR. MOORHEAD: I do.

DR. FORT: Okay. Thank you.

DR. MOORHEAD: Our concern was primarily out of liability, which is not a regulatory issue.

DR. FORT: Okay.



DR. MOORHEAD: But we've also seen other states follow the same pattern where a dentist can only have a CRNA do things to the level that the dentist is permitted.

DR. FORT: Okay. And so -- I mean, that's -- that seems to be intertwined to me with the discussion we're having now.

DR. MOORHEAD: However, when we're looking at other states and what they do, they have different regulations. We have to look at Kentucky regulations, and that's what you-all have been discussing, and that's what's appropriate.

DR. FORT: Okay.

MRS. SHACKELFORD: Well, my comment to that would be that if you require the dentist to have the same level of education as a CRNA or anesthesiologist, why do they need the CRNA or the anesthesiologist?

DR. RICH: Exactly right.

MR. FRANCIS: Call for the question, Mr. President.

DR. FORT: Huh?

MR. FRANCIS: Call for the question. Let's vote on this thing.

DR. RICH: You can call.



DR. FORT: Okay.

MR. BISHOP: Where is -- what are we on motion-wise? Is there a motion pending?

MS. TURNER: No.

DR. R. PAPE: Can I make one more comment?

DR. FORT: Certainly.

DR. R. PAPE: And Rich Pape, again, dentist practicing in Kentucky.

In response to Ms. Shackelford's last comment, it depends what you're doing as why you might want to have somebody else practicing anesthesia.

So, for example, if I'm doing orthognathic surgery in my office, which is -- orthognathic surgery is the repositioning of people's jaws, typically you would have somebody else come in and provide the sedation, whether that's another physician, a nurse, so that's an example of a very extensive procedure.

You may want to be focused on the surgery. That would be one example.

MR. FRANCIS: So what are we considering?

DR. FORT: Go ahead, Brian.

MR. BISHOP: I don't want us to get too



far away from where we were with respect to this comment over here we were originally discussing.

But if you'll look in the regulation that I handed out this morning that says, "filed version," on page 12, lines 14, 15, and 16. It says, "To qualify for an anesthesia sedation facility certificate, the facility shall pass an evaluation of facility equipment, medications and clinical records to include at least the following." And then it lists a laundry list of things that you have to have.

Dr. Robinson and I were just having a sidebar -- well, what does facility equipment mean. I think if we want to tighten that up or if we want to change that language, we had better change that language because maybe I've been a bureaucrat for too long, but I can read that to say either way.

That is the equipment that belongs to the facility or that it is the equipment that the facility uses whenever they're doing sedation patients. So if the board has a position on it, you want to make a strong stance one way or the other. I think we better fix that because I can -- I can argue both sides against the middle.

DR. RICH: I think the only time it

needs to be there is when the sedation is being administered.

DR. ZENA: Yeah, I agree.

DR. S. KING: I disagree.

I mean, I think that the facility ought to maintain a minimum level of equipment at all times, and it should be present at all times.

Now, if you have certain things -- if you prefer a certain kind of EKG machine and you want to bring it with you, and that is this -- it is equivalent or better, then I would say that's reasonable and appropriate. But for those basic things not to be present in the office is problematic for the facility, and I think it should be there at all times. That's just my opinion.

DR. MOORHEAD: Susan, would you please explain why. Please explain why.

DR. S. KING: Why do I think that?

DR. MOORHEAD: Yes.

DR. S. KING: If, for example, the facility is supposed to maintain oxygen, and let's say he brings a faulty, you know, portable oxygen unit -- I think there has to be a basic level of protection for the patient.

So I think transporting things that may or may



not be functional -- if you say that you were going to have these things in your office, they need to be there.

DR. MOORHEAD: Like reversal drugs or pulse oximeter?

DR. S. KING: I think they should be there if you are having your facility inspected and maintained as a facility.

MR. BISHOP: I will say this from a regulatory standpoint. We permit the facility through the dentist's license. If there's something wrong with that facility, from a Board of Dentistry standpoint, from a law enforcement standpoint, that's going to run to the license of the dentist.

So if we make this language read to where Mr. Gaither can bring his own toy box, let's say, and something goes wrong, that -- we then have an issue where the dentist is responsible to the Board of Dentistry because that facility certificate said all the stuff was there.

And if we don't care who it comes from, then every dentist in the Commonwealth would need to be aware that before they start a sedation case, they should probably have somebody inventory everything Mr. Gaither brings to make sure he is meeting this



regulatory minimum and has maintained that from the time you got your facility inspection, because if not, you're going to have -- sooner or later, there will be a case before the Law Enforcement Committee that says, you know, he didn't have Romazicon with him when he came that day or it was out of date or his backup lighting unit --

DR. RICH: I think it would be a lot less likely to be out of date if he brought it with him and was doing sedation cases constantly than if there was somebody coming to my office doing a sedation case once a month.

MRS. SHACKELFORD: And I think from a cost perspective to require dentists to have that -- all that equipment on staff themselves versus having the CRNA who uses it every day bring it, I just see that as potentially a little bit burdensome to require the dentist to fit up their office.

MS. BURCH: Here's a question I had. If a patient was treated --

DR. FORT: Well, we -- well, I'm sorry.

MS. BURCH: I'm sorry. If a patient was treated and then you think you're finished and you go on and you leave and go to your next office or you're finished for the day and you go home, what



happens if there is a complication for that patient, and they come back to that facility and the equipment is not there anymore because you've already gone?

You thought your job was finished, and you left. The dentist that's there to cover that post-op problem may not have what he or she needs.

MR. BISHOP: Well, the dentist that was there wouldn't be able to utilize it anyway, though, in that particular scenario. If they're not --

MS. BURCH: They're not trained.

MR. BISHOP: If the dentist and facility are not licensed for sedation --

DR. RICH: The provider's instruction should include ER.

MR. BISHOP: And the reg does say that the patient can't leave until they're able to meet -- you know, they're conscious, can walk on their own, blah, blah, blah.

DR. FORT: I guess, thinking about the Law Enforcement Committee standard, you know -- you're going to come back to this case and you're going to be the he said/she said thing, and you're really only as good as your last inspection anyway.

But it's, like, well, yeah, he had all that

stuff, you know. And, yeah, he had all the current drugs, and everything was left there. And you really can't -- really, I mean --

MR. FRANCIS: I mean, the way you make it sound -- I mean, you make it sound like these guys are almost incompetent. You know, if they're going to come inside to do a procedure, I don't see how they're going to just leave without making sure everything is --

MS. BURCH: I didn't mean to -- I was just worried about when you're gone and a patient comes back and needs something that's not there.

MR. FRANCIS: The person that's certified will do on what needs to be done, or I will take for granted that they would do what -- follow the proper procedures that is standard and get it accomplished. So I don't think that's a concern, you know, from one profession to another.

MRS. SHACKELFORD: And I think you ran into the same problem in an ambulatory care center. So I go get tubes put in my ears, and they release me. And then I have a problem at 7:00, and the center is closed. I can't go back to the center because they're not -- I would go to the ER or seek treatment at some other facility.



I think it's the same thing. You don't release the patient until the patient meets the criteria that you have determined it's safe for the patient to be released. The anesthesia provider needs to be onsite until that patient meets that criteria and can be released.

MR. FRANCIS: Well, is that what you did?

MR. GAITHER: Yes.

MR. FRANCIS: Would you just leave, play golf? Professionally --

MRS. SHACKELFORD: Well, you don't even have to go play golf.

MS. BURCH: Well, what about if they have --

DR. FORT: Well, we are also talking about not only facilities that CRNAs come to; we're talking about facilities that people -- that sedating dentists practice out of, also.

DR. RICH: Okay.

DR. FORT: So --

DR. RICH: I didn't mean to interrupt you.

DR. FORT: Sure. I was done.

DR. RICH: Okay. I say we go ahead and



deal with 21 and we come back and we revisit --

MR. BISHOP: 13.

DR. FORT: Okay.

MS. TURNER: Before you motion --

MR. BISHOP: I don't know that we've got those yet.

MS. TURNER: Okay. But when you motion it --

DR. RICH: And at this point -- we don't have a motion. But I think at this point, the only thing we were going to put in there was a licensed individual. Everything else -- I haven't heard any comment that anyone was --

MR. BISHOP: What I scribbled down here was a treating dentist who desires to allow a currently licensed -- and then that list: physician, anesthesiologist, certified registered nurse anesthetist or another dentist.

DR. RICH: I'll motion as such.

MR. FRANCIS: And I second it.

DR. FORT: Okay. Any addition -- and so we're going to --

MR. BISHOP: Are you just doing parenthesis one, or are you taking everything that they provided for Section 21? I just want to be



sure I'm clear.

MR. FRANCIS: I'll second it.

DR. RICH: Section 21.

MR. BISHOP: Okay. Section 21. Okay.

DR. FORT: Okay. You got that, Lisa?

MS. TURNER: Well, I will now that we have the court reporter. But, yeah. I'm with you.

MS. BURCH: So we're not having to put licensed in front of the second paragraph where it says or certified registered -- we're not putting licensed in front of each of those that's covered under the first paragraph?

MR. BISHOP: In the preamble.

DR. FORT: In the preamble -- yeah.

MS. BURCH: Okay.

DR. FORT: Okay. Any additional discussion? All in favor of accepting that comment -- that modified comment -- aye.

BOARD MEMBERS: Aye.

DR. FORT: Any opposed?

BOARD MEMBERS: (No response.)

DR. FORT: Okay. Comment number -- comment referring to Section 22, which basically would be a repetition of this, of what we just put in 21. Is there any additional commentary on that

for discussion -- I'm sorry. We've got the comment.
DR. RICH: I almost amended my motion to include that.
DR. FORT: I did, too, but I didn't want to do it.
Okay. Do I have a motion to accept that comment?
MS. BURCH: So in 22, we're deleting --
DR. FORT: We delete all of Section --
MS. BURCH: -- we're deleting this?
DR. FORT: Because that -- because it throws up into 21.
Okay. Is there a motion for that, Adam?
DR. RICH: Certainly.
DR. FORT: And there's a second?
MR. FRANCIS: Yes, there is.
DR. FORT: Allan, I thought there would be.
Any additional discussion?
BOARD MEMBERS: (No response.)
DR. FORT: All in favor?
BOARD MEMBERS: Aye.
DR. FORT: Any opposed?
BOARD MEMBERS: (No response.)
DR. FORT: All right. The final



comment -- or maybe it's the final one, Brian.
MR. BISHOP: Okay. I think at this -- Mrs. Shackelford, from your comments and what we've just done with their comments -- "their," being the CRNAs -- are we okay with your stuff then?
MRS. SHACKELFORD: (Nods head yes.)
MR. BISHOP: Anything else you'd like to add or have us discuss related to the comments you've provided?
MRS. SHACKELFORD: (Nods head no.)
MR. BISHOP: Okay. So then --
DR. FORT: We will motion to reject.
MR. BISHOP: Well, we -- no, we'll take no action.
DR. FORT: No action. Okay.
MR. BISHOP: It would just be best to take no action because they were incorporated in what we had done.
MRS. SHACKELFORD: Yeah, don't reject me. Geez.
MR. BISHOP: Is there anything --
DR. MOORHEAD: May I suggest before you look at the other things that you addressed in facility in Section 13 to do with --
DR. FORT: Yes.



MR. BISHOP: Yeah. Let's take now to look at Section 13.
DR. FORT: Okay.
MR. BISHOP: Yeah. Let's do that.
DR. FORT: Okay. Are you dancing? Let's just take a small break so we can review this.
MS. TURNER: Dr. Fort, just to let you know, the court reporter has to leave at 1:00.
DR. FORT: Okay. Brian?
MR. BURCH: We're on track. We're good.
MS. TURNER: I just wanted to remind you.
DR. FORT: Okay.
(OFF THE RECORD.)
(BACK ON THE RECORD.)
MR. BISHOP: All right. In the interim, the next item we wanted to discuss was Section 13 on page 12.
There has been a proposal made that I think kind of fits all of our niches. We're just going to have to go through this list real quick.
How about we consider splitting this list up into things that the facility must have and things that the facility would be allowed to have the provider of anesthesia services bring. And in



addition to that, if they were going to allow the CRNAs to bring some of the stuff -- monitors, drugs, some of those things -- prior to the beginning of a sedation case, the dentist and the individual providing anesthesia services would check off a checklist of what was -- who had what, basically.
So if -- Mr. Gaither, since you're here, I'm going to just keep picking on you. That's just kind of the way I work. Sheila will tell you. For drugs, let's say, Romazicon, Versed, Epi, Lidocaine. I don't know what all -- whatever all the stuff we're going to require -- all those things would be checked off as he brought those, and that would be a part of the patient record.
So we could take this list and things like oxygen and gas delivery system, backup system failsafe, that's probably something the facility is going to have to have. Gas storage facility, safety indexed gas system, suction and backup system, auxiliary lighting system -- that's all going to be required by the facility potentially in a suitable operating room to include the size dimensions, operating primary lighting source, secondary portable backup, accessibility to emergency medical staff, the recovery area.

When you get to stuff like appropriate drugs, that's probably something we could pull out and put in this. You know, either the facility can have it or they can allow the practitioner to bring it with them. Obviously, those drugs cannot be expired. Appropriate devices to maintain airway with positive pressure ventilation.

The PPV, I guess, would have to be the facility, but the intubation kit could be brought. You guys use combitubes, King airways; anything other than endotrach -- the whole scenario?

MR. GAITHER: It's the individual practitioner's preference --

MR. BISHOP: Okay.

MR. GAITHER: -- on rescue airway.

MR. BISHOP: So the appropriate device to maintain the airway could be something that could be brought out. The history and evaluation form, that's going to be a part of the record anyway. Anesthesia record is a part of the record. Monitoring equipment with pulse oximetry and blood pressure monitoring.

I think that's something you can pull out that the facility can have or Mr. Gaither could bring with him. I mean, you have a monitored -- do you



own your own monitor?

MR. GAITHER: No.

MR. BISHOP: Okay. I got a life pack 10 I might sell you cheap.

But do some providers have their own that they prefer to take them with them you know of?

MR. GAITHER: I do not know. Honestly, I'd be guessing if I said. I'm sure that there are probably some out there, but I do not know of any specific cases, so I'm not sure of that.

MR. BISHOP: Okay. I think those are things we can make permissive because there may be some that would have it, along with the EKG.

And basically just go through that -- just go through these lists and pull out the ones that are really easily portable and allow the individual to bring them so long as the dentist and the individual providing the sedation services checked those to do a formal checklist to make a part of the patient record prior to the sedation case.

DR. FORT: Is that cumbersome?

DR. MOORHEAD: Cumbersome to separate out the list?

DR. FORT: No, to require a part of that -- instead of being implied that all of those



things are in place and up to date and everything like that, is that cumbersome to require that to become part of the record?

DR. MOORHEAD: You take a sheet of paper, and you put some checkmarks on it.

DR. FORT: I'm just asking. I mean, it was going to be -- well, never mind. That's a different regulation.

DR. MOORHEAD: I can even show you how to do it electronically.

DR. ZENA: Well, you know what? If you think about it from a common sense approach when you do the inspection, you're going to inspect the facility to see if they have a oxygen delivery system built into the wall. That's not going to change anyway.

MR. BISHOP: Right.

DR. ZENA: And whoever brings the equipment, who cares who brought it? It's there. So it's, like, do you really need to go through a checklist as to what's there and what isn't as long as it's there to begin with at inspection.

MR. BISHOP: Well, here's what I want to --

DR. ZENA: But what you're saying makes



perfect sense --

MR. BISHOP: Okay.

DR. ZENA: -- you know, but to be clear about it, but it's kind of going to work itself out anyway.

MR. BISHOP: Well, I just want to protect the dentists because with the facility permit, it is tied to the dentist's license. And I don't want to put our dentists in a position where they're assuming -- not that Mr. Gaither would in any way do this, but he brings all the drugs, let's say.

DR. ZENA: Right.

MR. BISHOP: And everything is in check except for his Romazicon on that day. So -- and they get about halfway through the case. And all of a sudden, the patient has a negative reaction, and he needs to bring him out of the sedation, and he goes, "Crap, I knew I meant to order something." You know, "I didn't order my Romazicon."

Well, in the lawsuit that would be pending immediately following that by the patient's family, let's say, they're going to ask us: "Did this facility have the appropriate permit?"

"Yes, they did." And here are the

requirements. They have to have all this stuff. If we leave it up to a gentleman's agreement that he's going to make sure he has all the right toys and you're going to assume that he does, you are now liable.

DR. ZENA: So what you're saying is, then, rather -- they're going to have to have an initial inspection where he's going to have to come and have all the stuff there anyway, whatever.

Then subsequent to that, you're going to have to go through this checklist mandatorially -- the clinician is going to have to mandatorially go through the checklist with the CRNA every time they do a procedure; is that what you're saying?

MR. BISHOP: Yes, sir. For every sedation case they were going to do, there would be a checklist in the record as a part that appropriate drugs, EKG machine, monitor --

MS. BURCH: Anesthesia record --

MR. BISHOP: Yeah, it's just -- basically an anesthesia record.

DR. MOORHEAD: I would hope so that we don't introduce unnecessary paperwork, that if there is not -- if the dentist is providing sedation and the facility has already inspected for that dentist



to be there, that you don't have to add that paperwork to the dentist that's always there.

MR. BISHOP: No, no. If you're doing this and it's your facility and you keep a stock all the time, then that's fine. This is only going to be in cases where you're contracting with an outside individual like a physician anesthesiologist or a CRNA to do these things.

DR. FORT: Yeah, you'll have to write it in such a way that it's an and/or. But I think you get a facility inspection, and every time you put somebody -- every time you inspect somebody, you don't have to go check and see if the plumbing is working. But I think that the nurse anesthetist coming in, you do have to -- you hand them the paper and say, "Do you have a checklist" --

DR. S. KING: What if they have it on the bracket table and you just go, "Okay. There is five things on this list; I see all five of them"?

MR. FRANCIS: Checklist.

DR. S. KING: I mean, you know, or 10, whatever it is; it's just not that big of a deal.

DR. MOORHEAD: For instance, when we do a weekly inspection in our office, we have a list of what's supposed to be on there, and we sort them by



expiration date, and we check the top of the list and see what's coming up expired next. And as long as we're okay there, we don't check the whole cart.

DR. FORT: And Mr. Gaither comes and he's not going to empty out his purse there on the table and have all this stuff laid out to do this. You're going to have it in a crash kit, right?

MR. GAITHER: Possibly. I speak for me. Yes, I have a little bag. I can't speak for all. Just one comment I might make.

If you do this, are you talking about each individual case, check, check, check, or at the beginning of your day, if you've got 20 patients or five patients at the beginning of the day, you verify that you have this equipment at the beginning of the day sufficient to last you for this number of cases?

DR. RICH: That's fine. I mean, the paperwork will carry it over.

MR. GAITHER: If you're doing it on a case-by-case basis, it's going to be redundant paperwork. It's going to be more for you to check off.

If, for instance, I come in to your facility to provide services for six cases today and you have an



add-on, you're off, so I'm going to do number seven case. I'm certifying that -- or I'm establishing to you at the beginning of the day that, yes, I do have this equipment with me sufficient to provide services for this number of patients throughout the day and backup equipment if I need it.

And all I'd have to do is -- whether it's a signed agreement, a checklist or something electronic like Dr. Moorhead suggested, I do just -- the provider, whoever it is, certifies that he had that equipment. That could be something that would save you some paperwork instead of on a case-by-case basis.

DR. ZENA: Do you feel like this is a good idea with the proposal?

MR. GAITHER: Actually, I think from a legal standpoint, I think it would take the burden off the dentist provider. I honestly do.

I think from a legal standpoint, that if you certify that -- if I come into your office and I tell you that, yes, I have all this drug, and you have a document that I have verified that I had this and I'm responsible for this, if there's a untoward outcome, and I didn't have that, then I'm the one that's liable, not you.

DR. RICH: Let me expand on that too. If you've got this stuff in your office and you don't know how to use it, that can be a liability, as well, when you're there and the nurse practitioner or whoever does it, is not, if you had an emergency situation.

Now, I mean, that could come up just as well in court. Well, you had this drug. Why didn't you use it? I didn't know how to use it because I didn't know it was there. Well, why didn't you, you know?

DR. RICH: Yeah, I just bought the kit. I mean, that's where emergency kits get you in trouble; so --

DR. S. KING: Except that we're differentiating between facility and provider because in the facility, you're still going to have liability whether you're present or not and whether you know how to use the drugs or not.

DR. FORT: Have you got a draft, Brian?

MR. BISHOP: I do.

I think the easiest thing for us to do is, like, for example, page 13, line 6, appropriate emergency drugs which may be provided by the individuals listed in Section 21 of this regulation because that lists everybody that we're going to



allow to provide these procedures.

MR. FRANCIS: 13, line?

MR. BISHOP: Page 13, line 6. "You will make the same addendum after appropriate devices to maintain an airway with positive pressure ventilation which may be provided by the individuals listed in Section 21 of this regulation." Same thing with line 11.

DR. ZENA: Same thing being what? I missed that.

MR. BISHOP: I'm sorry. The language would read -- you would add this clause: "Which may be provided by the individuals listed in Section 21 of this administrative regulation."

We would add that language.

DR. FORT: So you're going to kind of pull those out and put them under that heading?

MR. BAUSCH: Between G and H?

MR. BISHOP: Well, rather than -- because the way this is listed --

DR. FORT: Or is that behind every one of them?

MR. BISHOP: Behind every one, we would just put that in there.

DR. FORT: Okay.



MR. BISHOP: Because the way these are ordered right now, it's going to be kind of cumbersome to make a separate list.

DR. FORT: Okay.

MR. BISHOP: So behind each one of the ones that decide -- and at this point I'm just suggesting you consider adding it to line 6, parenthesis H; line 8, parenthesis J; line 11, parenthesis M; line 12, parenthesis N.

Are we okay?

DR. FORT: Page 13.

MR. BISHOP: Are we on page 13?

DR. ZENA: Yeah.

MS. BURCH: Did you skip nonexpired for a reason? Number -- like page -- I mean line seven?

MR. BISHOP: Well, I didn't want to put it there because I don't want them to think that they can provide nonexpired drugs. I'm a little concerned about the nonexpired drugs being listed in there.

I think, we might ought to look at parenthesis H and say, "Appropriate emergency medical drugs which are not expired," or, you know, something. I mean --

DR. RICH: Are expired drugs appropriate



anyway?

MR. BISHOP: No. Expired drugs are never appropriate, unless of course you're selling them in South America.

DR. RICH: So, I mean, you can probably leave out nonexpired --

MR. BISHOP: I think you can probably delete line seven totally.

DR. MOORHEAD: I think that's assuming that that covers all drugs, not just emergency.

MR. BISHOP: Okay.

DR. FORT: That's why that's in there?

MR. BAUSCH: What about appropriate drugs, including but not limited to, emergency drugs?

MR. BISHOP: Yeah. We could just make H appropriate drugs which shall be of a current date.

DR. MOORHEAD: Appropriate nonexpired drugs? You said of a current date?

MR. BISHOP: Yeah -- or of a -- something, yeah. Which would include the emergency drugs.

So we have six appropriate drugs which are not expired and which may be provided by the individuals listed in Section 21. So that's line six. We're

deleting line seven. This is all just proposal stuff. I'm not putting words in anybody's mouth.
Line eight, we would insert that same clause. Line 11, line 12, line 17, line 18, line 21 and 22.
Mr. Gaither, are you both -- are you comfortable with 21 and 22, precordial stethoscope and peritracheal stethoscope? But -- not that it would have to be provided by you, but it --
MS. SCHUSTER: Because it's permissive, right, Brian --
MR. BISHOP: I'm looking at the file version.
Yes, ma'am. I'm sorry?
MS. SCHUSTER: It's permissive language?
MR. BISHOP: Yes.
MS. SCHUSTER: Which would be --
MR. BISHOP: Yes. Which may be. Yeah, it's all permissive language.
DR. ZENA: I knew I had the wrong one.
MR. BISHOP: I'm sorry. I'm looking at the file version. I apologize. I apologize.
DR. MOORHEAD: The stethoscope requirement for under shall be present for deep.
MR. BISHOP: No. The permissive language is "which may be provided by him instead of



you." You have to have it. It just depends on who has ownership of it.
Okay. Let's go back to the top, Dr. Zena; page 13.
DR. ZENA: I'm sorry.
MR. BISHOP: That's okay. Everybody on the right copy now. I'm looking at the filed version. I apologize.
So on page 13, line six, we would delete line seven. We would put that clause behind line eight, line 11, line 12, line 17, line 18, 19, 21, and 22, and that would be it. And that gives us the option for those things which are portable to be brought in.
DR. ZENA: Now, where are you going to insert the language about a checklist?
MR. BISHOP: We will insert that --
MR. BAUSCH: But just in generic language, it says, "Those items which may be provided by outside shall be subject to a checklist and placed in each patient's anesthesia file."
MR. BISHOP: Well, look at page 13, line 10. "Anesthesia records including monitoring and discharge records and" --
MR. BAUSCH: Check sheet for --



MR. BISHOP: -- "check sheet for those items which may be provided by the individuals listed in Section 21."
Dr. Moorhead, does that sound reasonable?
DR. MOORHEAD: Yes.
MR. BAUSCH: Something when Mr. Gaither was talking -- and I'm looking at it from protecting the dentist's liability standpoint. If you start today with seven different cases and you check them at the beginning of the day, you would still need something in each patient's chart.
MR. BISHOP: You can just make a copy of that same sheet.
MR. BAUSCH: You can make a copy of that one, but I just -- just to make clear that that -- that's not something that you can do one at the beginning of the day and say, "I got my check sheet." And then you get sued, and you go, "Wait a minute; it's not in that file."
MR. BISHOP: So on line 10, just to be clear, parenthesis L would read: "Anesthesia records including monitoring. Then we would insert a check sheet of items which may be provided by individuals listed in Section 21 and discharge records."



That takes you through the whole process; your monitoring, the items that you allowed the other individual to bring, and then your discharge records.
MR. BAUSCH: Okay. Add one little bit on that, and that would be a signed check sheet by both practitioner and person providing those items?
You would want both people to sign off somewhere, put that in that file so that you -- you know, a year from now when you go back to look and you forget which CRNA you used.
MR. BISHOP: So you want to say a check sheet of items which may be provided by the individuals listed in 21 signed by --
MR. BAUSCH: By both.
MR. BISHOP: -- by both?
MR. BAUSCH: By practitioner and --
MR. BISHOP: Provider?
MR. BAUSCH: -- a provider as listed in Section 21.
MR. BISHOP: Okay.
DR. FORT: Okay. So now are we going to make that -- are you happy with it?
MR. BISHOP: Well, it's not about me being happy. I'm happy with anything.

DR. FORT: You have got it written down. Is everybody else -- are we on the same -- on the page? Do we know what we think we've got?
MR. BISHOP: I know what I've written.
DR. FORT: Okay. All right.
MR. BISHOP: Would you like me to go through it one more time?
MR. FRANCIS: No.
MR. BISHOP: No? Okay. As long as you're cool, I'm good.
DR. FORT: Okay. So we will entertain a motion to accept that language into the new, old regs.
MR. BURCH: Section 13.
MR. FRANCIS: I move.
DR. FORT: The modifications outlined here.
MS. BURCH: Second.
DR. FORT: Allan and -- blank --
MS. BURCH: Burch.
DR. FORT: Burch.
DR. MCKEE: More coffee needed?
DR. FORT: Any additional discussion?
BOARD MEMBERS: (No response.)
DR. FORT: All in favor?



BOARD MEMBERS: Aye.
DR. FORT: Any opposed?
BOARD MEMBERS: (No response.)
DR. FORT: Passed. Thank you.
MS. TURNER: Go on to the next topic.
DR. FORT: I don't think there are any.
MS. TURNER: Oh, is that it?
DR. FORT: Oh, yeah, we need to do --
MS. TURNER: Oh, credentials. Oh, good.
DR. FORT: Brian is gone, so we will pause --
DR. MOORHEAD: We've still got to deal with the work group's recommended changes.
DR. FORT: Oh, okay.
DR. MOORHEAD: Nitrous oxide and moderate sedation.
DR. FORT: Yes.
DR. RICH: AED.
DR. MOORHEAD: AED, yeah.
DR. FORT: Okay. That's right. Yeah. I'm sorry.
Now, we'll separate those recommendation of the work group. That was on page -- it's not on any page in the file group.
MS. TURNER: It's in a separate one.



DR. FORT: It's on -- yeah.
MS. TURNER: What section, Dr. Moorhead?
DR. MOORHEAD: Yeah, it's labeled X and it's between --
DR. FORT: The Section X on the nonfile top.
DR. E. PAPE: It's after the definitions at the beginning, page four, line seven.
DR. MOORHEAD: On the revised documents on page four, line seven.
MR. BISHOP: That's going to be on the copy that does not say filed version.
DR. FORT: Okay. I'll either entertain discussion or a motion or anything else.
DR. MOORHEAD: Lisa, move the page down to show that line 18 below too because that's the most important meat of it.
MS. TURNER: Okay.
DR. MOORHEAD: Just a little bit more.
DR. FORT: Line 18 on page five.
DR. MOORHEAD: Yes.
And I especially want to call your attention to page five, number four, that is in direct conflict to the old regulations. Make sure that you're okay with that.



DR. FORT: Yeah.
DR. ZENA: Oh, about the dental assistant.
MR. BISHOP: Can I ask a question about that?
DR. MCKEE: I have a question too.
MR. BISHOP: Well, you go first, because you got the degree.
DR. MCKEE: On the KDA version, page five, line four, "Be present in the office." Is the intent on-site, or is the intent in the treatment area?
DR. E. PAPE: Direct supervision means the dentist has to be in the facility, not at the mailbox outside, not at the post office.
DR. MCKEE: Not in the treatment room.
MS. BURCH: And not face to face.
DR. E. PAPE: That's correct. Right.
DR. MCKEE: I just want to make sure.
MS. BURCH: Why is this directly in conflict before --
DR. E. PAPE: When using the Board of Dentistry's definition, correct.
DR. MCKEE: Cool.
MS. BURCH: -- assistants weren't able

to use nitrous --
DR. FORT: No, not at all.
MS. BURCH: -- without the dentist there now, right? Why is it --
DR. FORT: No. They couldn't start it.
DR. RICH: They couldn't start it. They were not allowed to administer it.
MR. BISHOP: All they can do previously was just monitor the patient while they were on it.
My question is this: Is it -- and help me understand -- isn't parentheses four actually in direct conflict with our new and old hygiene regs and the need for the nitrous oxide block infiltration certification level. I mean, we make all of our hygienists go to a course before they're able to administer nitrous.
DR. S. KING: But they're tied together.
DR. FORT: We made them go to a course to do local anesthesia and nitrous got --
DR. S. KING: Unbundle them is maybe what --
MR. BISHOP: Well, and we -- and under the new reg, though, we unbundled block infiltration from nitrous because we got folks caught in that sticky wicket a couple of years ago where --



MR. FRANCIS: Oh, they did unbundle it?
MR. BISHOP: Yeah. Because they had -- the complaint was they had -- they worked in an office that didn't do block infiltration but did do nitrous. And so they still have to take the whole course. There's no change there, but they can practice one or the other. As long as they practice one or the other, they don't have to take the refresher in both.
DR. ZENA: "They," being a hygienist?
MR. BISHOP: Yes, sir. I'm sorry. "They," being the hygienist. They only have to take the refresher course. I just want to be sure we're not going to upset the entire dental hygiene world.
DR. MOORHEAD: Well, I would put to you that if the hygienist is working, even though she's still in the -- let me ask first. Can a hygienist use nitrous oxide under general supervision without the dentist there?
MR. BISHOP: No.
DR. MOORHEAD: Okay. I would put to you that the hygienist can make the decision on what they want to do with the nitrous, the level and the like, by themselves. The dental assistant would have to take direct orders from the dentist that's



in the office.
MS. BURCH: Under direct supervision --
DR. MOORHEAD: Under direct supervision.
MS. BURCH: -- the dentist would always be there.
DR. MOORHEAD: Yeah. The hygienist could change the level because she's trained; she understands what's going on. The assistant must do what the dentist says.
MS. BURCH: Is it my understanding correct now that a hygienist that's not been to the anesthesia nitrous course can monitor it? So if the dentist starts it, the hygienist can monitor it.
DR. MOORHEAD: That's correct. Same as an anesthetist.
MS. BURCH: As -- right.
DR. FORT: So under the -- in the anesthesia course, Brian, then if your -- if the hygienist is in there and patient starts getting apprehensive, the hygienist can go on and apply nitrous oxide without going to ask the dentist because the dentist is in there; whereas, the dental assistant can't do that?
The dentist has to say -- you know, dental assistant go start Jane Doe on, you know, 30 percent



nitrous.
MR. BISHOP: Okay. Let me -- I just want to be sure that I know exactly where we are. Because direct supervision in my mind as we have defined it in both statute and reg is not what I see as direct supervision. So I want to be sure that everybody understands where we are.
We define direct supervision as the dentist is in the office.
DR. FORT: Right.
MR. BISHOP: And so what we're saying, as long as the dentist is in the office somewhere, you can tell Brian Bishop's dental assistant go put the patient in operatory three on 30 percent nitrous, and that's what we're wanting to do.
Okay. All right. I'm fine with that.
MS. BURCH: Is there a reason not to add hygienists as well as dental assistant to line four -- I mean, line five, number four?
DR. ZENA: She is already licensed.
MR. FRANCIS: Yeah. The hygienist is licensed.
DR. MCKEE: If she's taken that course.
MS. BURCH: Oh, if she's taken that course.

MR. BISHOP: Yeah. That's the sticky wicket.
DR. MOORHEAD: If you added hygienist, then the hygienist could -- then the assistant could technically be working under the hygieist and that could be something --
MR. FRANCIS: Yeah, that could cause a problem --
MS. BURCH: Say that again?
DR. RICH: Are you adding this at the beginning or at the end?
MS. BURCH: I was going to say, "Dental assistant and/or hygienist may administer nitrous oxide."
MR. BISHOP: Yeah. Under the dentist's direct supervision and direct order, a dental assistant or a dental hygienist may, yes. I agree with -- yeah. I think that alleviates any appearance of problems that we might have.
DR. ZENA: What if the dental assistant wants to work under the supervision of the hygienist then?
MR. BISHOP: It only -- because this says under the dentist's direct supervision and direct orders. Either one of those two individuals



may go administer the nitrous.
DR. FORT: Yeah, go ahead.
DR. ANDERSON: Steve Anderson, oral surgeon in London.
I just wanted to have you consider a little ambiguity because there's a portion under moderate and deep sedation where IV medications can be administered under the direct supervision. So you have direct supervision there which, in my thinking, is you're actually seeing it administered into the actual IV lines.
DR. FORT: Did it say direct supervision or direct order?
DR. MOORHEAD: Direct supervision there means the dentist is in the office.
DR. E. PAPE: And you gave an order -- you're in the next room and you give an order to have your assistant go to start pushing the med.
DR. MOORHEAD: And our oral surgeon on the work groups specifically asked it to be left that way. Said that was common practice.
DR. ANDERSON: What section is that?
DR. MOORHEAD: The last section, not counting the --
MR. BISHOP: It's on page 20. And



actually, I do have a question about that now that you've brought it up, but go ahead with your comment.
DR. ZENA: So to make sure I understand this then, so these dental assistants have no training whatsoever or requirements for training. They -- just because they're hired as a dental assistant, they can go ahead and do this?
MS. BURCH: That's what I was --
MR. BISHOP: That's what they're proposing.
DR. ROBINSON: Should they not be required to take the same nitrous oxide course that the hygienists are or can it be packaged because we're going to have a sedation, like where they can start a line. A dental assistant maybe could package the nitrous oxide with that one, as well. I think that group is working on the educational components.
DR. FORT: Don't you think -- I'll try not to get myself in trouble.
DR. MCKEE: Do you need a paper bag?
DR. FORT: We're giving the hygienist more leeway to adjust. I mean, what we're talking about here is saying you go in there start the



nitrous on this patient and stay with them at blankety-blank level. And you're not asking them to do anything other than stick it on their nose and turn the gas on. You're not required to make any kind of judgments whatsoever other than just if they can find their nose.
DR. ROBINSON: And knowing how to do it.
DR. FORT: Well, and turning the machine on, which the machine is -- okay, that's true. Now, with the dental hygienist, with the class -- and I've not been to this class -- but we're giving them permission to use -- to almost prescribe nitrous oxide, so to speak.
Now, the dentist still has to be in the house, but they can -- but they can have that. So there is just a little step up in my understanding.
DR. ZENA: But -- I'll make sure I understand this. But that particular dental hygienist has to have had a certain course.
DR. FORT: She's gone to that class.
DR. ZENA: Right. Now, the reason that she wanted to add the hygienist, which I understand the language here, would be that if an untrained hygienist in nitrous oxide would have the same capability as a dental assistant.

DR. RICH: Right.
DR. ZENA: Because if it's not put in there, then really she wouldn't; so --
DR. FORT: I mean, like, on the delegated duties list, a dental hygienist can do anything that a dental assistant can do.
DR. ZENA: So, then, we don't need the language in there.
DR. FORT: I mean -- yes.
MR. BISHOP: I think we're in conflict with our statute if we do this.
Bill, this is where I retire my law license. Do you have your statute book with you?
MR. BAUSCH: I don't think I have the latest one.
MR. BISHOP: Okay. Here's 313-045.
MR. BAUSCH: I was just sitting here thinking what they --
MR. BISHOP: Lisa, pull up the LRC web site, please.
MR. BAUSCH: This gets into about four of your questions. In paren three, "A registered dental assistant shall practice under the supervision, order, control, and full responsibility."



Does that fall outside of what you were asking before about being in the house?
MR. BISHOP: No. No, that's fine.
MR. BAUSCH: That's one.
MS. TURNER: You just want 313?
MR. BISHOP: I want 313-045.
MR. BAUSCH: And then the other one about only assigned to registered dental assistants procedures that do not require the professional competence. That's one where you could be stepping on the line of administering -- you're getting -- as you said, it's a step up, but I'm not sure it's a step out.
MS. TURNER: 145?
MR. BISHOP: Yes.
MR. ZENA: Would you repeat that language again.
MR. BAUSCH: "Supervising dentists shall only assign to registered dental assistants procedures that do not require the professional competence of a licensed dentist or a licensed dental hygienist."
MR. BISHOP: And if you're requiring the hygienist to go take a course in nitrous --
MR. BAUSCH: And then not the --



DR. ROBINSON: And not have the dental assistant --
MR. BAUSCH: And this is in conflict with what you said that the doctor has to go and tell the assistant to go out, whereas under paren five, you're saying that they can only do procedures as told by the dentist or licensed dental hygienist.
So you are allowing your hygienist to, in turn, just what you said, your hygienist could take the step, which is already in our statute; so --
MS. BURCH: Can you say that one more time?
DR. RICH: Basically, it just comes down to whether or not we want to allow dental assistants to give nitrous under direct supervision.
MS. BURCH: I think that the kicker is either monitor or administer. Administer to me means start it, decide what level it's on, where monitor would be if the dentist started it and the assistant monitored it without the dentist in the room. To me, that's what I thought it already is now; that the dentist decides and the assistant monitors.
MR. BAUSCH: When you get that pulled up -- it's 313-045, paren five.



DR. MOORHEAD: The key words are "may administer nitrous oxide at the level prescribed by the dentist."
MS. BURCH: So the dentist could have that in the chart that said this patient's level needs to be --
MR. BAUSCH: And then, in turn, reading this, if you want to carry it to its natural conclusion, the hygienist could then after the doctor tells him what to do, go tell the assistant.
MS. BURCH: Where does it say the hygienist can tell the assistant --
MR. BAUSCH: It says, "supervising dentist shall only assign the registered dental assistant procedures that do not require the professional competence of a licensed dentist or a licensed dental hygienist."
DR. FORT: Brian, where do you see the problem?
MR. BISHOP: Well, that does -- here's the question. It's a simple question. Does the administration of nitrous or to where Dr. Anderson was going a moment ago, the administration of medications or the administration of IV lines require the professional judgment and skill.

I think -- because parenthesis five says that a dentist can't delegate anything to an assistant that requires the professional judgement and a skill of a dentist or a hygienist.

So if those three things require professional judgment and skill to pull off, then you can't delegate those duties to a dental assistant.

DR. FORT: But we have already included the ability of an assistant. I mean, that's in there to push IV drugs on the order of a dentist.

DR. RICH: If they can do that, surely they can --

DR. FORT: We've already -- that's already included. We've already plowed that field.

DR. RICH: Okay.

DR. FORT: Haven't we? Haven't we?

MR. BISHOP: I'll have to go back and get the delegated duties list. That might be on there. I don't remember right off the top of my head.

DR. FORT: I see a bunch of -- but I can't find the number. I mean -- so if you can say, "Push 30 milligrams of" something that would be appropriate, then surely you can say start 30 percent nitrous oxide.



DR. MOORHEAD: And that was our exact rationale.

MR. BISHOP: As long as you-all are comfortable, I'll learn to be. I'm not comfortable but --

DR. ZENA: There's a difference there because if you're telling somebody -- an assistant to push a drug, you're standing right there.

MS. BURCH: No, you're in the facility.

MR. FRANCIS: No, you're in the facility --

DR. ZENA: So you stand down the hall in the x-ray room and push in 20 milligrams of whatever?

DR. RICH: Right.

MR. BAUSCH: And I agree with -- after re-reading this thing, I don't think this -- this is still under the direct supervision of the dentist. God, that is strange language.

Well, okay. You're defining language is "Dentist shall only assign to registered dental assistant." So it preempts any hygienist telling assistants what to do.

DR. FORT: Oh, well, that's okay.

MR. BAUSCH: Okay. Well, I just want to



make sure it wasn't inconsistent.

DR. FORT: I didn't know we were arguing that one. Okay.

MR. BAUSCH: Well, it's all under paragraph five of 313-045.

MR. BISHOP: Is everybody here comfortable with a dental assistant pushing a drug on an order from a dentist who is not in that operatory?

DR. ZENA: I've got a problem with that.

MS. BURCH: I'm not comfortable with that.

MR. BISHOP: I just want to be sure we're all --

DR. RICH: I don't have a problem with it. I think we've been doing it for years, not necessarily general dentists, but I think your oral surgeons and whatnot have been. So, I mean, we obviously don't have -- it's hasn't --

DR. FORT: We're going way backwards now.

DR. RICH: It hasn't created a problem.

MR. BISHOP: Well, I think -- I think we're defining what we mean by our delegated duties list. But, I mean, as long as everybody is



comfortable, I'll learn to get there.

MR. FRANCIS: It's not going to change your scope of what we did for years and years.

DR. RICH: Are you-all comfortable -- I mean, it's standard practice, right? Has been for years, right?

MR. BAUSCH: Yes, that's correct.

DR. RICH: I don't see any reason to change it now.

MR. BISHOP: Okay. Cool. I'm fine.

DR. RICH: It's not -- it hasn't been a problem in the past. I don't know why it creates a problem now just by talking about it.

MS. BURCH: I would be more comfortable with 1-5 if it also required that a dental assistant have a course before she administers nitrous if a hygienist has to have a course. So if we want to someway include that into the I.V.

DR. S. KING: No, it's different.

MR. FRANCIS: It's different. I don't think it's the same thing at all.

MS. BURCH: Yeah, help me understand it.

DR. HARGAN: I'm sorry. James Hargan, representing myself.

If the hygienist had that special course to be able to adjust -- I'm asking -- to adjust the nitrous level up and down based on judgements that she learned in the classroom how the patient is doing, is that correct or not correct?

MS. BURCH: Well, it's my understanding a hygienist could -- if they took that course -- could start the nitrous and administer it, monitor it if they had the course. If they have not had the course, the dentist would tell them how much to start, and they can monitor.

DR. HARGAN: And they have to leave it there and don't move; is that correct?

MS. BURCH: That was my understanding.

DR. HARGAN: They have to leave it at that level. You can't adjust it. The dentist says you start it at 30 percent --

MS. BURCH: Monitor it. I thought you could adjust it.

DR. HARGAN: Monitor to me means you start it at what you're told to do, and you monitor the patient to make sure they're all right. And if they're not all right, you run and get the dentist and get their butt in there.

That's my understanding, and that's my



question. Because if that is true, then I don't see a difference between that and saying, "You go give 2.5 of Versed and monitor the patient."

There's no difference. That's why I wanted to clarify what the class taught will allow them to do. If that's the case, then there would be no difference in my opinion. So you can't adjust. There's no judgment. You just start -- I mean, that's my --

DR. E. PAPE: I think -- didn't you bring this up earlier that the hygienist over in her operatory comes upon an anxious patient, and she can make the decision whether or not to turn that nitrous on and get it going without him to yell over at me to see if it's okay.

DR. FORT: So the same as you would -- same as you wanted to apply some anesthesia --

DR. E. PAPE: Right. And she can pick up the syringe and inject and not have to come ask me because she has the training. She has taken the courses or she graduated with that upon her registered dental hygienist. Yeah, her RDA.

DR. FORT: So it's sort of the ability to prescribe it.

DR. E. PAPE: That's correct.



MS. BURCH: I guess my question still goes back to the administer. This is a dental assistant or a hygienist, we're going to say, may administer nitrous oxide at the level prescribed by the dentist. And "administer," does that mean start?

DR. RICH: Yes, it is.

MR. FRANCIS: Yes.

MS. BURCH: Okay. So are you going to require the hygienist to have the course to be able to start it, but you're not saying here that you'll require --

DR. FORT: No. But she can start it on her own.

DR. RICH: Because the hygienist can do every --

DR. FORT: The dentist prescribes it -- the dentist says, "Go start her on gas."

DR. RICH: The hygienist can already do everything an assistant can do.

MR. FRANCIS: Yeah.

DR. FORT: It's not limiting the hygienist --

MR. BAUSCH: It can be easier if you leave out hygienist, and let's just keep assistant.



MS. BURCH: Yeah, I'm thinking keep assistant because I think it's assumed that the hygienist can do anything the assistant does.

DR. ROBINSON: But that's only with training; is that correct? It's only with training, so you may have a dental hygienist so that -- does that leave out a category of individuals if I want to tell a dental hygienist to go start at a percentage of nitrous, the dental hygienist who has not had a course, cannot do that. But we're letting a dental assistant --

DR. RICH: No. No. No. And, then, a hygienist that had the course doesn't even need a dentist to start nitrous?

DR. ROBINSON: So a hygienist can start nitrous --

DR. RICH: With a course without the dentist.

MR. BAUSCH: An assistant can only start with the direct order of the dentist without the course.

DR. ROBINSON: I just don't have that list in front of me of the delegated duties.

MS. TURNER: It's right here. I just brought copies.

DR. ROBINSON: Oh, thank you.
MR. BISHOP: All right. Are we comfortable?
DR. FORT: Adam?
DR. RICH: I'd like to motion that we're comfortable with the language and move on; and if we don't like the idea we can vote it down, come back and do something else.
DR. FORT: Okay.
MS. TURNER: So comfortable with the, language, Doctor, or is it just that one section? I've got lost in the shuffle.
DR. RICH: It's basically the --
MS. TURNER: Dental assistant administering nitrous oxide under direct supervision? Is that the only thing that you-all covered in this motion?
DR. RICH: Well, actually the whole nitrous oxide section has been added, correct?
MS. TURNER: And that's what your motion is?
MR. BAUSCH: Which is page 18.
DR. FORT: Yeah.
MR. BAUSCH: Items five and four.
MS. BURCH: We are including the



hygienist there; dental assistant and/or hygienist?
DR. RICH: I think a hygienist is included by default, but as a hygienist has all the rights of a dental assistant.
DR. FORT: So Adam moves to accept the comment.
MR. FRANCIS: I second that comment.
MS. BURCH: Is there a problem with adding hygienist back into that clause?
MR. BISHOP: No. I just think you're taking the rights that the hygienist already has and backing them out and making it look like there would be a conflict as to whether or not you would have to have the doctor tell the hygienist who was previously able to start nitrous now has to do it under this provision under the order of a doctor.
MR. FRANCIS: We're making this dirty ourselves. We're clouding our own --
MR. BISHOP: Yeah, you're backing the rights of a hygienist.
MS. BURCH: I see what you're saying.
DR. FORT: Okay. So is there --
MR. FRANCIS: Second.
DR. FORT: Allan has got the second. Any additional discussion?



BOARD MEMBERS: (No response.)
DR. FORT: All in favor?
BOARD MEMBERS: Aye.
DR. FORT: Any opposed?
BOARD MEMBERS: (No response.)
MR. BISHOP: I just want to make sure that was all the language that they proposed without modification?
DR. FORT: Without modification.
MR. BISHOP: Okay.
DR. FORT: Okay.
MR. BISHOP: Because I've scribbled all over mine, I want to make sure I go back to a clean version.
DR. FORT: Now, we're going to the AED section. We've got 55 minutes left with the court reporter. Page 14.
MR. BAUSCH: Just so you know, the changes that were proposed without modification in the revised section are in entirety of document.
MR. BISHOP: Okay.
MR. BAUSCH: So no verbiage change.
MR. BISHOP: Okay.
DR. FORT: Okay. So now we're on line 11.



DR. S. KING: Of which document?
DR. FORT: That would be an unfiled document, line 11, page 14, and I think it's line --
DR. RICH: Line 13.
DR. FORT: Line 13 is where the change -- 13 and 14 are the change. They would have added moderate sedation and struck adult patients. Is that all?
DR. ZENA: I thought they put in no EKG, was my understanding, because it's not written on here for some reason.
The way it's written -- I don't want to interrupt you, but this was my thought. The way I understand what they were proposing is that you had to have a AED but the language deliberately excluded EKG; is that correct?
DR. FORT: That was the compromise. Now, this is not in -- this is in no way a contradiction to the other thing we passed earlier, right?
MR. BAUSCH: Are you talking about the very first one?
DR. FORT: Well, the one from the --
DR. RICH: This is just moderate sedation.

DR. FORT: So I guess it is -- I guess it's --
DR. ZENA: This contradicts Dr. Look's.
DR. FORT: Yeah, it does contradict.
DR. RICH: It does contradict Dr. Look's, but we already --
MR. BISHOP: We already rejected his comment; so --
MR. FRANCIS: We rejected that.
DR. FORT: Okay. Do we have any other conflicts?
DR. ZENA: No.
DR. FORT: All right.
MS. BURCH: Requires an AED but not EKG?
DR. FORT: Correct. Motion?
DR. ZENA: Well, that wasn't -- we're going to go through line 14 as well or do both or just one line at a time?
MR. BAUSCH: I think you're looking at comparing 11 -- taking 11, 12, 13 and 14 --
DR. ZENA: What was the change on line 14? Was it -- I've got holders on adult patients. What does that mean?
DR. MCKEE: On adult patient is stricken on the KDA's copy.



MR. FRANCIS: It's permit holders --
DR. ZENA: Can you explain 14 again to us? I'm confused.
DR. MOORHEAD: Are we talking about the defibrillator?
DR. FORT: No, line 14 where you struck "adult patients." I think that's it.
DR. ZENA: Yeah, that's it. That's it.
DR. MCKEE: It looks like to me it was "holders inserted." I can't tell.
DR. RICH: Yeah, there is something else inserted --
MR. BAUSCH: It's for patient -- yeah, "holders for patients with significant cardiac history" or is that no?
DR. MOORHEAD: There's a pediatric level of moderate sedation and --
THE COURT REPORTER: I'm sorry. I can't hear you.
DR. MOORHEAD: There's a pediatric level of moderate sedation, and Dr. Charlotte Haney, pediatric dentist at UK that was on the work group recommended we strike the words "on adult patients" there so it would apply to anyone that's moderately or deep sedated.



DR. ZENA: Oh, I see. So if it was a child as opposed to an adult, so this way if he -- that includes everybody.
DR. MOORHEAD: Yes.
DR. ZENA: Okay. Got it. So it should read "on patients," not "on adult patients."
DR. MOORHEAD: Uh-huh. And while we're making revisions, I noted that -- it says "permits holder." We need to strike a S on the -- it should say "permit holder." "Sedation general anesthesia permit holder/holders."
DR. ZENA: I wish these things were indented in sedation --
DR. MOORHEAD: I wish these things were indented too.
DR. ZENA: And put in there on "deleted adult patients," just put "on patients." Is that correct?
DR. E. PAPE: No.
MR. BISHOP: No. Just leave it --
DR. ZENA: Just leave it off of --
MR. BISHOPS: "Holders," period.
DR. FORT: And then it talks about it. So what it does, it permits the holders for the next one for deep sedation. On pediatric patients,



you've got to have a precordial and pretracheal stethoscope.
So it only refers to those next three lines. Line 14 refers to 15, 16 and 17 only; is that correct?
DR. MOORHEAD: Say again, please.
DR. FORT: Line 14 only refers to line 15, 16 and 17, or does it carry on farther?
DR. MOORHEAD: Line 14 is by itself, but 15 is separate.
DR. FORT: Oh, 15 is separate.
MR. FRANCIS: You have got to have deep sedation.
DR. FORT: Okay. 14 goes with 13. I'm sorry.
DR. E. PAPE: Yeah, it's confusing.
DR. FORT: 14 goes with 13.
DR. MOORHEAD: Slightly off subject, but can the final document, is it allowed to have indentions?
MR. BISHOP: That's at the pleasure of the administrative regs review subcommittee, but I don't think it does. I think it's all right justified -- or left justified.
DR. MOORHEAD: It would be so much

easier to read this document if it were -- if indentions were allowed.
MR. BISHOP: That's the point of good government, though, to keep things kind of in a constant state of confusion.
You've got -- we've got to pass it before we can understand it. I mean, that's the long and the short of it here today.
DR. FORT: Okay. So are we acceptable to that -- to that compromise that was made by the KDA group?
DR. RICH: It's either AED or nothing, right?
DR. FORT: It's AED -- you got to have a defibrillator, or you've got to have an AED. You don't have to have an EKG for moderate or deep sedation patients. And that was the agreement.
DR. MOORHEAD: We're talking about moderate? Deep, you have to have both?
DR. FORT: Yeah, you have to have it. Okay. So are we on motion? Allan?
DR. RICH: Sure. I'll motion to phrase as we have just --
MR. FRANCIS: Of course, I'll second Rich.



DR. FORT: Okay. Any further discussion?
MS. BURCH: Help me see where it says, deep, you have to have both.
DR. FORT: You don't have EKG on anybody.
MS. BURCH: On either. Okay.
DR. MOORHEAD: No, you have to have EKG on deep.
DR. FORT: Oh, you do?
MS. BURCH: Where does it say that?
DR. E. PAPE: It's in a different section.
DR. MOORHEAD: Line N of -- line 7 under N.
DR. FORT: Right there. Okay.
MS. BURCH: I gotcha. Okay.
DR. MOORHEAD: Line 7 and line 11 go together. "Shall be present for use by deep sedation general anesthesia permit holders."
MR. BISHOP: And I will tell you now that the LRC is probably going to reorder that -- my guess.
DR. MCKEE: Rearrange it?
MR. BISHOP: Yeah, probably so.



DR. MCKEE: Okay.
MS. BURCH: Why is that?
MR. BISHOP: Well, because I agree with -- the way it is, one and two need to be indentions. They'll do something to make that more clear. I don't know exactly what they'll do, but they'll do something.
DR. ZENA: Wait a minute. I'm a bit confused here. My understanding was that we put 7-N, EKG, that that could be delegated to a CRNA bringing it to the facility; is that right?
MR. BISHOP: Correct.
DR. ZENA: Okay. So --
MR. BISHOP: We haven't changed that.
DR. ZENA: Right. Now, somehow or another, if you're going to do deep sedation on a pediatric patient, then you need to have an EKG.
MR. BISHOP: That's correct.
DR. ZENA: And they said, well, you don't need to worry about that because it's already in seven -- wait a minute now. That says as long as the CRNA is there and brought his machine or her machine with them --
MR. BISHOP: Well, one and two -- the numbers one and two under parenthesis N in line



seven. So lines 8, 9, 10 and 11 go with parenthesis N in line seven.
So you have to have -- the equipment list reads an EKG. "One, may be present by use by minimum pediatric sedation, moderate enteral, moderate parenteral, moderate pediatric sedation permit holders for pediatric patients with significant cardiac history, and the EKG shall be present for use by any type of deep sedation, general anesthesia permit holders."
DR. ZENA: Okay. I just want to make sure we weren't being --
MR. BISHOP: Yeah. No, we haven't been in conflict there. We're fine.
MS. BURCH: The indent would help.
DR. S. KING: It sure would.
DR. FORT: Okay. Okay. So we have the motion on the table and the second.
MR. FRANCIS: Second.
DR. FORT: And do we have any additional discussion?
BOARD MEMBERS: (No response.)
DR. FORT: All in favor?
BOARD MEMBERS: Aye.
DR. FORT: Any opposed?

BOARD MEMBERS: (No response.)
DR. FORT: Okay. Is that everything?
MR. BISHOP: Dr. Moorhead, is there anything else?
DR. MOORHEAD: I don't think so.
MR. BISHOP: I think we're okay.
DR. FORT: Another motion?
MR. BISHOP: No, I haven't --
MR. GAITHER: Excuse me. First of all, very quickly, I'd like to thank the board for their attention and, on behalf of myself and the Kentucky Association of Nurse Anesthetists, I think it has been very informative for me personally to be present today, and I appreciate all your input.
The only other question that I have is we greatly appreciate the adoption of the rules as you have modified them. The question that I have is in the interim time between since your emergency regulations have already been issued and the time that your final rule is adopted, do we need to look at an advisory opinion statement or to the CRNA stand at this initial point right now today or tomorrow?
MR. BAUSCH: We have a special meeting immediately after this meeting to follow the open



meetings act, so we'll close one and go back in and address that very issue.
MR. GAITHER: Okay. Thank you so much.
MR. FRANCIS: That shouldn't take long?
MR. BAUSCH: No.
MR. FRANCIS: Okay. And that won't take long; so --
MR. GAITHER: Okay. Thank you.
DR. FORT: Okay.