MINUTES OF THE MEETING
HUMAN SERVICES AND AGING COMMITTEE
MONTANA STATE
HOUSE OF REPRESENTATIVES

January 23, 1985

The meeting of the Human Services and Aging Committee was called to order by Chairperson Nancy Keenan on January 23, 1985 at 3:00 p.m. in Room 312-2 of the State Capitol.

ROLL CALL: All members were present with the exception of Representative Gould who was excused by the Chairperson.

HOUSE BILL NO. 235: Hearing commenced on House Bill No. 235. Representative Ray Peck, District #15, sponsor of the bill indicated that an act to require an anethesiologist or anesthetist to administer and monitor general anesthetic in dental procedures was needed. Representative Peck added that he did have amendments to propose. Peck felt that House Bill No. 290, which is the authority for the Board of Dentistry to make rules and regulations is really not related, although he felt that the Committee may hear that these bills are related. The authority to make rules by the Board of Dentistry is something very different than the concern that we have with House Bill No. 235. Dr. Peck testified as to the case of two parties who will speak as proponents today. Dr. Peck referred the Committee to the ABC News of September 29, 1983. The program dealt with the administration of a general anesthetic by people who do not not have specific training in the area of anesthesiology. Careless or indiscriminate administration of an anesthetic is not being done. There may, however, be a tendency for people to do certain procedures that are beyond their skill and training. Representative Peck indicated that he had spent several hours on the telephone talking with dentists, oral surgeons and physicians during the last six weeks about the matter. Representative Peck has found none of them that will say it is a proper procedure for any practitioner to administer a general anesthetic by himself. Generally, the legislators do not put into law, restrictions on the medical profession. According to recent surveys, there have been fifty deaths attributed to anesthetics over the last two decades and the dilemma is getting worse.

Proponents to this bill included Clair Clark of Lewistown. His daughter received serious brain damage as a result of the administration of an anesthetic in a dental office in Billings. Greg Kegel of Havre talked of the death of his younger brother which resulted because of misuse of a general anesthetic. Representative Bob Bachini and Representative Rapp-Svrcek both support the bill; Jo Shipman added her support.

Opponents to this bill included Roger Tippy of the Montana Dental Association who is an attorney representing this organization. His opposition is expressed in Exhibit 1. Dr. Doug Smith, a dentist/anethesiologist explained the history of anethesiology and indicated that he opposed this bill because the bill excludes the use of nitrous oxide as a variable and because of his profession of being a dentist/ anethesiologist, would be unable to administer anesthetics and perform the surgery simultaneously. Dr. Smith provided Exhibits 2, 3 and 4. Dr. E.W. Crawford, Great Falls, an anethesiologist opposes the bill as it is written. Dr. Crawford also represents the Montana Medical Association. They oppose the bill as written. Dr. George Carson, a pediatric dentist from Bozeman, opposes this bill as written. Dr. Carson's practice consists of dental care of children and physically and emotionally handicapped children and adults who in most cases require some sort of anesthetic. Dr. Robert Fritz, a member of the Montana State Board of Dentistry indicated that the Board does oppose House Bill No. 235 and that the Board has worked out the rules for general anesthia, conscious sedation and local sedation. Dr. Jim Olson, President of the Montana State Board of Dentistry said that CPR training, updating in emergency procedures and other problems could be worked out by the Board. An ad hoc committee proposed changes in the present rules of the Board regarding anethesiology, displayed in Exhibit 5. Dr. Steven Black, an oral surgeon from Bozeman represented the Montana Society of Oral and Maxillofacial Surgeons. Testimony of the safety record in the administration of anesthetics is displayed as Exhibit 6. The Montana dental practice act, at this time, does not regulate the use of anesthetics in dentistry - it does not regulate any of the varying forms of oxygen anesthetia. A copy of the Office Anesthesia Evaluation Manual is attached as Exhibit 7, it being a part of Dr. Black's testimony. Written testimony was supplied by Dr. Douglas E. Wood, Dr. Robert W. Bowman and Dr. Larry Clayton and is attached hereto as Exhibits 8, 9 and 10 respectively.

Questions were asked by Representative Connolly regarding additional charges by dentists if an anethesiologist was present; Representative Hansen questions the procedure followed by an anethesiologist; Representative Cohen questioned Dr. Doug Smith regarding whether or not he practiced in any other dental offices other than his own; Representative Bergene asked if there were any dentists in the room that administered their own anesthetics; Representative Simon, Wallin, Darko and Bradley then questioned fees and facilities required.

Chairperson Keenan then closed the hearing on House Bill No. 235 and the Committee recessed for five minutes.

HOUSE BILL NO. 228: Hearing commenced on House Bill No. 228. Representative Cal Winslow of District #89, sponsor of the bill, stated an act to authorize the preparation and implementation of a declaration instructing an adult's physician to withhold or withdraw life-sustaining procedures if the person is in a terminal condition and is unable to participate in medical treatment decisions; providing methods for revocation of the declaration; limiting the liability of physicians and health care providers who implement the declaration; and establishing criminal penalties for failing to comply with a declaration and for other related violations was needed. A synopsis of the bill was discussed by Representative Winslow. We have seen or heard about people who have been kept alive by machines when there is no chance of recovery; the aged, those in serious automobile accidents or victims of drug overdose. These people often suffer the complications which leave them in a vegetable state with no hope of recovery. Breathing and other life functions are performed by machines. The cost may be staggering. The emotional stress on the loved ones may be unbearable. Yet, modern medicine keeps this patient alive. The doctor has a solomn obligation to do everything in his power to preserve life. If he does not do everything, perform every test, undertake every available measure, he may be sued by the relatives. There is now a growing demand for the right of officials to participate in decisions affecting their lives and their deaths and to have this decision respected by medical professions. Twenty-three states have adopted death laws and there are strong indications that many others will follow soon. This process has had the assistance of every important interest group affected by this legislation. This bill has been supported by the American Hospital Association, American Bar Association, The Society for the Right to Die, and the Catholic Health Association of the United States. Most of the response to this bill was from senior citizens who are facing the reality of death and are requesting the right to die with dignity. They do not want to end their lives in a comatose state or months on end on a machine were the comments of Representative Winslow.

Proponents to this bill were Charles Briggs, Office of the Governor who reiterated a letter sent to Governor Schwinden regarding the support of this bill. Doug Olson, Elderly Human Services Developer, Office of the Governor, indicated his support and is attached hereto as Exhibit 11. Henry Siberious of Kalispell supports this bill as did Joe Upshaw of the American Association of Retired People. Molly Monroe indicated her support and is attached hereto as Exhibit 12. Representative Marian Hanson supports this bill as does Wade Wilkerson of the Senior Citizens Advocate. Representative Harry Fritz, acting and speaking on behalf of Vi Thompson extended his support. Jerry Loendorf, an attorney representing the American Medical Association supports this bill as did Earl Riley of the National Association of Retired Employees indicating his support as displayed in Exhibit 13. Chad Smith, Montana Hospital Association and a Helena attorney, indicated that the hospitals in Montana see the need for this type of legislation. Walter Taylor of Missoula, a member of the Legacy Legislature and the interim committee supports this bill. Sam Ryan, Montana Senior Citizens also supports this bill as does Ed Sheehy representing the National Association of Retired Public Employees said that a simpler execution of the living will was needed. Sue Winegartner, representing the Montana Health Care Association supports this bill. Senator Chris Christiaens of Great Falls, a supporter, also worked extensively on the drafting of this legislation. There were no further proponents or opponents to this bill.

Representative Winslow closed the discussion on this bill by indicating that 65% of the health care is spent on the last year of life.

Questions were raised by Representative Connolly. She questioned the court challenges. Representative Bradley questioned the amendments and Representative Wallin questioned as to whether this bill could eventually result in euthanasia. Representative Simon questioned the writing of the bill and Representative Keenan questioned as to whether an amendment on witnesses was needed.

There being no further discussion on House Bill No. 228, the hearing was closed.

EXECUTIVE SESSION

Executive Session was not held at this Committee meeting.

ADJOURN: There being no further business before the committee, the meeting was adjourned at 6:28 p.m.

Nancy Keenan
NANCY KEENAN, Chair

DAILY ROLL CALL

HUMAN SERVICES AND AGING COMMITTEE

49th LEGISLATIVE SESSION -- 1985

Date January 23, 1985

NAME	PRESENT	ABSENT	EXCUSED
NANCY KEENAN	X		
BUDD GOULD			X
TONI BERGENE	X		
DOROTHY BRADLEY	X		
JAN BROWN	X		
BUD CAMPBELL	X		
BEN COHEN	X		
MARY ELLEN CONNELLY	X		
PAULA DARKO	X		
BOB GILBERT	X		
STELLA JEAN HANSEN	X		
MARIAN HANSON	X		
MARJORIE HART	X		
HARRIET HAYNE	X		
JOHN PHILLIPS	X		
BRUCE SIMON	X		
STEVE WALDRON	X		
NORM WALLIN	X		

EXHIBIT 1
January 23, 1985

BEFORE THE COMMITTEE ON HUMAN SERVICES AND AGING
MONTANA HOUSE OF REPRESENTATIVES

House Bill 235 by Peck (Restricting General Anesthesia Usage by Dentists)	))))	STATEMENT OF MONTANA DENTAL ASSOCIATION

I am Roger Tippy of Helena, attorney and lobbyist for the Montana Dental Association. The Dental Association is technically an opponent to HB 235, because the Association believes HB 290, introduced by Representative Lory for the Board of Dentistry, addresses the same problem in a better way. Unfortunately, HB 290 could not be introduced in time to be set for hearing today along with HB 235. Some of the witnesses who have come from out of town today will in essence be testifying in favor of HB 290 since they may not be able to return for the formal hearing on that bill. So, although we speak as opponents to HB 235, please bear in mind that we are proponents of the alternative.

That alternative is to authorize and direct the Board of Dentistry to adopt rules governing the use of anesthesia and sedation. The debate over whether the Legislature ought to delegate the amount of rulemaking power to the various state agencies and boards which it in fact delegates has been going on for many years. If you don't let the boards adjust the details of professional regulation, you'll have to try to write those details into the statute. Dentists who testify today will point out a number of details or variations not now addressed in HB 235. Further, once you decide to put the details of regulation into the statutes, you have to be prepared to deal with amendments every session or two. The third drawback is the twenty-month interim between sessions. If the Board adopts a rule that isn't quite right, it can amend the rule in about three months. If you enact a statute that isn't quite satisfactory, we all have to live with it for two years.

DATED: January 23, 1985.

ABRIEL R. FERJESSY D.D.S. FAMILY DENTISTRY HIGHLAND PARK PROFESSIONAL BLDG. #2, KALISPELL, MT. 59901 406-755-07

January 22, 1985

Human Services Committee
Montana State Legislature

Committee Members,

This letter is in reference to the proposed bill, H.B. #235, which will be discussed and evaluated at the hearing - Wednesday, in the Capital building, Helena, January 23, 1985.

It has been suggested that I submit my background, although I don't know whether it should be necessary.

I graduated from Baylor University School of Dentistry, Dallas, Texas in May 1971. I enlisted with the U.S. Army and spent the next three years at Fort Knox, Kentucky. There were ninty Dentists on staff. One and a half years were involved in a rotating internship type program (3 months each under a board certified specialist in each major phase of Dentistry). During my last year I was stationed at the dental clinic in Ireland Army Hospital as Assistant Clinic Chief. I was also the dentist assigned to MEDIVAC. During the last year I received a certificate in training for N^2O-O^2 inhalation sedation and basic Intravenous Conscious sedation.

I have been in general practice in Kalispell since September 1974.

In August 1981, I furthered my training by attending a one week course in basic Intravenous sedation under Dr. Stanley Malamed (author of Medical Emergencies in the Dental Office), at U.S.C. School of Dentistry in Los Angeles, California. Then in June 1983 I recieved a certificate of training in advanced Intravenous sedation under Dr. Malamed.

I should add that both courses are conscious sedation and require constant monitoring.

ABRIEL R. PERJESSY D.D.S. FAMILY DENTISTRY HIGHLAND PARK PROFESSIONAL BLDG. #2, KALISPELL, MT. 59901 406-755-0707

I have been annually certified in CPR, as has my entire dental staff, for over 5 years.

I am presently chairman of the First District Peer Review Committee and was recently elected to be a fellow in the International College of Dentists.

My first statement is in reference to 37-4-101 Section 1 part (C) the proposed limitation of N^2O-O^2 concentration to maximum of 50%. It is quite apparant that the introductors of the bill have had some misinformation. At no time should set values be used with N^2O-O^2 concentrations. An extremely wide range exists in the human population at which each individual will feel sedative effects with N^2O-O^2. Whereas one individual will feel relatively sedate at 20% N^2O in relation to 80% O^2 another will feel the same effects at 65% N^2O and 35%O^2, and anywhere inbetween. It has been rare, but I have a handfull of patients who are sedate at 10 - 15% N^2O in relation to O^2. At the other extreme, there are a small number of people who are barely affected at 70% N^2O-O^2 - - considered the maximum level on most machines that are produced. At these levels other modes of sedation must be considered and evaluated.

Variables of age, sex, weight, conditions of medical history, levels of anxiety - all can influence levels of N^2O-O^2 variability. Constant monitoring is required - even throughout the course of a treatment, ie: the patient may require a higher level of N^2O-O^2 at the beginning of a proceedure and have it adjusted as they progressively relax throughout the course of treatment.

The N^2O-O^2 variability ratios must be left up to the evaluation of the practitioner.

In my practice Intravenous Sedation was used via a continous-drip system for ease of administration and for safety. A thorough medical history was taken along with a medical consultation to the patients' physician when necessary. Drugs used were limited to those I have had training in.

A third member of the dental team, an R.N., was utilized strictly for monitoring the patient throughout the course of treatment. Our level of sedation was concious sedation - the level at which the patients' protective reflexes were present, ie: coughing, swallowing, responding to commands, etc.

Since September 1983, Dr. Douglas Smith, a dentist-anesthesiologist, has been performing all of my IV sedations. The entire scope of sedation that we can offer patients has expanded tremendously. With his background, a much broader specific array of medications could be utilized for the specific needs of the patient. Continous cardiac monitoring with a portable EKG; respiratory monitoring with pre-trachael stethoscope; as well as the standard monitoring of vital signs: blood pressure, pulse, respiration, were accomplished with each case - whether 20 minutes in length or 3 hours.

I believe the committee has Dr. Smith's background in training - therefore I feel the only information I may add is that out of a class of 21 in the Anesthesia Residency program at Boston General Hospital, out of which 5 were dentists and 16 were physicians, Dr. Smith graduated first.

I feel that the state of Montana is extremely fortunate in having his expertise to rely on.

This leads into my second statement which is in reference to

ABRIEL R. PERJESSY D.D.S. FAMILY DENTISTRY HIGHLAND PARK PROFESSIONAL BLDG. #2, KALISPELL, MT. 59901 406-755-0707

37-4-101 Section 1 (1) New Section. Section 2. Limitation on General Anesthesia.

Dr. Doug Smith is not an M.D., however, he has had the same specialty training in Anesthesia as a Medical Anesthesiologist, which is well above what an Oral Surgeon residency requires and certainly considerably above what a nurse anesthetist residency requires. The certificate of degree is the same, however, because of medical licensure regulations in this state he is limited. Non-dental anesthesia should be based on certificate of degree as spelled out by the American Society of Anesthesiology.

My third statement is in reference to Dentists performing Intravenous conscious sedation and / or Intramuscular conscious sedation.

The Board of Dental Examiners has spent numerous hours researching data and expert opinion on required training. I propose that the committee evaluate and accept their recommendations.

My only additional recommendation would be in agreement with Dr. Smith that any Dentist performing IV Sedation be annually certified in advanced cardiac life support.

I don't know all of the specific backgrounds in the two tragedies in Billings. We grieve for their families and loved ones.

The ultimate goal in all this should be what is best and safest for all of our patients and, God willing, should cool heads prevail - that will be the end result.

My personal request is that for those in the health fields who want to further their knowledge and expertise in order to provide a higher level of care for their patients - don't establish

regulations that would make it impossible for them to achieve these goals.

Sincerely,

G. Perjessy

Gabriel R. Perjessy, D.D.S

GRP/nls
cc: file

EXHIBIT 3
January 23, 1985

DOUGLAS CARLTON SMITH
P.O. Box 266
Bigfork, Montana 59911

OBJECTIVE: A position as STAFF ANESTHESIOLOGIST within a medical-surgical hospital.

SUMMARY

. . Completed a two-year anesthesiology residency at Boston City Hospital, Boston's major trauma center, obtaining clinical anesthesia experience in the major medical disciplines.

. . Completed a rotational Dental Internship at Denver General Hospital 1969-1970 with rotations and clinical experience in anesthesiology and oral surgery.

. . Conducted a private dental practice for eleven years in a rural area, received Certification in Advanced Cardiac Life Support, and participated in, and initiated, a First Responder Rescue Unit within our community.

PROFESSIONAL EXPERIENCE

SURGICAL ANESTHESIOLOGY RESIDENT- Boston City Hospital, Boston, MA (1981-1983)

This 500-bed medical-surgical facility is one of New England's major trauma centers, and, along with University Hospital, is the primary teaching affiliation of Boston University School of Medicine. The surgical anesthesiology residency program is based in this hospital, with additional clinical training at Kennedy Memorial Hospital for Children, Massachusetts Hospital for Crippled Children, and University Hospital. My training also includes two months of pediatric anesthesiology at the Children's Hospital of Buffalo, New York. As a surgical anesthesiology resident my responsibilities were to:

. . Attend daily general lectures on various subjects pertaining to anesthesiology, which are delivered by attending and resident staff members of Boston City Hospital and University Hospital... Give numerous lectures on various aspects of anesthesiology.

. . Rotate through the various resident program hospitals, gaining clinical experience with the anesthesiology aspects of obstetrical, neurosurgical, cardiac, pediatric, orthopedic, ENT, ophthalmic, and general surgery.

. . Rotate through the Surgical ICU and participate in the pre-operative and post-operative management of the surgical patient.

. . Provide emergency anesthesia services during 24-hour rotations at Boston City Hospital and The Children's Hospital of Buffalo, handling a wide range of trauma cases, as well as cardiac and respiratory arrests.

DENTAL INTERNSHIP-DENVER GENERAL HOSPITAL-Denver, Colorado (1969-1970)

. . Rotation included two months clinical experience in anesthesiology, three months of oral surgery training, and two months of pediatric dentistry at The University of Colorado Medical School Hospital.

DENTAL PRACTITIONER- Private Practice, Bigfork, MT. (1970-1981)

. . Established and conducted the practice of dentistry, including eleven years of experience in the administration of intravenous sedation. EMT and CPR Instructor Trainer for laymen and the instruction of CPR to dentists and office staff.

EDUCATION

University of Oregon Health Sciences Center, Portland, Oregon
D.M.D. 1969

University of Montana 1955-1956, Missoula, Montana

University of Colorado 1961-1965, Boulder, Colorado

RESIDENCY

Boston City Hospital, Boston, Massachusetts
Surgical Anesthesiology, 1981-1983

Denver General Hospital, Denver, Colorado
Rotational Dental Internship, 1969-1970

PROFESSIONAL AFFILIATIONS

American Society of Regional Anesthesia
International Anesthesia Research Society
American Dental Society of Anesthesiology
American Dental Association
Montana Dental Association

PERSONAL

Date of Birth: February 4, 1938 - Married, and 3 Married Children

CITY OF BOSTON

DEPARTMENT OF HEALTH AND HOSPITALS

818 HARRISON AVENUE
BOSTON, MASSACHUSETTS 02118

Tel. No. (617) 424-4107

August 19, 1983

Administrator
North Valley Hospital
Highway 95 South
Whitefish, Montana 59937

Re Douglas C. Smith, D.D.S.

This is in reply to your request for my opinion of Douglas Smith, D.D.S. who completed a two year residency in anesthesiology here on June 30, 1983.

During his years here, Doug was one of twenty one (21) residents in the combined Boston City Hospital - Boston University Medical Center residency program. This is a mixed group of American M.D.'s foreign M.D.'s and dentists. Regardless of their degree or their previous training, Doug beat them all and became our very best resident. Whenever we wished to send our top resident to represent our department, we sent Doug Smith. In short, in the area of clinical competence, he is simply excellent.

On a personal basis, he is equally as recommendable. He is a mature man who gets on well with surgeons and O.R. personnel alike. He treats patients with courtesy and kindness. We thought so highly of him that we wanted to keep him here as a staff member of our own department, but he is anxious to return to his home in Montana.

I am pleased to recommend him to you without reservation.

Sincerely,

Dean Crocker, M.D.
Director
Division of Anesthesia
Boston City Hospital

DC/dmn

University Hospital

75 East Newton Street
Boston, MA 02118

617 247

September 12, 1983

Administrator
Kalispell Regional Hospital
310 Sunnyview Lane
Kalispell, Montana 59901

RE: Doug Smith

To Whom It May Concern:

I am more than happy to recommend Dr. Doug Smith to conduct the service of Anesthesiology on any patient in the greater Montana region based on the following observations I have made while working with him for two years. I have found him to be quite competent in terms of physiologic management of the anesthetised patient, and in particular, his ability to handle patients in a trauma situation in which hypotension, hypoxia, acidosis and imminent death were the order of the day. Doug has, in my opinion as well as the opinion of others, stood up well under this extreme pressure and has always maintained a cheerful and bright and very pleasant attitude and onlook on life. I know of his interest to do further fellowships to make himself even more expert in the field of Anesthesiology. I feel quite confident at this time that he would be able to pass any Anesthesia Boards were he to take them and would be more than adequate in any hospital environment in the United States as an anesthesiologist with primary patient responsibility.

Should you have any questions relative to his capabilities or any further thoughts relative to Dr. Smith, please do not hesitate to contact me.

Sincerely yours,

Dennis F. Devereux, M.D.
Assistant Professor of Surgery
Director of Surgical Oncology
Boston City Hospital

DFD/MTS/ljm
9/12/83

cc: Dr. Doug Smith

Boston University Medical Center

School of Medicine
Department of Neurological Surgery

University Hospital
Doctors Office Building, Suite 710
720 Harrison Avenue
Boston, Massachusetts 02118
617/227-0723
617/247-6778

Ronald W. Mortara, M.D.
Neurological Surgery

September 22, 1983

Administrator
North Valley Hospital
Hiway 93 South
White Fish, Montana 59937

Re: Doug Smith, D.M.D.

Dear Sir:

I am pleased to recommend Doctor Dough Smith for a post in anesthesia at your hospital. I have worked closely with him for several years at Boston City Hospital. In that capacity he has done a huge volume of work of all types. I know specifically that he is perfectly expert and comfortable handling all sorts of trauma. I have also done complex neurosurgical cases with him and he has always proved perfectly capable. He is extraordinarily congenial, direct and capable person. He is easy to get along with. He is a tireless worker. I am sorry that he is leaving us but wish him every success in Montana.

I will be happy to provide additional information should you wish it.

Sincerely yours,

R Mortara MD

Ronald Mortara, M.D.

RM/ww

Division of Surgery

Boston City Hospital
Boston University School of Medicine

818 Harrison Avenue
Boston, Massachusetts 02118

October 4, 1983

Mr. Dale Jessup
Administrator
Northvalley Hospital
Highway 95 S
White Fish, Montana 55937

Dear Mr. Jessup:

I am writing this letter in support of an application being made to your anesthesia staff by Douglas Smith, DMD. I feel qualified to make this recommendation since I am a staff surgeon at Boston City Hospital where Dr. Smith did his anesthesia training.

From a surgeon's point of view, I believe that Dr. Smith is a good anesthetist and rendered a good quality of anesthesia and patient care. In addition, he was a pleasant individual who was anxious to be of help and was anxious to see to it that the patients did get a high quality of care.

Based on my previous experience with Dr. Smith, I feel confident that you will be pleased with his performance and that he will represent a welcome addition to your anesthesia staff. Please feel free to contact me if I can be of further help.

Sincerely,

James O. Menzoian, M.D.
Associate Professor of Surgery

jc

UNIVERSITY OF SOUTHERN CALIFORNIA
DEPARTMENT OF ORTHOPAEDICS
2300 SOUTH FLOWER STREET, SUITE 202
LOS ANGELES, CALIFORNIA 90007

September 1, 1983

Administrator
North Valley Hospital
Highway 93 South
Whitefish, Montana 59937

RE: Douglas Smith, M.D.

To Whom It May Concern:

I am writing in support of Doctor Douglas Smith's application for staff anesthesiology privileges at the North Valley Hospital. I worked with Doctor Smith at Boston City Hospital during the academic year July, 1982 through June, 1983. At that time I was the associate director of orthopaedic services and Doctor Smith was senior resident in the department of anesthesiology.

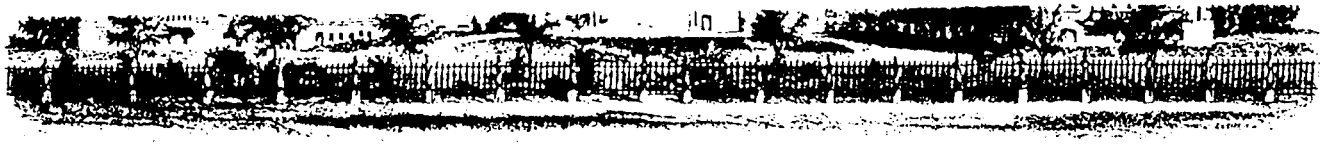
Doctor Douglas Smith very simply was the most outstanding resident in his class. His maturity, self confidence and knowledge were a notch above the rest. He was respected and well liked by his peers, the operating room nursing staff and the surgeons alike. Working in a large urban hospital such as Boston City, Doctor Smith was exposed to a very broad spectrum of patients, pathology, and complications. He handled this experience with enthusiasm, dedication and skill.

I would also add that Doctor Smith spent his elective time in the surgical intensive care unit, caring for the critically ill and multiply injured patient. His knowledge and expertise in this area may be a valuable addition to your hospital staff. Doctor Smith is an extremely competent, hard working individual who is well trained in all facets of anesthesia. In my opinion, the North Valley Hospital cannot afford to pass up an opportunity to retain the services of such a gifted individual. I recommend him to you without reservation or qualification.

Yours sincerely,

Donald A. Wiss, M.D.
Assistant Professor
Department of Orthopaedics/USC

DAW:dp



Boston, June 30, 1983

This certifies that Douglas C. Smith, D.M.D.

has faithfully served Anesthesiology Service

Boston City Hospital,

Department of Health and Hospitals

Junior Assistant Resident, Senior Assistant Resident

July 1, 1981 to June 30, 1983

President Medical Staff — Edward Alexander, M.D.

Secretary Medical Staff — Richard P. Kukorowski M.D.

Dean Cocker M.D.
Chief of Service

Chairman Board of Department — Jos Healey

Secretary Board of Department — Ruth M. Lynch

Commissioner — Lu Tullock

Denver General Hospital

This is to Certify that

Douglas C. Smith, D.M.D.

has served as

Dental Intern

with satisfaction and credit

June 24, 1969 through June 23, 1970

For City and County of Denver

Manager, Department Health and Hospitals

For Denver General Hospital

Director, Service

American Heart Association

Cardiopulmonary Resuscitation and Emergency Cardiac Care

This certifies that

JOUG SMITH, D.M.D.

has successfully completed the national cognitive and performance examinations in accordance with the Standards of the American Heart Association for

ACLS INSTRUCTOR

10/84
Date of Issue

7/85
Date of Expiration

American Heart Association

Cardiopulmonary Resuscitation and Emergency Cardiac Care

This certifies that

DOUG SMITH, D.M.D.

has successfully completed the national cognitive and performance examinations in accordance with the Standards of the American Heart Association for

ACLS PROVIDER

5/84
Date of Issue

5/86
Date of Expiration

Name of Heart Association	MONTANA
Heart Assn. Representative	MADELYN MOORE, E.D.
Instructor's Name	JACK DAVIS, M.D.
Instructor's SS#	517-36-3236
Holder's Signature	[signature]

This certification is subject to the provisions and limitations of applicable state statutes and licensing acts.

American Heart Association

78-003-B
78-81-5.7MM
12-81-2MM

Name of Heart Association	MONTANA
Heart Assn. Representative	JOHN P. CONNOR, E.D.
Instructor's Name	JACK DAVIS, M.D.
Instructor's SS#	517-36-3236
Holder's Signature	[signature]

This certification is subject to the provisions and limitations of applicable state statutes and licensing acts.

American Heart Association

78-003-B
78-81-5.7MM
12-81-2MM

EXHIBIT 4
January 23, 1985

WITNESS STATEMENT

Name Douglas C Smith, DMD. Committee On Human Services

Address P.O. Box 266 Date Jan. 23, 1985

Representing SELF Support NO.

Bill No. HB 235 Oppose Yes

Amend Yes.

AFTER TESTIFYING, PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

1. I oppose the definition of general anesthesia as written. It is not the "usual" accepted definition by experts in anesthesia
2. I oppose the restriction of nitrous oxide - oxide concentration because the percentage as written is meaningless.
3. I oppose the omission of dentist anesthesiologists from providing dental and non-dental anesthesia
4. in the State of Montana.

I support amendments as agreed with D.C. Roy Peck and Dr. Crawford.

Respectfully,

Douglas C. Smith DMD

Dentist Anesthesiologist

Itemize the main argument or points of your testimony. This will assist the committee secretary with her minutes.

FORM CS-34
1-83

EXHIBIT 5
January 23, 1985

WITNESS STATEMENT

Name [illegible] W [illegible] — Committee On House [illegible]

Address 215 NO [illegible] — Date [illegible]

Representing Mont State Dental Bd — Support

Bill No. [illegible] — Oppose ✓

Amend

AFTER TESTIFYING, PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

1. Regarding H.B. 290 - we have this area covered in proposed rule to
2. establish Education requirements & training for Dentist who administer General & IV
3. conscious sedation - [illegible] & local anesthesia w/ [illegible] emergency procedures & CPR
4. We [illegible] in office [illegible] from proper [illegible] in which office doing these procedures will be evaluated [illegible] technique training and equipment [illegible]

We are willing to [illegible] proposed [illegible] bill - but we need

Itemize the main argument or points of your testimony. This will assist the committee secretary with her minutes.

enabling legislation to do this HB 290 will give us this power we need rules [illegible]

FORM CS-34
1-83

EXHIBIT 6
January 23, 1985

AMERICAN ASSOCIATION OF ORAL
AND MAXILLOFACIAL SURGEONS

211 E. CHICAGO AVENUE CHICAGO, ILL. 60611

TELEPHONE
(312) 642-6446

Established 1918

ANTHONY L. CHECCHIO, D.D.S.
PRESIDENT AND CHAIRMAN
BOARD OF TRUSTEES

BERNARD J. DEGEN II
EXECUTIVE DIRECTOR

December, 1983

Dear Colleague:

Today's consumer is generally better educated and informed and expects full value for goods and services purchased. Part of this trend includes the consumer's wish to be more knowledgeable about what he or she is buying.

In the health care arena, the patient rarely accepts a diagnosis or proposed treatment plan from a dentist or doctor at face value. They ask many questions and often seek second (or several) opinions. They want to be as sure as they can be that the practitioner whom they choose to use is qualified, competent and will provide the best care possible.

Your Committees on Anesthesia and Public Information have collaborated to produce this fact sheet on pain control to help you to better deal with the more sophisticated consumer described above. It contains information about our training in pain control and our system of peer review to assure not only that our fellows maintain quality and care in the administration of anesthesia, but also to assure that the patient is treated in the safest manner possible. We have also included documented statistics of the record that our specialty has in the administration of anesthesia and how this record compares with other professionals.

We hope you will read this document carefully, and that you'll use it frequently when discussing this subject with your patients, and if asked, with your local media. We think the facts speak for themselves and that we can be proud of our record.

Sincerely,

Edwin D. Joy Jr.

Edwin D. Joy, Jr., D.D.S. Chairman
Committee on Public Information

Donald C. Zimmerman

Donald C. Zimmerman, D.D.S. Chairman
Committee on Anesthesia

ORAL AND MAXILLOFACIAL SURGERY TRAINING

Following completion of four years of dental school, a dentist who wishes to become an oral and maxillofacial surgeon must complete three or more years in a hospital based residency. The training in the utilization of local and general anesthesia is an integral part of the residency program.

Three to six months is devoted, full time, to the study of anesthesia in the operating room. To accomplish this, the resident is rotated through the hospital anesthesia service. During the time spent on that service, the oral and maxillofacial surgery resident actively participates in departmental teaching and clinical sessions under the supervision of an anesthesiologist.

In addition, because much of an oral and maxillofacial surgeon's practice is done on an outpatient (or office) basis, he or she receives extensive training in ambulatory general anesthesia. The minimum requirement per year for a resident is administration of 100 ambulatory general anesthetics.

PEER REVIEW ON PAIN CONTROL (OFFICE ANESTHESIA EVALUATION PROGRAM)

In 1975, the AAOMS established the Office Anesthesia Evaluation Program. The program is designed to assure that each fellow of the Association maintains a properly equipped office and is prepared to use accepted techniques for managing emergencies and complications of anesthesia in the treatment of the oral and maxillofacial surgery patient in the office or outpatient setting. The program was not mandated or suggested by any government or outside agency. It was conceived and is being implemented by the Association to benefit the public it serves.

The evaluation program is coordinated through state oral surgery societies and consists of observation of actual surgeries conducted in the office; a demonstration by the oral and maxillofacial surgeon being evaluated and his surgical team, of the management of simulted office emergencies; an evaluation of the office facilities and the medications available; and a personal interview to discuss the office's facilities and procedures.

Re-evaluation is recommended every five years.

DOCUMENTED STATISTICS

The following two pages contain statistics from 1947 to the present, regarding the number of deaths resulting from the administration of anesthesia in oral and maxillofacial surgery offices in the U.S.A. for office (outpatient) procedures. The last two listings give recent mortality statistics for other professionals and shows how favorably dental or OMS statistics compare.

1. **Seldin, Harry M. - Use of Nitrous Oxide-Oxygen Anesthesia in Dental Surgery Anesthesia & Analgesia 26:248 Nov-Dec, 1947**

   Survey 207 O.S. 5 year period 1943-1947,
   15 fatalities; 2,429,148 anesthetics
   1:161,943

2. **Seldin, Harry M. and Recant, Benjamin, S. - The Safety of Anesthesia in the Dental Office J.O.S. 13:199 July, 1955**

   Survey New York City, 10 year period 1943-1952
   6 fatalities; 1,000,000 Anesthetics
   1:166,666

3. **Driscoll, Edward J. - Proceedings of the Conference on Anesthesia for the Ambulatory Patient A.S.O.S. 48th Annual Meeting, Pre-Meeting Conference September 19, 1966 pp. 48-54**

   Survey 73% of AAOMS membership (1,098 respondents)
   1 year - 1965
   1:511,333 (local and general)
   General Anesthesia (alone) 5 fatalities - 1,575,000 - 1:315,000
   Local Anesthesia (alone) 1 fatality - 1,493,000 - 1:1,493,000

4. **Driscoll, Edward J. - A.S.O.S. Anesthesia Morbidity and Mortality Survey J.O.S. 32: October, 1974 pp. 733-38**

   Survey 66% of AAOMS membership (1,507 respondents)
   1 year - 1972
   11 fatalities - 5,250,000 Anesthetics
   1:477,273 (local and general)
   General Anesthesia (alone) 7 fatalities - 2,445,853
   1:349,408
   Local Anesthesia (alone) 4 fatalities - 2,839,517
   1:709,977

5. **Lytle, John J. - Anesthesia Morbidity and Mortality Survey of the Southern California Society of Oral Surgeons J.O.S. 32:October, 1974 pp. 739-744**

   Survey 88.6% of S.C.S.O.M.S. membership (117 respondents)
   5 year 1968 - 1972
   3 fatalities - 1,295,000 anesthetics 1:432,000

6. **Lytle, John J. & Yoon, Charles - 1978 Anesthesia Morbidity and Mortality Survey: Southern California Society of Oral and Maxillofacial Surgeons J.O.S. 38: November, 1980 pp. 814-819**

   Survey 100% of S.C.S.O.M.S. membership (153 respondents)
   5 year period 1973-1977 (second 5 year survey)
   0 fatalities - 1,285,000 anesthetics

   Combined 10 year period 1968-1977
   3 fatalities in 10 years or 1:860,000

7. **Personal Communication D'Eramo, Edward M. - Massachusetts Society of Oral and Maxillofacial Surgeons**

Survey 100% of M.S.O.M.S. membership (157 respondents)
5 year period 1976-1980
2 fatalities - 2,353,320 Anesthetics
1:1,176,660

8. **Personal Communication Snyder, Bernard S. - State of Ohio information**

State law in Ohio requires reporting of any deaths to the State Board of Dental Examiners since 1974 - reported February, 1982.
2 fatalities - 3,500,000
1:1,750,000

9. **Personal Communication Huntington, Robert E. - Southern California Society of Oral and Maxillofacial Surgeons Preliminary Report S.C.S.O.M.S.**

Survey 100% of the S.C.S.O.M.S. membership (172 respondents)
5 year period 1978-1982
3 deaths - 1,198,965 anesthetics (general anesthesics)
1:399,655

Combined 15 year surveys 1968 through 1982 S.C.S.O.M.S.
6 deaths - 3,778,965
1:629,828

10. **Allen, Gerald, MD - The Role and Responsibilities of the Anesthesiologist in Education and Training in Ambulatory General Anesthesia, Proceedings of 1983 Meeting of Directors and Faculty of Oral and Maxillofacial Surgery Residency Programs, Educational Foundation - AAOMS, New Orleans, LA, p. 57**

The record of patient care in anesthesia for outpatient oral surgery is excellent.

1 fatality in 100,000 outpatient general anesthesia for dentistry
1:100,000
1 fatality in 1,000,000 local anesthesia for dentistry
1:1,000,000
1 fatality in 283,658 in free-standing ambulatory clinics by anesthesiologists (MD)
1:283,658

11. **Lunn, J.N. and Mushin, W.W. - Mortality Associated with Anaesthesia, Anaesthesia, 1982, Vol. 37, p. 856, Nuffield Provincial Hospital Trust, London, England**

1 fatality in 10,000 general anesthesia for surgery in the hospital and outpatient setting
1:10,000

EXHIBIT 7
January 23, 1985

Office Anesthesia Evaluation Manual

American Association of Oral and Maxillofacial Surgeons

Established 1918

1978 Edition

EXHIBIT 8
January 23, 1985

FAMILY DENTAL GROUP
10 THREE MILE DRIVE
KALISPELL, MONTANA 59901
PHONE 755-7890

Human Services Committee
Montana State Legislature
Helena, Montana 59601

January 21, 1985

I am writing to you in regard to House Bill 235, "An Act To Require an anesthesiologist or anesthetist to administer and Monitor General anesthetics During Dental Procedures."

On page 4 of this bill I object to lines 9,10, & 11. This part of the bill would prohibit dentists trained as anesthesiologists from practicing in Montana. There is at least one such dentist in Montana Douglas Smith, D.M.D. Dr. Smith has had a full anesthesiology residency at Boston General Hospital, Boston, Mass. This is a fully recongnized residency program that trains M.D.'s as well as D.M.D.s and D.D.S.s. His training is much more advanced than that of a nurse anesthetist. This bill would let a less trained person provide this service, but block a fully trained anesthesiologist with a dental degree from providing the service.

I would like to see the bill amended to read as follows on page 4 line 9. anesthesiologist licensed to practice medicine or dentistry by the board of medical examiners or by the board of dentistry or by a nurse— — — .

Dr. Smith now practices anesthesiology at the North Valley Hospital, Whitefish, Mt. and for Dr. Dan Smith a Kalispell, Oral Surgeon. This bill as written would put Dr. Douglas Smith out of business.

Sincerely,

Douglas E Wood

Douglas E. Wood, D.D.S.

EXHIBIT 9
January 23, 1985

FAMILY DENTAL GROUP
10 THREE MILE DRIVE
KALISPELL, MONTANA 59901
PHONE 755-7890

January 21, 1985

Human Services Committee
Montana State Legislature Capital Building
Helena, Montana 59601

Dear Ladies and Gentlemen:

I am writing in regard to H B 235, a bill for an act entitled: "An Act to Require an Anesthesiologist or Anesthetist to Administer and Monitor General Anesthetics During Dental Procedures: Amending Section 37-4-101, MCA."

I am a strong advocate of adequate training in any area of medicine or dentistry before a practioner delivers that kind of care, including anesthesiology. There are several areas of concern to me in the wording of this bill which will result in decreased quality of care or make it prohibitively expensive, an unacceptable alternative in this day of increasing medical costs.

On page two I would like the first sentence to read "The term "general anesthetic" does not include a nitrous oxide/Oxygen mixture used for the purpose of achieving analgesia during dental procedures or other oral surgical procedures." This would delete any reference to concentrations of nitrous oxide. Although they are in the minority some patients do not acheive a state of analgesia until a concentration of 50% nitrous oxide or greater is used. In other words reaching a state of analgesia is a clinical judgement and is not dependent upon a universally applicable concentration of nitrous oxide. If that portion is not deleted then a segment of the patients I treat will either have to go to the hospital for treatment with general anesthesia or go without treatment, as they will not accept treatment without nitrous oxide analgesia.

The other area that greatly concerns me relates to the main thrust of this bill; that of limiting the administration of general anesthetics in dentistry (not medicine) by the degree an individual holds rather than by training and continuing maintenance of clinical standards. A more sound approach in my view would be for the legislature to mandate controls and monitoring of clinical standards and delegate to The Board of Dentistry the responsibility of implementing the legislatures intent. The views of all dental specialties currently represented in the State of Montana should be solicited in drafting legislation in this matter.

If the committee and the legislature choose to recommend and enact HB 235 substantially intact then I would strongly recommend additional modification as follows. Section 1. (2) (i) should remain unchanged. Section 2 (New section) should be amended in lines 9 and 10 to read "-- anesthesiologist licensed to practice medicine or dentistry by the state board of medical examiners or board of dentistry or--------". This modification would

accomodate trained dentist anesthesiologists. Dentist anesthesiologists trained in identical training programs as physician anesthesiologists do exist in small numbers and the state of Montana currently has a dentist anesthesiologist practicing in the Flathead Valley.

Thank you for your consideration.

Sincerely yours,

Robert W. Bowman, D.D.S.

EXHIBIT 10
January 23, 19[illegible]

LARRY CLAYTON, D.D.S.
P.O. Box 335
100 Village Lane
Bigfork, Montana 59911
(406) 837-4806

January 22, 1985

Human Services Committee
Montana State Legislature

Committee Members:

I have serious concerns regarding the proposed legislation (House Bill 235) which would restrict dental anesthesia. My concern relates to both the proposal requiring an anesthesiologist or anesthetist to provide general anesthesia and to the portion restricting the nitrous oxide concentration during dental procedures to "no greater than 50%".

There are persons other than anesthesiologists "licensed to practice medicine" and nurse anesthetists "recognized in that specialty by the board of nursing" fully qualified to perform and monitor general anesthesia. An excellent example is Dr. Douglas Smith of Bigfork who is eminently qualified to administer general anesthesia, but does not meet the aforementioned criteria. Therefore, the wording of the bill is needlessly restrictive and a more logical approach would be to allow the performance of general anesthesia (dental and medical) based on credentials rather than by degree.

The restriction upon the use of nitrous oxide is also unnecessary since its use is already legally restricted to persons possessing proper training and equipment in the office. When used in the dental office with proper monitoring by trained dental personnel, the dangers or risk factors involved are virtually non-existent. Perhaps some standardization and review procedure could be implemented, but the proposed restriction would be a disservice to the public and the dentist.

I understand the feelings behind the attempt to establish safe anesthesia guidelines in reaction to the recent fatality in Billings, however an ill-conceived, needlessly restrictive law passed without proper discussion with and input from the dental community is hardly in anyone's interest. I urge you to reconsider the entire wording of House Bill 235.

Thank you,

Larry Clayton

EXHIBIT 11
January 23, 1985

SENIORS' OFFICE

LEGAL AND OMBUDSMAN SERVICES

TED SCHWINDEN, GOVERNOR

P.O. BOX 232
CAPITOL STATION

STATE OF MONTANA

(406) 444-4676
1-(800) 332-2272

HELENA, MONTANA 59620

January 23, 1985

Members,
Committee on Human Services
& Aging
House of Representatives
Montana 49th Legislative Session
State Capitol
Helena, Montana 59620

re: House Bill 228
"Living Will"

Dear Representatives:

I serve as the attorney-elderly legal services developer with the Seniors' Office of Legal & Ombudsman Services and I am appearing here today at the request of Rep. Cal Winslow to offer testimony in support of House Bill 228. My position is a federally mandated and funded position under the federal Older Americans Act with one of its goals to assist senior citizens in their advocacy efforts. One of my responsibilities has been to work with senior citizens in their planning of their "Legacy Legislature". This past summer at the request of Mrs. Vi Thomson a legacy legislator from Missoula I drafted Legacy Legislature Bill No. 18 to formally recognize the concept of a "Living Will" in Montana.

As many of you know, a "Living Will" allows a competent adult to express his or her intentions regarding their desire to be kept alive by artificial means should they at some future date suffer from a terminal condition due to illness or injury. Twenty-three (23) states (including the District of Columbia) have already recognized in their laws the concept of a living will. The 1984 Montana Legacy Legislature composed of Montana's senior citizens also supported this concept.

House Bill 228 as introduced by Rep. Winslow and Senator Christians and numerous other legislators is almost verbatim the November 16, 1984 draft of the "Rights of the Terminally Ill Act" as proposed by the National Conference of Commissioners on Uniform State Laws. It includes most of the provisions of the Legacy Legislature Bill but there are several distinctions that are worth noting.

The Legacy Legislature Bill #18 required that two physicians had to certify that a declarant suffered from a terminal condition before his declaration would take effect whereas House Bill 228 requires only one (1) physician. House Bill 228 should in this regard be supported for due to the rural nature of most of Montana it may be impossible in some parts of the state to obtain the certification of more than one physician.

The Legacy Legislature Bill #18 also required that witnesses to a declaration had to meet certain qualifications:

1. They could not be related to the declarant by blood or marriage;
2. They could not be entitled to any portion of the declarant's estate under any will or by the Montana intestate laws if there was no will;
3. They could not be directly financially responsible for the declarant's medical care;
4. In those situtations in which the declarant was physically incapable of singing due to a disability and someone signed the living will for the declarant, the signator for the declarant could not also serve as a witness.

House Bill 228 imposes no conditions on witnesses to a declaration in keeping with the draft uniform state law on the rights of the terminally ill. It should be noted that the draft upon which HB 228 was based has <u>not</u> been formally adopted by the Commissioners on Uniform Laws and that it will not be voted on until August, 1985. The Committee draft does note that its proposal that there be no conditions placed on witnesses is not supported by the legislation that most of the states have adopted. "The draft does not require witnesses to meet any specific qualifications, and as such, departs quite signficiantly from the statutory law established in almost every state." [See COMMENT, pg. 7, November 16, 1984, Draft, Rights of the Terminally Ill Act].

Because of the concern for the potential for fraudulent or fake "Living Wills" being executed by persons who might inherit from a person's estate, I would urge the Committee to consider amending HB 228 to impose some qualifications on who might serve as a witness. I would propose for your consideration that only one (1) of the two (2) persons who would witness the declaration may be related to the declarant by blood or marriage. Many states expressly preclude all relatives by blood or marriage from serving as witnesses but by allowing one of the witnesses to be a relative there may be an occasion in which someone who is terminally ill would be able to execute a living will whereas he might otherwise not be able to do so.

A number of states that have enacted "Living Will" statutes have placed a time-limit on the effectiveness of these documents once they have been executed, for example 5 years in the case of Idaho and Georgia and 7 years in California. My recommendation after reviewing this issue with the New York based "Society for the Right to Die" is not to place a time-limitation in Montana's law on this point. There are occasions in which a person who executes a valid living will may suffer from a disease such as Alzheimer's that would preclude him from re-executing a new living will if Montana imposed a 5 or 7 year time-limit on their effectiveness. As an alternative to statutorily placing a time-limit on living wills'effectiveness, I would recommend that in the sample declaration listed in the bill that a statement be added to the effect that: "This declaration [shall be valid until revoked or shall expire in _____ years from the date of its execution]."

I would also urge your committee to consider including a "Short Title" section in the bill such as, "This Act (sections 1 through ___) may be cited as, "The Montana Living Will Act".

Under the penalty section, I would recommend that in Section 8, paragraph (4), that a statement be included to expressly state that this penalty (for those who are found to have falsified or forged a declaration) is in addition to any other penalties that may be applicable under the criminal code. This is being suggested for it is possible that in some cases a charge of conspiracy to commit deliberate homocide may be applicable in these cases.

Finally, I would urge your consideration of an amendment to include a section in the bill recognizing an "effective date" of prior to October 1, 1985. You may also wish to include a statement that recognizes the validity of "Living Wills" that were executed prior to the effective date of this bill as long as they meet the minimum conditions required in this bill.

Thank you for an opportunity to address this issue before and I would be happy to answer any questions you may have after the public testimony on this bill has been completed. I am attaching some suggested amendments for your consideration as well as some articles on this issue that may be of interest.

Sincerely,

Douglas B. Olson
Attorney
Seniors' Office of Legal &
Ombudsman Services

Attachments

Proposed Amendments to HB 228
"Living Will"
from: Doug Olson, Atty.
Seniors' Office of Legal & Ombud. Svcs.
January 23, 1985

1. Page 1
Following: Line 15
Insert: "NEW SECTION. Section 1. Short Title. Sections 1 through 13 may be cited as the "Montana Living Will Act."
Renumber: Subsequent sections

2. Page 2
Following: Kine 25
Insert: "Only one of the two witnesses may be related to the declarant by blood or marriage."

3. Page 3, line 20
Following: "pain."
Insert: "It is my intention that this declaration [shall be valid until revoked by me; or, shall expire in ___ years from the date of its execution]."

4. Page 7
Following: Line 13
Insert: "This penalty is in addition to any other penalties that may be imposed pursuant to Title 45."

5. Page 9
Following: Line 7
Insert: "NEW SECTION. Section 13. This act is effective on

[choices:
(a) passage and approval. or
(b) July 1, 1985.]".

***

Please note that changes or amendments in the bill's title may also be necessary.

EXHIBIT 12
January 23, 1985

WITNESS STATEMENT

Name Polly Munro Committee On Human Services & Aging

Address 1207 Winne, Helena Date 1-23-85

Representing Self Support ✓

Bill No. 228 Oppose

Amend ✓

AFTER TESTIFYING, PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:
1.

2.

3.

4.

Itemize the main argument or points of your testimony. This will assist the committee secretary with her minutes.

FORM CS-34
1-83

TESTIMONY BEFORE THE HOUSE

HUMAN SERVICES AND AGING COMMITTEE

Wednesday, January 23, 1985

RE: HB 228

BY: Molly Munro, Concerned Citizen

I am Molly Munro and I appear here today as a concerned citizen. It is possible, at the present time, in the state of Montana for a person to draw up a declaration as is described in this bill. However, there would be no obligation for the physician to follow it; no immunity for the physician who did follow it; and no requirement that the physician transfer the person to the care of another physician if he/she found he could not follow the dictates of the declaration.

I, personally, feel that it is imperative that this law be passed to provide a legal and effective means for those wishing to make such a declaration.

I wish that this law had been in effect several years ago. My father-in-law, aged 83, and diagnosed as a victim of Alzheimer's disease, in no longer able to make such a declaration. Consequently, within a few short years or sooner, his family may be faced with the decision of whether or not his life should be maintained by life support systems. Had he been able to make this decision for himself, this could have been avoided.

A few years ago, I had to take my mother, who is 89 years old, to the Mayo Clinic for care. My family is fairly close knit, but I spent a lot of time, while there, on the phone justifying to my sister and two brothers the decisions made by my mother and me regarding her treatment and care--and this was no life-and-death situation.

So I feel that this bill addresses a situation that can be handled before it develops into a time of high emotional stress for the persons involved and their families.

However, I cannot urge you strongly enough, to adopt the proposed amendment concerning qualications of witnesses to the declaration. This must be an integral part of this bill. Family members and relatives must be afforded this protection.

I also encourage you to make this bill effective immediately, or by July 1, 1985, at the very latest. I can see no good reason for delaying it further.

One last suggestion--a very minor one--but one which I think would strengthen the wording of the sentence involved. On line 1, page 5 delete "the" and insert "that" so that the sentence reads, "...use of life sustaining procedures if <u>that</u> patient is able to do so."

Thank you for your time and for allowing me the opportunity to speak on behalf of HB 228.

EXHIBIT 13
January 23, 1985

TESTIMONY BEFORE THE HOUSE HUMAN SERVICES COMMITTEE 1/23/85

My name is Earl Reilly and I am a member of the Montana Senior Citizens Association. I am here today in support of HB 228. This legislation enables each of us to make a choice while we are competent, able and without pressure or duress to determine a course of action to be followed when faced with a terminal affliction.

The purpose, of course, is to eliminate needless suffering, needless expense and needless trauma inherently present in these situations.

We, however , want to be assured that proper safeguards are in place to make sure that the maker of each will is making a free choice, the will is properly witnessed and notarized or whatever may be necessary to make the "living will" a legally accepted document. We want to further ensure that the conflict of interest problems are properly addressed, that is, that health-care providers and persons who are direct beneficiaries not be allowed to witness the document.

We understand that the "Living Will" is now legal in 22 states and Washington, D.C.

We would appreciate your favorable consideration in this matter.

EXHIBIT 14
January 23, 1985

January 23, 1985

TESTIMONY OF ELSIE FOX, MILES CITY, MONTANA IN FAVOR OF "LIVING WILL"

Twenty-two states and the District of Columbia have enacted laws that recognize a person's advance written instructions to withhold or withdraw life-sustaining procedures in the event of a terminal condition.

I and many other Senior Citizens in Custer County feel very strongly on the issue of "Living Will". We have seen instances where there have not been living wills, and the family is under undue but tremendous pressure to agree "to anything that can be done to keep Grandma (for instance) alive": and the result is that Grandma is propped up, not knowing anything, and the bills run into many thousands of dollars to no avail. The "Living Will" is only valid when it is signed while the person involved has all his or her faculties, therefore danger of abuse is removed.

At a recent discussion on the priority of current legislation at our Senior Citizen meeting in Miles City, Living Will was considered to have No. 2 priority.

Therefore, I strongly urge you to lend your support to this legislation.

Elsie Fox

ELSIE FOX
P.O. BOX 222
MILES CITY, 59301
(406) 232-1841

WRITTEN TESTIMONY
January 23, 1985

STEPHEN L. BLACK, D.D.S., P.C.
Diplomat of the American Board of
Oral and Maxillofacial Surgery
115 West Kagy Boulevard
Bozeman, Montana 59715
(406) 587-0767

January 25, 1984

State of Montana
Department of Commerce
Board of Dentistry

Dear Board Members:

The enclosed statements are made for your consideration during the public hearing on the adoption of a new Sub-Chapter 5, Standards for Dentists Administering Anesthesia. These suggested changes are my own personal opinions and should not be construed as statements that are policies of the Montana Dental Association. Having studied the issues related to these rules and regulations for the past six years, I feel that some of the changes that I propose are relevant to the formulation of changes in the practice act which are pertinent and yet reasonable for professionals and protective of the public. I will be happy to answer any questions that you may have regarding these suggestions.

Sincerely,

Stephen L. Black, D.D.S., P.C.

SLB/cjw
Enclosure

NEWS RELEASE

STATE OF MONTANA
DEPARTMENT OF COMMERCE
BEFORE THE BOARD OF DENTISTRY

In the matter of the proposed adoption of new rules concerning anesthesia under a new sub-chapter 5.	))))	NOTICE OF PUBLIC HEARING ON THE ADOPTION OF A NEW SUB-CHAPTER 5, STANDARDS FOR DENTISTS ADMINISTERING ANESTHESIA

TO: All Interested Persons:

1. On January 27, 1984, at 1:00 p.m., a public hearing will be held in room 107, the Department of Highway auditorium, at 2701 Prospect, Helena, Montana, to consider the adoption of new rules concerning standards for dentists administering anesthesia.

2. The proposed rules do not replace or modify any sections currently found in the Administrative Rules of Montana.

3. The proposed rules will provide as follows:

"I. PROHIBITION (1) Dentists licensed in this state cannot use general anesthesia, conscious sedation, nitrous oxide inhalation conscious sedation, or local anesthetic techniques, in the practice of dentistry, until they have met all of the requirements set forth in these rules.

(2) Violation of these rules shall constitute grounds for disciplinary action as provided in 37-4-321, MCA."

Auth: 37-1-131, 37-4-205, MCA Imp: 37-1-131, 37-4-101 (1) (i), MCA

"II. EXEMPTION (1) A dentist who can show evidence of competence and skill in administering ~~general anesthesia or a~~ form of conscious sedation by virtue of experience, ~~demonstration,~~ and/or comparable alternate training shall be presumed by the dental board to have appropriate credentials for the use of that category of anesthetic or sedation. In applying for an exemption status, the dentist must have documented written evidence of his background for the board to evaluate and determine the appropriateness of training and experience."

Auth: 37-1-131, 37-4-205, MCA Imp: 37-1-131, 37-4-101 (1) (i), MCA

"III. DEFINITIONS (1) For the purpose of these rules the following definitions shall apply:

(a) General anesthesia is a controlled state of unconsciousness, accompanied by partial or complete loss of protective reflexes, including inability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof.

(b) Anesthesia is the loss of feeling or sensation, especially loss of the sensation of pain.

(c) Local anesthesia is the loss of sensation of pain in a specific area of the body, generally produced by a topically applied agent or injected agent without causing the loss of consciousness.

(d) Analgesia is absence of sensibility to pain, designating particularly the relief of pain without loss of consciousness.

(e) Nitrous-oxide inhalation conscious sedation is a state of sedation in which the conscious patient has reduced fear, apprehension and anxiety through the inhalation of nitrous-oxide and oxygen, and is maintained in a level of conscious sedation capable of communication or other appropriate response to physical stimulation, but has not yet obtunded his protective autonomic reflexes.

(f) Conscious sedation consists of the use of any drug element or other material which results in relaxation, diminution or loss of sensation with the retention of intact protective reflexes, spontaneous respirations, and the ability to maintain an airway.

Auth: 37-1-131, 37-4-205, MCA Imp: 37-1-131, 37-4-101 (1) (i), MCA

The next suggestion is relevant to all phases of training and education in the rules and regulation where it is suggested that a certificate in competence should be tested annually. It is my suggestion that this period of certification and evaluation of competence should be every three years instead of every year. The statement might read as such (IV b):

"IV. GENERAL ANESTHESIA TRAINING AND EDUCATION (1) A licensed dentist may employ or use general anesthesia on an outpatient basis for dental patients provided:

(a) He has a minimum of one year or its equivalent of training in anesthesiology and related subjects beyond the undergraduate dental school level which shall be completed prior to the use or administration of general anesthesia.

(b) The dentist and operatory staff must have a current cardiopulmonary resuscitation (CPR) certificate and shall every three years verify competence in other emergency procedures.

Auth: 37-1-131, 37-4-205, MCA Imp: 37-1-131, 37-4-101 (1) (i), MCA

This change should apply to the training and education for other forms of anesthesia and sedation as well.

"V. GENERAL ANESTHESIA FACILITY (1) A licensed dentist administering general anesthesia shall have a facility that is properly equipped for the administration of general anesthesia and staffed with a supervised team of auxiliary personnel capable of reasonably handling procedures, problems, and emergencies incident to the use of administration of general anesthesia. The staff shall be under close supervision of the licensed dentist."

Auth: 37-1-131, 37-4-205, MCA Imp: 37-1-131, 37-4-101 (1) (i), MCA

It is my suggestion that the word "close" be specifically defined to include the meaning that the dentist shall be in the operatory at all times when anesthetics are being utilized. This definition should apply throughout the entire text of the these proposed rules and regulations.

"VI. CONSCIOUS SEDATION TRAINING AND EDUCATION (1) A licensed dentist may employ or use conscious sedation technique on an outpatient basis for dental patients provided:

(a) He has received formal training in the use of conscious sedation techniques.

(b) He is certified by the institution where the training was received to be competent in the administration of conscious sedation techniques. Such certification shall specify the type and number of hours and the length of training. The minimum of didactic hours shall be 40 and the minimum of patient contact hours shall be 20. A formal training program shall be sponsored by or affiliated with a university, teaching hospital or other facility approved by the board of dentistry or part of the undergraduate curriculum of an accredited dental school.

(c) The dentist and operatory staff must have a current cardiopulmonary resuscitation (CPR) certificate and shall ~~annually~~ update competence in other emergency procedures."

"VII. CONSCIOUS SEDATION FACILITY (1) When using conscious sedation with oral or injected drugs, the dentist shall have a facility that is properly equipped for the administration of conscious sedation and staffed with a supervised team of auxiliary personnel capable of reasonably handling procedures, problems, and emergencies incident to the use and administration of conscious sedation agents. The staff shall be under the close supervision of a licensed dentist."

"VIII. NITROUS-OXIDE INHALATION CONSCIOUS SEDATION TRAINING AND EDUCATION (1) A licensed dentist may employ or use nitrous-oxide inhalation conscious sedation only, or in conjunction with local anesthetic agents, on an outpatient basis for dental patients provided:

(a) He has a minimum of 20 hours of technique instruction sponsored by an accredited hospital, accredited dental school, or dental society including instruction in safety and management of emergencies.

(b) The dentist and operatory staff must have a current cardiopulmonary resuscitation (CPR) certificate.

Auth: 37-1-131, 37-4-205, MCA Imp: 37-1-131, 37-4-101 (1) (i), MCA

"IX. NITROUS-OXIDE INHALATION CONSCIOUS SEDATION FACILITY (1) When using conscious nitrous-oxide sedation for dental patients, the dentist shall have a facility that is properly equipped for the administration of nitrous-oxide conscious sedation and staffed with a supervised team of auxiliary personnel capable of reasonably handling procedures, problems, and emergencies incident to the use and administration of nitrous-oxide conscious sedation. The staff shall be under the close supervision of the licensed dentist.

(The board must consider coordination of the current rules and regulations relative to the use of nitrous-oxide conscious sedation as they would apply to the proposed rule changes. If there are any discrepancies between the old and the new rules, these should be specified and the old rules deleted so that there is unanimity within the practice act regarding the use of nitrous oxide and oxygen conscious sedation).

(2) The following shall be present in any facility where nitrous-oxide inhalation conscious sedation is utilized:
(a) an anesthesia delivery machine which provides not less than 30% oxygen.
(b) equipment capable of deliverying positive pressure oxygen.
(c) equipment for adequate suction.
(d) a portable backup oxygen unit."
Auth: 37-1-131, 37-4-205, MCA Imp: 37-1-131, 37-4-101 (1) (i), MCA

"X. LOCAL ANESTHETIC TRAINING AND EDUCATION
(1) Dentists licensed to practice in the state of Montana may use local anesthesia as is indicated in their practice.
(2) The dentist and operatory staff must have a current cardiopulmonary resuscitation (CPR) certificate. (Strike words, competence)
Auth: 37-1-131, 37-4-205, MCA Imp: 37-1-131, 37-4-101 (1) (i), MCA

(It is my feeling that the ad hoc committee on anesthesia never intended that every office using any kind of anesthetic, including local anesthetic, had annual updates in their competence. Although that may be ideal for all dentists and their staff to have current CPR certification, I believe this is an unwieldy rule and would be very difficult to keep track of or enforce. There are also many extenuating circumstances which may make it virtually impossible for dentists and their staff to obtain CPR training which would also make this rule difficult to enforce. The board should perhaps reconsider on demanding manditory CPR for all dentists and all dental staff).

"XI. LOCAL ANESTHETIC FACILITY (1) When using local or regional anesthetic agents for dental patients the dentist shall have a facility that is properly equipped for the administration of lcoal anesthesia and be capable of reasonably handling procedure problems and emergencies incident to the use and administration of local anesthetic agents.
(2) The following shall be present in an office utilizing local anesthesia:
(a) portable backup oxygen unit.
(b) equipment capable of delivering positive pressure oxygen.
(c) equipment for adequate suction."
Auth: 37-1-131, 37-4-205, MCA Imp: 37-1-131, 37-4-101 (1) (i), MCA

"XII. LIMITATION ON ADMINISTRATION OF ANESTHESIA (1) Nothing in these rules shall be construed to allow a dentist, dental hygienist, or auxiliary to administer to himself/herself or to any other person, other than in the course of the practice of dentistry, any drug or agent used for anesthesia."

Auth: 37-1-131, 37-4-205, MCA Imp: 37-1-131, 37-4-101 (1) (i), MCA

"XIII. IN-OFFICE EVALUATION (1) The board of dentistry shall appoint an in-office evaluation team which shall be a permanent arm of the board. The evaluation team shall evaluate dental offices utilizing anesthetic agents for general anesthesia and conscious sedation. Evaluation shall be every three years by the evaluating team and guidelines for this evaluation shall be specified under paragraph XIX of this sub-chapter 5. This team shall be made up of two general practitioners, three oral surgeons, a periodontist and a pedodontist. Each evaluation shall be done by two members of the team, such that one member is an oral surgeon and the other member is an individual practicing in the same manner as the individual to be evaluated (that is, if a pedodontist's practice was to be evaluated the evaluation team would be an oral surgeon and a pedodontist. If a general practitioner was to be evaluated, the evaluating team would be made up of an oral surgeon and a general practitioner, etc.

(This team must have the authority of the board such that their evaluation shall be meaningful to the practitioners being evaluated as well as to the board of dentistry in determining whether an individual should obtain or maintain his anesthetic credentials).

Auth: 37-1-131, 37-4-205, MCA Imp: 37-1-131, 37-4-101

"XIX IN-OFFICE EVALUATION GUIDELINES (1) Two cases appropriate to the practice being evaluated shall be observed. This portion of the evaluation should not exceed one hour. No evaluation can be considered complete unless this part is included.

(2) Simulated emergency procedures are to be demonstrated in the operating area with full participation of the office staff. An exact simulation of the emergency situation should be demonstrated. A simulated intravenous administration set should be taped into position and all emergency equipment should be supplied including syringes and medications in proper sequence. The evaluation team and the dentist being evaluated should not just talk about the emergency situation and how it should be managed. The dentist and his team must perform an actual demonstration of their method for managing the following emergency situations:

(a) laryngospasm,
(b) bronchospasm,
(c) emesis and aspiration of vomitus,
(d) management of other foreign bodies in the airway,
(e) angina pectoris,
(f) myocarial infarction,
(g) hypotension,
(h) hypertensive crisis,
(i) cardiopulmonary resuscitation,
(j) acute allergic reactions,

(k) hyperventilation syndrome, and
(l) convulsion of unknown etiology.

(3) (As listed on page 6, paragraph 3, the office equipment, records, and emergency medications specifics seem relevant only to the use of general anesthesia. As this listing was taken from the AAOMS Guidelines on Anesthesia Office Evaluation, the board should consider the possibility of dividing this particular portion into general anesthesia for which this list is appropriate and conscious sedation for which this list may be inappropriate. The board must decide about the appropriateness for such things as backup systems and suctioning, lighting and monitoring equipment as it perttains to conscious sedation techniques. The board may also consider giving the evaluation team guidelines as to what monitoring equipment the board deems necessary in using general anesthesia vs. conscious sedation.

The board must consider the mechanics of the reporting of this evaluation team. For example, if the evaluation team found the dentist or staff incompetent what would the alternatives be and what specifically would be done in this incidence. The board should also consider a manditory reporting of morbidity and mortality related to anesthetic complications in dental offices.

I also believe that the board must consider a period of grace following the inception of these rules and regulations so that the evaluation team can be set up and do appropriate office testing and reporting back to the board. The board should also consider a grace period for new dentists applying for such credentials to obtain appropriate evaluation and credentialing.

I think it is also appropriate for the board to address the issue of a dentist who is trained in general anesthesia and wishes to perform such anesthetics, either in outpatient settings or in hospital settings.

The board should also consider specifying the costs of in-office evaluation and how much the evaluation team members should be paid).

All office equipment, records, and emergency medications related to patient care should be available for inspection by the visiting team. Specific attention should be directed to the following areas:

(a) the oxygen and supplemental gas-delivery system and back-up system.
(b) provision for suction and backup system,
(c) auxiliary lighting system,
(d) the gas storage facilities,
(e) suitability of the operating suite,
(f) patient transportation equipment, if used,
(g) recovery areas,
(h) sterilization areas,
(i) medication preparation,
(j) completeness of emergency anesthesia equipment and medications,
(k) completeness of office patient-care records, and
(l) monitoring equipment.

(4) The discussion period shall be the final part of the evaluation and should be conducted in private away from staff and patients. The evaluators at this time may note deficiencies and make positive suggestions to the dentist for improving the office facility and patient management. It shall also be appropriate at this time to discuss management of risk patients if this has not been covered furing an earlier stage of the evaluation."

Auth: 37-1-131, 37-4-205, MCA Imp: 37-1-131, 37-4-101 (1) (i), MCA

ANESTHESIA

Dear Ladies and Gentleman:

I thank you very much for the opportunity to present some very important information that needs to be considered when evaluating anesthesia in its proper perspective. The use of general anesthesia in the past was very wide-spread. Over the years oral surgeons have felt that definite action by the professions (both medical and dental) to insure a high standard of anesthesia in the out-patient setting is necessary. The timely, energetic response of oral surgeons has resulted in the upgrading of office anesthesia facilities, acceptance of office anesthesia evaluation, initiation of morbidity and mortality studies, review for training of oral surgery auxillary personnel and renewed interest in clinical research in outpatient anesthesia.

1. How safe is outpatient anesthesia?

2. Is it really necessary?

In 1974 in Southern California a five year review of anesthetic morbidity-mortality was undertaken by the oral surgery society. This was done just prior to the initiation of an office anesthetic review requirement. They surveyed 100% of the oral surgeons in southern California. From 1968 to 1972 there were 3 fatalities in 1,300,000 anesthetics or 1 for every 430,000. In 1980 they reviewed the same group again. 100% participation during the second 5 year review of southern California was achieved. There were no deaths in over 1,285,000 anesthetics. In Massachusetts, an anesthetic study revealed that from 1976 to 1980 there were 2 fatalities in 2,353,320 anesthetics or 1 death for every 1,766,660. In Ohio there have been two fatalities in over 3,500,000 anesthetics since 1974, or 1 death for every 1,750,000 anesthetics. Furthermore, 1 in every 600,000 local anesthetics will result in a death.

Now lets compare these statistics to those found in hospitals with anesthesiologists and certified nurse anesthetists. In Dripp's textbook, Introduction to Anesthesiology, Dripp addresses this issue in the section on physical status and risk. In 1954 Beach and Todd found that anesthesia played a primary contributory role in the death of one in every 1,500 patients. More recent statistics reveal one in every 30,000 to 40,000 general anesthetics result in a death. A personal communication with anesthesiologists at a surgicenter in Montana revealed that for surgicenters these numbers are 1 death for every 150,000 anesthetics. When we compare out-patient anesthetic to in-patient in hospital anesthetics of a general nature, it is apparent that out-patient anesthetics by oral surgeons results in a very admirable and statistically safe approach. Oral surgeons are constantly striving to eliminate risks. However, risks can only be eliminated to a certain point. It is important to remember that even with local anesthesia 1 death results in every 600,000 administrations. So local anesthesia in itself is not a sure way of avoiding a significant problem.

Next I would like to address the question of, "Is sophisticated anesthesia care really necessary?" I feel that it truly is. The practice of dentistry has evolved in the sophisticated level of care of pain and anxiety. For example, the patient who refuses treatment until the process has advanced to a potentially body compromising situation requires a sophisticated approach. If local anesthesia alone is employed, many times effective pain control is not attainable. With intravenous sedation or a light plane of general anesthesia, performed in the correct environment, this apprehensive patient can be treated in a very safe and cost-effective manner. It must be realized that the use of a surgi-center or a hospital for elective out-patient surgery adds from $600 to $1,000 or more per situation.

At this time I would like to discuss some very important terms, to clarify the concept of anesthesia for this committee.

Anesthesia is a loss of sensation in part or in the body generally induced by the administration of a drug.

Local Anesethesia is produced by the injection of a local anesthetic drug into the soft tissue.

Regional Anesthesia is produced by the selected injection of a local anesthetic drug into or in close proximity to a specific nerve to produce anesthesia alon that area of innervation.

General Anesthesia is a loss of consciousness in addition to the loss of sensation produced by the administration of either intravenous, oral or inhalation anesetics.

Sedation is the calming by the means of psychologic or pharmacologic (by route of administration) methods that do not impair obligatory anatomic functions such as respirations or cardiac function.

With the administration of any of these medicines there is an anesthetic risk. The anesthetic risk incorporates the present physical status of the patient. These are classified according to The American Society of Anesthesiology.

Class I: This patient is a healthy patient without systemic disease.

Class II: This patient is one with a mild systemic disease such as moderate anemia, history of heart disease without symptoms or a mild diabetic under good control.

Class III: This is a patient with a severe systemic disease that limits activity, but is not yet incapacitating and is not yet a threat to life. Examples of this are gross obesity, asthma, COPD, symptomatic heart disease and moderate trauma.

Class IV and V: These patients have risks not applicable to office practice.

To further enhance the continued safe use of out-patient anesthetics, I feel the following recommendations should be incorporated into any such approach that is ultimately adopted.

1. One year of anesthesia training or its equivalent be required to provide such services.

2. Advanced life support or it's future equivalent be required to administer anesthesia.

3. An office evaluation be required before a certificate of competency be given to a practitioner. This evaluation should include patient's history, montoring protocols, use of anesthetics, understanding of anesthetics, and any other adjunctive considerations that may be required.

4. A mandate that the state board implement its regulations within the next year.

5. No provision for a grandfather clause be permitted.

Thank you very much for your time and concern.

Dr. Donald Roberts
Board of Oral and Maxillofacial Surgeons

Suggested Rules Governing Out-patient Anesthesia

Defined: General Anesthesia

The elimination of all sensations accompanied by a state of unconsciousness. The unconscious patient is defined as one without intact proprioceptive reflexes including the inability to maintain an airway and one who is incapable of rational responses to questions on command. This definition does not limit the use of conscious sedation or nitrous oxide analgesia and pertains only to general anesthesia.

Guidelines

A. No dentist shall employ or use general anesthesia on an out-patient basis for dental patients unless such dentists possess a permit of authorization issued by the Montana State Dental Board. The dentist holding such permit shall be subject to review and such permit must be renewed annually.

B. In order to receive such permit the dentist must apply on a prescribed application form to the Montana State Dental Board and produce evidence showing that he or she:

1. Has completed a minimum of one year of advanced training in anesthesiology and related academic subjects (or its equivalent) beyond the undergraduate dental school level in a training program as described in Part II of the guidelines for the teaching of comprehensive control of pain and anxiety in dentistry; or

2. Is a diplomat of the American Board of Oral Surgery, or is eligible for examination by the American Board of Oral Surgery, or is a member of the American Society of Oral Surgeons ; or

3. Is a fellow of the American Dental Society of Anesthesiology; or

4. Employs or works in conjunction with a trained M.D. or D.O. who is a member of the anesthesiology staff or an accredited hospital, provided that such anesthesiologist must remain on the premises of the dental facility until any patient given a general anesthetic regains consciousness; and

5. Has a properly equipped facility for the administration of general anesthesia staffed with a supervised team of auxiliary personnel capable of reasonably handling procedures, problems, and emergencies incident thereto. Adequacy of the facility and competence of the anesthesia team may be determined by the consultants appointed by the board as outlined in Part C of this rule.

C. Prior to issuance of such permit the Montana State Dental Board shall require an on-site inspection of the facility equipment and personnel to determine if in fact the aforementioned requirements have been met. This evaluation shall be carried out in a manner following the principles but not necessarily the specifics described in the American Society of Oral Surgeons' Office Anesthesia Emergency Self-evaluation Manual. The evaluation shall be carried out by a team of consultants appointed by the Montana State Dental Board. Within one year of the effective date of these rules, each dentist using or employing general anesthesia prior to the adoption of the rule shall make application to the Montana State Dental Board for such permit and undergo an on-site evaluation of their facilities, equipment and personnel.

D. For new applicants who are otherwise properly qualified, a temporary provisional permit of one year in duration may be granted by the board based solely upon the credentials contained in the application pending complete processing of the application and on-site evaluation as described in Part C of this rule.

E. Anesthesia permits must be renewed annually with re-examination as described in Section C at intervals no longer than five (5) years.

Conscious Sedation

Defined: Conscious sedation is a type of sedation in which the conscious patient is rendered free of fear, apprehension, and anxiety through the use of pharmaceutical agents without the intent to produce a state of general anesthesia.

Guidelines

A. No dentist shall employ or use conscious sedation on an out-patient basis for dental patients unless such dentist possesses a permit of authorization issued by the Montana State Dental Board. A dentist holding such permit shall be subject to review and such permits must be renewed annually.

B. In order to receive such permit the dentist must apply on a prescribed application form to the Montana State Dental Board and produce evidence showing that he or she:

1. Has successfully completed a course in conscious sedation recognized by the Montana State Dental Board, or

2. Has completed a specialty residency program approved by the American Dental Association Council on Dental Education where conscious sedation was routinely utilized.

3. Has a properly equipped facility for the administration of conscious sedation staffed with supervised team of auxiliary personnel capable of reasonably handling procedures, problems, and emergencies incident thereto. Adequacy of the facility and competence of the team may be determined by consultants appointed by the board as outlined in Part C of this rule.

C. Prior to issuance of such permits, a Montana State Dental Board shall require an on-site inspection of the facility, equipment and personnel to determine if in fact the aforementioned requirements have been met. Evaluation shall be carried out by a team of consultants appointed by the Montana State Dental Board. Within one year from the effective date of these rules, each dentist using or employing conscious sedation prior to the adoption of these rules shall make application to the Montana State Dental Board for such permit and undergo an on-site evaluation of their facility, equipment and personnel.

D. For new applicants who are otherwise qualified, a temporary provisional permit of one year in duration may be granted by the board based solely upon the credentials contained in the application pending complete processing of the application and on-site evaluation as described in Part C of this rule.

E. Conscious sedation permits must be renewed annually with re-evaluation at intervals deemed appropriate by the Montana State Board of Dentistry.

Nitrous Oxide and Oxygen Conscious Sedation

1. Those dentists with a valid Montana Dental License who have utilized Nitrous Oxide conscious sedation in their practices for a length of time to be determined by the Montana Board of Dentistry prior to enactment of this legislation shall be granted a Nitrous Oxide conscious sedation permit.

2. Those dentists licensed in the State of Montana after the effective date of this legislation shall be required to successfully complete a course in Nitrous Oxide conscious sedation acceptable to the Montana Board of Dentistry.

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ORAL SURGICAL ASSOCIATES

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Representative Raymond Peck
Capitol City Station
Helena, Montana 59601

Dear Representative Peck:

You will recall, Dr. Torgerson and I discussed HB 235 with you Wednesday morning, January 31, 1985, prior to the committee hearing on HB 290. We discussed that we agree on nearly every issue. We agree that general anesthesia is dangerous when administered improperly or carelessly. We agree that the primary thrust of legislation whether it be by a combination of HB 235 and rules or by rules alone should be to promote performance of out-patient anesthesia at the highest possible level of safety. You contend that a second person distinct from the surgeon must be present who is competent in administering the anesthetic, monitoring the patient, and treating emergencies. We have shown that an oral surgeon can perform surgery in the mouth with a safety record that exceeds that achieved in hospitals or out-patient surgery facilities staffed with anesthesiologists while working with a team of two additional persons, one assisting with the surgery and the other aiding with the anesthetic.

When you researched this question by quizzing numerous physicians and dentists, they answered truthfully but inaccurately because their understanding of anesthesia was gained in the hospital operating room. It is not possible to judge the technique used in oral surgery without observing it. In the hospital the patient is placed into a deep state of anesthesia where he is totally free from stimulation by pain and protective reflexes are completely lost. The

patient is under the influence of large quantities of anesthetic drug and is helpless. He is incapable of breathing by himself. The anesthesiologist must ventilate the patient; that is, he must actively supply the unconscious patient with each breath of squeezing a rubber bag. The anesthesiologist must actively maintain the deep level of anesthesia by modifying the concentration of inhaled anesthetic agent based on the patient's vital signs. Monitoring the patient is complicated by the fact that the patient is virtually invisible under surgical drapes. It must be done entirely by indirect methods. This method of anesthesia is an active process. It requires a professional who can devote his entire time and attention to it.

The contrast between this and what generally is done in Oral Surgery offices is striking. The intent is not to place the patient in a deep plane of anesthesia. The patient is kept very light, only occasionally may his protective reflexes be lost and he breathes normally without assistance. Drugs used to achieve this state are often tranquilizers and painkillers, rather than potent inhalation anesthetics. Local anesthetics are an integral part of the technique. Under usual circumstances it would be impossible to remove a third molar without numbing the area also. The patient's face is not covered and the anesthesia team stands within one and a half feet of the patient's airway, focusing their attention on it. Breathing is constantly monitored in the most appropriate fashion by hearing it and observing it from an excellent vantage point. The patient's skin and lip color, also an excellent indicator of the patient's well-being, are constantly under close observation. Also we communicate with the patient. We ask them if they are comfortable, if they are felling well. Most of the time they are able to answer appropriately once local

anesthesia is established and the procedure is underway. In addition to these clinical signs, the blood pressure is checked at regular intervals and the pulse is continuously monitored by the anesthesia assistant. Heart and breath sounds are continuously monitored by way of a specially fitted stethoscope which fits into the oral surgeon's ear. In our practice, as well as in most others, the patient is monitored by a portable EKG machine which displays the electrical activity of each heartbeat, as well as the pulse rate. Please believe me, with this team approach to out-patient anesthesia the patient's vital signs are monitored closely with considerable duplication and confirmation of results.

This method of ultra-light general anesthesia is practiced not only throughout the United States, but throughout the world. Anesthesia is an integral part of oral surgery training programs. It is taught and practiced from UCLA to the Mayo Clinic, from the University of Washington to the University of Alabama. As the statistics supplied by Dr. Roberts indicate from samples across the country, the relative safety of ultra-light anesthesia is extraordinary.

Massachusetts	1 death/1,766,660
Ohio	1 death/1,750,000
California	1 death/430,000 improved to 0 deaths/1,285,000 following institution of on-site inspection

These figures compare very favorably with hospital statistics where there is one death in 30,000 to 40,000 anesthetics or with out-patient surgicenters where the ratio is 1 death per 150,000 anesthetics. The contrast in these figures is so great that it defies belief. How can anesthesia in an oral surgeon's office be so much safer than that provided by a trained individual in a hospital focusing his entire attention on the anesthetic. The answer lies in

the point I have been trying to make. The technique is different. It is a hybrid especially adapted for the requirements of oral surgery.

1. The procedures are short.
2. Local anesthesia plays an integral part.
3. The patient is kept very light. He is able to breathe for himself and in the majority of circumstances he is arousable with protective reflexes intact.

Again you have the right to be skeptical. What is wrong in Montana? What should be done? As you know, there is presently no regulation of anesthesia in dental offices. It is needed. Please consider what I have written objectively. The key to optimizing safety is through mandating proper educational requirements and through the on-site inspection process. This on-site inspection process is beneficial in two ways.

1. It is a powerful stimulus to the examinee to review his technique, facility and emergency procedures.
2. It is a certain method of assuring that anesthesia is being administered appropriately.

This is the tact that has been taken in virtually every state which has studied the matter. Enclosed is an example of rules which I have compiled from other states along with the source legislation. It is rules such as these that should be developed by the State Board of Montana. In order to achieve this end the board must be empowered to enact such rules by passage of HB 290 and strong positive assurance, perhaps written, must be extracted from the board that they will in fact move with dispatch in adopting such rules. I believe that under the present circumstances the mood in the state has changed and the board will consider the enactment of strong rules a high priority. Should you consider legislative direction to the board a necessity, please consider an additional

amendment to HB 235 which I have listed on the front sheet as No. 5. It provides for the on-site inspection of out-patient anesthesia practices, the key to upgrading safety in out-patient anesthesia. Note also that it is essential for the phrase "or having at a minimum special training in monitoring patients during anesthesia and a current basic life support certificate" to be retained in Item No. 3 of the first page. I have tried to show you by explaining the unique characteristics of out-patient anesthesia that the presence of two people highly trained in anesthesia is an unnecessary and impractical redundancy. The people assisting are not dental assistants, their training is quite different and unique. They are trained to monitor BP, pulse, and through experience become keen observers of respiration and skin color. They are trained to respond to the unique emergencies that may develop during a procedure and all have formal CPR training. They have various backgrounds. To illustrate, two worked as Doctors' Assistants to cardiologists, one worked as a Doctor's Assistant to a pediatrician, one is a trained operating room technician and one worked for two oral surgeons in other cities before being employed by us. All are mature, responsible and intelligent individuals. We have had nurses in our employ and would have no objection to hiring one or more of them again; however, we did not find that they offered any particular advantage. Also, on a related issue, I worked in an oral surgical practice in Tacoma, Washington, which employed a nurse anesthetist. It was my experience there that patients were placed in much deeper plans of anesthesia and were certainly no better monitored than is done with our present method.

Ultra-light out-patient anesthesia is very adaptable and is modified with individual circumstances. It is not a rigid technique. It is a spectrum which

varies from slight dulling of the sensorum and reduction in anxiety levels to loss of consciousness. Between Dr. Torgerson and myself we have employed it over a combined total of 23 years in thousands of cases. Our method has been used on two of my children, Dr. Torgerson's wife, numerous members of our staff, numerous physicians and their families, numerous dentists and their families. It is very safe, convenient, and provided at literally one-tenth to one-twentieth of the cost of a hospital anesthetic experience.

This letter is lengthy, but does not contain all the information I would like you to have. I would, therefore, welcome the opportunity to talk to you further at your convenience on this subject. Please feel free to contact me at any time in this regard. My home telephone number is 721-2284; my office number is 728-6840.

Very sincerely yours,

Mark H. Nedrud

Proposed Amendment to House Bill 235

1. Title, page 1, line 5.
Following: "ANESTHESIOLOGIST"
Strike: "OR"
Insert: ","
Following: "ANESTHETIST"
Insert: ", OR OTHER TRAINED PROFESSIONAL"

2. Page 4, line 5.
Following: "anesthesia."
Insert: "(1)"

3. Page 4, line 8.
Following: "by"
Insert: ":
(a)"

4. Page 4, line 10.
Following: "examiners"
Strike: "or by"
Insert: ";
(b)"

5. Page 4, line 11.
Following: "nursing"
Strike: "."
Insert: "; or

(c) a person with at least one year postgraduate training in the administration of general anesthesia.

(2) No person engaged in the practice of dentistry or oral surgery may administer a general anesthetic to any other person unless he has satisfied the requirements of the board of dentistry for training in the administration of general anesthesia and in the treatment of the complications thereof.

(3) No person engaged in the practice of dentistry or oral surgery may perform any dental or surgical procedure upon another person under general anesthesia unless the vital signs of the patient are continually monitored by another health professional person, having no other duties and who is trained in the administration of general anesthesia or having, at a minimum, special training in monitoring patients during anesthesia and a current basic life support certificate.

(4) The facility in which general anesthesia is to be administered must be equipped with drugs and equipment to safely administer anesthesia agents, to monitor the well-being of the patient under general anesthesia, and to treat the complications of general anesthesia."

(5) Prior to granting of general anesthesia privileges the Montana State Dental Board shall require an on site inspection of the facility, equipment and personnel to determine if, in fact, the aforementioned requirements have been met. This evaluation shall be carried out in a manner following the principles but not necessarily the specifics described in the American Society of Oral Surgeons Office Anesthesia Emergency Self Evaluation Manual. The evaluation shall be carried out by a team of consultants approved by the Montana State Dental Board. The examination shall be carried out regularly. Intervals between examinations shall not exceed 5 years.

RECEIVED JAN 30 1985

Copies sent members Board of Dentistry
Lisa Casman
MDA ex cte
MDA oral surgeons
Leo Carson

3. Page 1 Strike lines 18-25

Page 2 Strike lines 1-5

Page 1 Beginning at line 18

Following " part 18," of line 17, insert:

3. " General anesthesia defined" The elimination of all sensations by a state of unconsciousness. The unconscious patient is defined as one without intact proprioceptive reflexes including the inability to maintain an airway and one who is incapable of rational responses to questions on command. This definition does not limit the use of conscious sedation or nitrous oxide analgesia and pertains only to general anesthesia.

BOARD OF DENTISTRY

1985 LEGISLATION:

a. "37-4-101(i) Administers an anesthetic of any nature in connection with a dental operation or in connection with a non-dental operation, provided he has met requirements for administering anesthetics as established by rules adopted by the Board.

b. "37-4-205 The Board may adopt, amend, or repeal rules necessary for the implementation, continuation, and enforcement of this chapter in accordance with the Montana Administrative Procedures Act. Rules adopted by the Board under this section may include, but not be limited to such subjects as false deceptive or misleading advertising by licensees, fee information, areas of practice specialization, personal information, quality of service, warning or disclaimers.

ARIZONA

ARTICLE 8 GENERAL ANESTHESIA

R4-11-801 Definitions

For the purpose of these Rules, general anesthesia shall be defined as the elimination of all sensations accompanied by a state of unconsciousness. The unconscious patient is defined as one without intact protective reflexes, including the inability to maintain an airway, and one who is incapable of rational responses to question on command. This definition does not limit the use of intravenous sedation or nitrous oxide analgesia and pertains only to general anesthesia.
(adopted March 28, 1978)

R4-11-802 Guidelines and rules

A. In order to be responsible for the administration of general anesthesia (see definition) on an outpatient basis, the dentist must show evidence that he or she:

1. Has a properly equipped facility for the administration of general anesthesia, staffed with a supervised team of auxiliary personnel capable of reasonably handling procedures, complications, and/or emergencies incident thereto. Adequacy of the facility and competence of the anesthesia staff shall be determined by the consultants appointed by the Board of Dental Examiners as outlined in R4-11-803 of these Rules.
2. Has notified the Board of Dental Examiners in writing that he or she does administer or plans to administer general anesthesia in the course of dental practice.

NOTE

B. The dentist who is performing the procedure for which general anesthesia was induced, shall not administer the general anesthesia and monitor the patient without the presence and assistance of the staff or one of its members described in R4-11-802.A.1.
(adopted March 28, 1978)

R4-11-803 Mechanism of implementation

A. In order for a licensed dentist to assume responsibility for the administration of general anesthesia on an outpatient basis, the Board of Dental Examiners will require an on-site inspection of the facility, equipment, and personnel, to determine if the requirements described above (R4-11-802.A.1) actually exist. This evaluation shall be carried out in a manner described in the Arizona State Board of Dental Examiner's Office Anesthesia Emergency Self Evaluation Manual. The evaluation shall be carried out by a three (3) person team of consultants, appointed by the Board, and made up of members of the American Society of Oral Surgeons and/or fellows of the American Dental Society of Anesthesiology and/or general practitioners engaged in the providing of an outpatient general anesthesia service. At least two of the consultants must be practitioners utilizing general anesthesia in an outpatient facility other than an institution. A report concerning the one-site evaluation shall be made to the Board for their guidance.

B. Within one (1) year of the effective date of these Rules, each dentist previously assuming responsibility for administration of general anesthesia, shall have an on-site evaluation of the facilities, equipment, and personnel as required and described above (R4-11-803.A), if deemed appropriate or advisable by the Board.

C. On the effective date and from that date forward, any dentist not previously assuming responsibility for the administration of general anesthesia as part of his or her practice, but wishing to do so, must be subject to all rules established by the Board as outlined by the guidelines of this document.

D. For licensed practitioners wishing to begin administering general anesthesia after adoption of these Rules, a thorough investigation by an on-site evaluation, and a subsequent report must be made by the consultants to the Board to insure the safety and well being of patients of that office.

E. The Board shall bi-annually re-evaluate all facilities that administer general anesthesia. Such re-evaluation to be carried out in a manner similar to that described in R4-11-803.A of this document. At the discretion of the Board, and without regard to the bi-annual re-evaluation of the anesthesia permit, a re-evaluation may be instituted with just cause. In any instance where the Board has decided to re-evaluate a facility, the Board is required to present in writing the specific date on which it will make the re-evaluation. This notice of re-evaluation must be sent at least 30 days prior to the date selected for the re-evaluation to the practitioner or practitioners registered to administer general anesthesia at that facility. (adopted March 28, 1978)

R4-11-804 Reports of adverse occurrences

All licensees engaged in the active practice of dentistry in the State of Arizona must submit a complete report within a period of thirty (30) days to the Arizona State Board of Dental Examiners regarding any mortality or unusual incidents which occur in dental outpatient facilities, producing temporary or permanent physical or mental injury of patients as a direct result of the administration of general anesthesia.
(adopted March 28, 1978)

MANAGEMENT OF PAIN, ANXIETY AND EMERGENCIES - GENERAL GUIDELINES

Pain and anxiety management can be defined as the application of various physical, chemical, and psychological modalities to the prevention and treatment of patients' preoperative, operative, and post-operative apprehension and pain.

Proper management of pain, anxiety and emergencies requires training in selection and use of techniques, agents and armamentarium and preanesthetic evaluation. Management of pain and anxiety should be based upon the professional judgment of the dentist after consideration of the needs and desires of the patient.

The management of pain and anxiety attempts to achieve the following goals for the patient:

——— Relief of anxiety, apprehension and fear
——— Pain-free treatment
——— Freedom from pain and anxiety during the post-treatment period

There are a variety of terms used to describe the different methods of managing pain and anxiety. The following are definitions of the terms used in this document:

Sedation: The calming of a nervous, apprehensive individual by the use of systemic drugs, without inducing loss of consciousness, where agents may be given orally, parenterally or by inhalation.

Analgesia: The diminution or elimination of pain in the conscious patient.

Local Anesthesia: The elimination of sensations, especially pain, in one part of the body by the topical application or regional injection of a drug.

General Anesthesia: The elimination of all sensations, accompanied by a state of unconsciousness.

Premedication: Premedication by one of the following routes; oral, rectal, parenteral or inhalation results in relief of apprehension, anxiety and fear, provides elevation of the pain threshold and potentiates the action of local, inhalation and parenteral anesthetic agents. Nitrous oxide analgesia is in essence a form of premedication. The patient should be properly accompanied after premedication by a responsible individual.

Postoperative Care: Adequate postoperative instructions and postoperative medications, as well as appropriate provisions for post-treatment professional care should be provided.

Emergencies: A plan for management of emergencies should exist and be rehearsed on a regular basis. See the general guidelines for "Preventive Measures" for detailed information on this subject.

Since many of the features of evaluation in anesthesia, anxiety and pain control are common to all of dental practice, they will not be discussed in detail in this section. Only those aspects that have specific importance for this area will be included.

Article 2.6. Continuing Education

1645. Effective with the 1974 license renewal period, if the board determines that the public health and safety would be served by requiring all holders of licenses under this chapter to continue their education after receiving such license, it may require, as a condition to the renewal thereof, that they submit assurances satisfactory to the board that they will, during the succeeding two-year period, inform themselves of the developments in the practice of dentistry occurring since the original issuance of their licenses by pursuing one or more courses of study satisfactory to the board or by other means deemed equivalent by the board.

The board shall adopt regulations providing for the suspension of the licenses at the end of such two-year period until compliance with the assurances provided for in this section is accomplished.

(Added by Stats. 1975, Ch. 872.)

Article 2.7. Use of General Anesthesia

1646. (a) General anesthesia, as used in this article, consists of the use of any drug, element, or other material which results in the elimination of all sensations accompanied by a state of unconsciousness.

(b) The conscious patient, as opposed to the patient in an unconscious state, is defined, for purposes of this article, as one with intact protective reflexes, including the ability to maintain an airway and who is capable of rational response to question or command.

1646.1. No dentist shall administer or directly supervise the administration of general anesthesia on an outpatient basis for dental patients unless such dentist possesses a permit of authorization issued by the board. The dentist holding such permit shall be subject to review by the board and such permit shall be renewed annually.

This article shall not apply to the administration of local anesthesia or to conscious patient sedation.

1646.2. In order to receive a permit for the use of general anesthesia, a dentist shall apply to the board on an application form prescribed by the board. The dentist must submit an application fee and produce evidence showing that he or she has completed a minimum of one year of advanced training in anesthesiology and related academic subjects approved by the board, or equivalent training or experience approved by the board, beyond the undergraduate school level. The board may, by regulation, establish additional requirements under this section.

1646.3. Prior to the issuance or renewal of a permit for the use of general anesthesia, the board may, at its discretion, require an onsite inspection and evaluation of the facility, equipment, personnel, licentiate, and the procedures utilized by such licentiate. Every person issued a permit under this article shall have an onsite inspection at least once in every five-year period. An onsite inspection performed by a public or private organization may be accepted by the board in satisfaction of the requirements of this section.

1646.4. On or before January 1, 1981, each dentist who has been using general anesthesia prior to the enactment of this chapter, shall make a permit application to the board if such dentist desires to continue to use

general anesthesia.

The board shall issue the permit to such dentist and may only refuse if, at the board's discretion, an onsite inspection and evaluation of facilities, equipment, personnel, the licentiate, and the procedures utilized by such licentiate indicates that a permit should not be issued.

1646.5. New applicants not subject to Section 1646.4, who are otherwise properly qualified, may be granted a temporary permit by the board for one year, and such permit may be renewed at the option of the board.

1646.6. The board shall renew permits for the use of general anesthesia annually, unless the holder is informed in writing 60 days prior to such renewal date that a reevaluation of his or her credentials is to be required. In determining whether such reevaluation is necessary, the board shall consider such factors as it deems appropriate, including, but not limited to, patient complaints and reports of adverse occurrences.

A reevaluation may include an onsite inspection of the facility, equipment, personnel, licentiate, and the procedures utilized by such licentiate.

1646.7. The fee for a permit or renewal under this article shall not exceed fifty dollars ($50). The fee for an onsite inspection shall not exceed one hundred fifty dollars ($150).

1646.8. The board may contract with private organizations expert in dental outpatient anesthesia to perform onsite inspections. The board may not, however, delegate its authority to issue permits or to determine the persons or facilities to be inspected.

1646.9. Violation of any provision of this article may result in the revocation or suspension of the dentist's permit, license, or both, or the dentist may be reprimanded or placed on probation. The proceedings under this section shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the board shall have all the powers granted therein.

(Added to Stats. 1979, Ch. 886.)

Continuing Education

1647. (Repealed by Stats. 1975, Ch. 872.)

Article 3. Registration

Registration

1650. Every person who is now or hereafter licensed to practice dentistry in this State shall register on forms prescribed by the board, his place of practice with the Secretary of the State Board of Dental Examiners, or, if he has more than one place of practice, all of said places of practice, or, if he has no place of practice, to so notify the secretary of the board. A person licensed by the board shall register with the secretary within 30 days after the date of his license.

(Amended by Stats. 1963, Ch. 606.)

Change of Place of Practice

1651. Any dentist who removes his place of practice shall register each change made by him within one month after making said change. In the event any licensed dentist fails to notify the board of any change in the address of his place of practice within the time prescribed by this section,

(E) Dentists should not claim or imply superiority by using the phrases, "Specialist in. . ." or "Specialist on. . ." The use of the phrase, "Practice limited to. . ." or "Diplomate, American Board of. . ." is required.

Orig. Effective Date August 1, 1974
Former Rule Number OE-5-04
Promulgated under RC S 119
Statutory Authority: RC S 4715.03

4715-5-05. Use of General Anesthesia.

(A) No dentist shall employ or use general anesthesia on an outpatient basis for dental patients, unless such dentist possesses a permit of authorization issued by the Ohio State Dental Board. The dentist holding such permit shall be subject to review and such permit must be renewed annually. This rule is subject to the exception noted in Part D of this rule.

(B) In order to receive such permit, the dentist must apply on a prescribed application form to the Ohio State Dental Board, submit a fifty dollar ($50.00) application fee and produce evidence showing that he or she:

(1) Has completed a minimum of one (1) year of advanced training in anesthesiology and related academic subjects (or its equivalent) beyond the undergraduate dental school level in a training program as described in Part 2 of the Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry; or

(2) Is a Diplomate of the American Board of Oral Surgery, or is eligible for examination by the American Board of Oral Surgery, or is a member of the American Society of Oral Surgeons; or,

(3) Is a Fellow of the American Dental Society of Anesthesiology; or,

(4) Employs or works in conjunction with a trained M.D. or D.O. who is a member of the anesthesiology staff of an accredited hospital, provided that such anesthesiologist must remain on the premises of the dental facility until any patient given a general anesthetic regains consciousness; and,

(5) Has a properly equipped facility for the administration of general anesthesia staffed with a supervised team of

auxiliary personnel capable of reasonably handling procedures, problems, and emergencies incident thereto. Adequacy of the facility and competence of the anesthesia team may be determined by the consultants appointed by the Board as outlined in Part C of this rule.

(C) Prior to the issuance of such permit, the Ohio State Dental Board may, at its discretion, require an on-site inspection of the facility, equipment and personnel to determine if, in fact, the aforementioned requirements have been met. This evaluation shall be carried out in a manner following the principles, but not necessarily the specifics, described in the American Society of Oral Surgeons Office Anesthesia Emergency Self Evaluation Manual. The evaluation shall be carried out by a team of consultants appointed by the Ohio State Dental Board.

(D) Within one (1) year of the effective date of these rules, each dentist who has been using or employing general anesthesia prior to adoption of this rule shall make application on the prescribed form to the Ohio State Dental Board if such dentist desires to continue to use or employ general anesthesia. If he meets the requirements of this rule he shall be issued such permit. An on-site evaluation of the facilities, equipment, and personnel may be, but is not necessarily, required prior to issuance of such permit.

(E) For new applicants who are otherwise properly qualified a temporary provisional permit of one year in duration may be granted by the Board, based solely upon the credentials contained in the application, pending complete processing of the application and thorough investigation via an on-site evaluation as described in Part C of this rule.

(F) The Board shall without charge renew the permit annually unless the holder is informed in writing that a re-evaluation of his credentials and facility is to be required. In determining whether such re-evaluation is necessary, the Board shall consider such factors as it deems pertinent including, but not limited to, patient complaints and reports of adverse occurrences. Such re-evaluation shall be carried out in the manner described in Part C of this rule.

(G) The Ohio State Dental Board, based on formal application stating all particulars which would justify the granting of such permit, may grant the permit authorizing the use or employment of general anesthesia to those licensed dentists who have been utilizing general anesthesia in a competent and effective manner in the past, but who have not had the benefit of formal training as

outlined in this rule.

Orig. Effective Date August 1, 1974
Former Rule Number DE-5-05
Promulgated under RC S 119
Statutory Authority: RC S 4715.03

4715-5-06. Reports of Adverse Occurrences.

(A) All licensees engaged in the practice of dentistry in the State of Ohio must submit a complete report within a period of thirty (30) days to the Ohio State Dental Board of any mortality or other incident occurring in the outpatient facilities of such dentist which results in temporary or permanent physical or mental injury requiring hospitalization of said patient during, or as a direct result of, dental procedures or anesthesia related thereto.

(B) Failure to comply with this rule when said occurrence is related to the use of general anesthesia may result in the loss of such permit described in Rule 4715-5-05.

Orig. Effective Date August 1, 1974
Former Rule Number DE-5-06
Promulgated under RC S 119
Statutory Authority: RC S 4715.03

4715-7-01. Dental Intern Certificate.

(A) An application for a dental intern certificate must be certified by both the appointing officer or directing head of an institution employing the applicant and the chief of dental services of said institution. The application shall contain a statement signed by the applicant as to his knowledge of the dental laws of this state.

(B) A dental intern certificate shall be issued for one year, subject to annual renewal. Such certificate shall be issued only to such applicant who is qualified in accordance with Section 4715.16, Ohio Revised Code, and other provisions of this Rule, and who is enrolled in an internship program that has been approved or accredited by the Council on Education of the American Dental Association and the Ohio State Dental Board.

(C) A dental intern certificate entitles such certificate holder to practice dentistry only within the provisions of the approved internship program and according to Section 4715.16, Ohio Revised Code.

Orig. Effective Date August 1, 1974

recognized dental or medical schools or colleges must be approved in advance by the Texas State Board of Dental Examiners.

382.19.18 ANESTHESIA AND ANESTHETIC AGENTS

.001. Definitions:

For the purposes of this Rule the following definitions shall apply: (1) Anesthesia - loss of feeling or sensation, especially loss of the sensation of pain; (2) General Anesthesia - a state of unconsciousness, produced by anesthetic agents, with absence of pain sensation over the entire body and a greater or lesser degree of muscular relaxation; (3) Analgesia - absence of sensibility to pain; designating particularly the relief of pain without loss of consciousness; (4) Narcolocal Analgesia - local analgesia preceded by premedication; (5) Relative Analgesia - in dental anesthesia, a maintained level of conscious-sedation, short of general anesthesia, in which the pain threshold is elevated, usually induced in inhalation of nitrous oxide and oxygen; (6) Analgesic Agent - an agent that alleviates pain without causing loss of consciousness; (7) Conscious Sedation - in dental anesthesia a state of sedation in which the conscious patient is rendered free of fear, apprehension, and anxiety through the use of pharmacological agents. (Reference: Dorland's Illustrated Medical Dictionary, 25th Edition.)

.002. Professional Requirements:

(a) General Anesthesia - All parenteral medication (Intramuscular (I.M.), Intravenous (I.V.), Subcutaneous (S.C.), or Submucosal (S.M.) or Rectal medications for general anesthesia and/or inhalation general anesthetic agents shall be induced and maintained only by a dentist licensed by the Texas State Board of Dental Examiners and practicing in Texas, a physician or osteopath licensed by the Texas State Board of Medical Examiners, or a certified Registered Nurse

Anesthetist licensed in Texas. Each of the aforementioned professionals must have successfully completed a course in anesthesiology of at least six (6) months duration, approved by the Texas State Board of Dental Examiners (such as a graduate of a recognized and approved anesthesiology course of training or of an accredited hospital anesthesia training program approved by the American Dental Association Council on Dental Education) or is a licensed professional who has regularly administered parenteral or rectal general anesthetic medications and/or inhalation general anesthetic agents for the ten year period immediately before January 1, 1986. It shall be incumbent upon the licensed dentist utilizing general anesthesia in the dental office to present documented proof of compliance with the above requirements to the Texas State Board of Dental Examiners. A dentist approved for office general anesthesia, as well as certified registered nurse anesthetists and physician anesthesiologists shall be automatically approved for all forms of parenteral or rectal conscious sedation as well as nitrous oxide and oxygen conscious sedation.

(b) Parenteral Conscious Sedation (I.M., I.V., S.C., or S.M.) and Rectal Conscious Sedation - Specific routes of administration of parenteral or rectal medications for conscious sedation may be administered by a dentist licensed in the State of Texas and practicing in Texas, who has successfully completed a course in the particular route of administration being utilized, approved by the Texas State Board of Dental Examiners (such as an approved advanced educational course given by a Texas dental school that follows the Guidelines of Teaching the Comprehensive Control of Pain and Anxiety in Dentistry established by the American Dental Association Council on Dental Education and the American Dental Association Council on Dental Education and the American Dental Society of Anesthesiology or a specialty residency program approved by the American Dental Association Council on Dental Education where the particular route or routes of parenteral or rectal conscious sedation were

routinely utilized - I.V., I.M., S.C., or S.M.) or is a licensed dentist who has regularly practiced dentistry and has regularly administered conscious sedation medications via one or more particular routes for the ten year period immediately before January 1, 1986. Physicians administering parenteral or rectal medication to dental patients for dental procedures shall be governed by the Rules and Regulations set forth in the Texas Medical Practice Act. It shall be incumbent upon any licensed dentist utilizing parenteral or rectal routes for conscious sedation in the dental office to present documented proof of compliance with the above requirements to the Texas State Board of Dental Examiners.

(c) Nitrous Oxide and Oxygen Conscious Sedation - Nitrous Oxide and Oxygen for conscious sedation may be induced and maintained by a dentist, licensed in the State of Texas and practicing in Texas, who has successfully completed a course of instruction in Nitrous Oxide and Oxygen conscious sedation which has been approved by the Texas State Board of Dental Examiners or is a licensed dentist who has regularly administered Nitrous Oxide and Oxygen conscious sedation for the five (5) year period immediately before January 1, 1980. It shall be incumbent upon any licensed dentist utilizing this modality of conscious sedation in the dental office to present documented proof of compliance with the above requirement to the Texas State Board of Dental Examiners.

EXCEPTIONS TO THE ABOVE REGULATIONS (a), (b), AND (c) WILL BE MADE ONLY BY THE TEXAS STATE BOARD OF DENTAL EXAMINERS.

(d) The inducing and administering of any anesthesia or anesthetic agent producing anesthesia, general anesthesia, analgesia, narcolocal analgesia, relative analgesia, or conscious sedation, whether for the control of anxiety or pain or to induce relaxation or cooperation of a dental patient, shall only be induced and administered as provided in the rules governing anesthesia and anesthetic agents.

.003. Emergency Equipment:

All dentists practicing in Texas shall have and maintain emergency equipment appropriate for patient resuscitation. Such equipment shall include a positive pressure breathing apparatus including oxygen. All emergency equipment shall be present in the dental office and shall be utilized by the licensed professional or under his direct supervision. Training of emergency procedures shall be given to all dental personnel.

.004. Current History and Evaluation:

Each Dentist licensed by the Texas State Board of Dental Examiners and practicing in Texas shall be responsible for a current history and evaluation of all dental patients.

.005. Application for Permit:

Within two (2) years (by October 1, 1977) of the effective date of these rules, each dentist licensed and practicing in Texas who has been using or employing intravenous drugs or agents and/or inhalation anesthetic agents prior to the adoption of this rule, shall make application to and on the forms prescribed by the Texas State Board of Dental Examiners if such dentist desires to continue to use or employ intravenous drugs or agents and/or inhalation anesthetic agents. If he meets the requirements of this rule, he shall be issued a permit. An on-site evaluation of the facilities, equipment, and personnel may be, but is not necessarily, required prior to issuance of such permit. A permit issued hereunder must be annually renewed by the holder who shall furnish such information as the Board may require and pay a renewal fee as authorized by law.

.006. Office Team:

(a) General Anesthesia - A dentist licensed by the Texas State Board of Dental Examiners, practicing in the State of Texas, who has been approved by the Board to induce and maintain parenteral or rectal general anesthetic medications and/or inhalation

general anesthetic agents, when not employing a physician anesthesiologist, certified registered nurse anesthetist, or another dentist approved for general anesthesia, must employ a personally supervised team of auxiliary personnel who shall be capable of reasonably handling procedures, problems and emergencies incident to the use of general anesthesia. The operating dentist, who is assuming responsibility for administering the general anesthesia, shall induce and maintain general anesthesia with the aid of properly trained office auxiliary personnel. Evaluation of adequacy of the facility and competence of the anesthesia may, at the Board's discretion, be determined by the consultants appointed by the Board. This evaluation shall be carried out in a manner following the principle but not necessarily the specifics described in the American Society of Oral Surgeons Office Anesthesia Manual.

(b) Conscious Sedation - A dentist licensed by the Texas State Board of Dental Examiners, practicing in Texas, who has been approved by the Board to administer parenteral or rectal conscious sedation medications or inhalation analgesics shall be staffed with a personally supervised team of auxiliary personnel capable of reasonably handling procedures, problems, and emergencies incident to the use of conscious sedation.

.007. CPR Course Requirement:

All dentists licensed and practicing dentistry in Texas who have not taken and passed the American Heart Association or the American Red Cross sponsored course in Cardiopulmonary Resuscitation since January 1, 1975 are required to take and pass such course before October 1, 1977. (See CPR requirement for new licensees.)

.008. Report of Injury (Morbidity) or Death (Mortality) in the Office or Hospital:

All licensees engaged in the practice of dentistry in the State of Texas must submit a written report within a period of 30 days to

the Texas State Board of Dental Examiners after the occurance of any incident, injury (morbidity), or death (mortality) resulting in temporary or permanent physical or mental disability or injury to any patient for whom said doctor has rendered any dental or medical service. Routine hospitalization to guard against postoperative complications or for patient comfort need not be reported where complications do not thereafter result in injury (morbidity) or death (mortality) as herein before set forth.

.009. Special Considerations:

A licensed professional not qualifying under the foregoing rules may apply to the Board for special consideration.

.010. Advisory Consultants:

The Texas State Board of Dental Examiners shall appoint Advisory Consultants to aid the Board to determine the adequacy of the facility inspected and the competence of all applicants under these rules.

.011. Effective Date of Rules:

This Rule shall become effective on October 1, 1975.

.012. Authority to Demonstrate Anesthesia:

Any course, clinic, lecture, or demonstration involving the use of any anesthesia or anesthetic agent except local or topical anesthesia must have prior approval of the Texas State Board of Dental Examiners unless such course, clinic, lecture, or demonstration is given and supervised within the confines of an established and recognized school of dentistry or medicine.

.013.
Guidelines for N_2O/O_2 Conscious Sedation:

It is recognized that many dental practitioners have acquired a high degree of competency in the use of N_2O/O_2 conscious sedation by a combination of short courses and

experience. Except for such dental practitioners who have been licensed in Texas prior to January 1, 1980, and who have filed the required anesthesia report with the Texas State Board of Dental Examiners, the board will require the following beginning January 1, 1980:

(1) After January 1, 1980, dentists who are licensed to practice dentistry in Texas and who desire to use N_2O/O_2 must produce satisfactory evidence of completion of a didactic and clinical course of instruction in N_2O/O_2 conscious sedation. Such courses of instruction shall be directed by qualified instructors with advanced education in comprehensive pain control and with broad clinical experience in N_2O/O_2 conscious sedation. All such courses of instruction must be approved by the Texas State Board of Dental Examiners.

(2) The minimum requirements after January 1, 1980, shall be:

(A) Cardiopulmonary resuscitation (CPR)--four hours

(B) Continuing education course in the prevention and management of emergencies in dental practice. Such eight-hour course must be approved by the Texas State Board of Dental Examiners--eight hours

(C) Didactic--Pharmocodynamics of N_2O/O_2 conscious sedation--four hours

(D) Clinical experience under direct supervision--six hours

382.19.19 DOUBLE DEGREES

.001. Dentists Possessing Additional Earned Degrees:

Dentists who are also authorized to practice medicine in Texas may use the initials "M.D." along with "D.D.S.". Such "double degree" dentists may use "M.D." in any letter, sign, newspaper listing, telephone directory or other media permitted by these Rules and Regulations. A Texas dental licensee who has earned certificates in two (2) dental specialties may apply to the Board to grant him permission to announce limitation of practice in both specialties.

382.19.20 ADVERTISING

.001. Routine Dental Services:

A routine dental service is defined as that service which does not alter the natural dentition or supporting structures. Any advertised routine dental service shall include all professionally recognized components within generally accepted standards and precludes the purchase of any additional goods or services in order to receive the advertised service. The Texas State Board of Dental Examiners has determined that the following listed dental services are routine dental services and may be advertised in conformity with the laws and rules and regulations governing same, to-wit:

(1) Oral examination shall include the examination of all hard and soft tissues of the oral cavity by a dentist, and the charting of such findings.

(2) X-rays shall include the exposing and developing and interpretation of same.

(3) Prophylaxis shall include all necessary hard and soft deposit removal and the polishing of exposed tooth structure.

(4) Full or complete denture(s) are routine where performed for an edentulous patient after oral examination and interpretation and determined by the dentist that no alteration of the supporting structures is necessary.

(5) Partial denture(s) are routine for a patient if, after oral examination and interpretation and determined by the dentist, no alteration of the dentition or supporting structures is necessary.

.002. Time Requirements on Advertising:

Any advertisement of Routine Dental Services with or without price or fee thereof permitted under Board rules shall be valid and binding on the advertising dentist for not less than six months following the date it is last offered and the dentist offering same shall honor all patient requests for such dental service made by dental patients within the six-month period following the last date such advertisement was presented to the public; further, all such services must be

VISITOR'S REGISTER

HOUSE Human Services and Aging COMMITTEE

BILL HB 228 DATE 1/23/85

SPONSOR Winslow

NAME	RESIDENCE	REPRESENTING	SUPPORT	OPPOSE
Molly Munro	Helena	Self	✓	
Joe Gershaw	Helena	AARP/Leg Legislative	✓	
Walter J. Taylor	Missoula	Legacy Legislature	✓	
~~Ed Eden DDS~~	~~HAVRE~~	~~Mont. Dental Assoc~~		
~~John M. Coleman~~	~~B~~			
Dorothy M. Johnson	Helena			✓
Colleen Wood	Bozeman			✓
Sam Byron	Helena	M.S.C.A.	✓	
Claire Brusendine	Clancy			
Don L Brusendine				
Doug Olson	Helena	Elderly Legal Serv Senior Office Legal Comm Serv.	✓	
Ed Kreisler	1731 Sth Helena	NARPE	✓	
Joe Sedgwick	Kalispell	Self	✓	
ELSIE FOX	MILES CITY	SELF	✓ X	
Everett VanDenEeden	Billings	self	✓ X	~~No Position~~
Fred Wood	Livingston	SELF	✓ X	~~Neutral~~
Helen Lang	Helena	Montana Hosp. Assn	✓	
Jarvis Tutty	Missoula	HD 56	✓	
Chad Smith	Helena	Mont Hosp Assn	amend	
Jerry Loendorf	Helena	Mt. Med Assn		
Chris Williams	Helena	Self	✓	

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR LONGER FORM.

WHEN TESTIFYING PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

FORM CS-33

VISITOR'S REGISTER

HOUSE _____ COMMITTEE

BILL 228 DATE _____

SPONSOR _____

NAME	RESIDENCE	REPRESENTING	SUPPORT	OPPOSE
David Lackman	Helena	MT Public Health Assn	X	
Lee Waingartner	Helena	MT Health Care Assn M.S.I.C.A.	X	
Earl Reilly	Helena	Mont. Senior Citizens Assn	X	
Charles Briggs	Helena	Governor's Office	X	

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR LONGER FORM.

WHEN TESTIFYING PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

FORM CS-33

VISITOR'S REGISTER

HOUSE Human Services and Aging COMMITTEE

BILL HB 235 DATE 1/23/85

SPONSOR Peck

NAME	RESIDENCE	REPRESENTING	SUPPORT	OPPOSE
DOUG SMITH DMD	P.O. Box 266 BIGFORK	SELF Amendments		X
Paul G. Sims DDS	105 BLACKTAIL COURT	Butte MONTANA ORAL & MAXILLOFACIAL SURGEON		X
R B Torgerson DDS	1547 So. Higgins Missoula Montana	Mt. Oral & Maxillofacial Surgeons		X
Jerry Kegel	2121 Rush Ft. Harr.	Self	X	
ROBERT FRITZ	907 HELENA AVE HELENA	MT. ST. BOARD OF DENTISTRY		X
Jim Olson	215 NORTH 10th Hamilton	plus Mt ST board of Dentistry		X
8— Betty Ogden	8715 N Montana	self		X
8 Karen Nelson	904 E Middle Mis	self		
Jerry Lippert	Carter Mont	self	X	
Joan Lippert	Carter Mont	self	X	
Barbara Kegel	Fort Benton Mt	self	X	
Fred B Kegel	Ft Benton Mt	Self	X	
Jackie Lippert	Ft. Benton, Mt.	Self	X	
Kelly Donnelan	Chester, MT	Self	X	
Joe Shipman	Lewistown, Mont	Self	X	
[illegible]	Moore MT	Self	X	
Jackie Kegel	Thompson Falls, MT	self	X	
Kathryn Kegel Rowe	Loma, MT	self	X	
Harry Rowe	Loma, MT	Self	X	
Clint Kegel	Thompson Falls MT	Self	X	

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Rep. Paul Rapp-Svrcek T. Falls, MT Self X

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Rep Bob Bachin Havre, Mt. Self X

FORM CS-33

VISITOR'S REGISTER

HOUSE _____ COMMITTEE

BILL 235 DATE _____

SPONSOR Peck

NAME	RESIDENCE	REPRESENTING	SUPPORT	OPPOSE
John W. Hart	818 29th Ave NE Great Falls	Self	X	
John Talmen	Butte	MT Dent Assn		✓
[illegible]	HAVRE	Mt. Dent Assn		✓
[illegible]	Kalispell	self		
Don Peterson	Billings	Self		✓
Mark Nelsen	Missoula	Self		
Karl W. Hafer	Great Falls	Self		
Ed Crawford	Great Falls	Self MMA + MSA		
Brent Kuntz	KALISPELL	SELF	X	
H. Enderud	"	Self		
Frank Bianchi		Restaurant	X	
Clair Clark	Lewistown	Self	X	
Phillip D. Palm	"	"	X	
Stephen L. Black	Bozeman	MT Society of Oral Surgeons	X	
George Carson	BOZEMAN	MT. SOC. PEDIATRIC DENTISTS		✓
Sherry Kegel	Hare	Self	X	
ELSIE FOX	MILES CITY	SELF	X	
DAVID LACKMAN	HELENA	MT Public Health Assn	X	
Patrick G. Brannon	"	Myself.	X	
Lynda Brannon	Helena	myself	X	

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Peg M. Olsen Livingston SELF X

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Joan Bilyeu Helena SELF X

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