GEORGIA BOARD OF DENTISTRY
2 MLK Jr. Drive, SE, 11th Floor, East Tower
Atlanta, GA 30334
October 6, 2023
10:00 a.m.

The following Board members were present:
Dr. Michael Knight, President
Dr. Lacey Green
Dr. Glenn Maron
Dr. Larry Miles
Dr. David Reznik (via Teams)
Mr. Mark Scheinfeld
Dr. Jeffrey Schultz
Ms. Lisa Selfe
Dr. Lisa Shilman
Dr. JC Shirley
Dr. Brent Stiehl
Dr. Nancy Young

Staff present:
Eric Lacefield, Executive Director
Max Changus, Senior Assistant Attorney General
Thomas McNulty, Assistant Attorney General
Justin Cotton, Assistant Attorney General
Stacy Altman, Chief Investigator
Clint Joiner, Attorney
Brandi Howell, Business Support Analyst I

Visitors:
Dr. Jerry Cooper, Promethean Dental Systems
Kathy Mann
Dr. Gregg Codelli
Wesley Karcher, GANA
John Walraven, GANA
Dr. Stephan Holcomb, CRDTS
Dr. Skyler Holcomb
Emily Yona, ADSO
Ashton Blackwood, Dental College of Georgia
Dr. Ranjitha Krishna, Georgia Society of Periodontists
Dr. Sadja Gaud
Dr. Richard Weinman
Theresa G. Robertson, GDA
Dr. Lewis Petree, GDA
Pam Cushenan, GDHA
Tatiyana Matthews, GDHA
Elaine Kennedy, GDHA
Dr. Randy Kluender, Georgia School of Orthodontics
Callie Michael, Georgia School of Orthodontics
Dr. Tarek Elseweifi
Merrilee Gober, Medical Association of Georgia

Public Hearing

Dr. Knight called the public hearing to order at 10:04 a.m.

Rule 150-13-.01 Conscious Sedation Permits

Dr. Stephan Holcomb spoke to the Board. Dr. Holcomb stated that there is a considerable amount of controversy and concern regarding certain pieces of the proposed changes to Rule 150-13-.01 Conscious Sedation Permits. He further stated that there has not been a substantial enough review of the scientific material or of the impact of access to care. He continued by stating that he was sure there would be people that would be able to present scientific information to the Board, which he hopes the Board will take into

consideration. He requested the rule change be tabled in order for that material to be digested and allow additional time for the Board to get a full grasp of how it impacts access to care.

Mr. John Walraven, Georgia Association of Nurse Anesthetists, spoke to the Board. He stated that he submitted written comments only to Dr. Schultz. Mr. Lacefield responded by stating that Mr. Walraven's comments were received and provided to the full Board.

Mr. Wesley Karcher, Past President of Georgia Association of Nurse Anesthetists, spoke to the Board and read the following statement:
"Good morning and thank you to the Georgia Board of Dentistry and the Sedation Committee for allowing me to make public comments about the proposed rule for conscious sedation permits. My name is Wesley Karcher and I am a Certified Registered Nurse Anesthetist, or CRNA, here in Georgia. I am a past President for the Georgia Association of Nurse Anesthetists (GANA) and I am here today to make comments on behalf of the almost 1600 members of our organization.

My understanding for the impetus of this rule change is that there is a concern amongst the Board about patient safety related to the administration of certain drugs with a narrow margin of safety or no reversal medication. The problem seems to come from either a dentist performing both a procedure and the anesthetic at the same time or a dentist delegating the administration of anesthetic drugs to an underqualified provider, such as a tech or a dental assistant. In this sense, the concerns of both GANA and the sponsors of the proposed rule are wholly aligned.

As aligned as we are on patient safety, we believe the unintended consequences of this rule change, as it is currently written, would be to penalize a dentist utilizing a CRNA to provide anesthesia for their practice. The proposed rule would prevent that unqualified provider from using drugs they have not been adequately trained on, but the way it is drafted would also take tools out of a CRNA's toolbox and leave us only able to use versed and fentanyl for conscious sedation procedures. It is GANA's opinion that the utilization of a second qualified provider (such as a CRNA) that is solely focused on the anesthesia during a dental procedure is THE best way to maximize patient safety.

GANA would like to propose an amendment to the proposed rule that keeps the spirit of the rule change without limiting anesthesia options for patients whose dentist utilizes a second qualified anesthesia provider. A copy of our proposal has been provided to you which would carve out CRNSs from the proposed rule.

Section (12) would now read: (12) Drug Restriction: No dentist issued a conscious sedation permit pursuant to this Rule shall Administer any general anesthetic agent which has been identified by the Board of Dentistry in Rule 150-13-.01 as exhibiting a narrow margin for maintaining consciousness, unless such dentist (1) simultaneously holds a permit to perform deep sedation/general anesthesia procedures in that location, pursuant to Rule 150-13-.02, ***or (2) holds a moderate parenteral conscious sedation permit and is using a CRNA to administer conscious sedation pursuant to paragraph (6)(c) of this section.***

CRNA's are safely delivering anesthesia in this manner in 23 states that have no requirements for permits to perform anesthesia for dental procedures. I am not suggesting that the Board consider changes to the permit system today but tell you this to highlight how nearly half of the United States has increased access to sedation dentistry.

The success in these 23 states validates GANA's position that trying a CRNA-who has almost 10,000 hours of training and three years of direct hands-on anesthesia experience before graduating from an accredited CRNA training program-to the level of permit that a dentist has obtained is restricting patient access to

sedation dentistry with no data to show any corresponding increase to patient safety. GANA is ready to help Georgia's dentists increase access to care while also bringing down the costs associated with it.

Thank you again for allowing me the opportunity to speak to the Board about our mutual concerns about patient safety. GANA does not believe that a weekend course qualifies anyone to use drugs that the proposed rule seeks to limit.

I humbly ask for your consideration of our amendment and I am available for questions if the Board has any. Thank you."

Dr. Maron requested to address the CRNA issue. He stated that there are two (2) separate issues. He stated that the first comment he would like to make is that the Board appreciates the qualifications of CRNA's and their contribution to safe anesthesia. He further stated that, as the rule is currently written, CRNA's are already bound by the rules that are there. He continued by stating that the 1600 members of GANA needs to understand that if at any point in time if they have ever had to support an airway or have ever had to give supplemental oxygen then they have been going beyond moderate sedation and have been practicing outside the rules. Dr. Maron stated that the rule is broken. He added that everyone realizes the time to retire the terminology "conscious sedation" from medicine and literature has gone. He went on to state that to say something is moderate conscious sedation is an oxymoron as one cannot be conscious and moderately sedated. He continued by stating that there is an issue with the wording to begin with.

Dr. Maron stated that where the issue comes in is what defines moderate sedation and where is the line between moderate sedation and deep sedation. He stated that the issue at hand is anesthesia is a continuum. He further stated that a patient can go from moderate to a deep level no matter what drug is used. He explained that there are certain drugs that are available and are non-reversable, in which case your only ability is to be able to manage the airway appropriately if the patient goes into that deeper level. He added that, based on the information that we have, what happens is if you have a drug that is not reversable you have to be able to manage the airway and if you are managing the airway then you are technically already in deep sedation; therefore, having a permit that is only moderate sedation is inappropriate.

Dr. Maron stated that nothing in the rule or law is trying to restrict a CRNA from any drugs that a CRNA is qualified to provide. He further stated that the problem a CRNA will have is if the Board does not do anything today and if a CRNA puts a patient into deeper than moderate sedation now in someone's office who holds a moderate sedation permit, the CRNA is violating the rules of the Georgia Board of Dentistry. Dr. Maron stated that is an issue. He explained that the Board is not trying to restrict access to care. He added that the Board is trying to become appropriate for the practice of medicine and anesthesia in 2023 based on drugs that are available and the levels of anesthesia that we all know can occur.

Mr. Karcher commented that anesthesia is a continuum and agrees that moderate conscious sedation is an oxymoron. He stated that he would make the fact that an anesthesiologist is in the dentist office and over sedates a patient, and although they are not tied to the permit level of the dentist, they are going beyond on as well, but it is a continuum. He continued by stating that there will be times when a patient is waning, but who would be better to maintain an airway or give oxygen than having a second anesthesia provider in the room. He added that the Board is saying it is moving dentistry forward in 2023, but to him by making this rule he understands the Board is not saying to a CRNA that it is taking the drugs away, but it is taking away from the dentist. Mr. Karcher stated that a CRNA does not have prescriptive authority or hold a DEA license to order medications. He further stated that if a dentist is unable to order medications for his/her practice, by delegation a CRNA can only use fentanyl and versed when they are using Precedex and Propofol daily in the practice. He added that a CRNA is an expert in the administration of these medications. He stated that he could understand what Dr. Maron was saying, but in the end it is limiting what a CRNA is doing.

Dr. Schultz stated that Dr. Maron spoke succinctly in that it is a continuum. He further stated that it is good to see so many dentists here. He added that the one thing they have in common is that they are all dentists; however, one difference between many of the dentists and him is that he has been performing anesthesia for 43 years. He stated that he thinks he has a little bit of experience with this. He continued by stating that if the issue is a DEA issue with the dentist not being able to order these medications and have them onsite, that is a different subject. He added that if the intent is moderate sedation or conscious sedation, you can use whatever medications you want. Dr. Schultz stated that CNRAs and Physician Assistants are talented enough to not walk up to that line of deeper sedation. He added that in knowing those limitations and knowing what you are tasked to perform for a particular patient and maintaining the level of safety, he has no doubt it can be done. He explained that the Board's issue concerns the medications used.

Dr. Schultz asked Mr. Karcher if it was correct in that a CRNA does not bring their own medications to an office for sedation procedures. Mr. Karcher responded by stating that transporting controlled substances beyond where the physical location of the DEA license is cannot be done. Mr. Karcher stated that in essence the problem would be if a dentist has a conscious sedation permit and the proposed rule amendments state they can no longer give these medications, then a CRNA would not be able to order the medications either. He stated that, in essence, that office is no longer able to utilize a CRNA. Dr. Maron inquired if a CRNA can sedate a patient with fentanyl and versed. Mr. Karcher responded affirmatively, but stated that Propofol is cleaner to use than Fentanyl and Versed. Dr. Maron inquired as to what Propofol is a better drug for. Mr. Karcher responded by stating that it is good for anti-nausea properties. Discussion ensued. Mr. Karcher stated that qualified anesthesia providers or medical providers are giving these medications, but relegating someone to only give Fentanyl and Versed where you will be increasing nausea risks does not make sense from a science standpoint in the practice of anesthesia.

Dr. Tarek Elseweifi spoke to the Board. He discussed his educational background. He discussed his one year dental anesthesia fellowship where he was treated like a first year anesthesia resident. He stated that he and his co-fellow were the only two (2) dentists in the whole hospital. He continued by stating that his duties included training the oral surgeons who came for their five (5) to six (6) month anesthesia rotation. He explained that when he moved to Georgia, he applied for a moderate conscious sedation permit. Dr. Elseweifi stated that he was evaluated using Ketamine and Propofol and passed the evaluation. He further stated that he qualifies for a deep sedation/general anesthesia permit. He continued by stating that he was concerned because unless you are an anesthesiologist you are not an expert in anesthesia. He added that they all have to have the humility to see that dentists are not the leaders in anesthesia. Dr. Elseweifi stated that the American Society of Anesthesiologists (ASA) can release a statement advising all non-anesthesiologist physicians, which would include dentists. He stated the American Dental Association (ADA) or American Association of Oral and Maxillofacial Surgeons (AAMOS) cannot release a statement addressing all anesthesiologists because it is something dentists have experience with, but it is not where the dentist's expertise is.

Dr. Elseweifi discussed the ASA guidelines for anesthesia monitoring. He stated that the standards for basic anesthesia monitoring state, "During all anesthetics, the patient's oxygenation, ventilation, circulation and temperature shall be continually evaluated. To ensure adequate oxygen concentration in the inspired gas and the blood during all anesthetics." He continued by stating that the Board's Guidelines for General Anesthesia-Conscious Sedation Evaluation state that equipment such as EKG monitoring equipment, laryngoscope and tubes are optional. He added that the Board's guidelines do not mention end tidal CO2. Dr. Elseweifi stated that under the "Drugs" portion of the guidelines it does not list Succinylcholine, but lists Anectine. He inquired if we are being sponsored by a pharmaceutical company to use a brand name. He stated that it was not appropriate.

Dr. Elseweifi apologized for his demeanor and stated that he had to wait two (2) years and drive three (3) hours to get to the meeting for this moment. He continued by stating that we are at a point where dental

anesthesiology is becoming a real thing. He added that according to the ASA moderate sedation is a procedure-less guided thing. Dr. Elseweifi commented that if the Board changes the rule and states that if using Propofol and Ketamine, for example, the dentist will need to have a general anesthesia license. He stated that from the perspective of the ASA and the incoming general anesthesiologists, general anesthesia should not be administered by someone who is performing the procedure. He added that if the Board states by using propofol the dentist would need to have a general anesthesia permit, it would hurt those dentists who administer Propofol and extract wisdom teeth, for example.

Dr. Elseweifi read the back of an old generic box of propofol. He read the following from the box: *"Propofol should be administered by only persons trained in the administration of GA and not involved in the conduct of the surgical and diagnostic procedure."* Dr. Elseweifi stated that this was approved by the FDA. He went on to say that he does not think the Board should go against the FDA, ASA and other established organizations to maintain privileges because he does not want see dentists' privileges become restricted.

Dr. Skyler Holcomb spoke to the Board. Dr. Holcomb discussed his educational background. He stated that he holds a conscious sedation permit and performs IV sedation in middle Georgia. He further stated he was present to speak about several issues, one of which was already discussed about CRNAs. He continued by stating the first issue concerns the inclusion of Dexmedetomidine in the proposed rule amendment. He explained that he does not feel it should be included because he believes it is a highly preferred safe medication for conscious sedation. Dr. Holcomb continued by stating that the brand name is Precedex and causes sedation, anxiolysis, analgesia and amnesia. He stated that it has the half-life of Versed. He went on to state that it does not cause respiratory depression and is not as risky as far as causing an airway issue. Dr. Holcomb stated that there has not been an adverse event in the dental chair. He further stated that he brought ten (10) studies with him that speak to the safety and effectiveness of Precedex in the dental setting. One study is the practice guidelines from the ASA where it classifies Dexmedetomidine as not a general anesthetic in the use of moderate sedation. He stated that it was one of the regimens taught to him by faculty at the dental college and has been one of the most effective medications he has used.

Dr. Holcomb stated that another point he wanted to mention is Versed is not as effective because of the population of young adults on daily benzodiazepines. He further stated that every now and then there will be a patient that will not respond to the Versed as expected and he feels Precedex is good adjunct medication to include to get the patient to that comfort level where you are able to complete the procedure. He explained that the issue with that is he feels that number of patients using benzodiazepines daily is growing and dentists need to have that other medication to be able to achieve the level of sedation that dentists are trained and permitted for. He stated that he would be happy to leave the studies with the Board. He added that if the argument is that there no reversal agent there is a reversal agent. He stated that he has case studies of accidental overdoses of Precedex where there was no intervention required other than saline and Epinephrine and the issue resolved within an hour.

Dr. Schultz commented that Precedex does not have the amnesic properties that Midazolam and Lorazepam have and that is one of the differences in choosing Precedex over any benzodiazepines. He stated that none of the board members were arguing or disagreeing about its sedative properties. He further stated that what he considers to be the gold standard is the 2018 Practice Guidelines for Moderate Procedural Sedation and Analgesia by the ASA, American Dental Association, American Association of Oral and Maxillofacial Surgeons, American College of Radiology, American Society of Dental Anesthesiologists, and Society of Interventional Radiology. He continued by stating that according to the paper, Precedex could be used as an alternative to Midazolam or any other benzodiazepines on a case by case basis. He added that it is not meant to be a cart blanche substitute for Midazolam or Fentanyl. Dr. Schultz stated that his particular issue with Precedex is its incidence of hypotension and bradycardia. He stated he does not use it in his practice because he is already using a vagolytic drug in Fentanyl. He added that his question would be is do we

want general dentists, who he respects and admires, to have experience using Ephedrine, Neosynephrine, or quick volume replacements for sedation procedures that could be easily done under their current license using Midazolam and Fentanyl. Dr. Schultz stated that if dentists want to pursue the use of these other types of medicines, which include Ketamine, Etomidate, and Propofol, the avenues are there to qualify for a general anesthesia permit. He added that the Board was not saying a dentist could not do it; however, the side effects and treatment of medicines such as Precedex, are not meant for a general dentist. Dr. Skyler Holcomb responded by stating that he has a study that talks about the amnesic properties of Dexmedetomidine. He stated that what he thinks Dr. Schultz is speaking of is about the issues that are run into at higher doses; however, you will run into issues with any medications at higher doses.

Dr. Lewis Petree spoke to the Board and read the following statement:
"Good morning, I'm Dr. Lewis Petree. I own a dental practice in Winder, Georgia and have routinely practiced sedation dentistry since I was issued a Conscious Sedation permit #99 in 1989. I am also an adjunct faculty member at the Dental College of Georgia in the General Practice Residency Program, and have been volunteering to cover clinical procedures and conscious sedation on a monthly basis for the past 17 years. I also serve as the Co-Chair of the Governmental Affairs Committee for the GDA.

I come before you today to voice my opposition to the limitation of drug modalities available for sedation procedures. While I understand the intent of the board is to maximize patient safety, having Propofol available for certain cases is necessary in my practice. I not only treat my patients but also receive referrals from other dentists in my area for sedation dental treatment in my office. Many of these are gaggers, have extreme anxiety, or are special needs and I am the last hope short of going to a hospital setting. Many times, in these cases, titration of an amount of Propofol in addition to my Fentanyl/Versed regimen smooths that procedure so we can safely finish. I realize Propofol is now classified as a general anesthetic (formerly an emulsifying agent) and has a narrow window of safety but used in a titration manner can also be used as a conscious sedation sedative. Experience makes a difference when using a medication like this! Propofol is short acting and time is our reversal agent!

In our times of seemingly limited access to care across our state, these special needs individuals need care and dentists willing to treat them. Saving teeth and patient safety is our reason for being here!"

Dr. Richard Wyman, Georgia Dental Association (GDA), spoke to the Board. He stated that he echoed much of what Dr. Holcomb said. He added that last year he was before this Board talking about local anesthesia for dental hygienists. He explained the concerns GDA had regarding blocks. He stated that the President of the Board at that time told GDA to provide literature showing there were issues with dental hygienists issuing anesthetics. Dr. Wyman stated that there was no literature available. He further stated he would hope there are studies showing there is a danger using the drugs now the way they are supposed to be used and having untoward affects. He continued by stating that if there is literature we have to accept that and suggested a thorough search be done. Dr. Wyman stated that doctors like Dr. Petree are heroes in the community because they are seeing patients that no one else sees. He added that the patient's only alternative is hospital dentistry. He suggested the Board table the matter and stated that it is the level of anesthesia that is the issue and not so much how you get there.

Dr. Ranjitha Krishna, Georgia Society of Periodontists, spoke to the Board. Dr. Krishna stated that the Board should have received multiple letters from the periodontists. She further stated that there are concerns about creating a cookbook of acceptable drugs. She added that having a laundry list and cookbooks were not appropriate for doctorate level professionals. She continued by stating that if more training need to be done, it should be done in the form of continuing education. Dr. Krishna stated that eliminating certain drugs from well-trained dentists' armamentarium only necessitates increased dosage of other drugs and puts the patient at risk.

Dr. Greg Codelli spoke to the Board and read the following statement:
"The decision to consider restricting the medications used for moderate sedation in dentistry will have a negative impact on comfort and safety on a large number of the public in Georgia some of whom I provide care for.

I have been in periodontal specialty practice for more than 35 years and have safely provided IV sedation procedures on patients 2-4 times daily 5 days a week; my practice is to monitor pulse, blood pressure, ECG, end tidal CO2, ensure adequate adjunctive and emergency infrastructure and retain well-trained and prepared staff. Many of the patients I see in both rural north Georgia and metropolitan Atlanta are over the age of 70 and have significant medical compromise, multiple chronic conditions, and take multiple medications.

First, IV sedation is necessary to treat patients who have had significant dental traumatic episodes in the past (and many times it is just one dental episode) which contributes to a high degree of dental anxiety and the need for a higher degree of anxiolysis. I have always titrated drug administration to the desired level of moderate sedation and over 30 years I've observed an increasing need for a higher amount of midazolam administration to sedate in spite of concurrent narcotic administration. However anesthesia literature suggests limiting the amount of midazolam in the elderly, hence, it seems helpful to adjunctively administer dexmedetomidine or propofol or even ketamine in small and continued titrating doses. The intent is to maintain patient comfort and safety at moderate sedation levels, and not to provide deep sedation or general anesthesia. Simply limiting the medication to higher doses of midazolam and a narcotic will provide for a more challenging, less safe and less comfortable procedure in all patients. And, in patients over 70, post-op confusion and cognitive deficit become more challenging.

Second, there is the paradoxical situation for patients taking selective serotonin receptor inhibitors (SSRI's). Benzodiazepines seem to have minimal anxiolytic effect even at higher doses when a patient is taking a SSRI. According to the CDC, approximately 25% of women over the age of 60 are taking a SSRI: without adjunctive medications, how can this large group of patients in a periodontal population be comfortably and safely treated?

Third, I re-read the drug package inserts for midazolam, propofol, dexmedetomidine and ketamine. All contain warnings and suggested precautions specifically related to impact on airway or respiration and cardiac statuses. Anesthesia textbooks by Morgan & Mikhail as well as Stoelting & Millier reflect similar warnings. These resources do not suggest propofol, dexmedetomidine or ketamine specifically as drugs with narrow margins of safety. It also is difficult if not impossible to determine true mortality and morbidity rates associated with moderate sedation in Georgia to help in education.

I do appreciate and respect the need to keep Georgia citizens safe, however, there is scant evidence or literature to suggest the near draconian proposal of restricting medications.

I do agree that advanced airway training and ongoing education are essential. For instance, in my office, when a new clinical employee is retained we start with airway maintenance and sterilization techniques as I consider both essential building blocks for patient safety. With nearly every dental anesthesiologist I've interacted with there has been an agreement that moderate sedation in ways is more challenging to administer and maintain than deep sedation or general anesthesia. All of the requirements to maintain moderate sedation are also all of the skills and equipment required should a patient become more deeply sedated than intended. With midazolam or propofol or dexmedetomidine, if the intended level of sedation is surpassed, we are prepared to manage and safely care until full recovery is achieved.

As a private practitioner I cannot realistically stop practicing and care of my patients, complete a dental anesthesiology residency and then return to practice. I am not interested in deep sedation or general

anesthesia for my patients. Moderate sedation in my experience of 35 years has been effective, predictable, comfortable and safe for many patients. Please carefully consider the impact of restricting drugs."

Katherine Mann spoke to the Board and read the following statement:
"I am a CRNA graduating from Georgia Baptist Hospital, School of Anesthesia, here in Atlanta in 1977. I have also served on the Board of Nursing for the State of Georgia and I appreciate the weight of your responsibility to the citizens of the State of Georgia.

The position statement for the American Society of Anesthesiologists and the American Association of Nurse Anesthetists still stands that the people who give sedation with Propofol should basically be us. But that has not always been followed in other specialties. That position statement is greater than 20 years old and standards of care and monitoring techniques have changed. I first started working in rural Georgia in 1980. There was an issue with access to care for dental patients who had very real dental anxiety, the inability to cooperate, or comorbidities. These patients needed sedation to have their procedures. There wasn't any dentist in the area who had a sedation certificate and so they came to the hospital and we had to have a family doctor who was willing to admit that patient and then I could do sedation. I did both adults and children. Incidentally the family doctors that admitted that patient did not have credentials or privileges to do sedation or general anesthesia. In fact, none of the surgeons that I worked with had credentials.

So I want to commend the dental board for having a path for certification and privileges for the different levels of sedation. By doing so you have allowed the citizens of Georgia to have a path for dental care. Dental anxiety is a phenomenon that I don't completely understand, but it is extremely real. The standard of care for providing the anesthesia, monitoring the patient, intraoperative and postoperatively and especially in the recovery room should mean that the patient can expect those same standards whether you are a dentist doing the sedation or CRNA or an MD.

I am very concerned today that if you take away modern and safe sedation medications you have done a disservice to our patients and even your own members. I am asking you to reconsider your statement proposal.

There is no doubt that Propofol and Ketamine are safe and have been safely used for greater than 20 years for moderate sedation techniques in and out of the hospital operating room. For over 20 years I have been giving small doses of Ketamine after the first dose of Midazolam because studies show this small dose allows your patient to require less postoperative narcotic. Ketamine is also a wonderful drug to add to the sedation of patients who have COPD and asthma.

But highest on my list of concerns is the overwhelming amount of literature stating we should be very cautious about the amount of drugs that we give to our older patients and one of the drugs that we are particularly talking about are benzodiazepines and our favorite drug Midazolam.

The patients over 65 come to us for much needed dental care and may have comorbidities including anxiety and sleep disorders, Parkinson's disease, COPD, and chronic arthritic pain. The last thing we want to do is to add to their problems with postop confusion and cognitive deficit. That adds a greater incident of post-op dizziness and possible falls. We do not want to keep adding benzodiazepines and narcotics to these patients who take medications for these disorders and now require more to get them comfortable and then we are stuck reversing it. We don't want to do that. They need to take their normal medicines. We don't want these medications to have just been reversed.

Propofol on the other hand is rapid on and off. Complications of using the small doses of Propofol for moderate sedation is not there in the literature, but instead studies show that Propofol is effective and safe.

Patient satisfaction is greater with this technique than any other. Literature even recommends 20 to 30 mg of Propofol in the recovery room for complaints of nausea. This would not be a recommendation if these doses caused deep sedation or general anesthesia.

A typical sedation is primarily remifentanil, occasionally precede, along with an initial dose of midazolam and the small dose of propofol if required. Patients communicate during the procedure but they don't feel the pain. After a fully monitored recovery room period they walk out the door without reversal and without me having to worry about the medications that they need to take when they get home. Please allow patient access to 2023 moderate sedation techniques and medications."

Dr. Maron commented that he would like to address the issues mentioned. He stated that nobody is denying the use of those drugs. He inquired as to whom amongst the periodontists present included on their sedation application the use of Propofol, Precedex, or Ketamine. He stated that has reviewed sedation applications for years. Dr. Maron continued by stating that Precedex and Propofol have become more common drugs. He added that the issue is that sedation is a continuum. Dr. Maron stated that one cannot predict how an individual patient will respond. He further stated that every now and then the patient's airway will have to be supported. Ms. Mann commented that she had to support an airway with Fentanyl alone.

Dr. Maron stated that this was concerning the definition of the term "moderate sedation" and the definition of the term "deep sedation". He further stated that there are errors in the way the statute reads in regards to sedation. Dr. Maron read the following statement from the American Society of Anesthesiologists: *"Rescue of a patient from a deeper level of sedation than intended is an intervention by a practitioner proficient in airway management and advanced life support. The qualified practitioner corrects adverse physiologic consequences of the deeper-than-intended level of sedation (such as hypoventilation, hypoxia and hypotension) and returns the patient to the originally intended level of sedation. Therefore, pts who have a moderate level of sedation should be able to rescue people in a deeper sedation while those with deep sedation should be able to rescue patients in general anesthesia."*

Dr. Maron stated that the law requires an applicant to have a minimum of one (1) year of advanced training in anesthesiology in order to be an oral surgeon. He continued by stating that anyone with advanced training needs to make sure they have the correct level of sedation permit. He added that when administering Propofol, Ketamine, etc., those drugs can potentially put someone into a deeper level of sedation that is non-reversable. Dr. Maron stated to the audience that if they ever had to rescue an airway that means the patient is at a deeper level of sedation and the dentist is outside of the scope of their permit. He inquired if anyone disagreed. Dr. Wyman responded by stating that would apply to all medications and the patient can get to that same level with any one of those medications. He added that the Board is picking out one or two medications without the literature showing there is a problem. He continued by stating that the Board is trying to treat a problem that does not exist and suggested reviewing the literature.

Dr. Elseweifi commented that he did not disagree with Dr. Maron, but if someone is doing moderate conscious sedation and the patient experiences a laryngospasm and is given Succinylcholine, that could be a risk for certain populations and certain situations can arise for a patient that has no history of anesthesia. He inquired as to what would happen if someone encountered a situation but does not have inductive agents to stabilize that patient. Dr. Elseweifi stated that regardless of what level is administered, you must always be prepared to convert to a general anesthetic.

Dr. Schultz commented that the 2018 Practice Guidelines for Moderate Procedural Sedation and Analgesia is the gold standard. He explained that this was a robust panel of investigators and not only did they do research, but they also analyzed literature that was valid. He added that the studies they utilized were multiple randomized controlled trials and they graded those. He continued by stating that they asked the

board members to be surveyed. Dr. Schultz stated they took the recommendations made to the ADA and the ADA signed off on these recommendations.

Dr. Skyler Holcomb inquired as to what it is about the study they are recommending. Dr. Schultz responded by stating that the medicines classified as those intended for non-general anesthesia and those intended for general anesthesia. Discussion was held about Dexmedetomidine. Dr. Schultz commented that his issue with Dexmedetomidine are the side effects.

Dr. Shirley commented that several people contacted him from the pediatric dentistry community and the concern was Dexmedetomidine and that it is used orally. He stated that there are studies where it was compared with oral Midazolam. He further stated the concern was that if this rule change was instituted it would take out that option and it is considered moderate sedation and not deep sedation. He continued by stating there were 49 written comments received. Dr. Shirley stated that he understood the need for revisions that prevent someone from doing general anesthesia without the proper permit. He added that he did not disagree with that aspect at all. He stated that there is a concern with Dexmedetomidine and if that would prevent someone from using it in the proper setting. He inquired if this proposed rule amendment would really get the result the Board wants.

Dr. Young commented that there seems to be a lot of concern regarding the proposed amendments. She made a motion to table the matter until further information could be gathered. Dr. Shilman seconded, and the Board voted unanimously in favor of the motion. Dr. Knight suggested the proposed rule be referred back to the Sedation Committee for further review. The Board agreed.

Dr. Stephan Holcomb stated that he would assume the Sedation Committee would solicit and welcome publications and scientific information that may give a different perspective than what has been presented. He said that it was not a reflection of the hard work the board members do. He added that there are studies that can give an opposing view of some of the other studies that are out there. He stated that Precedex is a classic example of this in the pediatric world and even in the paper Dr. Schultz cited from recommends that it is a moderate drug and is not to be used for general anesthesia. He further stated that he wanted the Board to understand a lot of work went into developing this level of permit for access of care. He continued by stating that it is an evolving process and the safety of the public is important. Dr. Holcomb stated that there are approved courses and individuals have been granted a permit after taking those courses and they are following the rules of the Georgia Board of Dentistry for the protection of the public. He further stated to make a dramatic change is unfair to the licensees and the people they serve and would create a significant access to care issue.

Dr. Maron stated that the Sedation Committee will have a public meeting on this matter, which will be held via Microsoft Teams. He continued by stating that the meeting will be posted and anyone is welcome to attend and voice opinions on the subject.

Dr. Maron commented that he wanted to clarify his point on the subject and asked everyone to take a note of caution in his/her practices. He stated that you are on the precipice between moderate and deep sedation and it is a continuum. He stated that if you look at the terminology of the current permits as written and if you have a complication where the patient goes into deeper sedation by using these drugs, you are not practicing within the scope as it is currently written. He added that he wanted to point that out for the sake of the safety of the patients.

Dr. Knight requested the members of the public that were present and for anyone they know to supply the numbers of procedures done under anesthesia and if there were complications, to provide that information as well.

Ms. Mann commented that she previously taught sedation to doctors at different hospitals. At that time she told everyone they would have to rescue a patient. She added that her message to them when she taught the class was to make sure they knew how to handle it because it would happen, and because it is a continuum it is part of the risk. She stated that teaching airway was part of the course. She discussed the standard of care of monitoring.

No further comments were received.

Written responses were received from Dr. Kara Kramer, John Walraven, General Counsel, GANA, Dr. Tarek Elseweifi, Dr. Stephan F. Holcomb, Dr. Daniel West, Dr. Darron Alvord, Dr. Aaron Rawlings, Dr. W. Lee Young, Dr. Sadja Gaud, Dr. Brock Pumphrey, Dr. Vinamra Bhasin, Dr. R. Lee Fletcher, III, Dr. Zackary Bentley, Dr. Mandy Olson, Dr. Aaron Pryor, Dr. Braden Putich, Dr. Charles Sauls, Dr. Timothy Grantham, Dr. Latosha Harris, Dr. Dianne Hogan, Dr. Parker Westbrook, Dr. Jay Williams, Dr. Frank Winn, Dr. Nicole Yates, Dr. Nathan Laughrey, Dr. Carlos Martinolas, Dr. Richard McNeely, Dr. Amanda Merritt, Dr. Christina Cox, Dr. Alexa Cueli, Dr. Chad Curry, Dr. Stanton Dotson, Dr. Roderick Dunham, Dr. Jake Evans, Dr. William Fussell, Dr. Jon Simmons, Dr. Tyler Slate, Dr. Molly Smith, Dr. Michael Spencer, Dr. Tyler Strom, Dr. Benjamin Alverson, Dr. Mark Benner, Dr. William Clance, Dr. Eric Hodges, Dr. Richman Margeson, Dr. Lee Martin, Dr. Turner Welch, Dr. Grant Dye, Dr. Nathan Buck, Dr. Janet Sieweke, and Dr. Russell Eyman.

The public hearing concluded at 11:15 a.m.

Open Session

Dr. Knight established that a quorum was present and called the meeting to order at 11:31 a.m.

Introduction of Visitors
Dr. Knight welcomed the visitors.

Approval of Minutes
Dr. Maron made a motion to approve the Public and Executive Session minutes from the September 8, 2023, meeting. Ms. Selfe seconded, and the Board voted unanimously in favor of the motion.

Report of Licenses Issued
Dr. Maron made a motion to ratify the list of licenses issued. Dr. Stiehl seconded, and the Board voted unanimously in favor of the motion.

Petitions for Rule Waiver or Variance
Rule Waiver Petition from Dr. Rui P. Fernandes: The Board discussed this request for a waiver of Rule 150-3-.01(7). Dr. Shilman made a motion to deny the rule waiver petition as there was no substantial hardship demonstrated. Ms. Selfe seconded, and the Board voted unanimously in favor of the motion.

General – Dr. Michael Knight
No report.

External Committee Reports
Electronic Database Review Advisory Committee (PDMP) Report – Dr. Lisa Shilman: No report.

CRDTS Steering Committee Report – Dr. Brent Stiehl: No report.

CRDTS Examination Committee Report – Dr. Ami Patel: No report.

Dental College of Georgia Liaison Report – Dr. Michael Knight: Dr. Knight reminded the board members and members of the public that the Board's December meeting will be held at the Dental College of Georgia at Augusta University.

CDCA-WREB-CITA Steering Committee Report – Dr. Ami Patel, Dr. JC Shirley, Ms. Misty Mattingly, RDH: Dr. Shirley reminded the Board that there has been a compact proposed that is supported by several organizations and has been adopted in a few states. He stated that the American Association of Dental Boards (AADB) is considering an additional compact that has been proposed. He further stated that CDCA-WREB-CITA is currently watching that. He added that he just wanted to make the Board aware of what was going on and that there are two (2) compacts that potentially any state legislature could evaluate.

Ms. Pam Cushenan commented by stating that there are three (3) states that have already adopted the original compact. She stated that there are another six (6) that have applied. She further stated that it takes seven (7) states as a minimum for the original compact to be adopted. She added that the AADB came forward with the most recent compact and stated that she hopes everyone reviews it due to the negative impact it can have.

Dr. Stephan Holcomb stated that there are two (2) compact bodies that are growing. He explained that one is by the American Dental Association (ADA) and the other is with the AADB. He explained that the AADB compact is sponsored by the CDCA and continued by stating that it is not the AADB representing the dental boards, but rather another testing entity saying this will be the only exam that will be accepted. He suggested the Board continue to review that information.

Dr. Holcomb stated that Marquette University School of Dentistry just eliminated a third party assessment. He explained that this means by joining a compact with other states, one of the rules is the state has to accept the conditions of the compact and it is basically a reciprocity issue. He added that Georgia had reciprocity in its statute many years ago, but did away with it because the intent of what the General Assembly thought reciprocity was actually credentialing. Dr. Holcomb explained that reciprocity means if a state accepts you, you have to accept them. He further stated that by statute if the state accepts licensure into Georgia, Georgia will have to accept licensure from that state regardless of the conditions. He continued by stating that the compact situation is basically binding the state legally to another state's qualifications that will have to accepted. Dr. Holcomb stated that in regards to the compact and before the Board makes a decision that could impact quality of care in this state, he hoped the Board would reach out to other agencies for more information.

Dr. Maron commented by stating that it was his understanding the compact can be arrived at outside of the Board's purview, so it would not have control. He stated the compact could be done at the state or federal level. Dr. Holcomb responded by stating that members of the Board do not have the right to lobby, but could affect change through legislation. He stated that one of these organizations stated that they did not need the Board's approval and would go around the Board through legislation or a federal mandate. He urged the Board to be aware and stated that the compact was extremely dangerous from both of the sources.

Ms. Cushenan presented comments to the Board on the interstate dental compacts.

Dr. Shirley stated that, as board members, they need to be aware of what is going on. He further stated that a representative from one of the organizations would be coming to a future meeting to present information and answer questions. He suggested having a representative from the other organization present as well.

GDHEA Liaison Report – Dr. David Reznik, Ms. Lisa Selfe, RDH: No report.

Attorney General's Report – Mr. Max Changus
No report.

Executive Director's Report – Mr. Eric Lacefield
Renewals: Mr. Lacefield reported that online renewals were live for dentists, dental hygienists, and sedation permit holders. He reminded the board members and members of the public that licenses and permits needed to be renewed prior to 12/31/2023.

DEA Course: Mr. Lacefield stated that Ms. Merrilee Gober, Medical Association of Georgia (MAG), had to leave the meeting, but requested Mr. Lacefield pass along information regarding a DEA course that will be offered by MAG for free that will meet two (2) of the eight (8) hours that are required for all DEA registrants.

Legal Services – Mr. Clint Joiner
No report.

Miscellaneous
Treatment Facility Request: The Board considered the request from Caron Treatment Center-Atlanta to be a board-approved treatment facility. Dr. Maron made a motion to table the request until the Board's November meeting to allow for additional time to review. Dr. Shilman seconded, and the Board voted unanimously in favor of the motion.

Local Anesthesia Course Submissions: Dr. Maron made a motion to approve the course titled, "Local Anesthesia for Today's Dental Hygienist Certification Course" provided by Dr. Laura Braswell and Dr. Sam Low. Ms. Selfe seconded, and the Board voted unanimously in favor of the motion.

The Board discussed the course submitted by the Georgia Dental Hygienists' Association. Ms. Kennedy, President of the Georgia Dental Hygienists' Association (GDHA), provided the Board with supplemental information to be included with the original course submission. Dr. Maron made a motion to approve the course with the additional information provided. Ms. Selfe seconded, and the Board voted unanimously in favor of the motion.

Rules Discussion: Mr. Joiner discussed the amendments made to Rule 150-3-.09 Continuing Education for Dentists. He explained that the draft provided to the Board will allow continuing education credit for dentists that conduct site evaluations for CODA. Discussion was held whether or not CODA issued a certificate to the individual who performed the site visit. Dr Shirley noted that the draft speaks to in-person site evaluations. He stated that a few years ago some site visits were virtual and hybrid. He further stated that the evaluator had to do more preparation for those types of visits than on-site. He inquired if the word "in-person" should be removed. Dr. Holcomb commented that all site visits are back to being in-person.

There being no further discussion, Dr. Maron made a motion to post Rule 150-3-.09 Continuing Education for Dentists. Dr. Shilman seconded, and the Board voted unanimously in favor of the motion.

Rule 150-3-.09. Continuing Education for Dentists

(1) Dentists licensed to practice in the state of Georgia shall maintain and furnish to the Board, upon request, official documentation of having completed a minimum of forty (40) hours of continuing education during each biennium. Official documentation shall be defined as documentation from an approved provider that verifies a licensee's attendance at a particular continuing education course. Official documentation of course attendance must be maintained by a dentist for at least three (3) years following the end of the biennium during which the course as taken.

(a) Compliance with all continuing education requirements is a condition for license renewal. Failure to complete all hours of mandatory continuing education shall serve as grounds to deny the renewal of a license and may also result in disciplinary action being taken against a licensee.
(b) Upon its own motion, the Board may at any time randomly select a percentage of actively licenses dentists for the purpose of auditing their compliance with the continuing education requirements of the Board. Those licensees selected for an audit shall submit official documentation of their compliance within thirty (30) days of receipt of the audit letter. Failure to respond to an audit request in a timely manner shall be grounds for disciplinary action against a licensee.
(c) The continuing education requirements shall not apply to dentists whose licenses are on inactive status.
(d) The continuing education requirements shall apply within the first biennium that a dentist is licensed in Georgia. However, in order to meet the continuing education requirements during the first biennium, a newly licensed dentist may submit as their continuing education hours proof of dental coursework taken within the previous two (2) years of the date of the renewal application from a university or other institution accredited by the Commission on Dental Accreditation of the American Dental Association, or its successor agency. Following the first biennium that a dentist is licensed in Georgia such licensees shall comply with the continuing education requirements set forth in Rule 150-3-.09(2) and (3).
(e) The continuing education requirements for dentists holding volunteer licenses may be satisfied by compliance with this rule, or they may alternatively be satisfied by compliance with Rule 150-3-.10.

(2) Coursework, including home study courses, sponsored or approved by the following recognized organizations will be accepted:
(a) American Dental Association/American Dental Hygienists association, and their affiliate associations and societies;
(b) Academy of General Dentistry;
(c) National Dental Association and its affiliate societies;
(d) Colleges, and universities and institutions with programs in dentistry and dental hygiene that are accredited by the Commission on Dental Accreditation of the American Dental Association when the professional continuing education course is held under the auspices of the school of dentistry or school of dental hygiene;
(e) CPR courses offered in-person by the American Red Cross, the American Heart Association, the American Safety and Health Institute, the National Safety Council, EMS Safety Services, or other such agencies approved by the Board.
(f) National and State Associations and/or societies of all specialties in dentistry recognized under Georgia law;
(g) Veterans Administration Dental Department;
(h) Armed Forces Dental Department;
(i) Georgia Department of Public Health;
(j) American Medical Association, the National Medical Association and its affiliate associations and societies;
(k) Hospitals accredited by the Joint Commission on Accreditation of Hospital Organizations (JCAHO).

(3) Course content:
(a) All courses must reflect the professional needs of the dentist in providing quality dental health care to the public;
(b) At least thirty (30) hours of the minimum requirement shall be clinical courses in the actual delivery of dental services to the patient or to the community;

(c) Four (4) credit hours for successful completion of the in-person CPR course required by Georgia law may be used to satisfy continuing education requirements per renewal period. This requirement may be satisfied by successful completion of an in-person Basic Life Support (BLS) or Advanced Cardiovascular Life Support (ACLS) course;
(d) Effective on and after January 1, 2024, two (2) hours of the minimum requirement shall include education and training regarding infection control in the practice of dentistry, which shall include education and training regarding dental unit water lines;
(e) One (1) hour of the minimum requirement shall include the impact of opioid abuse, proper prescription writing, and/or the use of opioids in dental practice;
(f) Effective on and after January 1, 2022, one (1) hour of the minimum requirement shall include legal ethics and professionalism in the practice of dentistry, which shall include, but not be limited to, education and training regarding professional boundaries; unprofessional conduct relating to the commission of acts of sexual intimacy, abuse, misconduct, or exploitation with regard to the practice of dentistry; legislative updates and changes to the laws relating to the practice of dentistry and rules, policies, and advisory opinions and rulings issued by the Board; professional conduct and ethics; proper billing practices; professional liability; and risk management.
(g) Up to fifteen (15) hours of continuing education per year may be obtained by assisting the Board with administering the clinical licensing examination. These hours shall be approved by the Continuing Education Committee of the Georgia Board of Dentistry and need not be sponsored by any agency listed in ~~150-3-.09 (2)~~150-3-.09(2);
(h) Up to ~~E~~eight (8) hours per biennium may be obtained by assisting the board with investigations of licensees. This may include consultant review on behalf of the Georgia Board of Dentistry and peer reviews completed by committees of the Georgia Dental Association but shall be limited to two (2) hours for each case reviewed. These hours shall be approved by the Continuing Education Committee of the Georgia Board of Dentistry and need not be sponsored by any agency listed in ~~150-3-.09 (2)~~150-3-.09(2);
(i) Up to ten (10) hours of continuing education per year may be obtained by teaching clinical dentistry or dental hygiene at any ADA-approved educational facility. These hours shall be awarded in writing by the course director at the facility and approved by the Continuing Education Committee of the Georgia Board of Dentistry;

(3) Course content:
(a) All courses must reflect the professional needs of the dentist in providing quality dental health care to the public;
(b) At least thirty (30) hours of the minimum requirement shall be clinical courses in the actual delivery of dental services to the patient or to the community;
(c) Four (4) credit hours for successful completion of the in-person CPR course required by Georgia law may be used to satisfy continuing education requirements per renewal period. This requirement may be satisfied by successful completion of an in-person Basic Life Support (BLS) or Advanced Cardiovascular Life Support (ACLS) course;
(d) Effective on and after January 1, 2024, two (2) hours of the minimum requirement shall include education and training regarding infection control in the practice of dentistry, which shall include education and training regarding dental unit water lines;
(e) One (1) hour of the minimum requirement shall include the impact of opioid abuse, proper prescription writing, and/or the use of opioids in dental practice;
(f) Effective on and after January 1, 2022, one (1) hour of the minimum requirement shall include legal ethics and professionalism in the practice of dentistry, which shall include, but not be limited to, education and training regarding professional boundaries; unprofessional conduct relating to the commission of acts of sexual intimacy, abuse, misconduct, or exploitation with regard to the practice of dentistry; legislative updates and changes to the laws relating to the practice of dentistry and rules, policies, and advisory opinions

and rulings issued by the Board; professional conduct and ethics; proper billing practices; professional liability; and risk management.

(g) Up to fifteen (15) hours of continuing education per year may be obtained by assisting the Board with administering the clinical licensing examination. These hours shall be approved by the Continuing Education Committee of the Georgia Board of Dentistry and need not be sponsored by any agency listed in ~~150-3-.09(2)~~150-3-.09(2);

(h) Up to ~~E~~eight (8) hours per biennium may be obtained by assisting the board with investigations of licensees. This may include consultant review on behalf of the Georgia Board of Dentistry and peer reviews completed by committees of the Georgia Dental Association but shall be limited to two (2) hours for each case reviewed. These hours shall be approved by the Continuing Education Committee of the Georgia Board of Dentistry and need not be sponsored by any agency listed in ~~150-3-.09(2)~~150-3-.09(2);

(i) Up to ten (10) hours of continuing education per year may be obtained by teaching clinical dentistry or dental hygiene at any ADA-approved educational facility. These hours shall be awarded in writing by the course director at the facility and approved by the Continuing Education Committee of the Georgia Board of Dentistry;

(j) Up to ten (10) hours of continuing education per biennium may be obtained by providing, uncompensated dental care at a charitable dental event as defined by O.C.G.A § 43-11-53;

(k) Up to twenty (20) hours of continuing education per biennium may be obtained by members of the Georgia Board of Dentistry for member service, where one continuing education hour is credited for each five hours of Board service provided.;

(l) Up to ~~E~~eight (8) hours per biennium may be obtained by assisting the Board with conducting onsite sedation evaluations. This shall be limited to a maximum of four (4) hours per evaluation. These hours shall be approved by the Continuing Education Committee of the Georgia Board of Dentistry and need not be sponsored by any agency listed in 150-3-.09 (2)150-3-.09(2).

(m) Up to eighteen (18) hours per biennium may be obtained by conducting in-person site visit evaluations for the Commission on Dental Accreditation of the American Dental Association. This shall be limited to a maximum of six (6) hours per evaluation. These hours shall be approved by the Continuing Education Committee of the Georgia Board of Dentistry and need not be sponsored by any agency listed in 150-3-.09(2).

(4) Criteria for receiving credit for attending an approved continuing education course:

(a) Credit hours are not retroactive or cumulative. All credit hours must be received during the two (2) year period to which they are applied;

(b) One credit hour for each hour of course attendance will be allowed;

(c) Only twelve hours of credit will be accepted per calendar day;

(d) Effective January 1, 2008, at least twenty (20) of the required forty (40) hours of credit must be acquired in person at an on-site course or seminar; you are not allowed to acquire all CE hours through on-line courses, electronic means, journal studies, etc.

(5) Criteria for receiving credit for teaching an approved continuing education course:

(a) Credit hours for teaching an approved course must be obtained and used during the biennium that the approved course is taught;

(b) A dentist who teaches an approved continuing education course is eligible to receive two (2) credit hours for each hour of course work that he or she presents at a particular course. Credit will be given for teaching a particular course on one occasion. A maximum of ten (10) credit hours per biennium may be obtained by a dentist by whom an approved continuing education course is taught;

(c) Only continuing education courses sponsored by organizations designated in Rule 150-3.09(2) will be considered for credit pursuant to this subsection of the rule.

(d) In the event that an audit is conducted of the continuing education hours of a dentist who has taught a course approved by a recognized organization, the following information shall be required to document the dentist's role in presenting a continuing education course:
(i) Documentation from an approved provider verifying that the dentist presented an approved continuing education course;
(ii) Documentation from an approved provider reflecting the content of the course; (iii) Documentation from an approved provider specifying the list of materials used as a part of the course; and
(iv) Documentation from an approved provider verifying the hours earned and the dates and times that the course in question was given.

(e) In the event that an approved continuing education course is taught by more than one dentist, continuing education credit will be given for those portions of coursework for which the dentist is directly involved and primarily responsible for the preparation and presentation thereof. Continuing education credit will not be available to a dentist whose participation in preparing and presenting an approved course is not readily identifiable.

(6) Criteria for receiving credit for providing uncompensated indigent dental care.
(a) Up to ten (10) hours of continuing education per biennium may be obtained by providing, uncompensated dental care at a charitable dental event as defined by O.C.G.A § 43-11-53.
(b) Dentists may receive one hour of continuing education for every four hours of indigent dental care the dentist provides, up to ten (10) hours. Such continuing education credits will be applied toward the dentist's clinical courses.
(c) All credit hours must be received during the two (2) year renewal period;
(d) All appropriate medical/dental records must be kept;
(e) Dentists shall at all times be required to meet the minimal standards of acceptable and prevailing dental practice in Georgia;
(f) The Board shall have the right to request the following:
1. Documentation from the organization indicating that the dentist provided the dental services;
2. Documentation from the organization that it provided medical and/or dental services to the indigent and/or those making up the underserved populations;
3. Notarized verifications from the organization documenting the dentist's agreement not to receive compensation for the services provided;
4. Documentation from the organization detailing the actual number of hours spent providing said services; and
5. Documentation from the dentist and/or organization verifying the services provided.

(7) Effective January 1, 2012, dentists may receive continuing education credit for dental coursework taken during a residency program from a university or other institution accredited by the Commission on Dental Accreditation of the American Dental Association. Such coursework must have been taken during the current license renewal period.
(1) Submission of a copy of the certificate of completion of program showing dates of completion is sufficient proof of coursework.
(2) One (1) credit hour equals one (1) continuing education credit.

Dr. Maron made a motion and Dr. Stiehl seconded that the formulation and adoption of the proposed rule amendment does not impose excessive regulatory cost on any licensee and any cost to comply with the proposed rule amendment cannot be reduced by a less expensive alternative that fully accomplishes the objectives of the relevant code sections.

In the same motion, the Board voted that it is not legal or feasible to meet the objectives of the relevant code sections to adopt or implement differing actions for businesses as listed at O.C.G.A § 50-13-4(a)(3)(A), (B), (C) and (D). The formulation and adoption of the proposed rule amendment will impact every licensee in the same manner, and each licensee is independently licensed, owned and operated and dominant in the field of dentistry.

Opioid CE Requirement for Non-DEA License Holders: The Board discussed this topic that was tabled at the Board's September meeting. Dr. Maron stated that there is no law that requires non-DEA license holders to take the required opioid course. He added that it was required by the Board who amended its rule to include such. He continued by stating that the question was brought up by orthodontists because they mostly do not prescribe medications. Dr. Maron stated that they felt it was an undue burden to have to take the required continuing education every two (2) years. He further stated that the rule would need to be amended in order to not require non-DEA license holders take the course. He continued by stating that he felt it was not an undue burden to require the course. He stated that there are certain indications where he feels everyone should have narcotics training and it was his opinion that the requirement should remain. Dr. Shilman commented by stating that there is an opioid crisis going on. Dr. Shirley agreed and stated that Licensure Overview Committee members that have reviewed cases and see it is an important issue. After further discussion, the Board agreed to leaving the requirement in the rule as is and take no action.

Request for Interpretation: Dr. Maron discussed O.C.G.A. § 43-11-21.1(b)(1)(A), which states:
(b) No dentist shall be issued a permit under this Code section nor have such permit renewed unless the board has received satisfactory evidence that such dentist:
(1)
(A) Has successfully completed a minimum of one year of advanced training in anesthesiology and related academic subjects beyond the undergraduate dental school level at an institution accredited by the Commission on Dental Accreditation of the American Dental Association or its successor agency or by a nationally recognized health care accreditation body for hospitals; or

Dr. Maron requested an interpretation from the Attorney General's office as to whether the above-mentioned code section includes those who have taken General Practice Residencies, Periodontal Residencies, etc., where the individual has been in a hospital setting and has had advanced training, and would that training qualify them to apply for general anesthesia/deep sedation permit versus dealing with the situation the Board is currently dealing with concerning moderate conscious sedation permits. He stated the reason for the request was that otherwise the Georgia Dental Association or another association would have to lobby to change the law to allow an avenue for an individual to obtain a more appropriate level of sedation permit. Dr. Maron made a motion to refer the matter to the Attorney General's office for an interpretation of O.C.G.A. § 43-11-21.1(b)(1)(A). Mr. Scheinfeld seconded the motion. Discussion was held. Dr. Shirley agreed and stated that he thought it was a good idea to look into. He stated that how it is written will depend on what the training is for a General Practice Residency or Periodontal Residency and will the individual meet the criteria required by the Board. Dr. Shilman commented by stating that she completed a hospital-based General Practice Residency and there was no sedation training. Dr. Shirley responded by stating that CODA standards are minimum for that and some programs have a lot of training in that area and some have none.

Mr. Changus stated that when he looks at the language in the statute it seems to not be overly specific and does not seem to articulate that it has to be meeting certain standards. He further stated that it has to do with comfort with whatever programs are being offered and whether or not the Board feels the statute gives it enough room to determine that someone has met that threshold. He stated that the Board may also need to put language in its rules that identify the length of time for other related subjects. There being no further discussion, the motion passed unanimously.

Dr. Maron made a motion and Ms. Selfe seconded and the Board voted to enter into **Executive Session** in accordance with O.C.G.A. § 43-1-19(h), § 43-11-47(h), and § 43-1-2(h), to deliberate and receive information on applications. Voting in favor of the motion were those present who included Dr. Lacey Green, Dr. Michael Knight, Dr. Glenn Maron, Dr. Larry Miles, Dr. David Reznik, Mr. Mark Scheinfeld, Dr. Jeffrey Schultz, Ms. Lisa Selfe, Dr. Lisa Shilman, Dr. JC Shirley, Dr. Brent Stiehl, and Dr. Nancy Young.

Executive Session

Licensure Overview Committee Discussion Case

- T.C.

Applications

- R.P.F.
- H.S.H.
- T.M.O.
- L.M.H.
- B.T.A.
- H.K.B.
- J.S.P.
- F.A.D.
- M.K.W.
- M.E.P.
- E.H.W.
- A.F.R.
- F.J.H.
- J.T.H.
- W.K.S.
- B.J.H.
- K.B.B.
- A.C.P.
- J.E.C.

Correspondence

- S.A.R.

Investigative Committee Report – Dr. Glenn Maron

Dr. Maron provided the Board with an update regarding the cases discussed by the Investigative Committee earlier that morning.

Attorney General's Report – Mr. Max Changus

Mr. Changus provided an update regarding pending litigation.

The Board received legal advice regarding teledentistry.

Executive Director's Report – Mr. Eric Lacefield

No report.

Legal Services – Mr. Clint Joiner

No report.

No votes were taken in Executive Session. Dr. Knight declared the meeting back in Open Session.

Open Session

Dr. Maron made a motion to approve all recommendations based on deliberations made in Executive Session as follows:

Licensure Overview Committee Discussion Case

• T.C.	Request to Lift Suspension	Approved request and refer to the Department of Law

Applications

• R.P.F.	Dental Exam Applicant	Denied application
• H.S.H.	Dental Exam Applicant	Denied application
• T.M.O.	Dental Hygiene Exam Applicant	Approved application
• L.M.H.	Dental Hygiene Exam Applicant	Approved application
• B.T.A.	Dental Exam Applicant	Approved application
• H.K.B.	Dental Exam Applicant	Approved application
• J.S.P.	Dental Exam Applicant	Approved application
• F.A.D.	Dental Exam Applicant	Approved application
• M.K.W.	Dental Hygiene Credentials Applicant	Denied application
• M.E.P.	Initial Moderate Parenteral CS	Approved for provisional permit
• E.H.W.	Initial Moderate Parenteral CS	Approved for provisional permit
• A.F.R.	Initial Moderate Enteral CS	Denied application
• F.J.H.	Notification of Change in Location	Schedule to meet with the Sedation Committee
• J.T.H.	Notification of Additional Site	Table pending receipt of additional information
• W.K.S.	Notification of Additional Site	Schedule to meet with the Sedation Committee
• B.J.H.	Notification of Change in Location	Table until November meeting to allow additional time to review
• K.B.B.	Dental Hygiene Reinstatement	Table pending receipt of additional information
• A.C.P.	Public Health Applicant	Approved application
• J.E.C.	Public Health Applicant	Denied application

Correspondence

• S.A.R.	Request regarding remediation	Board directed staff to respond by stating that remediation was not required due to failures occurring while individual was in dental school.

Investigative Committee Report – Dr. Glenn Maron

Dr. Maron provided the Board with an update regarding the cases discussed by the Investigative Committee earlier that morning.

Attorney General's Report – Mr. Max Changus

Mr. Changus provided an update regarding pending litigation.

The Board received legal advice regarding teledentistry.

Executive Director's Report – Mr. Eric Lacefield
No report.

Legal Services – Mr. Clint Joiner
No report.

Ms. Selfe seconded, and the Board voted unanimously in favor of the motion.

Dr. Knight requested a discussion regarding peer reviewer fees at the next meeting.

There being no further business to come before the Board, the meeting was adjourned at 1:37 p.m.

The next scheduled meeting of the Georgia Board of Dentistry will be held on Friday, November 3, 2023, at 10:00 a.m. at 2 MLK Jr. Drive, SE, 11th Floor, East Tower, Atlanta, GA 30334.

Minutes recorded by Brandi Howell, Business Support Analyst I
Minutes edited by Eric R. Lacefield, Executive Director