Hansford, Carson

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Sent: Sunday, November 24, 2024 10:02 PM
To: Hansford, Carson
Subject: Den 304.08

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Good evening. I understand there is an upcoming meeting for which comments are allowed. I am unable to attend, but wanted to voice concerns I have over this regulation.

Oral and maxillofacial surgeons undergo am extensive training program that focuses on general medicine, surgical, and anesthesia training. Including training in the OR similar to general surgeons and specialty surgeons. It is unfortunate that our specific and unique training is not recognized and in this particular bill we are being included alongside providers that do not have comparable training in the state. Personally, I've had several concerning phone calls from dentists with CRNAs in their practice regarding bleeding concerns on patients that should never have been treated in an office setting. The procedure had already been performed with the proposed 2 provider model in this bill but due to the incomplete training of these 2 providers in this setting they called me for guidance due to complications. Again in this particular situation given my training and the unique medical concerns of this particular patient I would not have treated this type of patient in the office. The two provider model fails to recognize the importance of having a provider that is knowledgeable in case selection. As an oral and maxillofacial surgeon I was trained to look at not just a surgical procedure, but the entire patient and their unique background in relation to this particular procedure. This regulation fails to recognize the clinical judgement that is instilled as a part of our training.

More importantly, access to care is a huge concern as this has happened in my practice region. Pediatric dentists have difficulty getting OR time for their cases. They often will refer these patients to oral and maxillofacial surgeons for treatment due to these delays. This bill will further delay their access to care and will lead to a significant increase cost to the state-from a healthcare cost standpoint with transfers to Boston for treatment, as well as poor experiences for patients having delays in treatment or patients being traumatized by having an infected tooth treated under local anesthesia due to anesthesia delays related to schedule coordination. It can take weeks to months to get OR time.

Having also gone through medical school, I was always encouraged to treat a problem and not a symptom. In order to do this, we must understand the entire picture. On the surface, the idea of limiting anesthetic drugs for an age range based off of reversible agents may sound reasonable, but it fails to recognize how different agents can work and the benefits of them. If administered properly. For instance the use of an intramuscular ketamine injection can maintain a patients respiratory drive while giving them a dissociative state to allow them to safely be treated. Ketamine is a bronchodilator as well, which can be very beneficial in the pediatric population. Also, the use of propofol is dose dependent and offers varying benefits to treatment. A comprehensive understanding of the pharmacology is needed to create

a balanced anesthetic plan specific to the procedure being performed. And it is imperative that there is an equal understanding of the procedure itself.

I choose to go to the hospital to treat patients I do not feel are appropriate to be treated in an office setting. I can make that determination because of my extensive training. I would ask the state to carefully consider and listen to the recommendations of those who have this background of both the surgical and the anesthetic side, especially given that they are consistent with those from CODA. Ultimately, we all want to keep our children safe.

Thank you for your time.

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