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November 1, 2012

Mr. Lloyd Jordan
Chairman, Board of Zoning Adjustment
441 4th Street, N.W. Suite 200/210-S
Washington, D.C. 20001

Re: BZA Application No. 18440

I am filing an amendment to our application on advice from the Office of Planning asking for an Area Variance Relief instead of Special Exception to allow a dental office as a home occupation with three (3) employees occupying the first floor under ~~subsection 202.2(c), in the R-3 District at premises 641 G Street~~, S.W. (Square 467 Lot 212).
Does the property satisfy the area variance test to have three employees when only two are permitted?

1. **The property exhibits uniqueness for a dental office in that it is a corner property with a special entrance-way in the rear of the building on the ground floor. This entry –way does not interfere with normal community traffic.**

2. **The limit of two employees imposes a practical difficulty in the practice of Oral and Maxillofacial Surgery. An example of a common activity in this ~~type of practice is extraction of teeth with the use of Sedation anesthesia.~~ The number of assistants required for a dentist to safely administer sedation anesthesia would be 1) Anesthesia/ Surgical assistant 2) circulating assistant 3) Front desk person available to alert emergency assistance if necessary. This is in compliance with the American Association of Oral and Maxillofacial Surgeons (AAOMS) requirements outlined in it's 2006 Office Anesthesia Evaluation Manual 7th Edition. Further, the DC Board of Dentistry has submitted legislation for how oral surgery and sedation dentistry is practiced in the District of Columbia. At least three assistants are required to practice safe anesthesia in this new proposed law.**

3. **~~The relief could be granted without substantial detriment to the public good~~ and without substantially impairing the intent, purpose and integrity of the Zoning Regulations and Map. I've purchased parking spaces and often my employees utilize public transportation to and from work. My office staff and**

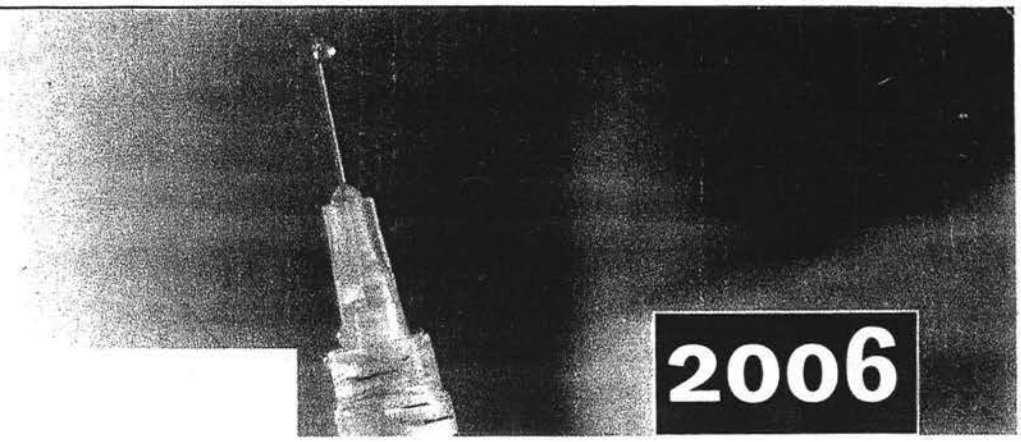
patients utilize the practice in a discreet manner. I've not had any issues over the past thirty years with residents of the neighborhood. In fact, the neighborhood residents have utilized my services and consider my presence in the neighborhood to be an asset.

Please do not hesitate to contact me at the above telephone or email address should you require further information to effect my permit request.

Sincerely,

Daniel N. Howard, DDS
Oral and Maxillofacial Surgeon

American Association of Oral and Maxillofacial Surgeons



Office Anesthesia Evaluation Manual

7TH EDITION

Cardiac arrest classically has been associated with an ashen-gray appearance of the skin, flaccid body posture, and dilated pupils. It is important to realize that these signs may not occur until several minutes after arrest. Therefore, it is important to monitor vital signs, particularly heart rate and blood pressure, to allow detection of cardiac arrest before there is gross evidence of hypoxia. The more hypoxic the tissues become, the poorer is the prognosis for successful resuscitation.

THE RESUSCITATIVE TEAM

The basic CPR team usually consists of two members, but in OMS offices in which IV and inhalation anesthetic techniques are employed, a three-member team with the following assignments is suggested:

- Member 1 – Maintenance of the airway and ventilation of the lungs
- Member 2 – Compression of the heart
- Member 3 – Drug administration

If additional personnel are available, they can assume the following responsibilities:

- In-room circulating assistant to marshal equipment, maintain a continuous record of events, and other activities
- Outside-of-room circulating assistant to make telephone calls for ambulance, hospital, physician, and other necessary personnel

It is essential that the team have regularly scheduled practice drills to ensure their preparedness.

CPR TRAINING

It is recommended that the oral and maxillofacial surgeon and assistants participate in CPR training programs offered by the American Heart Association through its local offices. The AAOMS Committee on Anesthesia requires that the oral and maxillofacial surgeon also be current in ACLS protocol. This offers the entire staff the opportunity to become trained in proper CPR techniques and enables personnel to be updated in CPR methods through periodic refresher courses.

The EMS system should be activated as soon as cardiac arrest is diagnosed.

Treatment

This section is derived directly from 2005 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care: Part 7.2: Management of Cardiac Arrest. Circulation. 2005;112(suppl IV):IV-57-IV-66.

The patient should be supine on the operating table or in a chair that is firm enough to administer CPR, with the feet slightly elevated. The patient should not be moved from the operating chair or table onto the floor because if intubation is necessary, it may be very difficult to execute on the floor. Further, such movement may dislodge the IV catheter.

Treatment begins by assessing the patient and initiating CPR. The patient should be defibrillated according to current ACLS protocol, and the EMS should be activated as soon as the diagnosis is made. In 80% of cardiac arrest victims, VF is the initial arrhythmia. Using quick-look paddles and after ascertaining the presence of VF/pulseless VT, the patient should be given one shock (rather than the previously recommended three successive "stacked shocks") because the first-shock success rate for biphasic defibrillators is high, and it is important to minimize interruptions in chest compressions. The time required to charge a defibrillator, deliver a shock, and check a pulse can interrupt compressions for 37 seconds or longer, and interruption of chest compressions reduces coronary perfusion pressure. Several defibrillators now use defibrillation waveforms that differ from traditional monophasic waveforms. In most patients, biphasic waveform shocks have proved to be effective at lower current levels than monophasic waveforms. Importantly, early defibrillation increases patient's chance of survival, regardless of waveform.

Based on limited evidence of efficacy and reports of potential harm (e.g., deterioration in cardiac rhythm and asystole), the American Heart Association does not recommend use of the precordial thump by BLS providers and makes no recommendation for its use by ACLS providers.