



**TEXAS STATE BOARD OF DENTAL EXAMINERS**  
1801 Congress Avenue, Suite 8.600, Austin, Texas 78701

Advisory Committee on Dental Anesthesia  
March 2024 Report and Recommendations

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On March 1, 2024, the Advisory Committee on Dental Anesthesia (ACDA) met to review de-identified data provided by the staff of the Texas State Board of Dental Examiners (TSBDE). There were no public comments made during the open meetings. The ACDA consists of members of the dental and medical community appointed pursuant to Board rule 22 Tex. Admin. Code §100.12. The six members present and participating in the preparation of this report were:

Dr. Shelby Nelson, DDS (Chairperson) – Periodontist, Level 3 Provider

Dr. Zeeshan Moorani, DDS – Pediatric Dentist, Level 2 Provider

Dr. Penelope Duke, MD – Physician Anesthesiologist

Dr. Vincent Cavaretta, DDS - Oral and Maxillofacial Surgeon, Level 4 Provider

Dr. Jinsoo Kim, DDS - Dental Anesthesiologist, Level 4 Provider

Dr. Matthew Palmer, DDS – General Dentist, Level 1 Provider

The ACDA was provided a data set pulled from available cases in the TSBDE's complaint files. The criteria to identify these cases came from the statutory authorization for the ACDA in Chapter 258, Subchapter E of the Texas Occupations Code and Board rule 22 Tex. Admin. Code §100.12.

The criteria applied to select the fifteen cases for review were as follows. The TSBDE staff determined all jurisdictional cases where an official investigation was resolved during September 1, 2022 through August 31, 2023 (Fiscal Year 2023), which involved a sedation or anesthesia-related death or incident. Determination of a death or incident was made by applying the criteria present in 22 Tex. Admin. Code §100.12(c)(1),

[a] death shall be considered anesthesia-related if the dental treatment involved the administration of an anesthetic or sedative agent in the dental office, including local anesthesia, and a death occurred. An incident shall be considered anesthesia-related if the dental treatment involved the administration of an anesthetic or sedative agent in a dental office, including local anesthesia, and the Dental Review Panel identified a

complication associated with the administration of the anesthetic or sedative agent.

After compiling the full body of responsive cases, staff determined which cases were resolved by the TSBDE during the prior fiscal year. The body of cases considered for this report were resolved by the TSBDE on or before August 31, 2023, representing cases closed in Fiscal Year 2023.

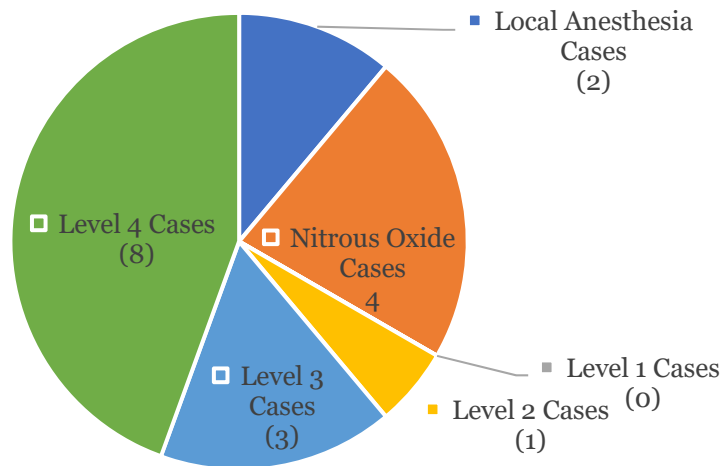
For purposes of the cases identified, “resolved” means closed by the TSBDE through any type of case resolution. This means that the group of cases provided to the ACDA may contain closed investigations that did not result in a public disciplinary action against the licensee in question. The ACDA does not review the disposition status of the resolved cases, and is not provided any identifying information related to the licensee. The resolution date for purposes of identifying data comes from the official date of disposition in the TSBDE’s records, not the date when a licensee or complainant was notified of the outcome of a case.

The data provided to the ACDA by TSBDE staff was de-identified and remained confidential throughout the review process. For purposes of the ACDA’s review, “de-identified” means that the data did not include identifying information of a patient or health care provider; the name, address, or date of birth of the patient or a member of the patient’s family; or the name or specific location of a health care provider who treated the patient. These de-identification and confidentiality provisions were applied by statutory direction pursuant to Tex. Occ. Code §258.206. However, the ACDA was provided with summary information on each complaint and provider, including the Dental Review Panel review for each case (redacted as necessary), along with the full information identified in Board rule 22 Tex. Admin. Code §100.12(c)(2).

## I. Review of Data Provided to Committee

The ACDA reviewed de-identified data provided by the TSBDE's staff pursuant to the methodology discussed in the summary *supra*. The data set for the meetings of the ACDA included fifteen de-identified cases, with patient ages ranging from 3 to 80 years in age. Below are selected data points for the cases included in the ACDA's review.<sup>1</sup>

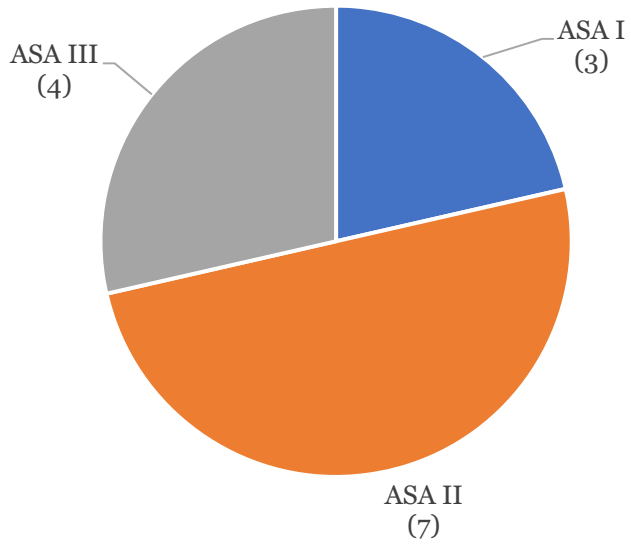
### Highest Level of Sedation or Anesthesia Administered



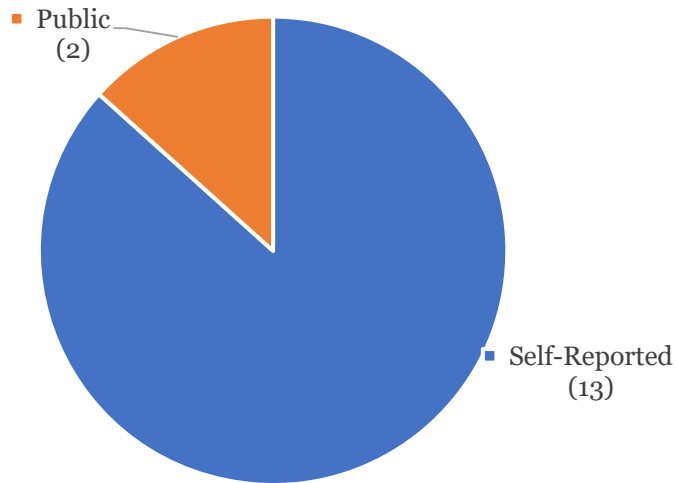
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<sup>1</sup> For one Level 4 anesthesia case, no complications occurred with the administration of Level 4 anesthesia; however, a complication occurred with the administration of local anesthesia.

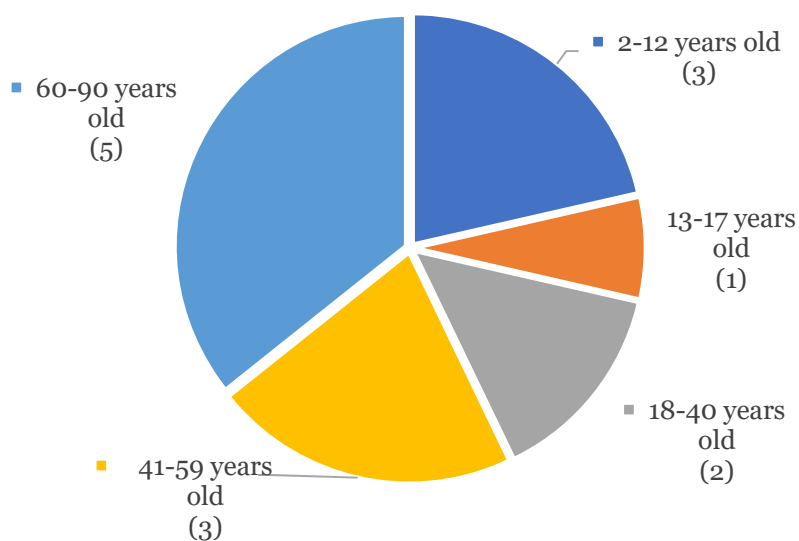
### ASA Status



### Source of Complaint



## Patient Age



The ACDA conducted a review of the data associated with each of the fifteen complaints during its meeting on March 1, 2024. After a thorough review of the available data, the ACDA provides the following trends, recommendations and guidance to the TSBDE for consideration.<sup>2</sup>

## II. Trends

During discussion of the data, the ACDA identified the following trends present in the cases reviewed:

- Local Anesthesia Presents a Risk of Complications – Two out of the 14 cases reviewed had local anesthetic administered beyond maximum recommended dosages.
- Patient Selection – Adverse events occurred in patients where the providers made poor choices pertaining to patient selection. For example, patients with high body mass indices with comorbidities had sedation related complications.

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<sup>2</sup> ACDA Member Dr. Duke appeared remotely via Zoom during the meeting, but because she experienced technical difficulties, she was unable to participate in the committee's vote on the trends and recommendations provided in this report.

- Length of Procedures – Adverse events are more likely when procedures are lengthy. Two out of the 14 cases reviewed were beyond three hours, with one case being 7½ hours long.
- Insufficient Monitoring – The ACDA noted that the most common time for when complications occurred was post-operatively during patient recovery. Some patients were inadequately monitored based on how deeply they were still sedated, or not monitored at all. Factors such as medically complex patients and high body mass indices played a role in these complications.

### III. Recommendations

Based upon the discussion of cases available to the ACDA, the committee makes the following recommendations to the TSBDE for consideration and possible action:

- Change Board Rule Relating to Deep Sedation/General Anesthesia – The ACDA noted that in some cases of deep sedation/general anesthesia, the sedation provider may have delegated monitoring to auxiliary personnel prematurely. Board rule 22 Tex. Admin. Code §110.6 requires a dentist who administers deep sedation or general anesthesia to monitor the patient. Specifically, subsection (c)(4) provides that “A qualified dentist administering deep sedation or general anesthesia must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for discharge to the recovery area. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility.” The ACDA recommends that the TSBDE amend the rule to make it clearer that the sedation provider is responsible for direct monitoring until the patient is no longer under deep sedation/general anesthesia, i.e. the patient has entered a level of moderate sedation or lower, at which time the sedation provider may delegate monitoring to auxiliary personnel. The amended version of the rule could add a definition to clarify the “criteria for discharge to the recovery area” to mean the following: “The patient may be discharged to a recovery area for monitoring by auxiliary personnel once the patient has reached moderate sedation or lower.”
- Change Statute Relating to Confidential Investigation Files – Section 254.006 of the Texas Occupations Code provides that the Board’s investigation files are confidential. The ACDA recommends changing the statute to allow sedation providers to review de-identified investigation cases, which involve a sedation or anesthesia-related death or incident as defined in 22 Tex. Admin. Code §100.12(c)(1), for educational/learning purposes. The ACDA believes that reviewing the cases will help providers have a better understanding of the importance of patient selection. The ACDA also recommends that the Board allow continuing education credit for providers who review such cases.

- Length of Procedures – The ACDA notes that providers should consider the anticipated length of procedures in sedation/anesthesia cases for in-office procedures because longer procedure times can lead to complications.

The ACDA would like to thank the TSBDE team for their support and assistance with the meetings. We all strive to make dental care and sedation/anesthesia safe and effective for Texas residents.