



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

Advisory Committee on Dental Anesthesia
March 2026 Report and Recommendations

On March 27, 2026, 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 meeting. 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. Jinsoo Kim, DDS (Chairperson) - Dental Anesthesiologist, Level 4 Provider

Dr. Shelby DeMayo, DDS – Periodontist, Level 3 Provider

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

Penelope Duke, MD – Physician Anesthesiologist

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

Dr. Ellis Shwartz, 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 twenty cases for review were as follows. The TSBDE staff determined all jurisdictional cases where an official investigation was resolved during September 1, 2024 through August 31, 2025 (Fiscal Year 2025), 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, 2025, representing cases closed in Fiscal Year 2025.

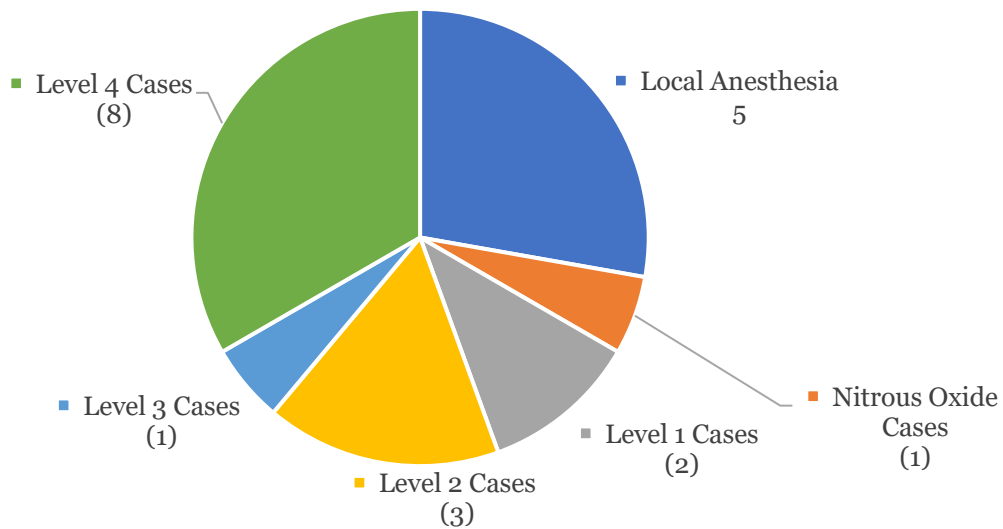
For purposes of the cases identified, “resolved” means closed by the TSBDE through any type of case resolution. This means that the group of cases provided to the ACDA may contain closed investigations that did not result in a public disciplinary action against the licensee in question. The ACDA does 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).

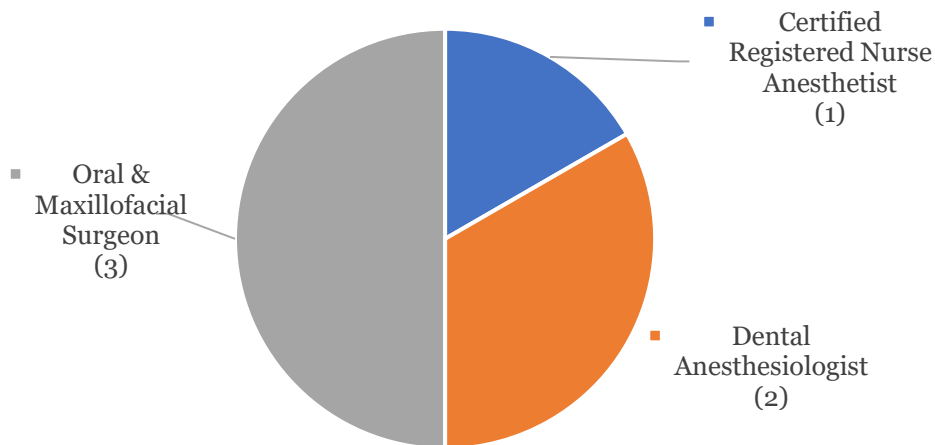
I. Review of Data Provided to Committee

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 meeting of the ACDA included twenty de-identified cases, which included 18 patients who were 4 to 80 years in age. Below are selected data points for the cases included in the ACDA's review.

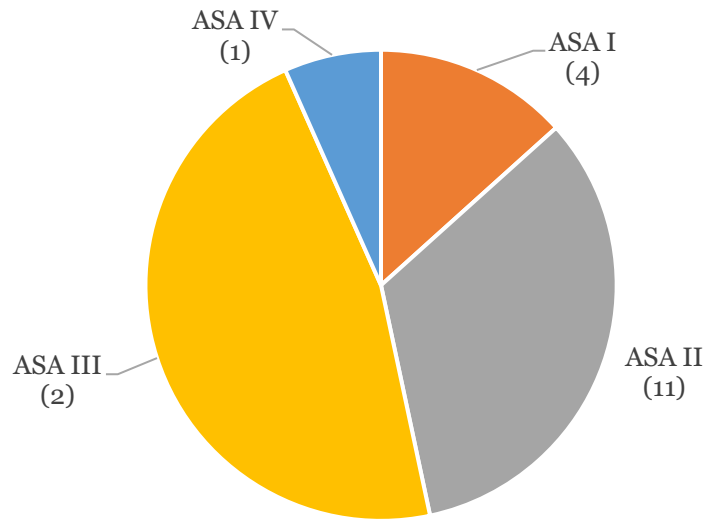
Highest Level of Sedation or Anesthesia Administered



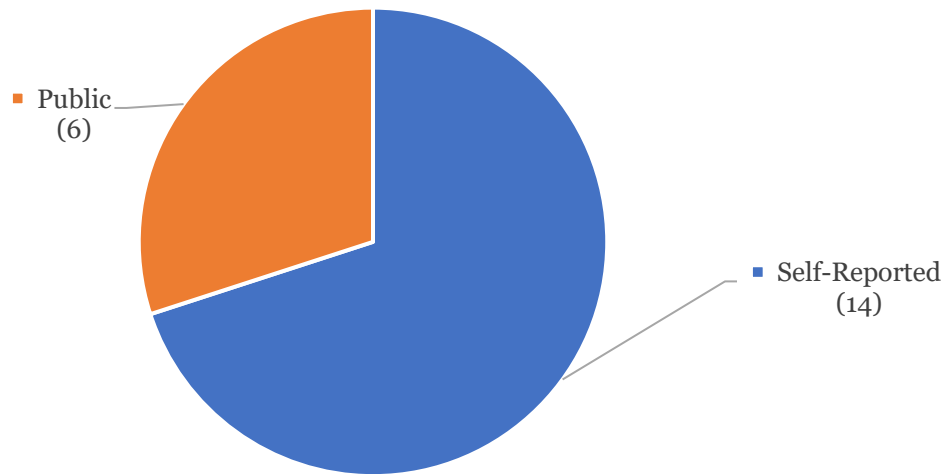
Providers Who Administered Level 4 Sedation/Anesthesia



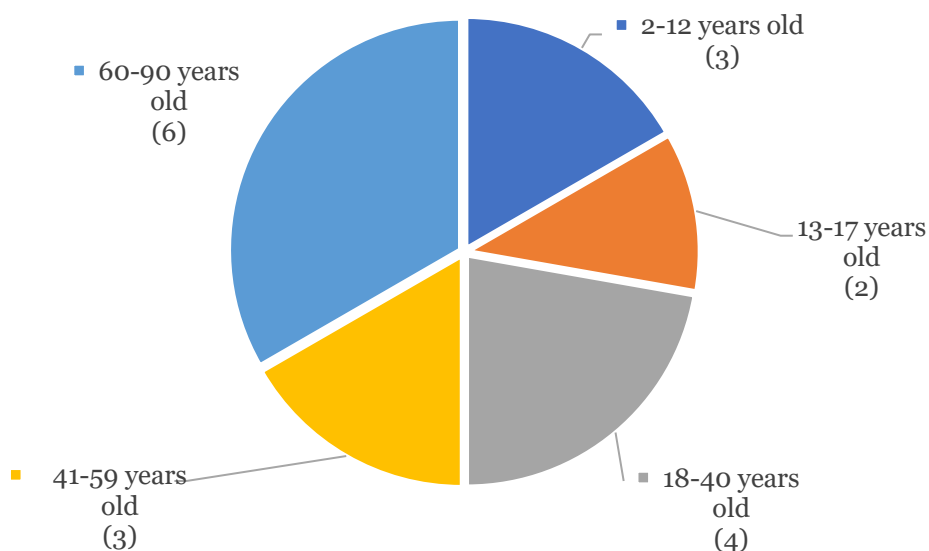
ASA Status



Source of Complaint



Patient Age



The ACDA conducted a review of the data associated with each of the twenty cases during its meeting on March 27, 2026. After a thorough review of the available data, the ACDA provides the following trends, recommendations and guidance to the TSBDE for consideration.

II. Trends

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

1. Patient Selection. Adverse events occurred in patients in 2 out of the 20 cases where the providers made poor decisions pertaining to patient selection. The ACDA noted the following:
 - a. Providers did not update the patient's health history.
 - b. Providers ignored pertinent information in the health history and failed to obtain additional information to delineate extent of co-existing disease.
 - c. Providers failed to appreciate accumulative risk when comorbidities are combined with extensive surgical procedures in the office-based setting.
2. Length of Procedure. The ACDA noted that 3 out of the 20 cases lasted more than 4 hours under general anesthesia in an office-based setting.
3. Local Anesthetic Dosage. 3 out of the 20 cases involved adverse events after administering local anesthetic beyond the maximum recommended dose (MRD).

4. Delay in Activating EMS. The ACDA noted that a provider waited 5 hours before activating EMS when emergence from anesthesia lasted longer than anticipated.

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:

1. Patient Selection
 - a. Coordination of care must occur between ALL providers. The decision to proceed with the procedure is the result of careful pre-operative evaluation by both the operating dentist and the anesthesia provider. All providers share in the responsibility to NOT move forward with a procedure if contraindications exist.
 - b. Pre-operative evaluations from medical specialists should be requested when clinically indicated.
 - c. Consider listing the estimated length of procedure, estimated MRD of local anesthesia, and the level of anesthesia on the consult form.
 - d. Communication prior to the day of the procedure between the anesthesia provider and the treating dentist allows for effective and meaningful coordination of care.
2. Length of Procedure
 - a. Consider listing the estimated length of the procedure on the pre-operative checklist.
 - b. Prolonged procedures should be segmented to minimize risks associated with extended anesthesia time.
3. Local Anesthesia Toxicity. Document the MRD of local anesthesia on the pre-operative checklist by recording the patient's body weight on the day of the procedure and recognizing that different local anesthesia may have a cumulative toxic effect.
4. EMS Activation. Early EMS activation impacts patient survival. Providers and their office staff should regularly train on EMS activation so they are comfortable in the event it is required.

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