TEXAS STATE BOARD OF DENTAL EXAMINERS
333 Guadalupe Street, Tower 3, Suite 800, Austin, Texas 78701-3942

Advisory Committee on Dental Anesthesia
March 2022 Report and Recommendations

On March 4, 2022, the Advisory Committee on Dental Anesthesia (ACDA) met for the third time 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 five members present and participating in the preparation of this report were:

Dr. Lisa Masters, DDS (Chairperson) – Periodontist, Level 3 Provider

Dr. Frank Ford, DDS - Dental Anesthesiologist, Level 4 Provider

Dr. Scott Ludlow, DDS - Pediatric Dentist, Level 2 Provider

Dr. Robert Peak, DDS - Oral and Maxillofacial Surgeon, Level 4 Provider

Dr. Wayne Radwanski, DDS - General Dentist, Level 1 Provider

One member, Dr. Joseph (Max) Hendrix, MD (Physician Anesthesiologist), was absent from the meeting, but participated in the preparation of this report. 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 fifty-four cases for review were as follows. The TSBDE staff determined all jurisdictional cases where an official investigation was initiated on or after September 1, 2016, 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.

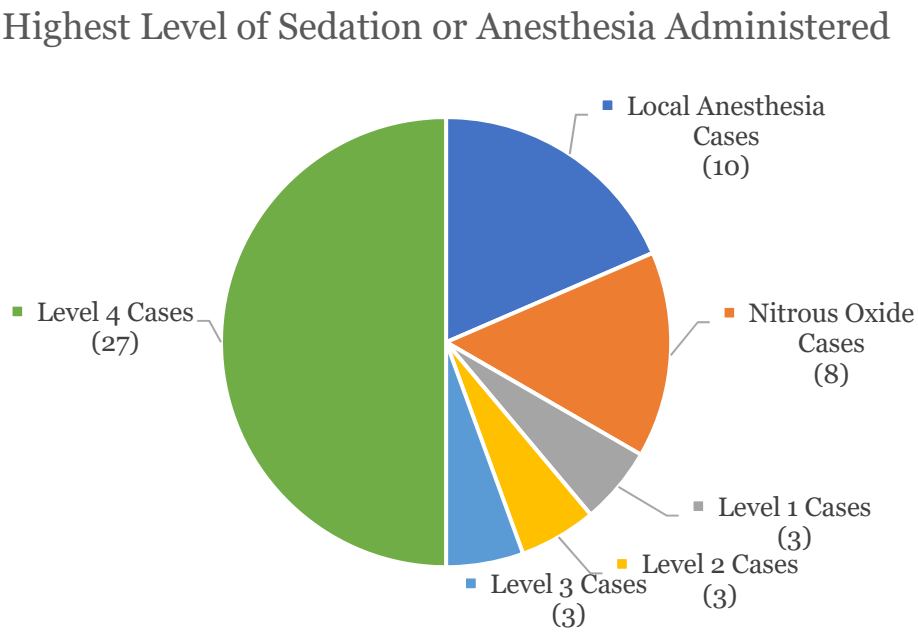
After compiling the full body of responsive cases, staff determined which cases were resolved by the TSBDE during the prior fiscal years. Because the ACDA did not meet in 2021, the body of cases considered for this report were resolved by the TSBDE on or before August 31, 2021, representing cases closed in Fiscal Years 2020 and 2021.

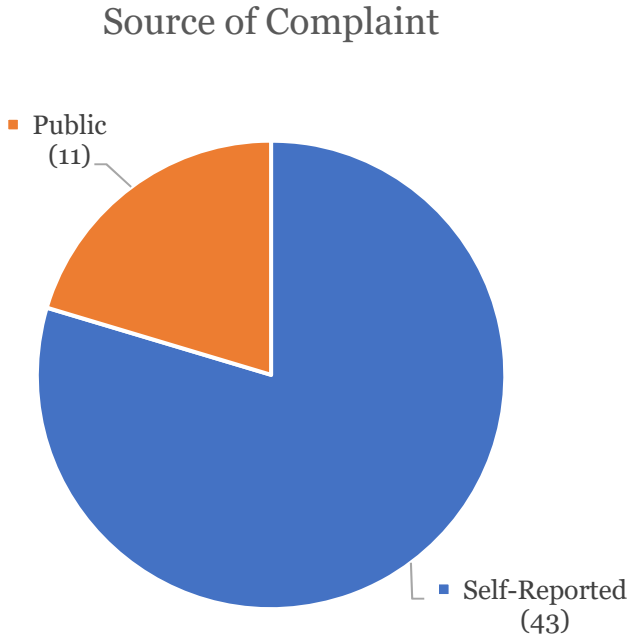
For purposes of the cases identified, "resolved" means closed by the TSBDE through any type of case resolution. This means that the group of cases provided to the ACDA may contain closed investigations that did not result in a public disciplinary action against the licensee in question. The ACDA does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

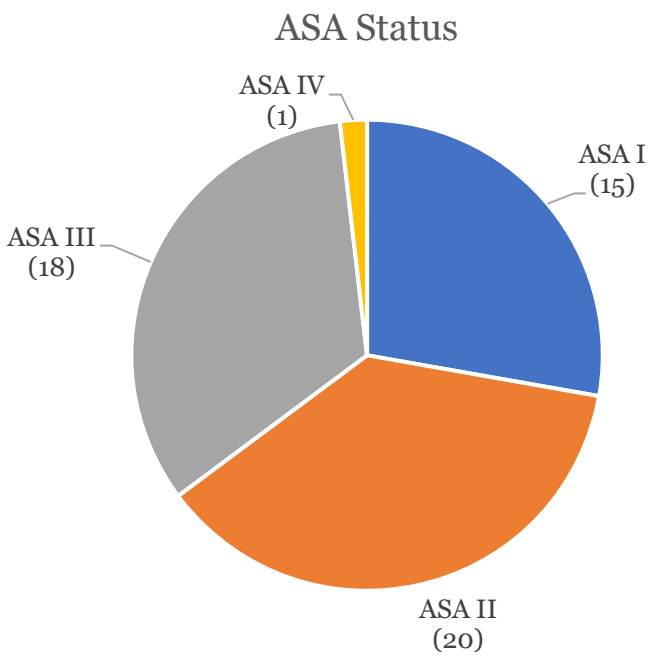
The data provided to the ACDA by TSBDE staff was de-identified and remained confidential throughout the review process. For purposes of the ACDA's review, "de-identified" means that the data did not include identifying information of a patient or health care provider; the name, address, or date of birth 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).

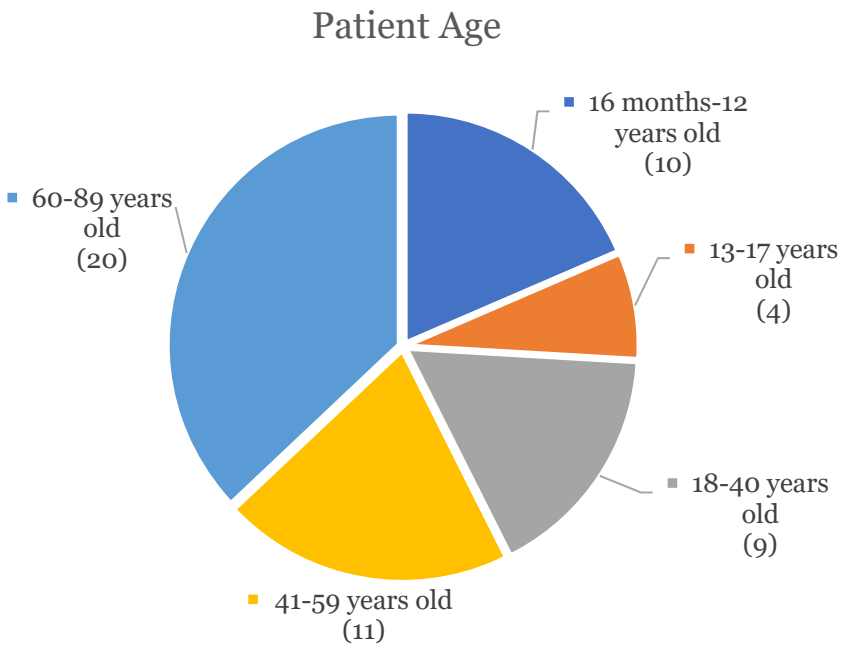
I. Review of Data Provided to Committee

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 third meeting of the ACDA included fifty-four de-identified cases, with patient ages ranging from 16 months to 89 years in age. Below are selected data points for the cases included in the ACDA's review.






ASA Status
ASA IV
(1)
ASA I
(15)
ASA III
(18)
ASA II
(20)


Patient Age
16 months-12 years old
(10)
13-17 years old
(4)
18-40 years old
(9)
41-59 years old
(11)
60-89 years old
(20)

The ACDA conducted a review of the data associated with each of the fifty-four complaints during its meeting on March, 4, 2022. 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.

- Patient Consults – Providers did not provide sufficient information to the patient's primary care physician or specialist to obtain an adequate response. Medical professionals did not adequately evaluate patients prior to their dental office sedation/anesthesia, which led to improper ASA classification. Thus, providers were treating high risk patients although the providers did not have the required authorization from the Board to administer sedation/anesthesia to high risk patients.

- High Risk Patients - Providers who treated high risk patients did not have the required authorization from the Board to administer sedation/anesthesia to high risk patients. It is unknown whether patients mispresented their medical status, or providers were attempting to include more patients in their scope of practice, but providers should be prepared in the event patients are not forthcoming with their medical status.

- Adverse Events - Adverse events occurred in patients where the provider under classified the patient's ASA status, i.e. patients were sicker than the provider classified. This led to providers treating patients beyond the providers' permit level. Providers are required to receive authorization from the Board before administering sedation/anesthesia to high risk patients. The ACDA also noted that adverse events were more common in medically compromised patients or patients with comorbidities, especially when combined with long treatment times. Extra caution should be taken when planning and performing these cases including considering shorter, less intensive appointments for these patient populations. Overall, adverse events occurred because providers used poor judgment and did not adhere to TSBDE rules.

- Access to Hospitals is Critical - Adverse events occurred when medically compromised patients or pediatric patients were treated in a dental office setting in lieu of a hospital or surgery center where medical support was readily accessible. Patient care would have occurred sooner if the patient's treatment occurred in the hospital. Although access to treating patients in a hospital setting is lessening for dental practitioners, the ACDA encourages a utilizing a hospital setting for pediatric and medically compromised patients to lessen the possibility of adverse events.

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.

- Medical Evaluations and Advanced Training – The ACDA recommends the TSBDE require providers to obtain a medical evaluation for patients who were not evaluated by their medical professional within the past year. The ACDA encourages providers to obtain more advanced training in the event that a patient has an undiagnosed medical condition.

- Providers Should Review the PMP Prior to Administering Sedation/Anesthesia - Although the ACDA did not have any cases where patients experienced an adverse event due to false reporting of medications taken, the ACDA still recommends a rule change to require providers to consult the Texas Prescription Monitoring Program (PMP) prior to patients receiving sedation/anesthesia for a dental procedure. Significant adverse events can be prevented with full knowledge of medications that patients are taking prior to induction of sedation/anesthesia.

- Change Board Rule Relating to Preoperative Checklist for Administration of Nitrous Oxide - Board rule 22 Tex. Admin. Code §110.13 requires dentists administering nitrous oxide or Level 1, 2, 3, or 4 sedation/anesthesia to create and maintain a preoperative checklist. Subsection (c) lists the documentation a preoperative checklist must include "as applicable for each level of sedation/anesthesia administered, consistent with the requirements of §§110.3-110.6." In the eight nitrous oxide cases the ACDA reviewed, the ACDA believes the completion of the pre-operative checklist was not helpful to deter the complications. The ACDA recommends the TSBDE change the rule to make it clearer that the preoperative checklist for nitrous oxide does not require the same documentation for a preoperative checklist for Level 1, 2, 3, or 4 sedation/anesthesia, or remove the nitrous oxide preoperative checklist requirement from the rule.

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.