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

Advisory Committee on Dental Anesthesia
October 2020 Report and Recommendations

On October 14, 2020, the Advisory Committee on Dental Anesthesia (ACDA) met for the second 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 22 Tex. Admin. Code § 100.12. The six 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

Dr. Joseph (Max) Hendrix, MD – Physician Anesthesiologist

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 forty-one cases for review were as follows. The TSBDE staff determined all jurisdictional cases where an official investigation was initiated on or after September 1, 2017, 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.

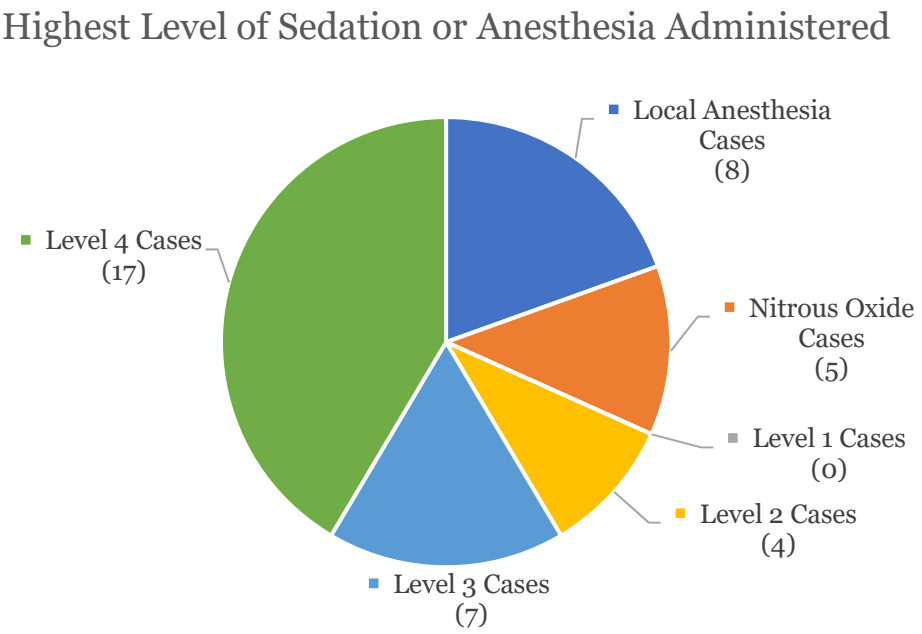
After compiling the full body of responsive cases, staff determined which cases were resolved by the TSBDE during the prior fiscal year. The body of cases considered for this report were resolved by the TSBDE between September 1, 2018, and August 31, 2019, representing the cases closed in Fiscal Year 2019.

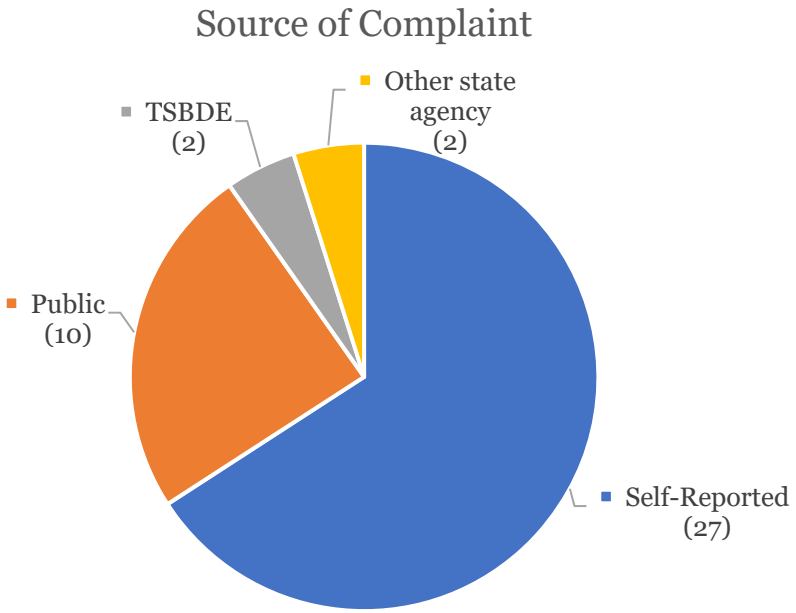
For purposes of the cases identified, "resolved" means closed by the TSBDE through any type of case resolution. This means that the group of cases provided to the ACDA may contain closed investigations that did not result in a public disciplinary action against the licensee in question. The ACDA does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

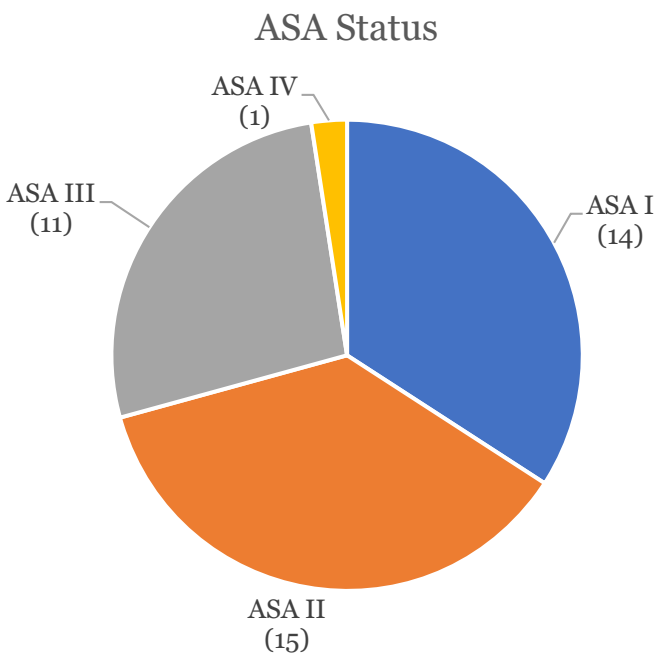
The data provided to the ACDA by TSBDE staff was de-identified and remained confidential throughout the review process. For purposes of the ACDA's review, "de-identified" means that the data did not include identifying information of a patient or health care provider; the name, address, or date of birth 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 second meeting of the ACDA included forty-one de-identified cases, with patient ages ranging from 6 months to 70 years in age. Below are selected data points for the cases included in the ACDA's review.







The ACDA conducted a review of the data associated with each of the forty-one complaints during its meeting on October 14, 2020. 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.

- Portability - Portability did not appear to have any relationship to adverse events.

- Administration of Benzodiazepines Prior to Dental Procedures for Anxiolytic Purpose - Enteral administration of benzodiazepines prior to dental procedures for anxiolytic purposes did not appear to have any relationship to adverse events.

- Local Anesthesia Presents a Risk of Complications - Even local anesthesia, which is routinely used for most dental procedures, is not without risk. Many minor, yet adverse events, occurred with local anesthesia.

- Patients May be Sicker Than They Report on Their Medical History - Caution should be taken with adult patients who have not had regular medical examinations. Dentists who provide sedation/anesthesia in the dental office setting are encouraged to consult with medical professionals, providing specific information relative to planned treatment with that consult, and request specific guidelines for modifications to proposed treatment. Medical optimization (not clearance) is a process of assessment and planning prior to treatment, which

enables dentists to gather necessary information prior to making critical decisions regarding administering anesthesia to medically compromised patients as it is the dentist who is ultimately responsible for administering anesthesia.

- Adverse Events - Adverse events are more likely to happen in pediatric and medically compromised patients. The ACDA also noted that adverse events were more common in medically compromised patients 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.

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.

- Providers Should Review the PMP Prior to Administering Sedation/Anesthesia - Although the ACDA did not have any additional 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.

- Providers Should Determine the Appropriate Treatment Location - Adverse events occurred when medically compromised patients or patients with comorbidities were treated in a dental office setting in lieu of a hospital or surgery center where medical support was readily accessible. The ACDA recommends that the treatment location for dental services be appropriate for the patient's overall health status.

- Expand the Scope of Information Presented to ACDA for Review – Section 258.206(a) of the Texas Occupations Code provides "[t]he board shall identify complaints resolved by the board that involve anesthesia-related deaths or incidents and compile confidential, de-identified information derived from the investigative files on each complaint identified under this subsection." Section 258.206(b) provides in part "[t]he board shall provide information compiled under Subsection (a) to the advisory committee." In accordance with the statute, the ACDA reviews data from complaints received by the TSBDE that involve anesthesia-related deaths or incidents. However, the ACDA recommends a change to the statute to expand the scope of information reviewed by the ACDA. In other words, the ACDA requests authorization to review data compiled by Board staff including, but not limited to, complaints resolved by the TSBDE. Board rule 22 Tex. Admin. Code § 108.6 lists the self-reporting requirements for when a patient death or hospitalization occurs. The ACDA recommends the TSBDE expand the rule to include self-reporting of adverse events in order to allow for compilation and review of more information. The ACDA also recommends Board staff create a

mechanism in the proposed expanded self-report rule that does not allow disciplinary action to occur in order to encourage dentists to report adverse events.

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.