Ohio State Dental Board
77 S. High Street, 17th Floor
Columbus, Ohio 43215-6135

REDACTED

(614) 466-2580 Tel
(614) 752-8995 Fax
Dental.Ohio.Gov

NOTICE OF OPPORTUNITY FOR HEARING
Case # 2023-00307

April 30, 2025

Faisal A. Quereshy, D.D.S
3591 Reserve Commons Drive
The Keystone Building
Suite 300
Medina, Ohio 44256

VIA: RPost Registered Email
faq@case.edu

Dear Dr. Quereshy,

In accordance with Chapter 119. of the Ohio Revised Code ("O.R.C."), you are hereby notified that the Ohio State Dental Board ("Board") proposes under authority of O.R.C. Sections 4715.30 and 4715.03 to suspend, place on probationary status, revoke, refuse to renew, or refuse to reinstate, or censure your license to practice dentistry for the following reasons:

1. On or about August 4, 2023, you treated Patient 1 (as identified in the Patient Key, to remain confidential and not subject to public disclosure). You intended to extract several of Patient 1's teeth while Patient 1 was under anesthesia. Patient 1 went into cardiac arrest within minutes of receiving anesthesia.

2. You deviated from the standard of care in the following ways:

    a. You incorrectly assessed Patient 1's American Society of Anesthesiologist's ("ASA") classification as an ASA I, which indicated the lowest level of risk despite the fact that Patient 1 was morbidly obese with multiple risk factors regarding airway compromise and respiratory complications. The risk of losing Patient 1's airway was apparent from his physical description and the photos provided of this patient.

    b. You failed to accurately determine Patient 1's weight. You charted Patient 1's weight as three hundred fifteen (315) pounds when the patient's actual weight was forty (40) pounds greater.

c. You failed to have Patient 1 receive a full evaluation by a physician prior to Patient 1's dental procedure. Patient 1 had a BMI of 40 or greater, which made the patient's physical status classification an ASA III. This classification demanded a full evaluation by a physician prior to Patient 1's dental procedure.

d. You changed (or permitted to have changed) the anesthesia record regarding Patient 1's airway risk stratification on the preoperative evaluation *after* the events of the operative day.

e. You failed to perform a STOP BANG evaluation on Patient 1 when Obstructive Sleep Apnea was marked on his preoperative evaluation.

f. You failed to properly assess Patient 1 during the administration of anesthesia, giving medications one after the other without any pause between administration to assess effectiveness and then, within minutes, placing a throat pack and starting surgery.

g. You assigned a research fellow who is not licensed to practice dentistry in Ohio, to take the clinical role of dental assistant when your contract specified that he was only to observe and have no patient contact. The research fellow monitored Patient 1's vital signs and assisted with optimization of the airway when it was found that the patient was not ventilating properly. The research fellow also performed CPR along with the rest of the team after the patient was found to be pulseless.

3. Once Patient 1 entered cardiac arrest, you deviated from the standard of care in the following ways:

   a. You administered epinephrine through an endotracheal tube.

   b. You failed to administer epinephrine every two (2) minutes with pulse checks, administering only one dose of epinephrine before emergency medical services arrived fifteen minutes later.

   c. You failed to administer reversal agents to counter the narcotics and benzodiazepines administered to Patient 1.

4. Patient 1 expired because of acute hypoxic respiratory failure as a result of procedural sedation.

Section 4715.30(A), O.R.C., authorizes the Board to discipline the holder of a license issued under this Chapter for any of the following reason(s): (9) Providing or allowing dental hygienists, expanded function dental auxiliaries, or other practitioners of auxiliary dental occupations working under the certificate or license holder's supervision, or a dentist holding a temporary limited continuing education license under division (C) of section 4715.16 of the Revised Code working under the certificate or license holder's direct supervision, to provide dental care that departs from or fails to conform to accepted standards for the profession, whether or not injury to a patient results. The conduct alleged in paragraphs (1) through (4), inclusive, constitutes violations of Section 4715.30(A)(9), O.R.C.

Accordingly, the Board is authorized to impose one or more of the sanctions cited in Section 4715.30 O.R.C.

Pursuant to Chapter 119. of the Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request a hearing, the request must be made in writing and must be received in the offices of the Board within thirty days of the date of service of this notice.

You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or you may present your position, arguments or contentions in writing. At the hearing you may present evidence and examine witnesses appearing for or against you.

If you timely request a hearing, you are entitled to receive at least sixty (60) days in advance of the hearing, if so requested, a copy of each item the Board procures or creates in the course of the investigation. Such items may include, but are not limited to, the one or more complaints filed with the Board, correspondence, reports and statements; deposition transcripts; and the patient(s) dental records. The Board may charge a reasonable fee for providing copies. Before providing the copies, the Board shall determine whether the investigative items contain any personal identifying information regarding a complainant. If the Board determines that the investigative items contain such personal identifying information, or any information that would reveal the identity of a complainant, the Board shall redact the information from the copies it provides. The Board shall not provide any information that is subject to the attorney-client privilege or work product doctrine, or that would reveal the investigatory processes or methods of investigation used by the Board. The Board shall not provide any information that would constitute a confidential law enforcement investigatory record.

If you do not request a hearing within thirty (30) days of the date of service of this Notice, the Board may, in your absence and upon consideration of the foregoing charges, determine whether or not to limit, suspend, place on probationary status, revoke, refuse to renew, or refuse to reinstate, or censure your license to practice dentistry.

BY THE ORDER OF THE OHIO STATE DENTAL BOARD

Supervisory Investigative Panel

KATHY BRISLEY-SEDON, DDS
Secretary

PAUL M. KELLEY, DDS
Vice Secretary

S E A L

CC: Henry G. Appel, Principal Assistant Attorney General, Health and Human Services Section
Joseph T. Palcko, Esq.

I, Miguel A. Santiago, Interim Executive Director of the Ohio State Dental Board, hereby certify that the foregoing Notice of Opportunity for Hearing was emailed to Dr. Faisal A. Quereshy by RPost Registered Email, on this 2nd day of May 2025.

MIGUEL A. SANTIAGO, ESQ.
Interim Executive Director

S E A L

CONFIDENTIAL
PATIENT IDENTIFIER KEY
Case #2023-00307

Patient Number Referenced in Notice of Opportunity for Hearing	**Patient Identity**
Patient 1	[redacted]

Ohio State Dental Board
77 S. High Street, 17th Floor
Columbus, Ohio 43215-6135

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Dental.Ohio.Gov

BEFORE THE OHIO STATE DENTAL BOARD

IN THE MATTER OF:

FAISAL A. QUERESHY, D.D.S.
License No. 30.021003
CASE NO. 2023-00307

ADJUDICATION ORDER

This matter came for consideration before the Ohio State Dental Board (hereinafter "Board") on March 4, 2026. At such time the Board verified that it reviewed the following materials prior to consideration of this matter:

> State's Exhibits; Respondent's Exhibits; Hearing Transcript; Hearing Examiner's Report and Recommendation; Respondent's Objections to the Hearing Examiner's Report and Recommendation; Respondent's Address to the Board; and State's Address to the Board.

Celia Schnupp, Esq., was the Hearing Examiner designated in this matter pursuant to Section 119.09, Ohio Revised Code (ORC). *A true copy of the Report and Recommendation of Celia Schnupp, Esq., is attached hereto and incorporated herein.*

A Notice of Opportunity for Hearing (Notice) was issued on April 30, 2025, which provided notice to FAISAL A. QUERESHY, D.D.S. ("DR. QUERESHY"), that under authority granted by ORC 4715.30, and 4715.03, the Board proposed to suspend, place on probationary status, revoke, permanently revoke, refuse to renew, or refuse to reinstate, or censure his license to practice dentistry.

On this date, the Board weighed the evidence using the legal standard, preponderance of the evidence.

The Board accepted the findings of facts, except as to Fact 27, and modified the findings of fact to include the following findings of fact:

1. Dr. Quereshy failed to perform a full pre-anesthetic physical assessment of Patient 1, including measuring height and weight, and he assessed the patient as an ASA 1 when based on the stated BMI Patient 1 was an ASA 3.

2. Patient 1 reported sleep apnea.

3. Dr. Quereshy did not perform a STOP BANG Test with the patient.

4. Pre-surgery evaluation listed the patient as a 2 on the Mallampati score. After the adverse occurrence, the evaluation was changed and the Mallampati score was changed from a 2 to a 4 on the pre-op exam.

5. Dr. King has extensive experience performing anesthesia for dental procedures.

6. The death certificate states the patient died of acute hypoxic respiratory failure, which is prima facia evidence.

The Board accepted all the conclusions of law and modified the recommendation in the Hearing Examiner's report and recommendation, as set forth below. The rationale for the modification is the following: The Board in its expertise has determined that suspension of the dental license and permanent revocation of the general anesthesia permit are necessary to adequately protect the public.

SUSPENSION

The Board ORDERS that DR. QUERESHY's license to practice dentistry in the state of Ohio shall be suspended for an indefinite period of time but not less than ninety (90) days. It is expressly understood that during this period of suspension the following conditions shall apply:

a. DR. QUERESHY may not perform dentistry or dental hygiene duties, administer anesthesia/sedation, or otherwise treat patients in any manner during the period of suspension;

b. DR. QUERESHY shall not derive income from either a legal or beneficial interest in a dental practice, except income for treatment provided prior to the beginning of the suspension;

c. DR. QUERESHY may not employ any licensed operators, e.g., dentists, dental hygienists, expanded function dental auxiliaries, radiographers, or dental assistants. Independent contractors are deemed to be employees for purposes of this ORDER; and,

d. A receptionist may answer the telephones saying, "Dr. QUERESHY's office" or the name of the practice for the sole purpose of answering questions, scheduling/rescheduling appointments, or making referrals.

e. DR. QUERESHY shall provide a copy of this ORDER to his current employer within three (3) days of the effective date of this ORDER.

PROBATION

After reinstatement of his license to practice dentistry, DR. QUERESHY shall be subject to probationary terms and conditions for a minimum period of five (5) years.

1. DR. QUERESHY shall obey all federal, state, and local laws, and all laws and rules governing the practice of dentistry in Ohio.

2. DR. QUERESHY shall appear in person for interviews with the Board's designated representative, as requested by the Board or its designee.

3. DR. QUERESHY shall fully cooperate with Board investigators in accordance with the Dental Practice Act.

4. DR. QUERESHY shall complete the following continuing education within six (6) months of the effective date of this ORDER:

    a. Five (5) hours of Ethics.
    b. Ten (10) hours of Medical Assessments to include sleep apnea and airway management.
    c. Five (5) hours of Documentation and Record Keeping.

    The continuing education must be taken through a BOARD approved provider and must be approved in advance by the BOARD's Secretary and Vice Secretary. The continuing education hours shall not count towards the continuing education requirements set forth in section 4715.141, ORC.

5. DR. QUERESHY shall submit to the Secretary and Vice Secretary, by the fifth (5th) day of each month, a list of patient initials on whom he has performed the following therapies: oral maxillofacial surgery where sedation has been performed. The Secretary and Vice Secretary, or their designee, may select up to ten (10) cases for whom DR. QUERESHY provided the above-referenced therapies during the preceding month. For each patient selected, DR. QUERESHY shall provide the following documentation:

    a. Pre-operative, working, and post-operative radiographs for each tooth;
    b. Patient clinical notes;
    c. Documentation of symptoms and diagnosis;
    d. Treatment plan;
    e. Treatment records;
    f. Working lengths (if applicable);
    g. Endodontic materials used (if applicable);
    h. Prescriptions and anesthetics used for treatment; and
    i. Any other records requested by the Secretary and Vice Secretary.

    In fulfilling the requirements in this paragraph, DR. QUERESHY may submit color copies of progress notes. Radiographs can be duplicates or copied to a memory stick. At the Secretary and Vice Secretary 's discretion, such records may be reviewed by a consultant to the Board.

    Documents requested by the Secretary and Vice Secretary pursuant to this paragraph must be received by the Board office within fourteen (14) days from the date the request is sent.

    DR. QUERESHY shall not be released from probation until he submits ten (10) cases for which he

has performed oral maxillofacial surgery where sedation has been performed that have been reviewed by the Secretary and Vice Secretary and approved as meeting the standard of care.

6. DR. QUERESHY, upon request by the Board, shall make any or all of his patient records available for inspection and review. At the Board's discretion, such records may be reviewed by a consultant to the Board;

7. DR. QUERESHY shall disclose a copy of this ORDER to every employer on or before his first date of employment as a dentist or before the first date he returns to practice with his current employer;

8. DR. QUERESHY shall submit monthly declarations, to be received by the **fifth (5th) day of the month**, under penalty of Board disciplinary action stating whether there has been compliance with all the conditions of this ORDER;

9. DR. QUERESHY shall submit all reporting and communications required by this ORDER by email to the Board;

10. DR. QUERESHY may not instruct, teach, or present any continuing education courses or training during the probationary period;

11. DR. QUERESHY shall be responsible for the expenses associated with the above probationary requirements;

12. In the event DR. QUERESHY is found to have failed to comply with any provision of this ORDER, and is so notified of that deficiency in writing, such periods of noncompliance will not apply to the reduction of the probationary period;

13. In the event that DR. QUERESHY should leave or reside or practice outside Ohio for three (3) continuous months, DR. QUERESHY must notify the Board in writing of the dates of departure and return. Periods of time spent outside Ohio for three (3) continuous months or more will not apply to the reduction of this period under the ORDER, unless otherwise determined by motion of the Board in instances where the Board can be assured that probationary monitoring is otherwise being performed;

14. Subject to the provisions of Chapter 119, if, in the discretion of the Board, DR. QUERESHY appears to have violated or breached any terms or restrictions of this ORDER, the Board reserves the right to institute formal disciplinary proceedings as provided in ORC 4715.30(C) for any and all possible violations or breaches, including, but not limited to, alleged violations of the laws of Ohio occurring before the effective date of this ORDER.

15. Upon successful completion of his probationary terms, DR. QUERESHY must appear before the Board or its designee before the Board will fully restore DR. QUERESHY's license to practice dentistry.

PERMANENT PRACTICE RESTRICTION

DR. QUERESHY's general anesthesia permit, permit no. GA000815, shall be permanently revoked.

DURATION/MODIFICATION OF TERMS

The Board may only alter the probationary period imposed by this ORDER if: (1) the Board determines that DR. QUERESHY has complied with all aspects of this ORDER; and (2) the Board determines that DR. QUERESHY is able to practice dentistry according to accepted standards of the profession without Board monitoring, based upon an interview with DR. QUERESHY by the Board or its designee.

The Board hereby certifies that this ORDER shall become effective upon the date of certification of service signed below, and is hereby entered upon the journal of the Board for the 4th day of March, 2026.

TIME AND METHOD TO PERFECT AN APPEAL

Any party desiring to appeal shall file a Notice of Appeal with the Ohio State Dental Board, 77 S. High St., 17th Floor, Columbus, OH 43215, setting forth the order appealed from and stating that the agency's order is not supported by reliable, probative, and substantial evidence and is not in accordance with law. The notice of appeal may, but need not, set forth the specific grounds of the party's appeal beyond the statement that the agency's order is not supported by reliable, probative, and substantial evidence and is not in accordance with law.

The Notice of Appeal shall also be filed by the appellant with the court of common pleas of the county in which the place of business of the party is located or the county in which the party is a resident. If any party appealing from the order is not a resident of and has no place of business in this state, the party shall appeal to the Court of Common Pleas of Franklin County. In filing a notice of appeal with the agency or court, the notice that is filed may be either the original notice or a copy of the original notice. The party filing the appeal shall comply with all requirements of Ohio Revised Code Section 119.12. The notice of appeal shall be filed within fifteen days after the service of the notice of the Ohio State Dental Board's Order as provided in Section 119.05 of the Ohio Revised Code.

BY ORDER OF THE
OHIO STATE DENTAL BOARD

The State of Ohio
County of Franklin

I, the undersigned Miguel A. Santiago, Executive Director for the Ohio State Dental Board, hereby certify that the foregoing is a true and exact reproduction of the original Order of the Ohio State Dental Board entered on its Journal, on the 4th day of March, 2026.

By:
Miguel A. Santiago, Esq.,
Executive Director

Date March 16, 2026

(SEAL)

CERTIFICATE OF SERVICE

I hereby certify that a true and accurate copy of the foregoing Order, concerning Faisal A. Quereshy, D.D.S., was sent electronically via RPost this 16th day of March, 2026, to Faisal A. Quereshy, D.D.S., at the following email address: drface@me.com.

By
Miguel A. Santiago, Esq.
Executive Director

cc: Henry Appel, Assistant Attorney General, Ohio Attorney General's Office
Brian Gannon, Esq. and Joseph Palcko, Esq.

RECEIVED
By Ohio State Dental Board at 6:46 am, Jan 13, 2026

OHIO STATE DENTAL BOARD
77 S. High St., 17th Floor
Columbus, Ohio 43215-6135

In the Matter of:	:	Celia Schnupp, Hearing Examiner
Faisal A. Quereshy, DDS	:	
	:	Case No. Case No. 2023-000307
Respondent	:	
	:	
	:	January 12, 2026
	:	
	:	**Hearing Dates: October 22, 23, and 24, 2025.**
	:	
	:	

HEARING OFFICER'S REPORT & RECOMMENDATION

Appearances:
For the Ohio State Dental Board:
Dave Yost, OHIO ATTORNEY GENERAL, and Henry Appel and Caitlyn Johnson, Assistant Attorney Generals, Health & Human Services Section, 30 East Broad Street, 26th Floor, Columbus, Ohio 43215-3400. Telephone: (614) 466-8600;
Emails: Henry.Appel@OhioAGO.gov; Caitlyn.Johnson@OhioAGO.gov.

For the Respondent-Licensee:
Brian Gannon and Joseph Palcko REMINGER Co., LP.A., 200 Public Square, Suite 1200, Cleveland, Ohio 44114; Telephone: (216) 687-1311;
Emails: BGannon@reminger.com; JPalcko@reminger.com

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PRELIMINARY STATEMENT

Before addressing the procedural and substantive matters in this case, the undersigned begins by acknowledging the profound tragedy at the center of this case. On August 4, 2023, Patient 1, a 48-year-old man, underwent dental extractions under general anesthesia at Respondent's practice. Four days later, he died. Patient 1 was a husband, father, and son. His death represents an immeasurable loss to his family and loved ones. The undersigned extends deepest sympathy to Patient 1's family.

SUMMARY OF THE EVIDENCE

All exhibits, even if not specifically mentioned, were reviewed and considered by the Hearing Examiner prior to preparing this Report and Recommendation.

I. PROCEDURAL BACKGROUND

This is an administrative proceeding under Ohio Revised Code (ORC) Chapter 119 and 4765 and Ohio Administrative Code (OAC) Chapter 4715-15. Faisal A. Quereshy, DDS, MD, (hereinafter "Respondent") holds an active license to provide dentistry in the state of Ohio. He also has an active general anesthesia permit that permits him to administer general anesthesia or deep sedation to a patient.

The Ohio State Dental Board (hereinafter the "Board") investigated Respondent after he self-reported an incident involving one of his patients, Patient 1. Respondent saw Patient 1 on July 11, 2023 for a presurgical visit and on August 4, 2023, to extract several teeth while Patient 1 was under anesthesia. At some point after surgery began, Respondent learned that Patient 1 was not breathing. Respondent immediately secured an airway with an endotracheal tube. Respondent directed his staff to call 911 and initiate the ACLS protocol. Patient 1 was transported by EMS to Cleveland Clinic's hospital in Medina where the staff was able to restart Patient 1's heart. Patient 1 died on August 8, 2023. [Stipulation No. 7 (the "Stipulation") filed on October 22, 2025.]

On April 30, 2025, as a result of their investigation, the Board issued a Notice of Opportunity for Hearing ("NOH") to Respondent that pursuant to ORC Sections 4715.30 and 4715.03 it intended to "suspend, place on probationary status, revoke, refuse to renew, or refuse to reinstate, or censure" Respondent's licenses to practice dentistry and to administer general anesthesia due to allegations that Respondent's care to Patient 1 deviated from the standard of

care. The Notice stated that Respondent's care of Patient 1 violated ORC 4715.30(A)(9). Patient 1 was identified in a confidential patient key attached to the Notice. The Notice advised Respondent of his right to request a hearing, if he did so in writing within 30 days. [Ex. 1a]

Respondent requested a hearing through his counsel. [Ex. 2] The Dental Board properly served the notice letter on Respondent and Respondent timely made a request for hearing. [Stipulation No. 5] The Board initially scheduled the hearing for June 12, 2025, but then continued the hearing on its own motion, and advised Respondent that he would be notified of the date, time, and location of the hearing. After the Board appointed the undersigned as a hearing examiner, the parties agreed that the hearing would be held October 22, 2025 through October 28, 2025. [Exs. 3 & 4]

On October 22, 2025, the hearing commenced. Respondent attended the hearing with his counsel as listed above. The hearing provided Respondent the opportunity to testify, to call witnesses, and to cross-examine the State's expert witness through his counsel. The Board was represented by the counsel listed above. The Board was afforded the opportunity to call Respondent as on cross-examination and called Nicole M. King, MD, EM-CQSL ("Dr. King") as an expert witness.

Respondent testified on his own behalf and presented his own testimony to serve as an expert witness.

Exhibits Admitted into Evidence by Stipulation filed on October 22, 2025:

State Ex. 1a	Notice Letter
State Ex. 1b	Confidential Patient Key
State Ex. 2	Request for Hearing
State Ex. 3	Initial Scheduling Order
State Ex. 4	Current Scheduling Order
State Ex. 5a	Self-Report to Dental Board
State Ex. 10	Second Anesthesia Record
State Ex. 12	Controlled Substances Tracking Form
State Ex. 13	Intravenous Daily Log for 8/4/2023
State Ex. 16	Command Log for Medina Police
State Ex. 18	Response to Interrogatories and Requests for Admissions

State Ex. 19	Response to Second Interrogatories
State Ex. 20	ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists
State Ex. 22	Curriculum Vitae of Dr. Nicole King
State Ex. 23	Report from Dr. Nicole King
State Ex. 26	Deposition of Wife of Patient #1
State Ex. 29	Photo of Patient #1
State Ex. 30	Facebook Posts of Patient #1
State Ex. 31	Photos of Surgical Suite
State Ex. 32	Photos of Medication Cart
State Ex. 35	Office-Based Anesthesia Evaluation Manual (excerpt)

Respondent Ex. A	Notice Letter
Respondent Ex. B	Medina EMS Records
Respondent Ex. C	CCF Medina Hospital Records
Respondent Ex. D	Wellington Dental Records
Respondent Ex. E	Mercy Medical Records
Respondent Ex. F	911 Audio
Respondent Ex. G	E-mail from Attorney Pasternak and Doc. 120
Respondent Ex. H	Contract with Ramtin Dastgir
Respondent Ex. I	CV of Ramtin Dastgir
Respondent Ex. J.1	CV of Faisal Quereshy
Respondent Ex. K	Expert Report of Faisal Quereshy

Respondent Ex. L	Referral Slip
Respondent Ex. O	CME and Re-Certification Forms
Respondent Ex. Q	Deposition of Hallie Nunnari
Respondent Ex. R	Deposition of Alicia Carnes
Respondent Ex. S	Deposition of Urszala Suskiewicz
Respondent Ex. T	Deposition of Ramtin Dastgir
Respondent Ex. U	Deposition of Nadeen Haj Ahmed

Exhibits Admitted into Evidence During the Hearing:

State Ex. 17	Death Certificate
State Ex. 21	Article Titled "Causes of the Difficult Airway"
State Ex. 24	Investigatory Deposition Transcript of Dr. Faisal Quereshy
State Ex. 25	Civil Deposition Transcript of Dr. Faisal Quereshy
State Ex. 27	Deposition of Kaitlyn Stupak, Volume One
State Ex. 28	Deposition of Kaitlyn Stupak, Volume Two
State Ex. 33	Transcript of 911 Call
State Ex. 36	Photos of Elevator

II. RESPONDENT'S EDUCATIONAL BACKGROUND, PROFESSIONAL PRACTICE, AND PRIVATE PRACTICE

Educational Background:

1. Respondent was born in Pakistan and raised in Toronto, Canada, where his mother was a physician. [Tr. at 617-618.] He completed his undergraduate education at the University of Toronto and earned his dental degree from SUNY Buffalo Dental School, graduating in 1994. [Tr. at 617-620.] He completed his oral and maxillofacial surgery residency at Case Western Reserve University in Cleveland, Ohio and at the same time, he completed medical school at Case Western.

[Tr. at 619-620.] In 1999, Respondent received both his medical and dental licenses from the State of Ohio. [Tr. p. 621.]

2. In 2000, following the completion of his residency, Respondent completed a one-year CODA-accredited fellowship in facial cosmetic surgery in Salt Lake City, Utah. [Tr. at 618, 621.] He obtained his general anesthesia permit from the Ohio State Dental Board in 2001 and has maintained it by completing required continuing education and maintaining ACLS/BLS certifications. [Tr. at 622-624, 627.]

Professional Relationship with Case Western Reserve University School of Dental Medicine:

3. Respondent joined the faculty at Case Western Reserve University School of Dental Medicine ("Case Western") in 2000 and served there for over two decades. [Tr. at 618.] He was appointed Program Director of the oral and maxillofacial surgery residency program in 2002, a position he held until June 2025. [Tr. at 628, 771.] In this role, he was responsible for accepting and training residents throughout their five-year training period, which included both didactic lectures and clinical skills-based training in the dental school clinics and affiliated university hospital locations. [Tr. at 628, 770.] Respondent, through his private practice Visage Surgical Institute, maintained an "Affiliation Agreement" that allowed residents to observe specialized facial cosmetic surgery cases at his private practice on a case-by-case basis. [Tr. at 629, 757-758.]

4. In July 2025, Case Western placed Respondent on paid suspension and prohibited him from student contact. [Tr. at 771.] Earlier that year, in May 2025, the university discontinued allowing residents to rotate at his private practice, and in June 2025, he was removed as Program Director and the agreement with his private practice was terminated. [Tr. at 770-771.]

Private Practice – Visage Surgical Institute:

5. Respondent owns and operates Visage Surgical Institute ("Visage"), a full-service oral and maxillofacial surgery private practice in Medina, Ohio, which he opened in 2003. [Tr. at 558, 628-629.] The practice focuses on specialized cases, particularly facial cosmetic surgery procedures not commonly seen in university settings. [Tr. at 757-758.] His wife, an endodontist since 1994, is also part of private practice. [Tr. at 618.]

6. As of 2023, Visage employed four dental assistants, all of whom were BLS certified and either ACLS and DAANCE certified or in the process of becoming certified. [Tr. at 558] Hallie Nunnari has been DAANCE certified since 2019. [Ex. Q, p. 16.] Urszula Suskiewicz completed her DAANCE certification in August 2023. [Ex. S, p. 14.] Alicia Carnes was in the process of completing her DAANCE certification in August 2023 and was certified shortly thereafter. [Ex. R, p. 73.]

7. Beyond his private practice, Respondent has hospital privileges to practice oral and maxillofacial surgery at several hospitals including: University Hospitals Cleveland Medical Center, University Hospitals Ahuja Medical Center, and various UH outlying surgery centers. [Tr. at 624.]

8. According to Respondent, he has performed approximately 20,000 cases of office-based general anesthesia over his career, involving induction, maintenance, and emergence. [Tr.

at 634, 742, 797.] Prior to the incident with Patient 1, he had never experienced any patients with significant adverse responses to general anesthesia or had a patient code in his office. [Tr. at 634.]

9. Respondent is Board Certified by the American Board of Oral and Maxillofacial Surgery and American Board of Cosmetic Surgery. His awards, recognitions, academia status, and accolades are numerous. His CV outlines his experience, research, and provides much more information into Respondent's thirty-year career. [Ex. J.]

III. RESPONDENT'S CARE OF PATIENT 1

Referral and Preoperative Consult:

10. Wellington Dental, a general dentistry practice, referred Patient 1 to Visage Surgical Institute for dental extractions due to Patient 1's hyper dental phobia. [Tr. at 664.] Prior to his evaluation at Visage, Patient 1 completed a pre-questionnaire health history form or patient registration information. [Tr. at 145-146, 467; Ex. A at 7-8.] This form is prepopulated by the patient. [Tr. at 467.] On Exhibit A, Patient 1 listed his dentist as "Jonathan Siefker" but did not include a name of a medical doctor or primary care physician. [Tr. at 145-146; Ex. A at 7-8.] In response to the question "Are you under the care of a physician?" on line 3 of page 8 of the form, Patient 1 marked "No." The date of his last physician visit was left blank. [Tr. at 146, 469; Ex. A at 8.]

HEALTH HISTORY:

To our patients: *Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.*

Reason for today's office visit? Impacted wisdom

		Yes	No
1.	***Height*** 5'8" ***Weight*** 315 Are you in good health?	☑	☐
2.	Have there been any changes in your general health in the past year?	☐	☑
3.	Are you under the care of a physician? ***Date of last visit***	☐	☑
	If so, for what are you being treated?		
4.	Have you had any illness, operation or been hospitalized in the past five years?	☐	☑
	If so, describe		
5.	Do you have unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?	☐	☑
	If so, describe where		
6.	Do you have a prosthetic joint / implant? ***If so, describe where***	☐	☑
7.	Have you had a heart valve replacement or vascular graft?	☐	☑
8.	Have you ever had general anesthesia?	☑	☐
9.	Have you, or a family member, had any unusual or serious reactions to general anesthesia?	☐	☑
10.	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☑	☐

11. On the same health history form, Patient 1 indicated the following conditions:

- Item 23 (Hay fever and sinus problems): marked "yes"
- Item 24 (Snoring): marked "Yes"
- Item 25 (Sleep apnea/CPAP): marked "No"

22. Asthma?		✓
23. Hay fever / sinus problems?	✓	
24. Snoring?	✓	
25. Sleep apnea / CPAP?		✓
26. Difficult breathing / other lung trouble?		✓
27. Tuberculosis?		✓

[Tr. at 146; Ex. A at 7-8. First column was yes and second was no.]

Initial Consultation and Pre-operative Evaluation on July 11, 2023:

12. Information on what occurred at the initial consultation was derived from both the patient file and direct testimony. After the referral, Respondent first saw Patient 1 for a consultation at Visage on July 11, 2023. [Tr. at 466, 650, 652.] A preoperative consultation record or note for Patient 1 was completed with some information from the patient form [Ex. A p. 7-8] and then additional information was added from Respondent or his staff. [Tr. at 648 – 649.]

Jonathan R. Siefker, D.D.S

Chief Complaint: Patient presents for extraction of teeth #30 and 32. After discussing with the patient he states that the ref. is incorrect and it should be teeth #1,2 and 30. Pain on and off for over about 2 months. Originally thought he had an ear infection but realized its the upper teeth causing pain. Told the patient we would contact Dr. Siekfers office for a new ref. form. Reviewed medical history with patient. Denies tobacco, marijuana or CBD use.

Dr. Quereshy had medrol dose pack sent to patients pharmacy

Past Medical History: Hay Fever or Sinus Problems, Pre-med needed, Snoring

Medications: 1 NONE

Allergies: 1 NKDA

Physical Exam: Height:____68____ Weight: ____315_____lbs/kg

Airway Classification: class 2

Panorex / PA Date:_05/31/2023_____

PLAN: ___Local __x_General Anesthesia

Removal of teeth # ___1,2,30_____ Other _____

Called Dr. Siefkers office and spoke with Taylor. SHe stated that nothing was written about the upper teeth when the patient was at thier office in may only the lower teeth per. ref. After discussing with the patient the decision was to move forward with extracting teeth #1,2 and 30.

Discussed the general nature of patient's condition and planned procedure, alternative treatments and associated risks Informed Consent signed and in chart. NPO explained; escort required; preop and postop instructions written/ verbal; special risks discussed.

KD

Faisal A. Quereshy, MD, DDS, FACS

[Ex. A, p. 2.]

13. Patient 1's height was listed as 68 inches (5 feet 8 inches) and his self-reported weight was listed as 315 pounds. [Tr. at 119-120, 129; Ex. A at 2.] Respondent did not weigh the patient on the day of the consultation, stating: "We have a scale in our office. * * * Patients can -- are welcome to use it. We do not mandate patients to use that scale." [Tr. at 637.] Respondent stated he had no reason to believe Patient 1's self-reported weight was inaccurate: "I never thought there was a reason to question his reported weight because he had a proper body habitus for that weight and height." [Tr. at 638.] Kaitlyn Stupak, a Visage employee and dental assistant, testified that she had never had an opportunity to believe there was a weight discrepancy such that she felt she needed to weigh a patient. [Tr. at 638; testimony referenced by Respondent.] Visage employee Hallie Nunnari agrees that weight is confirmed if there is a visual discrepancy from the patient's self-reported number. [Ex. Q at p. 72].

14. There were photographs of Patient 1 included in the record. Those were identified as Exhibits 29, 30.

15. General anesthesia was checked as the planned anesthetic approach, and "Pre-med needed" was noted on the form. [Tr. at 119-120; Ex. A at 2.] The Mallampati score was marked as "2" with "class 2 classification for airway" on the pre-operative evaluation. [Tr. at 119, 139; Ex. A at 2.]

16. At the July 11, 2023 appointment, Respondent indicated that he performed a clinical assessment of Patient 1. [Tr. at 656.] He testified that his examination included:

- An interview with the patient regarding why they were there that day.
- Discussion of patient needs and reasons for coming, including the specific teeth to be extracted.
- Review of general health.
- Inquiry about pertinent positives.
- Discussion and review of treatment options including the use of anesthesia.
- Observational assessments done "just by my clinical judgment while talking with the patient, getting a sense of all those things about airway and risk, and getting a risk assessment for the plan."

[Tr. at 656-657.]

17. Beyond this clinical assessment, Respondent provided that he performed a heart and lung exam that day, but he acknowledged he did not use a stethoscope for the heart exam or auscultation of lungs. [Tr. at 652.] Instead, Respondent explained that his clinical assessment was based on observation:

> "If he's tachycardic, fast heart rate, I can see that in his general visual appearance. I can see if he has rapid breathing. I can hear if he has an audible wheeze with some sort of some bronchial problem. I can hear if there is disrupted speech, his overall, just perfusion, and color is a good sense of perfusion, vascular blood supply, cardiac function."
>
> [Tr. at 651-652.]

18. Regarding specific measurements such as thyromental distance, neck circumference, neck range of motion, and interincisal opening, Respondent testified these were done "by more of an eyeball based on [his] experience with patients" rather than actual measurements with instruments. [Tr. at 652-653.]

19. Respondent summarized his examination approach on July 11, 2024 as "[a] lot of it was eyeballing and based on what I physically saw from the patient, and how good general health he was during that consultation day." [Tr. at 657.] Respondent did not require Patient 1 to have a primary care physician consultation prior to surgery. [Tr. at 769.] Patient 1 listed that he was not currently under the care of a physician and did not list a physician on his intake form. [Tr. at 146, 469, Ex. A, at 8.]

20. Patient 1's wife considered him in good health at the time of the surgery and described her husband was healthy, strong, and active. [Tr. at 660.] Respondent agreed with his wife's assessment. [Tr. at 661.]

21. Patient 1 also told Respondent's staff that he considered himself in good health.

	Yes	No
Are you in good health?	☑	☐

[Ex. A.]

22. Besides his weight, Respondent testified that he felt Patient 1 was in relatively good health. [Tr. at 660.]

Day of Surgery – August 4, 2023:

23. Respondent, Visage employees Urszula Suskiewicz, Hallie Nunnari, Alicia Carnes, Kaitlyn Stupak) and Ramtin Dastgir were all part of the initiation of Patient 1's surgery or part of the ACLS protocol after Patient 1 stopped breathing. Patient 1's medical file, data pulled from the medical equipment, and review of a 911 call also provided additional evidence of the surgery timeframe and some audio of the surgical room. There were three people in the room with the patient during the procedure: Respondent, Urszula Suskiewicz, and Ramtin Dastgir. [Tr. at 502.] According to Respondent, Suskiewicz was suctioning and assisting with the surgery and Dastgir's job was holding the airway and looking at the monitors. [Id.]

24. Respondent and Stupak testified that Patient 1 was scheduled for surgery on August 4, 2023, and scheduled to arrive at 6:30 a.m. [Tr. at 436, 684.] Respondent testified that Patient 1 went through the general procedure for surgical patients on the day of surgery including: staff would bring the patient from the waiting room, verify NPO status (nothing to eat or drink for six hours), verify medications taken or stopped, and discuss who would drive the patient home. [Tr. p. 671-672.]

25. Timing of the start of the surgery and when vitals were measured is generally unclear. From the EMS report, the 911 call occurred at 6:56 a.m. [Ex. B] The testimony about the start time of the surgery, the recording from the equipment and machines, and what was tracked and when, were all inconsistent and unclear. The "T=0" on the equipment print out lined up with the start of the capnography machine.

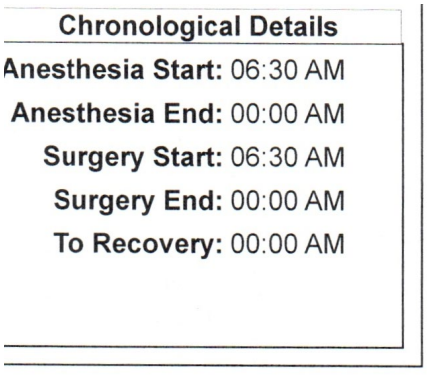


Exhibit A p. 14

Exhibit 10, bates number 42

Vital Signs

	T = 0	T = 10	T = 15	T = 20	T = 24	T = 25
BP	163/103	109/81	115/82	111/86	111/86	115/86
CO2 Exp	4.0	5.0	6.0	8.0	8.0	12.0
CO2 Ins	9.0	5.0	7.0	10.0	10.0	12.0
O2 Sat	92.0	74.0	72.0	75.0	75.0	76.0
Pulse	98.0	43.0	51.0	130.0	64.0	64.0
Resp	4.0	4.0	6.0	7.0	7.0	16.0
Temp	1.0	4.0	4.0	5.0	5.0	8.0

Exhibit A p. 16

PATIENT #001 04-AUG-23
INTERVAL 2M

TIME	RATE	SP02 SYS	DIA	MAP
07:03 AM	---	---		
07:05 AM	94C	---		
BP	80 / 55			70 mmHg
07:05 AM	94C	---		
07:07 AM	---	---		
07:08 AM	82C	---		
BP	63 / 43			51 mmHg
07:09 AM	107P	62%*		
07:11 AM	81C	---		
BP	97 / 77			90 mmHg
07:11 AM	81C	---		
07:13 AM	121P	87%*		
07:14 AM	120P	88%		
BP	72 / 59			64 mmHg
07:15 AM	81P	88%		
07:17 AM	97P	88%		
BP	186 / 77			134 mmHg
07:17 AM	133P	88%		
07:19 AM	---	---		

TIME	RATE	SP02 SYS	DIA	MAP
07:03 AM	---	---		
07:05 AM	94C	---		
BP	80 / 55			70 mmHg
07:05 AM	94C	---		
07:07 AM	---	---		
07:08 AM	82C	---		
BP	63 / 43			51 mmHg
07:09 AM	107P	62%*		
07:11 AM	81C	---		
BP	97 / 77			90 mmHg
07:11 AM	81C	---		
07:13 AM	121P	87%*		
07:14 AM	120P	88%		
BP	72 / 59			64 mmHg
07:15 AM	81P	88%		
07:17 AM	97P	88%		
BP	186 / 77			134 mmHg
07:17 AM	133P	88%		
07:19 AM	---	---		

Exhibit A pp. 3-4

26. Dr. King, along with others, could not determine what time the surgery started, what time anesthesia was given, or what time Patient 1 crashed from reviewing the records. She only knew it was sometime between 6:30 and 7:00. [Tr. at 164.] According to multiple places in the record, Patient 1 crashed approximately five minutes after administration of the anesthesia medications. [Tr. at 169.] The pulse oximetry readings on the test strip [Exhibit A, page 5] showed: 72% at 6:30, 73% at 6:35, 72% at 6:40, and nothing at 6:45, 6:50, and 6:55. [Tr. at 161.]

27. Respondent acknowledged the time on the tape and the time in his record do not align [Tr. at 499]. There are things listed in the vital signs on the tape that are not on the anesthesia record. [Id.] He doesn't know what happened to cause that discrepancy. [Id.] He can't say for certain exactly what time the patient was administered anesthesia, but can give "a best guesstimate." [Id.]

28. Suskiewicz, dental assistant for Patient 1, provided that the anesthesia start for Respondent is when the patient enters the room and surgery time is the time the patient is in the room. [Ex. S at p. 38.] It is not the time Respondent started the procedure. [Id.]

Additional Medical History and Forms completed on August 4, 2023

29. Beyond the information gathered at Patient 1's initial appointment, Respondent and his staff fill out additional medical chart information on Patient 1 on the day of his surgery. This information is included in Exhibit A.

30. Exhibit A pp. 14-16 and Exhibit 10 were both identified as Patient 1's anesthesia record. One was submitted as an attachment to Respondent's self-report and the other was obtained and submitted at a later date. In line with the lack of consistent testimony about the start time of the anesthesia, procedure, or surgery, there are inconsistencies about the information obtained, revised, and contained in Patient 1's anesthesia reports.

31. Exhibit A listed "sleep apnea," which was not present in his medical history records from the July 11, 2023 appointment. The Pre-Operative Evaluation listed a Mallampati Score of 4 and had blanks for all additional physical measurements such as thyromental distance, neck circumference, interincisal opening, and cervical range.

Allergies
1 NKDA

Medical History	
Hay Fever or Sinus Problems	Snoring

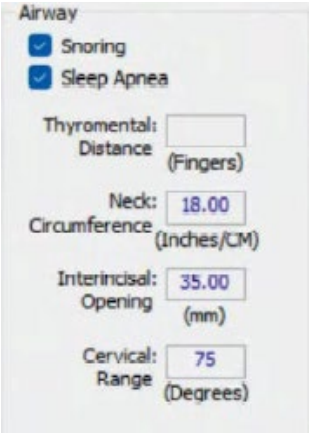
Medications
1 NONE

Surgical History	
Back Surgery	appendix removed
Hernia Repair	

Pre-Operative Evaluation

BP Site :	Left Arm	**Left Arm Position :**	Armboards; Pads; Arm Rest; Restrair
Position :	Supine; Legs Uncrossed;	**Right Arm Position :**	Armboards; Pads; Arm Rest; Restrair
		Eye Care :	Goggles;
Dental Status :	N/A	**Airways :**	☐ Snoring ☑ Sleep Apnea
Lungs :	Clear to P&A;	**Thyromental Distance :**	
Heart :	Normal Sinus Rhythm;	**Neck Circumference :**	
BMI :	47.9	**Interinsical Opening :**	
Category :	Obese	**Cervical Range :**	
		Mallampati Score :	4
Comment :			

32. According to Respondent, Exhibit A is a printout of the record and Exhibit 10 is the second anesthesia report that are screen shots printed from Respondent's computer. [Tr. at 480.] On Exhibit 10, page bates numbered 41, there are entries for thyromental distance (blank), neck circumference, interincisal opening, and cervical range. [Tr. at 482.] Respondent did not document these on the initial printed record and all four measurements were left blank. [Exhibit A at 14] [Tr. at 477 – 478.]



[Ex. 10, bates numbered 41]

Administration of Anesthesia and Starting the Surgery

33. Respondent administered four medications. [Tr. at 513.] According to Exhibit 19 (Second Set of Interrogatories), at approximately 6:45 am, Patient 1 was given: 5 milligrams of Versed, 25 micrograms of Fentanyl, 12.5 milligrams of Ketamine, 3ccs of Propofol, 8 milligrams of Dexamethasone, and 2.5 ccs of Azithromycin. At approximately 6:50 am, 5.4 ccs of 2 percent Xylocaine were given. [Tr. at 165.] He did not titrate between the administration of those medications [Tr. at 513.] Respondent explained titration means after a certain amount of drug you look at the effects and give more if you require deeper effect. [Tr. at 513.] According to Respondent, the medications are synergistic and the amounts were quite low, so giving them together with a pause in between allows the desired effect. [Tr. at 514.]

34. Respondent testified that in his experience of 23 years administering anesthesia to patients of various sizes and ages, the amount he gave was "a very minor, minuscule amount to cause this kind of reaction." [Tr. at 526.]

35. According to Dr. King, the medications (Versed, Fentanyl, Ketamine, Propofol) were given "one after the other, not mixed in one vial, but literary given one, handed off, two, handed off, three, handed off, four, handed off" without allowing circulatory time to titrate to effect. [Tr. at 167.] Dr. King testified this rapid succession administration is problematic because "you're not giving the patient any circulatory time to titrate to effect." This method is used when preparing for general anesthesia with airway takeover, not for moderate to deep sedation where the airway is not secured. [Id.]

36. Suskiewicz recalled that Respondent does not give the medications at the same time and that she was handing him the medications in the syringe to give. [Ex. S at p. 88.] She said there has to be enough time to hand over the syringe and for him to put it on the cannula, take it off, and then pass it back to take another syringe. [Id. at 86.] She also said it is hard to explain the timing and monitoring of the medication, but that Respondent monitors the patient during the administration of the medication. [Id. at 88.]

37. Respondent testified that Suskiewicz was suctioning and assisting him during the surgery and Dastgir's job was holding the airway and looking at the monitors. [Tr. at 503.]

38. Suskiewicz provided that the person holding the airway for Respondent is also the assistant in the room who is in charge of watching the monitors. [Ex. S at p. 172.] Dastgir testified that he did not have the job of watching the monitors and that was Respondent's job. [Ex. T at p. 9.]

Code for Patient 1

39. Although the exact timing is unknown, within minutes of starting anesthesia, Patient 1 became unresponsive. [Tr. at 526.]

40. Respondent and Visage employee Stupak noticed simultaneously that Patient 1 was turning blue in the hands and face and that his vital recordings were off. [Tr. at 761.]

41. Stupak walked by and looked in the window of the operating room to check where they were in the procedure. [Tr. at 437.] She noticed Respondent and Suskiewicz were looking at the TV screen connected to the monitor behind the patient and walked in to see if they needed help. [Tr. at 437-438.] According to Stupak, the pulse-ox "was not loaded on the monitor" so it wasn't showing the number and she walked around to adjust it on a different finger. [Tr. at 438.] At that point, that is when Stupak noticed Patient 1's fingers were turning blue. [Tr. at 439.]

42. According to Respondent, about five minutes after medications were given, while giving local anesthetic, he noticed Patient 1's breathing had slowed down and he had discoloration around his lips. [Tr. at 695-696.] Patient did not respond to local anesthetic (painful stimuli). [Tr. at 696.] Respondent then noticed Patient 1's diminished breath sounds, cyanotic/bluish discoloration around lips, Pulse-ox dropping, and lack of perfusion. [Tr. at 695-696.]

43. There is mixed testimony from the hearing and Respondent's civil deposition about the Pulse-ox alarms. At the hearing, Respondent testified that the Pulse-ox alarm was set at 90% on low end and that he did hear alarms that were all "kind of going off at the same time." [Tr. at 681, 698.] Respondent does not recall the timing of the alarms relative to when he noticed Patient 1's conditions. [Tr. at 698.] According to his civil deposition from January 16, 2025, alarms were not set for C02, only for blood pressure, heart rate, and pulse-ox. [Tr. at 763; Ex. 25 at 243.]

44. Respondent directed his staff to call 911. [Tr. at 561.] The time between when Stupak noticed Patient 1's fingers were turning blue and Respondent asking the front staff to call 911 was "pretty quick" - "Everything happened very quickly". [Tr. at 443-444.] At 6:56 a.m., the 911 call was received. [Tr. at 63, Exhibit B]

45. Stupak remembered other employees coming in who weren't assisting the procedure and bringing in another blood pressure monitor from the recovery room because the blood pressure wasn't picking up. [Tr. at 443-444.]

46. On cross-examination, Stupak recalled that she is unsure of timing as far as who noticed that Patient 1 was turning blue, her or Respondent. [Tr. at 455.]

Ventilation, ACLS, and CPR Efforts

47. Respondent initially suspected airway obstruction. [Tr. at 516.] The details around what happened next are naturally without an accurate timeline from those that were in the room with Patient 1. Respondent testified that they were "[v]ery stressed, very chaotic, we had done mock ACLS training, and we all need to do what we can do to save this patient." [Tr. at 703]

Shortly after the 911 call was received, the Visage front desk transferred the call into the surgical room. [Tr. at 532.] The 911 recording captures some of the communication and timing of Respondent and Visage staff along with recording once the EMT arrived. [Ex. F.]

48. Witnesses provided firsthand eyewitness testimony and also reviewed the audio from the 911 call to provide insight on what happened after Patient 1 became nonresponsive. From the 911 audio and the witness testimony recounting what happened, the following ventilation, ACLS, and CPR efforts were undertaken:

a. Respondent called in extra help from employees. [Tr. at 441.]

b. Respondent directed Alicia Carnes to call 911. [Ex. R at p. 47, 49.] She buzzed the front desk who called 911. [Id. at p. 50.]

c. Suskiewicz alerted Respondent that the pulse ox was somewhere in the 80s and provided a mosquito hemostat so Respondent could pull the tongue forward. [Ex. S at p. 90.] She also observed Dastgir and Respondent tilting Patient 1's jaw forward to aid in opening the airway and she turned up the oxygen on the nasal cannula. [Id. at 90.]

d. Respondent immediately inserted an endotracheal tube (ET) in Patient 1. [Tr. at 517, 701.] Everything was quite collapsed, the lack of tongue, the administration of anesthesia and the recumbent position of the patient. [Tr. at 702.]

e. Hallie Nunnari, Visage employee, immediately started doing chest compressions. [Tr. at 440.] The employees, including Dastgir and Carnes, were rotating compressions. [Tr. at 517.]

f. Respondent could determine that when he instituted the code, airway maneuvers (use of the bag and trach) were working as Respondent could tell that airway was established because Patient 1's chest rising. [Tr. at 700.]

g. Respondent gave Patient 1 epinephrine into the trach airway. He only gave one administration. In hindsight, Respondent admits that he would have administered more epinephrine but his known administration was to give it as quick as possible and since he was holding the bag and trach, he administered it that way. [Tr. at 703-704.]

h. Respondent did not give Patient 1 Narcan. Respondent did not give Narcan as it "[w]asn't a forethought that the this is what was happening due to the small amount of anesthetic drugs that were given that he thought it would need a reversal agent." [Tr. at 707.] Respondent did not give a reversal agent for the narcotics because Respondent believed that the amount of anesthesia medication he used was "relatively minuscule for a patient of this size." [Tr. at 706.]

i. Respondent along with several Visage employees, maintained an open airway, and continued chest compressions until EMS arrived. [Tr. at 444.]

j. An AED was placed on Patient 1. [Tr. at 183.]

49. EMS arrived around 7:08 a.m. [Ex. B.] When EMS arrived, it was noticed that Patient 1 was in cardiac arrest in the dental chair. [Tr. at 54.] He saw approximately 4-8 people in the room doing CPR on Patient 1 and he was intubated. [Tr. at 53.] Although not certain, it is believed it took about six people to move Patient 1 from the dental chair. [Tr. at 55.] Once safely out of the surgical chair, EMS set up the LUCAS device on Patient 1 and administered epinephrine and atropine. [Tr. at 55-58.] EMS noticed that Patient 1's heartrate was PEA (pulseless electrical activity). [Tr. at 57.]

50. EMS provided that responding to a code at a dental office is an unusual situation. [Tr. at 51.] There was confusion in the EMS report that Narcan was administered, but in fact, the 911 recording picks up Respondent saying "No Narcan." [Tr. at 92.]

51. EMS confirmed the endotracheal tube placed by Respondent was successful using capnography in the office. The tube did not need to be adjusted or moved. [Tr. at 84, 94.]

52. Respondent spoke to Patient 1's wife and informed her that soon after administration of anesthetic, he realized Patient 1 stopped breathing and went into arrest. [Tr. at 711.] He informed Patient 1's wife that he started CPR, intubated and secured his airway, EMS was there, and they were all doing everything in their power to make sure he survives. [Id.]

53. EMS transported Patient 1 to Medina General Hospital at 7:33 a.m. [Tr. at 81; 711.]

54. Respondent passed away on August 8, 2023. [Stip. No. 7.]

55. Patient 1's cause of death was listed as acute hypoxic respiratory failure. [Ex. 17.] There was no autopsy performed. [Tr. at 527, 741.]

IV. RESPONDENT'S CHANGES SINCE PATIENT 1 & DENTAL BOARD INVESTIGATION

56. Although not considered by the undersigned as an admission to liability or causation, Respondent did provide additional changes he has made to his practice since August 2023:

a. Patients are weighed again day of surgery despite patient entry and their weights are verified every time [Tr. at 638.]
b. Weighing patients on day of consultation and day of surgery. [Tr. at 639; 673.]
c. Taking actual measurements (not eyeball estimates) of thyromental distance, neck circumference, neck range of motion, interincisal opening. [Tr. at 653.]
d. More thorough heart and lung exams with stethoscope on day of consultation and day of surgery. [Tr. at 653; 659.]
e. Asking more questions regarding health history at consultation and conducting a more thorough medical history review, not taking patient reports for granted. [Tr. at 654; 658.]
f. Referring patients to physicians if underlying problems or risk factors suspected. [Tr. at 658.]
g. Taking vital signs on day of consult and day of procedure. [Tr. at 658.]
h. Full measurements of airway on consultation day and confirmed on day of surgery. [Tr. at 658.]

i. Using measure tape for thyromental distance and neck circumference. [Tr. at 659.]
j. Conducts full Mallampati classification, neck extension/flexion. [Tr. at 659.]
k. Conducts full review of anesthetic plan and past anesthesia experiences. [Tr. at 659.]
l. Syncing machine chronological times daily. [Tr. at 683, lines 11-22.]
m. Following published ASA guidelines for risk stratification. [Tr. at 662.]
n. Referring patients with BMI greater than 40 for physician consultations. [Tr. at 662.]
o. Would refer patients with higher STOP-BANG risk scores for appropriate referral. [Tr. at 668.]
p. All assistants working toward or required to be DAANCE certified. [Tr. at 772- 773.]

V. TESTIMONY & OPINION OF STATE'S EXPERT– DR. NICOLE KING

57. Nicole King, M.D., has been a licensed physician since 2009 and a diplomate of the American Board of Anesthesiology since 2016. She is not a dentist or oral surgeon. [Exhibit 22.]

58. The State hired Dr. King as the "regular" state dental expert was conflicted out. As such, there was no dentist or oral surgeon who provided expert opinion on behalf of the state's claims.

> Q. All right. Do you typically have a contract with the Dental Board?
> A. No.
> Q. Who do you have -- do you typically have a contract with another State Agency for review?
> A. The Medical Board.
> Q. And is it your understanding that they brought you in because the regular experts were conflicted off?
> A. Correct.
>
> [Tr. at 108-109.]

59. Dr. King is a critical care anesthesiologist and was contracted by the board to review a dentist, although she is not a dentist and does not have first-hand experience with that area of medicine. [Tr. at 248.]

60. Dr. King admitted that her experience is not typically for outpatient dental surgical procedures such as this.

Q. The three -- estimated 300 to 500 dental cases in which you've served as an anesthesiologist, how many of them have been outpatient procedures?
A. I mean, even if they are done in the operating room, almost all of them are outpatient.
Q. Okay. How many of them are done in a facility that is not attached to a hospital or operative standalone?
A. Well, zero, because I'm not employed by an anesthesiology company that goes to outpatient clinics -- to clinics or to offices. We specifically practice anesthesia in an operating room setting.
Q. And the guidelines, the ADA guidelines and the AA OMS guidelines that you've looked at that serve as the bases for the rules set forth by the Ohio Dental Board for its licensees, the ones that you looked at were specific to anesthesia in an outpatient setting, true?
A. Yes.
Q. And that would cover a private practice like Dr. Quereshy?
A. Correct.

[Tr. at 259.]

61. Dr. King identified that what happened with Respondent and Patient 1 is a complicated question, but that "baseline facts" were:

> A. Baseline facts is that anesthesia was given, a specific set amount of anesthesia was given, and because of that anesthesia, after that we then have the collapse of an airway, and even though it was then secured with an endotracheal tube, there had already been a prolonged amount of time of hypoxia and hypercarbia that then inhibited the patient from recovering respiratory or cardiac function once an endotracheal tube was placed. * * *
>
> [Tr. at 109.]

62. Dr. King also testified that Respondent did not have an appropriate person monitoring the patient. [Tr. at 323.] This failure is akin to not having an essential piece of equipment in his office because having a person as a monitor is a mandated piece of equipment when doing any sort of anesthesia. [Tr. at 323.]

63. In general, considering anesthesia for a person like Patient 1, Dr. King said she would prefer to see additional information on Patient 1's medical history in order to have more information on the airway and any risk of airway. [Tr. at 124.] Even though Respondent is himself a licensed physician, Dr. King testified that the ADA guidelines, as well as state guidelines, require a primary care physician to determine where and when the anesthesia should take place. [Tr. at 125.]

64. According to her report [Exhibit 23], Dr. King first reviewed whether Respondent violated Ohio Revised Code Section 4715.30(B)(9). Specifically, did Respondent "Provid[e]…

dental care that departs from or fails to conform to accepted standards of the profession, whether or not injury to a patient results"? [Ex. 23 at 3.] Although it is not clear exactly Dr. King's conclusion as it relates to each individual allegation of the deviation of standard of care stated in the NOH (her report is not organized in those sections) she testified more to her conclusions at the hearing. Overall, Dr. King concluded the following:

> "Overall, the lack of optimal patient selection while also changing of the patient's risk factors on documentation after the event is clearly a violation of Section 4715.30 (B)."
>
> [Ex. 23 at p. 3]

> In conclusion, based on the information outlined above, thorough review of all case materials, and the referenced violations, it is my opinion that the patient's death was directly caused by the actions and judgments of Dr. Quereshy.
>
> [Ex. 23 at p. 4]

65. Some of the specific actions and misjudgments noted by Dr. King were:

- "Patients who are deemed at higher operative risk, IE those patients who are ASA III or higher, should be fully assessed by a primary care physician to assess for optimization prior to sedation and/or anesthesia in a non-hospital setting." [Ex. 23 at p. 3.]
- "This would then demand a full evaluation by a physician prior to his dental procedure." [Ex. 23 at p. 3.]
- "Risk of losing this patient's airway was apparent from his physical description." [Ex. 23 at p. 3.]
- 'More concerning than this though, is that the information pertaining to the patient's airway risk stratification was changed on the anesthesia record from the preoperative evaluation after the events of the operative day." [Ex. 23 at p. 3.]
- "Regarding the intraoperative events, the lack of assessment of the patient in between the administration of medications to induce anesthesia is concerning. As this patient was at risk of apnea, and the patient was assumed to continue ventilating on his own without the need for a ventilator or breathing tubes, greater restraint would have been expected in terms of speed of medication administration." [Ex. 23 at p. 3.]
- "Additionally, the pace of giving medication, placing a throat pack (also questionable in a spontaneously ventilating patient who is under deep sedation vice general anesthesia with a secured airway), and starting the surgery within a couple of minutes is extraordinary and calls into question whether the patient was ever adequately ventilating after the medication administration." [Ex. 23 at p. 3.]

66. From the language in her report, she is most concerned about the "change" in the patient's record, which arguably cannot play a role in the actions or judgments of Respondent as far as it relates to the cause of Patient 1's death. [Ex. 23]

67. The second violation addressed in Dr. King's report is Ohio Revised Code Section 4519.30(B)(9) which states "[A]llowing dental hygienists, expanded function dental auxiliaries, or other practitioners of auxiliary dental occupations working under the certificate or license holder's supervision, or a dentist holding a temporary limited continuing education license under division (C) of section 4715.16 of the Revised Code working under the certificate or license holder's direct supervision, to provide dental care that departs from or fails to conform to accepted standards for the profession, whether or not injury to a patient results." [Ex. 23 at p. 4.]

68. In Dr. King's report, she indicated that she did not read, hear, or see anything that was "out of the ordinary as it pertains to the dental assistant's actions or inactions themselves." "Rather the failure of Dr. Quereshy to verify the presence of a DAANCE certified assistant in a patient with these risk factors is inappropriate and lacking in standard of care. Additionally, there is a flagrant violation of this code with the use of the research fellow, Ramtin Dastgir, as an assistant." [Ex. 23 at p. 4.]

69. Dr. King also found that Respondent's use of Ramtin Dastgir was a violation of Ohio Revised Code 4519.30(B)(9), because he should not have been allowed to act as a dental assistant. [Ex. 23 at p. 4.] Dr. King did not believe that Dastgir had proper training to be acting as a dental assistant for Patient 1's procedure. [Tr. at 217.]

70. Dr. King admitted on cross-examination that there is nothing in the Ohio Dental Practices Act that requires dental assistants to be licensed or certified other than in BLS. [Tr. at 372.]

> Q. You did not see anywhere in the Ohio Dental Practices Act, or in the AAOMS or in the ADA, that the dental assistant needed to be licensed or certified other than in BLS, correct?
> A. Correct.

[Tr. at 372.]

71. On cross-examination, Dr. King provided that she was reviewing the standard of care as it relates to giving deep and general anesthesia, not necessarily the standards for a licensed dentist who holds an anesthesia license. [Tr. at 247.]

72. Dr. King admitted on cross-examination that there is nothing within the ASA classifications that indicate that lapse of seeing a primary care physician for this period of time automatically increases an ASA classification number. [Tr. at 315.] Dr. King also admitted that even if classified by Respondent as an ASA III, Patient 1 was not precluded from having general anesthesia in an office setting.

> Q. You saw materials that said that if the patient's an ASA 3 they must have dental procedures with general anesthesia in a hospital setting?
> A. It does not say they need general anesthesia in a hospital setting.
> Q. Okay. That's what I am -- maybe we were crossing signals then, so you're not aware of it.
> Just because somebody is an ASA 3 doesn't preclude them from having general anesthesia in an office setting, correct?
> A. It absolutely does not preclude them.

[Tr. at 316.]

73. Dr. King also admitted on cross-examination that based upon the known information (Patient 1's health history and known medical information), nothing was an absolute contradiction restricting Respondent from performing Patient 1's procedure in his office. [Tr. at 324.]

74. Dr. King shared that Respondent's use of his anesthesia machines and the inconsistent time recordings prevented anyone from knowing Patient 1's accurate vitals at the time of receiving anesthesia medications or at the start of the surgery. [Tr. at 163-164.] Dr. King recognized that inconsistencies between anesthesia machines is typical, but she notes that here, there was an additional concern because all of Respondent's machines' tracking were so inconsistent, one couldn't put together the "story" because there are too many forms of inconsistent information. [Tr. at 181.]

75. As far as the succession of administration of medication, Dr. King admitted that based upon both Dastgir and Suskiewicz's deposition testimony, there was some "pause" witnessed by both of them when Respondent was administering the anesthesia medications. [Tr. at 345.]

76. As far as opinion on the emergency procedures and Respondent's use of ACLS, Dr. King concluded:

> A. The only thing that was done out of line that could have had an affect was the lack of Epinephrine.

[Tr. at 352.]

77. Overall, Dr. King's opinion on the emergency response and any issue with providing ACLS and care was that "they did what they felt like they could do – to follow the algorithm" and "they didn't do anything wrong, and I will stick to that." [Tr. at 353-354.]

78. The Office Anesthesia Evaluation Manual states that "proper patient selection is an important first step in maintaining patient safety. Excluding higher risk patients from anesthesia in the office-based setting helps to minimize risk for an adverse event." [Ex. 35 at p. 599.]

Appendix 7: Patient Selection Criteria

Improving outcomes for office-based anesthesia and increasing patient safety is a continuing goal for the AAOMS. We realize that there is no such thing as absolute safety, however we are dedicated to making office based anesthesia as safe as possible. Adverse outcomes in office-based anesthesia are most often related to the following circumstances:

Failed patient selection, then
Over-sedation, then
Failure to recognize over-sedation, then
Inadequate airway management.

One can see by reading the above chain of events that proper patient selection is an important first step in maintaining patient safety. Excluding higher risk patients from anesthesia in the office-based setting helps to minimize risk for an adverse event. For the first time, the OAE manual has included patient selection criteria for adult and pediatric patients. These criteria will help the reader in clinical decision making when determining which patients are appropriate candidates for our anesthesia team model in the office setting. In the criteria, the reader will note that there are absolute and relative contra-indications for anesthesia in the office setting. Those with absolute contra-indications will best be managed in another setting because of the severity of their co-morbidities or because of the severity of a possible adverse event.

[Ex. 35 at 599.]

79. Dr. King agreed that this Appendix is not the same as establishing standard of care. [Tr. at 325.] The Notes underneath Appendix 7 states this as well. [Tr. at 325.]

Notes

1. The AAOMS Committee on Anesthesia recommends conservative patient selection.
2. These selection criteria are not meant to be all inclusive as it would be impossible to define the myriad of conditions that require additional consideration for anesthetic management. These patient selection criteria are *guidelines* for AAOMS members are not intended to establish a standard of care for office-based anesthesia.

[Ex. 35 at 599.]

80. Dr. King testified that Respondent had a failed patient selection, over-sedated Patient 1, failed to recognize the over-sedation, and had improper airway management. [Tr. at 407-408.]

81. It appears from Dr. King's written report and testimony, both direct and cross-examination, her conclusion on Respondent's treatment of Patient 1 is related to patient selection. Dr. King believes that Respondent did not select Patient 1 with full knowledge of the risk of the procedure for Patient 1. [Tr. at 320, 325, 354, 357, 407, 412, 413.] Dr. King said "the failure to have adequate patient selection and adequate monitoring of the patient" is a severe failure of Respondent's care of Patient 1. [Tr. at 412-413.]

82. Overall, Dr. King concluded that an experienced oral surgeon would not have performed the same way:

> Q. Put another way, if you were given a description of the treatment of Patient 1, would you expect that to be coming from an experienced oral surgeon, or someone who is not experienced?
> A. Not experienced.
> Q. Why do you say that?
> A. Because of lack of monitoring, a lack of patient -- appropriate patient selection, lack of increased awareness of the risks associated based on the patient's body habitus and risk factors, lack of appropriate intervention to open an airway, whether it was due to apnea or collapse, and then lack of an ability to follow an ACLS algorithm in a -- you know, over on extended period of time.
>
> [Tr. at 412.]

VI. TESTIMONY & OPINION OF RESPONDENT'S EXPERT– DR. FAISAL QUERESHY

83. Since Respondent was his own expert witness, his background and credentials have already been discussed at length earlier in this Report & Recommendation. His CV was also an exhibit as part of the hearing record admitted as Exhibit J. In Respondent's expert report, he disputed the substantive allegations of the April 30, 2025 NOH.

84. Respondent's expert report was admitted as Exhibit K. In Respondent's expert report, he disputed the substantive allegations of the April 30, 2025 NOH. He did not make a determination of the overall standard of care he provided to Patient 1, but instead discussed what is and is not the standard of care to the allegations made in the NOH.

85. Respondent was determined to be qualified as an expert in anesthesiology and oral and maxillofacial surgery in an office setting. [Tr. at 627.]

86. Respondent testified to all the allegations raised in the NOH which is provided below in respect and response to each section of the NOH.

87. Respondent provided that he had performed surgeries in a hospital setting, but those procedures were not equivalent to Patient 1's surgery. [Tr. at 792.]

88. Respondent provided opinion that "all oral and maxillofacial surgeons typically hold a general anesthesia permit to be able to be the operator and the anesthesiologist for their cases, and the cases are very short typically." [Tr. at 796.] He provided additional opinions that at times, there could be longer procedures and there may be a need for a certified registered nurse anesthetist or a referral to a hospital for the procedure. [Id.]

89. As far as Patient 1's weight was concerned, it played no role in the amount of medications that were administered.

> Q: Does weight play a role into determining how much medication to administer?

A. Yes, absolutely.
Q. And would that have changed had his weight been 355?
A. No, the same. In fact, my dosages are relatively low for patients of 315.
Q. Would the dosage amounts that you gave for -- if he was, in fact, 355 still have been on the low end?
A. Yes, absolutely.
Q. Okay.
A. And the opposite would be true. If a patient was underweight, we would not be given the same amount of drug, it's dose dependent based on weight.
Q. Okay. But as far as, you know, failing to adequately -- accurately determine his weight, I know we talked about other complications that could arise from weight, but as far as dosing, that wouldn't have changed what you did necessarily?
A. Correct.

[Tr. at 798-799.]

90. The undersigned questioned Respondent regarding patient selection and criteria. Respondent provided that he has engaged in patient selection several times. [Tr. at 791-792.]

Q. So I'm going to move on to kind of patient selection, because there was a lot of talk about -- mostly from Dr. King, about patient selection, and also about evaluation from a physician and when and where that should happen.
You answered a lot of questions that you have sent patients before 2023, and currently, to get separate physician evaluations?
A. Yes.
Q. And then have you turned down somebody completely for sedation and surgery?
A. Yes.

A. So what I would say to you is that turned down meaning not be able to do surgery for them at all because their health status would only be determined after a medical clearance came back, and we couldn't because the patient was a higher risk.

We would often get information back from our physician colleagues that this patient is best treated in a hospital setting.

So to turn them down, I've never really turned anyone down, I've always been able to provide care, but in a different environment. And I had the ability to do that and have done so over the years.

Q. Okay. So that answered my next question. So you have conducted surgery in a hospital setting to maybe a patient that had a higher risk level?

A. Many times. Many times, and after and since August 4th, 2023.

[Tr. at 791-792.]

VII. CHARACTER TESTIMONY – DR. JEROLD GOLDBERG

91. Dr. Goldberg provided character testimony spanning approximately 30 years of professional acquaintance with Respondent, characterizing him as consistently ethical, trustworthy, and accomplished. His testimony was limited to character and reputation evidence, explicitly excluding any opinion on the specific care provided to Patient 1 or clinical matters, as he had not observed Respondent's clinical practice since 1996 and had not reviewed the case records.

92. Dr. Goldberg served as Dean of Case Western Reserve Dental School from approximately 1996-97 until 2014. He described his current relationship with Respondent as "a very friendly colleague," noting they serve on two committees together and occasionally meet for lunch, though their contacts are less frequent since Dr. Goldberg stepped down as Dean in 2014. [Tr. at 593-595, 606.]

93. On cross-examination, Dr. Goldberg acknowledged he had not been in a consultation room with Respondent when he was consulting with a patient since becoming Dean in 1996, had not been in an operating room with Respondent performing surgery on a patient since 1996, and never practiced together with Respondent clinically.

94. Dr. Goldberg characterized Respondent as a "star resident" during his training, describing him as someone who could always be counted on for being truthful, someone who didn't cut corners, someone who treated people with respect regardless of their position in the hierarchy, someone with real care for quality patient care, and someone who could always be relied upon for "doing the right thing." He added that Respondent had a quest for knowledge and being the best he could be. [Tr. at 596.]

95. Dr. Goldberg explained his decision to recommend Respondent as Program Director, stating: "When [Respondent] was a resident, I trusted that he would do the right thing. I didn't have to worry about him. If I asked him to do something, I knew it would be done correctly and properly." He emphasized that there is a real relationship between ethical behavior and trust, and that people who practice and conduct themselves ethically tend to be people who are trusted. [Tr. at 599-600.]

96. Dr. Goldberg testified about Respondent's value to society and described Respondent's career progression as "clearly impressive," noting his development of a practice where patients and referring physicians have great trust, his membership in prestigious organizations with leadership roles, his service as past president of the Cleveland Dental Society and as president of the American College of Oral and Maxillofacial Surgery, his service as an examiner for the American Board of Oral and Maxillofacial Surgery, and his role as vice-president of the Ohio State Dental Board prior to the incident. [Tr. at 601-603.] He said Respondent has impacted the trajectory and the face of oral surgery on a national and sometimes international basis, and has clearly impacted the lives of generations of new oral surgeons and new dentists. [Tr. at 603-604.]

97. Dr. Goldberg testified: "Nothing has changed since he's been a resident... I think he's the same person who is driven to do good, driven to accomplish a lot in his life... I've never seen him demean or undercut anybody else in order to get to where he goes." He added that Respondent has achieved his success "because of talent, drive, and just amazing energy and work ethic. I mean, he just outworks everybody else." [Tr. at 605.]

98. Dr. Goldberg acknowledged that when he talks to people who are leaders nationally, they all have the highest regard for Respondent. However, he noted there is "an issue with local oral surgeons, and not all of them, only some of them" regarding Respondent, which he attributed to "envy or jealousy" about his "amazing accomplishments." He explained that oral surgeons who incorporate broader scopes of practice are sometimes "marginalized by the community that feels like they are competing with them." [Tr. at 604-605.]

99. When asked about a hypothetical regarding completing records after a medical emergency (not to avoid liability but for completeness), Dr. Goldberg stated that changing a record on the same day to add information for completeness or accuracy that was not recorded due to distraction does not seem objectionable on an ethical basis. However, he stated that changing a record to not accurately reflect what happened or to deceive would be wrong. He testified he would be "very surprised" if Respondent did something inappropriate intentionally, stating: "I would be very surprised that he would, with intent, do something that was inappropriate." [Tr. at 608-609.]

100. Dr. Goldberg concluded his testimony by stating: "I think this is a really good person who has made real positive contributions to society within the framework of being an oral and maxillofacial surgeon, and I think that... over a long period of time I have seen him consistently and persistently conduct himself in an admirable way." [Tr. at 610.]

VIII. SUMMARY OF TESTIMONY RELATED TO SPECIFIC ALLEGATIONS RAISED IN THE NOH

101. In the April 30, 2025 NOH, the Board listed ten different areas where Respondent deviated from the standard of care. Many of the facts related to those allegations have already been provided and will not be restated but referred to as written above.

102. The intention of this summary is to direct the Board to the disputed testimony over the facts that support a deviation or not from the standard of care for each allegation:

NOH Section 1: Patient 1 went into cardiac arrest within minutes of receiving anesthesia.

Respondent provided that:

> While Patient 1 had an untoward event that arose within minutes of receiving anesthesia, I cannot state with certainty that the event that precipitated Patient 1's decompensation was a cardiac arrest. There was never an autopsy or posthumous toxicology screen completed that would provide reliable information as to whether the anesthesia caused Patient 1's decompensation, and as to specifically what caused his death.

[Ex. K]

103. The death certificate for Patient 1 was admitted into the record as Exhibit 17 but was not identified or discussed by any witness.

104. Overall, there was no testimony or exhibit that determined to a substantial certainty Patient 1's cause of death.

NOH Section 2(a): Respondent incorrectly assessed Patient 1's American Society of Anesthesiologist's ("ASA") classification as an ASA I, which indicated the lowest level of risk despite the fact that Patient 1 was morbidly obese with multiple risk factors regarding airway compromise and respiratory complications. The risk of losing Patient 1's airway was apparent from his physical description and the photos provided of this patient.

105. Generally, Dr. King testified that an airway exam to determine airway compromise and respiratory complications is completed by accessing multiple factors including medical history (breathing issues, history of snoring, or sleep apnea), physical appearance and measurements of patient, ASA classification, and Mallampati score. [Tr. at 117, 137, 141-144.] "This patient, even with his reported weight (40 pounds less than weight on admission to the ER), was morbidly obese

with multiple risk factors concerning for airway compromise and respiratory complications in the setting of providing deep sedation or MAC anesthesia." [Ex. 23, Dr. King Expert Report.]

- Respondent's response from Expert Report (Ex. K):

2.(a) My preoperative risk assessment of the patient was based in large part on my many years of experience with similarly situated patients. My decision to move forward with the proposed anesthesia plan was within the standard of care and appropriate for Patient 1, considering the anesthesia medications and the amount of those medications I intended to give Patient 1. A patient's body habitus and physical appearance alone cannot serve as the basis for determining a patient's level of risk.

- Respondent used ASA "as just a scale. It's one aspect of risk, or assessment of the patient's risk level, and to me, weight didn't play a large role in that. I was more focused on underlying systemic conditions. To me giving him a 1 or a 2 really didn't affect my relative risk for this patient." [Tr. at 661 – 662.]
- Respondent determined Patient 1 was an ASA I due to patient's age, negative review of systems, and no significant medical history. [Tr. 488.]
- On cross examination, Respondent admitted that he now knows that morbid obesity classifies someone as an ASA III. [Tr. at 489.]
- Respondent co-authored an article titled: "Causes of the Difficult Airway."

Dr. King's expert opinion on the ASA classification:

> Q: Did [Respondent] have enough information to be able to say that this patient was an ASA 1?
> A: No.
> Q: Why do you say that?
> A: Because the patient is 48, morbidly obese, and had not been seen by a primary care physician in a prolonged amount of time. There's no way of knowing if this patient had high blood pressure, hyperlipoidemia, or high cholesterol, diabetes. None of that could have been told by just looking at the patient.
> [Tr. at 133]

- Dr. King testified that Patient 1 should have at least been determined to be an ASA III. [Tr. at 116.]

- Dr. King explained the ASA classifications as an individual risk of patient morbidity and mortality during anesthesia in surgical procedures. [Tr. at 114.] Further, Dr. King explained the three levels of classification:

> The American Society of Anesthesiology classification needs to take into account what procedure is being done, where is the procedure being done, and who is monitoring the patients.
>
> ASA 1 is literally a patient that has no past medical history, they cannot be a smoker, they cannot be a regular drinker, they cannot be pregnant, they cannot even have high blood pressure or high cholesterol.
>
> An ASA 2 is somebody that has a systemic disease that is not -- that does not interfere with their activities of daily living; somebody who has controlled high blood pressure, somebody who is obese but not morbidly obese, most pregnant patients fall into that category.
>
> ASA 3 are those patients who have a systemic disease that significantly impacts kind of their overall bodily function.

[Dr. King Direct Testimony, Tr. at 115.]

- A BMI over 40, or morbid obesity, is considered an ASA III. [Tr. at 116.] Patient 1, with his weight alone, could only be classified at an ASA III. [Tr. at 125-126, 134.]

- Even at the self-reported incorrect weight of 315 pounds, Patient 1 would have been classified an ASA III. But his actual BMI was "in the 50s, which is super morbidly obese, which astronomically increases your risk of airway issues or concerns with anesthesia." [Tr at. 200.]

- In summary, Dr. King testified that ASA III classified patients require primary care physician clearance per ADA guidelines and state guidelines, elective surgery should not proceed without full medical evaluation for morbidly obese patient, and that Patient 1's risk of airway loss was apparent from physical description and photos. [Tr. at 137, 215, 306.]

- Dr. King testified "[s]o the Mallampati, itself, is -- it is not technically the only indicator of a difficult airway, but what it can tell you is, it can explain to you how much adipose tissue or redundant tissue is in the oral and pharyngeal cavities that can prevent or inhibit adequate environment for successful intubation." [Tr. at 118.]

- Dr. King testified that Patient 1's beard was a risk factor to consider about his airway and ability to secure the airway. "A seal with that mask around the nose, the mouth, and on the chin is extremely difficult based on certain factors, one of which is having a beard...having a beard makes it more difficult to secure a seal with a mask when you're trying to ventilate for a patient, meaning the mask itself does not

seal to the skin around the face, so then when you're providing air with the mask it can leak out into the air instead of into the airway." [Tr. at 219.]

- As of 2023, Respondent had performed in-office general anesthesia for patients who would fall within the category of an ASA III. [Tr. at 663.]

- Dr. King testified that there was a collapse of an airway, it was then secured by the placement of an endotracheal tube, but that they were unable to get Patient 1's heart restarted once the airway was open. [Tr. at 109-110.]

- Dr. King provided that Respondent did not have enough information on the risk of losing airway for Patient 1. Morbid obesity put Patient 1 into an ASA III category, without any other additional risk factors. The guidelines state that patients with this category of risk should be seen by another physician to assess risk prior to deep sedation anesthesia. [Tr. at 329.]

- Respondent is aware of risk of loss of airway as he has authored articles about airway constriction and possibility of result of loss of airway. [Ex. 21, Tr. 465, 627.]

NOH Section 2(b): Respondent failed to accurately determine Patient 1's weight. Respondent charted Patient 1's weight as three hundred fifteen (315) pounds when the patient's actual weight was forty (40) pounds greater.

106. Patient 1's weight was self-reported. [Tr. at 119-120, 129; Ex. A at 2.] Patient 1 was weighed upon admission to Cleveland Clinic and his weight was reported to be 366 pounds. [Tr. p. 198-199, Ex. C.] So it was likely that his actual weight the day of the surgery at Respondent's office was 350-360 pounds and not 315 pounds. [Tr. p. 199. See Ex. A for Visage records of 315 pounds.]

107. Dr. King said the weight alone places Patient 1 in class ASA III. However, even at the 315 self-reported weight, Patient 1 had a BMI that would place him as an ASA III. "The patient was always an ASA 3 because the BMI was over 40. This now puts the BMI in the 50s, which is super morbidly obese." [Tr. p. 200-201.] Dr. King provided that Patient 1's actual weight "astronomically increases your risk of airway issues or concerns with anesthesia" and reduces time available between not breathing and being unable to rescue airway. [Id.]

108. Respondent admitted that he did not know that the weight classification alone placed Patient 1 into the ASA III category and now he does. [Tr. at 660.] He also testified that Patient 1's appearance was not far off from his weight that was listed. [Ex. K.]

- Respondent's response from Expert Report (Ex. K):

> 2.(b) Patient 1 self-reported his weight as 315 pounds. He appeared to be his stated weight, and the standard of care does not require that all patients be weighed on a scale before being administered in-office sedation.

109. Respondent agreed that weight is considered in determining the amount of medication used in anesthesia. [Tr. at 798.] But here, Respondent clarified that if a patient under reported their weight, that determination effects medication administration more than over reporting the weight. [Id.] Respondent testified that his dosage for Patient 1 would not have changed if his reported weight was 355 instead of 315 and that the dosage given was even "relatively low for patients [weighing] 315." [Id.]

110. As far as standard of care for weight requirements, Respondent testified that he could not find any published standard of care in 2023 requiring patients be put on scale for in-office anesthesia but also acknowledged weighing is "best practice." [Tr. at 639.]

111. Respondent changed his practice and now weighs every patient on consultation day and reweighs the patients on surgery day. [Tr. at 639, 658.]

NOH Section 2(c): Respondent failed to have Patient 1 receive a full evaluation by a physician prior to Patient 1's dental procedure. Patient 1 had a BMI of 40 or greater, which made the patient's physical status classification an ASA III. This classification demanded a full evaluation by a physician prior to Patient 1's dental procedure.

112. Respondent did not require Patient 1 to have a "full evaluation" by a physician, other than himself, prior to Patient 1's dental procedure. [Tr. at 493.] He believed that he had enough information on Patient 1 to make a clinical judgment prior to the procedure. [Id.]

> Q: "As of July 11 of 2023, why did you not send this patient for a physician consultation?"
>
> A: "I felt, prospectively, that I had enough information to make a good assessment based on my 23 years, at that time, of clinical experience, and taking care of many thousands of patients, that I had enough information with his overall general good health and condition to make that assessment that day."
>
> [Tr. at 662.]

- Respondent's response from Expert Report (Ex. K):

> 2.(c) Under these circumstances, the standard of care did not require an outside physician to fully evaluate Patient 1 before undergoing this procedure, considering Patient 1's reported history and my interactions with Patient 1. As a licensed medical doctor, I am qualified to assess a patient's risks for office-based anesthesia administration.

113. Dr. King's report stated that Patient 1's ASA III classification demanded a pre-clearance from a primary care physician. [Tr. at 305, Ex. 23.] Dr. King said the standard of care for a planned surgery was to send the patient to their primary care physician for a full evaluation and clearance for surgery. [Tr. at 130.] She disagrees that even though Respondent is a licensed physician, he can serve as a physician to give a preliminary medical exam prior to surgery. [Tr. at 125.]

114. Dr. King was adamant during her testimony that: "I would have wanted more information regarding the airway and the risk of airway. Also, this patient is morbidly obese, he's in his 40s, and I would want more information about any kind of past medical history, or if he had been seen by a physician any time in the recent history." [Tr. at 124-125.] Her opinion is that a patient with an ASA III classification should be seen by their primary care physician prior to elective surgery. [Tr. at 125, 215-216.] On direct examination, Dr. King testified:

> Q: "Are there any other concerns you have about this -- that you know about the pre-evaluation?"
> A: "I mean, the main thing I'd say is that the airway exam is incomplete. If we're looking at -- and I understand that this is different from the anesthesia record, but when you're determining that the patient can be taken care of in an outpatient setting without an anesthesia provider there with you, I would assume that the exam would include a full airway exam, and then a cardiac and respiratory exam, otherwise, it's kind of hard to know." [Tr. at 130-131.]

115. Respondent provided testimony on the AAOMS guidelines as it relates to "must" or "should." [Tr. at 775.] According to the AAOMS guidelines, a BMI greater than 40 is listed as a relative contraindication requiring "Consultation Consideration" which Respondent provided is a "should" as opposed to a "must." [Id.] He also identified that the AAOMS guidelines explicitly state at page 599, Note 2: "These patient selection criteria are guidelines...for AAOMS members and are not intended to establish a standard of care."

116. The testimony between Dr. King and Respondent differed on what is a requirement or contraindication under the ADA Guidelines and the AAOMS Manual. The following references where discussed: Exhibit 20, page 168 - ADA Guidelines requiring physician consultation for ASA III patients Exhibit 35, pages 599-600 - AAOMS Manual, Appendix 7 on patient selection criteria and contraindications.

117. Discussed throughout the hearing was Patient 1's pre-surgical health questionnaire. Specifically, Exhibit A, page 8 was the patient health questionnaire that showed that Patient 1 indicated he was not under any current physician care.

118. The undersigned did not have the benefit of hearing from another licensed physician and oral maxillofacial surgeon in order to understand the practice standard of care and the application of the guidelines. There was no information that an MD/DDS is not allowed to be the physician transcript contains NO testimony addressing whether Respondent, as an MD, could

serve as "the physician" to provide medical clearance for his own dental patients. This issue was not explored during examination.

NOH Section 2(d): Respondent changed (or permitted to have changed) the anesthesia record regarding Patient 1's airway risk stratification on the preoperative evaluation after the events of the operative day.

119. There is somewhat mixed testimony regarding Patient 1's records as they relate to his ASA classification and his Mallampati score. The ASA classification and Mallampati score are both indicators of airway risk. [Tr. at 114-117.] Prior to surgery, Patient 1 was listed as ASA I and a Mallampati score of 2. [Tr. 119, 132, 269.] In fact, the initial patient file sent to the Board with Respondent's self-report had the ASA and Mallampati listed differently than the records that were provided at a later date. [Tr. at 522.] Respondent provided that after Patient 1 was transported by the EMS, he finalized his surgical file and records for Patient 1, which is a practice that he routinely does after his surgery day. [Tr. at 524.] Dr. King testified that it does not make sense why there would be an airway classification change made to the record. [Tr. at 140.] However, both airway classification changes made Patient 1 more at risk, so it does not make logical sense why Respondent would make Patient 1 look risker after the fact.

120. Respondent provided the following testimony regarding the record issue:

> "I'd like to clarify for the record the term change. It's a very insinuating remark that undermines my credibility and my ethics. I don't change records. I have the privilege to go back to my records during the day of the event, even when patients come in for consultations my normal practice is to review all records of the day before they lock. EMR systems lock, and if I was going to change records, I would alter them, I would add an addendum, if it was added a different day. To change and to insinuate changing of records is very accusatory and incorrect in this particular case."
>
> [Tr. at 523-524.]
>
> Q: "Why would you change the patient's Mallampati score from a class 2 to a class 4 in a tab entitled Pre-Op Evaluation if it's based on information that you had learned intraoperatively?"
>
> A: "I didn't think of it as a pre-op change, it was my assessment on the day of the procedure that his airway was a class 4 based on the apneic response and the obstruction that we observed at the time of surgery."
>
> [Tr. at 725]
>
> Q: "You heard Dr. King yesterday indicate -- these are her words -- that you made these changes -- she used the word changes, in an effort to cover up your liability or your culpability as it relates to the circumstances surrounding Patient 1. How do you respond to those allegations?"
>
> A: "Those are very serious allegations for me. Changing is an unethical act of altering records to cover something up, and that's something that I have never done, I preach to the

choir, I preach to my residents not to do. I would never change anything to cover things up. If I was going to change things I would change it to be more consistent with -- if I was truly trying to cover things up -- I was actually trying to be as accurate and realistic as possible of what I observed that day because I knew that that event would need to be reported to the Board, and there was no intention for me to show that there was any sort of coverup or any alteration of records. Nothing was changed, it was just completed. What I changed was my assessment of the airway. It was never changed."

[Tr. at 726-727.]

- Respondent's response from Expert Report (Ex. K):

2.(d) I supplemented the anesthesia record to attempt to make a complete record. The supplementation occurred on the day of the events at issue, August 3, 2023, before any self-report and production of records to the Ohio State Dental Board.

NOH Section 2(e): Respondent failed to perform a STOP BANG evaluation on Patient 1 when Obstructive Sleep Apnea was marked on his preoperative evaluation.

121. Respondent argues that there was not a concern for sleep apnea with Patient 1, however, even if there was a concern for sleep apnea, the assessment outlined in a STOP BANG evaluation was completed for Patient 1 and that STOP BANG evaluations are assessment tools to determine airway risks and not diagnostic or a full restriction from surgery for a patient. [Tr. at 490, 667.]

- Respondent's response from Expert Report (Ex. K):

2.(e) The standard of care does not require a STOP BANG evaluation for every patient who reports a history of sleep apnea and/or snoring. Additionally, Patient 1 did not report a history of sleep apnea.

122. On the health history form completed by Patient 1, Patient 1 indicated that he had the following conditions:

- Item 23 (Hay fever and sinus problems): marked "yes"
- Item 24 (Snoring): marked "Yes"
- Item 25 (Sleep apnea/CPAP): marked "No"

22. Asthma?		✓
23. Hay fever / sinus problems?	✓	
24. Snoring?	✓	
25. Sleep apnea / CPAP?		✓
26. Difficult breathing / other lung trouble?		✓
27. Tuberculosis?		✓

[Tr. at 146; Ex. A at 7-8. First column was yes and second was no.]

123. On the day of Patient 1's surgery, Respondent and his staff filled out additional medical chart information that included a checked box that Patient 1 had sleep apnea, although this is different than what he self-reported initially. This information is included in Exhibit A.

124. Dr. King testified that Respondent failed to perform a STOP BANG evaluation on Patient 1. [Tr. at 216.]

125. Dr. King agreed on cross-examination that Obstructive Sleep Apnea (OSA) is listed as a relative contraindication for this elective surgery, not an absolute contraindication. [Tr. at 337.] Dr. King was referencing the AAOMS manual, page 600, which was identified as Exhibit 35. There is no restriction for an OSA patient to receive anesthesia in office, but there is a heightened risk of loss of airway. [Id.] She concluded that STOP BANG evaluations are the minimal standard of care when it comes to a patient with OSA and physical characteristics like those in Patient 1. [Tr. at 122 - 123.]

126. The STOP BANG evaluation is an assessment and screening tool for individuals with OSA. [Tr. at 123.] It is used to determine risk of airway obstruction. [Id.]

127. On cross-examination, Respondent admits that a STOP BANG evaluation form was not completed on Patient 1. [Tr. at 490.] Respondent provided additional testimony that the decision not to do a STOP BANG evaluation form was not due to the inconsistency of the health records identifying OSA, but instead because he believed that he completed all of the assessment required in the STOP BANG evaluation through his own pre-surgical assessment of Patient 1. [Tr. at 490, 667.]

128. Dr. King referenced Patient 1's wife's testimony that the questions in a STOP BANG evaluation were not asked by Respondent prior to surgery. [Tr. at 336.]

129. Respondent also provided in his investigatory deposition that unless a patient has diagnosed OSA, he is not completing a STOP BANG evaluation form on the patient, including Patient 1. [Ex. 24, p. 12.] Dr. King disagrees with Respondent's practice to only do a STOP BANG evaluation on patients with diagnosed sleep apnea and instead testified that the STOP BANG screening tool is to be used with patients who have "suspected" sleep apnea. [Tr. at 401.]

NOH Section 2(f): Respondent failed to properly assess Patient 1 during the administration of anesthesia, giving medications one after the other without any pause between administration to assess effectiveness and then, within minutes, placing a throat pack and starting surgery.

130. Respondent disagrees that he did not properly access Patient 1 during the administration of anesthesia. In response, Respondent provides that the criticism is not the amount of medication, but the administration and that the evidence demonstrates that they were not given at one time, but there was time between the medications and Patient 1 was adequately monitored by Respondent during the administration of the medication.

- Respondent's response from Expert Report (Ex. K):

> 2.(f) The anesthesia medications and the amount of those medications I administered to Patient 1 were reasonable, appropriate, and not excessive given Patient 1's reported or actual weight. In addition, the medications were not given all at once but were administered one after another in appropriate succession.

131. Dr. King referred to Exhibit 19 (Second Set of Interrogatories) regarding what medication was given to Patient 1 and approximate timing. [Tr. at 165.] As stated in Exhibit 19, at approximately 6:45 a.m., Patient 1 was given: 5 milligrams of Versed, 25 micrograms of Fentanyl, 12.5 milligrams of Ketamine, 3ccs of Propofol, 8 milligrams of Dexamethasone, and 2.5 ccs of Azithromycin. At approximately 6:50, 5.4 ccs of 2 percent Xylocaine were given. At 7:02, Epinephrine was given by the ET tube. [Tr. at 165.]

132. According to Dr. King, the medications (Versed, Fentanyl, Ketamine, Propofol) were given "one after the other, not mixed in one vial, but literary given one, handed off, two, handed off, three, handed off, four, handed off" without allowing circulatory time to titrate to effect. [Tr. at 167.] She testified this rapid succession administration is problematic because "you're not giving the patient any circulatory time to titrate to effect." This method is used when preparing for general anesthesia with airway takeover, not for moderate to deep sedation where the airway is not secured. [Tr. at 167.]

133. Respondent testified that he gave the medication in succession with pauses of 30-40 seconds between each medication. [Tr. at 693-694.] He provided that during pauses, he talked to patient to assess level of alertness and mental status. [Tr. at 694.]

134. As far as the succession of administration of medication, Dr. King admitted that based upon both Dastgir and Suskiewicz's deposition testimony, there was some "pause" witnessed by both of them when Respondent was administering the anesthesia medications. [Tr. at 345.]

NOH Section 2(g): Respondent assigned a research fellow who is not licensed to practice dentistry in Ohio, to take the clinical role of dental assistant when your contract specified that he was only to observe and have no patient contact. The research fellow monitored Patient 1's vital signs and assisted with optimization of the airway when it was found that the patient was not ventilating properly. The research fellow also performed CPR along with the rest of the team after the patient was found to be pulseless.

135. During Patient 1's procedure and for around 11 months, an individual named Ramtin Dastgir was serving as a dental assistant at Visage. [Tr. at 731.] At the time of his deposition, and Patient 1's surgery, Dastgir was a dental student with Case Western Reserve

University. [Tr. at 788.] As a student, Dastgir is considered a part of the research fellowship program so he is referred to as a research fellow. [Tr. at 730.]

136. In his deposition, Dastgir testified he got his D.D.S. degree in Iran, did not practice as a dentist in Iran, went from high school directly to graduate dental school (six years), received a degree as a licensed dentist. [Ex. T, p. 87] Dastgir's CV described himself as "an attentive dentist" with "five plus years of experience providing dental and surgical healthcare services to a large population of patients in Iran." He listed approximately 35 peer reviewed articles published. [Id. p. 82.]

137. Respondent testified that he trained Dastgir as a dental assistant, the same as he trained all of his assistants in his office over an 11 months' period. [Tr. at 732.] Dastgir was BLS certified on the day of the surgery, and he was ACLS certified as well. [Tr. at 736.]

138. Respondent testified that Dastgir's "only job was really monitoring." [Tr. at 755.] On cross-examination, Respondent admitted:

> Mr. Appel Q: "Mr. Dastgir had two jobs. He had to maintain the airway by holding the head straight, and you expected him to monitor the vital signs?"
>
> A: "Not very difficult to do both jobs."
>
> [Tr. at 752.]

139. As far as Dastgir's role during Patient 1's procedure, there is conflicting evidence. Unlike Respondent's recollection above, in his deposition Dastgir claimed that it was not his job to monitor the patient. [Ex. T, p. 56.] Dastgir went on to say "…but monitoring the patient, again, that was not my role or duty to monitor the patient... My only role was to support the chin... A trained observer, as -- as for training, the only training I got was in holding the chin. And I had no responsibility or duty to monitor the patient." [Ex. T, p. 151.] In contradiction, Dr. King's expert report stated that "by his own violation, [Dastgir] was responsible for monitoring the vital signs and assisting with optimization of the airway when it was found the patient was not ventilating properly." [Ex. 23, p. 4.]

140. Stupak also testified that it was Dastgir's role during Patient 1's procedure to monitor Patient 1 under anesthesia.

> Q. And who typically monitored the patient?
> A. Dr. Quereshy would watch the monitor, but also the assistant that was supporting the airway.
> Q. Do you remember who that was with Patient 1?
> A. That was Ramtin.
> [Tr. 460]

141. Dastgir did perform CPR on Patient 1. [Ex. T, p. 58.] Dastgir stabilized the jaw and did jaw thrusts for airway maintenance. [Ex. T, p. 139.]

142. As part of the Dastgir's research fellowship role, he had a contract between him and Case Western Reserve University. [Ex. H.] The contract was signed by Respondent in his role as a Residency Director of Oral and Maxillofacial Surgery with Case Western Reserve University. [Id.]

143. The June 1, 2022 contract stated:

> Responsibilities of this position include clinical observation in the clinic and operating room, participation in department didactic activities, and possibly participation in ongoing or new department research, time permitting. Other than observation, you will not be allowed to have patient contact. You will be working under the direction of Dr. Faisal A. Quereshy, and Dr. Dale Baur (Dept Chair).

[Ex. H]

144. Dr. King's conclusion was that Respondent deviated from the standard of care because he allowed Dastgir patient contact despite having an agreement that he was not allowed to have patient contact.

> Additionally, there is a flagrant violation of this code with the use of the research fellow, Ramtin Dastgir, as an assistant. During this case, it was clearly stated in multiple interviews, interrogatories and the deposition that Mr. Dastgir was acting as a dental assistant. Even by his own volition, he was responsible for monitoring the vital signs and assisting with optimization of the airway when it was found that the patient was not ventilating properly. He also then performed CPR along with the rest of the team after the patient was found to be pulseless.
>
> As a research fellow, it was clearly outlined in his contract that he was to be an observer only and have no patient contact. At no point should he have been allowed to act as a dental assistant. His use for chest compressions could be justified considering his presence, prior knowledge of ACLS, and the acuity of the situation, but prior to that need, his being assigned any clinical role is a violation of his contract and Section 4519.30(B)(9) of the Ohio Revised Code.

[Ex. 23.]

145. However, on cross-examination, Dr. King admitted that the "no patient contact" was not from the Dental Practices Act. [Tr. at 377.] Dr. King then testified that the real concern was that Dastgir was not legally considered an employee of Visage and had patient contact. [Tr. at 372.] But she also admitted that is not a requirement in the Dental Practices Act. [Tr. at 363.]

> Q. Your -- the predicate to your belief that Mr. Dastgir should not have been having patient contact is based on the -- Mr. Dastgir's contract with Case Western Reserve?
>
> A. No. Because once I found out that that didn't extend to that, then my issue is actually more so, then he should have been employed.

[Tr. at 371.]

> As a nonemployee, who is nonlicensed to practice dentistry, or anything, in the State of Ohio, is touching patients, my question is do the patients and their families know who he is, have they ever been introduced to him, do they know his qualification?
>
> Q. So let me go back to my point. You didn't see anywhere in the Ohio Dentist Practices Act that the dental assistant needed to be employed, correct?
>
> A. Correct.
>
> Q. You did not see anywhere in the Ohio Dental Practices Act, or in the AAOMS or in the ADA, that the dental assistant needed to be licensed or certified other than in BLS, correct?
>
> A. Correct.
>
> Q. Mr. Dastgir, you acknowledge that upon further review, that you saw that that contract applied only to his role at Case Western Reserve?
>
> A. Yes.
>
> Q. You acknowledge that that contract did not apply to Mr. Dastgir's activities, whether employed or not, at the private practice, correct?
>
> A. Correct. So you are saying that

[Tr. at 372.]

- Respondent's response from Expert Report (Ex. K):

> 2.(g) I did not have a contract with Ramtin Dastgir. Rather, Mr. Dastgir had a contract with Case Western Reserve University School of Dental Medicine, where I served on its faculty. This contract applied to Mr. Dastgir's actions while he observed dental procedures at Case Western Reserve University. This contract did not apply to his voluntary involvement with procedures at my private practice. Additionally, Mr. Dastgir does have training in dentistry and was qualified to serve the roles he served during Patient 1's care at Visage.

NOH Section 3(a - c): Once Patient 1 entered cardiac arrest, Respondent deviated from the standard of care in the following ways: (a) Respondent administered epinephrine through an endotracheal tube; (b) Respondent failed to administer epinephrine every two (2) minutes with pulse checks, and administering only one dose of epinephrine before emergency medical services arrived fifteen minutes later; and (c) Respondent failed to administer reversal agents to counter the narcotics and benzodiazepines administered to Patient 1.

146. Respondent agrees that he administered epinephrine through an endotracheal tube, did not administer epinephrine every two (2) minutes (he admitted he only administered the

epinephrine once), and did not administer reversal agents. However, he disagrees that his emergency care deviated from the standard of care. [Tr. at 702-704.]

147. The proper procedure for emergency lifesaving efforts is called ACLS. [Tr. at 197.] Dr. King was an ACLS instructor for over 10 years and she is ACLS certified. [Tr. at 194.]

148. Dr. King admitted that Respondent did the following appropriate steps immediately upon noticing that Patient 1 was not breathing:

- Respondent did painful stimulation, clamping the tongue, skin pinching, and smelling salts when trying to wake Patient 1. [Tr. at 182.]
- Respondent noted absent breath sounds and absent pulse, and asked for his staff to call 911 while starting CPR. [Tr. at 182 – 183.]
- An AED (Automatic External Defibrillator) was placed on Patient 1, which was the right thing to do (though Dr. King noted it was delayed). [Tr. at 183.]
- CPR was initiated, which was the right thing to do. [Tr. at 183.]
- Respondent intubated Patient 1, which was appropriate since they could not ventilate Patient 1 any other way. [Tr. at 183.]
- Respondent took steps to open the airway including jaw thrust and chin lift, which was the right thing to do. [Tr. at 174.]
- These maneuvers didn't work because "the patient was already apneic for a prolonged amount of time" and "once you become apneic to where your brain has literally turned off because the carbon dioxide is too high, or the oxygen level is too low, then what will end of happening is that there is no respiratory drive anymore." [Tr. at 174-175.]

149. Upon review of his own ACLS performed on Patient 1, Respondent provided that he was working on the airway from the endotracheal tube and so he administered epinephrine that way since he was actively focused on the breathing airway and chest compression exercises and was far from the IV. [Tr. 703-704.] He did not consider the administration of reversal agents due to the low amount of anesthesia medications. [Tr. at 530.]

150. Respondent placed bag valve mask device to give breaths to Patient 1 and confirmed by Patient 1's chest rising that it was working and Patient 1 was ventilated. [Tr. at 700] Respondent then decided to intubate Patient 1 and was successful at placing the endotracheal tube on his first attempt. [Tr. at 701.] Once intubated Respondent connected the anesthesia machine. [Tr. at 704.] The focus of Respondent and his team was on good chest compressions, CPR, and oxygenation. [Tr. at 705.]

151. Respondent, Stupak, and Sucieswicz recognized that it was a chaotic time. [Tr. at 703.]

152. All staff rotated giving chest compressions until the EMT arrived. [Tr. at 703; 705.]

- Respondent's response from Expert Report (Ex. K):

3.(a) Administration of epinephrine through an endotracheal tube does not constitute a deviation from the standard of care and can be appropriate in certain circumstances.

3.(b) The administration of epinephrine every two minutes is not necessarily required by the standard of care. At the time of the code response, my focus was on running the code and trying to save Patient 1's life.

3.(c) Under these circumstances, reversal agents were not required given the doses of fentanyl and midazolam that I administered.

153. The responding EMT confirmed that the Visage staff and Respondent were doing chest compressions and had the AED applied so that was "a good sign to see." [Tr. at 54.] He also agreed that Respondent successfully placed the endotracheal tube and that he did not need to move or adjust the tube. [Tr. at 84.]

154. In conclusion when recalling that day, Respondent provided:

"It was a very traumatic day. The team, I feel, responded very quickly. It was very sad to see the events play out. The efforts by the entire team members, you know, it was - I will never forget that day, it's very vivid. And every time I perform an anesthetic, that day has flashed back every single time since that day it happened." [Tr. at 545.]

NOH Section 4: Patient 1 expired because of acute hypoxic respiratory failure as a result of procedural sedation.

155. Patient 1 passed away on August 8, 2023. [Stip. No. 7; Ex. 17.]

156. The death certificate for Patient 1 was admitted into the record as Exhibit 17 but was not identified or discussed by any witness.

28. Part I. Enter the disease, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Type or print in permanent blue or black ink.		Approximate Interval Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a ACUTE HYPOXIC RESPIRATORY FAILURE	10 MINS
Sequentially list conditions, if any, leading to immediate cause.	b. Due to (or as Consequence of) PROBABLY PROCEDURAL SEDATION	10 MINS
	c. Due to (or as Consequence of)	

157. There was no direct testimony on cause of death and without that testimony, the Death Certificate should not be considered by the Board as an expert medical opinion.

158. Dr. King's report stated that Patient 1 was "found to have global anoxic brain injury. While awaiting the necessary time to perform a brain death exam for potential organ

transplantation, the patient became unstable and passed on the 8th of August due to florid shock." [Ex. 23, p. 2.] At the hearing, Dr. King provided the following on Patient 1's cause of death:

> Q. Okay. Finally, why do you think Patient 1 died?
> A. Hypoxic respiratory arrest.
> Q. And just in layman's terms, that means?
> A. The airway was lost and -- which caused there to be enough C02 in the blood, and not enough oxygen in the blood to feed the heart, leading the heart to cardiac arrest.
> Q. And was that hypoxia as a result of the sedation given by Dr. Quereshy?
> A. Yes.
> [Tr. at 224-225.]

159. Around five minutes after the administration of anesthesia, Patient 1's airway collapsed and he had a loss of airway. [Tr. at 406.] Respondent testified that Patient 1 had widespread brain damage within hours of arriving at the hospital and that with that much brain damage, the patient passing away is likely imminent. [Tr. at 527-528.] Respondent noted that he does not know what caused the airway reaction in Patient 1 and that the amount of anesthesia given to Patient 1 was actually "very minor, minuscule" for someone of his size. [Tr. at 526-527.] Respondent was asked about he knowledge of the cause of death and he testified that he just "does not know." [Tr. at 742.]

- Respondent's response from Expert Report (Ex. K):

4. Without the benefit of an autopsy and/or toxicology screen, I cannot state that Patient 1 expired because of acute hypoxic respiratory failure as a result of procedural sedation.

IX. RESPONDENT'S STATEMENT

Respondent's counsel asked Respondent: Doctor, my last question, at least for the time being, is there anything else you want the Hearing Examiner to know, the Board to know, that you feel is important? Go ahead.

A: "You know, this was a tragedy that day. My deepest sadness and condolences to patient and the widow of this patient will never leave me.

I thought long and hard about what took place, why it happened. I've spent 25 years post residency in devoting my life and energy to training others in this specialty to help patients of this state, and I get patients from many different patients outside the state.

I try to stay on the forefront of knowledge and being an academic and pushing research to better the specialty of oral maxillofacial surgery to providing a safe environment for our

patients, and this event will never leave me, and I approach every patient with a heightened sense of awareness to make sure that this never happens again.

You know, I pride myself on practicing with ethics, knowledge, and excellence and, frankly, this has really jarred me to the core, and I want to continue to be a good influence on surgeons of tomorrow for our state, and to help all those patients in need, because we are providing a service for these patients who can't get into healthcare for whatever reason, the burdens of healthcare, the inherent system flaws that we have.

We have a role to play, and I would like to continue that role in a positive manner and just do better.

I can't take back what has happened, I can only influence the future, and I know I can do better."

[Tr. at 744-746]

FINDINGS OF FACT

FACT 1. Respondent has held a General Anesthesia Permit and Dental License since May 5, 1999. He also has an active Doctor of Medicine (MD) license since March 4, 1999. His two Dental Board licenses are valid through December 31, 2027 and his Medical Board license is valid through April 1, 2028. [Verified from elicense.ohio.gov on January 8, 2026.]

FACT 2. Wellington Dental, a general dentistry practice, referred Patient 1 to Visage due to Patient 1's hyper dental phobia.

FACT 3. On July 11, 2023, Patient 1 was seen by Respondent, and Respondent's staff, for a initial consultation and pre-operative evaluation. After discussion, Patient 1 and Respondent agreed to move forward with the surgical removal of teeth #1, 2, and 30. Respondent discussed the general nature of patient's conditions and planned procedure, alternative treatments, and associated risks. Respondent provided Patient 1 with surgical instructions and also discussed special risks.

FACT 4. On July 11, 2023, Respondent performed a physical examination of Patient 1, but failed to document any of Patient 1's measurements, including his thyromental distance, neck circumference, interincisal opening, and cervical range. All of which are areas on Respondent's pre-operative evaluation form. Respondent also failed to verify Patient 1's self-reported weight.

FACT 5. Respondent did not require Patient 1 to seek an outside medical evaluation by any physician, including a primary care physician, prior to surgery.

FACT 6. Respondent did not perform a full medical evaluation of Patient 1 prior to surgery.

FACT 7. Respondent did not fill out a STOP BANG questionnaire form for Patient 1.

FACT 8. Respondent determined that Patient 1's airway risk values were a Mallampati Score of 2 and classified as an ASA 1.

FACT 9. On August 4, 2023, Patient 1 presented for the extraction of three teeth. Patient 1's surgery was assisted by an employee of Visage and Ramtin Dastgir.

FACT 10. Respondent administered anesthesia medication measured for Patient 1's recorded weight of 315 pounds and started the procedure. Between 5-10 minutes after the medication was administered and Respondent started the procedure, Respondent noticed Patient 1's breathing had slowed and there was discoloration around his lips. Respondent performed painful stimuli (local anesthetic), which he noticed Patient 1 failed to respond to. At the same time, another Visage dental assistant walked by the surgery room and noticed Patient 1's hands turning blue. Respondent quickly recognized that Patient 1 was not breathing and had lost his airway.

FACT 11. Although unclear on the exact timing or order, Respondent, immediately after recognizing that Patient 1 was not breathing, directed his staff to call 911, inserted an endotracheal breathing tube, attached a bag, and initiated the appropriate ACLS protocol for a code, including administering epinephrine, performing and rotating CPR every two minutes, placing an AED. Respondent did not give more than one dose of epinephrine and did not administer any other reversal agents. After Patient 1 was transferred by EMS to the hospital, he expired on August 8, 2023.

FACT 12. Respondent's equipment adequately functioning on August 4, 2023, but the equipment was not calibrated to the actual time.

FACT 13. On August 4, 2023, Respondent was competent in ACLS. His dental assistant and Dastgir were both competent in BLS. The individual designated to monitor the patient's level of sedation was Dastgir and that was not his only responsibility. He had another responsibility of maintaining the airway by holding Patient 1's head straight.

FACT 14. Respondent did not have a clear practice to assign his dental assistants to direct tasks or responsibilities prior to the start of a surgical procedure to assign adequate roles to each dental assistant.

> were -- whichever assistant we were with in the room, we would kind of discuss amongst ourselves who would be assisting, or who would be the third person, or who would be supporting airway.
>
> Q. And then was Dr. Quereshy involved in these discussions, or was it just a discussion among the assistants?
>
> A. Usually among the assistants.
>
> Q. When Dr. Quereshy starts a surgery, did he clarify with you all, you know, whose role was which role before the surgery started?
>
> A. No.
>
> [Stupak Testimony, Tr. 461.]

FACT 15. Ohio Administrative Code Rule 4715-5-05 outlines the requirements for dentists that administer general anesthesia or deep sedation to a patient. Section (B)(2) requires that in order to have a general anesthesia permit, the dentist must produce evidence that he:

> Has a properly equipped facility(s), whether fixed, mobile, or portable, for the administration of general anesthesia or deep sedation in which the permit holder has available and agrees to utilize adequate monitoring, personnel, emergency equipment and drugs as recommended in the "Guidelines for the Use of Sedation and General Anesthesia by Dentists" as adopted by the October 2016 American dental association house of delegates and/or the American association of oral and maxillofacial surgeon's "Office Anesthesia Evaluation Manual," 9th edition.

FACT 16. The anesthetic team required in Ohio Administrative Code Rule 4715-5-05 (K) is:

(1) A general anesthesia provider;

(2) Either of the following:

(a) An Ohio-licensed dentist with current BLS-HCP or ACLS certification who can assist the anesthesia provider in an emergency if needed; or

(b) An individual currently certified in BLS-HCP who is experienced in patient monitoring and documentation and whose duties are solely dedicated to patient monitoring and documentation and, if needed, assisting the general anesthesia provider in an emergency.

(3) One individual whose duties may include assisting with dental procedures.

FACT 17. The AAOMS, Office Anesthesia Evaluation Manual, 9th Edition (the "AAOMS Manual") states that the Anesthesia Team for Deep Sedation/General Anesthesia consists of "the surgeon, trained and currently competent in ACLS, and two additional persons trained and currently competent in BLS for Healthcare Providers. The individual designated to monitor the patient's level of sedation should have no other responsibilities."

FACT 18. The AAOMS Manual also provides Appendix 7: Patient Selection Criteria which states that there are absolute and relative contra-indications for anesthesia in the office setting. These are noted to be guidelines for AAOMS members and not intended to establish a standard of care for office-based anesthesia.

FACT 19. The American Dental Association also has "Guidelines for the Use of Sedation and General Anesthesia by Dentists." (the "ADA Guidelines") According to the ADA Guidelines, the guidelines for Deep Sedation or General Anesthesia:

C. Deep Sedation or General Anesthesia

1. Patient History and Evaluation

Patients considered for deep sedation or general anesthesia must undergo an evaluation prior to the administration of any sedative. This must consist of at least a review of their medical history and medication use and NPO (nothing by mouth) status. In addition, patients with significant medical considerations (e.g., ASA III, IV) should also require consultation with their primary care physician or consulting medical specialist. Assessment of Body Mass Index (BMI)[4] should be considered part of a pre-procedural workup. Patients with elevated BMI may be at increased risk for airway associated morbidity, particularly if in association with other factors such as obstructive sleep apnea.

2. Pre-operative Evaluation and Preparation

- The patient, parent, legal guardian or care giver must be advised regarding the procedure associated with the delivery of any sedative or anesthetic agents and informed consent for the proposed sedation/anesthesia must be obtained.
- Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.
- A focused physical evaluation must be performed as deemed appropriate.
- Baseline vital signs including body weight, height, blood pressure, pulse rate, respiration rate, and blood oxygen saturation by pulse oximetry must be obtained unless invalidated by the patient, procedure or equipment. In addition, body temperature should be measured when clinically appropriate.
- Pre-operative verbal and written instructions must be given to the patient, parent, escort, legal guardian or care giver, including pre-operative fasting instructions based on the ASA Summary of Fasting and Pharmacologic Recommendations.
- An intravenous line, which is secured throughout the procedure, must be established except as provided in part IV. C.6. Special Needs Patients.

3. Personnel and Equipment Requirements

Personnel: A minimum of three (3) individuals must be present.

- A dentist qualified in accordance with part III. C. of these Guidelines to administer the deep sedation or general anesthesia.
- Two additional individuals who have current certification of successfully completing a Basic Life Support (BLS) Course for the Healthcare Provider.
- When the same individual administering the deep sedation or general anesthesia is performing the dental procedure, one of the additional appropriately trained team members must be designated for patient monitoring.

FACT 20. The ADA Guidelines adopted the American Society of Anesthesiologists (ASA) Patient Physical Status Classification:

American Society of Anesthesiologists (ASA) Patient Physical Status Classification[2]

Classification	Definition	Examples, including but not limited to:
ASA I	A normal healthy patient	Healthy, non-smoking, no or minimal alcohol use
ASA II	A patient with mild systemic disease	Mild diseases only without substantive functional limitations. Examples include (but not limited to): current smoker, social alcohol drinker, pregnancy, obesity (30 < BMI < 40), well-controlled DM/HTN, mild lung disease
ASA III	A patient with severe systemic disease	Substantive functional limitations; One or more moderate to severe diseases. Examples include (but not limited to): poorly controlled DM or HTN, COPD, morbid obesity (BMI ≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, *ESRD undergoing regularly scheduled dialysis, premature infant PCA < 60 weeks, history (>3 months) of MI, CVA, TIA, or CAD/stents.
ASA IV	A patient with severe systemic disease that is a constant threat to life	Examples include (but not limited to): recent (< 3 months) MI, CVA, TIA, or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, sepsis, DIC, ARD or *ESRD not undergoing regularly scheduled dialysis
ASA V	A moribund patient who is not expected to survive without the operation	Examples include (but not limited to): ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction
ASA VI	A declared brain-dead patient whose organs are being removed for donor purposes	
*The addition of "E" denotes Emergency surgery: (An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part)		

FACT 21. The guidelines set forth in the ADA Guidelines and AAOMS Manual are guidelines and not alone requirements to meet a standard of care.

FACT 22. Ohio Administrative Code Rule 4715-5-06 states:

> (A) All licensees engaged in the practice of dentistry in the state of Ohio must notify the board within seventy-two hours of knowledge of an adverse occurence, and submit a complete written report within thirty days of any adverse occurrence requiring hospital admission within twenty-four hours of patient treatment or any mortality which occurred as a direct result of treatment in a dental facility.

FACT 23. Respondent co-authored an article in 2010 titled the "Causes of the Difficult Airway." In that article he identified that "recognizing a potentially difficult airway is important in avoiding a life-threatening emergency. Therefore, it is critical to preoperatively assess every

patient by completing a full history and physical. A thorough history can provide clues in detecting a possible difficult airway."

FACT 24. The post-surgical records had different airway risk values, as charted by Respondent. The post-surgical values that Respondent charted were a Mallampati Score of 4 and an ASA III.

FACT 25. Section 4715.30(A), O.R.C., authorizes the Board to discipline the holder of a license issued under this Chapter for any of the following reason(s): (9) Providing or allowing dental hygienists, expanded function dental auxiliaries, or other practitioners of auxiliary dental occupations working under the certificate or license holder's supervision, or a dentist holding a temporary limited continuing education license under division (C) of section 4715.16 of the Revised Code working under the certificate or license holder's direct supervision, to provide dental care that departs from or fails to conform to accepted standards for the profession, whether or not injury to a patient results.

FACT 26. Upon finding of a violation, and after a hearing provided under R.C. Chapter 119, the Board may take any of the following actions, pursuant to R.C. 4715.30(C), which provides:

> (C) Subject to Chapter 119. of the Revised Code, the board may take one or more of the following disciplinary actions if one or more of the grounds for discipline listed in divisions (A) and (B) of this section exist:
>
> (1) Censure the license or certificate holder;
>
> (2) Place the license or certificate on probationary status for such period of time the board determines necessary and require the holder to:
>
> (a) Report regularly to the board upon the matters which are the basis of probation;
>
> (b) Limit practice to those areas specified by the board;
>
> (c) Continue or renew professional education until a satisfactory degree of knowledge or clinical competency has been attained in specified areas.
>
> (3) Suspend the certificate or license;
>
> (4) Revoke the certificate or license.

FACT 27. The standard of review for the finding of a violation is whether or not the State has proven by reliable, probative and substantial evidence that Respondent has departed from or failed to conform to accepted standard for the profession.

FACT 28. Respondent's treatment of Patient 1, as described in Findings of Fact 5, 6, and 14 individually or collectively constitute "providing * * * dental care that departs or fails to conform to accepted standards for the profession, whether or not injury to a patient results" as that language is used in R.C. 4715.30(A)(9).

FACT 29. Accordingly, the Board is authorized to impose one or more of the sanctions cited in Ohio Revised Code Section 4715.30.

CONCLUSION OF LAW

The Board has the authority to take disciplinary action against Respondent's licenses to practice dentistry and administer anesthesia in the State of Ohio pursuant to R.C. 4715.30(A)(9) because he provided dental care to Patient 1 that departed from or failed to conform to the accepted standards for the profession.

DISCUSSION

A. The undersigned proceeds with this discussion with full recognition that Patient 1's death was tragic and unfortunate. The death and loss of Patient 1 demands serious review and careful examination of what occurred and why. Patient 1's wife described him as a really great guy who was so special. He was a big, tough, strong man with Christmas tattoos down his arm, a good friend, and a great dad who loved his kids fiercely. The death of a patient is a matter of utmost seriousness, and the undersigned has conducted this review with appropriate gravity. At the same time, this proceeding must afford due process to all parties and base its conclusions on the evidence presented and the professional standards established in Ohio law.

B. While the practice of medicine and dentistry involves inherent risks, and while not every tragic outcome indicates professional failure, the findings in this case establish that Respondent departed from accepted standards of care in ways that are significant and cannot be overlooked. These departures occurred in the context of administering general anesthesia, a procedure that carries serious risks and demands the highest level of care, preparation, and vigilance. It is very clear that Respondent never meant to harm this patient. In fact, Respondent noticed that Patient 1's dentist actually had the wrong procedure on the referral and wrong teeth marked for extraction and upon intake, corrected that and informed Patient 1 of that change.

C. Respondent is a well-respected Dentist and Oral and Maxillofacial Surgeon in Ohio and it appears nationally. His CV is full of awards, accolades, research studies, presentations, and articles. His CV demonstrates his commitment to the profession and educating others. The undersigned also places a lot of value on Dr. Goldberg's opinion and testimony as it relates to Respondent and his background. Dr. Golberg testified about Respondent's impact not only on his patients, but also on the face of oral surgery on a national and international level for this profession. Respondent's respected history is supported by the over 20,000 cases of office-based general anesthesia over his career. From any review of Respondent's history, he is considered a good dentist and oral surgeon. There was no other negative evidence or testimony except for the review of his care and procedure as it relates to Patient 1.

D. Unfortunately, on August 4, 2023, Respondent's treatment of Patient 1 departed from or failed to conform to the accepted standards for the profession.

E. The State in its opening stated, if you have something that a good dentist could do on a bad day, you should not issue discipline. If you have a dentist that (1) doesn't know what they are doing or (2) are endangering patient safety, then there are issues beyond that. Respondent is a

good dentist and the majority of his care of Patient 1 was absolutely something that another good dentist would have done. It also appears that there is not a systemic issue with Respondent's care and that what happened to Patient 1 was a isolated failure.

F. As a surgeon, the question and responsibility lie with the Respondent whether or not he has enough information on his patient to proceed with putting the patient under anesthesia. Respondent viewed that he did. Although some risk is always present in anesthesia, the patient selection criteria used on Patient 1 did not provide enough information on Patient 1's medical history or current medical status at the time of the procedure for Respondent to have fully appreciated and accepted that risk.

G. Respondent did not testify that his care of Patient 1 on August 4, 2023 was without shortcomings. The two areas that the undersigned recommends that the Board should review for determination of whether or not he departed from or failed to conform to the accepted standards for the profession are: (1) the failure to conduct a full medical evaluation of Patient 1 prior to surgery, and (2) the failure of adequate monitoring of the patient under anesthesia. The State has provided reliable and probative evidence that Respondent's failure departed from or failed to conform to the accepted standards for the profession in both of these areas.

H. The other areas mentioned by the State are worth discussing, and perhaps together demonstrate that additional education and training should be required, but the other areas are not supported by reliable and probative evidence that Respondent's failures departed from or failed to conform to the accepted standards for the profession.

I. It appeared from Dr. King's testimony that she researched and educated herself about the Ohio Revised Code, Ohio Administrative Code, AAOMS Manual and ADA Guidelines as it relates to dentistry, oral surgery in office settings, and dental assistants. Dr. King's knowledge on these areas are not from practice herself. At times, Dr. King made conclusions or testimony about requirements in the Ohio Revised Code or Ohio Administrative Code that were inaccurate. This is not to say that Dr. King intentionally did this, but this would be common for anyone that is testifying about regulations that are not applicable in their own field of study/profession. Specifically about Respondent's dental assistants, her opinions on their required qualifications were stated to a higher degree than what is required. There was no evidence that the dental assistants at Visage, or Ratmin Dastgir, were not appropriately trained, certified, or supervised.

J. It has been stated and it should be noted again for the Board that the undersigned did not have the privilege to hear testimony or evidence from another Oral Surgeon in private practice about the accepted standards for the profession. Since the undersigned is not a healthcare professional, it is crucial that the Board members consider the medical testimony and the medical records to evaluate this case with their knowledge of accepted standards for the profession and whether or not there was a departure or failure to conform with the standards.

K. The undersigned disagrees with the State that Respondent's expert testimony is biased because he is attempting to minimize his own conduct. However, the lack of another

similarly situated dentist and oral surgeon to review and evaluate Respondent's patient selection and care and treatment of Patient 1, is what would have been helpful to hear. Understanding that this Board is made up of other similarly situated dentists and oral surgeons, the undersigned is confident that that the Board can use the information this Report and Recommendation and the evidence and testimony to determine whether or not Respondent's actions departed from or failed to conform with the standards.

Failure to Conduct a Full Medical Evaluation of Patient 1

L. The Board's concern should not be limited to the fact that Respondent did not require Patient 1 to be evaluated by an outside physician, or a primary care physician, prior to surgery, but that Respondent did not actually fully perform an evaluation of Patient 1 to identify any underlying medical conditions.

M. Absent from the guidelines reviewed and presented at the hearing is any requirement that Patient 1 would be required to see an outside physician prior to surgery. But it is clear that Patient 1 should at a minimum be fully evaluated by Respondent prior to surgery. Respondent's own documents have areas to complete for vitals and measurements which were left blank. Respondent's failure to fully evaluate Patient 1 departed from or failed to conform to the accepted standards for the profession.

N. Patient 1 was not forthcoming with his own medical history. Perhaps Patient 1 did not know his medical history, he downplayed the risks of the surgical procedure, or he did not understand he was able to ask more questions in his pre-surgical appointment. Patient 1 indicated to Visage that he was in "good health." This is supported by Patient 1's wife's deposition where she described her husband as very healthy and active. Patient 1's wife's testimony also supports that Patient 1 likely was not taking the preoperative forms he filled out himself seriously. There was some discussion that perhaps Patient 1 did not fully understand what level of anesthesia he was receiving. Whether or not that is true is not an issue that can be determined, unfortunately. However, this also supports the conclusion that Patient 1 may not have taken this procedure seriously and did not provide full, complete, and truthful information on his pre-operative forms. There was also quite a bit of discussion about identification of snoring or sleep apnea, or when that was disclosed, overall, by Patient 1. As far as the STOP BANG analysis is concerned, Respondent's failure to fill out the evaluation did not depart from or fail to conform to the accepted standards for the profession, on its own. But this requirement is related to the overall pre-surgical evaluation. Patient 1's conflicting statements on snoring and sleep apnea allow for Respondent a benefit of the doubt that Patient 1's history was never fully disclosed, identified, or discussed.

O. As the licensed dentist and surgeon, Respondent holds the duty and responsibility to completely assess a patient's risk for anesthesia prior to surgery. With Respondent's level of expertise, he should understand that patients tend to discount their medical history or are embarrassed to fully reveal medical complications. Additionally, a patient may not understand the full risks of the procedure, especially the risks associated with the administration of anesthesia. It is Respondent's job to assess that risk and not rely on Patient 1's self-reported medical history.

P. It is the Respondent's responsibility to ensure that he has a full understanding of his patient's medical history and current medical status. It should have been alarming to see a 315–350-pound, 5-foot 8-inch, 48-year-old male report that he is good health, yet had not seen a primary care physician in years. This knowledge was apparent from a review of his pre-operative forms and Patient 1's physical appearance. Dr. King's testimony on this was persuasive here.

Q. The fact that Respondent has successfully performed over 20,000 procedures leads one to believe that his process and risk assessment isn't faulty. But looking at this particular situation with Patient 1, and the fact that he was an identifiable large man, with a large neck circumference, and a beard, should have led Respondent to seek out an outside medical evaluation. But, Respondent is a licensed physician, he could have performed a medical evaluation himself. Respondent's medical examination was cursory and was not a full physical that adequately identified Patient 1's risk.

R. Patient 1's wife even denied that Patient 1 had dental anxiety, which is the primary reason his dentist referred him to an oral surgeon for the removal of these teeth under general anesthesia. It is also unclear if Patient 1's wife fully understood what procedure Patient 1 was receiving, the risks associated with the procedure, or whether he was going to be under general anesthesia and deep sedation. This is not to suggest that Respondent did not inform Patient 1 or his wife, but more to demonstrate that Patient 1 and his wife, may not have fully appreciated the seriousness and importance of supplying Respondent and Visage with a full and complete medical picture prior to the procedure.

S. Patient 1 and his wife are not unique in the fact that they downplayed his weight and unidentified underlying medical conditions. Respondent's failure to require Patient 1 to do a full medical evaluation, with himself or an outside physician, is problematic and departed from or failed to conform to the accepted standards for the profession.

T. The undersigned agrees with Respondent's counsel, that obesity by itself is not an indicator of failed patient selection and doesn't, on its own, preclude a office-based anesthesia procedure. But the presence of obesity and height of Patient 1, should have alerted Respondent to verify with certainty there were no other medical conditions that coupled with the obesity, would preclude Respondent from office-based anesthesia. Respondent's medical evaluation was not thorough enough to support his patient selection.

U. Unfortunately, there was no evidence provided about Patient 1's known medical status prior to surgery or at surgery on August 4, 20213, as he had not seen a physician for over a decade and there was not a full medical evaluation completed on Patient 1. There is no medical information, nor can there be at this point, that Respondent understood the risks associated with administering anesthesia to Patient 1. Respondent did not have a full picture of Patient 1's current medical status in order to evaluate risk prior to the procedure on August 4, 2023.

V. The existence of the ADA Guidelines and AAOMS Manual in the Ohio Administrative Code supports the fact that the Board would expect that its licensees would follow the guidelines set forth in both publications. The undersigned understands Respondent's counsel's

arguments that these guidelines are not equivalent to define or establish the standard of care. However, without expert testimony to the contrary, the fact that there were many guidelines that weren't followed as it relates to Patient 1's care, the undersigned considers these guidelines as just that – guidelines – but the failure to follow these guidelines coupled with other facts, can support a conclusion that Respondent departed from or failed to conform to the accepted standards for the profession.

W. There was no expert witness testimony that Patient 1 would have otherwise been cleared for office-based anesthesia and oral surgery. There is no benefit of hindsight to determine what a medical evaluation would have uncovered. Respondent performed a medical evaluation on Patient 1, but it was minimal and not to the standard of detail needed in order to assess the risk of providing general anesthesia or deep sedation to Patient 1 according to Dr. King. The undersigned did not have the benefit from hearing expert testimony from another dentist or oral surgeon in order to determine whether or not Respondent's knowledge of Patient 1's medical history was comparable to other similar patients undergoing general anesthesia or deep sedation for tooth extraction. The hearing examiner is aware that Dr. King's background, experience, and education in anesthesia is extensive, but overall, the weight of her testimony as to the standard of care as it relates to a licensed dentist and oral surgeon is less than it would have been if the testimony was from an expert in an equivalent practice or experience as the Respondent.

X. Perhaps Patient 1 would have received clearance from a physician and the same tragic conclusion would have occurred, but that is not what the facts support.

Y. When considering both Dr. King and Respondent's expert testimony about the adequacy of Patient 1's medical evaluation prior to surgery and adequate patient selection, Dr. King's testimony is more persuasive.

Z. The biggest deviation from the standard of care here is more related to the failure to have a preoperative evaluation by an outside physician or a full physical and medical evaluation conducted by Respondent. Perhaps, an outside physician would have determined that Patient 1 could not or should not undergo this procedure or dictated a higher risk location for the procedure. But the facts as they relate to Patient 1 are that Respondent did all the initial evaluations and approved him for surgery. Even if Respondent correctly determined a higher level of risk of airway obstruction, he could still decide to proceed with the surgery at Visage.

AA. The undersigned agrees with Respondent's counsel that: "[t]he law doesn't demand an ASA III to go to a physician for clearance, again, not a must, but it's a should, something that the oral surgeon should consider." However, the lack of medical history from Patient 1 coupled with being classified as ASA III, morbid obesity, and physical body habitus changes that "should" to a "must" as it relates to a patient like Patient 1. The undersigned finds that Dr. King's testimony is more persuasive that most other physicians administering anesthesia would make that decision based upon Patient 1's appearance alone.

Failure of Adequate Monitoring of the Patient Under Anesthesia

BB. The undersigned puts less emphasis on the fact Dastgir was serving as a dental assistant at Visage and more emphasis on Respondent's admission that he does not have an assistant solely assigned to monitor the patient and the machines as outlined in the AAOMS Guidelines.

CC. More importantly, Respondent relies upon the assistants to assign themselves roles and responsibilities in the procedure and during surgery instead of directing each one of them himself. Although Respondent may be able to quickly glean which assistant is doing what, he is the licensed physician and he needs to take full control of all responsibilities of monitoring, equipment, and personnel as specifically required in Ohio Administrative Code Rule 4715-5-05. There should be no question from the personnel assisting Respondent about their assigned role during the procedure. Respondent's failure to fully control the personnel during Patient 1's procedure departed from or failed to conform to the accepted standards for the profession.

Other Allegations in the NOH

DD. Proper documentation does not necessarily prevent tragic incidents from occurring, but proper documentation does allow for a review after the fact to determine whether there was something missed or whether all procedural steps were taken and all risks were acknowledged prior to surgery.

EE. The wrong ASA classification, low and incorrect Mallampati score, failure to do the physical body measurements, the failure of a physical or full medical evaluation prior to surgery, all support a deviation from what is recommended by the Administrative Code and the referenced sections of the Administrative Code. However, even with all the proper classifications of ASA III, Mallampati IV, body measurements, and known airway risk, there was no opinion or evidence provided that support that Patient 1 should not have undergone the surgery at Visage. Any failures related to the other NOHs are more aligned to the failure to have a full medical evaluation of Patient 1.

FF. Further, there was no evidence, testimony, or other information that supports what additional protocols should be in place that were not, on that day, at Visage. So, although the additional risk factors would alert Respondent to further evaluate risk, it would not have required Respondent to decline surgery or take different precautions (than already taken) during surgery.

GG. Respondent did not have an accurate weight for Patient 1 prior to surgery. This failure is not one that rises to demonstrate that Respondent departed from or failed to conform to the accepted standards for the profession. This failure supports the argument that Respondent failed to have a full and accurate medical picture of Patient 1 prior to surgery.

HH. As far as the timing and administration of the anesthesia medication, the testimony from Dr. King here is not as persuasive as the testimony from Respondent and the two dental assistants in the surgical room. One factor that negatively impacted Dr. King's opinion on the

medication timing is the fact that Dr. King is not an oral surgeon and her anesthesia experience is not similar to Respondent's experience. Respondent provided persuasive testimony that anesthesia in teeth extractions is different from other surgeries as the procedures are short and less complex. The undersigned did not find that the State proved that Respondent departed from or failed to conform to the accepted standards for the profession as it relates to the administration of the anesthesia medication.

II. Respondent's testimony related to the reason and basis for the changes made in Patient 1's surgical charts and notes was credible. The fact that Respondent's changes made Patient 1 appear more at risk for the procedure support the fact that Respondent did not alter or change the records for any other reason than to complete them as he does for all his surgical cases. The documentation was different from Respondent's self-report as those were immediately printed documents. It did not appear that Respondent changed the records in order to deceive. Further, Respondent's credibility was not negatively impacted by the testimony of the changed information.

JJ. The contract requiring Dastgir to have "no patient contact" was his role through Case Western Reserve University and not specifically related to assistance at Visage. Dastgir met all the requirements of dental assistants by being BLS and ACLS certified.

KK. When Respondent noticed that Patient 1 was non-responsive, he took immediate, swift, and appropriate actions that followed ACLS protocol. Although Respondent admitted that he only pushed epinephrine once, and not through the IV, the testimony provided that this departure from ACLS protocol is aligned with that another reasonable physician would do, as Respondent was attempting to secure the airway and provide airflow through the placement of the endotracheal tube, bag, and holding the Patient's head. Respondent and his staff provided appropriate emergency care.

LL. Since August 2023, Respondent has taken mitigation measures that were identified during the hearing and mentioned above in detail. Many of Respondent's mitigation measures should alleviate the identified actions which may have departed from or failed to conform to the accepted standards for the profession.

MM. The State recommended that Respondent's anesthesia license is permanently revoked. This would afford the opportunity for Respondent to perform oral surgery, but he would have to engage an anesthesiologist or CRNA to assist him with the procedures. The State also recommended a 6-month suspension of Respondent's dental license, unless the Board finds that Respondent did not change the Mallampati score. The State provided that the Board could determine if continuing education or a fine is necessary.

NN. Respondent's counsel did not recommend discipline as they argued the State did not meet its burden and Respondent made significant changes that he has incorporated into his practice. Respondent's counsel argued that if discipline is warranted, the only discipline should be limited to his anesthesia license. As for whether the Board feels discipline is warranted,

Respondent's counsel argued that a six-month suspension and perhaps some continuing education requirements in anesthesia, ACLS protocol, and documentation would be ordered.

RECOMMENDATION

Patient 1's death is a profound tragedy that the undersigned does not minimize or overlook.

The findings establish that Respondent departed from accepted standards of care in significant ways. However, after carefully weighing all the evidence, including Respondent's immediate and appropriate emergency response, his demonstrated competence in other aspects of care, and his substantial mitigation efforts since this incident, **the undersigned recommends that the Board SUSPEND the anesthesia license of Faisal Quereshy, D.D.S., M.D., to administer anesthesia in the State of Ohio for six (6) months to one (1) year.**

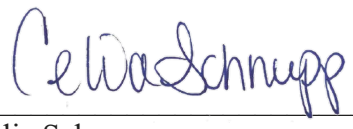
During the period of suspension, Respondent should complete a comprehensive anesthesia continuing education course and the Board should audit Respondent's anesthesia protocols, procedures, and employee training to ensure that the adequate procedures and operations are in place.

After the suspension, the undersigned recommends that the Respondent have a two (2) year probation where there are required reports made to the Board and random independent medical reviews of high-risk patient selection.

A full revocation of Respondent's license would not undo what happened, and although the Board cannot determine if what happened to Patient 1 was preventable if Respondent fully appreciated the risk of anesthesia or even if Patient 1 was in a hospital setting, Respondent's failure to do a full medical evaluation on Patient 1 was preventable. However, given there was no evidence of systemic failures, a full revocation does not seem appropriate as discipline.

I do not recommend that the Board discipline Respondent's dental license as the failures are related to his anesthesia license.

In its discretion and expertise, the Board may modify these terms or may adopt any additional terms that it finds necessary or appropriate.



Celia Schnupp
Hearing Examiner