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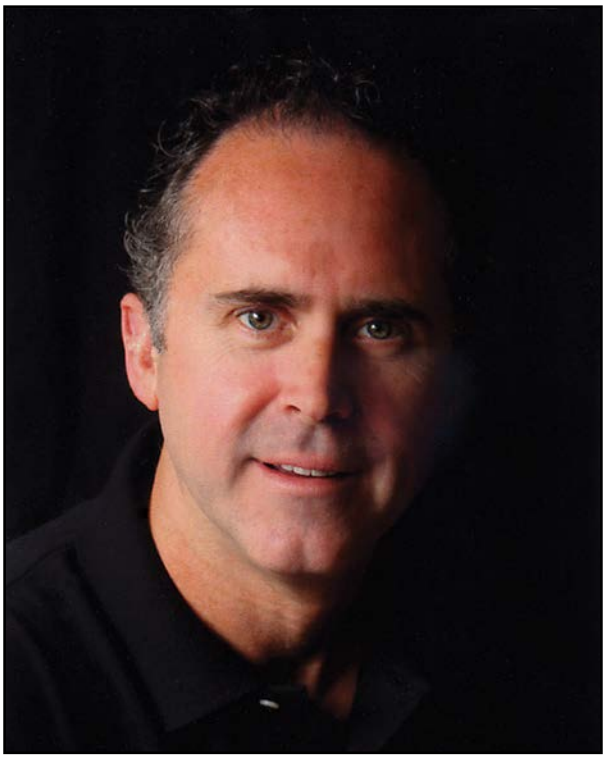
My friend, Dr. Steve Leighty (1954-2015)

Steve and I first met in 1999 at a conference in Oregon and quickly learned we shared a lot in common. We both enjoyed fast cars; German autos, in particular. I was envious when he took European delivery of his Porsche in Stuttgart and toured the country with his wife, Karen. Steve often did things in a way that got my immediate attention. For example, I was tickled to have obtained seats for a sold-out Santana concert in Reno, almost nose bleeder seats. I texted Steve to boast of my tickets, and to my chagrin found out he was already there. Steve turned around and waved to me from his front row seats—with a big smile and Karen by his side! Unlike me, he wasn't a goofball, but a classy guy with a sense of humor and an appreciation for fun things in life.

Steve went out of his way to help others and worked relentlessly on multiple projects at the same time—lots of candles burning. I don't know how he did all of it while maintaining two private practices. Many of these projects continue to benefit our profession: on diplomatic levels with our CDA/OFSOC groups, as well as altruistic giving of his time and surgical talents in 3rd world countries, California CareForce, and Rotary. If Steve found a way to improve a committee's mission statement, he just didn't talk about it and wait for something to happen. He jumped into problem solving, helped to formulate a solution, and implemented change. He was not a benchwarmer. Often I used him as a sounding board and appreciated his insight and wisdom. Steve even took a huge salmon treble fish hook out of my thumb in his office; after hours of course, no consent signed—with root tip picks!

When Steve met Karen, it was game over; bachelor days done. Their wedding was beautiful. He put Karen on a pedestal and took the time to be a husband, and she gave him space to engage his many commitments. When I'd try to get together with Steve, often he'd say, "Can't…have plans with Karen."



I will miss most my 1st Monday of the month lunches with Steve. We would talk about anything from the assistant not assisting correctly, challenges with interesting patient cases, the difficult patient, the grateful patient, running an office, as well our personal triumphs, challenges, and setbacks. We shared a common faith in Christ and would pray for each other. That was huge.

So to wrap this up, Steve was a blessing in my life and a friend to many. I won't forget his big bear hugs, that smile, and the unmistakable chuckle. A one-of-a-kind best buddy. A man's man and a true friend.

Greg Pluckhan, DDS

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in this issue:

CALAOMS also does business as:
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EDITORIAL

Your Behavior Defines You

by Jeffrey A. Elo, DDS, MS

"Sow a thought and you reap an action; sow an act and you reap a habit; sow a habit and you reap a character; sow a character and you reap a destiny." — Ralph Waldo Emerson

As an attending to OMS residents, faculty professor to dental students, and dad to my two young sons, I am very aware of how I make my decisions, and how those decisions can, in turn, make me. Ethics comes into play in many decisions you and I make every day. Have you ever received too much money back when you paid for something in a store (*who uses cash anymore?*), didn't get charged for something you ordered from a surgery vendor (*rare occurrence, I know*), or called in sick to work when you just wanted a day off?

Each of these, technically, poses an ethical dilemma. We make our decisions about which path to take based on our personal ethics. Our actions reflect our own moral beliefs and moral conduct. Our ethics are developed as a result of our family, church, school, community, and other influences that help shape these personal beliefs—that which we believe to be right versus wrong.

A good starting point for our personal ethics is the so-called "golden rule": "*Do unto others as you would have them do unto you*." That is, I need to treat people the way that I would like to be treated. I want people (my staff, patients, insurance companies) to be honest with me, so I must be honest with them. This strong sense of personal ethics can help guide us in our decisions.

Compromising our ethics even just once can potentially lead us down a slippery slope of consequences. One bad decision can naturally lead to allowing another until we find ourselves sliding rapidly downhill. Ethics is all about the art of navigating this slippery slope: we have to draw a line for ourselves (*not a red line, I hear those are meaningless; for those of you that understand that reference, we can amicably talk politics*), decide what we will and won't do—and then stick to it. Without a strong set of ethics, we have nothing to use as a guide when we're faced with a situation that challenges us morally. A highly developed set of personal ethics can guide our actions. The only way to develop a strong sense of ethics is to do what we believe in, and to take actions consistent with our principles time and time again.

Do the Right Thing

Every day in our offices we're faced with seemingly simple, but in reality, complex decisions. Do we bill for an hour of anesthesia even though we were finished in 20 minutes and the patient was out the door shortly thereafter? Do we place a piece of collagen into a socket and bill it as a "bone graft?" Do we give multiple IV anti-emetic medications or hang an extra bag of saline to a nauseated patient even though our profit margins get smaller with each dose? If we rationalize our decisions by saying, "*Everyone does it* or *no one does it*," we probably can reconsider.

Unethical behavior is not only what we believe to be right and fair, it is a reflection of our personal brand and what people can expect from us personally and professionally. The consequences of unethical behavior can range from embarrassment to license suspension, loss of a job, or even jail time, depending on the egregiousness of the act.

We have all heard the expression "Do the right thing." It is the essence of ethics: choosing to do the right thing when you have a choice of actions. Being ethical means we will do the right thing regardless of whether there are possible consequences—we treat other people well and behave morally for its own sake, not because we're afraid of the possible consequences. Simply put, people do the right thing because it is the right thing to do. Thomas Jefferson summed up ethics in a letter he wrote to Peter Carr in 1785: "*Whenever you are to do a thing, though it can never be known but to yourself, ask yourself how you would act were all the world looking at you, and act accordingly*."

Ethical decisions are not always easy to make. There are some gray areas depending on how you approach a certain situation. People have different approaches, so there may be multiple solutions to each ethical dilemma, and every situation may have multiple options. For example, if a colleague and friend told me in confidence that he or she has discovered an insurance "loophole" to double bill for a procedure—would I say nothing, use the loophole, or report him or her? Certainly, using the loophole would not be ethical, but the ethical dilemma doesn't end there. Reporting this colleague/friend would be the right thing to do. But if I didn't report him or her would it be unethical? You might not consider that unethical, but what if I just didn't say anything—is that still ethical? This is the gray area where our personal ethics come into play. Looking the other way doesn't help them or me. While I might be concerned about jeopardizing this friendship, it might be a small price to pay compared with jeopardizing my personal ethics.

Ethics apply to our businesses as well as our personal behavior. Business ethics is the application of ethical behavior by a business or in a business environment. An ethical business not only abides by laws and appropriate regulations, it operates honestly, competes fairly, provides a reasonable environment for its employees, and creates partnerships with patients, vendors, and lenders. In other words, it keeps the best interests of all at the forefront of all decisions.

An ethical office operates honestly and with fairness. Some characteristics of an ethical business include the following:

- Respect and fair treatment of employees, patients, lenders, vendors, community, and all who have a stake in and come in contact with the professional office.
- Honesty and integrity in all communication to all stakeholders internally and externally.
- High standards for personal accountability and ethical behavior.
- Clear communication of internal and external policies to appropriate stakeholders.

Ethical Dilemmas in Business

Not all behavior that is unethical is illegal. Dental offices and surgeons frequently are faced with ethical dilemmas that are not necessarily illegal but are just as important to navigate. For example, if a dental office wants to attract a lot of new patients, it can honestly state the price of an implant in its advertising and let patients decide if they want to purchase the implant treatment. This would be ethical behavior. However, if the office advertises a "free CBCT and exam" in order to get patients to call and come in, but the "free CBCT" includes a $500 radiology interpretation fee, it is unethical.

Another example of unethical behavior is not disclosing information. For example, if a group dental practice misleads the public and advertises invalid credentials of their "specialty" providers, that is unethical. Bribing patients or referring doctors, saying or promising things that are knowingly untrue, or treating employees unfairly are all examples of unethical behavior in business. Good ethics = good business.

Understanding Values

Ethics are defined by moral principles; they are actions that are viewed by society as "right," "just," or "responsible." Values define what is important to us: they are our guiding principles and beliefs, they define how we live our lives, and they inform our ethics. While certain values might be important to *us*, they may not be important to our best friends or even every member of our family. While family, friends, and our environment have a significant influence, *we* ultimately develop our own set of values.

Values provide our personal compass and direction in life. When something is not in line with our values, we (*should*) feel unhappy and dissatisfied. Many people feel passionately about their values and want to have their environment align with their values. Examples of this are evident during political elections when people take sides on issues such as education, health care, and other social issues that reflect personal values.

Our values inform our ethics, which in turn inform our decision-making. No one can tell us what our values are; that's something we have to decide for ourselves. John C. Maxwell, in his book *There's No Such Thing as "Business" Ethics*, lists the values that he lives by, such as "put your family ahead of your work (having a strong and stable family creates a launching pad for many other successes during a career and provides a contented landing place at the end of it)."

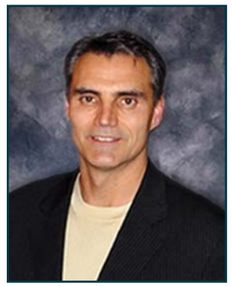
Character and Its Influence

As you have probably figured out, ethics, values, and missions are all very personal. Together they guide us in the way we behave at home, at work, or out with our friends and family in public. Character is what sets us all apart; it includes the features and beliefs that define you as an individual. The Josephson Institute defines character as being composed of six core ethical values:

- Trustworthiness
- Respect
- Responsibility
- Fairness
- Caring
- Citizenship

CONTINUED ON PAGE 7

PRESIDENT'S MESSAGE



2015 In Review

Dear OFSOC members,

By the time you all are reading this, I will have returned home from the AAOMS Annual Meeting in Washington, D.C. From my previous four AAOMS House of Delegates meetings, it is clear that **if** our California issues are to be heard by the AAOMS, we must be united in our (OFSOC) efforts. Therefore, I encourage each and every member to join the Western Society of Oral and Maxillofacial Surgeons (WSOMS) as this is our AAOMS District VI component. You can join by going to the website "wsoms.org." This organization is our political arm of the AAOMS with our regional concerns. District VI is the largest AAOMS district in the nation, yet we have one of the lowest numbers of members compared to the other five districts. Your support and District VI's higher numbers are a must—please join as soon as possible. Dr. Tom Indresano (currently, District VI Trustee) has announced his candidacy for election to the Board of the AAOMS, a position which will lead to the presidency. Having a Californian as the AAOMS president is invaluable to our state's society, and this can help nationally drive oral and maxillofacial surgery in California to greater heights.

The OFSOC's sponsored legislative bill, AB 880 (Ridley-Thomas), *unanimously* passed both the full assembly and the senate, and was signed into law by Governor Brown on October 1, 2015. This bill will allow dental students in their final year of training at California dental schools to treat patients at our California Care Force (CCF) clinics, as well as any other sponsored events provided that the event organizers are amenable. We received support from all six of the dental school deans in California. This additional dental workforce will provide much needed general dentistry care and treatment to the underserved dental patients at our CCF clinics in California. Our lobbyist, Mr. Gary Cooper, has been instrumental in this endeavor, and we all owe him a great deal of thanks for his outstanding hard work. His guidance and knowledge of legislation has been invaluable, and we are privileged to have him working for and with us. One of OFSOC's strategic planning items over the last several years has been to increase our face time with dental students, thereby educating the general dentists about our training, practice, and expertise. Recognizing that the current dental students are tomorrow's referring doctors, we feel that this an opportunity to get our message out that oral and maxillofacial surgeons are "*The Experts in Face, Mouth, and Jaw Surgery*." By spearheading the passage of this bill, we should all be proud of this accomplishment.

Our Marketing and Public Relations Committee is continuing to find alternative ways to generate awareness and educate the public as to what an Oral and Maxillofacial Surgeon does, and how we as surgeons can be the first line of reference for wisdom teeth removal, pain control, and dental implants. Whenever there is a public awareness campaign, there is always a significant amount of work and energy to change and/or increase public perceptions. We are looking for ways to provide OFSOC members with ready-made advertisements for the removal of wisdom teeth and placement of dental implants which would allow you to place your name, logo, etc. on them to send directly to your referral base and media venues for distribution.

Many of you may not have heard about "CURES." This is the Controlled Substance Utilization Review and Evaluation System. Starting on July 1, 2016, all dentists who are authorized to prescribe, order, administer, or dispense controlled substances *must* register for CURES. Dispensed controlled substance prescriptions can be recorded online in CURES, which allows providers to look up patients' controlled substance usage and past history. Additional information will be forthcoming and can also be found at cures@doj.ca.gov.

Denti-Cal has changed their guidelines for general anesthesia (GA) and IV sedation protocols. The OFSOC, working closely with California Dental Association (CDA), took an active role in this issue. Together we were able to convince the Department of Health Care Services (DHCS) to allow dentists to continue to use their best clinical judgement when making treatment decisions that include GA and IV sedation recommendations. However, effective November 1, 2015, Denti-Cal providers are required to submit a Treatment Authorization Request (TAR) for GA and IV sedation services to the DHCS for pre-approval.

On another front, United Concordia dental insurance company recently stated that periapical radiographs taken with a Periodic Oral Examination will no longer be covered when the patient is without complaint or without specific signs or symptoms, and a participating dentist may not bill the patient. United Concordia stated that this policy was to reduce patients' exposure to radiation. This is yet another avenue for insurance companies to increase their revenue by providing fewer services for patients. This is quite alarming to me. I continue to see medical and dental insurance companies practice business models which other businesses—such as ours—cannot. Why do the patients (the ones paying the premiums) and the surgeons (the ones providing the work) continue to get the short end of the stick?

As I conclude my seventh year on the Board and my year as your President, I would like to thank you—the members of OFSOC—and our Board for their support. This has indeed been an opportunity of a lifetime, and one that I hope has led to improvements in our practices. Thank you for allowing me to guide our organization this past year.

Best regards,

Monty C. Wilson, DDS
President, Oral and Facial Surgeons of California

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YOUR BEHAVIOR, CONTINUED FROM PAGE 5

How do we perceive others? It's their character that defines who they are. Can I depend on him? Is she fair? Does he respect me? Just as these ethical pillars define other peoples' character, they also define our character to other people. Patients ask the same questions about you and me: Can I trust her? Will he give me fair pricing for my surgery? Is she honest? Does he care about my best interest? Is she telling me the truth about my condition and my treatment options?

The Power of Your Reputation

Your overall character as judged by other people is your reputation. Consider some celebrities who have had unethical acts negatively impact their reputation: Tiger Woods, one of golf's greats has been reduced to tabloid fodder since the news of his extramarital affairs; Michael Phelps, the only person to ever win eight gold medals in a single Olympic Games, has become the poster boy for marijuana use. Both had stellar reputations and were considered role models before their widely publicized falls. Now both are working to gain back the trust of the public. Reputation isn't limited to the wealthy or powerful. We have to own and operate our reputations, as well.

Today's dental market is inundated with providers of all types of training performing specialized treatments; many of whom are not necessarily fully equipped or trained to do such procedures. How do we as OMSs set ourselves apart? A great way to build your reputation in a specific geographic community is to become an "industry expert": write a dental/oral surgery blog, give an interview to your local online media or news outlet about oral and maxillofacial surgical issues, be a guest speaker or panelist at local/regional conferences or events online or in person. Decision makers hear and see you take on a leadership role and seek you out to gain your expertise. You can build your reputation, which, in turn, will help build your practice.

When I suspect that my kids are up to no good, I go to them and say, "Now I already know what you did (even if I don't), but I'm going to give you the opportunity to tell me. If you tell me, then the punishment will be lighter." Over time, I've found that this technique has led them to do wrong less and less (I think); perhaps because they think I'm always watching and they decide it's not worth it. It's my goal for myself, as well as all of you, that we will act at all times as if someone is watching.

CALIFORNIA CAREFORCE

Oral Surgeons and California CareForce Help Veterans and the Underinsured in California

Pamela Congdon, CAE, IOM
OFSOC Executive Director
California CareForce President

California CareForce is the charitable arm of the Oral & Facial Surgeons of California. In September of this year, California CareForce partnered with two Veteran Stand Down organizations to provide dental and vision services to our veterans in Roseville and Sacramento. The first clinic was held at the Placer County Fairgrounds in Roseville on September 14 and 15 and September 17 & 18 in Sacramento at Mather AFB. We provided dental services and vision services to these extraordinary people that fought for us. To be thanked by a veteran for giving them services that we can get without much trouble is humbling. We all found ourselves saying, "no thank you for what you do for us every day. In talking with the veterans you find that services for them are little if at all available. – reference Gary's article. The veterans are no different from the under insured population in California. They all have a huge need for dental and vision care. It is not just homeless that are in line for services at our clinic. It is the college grad that is no longer on their parent's insurance, it is the hard working person that may have medical insurance but does not have dental or vision. It is the hardworking couple that has insurance for their children but not for them.

Oral & Facial Surgeons of California has California CareForce. CA CareForce, that started out as RAM CA, had their first clinic in Sacramento in 2011. It was through a meeting with CALAOMS staff, Dr. Steve Leighty and others from the Sacramento community that led to the inception envision of the concept of providing free clinics to the under insured in Northern CA. In 2010, a number of our members and I attended a RAM clinic in LA. We were so moved by the powerful image of volunteers helping those in need that we asked if we could work to bring the same set up to Sacramento. Our organization, hosted the clinic, with help from staff, to raise money and in kind donations from the hospitals and other entities to help pay for the clinic.

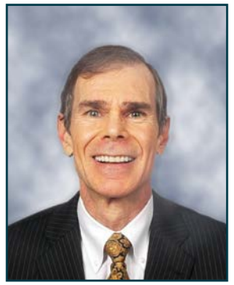
We spent two years working with RAM as an affiliate, we broke off and became CA CareForce. There were many reasons for this, let's just say that we needed to protect OFSOC/CALAOMS' interests and all that we had accomplished.

Housed in the OFSOC offices, CCF has one paid Executive Director and two core volunteers (Steve and Pam), who oversee the operations of CCF. Many of our members many not know that just like CDA has CDA Cares, CCF is our association's way for our members to show their compassion and to give back to the community.

I hope that you will all embrace what CCF does on behalf of our accociation and our communities.

Volunteers at the Gold Country Stand Down clinic at the Placer County Fairgrounds. left to right: OMS Assistant Katie Ruedger, OFSOC Director Shama Currimbhoy, DDS, and OFSOC Member Larry Saunders, DMD, MS

BENEFICENCE



A Vision of Beneficence in Healthcare

Richard Boudreau, MA, MBA, DDS, MD, JD, PhD

Beneficence remains the central moral principle in the ethics of medicine and this entails all of the components packed into the complex notion of the patient's good. In defining a vision of beneficence, I offer a broad scope that goes beyond the strict medical values to embrace the moral and other values of the patient.

The world of modern medicine can work wonders, miracles. Medical technology can save lives, prolong lives, cure disease, and restore health. However, the miracles of medicine often only serve to prolong the suffering of the terminally ill and make death a long and drawn out process. As this indicates, medical miracles also frequently encompass knotty ethical issues in which it is difficult to unravel positive and negative factors.

The complex and often controversial principle of beneficence balances the benefits of medical intervention against possible harms or risks.

Medicine is dedicated to the principle of beneficence; that is, "to do good," and this perspective has been frequently cited in support of medical decisions. However, deciding what is "good" within the realm of medical possibility is often difficult. Is it "good," for example, to sacrifice one twin to save the life of the other in cases of conjoined twins? Medical science can keep the bodies of patients alive long after all signs of consciousness have ceased. Is this "good"? Is this beneficent? The news tells us of parents confronting medical decisions in regards to their children and situations in which families face the awful choice of whether or not to use extensive life-sustaining procedures in cases where a positive outcome is almost certainly doubtful. Then again the news occasionally reports on a comatose patient who "awoke" after years in a coma. How can the public, the courts, or healthcare practitioners approach the daily requirements of making clinical decisions within an ethical framework?

The complex and often controversial principle of beneficence balances the benefits of medical intervention against possible harms or risks. This is the tricky ethical territory that requires a logical systematic approach. This task constitutes a diligent search for a coherent philosophy of medicine and, therefore, offers considerable insight to the complicated problems created by the wonders of modern medicine. As virtually all healthcare practitioners have to confront at some time in their careers, examination of difficult ethical situations offers healthcare professionals a nuanced and insightful examination of the issues that can help lead people of conscious towards morally sound and ethically based decision making. The goal is to make beneficence, that is, what is "good" the overriding value of medical practice, rather than various rights which are the contention of some ethicists, or, as others have argued, 'consequences.' As this suggests, one must negotiate the tricky path between rights and consequentialism.

Consequentialism is a class of normative ethical theories holding that the consequences of one's conduct are the ultimate basis for any judgment about the rightness or wrongness of that conduct, and is distinguished from deontological ethics, in that deontology derives the rightness or wrongness of one's conduct from the character of the behavior itself rather than the outcomes of the conduct. A theory of "the good" in medicine provides a template, an 'ordering principle,' which can be used effectively to resolve conflicts between 'social and individual good,' and act as a framework for a 'beneficence-in-trust' model.

Although beneficence is the key overriding principle in medicine, there is no one principle of ethics that should govern all health care practice; hence, the concept of the principle of beneficence coupled with concern for the best interest of the patient, including autonomy, is one which works best when there is a cooperative and consensual relationship between patients and physicians.

PRACTICE MATTERS

Practice Transition Options

Daniel Witcher, DDS

As 2015 draws to a close and 2016 quickly approaches, many resident oral & facial surgeons (OFS) will begin to shift their focus from completing O.R./clinic cases and fulfilling program requirements to searching for employment opportunities. At the same time, the close of the calendar year allows established practices the ability to reassess their patient flow and financial situations, and evaluate their plans for the future. It is important for both new and established surgeons to understand the specifics of the employment options available in today's market, as this best presents all parties the opportunity to develop a transition plan that works for everyone involved.

There are essentially five main options available to a surgeon searching for employment opportunities in California. These include acquiring a solo practice, joining an existing practice (either as an associate or a partner), starting a *de novo* practice, working in a hospital-based organization (e.g., Kaiser Permanente or one of the teaching institutions), or working as an itinerant surgeon. Each option has a unique set of pros and cons, as well as varying degrees of potential risks and rewards. And while general rules can be set forth regarding the nature of each practice opportunity, both buyer and seller must be aware of the fact that every situation is unique, and often comparing two seemingly similar situations can be akin to comparing apples to oranges. For instance, some of the biggest misconceptions about solo private practice include the notion that there is an inability to share call with other providers, and no opportunity to take on large cases that may require a second surgeon's assistance. There are plenty of solo practitioners that share a call schedule with other oral and facial surgeons at the hospital they maintain privileges in, and plenty of opportunities to work with other surgeons who practice in the surrounding area. It may require a bit more work to develop working relationships with surgeons outside of one's own practice, but it's certainly not a new concept.

Along those same lines, an established group practice may not offer the scheduling freedoms that a new surgeon may have anticipated. Because no one practice fits perfectly into a preconceived mold, it is important to thoroughly investigate the terms of any potential practice opportunity.

With such a diverse variety of options, narrowing down one's choices can prove to be difficult. A good way to approach the decision making process is to think about one's long term goals and work backwards toward achieving those objectives. The main questions one should ask are: 1) "Where do I want to live?" and 2) "Do I see myself in a solo or group practice?" The first question is fairly self-explanatory, but the second deserves some discussion.

Many solo practitioners will tell you that they revel in their complete autonomy, and ability to make decisions about their practice without having to discuss it with anyone else.

Many solo practitioners will tell you that they revel in their complete autonomy, and ability to make decisions about their practice without having to discuss it with anyone else. However, with that independence comes a great deal of responsibility, some of which may be unwanted. Along those same lines, joining a group practice may allow a new surgeon the opportunity to step into a practice and begin working immediately, but often places the practitioner in a situation in which they feel a significant lack of independence.

After deciding on a location and practice model, the search for an office can begin. It's important to start early, be patient, and explore all options. There are a plethora of resources available for a motivated surgeon searching for his or her dream practice in California. A good place to start is right here in this publication. OFSOC's and AAOMS' classified ads both in the print journals and their respective websites (*ofsoc.org*, *aaoms.org*) are good jump-off points for practice opportunities. In addition, attending society meetings and talking/networking with members about openings can be helpful as well. OFSOC Executive Director Pamela Congdon is a great resource for surgeons, and she prides herself in helping match providers up with their dream positions.

Staying active in your local dental societies can help. These groups can match you up with practice brokers specific to your region, as well as with those that specialize in OFS practices. And if a new practice startup is what you have planned, large banks like Bank of America and Wells Fargo have entire departments dedicated to dental/OFS startups. There are also practice management consultants available that (for a fee) will offer to guide you through the process. But many who have gone before you will attest to the fact that often meeting with fellow OFSOC members and trusting your gut is the most successful route to take.

A more successful transition plan involves strategies that make the success of the practice something that is financially beneficial to both the seller and the prospective buyer.

If joining or purchasing an existing practice is the option selected, once the right practice is found a transition plan should be created that is as equally advantageous for all parties involved as possible. As transition consultant Scott Price, of Brady Price and Associates, points out, "One of the most common mistakes made in unsuccessful practice transitions involves a practitioner joining a solo practice as an associate to investigate whether or not to buy that practice." Using the associate position as a "test drive" for an office has the potential to be problematic as both seller and potential buyer lack the financial incentive for the practice to do well during that time period. From the buyer's point of view, unless a selling price is agreed upon in advance, any additional efforts to build the practice will only increase the eventual selling price. Conversely, from a seller's point of view, working hard to acclimate an associate has the potential to decrease the value of the practice in the associate's eyes. After gaining the knowledge of a practice and its income and referral sources, there's little to keep an associate from opening a new practice in a similar location rather than purchasing the existing practice. Because non-competition provisions are largely unenforceable in California, this is an especially important concern for a seller.

A more successful transition plan involves strategies that make the success of the practice something that is financially beneficial to both the seller and the prospective buyer. One way to achieve this is to agree upon a realistic price and sell the practice to the buyer prior to their ever working in the office. The previous owner can then be hired on as an associate with a modest salary based on a percentage of their production. This will encourage both parties to build the practice during the transition period without fear of suffering a monetary loss as a result.

If a solo or group OFS practice that meets a buyer's needs isn't readily available, itinerancy is another option. Economic conditions have created the opportunity for surgeons to go into other offices and work as traveling doctors. This model may appear especially attractive to new surgeons with significant debt because overhead is essentially nonexistent, as are startup costs. This option does, however, often lack any form of autonomy; and in addition, has raised significant controversy regarding patient safety, a surgeon's ethical obligations, and its effect on the future of oral and facial surgery in California. A full discussion regarding itinerancy is far beyond the scope of this article, but readers should be aware of the existence of this practice model. In addition, they should also be aware of the fact that the Dental Board of California, Medical Board of California, and all other state and local governing bodies and peer review committees will hold a traveling surgeon to the same standards that they would for a provider practicing in a hospital or surgical center.

California is an incredibly unique state with some of the most desirable weather, available activities, and living conditions in the world. World-class universities and hospital systems are second to none, and have attracted over 600 of the best and brightest oral and facial surgeons in the world. As such, some would consider the market for practice opportunities "saturated." In addition, state income taxes are some of the highest in the nation, with rates as high at 13.30% for high income earners. But this should not deter a new provider from following their dreams if those include practicing in the Golden State. Rather, it just means that much more care needs to be taken when selecting the right opportunity.

For many of us, this may mean stepping outside of our comfort zones and delving into more in-depth financial analysis than we're typically accustomed to. But if time is taken to analyze a practice transition from a cash-flow based approach, a plan can be derived that is beneficial to all involved. Most importantly, transitioning surgeons should take the time to really think about what they want in both their personal and professional lives, make a plan, and stick to it. It may take some time, but the right position is out there for those that are willing to work at making it a reality.

ORAL & FACIAL SURGEONS of CALIFORNIA

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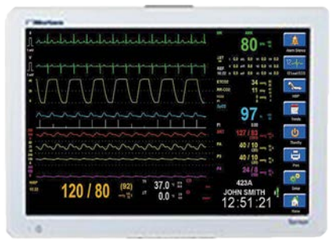

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ETHICS

Ethics Stories Ripped From the Headlines

Steve M. Leighty, DDS

There's almost too much ethics-related material in the news to cover in this issue. In the "old news" category, "Deflategate" apparently has run its course as the NFL's suspension of Tom Brady was overturned by the courts, and he was reinstated as quarterback. The New England Patriots are undefeated and on top of their division so far this season. Are you surprised? One analysis I read pointed out that the courts overwhelmingly rule in favor of the individual athlete in cases involving a team.

Red herrings, or distractions, in this controversy include whether or not Tom Brady was involved in the decision to deflate game footballs or not, or whether he was aware of the infraction. He also got a new cell phone around the time of the investigation, while his old phone was destroyed or lost. Some reports claimed that his old cell phone had text messages that included the deflation as their topic. From what I've heard, the balls were deflated, but the mechanism and order of events hasn't been documented or publicized. What, if anything, will be done to address the issue of control and security of the footballs has not been decided.

Does the NFL need more ball control? More regulations? More cameras? Do the managers, players, and owners need to have ethics or honesty training? Finally, in a pragmatic sense, does it make any difference? Was the air pressure directly responsible for the Patriots winning that questionable game? How important is it to maintain proper ball inflation to protect the integrity of the NFL and its players? I don't know the answers to any of these questions. Looking past the details and concentrating on the reputation, I have family and friends who don't hold much respect for professional sports at all, and so this ethical controversy just serves to damage the reputation of the NFL even further.

One of the best scenes in Johnny Depp's new film Black Mass happens at the kitchen table. Depp portrays the gangster Whitey Bulger who is having a meal with his wife and young son. His son was involved in a fist fight at his school, and the conversation centered around whether it was right or wrong to throw punches at a classmate he was arguing with.

Depp's character said that the important part was who saw the confrontation. If the attack happened between the two classmates and nobody else saw the fight, "it didn't happen." Clearly and carefully stated, no blame or wrongdoing could be assigned without a witness. A secondary perspective was that the mother didn't think the father was giving good advice, but she barely challenged the conversation and the ethics of personal violence.

Why do I say it was one of the best scenes? Because I think the perception is widely held and accepted that behavior is shaped or throttled by who is watching.

In the world of ethics, a person's true behavior is judged by how they act when nobody is watching.

In the world of ethics, a person's true behavior is judged by how they act when nobody is watching. The critical element is the internal decision or control that a person exhibits based on his belief system and sense of right and wrong. Integrity is the character quality in focus here. Some people believe that ethics can be arbitrarily assigned and can change depending on certain situations or conditions. There is not much of a leap from that concept to an "anything goes" attitude that is in opposition to the concepts of true character and integrity.

If you're interested at all in the study or consideration of ethical (and moral) issues, Black Mass is a cornucopia of thoughts, ideas, and shifting concepts. The overriding theme of the film is the relationship of the gangster Whitey Bulger, his brother (a Massachusetts senator), the FBI agent John Connolly, and a cast of family and small-time crooks set in south Boston in the 1970s. I'm not a film expert, but I was completely caught up by the ever-morphing ethical situations presented during the movie. The colors, scope, and reality of the ethical challenges have continued to haunt me for weeks.

And what about Volkswagen? The exposure of Volkswagen using software to alter their emissions came out recently. The cars exhibited good (low) emissions during mandatory licensing vehicle tests, while the actual smog emissions were much higher during "normal" driving. An article in the 10/4/15 edition of the Sacramento Bee points toward the discovery being broken in California by some auto emission standard employees.

What about the idea of something not being unethical or damaging unless it is witnessed? In this case, there is plenty of fallout. You can argue that the damage has occurred after the publicity, however, not before. Volkswagen's stock fell by 25% the week this story was announced. The CEO has resigned despite his claims of being unaware of the software. Class action lawsuits are being assembled; at least one of which by an attorney who owns several of the cars affected by the software deception. He bought the cars for himself and his children because of his high interest in the environment and clean-burning diesel engines. It is interesting to watch the reaction of Volkswagen (now headed by Porsche's CEO) explaining and apologizing for the wrongdoing, and to start positioning the company to fix the problems.

Finally, Pope Francis, himself, is not (completely) immune from ethical situations.

I like the Farmer's Insurance commercials that demonstrate a policy holder's gaps in coverage. I can't help but wonder whether international businesses, professional sports, or personal relationships are more affected by gaps in their behavior or performance on the world stage. Does it make any difference, or does it just point toward a universal lessening of ethical behavior? If I were highly optimistic, I might think that the emergence of ethical topics into the media or our news reports was consequence of reported incidents, and that the outcome of these scandals was increased sensitivity of the issues. Perhaps this focus encourages us to open more dialogue and grapple with ethical issues more often in a more open manner? Or are we getting numb to the important part of the argument and settling for the entertainment value alone?

Finally, Pope Francis, himself, is not (completely) immune from ethical situations. Following last week's visit to the U.S., it was announced that he had met privately with Kim Davis, the Kentucky county clerk who was made famous by refusing to issue same-sex marriages. The announcements have all been made by Ms. Davis' attorney, Mat Staver.

Some reports said the Vatican did not or would not confirm the story. Apparently a photo from Peru of an unrelated event which had been confused with a prayer rally in support of Davis and had been published had subsequently been removed. Whether the meeting took place, whether the Pope asked Ms. Davis to pray for him, and whether the meeting was or was not meant to be an endorsement of her actions is now all called into question.

Did the meeting happen? What was the reason for the secrecy and non-confirmation of the story? Did the Pope give Ms. Davis two pontiff-blessed rosaries to pass along to her parents (supposedly devout Catholics)? Who set up, or proposed, the meeting? The word parsing was amusing as Davis' lawyer claimed that the meeting was not publicized by the Vatican so as not to draw undue attention on the 15-minute meeting. Some would question the initial article being solely in the USA Today, although one article later appeared in the Wall Street Journal. Not that the WSJ is more ethical than USA Today, but that the latter newspaper has very few original articles.

The unsolicited comments by readers of the WSJ were also worth consideration. Some readers pointed out the fallacy of Kim Davis and that her refusal to comply with court orders was self-serving and not ethical in itself. She says that she is being attacked by standing on her religious beliefs. Others point out that if she truly wanted to distance herself from the controversy she would resign. But she wants to keep her job, which is a government position and not a religious one, all the while ignoring a court order. This seems parallel to pharmacists who refuse to fill birth control prescriptions on religious grounds which were not considered upon their hire.

This issue's column has not mentioned dentistry or oral surgery or healthcare bioethics. My goal was to challenge our readers to confront ethical controversies from contemporary stories in the public forum. Michael Josephson, an attorney who offers ethics training for professional groups, was a speaker to CALAOMS members at a recent risk management seminar in Oakland.

As an attendee, I found myself involved (for much longer than I was comfortable) in the discussion of whether it was ethical for me to use a radar detector in my car or not. That discussion has come back to my mind a number of times even though the meeting was months ago. While having no real connection with OMS, it had (has) a strong connection with ethics, character, and our behavior even when "nobody is watching."

RISK MANAGEMENT

Frequently Asked Questions: Treating Patients in a Difficult Economy

by Susan Shepard, MSN, RN, Director, Patient Safety Education; and Richard Cahill, Esq., Vice President and Associate General Counsel, The Doctors Company.

This article answers questions that our regional patient safety risk managers receive about serious problems that can occur when patients are unable to or don't pay their co-pays or when patients refuse to pay their doctor charges.

Q: When a patient is dissatisfied with care, can he or she dispute the charge with the credit card company?

A: A credit card customer can always request that a charge be questioned. Normally, when this situation occurs, the credit card issuer will open an investigation into the disputed charge. During the investigation, the card issuer may withhold payment of the credit charge amount to the doctor.

Office practices need to exercise caution when interacting with credit card companies to ensure they don't violate patient confidentiality required under federal and state law. In this situation, your patient safety risk manager can help you ensure that patient confidentiality is maintained.

Q: What is the appropriate response when an established patient receives care but is unable to pay?

A: Talk with the patient first. Investigate why he or she isn't paying the bill; e.g., is there dissatisfaction with the care? After your discussion, you can consider alternative financing options, including bill collection.

It is helpful to have a written document summarizing the practice's policy on financial matters that you give to each patient during the initial visit. A doctor has the right to expect payment for services rendered. The practice should have a policy and apply it consistently in a nondiscriminatory fashion. Often, signage at the reception desk indicating that payment is expected at the time of service is an appropriate way to notify patients. When you can, remind each patient that he or she received a copy of your policy at the time of the first visit. It makes handling nonpayment situations easier.

If you decide to terminate the patient relationship for nonpayment, you must follow a formal process that includes giving the patient proper notice and treating emergencies in the interim.

Q: Can the doctor refuse to establish a doctor-patient relationship based on the patient's inability to pay?

A: Yes, as long as the patient is not seeing you based on a referral from an emergency department (ED) where you were on call when the patient was seen. If that is the case, determine the requirements of the particular hospital as established in the hospital's medical staff bylaws and rules and regulations. You must follow those requirements.

At a minimum, it is likely you will be required to see the patient at least one time to determine the patient's status and whether he or she has an emergency medical condition that qualifies under the Emergency Medical Treatment and Labor Act. If the patient is in need of emergent treatment, you will likely be required to provide the care regardless of his or her ability to pay, although you can ask for payment or payment arrangements.

If the patient did not come to you as a result of an ED call and you have an established policy of not accepting patients who cannot pay, you can refuse to establish the relationship. Potential patients should be given some indication of your practice's financial requirements when they make an initial appointment for treatment.

We recommend that doctors include a disclaimer on their websites and on their data collection tools (e.g., preliminary healthcare and insurance questionnaires). The disclaimer should state that the practice does not consider an individual seeking treatment to be a patient until a preliminary assessment is completed and the individual has been notified that he or she has been accepted as a patient. Similarly, prospective patients should be advised at the outset that simply making an appointment does not automatically trigger the relationship.

If the potential patient is not aware of your financial requirements, he or she may delay making other care arrangements while waiting for an appointment with you. If the patient then arrives for an appointment and you decide not to accept him or her for financial reasons, your decision can appear questionable if the patient is injured by the subsequent delay in receiving medical care.

Having the biller check the status of coverage before a patient arrives for an appointment can expedite your decision about whether to accept an individual as your patient.

Q: If a patient is dissatisfied with the result of an elective procedure and demands a concession (e.g., a free revision, a refund, or a discount) or refuses to pay credit card charges, what recourse does the doctor have?

A: Selecting the correct patient, providing very thorough informed consent, and keeping the lines of communication open is the best defense against patient dissatisfaction. However, if a patient who is dissatisfied asks for compensation, contact your patient safety risk manager for help in evaluating the situation from professional liability and compliance standpoints. In some situations, making a concession may be viewed as a courtesy gesture and may be a positive factor in the defense of a claim. Other situations may warrant the use of a Release of Claims form.

Q: What factors should I consider when choosing a commercial credit company to provide a line of credit to my patients? Where can I find a reputable company?

A: Some commercial credit companies hold the doctor responsible if the patient defaults on a payment. Before using a commercial credit company, read the contract carefully to make sure you won't be liable for a patient's outstanding balance.

You should also be aware of your state's consumer protection laws regarding lending and disclosure, and make sure that your patients understand the terms and conditions of the financing.

Your bank, local medical society, or professional society can help you locate a commercial credit company.

Patient Safety Tips

- Make sure your office staff recognizes correspondence regarding disputed credit card charges and brings all notices to your attention promptly. It is necessary to make a response that is in accordance with federal and state privacy laws.
- If you accept credit cards for payment, you may want to consider setting a limit on allowable credit card charges. The limit can be a percentage of the total treatment charge or a dollar limit; e.g., $3,500, $5,000, or not more than 50 percent of the procedure cost.
- Payment plans should be in writing and signed by the patient.
- Be sure to obtain a reference for credit applications. This will ultimately assist you in locating the patient if the account needs to be sent to a collection agency.
- Put a time limit on any adjustments or revisions to the original procedure (such as 60 or 90 days from the procedure date). Otherwise, a patient could come in years later and request a revision that was discussed when the procedure was first done.
- Identify poor payers early on and deal with the problem. Do not wait until the situation reaches a crisis point and puts your doctor-patient relationship at risk.
- Make sure you select a reputable collection agency. There are very specific state laws dealing with fair debt collection. A doctor who selects an agency that violates state laws could face liability for negligent selection.
- It is always good practice to resolve financial disputes in an amicable and professional manner. Maintaining a good doctor-patient relationship can help you avoid negative comments posted on the Internet or retaliatory lawsuits for medical malpractice.

Telemedicine as a Growing Practice Model

By Til Jolly, MD
The Doctors Company

Healthcare in the United States is often compromised by fragmentation in its delivery, limited patient access due to a shortage of primary care doctors, long wait times (even for patients who have appointments), and spiraling costs.[1] As a result, innovative approaches to delivering healthcare are becoming increasingly important in America's continued pursuit of improved outcomes and reduced cost of care.

Healthcare delivery models such as telemedicine aim to address the long wait times and high administrative costs associated with traditional care and offer important insights for improving the healthcare process.

By definition, telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status.[2] Although telemedicine is rapidly expanding, it is a concept that has existed for more than half a century. At its basic level, telemedicine is a physician talking on the phone to a patient or another physician. Today, the term telemedicine includes remote physician consultations through channels such as texting, video, e-mail, and other wireless tools.[2] Ultimately, the goal is to connect a physician with a patient to provide a diagnosis and recommend treatment options.

The U.S. population is getting older and more patients are dealing with chronic conditions. The result is an increasing demand for care. Unfortunately, communities across the country are simultaneously experiencing physician shortages. The Association of American Medical Colleges estimates that the U.S. will face a shortage of more than 130,600 physicians by 2025.[3] The use of telemedicine has the potential to provide some relief from this shortage, which is expected to be equally distributed among primary care and medical specialties such as general surgery, cardiology, and oncology.

Telemedicine can be a cost-effective way to monitor patients, promote better health habits, and provide patients with access to healthcare professionals beyond the walls of their local hospitals and health practices. Telemedicine can help with urgent requests to see a physician as well as more routine follow-up appointments and visits specifically for prescription refills.

Although telemedicine has a lot to offer America's health system, physicians must carefully consider when to incorporate it into the continuum of care. According to The Doctors Company, the nation's largest physician-owned medical malpractice insurer, the following are some potential risks providers should be aware of:

- **Telemedicine can pose challenges for the traditional physician-patient relationship.** Office visits allow time for conversations that build relationships and have a positive impact on care. Personal relationships matter in healthcare, and patients need engaged care providers to become engaged themselves. Done properly, telemedicine provides connection, communication, and continuity that can enhance patient care and the physician-patient relationship. Consider developing strategies to ensure patients understand how telemedicine improves their medical care.
- **A physician cannot perform the onsite portions of a physical exam.** Not having a physician on-site to perform a physical examination can mean inaccuracies from patient self-reporting and missing additional findings that may only be caught in person. These risks should be communicated to the patient and documented very clearly in the medical record. In some settings, local onsite support personnel can be part of a complete telemedicine program. The literature increasingly supports inclusion of telemedicine in many practice settings.
- **Telemedicine is very dependent on technology.** It relies on equipment like examination cameras, remote monitoring devices, and surgical robots. If the equipment is inoperable, patient safety and health are at risk. Faulty technology or equipment may cause a physician to act on inaccurate information or prevent the physician from facilitating adequate or continuous care.
- **Be aware of privacy, security, and patient confidentiality.** It's important to remain HIPAA-compliant. Physicians interested in integrating telemedicine into their practices should ensure patient data files are encrypted to prevent a data breach or cyberattack, clearly define proper protocol for webcams and web-based portals, and ensure there is a mechanism in place to protect the privacy of individuals—including staff members, other patients, or patients' families—who do not want to be videotaped if sessions are being recorded.

Managing the social aspects of telemedicine can be challenging, but telemedicine has the potential to support a stressed delivery system by increasing patient access to care, improving outcomes, and reducing healthcare costs.

(Endnotes)

1 Health Care Delivery System Reform. The Commonwealth Fund. http://www.commonwealthfund.org/grants-and-fellowships/programs/health-care-delivery-system-reform. Accessed September 5, 2014.

2 What is Telemedicine? American Telemedicine Association. http://www.americantelemed.org/about-telemedicine/what-is-telemedicine#.VAlPv_ldWSo. Accessed September 5, 2014.

3 Physician Shortages to Worsen Without Increases in Residency Training. Association of

American Medical Colleges. https://www.aamc.org/download/153160/data/physician_shortages_to_worsen_without_increases_in_residency_tr.pdf. Accessed September 4, 2014.

IN MEMORIAM

Steve M. Leighty, DDS
June 7, 1954 - October 15, 2015

I first got to know Steve through our involvement in organized dentistry. Steve really enjoyed the politics and had a keen mind for strategy. Frequently, Steve and I would stand shoulder to shoulder expressing our opinions on issues affecting the practice of dentistry and the care of patients. For the last few years, we both attended the annual meeting of the California Dental Association House of Delegates. Early in the morning on the first day of those meetings, a group of us would get together for a time of prayer. We would pray for wisdom in our deliberations. Steve was a member of that group. As a former Baptist minister, Steve's words were always insightful and meaningful. As I think back on those times, I don't remember many of the issues we thought were so pressing or important. What I do remember are those cherished mornings that I spent with Steve and our group.

George Maranon, DDS

For most of us, assuming the perspective of "others" in daily life, whether with family, friends or patients, requires a concerted and conscious effort. For a small few, Steve being one of those, the perspective of others is the default state with the perspective of "self" entirely secondary. This rare world view led Steve, as naturally as breathing, to a life of service. I will remember Steve as laughing easily and often; of freely and disclosively sharing of himself and his experiences, and as a trusted keeper of confidences. We are all diminished by his loss but left better for having known him.

Mark Grecco, DMD, FACD

Lonnie W. Tiner, DDS
August 11, 1934 - May 18, 2015

Lonnie Walter Tiner, 80, and Patricia Lucille Aqui Tiner, 76, 15-year residents of Twentynine Palms, passed away in Palm Springs on May 18, 2015, as the result of a motor vehicle accident.

Read full obituary at
www.dentistry.ucla.edu/news/memoriam-dr-harold-hargis

Harold W. Hargis, DDS
June 11, 1925 - November 17, 2015

Dr. Harold Hargis, a well-known UCLA professor of oral and maxillofacial surgery (OMS), died on Nov. 17 at his home in Los Angeles at the age of 90.

Read full obituary at
http://www.hidesertstar.com/the_desert_trail/obituaries/article_063af0fe-ffe4-11e4-a638-63c3a6da0f80.html

ORAL & FACIAL SURGEONS OF CALIFORNIA UPCOMING CE EVENTS

2016 Meetings

2016 January Anesthesia Meeting - San Francisco	January 15 – 17
ACLS - Solano	March 12
OMSA Spring 2016 - Anaheim	April 16 – 17
16th Annual Meeting - San Diego	May 20 – 22
ACLS - Solano	October TBD
OMSA Fall 2016 - Foster City	October 15 – 16
Medical Emergencies - Southern CA TBD	November 2

Legislative Update

2015 Legislative Review

By Gary Cooper, Legislative Advocate

Oral and Facial Surgeons Of California (OFSOC) actively participated in the legislative process in Sacramento in 2015. While we were involved on different levels in several issues, two that took the most well spent energy were AB 8**80** and **AB 533**. Both bills were clear demonstrations that active involvement in the legislative process by members of the profession working with the professional association is often rewarded with successful outcomes.

AB 880 (Ridley-Thomas) is legislation that *OFSOC* sponsored to allow dental students enrolled in their final year of completion in a California dental school to treat patients under supervision at sponsored free healthcare and dental clinics. The bill received the support of all six California dental schools and ultimately the California Society of Pediatric Dentistry. *OFSOC* worked very closely with the Dental Board of California to satisfy their concerns about the bill. Eventually the Board removed any opposition to the bill. AB 880 unanimously passed both houses of the legislature and was signed into law by Governor Brown on October 1, 2015. The statute will take effect on January 1, 2016.

OFSOC should be very proud of sponsoring and enacting legislation that will enhance the pool of volunteer providers at the much needed free healthcare clinics in California's many underserved communities. It is common acknowledged that regular dental care is extremely important to everyone's overall health and well-being. Yet in these all too many underserved communities, access to regular dental care is almost non-existent. Since Medi-Cal and Denti-Cal programs are woefully underutilized, free healthcare and dental clinics are an essential source of dental care for members of the communities. **AB 880** goes a long way in increasing the probability that many of the most needy patients will be able to be seen and get the care they so desperately need. In addition, it is *OFSOC's* hope that the ability to work in free healthcare clinics as a final year dental student will inspire those same students to continue to volunteer once they are a licensed practitioner.

AB 533 (Bonta) is a "well intentioned" bill sponsored by several of the healthcare insurance plans with the stated goal of addressing the long standing balance billing issue. Under the balance billing scenario, patients may receive unexpected billing amounts after receiving care at a facility that is part of their insurance plan's network but from an out-of-network provider who contracts with the facility. *OFSOC* along with CDA continued to watch this bill until the last week of the session. Amendments added to the bill over the Labor Day weekend would have limited payments to Medicare rates for out-of-network providers. In addition providers would be required to adhere to a dispute resolution process that has yet to be determined to collect additional payments. **AB 533** would apply to dentists and oral surgeons practicing in hospitals, surgery centers or offices that provide care under general anesthesia. The Medicare rates amendment raised enough concerns, particularly in the dental care arena that *OFSOC* joined with CDA, California Medical Association, and other provider groups to oppose the current version of the bill. The bill was heavily supported by an unusual coalition of organized labor, California Chamber of Commerce and most of the healthcare insurance plans. After several days of **INTENSE** lobbying, both in the Capitol and in the local districts by individual providers, *OFSOC* and CDA were instrumental in stopping the bill by 3 votes after midnight on the last night of the legislative session. While **AB 533** was stopped for the 2015 legislative session, it will return in January 2016. *OFSOC* is committed to working with the author of the bill and other stakeholders to create a viable and reasonable legislative solution to the balance billing problem. This could occur by amending **AB 533** or by the introduction of another bill. In either case, to participate in the successful collaboration of so many provider groups in such a short time frame was a rewarding experience.

ORAL & FACIAL SURGEONS of CALIFORNIA

Assembly Bill No. 880

CHAPTER 409

An act to add Section 1626.6 to the Business and Professions Code, relating to dentistry.

[Approved by Governor October 1, 2015. Filed with Secretary of State October 1, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

AB 880, Ridley-Thomas. Dentistry: licensure: exemption.

The Dental Practice Act provides for the licensure and regulation of persons engaged in the practice of dentistry by the Dental Board of California, and prohibits the practice of dentistry by any person without a valid license, except in certain circumstances.

This bill would additionally exempt from that prohibition the practice of dentistry, as specified and as approved by the board, by a final year student, as defined, without compensation or expectation of compensation and under the supervision of a licensed dentist with a clinical faculty appointment at a sponsored event, as defined, if specified conditions are met. This bill would require the sponsoring entity of the sponsored event to provide the board with a list of the names of the students practicing dentistry exempted pursuant to this bill at the sponsored event, the name of the school of enrollment of those students, and the name and license number of the supervising licensed dentist.

The people of the State of California do enact as follows:

SECTION 1. Section 1626.6 is added to the Business and Professions Code, to read:

1626.6. (a) (1) In addition to the exemptions set forth in Section 1626, the practice of dentistry by a final year student rendered or performed without compensation or expectation of compensation under the supervision of a licensed dentist with a clinical faculty appointment at a sponsored event, is exempt from the operation of this chapter.

(2) The practice of dentistry exempted by paragraph (1) only includes those operations, approved by the board, that are rendered or performed under the same conditions as operations exempt under subdivision (b) of Section 1626.

(b) For purposes of this section, all of the following shall apply:

(1) "Final year student" means a student of dentistry in his or her final year of completion at a dental school approved by the board. "Final year student" also includes a dental student enrolled in an advanced dental program.

(2) "Licensed dentist" means a dentist licensed pursuant to this chapter. (3) "Patient" means a dental patient or, in the case of a minor, the patient's representative.

(4) "Sponsored event" means an event, not to exceed 10 calendar days, administered by a sponsoring entity or a local governmental entity, or both, through which health care is provided to the public without compensation, or expectation of compensation.

(5) "Sponsoring dental school" means a dental school that sanctions student and clinical faculty participation at a sponsored event.

(6) "Sponsoring entity" means a nonprofit organization pursuant to Section 501(c)(3) of the Internal Revenue Code, or a community-based organization.

(c) The volunteer practice of dentistry by students pursuant to this section shall comply with all of the following requirements:

(1) Each patient shall be sufficiently informed that a dental student may be providing some of the treatment that he or she will be receiving.

(2) Any information provided to the patient to give informed consent shall offer the patient the option to decline to be treated by the student.

(3) The volunteer practice of a student shall be supervised by clinical faculty from the dental school in which the student is enrolled.

(4) Each volunteer student shall wear an identification badge that clearly identifies the student as a dental student. The identification badge shall display the student's name, the name of the student's dental school, and the name and the telephone number of the Dental Board of California. That information shall be displayed in 14-point font, at minimum.

(5) Supervision ratios and student oversight shall be at least as stringent as the standards set for the procedure being performed by the student and the age of the patient, in accordance with the standards at the sponsoring dental school's clinical department, laboratory, or dental extension program operated pursuant to subdivision (b) of Section 1626.

(6) The student shall perform only those procedures in which he or she is credentialed or those procedures he or she is permitted to perform in the school's clinical department, laboratory, or dental extension program operated pursuant to subdivision (b) of Section 1626.

(d) The student or the student's sponsoring dental school shall ensure liability insurance coverage is obtained that covers all services provided by the student, including diagnosis, treatment, and evaluation.

(e) The sponsoring entity of the sponsored event shall provide the Dental Board of California with a list of the names of the students practicing dentistry exempted by this section at the sponsored event, the name of the school of enrollment of those students, and the name and license number of the supervising licensed dentist.

PRACTICES FOR SALE

AUBURN: Beautiful, State-of-the-art digital Oral Surgery practice in historical old town Auburn, CA. Designed as an outpatient surgery center. Built in 2011, it has three operatories, three exam rooms, x-ray area with pano and CBCT. Currently using DSN software EMR. Call for details. 530.886.8871 office. Karen Leighty 916.425.2414 cell

ORAL SURGERY PRACTICE FOR SALE--SONOMA COUNTY High quality and high volume oral surgery practice seeks buyer to carry on an excellent tradition of providing oral surgery services to patients and a strong referral base of general dentists. This practice has consistently collected in excess of $1,000,000 with an owner's net in excess of $450,000. Seller is willing to assist buyer in a short or long-term transition and 100% financing is available. Interested prospects should send a cover letter and current CV by email to molinelli@aol.com or by calling Steve Molinelli at 650-347-5346

NORTHERN CALIFORNIA COASTAL OMS Practice Available for Sale - Well equipped 1600 sq.ft. office contains 3 ops & 2 exam rooms. 2014 collections $1.15 Million, net income >$600K working 3.5 days/wk. Seller retiring after transition. For more information please contact Brady Price & Associates (925) 935-0890 or email Scott Price at scott@bradyprice.net. All inquired held strictly confidential.

SAN DIEGO Office Based OMS Practice Available for Sale - Exclusively fee-for-service dentoalveolar and implant focused practice. Collections average $1.5 Million annually, net income of $1 Million per year working 4 days/wk. Recently renovated office suite includes 2 exam rooms, 2 operatories and CBCT scanner. Seller will assist buyer in transition. For more information please contact Brady Price & Associates (925) 935-0890 or email Scott Price at scott@bradyprice.net. All inquired held strictly confidential.

ASSOCIATE/PARTNERSHIP OPPORTUNITIES

OMS PRACTICE IN THE SUBURBS OF SACRAMENTO CALIFORNIA A flourishing OMS private practices at the doorstep of the Sierra Mountains, seeking single/dual degree surgeon for associate with potential partnership. Send CV to dentalimplants4420@gmail.com with earliest date of availability and contact information. . Contact us immediately for an opportunity that will not last long

CALIFORNIA: Full time position with opportunity for buy-in. Position includes two practice locations. Clear Choice Dental is located in San Jose and our private practice is located in beautiful Santa Cruz. Full scope practice specializing in Orthognathic surgery, implants and wisdom teeth. Please e-mail resume to Dr. George M. Yellich at gmyel1@aol.com, or call Dr. Yellich at Clear Choice Dental (408) 556-9587, or Santa Cruz Oral and Maxillofacial Surgery at (831) 475-0221.

PLACERVILLE: Solo Oral and Maxillofacial Surgery practice seeks Board Certified, eligible Oral and Maxillofacial surgeon. Well established and growing OMS practice in Placerville (Northern California) looking for a Part-Time associate. Our office is mostly focused on dentoalveolar surgery with special emphasis on dental implants. The practice has experienced tremendous growth and will be continually growing. This is an excellent opportunity for a motivated surgeon who wants to excel in private practice. The compensation is competitive. Please email qualifications to placervilleoralsurgery@gmail.com

SACRAMENTO: Thriving full scope group OMS practice seeks single/dual degree surgeon for associateship leading to partnership position. Ideal candidate must have strong communication skills and quality surgical training. For more information please send cover letter and CV to scott@bradyprice.net or contact Scott Price of Brady Price & Associates (925) 935-0890.

TUSTIN: We offer an excellent opportunity for a board certified/eligible surgeon to join our well-established, well-respected, full scope modern Oral and Maxillofacial surgical practice. We are seeking a full time, energetic and motivated surgeon, who is personable and caring with excellent communication and interpersonal skills, who wants to practice a full-scope of oral and maxillofacial surgery. Our practice, established over 20 years ago, has a very wide referral base and is considered a cornerstone in the dental community. For more information about our office, please visit our website at drjeffreyleemddmd.com. If you would like to be part of an elite OMS practice, please contact Beth Bushling @hr@drleeoms.com.

WOULD LIKE TO BUY

LOOKING TO PURCHASE AN OMFS OFFICE in Southern California (LA and surrounding areas). Please email me at omfsbuyer@gmail.com if interested.

EQUIPMENT FOR SALE

ATTENTION! New or established oral surgeon looking to develop an independent contractor PT work; equipment and instruments packaged to travel and guidance to get started. Excellent way to generate income as starter with no serious overhead expenses. Call retired OMS at 650-544-5297 for more information.

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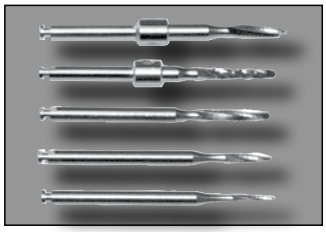
- Measures 1" x 1/2"
- Made from deep flexor tendon
- Sterile and non-pyrogenic

Lindemann Burs



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- High-quality PTFE material
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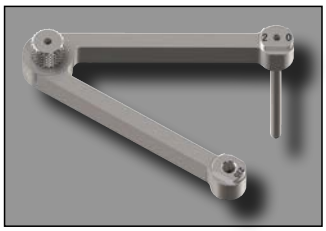
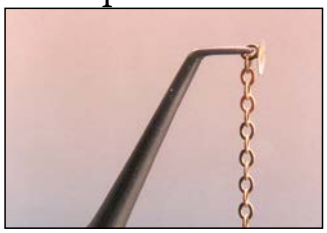


- Highly intuitive and easy-to-use implant paralleling device
- Compatible with any contra-angle or E-type handpiece

Xemax Bone Mill

- Simple disassembly and cleaning
- Easily mills cortical bone

Cusp-Lok Impacted Cuspid Brackets



- Strong 14k gold chain attached to orthodontic bracket
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- Highly absorbent; can be drained while remaining in place