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CALAOMS Surgeon Participates in Care of Las Vegas Shooting Victim

The country music concert in Las Vegas on October 1, 2017 began as a celebration of music and fun, as well as a getaway from the responsibilities of everyday life. Before the evening was over, a lone gunman, perched from over thirty floors above in an adjacent high-rise hotel, transformed the pleasant evening into a nightmare, as he killed 58 innocent concert-goers and wounded hundreds more.

Emergency response professionals were instantly overwhelmed, as were area hospital emergency rooms and trauma services. A female medical service professional from Orange County, CA was hit by a round in the left side of her face. Upon being hit, the patient was immediately disoriented and credits bystanders for helping her to safety. She was transported to an area hospital where she was evaluated by the trauma service and underwent a tracheostomy to secure her airway. CT scans (Figure 1) revealed the patient to have highly comminuted left mandibular fractures with associated metal fragments; the round having struck her face over the body of the left mandible. The on-call OMS was summoned and he recognized the need to stabilize the mandible with

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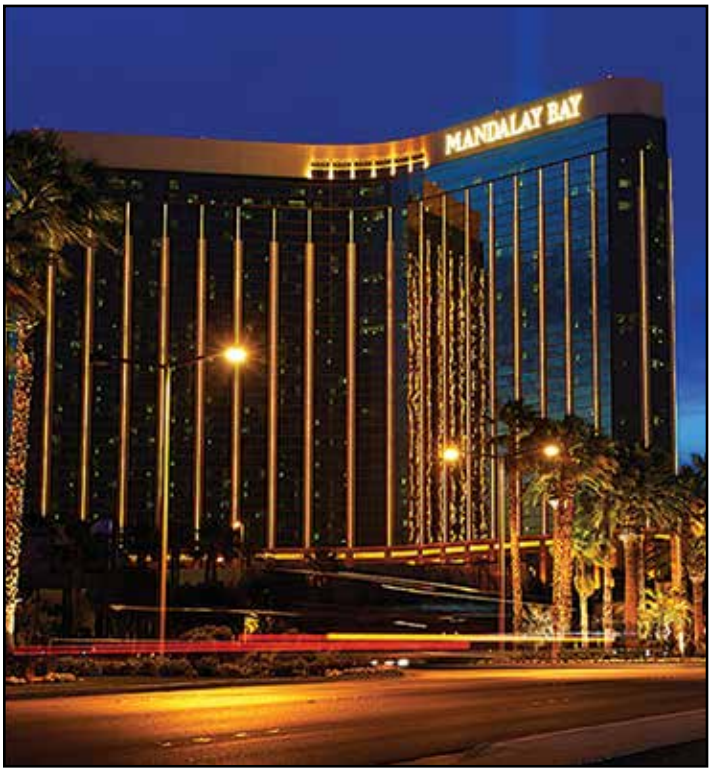

The gunman used a room on the 32nd floor of the Mandalay Bay Hotel in Las Vegas as his perch to carry out the unspeakable atrocity on the concert-goers.

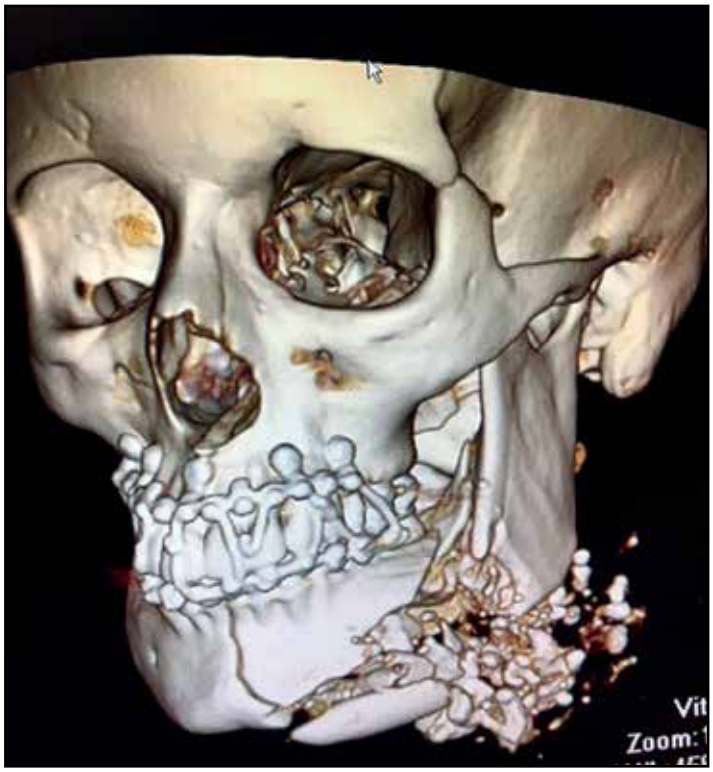

Figure 1. 3-dimensional CT scan revealed highly comminuted left mandibular fractures with associated metal fragments.

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in this issue:

CALAOMS also does business as:
* Oral & Facial Surgeons of California
* Southern California Association of Oral and Maxillofacial Surgeons
* Southern California Society of Oral and Maxillofacial Surgeons
* Northern California Association of Oral and Maxillofacial Surgeons
* Northern California Society of Maxillofacial Surgeons
* California Society of Oral and Maxillofacial Surgeons
* Southern California Oral and Maxillofacial Surgeons

EDITORIAL

T.H.I.N.K. before you speak

by Jeffrey A. Elo, DDS, MS, FACS

"Even fools are thought wise if they keep silent, and discerning if they hold their tongues." – Proverbs

Recently, while in my clinic seeing consults, my patient and I could overhear several staff members gossiping in the hallway while we discussed her serious mandibular lesion and proposed treatment. This noisy gossip was nasty, untrue, and hurtful toward other staff members in its content, and it was also incredibly disruptive to patient care. I suspect, though, as others would, they figured no one else was listening and deemed it okay.

I work in a large university setting, so there are always many people around; but I was nonetheless embarrassed that it was happening. Following my profuse apologies to the patient and the completion of the consult, I began to think about how bad this whole production must have looked to the patient.

You see, like many of you I'm sure, I pride myself in "controlling" what the patient sees as the final "production," no different than if it was a stage performance after many hours of rehearsal. I obsess about what patients might experience when they come see me – meticulously clean counters and floors and fresh scents filling the air (yes, I even have a particular scent that I use – it's called Walt's Wonderful World – it's great, look it up and try it), as well as the timeliness of getting patients seated, treatment planned, consented, and appointed for surgery. I make sure there's pleasant music on, that the lights are not too bright; yet bright enough to see comfortably; and I want the temperature a certain degree. All of these are usually in tip-top working order and provide a professional and well-received patient experience.

However, here I found myself embarrassed and upset that I was unsuccessful in pulling off another positive "production." And all because of gossip and lies. People did not think before they spoke.

But then it forced me to think to myself: how many times have I gossiped or talked negatively about others? Did I look and sound as bad as that did? Perhaps. I most certainly have violated what I found myself angry at in that moment. Was it fair for me to be upset at them when I've been guilty of violating this standard myself? How can I make myself a better example so that other faculty, staff, residents, and students who see how I act and speak may be inspired to act and speak better themselves?

Since we were young, we have all been taught not to lie. That can be hard to follow all the time. There are outright, bald-faced lies, of course; but there are times when you do not want to tell the truth because you know it will hurt someone. In fact, when a survey was done in which people were asked their reasons for lying, the number one explanation given was the fear of offending someone. Maybe you were invited to someone's home for dinner, and someone worked long and hard on preparing it, but it was awful. After the meal, you felt completely nauseated. Then the person who prepared it asked, "How did you like the meal?" "Well, I have never seen those particular ingredients put together in such a way!" You didn't want to say what is true, so maybe you said something else. We tell these little white lies, so called, every day.

Gossip is another way we can lie. Gossip topples governments, wrecks marriages, ruins careers, destroys reputations, causes nightmares, spawns suspicions, and generates grief.

J. Vernon McGee used to say that the only exercise some people get is running down others and jumping to conclusions. Slander and gossip are actions that, unfortunately, are far too common in society and in our workplaces today. Have you ever read Facebook comments on just about any post out there? Then you know what I'm talking about.

How many times have rumors been spread that are based on information that simply is not factual because a person did not take the time to look into it? Gossip and slander are far easier to dish out than they are to take, aren't they? Has someone ever gossiped about you? Has something ever been said about you that simply wasn't true? "Did you hear about this?" someone might say. So we take that tasty little trifle of information. We may swallow it easily, but in the end, it is like a wound. It hurts other people, and it can hurt us.

So when we hear gossip or slander, what should we do? One thing we can do is consider the importance of thinking about what we say before we say it. Here is a little acronym from Greg Laurie that is helpful for us to remember and that can be used when wondering if you should spread a certain piece of information: T-H-I-N-K.

T.H.I.N.K. Ask yourself the following questions:

T – Is it true? In other words, this thing that you have heard about someone else, is this accurate information? Or is it just gossip or something someone heard about someone else. If it is not true, then don't repeat it. Have you ever had anyone tell a lie about you? How did that make you feel? How about someone gossiping about you? The very word "gossip" just hisses. Gossssssssip! We are far too ready to pass on information before verifying if it is true or not.

H – Is it Helpful? Will sharing this information be helpful to the other person?

I – Is it Inspiring? That is clear enough.

N – Is it Necessary? Do we really need to spread this information?

K – Is it Kind? Pretty clear there.

You might say, "If I applied that T.H.I.N.K. acronym to what I said about others all the time, there would be a lot of things I wouldn't say!" Good! Then don't say them. Perhaps that is not such a bad idea. You will be better for it. And so will many other people. THINK before you speak. And if it does not pass this test, then don't say it. You never know who may be watching and listening.

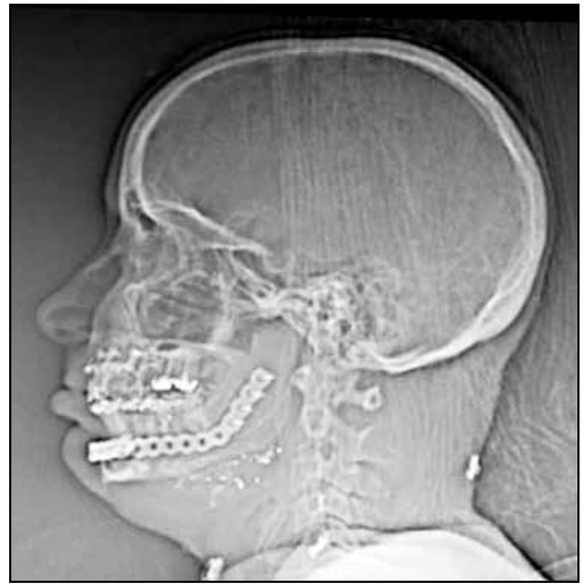


Figure 2. Post-op lateral skull radiograph demonstrating revised maxillomandibular fixation, reduction of the comminuted mandibular fractures, and placement of a titanium reconstruction plate.

OMS CARE OF LAS VEGAS VICTIMS - CONTINUED FROM PAGE 5

maxillomandibular fixation as an initial measure. An initial facial soft tissue reapproximation was undertaken as well. A gastrostomy tube was placed by a general surgeon in anticipation of feeding difficulty due to the injury.

Once stabilized, the patient expressed the desire to be transferred for additional care to her home in Orange County. A family member started a "GoFundMe" campaign, and within a day the funds were available for the transfer. She was transported to Mission Hospital Regional Medical Center in Mission Viejo, CA. Further evaluation by OMS and Plastic Surgery services at Mission Hospital revealed the patient to need additional facial skeletal and soft tissue surgery. The treatment was carried out jointly with OMS and Plastic Surgery. OMS revised the maxillomandibular fixation, reduced the mandible fractures, performed debridement of the skeletal injury, and placed a titanium mandibular reconstruction plate (Figure 2). Plastic Surgery revised and closed the soft tissue injury.

Post-operatively, the patient did well and required an additional soft tissue revision with a cervicofacial skin flap performed by Plastic Surgery. Her tracheostomy tube was removed, and once proper swallowing could be demonstrated, her gastrostomy tube was removed as well. The patient will be in maxillomandibular fixation for several weeks. Once the soft tissue and mandible healing are stable, she will undergo bone grafting and removal of the titanium reconstruction plate by OMS to optimize facial form and mandibular function.

The commitment and skill of health care professionals was notable in the context of this event. However, most inspirational were the countless stories of Good Samaritan bystanders, heroic concert attendees, first responders, and individuals and businesses who freely donated their time and money to facilitate the care of those involved in the shooting. Hopefully, these stories will get media attention and demonstrate that while evil exists in our world, there are also great people with good hearts who display bravery, kindness, and humanity every day.

David W. Nicholls, DDS

PRESIDENT'S MESSAGE

Alan H. Kaye, DDS
CALAOMS President

As is so often said, "As California goes, so goes the nation." As so many of you are aware, the very existence of the idea of "specialty" is being tested on the national level in organized dentistry, and the liberalization of our courts is not making things easier.

As I write this, here in California, our anesthesia model is being tested, and CALAOMS is in the midst of developing laws to protect the public, specifically our children, while at the same time making sure there is access to care for the disadvantaged. This has not been easy, but because of the support and countless hours of dedication – including the help from our lobbyist, Gary Cooper, and our CALAOMS Anesthesia Legislative task force members Jeff Elo, Len Tyko, Larry Moore, George Maranon, as well as CALAOMS Executive Director Pamela Congdon, and CALAOMS staff members Steve Krantzman and Teri Travis – there may be light at the end of the tunnel.

I also want to recognize and thank the AAOMS board and staff for their support of our efforts. They have been with us every step of the way in this anesthesia effort.

We need to turn our attention to new historic events that are taking place all around our nation. Statues are being defaced or removed in an attempt to whitewash our national history, and, unfortunately, we specialists have not escaped this phenomenon. From my understanding, it appears the Commission on Dental Accreditation (CODA) is removing the term "specialist" from all of their communications. Not Good! I guess I will have to refer to all of you as my "fellow Health Care Providers," while I refer to general practitioners as my "fellow Super Dentists!"

Please keep your eye on California and have your checkbooks ready. We have work to do, because in today's climate we must rely on ourselves, along with AAOMS, to carve a path that will sustain and protect our honorable SPECIALTY for years to come.

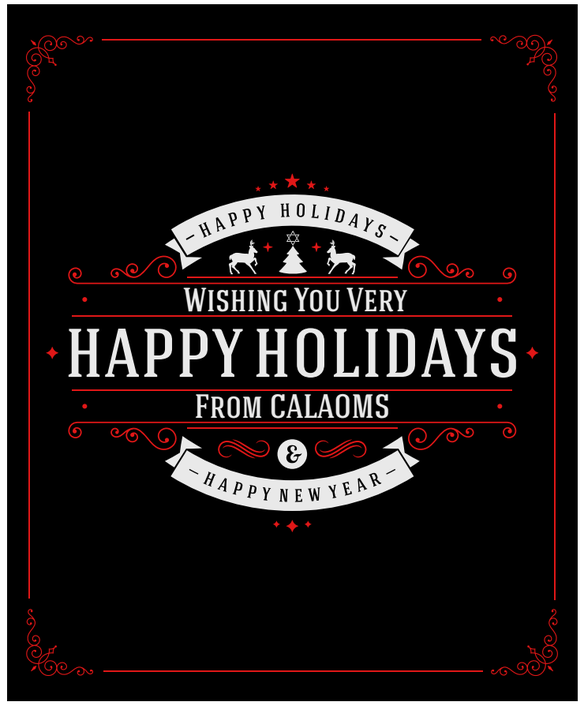
Never let anyone – professional or organizational – denigrate or minimize what we do! Just remember, you did not receive your training or degree from a weekend course or a Kellogg's Corn Flakes box. You are the real McCoy, and if the rest of organized dentistry is not getting the message then we oral and maxillofacial surgeons, acting as our own ambassadors, must educate the public as well as our peers, including state legislators!

We are a true surgical specialty, in the truest sense of the word, and never allow that to be lost on your dental colleagues!

It has been a pleasure and an honor to have served as your President for 2017. It is my sincere hope that CALAOMS continues to lead the way, not only in our great state, but in also leading the way for OMSs around the country.

With gratitude,

Alan Kaye, DDS
CALAOMS President



AAOMS District VI Trustee Report

Mark Egbert, DDS, FACS

Greetings from the AAOMS District VI Trustee. At the time of this writing, the AAOMS Annual Meeting and Scientific Sessions is approaching. The business of your association has never been greater. This update will touch on many of the important things going on here with headlines and bullets so you can focus on your own areas of interest, or read it all. As always, if you have questions or concerns, I am available by phone or email to listen, discuss, and act to support the needs of our members and the District.

Anesthesia Simulation

- To ensure that OMSs can seamlessly and quickly manage any unexpected airway emergencies, the Committee on Anesthesia (CAN) has developed a simulation office-based management course that consists of three modules:
  - Basic Emergency Airway Management (BEAM)
  - Office Based Crisis Management
  - Office Based Sedation Training
- Phase 1, the BEAM module, focuses on critical airway management skills needed for handling potential office based emergencies.
  - Four pilot studies of the BEAM course were conducted in 2016 at the Medical University of South Carolina (MUSC), University of Cincinnati, University of Pittsburgh, and University of Minnesota.
- The Simulation Course:
  - Includes self-paced, internet-based participant curriculum combined with hands-on intensive simulation-based training.
  - Will allow AAOMS members to practice and master critical techniques for administering and monitoring office-based anesthesia.
  - Is standardized to assure that every participant experiences the same simulated events. Its state-of-the-art technology enables us to automatically evaluate the performance of every participant, and pinpoint those areas that may benefit from additional training.
- Phase 2, the Office-Based Crisis Management module was piloted at MUSC on Feb. 17-18 and promises to offer a new approach to simulation education for the OMS anesthesia team model. The second pilot will be completed this fall with the goal of being available to the membership in 2018.

Committee on Anesthesia

- CAN is revising the Office Anesthesia Evaluation, with the following modifications:
  - Adding emergency scenarios for the anesthesia team to use as drills
  - Adding a chapter on considerations for the geriatric patient
  - Adding a chapter on considerations for patients using illicit drugs
  - Adding a chapter on training OAE inspectors
  - Adding medical illustrations as reference materials
- CAN is developing a standardized OAE form that will be submitted to AAOMS.
- CAN is developing a White Paper on Office Based Selection Criteria, and a Position Statement on the definition of a pediatric patient/pediatric anesthesia.
- CAN is investigating the feasibility of developing a web application for OAE evaluators to use.

Association Management System

- AAOMS has converted to a new Association Management System, which went live on May 22. The new system offers a more streamlined user experience for meeting registration, contact information updates, and membership renewals, with more features rolling out throughout the year.
- The login to the website has changed.

- You will be able to choose your own login ID and password similar to other websites. Login IDs must be a minimum of 6 digits, and passwords must be a minimum of 8 digits with an uppercase, lowercase, and numeric combination.
- You **must** have a unique email on file with AAOMS; if you do not have one on file, please contact **AAOMS** HQ.
- Upon initial login, enter your email and request a password reset. You will be sent an email to reset your password. Once you change your password and login you will be able to change your user ID or leave it as your email. Instructions are available on aaoms.org.

ADA Specialty Recognition

- The ADA formed a Task Force looking at establishing a separate Commission for Specialty Recognition to counter potential regulatory arena (example: FTC) concerns with the current recognition process which resides in the ADA House of Delegates (HOD)
- The Task Force proposed a Commission made up of 9 dental specialists (one for each of the ADA recognized specialties), 9 general dentists, and one public member
- AAOMS and 7 of the 8 other dental specialties communicated to the ADA Board that a more appropriate representation would be 9 dental specialists, only 5 general dentists, and one public member
- The ADA Board is recommending to the ADA HOD that the Commission's representation be aligned with the Task Force recommendations
- Based on the recent AAOMS Caucus meetings, the AAOMS HOD will be reviewing resolutions directing the AAOMS Board to investigate possible alternatives for specialty recognition and accreditation processes with a report back to the 2018 HOD

Informational Campaign

- The Informational Campaign continues to expand its national reach to inform consumers of OMS expertise and scope of practice following some substantial campaign management changes this spring. AAOMS's Communications and Publications Division has been restructured to absorb direct management of all facets of the campaign except digital marketing (such as Google AdWords, retargeting ads and YouTube preroll). This change is allowing more resources to be reallocated to campaign advertising and initiatives.
- The three video public service announcements (PSAs) – focusing on 1) how to do an oral self-exam, 2) the connection between HPV and oral cancer, and 3) obstructive sleep apnea – have been playing on TV stations across the country. Metrics show that the two oral cancer PSAs have been played more than 45,000 times since 2015 to an audience of 280 million since their release, with an equivalent ad dollar value of $6 million. The OSA video was released late in 2016 and has been played more than 9,000 times to an audience of more than 46 million with an equivalent ad dollar value of $1.2 million. Radio versions of the PSAs are in the works.
- The AAOMS Informational Campaign introduced its first-ever national, consumer-facing, print advertisement this spring. The ad was unveiled in an Oral Health supplement inserted into USA Today newspapers around the country. The tabloid-format, semi-gloss insert reached about 750,000 readers, as the Informational Campaign ad touts the full range of procedures in which OMSs specialize. Additionally, the print and online publication features an article submitted by AAOMS President Douglas Fain titled "Understanding the Wisdom Behind Extracting Wisdom Teeth." This is intended to be the only consumer-facing print ad purchased this year. A copy was mailed to each member with the May/June AAOMS Today.
- The Informational Campaign has won the following awards:
  - 3 **Videographer Awards** (2 PSAs and the "What is an OMS?" video)
  - **dotCOMM Awards**: one platinum and two golds
  - **Apex Award of Excellence** in the Health and Medical Campaign category
  - **Hermes Creative Awards**: 3 Platinum, 4 golds, and 2 honorable mentions
  - **Healthcare Advertising Awards**: one gold and one bronze
  - **Aster Awards**: 2 golds
  - **Cancer Awareness Advertising Awards:** 2 golds

Media Relations

- **Pediatric dental anesthesia:** This issue was in the national spotlight in early July, with both Sunday Night with Megyn Kelly and the NBC Today show airing segments and Today.com posting a story on the issue. The two television shows primarily focused on the stories of families in California and Texas, along with additional interviews featuring Dr. Wendy Sue Swanson of the American Academy of Pediatrics; Dr. Karen Sibert, president of the California Society of Anesthesiologists; Dr. Roger Byrne, a Texas OMS who reviewed records on behalf of one of the families; Dr. George Maranon, an OMS testifying in California; and Dr. Louis Rafetto, AAOMS Immediate Past President.

  AAOMS worked with NBC producers to answer questions and set up the on-camera interview with Dr. Rafetto, who traveled to New York for the taping. None of his interview was included in the Sunday Night show, and only a few seconds were featured in the Today show segment. In the Sunday Night show, reporter Kate Snow did mentions that AAOMS ("the professional society that represents oral surgeons nationally") is working to collect better data and "beef up their anesthesia training," referring to the soon-to-be-released OMSQOR registry for surgery quality outcomes, the new simulation office-based management course, and a proposal to enhance educational opportunities for fellows, members, and residents.

  For the Today.com story on questions parents should ask their dentist before their children have sedation, Dr. Lou Rafetto crafted both questions and what parents should want to hear as answers in a document sent to the news website. Some of his information was included in the published story.
- Press releases: AAOMS has been posting news articles on various wire services and AAOMS.org this summer:
  - JOMS study: Public, patients agree – Oral and maxillofacial surgeons most qualified for dental implant procedures. Pickup: 220 websites; potential audience, 19 million.
  - JOMS study: Some treatments for medication-related jaw necrosis produce better outcomes. Pickup: 217 websites; potential audience, 18.5 million.
  - AAOMS conference shares innovations in research. Pickup, 199 websites; potential audience, 216 million.
  - AAOMS conference focuses on anesthesia patient safety. Total pickup: 198 websites; potential audience, 221 million.

Opioid/Prescription Drugs

- State Activities:
  - At least 20 states currently place limitations on the number of days' worth of pills a prescriber may issue for an opioid. We're currently tracking 10 states that have proposed such requirements.
  - At least 32 states currently require practitioners to register with the state's PDMP. We're currently tracking three states that have proposed such a requirement. Several states may require practitioners to register with the PDMP but do not require its utilization.
  - At least 29 states currently require practitioners to check the state's PDMP prior to issuing a prescription for a controlled substance in the treatment of acute pain. We're currently tracking six states that have proposed such requirements. There are nuances to these laws and some providers may be exempt if the prescription is for a limited period of time (i.e. 7-14 days) or following surgery, so it's best to speak in generalities.
- AAOMS is committed to educating our membership about the potential for opioid abuse and has initiated the following activities:
  - AAOMS released a White Paper on Opioid Prescribing: Acute and Post-operative Pain Management which outlines best prescribing practices.
  - Partnered with the Substance Abuse and Mental Health Administration (SAMHSA) to create the free CE program, Safe Opioid Prescribing for Acute Dental Pain, specifically for dentist prescribers. The online program is available for free at aaoms.org
  - Partnered with National Institute for Drug Abuse (NIDA) to develop CE that teaches medical and dental prescribers how to talk to adolescents about substance abuse.
  - Hosted CE programs at past annual meetings on opioid abuse that addressed pain management alternatives to opioids. Keynote Speaker 2017 will also discuss opioid abuse.
  - Promotes the Drug Enforcement Administration's National Prescription Drug Take Back Days to our membership and encourages them to inform their patients.

- Developed educational materials for patients and caregivers, including an informational card on the Safe Use and Disposal of Prescription Medications that members can provide to their patients and communities.
- Participates in and promotes to our membership the Partnership for Drug Free Kids Medicine Abuse Project.

Oral and Maxillofacial Surgery Quality Outcomes Registry (OMSQOR)

- Benefits of participation:
  - Success will depend on utilization and participation by our members
  - Encourage standardized documentation and complications reporting – electronically. A must-ask to the vendors and doctors.
  - Will be little to no disruption to the practice, once signed up to participate
  - Pilot testing to begin in 3rd Quarter 2017
  - Long-term results will provide provider, practice, and specialty the ability to develop quality-based research, outcomes, and quality measures.
  - Members are encouraged to participate with certified EMR – AAOMS continues to seek solution driven methods for well-coordinated care.
  - Dental Anesthesia Incident Reporting will be available to all members; confidential self-reported information related to anesthesia

OMS Foundation

- Over the past year, the AAOMS and OMS Foundation Boards have worked together to strengthen the collaboration between the two organizations, focusing on the Foundation's board structure and operations
- The two groups looked at the structural relationship of other peer associations and their affiliated foundations; this review found that in dentistry and medicine, a close alignment of strategic plans, board composition and supporting staff has increased participation in supporting related foundations
- AAOMS and OMSF developed a strategic alliance agreement that culminated in a new approach to the selection of the Foundation leadership, resulting in a revision of the OMSF's Bylaws and changes to the Board of Directors and operating structure.
- The AAOMS Board believes these changes will lead to renewed membership enthusiasm for participation in the Foundation with a genuinely collaborative and mutually supportive approach to the management of the relationships between the two organizations.
- These are some of the important current activities going on with your AAOMS. I look forward to a successful meeting in San Francisco. Thank you for your interest in, and support of your association and profession!

Thank you for honoring me with this opportunity to serve our great association.

CALIFORNIA CAREFORCE

The Charitable Arm of CALAOMS

California CareForce Volunteers

California CareForce and CALAOMS Shine in Sacramento

by Robert Charette

California CareForce (CCF) held its free medical/dental/vision mobile clinic in Sacramento over the September 22-24, 2017 weekend where several of our fellow CALAOMS members joined with other medical, dental, and vision professionals and volunteers to provide free health care. For many patients, it was their first visit to a health care provider of any sort in several years. CCF is so thankful to all of our volunteers and sponsors who work so hard to make these events so successful.

California CareForce Volunteers bring smiles to the patients they treat as well as their families.

CCF is a group of volunteer medical professionals, community leaders, and general volunteers who provide free medical, dental, and vision care to those in need at mobile health clinics across California. CCF makes no restrictions based on income, employment, or immigration status. CCF volunteers believe that everyone, regardless of their background, deserves access to basic healthcare. CCF does not require insurance or ID to serve patients, and all services are free.

Since 2011, over 10,000 volunteers have provided health care services to over 25,000 individuals, delivering $11,000,000 worth of care.

CCF wishes to offer a big Thank You to the 634 volunteers who donated their time, energy, and talents in Sacramento. In just three days, CCF volunteers provided $770,133 worth of care to 1,564 patients, all at no cost to patients.

It is fantastic to know that so many dental, vision, medical, and general volunteers can come together to help bring people out of pain, help them see clearly again, and put them on the path to better health.

From the partially quadriplegic veteran who received multiple dental services in his own electric wheelchair to the 8-year old girl receiving her first pair of glasses, the true human impact of what your fellow volunteers have accomplished cannot truly be measured, but must be felt. We hope our volunteers have come away with a fulfilling and rewarding experience that will stick with them always.

If you were not able to make it to this clinic, there are other ways to help make a difference. Until December 31, 2017, a generous foundation will match every dollar donated to California CareForce up to $25,000. We are already almost at our goal because of the donations of community-minded individuals like you, but we need your help to make it over the top!

If you really believe in our mission of providing basic medical, dental, and vision care to those without access, now is the time to donate and make the biggest impact with your tax-deductible gift.

For those of you interested in learning more about how you can get involved in this effort, please visit https://www.californiacareforce.org/volunteer/ or contact Pamela Congdon, CAE, IOM at CALAOMS headquarters (Phone: 800-500-1332).

We hope you had fun and found it a rewarding experience. We hope to see you at another CCF clinic soon. On behalf of every patient who was touched by your generosity and kindness, thank you!

Some comments from volunteers at the 2017 CCF clinic in Sacramento:

Dear Pam and CCF staff,

A few days have passed since participating in the September Sacramento California CareForce clinic and I've had the chance to reflect on the experience. The memories of an exquisitely sore back and neck, along with the difficulties of treating certain cases in a remote setting, are fading. The memories that remain are both uplifting as well as a bit disheartening, to be honest.

After a decade of volunteering at similar clinics, the anxiety accompanying my participation was not as poignant before the event as it has been in the past. I recall in the past being

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CALIFORNIA CAREFORCE - CONTINUED FROM PAGE 11

very concerned of trying to effectively treat people outside of my comfort zone without my normal instruments, lighting, chairs, etc. I have come to realize two realities of these clinics. First, the organization of the clinic infrastructure is nothing short of remarkable. Every clinic, I find it mind boggling how such a well-equipped dental clinic can spring from the floor of an exhibit hall that recently hosted a state fair. Sure, the clinics are not ideal for every treatment scenario, but the organizers do a phenomenal job.

The second reality I have come to realize is that we are there simply to do the best we can, but cannot do everything. The amount of dental need that presents itself is so incredibly vast that volunteers must have the mentality that we are there to "make a dent" but cannot come close to thoroughly treating peoples' comprehensive dental needs. A glaring example is a mother who brought her 3 young children to be treated when these unfortunate children desperately need comprehensive care.

I feel blessed that there are so many volunteers that all come together to put on these clinics. It is heartening to see examples such as the CareForce clinics that our society will come together to help our fellow people. More specifically, I am proud to be part of a dental community that values treating people who are less fortunate. This community involvement truly makes our profession stronger.

I remain, however, a bit discouraged after these events. I wonder what occurred throughout someone's life that led to the desperation of seeking dental care at a temporary dental clinic. Numerous factors undoubtedly "failed" these individuals: educational deficiencies, psychosocial factors, economic barriers, previous failed dental experiences, poor allocation of resources, and lack of adequate social safety nets. Rarely are there patients who are choosing to be treated there to "beat the system" from having to pay for their treatment. Most patients have nowhere else to turn and are desperate for any help they can get.

In summary, I feel like we were able to do a great deal of good for people. The more you try to help though, the more you realize there is so much more that is necessary. Are these clinics the best our society can do to treat the dental needs of people on the economic fringes? There are enormous barriers to a better system, but I am saddened to some degree that these clinics have to exist at all. Transformational changes will not happen overnight (or ever), but we all should be part of a better solution. In the meantime, I highly encourage all of our dental colleagues to be a part of an upcoming CareForce clinic. Your involvement, however big or small, will undoubtedly make a difference in someone's life.

Sincerely,

Craig X. Alpha, DDS
Oral and Maxillofacial Surgeon, Sacramento

L to R. OMS assistant Katie Ruedger, CALAOMS members Dr. Shama Currimbhoy, Dr. John Tomaich, Dr. Donald Liberty, and Karen Leighty RN.

CALAOMS member, Dr. Donald Liberty with his assistants Sabrina Westphal and Ashlee Mclane, treat a patient at the Sacramento clinic.

Dear CCF board and staff,

As an oral and maxillofacial surgeon practicing in the greater Sacramento area, I had been searching for an opportunity to give back to this great community. Last weekend, I had the privilege of volunteering at the California Care Force (CCF) clinic at the Cal Expo in Sacramento. Along with many other local oral and maxillofacial surgeons, general dentists, and medical doctors, we examined and treated many patients in need of medical and dental care. After each patient was triaged, they were escorted to the appropriate health care provider. Those requiring oral surgery services were seen at our station where we provided treatment that patients may not have otherwise been able to afford. General dentists kept busy providing restorative treatment, while medical doctors provided health care and vision screenings. At the end of the event, over 1,500 patients were treated.

I was pleasantly surprised to learn that CCF (and CALAOMS) sponsored this event, along with many similar events. Thanks to their generous support, CCF is helping to ease the burden of the unmet dental care needs in our communities. However, it came to my attention that, unfortunately, CCF is not as widely publicized or understood as other charitable organizations. CCF is the charitable arm of CALAOMS; and as members of CALAOMS, we have an obligation to support CCF's efforts by volunteering at their events and giving back to our community.

Our profession has endured great scrutiny over the past couple of years, and I believe it is critical for the profession of oral and maxillofacial surgery to reach out to the community in order to educate the public and influence lawmakers to support our specialty. It is easy for members of the public to see oral and maxillofacial surgeons through the lens of the media who sensationalize isolated negative outcomes. Giving back to the community through CCF is not only beneficial to the public need as a whole, but it will also help shed light on the great services we provide every day in practice.

With gratitude for your service,

Samer Albadawi, DMD, MPH

CALAOMS member, Dr. David Rainero and his assistant Trissy Riggs prepare to treat a patient in the dental extractions section of the dental floor.

Dear Pam and CCF staff,

I hope you all have recovered, or are recovering, from the (recent Sacramento) CCF clinic. Now that I have had a chance to seen it first hand, it is pretty amazing and I am even prouder to be associated with you and CALAOMS and CCF.

Thanks for allowing me to visit the clinic,

Gary Cooper, CALAOMS lobbyist

Staff of CCF,

Thank you so much for planning and hosting the California CareForce clinic (in Sacramento). I cannot emphasize how grateful I am to have had this volunteer experience, and to take away such an amazing feeling from being able to work with awesome patients and providers. There were many things I have had the opportunity to learn while handling the front of the medical section with Nancy, and I thought it was super fun!

I also met Dr. Susan Adler-Bressler, whom I have heard about from scribing at John Muir Concord ED from patients, and I

CONTINUED ON PAGE 19

CALAOMS MEMBER Dr. Jared Antrobus and his assistant in the middle of an extraction procedure.

LEGISLATIVE UPDATE

Fall 2017 Update

by Gary Cooper
Legislative Advocate, CALAOMS

Last year, the 2016 legislative session concluded with the passage and governor's approval of AB 2235, which mandated a Dental Board of California (DBC) study of dental anesthesia in California, specifically pediatric anesthesia. CALAOMS was supportive of the study being completed and thoroughly cooperated with the Board as much as was requested. Ultimately, the Dental Board submitted its report to the legislature on December 30, 2016. While concluding that California's present laws, regulations, and policies are sufficient to provide protection of pediatric patients during dental sedation, the DBC, with one glaring exception, made several moderate recommendations with regard to education, personnel, and administration of drugs for pediatric minimal, moderate sedation, and general anesthesia. Unfortunately, the glaring exception was a last minute recommendation to add a second general anesthesia permit holder to the procedure other than the practicing dentist who may already be a general anesthesia permit holder for cases of children under seven years of age. The DBC did recommend that a study on access to care be completed before any significant changes were implemented. However, that did not stop a flurry of legislative activity to start off the 2017-18 legislative session.

In January 2017, Assemblymember Thurmond introduced AB 224, which is a follow up to his bill, AB 2235. Mr. Thurmond's bill is sponsored by the California chapter of the American Academy of Pediatrics, and actively supported by the family of Caleb Sears, the little boy who tragically passed away as a result of anesthesia complications. The measure was intended to mandate various changes to the statutes governing the administration of anesthesia to pediatric dental patients. Included in those changes would be the requirement that a second General Anesthesia (GA) permit holder other than the operating dentist be present for procedures on patients under seven, even if the dentist was a GA permit holder. This language was recommended at the last minute by the DBC, but only after a study was completed to analyze access to care issues. That study language was not included in AB 224.

Subsequently, on February 13, 2017, a lengthy informational hearing by the Senate Business and Professions Committee was held to review the findings of the DBC and discuss any possible legislation that would be introduced. After an emotional three-hour hearing at which many stakeholders presented, including members of CALAOMS, the issue and its possible resolution remained open and fluid. Immediately following that hearing, CALAOMS made the decision to introduce two pieces of legislation that would be able to be used as alternatives to AB 224 as the legislative process moved forward. Those bills are SB 501 by Senator Steve Glazer and SB 392 by Senator Patricia Bates. Both bills include language that requires an access to care study to be completed prior to changing statutes requiring a second GA permit holder to be present for patients under 7.

During the course of the legislative session, AB 224 (Thurmond) was amended numerous times, but unfortunately each time, the amendments proved more unworkable specifically as they dealt with training of assistants and numbers of cases needed to demonstrate proficiency and competence of practicing dentists. Simultaneously, CALAOMS' bills, SB 501 and SB 392, tried to strike a note of reason and practicality while maintaining a strong emphasis on safety and patient care. To add a higher level of interest and emotion to the debate on the anesthesia issue, media coverage was very prevalent. Included in the national media was coverage by NBC's Kate Snow and Megyn Kelly. CALAOMS members were interviewed on multiple occasions and presented the OMS strong safety record very impressively.

While all three bills passed their house of origin (Assembly for AB 224, and Senate for SB 501 and SB 392), the story became somewhat different moving forward. CALAOMS made the decision to make SB 392 a two-year bill to be heard in the Assembly in January 2018. With regard to AB 224 (Thurmond), CALAOMS was successful in convincing the Senate Business and Professions Committee that many of the provisions of the bill were problematic. Mr. Thurmond realized he did not have the votes to move the bill forward, and opted to cancel the vote on the measure and will make a decision as to how to proceed in January (2018). The chair of the Assembly Appropriations Committee very suddenly decided that SB 501 was too important a measure to move this year and made the bill a two-year bill, as well. The end result being that all three pieces of legislation will have some action taken in January 2018.

While CALAOMS is very proud of the work done dealing with all three bills, we realize that much more work will need to be done on this issue. During the 2017 legislative year, CALAOMS worked very closely with the California Dental Association on this issue and we feel comfortable that much progress is being made. In addition,

CALAOMS has engaged with the DBC to keep them involved in our activities.

2018 will be another very active year. Please take the time to enhance your profession, and, more importantly, the safety of your patients by getting involved with CALAOMS.

CALAOMS also sponsored legislation, Senate Bill (SB) 501 (Glazer), creating an offramp for lawmakers to consider an alternative to AB 224 that would further advance patient safety, but not at the risk of patient access to care. This positioned CALAOMS as a thought leader willing to offer an alternative solution.

Given the uncertainty over federal health care reform as a backdrop, the CALAOMS strategy and messaging resulted in unwillingness by lawmakers to support policy that might further limit access to care.

While CALAOMS has been successful in staving off AB 224 this year, 2018 is the second year of the two-year session and legislative threats are often heightened in election years. The bill author, who is running for statewide office and proponents, will be back next year with a similar proposal.

Building on the success of 2017, CALAOMS has an opportunity to define the debate early and ensure balance in traditional news coverage and political debates. Proactive communications and education to lawmakers, legislative staff and media, will strengthen the industry narrative and positioning for 2018.

Smart Public Affairs and Communications Coupled with Strong Advocacy Led to Legislative Success

By Randle Communications

Over the last two years, oral and maxillofacial surgeons, as well as the dental profession, have faced serious threats from powerful policy and political advocates who sought to overhaul the industry's scope of practice following the tragic case of a 6-year boy who passed away during an in-office procedure.

The Randle Communications partnership with the California Association of Oral and Maxillofacial Surgeons (CALAOMS) Anesthesia Task Force and CALAOMS legislative advocate Gary Cooper dramatically changed the communications paradigm and legislative debate in the state capitol surrounding the administration of anesthesia in pediatric procedures. A fresh strategy with aggressive communications reframed Assembly Bill (AB) 224 (Thurmond D-Richmond) as a question of access to care, not whether an oral and maxillofacial surgeon should have authority to administer anesthesia in pediatric cases. The politically astute messaging and savvy media relations changed the discourse and gained traction in the legislature.

MEANING IN ETHICS

INTENTIONALITY AND CLINICAL JUDGMENT

by Richard Boudreau, MA, MBA, DDS, MD, JD, PHD

Philosopher, psychologist and priest Franz Brentanoa introduced the notion of intentionality to contemporary philosophy. In philosophical context, 'intentionality' indicates a relevant idea of directedness pointing towards or attending to some target. In medieval logic and philosophy, the Latin word *intention* denoted a 'concept' or an 'intension': something that can be both true of non-mental things and properties—things and properties lying outside the mind—and present to the mind.

In Essays on Actions and Events, American philosopher Donald Davidson presents a theory of action in which the distinctive teleological character of action is subordinated to a causal conception of explanation. Causal explanation serves, in its turn, to place actions within a general ontology in which events are understood as incidental occurrences, as irreducible entities placed on the same level of substances as fixed objects. This ontology of "impersonal events" ends up structuring the entire gravitational sphere of the theory of action, preventing an explicit, thematic treatment of the relation between action and agent.

In light of an impersonal ontology of events, clinical judgment could very well be interpreted as the result of a computer based operation that depends exclusively on the completeness and accuracy of the information being submitted. A computer-assisted diagnosis is part of a larger trend in medicine leading to a "technologization of the medical subject" as espoused by philosopher and epistemologist Marx Wartofsky. The increasing specialization of medicine as a discipline, the anonymity of hospital procedures, and the powerful influences of economic forces operating behind the health care industry contribute to, slowly but surely, concealing the reality of a personal agent in medicine. And yet, the question of the subject cannot be ignored in a phenomenological analysis of experience. Here, the symmetric polarity of subject and object must be interpreted by the necessity of an essential connection with the frame of an intentional relation. How does the question of the subject become relevant in the specific case of the action at hand, namely the clinical judgment?

Intentionality refers originally to the theory of knowledge and underscores the fact that the consciousness of the knowing subject does not exist in-itself, prior to its relations to an object, but it is always object oriented, i.e. consciousness of something. Correlatively, the object never exists as an object-in-itself, but always as a correlate of a consciousness. Along the same line, philosophers working in phenomenology have uncovered the intentional dimension of operations in the subject. For example, Max Scheler (The Nature of Sympathy) points to the intentional meaning of emotions and feelings, bringing forth their deeply personal and spiritual dimensions against deterministic and materialistic hermeneutics of instinct.

The application of the notion of intentionality in the realm of action, however, represents a kind of extension in the phenomenological theory. In fact, it provides a framework for the interpretation of clinical judgment within the content of a personal relation; better, in terms of a personal encounter.

The intentional dimension of action can be described retrospectively. It implies going up-stream against the intentional flux, in order to reach out for the agent, or the agents, involved in the action. In this light, an action always proceeds from somebody and is directed at somebody else. Looking at the action intentionality means, therefore, overcoming an objectivistic attitude that rests, de facto, upon the separation between subject and object. An action is never just an impersonal state of affairs out-there-in-the-world. Attending to the intentional meaning of an action is central for ethics as well: it entails recognizing that formal modes of logical argumentation are only derivative functions of the moral language. Prudential or practical reasoning unfold as dimensions of a more original form of mindfulness, a synthetic act of discernment that includes elements of detecting, sensing, sifting, discriminating, comparing, connecting, and, ultimately, deciding.

This mode of moral reasoning is certainly relevant to all settings, but it becomes particularly important when questions of meaning need to be addressed beyond the application of normative strategies for "solving" moral problems. In fact, relying upon these strategies might precisely be a way to by-pass larger questions of meaning, questions for which ethicists have long since declared their incompetence, and therefore, gladly pass on to the "care" of alternative agencies, spiritual care personnel, psychologists, etc. There is something ambiguous about the language of bioethics when reference is being made to the notion of the "puzzle" posed by clinical cases, as noted by philosopher Thomas Kuhn (The Structure of Scientific Revolution).

Taken by itself, a case represents an abstraction, an objectification that extrapolates from the intentional context or life-world of meaning and experience within which it is always embedded. In the words of Hans-Georg Gadamer who developed a distinctive dialogical approach grounded in Platonic-Aristotelian and Heideggerian thinking: "The concept of life-world is the antithesis of all objectivism. It is an essentially historical context…'It' means the whole in which we live as historical creatures…It is clear that life-world is always at the same time a communal world that involves being with other people as well. It is a world of persons, and in the natural attitude, the validity of this personal world is always assumed."

The context of clinical judgment is always a personal context. A "case" is always somebody's case: somebody's life, but also somebody's responsibility and conscience in dealing with the complexity of the situation are more than accidental variables in the circumstantial texture of the case. They are the very fabric of which the case is made. In the same fashion, a particular decision on behalf of the patient is not just a strategic solution, or technical fix to the complexity of an anonymous incident. From a phenomenological point of view, that action represents, first of all, the actualization of a subject, a person's practical involvement whose effect is more than a change in reality. Indeed, it represents a change in the subject's experience, a modification of the subject's being-in-the-world.

The change pertains primarily to the subject who is a patient. The modification brought about by the doctor in restoring health cannot be adequately described as simply as the production of a biological state of affairs; rather, it represents the re-composition of a natural equilibrium whose essential features extend to the patient's life-world. Just as illness represents a situation of disease, a rupture and break in the position of the human individual within the totality of being, so restoration of health predisposes the ground for a new personal synthesis, the re-unification of a life-world previously shattered or compromised by the event of illness.

CALIFORNIA CAREFORCE - CONTINUED FROM PAGE 13

finally met her in person. It turns out she and her husband, Dr. David Bressler, graduated from UC Davis, my alma mater, and my dream medical school! I've also had the chance to run into former classmates and even made some new friends. I am very thankful, and I would love to volunteer at future events or help in any other way in the planning of these events.

Sincerely,

Cindy M.

Dear CCF board and staff,

Working with the patients at the CareForce clinic in Sacramento was a great opportunity not only in serving those in need but also in helping train the future generation of dental professionals. I had the pleasure of bringing with me three senior dental students from my alma mater - Western University of Health Sciences - who all performed marvelously and helped fulfill the healthcare needs of many patients from the Sacramento area. I am grateful to the CCF leadership for its consideration of the community, students, and providers alike, and would find it an honor to continue my participation in the future.

Sincerely Yours,

Ho-Hyun (Brian) Sun, DMD, MS
Resident Physician
Department of Oral and Maxillofacial Surgery
University of the Pacific/Highland Hospital

RISK MANAGEMENT

Cyberattacks Threaten Patient Safety

By Robin Diamond, MSN, JD, RN, Senior Vice President of Patient Safety and Risk Management, The Doctors Company

The recent WannaCry ransomware attack that crippled the United Kingdom's National Health Service (NHS) showed how more than money and IT security are at risk—patient safety is also compromised by a cyberattack.

Hospitals and doctors' offices in parts of England had to turn away patients and cancel appointments because their IT systems were infected with ransomware. Electronic health records (EHRs) were not accessible, and entire communities were advised to seek medical care only in emergencies. The same scenario could play out here in the United States.

Ransomware is not the only risk to patient safety. As the use of computerized medical devices continues to grow, hackers may target these devices. And because healthcare is the most frequently attacked form of business, more cyber threats to patient safety are certain to arise. Our nation's healthcare providers must approach cybersecurity as an organizational risk management and quality-of-care issue. And they must do it now.

After WannaCry, I asked myself: Would physicians and hospital staff know how to respond to protect patient safety if all computer access suddenly vanished? With 79,000 member physicians nationwide, The Doctors Company has access to experts in specialties that might be most affected by a cyber attack: obstetrics, emergency medicine, anesthesiology, and surgery. So I reached out to some of these experts to share their concerns as well as their plans to protect patients. Their insights are a wake-up call to be prepared.

Some physicians have considered the potential danger and prepared a response, which is often a return to paper records when EHR systems go down. But that might not always be easy, or even possible. Paper copies of patient medical records may not always be available, a situation that could jeopardize patient care when clinicians must act without sufficient knowledge of allergies, medications, and past treatment.

This is why Marcus Tower, MD, director of gynecology at Hillcrest Hospital (part of the Cleveland Clinic Health System), always keeps a paper backup of patient records that can be accessed quickly in the event of a computer failure. While he said losing access to computer records would be devastating to patient safety, access to paper backups would enable him to continue seeing patients even if his system was offline. Without a computer system, Dr. Tower would keep notes with time stamps. Diligence with time stamping is particularly important in obstetrics, where so much hinges on exactly when decisions were made and care was provided.

Anesthesiologist Randolph Steadman, MD, MS, at the University of California, Los Angeles, said in case of computer failure, ordering labs, imaging, and other diagnostic tests would be done by paper form and transmitted within the hospital by fax and/or conveyed by phone with paper forms to follow. But that would only be a workaround. Patient care overall would be affected, with registration slowed, he noted. Many clinicians and staff would be challenged to adapt to non-digital processes, as happened in the March 2016 cyberattack on the MedStar Health system, which has 10 hospitals and more than 250 outpatient clinics. When hackers seized control of their computer data, senior staff had to assist their younger counterparts with learning how to use paper messages and record-keeping.

The ER could be hit hard by a cyberattack, but the physicians and staff there might be best prepared to respond, says Roneet Lev, MD, FACEP, chief of emergency medicine at Scripps Mercy Hospital in San Diego, California, and president of the Independent Emergency Physicians Consortium.

"Emergency departments have all experienced downtime with computer systems," Dr. Lev said. "At our facility, we call this 'Code White.' When we hear 'Code White' on the speaker system, we know to get out the white board and the markers, and that things will be slower. It's annoying and no one likes it, but we'd manage by keeping track of patients the old-fashioned way."

Even so, a "Code White" still leaves clinicians without a way to refer to any medical records that are stored electronically. Not knowing a patient's allergies or medical conditions is not optimal, she said, suggesting that all patients should always carry a list of their medications, allergies, and pertinent medical history on paper or on their smartphone.

Workarounds can only accomplish so much, Dr. Lev noted. A cyberattack could affect all computer-related hospital activities such as labs, x-rays, patient tracking, operating room scheduling, access to previous medical records, and treatment recommendations.

"While the emergency department would function using 'Code White' procedures, this is not sustainable for long-term operation of a hospital," she said.

What these experts all seem to agree on is that in the face of an attack, the best way to protect patients is to return to practices that worked before computers.

As Ralph Gambardella, MD, orthopedic surgeon and president of the Kerlan-Jobe Orthopedic Clinic (affiliated with Cedars-Sinai) in Los Angeles, so aptly stated: "Rather than relying on computers, I still believe that talking to—and communicating directly with—my patients is the best way to impact patient safety."

Contributed by The Doctors Company. For more patient safety articles and practice tips, visit www.thedoctors.com/patientsafety.

Prescribing Opioids Safely

by Howard Marcus, MD, FACP

Opioids play an important role in pain management—both in acute and chronic settings. Prescribing safely is a laudable goal for healthcare providers, especially considering that 60 percent of Americans over age 65 seek relief from persistent pain. However, the dramatic increase in opioid use over the past few decades has resulted in an opioid-related epidemic of addiction and death. There has also been substantial misuse of opioids obtained by diversion—that is, by a person for whom they were not prescribed.

Consider these facts:

- The United States consumes 99 percent of the world's hydrocodone.
- The number of annual opioid prescriptions written in the United States is roughly equal to the number of adults in the country.
- Nine million Americans take prescribed opioids on a long-term basis.
- Five million Americans report nonmedical use of opioids without a prescription.
- Nearly 60 percent of Americans have leftover opioids in their homes, and 20 percent have shared their opioids with others, often to help with pain management.
- Thirty-eight percent of teens have misused or abused prescription drugs obtained from the home medicine cabinet.
- One of every 550 patients started on opioid therapy died of opioid-related causes a median of 2.6 years after the first prescription.
- In 2015, 19,000 Americans died of an opioid overdose, and the death rate from all opioids (including heroin) now exceeds the death rate from motor vehicle accidents.
- Opioid diversion is an enormous problem. About 50 percent of opioid-related deaths are caused by opioids obtained from a family member or friend.

Poor patient outcomes related to opioids are a common cause of litigation. The Doctors Company studied 272 claims that closed between 2007 and 2015 in which opioids resulted in patient harm. Contributing factors included:

- Inappropriate selection and management of therapy.
- Errors in patient monitoring.
- Inadequate patient assessment for risks and contraindications to opioids.
- Failure in communication among providers.
- Insufficient documentation and/or support for clinical decision making.
- Failure to take psychiatric and/or abuse history.
- Communication errors with patients and their families, including insufficient warning of risks of opioids.
- Patient factors, including noncompliance with treatment plans and follow-up appointments.

Prescription opioids (mu receptor agonists) are no less addictive than heroin, and the increase in prescription opioids fuels

illicit drug use. The dramatic increase in heroin addiction and related deaths has accelerated as a result of the low street price of heroin, compared to the relatively high cost of Percocet (*New York Times,* June 14, 2016).

While physicians prescribe many medications with high risk/benefit ratios and a narrow therapeutic window, the high opioid complication rate is unique—largely because opioids induce euphoria, have a high potential for addiction, and have a therapeutic endpoint (i.e., suppression of pain) that is subjective. Healthcare providers must work to prevent opioid misuse and addiction while protecting the well-being of patients experiencing the devastating effects of acute or chronic pain.

In March 2016, the Centers for Disease Control and Prevention (CDC) published guidelines for prescribing opioids for chronic, noncancerous pain. The following is a distillation of these guidelines, with recommendations from other sources:

1. Document a detailed history, physical findings, and lab or imaging findings, and provide a diagnosis and rationale for pain management.

2. Establish realistic treatment goals for pain and function. Total cessation of pain is usually unrealistic, and *improvement of function* should be a focus of therapy.

   Consider alternatives to opioids: Nonpharmacologic treatment, such as physical therapy and nonopioid pharmacologic therapy, is preferred for chronic pain. Some conditions, such as headache, fibromyalgia, and peripheral neuropathy, are better managed with alternative medications, including nonsteroidal anti-inflammatory drugs (NSAIDs), acetaminophen, anticonvulsants, and serotonin–norepinephrine reuptake inhibitors (SNRIs).

   The FDA has approved nonopioid medications for chronic pain, including gabapentin (Neurontin), pregabalin (Lyrica), milnacipran (Savella), and duloxetine (Cymbalta).

3. Evaluate risk factors carefully when determining opioid dosing and to assess for contraindications for opioid use. Preexisting conditions that increase the risk of side effects and overdose include asthma, obstructive sleep apnea (OSA), and chronic obstructive pulmonary disease (COPD). Patients over age 65, patients with renal and hepatic disease, and elderly patients (at risk for falls) will likely require a reduction in starting dose.

   Beware of drug interactions, including antihypertensives, resulting in orthostatic hypotension, and tricyclics and anticholinergics, resulting in confusion and urinary retention. Beware of specific drug interactions, such as with fentanyl and CYP-450 3A4 inhibitors (antifungals, erythromycin, and verapamil).

   About half of prescription opioid deaths involve at least one other drug, including benzodiazepine, cocaine, heroin, and alcohol. Whenever possible, avoid concomitant use of opioids with sedating drugs, such as benzodiazepines and muscle relaxants—particularly Soma—and caution against the use of alcohol.

4. Be aware that the risk of side effects, particularly respiratory depression, dramatically increases with doubling from 50 to 90 morphine milligram equivalents (MME) per day and increases ninefold at doses over 100 MME per day.

   Forty-seven states and the District of Columbia now have laws providing immunity to medical professionals who prescribe or dispense naloxone or individuals who possess or administer naloxone. Offer naloxone when prescribing doses over 50 MME/day or with concurrent benzodiazepine use.

5. Assess potential risk of opioid abuse. Red flags include tobacco use, family or personal history of substance and alcohol abuse, psychiatric disorders, and a history of sexual abuse.

   Use risk assessment tools, which may be available in your electronic health record. These types of tools include the following: Screener and Opioid Assessment for Patients with Pain (SOAPP); Diagnosis Intractability, Risk, Efficacy (DIRE); and Opioid Risk Tool (ORT).

   Start with the lowest effective dosage, and reassess before increasing the dose, particularly when prescribing for opioid-naive patients. Advise patients about potential side effects, including warnings about sedation and driving.

6. *Always* start pain management treatment with a *short-acting opioid* instead of an extended release (LA/ER) formulation. Avoid concomitant use of both short-acting and long-acting opioids.

   Consult the MME dosage tables when switching from one opioid to another. For example, conversion factors for oral daily dosing of the equivalent of morphine 30 mg are the following: oxycodone 20 mg, hydrocodone 20 mg, hydromorphone 7.5 mg. Note that fentanyl is 80 times more potent than morphine.

7. Use the lowest effective immediate-release dose when prescribing opioids for acute pain. A supply of more than seven days is rarely required, and a three-day supply is often sufficient. Massachusetts has established limits on dosing for acute pain and has enacted a law limiting an opioid prescription to a seven-day supply for first-time adult prescriptions.

8. Evaluate the benefit and harm within one to four weeks of starting opioid therapy. Reassess treatment goals at each visit, and consider reduction of the opioid dose when appropriate.

9. Consult the state prescription drug monitoring program (PDMP) when starting opioid therapy for chronic pain and periodically thereafter. Many states *require* consultation with the PDMP.

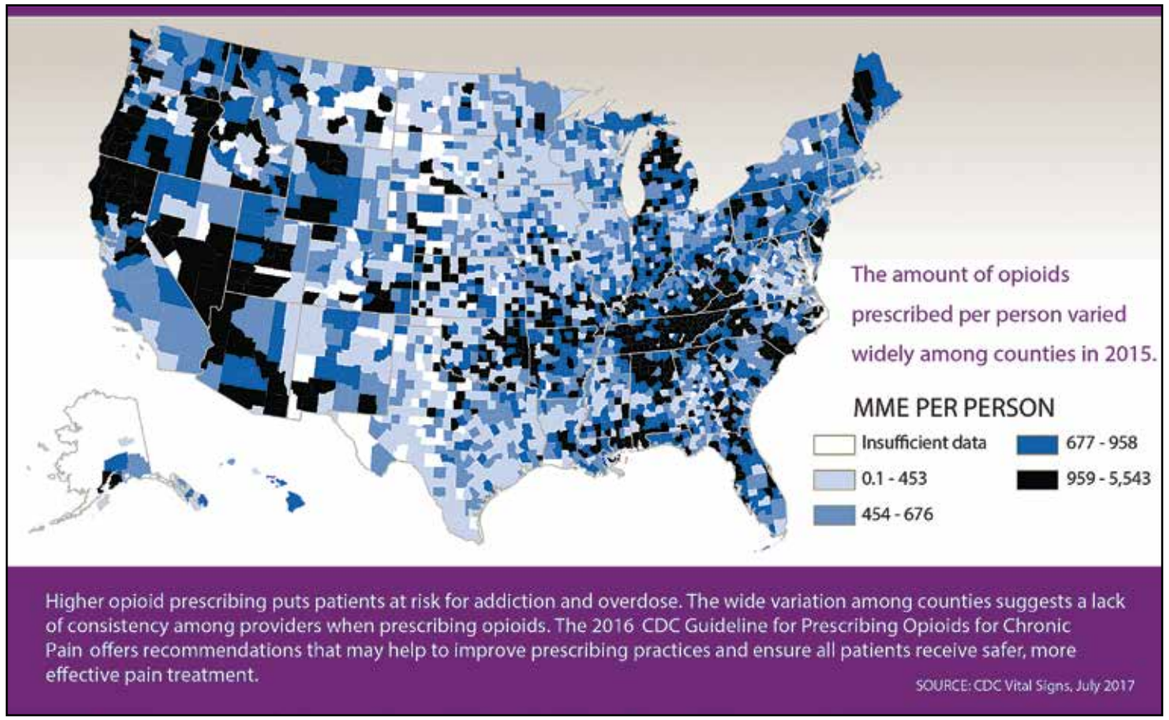
   Data from Kentucky demonstrates that since the state's PDMP mandate was implemented, there has been a 26 percent decrease in overdose hospitalizations and a 25 percent reduction in opioid-related deaths.

10. Use urine drug testing before starting chronic opioid therapy and at least annually to test for prescribed opioids, other controlled substances, and illicit drugs.

    Negative results on urine drug testing should raise concerns about diversion or maladaptive drug-taking behavior. Most drugs have a window of detection of about two days, although marijuana is detectable at a week. Oxycodone is not reliably detected by routine assay.

11. Advise patients to avoid and prevent opioid diversion. Store opioids in a location with limited access. Recommend that patients discard unused opioids by flushing them down the toilet, transferring them to police station receptacles, or turning them in at "take-back" events in the community.

12. Be aware of risk factors for opioid use in managing postoperative pain, particularly for respiratory depression in patients with diagnosed or suspected OSA, morbid obesity, COPD, heart disease, sedating



drugs already in use, or those who use tobacco, are over 65 years old, have surgery with general anesthesia lasting more than six hours' duration, or have surgery performed on airway, upper abdominal, or thoracic regions.

Many state medical boards across the country require documentation of the following when prescribing opioids:

- An established physician-patient relationship.
- A history and physical, diagnosis of pain condition, objective studies, expectation of the treatment's effects, documentation of each prescription, and reasons for early refills and changes.
- A discussion of alternative therapies and substance abuse.
- PDMP consultation, urine drug screen, and an opioid contract.
- Monitoring the effectiveness of therapy, dependence, and withdrawal.

In summary, it is possible to prescribe opioids responsibly and safely for patients with chronic pain who do not obtain sufficient relief and reasonable function with nonopioid treatment. However, to do so, it is necessary to have adequate knowledge of the pharmacology of opioids, risk factors, and side effects. Safe opioid prescribing requires thorough patient evaluation, attention to detail, and familiarity with guidelines and regulations.

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The guidelines suggested here are not rules, do not constitute legal advice, and do not ensure a successful outcome. The ultimate decision regarding the appropriateness of any treatment must be made by each health care provider in light of all circumstances prevailing in the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.

CALIFORNIA ASSOCIATION OF ORAL & MAXILLOFACIAL SURGEONS UPCOMING CE EVENTS

2018 Meetings

2018 January Meeting - Ritz Carlton, Rancho Mirage	January 13 – 14
ACLS - Solano Community College	March TBD
OMSA Spring - Renaissance LAX, Los Angeles	April 14 – 15
18th Annual Meeting - Claremont Club & Spa, Berkeley	May 5 – 6
OMSA Fall - (Northern California)	September TBD
ACLS - Solano Community College	October TBD
Medical Emergencies - (Southern California)	November TBD

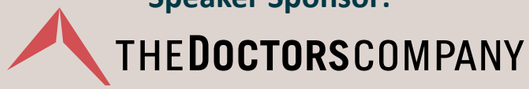
2019 Meetings

2019 January Meeting - Palace Hotel, San Francisco	January 19 – 20
19th Annual Meeting - Island Hotel,Newport Beach	May 4 – 5

Vendor Spotlight

CALAOMS Wishes to Thank the Vendors That Graciously Sponsored the 17th Annual Meeting at the Disneyland Grand Caifornia Hotel

Speaker Sponsor:



Membership Luncheon Sponsor:

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ASSOCIATE/PARTNERSHIP OPPORTUNITIES

Dixon: Thriving full scope group OMS practice seeks single/dual degree surgeon for associateship leading to potential opportunity to purchase practice. Current opening is 2 days per week with potential opportunity to expand. Ideal candidate must have strong communication skills and quality surgical training. Contact: Dr. Tyler Nelson DMD MD Email: nelsonimplants@gmail.com

Inland Empire: Immediate full-time oral maxillofacial surgeon wanted in Southern California's Inland Empire. We promote a workplace with a supportive and efficient staff, individual growth and personal achievement. The right individual should demonstrate creativity, interpersonal skill and have a team player attitude. We emphasize dentoalveolar surgery, dental implants and pathology but also practice orthognathic, TMJ and trauma surgery. Compensation includes competitive salary, incentive bonus system, health insurance stipend and relocation advancement. Interested applicants should call (909) 331-0227 or email MDudziak@inlandempireomfs.com.

Los Angeles: Opportunity for full-time associate / future partner to join highly productive modern Los Angeles area OMS practice. Desired candidate is board certified/ eligible with motivation and interpersonal skills to complement surgical abilities. Interested parties please contact Scott Price of Brady Price & Associates @ 925-935-0890 or email CV to scott@bradyprice.net. All inquires strictly confidential.

Placerville (Northern California) Premier full scope OMS practice, has partnership or associate, opportunity availible. State of the art CBCT, EMR Practice Management software. This is an established practice with continued growth and a wide referral base. Routine office based practice that includes: dentoalveolar surgery, bone grafting, implants, IV general anes., orthognathic surgery, and All on four/five implant cases. Located at the base of the Sierra foothills. Please contact: jstraw@edoralsurgery.com 916-990-3644

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.

PRACTICES FOR SALE

San Francisco: Longstanding OMFS practice available for sale with transition. Well-maintained 2,272 sq.ft. +/- office in distinguished medical/dental building. Collections average approx. $500K/yr. based on 4 half-days per week. 3-year average net income of $300K/yr. with unlimited potential for growth. Interested parties please contact Brady Price & Associates @ 925-935-0890 or email scott@bradyprice.net.

Los Angeles: Upscale Los Angeles area OMS practice available for sale with transition. Collections average $700K/yr. on 3.5 days of services per week of services. +/- 1,700 sq.ft. office contains 2 Exam, 2 OPs, Interested parties please contact Brady Price & Associates @ 925-935-0890 or email scott@bradyprice.net

WOULD LIKE TO BUY

Southern California: I am currently out-of-state and would like to relocate to California. I am looking for an OMS practice for purchase with transition. Southern California preferred (Greater Los Angeles, Inland Empire or Greater San Diego) / mid-size city or suburban community. 1,500-2,000 sq. ft. 2-3 operatories. Please email me @ surgeryoms@gmail.com

OMS SEEKING WORK

Looking For PT Work: Retired OMS Seeking Part Time OMS Job Between San Francisco and Sacramento. Oral and maxillofacial surgeon with 40 years of experience in private practice seeing part time job. Grad of UOP and Highland Hospital. Reason, full time retirement is boring. Experience includes teaching at Highland Hospital. Contact John Kiesselbach at (530) 613-7833 or email jekiesselbach@gmail.com

Seeking Associateship: Native Northern Californian finishing OMFS residency in Brooklyn in June 2018. Seeking full-time Associateship in Northern California. Hard-working, ethical, and personable with great chairside manner. Please contact irvinggb@gmail.com or call (925) 788-2918 for C.V.

EQUIPMENT FOR SALE

Fantastic Deal!!! VaTech Low Dose CT Scan PaX-i3D. 2 years old with 5 years warranty for parts and remote support. Includes CT, panorex, ceph. Perfect for implants, orthognathic surgery, pathology Was $131,500 new. Assume lease for $2,300/ month with no payments until 2018. Or Purchase for $89,900 with your own financing. Contact Chuck Hasse @ (949) 378-2719.

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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Photo: Heath H. Evans, DDS, oral and maxillofacial surgeon at Eastern Oklahoma Oral & Maxillofacial Surgery, Broken Arrow and Owasso, Oklahoma