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CALIFORNIA CAREFORCE RECEIVES JOINT LEGISLATIVE RESOLUTION

From left to right: CCF Director, Michael Luszczak, MD; CALAOMS & CCF Executive Director, Pamela Congdon, CAE, IOM; CALAOMS President, Larry J Moore, DDS, MS; 4th Senate District Senator, Hon. Jim Nielsen; CCF President, Craig Bloom, DMD.

The California Legislature recognized California CareForce (CCF) on Thursday, August 29, 2019 by presenting the leadership of CCF with a joint resolution authored by Senator Jim Nielsen and Assemblymember James Gallagher. Both legislators represent the city of Paradise, California and the surrounding communities. The framed resolution was presented by Senator Nielsen in his Capitol office and on the Senate floor.

Legislative resolutions are presented to acknowledge extraordinary accomplishments by individuals or organizations. CCF was honored for the incredible work done by CCF and the California Association of Oral and Maxillofacial Surgeons (CALAOMS) volunteers in organizing the Chico health clinic held August 2-4, 2019. Senator Nielsen specifically noted the tremendous outpouring of support shown for the victims of the 2018 Paradise fire, and included CCF as a major part of that support.

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THE CALIFORNIA JOURNAL OF ORAL & MAXILLOFACIAL SURGERY
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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

by Jeffrey A. Elo, DDS, MS, FACS

The Moral Pursuit Of Happiness

In California, we are blessed with the abundant opportunities that come with nice weather and ample public attractions; however, we also live in a pathetically dumbed-down culture. The levels of literacy and numeracy continue to plummet (*California public schools rank 38th nationally in quality*), while levels of unintelligence keep rising. Accurate knowledge of events from the past evaporates with its hard lessons unlearned, as the present culture demonstrates its contempt for the wisdom of the ages. In short, we are living in a time that is characterized by the arrogance of ignorance, which knows nothing but is certain nonetheless that it's smarter than every age prior. All one needs to do is spend five minutes with our Founding Fathers reading their exquisitely worded, meticulously drafted nation-forming documents to confirm that we all know less than we think; or, for that matter, spend five minutes with Dante or Shakespeare or C. S. Lewis (*insert a teenager's voice/text/Tweet here that says, "Who?"*). Students are also no longer being taught to ask the big life questions: What is true, beautiful, and good? Non-classical-type schools very rarely spend any time with these paragons of wisdom, and one most certainly will not find them in the public square, from which they have been unceremoniously banished. It's my belief that these are just some of the factors that combine to adversely contribute to some people's happiness.

In my observation, happiness is not only an important personal character trait; it's a moral achievement. Happiness, or acting happy (*or at least not inflicting your unhappiness on others*), is no less important in making your own small community better than any other human trait. This is a foreign concept to the majority of people.

Like you, possibly, for much of my life, I considered pursuing happiness to be somewhat of a selfish pursuit. However, an interesting discovery I've made in middle age has been that happiness is really a moral demand. With probably some exceptions (*every rule has exceptions, right?*), happy people make their communities better and unhappy people make them worse. This is true on the local (personal) and more global levels. Ask your friend who was raised by an unhappy parent if that unhappiness hurt them. Is there reason not to believe that a chronically unhappy spouse can negatively affect a marriage? Consider the effects of a negative staff member on your practice's morale and you can then realize the moral obligation to be as happy as you can be.

On a more global consideration, it doesn't seem to be the case that the happiest among us are those who are joining cults or are otherwise acting irrationally. Of course not. Commonly, following some terrible event we hear information slowly leak out that these offenders were often unhappy and anti-social. It is yet another example of the divine wisdom of America's Founders to include "*Life, Liberty and the pursuit of Happiness*" in the Declaration of Independence. Where else on this great earth is happiness as a core principle so enshrined? The American belief in the societal merit in pursuing happiness is in no small way responsible for why America has developed quite differently than other countries of the world.

> ***"Most people who are unhappy don't engage in evil doings; however, most evil doings are performed by unhappy people."***

Most people who are unhappy don't engage in evil doings; however, most evil doings are performed by unhappy people. I'm not necessarily even referring to *major* evil events. Small ones qualify just the same. If we're being honest, aren't we all more likely to lash out at others when we, ourselves, are unhappy; and don't we try to make others feel good when we feel happy? Just think of how much more you want to help people when you are in a particularly happy mood and you can then realize how much more good the happy are likely to do in their communities.

If you concede the idea that there is an association of evil acts with people who are unhappy, then it might seem difficult to understand why there is little attention given to treating happiness as a moral issue rather than simply a psychological one. Now please don't misunderstand what I'm saying. I'm not talking about the pursuit of happiness as the pursuit of fun or pleasure; as in buying a light-up Disneyland souvenir necklace right before nighttime fireworks – that's fun, but not necessarily happiness. Pursuing happiness is one of the most valuable things someone can do for everyone else in his or her life and the community around them.

So, what contributes to happiness? Better economics? Maybe…but maybe not. I am not one who believes that money can buy happiness, though if I should come into a large sum of money any day now perhaps we can revisit this topic. Money can buy *things* and perhaps alleviate some stress brought on by bills, but someone else will always have more things than you so you will be back drawing from that well again. What about moral and ethical values; can they contribute to happiness? Perhaps; and I would argue yes. In my view, values appear to be more determinative than economics. Few people have values that are so strong that those values will always overcome their unhappiness and lead him/her to act according to those values. Happy people with weak characters are still not likely to engage in cruel behavior; but unhappy people who lack strong character are likely to act out their unhappiness in anti-social, potentially cruel ways. Don't we see this in our everyday lives where someone's unhappiness overwhelms their value system? Think about someone you know who is often unhappy but with generally good values and good character who nevertheless acts indecently toward you or those close to them.

How should we handle our fluctuating moods to pursue happiness? Well, how is a bad mood any different than bad breath? We brush our teeth every day – partly for ourselves (*we are dentists, after all*) and partly out of obligation to others. The same can hold true for our moods. Just as we might avoid someone who does nothing about their terrible breath, we should avoid whenever possible someone who does nothing about their terrible mood.

As best-selling author and commentator Dennis Prager has well stated: "*The pursuit of happiness is not the pursuit of pleasure. The pursuit of pleasure is hedonism, and hedonists are not happy because the intensity and amount of pleasure must constantly be increased in order for hedonism to work. Pleasure for the hedonist is a drug. But the pursuit of happiness is noble. It benefits everyone around the individual pursuing it, and it benefits humanity. And that is why happiness is a moral obligation*." Well said.

CALAOMS and California OMS Residency Programs

CALAOMS has always supported OMS Residency Programs within the state of California. When CALAOMS shut down its Health Foundation, the remaining funds from the foundation were divided amongst the state's Residency Programs. More importantly, CALAOMS has encouraged California OMS Residents to become active in organized Oral and Maxillofacial Surgery through programs such as CALAOMS' Residents' Night Presentations.

Residents' Night Presentations is where a representative from each of the various OMS Programs gets to present on a topic (usually chosen by the CALAOMS CE Committee) and their related case experiences. Residents' Night was traditionally held twice a year on Wednesday nights (one in Northern, and one is Southern California.) Over the years this has slowly morphed into being just Resident Presentations which are held in conjunction with our two major meetings, the January Meeting and the Annual Meeting.

Not only are these presentations great experiences for the Residents, but they are a great opportunity for our members to not only learn something new, but to also meet California's best and brightest residents. If you have never attended one of our Residents' Night Presentations, or one of CALAOMS' major meetings, you should take the next opportunity to support both CALAOMS and California's OMS Residency Programs. We hope to see you at the next meeting.

Residents from Southern California that presented at the CALAOMS 19th Annual Meeting. From left to right: Taylor Parker, DDS (Naval Medical Center, San Diego); Jayini Thakker, DDS, MD (CALAOMS Resident Presentations Co-Chair); Brittney Barrow, DMD (Harbor-UCLA): and Parker Shiffler, DDS, MD (Loma Linda). Not Pictured, Oz Simel, DDS, MD (UCLA); Rozbeh Hossieni, DDS MD (LA County USC)

CONTINUED FROM PAGE 1

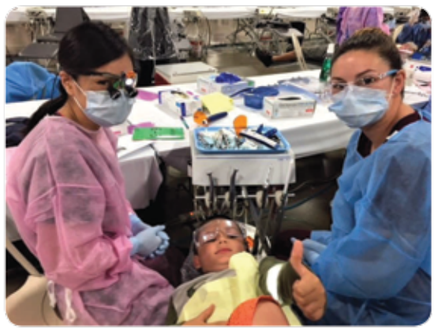
Legislative resolutions are prestigious and should be cherished by their recipients. The fact that Senator Nielsen, the Dean of the Senate, enthusiastically presented the resolution says a great deal about his respect for both California CareForce and CALAOMS. That respect will go a long way as we enter a new legislative year with many new issues to face. Members of CALAOMS have reason to be proud of their leadership and of the organization as a whole. ***View the Resolution on the opposite page.***

California CareForce

2019 CHICO CLINIC

$603,515 WORTH OF CARE PROVIDED TO **1,247** PATIENTS

562 Dental Patients Served
Restorative: 327 fillings
Oral surgery: 245 extractions
Hygiene: 494 cleanings
Fluoride treatment: 143
X-rays: 651
Partials: 11 stay plates
Oral health education: 59
Endodontics services: 15



441 Vision Patients Served
Comprehensive eye exams: 441
Bifocals: 251
Single vision glasses: 269
Second pair of glasses: 74
Eye health education: 441

244 Medical Patients Served
Acupuncture services: 58
Medical exams: 251
Case management: 16
Behavioral health: 21
Medical referrals: 14
Narcan education and distribution: 11

5,086 HOURS SERVED BY **600** VOLUNTEERS

RESOLUTION
CALIFORNIA LEGISLATURE

By the Honorable Jim Nielsen, 4th Senatorial District;
and the Honorable James Gallagher, 3rd Assembly District;
Relative to Commending

California CareForce

WHEREAS, The relationship between a community and nonprofit organization is a vital and interdependent one, deriving strength from the civic involvement and dedication of those who engage with such organizations, the many positive outcomes these organizations make possible, and the spirit of cooperation and respect they foster within the community; and

WHEREAS, One such laudable nonprofit organization is California CareForce, which has offered health care services to medically underserved communities for nearly a decade, and it is appropriate at this time to highlight its many achievements and underscore the positive impact it has made in the local community and beyond; and

WHEREAS, Steadfast in its mission to promote the health and well-being of those in need through volunteer-supported, no-cost health care clinics across the State of California, California CareForce brings together health care professionals, community leaders, and engaged citizens to sponsor temporary clinics where free care is provided; and

WHEREAS, As the philanthropic arm of California Association of Oral and Maxillofacial Surgeons, California CareForce serves thousands of patients who lack the resources for much-needed health care, providing educational opportunities for those patients to learn about the importance of good nutrition, strong oral health, and disease awareness and management and helping them establish a medical, dental, and vision home, in addition to offering students, such as those seeking professional health care degrees, vital hands-on experience; and

WHEREAS, Since its inception in 2011, California CareForce has sponsored 21 clinics in a variety of locations, including the Coachella Valley, Sacramento, Oakland, Gold Country, and the greater Los Angeles area, bringing together 15,056 volunteers to provide vital health care services valued at more than $14 million to 32,451 patients; and

WHEREAS, On August 3 and 4, 2019, California CareForce will hold a health clinic in Chico to offer services at no charge to hundreds of Northern California residents who are in serious need due to a variety of circumstances, but most specifically to those affected by the Paradise fire; and

WHEREAS, The invaluable contributions California CareForce has made toward increasing access to quality health care services in the State of California reflect an organization devoted to the highest ideals of community service; now, therefore, be it

RESOLVED BY SENATOR JIM NIELSEN AND ASSEMBLY MEMBER JAMES GALLAGHER, That California CareForce be commended for the outstanding contributions it has made across the State through its health care clinics and extended sincere best wishes for success in the future.

Joint Members Resolution No. 347
Dated this 3rd day of August, 2019.

Jim Nielsen
Honorable Jim Nielsen
4th Senatorial District

Honorable James Gallagher
3rd Assembly District

PRESIDENT'S MESSAGE

by Larry J. Moore, DDS, MS, FACD, FICD
CALAOMS President

A Perfect Storm

Oral and Maxillofacial Surgery (OMS) is facing an existential crisis in California. The unique nature of our residency training and the development of our team delivery model of safe and affordable office-based anesthesia are being threatened by an emotion-driven campaign supported by opinions, not scientific evidence. OMS is the only surgical specialty in medicine or dentistry to receive extensive training in all forms of procedural sedation, including deep sedation and general anesthesia. Our objective safety record is the best in dentistry, yet we are facing the very real possibility of losing our ability to provide safe procedural sedation.

Earlier this year, the American Academy of Pediatrics (AAP) and the American Academy of Pediatric Dentistry (AAPD) issued joint guidelines for monitoring and management of pediatric patients undergoing procedural sedation (2019 AAP/AAPD Guidelines). These guidelines specifically targeted the specialty of Oral and Maxillofacial Surgery and our use of the team model of anesthesia delivery. On July 29, 2019 the American Society of Anesthesiologists (ASA) issued a statement titled "The Joint Statement from the American Society of Anesthesiologists, the Society for Pediatric Anesthesia, the American Society of Dentist Anesthesiologists, and the Society for Pediatric Sedation **Regarding the Use of Deep Sedation/General Anesthesia for Pediatric Dental Procedures Using the Single-Provider/Operator Model**." [Emphasis added]

The concern expressed in the Joint Statement about the OMS anesthesia model is not the education, training, and capabilities of the Oral and Maxillofacial Surgeon, but rather, the Joint Statement's concern focuses on the need for "…an appropriately qualified, dedicated monitor who is prepared to meaningfully help in the event of a patient emergency" for patients undergoing deep sedation/general anesthesia. It has long been the position of the ASA – the people who provide medical anesthesia training in our residencies – that the surgeon cannot also be the monitor.

While the Joint Statement focuses on pediatric patients without defining a specific age range for pediatrics, based on my personal experience as an AAOMS officer with multiple face-to-face meetings with the leadership of the ASA, the ultimate position of the ASA is not limited to pediatric cases. The unprecedented and unjustified attacks we are experiencing are likely only the beginning of a long-term plan to completely strip OMS of the team model of office-based anesthesia delivery.

Defense Against the Perfect Storm

Part 1

It is critically important for every OMS in California to understand that the training we provide to our anesthesia assistants is really the point of attack being used by our competitors to demean our team model for the delivery of office-based anesthesia. The majority of CALAOMS members provide Oral and Maxillofacial Surgery Anesthesia assistants (OMSA) training to their assistants through CALAOMS programs. Alternatively, our members may provide Dental Anesthesia Assistants National Certifying Examination (DAANCE) training through AAOMS. Unfortunately, these programs are **not** recognized by the Dental Board of California (DBC) as a license or permit that would legally empower our assistants to monitor patients during, or recover patients from, deep sedation/general anesthesia.

Fortunately, there is a program in California Statute (Law) that is recognized by the Dental Board of California: the Dental Sedation Assistant (DSA). The DSA was specifically created to provide both didactic education and hands-on training in OMS office-based anesthesia assisting in, and recovery of patients from, deep sedation/general anesthesia. Successful completion of the DSA curriculum and the psychometrically validated examination results in a state-issued permit. This permit is exactly analogous to your general anesthesia permit. The DSA permit requires renewal every 2 years and requires the completion of 25 hours of DBC-approved continuing education every 2 years for renewal.

As your CALAOMS President in 2019, I have been urging our members to offer DSA training to their assistants. The first step is to fill out the document *"Dental Sedation Assistant Course, Application for Approval by the Dental Board of California."* This process empowers you to train your assistants to become DSAs and be permitted (licensed) providers of monitoring and recovery assisting services in California. CALAOMS stands ready to assist you in this important endeavor. Contact CALAOMS Executive Director Pamela Congdon at (800) 500-1332 and ask for the DSA Application materials.

Defense Against the Perfect Storm

Part 2

The power of an evidence-based legislative campaign was proved in 2018 by the passage of CALAOMS-sponsored bill SB 501. This landmark pediatric dental anesthesia safety bill is now in California Law, but it does not take effect until 2022. There is plenty of time for our enemies to take action that could undo SB 501 before it has a chance to take effect. CALAOMS fully expects legislative challenges to our anesthesia model in the next year or two. The power of an emotion-driven legislative campaign against us cannot be underestimated. In spite of evidence and reason, emotion sells; and media – especially social media – thrives on it.

As the storm clouds gather, remember that Oral and Maxillofacial Surgery is a **legislated** specialty. The content of California Law directly determines everything we do as Oral and Maxillofacial Surgeons. What we may have believed to be entitlements have always been privileges subject to the wisdom, or the whim, of our legislators. It has never been more important to be politically active than now. Get to know your state Senators and Assembly Members. Show up at their district events and show support. Invite them to see your offices and ambulatory surgery centers. At a minimum, **give generously** to the California Association of Oral and Maxillofacial Surgeons Political Action Committee (CALAOMSPAC). Go to www.calaoms.org, Member Resources, Dues and Contributions, calaomspac.

Defense Against the Perfect Storm

Part 3

Take action now. Train your anesthesia assistants to become DSAs. Give to CALAOMSPAC to assure we have a strong voice in the legislature. Most importantly, adhere to the Culture of Safety that has always been the foundation of OMS office-based anesthesia. Patient safety is our first priority.

Take personal responsibility for the future of OMS office-based anesthesia. Rethink and redefine your parameters for patients who qualify for office-based deep sedation/general anesthesia. Not every patient is a candidate for deep sedation/general anesthesia in the office setting. Develop guidelines for your office based on patient age, weight (BMI), and health – with regard to who can be treated in your office based on your training, experience, and comfort level. Know when to say no; and say no when you know it is best.

President's Farewell

It has been an honor being your President in 2019. I wish to extend my profound and sincere thanks to your CALAOMS Board of Directors: Dr. Jeff Elo, Immediate Past President; Dr. Chan Park, President Elect; Dr. Shama Currimbhoy, Vice President; Dr. Ed Bedrossian, Treasurer; Dr Sam Khoury, Senior Director; Dr. Dave Cummings, Director; Dr. Ashok Veeranki, Director; Dr. Jayini Thakker, Director; and Long-Term Delegates, Dr. Frederick Stephens and Dr. Alan Kaye. Special thanks to Jeff Elo who does double duty as our Journal editor and emergency ghost writer for yours truly.

It would be impossible to execute the duties of CALAOMS President without the dedicated services of our loyal and capable staff, led by the incomparable Pamela Congdon, CAE, IOM, Executive Director. Pam is the hardest working and most effective association executive I have had the pleasure of working with. Steve Krantzman, Associate Director, has been invaluable in supporting the technology needs of CALAOMS and is the creative genius behind the CALAOMS Opioid Education Presentation. Teri Travis, CMP, Director of Continuing Education Services, is the backbone of CALAOMS's CE from OMSA to the Annual Meeting. We are fortunate to have such talented individuals on our Senior Management Team.

Thank you to the loyal CALAOMS Fellows and Members who serve on our Committees. Thanks to all who have maintained faithful attendance at our continuing education events.

Thanks to California CareForce for being the conscience of CALAOMS and for enabling us to give back to the victims of unfortunate events and circumstances in California.

Sincerely,

Larry J. Moore

AAOMS DISTRICT VI TRUSTEE REPORT

by Mark Egbert, DDS, FACS
AAOMS District VI Trustee

Greetings from the District VI Trustee,

I am grateful to CALAOMS – and to all of District VI – for the support and confidence shown me as your AAOMS Trustee. As Dr. Tom Indresano has done, and Drs. Larry Moore, Jay Malmquist, Elgan Stamper, and Terry Slaughter before him, I will continue to bring hard work, dedication, and a love for the specialty to the AAOMS Board table from our district. That four of these five past AAOMS Presidents are from California speaks to the importance of CALAOMS in leading the district and AAOMS.

We have just returned from our 101st AAOMS Annual Meeting in Boston. We had a successful meeting! The House of Delegates completed the work of the association and elected a new slate of officers. Dr. Victor Nannini (New York) is AAOMS' new President, Dr. B.D. Tiner (San Antonio, TX) ascended to President-Elect, and Dr. J. David Johnson (Oak Ridge, TN) was elected Vice President. Dr. Robert Clark (Lexington, KY) – previously District III's Trustee – is now AAOMS Treasurer, and our own Dr. Tom Indresano has moved to the Immediate Past President office where he will continue to provide wise counsel to the AAOMS Board. On a historic note, District III has elected the first woman to sit as District Trustee. Congratulations to Dr. Debra Sacco (Durham, NC)! Her election occurs in the same year the House of Delegates overwhelmingly approved gender-neutral language for the Constitution, Bylaws, and Policies that govern our organization.

The National Commission on the Recognition of Dental Specialties and Specialty Boards approved the tenth ADA specialty of Dental Anesthesiology in March of this year (2019). There are two more applications currently in their 60-day public comment period. These are from the American Academy of Orofacial Pain and the American Academy of Oral Medicine. AAOMS member Dr. Jim Boyle is the current chair of the Commission.

Other recent news:

The American Academy of Pediatrics (AAP) and the American Academy of Pediatric Dentistry recently released revised guidelines indicating a separate (second) anesthesia provider should be used for pediatric patients. Pediatric age was not addressed in the guidelines, but the AAP has previously defined pediatric age as 21 years old and under. The American Society of Anesthesiology released a Joint Statement with the American Society of Dental Anesthesiology supporting the AAP's revised guidelines. The statement specifically criticized the OMS anesthesia team model of safe anesthesia delivery. AAOMS has responded to both publications, as neither the above guidelines nor statement provided any scientific evidence supporting these recommendations. AAOMS sent a letter to the editor of the AAP journal, and submitted a rebuttal in the Journal of Oral and Maxillofacial Surgery (JOMS) to the Joint Statement which has been posted online (https://www.aaoms.org/member-center/member-news) and will appear in the December 2019 issue of the JOMS.

> ***"The American Academy of Pediatrics (AAP) and the American Academy of Pediatric Dentistry recently released revised guidelines indicating a separate (second) anesthesia provider should be used for pediatric patients."***

In the long run, data will be the key to maintaining the safe OMS anesthesia team model of sedation and anesthesia delivery. The OMS Quality Outcomes Registry is accepting enrollment and has been well received by participating members (https://www.aaoms.org/member-center/oms-quality-outcomes-registry). A March/April AAOMS Today article reviewed and explained this initiative in detail.

To best advocate for our specialty, we need all members to participate with OMSQOR. Obtaining the total number of procedures performed – with and without anesthesia – and on what patient demographic is critical to providing stakeholders with evidence of the safety of the services that OMS practices provide. Visit www.aaoms.org/member-center/omsqor

to review the FAQs and Resource Guide to help with participation.

The Dental Anesthesia Incident Reporting System (DAIRS) has been live for over a year now and links to DAIRS are available on the AAOMS website (https://www.aaoms.org/member-center/dental-anesthesia-incident-reporting-system). Members are asked to report any anesthetic event. State dental boards are being petitioned to accept DAIRS reporting to satisfy state requirements. The information is not identifiable, but will assist in the understanding of anesthetic events. In addition, this data will be used to guide and direct the development of future educational programs.

Advocacy

The importance of monitoring legislative and regulatory proposals that could affect patient safety and access to care remains high. AAOMS remains dedicated to assisting each state with monitoring and managing issues that may arise affecting your ability to provide safe and affordable care to your patients. CALAOMS remains a model for the rest of the nation in this regard. In the area of advocacy and surveillance – and with proactive legislative initiatives – you are the leaders. Congratulations to you and thank you for your diligence.

By the time you read this, I will have attended the CALAOMS Board meeting in late October, and I look forward to attending the next CALAOMS meeting this winter. I hope to meet many of you there.

Mark A. Egbert, DDS, FACD, FACS
AAOMS District VI Trustee

VENDOR SPOTLIGHT

CALAOMS WISHES TO THANK THE VENDORS THAT GRACIOUSLY SPONSORED CALAOMS' 19TH ANNUAL MEETING AT THE ISLAND HOTEL NEWPORT BEACH

Speaker Sponsor:

THE DOCTORS COMPANY

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MEANING IN ETHICS

Latent Meanings and Nuances in Bioethics

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

The study and value of etymology (G-etumologia "true sense") in bioethics cannot be overstated. It is fair to say that use of explicit language when joined to the ethical nature of man combine to form a separation between mankind and other existing life. One task of the bioethicist is to critically examine the resources of ordinary language and reveal their latent meanings and nuances. Terms of ordinary moral discourse function like a conceptual prism through which we view different human relationships, activities, and forms of life. Most of the time we take such terms for granted. In the West, notions like rights, individual freedom, autonomy, and justice have become part of ordinary language, yet the interpretation of their meaning may generate different understandings of human capacities for purposive activity and, ultimately, different normative conceptions of the society in which we live.

Take, for example, society's understanding of the terms "public" and "private." One version of the private means "not open to the public," and public, by contrast, is "what pertains to the whole, what is done or made on behalf of the community as a whole." One can draw the meaning of this contrast directly from the etymology of the terms in question. "Public" derives from the Latin pubes, the age of maturity when signs of puberty begin to appear; only then does the child enter, or become qualified for, public activity. Similarly, publicus is that which belongs to, or pertains to, "the public," the people.

But there is another meaning: public as open to scrutiny; private as not subjected to the persistent gaze of publicity. In light of this latter interpretation, defenders of constitutional democracy have long insisted on the protection of privacy as the condition for preventing government from becoming all-intrusive, as well as to preserve the possibility of different sorts of relationships: to be a mother or father, for an example, is different from being a citizen; to be a friend is different from being a public official.

Of course, it is inescapable for us to be involved in a number of competing ethical or normative perspectives. The way to solve the possible conflict of opposing claims will be influenced by what we take to be the appropriate relationship between private and public life. This, in turn, will define our understanding of what politics should or should not attempt to define, regulate, and even control.

There is widespread disagreement over the respective meaning of public and private within societies. The boundaries between the public and private help to create a moral environment for individuals, to establish norms for what is appropriate

"What happens to a society's view of the family and inter-generational ties if more couples resort to artificial insemination? "

or worthy actions, and to establish barriers to action in different areas, particularly in areas such as the taking of human life, promulgation of familial duties and obligations, and the arena of political responsibility. Public and private, therefore, are embedded within a dense conceptual web of meanings and implications linked to other basic notions, including nature and culture, male and female, individuality and community, and so on.

According to political theorist Brian Fay, these notions are conditioned on "society's understanding of the meaning and role of work; its view of nature; its concept of agency; its ideas about authority, the community, the family; its beliefs about God and death, and so on" (*Contemporary Philosophy of Social Science: A Multicultural Approach*). The content, meaning, and range of public and private vary within each society, defining the virtues of political and private life and their normative significance.

In the history of Western political thought, public and private imperatives, concepts, and symbols have been ordered in a number of ways. They Include: the demand that the private world be integrated fully within the public arena; the insistence that the public sphere be "privatized," with politics controlled by standards, ideals, and purposes emerging from a particular vision of the private sphere; or, finally, a continued differentiation and bifurcation between the two spheres.

Bioethics is deeply implicated in each of these broad, general theoretical tendencies that often touch on the private and the public. Consider the example of a couple who decides to conceive a child through artificial insemination by donor. One could wonder: What happens to a society's view of the family and inter-generational ties if more couples resort to artificial insemination? What is the effect on the psycho-social development of donor children? What are the responsibilities, if any, of the donor father beyond the point of sperm donation for a fee? Do contractual agreements suffice to "cover" not just the legal but also the ethical implications of such agreements?

All these questions could be solved simply by an appeal to privacy. In such a view, those questions are the exclusive business of the individuals involved in the contractual transaction at stake. And yet other questions loom large: Does society have a legitimate interest in such "private" choices, given the potential social consequences of private arrangements? Or should such procedures be covered by health insurance?

The ways in which our understanding of public, private, and politics plays itself out is dauntingly complex. Contemporary Western societies are marked by moral conflicts with deep historical roots which are reflected in our institutions, practices, norms, and values.

Perhaps the intractability of the debates surrounding bioethics can best be understood as flowing from a central recognition of the importance of language in the absence of a shared moral consensus. A central theme of contemporary social and political theory is the notion of language as "meta-institution," (i.e., as the condition of possibility for any intersubjective exchange that constitutes social reality and frames available forms of action). We are all participants in a language-community and hence share in a project of theoretical and moral self-understanding, definition, and evaluation.

Our values, embedded in language, are not like icing on the cake of social reasoning but are, instead, part of a densely articulated web of social, historical, and cultural meanings, traditions, rules, beliefs, norms, actions, and visions. Bioethical dilemmas do not take place in isolation but emerge from within the culture and thus engage in the wider context over meaning that culture generates.

CALIFORNIA ASSOCIATION OF ORAL & MAXILLOFACIAL SURGEONS UPCOMING CE EVENTS

2020 Meetings

- **2020 January Meeting** - Palace Hotel, San Francisco — January 18 – 19
- **Spring ACLS/BLS** - Solano Community College — March – TBD
- **OMSA Spring 2020** - Hilton Hotel, Glendale — April 4 – 5
- **20th Annual Meeting** - Westin Hotel, San Diego — May 2 – 3
- **OMSA Summer 2020** - Holiday Inn, San Jose — July 25 – 26
- **OMSA Fall 2020** - Marriott Hotel, Long Beach — September 19 – 20
- **Fall ACLS/BLS** - Solano Community College — October – TBD
- **Medical Emergencies** - Southern California — November – TBD

California CareForce

Attention CALAOMS Members. Save the Date for an Upcoming California CareForce free clinic.

- **Grass Valley on January 11 - 12, 2020**
- **Coachella Valley end of March, 2020**

Since 2011, California CareForce has held 24 clinics. With the assistance of 15,000 dedicated volunteers, we have served 32,000 individual patients for a total of $14,000,000 worth of care. You'll enjoy being part of our community of caring, dedicated healthcare professionals. Don't hesitate to ask your referring dentist to join us too! By the end of the weekend, our volunteers are smiling even wider than our patients. Visit www.californiacareforce.org to sign up.

LEGISLATIVE UPDATE

by Gary Cooper
Legislative Advocate, CALAOMS

Fall 2019 Legislative Report

The first year of the 2019-2020 legislative session ended on Sunday, October 13, 2019 with Governor Gavin Newsom taking action on the final group of bills that reached his desk this year. 2019 was Governor Newsom's first year as governor, and the pattern of his signing and vetoing legislation will become much more apparent in the coming years. He is, however, demonstrating an active interest in healthcare legislation, which should prove to be very positive as his administration moves forward.

One of the more relevant bills to be signed (October 13, 2019) was AB 1519 by Assemblymember Evan Low. This measure is the traditionally non-controversial legislation that extends the operation of the Dental Board of California (DBC) after the legislative Sunset Review process. While AB 1519 did extend the operation of the DBC, other provisions were added to the bill as well. Specifically, the bill requires that dentists who provide orthodontic services either in a dental office or via telehealth shall meet the accepted standard of care of reviewing the patient's recent radiographs prior to the movement of teeth. While these provisions are beneficial to patients - and CALAOMS agrees with the policy, Governor Newsom indicated his displeasure of including non-related DBC policy language in a "sunset bill." He indicated that these separate policy measures should be legislated in separate bills. Again, this is Governor Newsom indicating his preference on the passage of legislation.

"The fact that the pediatric anesthesia issue was not on the legislative radar screen in 2019 belies the fact that the issue is just under the surface. "

While the pediatric anesthesia issue was not a front-and-center issue in 2019, the governor signed one bill - AB 1622 (Carrillo) - that added the requirement to the Dental Practice Act that the informed consent form used prior to administering general anesthesia to a pediatric dental patient encourage the parents to consult with the patient's dentist, pediatrician, or family physician.

The fact that the pediatric anesthesia issue was not on the legislative radar screen in 2019 belies the fact that the issue is just under the surface. CALAOMS has every reason to believe it will be a very hot and emotional legislative topic once again in 2020. Since the American Academy of Pediatrics (AAP) and the American Academy of Pediatric Dentistry (AAPD) issued their guidelines recommending a second anesthesia provider be present during pediatric general anesthesia, the American Society of Anesthesiologists (ASA) and the American Society of Dental Anesthesiologists have added their support. This has the potential to reintroduce the issue to the California legislature and could undermine the very positive legislation enacted in the CALAOMS-sponsored SB 501 (Glazer) that was signed into law in 2018 but does not take effect until January 2022.

CALAOMS will remain vigilant and garner support from those many stakeholders who agree that the anesthesia team model used for over 50 years by the OMS profession is safe and should not be changed; only strengthened.

VAPING

by David Y. Park, DDS, MD

What is Vaping?

Recently, I introduced my 18-year-old niece to the concept of renting a movie. And by renting a movie I mean really renting a movie, as in getting off the couch, getting in a car, driving to the store, picking up a movie, watching it, and then returning it back to the store (yes, people still do this). For most young people in her generation, the act of renting a movie is carried out simply by pushing a button on her smartphone, computer, or smart tv. There is a distinct generational gap in how each of us sees the world. Unfortunately, this gap doesn't extend just one way; I'm also clearly unable to see how her generation views the world.

As an oral and maxillofacial surgeon in private practice, a large percentage of my patient population is near my niece's age. It doesn't take long to find evidence that I am out of touch with people this age in my practice. That evidence is present on one of the first forms that our patients complete as they enter our waiting room – the health history. Like yours, our health history queries about smoking and tobacco products – what is used; how much is used, etc. From our experience, many patients in this age group "smoke" by vaping, but they don't check that box. They often view smoking and vaping as separate and distinctly different things.

What is vaping? Vaping is a rapidly growing trend especially in the high school-aged population. A recent study showed that 37% of high school seniors reported vaping in 2018; an approximate ten percent increase from just the year prior. There are many challenges to this growing trend for health care providers. We simply do not have long-term data on the negative health effects of vaping. We also don't have an adequate way to measure dose when patients vape.

Newer-generation devices are able to deliver a higher concentration of nicotine to users than previous devices. The lack of a strong odor or lasting residue allows vapers to use the products more often in a multitude of settings. Vaping per nicotine dose is also cheaper than equivalent tobacco products in California. Medicine has always measured tobacco use by the number of packs consumed over a period of time. This simple dose and frequency calculation cannot be similarly or accurately applied to vaping. The variables of vaping dose and frequency of vaping are extremely difficult to adequately measure.

Many young teens view vaping as a safe alternative to smoking. People believe that vaping is inhaling a water vapor that caries nicotine; yet the truth is that the device heats propylene glycol and glycerol to produce a hyperosmolar aerosol that is deposited deep within the lungs along with nicotine and harmful byproducts of the process. Some of these byproducts are formaldehydes and acetaldehydes that can cause lung disease as well as cardiovascular disease. The devices can also contain acrolein – a commercial herbicide – that is known to cause asthma and lung cancer.

Vaping devices can also vary on what type of consumables are being used. Some patients may be using wax-based or oil-based devices to inhale tetrahydrocannabinol (THC) products. The contents and byproducts of these consumables are also difficult to measure due to lack of standardization and regulation. Many cases of severe lung damage are from oil-based vaping devices.

We are finally seeing that vaping is not as harmless as previously believed and promoted. The U.S. Surgeon General has issued a warning about the risk of secondhand vape smoke and some cities have subsequently outlawed and regulated the use of vaping devices. Most recently, the Centers for Disease Control and Prevention (CDC) has been investigating an outbreak involving 1,080 patients with severe lung injuries that have been reported from 48 states and resulted in the confirmed deaths of 18 patients.

If the numbers are correct, more than one-third of patients in this prevalent age for undergoing wisdom tooth removal surgery may be vaping (and not admitting to it). While many people vape nicotine, there is also a population of users that vape THC and marijuana products. A recent study found that patients using marijuana and THC products can require up to three times the dose of propofol to achieve similar levels anesthesia as control patients.

The negative implications of vaping in our patient population are evident. THC use can adversely affect anesthesia delivery and nicotine's potent vasoconstrictive effects are known to delay wound healing. These ramifications and challenges must be addressed, but the first step in facing those challenges is awareness and understanding so that we can be a part of the conversation to standardize and regulate this new trend.

E-cigarettes and Youth: What Health Care Providers Need to Know

WHAT ARE E-CIGARETTES?

Electronic cigarettes (e-cigarettes) are battery-powered devices that deliver nicotine, flavorings, and other ingredients to the user. Using e-cigarettes is sometimes called "vaping." E-cigarettes do not create harmless "water vapor" – they create an aerosol that can contain harmful chemicals.

HOW MANY YOUTH ARE USING E-CIGARETTES?

- E-cigarettes have been the most commonly used tobacco product among U.S. youth since 2014.
- In 2018, CDC and FDA data showed that more than 3.6 million U.S. youth, including 1 in 5 high school students and 1 in 20 middle school students, were past-month e-cigarette users.
- During 2017 and 2018, e-cigarette use skyrocketed among youth, leading the U.S. Surgeon General to call the use of these products among youth an epidemic in the United States.

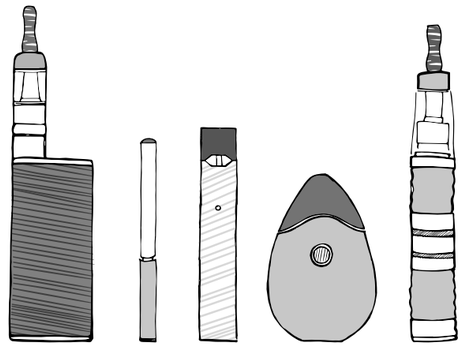
WHAT ARE THE RISKS FOR YOUTH?

- Most e-cigarettes contain nicotine, which is highly addictive. Nicotine exposure during adolescence can:
  - » Harm brain development, which continues until about age 25.
  - » Impact learning, memory, and attention.
  - » Increase risk for future addiction to other drugs.
- Young people who use e-cigarettes may be more likely to go on to use regular cigarettes.
- Many e-cigarettes come in kid-friendly flavors – including mango, fruit, and crème – which make e-cigarettes more appealing to young people.
- E-cigarette aerosol is not harmless. It can contain harmful substances, including:
  - » Nicotine
  - » Cancer-causing chemicals
  - » Volatile organic compounds
  - » Ultrafine particles
  - » Flavorings that have been linked to lung disease
  - » Heavy metals such as nickel, tin, and lead

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

WHAT DO E-CIGARETTES LOOK LIKE?

- E-cigarettes come in many shapes and sizes. Some look like regular cigarettes, cigars, or pipes. Larger e-cigarettes such as tank systems – or "mods" – do not look like other tobacco products.
- Some e-cigarettes look like other items commonly used by youth, such as pens and other everyday items. New e-cigarettes shaped like USB flash drives are popular among youth, including JUUL and the PAX Era, which looks like JUUL and delivers marijuana.



WHAT CAN YOU DO AS A HEALTH CARE PROVIDER?

As a health care provider, you have an important role in addressing this epidemic among youth.

- Ask about e-cigarettes and vaping - including discreet devices such as JUUL - when screening patients for tobacco product use.
- Educate patients about the risks of tobacco product use, including e-cigarettes for young people, and counsel youth and young adults to quit.
- Learn about the different shapes and types of e-cigarettes and the risks of e-cigarette use for young people at **www.CDC.gov/e-cigarettes**.

ABOUT USB FLASH DRIVE-SHAPED E-CIGARETTES

As a health care provider, you may have heard about the use of USB flash drive-shaped e-cigarettes, including JUUL (pronounced "jewel"). JUUL is the top-selling e-cigarette brand in the United States.

JUUL is being used by students in schools, including in classrooms and bathrooms. JUUL's nicotine liquid refills are called "pods." According to the manufacturer, a single JUUL pod can contain as much nicotine as a pack of 20 regular cigarettes.

JUUL delivers nicotine in a new form called "nicotine salts," which can make it less harsh on the throat and easier to use by youth. JUUL also comes in flavors that can appeal to youth.

www.CDC.gov/e-cigarettes

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

by Solomon Poyourow, DDS, MD, MPH

Platelet Rich Fibrin – What is it Good For?

After years of sitting on the sidelines listening to other clinicians extoll the virtues of platelet rich plasma/fibrin (PRP/PRF), I decided to give it a try. It seemed worthwhile to first perform a literature search and learn what PRF can improve and where it might fall short.

Platelet concentrates have been reported about in medical and dental literature for decades. The term "PRP" was first coined in 1954 during coagulation experiments. In the 1970s, researchers developed an appreciation for the ability of platelet concentrates to aid in wound healing and adhesion of tissues. "Fibrin glue" was found to improve skin healing in rats. From 1975 - 1978, several studies reported on the use of platelet-fibrin mixtures to facilitate closure of epithelial wounds.[1]

PRP entered the dental literature in 1984 with an article entitled, "Use of PRP in bone volume augmentation" in the Belgian Review of Medicine and Dentistry.[2] PRP gained popularity in oral and maxillofacial surgery (OMS) after Marx et al. published "Platelet-rich plasma: Growth factor enhancement for bone grafts" in 1998. Marx commented that adding PRP to cancellous bone marrow grafts yielded more rapid maturation and density of the graft.

A significant advance came in 2001 when French anesthesiologist Joseph Choukroun and his team developed PRF. PRF had the following advantages over PRP: easier preparation, completely autologous, more gradual release of cytokines and growth factors, and antimicrobial properties due to neutrophil chemotaxis and the presence of leukocytes. The protocol for making PRF has changed and several types of PRF have been described, including L-PRF (leukocyte), A-PRF (advanced), T-PRF (titanium prepared), and i-PRF (injectable).[4]

Different researchers have claimed their discovery of slightly different PRF subtypes based on centrifuge protocol. Choukroun markets the only FDA-certified centrifuge for making L-PRF (IntraSpin). The original PRF centrifuge protocol called for 3000 rpm for 10 minutes. This changed to 2700 rpm for 12 minutes to make standard or leukocyte-rich PRF (L-PRF). Advanced PRF (A-PRF) is spun at 1500 rpm for 14 minutes.[5] T-PRF simply uses titanium blood collection tubes instead of glass or plastic. i-PRF is made by spinning at 700 rpm for 3 minutes.

A variation on PRF – named concentrated growth factor (CGF) – was touted by Sacco in 2006. He claimed the fibrin matrix was larger and possessed more cytokines.[6] CGF is made in a proprietary centrifuge (Medifuge) which accelerates for 30 seconds, spins at 2700 rpm for 2 minutes, 2400 rpm for 4 minutes, 2700 rpm for 4 minutes, 3000 rpm for 3 minutes, followed by a 36-second deceleration.[7] Interestingly, a group of researchers tested the mechanical and degradation properties of A-PRF compared to CGF and found no difference in microstructure, water content, tensile strength, or degradation time.[8] Visually, CGF looks identical to PRF and it is questionable whether there is any meaningful difference.

Regarding clinical benefit, many studies have evaluated the impact of PRF on third molar extraction outcomes. There is substantial evidence to support reductions in pain, swelling, trismus, and alveolar osteitis (AO). A double-blind study from 2014 found a decrease in AO from 15% to 7%.[9] The incidence of AO seems high, but the results were statistically significant and indicative of a strong benefit. A systematic review and meta-analysis from 2019 showed a greater than 60% reduction in AO as well as a decrease in pain and swelling after third molar surgery.[10] Another study looked at the incidence of AO as well as periodontal healing. This study used a split-mouth design where PRF was randomly placed in one of the mandibular extraction sockets but not the other. Pain, AO, and periodontal probing depths on the distal of the adjacent second molars were assessed. Similar to the first study cited above, 18% of non-PRF sockets developed AO compared to 8% in the PRF sockets. Among smokers, 37.5% of the non-PRF sites developed AO compared to none of the PRF sites. Pain was improved in the PRF sites. However, no difference was noted in periodontal healing.[11]

Regarding bone healing, study results are mixed on the ability of PRF to improve bone healing.[12] Many studies have been conducted analyzing the effects of adding PRF to allograft, xenograft, and alloplast. A great number indicate no benefit nor worsening of outcomes with the addition of PRF in sinus grafts.[13-16] There are some studies that indicate quicker sinus graft healing and less residual graft particles; however, this did not affect clinical outcomes.

Several studies have examined using PRF alone as a graft material. One such study compared L-PRF to no graft in socket preservation. PRF was found to be superior to no graft. The PRF group yielded decreased vertical and buccal resorption and increased bone mineralization compared to the no graft group.[17] However, the real question is how does PRF alone compare to allograft or xenograft in bone augmentation and preservation? De Angelis et al. evaluated three groups for socket preservation: L-PRF, L-PRF plus xenograft, and xenograft. The L-PRF group was found to have greater horizontal and vertical bone resorption than the xenograft groups.[18] This finding was echoed by another study which found greater horizontal bone loss with the use of PRF alone compared to alloplast. However, other studies commented that PRF sites showed greater cellularity and more mineralized bone despite greater resorption when used without solid graft material.[19] Another study showed no difference in post-extraction bone dimensions between PRF-augmented extraction sockets and those without a graft.[20] Thus, the value of PRF as a sole bone grafting material is questionable. Some clinicians are successful in utilizing PRF alone in sinus augmentation.[21] However, it is known that simply lifting the Schneiderian membrane and keeping it elevated will result in bone formation. It would be interesting to see how PRF compares to allograft/xenograft without simultaneous implant placement in the sinus.

In conjunction with traditional bone grafting, PRF can be used as a barrier membrane. Multiple studies support the use of PRF as a membrane in guided bone regeneration. In fact, one study indicated greater bone formation with the use of PRF membrane compared to resorbable collagen membrane or non-resorbable membrane.[22]

PRF is a readily available technique with multiple applications and low cost. I find myself integrating it into more aspects of clinical practice as I streamline the workflow and observe the clinical benefit to my patients. It can be fun to try different things and PRF is an easy, not-so-new thing to try.

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CALAOMS 19th Annual Meeting Award Recipients

Meeting Dedicatee

Mary Delsol Dobon, DDS, FACS was awarded the Meeting Dedicatee for her life-long commitment and leadership in the profession of Oral and Maxillofacial Surgery. She was presented the award by CALAOMS President Larry J. Moore, DDS, MS

Distinguished Service Award

Craig Y. Bloom, DMD, received the Distinguished Service Award for his selfless dedication to the charitable arm of CALAOMS by serving as President of California CareForce. Presented by CALAOMS President Larry J. Moore, DDS, MS

Committee Person of the Year

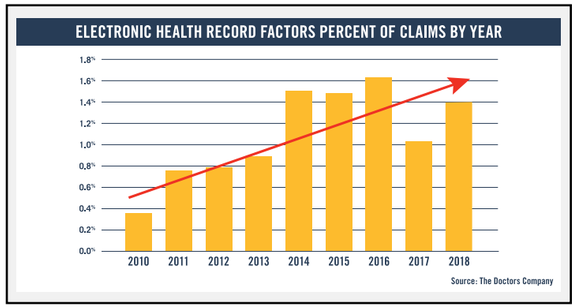
Rich C. Robert Jr. DDS, MS received the Committee Person of the Year award for his stalwart and indefatigable efforts to make Oral and Maxillofacial Surgery Assistants Training more relevant. Presented by CALAOMS President Larry J. Moore, DDS, MS

RISK MANAGEMENT

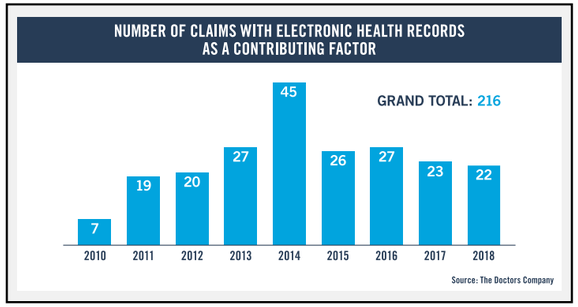
Electronic Health Records Continue to Lead to Medical Malpractice Suits

by Darrell Ranum, JD, Vice President of Patient Safety and Risk Management

For 8 years, claims in which the use of electronic health records (EHRs) contributed to patient injury have been on the rise.



The Doctors Company's analysis of claims in which EHRs contributed to injury show a total of 216 claims closed from 2010-2018. The pace of these claims grew, from a low of 7 cases in 2010 to an average of 22.5 cases per year in 2017 and 2018. EHRs are typically contributing factors rather than the primary cause of claims, and the frequency of claims with an EHR factor continues to be low (1.1 percent of all claims closed since 2010). Still, as EHRs approach near-universal adoption, they may become a more prevalent source of risk.



The EHR-related claims closed from 2010-2018 were caused by either system technology and design issues or by user-related issues.

Top System Technology and Design Issues	Claim Count	Percent
Other	30	14%
Electronic systems/technology failure-EHR	26	12%
Lack of or failure of EHR alert or alarm	15	7%
Fragmented record	14	6%
Failure/lack of electronic routing of data	10	5%
Insufficient scope/area for documentation in EHR	8	4%
Lack of integration/incompatible systems	5	2%
Failure to ensure information security	1	0%
Grand Total	104*	48%

**Note that the percentages are of the total number of electronic health record claims (n=216).*

Top User-Related Issues	Claim Count	Percent
Incorrect information	29	13%
Pre-populating/copy & paste	29	13%
Hybrid health records/EHR conversion issues	27	13%
User error-other	25	12%
Training and/or education	16	7%
Alert issues/fatigue, user-related	5	2%
Computer order entry workarounds	4	2%
Grand Total	129*	60%

**Note that the percentages are of the total number of electronic health record claims (n=216).*

Here are the top five risks and suggestions to avoid an EHR-related malpractice claim:

1, *Risk*: Copy/paste may perpetuate incorrect or outdated information.

Solution: Avoid copying and pasting except when describing the patient's past medical history.

2. *Risk*: Many EHRs auto-populate fields in the patient's history and physical exam and in procedure notes, causing the entering of erroneous or outdated clinical information

Solution: Contact your organization's IT department or your vendor if you notice that the auto population feature causes erroneous data to be recorded. If the auto populated information is incorrect, note it and document the correct information.

3. *Risk*: Templates with drop-down menus facilitate data entry, but an entry error may be perpetuated elsewhere in the EHR.

   Solution: Review your entry after you make a choice from a drop-down menu.

4. *Risk*: Doctors are responsible for the information to which they have reasonable access. EHR metadata documents what was reviewed. A patient injury may result from a failure to access or make use of available patient information.

   Solution: Review all available data and information prior to treating a patient.

5. *Risk*: The computer may become a barrier between the doctor and the patient.

   Solution: Relocate the computer so the physician's back is not to the patient and so the patient can view the screen. Remind the patient that you are listening carefully, even though you may be typing during the appointment and summarize or read the note to demonstrate you have listened.

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 healthcare provider considering the circumstances of the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.

Does Trial Lawyer Advertising Pose a Growing Risk to Public Health?

What would you do if you saw a TV ad about a lawsuit against a drug company over a medication prescribed by your physician that you were currently taking? In 2017, the U.S. Chamber Institute for Legal Reform (ILR) asked that question of 1,335 adults—500 of whom were currently taking or had taken one of 12 prescription drugs frequently targeted by personal injury lawyers. Nearly half of the survey respondents said they would definitely or probably stop taking the drug immediately after seeing the ad. When shown an actual TV lawsuit ad about a drug they or a household member had taken, more than half said they would reduce the dosage to below the prescribed amount.

Problems with litigation advertising are not new. The ILR study reinforces the findings of an earlier survey commissioned in 2007 by the National Council for Community Behavioral Healthcare. Its poll of 400 psychiatrists found that 97 percent had patients who stopped taking their medications or reduced their dosages. More than half of the respondents believed that their patients had reacted to litigation advertising. Another ILR poll found that, in 2003, one-third of surveyed physicians had prescribed drugs to patients who then refused to take them because of litigation.

The malignant effects of attorney advertising are significant enough that the American Medical Association (AMA) House of Delegates adopted a policy during its 2016 annual meeting: The AMA would advocate to require warnings in attorney ads, cautioning patients to not stop taking their medicines without discussing it first with their healthcare providers.

Predictably, attorneys have a different view. When interviewed about the AMA's new policy, Philadelphia plaintiffs' lawyer Max Kennerly told *Legal Newsline* (an ILR publication) that the warnings are unnecessary: "Attorney advertisements are one of the primary ways that the public learns about new dangers of drugs and medical devices." Although Mr. Kennerly lists medical malpractice and drug class actions among his areas of special expertise, he also stated, "I don't know of a single instance of a patient stopping a medication and being hurt because they saw an attorney's advertisement."

Contrary to Mr. Kennerly's statement, ILR's study notes that MedWatch, the U.S. Food and Drug Administration's Safety Information and Adverse Event Reporting Program, received reports that 31 patients quit taking prescribed blood thinners after seeing litigation advertising and then suffered injuries that included stroke, pulmonary embolism, paralysis, and death. These incidents occurred between September 2014 and December 2015. Another 61 reports through December 2016 described patients who had stopped taking blood thinners in response to attorney ads and suffered injuries that included cardiac arrest, stroke, deep vein thrombosis, transient ischemic attack, and death.

In an informational hearing on the subject in June 2017, the U.S. House of Representatives Judiciary Committee heard from practicing physicians whose patients had been negatively affected by attorney advertising—including one moving example of a patient who died because she stopped taking her prescribed anticoagulant after receiving a pamphlet in the mail from a plaintiffs' attorney targeting the medication. The committee also heard from a law professor who explained that much of the drug litigation advertising is funded by so-called "aggregators"—law firms that do not try cases but merely recruit plaintiffs. The aggregators then pass the plaintiffs to other law firms, often in jurisdictions far from the patients and their healthcare providers, where courts and juries are sympathetic to class action plaintiffs. The committee's final witness was a lawyer who counsels other lawyers on their ethical responsibilities. This witness felt that regulation of attorney advertising on drug litigation is unwise and unnecessary.

In Texas, the Senate passed SB 1189, Deceptive Advertising Practices. The bill precludes legal advertising from being presented as a medical alert, health alert, consumer alert, or public service announcement. It also prevents ads from using federal or state government agency logos to suggest an affiliation and prohibit ads from falsely claiming that a product has been recalled or is under investigation by the FDA. The legislation mandates specific warnings and disclosures—including a warning that patients should consult a physician before stopping a prescribed medication. The governor is expected to sign this bill. Similarly, the California State Assembly passed AB 3217 with bipartisan support, only to see it die in the California State Senate under pressure from the trial attorneys' opposition. Although it will be difficult to enact this kind of important legislation, it is essential that the healthcare community join us in supporting these measures when they are introduced at the state level.

Lawsuit advertising continues to grow. The American Tort Reform Association issues periodic updates on trial lawyer ad spending. While not all of the ads are related to drug litigation, the expenditures are staggering. In the third quarter of 2018, trial lawyers spent $226 million to air ads on local broadcast networks, up $50 million from the second quarter of 2018. That figure includes 23,000 ads in New York City alone, at a cost of nearly $9 million in three months. Those figures do not include local cable, national cable, or national broadcast networks. The ILR estimates that trial lawyer advertising in 2017 amounted to $1 billion nationwide.

Physician advocates continue to grapple with trial lawyer advertising—including concerns that misleading advertising may affect the objectivity of potential jurors—as evidence mounts that deceptive ads hinder a physician's ability to provide effective treatment. Providers may wish to add the pernicious effects of attorney advertising to the factors influencing when and how to assist patients in following their prescribed therapies.

We will continue to monitor legislative developments and advocate on behalf of our members and the medical profession. Look for updates in future issues of *The Doctor's Advocate*.

Track Legislation in Your State

Keep up to date on bills and regulations we're tracking in your state. Find our interactive Legislative Activity map at thedoctors.com/advocacy.

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