



A PUBLICATION OF THE CALIFORNIA ASSOCIATION OF ORAL & MAXILLOFACIAL SURGEONS

## Surgical Antibiotic Prophylaxis – Is It Needed for Every Implant Procedure?

by David R. Cummings, DDS, FACD, FICD, CALAOMS President-Elect

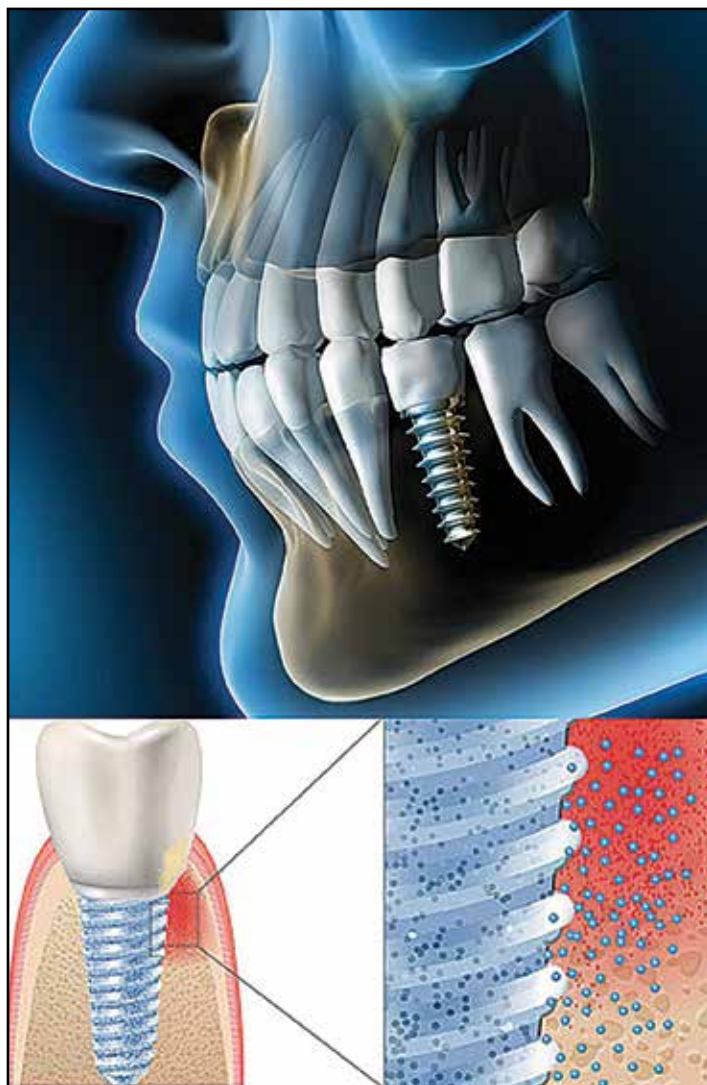
**A**s oral and maxillofacial surgeons, we make difficult decisions every day for our patients. These decisions can be potentially life-threatening, and we make them based on the combination of best evidence available and our clinical experience - what we have read, heard, or experienced that positions us to achieve the best outcome for each patient.

There are risks associated with all surgical procedures we perform. Similarly, there are risks associated with medications we prescribe. One such situation of concern is antibiotic prophylaxis.

- How do we decide when to prophylax with antibiotics and when not to?
- Should we prophylax every patient for every implant that we place?
- Is it necessary?
- What is the risk that the patient could have an anaphylactic reaction to something I have prescribed?

These and other concerns mandate consideration as we deliberate the management of our patients.

In the United States, surgical site infections contribute an additional cost of \$10 billion per year.<sup>(1)</sup> Surgical site infections are caused by bacteria that enter through incisions made during surgery.<sup>(2)</sup> According to the CDC, the incidence of surgical site infection in the U.S. is approximately 2.8%.<sup>(3)</sup> Surgical site infection prevention is defined as the



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\* Oral & Facial Surgeons of California  
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\* Southern California Society of Oral and Maxillofacial Surgeons  
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## EDITORIAL



by Jeffrey A. Elo, DDS, MS, FACS

### Compassion is a hallmark of CALAOMS members

During the past twelve years, I have had the honor, pleasure, and privilege to serve as CALAOMS's editor. During that time, I have been so very impressed by the extraordinary talent that exists in our association: our members and staff are truly remarkable.

However, most meaningful to me has been the consistent display of competence, confidence, and loyalty by the membership in the face of unrelenting challenges (e.g., anesthesia issues, dental insurance rate reductions, etc.), including a pandemic, changes in leadership (a regular part of every professional organization), and the accompanying instability that economic uncertainty brought/brings to our practices and lives.

At the same time, each of us has been confronted with demoralizing economic challenges as we slide toward, or find ourselves in, a national recession. Yet, our members continue to sacrifice and selflessly exemplify our profession's most coveted core value – compassion – in your daily work.

Despite these admirable efforts, in our current economic climate where we are persistently challenged with rising inflation, ever increasing costs for groceries, exorbitant gasoline prices, unstable rent and mortgages, soaring cost of living expenses, and volatility in financial markets, all of which contributes to further economic adversity for our members and staff, other potentially more serious and deadly hardships are taking place for many people around us.

Addiction, misuse, and overdose of prescription and nonprescription opioids continues to be a catastrophic public health problem affecting both adults and children. Serious measures are needed, and some have already been undertaken, to better inform the public of the risks associated with both the long-term and short-term use of opioids.

As is well known among oral and maxillofacial surgeons, the U.S. Drug Enforcement Agency (DEA) notes that fentanyl is a synthetic opioid that is up to 100 times more potent than morphine. "Because of its powerful opioid properties, Fentanyl is also diverted for abuse," the agency said. "Fentanyl is added to heroin to increase its potency or be disguised as highly potent heroin. Many users believe that they are purchasing heroin and don't know that they are purchasing fentanyl – which often results in overdose deaths. Clandestinely produced fentanyl is primarily manufactured in Mexico."

Fentanyl kills more young Americans than drug deaths from heroin, cocaine, meth, and all other prescription medications combined, according to the National Fentanyl Awareness Day, which adds that fentanyl causes more death in Americans under the age of 50 than any other cause of death, including heart disease and cancer.

CALAOMS members play a pivotal role in providing quality care, ensuring patient safety, and supporting the improvement of public health. Just as our messaging has always been clear regarding the delivery of safe in-office anesthesia, so, too, is our message consistent that safety must exist outside of the office, as well. As potential prescribers of opioids for perioperative dental and maxillofacial pain management, oral and maxillofacial surgeons have admirably and responsibly reduced the number of narcotic prescriptions in our practices.

Over the past several years, through various methods, CALAOMS has engaged in highly productive informational sessions and presentations with members and leaders of communities, as well as lawmakers, to discuss the dangers and risks associated with opioid use and abuse. Given the vast knowledge of various types of pain control, oral and maxillofacial surgeons are uniquely qualified in medicine and dentistry to educate patients and communities at large regarding these issues that have negatively impacted the health and welfare of our youth and young adults.

The last week of October was Red Ribbon Week. As most people know, Red Ribbon Week has been around for quite some time - well over thirty years, in fact. When a campaign has been around for this long, it is sometimes easy to forget the significant meaning behind it. Back in the 1980s and early 1990s, when the Red Ribbon Week tradition was starting to take hold in schools across the nation, "Just Say

No" was an advertising campaign spearheaded by Nancy Reagan that aimed to discourage children from trying drugs. In today's world, however, there is much more to it than just saying "no."

More than ever, young children are finding themselves face-to-face with the serious challenges of drugs and alcohol in our society. Beyond peer pressure, children and teens are exposed to movies, tv shows, and music that make drugs seem "cool" or "an okay thing to do." There is also a strong correlation between kids who struggle with depression, boredom, rebellion, and/or lack of confidence, and experimentation with drugs. With traffickers mixing various drugs with fentanyl, referred to as "the single deadliest drug threat our nation has ever encountered" by DEA administrator Anne Milgram, the stakes for protecting our children from drugs have never been higher.

Nearly every family has experienced, in some way or another, the negative impact drugs and/or alcohol can have on the lives of loved ones. The emotional pain and mental anguish that comes from addiction are like no other, leaving tremendous destruction and unmitigated agony in its wake. Sadly, there is no "silver bullet" solution as to what will spare a child from the disease of addiction. We all know the probabilities of children experimenting with alcohol and/or drugs at some point in their lives, and the possible consequence of addiction is real and downright frightening to think about.

The illegal drug epidemic that is attacking society is truly alarming, and no child or young adult is immune from its reach. It is critical that we work together to fight back against this evil by educating ourselves, our children/young adults, our staff, our patients, and our communities on the extreme dangers of drugs and alcohol.



We, as surgeons functioning as educators in our offices and in our communities and circles of influence, must do everything in our power to arm our youth and all our patients with weapons of knowledge and enduring support so that they can confidently face the battles that we know are sure to come.

CALAOMS is committed to doing our part to combat the opioid epidemic. CALAOMS supports our members with data, tools, and guidance for evidence-based decision-making to improve opioid prescribing and patient safety. Through our outreach efforts around the state, CALAOMS members have increased public awareness about prescription opioid misuse, abuse, and overdose; and have taught hundreds, perhaps thousands, of teenagers to make safe choices about opioids. CALAOMS past president Dr. Alan Kaye has been the pioneer of this selfless outreach effort.

Collaboration is essential for success in preventing opioid overdose deaths. Medical personnel, emergency departments, first responders, public safety officials, mental health and substance use treatment providers, community-based organizations, public health, and members of the community all bring awareness, resources, and expertise to address this complex and fast-moving epidemic. Together, we can better coordinate efforts to prevent opioid overdoses and deaths.

CALAOMS has brought and will continue to bring a positive and educational message to high school-aged students that OMSs can and do offer very effective non-opioid pain medications for post-operative discomfort. That doesn't mean we won't prescribe an opioid when necessary, but we do not view them as first-line or solo medications for the treatment of post-operative discomfort.

As members and leaders of our local communities, oral and maxillofacial surgeons demonstrating care and concern for vulnerable and influenceable youth in the community is extremely powerful and deeply impactful. The state legislature has and is taking notice and will applaud both our association and each of you for the proactive nature of our efforts to educate the next generation.

## PRESIDENT'S MESSAGE



Sam F. Khoury DMD  
CALAOMS President



It is my pleasure to address you as 2022 is coming to an end. CALAOMS wants to wish our members a prosperous 2023. COVID is still here with us, but hospitalizations are decreasing with more people vaccinated, and practices are getting back to some sort of normalcy. The CALAOMS board is steadily working hard behind the scenes to advocate for and protect our specialty.

Our organization is only as strong as its members. Member support is critical in keeping our organization healthy and viable. Our volunteer board is consistently advocating for the specialty and for our patients. Our organization, among the best in all of organized dentistry, is our collaborative voice representing oral and maxillofacial not only in this state, but also nationally.

CALAOMS continues to advocate for our anesthesia care team model and promote our outstanding safety record to state legislators and the Dental Board. We strongly recommend and advise that all Oral and Maxillofacial Surgery Assistants (OMSA) renew their critically important OMSA training every two years – this is more easily accessible now that OMSA has been taken completely online. The CALAOMS board believes the 5-year interval between the recertification of the anesthesia assistants is too long for meaningful retention of skills and information needed to be the most valuable team member possible. OMSA recertification every two years is compatible with the renewal of all other state health-care licenses and permits, as well as Basic Life Support.

CALAOMS has been working on logistics with AAOMS to bring the hands-on simulation course, Office-Based Emergency Airway Management (OBEAM), to California. This is a work in progress, but our goal is to pilot this course some time in 2023; so, stay tuned for details. As you will recall, the AAOMS House of Delegates voted in September 2021 to amend the membership qualification bylaws. They voted that by 2026, members who provide office-based moderate, deep, and/or general anesthesia must successfully complete an AAOMS-approved anesthesia simulation training course every five years. AAOMS developed the Office-Based Emergency Airway Management (OBEAM) anesthesia simulation modules. OBEAM uses intensive, real-life experiences to allow participants to practice and master critical techniques for administering and monitoring office-based anesthesia. Currently, the four-hour course is being offered at AAOMS headquarters and will also be offered at the 2023 San Diego Annual meeting. CALAOMS is working to bring this course to our state and hold simulation sessions during our in-person meetings.

### **SB 501 is now in effect**

Dentists who hold an existing general anesthesia permit are still able to practice under the terms of that permit until it expires, at which point they will need to apply for one of the new permits. The general anesthesia (GA) permit remains in place but is now a GA/deep sedation (DS) permit with deep sedation and GA redefined by the regulations.

Dentists are newly required to obtain a pediatric endorsement prior to administering or ordering GA/DS to patients **under age 7**.

Dentists must have patients continuously monitored during a DS/GA procedure with a pulse oximeter and ventilation using precordial stethoscope and capnography.

Additional staffing is required for patients **under age 13**: the operating dentist and two additional personnel must be present for the procedure. Of the three personnel, **two** must be certified in pediatric advanced life support (PALS) or a Dental Board-approved course in pediatric life support and airway management.

To obtain the pediatric endorsement, dentists must have: (1) completed at least 20 deep sedation/general anesthesia cases of patients under age 7 at the time of license application and renewal, and (2) certification in advanced cardiovascular life support and PALS.

Permitholders who have insufficient cases to receive a pediatric endorsement can administer DS/GA to patients under age 7 under the direct supervision of a permitholder with a pediatric endorsement to fulfill the 20-case requirement.

SB 501 does NOT change anything in terms of how OMSs and their staff members provide moderate sedation, deep sedation, or general anesthesia to patients **13 years old and older**. SB 501 only changes the way moderate and DS/GA are administered to patients 12 years old and younger.

If a separate medical or dental anesthesiologist is used, either the operating dentist OR the additional staff personnel (the 3rd person who is required to be present during the sedation) must have PALS for moderate sedation, deep sedation, or general anesthesia for patients 12 years old and younger.

### **Dental Sedation Assistant**

The Dental Sedation Assistant (DSA) permit program is in California Statute (law). 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.

The CALAOMS board has been urging our members to offer DSA training to their assistants. 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. Please contact CALAOMS and ask for the DSA Application materials.

It has been a true pleasure to serve as your President this year. CALAOMS is looked up to as one of the strongest oral and maxillofacial surgery associations in the country. We truly have great surgeons that are part of CALAOMS. I want to personally thank those members that have served on CALAOMS committees to advance our specialty. I also can't thank enough our Executive Board. They were always ready for any issues that arose. They sat through endless conference calls, email threads, and votes, and brought forth so many ways that we could positively represent our membership and the issues that we face.

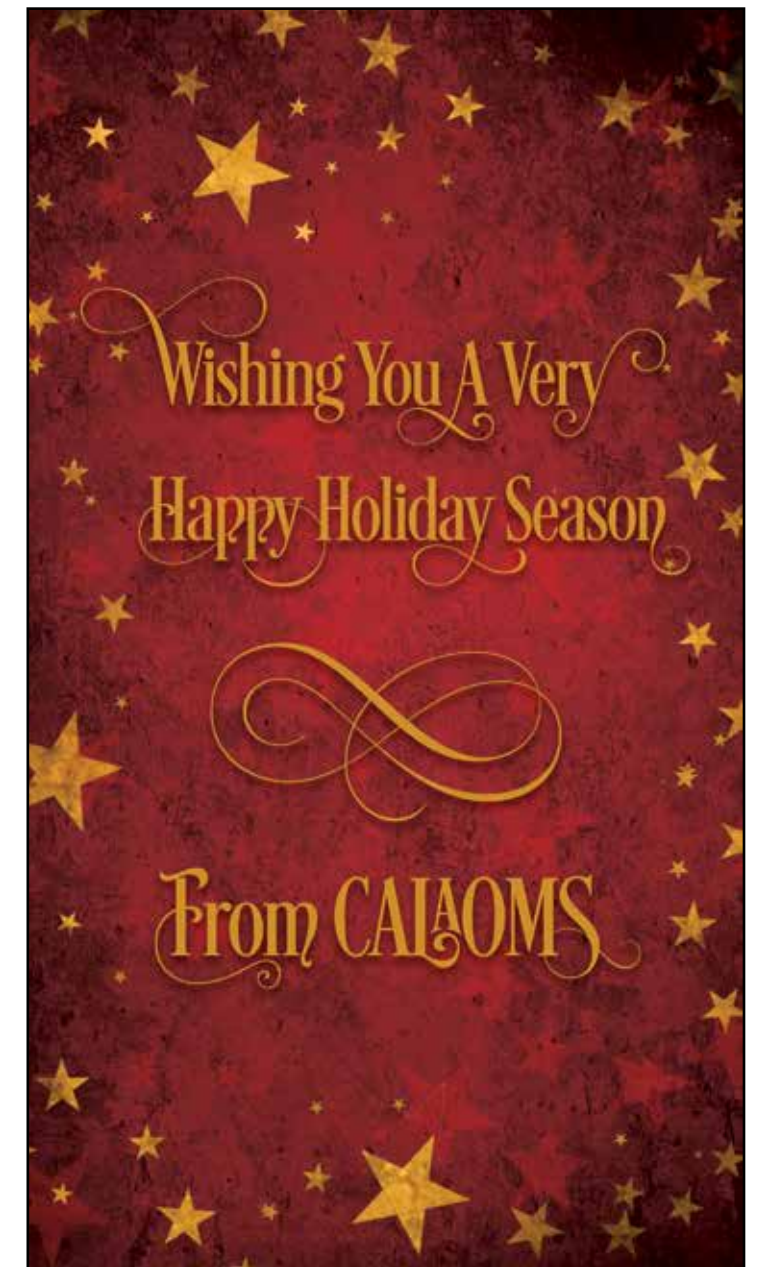
Lastly, we couldn't achieve our goals without the dedication of our talented executive director, Pam Congdon, and critical staff members, Steve Krantzman and Teri Travis. They are truly exceptional.

In the words of Henry Ford: "Coming together is a beginning. Keeping together is progress. Working together is success."

I want to thank you all for your continued support of our specialty.

Most sincerely,

Sam F. Khoury, DMD  
President, CALAOMS



## AAOMS DISTRICT VI TRUSTEE REPORT



by W. Frederick Stephens, DDS, FACD, FICD  
AAOMS District VI Trustee

I hope 2022 has been productive and y'all had a chance to attend the recent AAOMS Annual Meeting in New Orleans. It's been a very busy year for me wearing two hats. This marked my first year as your District VI trustee but in addition to my Trustee obligations, I am also completing my year as OMSPAC Chair. So, as you can imagine, I have seen a lot of the inside of airports and airliners over this last year.

The AAOMS has achieved many wins over the year under the great leadership of Dr. J. David Johnson. Now, Dr. Paul J. Schwartz has taken the reins as the new AAOMS President and your former District VI Trustee, Dr. Mark Egbert, is the AAOMS President Elect. I am sure that Paul, with the assistance of Mark, will continue the tradition of achievement over the next year.

Together, we all will continue to succeed and prosper. I appreciate all your support and if I can do anything for you, please do not hesitate to contact me.

We have achieved much this year. I have outlined only some of the more important areas of progress and the upcoming meetings below:

### Anesthesia

- AAOMS continues to work with states, when requested, on the **OMS anesthesia delivery model**. To this point, OMS has been able to successfully advocate for our team practice model. AAOMS has extensive resources to assist any state facing similar challenges.
- AAOMS has developed a partnership with Laerdal to deliver and capture simulation activity, to create customizable assessments and quality assurance for our

simulation courses. The simulation platform will be cloud-based to ensure data accessibility from anywhere. **Visit [aaoms.org](http://aaoms.org) to find a date that works for you to take the **OBEAM** course.**

- The American Society of Dentist Anesthesiologists (ASDA) and AAOMS continue to finalize a draft model of anesthesia regulations through a joint working group. This will put all the important players who provide office-based anesthesia on the same page.

### Education/Events

- AAOMS is now offering a Clinical CE Subscription service that will allow OMS members to access the entire on-demand Clinical CE Online Library courses for a full year. This 24/7 access to the AAOMS clinical course catalog includes over 100 hours of content and is updated with at least 20 new courses annually. The Clinical CE Subscription is \$249 for a full year. More information can be found at [AAOMS.org/CESubscription](http://AAOMS.org/CESubscription).
- Five sessions of the **Office-Based Emergency Airway Management (OBEAM)** module, part of AAOMS's National Simulation Program, will be offered at the newly named, **Daniel M. Laskin Institute for OMS Education and Innovation** at AAOMS headquarters in Rosemont, Ill. There, OMSs can expect to master techniques for administering and monitoring the office-based delivery of anesthesia through intensive, real-life experiences. OBEAM modules are limited to AAOMS members and fellows at a cost of **\$800 per participant**. Sessions are not yet available for professional staff.
- The **AAOMS Dental Implant Conference will be held Dec. 1 – 3, 2022** at the Sheraton Grand Chicago, in Chicago, Ill. Six preconference hands-on workshops will be offered. The theme of the General Sessions will be Merging Traditional Methods with Modern Updates. **Registration is now open. Up to date information to include information on available assistant courses held in conjunction with the Dental Implant Conference can be found at [AAOMS.org/DIC](http://AAOMS.org/DIC).**
- To see upcoming AAOMS meeting, webinar and other educational opportunities available, please visit <https://www.aaoms.org/meetings-exhibitions/upcoming-events>

### SCORE / Surgical Council on Resident Education

- Committee on Education & Training (CET) continues to work with the Surgical Council on Resident Education to create a national curriculum for OMS residents.
- The content is being developed in accordance with the ACGME six competencies required of a graduating resident: patient care; medical knowledge; professionalism; interpersonal and communication skills; practice-based learning; and systems-based practice.
- Costs include a \$500 enrollment fee for OMS training programs, and an annual fee of \$125 per resident.
- In addition to the OMS content, users will have access to 700+ modules, 12 leading textbooks, and hundreds of surgical videos.
- The OMS Foundation, ABOMS, and the ASC have provided significant funding to supplement the AAOMS investment in SCORE.
- The OMS Foundation offered scholarships to provide financial assistance to OMS programs for a one-year subscription to SCORE beginning July 1, 2022-June 30, 2023. Sixteen (16) OMS programs received SCORE scholarships
- The CET is collaborating with SCORE on additional marketing to increase the number of OMS programs utilizing this important online resource.

### AAOMS House of Delegates, 2022

- Resolutions adopted by the House include: tasking AAOMS to identify and share programs and resources to assist membership with issues of personnel and practice safety; development of strategies to promote the Pledge of the Association to the membership and public; renaming the OMS Institute for Education and Innovation to the Daniel M. Laskin Institute for OMS Education and Innovation; adoption of the 2023 operational budget; formation of a special committee of the House of Delegates (comprised of the District Caucus officers and Speaker of the House) to review volunteer and engagement opportunities to address delegate, alternate delegate, and leadership positions within the Association; and the ability to implement of an annual dues increase based on a five-year average of the US Consumer Price Index.
- Additionally, below are some details regarding the **2022 HOD Actions related to the new Anesthesia requirements**:

- Over the past year, the Board of Trustees and the Committee on Anesthesia have worked diligently to

address the 2021 HOD Resolutions regarding anesthesia membership requirements which included, Simulation, Mock Drills, Anesthesia Survey Data and Certified OMS Anesthesia Assistants.

- Over time, some challenges have been identified with the implementation of these new membership requirements.
- Resolution A-1 addressed the certified dental anesthesia assistant.
- It has been noted that practicing OMSs are reporting significant labor shortages and difficulty in establishing training timelines for new employees. It now appears impractical to mandate our surgeons achieve the goals of last year's resolution in this current environment.
- So, in lieu of any mandating of certification requirements for the OMS anesthesia assistants, AAOMS will focus on education and providing pathways to train office dental anesthesia assistants through existing educational offerings and development of additional enhanced programs.
- CAN (Committee on Anesthesia) is developing criteria that would help delineate a list of skillsets for OMS anesthesia assistants and the various time intervals these skills should be achieved following start of employment.
- The importance of lifelong learning and continuous training is the focus and should provide flexibility to the OMS member and the OMS anesthesia assistants.
- **RESOLUTION 22-A-1 (AMEND) (DISTRICT VI) RESOLVED**, that as soon as feasible, but not beyond 2026, a designated dental assistant (DA), registered dental assistant (RDA), registered dental hygienist (RDH), emergency medical technician (EMT), licensed practical or vocational nurse (LPN/LVN), registered nurse (RN), or similarly qualified person participating in OMS office-based moderate sedation, deep sedation and/or general anesthesia be encouraged to be certified by an AAOMS-approved Oral and Maxillofacial Surgery Anesthesia Assistant (OMSAA) certification process for any and all office settings that the AAOMS follows and members participate in the delivery of office-based anesthesia.
- Many practical concerns have come to light as voiced by our AAOMS members and our staff. Therefore, the Board of Trustees discussed **delaying implementation** of the mock drills and anesthesia survey membership

requirements until **2026** to allow the Association the opportunity to work through the details. This would also align with other anesthesia implementation requirements. As a result, the following resolution **B-2 (Amend) (District VI) (Amend) (BOT) (Amend) (RC)** was passed:

- **RESOLUTION B-2 (Amend) (District VI) (Amend) (BOT) (Amend) (RC) RESOLVED**, that an attestation of mandatory quarterly team mock emergency drills defined in the OAE manual or equivalent (done at every OMS practice location) be completed and verified during the scheduled Office Anesthesia Evaluation, or state equivalent, beginning in 2023 and/or reported through the AAOMS Anesthesia web application, beginning in 2026. This shall apply to for any and all office settings that the AAOMS fellows and members participate in the delivery of office-based anesthesia and be it further, **RESOLVED**, that Resolution 20-B-6 (Amend) (RC) be rescinded.
- Additionally, **RESOLUTION B-3 RESOLVED**, that the anesthesia survey be completed and verified during the scheduled Office Anesthesia Evaluation and/or reported through the AAOMS Anesthesia web application, **beginning in 2026**.

**Advocacy**

- **AAOMS Members are encouraged to download the Voter Voice app.** This easily downloaded app allows all AAOMS members to easily communicate with their legislators, with the help of AAOMS developed letters when necessary for AAOMS advocacy. Multiple grassroots campaigns are available on AAOMS’s federal priority issues, and several states have taken advantage of our ability to assist them with their grassroots efforts.
- The State Legislative Tracking Map on the AAOMS website provides quick access to the status of all issues impacting OMS. Access at AAOMS.org/TrackingMap.
- We continue to **monitor a wide range of issues** being introduced at the **state level** that would impact the specialty. **Areas of focus continue to be anesthesia, insurance, and auxiliary personnel.** Activity has been robust as states rebound from the pandemic.
- The Medicare provider community is increasing advocacy efforts to urge Congress to take action to prevent the Medicare provider cuts scheduled to take place Jan. 1, 2023. AAOMS signed onto a coalition **letter**, organized by the American College of Radiology, in support of HR 8800, the Supporting Medicare Providers Act

of 2022. The recently introduced legislation would increase payments to Medicare providers by 4.42 percent in 2023, partially offsetting a 4.5 percent cut CMS has proposed to take effect next year via the Medicare Physician Fee Schedule. Provider groups also are urging Congress to stop separate 4 percent cuts that are slated to take effect Jan. 1, 2023, due to budget deficit reduction requirements.

- AAOMS has been monitoring congressional and regulatory efforts to expand Medicare coverage for **medically necessary dental procedures**. In June, over 130 members of the House and Senate sent a letter to CMS urging the agency to expand and better define medically necessary dental procedures, while CMS – as part of their 2023 Medicare physician fee schedule proposed rule - proposes to cover dental exams and infection management for patients needing transplants and heart valve replacement, which AAOMS has supported. The agency also is seeking comment on other clinical scenarios for which coverage of dental procedures might be integral to the success of other Medicare covered medical conditions. AAOMS will be developing comments in response to the proposed rule.
- AAOMS continues to collaborate with the ADA and AAPD to develop a HCPCS level II code proposal to represent dental services rendered in the facility setting in efforts to improve low facility rates and access to hospitals and ASCs for dental procedures requiring general anesthesia at hospitals and ASCs. The coalition has met with CMS on several occasions over the last year, submitted testimony to the House Ways and Means and has initiated a grassroots campaign. On July 15, CMS released the proposed 2023 OPPS/ASC rule which appears to reassign CPT code 41889 from APC 5161 (with a mean cost of \$203.64) to APC 5871 (with a mean cost of \$1,958.92). Health Policy, Reimbursement and Coding staff and CHPCR will analyze this further to propose comment within the 60-day comment period, but, on its face, this appears to be a victory for improved facility fees and accordingly, access.
- AAOMS continues to monitor the recently enacted **No Surprises Act** and its impact on OMS. AAOMS has written several summaries, including a series of FAQs, which are posted on aaoms.org, printed multiple articles focusing on the Act in the AAOMS Today and Advocacy E-Newsletter, hosted a webinar presented by an attorney from New Jersey (*Tom Force*), and submitted comments related to various aspects of the law, highlighting the unique challenges many of the provisions represent for OMSs.

**JOMS**

- The new JOMS Editor-in-Chief, effective in 2022, is Dr. Thomas Dodson (University of Washington) and Dr. Tara Aghaloo (UCLA) is the new Associate Editor. In addition to a new Guide for Authors and cover design, Dr. Dodson has initiated an annual David Stanton Resident Research Award that will recognize the top article with a major resident contribution.

**Informational Campaign**

- **MyOMS.org** has been redesigned to feature more graphics/videos, increase search engine optimization, and be responsive on mobile devices.
- **More than 100 videos and 18 infographics** have been added to the MyOMS.org website and are available for members to download and use on their practice sites.
- **WebMD** includes an **AAOMS page** that continues to generate about 1/3 of the monthly referral traffic to the MyOMS website.
- AAOMS continues to get a lot of free advertising from the earlier **four TV Public Service Announcements** – two on oral cancer, one on OSA and one on wisdom teeth (with a cumulative equivalent ad dollar value of more than **\$28 million**); 2 radio PSAs have generated more than 72,000 broadcast reports with an equivalent ad dollar value of more than **\$4.5 million**. AAOMS distributed **three new PSAs in 2022** focusing on wisdom teeth, dental implants, and facial protection.

**OMS Foundation Communications:**

- The 2021 Annual Report is online at OMSFoundation.org

**Programs:**

- As travel restrictions ease, **GIVE** is again accepting applications from OMS residents and host humanitarian teams. Learn more and apply at OMSFoundation.org/GIVE

**Fundraising:**

- Mid-year appeal raised \$103,600 with support from a \$35,000 gift match from USOSM

- 161 OMSFIRE donors are collectively contributing \$600,000+ each year
- 18 Societies are OMSFIRE donors. New in 2022: NJ, VA, TX, IN

**Recognition**

■ **Thank you to donors** – Visit OMSFIRE.org and OMSFoundation.org to view names of their donors. You can also learn more about your political action committee (PAC) that advocates for the specialty and its patients and the OMS Foundation that advances the specialty through supporting research and education. Thank you to all those who have contributed and supported us all as a specialty.

Sincerely,



W. Frederick Stephens, DDS  
District VI Trustee  
Email: dr.wfstephens@gmail.com

**CALAOMS 2023 Board of Directors**

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## Actions of the 2022 AAOMS House of Delegates



**T**he 2022 AAOMS House of Delegates considered, voted on, and passed several resolutions that directly affect AAOMS members and fellows. Please read each of the resolutions carefully, as all AAOMS members and fellows are included in these resolutions.

The 2022 AAOMS House of Delegates convened in-person in New Orleans, LA, September 12-14, 2022. Several important resolutions dealing with AAOMS membership were considered and voted on. Resolutions that were **adopted** (passed) include:

### RESOLUTION 22-A-1 (Amend (District VI))

RESOLVED, that as soon as feasible, but not beyond 2026, a designated dental assistant (DA), registered dental assistant (RDA), registered dental hygienist (RDH), emergency medical technician (EMT), licensed practical or vocational nurse (LPN/LVN), registered nurse (RN), or similarly qualified person participating in OMS office-based moderate sedation, deep sedation and/or general anesthesia be encouraged to be certified by an AAOMS-approved Oral and Maxillofacial Surgery Anesthesia Assistant (OMSAA) certification process for any and all office settings that the AAOMS fellows and members participate in the delivery of office-based anesthesia.

### RESOLUTION 22-A-2 (District VI) (Amend) (BOT)

RESOLVED, AAOMS identify programs and resources to assist membership with issues of personnel and practice safety and share with the membership the availability and location of these resources.

### RESOLUTION 22-A-3 (District III) (Amend) (RC) (Amend) (District III)

RESOLVED, that the Pledge of the Association be recited by AAOMS Fellows and Members at the Opening Ceremony beginning in 2023, and that the Pledge appear in written

form in AAOMS Today as soon as feasible, and be it further resolved the Board of Trustees or appropriate committee develop strategies to promote the Pledge of the Association to our members and public with a report back to the 2023 House of Delegates.

### RESOLUTION 22-B-1

RESOLVED, that the Association rename the OMS Institute for Education and Innovation to the Daniel M. Laskin Institute for OMS Education and Innovation, to allow for recognition by generations of OMSs for years to come, with formal announcement during the 2022 AAOMS Annual Meeting Awards Ceremony

### RESOLUTION 22-B-2 (Amend) (District VI) (Amend) (BOT) (Amend) (RC) (Amend)

RESOLVED, that an attestation of mandatory quarterly team mock emergency drills defined in the OAE manual or equivalent be completed and documented and available for review during the scheduled Office Anesthesia Evaluation, or state equivalent, beginning in 2023 and reported through the AAOMS Anesthesia web application, beginning in 2026. This shall apply to any and all office settings that the AAOMS fellows and members participate in the delivery of office-based anesthesia and be it further

RESOLVED, that Resolution 20-B-6 (Amend) (RC) be rescinded.

[*RESCINDED* Resolution 20-B-6 (Amend) (RC)]

RESOLVED, that an attestation of mandatory quarterly team mock emergency drills defined in the OAE manual or equivalent (done at every OMS practice location) be completed through “checking a box” on the annual dues statement and through a log reviewed at the scheduled OAE, beginning in 2022. [*RESCINDED*]

### RESOLUTION 22-B-3

RESOLVED, that the anesthesia survey be completed and verified during the scheduled Office Anesthesia Evaluation and/or reported through the AAOMS Anesthesia web application, beginning in 2026.

### RESOLUTION 22-B-4

RESOLVED, that a special committee of the House of Delegates comprised of the District Caucus Chairs and Secretaries with the Speaker of the House of Delegates serving as Chair be established to review volunteer and engagement opportunities to address delegate, alternate delegate and leadership positions within the Association.

### RESOLUTION 22-B-5 (Amend) (BOT)

RESOLVED, that the amended or added policies as approved by the Board during the period Oct. 2021 through August 2022, as reflected in Appendix B of the 2022 Supplementary Report of the Board of Trustees, be approved.

### RESOLUTION 22-B-6

RESOLVED, to accept an operational budget with revenues of \$23,151,189 and expenses of \$23,121,148.

### RESOLUTION 22-B-7

RESOLVED, that *Chapter XII, Finances, Section 20. Dues and Assessments*, of the Bylaws be amended as follows with all conflicting bylaws, policies, etc. amended accordingly (strikethrough = deletion; bold underline = addition):

Dues of fellows and members shall be ~~\$1,550; dues of affiliate members shall be \$422; and dues of allied staff members shall be \$55 due January 1 for the ensuing year.~~ **established by the Board of Trustees with approval by the House of Delegates. Dues and assessments shall be due no later than January 1 of the ensuing year. Individual member exceptions** Exception to this shall be at the discretion of the Board of Trustees **upon recommendation by the Committee on Membership** in accordance with policy. (~~Oct. 18~~ **Sept. 22**)

**To keep pace with inflation, the amount of the annual dues can be increased each year by the average of the five prior years' U.S. Consumer Price Index-Urban (CPI-U) percent changes at the discretion of the Board of Trustees (“CPI escalation”) limited to a maximum of 3%. This change will be considered during budget development and approved by the House of Delegates in conjunction with review of the Association’s budget.**

**Assessments or changes to the** The amount of annual dues or assessments, **in excess of the CPI escalation**, shall be recommended to the House of Delegates by the Board of Trustees and shall be fixed by the House of Delegates by a two-thirds (2/3) affirmative vote of the delegates present and voting with a 60-day prior notice.

### RESOLUTION 22-B-8 (RC)

RESOLVED, that *Chapter XX, Amendment to Bylaws, Section 30.*, of the Bylaws be amended as follows with all conflicting bylaws, policies, etc. amended accordingly (strikethrough = deletion; bold underline = addition):

#### *Section 30. Special Notice*

~~Dues and Assessments:~~ Amendments to the Bylaws, which would ~~change the amount of dues or impose an~~ assessments for fellows, members and affiliate members, must have been submitted in writing to the House of Delegates 60 days prior

to the annual meeting or special meeting of the House of Delegates.

### RESOLUTION 22-B-9 (RC)

RESOLVED, that *Chapter V, Standing Rules of Procedure of the House of Delegates*, of the *Manual of the House of Delegates* be amended as follows with all conflicting bylaws, policies, etc. amended accordingly (strikethrough = deletion; bold underline = addition):

#### *V. Standing Rules of Procedure of the House of Delegates*

##### *E. Reading of Reports to the House of Delegates and Special Rules of Debate*

*7. Previous Notice and First Reading:* Resolutions to amend the Bylaws that affect ~~dues and~~ assessments (~~DA amendments~~) or membership qualifications (MQ amendments) require a 60-day notice or a one-year previous notice, respectively, and are submitted in writing to the House of Delegates, sometimes using the term “first reading”. ~~DA~~ **Assessment** and MQ amendments usually are referred to the Board of Trustees, or to the appropriate committee, for study and recommendations to be presented at the next annual meeting. Adoption by the House of Delegates at the next annual meeting requires a two-thirds vote.

In special cases, the House may wish to consider and adopt an **amendment** ~~DA~~ or MQ amendment during the same annual meeting at which it is introduced. A unanimous vote is required for waiver of the special 60-day or one-year notice. Following waiver of notice, a two-thirds vote is required for adoption of the amendment.

The House may also wish to oppose an **assessment** ~~DA~~ or MQ amendment at the first reading stage during the same annual meeting at which it is introduced. Since the rights to introduce a motion and to give notice are basic rights of the membership in a deliberative assembly, a two-thirds vote shall be required to reject an **assessment** ~~DA~~ or MQ amendment at the first reading stage. In addition, the sponsor(s) of the **assessment** ~~DA~~ or MQ amendment may request that the resolution be withdrawn, which can be granted by general consent or by a majority vote.



**CONTINUED FROM PAGE 1**

prevention of infectious complications by administering an effective antimicrobial agent *prior to* exposure to contamination during surgery.<sup>(4)</sup>

*Why should we consider antibiotic prophylaxis for every dental implant procedure that we perform?*

Bacterial colonization of the implant surface and surgical site infection have been implicated in early implant failure.<sup>(5)</sup> Implant failures will occur, but anything that can be done to minimize this risk is something that each clinician should consider. In 2015, the European Academy of Osseointegration published a summary and consensus statement on this topic. They concluded that in “straightforward” cases, antibiotic prophylaxis has not been shown to have a beneficial effect; and in “complex” cases (i.e., grafting, immediate implant placement, and/or a medically compromised patient), a beneficial effect of antibiotic prophylaxis cannot be excluded.<sup>(6)</sup>

In 2008, Abu-Ta performed a prospective, randomized, controlled clinical trial where patients were premedicated with 1 gram of amoxicillin and 500 mg of amoxicillin four times daily for two days post-op. He demonstrated that antibiotics do not provide significant advantages concerning postoperative infections where proper asepsis was maintained. The incidence of implant failure was 4%.<sup>(7)</sup> An older study by Gynther reported no significant difference with incidence of infections when comparing 790 implants with an antibiotic prophylaxis versus no antibiotic prophylaxis. He concluded that antibiotic prophylaxis for routine dental implant surgery offers no advantage for the patient.<sup>(8)</sup>

In contrast, Nolan performed a double-blind, random, controlled clinical trial where he found an 18% increase in implant survival with patients being pre-medicated with 3 grams of amoxicillin and no postoperative antibiotics. The incidence of implant failure was 17.8%.<sup>(9)</sup>

Esposito has probably published the most on this topic. He performed two multicenter, placebo-controlled, randomized clinical trials and completed a Cochrane Database meta-analysis review. In both of his randomized clinical trials, he found no statistical difference comparing an antibiotic premedication versus a placebo. All the patients performed a preoperative rinse with chlorhexidine and additionally took 2 grams of amoxicillin one hour prior to the procedure. No postoperative antibiotics were given, but patients were asked to continue with chlorhexidine rinses for one week postoperatively. The control group performed a preoperative rinse with chlorhexidine and continued postoperatively for one week also. The first trial had a total of 330 patients, and the second trial was performed because the author felt a larger sample

size was needed. The second trial had a total of 706 patients and the protocol followed was the same. The results for both demonstrated no statistical difference, but both displayed 2-4 times the number of implant failures in the group without the antibiotic prophylaxis. The incidence of implant failure for both articles was 5.1% and 4.7%, respectively.<sup>(10,11)</sup>

Esposito further performed a meta-analysis and published the results in the Cochrane Database of systematic reviews. In this review, he stated that scientific evidence suggests, in general, that antibiotics are beneficial for reducing failure of dental implants placed in ordinary conditions. Specifically, 2 or 3 grams of amoxicillin given orally - as a single administration - one hour preoperatively significantly reduces failure of dental implants. No significant adverse events were reported. It might be sensible to suggest the use of a single dose of 2 grams prophylactic amoxicillin prior to dental implant placement. It is still unknown whether postoperative antibiotics are beneficial, and which antibiotic is the most effective.<sup>(12)</sup> Two recent meta-analyses also showed a reduction in failed implants. Cannullo showed a 5.4% reduction in failed implants and Sanchez showed a 1.9% reduction.<sup>(13,14)</sup>

In what is now an older study, Dent performed a comprehensive, prospective, multidisciplinary study evaluating many implants (2,641). None of these patients in the study used a pre- or postoperative chlorhexidine mouth rinse. They had 2.6% failure *without* antibiotics and 1.3% *with* antibiotics. Dent's analysis revealed a higher implant failure rate when antibiotics were not given.<sup>(15)</sup> In all the previous studies<sup>(7,9,10,11,12)</sup>, all patients underwent a pre- and/or post-operative chlorhexidine rinse, potentially leading to more favorable outcomes as related to the incidence of postoperative infections. Veklsler showed that the salivary bacterial load was reduced by 97% when patients rinsed with chlorhexidine for 30 seconds, expectorated, and then rinsed again with chlorhexidine for an additional 30 seconds. This reduction in bacterial loads persisted for 60 minutes.<sup>(16)</sup> To me, this makes the Dent study even more accurate since his patients did not rinse with the chlorhexidine and this could potentially have changed the environment.

If implant surgeons choose to antibiotic prophylax for the implant surgical procedures, then choosing an antibiotic that will be effective against the most common bacteria is very important. These bacteria include aerobic streptococci, anaerobic gram-positive cocci, and anaerobic gram-negative rods.<sup>(9)</sup> Taking this into consideration, penicillin is the first choice of antimicrobial for prophylaxis in dental implant surgery.<sup>(17)</sup> There are no clear guidelines on the correct choice of antibiotic, dosage, or duration.<sup>(9)</sup>

*What is the best antibiotic for premedication for implant placement?*

Our medical colleagues note that surgical antibiotic prophylaxis is very well documented and there does not appear to be any confusion in terms of protocols. Our local hospital has an established protocol based on an algorithm developed by MD Anderson at the University of Texas. For head and neck surgeries, if the surgical site is considered *clean*, then patients are given 2 grams of IV cefazolin for patients weighing < 120 kg, and 3 grams if patients weigh > 120 kg. For *clean contaminated* surgical sites, the protocol is IV ampicillin and sulbactam 3 grams.<sup>(18)</sup> Most of the studies<sup>(7,9,10,11,12)</sup> have used amoxicillin for the antibiotic of choice based on the microbacteria involved with dental implant surgery; but Lindeboom compared 2 grams of penicillin to 600 mg of clindamycin as a single preoperative dose in patients treated with block grafts without implant placement. He found no statistical differences in postoperative infections between these two antibiotics.<sup>(19)</sup> Most surgical antibiotic prophylaxis regimens are based on the American Heart Association guidelines for the prevention of bacterial endocarditis.<sup>(9)</sup> Amoxicillin appears to be the antibiotic of choice.<sup>(7,9,10,11,12)</sup>

*If we decide to premedicate with antibiotics, what is the best surgical protocol?*

Deeb surveyed the American Association of Oral and Maxillofacial Surgeons in 2015 on the use of routine antibiotic prophylaxis in conjunction with dental implant placement. The results of the survey showed 25 different preoperative antibiotic regimens. The most common was 2 grams of amoxicillin preoperatively and no postoperative antibiotics. There were no recommendations for a specific antibiotic or protocol, but he suggested the need for a large-scale randomized controlled trial.<sup>(20)</sup> A similar survey was performed in the United Kingdom, and it showed similar results. There was no consensus on a set choice of antibiotic prophylaxis for routine implant placement. Interestingly, in that survey, more than 21% of the respondents said they prescribed antibiotics for routine dental implant procedures because of fear of litigation.<sup>(21)</sup>

As stated above, most surgical prophylaxis regimens for dental implant placement are based on the American Heart Association (AHA) guidelines for the prevention of bacterial endocarditis. In 1955, the AHA developed its first protocol for patients with bacterial endocarditis undergoing dental procedures. At that time, the recommendation was for patients with congenital or rheumatic heart disease to receive 600,000 IU of penicillin intramuscularly if undergoing dental extractions and then oral penicillin for five days postoperatively.<sup>(22)</sup> Over the years, there have been many updates to

this protocol, including the change in 1990 from penicillin to amoxicillin due to its more favorable pharmacokinetic and pharmacodynamic characteristics.<sup>(23)</sup> In 1998, the AHA changed their recommendations for perioperative endocarditis prophylaxis. They still included a preoperative dose of amoxicillin but eliminated the postoperative dose.<sup>(23)</sup>

In 2006, Fonseca followed 12,299 patients during their hospital stays for surgical site infections. All types of surgeries were included. 6,140 patients received only one dose of cefazolin while the other 6,159 had multiple doses of antibiotics. The researchers found that the rate of surgical site infections went from 2% to 2.1%, which was not statistically significant. They concluded that by only using a single dose antibiotic there was no change in the incidence of surgical site infections and that it saved the hospital an average of \$1,980 per day.<sup>(24)</sup>

The old saying that “less is more” may be prudent for antibiotic prophylaxis for dental implant therapy also. Based on the studies cited in this article, the most common protocol was amoxicillin 2 grams one hour prior to the procedure with no postoperative antibiotic dosing.<sup>(7,9,10,11,12)</sup>

In May 2021, the AHA most recently updated their SBE prophylaxis for dental procedures (Table 1). Amoxicillin is still the recommended antibiotic of choice; but if the patient is allergic to penicillin, then the new recommendations are to use cephalexin 2 grams PO, azithromycin 500 mg PO, or doxycycline 100 mg PO 30-60 minutes prior to the procedure as an alternative. They have *removed* clindamycin as a recommendation for someone who is allergic to penicillin.<sup>(25)</sup>

*Colitis and Anaphylaxis*

As with all medications – both prescription and over the counter – there are inherent risks. Risks associated with antibiotics are usually minor, and include nausea, vomiting, diarrhea, and urticaria; but more serious adverse events can also occur, including antibiotic-associated (pseudomembranous) colitis and potentially fatal anaphylaxis. The incidence of antibiotic-associated diarrhea ranges from 5% to 39%, and pseudomembranous colitis complicates approximately 10% of the cases of antibiotic-associated diarrhea.<sup>(26)</sup> Antibiotics such as clindamycin and second or third generation cephalosporins are most consistently implicated with pseudomembranous colitis.<sup>(27)</sup>

In 2003, a study by Rao was performed comparing the incidence of *Clostridium difficile* antibiotic-related diarrhea in hospitalized patients taking levofloxacin versus amoxicillin. There was no significant difference between levofloxacin and



amoxicillin groups in the incidence of Clostridium difficile antibiotic-related diarrhea.<sup>(28)</sup>

There are approximately 29,000 deaths per year in the U.S. due to pseudomembranous colitis.<sup>(29)</sup> The current population of the United States is 332 million, so the annual incidence of mortality from pseudomembranous colitis is approximately 0.008%.

Life-threatening anaphylaxis is always a concern with any antibiotic administration. Anaphylaxis accounts for 500 deaths in the U.S. per year and drug allergy is the most common cause.<sup>(28)</sup> The estimated incidence of allergy to amoxicillin ranges from 1-10%. These ranges cannot be interrupted with full confidence since not all allergic reactions are properly diagnosed.<sup>(30)</sup> The risk of fatal anaphylaxis with amoxicillin is not well documented, but the risk of fatal anaphylaxis with penicillin is estimated to be 1:100,000 or 0.001% per year in the U.S.<sup>(31)</sup>

**Conclusion**

There are many risks associated with antibiotic prophylaxis and we as healthcare professionals must ensure that the

benefit of preventing complications outweighs the risk related to an abundant prescribing of antibiotics. When we decide to premedicate with antibiotics for routine dental implant placement, we all must answer the question of, “What is the likelihood of my patient having an adverse allergic/possible anaphylactic reaction versus my implant failing?” (Figures 1 and 2).

When evaluating the incidence of both concerns, the percentages are thankfully very low. Albrektsson performed a retrospective study in 2016 on 10,906 implants and revealed an early failure rate of 6.36%.<sup>(32)</sup> The early implant failure rate in the articles cited in this review are 4%, 4.7%, 5.1%, and 6.36%, respectively.<sup>(7,10,11,30)</sup> The incidence of fatal antibiotic anaphylaxis is 0.001% for penicillin.

As surgical specialists, we must make difficult decisions for our patients every day based on the risk-benefit ratio. Each surgeon is entitled to his/her own opinion, of course, but based on the research and data presented here, the risks of premeditating for routine dental implants outweighs the risks of losing a dental implant without antibiotic prophylaxis.

Table 1. Antibiotic Regimens for Dental Implant Surgeries: Single Dose 30 to 60 Minutes Before Procedure

Situation	Agent	Adults	Children
Oral	Amoxicillin	2 g	50 mg/kg
Unable to take oral medication	Ampicillin OR Cefazolin or Ceftriaxone	2 g IM or IV	50 mg/kg IM or IV
		1 g IM or IV	50 mg/kg IM or IV
Allergic to Penicillin or Ampicillin - Oral	Cephalexin* OR Azithromycin OR Clarithromycin OR	2 g	50 mg/kg
		500 mg	15 mg/kg
	Doxycycline	100 mg	< 45 kg, 4.4 mg/kg > 45 kg, 100 mg
Allergic to Penicillin or Ampicillin and unable to take oral medication	Cefazolin or Ceftriaxone†	1 g IM or IV	50 mg/kg IM or IV

\*Clindamycin is no longer recommended for antibiotic prophylaxis for a dental procedure.

IM: intramuscular.

IV: intravenous.

\*Or other first- or second-generation oral Cephalosporin in equivalent adult or pediatric dosing.

†Cephalosporins should not be used in an individual with a history of anaphylaxis, angioedema, or urticaria with Penicillin or Ampicillin.



Figure 1. Pediatric patient with severe allergic reaction including urticaria and angioedema.

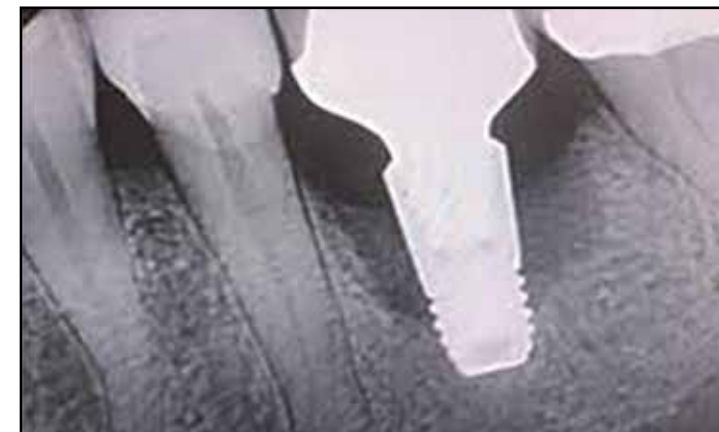


Figure 2. Peri-implantitis and circumferential horizontal and vertical bone loss around failing left mandibular first molar implant.

**References**

- de Lissovoy G, Fraeman K, Hutchins V, et al. Surgical site infection: incidence and impact on hospital utilization and treatment costs. Am J Infect Control. 2009;37(5):387-397.
- Anderson DJ, Chen LF, Sexton DJ, et al. Complex surgical site infections and the devilish details of risk adjustment: important implications for public reporting. Infect Control Hosp Epidemiol. 2008;29(10):941-6.
- Barie PS. Surgical site infections: epidemiology and prevention. Surg Infect (Larchmt). 2009;3 Suppl 1:S9-21. Hranjec T, Swenson BR, Sawyer RG. Surgical Site Infection Prevention: How We Do It. Surg Infect (Larchmt). 2010;11(3):289-294.
- Hranjec T, Swenson BR, Sawyer RG. Surgical Site Infection Prevention: How We Do It. Surg Infect (Larchmt). 2010;11(3):289-294.
- Sharaf B, Dodson TB. Does the use of prophylactic antibiotics decrease implant failure? Oral Maxillofac Surg Clin North Am.

2011;23(4):547-50.

- Klinge B, Flemming T, Cosyn J, et al. The patient undergoing implant therapy. Summary and consensus statements. The 4th EAO Consensus Conference 2015. Clin Oral Implants Res. 2015;26 Suppl 11:64-7.
- Abu-Ta'a M, Quirynen M, Teughels W, et al. Asepsis during periodontal surgery involving oral implants and the usefulness of peri-operative antibiotics: a prospective, randomized, controlled clinical trial. J Clin Periodontol. 2008;35(1):58-63.
- Gynther GW, Köndell PA, Moberg LE, et al. Dental implant installation without antibiotic prophylaxis. Oral Surg Oral Med Oral Pathol Oral Radiol Endod. 1998;85(5):509-11.
- Nolan R, Kemmoona M, Polyzois I, et al. The influence of prophylactic antibiotic administration on post-operative morbidity in dental implant surgery. A prospective double blind randomized controlled clinical trial. Clin Oral Implants Res. 2014;25(2):252-9.
- Esposito M, Cannizzaro G, Bozzoli P, et al. Efficacy of prophylactic antibiotics for dental implants: a multicentre placebo-controlled randomised clinical trial. Eur J Oral Implantol. 2008;1(1):23-31.
- Esposito M, Cannizzaro G, Bozzoli P, et al. Effectiveness of prophylactic antibiotics at placement of dental implants: a pragmatic multicentre placebo-controlled randomised clinical trial. Eur J Oral Implantol. 2010;3(2):135-43.
- Esposito M, Grusovin MG, Worthington HV. Interventions for replacing missing teeth: antibiotics at dental implant placement to prevent complications. Cochrane Database Syst Rev. 2013(7):CD004152.
- Canullo L, Troiano G, Sbricoli L, et al. The Use of Antibiotics in Implant Therapy: A Systematic Review and Meta-Analysis with Trial Sequential Analysis on Early Implant Failure. Int J Oral Maxillofac Implants. 2020;35(3):485-494.
- Sanchez FR, Andres CR, Arteagoitia I. Which antibiotic regimen prevents implant failure or infection after dental implant surgery? A systematic review and meta-analysis. J Cranio Maxillofac Surg. 2018;46:722-36.
- Dent CD, Olson JW, Farish SE, et al. The influence of preoperative antibiotics on success of endosseous implants up to and including stage II surgery: a study of 2,641 implants. J Oral Maxillofac Surg. 1997;55(12 Suppl 5):19-24.
- Veksler AE, Kayrouz GA, Newman MG. Reduction of Salivary Bacteria by Pre-Operational Rinses With Chlorhexidine 0.12%. J Periodontol. 1991;62(11):649-51.
- Peterson LJ. Antibiotic prophylaxis against wound infections in oral and maxillofacial surgery. J Oral Maxillofac Surg. 1990;48(6):617-20.
- Surgical Antibiotic Prophylaxis. University of Texas MD Anderson Executive Committee Medical Staff 2018.



## Mandated course in opioid prescribing among C.E. changes for dentists in 2023



*CDA course ‘Opioid Prescribing for Dentists’ will satisfy C.E. requirement pending Dental Board approval*

### Quick Summary:

Dentists will be required to successfully complete 2 units of C.E. on opioid prescribing as a condition to renewing a license with the Dental Board of California beginning in January 2023. A course created by Western University of Health Sciences in partnership with CDA will satisfy the C.E. requirement pending Dental Board approval. Other C.E. changes effective Jan. 1, 2023, include a new board-approved provider for the required course in basic life support and limited credit offered for providing direct patient care as an unpaid volunteer in specified settings.

Changes in continuing education regulations are coming for California dentists beginning January 1, 2023, including mandated C.E. that covers the responsibilities and requirements of prescribing **Schedule II opioid drugs**.

Dentists will be required to successfully complete 2 units of C.E. on opioid prescribing as a condition to renewing a license with the Dental Board of California. The new mandatory course is in addition to the courses in basic life support, California infection control, and the California Dental Practice Act that are already **required for license renewal**.

A course created by Western University of Health Sciences in partnership with CDA will satisfy the C.E. requirement pending approval by the Dental Board. Dentists will have other eligible courses to choose from.

### New approved course provider for required BLS course

Other changes in C.E. that will take effect Jan. 1, 2023, are:

- A basic life support course taught by a provider approved by the American Safety and Health Institute will meet the dental board’s requirement for the BLS course.
- Professional ethics will be included in the required content of a board-approved Dental Practice Act course.
- Limited credit — up to 3 units — will be permitted for providing direct patient care as an unpaid volunteer at specified settings.
- The required units of C.E. for license renewal for retired dentists who are only in uncompensated practice will be reduced to 30 units.

### Discounted opioid prescribing course for CDA members

California dentists can take **“Opioid Prescribing for Dentists: Pain Management, Addiction and Prescribing”** to satisfy the new C.E. requirement for license renewal. Created by Western University of Health Sciences in partnership with CDA, the course is eligible for 2 units of C.E. and is available to CDA members at a significantly discounted price as a benefit of membership.

The unique and engaging course format follows six fictional patients at a fictional dental practice over the course of a day. Through these six patient consultations, course attendees learn about the very different patient presentations they may encounter in their practice. The course ends with the dentists highlighting key points from the consultations.

Specifically, participants will learn:

- How to manage acute and chronic pain in the dental setting.
- The risks and identification of opioid use disorder.
- The practices and legal requirements for opioid prescribing and dispensing.

**Register through CDA Presents Online Learning** for “Opioid Prescribing for Dentists: Pain Management, Addiction and Prescribing.”

CDA members can also log in to their account to view CDA’s **Continuing Education Requirements and FAQ** for general rules related to C.E., how to ensure courses are eligible for C.E. credit and more information.



## Pay scale must be included in job postings by California employers with 15 or more employees



**Law takes effect January 1, 2023; also requires employers to maintain records of job title and wage rate history for all employees**

### Quick Summary:

California employers with 15 or more employees will be required beginning Jan. 1, 2023, to (1) disclose a position’s pay scale in any job posting or advertisement and (2) provide the pay scale to any third party used by the employer to announce, post, publish or otherwise advertise a job. The third party in turn will be required to include the pay scale in the job posting. Also under the new law, employers with 15 or more employees are required to provide to an employee, upon the employee’s request, the pay scale for the position in which the employee is currently employed.

A new state law will increase wage transparency for California job applicants and current employees beginning Jan. 1, 2023,

with resulting new job-posting, pay scale disclosure and records-maintenance requirements for covered employers.

Senate Bill 1162, signed into law in late September by Gov. Gavin Newsom, increases wage transparency in several ways. Few California dentists will be impacted by the revised annual pay data reporting requirement because it applies only to employers with 100 or more employees, but California dentists of all sizes should read continue reading to determine whether they must comply with three of the bill’s additional requirements beginning Jan. 1.

### Pay scale for positions must be included in all job postings

California employers of all sizes are already required under a state law that took effect in 2019 to provide a position’s pay scale to any applicant who is applying for that position upon the applicant’s “reasonable request.” Pay scale, as defined by existing law and SB 1162, means the salary or hourly wage range that the employer reasonably expects to pay for the position.

That requirement will continue, but the requirements of SB 1162 are intended to further ensure that employers do not rely on an applicant’s salary history information when determining whether to offer employment to an applicant or what salary to offer.

Effective Jan. 1, SB 1162 will require employers with 15 or more employees to:

- Disclose a position’s pay scale in any job posting or advertisement.
- Provide the pay scale to any third party used by the employer to announce, post, publish or otherwise advertise a job. The third party in turn will be required to include the pay scale in the job posting.

Companies that are based outside of California and hire for positions or work to be done in California will be required to disclose pay scales in job postings in compliance with the new law.

### Law increases wage transparency for currently employed

Also under the new law, employers with 15 or more employees are required to provide to an employee, upon the employee’s request, the pay scale for the position in which the employee is currently employed.

## Maintenance of job title, wage rate history required

Employers of all sizes will be required to maintain job title and wage rate history records for all their employees for the duration of the employment plus three years after the end of the employment.

The Labor Commissioner is authorized to inspect the employer's records, and the specified time frame allows the Labor Commissioner to determine if a pattern of wage discrepancy exists.

## Employers can be ordered to pay civil penalty between \$100 and \$10,000 per violation

An individual can file a written complaint with the Labor Commissioner alleging an employer has violated the pay-scale disclosure requirements within one year of learning about the violation.

The Labor Commissioner is required under the law to "promptly investigate" such complaints and, if a violation is found, can order the employer to pay a civil penalty of between \$100 and \$10,000 per violation with exception of a first-time violation if the employer demonstrates that all job postings for open positions have been updated to include the required pay scales.

Individuals themselves can also bring a civil action against the employer for appropriate relief.

## Revised pay data reporting requirements for large employers

SB 1162 also revises existing state law that requires employers with 100 or more employees to submit their annual pay data report known as the "Employer Information Report EEO-1." Most significantly, the bill changes the employer's reporting deadline. Private employers of 100 or more employees must submit their report by the second Wednesday of May beginning in 2023 and on or before the second Wednesday of each May thereafter.

The report must include specific data. Covered dentists can find [more details in a recent SHRM article](#) or in the [text of the bill \(Section 1\)](#).



## CONTINUED FROM PAGE 17

19. Lindeboom JAH, Tuk JGC, Kroon FHM, et al. A randomized prospective controlled trial of antibiotic prophylaxis in intra-oral bone grafting procedures: single-dose clindamycin versus 24-hour clindamycin prophylaxis. *Mund Kiefer Gesichtschir.* 2005;9(6):384-8.
20. Deeb GR, Soung GY, Best AM, et al. Antibiotic Prescribing Habits of Oral and Maxillofacial Surgeons in Conjunction With Routine Dental Implant Placement. *J Oral Maxillofac Surg.* 2015;73(10):1926-31.
21. Williams R. Antibiotic prophylaxis during dental implant placement in the UK. *Br Dent J.* 2020;229:787-92.
22. Tomás I, Álvarez-Fernández M. (2013). History of Antimicrobial Prophylaxis Protocols for Infective Endocarditis Secondary to Dental Procedures. In (Ed.), *Recent Advances in Infective Endocarditis.* IntechOpen.
23. Taubert KA, Dajani AS. Preventing Bacterial Endocarditis: American Heart Association Guidelines. *Am Fam Physician.* 1998;57(3):457-468.
24. Fonseca SNS, Kunzle SRM, Junqueira MJ, et al. Implementing 1-dose antibiotic prophylaxis for prevention of surgical site infection. *Arch Surg.* 2006;141(11):1109-13.
25. Wilson WR, Gewitz M, Lockhart PB, et al. Prevention of Viridans Group Streptococcal Infective Endocarditis: A Scientific Statement From the American Heart Association. *Circulation.* 2021;143(20):963-978.
26. Yasim SF. Pseudomembranous Colitis Surgery. 2021. <https://emedicine.medscape.com/article/193031>
27. McFarland LV, Surawicz CM, Stamm WE. Risk factors for Clostridium difficile carriage and C. difficile-associated diarrhea in a cohort of hospitalized patients. *J Infect Dis.* 1990;162(3):678-84.
28. Rao GG, Rao CSM, Starke I. Clostridium difficile-associated diarrhea in patients with community-acquired lower respiratory infection being treated with levofloxacin compared with beta-lactam-based therapy. *J Antimicrob Chemother.* 2003;51(3):697-701.
29. Abt MC, McKenney PT, Pamer EG. Clostridium difficile colitis: pathogenesis and host defence. *Nat Rev Microbiol.* 2016;14(10):609-620.
30. Antony SJ, Fisher RH. Association of penicillin allergy with idiopathic anaphylaxis. *J Fam Pract.* 1993;37(5):499-502.
31. Bhattacharya S. The fact about penicillin allergy: a review. *J Adv Pharm Technol Res.* 2010;1(1):11-17.
32. Chrcanovic BR, Kisch J, Albrektsson T, et al. Factors influencing early dental implant failures. *J Dent Res.* 2016;95:995-1002.



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## RISK MANAGEMENT



### Cultivating a Culture of Safety in Healthcare: Four Experts Tell Us Their Stories

David L. Feldman, MD, MBA, FACS, Chief Medical Officer, The Doctors Company and TDC Group

Despite more than 20 years of focus on patient safety, many hospitals and healthcare professionals still struggle to create an environment that engenders patient safety and reduces harm. Many medical professionals encounter a confusing array of programs and tools that are touted as necessary, such as team training, simulation, root cause analyses, and efforts to promote a just culture. They struggle with deciding where to focus and whether to recruit support from senior leadership or buy-in from other clinicians. At TDC Group, we believe there are four elements to creating a culture of safety, and everything begins with mutual respect. We then focus on optimizing how people, teams, and systems function, understanding how people think to keep them engaged during training, and finally, being sure that all providers are viewed through a just-culture lens. To help us explore each of these areas, I asked four experts for their stories from the trenches for the TDC Group [Leading Voices in Healthcare](#) podcast series. Each of these longtime patient safety leaders has deep experience in organizational change.

#### Building Mutual Respect in a Culture of Safety

When I interviewed Michael Brodman, MD, Professor and Chair Emeritus in the Raquel and Jaime Gilinski Department of Obstetrics, Gynecology and Reproductive Science at the Icahn School of Medicine and Senior Vice President for Professional Excellence, Mount Sinai Health System, New York, NY, he described some of the wakeup calls that showed

him the connection between mutual respect and patient safety. One happened years ago: “We did a survey on the labor floor. And this was shocking: 75 percent of the nurses said that if they saw a doctor doing something wrong, they wouldn’t say something,” because “they were afraid that somebody would yell at them or they’d get fired.” But after five-plus years of work on the institution’s culture, that figure had dropped to between 10 and 15 percent: “Basically, the point was, the nurses felt comfortable working on the floor.” Dr. Brodman says that when the labor floor team “created a just, level playing field, morale went up, and not surprisingly, adverse outcomes went down.”

To hear more of the story behind the creation of the Mount Sinai Code of Professionalism, [listen to my conversation with Dr. Brodman](#).

#### High-Performance Teams—Crucial for a Culture of Safety

Once upon a time, Michael Leitman, MD, Professor of Surgery and Medical Education and Dean for Graduate Medical Education at the Icahn School of Medicine at Mount Sinai, New York, NY, traveled with his team into the then-unknown world of TeamSTEPPS® training when they decamped from Mount Sinai Beth Israel in New York to Virginia for a week.

Dr. Leitman told me some of what he’s learned about high-performance teams over his years as a surgeon, as an institutional leader, and as a medical educator. His experiences highlight the value of performing a readiness assessment prior to training, the struggle to overcome team member skepticism, and the value of reaching medical professionals early in their careers. He thinks that residents need to understand that “essential to patient safety is teamwork and interprofessional performance. It’s just part of the way we practice caring in hospitals—with the complexity of healthcare being what it is, that is just essential.”

To continue your journey with your own high-performance team, [listen to my conversation with Dr. Leitman](#).

#### To Build a Culture of Safety, Use Human Factors Engineering

Amish Aghera, MD, emergency medicine physician and the Director for the Center for Clinical Simulation and Safety and the Simulation Fellowship at Maimonides Medical Center in Brooklyn, NY, had what he described as “an existential moment” when testing revealed that medical residents were retaining a lower proportion of his training content than he’d

hoped. He thought, “Am I just bad at this thing? Are our residents bad? And you know, the truth was neither. It just has to do with how we think as human beings.” From there, seeking training methods “to keep people engaged,” Dr. Aghera honed his skills in simulation training, and then in human factors engineering, which creates physical workspaces and workflows to support clinical decision making, teamwork, and patient safety. Dr. Aghera describes a variety of potential system interventions that institutions can consider, from the very low-tech to the innovative high-tech.

Dr. Aghera also addressed the necessity of considering large-scale organizational factors to make change: “Who are the people who are going to get things moving at a higher administrative level . . . and who are you going to work with? Who’s that working coalition, so to speak?” To learn more about simulation training, human factors engineering, and organizational change, [listen to my interview with Dr. Aghera](#).

#### Just Culture Enables a Culture of Safety

Elizabeth Duthie, RN, PhD, told me, “I always like to tell clinicians who are joining us that we expect that despite their best well-intentioned efforts, that errors are going to occur. Because that’s what happens to humans.” Dr. Duthie, Director of Patient Safety at Montefiore Medical Center, Bronx, NY, discusses how important a just culture is to creating a culture of safety. “If something bad happens, we want to learn from it,” she says—and in the absence of a just culture, many risks and near-misses go unreported. Dr. Duthie emphasizes that clinicians and staff need to experience psychological safety to report, and also to see the benefits of reporting risks. This includes knowing they can count on reliable follow-up: “When they put in an event report and it goes into a black hole and they never hear back from it, it says to them, ‘What I have to say doesn’t matter.’”

While just culture has always been critical to safety culture, many are particularly aware of this need today, given the recent criminal conviction of a former nurse for a medical error, which Dr. Duthie and I discussed. To learn more about the journey to a just culture, [listen to my interview with Dr. Duthie](#).

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.



### Dispensing Sample Medications: Risk Management Strategies

Debra Kane Hill, MBA, RN, Senior Patient Safety Risk Manager, The Doctors Company

Dispensing free sample medications to patients is commonplace in medical and dental offices. With safeguards in place, it can contribute to improved clinical results and generate goodwill between the practitioner and the patient.

Free sample medications are convenient for patients—particularly those who lack financial or transportation resources—and can improve timeliness and compliance with medication regimens. Sample medications also allow patients to try new and sometimes costly prescriptions on a trial basis to determine if they are effective and without unwanted side effects.

#### Potential Issues

Sample medications, if not carefully managed, can create issues that place patients and the practice at risk. Failure to control access to the sample drug closet can result in unauthorized individuals using sample medications without supervision. Additionally, sample medications, which are usually newer to the market, can have unforeseen side effects. Because they are brand-name medications, they are sometimes more costly for the patient on a long-term basis once the sample supply is depleted.

If a practice lacks a formal system for managing sample medications, it might inadvertently provide medications to patients without proper instructions or labeling, or it might distribute medications to individuals without thorough medical or dental evaluation. Allergies and contraindications might also be overlooked. In an office setting, the safety checks normally performed by pharmacists are often removed from the process of dispensing. Inadequate policies can result in patient harm and compromised regulatory compliance, creating considerable liability for the practitioner.

### Sample Medication Misuse

Without safeguards, staff, patients, and others with building access can divert samples to themselves, friends, and family without the provider's knowledge and proper management. Consider the following scenarios involving sample medication misuse.

- Offices allowed drug representatives to have full access to the sample closet without supervision, giving them free access to samples from other companies.
- Drug representatives gave sample medications to office staff or the practitioner without documentation or practice accountability.
- Office staff sold or bartered sample medications with other practices. In one case, ob/gyn practice staff traded birth control pills for cosmetic samples with dermatology practice staff in the same building.
- A medical assistant "treated" her own uncle for a chronic cough for several months with various antibiotics from the sample medication closet. The uncle received no medical evaluation by a physician, and the practice physician was entirely unaware of this activity. The uncle was later diagnosed with small-cell carcinoma of the lung, and the family reported the physician to the medical board for negligence and lack of supervision.
- A person who was homeless was found helping himself to the sample drug closet located near the practice's unlocked back door.
- A patient was found filling her purse with sample medications while waiting in the exam room to see the provider.

To comply with state and federal pharmaceutical regulations, providers must maintain an accounting of sample medications, both when they are received and when they are dispensed.

### Avoiding Risky Situations

Failure to implement safeguards creates significant liability. We have observed the following unsafe situations in offices that have no formal sample medication policies in place:

- Failure to recognize applicable state and federal regulations governing sample medications.
- Lack of record keeping (e.g., no logs) for medications received and dispensed.
- Inability to track drug recalls (e.g., not documenting lot numbers).
- Improper storage system (e.g., inattention to manufacturers' storage recommendations or storing samples alphabetically, which can result in medication errors).
- Improper storage location (e.g., storing samples in clinical care areas that are accessible to patients or in areas that are not routinely monitored).
- Failure to secure sample medications under lock and key, which can result in theft and misuse by patients and staff.
- Failure to label sample medications when dispensed according to state and federal guidelines, resulting in patient medication errors.
- Inattention to expiration dates.
- Incomplete patient instructions or failure to provide written instructions in a language the patient can understand.
- Incomplete patient assessment and monitoring.
- Incomplete documentation in the patient's health record, including failure to list sample medication on the patient's medication list.

### Patient Safety Strategies

Sample medications must be handled with the same level of accountability and security as other prescription medications—as required by the standard of care, federal and state pharmaceutical laws and regulations, and accrediting organizations. Practitioners have the same duty of care to patients receiving sample medications as they have to patients receiving prescriptions.

Consider implementing the following safety guidelines for drug samples in your practice:

### Practice Policies and Procedures

- Develop detailed policies and procedures that address sample medication inventory, storage, access, tracking, documentation, and patient care management.

### Drug Storage and Access

- Store, secure, and track samples to prevent inappropriate access and loss.
- Allow only designated clinicians and staff to access the drug closet.
- Group medications by drug type when setting up a sample medication closet. Never store sample medications in alphabetical order or next to drugs that have look-alike and sound-alike (LASA) names. (See the [Institute for Safe Medication Practices](#) for a current LASA list.)
- Assign staff to monitor and document safe storage per manufacturers' recommendations and to check medications for expiration.
- Follow state and federal guidelines for disposing of expired medications. Maintain logs in administrative files.
- Drug Dispensing
- Never allow staff to provide samples to anyone without provider orders, provider supervision, and patient record documentation. Give sample medications only when prescribed by a licensed provider with prescriptive authority.
- Label samples with prescribing information as required by law.

### Patient Record Documentation

- Document any dispensed samples in the patient record. Include the name of the drug, strength, lot number, manufacturer, instructions provided, and discussion of potential side effects.
- Provide written patient education regarding the medication, and document in the patient's record.
- Obtain and document informed consent from the patient when appropriate, e.g., for the type of medication, possible side effects, or the patient's first use of the medication.

### Administrative Logs

- Maintain administrative records to log a sample medication's receipt into the practice and to track its inventory and access. Creating a separate log for each medication simplifies the tracking process. Include the drug name, dosage, manufacturer, lot number, expiration date, date and quantity received by the practice, and by whom.
- Maintain administrative records to log a sample medication that is dispensed (separate from the patient record). This allows the practice to identify patients in the event a medication is recalled. Creating a separate log for each medication simplifies the tracking process. Include the date dispensed, patient name, drug name, dosage, lot number, expiration date, quantity dispensed, and by whom.
- Establish a system for identifying and managing drug recalls. (For more information, see the [FDA drug recall guidance](#).)
- Assign administrative staff to review logs routinely for any inconsistencies.

Creating a system for dispensing sample medications can be a significant undertaking, but it provides many benefits for the practice and the patient. For assistance with implementing sample medication safeguards in your practice, contact the Department of Patient Safety and Risk Management at [\(800\) 421-2368](#) or [by email](#).

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.



# Optum



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## Benefits of practicing gratitude

Practicing gratitude — meaning, being thankful and being ready to show appreciation for and to return kindness — can have a positive impact on your mental and physical health, as well as your overall well-being. By paying attention to, and expressing thanks for the good things in your life — big and small — you can gain and nurture a sense of satisfaction, contentment, fulfillment and humility.

In addition, being grateful can help build resilience, and is a means for coping with adversity. It also offers a positive way to deal with stress by giving you a way to draw your focus away from the stressor and toward positivity.

Gratitude also is associated with many physical benefits, such as a strengthened immune system, and decreased risk of depression, anxiety and substance use.

### How to practice gratitude

Gratitude starts with awareness, noticing and reflecting on things you appreciate. Then, savoring it, such as being in the moment and sitting with your gratitude to fully appreciate the positive feeling it gives you.

There is no right or wrong way to practice gratitude. It comes down to doing what feels the most genuine for you. Below are some suggestions for incorporating gratitude into your life.

- **Write** — Start a gratitude journal or list. Figure out what format and frequency of writing works best for you — notebook, phone, etc., and then regularly jot down people, experiences and items you're grateful for, whatever or whoever they are. Some people jot down three things a day; others do it weekly. Most importantly, find a routine that works best for you. The exercise will help train your focus to notice the positives in your life.

Also, strive to find new things to add to your list each time. Maybe write down something that made you smile, a moment worth savoring, or an accomplishment.

Over time, you'll likely get in the habit of noticing experiences, moments and items to add to your gratitude list. You also will have created a list to refer back to whenever you need a pick-me-up.

- **Savor** — Throughout the day, when you come across something that merits gratitude, take a moment to absorb the gratitude as it happens. Be fully present and notice the details, like the exact moment, the person, the taste, smell, colors, etc., that you're appreciating. For example, to practice "savoring" gratitude, try mindful eating. Eat slowly and give your full attention to each bite, notice the nuances of the flavors and textures, honor all the work that went into preparing the food, and the effort it took to get from farm to table to you.
- **Express** — Share your gratitude with others. If someone does something kind, or you feel grateful, share it. Tell the person in the moment or send them a message. Or maybe you pay the kindness forward to someone else, or channel it into volunteering and giving back to others and your community.

Try different ways of practicing gratitude to find what feels the most genuine to you. Gratitude is all about feeling heartfelt appreciation, and you're the only one who knows the best way to express that for yourself.

### Sources:

HelpGuide. Cultivating happiness.

[helpguide.org/articles/mental-health/cultivating-happiness.htm](https://helpguide.org/articles/mental-health/cultivating-happiness.htm). Accessed June 29, 2022.

CDC. Practicing gratitude works.

<https://www.cdc.gov/howrightnow/gratitude/> Accessed June 29, 2022

National Alliance on Mental Illness. Cultivating an "Attitude of Gratitude."

[namidanecounty.org/blog/2020/4/14/how-to-start-a-gratitude-journal](https://namidanecounty.org/blog/2020/4/14/how-to-start-a-gratitude-journal).

## Hope for better health

Depending on what's going on in your own life or the world around you, it sometimes might be difficult to remember all the good out there. But trying to can help your mental health and overall well-being.

A growing body of research is showing that positive thinking and optimism may provide a variety of health benefits, including:<sup>1</sup>

- Increased life span
- Lower rates of depression
- Lower levels of distress and pain
- Greater resistance to illnesses
- Better psychological and physical well-being
- Reduced risk of death from cardiovascular disease, stroke, cancer, respiratory conditions and infections
- Better coping skills during challenges and stress

While researchers are still studying how this works, they believe it's because people who think more positively feel more positive, which in turn helps them feel less stressed. They also tend to take better care of themselves and lead healthier lifestyles. Similarly, positive thinkers who are coping with a chronic or situational condition are more likely to proactively manage their condition and/or recovery.<sup>2</sup>

Here's more reason to be optimistic: Even if you tend to struggle to see the bright side, you can learn to think more optimistic.

## Practicing optimism

Shifting your thinking patterns from negative to positive takes time and effort, but with practice comes progress.

A first step is identifying negative thinking patterns. For example, do you tend to assume the worst will happen, or only see the bad in a situation? Do you criticize or blame yourself when something doesn't go according to plan, or a challenge arises? Are you quick to blame others when you make a mistake or fall on hard times? These are all some signs of negative thinking.

You can practice thinking more positively by proactively identifying your negative thoughts, and then finding ways to replace them with more positive ones. Let's say your boss schedules an impromptu meeting with you for the next day. A negative thinker will likely get nervous and assume the worst. A positive thinker is more likely to keep an open mind, knowing they will soon learn the topic of the meeting and can deal with it then. A positive thinker also keeps in mind that, whatever the topic is, the meeting may bring an opportunity to learn something or try new, even if it turns out the meeting is to give them constructive criticism.

Another helpful approach to positive thinking is to keeping perspective on what you can and cannot control. For example, you can control:

- What you eat and how active you are, at least to a certain degree, depending on your situation. Moving your body and eating nutritious foods promotes positivity and literally helps you feel good — exercising releases “feel-good” hormones, and eating healthily helps people feel more energetic and alert.
- Who's in your circle. Negative people can bring you down and make it easier to fall into a cycle of negative thinking. But you can control whether you spend time with them and work to make connections with people who add positivity, joy and support to your life.
- How you talk to and about yourself. Treat yourself with the same kindness you would afford others. If negative thoughts come into your mind, evaluate them and proactively try to think about the same thing more positively. For example, if you chastised yourself for failing short of a goal, retell yourself you can and will try again. Then follow through.
- Keeping things in perspective. Take stock of when good things happen around you and to you, and celebrate your successes. Thinking about the positive aspects in your life will help you remember that good things do and will happen to you, and will again, despite whatever challenge you're currently facing.

### Sources:

Mayo Clinic. Positive thinking: Stop negative self-talk to reduce stress. [mayoclinic.org/healthy-lifestyle/stress-management/indepth/positive-thinking/art-20043950](https://www.mayoclinic.org/healthy-lifestyle/stress-management/indepth/positive-thinking/art-20043950). Accessed July 5, 2022

Make-A-Wish. The health benefits of hope. <https://www.wish.org/newyork/health-benefits-hope>. Accessed June 29, 2022.

Frontiers in Psychology. Optimism and hope in chronic disease: A systematic review. Psychological assessment laboratory, Department of Health Sciences, Federal University of Health Sciences of Porto Alegre (UFCSA), Porto Alegre, Brazil. [frontiersin.org/articles/10.3389/fpsyg.2016.02022/full](https://www.frontiersin.org/articles/10.3389/fpsyg.2016.02022/full). Accessed June 29, 2022.

Extern. Why is hope important? [extern.org/why-is-hope-important](https://www.extern.org/why-is-hope-important). Accessed June 29, 2022.

Johns Hopkins Medicine. The power of positive thinking. [hopkinsmedicine.org/health/wellness-and-prevention/the-power-of-positive-thinking](https://www.hopkinsmedicine.org/health/wellness-and-prevention/the-power-of-positive-thinking). Accessed July 5, 2022.

TeensHealth. Optimism. [kidshealth.org/en/teens/optimism.html](https://kidshealth.org/en/teens/optimism.html). Accessed June 29, 2022. HelpGuide. Cultivating happiness. [helpguide.org/articles/mental-health/cultivating-happiness.htm](https://www.helpguide.org/articles/mental-health/cultivating-happiness.htm). Accessed July 5, 2022. PubMed.gov. The importance of hope against other factors in the recovery of mental illness. <https://pubmed.ncbi.nlm.nih.gov/28953841/>. Accessed June 29, 2022.

ScienceDirect. The role of hope in subsequent health and well-being for older adults: An outcome-wide longitudinal approach. *Global Epidemiology*. 2020;2:100018. <https://www.sciencedirect.com/science/article/pii/S259011332030002X?via%3Dihub>. Accessed June 29, 2022.

JAMA Network. Association of optimism with cardiovascular events and all-cause mortality: A systematic review and metaanalysis. Association of Optimism With Cardiovascular Events and All-Cause Mortality: A Systematic Review and Meta-analysis | *Cardiology* | JAMA Network Open | JAMA Network Accessed June 29, 2022.

## Building self-esteem

Appreciating your own worth is an important part of gratitude. People who have a healthy self-esteem feel good about themselves overall, while understanding and accepting their own strengths and weaknesses. A positive self-esteem also helps you navigate tough times.

While it's normal for your view of yourself to shift day to day, a low self-esteem can lead you into a cycle of negative thinking, jeopardizing your emotional and mental well-being, and sabotaging your ability to advocate for yourself.

As a result, you may be holding yourself back from personal and professional opportunities and life satisfaction. Also, chronic low self-esteem can be linked to mental health conditions, such as anxiety, depression and substance use disorders.

Tips for building and nurturing your self-esteem:

### Take control over your thoughts

Assess how you tend to think. Consider if you are someone who focuses on negatives over positives. If you hear yourself getting negative, it can be helpful to write down the negative thoughts and the circumstances, so you can review the facts and try to break the pattern. For example, maybe you're not the “big idea” person at work, but you're the one who knows how to implement a big idea, remember that work needs both people to succeed, So, don't beat yourself up.

If you tend to have an “all or nothing” style of negative thoughts, challenge those thoughts by considering additional evidence and other perspectives. For example, rather than focusing on the one person who seems to dislike you, consider all the people who do like you. Or, if you tell yourself you “always mess up,” proactively think about times you succeeded.

### Give yourself a break

Give yourself the same respect and patience you would another person in a similar situation, and work to actively reframe your thoughts. Rather than focusing on the negative, think about the positive that's linked to it. For example, if your supervisor gave you positive feedback along with some constructive criticism of areas to improve on, focus on the fact that your supervisor is helping support your growth and development.

### Set realistic expectations

When critical thoughts creep in, consider what is realistic based on your experience, environment and circumstances. You are not superhuman — no one is. Don't expect yourself to be.

It can also be helpful to allow yourself to feel what you're feeling, and move on. Meaning, don't let your negative thoughts influence your sense of self, how you act or what you do.

### Foster positivity

Helping yourself feel more positive can sometimes be as easy as spending time with people who you feel good around. When you hang around negative people, it can infect your own way of thinking and feeling. So, consider who gives you strength and joy, and who depletes your energy and happiness. Focus on the former, and limit the time spent with the latter.

Also, try new things, as it can help you see yourself in new ways. It also can help you gain new experiences, connections and skills. And all of these benefits can help you gain confidence in yourself and your self-worth.

### SEEK PROFESSIONAL HELP

If you are living with low self-esteem, consider seeking the help of a professional mental health provider who can help guide you to a healthier belief in own value.

Sources:

UK National Health Service. Raising low self-esteem. [nhs.uk/mental-health/self-help/tips-and-support/raise-low-self-esteem/](https://www.nhs.uk/mental-health/self-help/tips-and-support/raise-low-self-esteem/). Accessed June 28, 2022.

Mind.org. Self-esteem. [mind.org.uk/information-support/types-of-mental-health-problems/self-esteem/about-self-esteem/](https://www.mind.org.uk/information-support/types-of-mental-health-problems/self-esteem/about-self-esteem/). Accessed June 28, 2022.

Mayo Clinic. Self-esteem: Take steps to feel better about yourself. [mayoclinic.org/healthy-lifestyle/adult-health/in-depth/self-esteem/art-20045374](https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/self-esteem/art-20045374). Accessed June 28, 2022.

Mayo Clinic. Self-esteem check: Too low or just right? [mayoclinic.org/healthy-lifestyle/adult-health/in-depth/self-esteem/art-20047976](https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/self-esteem/art-20047976). Accessed June 28, 2022.

Frontiers in Psychology. The reciprocal relationship between gratitude and life satisfaction: Evidence from two longitudinal field studies. [frontiersin.org/articles/10.3389/fpsyg.2019.02480/full](https://www.frontiersin.org/articles/10.3389/fpsyg.2019.02480/full). Accessed June 28, 2022.

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## MEANING IN ETHICS



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

### Origin of Medical Ethics

Medical ethics is a system of moral principles that applies values to the practice of clinical medicine and to scientific research. They are based on a set of values that professionals can refer to in the event that they are in conflict or are confused. The values include: beneficence, non-maleficence, autonomy, justice, veracity, and dignity. The code of ethics is based on the understanding of the goals of medicine dating back to the 5<sup>th</sup> century B.C. and Hippocrates. By 1847, the code of ethics was based greatly on Thomas Percival's work. He was an English physician-philosopher and wrote a code of medical ethics for hospitals in 1803.

Hippocrates is important in the discussion of the meaning of medical ethics because he provided the drive to make the public understand that medicine was based on science and not on magical or religious activities that were used so often. Even so, those writings were put away and were not rediscovered until the Renaissance period in the early 16<sup>th</sup> century.

It was John Gregory, an 18<sup>th</sup> century physician and moralist, in Edinburgh who published his lectures in which he redefined medical humanism in the context of the Scottish Enlightenment of philosophers, such as David Hume. These writings opposed the work of Thomas Hobbes whose 'Leviathan' is considered by many as significant as the political writings of Plato, Aristotle, Locke, Rousseau, Kant, and Rawls. Gregory, like Hippocrates, wanted to set medicine apart and argued that medicine incorporated the ideal that physicians were empathetic, and their practice was based on medical science.

The medical code of ethics is a living document, which means that it grows and evolves as new information is gained. The first edition came about in 1847. It did not change very much until 1903 when the language was updated. It was retitled to "Principles of Medical Ethics." It was again updated in 1949 and again in 1957. Minor changes were made in 1980. The 1957 version adopted a preamble along with 10 statements of core values and commitments. The Judicial Council was given the authority of interpreting the ethical Principles.



It's been a busy year for CCF; but thanks to your continued support, we were able to host four successful clinic events in 2022. Together, we served 1,945 patients - totaling \$985,407 in free medical, dental, and vision services.

Now it's time for our 2023 clinic lineup! First will be our Amador Clinic taking place March 24-25 in Plymouth, CA. This will be our first time in Amador County, and we couldn't be more excited.

Next, CCF will be hosting the Placer Stand Down Clinic which will take place the beginning of May (exact dates still to be determined).

Lastly, we have our much-anticipated Santa Clara Clinic which will be October 6-8, 2023. Like the Amador County Clinic, this will be CCF's first time in Santa Clara County. We can't wait to bring our much needed and requested services to this new location.

Be sure to follow us on social media and regularly check our website for important updates. Go to [www.californiacareforce.org/Clinics](http://www.californiacareforce.org/Clinics) to stay up-to-date on all our upcoming clinic events.

#### Giving Tuesday

Save the date for November 29, 2022, and help us spread hope and healing to Californians in need this giving season!

CCF is kicking off our Year-End campaign by teaming up with Give65 for another Giving Tuesday celebration. Give65, a

partner of Home Instead Charities, is the first and only online giving platform exclusively for charitable organizations serving aging adults. During this 24-hour event, organizations like CCF will be using Give65 to help raise funds for underserved older adults in our communities.

As the charitable arm CALAOMS, CCF is committed to providing each patient in need with quality and compassionate dental, vision, and medical care. With nearly 1 in 6 adults over 65 years old living with untreated dental cavities\* and limited dental and vision coverage under many Medicare plans, many of our older patients struggle to access the necessary care and services they need, which is why they come to us. Living with untreated dental pain or limited vision has a big impact on a person's quality of life and overall health. This giving season, please help someone smile again, see again, and live again by supporting CCF.

#### How To Give

CCF's goal is to raise \$5,000 for seniors in need. All proceeds will go directly towards providing these services to the hundreds of aging adults we serve at our clinic events each year. There are many ways you can give, and no gift is too small.

The campaign will run from 10 pm PST on November 28th to 10 pm on November 29th.

Donations can be made either on our website ([www.californiacareforce.org/Donate](http://www.californiacareforce.org/Donate)) or on our Give65 platform page ([www.give65.org/CareForce](http://www.give65.org/CareForce)).

Thank you for supporting California CareForce!

\*Data gathered from Dental Caries Among Adults and Older Adults ([cdc.gov](http://cdc.gov))



# CALIFORNIA ASSOCIATION OF ORAL & MAXILLOFACIAL SURGEONS UPCOMING CE EVENTS

## 2023 Meetings

■ OMSA Course On-line	Open Year Round
■ January 2023 Meeting Webinar	January 14
■ ACLS & BLS Provider Recertification - Spring 2023	March (TBD)
■ CALAOMS 23rd Annual Meeting - San Jose	April 29 - 30
■ Medical Emergencies Course	November (TBD)

## VENDOR SPOTLIGHT

CALAOMS WISHES TO THANK THE FOLLOWING VENDORS THAT  
GRACIOUSLY SPONSORED CALAOMS' MEETINGS IN 2022

- **The Doctors Company** - Speaker January & Annual Meetings.
- **OMSNIC** - Breakfast & Breaks January Mtg., Wi-Fi Annual Meeting
- **US Oral Surgery Management** - Luncheon Sponsor Annual Meeting
- **Southern Anesthesia & Surgical** - Resident Presentations Annual Mtg.
- **KLS Martin** - Breakfast & Breaks Annual Meeting



## ASSOCIATE/PARTNERSHIP OPPORTUNITIES

**ALAMEDA COUNTY:** This practice has a strong presence in the community, first started in 1987 and acquired by present owner in 1992. 4 treatment rooms housed in an upscale location of approx. 2000 Sq. Ft. with average age of equipment 7-10 years. Digital X-Ray, Panoramic, Nitrous Oxide and IV Sedation Equipment included. Carstream WIN/OMS Software with 10 Computer Workstations and partial paperless charts. 2019 Revenue of \$548,000.00 on a 3 1/2 day work week with very solid post-Covid recovery. Great upside opportunity for any Oral Surgeon looking to practice in this diverse, high tech community. Please contact Jim Engel at jim.engel@henryschein.com or (925) 330-2207.

**BAY AREA:** OMS practice in search of associate or partner oral surgeon. The scope of practice includes dentoalveolar surgery, implants, bone grafting and oral pathology. Applicant should have a CA license, GA permit, and malpractice insurance. Please contact via email with CV at bayarea.ospractice@gmail.com

**BAY AREA:** Oral Surgery Group located in Pinole California is seeking Board Eligible or Certified Oral & Maxillofacial Surgeons to join our well-established team.

Full scope practices specializing in standard oral surgery, implants, orthognathic surgery, and trauma. Offices are fully equipped, including full-time staff and leadership. Seeking motivated and hard-working OMS with notable interpersonal skills. Exceptional opportunity for new graduates and experienced Oral Surgeons to join our established, very busy, profitable group. Competitive pay and bonus structure in place. Interested candidates, please email: jgutierrez@bayareaosm.com.

**CENTRAL CALIFORNIA:** Successful, established practice with the latest technology: optical scanning, 3D CBCT, etc.. Wonderful staff and support. Full time associate with quick path to partnership. We will assist with GA permit, etc. Email: rahnoms@yahoo.com

**CENTRAL VALLEY & BAY AREA:** Kids Care Dental & Orthodontics is on the move... come join our incredible Doctor Group!! KCD&O has part-time and full-time opportunities for oral and maxillofacial surgeons in the Sacramento, Stockton, and San Francisco East Bay regions.

KCD&O is a doctor-led and patient-centered pediatric practice that offers multi-disciplinary services across pediatric dentistry, orthodontics, and OMFS. We are the premier pediatric group in the state of California and currently have practices throughout Northern California. You will work with an experienced practice management staff, PALS-certified assistants, and have the opportunity to collaborate and share insight with our orthodontists and pediatric dentists. The scope of practice includes routine dentoalveolar surgery, benign pathology, etc. We can assist with hospital privileges for those interested. We accept fee-for-service or PPO's. This is a phenomenal opportunity, our surgeons enjoy competitive compensation with high earning potential, a path to equity/ownership for full-time providers, and group benefits including health, dental, vision, life/AD&D and professional liability insurance, and a 401(k) savings plan. Requirements are a CA license and a GA permit. If you are interested, please contact us at 916-661-5754 and send your CV to drtalent@kidscaedental.com

**FULLERTON:** Well-respected, active and established oral surgery practice in Fullerton, CA is in search of a board-certified or board eligible, motivated, hardworking and efficient oral surgeon. Our office provides a full scope of Oral & Maxillofacial surgery including IV sedation, extractions, bone grafting, PRF/ PRP, implant placement, biopsies and more. Applicant should have a California license and general anesthesia permit. Candidate would be able to showcase an array of surgical services, and would be expected to establish and maintain relationships with existing and potential referring doctors in the community. There would be an expectation for the candidate to help grow the practice. Please send CV to drsteve@fullertonoralsurgery.com.

**NORTHERN CALIFORNIA:** Well Established and busy/wide referral base Oral Surgery Office in Rural Northern California looking for Full time associate leading to partnership. Practice is established over 30 years with state of art facilities with 3D CT scan. We have two offices where the senior partner is looking forward to retirement. The offices provide full scope Oral and Maxillofacial surgery including IV-sedation/general anesthetic, extraction, bone grafting, pathology and implant surgery where candidate will have autonomy to "run" the practice but also has the benefit of a partnership with another surgeon. Applicant must have California license where we can assist in obtaining a GA permit. Candidate should reply via email with their CV to wtsb2021@yahoo.com

**NORTHERN CALIFORNIA:** Oral Surgery Group located in Stockton/Modesto California is seeking Board Eligible or Certified Oral & Maxillofacial Surgeons to join our well-established team.

Full scope practices specializing in standard oral surgery, implants, orthognathic surgery, and trauma. Offices are fully equipped, including full-time staff and leadership. Seeking motivated and hard-working OMS with notable interpersonal skills. Exceptional opportunity for new graduates and experienced Oral Surgeons to join our established, very busy, profitable group. Competitive pay and bonus structure in place. Interested candidates, please email: jgutierrez@bayareaosm.com.



**NORTHERN CALIFORNIA:** Sierra Foothills, well established practice seeking an associate leading to partnership. Very desirable community with opportunities for an active outdoor lifestyle. Send inquiries with letter of interest and CV to bizdocjay@mac.com and nfantovrn@aol.com

**ORANGE COUNTY:** We are currently seeking a motivated, compassionate surgeon to join our growing practice in the greater Orange County area. We have a two in one oral surgery office fully equipped in the beautiful city of Huntington Beach, CA. All current staff surgeons are board-certified with extensive experience in Dentoalveolar, implant, orthognathic, and trauma surgery. Currently both in the past and present all surgeons held or hold leadership positions in the local dental societies as well as local academic appointments. Primary surgeon is on staff at 3 local hospitals but no ER coverage is required with this position unless associated prefers. The scope of the practice includes but not limited to: dentoalveolar, orthognathic surgery, trauma, pathology, grafting, IV sedation.

Our position is for a unique individual who is caring of patients with exceptional interpersonal skills. Included with employment: salary, health coverage, 401K, CME reimbursement, mentorship with other surgeons, and more. All single or double degreed candidates will be considered as well as BE and BC. Currently this practice only has one doctor owner and seeking a well-qualified and skilled colleague with eventual partnership opportunity. Please contact Ofc managers- Rod or Mary 714-766-6560 or 949-514-8714 or send us an email: socalomfsdds@gmail.com

**ROSEVILLE, CA:** Immediate full-time oral surgeon needed to join our team. Practices a full scope of oral and maxillofacial surgery with expertise ranging from corrective jaw surgery to wisdom teeth extraction to teeth-in-an-hour/ Dental Implants. Diagnoses and treats facial pain, facial injuries and TMJ disorders, and performs a full range of dental implant and bone grafting procedures. Please contact- Courtney  
Phone: 916-783-2110  
Email: courtney@drantipov.com

**SACRAMENTO:** Exciting Associate Opportunity! Sacramento Surgical Arts is looking to add a surgeon, seeking a partnership track, to support the growth of 3 practice locations!

We are a full scope oral surgery private practice, providing a variety of services from advanced oral and maxillofacial surgery to non-surgical cosmetic procedures.

Sign on bonus; competitive base annual salary; quarterly production bonus; partnership opportunity; benefits; retirement. CV's and inquires can be directed to tkackley@mosaicdentalcollective.com.

**SAN DIEGO:** Well-respected oral surgery practice located in central San Diego. 25 years in practice and one of the most successful, busy practices in the city. Very active Seattle study club sponsor for over 21 years with 50 members. Scope of practice includes all dentoalveolar surgery, implants, bone grafting, PRF/PRP active use, orthognathic and TMJ surgery, sleep apnea treatment with MRD and bi-maxillary advancement and facial trauma. In house OR capable of supporting single jaw orthognathic/TMJ surgeries. Active hospital practice for more complex cases.

We are looking for a board certified/eligible surgeon with active skills in orthognathic/TMJ/Trauma surgery comfortable with outpatient anesthesia and dentoalveolar surgery that is interested in becoming a partner in this practice. Comfort with public speaking is a big plus. Outgoing personality with excellent patient care skills is mandatory. Interested parties, please contact via email at info@mvoms.com, or office phone at 619-298-2200 and ask for Kim, office manager

**SOUTHERN CALIFORNIA'S 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 MDudzziak@icomfs.com.

## DOCTOR SEEKING POSITION

**SAN DIEGO:** An Army OMS looking to join a well-rounded practice as a partner or associate to partner.

Currently, I am the Chief of Oral and Maxillofacial surgery at Winn Army Community Hospital on Fort Stewart, GA and have a very active dent-alveolar practice as an independent contractor.

I am separating this coming summer and would love an opportunity to come back home to San Diego. Please contact me for a CV or to schedule an interview. Sergey Gazarov, DDS sgsergey@gmail.com or 858-382-2254

## PRACTICE FOR SALE

**IRVINE:** Newly renovated oral surgery practice located in Irvine, CA. Located in a very desirable area near Hoag Health Center in a high rise medical building. The office is large enough to support multiple doctors with 3 operating suites and 3 consult rooms. All new state of the art equipment was added during the top to bottom renovation. The practice is currently in growth mode, which makes this a perfect time to purchase and turn this into a thriving practice for many years to come! Will provide transition support.

Located in Southern Orange County, Irvine is one of the nation's largest planned urban communities and encompasses more than 65 square miles. Irvine's central location—45 miles from Los Angeles, 85 from San Diego, and 15 minutes from Disneyland Resort—makes it a popular hub for Southern California travelers. There's a lot to love right in Irvine proper. From kid-friendly outdoor activities to full-service shopping, the little big city has something for everyone. Please contact: jstraw@edoralsurgery.com 916-990-3644

**SOUTH SAN FRANCISCO BAY AREA:** Excellent private practice opportunity in a very attractive South San Francisco Bay Area community. This is a well-known and respected practice with a 32-year history of providing the highest level of patient care. Our facility is a free-standing, 3,000+ square foot building located in a very desirable location. We are accredited by the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF). Anesthesia services are readily available as part our close, 11-year, relationship with the premier anesthesia group in our area.

Our surgeon is looking to transition his practice to a highly competent and deeply committed doctor who is willing to do what it takes to provide the standard of care our patients deserve. Practice transition options are available including clinical and/or business mentoring as desired. Please send preliminary inquiries to: oms.transition.2022@gmail.com

**SILICON VALLEY:** Oral Surgery Practice seeks buyer to continue a decades long tradition of providing quality OMS services to a traditional referral base in San Jose, Los Gatos and Saratoga. Interested prospects can send a CV to molinelli@aol.com or call 650-347-5346.

**WEST LOS ANGELES** oral surgery practice. Well Established, Excellent reputation and relationships within the community and amongst the Dental referral base. The office is 2,200 square feet in a multi-tenant building and has been remodeled with updated equipment and technology, including Cone Beam. 2 Consult Rooms, 3 Surgical Suites, Full surgical Area with Recovery, Nurses Station and Sterilization Center. Very well designed for Oral Surgery flow. This practice has been in the same location for 20+ years. \$2.1M Annual Revenue, Operating Expense below 55%, with \$1.0M net. Please contact Jason Owens at 855-546-0044 or jowens@ddsmatch.com for a confidential conversation about this opportunity.

## WOULD LIKE TO BUY

**GREATER SACRAMENTO AREA.** I am looking to purchase a practice with transition in Sacramento or surrounding areas. I am currently practicing in Northern California and I am looking for an OMFS practice with an emphasis on Dentoalveolar and implant surgery. Please contact me at omfspractice43@gmail.com if interested

**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



**MAXILLOFACIAL SURGEON-**  
Opening in Riverside, California  
\$30,000 Advance on Pay Bonus!

The Oral Surgeon clinic will be based out of the Riverside clinic location and any surgeries requiring a hospital OR will be performed at either our Riverside Hospital or Moreno Valley Hospital. Surgeries that can be performed at a surgery center will be performed at our Murrieta Surgery Center, opening in April 2023, or at a contracted non-Kaiser Permanente surgery center in the area. We perform elective surgeries 6 days/week, and most physicians rotate through the allocated Saturday OR blocks a few times/year. There will be an opportunity to partner with a community Oral Surgeon that we contract with for cases that require two surgeons. Our Riverside Service Area has 560,000 members and is the 4th largest for Kaiser Permanente nationally. We have HNS clinics in 4 locations: Riverside, Murrieta, Moreno Valley, and Palm Desert.

SCPMG is proud to offer its physicians:

- An organization that has served the communities of Southern California for more than 65 years
- A physician-led practice that equally emphasizes professional autonomy and cross-specialty collaboration
- Comprehensive administrative support
- An environment that promotes excellent service to patients
- A fully implemented electronic medical record system
- An excellent salary, comprehensive benefits, and partnership eligibility after 3 years

For consideration or to apply, please visit our website at <https://scpmgphysiciancareers.com/specialty/otolaryngology-head-neck/>. For questions or additional information, please contact Glenn Gallo at Glenn.Gallo@kp.org or 800-541-7946. We are an AAP/EEO employer.

You can trust OMSNIC to have your  
**BEST INTERESTS**  
at heart.



Dr. Cynthia Trentacosti Franck of Oral Surgery Associates of Chester County, West Chester, PA & Kennett Square, PA  
and Dr. Mark Zajkowski of Oral and Maxillofacial Surgery Associates, South Portland, ME

Over 85% of oral and maxillofacial surgeons choose OMSNIC insurance to protect their practice because at OMSNIC, you are also an owner and you have a voice.

Surgeons like you oversee member claims, participate in resource development, and guide corporate decisions. Every OMS insured by OMSNIC owns shares in the company, and the capital contribution you make upon joining entitles you to your share of profits upon retirement. In a world of faceless insurance companies, OMSNIC has faces you know and trust, those of your colleagues.

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