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# CALAOMS and the Specialty of Oral & Maxillofacial Surgery Loses One of Its Best Friends

**Richard C. Robert, DDS, MS**
**1945 – 2023**

Richard Robert passed away suddenly at home on November 21, 2023. Dr. Robert, originally from Atlanta, Georgia, became an oral and maxillofacial surgeon because of his interests in both surgery and medicine. He earned a bachelor's degree in applied biology from Georgia Institute of Technology in 1966. He earned his Doctor of Dental Surgery (DDS) degree from Emory University in 1970, and a Master of Science (MS) degree in oral and maxillofacial surgery from the University of Michigan Medical Center. After dental school, he began his service tour at the Letterman Army Institute of Research in San Francisco, conducting bone graft research to determine improved methods for reconstructing jaw injuries caused by trauma or pathology.

For 30 years, he ran a private practice of oral and maxillofacial surgery in South San Francisco; and more recently, merged his own private practice with 7 x 7 Dental Implant and Oral Surgery Specialists. During all his time in private practice, he maintained his burning interest in teaching and academia and was first associated with the dental service at Mount Zion Hospital in San Francisco, followed by an appointment with the Oral and Maxillofacial Surgery Department at the University of California San Francisco where he progressed to full clinical professor. He was an invaluable colleague at UCSF where he was in charge of the Sedation and Anesthesia program for the oral and maxillofacial surgery residents, as well as the Sedation and Anesthesia oversight committee for the whole dental school. He also coordinated the major anatomy class for residents from all the dental programs, as well as conducting monthly emergency drills throughout the dental school. He lectured nationally and internationally, talking on anesthesia topics, risk management, and dentoalveolar surgery. He was the recipient of the Distinguished Service Award and President's Award of CALAOMS. Outside of work, Dr. Robert enjoyed art, sculpture, architecture, history, and classical music (including classic rock). He took every opportunity to enjoy the great outdoors on weekends and traveled frequently. His adventures often took him to Europe to appreciate art and architecture, or to scenic destinations in the Western United States and Canada. He will be sorely missed by so many people, and our thoughts are with his wife Linda and children.

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# in this issue:





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

# EDITORIAL

*by Jeffrey A. Elo, DDS, MS, FACS*
*Editor, CALAOMS*

## The potential impact of cannabis use on the OMS patient

Cannabis use has increased significantly in recent years due to expanding legalization of cannabis for medical and recreational use in various U.S. states, although it remains federally banned. California was the first state to legalize medical marijuana in 1996. Since then, the medical use of cannabis has been legalized in 40 states and the District of Columbia. The recreational use of cannabis has been approved in the District of Columbia and 24 states.

State legislative changes that have legalized marijuana have brought both medical opportunities and challenges. One challenge involves understanding the effects of cannabis on procedural anesthesia. In a retrospective study published in the *Journal of the American Osteopathic Association* (2019; 119:307-311), it was examined whether patients who regularly used cannabis required more anesthesia during endoscopy, and found, unsurprisingly, that they did. "The research does not suggest that people should not use cannabis," said Mark A. Twardowski, DO, with Western Medical Associates in Grand Junction, Colo. "It just suggests that the use is *not without consequences*. One consequence is that more medications may be required for procedures. This increased dose may put people at a higher risk for respiratory suppression during endoscopic procedures." In this single-center study, 250 medical records were reviewed from a single endoscopist practicing in Colorado to minimize variability in sedation technique. The researchers investigated whether there was variation in relative amounts of sedation medication required in cannabis users versus nonusers. In Colorado, recreational cannabis use was legalized in 2012. For sedation, cannabis users needed an average of 125.93 mcg of fentanyl, 9.15 mg of midazolam, and 44.81 mg of propofol, compared with nonusers who needed 109.91 mcg of fentanyl, 7.61 mg of midazolam, and 13.83 mg of propofol. The differences translated to an additional 14% of fentanyl, an additional 19.6% of midazolam, and 220.5% more propofol during endoscopy needed by cannabis users.

Up-to-date research indicates that the half-life of tetrahydrocannabinol (THC), the main active component of cannabis, is 5-13 days, with total excretion taking up to 25 days. As for the mechanism underlying the effect of cannabis on anesthesia, it has been hypothesized that THC interacts with specific cannabinoid receptors, potentially including opioid and benzodiazepine receptors. Consequently, the interaction of opioids or benzodiazepines with these receptors in cannabis-using patients could be disrupted.

Historically, it has been difficult to study the effects of marijuana on dose requirements for sedatives because it is classified as a Schedule I drug by the DEA. A 2009 study out of Australia analyzed the induction dose of propofol necessary in patients using cannabis in 30 users versus 30 nonusers. The authors concluded that cannabis use increased the need for propofol during anesthesia when employing a laryngeal mask. Dr. Twardowski commented on the results of the study: "My medical opinion about cannabis is that it is a reality that we have to deal with. I am neither pro nor con, but I am frustrated – as everyone in health care should be – that a substance has been legalized for general consumption with almost no meaningful evaluation of its true medical effects, drug interactions, etc. The substance was demonized and therefore not able to be studied, then it was legalized without appropriate research."

A peer-reviewed study on a data set of nearly 60,000 Canadians showed that adults who use marijuana have a 60% higher risk of experiencing their first heart attack, stroke, or other major cardiovascular event; suggesting that marijuana is not simply a harmless vice but may be harmful, like cigarettes. And unlike cigarettes, its use may also possess negative psychological consequences. A Danish study based on nearly 7 million health records drew a strong correlation between heavy cannabis use and increased risk of schizophrenia in young men.

The evidence is clear – no matter what its advocates claim, marijuana use likely serves as a gateway drug: Evidence suggests a link between cannabis use in kids and later opioid use, and the drug can play a role in rewiring the reward circuitry in young brains.

When considering how politicians and others promote safety-ism in the culture, the crusade to legalize and normalize marijuana is bizarre in light of the increasing body of evidence of serious negative health consequences. Despite all this, nearly a third of adults under 35 regularly smoke marijuana and nearly 70% of Americans support legalization.

Research from the American College of Cardiology earlier this year found that using marijuana every day increases the risk of developing heart disease. People who use marijuana daily were also found to be more likely to develop coronary artery disease versus those who never used cannabis.

Based on these findings, it is important for people to be aware that cannabis use is not without risk and to inform their doctor if they use cannabis so that clinicians can take appropriate steps to monitor their heart health.

As anesthesia providers, oral and maxillofacial surgeons are acutely aware of the many – and seemingly ever-increasing number of – negative side effects associated with the regular use of marijuana. Regular marijuana users typically require higher doses of propofol for induction and maintenance of deep sedation and may suffer with cannabis withdrawal symptoms after surgery. These symptoms might include restlessness, irritability, insomnia, tremors, nausea, and vomiting. Heavy frequent cannabis users also report having more pain following surgery. Recent cannabis smoking before anesthesia may lead to cardiac problems – increased heart rate, irregular heart rate, even myocardial infarction – mainly in the first two hours after smoking cannabis.

There is a difference between cannabis used for medical purposes compared to that used for recreation. Cannabis used for medical purposes has low potency THC and is intended for use under the supervision of a physician. Conversely, cannabis used recreationally may have very high concentrations of THC, which can lead to perioperative complications.

THC in small doses may help with pain and nausea; however, in high doses usually leads to the opposite effect – increased pain and nausea or vomiting. The route of cannabis consumption is also significant. Historically, the primary mode of cannabis use has been smoking, but vaping cannabis is also common and cannabis-containing products have become increasingly available, including infused foods (edibles), beverages, oils, concentrates, and topical ointments.

Smoking cannabis causes high concentrations of THC in the blood very rapidly (minutes) – potentially leading to cardiac issues acutely, and lung complications over time. Oral cannabis' effect is much slower (hours). Cannabis smoking is associated with periodontal complications, xerostomia, and leukoplakia as well as potentially increased risk of developing mouth and neck cancer.

As medical and recreational cannabis use among the general population continues to rise steadily, it is vital for OMSs to understand the effects of cannabis on patients undergoing IV sedation to provide safe perioperative care.

With growing use of cannabis and cannabis derivatives nationwide, dental professionals can expect to encounter more patients experiencing various side effects of cannabis use, including effects on the oral cavity (e.g., higher risk of periodontal disease) and a wide spectrum of physical and mental side effects.

# PRESIDENT'S MESSAGE

*David Cummings, DDS*
*CALAOMS President*

CALIFORNIA ASSOCIATION of
ORAL & MAXILLOFACIAL
SURGEONS

It truly has been an honor to serve as your CALAOMS President for 2023. Our board members have made it such a fun and enjoyable experience this year. We have had a great time working hard together to help promote and serve our members to the best of our abilities. It does not come without a lot of hard work and dedication from not only our board members but from all our committee chairs and committee members. I would really like to thank every one of you for your time, efforts, and contributions to CALAOMS.

CALAOMS is blessed to have so many people involved who work behind the scenes making improvements for the profession of dentistry and the specialty of Oral and Maxillofacial Surgery. We had a very successful Annual Meeting in San Jose. We were the second state to bring AAOMS's Office-Based Emergency Airway Management course (OBEAM) to California, and we thank AAOMS Immediate Past President Dr. Paul Schwartz and the AAOMS Board for facilitating this effort so that we could educate CALAOMS members here at home.

OBEAM was a great addition to our in-person Annual Meeting, and we are planning to continue with this offering in the future. The Hayes Mansion was a phenomenal venue to host a meeting, and it was all led by our Continuing Education Committee chair, Dr. Vivian Jui. Dr. Jui worked countless hours to ensure that the course(s) would run smoothly. Dr. Sloan McDonald moderated and ran operations on-site – preventing and/or managing any unforeseen issues and ensuring a meeting that ran seamlessly. CALAOMS thanks Dr. Vivian Jui and Dr. Sloan McDonald for making our Meeting so successful.

CALAOMS' Legislative Committee was very busy again this year. Led by Dr. Jeff Elo and Dr. George Maranon, CALAOMS-sponsored Assembly Bill (AB) 936 unanimously passed both chambers of the California Legislature and was signed into law by Governor Gavin Newsom on October 8th. CALAOMS collaborated with Western University of Health Sciences College of Dental Medicine to sponsor AB 936 (Wood). This bill expands on the provisions of CALAOMS' sponsored AB 880 (Ridley-Thomas) that was signed in 2015. AB 880 permits students enrolled in their *final* year of completion in California dental schools to treat patients without compensation and under their respective school's faculty supervision at sponsored free healthcare and dental events. AB 936 allows California dental students enrolled in their *clinical years* to treat patients under the same faculty supervision as they would in their dental school clinics. The purpose of the legislation is threefold: First, to increase the volunteer workforce at free healthcare clinics. Second, hands-on training and experience has proven to be very beneficial to the dental students. Finally, exposing dental students to volunteerism early will hopefully inspire them to give back to their communities once they are licensed. CALAOMS added an urgency clause to the bill to allow it to take effect immediately upon signature by the Governor. We can be proud of our Association for sponsoring this important piece of legislation.

CALAOMS' Legislative Committee also worked extremely hard on a dental loss ratio (DLR) bill earlier this year. CALAOMS's legislative advocate, Mr. Gary Cooper, helped us navigate this important issue though significant opposition was encountered every step of the way. As a board, we put in countless hours through Zoom meetings, emails, text messages, and phone calls. Ultimately, the lawmaker decided that the timing was not right given the opposition, and he opted not to proceed with the bill this year.

I cannot even begin to express my gratitude to the CALAOMS staff for all the great work they do every day. Pam, Steve, and Teri have been dedicated to CALAOMS for so many years. For those of you who could not attend the Annual Meeting in San Jose, we had the opportunity

to recognize our Executive Director, Mrs. Pam Congdon, for 30 years of service to CALAOMS. Yes, 30 years! Pam is the heart and soul of CALAOMS. She is the ultimate executive director: professional, caring, giving, a leader, a mentor, a philanthropist, a wonderful daughter, a loving wife, an engaged mom, grandmother, and anything else that's positive that you can think of! I have joked with her this year that I think I may have only beaten her to one or two things. She is always one step ahead of us. Not sure what else we can even ask for from our Association's leader. Thank you, Pam, for all you do.

Mr. Steve Krantzman is CALAOMS' Associate Director and has served in this role for 22 years. CALAOMS is in the process of upgrading its day-to-day software platform to better serve our members. As one might imagine, this is a huge undertaking and will take approximately 6-9 months to complete. Steve is learning all the ins and outs of the new software and is helping Pam and Teri to learn it, as well. Steve is CALAOMS' I.T. professional as well as our graphic artist and Journal and website designer. Thank you, Steve, for all you do.

Ms. Teri Travis is the backbone of CALAOMS' Continuing Education endeavors. Teri not only manages our in-person meetings and our virtual meetings, but she also oversees all the OMSA, medical emergencies, ACLS courses, and more. Teri has been with CALAOMS for 19 years and we truly appreciate everything she does. Thank you, Teri, for all you do.

Lastly, I would like to thank you, our outstanding members, for allowing me to serve you this past year. It has been a very rewarding year for me. A special thank you to our CALAOMS board and staff because each one of you contributed in your own unique way to make our 2023 team so successful. We could not have done it without all of you.

CALAOMS will be in great hands as Dr. Ash Veeranki will take over the reins as the 2024 President of CALAOMS.

Thank you all for your care of our specialty,

David Cummings, DDS
President, CALAOMS

## CALAOMS-Sponsored AB 936 Signed into Law by Governor Newsom

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AB 936 allows California dental students enrolled in their *clinical years* to treat patients under the same faculty supervision as they would in their dental school clinics. The purpose of the legislation is threefold: First, to increase the volunteer workforce at free healthcare clinics. Second, hands-on training and experience has proven to be very beneficial to the dental students. Finally, exposing dental students to volunteerism early will hopefully inspire them to give back to their communities once they are licensed.

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# AAOMS DISTRICT VI TRUSTEE REPORT

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

A highlight for District VI was the election of **Dr. Mark A. Egbert as the AAOMS President for 2023-2024.** Mark, being from Seattle, is *"one of ours"* and has proposed a very active agenda for this year with the theme, ***"Stronger Together"***. This theme will lead us through the year for the betterment of the membership and specialty. All of us on the Board of Trustees look forward to the challenge.

***Finally, remember, I am your portal of communication to the AAOMS - <u>your</u> specialty's national association***. ***Please utilize me***! You can contact me via E-mail at dr.wfstephens@gmail.com or if urgent, call me at (626) 353-4575.

*Thanks for your continuing confidence and support.*

W. Frederick Stephens, DDS, FACD, FICD
AAOMS, District VI Trustee
dr.wfstephens@gmail.com

Well, 2023 is coming closer to completion and 2024 is rapidly appearing on the horizon. *Time just continues to accelerate the older I get!* It seems like only a year ago your Caucus honored me with the opportunity to represent you as your District VI Trustee. *But I have already completed my first two-year term!*

This September at the AAOMS House of Delegates, I was again given the honor to continue to represent you by being elected to a second two-year term as your District VI Trustee. I greatly appreciate your support and the confidence you continue to place in me.

I hope you were able to attend the **105th AAOMS Annual Meeting, Scientific Sessions, and Exhibition in San Diego,** this September. The meeting proved to be a great success with attendance beyond predictions and budgeted revenues. A diverse educational program revolving around the theme of "***Innovations in OMS"*** was presented, covering topics ranging from Dentoalveolar Surgery, Pathology, Anesthesia, Trauma and Reconstructive Surgery, Cosmetic Surgery, and Practice Management. In addition, the meeting offered the opportunity for airway simulation training via the OBEAM course, hands-on training courses in nerve repair and full arch reconstruction, and various clinical and managerial courses for staff.

The Presidents event, hosted by Dr. Paul and Olga Schwartz, was held on the USS Midway. All those who attended experienced a great time with friends and colleagues on a real piece of naval history. The fighter simulators were an especially big hit...*with minimal motion sickness encountered!*

**To update you on current topics and relevant issues to our specialty, I present the following:**

## Anesthesia

- ***<u>Anesthesia issues never seem to stop</u>***! As a result, AAOMS continues to work with states, when requested, on our ***OMS anesthesia delivery model***. To this point, AAOMS has been able to successfully advocate for our team practice model. AAOMS has extensive resources to assist any state facing similar challenges.

- ***CRNAs*** remain emboldened by recent successes in ***achieving independent practice*** and relative autonomy afforded during the pandemic. CRNAs also are ***looking for ways to enter dental practices and <u>eliminate</u> <u>the need</u>*** for the dental practitioner to hold any form of sedation permit or dental board-based office anesthesia inspection.

- ***AAOMS continues to gather essential data from third party entities***, such as privately billed insurance claims, to be utilized to ***advocate for the safety*** of the OMS anesthesia team model.

- ***AAOMS also promotes the submission of anesthesia incident reports*** from all dental anesthesia and sedation providers to the ***<u>Dental Anesthesia Incident Reporting System (DAIRS</u>***), which is a ***centralized registry*** where ***information related to adverse events in anesthesia*** may be examined and quantified at a national level. ***This adds to our data base***. Those who wish to submit an incident report may do so at AAOMS.org/DAIRS

- The American Society of Dentist Anesthesiologists ***(ASDA) and AAOMS*** have developed ***<u>Model Anesthesia Regulations</u>*** through a joint working group *(Dr. Paul Schwartz and J. David Johnson, among others...Drs. Sacco and Weber).*

- The Model Regulations - now also endorsed by the American Academy of Periodontology (AAP) - ***preserve the OMS model of anesthesia delivery***. While the model regulations have been approved for use, they are ***expected to be excerpted and adapted by states as they deem appropriate to meet their own unique needs.*** For more information, contact Sandy Guenther at 800/822-6637 ext. 4388 or via email at sguenther@aaoms.org.

- *Recently the <u>ASDA Board</u> voted to update the 'Model Regulations' into a single document. As you will recall the ASDA was planning on two versions to address independent practice and non-independent practice CRNA's. With the help of AAOMS staff and the urging of the AAOMS taskforce members (Drs. Sacco and Weber), the ASDA has agreed to formulate **one document** now.*

## OBEAM at State and Regional Society Meetings

- **The AAOMS National Simulation Program** offers oral and maxillofacial surgeons the opportunity to practice critical techniques for administering and monitoring office-based anesthesia through best-practice protocols during simulation of various real-life emergency airway situations.

- ***AAOMS*** *is providing the opportunity for OMS state societies and regional societies to offer the OBEAM (Office-Based Emergency Airway Management) module in their specific locations. This was offered at the CALAOMS Annual Meeting in January 2023 and proved to be very successful. We plan to expand this program to other regional societies to make fulfilling this requirement easier for AAOMS members.*

- This is a *two-hour OBEAM module.*

  During the ***two-hour OBEAM module,*** participants review and practice concepts and skills for sedation monitoring and techniques for supplemental oxygen, opening an airway, bag-valve-mask (BVM) ventilation using one- and two-handed techniques, laryngeal mask airway (LMA) insertion and use of the Airtraq laryngoscope for endotracheal intubation. Ventilation parameters are manipulated so difficult airway BVM techniques can be practiced after mastery of BVM in a normal configuration.

- Hands-on session will utilize ***five (5) of the AAOMS Laerdal 3G simulators, allowing 10 surgeons*** to participate during each ***two-hour session.***

- Registration will be handled through AAOMS. Registration is ***$850 per OMS and will offer 6 hours of continuing education (CE).***

***Please visit aaoms.org or calaoms.org to find a date that works for you to take the OBEAM course. Remember, as per the 2021 House of Delegates resolution, simulation training is required to be completed for all AAOMS Members & Fellows by the beginning of 2026.***

## Advocacy

### State Issues

- 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, especially with the help and expertise of Sandy Guenther, 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.*

### National Issues

- *The following AAOMS priorities were reintroduced in the **118th Congress:** (For those who attended Day on the Hill, you are familiar with these legislative priorities)*

- ***The Resident Education Deferred Interest (REDI) Act*** (HR 1202/S 704).

  - AAOMS secured the support of more than 40 other physician and dentist organizations for the REDI Act.

- ***The Dental and Optometric Care (DOC) Access Act*** (HR 1385).

- ***The Ensuring Lasting Smiles Act (ELSA)*** is still awaiting reintroduction. AAOMS is working with bill sponsors to address concerns raised in the last Congress.

- *AAOMS Members* are *encouraged* to sign up for advocacy alerts by **texting "AAOMS" to 50457**. Campaigns on the REDI Act and DOC Access Act are available at AAOMS.org/TakeAction.

- AAOMS continues to monitor ***efforts to expand Medicare coverage for medically necessary dental services*** and submitted recommendations to CMS supporting coverage of dental exams and treatment ***essential for successful medical outcomes***, including for patients with:

  **** MRONJ***
  **** Post-radiation for head and neck cancers***
  **** Prior to cardiac surgery or joint replacement surgery.***

- *AAOMS also* participated in an ADA ad hoc workgroup to *address and advocate against CMS' assignment of payment adjustment indicators and global periods to certain CDT codes in anticipation of coverage of additional medical necessary dental services.*

  *We are pleased to report that CMS has responded accordingly and will update its July RVU (relative value units) file to no longer include these payment indicators that would call for multiple procedure reductions and global periods for CDT codes.*

- Now...Having successfully collaborated with the ADA and AAPD for CMS to create a ***new HCPCS code (G0330)*** to ***increase facility fees for outpatient hospital services nearly ten-fold***, AAOMS continues to collaborate with *the coalition to support Medicaid adoption of the Medicare payment rate and to expand the facility fee increase to ASCs.*

  ***A new infographic*** for members to promote the ***new code and higher rate*** to their hospitals has been shared with AAOMS members and state societies. CMS will release its proposed rule shortly, and we have received information that it will ***likely propose extending the higher facility fee to ASCs***, ...which – once verified - would be ***yet another victory for AAOMS and its members.***

- AAOMS will *also* participate in a *multi-specialty practice expense survey of Medicare providers* with the intent to provide updated practice expense data to CMS for purposes of *updating the practice expense component of a procedure's RVU (relative value unit).*

- Finally, AAOMS *continues to monitor* the recently enacted **No Surprises Act (NSA)** and its impact on OMS. AAOMS has posted several summaries and FAQs which are posted on aaoms.org. A new infographic on the NSA is also available.

## Informational Campaign

- ***MyOMS.org*** received more than 950,000 page views in 2022 – 45% more than 2021. More than 65,000 visitors to the website used the Find a Surgeon function.

- ***More than 100 videos and 20 infographics*** are featured on 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 more than 22,000 clicks to MyOMS.org annually – with about 70% of those visitors using the Find a Surgeon function.

- AAOMS continues to get a lot of free advertising *(total broadcast audience of 1.4 billion)* from ***seven TV Public Service Announcements*** – two on oral cancer, two on wisdom teeth, and one each on dental implants, facial protection, and OSA *(with a cumulative equivalent ad dollar value of more than **$27.4 million**)*; radio PSAs have generated an equivalent ad dollar value of more than **$4.7 million.**

- A new public-facing podcast series – ***OMS Voices: An AAOMS Podcast*** – debuted in 2023. Members can listen to the podcasts on MyOMS.org or their favorite podcast platform. Podcast episodes will focus on the full scope of oral and maxillofacial surgery.

## Communications

- A new member-facing podcast series – called ***AAOMS On the Go*** – launched in November 2022 and is publishing new podcasts ***twice a month***.

- The podcasts can be downloaded or listened to on **AAOMS.org/podcasts** or popular podcast platforms such as Spotify.

  ***Topics cover research, advocacy, affiliate organization news, JOMS, practice management improvements, and more.***

## Education and 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.

- Throughout this year (***2023)***, ***ten sessions of the Office-Based Emergency Airway Management (OBEAM)*** module - part of AAOMS's National Simulation Program - will be offered at the Daniel M. Laskin Institute for OMS Education and Innovation at AAOMS headquarters in Rosemont, Ill. OBEAM modules are limited to AAOMS members and fellows at a rate of $850 per participant. Sessions are not yet available for professional staff.

- The ***AAOMS Dental Implant Conference*** will be held ***Nov. 30 - Dec. 2, 2023*** at the Sheraton Grand Chicago in Chicago, Ill. Registration is now open.

- To see upcoming AAOMS meetings, webinars, and other educational opportunities available, please visit https://www.aaoms.org/meetings-exhibitions/upcoming-events

## OMS Foundation

Most OMSs have neither the time nor the expertise to actively engage in the research that sustains our specialty. But, through the generosity of its donors, the Foundation can engage those who are most qualified to do this important work. Without these resources, our capacity to evolve and advance will inevitably decline, and the OMS specialty will become indistinguishable from its competitors.

Please consider supporting the Foundation as an **OMSFIRE** donor with an annual gift of **$2,500** or more for five years. Or include a gift in your estate plan to help sustain Dr. Walker's vision for the future of the specialty by joining the **R.V. Walker Society**.

Visit OMSFoundation.org or email Mary DiCarlo at mdicarlo@omsfoundation.org to learn more about OMSFIRE, legacy giving, and the Foundation's R.V. Walker Society.

## Western Society of Oral & Maxillofacial Surgeons

I strongly encourage all CALAOMS members and, for that matter, all Western District *(District VI)* members to join the **WSOMS**. This Society in the past was a respected component society known for its great CE and comradery with meetings usually located in great venues throughout the Western States. Recent times have changed the demand for such CE and the travel, but this component Society is still a very important legislative arm for the Western District in AAOMS. ***The WSOMS's primary role is to support our Western Caucus and our national representation.*** The WSOMS is our regional conduit - providing important two-way communication for national issues, elections, and national support.

Dr. Randal Blazic, the current president of the WSOMS, has done a great job reorganizing the Society and establishing an efficient budget and governing structure to maintain the important role of this component Society. ***He and I are asking that all Western District Members join the WSOMS for a mere $50.00/year.*** This will keep the Society healthy and functional, providing support for its members. Society dues can be paid through CALAOMS for California members.

## AAOMS's New Well-being Program

*(Recent Presidents Newsletter / E-mail)*

At AAOMS, we prioritize the well-being of our members. To that end, we're launching a program called ***"AAOMS Cares: Being Well Together"*** to serve as a resource for members of our specialty affected by substance use disorders.

As such, AAOMS is partnering with ***Parkdale Center for Professionals***, an independent treatment facility with a proven track record in treating professionals across the United States struggling with substance use disorders in highly accountable industries such as ours by offering innovative programs and solutions that meet their needs.

Privacy, confidentiality, and anonymity are of the utmost importance to the team at Parkdale and to AAOMS as we roll out this program. All aspects of treatment, private discussions, and information shared with Parkdale will be held with the strictest confidence to protect the privacy and dignity of all participants. ***AAOMS is only facilitating access to the experts at Parkdale; the Association will not receive identifiable information regarding individual inquiries or subsequent treatment.***

This confidential program marks a significant step toward providing comprehensive support and care for our AAOMS membership. We understand that seeking help for substance use can be challenging, and we want to assure our members that the Association is committed to fostering a supportive and non-judgmental environment. We encourage those who are struggling or know someone who is, be it a co-worker

or family member, to take advantage of this confidential well-being program by calling ***888-462-2706***.

Visit AAOMS.org/AAOMS-Cares for more information.

## Recognition & Thank You

***Finally, thank you*** for all your contributions to ***OMSPAC*** and ***The OMS Foundation***. Your support of these entities is extremely important to the stability of your practice and our specialty. You can visit ***OMSPAC.org*** and/or ***OMSFoundation.org*** to view the names of all our contributors and learn more about how these important entities help maintain and advance our specialty and, ultimately, our ability to practice.

As mentioned earlier, I have an open-door policy for all District VI members to voice questions, concerns, and suggestions. As such, please do not hesitate to contact me via E-mail or, if urgent, via phone as necessary.

Hope this report finds you all well.

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

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# Actions of the 2023 AAOMS House of Delegates

*CALAOMS Members, PLEASE READ:*

*The 2023 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 2023 AAOMS House of Delegates convened in-person in San Diego, CA, on September 18-20, 2023. Several important resolutions were considered and voted on. Resolutions that were **adopted** (passed) include:

## RESOLUTION 23-A-1 (Amend) (RC)

RESOLVED, that *CHAPTER IX • COMMITTEES AND SECTIONS* of the Bylaws be amended as follows with all conflicting bylaws, policies, etc., amended accordingly (strikethrough = deletion; bold underline = addition):

**F. Committee on Continuing Education and Professional Development (CCEPD)**

*Composition:* The committee shall be composed of nine (9) members, who should be fellows or life fellows, of whom one shall be the Chair of the committee, one shall be the Immediate Past Chair and one shall be the Chair of the Committee on Research Planning and Technology Assessment or the Foundation's Committee on Research. Six (6) members, one from each trustee district, shall be appointed to serve up to two (2) consecutive three-year (3) terms with appointments staggered so that two (2) members' terms expire annually. The Chair is to be appointed annually and may serve no more than two (2) consecutive one-year terms and must have completed at least three years on the committee as a member. The Immediate Past Chair shall be limited to serve one (1) one-year term, and, if necessary, may be reappointed to a one- year term as consultant. Service on this committee shall be limited to up to nine (9) years.

*Consultants*: Annually, the Committees on Anesthesia **(CAN)** and Cleft, Craniofacial and Pediatric OMS **(CCCPOMS)**, **CCEPD Subcommittee on Dental Implant Education (SCDIE)**, the Committee on Oral, Head and Neck Oncologic and Reconstructive Surgery **(CONHORS)**, **the Special Committee on Facial Cosmetic Surgery (SCFCS)**, the Committee on Practice Management and Professional Staff Development **(CPMPSD)**, the Committee on Research Planning & Technology Assessment (CRPTA), and the Executive Committee, Resident Organization (ROAAOMS) shall select one member each to serve as a consultant on the CCEPD. (Sept. 19; Sept. 21; Sept. 23)

**Objectives**: Appointees to the Committee on Continuing Education and Professional Development should have (1) recognized clinical and/or scientific expertise in oral and maxillofacial surgery, (2) demonstrated regular attendance at previous national meetings, (3) had previous committee experience on the national, regional or state level, (4) demonstrated experience in scientific program development, and (5) been a participant in continuing education activity.

*Duties:* The committee's responsibilities shall be to (1) identify and address the **professional learning gaps and** educational needs of the membership, (2) establish minimum **continuing education** guidelines ~~for the development of continuing education activities~~ for oral and maxillofacial surgeons, (3) create a program planning process that is open and participatory, (4) utilize organized agencies within the Association, such as **Clinical Interest Groups** (CIGs) **and Special Interest Groups (SIGs)**, as planning resources for general membership programs, (5) provide a high quality, integrated, educational experience for every fellow/member who participates, (6) encourage active participation by fellows and members who elect to focus their clinical endeavors within a particular aspect of the full scope of oral and maxillofacial surgery practice, and (7) assess the effect of continuing education, whether measured as **an increase in change of competence or performance**, ~~behavioral change~~ or an expansion of the commonly accepted knowledge base in oral and maxillofacial surgery **and/or continues to improve patient care.** (Sept. 23)

Fiscal Impact: $4,050 (for inclusion in the 2024 budget)

## RESOLUTION 23-B-1 (Amend) (RC)

RESOLVED, that *Section XI, Budget and Finance, 14. Honorarium Policies* of the Policies be amended as follows with all conflicting bylaws, policies, etc. amended accordingly (strikethrough = deletion; bold underline = addition):

*a. President, President-Elect, Vice President, Treasurer, Past President, Speaker of the House of Delegates and Trustees:* An annual honorarium of ~~$120,000~~ **$129,000** shall be disbursed to the President; ~~$96,000~~ **$103,200** to the President-Elect; ~~$60,000~~ **$64,500** to the Vice President; ~~$60,000~~ **$64,500** to the Treasurer ~~annually~~; ~~$60,000~~ **$64,500** to the Immediate Past President, and ~~$42,000~~ **$45,150** to the Speaker of the House of Delegates, and ~~$42,000~~ **$45,150** to each of the six Trustees during their term of office. All of the remuneration authorized under this policy is paid solely as remuneration for the service of the individuals as Trustees, with the differences in remuneration reflecting differences in time spent fulfilling Trustee duties. (HD- 79; Nov. 79; May 80; June 86; Jan. 90; Dec. 91; June 96; Dec. 97; March 99; April 00; March 04; March 08; Sept. 11; Oct. 18; **Feb. 23**)

Fiscal impact: $51,750 (for inclusion in 2024 budget)

## RESOLUTION 23-B-2

RESOLVED, that the amended or added policies as approved by the Board during the period October 2022 through June 2023, as reflected in Appendix I of the 2023 Annual Reports, be approved.

## RESOLUTION 23-B-3 (Amend)

RESOLVED, to accept 2024 operational budget with revenues of $24,428,365 and expenses of $24,418,400 as presented in Section II of the 2023 Annual Reports which includes a dues increase of $35 (2.26%) for full paying members with proportional increases for members in discounted dues categories.

## RESOLUTION 23-NB-1 (District III)

RESOLVED, that the Board of Trustees establish a Work Force Task Force to develop and deliver a program for the recruitment, training, and education of qualified Oral Surgery Assistants at the earliest time possible and report back to the 2024 House of Delegates.

## RESOLUTION 23-NB-2 (District VI)

RESOLVED, that AAOMS explores through the Committee on Anesthesia, that in conjunction with the American Society of Anesthesiology (ASA) the current usage guidelines for use of GLP-1 agonists be evaluated and provide any updates and recommendations to improve anesthesia safety in the oral and maxillofacial surgery delivery of care.

# LEGISLATIVE UPDATE

*by Gary Cooper*
*Legislative Advocate, CALAOMS*

## Fall/Winter 2023 Legislative Report

In October, CALAOMS was pleased and proud to announce our 2023 legislative success, the passage of AB 936 (Wood). Now in November, it is time to consider our legislative agenda for 2024. The 2023/24 legislative session reconvenes for the second year of the two-year session on January 3, 2024. During the next seven weeks, legislators and interest groups like CALAOMS formulate their planned agendas and proposed legislative bill packages for 2024. That is my anticipated strategy for CALAOMS.

The Dental Loss Ratio (DLR) issue remains a topic of great interest to CALAOMS. While our 2023 attempt at dealing with DLR was curtailed by CDA's opposition to introducing a bill now, the political landscape nationally has demonstrated significant interest in this topic, with several states moving bills in 2023. The ADA remains very supportive of states moving legislation if possible.

On November 3 and 4, I attended virtually the annual AAOMS Legislative Advocates Forum. OMS lobbyists from all over the country gather to share information on the hottest legislative issues in their specific states. Three specific issues stood out as somewhat universal throughout the country.

*Dental Loss Ratio Legislation*. While many states continue to attempt to move DLR legislation as a single issue, some states are using proposed DLR bills to leverage insurance providers to offer better coverage. The consensus was that DLR remains a hot and viable issue in most states.

*Dental Anesthesia*. As always, the administration of anesthesia in oral surgery offices is an area of concern in most states. We continue to advocate for and educate legislators on the OMS anesthesia team model, telling them about out the exemplary safety record of in-office anesthesia utilizing our standards of practice.

*CRNAs and independent anesthesia practice*. Many states continue to report that CRNAs are pushing for more independent practice ability in dental offices. It is possible that a CRNA bill will be introduced in 2024 in California. CALAOMS has been clear with the CRNA community as to our position: we support CRNAs providing anesthesia in a dental office where a 3-person team is present and at least one additional team member is trained in sedation and advanced life support.

The Dental Board of California (DBC) met on November 8 and 9. As always, I represented CALAOMS at the meeting. In 2024, the Dental Board has to appear and present before the Legislative Sunset Review Committee (Senate and Assembly Business and Professions Committee). This year, the DBC is recommending that the Elective Facial Cosmetic Surgery (EFCS) Committee be repealed for efficiency reasons. CALAOMS has already gone on record as opposing that recommendation. CALAOMS will work with the legislature to oppose that recommendation when the Sunset bill is drafted. I have already had preliminary discussions with Senator Roth, the chair of Senate Business and Professions Committee.

Dr. Alan Felsenfeld was re-elected for a third term as the president of the Dental Board.

Since 2024 is an election year, I continue to meet with candidates for Assembly and Senate. In addition, I continue to attend fundraising events for those legislators identified as meaningful to CALAOMS's interests.

Please feel free to contact me with any questions or concerns. I am always happy to discuss our issues.

Gary

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## Q4 Update to OMS Societies

Donate today to help the OMS Foundation meet a $25,000 gift-match challenge from OMS Partners, LLC during its 2023 year-end appeal. Gifts which will be matched include inaugural OMSFIRE gifts, Donor Advised Fund disbursements and Qualified Charitable Distributions from your retirement account.

Here are just a few things your donations supported this year:

- Four OMS-specific research grants
- Mentorship and training of promising OMS residency candidates
- Program support and resident travel scholarships to CSIOMS
- A free Lunch & Learn for AAOMS faculty at the Annual Meeting
- 14 GIVE stipends awarded to residents traveling with humanitarian healthcare teams
- Four resident families welcomed to the AAOMS community through Norma Kelly Resident Spouse Scholarships, in collaboration with OMSNIC and the OMS Foundation Alliance

*Learn more about the Foundation's programs and your colleagues who support them in the Fall 2023 issue of The TORCH, arriving with your Nov/Dec AAOMS Today.*

**Thank you to everyone who supported the Foundation with a gift in 2023**

OMSNIC's "cooler together" appeal at the Annual Meeting got off to a strong start with a $10,000 gift from the Massachusetts Society, and 14 new OMSFIRE donors were entered into the drawing for a new RTIC cooler. More than $125,000 was raised for research and education in September.

More than 225 AAOMS members, practices and industry partners have made the commitment to OMSFIRE. Enroll online or mail in a Donation Form before December 15 to qualify for the OMS Partners LLC gift-match.

**Join the R.V. Walker Society with a legacy gift**

A gift to the Foundation in your estate plan allows you to be generous without significantly impacting your current resources. Donating a life insurance policy or including a gift in your will are just two options. Learn more here, and contact Mary DiCarlo (mdicarlo@omsfoundation.org) to join the R.V. Walker Society.

**Podcasts address your urgent questions**

How does the OMS Foundation fit into an aspiring OMS researcher's funding plan? How can our specialty develop future OMS thought leaders? Should we be concerned about the soil on Mars? Drs. Louis Rafetto and Simon Young share their insights about these and other topics in two engaging episodes of the AAOMS On the Go podcast:

**OMS Research – The Future of the Specialty Depends on It** – guest Dr. Simon Young at UTHealth Katz Department of OMS

**Who Needs the OMS Foundation in this Day and Age? (Hint: You do)** – guest Louis K. Rafetto, DMD, MEd, Past Chair of OMS Foundation

AAOMS On the Go is a podcast series for OMSs and anyone interested in oral and maxillofacial surgery. Listen and/or subscribe to the series on your favorite platform: Apple Podcasts, Podcast Mirror, iHeart, Stitcher, Spotify, TuneIn or Google Podcasts. Or find these and other episodes at AAOMS.org/Podcast.

# MEANING IN ETHICS

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

## Meaning in Ethics & Existentialism - Part II

An existential 'rethinking of medicine' requires first of all a revelation of the root metaphysical assumptions and metaphors that shape the dominant 'biomedical' model of health and illness – first and foremost the mechanistic assumption that illnesses have biological 'causes' rather than existential meanings and secondly the basic military metaphor of 'war' against diseases and death – whether fought through the medium of biomedical research or the body's own so-called immune 'defenses'. Here it is not enough to question such metaphysical assumptions and metaphors merely within the framework of a general 'Philosophy of Medicine'. Instead, what is needed is a critical examination and rethinking of specific biological sciences and their languages (for example, the languages of genetics and molecular biology, immunology, virology, oncology, etc.).

This, in turn, is impossible without knowledge of both the philosophical roots and historical evolution of the biological sciences and their languages. A thorough phenomenological rethinking of medicine must also address in a new way the nature and essence, not just of body hood as such, but also the nature of specific organs, bodily functions and their associated organic 'disorders' or 'diseases', thus enabling us to understand their complex and intricate 'biology' in the root sense of this term – as an expression of the logos or 'speech' of life (bios), something in no way reducible to molecular-genetic 'alphabet and vocabulary'.

# OMS & TECHNOLOGY

*by David Cummings, DDS*

## Mesial Drift – Fact or Fiction

The decision to place endosseous implants affects patients' lives in many ways. Not only do patients have the desire to replace missing teeth, but they want and expect excellent long-term results. Patients rely on oral and maxillofacial surgeons (OMSs), as professionals, to guide them in making sound decisions that will affect them for many years. It is common for OMSs to receive referrals from orthodontists requesting evaluation of spaces left by congenitally missing teeth in young patients in preparation for implant placement. When is the best time to place a dental implant in a young patient?

As OMSs, we have dealt with various complex growth-related issues in orthognathic surgery for many years. If a 16-year-old male presents to the office with a diagnosis of mandibular horizontal hyperplasia (class III skeletal malocclusion) and the orthodontist suggests he is ready for surgery, how do we address the parents when they ask, "Isn't my son too young for jaw surgery?"

We all understand there are patients who look twenty years old but are only sixteen years old. This patients' mother was insistent on having implants placed right away since the patient was congenitally missing many teeth (Figure 1). The patient was only 14 years old at the time.

Whether for orthognathic surgery or the placement of endosseous implants, how do we know when patients are ready for these surgeries? There are multiple ways to evaluate growth utilizing patients' history, physical examination findings, and radiographic findings. We start with the basic historical questions regarding growth: Has there been growth in



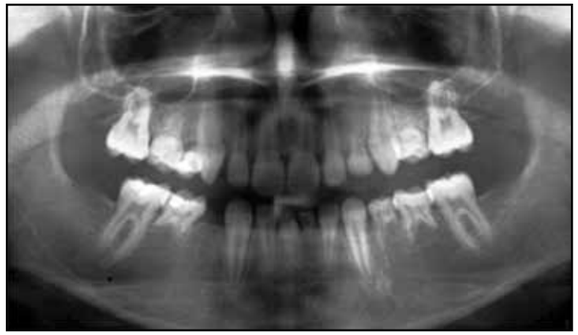

*Figure 1. 14-year-old female with multiple congenitally missing teeth.*

height in the last 6-12 months? Has their shoe size increased recently? For females, asking how long-ago menarche started. Radiographic imaging including serial lateral cephalograms, cervical vertebrae, and wrist films all can provide good insight to the growth of the patient.

Chronological age is not sufficient to estimate growth cessation. Kokich [1] suggests that a clinician should rely on:

1. Superimposing tracings of cephalometric radiographs taken at least 6 months apart.
2. Waiting until no growth changes have taken place for one year.
3. Evaluating bodily growth in length annually for 2 years to make sure that annual growth is less than 0.5 cm/year.
4. Observing changes of dental positions with the arch, such as the eruption of the second molar.

The concern we have when making these decisions is, "When is the right time to perform surgery? Should we wait?"

It has been well documented that infraocclusion can be seen with ankylosed incisors. Malmgren followed 42 children with reimplanted ankylosed incisors for 10 years. Over that 10-year period, children under the age of 10 years saw 3 mm of infraocclusion; children between 10 and 12 years saw 2.5 mm of infraocclusion; and ages 12-16 saw 1.5 mm of infraocclusion. [2]

When dental implants are placed in growing patients, it is well documented that they behave like ankylosed teeth. Studies have confirmed that implants placed into adolescent patients do not follow the changes in the alveolar process by continued eruption of the adjacent teeth. [3] In the early 1990s, both Odman and Sennerby, in different studies, concluded that implants placed into growing pigs behaved more like ankylosed teeth. [4, 5] Sennerby also noted that the tooth germs (buds) adjacent to implants had an altered path of eruption. Thilander followed ten adolescent patients for 8 years, ranging in age from 14-19 years old. He found changes in the vertical position of the implant-supported crown especially in subjects with no incisor contact. [6] He also noted that there was marginal bone loss on the teeth adjacent to the implant.

What causes mesial drift in implant cases (Figure 2)? The first thought that comes to mind is continuous growth of the patient and that maybe we should have waited until the patient was older to perform this surgical procedure. Interestingly, Bishara studied the dental arches and dentition in adults between the ages of 25-45 years of age. They found an increase in vertical overlap and a decrease in arch length measurements indicating crowding or mesial drift of the teeth with aging. [7] Forsberg looked at vertical craniofacial changes in thirty patients between ages 25-45 over a twenty-year period. They demonstrated an average increase of 1.6 mm in the vertical face height. [8]

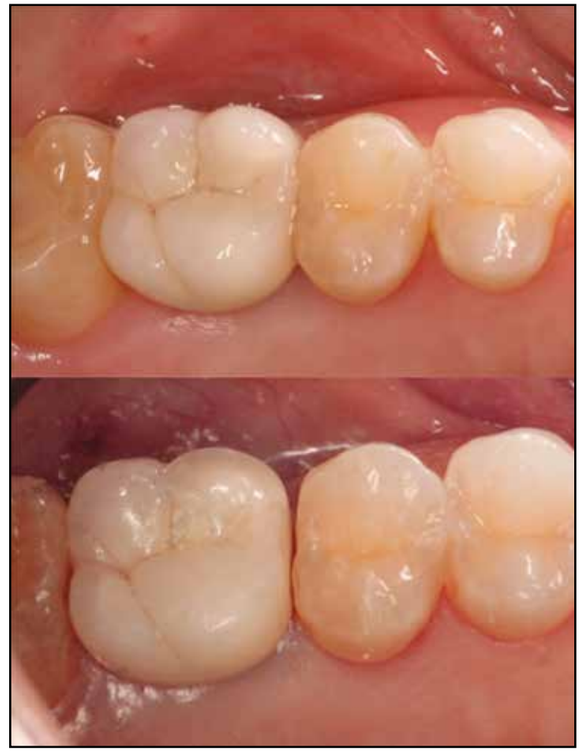

*Figure 2. Case courtesy of Dr. Baldwin Marchack. Implant crown at time of cementation (top), and at 5 years (bottom) showing mesial drift of teeth anterior to the implant crown.*

Thilander followed his adolescent patients for an additional five years. He found there was continued infraocclusion even though the patients showed no skeletal growth. He attributed this phenomenon to a lack of incisor stability. (6) If the incisors are not in occlusion, they will continue to erupt to "find" the opposing occlusion, creating infraocclusion of the adjacent implant.

Occlusal forces also must be mentioned as an etiology for mesial drift. In 2007, Wei retrospectively evaluated 55 posterior fixed implant prostheses to clarify interproximal contact loss after fixed implant prosthesis placement. Occlusal force analysis was performed using the Dental Prescale System. The results showed trends to a high proportion of lingual and anterior component forces with contact loosening and high occlusal forces in the intercanine region, resulting in a higher mesial force vector. Therefore, this is considered to drive the anterior teeth forward resulting in spacing anterior to the implant prosthesis creating a mesial interproximal contact loss. [9] Along with occlusal forces, Downs felt that the facial musculature could contribute to mesial drift. [10]

In 2010, Koori published a study on interproximal contact loss. He looked at 105 patients with an age range of 20–78 years. [11] The interproximal contacts were measured with a contact gauge 50 um thick every 6 months for 8 years. The initial contact was verified with the gauge at the time of prosthetic delivery. 43% of the interproximal contacts were lost. He noted that the mesial contact was lost more frequently than the distal (51.8% vs 15.6%). The loss of contact was seen more in the mandible versus the maxilla (49.2% vs 31.8%).

Tarnow also performed a similar study to determine the prevalence of open contacts between single tooth implant restorations and adjacent natural teeth. He evaluated 174 single implant restorations. [12] The patients ranged in age from 19 to 91 years. The period of evaluation was between every 3 months and 11 years. Dental floss (0.07 mm thick) was passed, and if no resistance was felt, then it was considered an open contact. His results had some similarity to Koori's study. There was more prevalence of the interproximal contact loss with the mesial side of the implant restoration versus the distal (78.2% versus 21.8%). He did note a higher percentage of open contacts in the maxilla versus the mandible (57.9% versus 49%). Tarnow also pointed out the antirotational and vertical discrepancies with machined implant components have been reported in the literature. If the restoration is screw-retained, this may lead to contact discrepancies resulting in applied forces to adjacent natural teeth. Cement-retained restorations would eliminate this issue, but cement-retained restorations have their problems too (i.e., retrievability and residual cement). For cement-retained restorations, he recommended the use of temporary cement and the use of a slot (Whitehead box) to lift the restoration off the abutment for the purpose of retrievability.

Why is all this important? Jernberg investigated the periodontal status of teeth with unilateral open contacts in 104 patients and found increasing probing depths and attachment loss were found at the proximal open contacts. [13] Food impaction between implant prostheses and adjacent teeth may lead to complications such as periodontal defects, recurrent decay, and peri-implant complications. Moreover, consideration needs to be given since the peri-implant tissue is more susceptible to damage than the periodontal tissue of natural teeth. [14] Ultimately, this can lead to loss of the implant or loss of the adjacent tooth.

There are many theories and philosophies as to why mesial drift occurs. These include continued growth well past puberty, occlusal forces, musculature of the face, incisor instability, interproximal wear, root angulation, and the influence of transeptal fibers.

Recommendations for decreasing the incidence of mesial drift include:

1. Completion of growth of the patient prior to implant placement. After the second decade of life, it is clinically insignificant. [15]

2. When orthodontics is completed, ensure good incisor stability and use of post-retention orthodontic appliances to maintain the most stable occlusion (e.g., retainers).

3. Screw-retained implant restorations make retrievability easier to correct the interproximal contact loss, or the use of an angulated screw channel to convert a cement-retained restoration to screw-retained restoration if an interproximal contact did open.

4. Cement-retained implant restorations – use temporary cement and use of a Whitehead box to facilitate crown removal in cases where interproximal contacts could be lost.

5. Lastly, the use of some form of Essex retainer or nightguard to prevent tooth movement once the final restoration is complete.

Since continued growth in adults has been shown to occur even after adolescents have gone through puberty, there is still a chance that mesial drift may occur even if we follow all these recommendations.



Many patients assume that endosseous implants will last forever, but nothing in life lasts forever. Implants do fail. The most important aspect is to make sure that our patients have realistic expectations, and they understand that we have limitations in dentistry and surgery. They need to understand that all we can do is try our best.

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*by Mahr Elder, DDS, MD*

## Anti-Resorptive Medications and Dental Clearance

Oral and maxillofacial surgeons are accustomed to receiving physician requests for dental clearance prior to joint replacement surgery, cardiac surgery, and head and neck radiation. We extract compromised teeth and perform surgery while referring dentists complete the necessary dental and periodontal procedures. These patients are treated to resolve oral infections, improve gingival health, and stabilize dentition with the intention of preventing dental procedures for a minimum of 6 months after surgery. Dental clearance prior to these medical procedures is the standard of care.

In 2003, oral and maxillofacial surgeons first noticed that some patients receiving bisphosphonate medications were developing osteonecrosis of the jaw – a condition rarely seen before then. Medication related osteonecrosis of the jaw (MRONJ) is now a well-recognized condition in the dental and medical community and is quickly becoming more familiar to the public. Patients administered bisphosphonates or similar antiresorptive medications for osteoporosis are at a much lower risk of MRONJ compared to those being treated for cancer. Patients who are planned to begin IV antiresorptive medications for cancer treatment or nonmalignant bone diseases have a 100x greater risk of developing MRONJ than patients being treated for osteoporosis, < 5% vs. < 0.05%. [1]

Dental clearance should be the standard of care prior to initiating IV antiresorptive medications and on an annual basis thereafter in these high-risk groups. Formal dental clearance does not appear to be necessary in the osteoporosis patient population as the risk of MRONJ is relatively low, but the prescribing physician should encourage normal dental maintenance. The incidence of dental origin morbidity is significantly higher in the IV bisphosphonate cancer population than the cardiac or orthopedic surgery clearance groups.

Dental clearance is used to determine the health of the oral cavity prior to surgery or radiation therapy to prevent infection of a separate surgical site or future osteoradionecrosis. The American Heart Association states, "A careful preoperative dental evaluation is recommended so that required dental treatment may be completed whenever possible before cardiac valve surgery, or replacement or repair of congenital heart disease. Such measures may decrease the incidence of late prosthetic valve endocarditis caused by viridans group streptococci." [2]

In the United States, surgeons perform about 106,000 heart valve operations each year. Nearly all these operations are done to repair or replace the mitral or aortic valves. [3] The incidence of infective endocarditis is reported between 1-3% at 60 months following valve replacement surgery. [4] Infective endocarditis (IE) has many causative organisms. Streptococci accounts for 50-80% of IE cases. Streptococcus viridans make up the normal bacterial flora of the pharynx and is the cause of most of these infections. Dental origin bacteremia can result in cardiac valve infections. Staphylococci accounts for 20-30% of subacute cases of IE. Enterococci accounts for 5-15% of IE cases. [5] The risk of infective endocarditis following heart valve replacement from dental infections, dental neglect, and dental origin bacteremia is clear. Dental clearance prior to cardiac surgery saves patient lives and significantly reduces post-operative morbidity and complications.

Total knee and hip replacement surgery are two of the most performed elective operations. About 1% of patients develop infections post-operatively. The most common ways bacteria enter the body include through breaks in the skin, during dental procedures, and through wounds from other surgical procedures. [6] The most common pathogens for prosthetic infection are bacteria, especially Streptococci and Staphylococci. [7] Approximately 790,000 total knee replacements and over 450,000 hip replacements are performed annually in the U.S. This number continues to grow as our population ages. [8] When a prosthesis becomes infected, three to four times as many resources are required compared to primary arthroplasty. [9] Approximately 30% of patients who are sent for dental clearance require extensive dental treatment prior to total joint replacement surgery. The treatment of dental pathology prior to elective arthroplasty remains an important intervention. Oral bacteria cause 6-13% of prosthetic joint infections. Poor oral health is considered a modifiable factor to improve the success of joint arthroplasty. [10]



The benefits of dental clearance prior to heart valve replacement and total joint replacement surgery are well established. Both surgeries have low incidence of post-operative infection reported in the 1-3% range. But when infections develop, the associated morbidity is high. Oral bacteria are a significant source of these infections, but, of course, not the only cause.

The role and importance of the dental professional has been clearly established. Dental clearance is the standard of care. I argue that patients who are going to begin IV antiresorptive medication treatment for cancer and nonmalignant bone disease need to have dental clearance prior to beginning treatment and on an annual basis thereafter for the same reasons. This should not be a general recommendation but should also be the standard of care.

MRONJ is a serious adverse drug reaction commonly associated with bisphosphonates and denosumab therapy. There are also several novel medications associated with MRONJ. These include bevacizumab, lenalidomide, corticosteroids (prednisolone and dexamethasone), docetaxel, paclitaxel, letrozole, methotrexate, imatinib, teriparatide, palbociclib, pomalidomide, radium 223, nivolumab, and cabozantinib. Recent data suggests a 0.7-6.7% risk of MRONJ amongst cancer patients exposed to bisphosphonate therapy, which is approximately 50-100 times higher than those treated with placebo. [11] MRONJ is going to remain a serious side effect for our patients. We need to develop consistent protocols to minimize the incidence of MRONJ.

"*Osteonecrosis of the Jaw has been reported predominantly in cancer patients treated with IV bisphosphonates. Many of these patients were also receiving chemotherapy and corticosteroids which may be risk factors for ONJ. Experience and literature suggest a greater frequency of ONJ based on tumor type (advanced breast cancer, multiple myeloma) and dental status (dental extraction, periodontal disease, local trauma including poorly fitting dentures). Cancer patients should maintain good oral hygiene and should have a dental examination with preventive dentistry prior to treatment with bisphosphonates*." [12] This statement is from the Zometa prescribing information provided by Novartis Pharmaceutical Company. Novartis stresses the importance of a dental exam prior to beginning Zometa to reduce the incidence of MRONJ. Requesting a dental clearance may be inconvenient for our medical colleagues especially when coordinating so many other therapies for cancer treatment but the benefit is clear.

Cancer therapy that utilizes IV bisphosphonate treatment mainly includes multiple myeloma and metastatic cancer that has spread to the bone. It is estimated that more than 50% of all cancers develop bone metastases. Approximately 350,000 people die each year from bone metastasis in the United States. They occur frequently in breast cancer (65-75%), prostate cancer (65-90%), and lung cancer (17-64%), and less frequently in thyroid cancer (65%), bladder cancer (40%), melanoma (14-45%), kidney cancer (20-25%), and colorectal cancer (10%). Bone lesions are found in 70-95% of multiple myeloma cases. It is estimated that there are approximately 280,000 new cases of bone metastases annually in the United States. Multiple myeloma, breast, and prostate cancer are responsible for up to 70% of bone metastases cases. The most common clinical symptom of metastatic disease is bone pain. Other symptoms include vertebral and long bone fractures, spinal cord compression, and immobility. The spine is the most common site of metastatic bone tumors. The most common site of spinal metastasis is the thoracic spine (60-70%), followed by the lumbosacral spine (20-25%), and the cervical spine (10-15%). ([13] In the early 1970s, the median survival time for patients with metastatic disease was 1 year. By 2007, it was 6 years; and by 2011, it was 10 years. Today, it is estimated that over 50% of patients survive their disease beyond 10 years. With the increased longevity, the age of patients with metastatic bone disease and rates of survival are on the rise. [14]

Multiple myeloma is a cancer of plasma cells, which is a type of white blood cell in the bone marrow that produces antibodies. When one tumor is present, the condition is called plasmacytoma; when multiple tumors are present, it is called multiple myeloma. Newly diagnosed multiple myeloma patients often present with the following symptoms: anemia (73%), bone pain (58%), elevated creatinine (48%), fatigue (32%), hypercalcemia (28%), and weight loss (24%). Bone pain from osteolytic lesions often results in pathologic fractures and vertebral collapse. [15] In 2023, an estimated 35,730 adults will be newly diagnosed with multiple myeloma in the United States. It is estimated that 12,590 deaths from this disease will occur in 2023. The 5-year survival rate is about 58%. [16] An estimated 170,405 people are living with multiple myeloma in the United States. Most patients are treated with IV bisphosphonates, either pamidronate or zoledronic acid. They may also receive denosumab (Xgeva®), a RANK ligand inhibitor (Table 1)... *Top of Page 22.*

Antiresorptive medications are a key component in the treatment of multiple myeloma and bone metastases. Bisphosphonates inhibit bone resorption by clinging to hydroxyapatite binding sites on the bone, particularly in areas with active bone resorption. As osteoclasts resorb bone, the bisphosphonate embedded in the bone is released and impairs the osteoclast's ability to continue bone resorption. [17] Among the intravenous agents, zoledronic acid is approved for the treatment of bone metastases in solid tumors and multiple myeloma. Pamidronate is approved for patients with breast cancer and multiple myeloma. Denosumab is a human

| Current Anti-Resorptive Medications | | | | | |
|---|---|---|---|---|---|
| **Name of Drug** | **Primary Indication** | **Dose** | **Route** | **MRONJ Risk** | **Non-Bisphosphonate** |
| Alendronate (Fosamax®) | Osteoporosis, Paget's Disease | 70 mg q week | Oral | Low | |
| Risedronate (Actonel®, Atelvia®) | Osteoporosis | 35 mg q week | Oral | Low | |
| Etidronate (Didronel®) | Paget's Disease, Heterotopic Ossification | 5-20 mg/kg/day for 3-6 mos. | Oral | Low | |
| Tiludronate (Skelid®) | Paget's Disease | 400 mg q day for 3 months | Oral | Low | |
| Ibandronate (Boniva®) | Osteoporosis | 150 mg once per month | Oral | Low | |
| | | 3 mg every 3 months | IV | | |
| Zoledronate (Reclast®) | Osteoporosis | 5 mg q year | IV | Low | |
| Zoledronic acid (Zometa®) | Bone Metastases, Multiple Myeloma | 4 mg q 3 weeks | IV | High (<5%) | |
| Pamidronate (Aredia®) | Bone Metastases, Multiple Myeloma | 90 mg q 3 weeks | IV | High (<5%) | |
| Denosumab (Xgeva®) | Bone Metastases, Multiple Myeloma | 120 mg q 4 weeks | SQ | High (<5%) | Antibody Against RANK-ligand |
| Denosumab (Prolia®) | Osteoporosis | 60 mg once every 6 months | SQ | Low | Antibody Against RANK-ligand |
| Romosozumab (Evinity®) | Osteoporosis | 210 mg q month x 12 months | SQ | Low | Monoclonal Antibody Inhibiting Sclerostin |

***TABLE 1***

monoclonal antibody that targets the receptor of NF-kB ligand (RANKL), a protein that acts as the primary signal to promote bone loss. Denosumab inhibits the interaction between RANKL and RANK, therefore reducing osteoclast maturation and activity. The guidelines for denosumab and bisphosphonates for metastatic bone disease are alike. Denosumab was found to be superior in some studies in preventing skeletal related events in patients with bone metastases. [13]

Antiresorptive medications prescribed for treatment of osteoporosis and osteopenia are considered a low risk for causing MRONJ. The data suggests incidence of MRONJ is less than 0.05% in this patient population. Approximately 54 million Americans have osteoporosis or osteopenia and are at increased risk of fractures. But the rate of treatment with these medications has dropped dramatically over the past decade from 15% to 8%. One of the reasons for the reduction in treatment is due to public concern about the medication side effects including MRONJ. [18] Patients may ask their dentist or oral and maxillofacial surgeon about the risk of MRONJ with these medications. We should encourage our patients to take anti-resorptive medications when recommended by their physician. The benefits of these medications are significant and the risk of MRONJ is low, especially with regular dental maintenance and collaboration with the prescribing physician.

The number of patients with bone metastases and multiple myeloma will continue to increase as treatment options improve their overall survival rate. The benefits of IV bisphosphonates are clear but the side effects are significant. Dental clearance prior to starting antiresorptive medications and annually thereafter is imperative in the prevention of MRONJ. Treatment options quickly become limited once the medication is initiated. Cancer patients are generally administered antiresorptive medications for the rest of their lives as part of their treatment. Therefore, communication between the prescribing physician, generally the oncologist, and the dentist or oral and maxillofacial surgeon should begin at the onset of treatment and updated on an annual basis. This should be part of the standard prescribing instructions of these medications. Collaboration between the oral and maxillofacial surgeon and treating physician would reduce the incidence and severity of MRONJ. I believe that the medical, dental, and pharmaceutical communities would agree that this is the ideal approach to patient treatment. There are well over 1 million patients with bone metastases and multiple myeloma in the United States, most of whom are being treated with IV bisphosphonates and denosumab. These patients are not routinely being referred to the dentist or oral and maxillofacial surgeon for clearance by the prescribing physician. We generally see these patients once treatment has been initiated and the patient is having a significant dental issue or signs of MRONJ.

The benefits of dental clearance prior to treatment are well established in the orthopedic and cardiothoracic fields. The incidence of MRONJ in cancer patients is significantly higher than the risk of valve or joint infection from dental origin. Why are we seeing a slow adoption of dental clearance in oncology? We all agree that once a patient is diagnosed with cancer, treatment should be initiated immediately. But the antiresorptive component of their treatment should not be initiated without dental communication. At a minimum, communication with the dentist should begin at the onset of treatment when the risks of MRONJ are still low.



Unfortunately, many prescribing physicians are not making the referral to the dentist. Dental clearance, release, and annual communication should be the adopted protocol for prescribing these medications. Currently, a clear protocol has not been adopted or accepted. Prescribing physicians and pharmaceutical companies should accept this as a best practice when administering IV bisphosphonates and denosumab for cancer treatment. We do not need malpractice attorneys to develop "CYA" protocols for us; our treatment should be driven by sound data.

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# Prevention of Wrong Site Surgery

*by David Cummings, DDS*

Mistakes are an inevitable part of every human endeavor even amongst the most highly conscientious professionals. [1] Tooth extraction is a common procedure for oral and maxillofacial surgeons (OMSs), and accounts for more than 70% of what OMSs do. [2] Given that, OMSs are at more risk for an "error" when performing these types of procedures. Many checks and balances have been instituted over time to reduce risk exposure, including recommendations from the Institute of Medicine (IOM), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and OMS malpractice carriers.

In 1999, the IOM issued a report on medical errors and patient safety. [3] They estimated the annual medical costs to be $37.6 billion, and of that, $17 billion was preventable. They encouraged and focused on implementing systems of delivery of care that would decrease these types of incidents.

The most influential changes came from JCAHO in 2004. They reviewed cases from 1995-2004 looking at wrong-site surgery. They found that orthopedic surgeons had the highest incidence of wrong-site surgery with 41%. Oral and maxillofacial surgery was clumped together with ENT, ophthalmology, and thoracic surgery; and that incidence of wrong-site surgery was 14%. [4]

In 2004, JCAHO mandated compliance with the Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery. The Universal Protocol is comprised of three basic principles: 1) Pre-operative verification process; 2) Marking the operative site; and 3) "Time out" before starting the procedure. [4] JCAHO mandates this protocol as part of their accreditation process so any hospital or surgery center that is JCAHO-compliant must follow these guidelines (i.e., our local hospitals and/or surgery centers).

The pre-operative verification process in the hospital setting may vary slightly from one facility to another. In most hospital settings, the pre-operative nurse will confirm the correct person and the correct procedure to be performed. They will also verify the consent, history and physical, labs, implants, imaging, and NPO status of the patients.

The second part of the Protocol is marking the surgical site. The nurse will have the surgeon mark the surgical site. "X" marks the spot is no longer utilized, as this can be confusing. The correct notation on the patient is to scribe the word "yes" over the surgical site (Figure 1). One of the exclusions to marking the surgical site is extraction of teeth. In hospital settings, the operative tooth is named, or teeth are marked on a dental radiograph. [5]

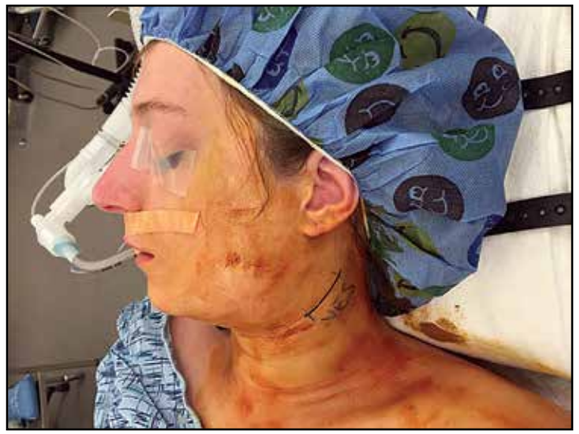

*Figure 1. The word "Yes" has been written on the patient's left submandibular area as part of the Universal Protocol pre-operative site verification process.*

The last part of the Universal Protocol is the "time out." This is a team approach with the surgeon, anesthesiologist, circulating nurse, surgical technician, and any other ancillary staff participating in the operating room. Who leads the time out process is not so important, but completing it is. Minimal requirements to include in the time out are: name of the patient, identification (medical record) number, the surgical site, and the correct procedure to be performed (Figure 2).

*Figure 2. The time out procedure is performed in the operating room with the surgeon, anesthesiologist, and circulating nurse to verify the correct patient, correct site, and correct procedure.*

The implementation of the Universal Protocol process has been a very successful tool to help improve patient outcomes regarding wrong-site surgery. This protocol is effective in the hospital setting but there are really no established protocols in the outpatient settings. Every practitioner needs to understand the causes of wrong-site surgery and develop some type of protocol for their own office.

There are many reasons that wrong-site surgery can occur. The reasons can be divided into three categories: Inadequate or incomplete communication, lack of independent examination, and inadequate imaging. The most common reason for wrong-site surgery (tooth) is lack of communication. [2] Peleg reported 54 cases of wrong tooth extraction over a nine-year period. He found 12% of those cases were because the referral was written incorrectly. [6] Communication can be via a handwritten referral, facsimile, telephone call, email, or text message. The use of a written referral that clearly defines the proposed procedure is strongly recommended. Prior to the procedure, the surgeon should review the referral, understand the referral, and confirm that the referral also makes logical sense. There are a few different numbering systems that dentists and orthodontists use to identify teeth. The American Dental Association recognizes the Universal Numbering System and the International Number System. If the numbering system is not clear or appropriate, then it is advised to contact the referring dentist and clarify exactly what he/she is requesting before proceeding with the surgery.

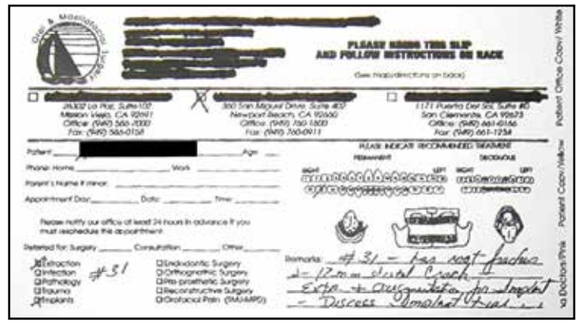


*Figure 3. Written referral requesting extraction of tooth #31 due to root fracture and 12 mm distal pocket.*

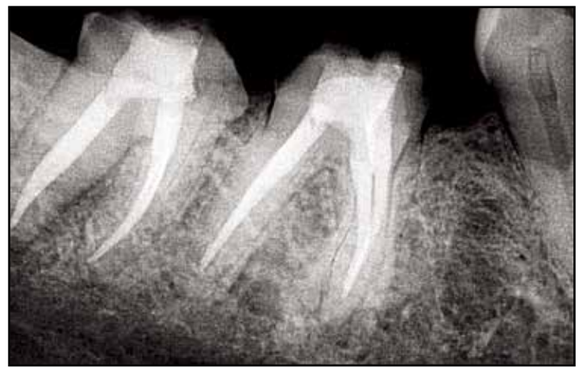

*Figure 4. Periapical radiograph demonstrating missing tooth #30 with mesial drift of root canal treated teeth #31 and 32.*

An independent examination by the OMS is very important. Many patients will ask the surgeon if he/she agrees with the diagnosis established by the referring provider or if there are alternative options that exist. The patient is looking to the OMS to confirm that diagnosis. Performing an independent examination allows the OMS to verify the diagnosis with the patient and confirm that the written referral is accurate and appropriate. Ultimately, this process leads to patients becoming more comfortable with both providers before proceeding with the treatment plan. If the OMS is not clear about the procedure or the referral, then it is prudent to delay the treatment until clarity has been obtained. For example: A 51-year-old male is referred to the OMS for extraction of tooth #31. The written referral requests extraction of tooth #31 and states that there is a 12 mm pocket on the distal of #31. The periapical radiograph shows two root canal treated molars. It appears that these molars have drifted anteriorly and that there was a previous extraction in the #30 position (Figures 3 and 4). Which tooth does the OMS extract? It is difficult to know for sure if the dentist is referring to "tooth #31" as the tooth in the second molar position (which would be tooth #32 in this case), or do we know for sure that the referral knows that #31 has drifted mesially into the first molar site? In this case, performing an independent exam is essential to obtain the correct diagnosis. Probing of both teeth confirms which tooth the dentist is referring to and which tooth should be removed. If, after the OMS's independent examination and he/she is still unclear, the OMS can always contact the referral for final confirmation of the correct tooth. The carpenter's adage, "Measure twice, cut once" very much applies in situations like this.

Inadequate imaging may result in wrong-site (tooth) surgery. Many images can be of poor quality and can interfere with making a correct diagnosis. Whether it is cone beam computerized tomography (CBCT) or plain film radiographs, images need to be appropriately labeled with the patient's name, date the image was obtained, date of birth, and most importantly, have the correct labeling of right vs. left side. Improperly labeled radiographs can easily lead to the removal of the wrong tooth or wrong-site surgery (Figure 5). If there is any confusion or doubt about the accuracy of an image, a new radiograph should be taken.

Other risk factors for wrong-site surgery include likeness of the site and procedure, similarity of patient's names (i.e., siblings, twins, multiple patients with the same name, etc.), and failure to implement safety checks or a universal protocol

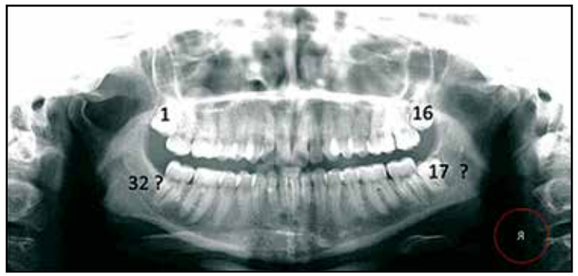


*Figure 5. Panoramic radiograph as sent to the OMS. While it is likely that the image was flipped, the OMS must ensure the accuracy of findings prior to initiating surgery to prevent wrong site surgery.*

process. At the 2015 AAOMS Scientific Session, Dr. Rich Robert and Mr. Art Curley, Esq., presented [7] an office protocol on prevention of wrong tooth extraction. They developed an acronym called "EXTRACT":

**E** – *Examine* – an independent examination preferably on a different day.

**X** – *X-ray check* – is it diagnostic, current, correct patient and date, and appropriate orientation?

**T** – *Treatment plan* – after your independent examination, do you agree with the referring dentist?

**R** – *Review* the chart prior to performing the surgery.

**A** – *Announce* your plan to the patient and your team – "Time out."

**C** – *Count* the teeth during the time out.

**T** – *Treat* the patient but start by recounting the teeth.

Whether this excellent protocol is used or not, the most important point here is to have a protocol; something that the OMS and staff perform routinely, and one where the staff can assist the OMS in the prevention of unwanted outcomes.

If the wrong tooth is inadvertently removed, it should be explained immediately to the patient (or responsible family member if the patient is a minor). The referring dentist/orthodontist should be notified. The malpractice carrier should also be notified and consulted for advice and support. With the counsel of the liability carrier, one can consider replacing the tooth at no charge and covering the restorative costs as a gesture of goodwill. Patients want full disclosure, and the risk of litigation is doubled if the patient is not informed of the mistake. [1]

Many of the OMS liability carriers offer various vehicles of continuing education on preventing wrong-site (tooth) surgery. These companies offer continuing education through webinars, online classes, or seminars. Some insurance carriers offer a discount on annual premiums for taking these classes. Taking advantage of these educational sessions can help reduce premium costs as well as reduce the chances of extracting the wrong tooth.

There are many factors that can affect wrong-site (tooth) surgery. Taking the time to establish an office protocol enables the doctor and staff to address the potential pitfalls of extracting the wrong tooth. A well-established protocol implemented routinely is the key to successful outcomes. As one of my attendings in residency used to say, "Better to be lucky than good."

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# CALIFORNIA CAREFORCE

## California CareForce Update

To be able to relieve pain is such a gift. It is almost magic – physically and psychologically. To be able to help someone read the fine print is just as important a gift. That is exactly what happens at California CareForce clinics. At many of these events, 2500 patients are treated and given these gifts.

It is exciting! California CareForce (CCF) will host five clinics in 2024. With the huge support of CALA0MS members, CCF is able to provide many patients the dental, vision, and medical care they so desperately need. We are adding a couple new locations – Eureka in July and Fresno in November. CCF will return to Coachella in March; Roseville in May; and Sacramento in September. Please check our website for the exact dates (CaliforniaCareForce.org). The volunteering of your time and talent as well as financial support for these events is always so appreciated.

My first year as a CCF volunteer nurse was in 2017 at Cal Expo. I was greeted by long lines of patients that had spent the night in the parking lot hoping and waiting for the chance to be treated by CCF's extraordinary team of volunteer medical, dental, and vision care providers. These were some of the most grateful patients I had ever seen. Most patients seeking care at these clinics are not homeless; they simply can't afford medical, dental, or vision insurance, or pay cash for the care they desperately need. The exceptional care they received was transformational and life changing. After that one day, I was hooked. I am so grateful to be one of many that provide this care.

It has been a privilege for me to serve as the President of the California CareForce Board for the past couple years. The Board is dedicated to keeping these clinics available so patients in need can be treated and served. Our efforts are enhanced with committed volunteers. Rarely do we have too many professional volunteers; but at times too many patients in need of care.

CCF staff has been busy with a new volunteer program, maintenance and inventory of our equipment, and promoting our cause. CCF also held a volunteer appreciation event at Top Golf this summer. It was well attended and lots of fun. The auction items raised some needed funds to put towards supplies, equipment, and clinics. Maybe you will be nominated as one of the outstanding volunteers at next year's event!

There will be an open house in Roseville at CALAOMS Headquarters for the holidays on December 14, 2023, from 5:30 pm - 7:30 pm. Please come and meet the staff, mingle with other volunteers, and enjoy some holiday cheer.

With grateful appreciation,

Terre Donaldson, CRNA
President – California CareForce

California CC F Volunteers CareForce™

# RISK MANAGEMENT

## Non-compliant Patients Increase Liability Risks for Practitioners

*by Richard Cahill, JD, Vice President and Associate General Counsel, The Doctors Company*


Practitioners face potential liability when patients do not follow up as instructed or refuse at-home help. In the event a claim results, even a verdict decided in the practitioner's favor does not negate the time, expense, reputational damage, adverse social media publicity, potential administrative investigations, or emotional toll created by a lawsuit.

### Case Example

An older adult with a history of obesity, hypertension, hypercholesterolemia, atrial fibrillation, and cardiovascular disease saw the same physician for 20 years. During one hospitalization, the patient was put on the anticoagulant Coumadin. The physician and the discharge nurse both educated the patient and the patient's spouse about the risks of Coumadin use and the importance of having blood work done every month. The conversations were appropriately documented in the patient record.

The patient did not, however, keep the first monthly appointment to check the international normalized ratio (INR). The physician's staff called to schedule a follow-up visit, but the patient did not return the call. Two days after the call, the patient fell at home and was taken to the emergency department. The patient's spouse told the staff that, although they had missed the appointment for blood work, the patient had taken the Coumadin as prescribed. The patient's INR was 8.8—an extremely elevated reading (the therapeutic range for individuals on Coumadin is generally 2 to 3).

The patient was diagnosed with a bilateral subdural hematoma and underwent a bilateral craniotomy. After being discharged home, secondary to problems with coordination and confusion, the patient presented to the emergency department several more times over the next few months.

The patient sued for medical malpractice, claiming that the physician failed to properly manage the medication regimen and monitor blood levels, resulting in the fall, subsequent injury, and poor recovery. The patient also claimed that the physician was negligent in providing warnings about the risk of bleeding when taking Coumadin.

The case went to trial after extensive discovery was conducted. Because of the thorough documentation, the jury agreed that the physician had properly educated the patient and made the appropriate resources available to monitor the effects of the Coumadin. The jury also found that the patient's failure to schedule necessary lab appointments and then follow up with an in-office visit as instructed was the cause of the injury. Accordingly, a defense verdict was rendered in favor of the physician.

### Discussion

The patient in this case example neglected to follow physician instructions. Patient reluctance to follow a treatment plan or accept help is often caused by a lack of understanding. Patients may say that they are managing well and do not need help, or they worry about the cost. If home care is recommended, some individuals assert they do not want strangers in their home due to fear of harm or infectious diseases, such as COVID-19.

Patients who decline help may not get the necessary follow-up and support that the practitioner outlined in the treatment plan. When a patient declines follow-up as instructed—for any reason—the practitioner can be at increased risk for professional liability exposure.

Clear and timely documentation in the patient record—along with notations indicating the patient's responses to instructions—enhance optimum outcomes, improve patient satisfaction, and help to mitigate the potential of being sued for professional negligence.



### Patient Safety Strategies

Consider the following strategies to help reduce potential patient safety and malpractice risks when treating patients who refuse help or do not follow up:

- Conduct a risk analysis to determine how likely the patient is to comply with at-home instructions. Consider the patient's age, mental capacity, ability to drive, independent living status, whether the patient provides self-care or requires a caretaker, the existence of a family support network, and any prior history of failing to comply with appointments, medication instructions, or orders for specialty referrals, diagnostic studies, therapeutic interventions, or other treatment regimens.
- Schedule the follow-up appointment before the patient leaves the office, and provide written documentation to the patient to reinforce all verbal instructions. File in the patient's record a copy of all written instructions given to the patient.
- Use the Agency for Healthcare Research and Quality's "Teach-Back" method to confirm the patient's understanding of home care and follow-up instructions.
- Provide telehealth services, if possible, if patients are unable to keep scheduled appointments or refuse home health visits. (See our article "Top Seven Tips for Telehealth.")
- Provide the patient and family with contact information for community home health resources, and document the information that was given to the patient. Educate the patient about why community resources are provided, and draw a distinction between what is and is not offered.
- Document the following actions:
  - The patient received and understood verbal and written instructions.
  - The patient and any family members present were given the opportunity to ask questions.
  - Your response to any concerns raised by the patient and family members.
  - The resources made available to help the patient overcome compliance challenges.
  - The practice's efforts to follow up and intervene if the patient was not in compliance.
- If the patient ultimately refuses to accept help or comply with follow-up, document the refusal in the patient's record, ideally with a signed informed refusal form. (See our article and form on "Informed Refusal.")

Taking the time to document patient discussions gives all caregivers valuable information to ensure that patients are following the plan. In the event of a lawsuit, it also demonstrates the high quality of care that was provided. Statistically, a well-documented patient record significantly decreases the likelihood of an adverse event and subsequent litigation.

For more information, see our article, "Nonadherent and Noncompliant Patients: Overcoming Barriers." For guidance and assistance in addressing any patient safety or risk management concerns, contact your patient safety risk manager 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.*

The Doctors Company
TDC GROUP

# CALIFORNIA ASSOCIATION OF ORAL & MAXILLOFACIAL SURGEONS UPCOMING CE EVENTS

## 2024 Meetings

| | |
|---|---|
| OMSA Course On-line | Open Year Round |
| January Meeting Webinar | January 13, 2024 |
| 24th Annual Meeting (Anesthesia) | The Westin, Long Beach CA - May 4 - 5, 2024 |

## Vendor Spotlight

### CALAOMS Wishes to Thank the Following Vendors That Graciously Sponsored CALAOMS' Meetings In 2023

- **The Doctors Company -** Webinar Sponsor, January 2023 Meeting.
- **The Doctors Company -** Speaker Sponsor, 23rd Annual Meeting.
- **OMSNIC/HUB International -** Residents Sponsor, 23rd Annual Meeting.
- **US Oral Surgery Management -** Luncheon Sponsor, 23rd Annual Mgt.
- **H & H Company -** WiFi Sponsor, 23rd Annual Meeting.




## ASSOCIATE/PARTNERSHIP OPPORTUNITIES

**Bay Area:** Oral & Maxillofacial Surgeon California Partner Opportunity. Part-time or Full-time Oral Surgeon in Northern California. IMMEDIATE OPENING! We are a well-established, high-tech, modern dental practice in the prestigious area of San Jose/ Milpitas with excellent patient population, fee-for-service, and looking for a licensed, outstanding Oral Surgeon. Offering option to buy and room for growth, excellent income, flexible schedule, sign-on bonus and competitive base salary. Please contact via email at: bayarea.ospractice@gmail.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@kidscaredental.com

**Lake Tahoe:** Dream opportunity to build an oral surgery career in the Lake Tahoe area. Our thriving, two-office practice has a reputation for taking great care of people and has excellent relationships with our referring offices in Truckee and Lake Tahoe. The practice scope is primarily dentoalveolar and implant-based, with very occasional trauma and hospital cases. Current doctors work three days a week with full-time income. Offices are all-digital with CBCT, X-NAVs, intraoral scanners, and updated equipment in both locations. Looking for an ABOMS certified (or active candidate for certification) associate leading to partnership. Must be personable, caring, and interested in making this area your forever home. Tahoe Oral Surgery is a proud supporter of 1% for the planet.
Please email inquiries to rachel@tahoeoralsurgery.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

**Northern California/Wine Country:** Part-time or Full-time Oral Surgeon Position - IMMEDIATE OPENING!

Offices are state of the art, with a solid patient base, fee-for-service and have full-time staff and leadership. Seeking motivated and hard-working OMS with excellent interpersonal skills. We have a well-established dentoalveolar/implant practice with room for growth and opportunity for additional procedures such as trauma and orthognathics. Candidates would be expected to establish and maintain relationships with existing and potential referring doctors in the community. This is a great opportunity for new graduates or experienced Oral Surgeons to join our established, very busy and profitable practice. Contact: 1161732OMFS@gmail.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

**Santa Barbara:** OMS Associate wanted to practice in Santa Barbara. Leading to partnership/owner position. Please contact Yvonne at 805-692-8500 or Email at drwelsh.oms@gmail.com

**Southern California:** Opportunity to work with a well-established office. Southern California location close to the beach. Looking for an oral surgeon focused on ethical patient care.
Contact: oralsurgeonjob1@gmail.com.

**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 MDudziak@ieomfs.com.

**Temecula:** Oral & Maxillofacial Surgeon In Temecula, CA Seeking Associate Leading To Partnership. We are offering an excellent private practice opportunity in the highly sought after Temecula Wine Country in California. This is a well-established, respected, and busy practice with an 18-year history of providing the highest level of oral and maxillofacial surgical care. We are located in the heart of Southern California that offers great weather year-round and suburban living with wineries and golf courses. Temecula is within travel distance to San Diego beaches and Big Bear ski slopes as well. Along with all these great assets, the Temecula Valley School District is ranked as one of the top school districts in California.

We are currently seeking a motivated and compassionate surgeon with exceptional interpersonal skills to join our high producing practice. Benefits of Joining the Practice:

Working with a friendly and hardworking team
Competitive compensation with bonus opportunity
Associateship that leads to Partnership opportunity
Benefits package – includes medical, dental, vision, and 401K
For Inquiries, Please Contact: Alexa Arcaira at alexa@innovativeimplant.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

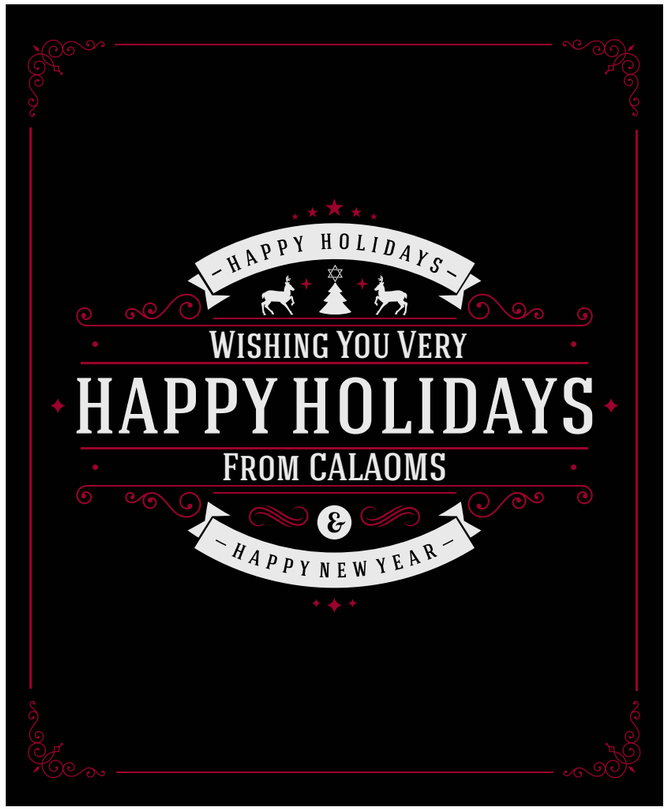
**Silicon Valley:** Oral Surgery Practice seeks buyer to continue a decades long tradition of providing quality OMS services to a traditional referral base in San Jose, Los Gatos and Saratoga. Interested prospects can send a CV to molinelli@aol.com or call 650-347-5346.

**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



Dr. Cynthia Trentacosti Franck and team
Oral Surgery Associates of Chester County,
West Chester, PA & Kennett Square, PA

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