The Compass
Staying the Course Through Service and Education
Volume XV, Issue 1, Spring 2013

# Twenty Years of Service

My life as I know it today started 20 years ago on March 23, 1993 when I applied for a job with the NCSOMS. I was looking for a meaningful part time position that allowed me to spend time with my children who were at the time one and two years old. They are now 21 and 22.

I was hired by Melinda Neher, who at the time was the Executive Director for the NCSOMS, although Dr. Bill Donlon says he takes the credit for my employment. The NCSOMS President was Dr. Andrew Harsany. The CALAOMS President was Dr. Elgan Stamper, while Dr. Roger Kingston was the President of the SCSOMS.

One of my first duties, in addition to answering the phones and sending out mailings was scheduling the general anesthesia and conscious sedation evaluations. During those early years, I did not have an email account or cell phone and gum balls were still a penny (just kidding). Gradually, my duties expanded to paying bills and handling registration for CE seminars including the OMSA, ACLS, and Risk Management courses.

In the 20 years I have been with the association, there have been quite a few momentous occasions for CALAOMS, for the specialty, and for me.

## Unification

Unification of CALAOMS which had begun as early as 1992, was initiated by Dr. George Yellich. At a meeting on March 20-21, 1993, objectives were set forth to formulate opinion towards unification. The proposal was sent to the members of NCSOMS and SCSOMS, where concerns of loss of identity and historical preservation were expressed by members of both associations. A series of meetings followed until those concerns were alleviated and the sentiment on all three boards was unanimous for unification.

On October 16, 1999, a multi-organizational board meeting comprised of the members of the CALAOMS, NCSOMS and SCSOMS Boards of Directors was held. The Combined Boards voted unanimously to unify the three organizations. Unification was completed by the end of 1999, and our first day as a unified Board and organization was January 1, 2000.

## A new Executive Director

CALAOMS Headquarters was in northern California as well, and I agreed to help out until an Executive Director was found. When the Board approached me with the offer to become the official Executive Director

*Continued on page 6*

In 2012, doctors faced over 10,500 alleged HIPAA violations. Make sure you're prepared.

For decades, The Doctors Company has provided the highest-quality medical malpractice insurance. Now, the professionals of The Doctors Company Insurance Services offer the expertise to protect your practice from risks beyond malpractice. From slips and falls to emerging threats in cyber security—and everything in between. We seek out all the best coverage at the most competitive prices. So talk to us today and see how helpful our experts can be in preparing your practice for the risks it faces right now—and those that may be right around the corner.

Call (800) 852-8872 today for a quote or a complimentary insurance assessment.

- Medical Malpractice
- Workers' Compensation
- Health and Disability
- Property and General Liability
- Employment Practices Liability
- Directors and Officers/Management Liability
- Errors and Omissions Liability
- Billing Errors and Omissions Liability

THE DOCTORS COMPANY Insurance Services

CA License #0677182

www.thedoctors.com/TDCIS



The COMPASS
*Published by the*
***California Association of Oral and Maxillofacial Surgeons***

**Board of Directors**

**Alan S. Herford, DDS, MD, FACS**
President (909) 558-4671
aherford@llu.edu

**Albert W. Lin, DDS**
President-Elect (909) 485-1290
alinomfs1@yahoo.com

**Monty C. Wilson, DDS**
Vice President/Secretary (714) 998-7450
montywilson@sbcglobal.net

**Alan H. Kaye, DDS**
Treasurer (310) 275-1134
bonegraft@aol.com

**W. Frederick Stephens, DDS**
Past-President (626) 440-0099
dr.wfstephens@mac.com

**Leonard M. Tyko, DDS, MD**
Director (707) 545-4625
ltyko@hotmail.com

**Steve M. Leighty, DDS**
Director (530) 272-8871
smlzenos@pacbell.net

**Jeffrey A. Elo, DDS, MS**
Director (909) 706-3910
jeff_a_elo@hotmail.com

**Tim Silegy, DDS**
Director (562) 496-1978
tsilegy@drsilegy.com

**Pamela Congdon, CAE, IOM**
Executive Director (800) 500-1332
pamela@calaoms.org

**Jeffrey A. Elo, DDS, MS**
Editor (909) 706-3910
jeff_a_elo@hotmail.com

**Steve Krantzman**
Associate Director (800) 500-1332
steve@calaoms.org

***CALAOMS' The Compass © Copyright 2010***

*Published 3 times a year by the California Association of Oral and Maxillofacial Surgeons. The Association solicits essays, letters, opinions, abstracts and publishes reports of the various committees and members; however, all expressions of opinion and all statements of supposed fact are published on the authority of the writer over whose signature they appear, and are not regarded as expressing the view of the California Association of Oral and Maxillofacial Surgeons unless such statement of opinions have been adopted by its representatives. Acceptance of advertising in no way constitutes professional approval or endorsement. The Editorial Board reserves the right to control article and ad content as well as placement. Changes may be made without notification.*

## Your CALAOMS Central Office Staff

Your staff is here to help you with any questions about membership, continuing education courses, certification, and events. Please do not hesitate to contact us with questions or concerns at:

950 Reserve Drive, Suite 120
Roseville, CA 95678
Office: (916) 783-1332
Office: (800) 500-1332
Fax: (916) 772-9220
Web Site: www.calaoms.org

**Executive Director**
*Pamela Congdon, CAE, IOM*
Phone Extension: 12
email: pamela@calaoms.org

**Associate Director**
*Steve Krantzman, CNE, MCP*
Phone Extension: 11
email: steve@calaoms.org

**Continuing Education Services**
*Teri Travis, CMP*
Phone Extension: 13
email: teri@calaoms.org

**Membership Services**
*Barbara Holt*
Phone Extension: 10
email: barbara@calaoms.org

***CALAOMS © 2010***

**CALAOMS also does business as:**

* 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

## Compass Direction

# Editor's Corner

*Jeffrey A. Elo, DDS, MS*
*Editor of the Compass*

## Practice Getting to Retirement

I'm an avid news reader and watcher. I can't get enough. I like to know where my local world—and the world as a whole—are heading. From what I read, there's recently been a steady drumbeat of discouraging news about retirement.

More than half of us won't have enough money to maintain our living standards in retirement—even if we work to age 65, about two years past the average retirement age, according to various estimates. No wonder more people are working into their golden years, or planning to do so.

Is there any good news? Perhaps. "Working longer allows you to start playing sooner," says Christine Fahlund, vice president and senior financial planner at T. Rowe Price Group. In her view, there are three kinds of retirees: the "cliff diver," who works to normal retirement age and then retires; the "worker bee," who works longer and delays retirement; and the "retiree-in-training," who works and starts retiring throughout his or her 60s. Which type of retiree you choose to be can have a big impact on how much money you will have to spend.

The number of actively working people age 65 and older rose to 16% in 2010 from 12% in 1990, according to data from the U.S. Census Bureau. Nearly one-third of 65- to 69-year-olds were working or actively seeking employment, compared with less than 22% two decades ago. Meanwhile, 62% of 45- to 60-year-olds surveyed in 2012 plan to delay retirement, according to a report from the Conference Board. In 2010, only 42% of workers in this age group planned to do so.

The reasons for such a significant change in trends are painfully familiar by now: fallen home values, job losses, depleted savings, and low interest rates—not to mention the disappearance of guaranteed pensions and retiree health-care benefits, the rise in Social Security's full retirement age, and people simply living longer and healthier lives.

"I'm not surprised that more people are working past 65, but I hope they make a point to enjoy the decade of their 60s by practicing retirement," says Ms. Fahlund. "Work, but start living some of your retirement dreams at the same time." Working through your 60s, even if only part-time, allows you to spend from your wages instead of your savings, she explains. This gives your nest egg more time to grow and shortens the time you'll need to support yourself on savings alone. It also allows you to delay taking Social Security benefits and to scale back, or even discontinue, contributions to your 401(k) retirement plan.

Although you can begin receiving Social Security benefits as early as age 62, your starting benefits will increase approximately 7% to 8% for every year you put off taking them, up to age 70. In addition, the higher your initial benefits, the larger the dollar value of any annual cost-of-living adjustments. The result: by waiting until age 70, your Social Security benefits would have almost twice the purchasing power they would have if you had started them at age 62, says Ms. Fahlund.

As for your 401(k), she says contributions in your 60s are the least important because there's less time for them to compound, so you should consider contributing only enough to qualify for any employer matching contributions. What this does is free up money to get your financial house in order and start enjoying the life you envisioned for yourself in retirement.

Let's look at an example…take a married couple—both age 60—with a combined salary of $100,000 and a $500,000 nest egg. If they saved 15% of their annual income until age 62 and then retired—the cliff-diver approach—their retirement income from savings and Social Security would be $52,000 per year, and their cumulative total income from age 60 through 69 (net of retirement-plan contributions) would be $586,000 pre-tax, assuming various investment, inflation, and withdrawal rates.

If instead they saved 15% from age 60 through 69 and retired at age 70—worker bees—they'd have $96,000 a year in retirement income, plus total income in their 60s of $850,000.

And what if they stopped saving at age 60 and retired at 70—retirees in training? They'd have $88,000 a year in retirement income—$8,000 less than the worker bees—but $1 million in total income through age 69 because they stopped making contributions to a (401)k—$150,000 more than the worker bees and nearly twice as much as the cliff divers.

With that extra money they could, for example, pay off their mortgage, make some home improvements, or buy some big-ticket items, such as a new car or recreational vehicle. If after camping two times in the wilderness they decide RVing isn't for them, they will have learned a valuable lesson without squandering their nest egg in the process.

My hope and plans for myself and all of you, my friends, is that you will practice getting to your retirement.

## Letter to the Editor

While perusing a popular blog site recently, I was drawn to a newspaper article entitled, "Dental health on decline for Chicago's needy." It struck me that the tone of the article was one in which the author seemed to suggest two things: that the dental profession is neglecting others, and the need for more government entitlements.

In California, we (CALAOMS) have taken a different and more proactive approach with the formation of RAM (Remote Area Medical) California, which we believe is having a dramatic effect on numerous underserved areas and citizens of our great state. Our numbers indicate we have treated thousands of people in both northern and southern California.

With so many OMS members in our state, we can—and will—have a huge impact on these people. There still is a lot more that can be done. In time, more organizations, such as the CDA and the AGD, will become more involved, as well. Our approach, by the service of our many members, will care for the needy without the financial consequences of more taxation and entitlement programs. Having participated in RAM events, I can honestly say it is a very rewarding way to give back.

Please call CALAOMS headquarters in Roseville (800-500-1332) and begin your own personal journey to help those in need in California! I am very proud of our solution to a very concerning problem. Thank you, Pam Congdon, for directing us in this new endeavor. I hope to see you all in Coachella Valley this April.

Sincerely,

John L. Lytle, MD, DDS
Private Practice La Canada, CA

*Continued from page 1*

of CALAOMS, I had a few concerns. At the time, my children were still young and my husband traveled quite a bit. It was important for me to be available for my family. The board agreed to work with me around soccer, and band practices, and I accepted the position.

After having worked for seven years with NCSOMS, I enjoyed the extra challenges of the Executive position for CALAOMS. The SCSOMS office was still open with two employees as a home base for the southern part of the state. However keeping a satellite office open was not cost effective and the CALAOMS Board voted on 1/11/2000 to close the southern office by the end of the year.

### Scope of Practice

Unification was important for CALAOMS because it gave us one voice with a unified group of OMSs on one board. Having one strong organization was crucial for CALAOMS to be a player within the state legislature and with AAOMS. This was never more evident than in our first go around with the "Scope Bill", SB 1338.

Although the CDA and CALAOMS worked together to present the safety and history of the OMS specialty, it would not be able to stand up to Hollywood politics. However, the only glimmer of hope was that instead of vetoing the bill outright, Governor Schwarzenegger asked for an Occupational Analysis to be done. With the help of Randi Andresen, and many of our members, CALAOMS was able to present facts on the safety of oral and maxillofacial surgeons. This led to the passing of our second introduction of our "Scope bill" SB 438.

### CALAOMS Purchases Office Space

In May of 2005, a letter was sent to the membership spelling out the benefits of CALAOMS purchasing its own office space over renting. The issue was put to a vote and purchasing office space was favored. CALAOMS opened its new doors in February 2007. The CALAOMS staff and I worked together to develop a viable floor plan for the office that would be suitable for our board and staff for years to come. We also wanted the office to be comfortable yet elegant, that both men and women would enjoy. We planned it with a gentleman's club feel, with feminine touches that have been appreciated by all. Our employees all feel thankful for the opportunity to work in such a beautiful office.

### Closing of the Health Foundation

When CALAOMS unified, there had also been a 501(c)(3) organization, The CALAOMS Health Foundation. The Foundation donated to various charities and resident training programs. One of the two great donations that the Foundations supported with extra help from our members was to the Disaster in Haiti and Katrina in New Orleans. However, with the increasing amount of dues and donations required of OMSs, the board voted to dissolve the Health Foundation on July 13, 2006. The Health Foundation funds were evenly donated between the seven OMS resident training programs within California.

### Resident Table Clinics

The Resident Table Clinics were originally started as a program of the Health Foundation. The CALAOMS Board felt it was important to have a program for the residents where they became acquainted with CALAOMS and and our members. The Board voted to continue supporting the Resident Table Clinics in 2007. I took over as chair of the Resident Table Clinics at this time.

### CAE and IOM Designations

Dr. Silegy and Dr. Machado, both members who I talked with frequently, suggested that I increase my professional knowledge by obtaining the designation as a Certified Association Executive, which I earned in January 2008. I was also able to attend the Institute on Management for a one week immersion course every summer for four years to also obtain my IOM. I appreciate the opportunities to improve myself for my career with CALAOMS. With this knowledge I was able to produce an Executive Director's Manual for CALAOMS' future staff leadership.





### Remote Area Medical (RAM) Clinics

I volunteered at the RAM clinic in LA at the Sports arena for seven days in 2010. Many of our CALAOMS members were there providing free dental care to the underserved. Later that summer, the board decided that CALAOMS should host the RAM clinics in northern California the following year. We did have a rocky start planning these clinics due to opposition of a few associations not wanting RAM or CALAOMS to succeed. Due to the perseverance of our board and the dedication of our members to helping people in our communities, CALAOMS hosted five clinics in three years with four in Northern California and a fifth in Southern California this April. With the help of CALAOMS, RAM California was established, September 19, 2011. CALAOMS' support and involvement with RAM CA has given our members an opportunity to give back to our communities and has helped instill a mutual respect with the CDA.

### In Gratitude

Since I have been with the association, I have had over 20 different bosses. Many have asked if it is hard to have a different boss every year with each one having a different management style. I am privileged to have learned something from each and every one of them. I have also grown to know many CALAOMS members, their families and their staff during my years here and cherish those relationships.

I have been fortunate to work with a great group of staff here at the CALAOMS Headquarters. I have also had the opportunity of having wonderful mentors both at CALAOMS and AAOMS. To all the many many incredible doctors, staff and people that have mentored me and that have contributed to my successful career with CALAOMS. I thank you all.

I am grateful for the career I have had with CALAOMS. CALAOMS's involvement hosting RAM CA and the clinics which inspired us to expand our mission statement to include helping the less fortunate in our communities. For 20 wonderful year, thank you.

Pam

# President's Message

***Alan S. Herford, DDS, MD, FACS***
***President, CALAOMS***

# Itinerant Surgery: Is it Time to Have a Discussion?

Itinerant dental practice has become a common modality in California. Current economic pressures seem to invite this form of practice, which potentially has consequences as it relates to both continuity of care and patient safety. Due to these economic pressures (which appear to have no end in sight), itinerant practice will most likely remain common. As a result, discussions among our members may be necessary in order to formulate recommendations to monitor and, perhaps, regulate this mode of practice.

In oral and maxillofacial surgery, the percentage of surgeons who perform itinerant surgery is increasing. The reasons are likely multifactorial. Residents who finish their programs are not finding as many opportunities to join as associates, and the increased

debt makes starting their own practices a more daunting endeavor. There is also a trend towards dental practices offering a range of services and hiring specialists to work in their offices. Many of these practices are recruiting oral and maxillofacial surgeons to work as a contracted specialist.

Itinerant dental practice is defined as a specialty dental service performed in the office of the employing dental practitioner. The itinerant specialist typically travels to these offices, frequently in other geographic regions, to provide contracted specialty services. The itinerant specialist provides specialty care in facilities that frequently are not specifically designed and equipped to support such specialty services. In addition, the specialist is typically not immediately available to manage patient emergencies or complications due to distant geographic location.

Itinerant surgery is nothing new. In the nineteenth and early twentieth century, surgeons would often travel to rural communities to provide care. The surgeon was typically not available for postoperative care—having traveled to another rural hospital or had returned home. The American College of Surgeons specifically prohibits itinerant surgery. Even so, medical opinions about the necessity and ethics of itinerant surgery and its effects on the quality of patient care vary greatly.

Each practitioner licensed to practice dentistry has the legal privilege to provide any dental care within the definition of each state Dental Practice Act. In spite of this legal privilege, we as dental providers all have an ethical duty to practice in a safe way, and to provide postoperative care for our patients. Itinerant surgery has specific issues related to patient care and safety.

## Office Design and Equipment

The office design of an oral and maxillofacial surgeon typically has unique equipment requirements. In addition, properly trained support staff with appropriate skill levels and certification is required in order to provide safe patient care. This is especially true with respect to anesthesia services. These unique requirements allow the OMS to provide care at an adequate level for their specialty, and to do so safely and efficiently. Without these safeguards, patient care could be suboptimal.

Delivery of in-office anesthesia services has a unique set of requirements. In the state of California, as it is in most states, an in-office anesthesia examination is required to obtain a permit to provide these services. Requirements for permitting include special equipment, drugs, emergency supplies, adequately trained support staff, and pre-established emergency protocols. Although not currently required, any office facility in which such anesthesia services are provided should be appropriately permitted. Therefore, if such anesthesia services are offered in the contracting office, office evaluation and permitting should be required.

## Patient Care and Safety

The model of the itinerant OMS has some unique concerns. Paramount to this is the question of safety. When itinerant OMSs perform anesthesia in a dental office that they are not as familiar with, there may be concerns for the optimal management of anesthetic emergencies. They may be working with the facilities' dental assistants who may not be as well trained as the OMS assistants that the surgeon works with in their own office. Without the appropriate equipment and supplies, safety and patient care may be compromised.

Preoperative consultation with the operating OMS is imperative in order to adequately evaluate, plan, and prepare the patient for surgery. This might include obtaining any necessary laboratory studies or appropriate medical consultations. This cannot be performed by the general practitioner, and, by definition of their request for specialty care, they would not be considered as having "similar training and proficiency" as the specialist. Ideally, preoperative consultation is preferably done *prior* to the operative date. The reliance on the general dentist to evaluate and "set up" the cases is not good OMS practice. OMSs are trained to perform thorough history and physicals and order preoperative tests as needed.





## Emergency Coverage

Just as the preoperative evaluation should not be relegated to someone other than the surgeon, neither should the postoperative care. Even healthy patients will occasionally experience complications, and it is paramount that the surgeon provides the availability of postoperative care and treatment when needed. If the operating surgeon is not available to manage postoperative complications, a specialist of similar training and proficiency must provide any necessary emergency care. The general dental practitioner, by definition of their request for specialty care, would not be considered as having "similar training and proficiency." The itinerant OMS must therefore be immediately available for postoperative emergency care. It is unacceptable to rely on area hospital emergency rooms.

One of the arguments given for itinerant surgery is "access to care." The majority of itinerant surgery is not taking place in underserved areas. Instead, it is in communities that often already have established OMSs. Another argument for itinerant surgery is that it is more convenient for the patient because they can have all of their dental needs taken care of at the same office. In 1987, the Office of the Inspector General performed an analysis of operations performed by itinerant surgeons. This included an analysis of 242 general surgical, orthopedic, neurosurgical, and urologic operations randomly selected that were performed at 72 rural hospitals with 50 or fewer beds. They found that 28 percent of the sampled rural hospitals employed itinerant surgeons, who performed 73 percent of the surgeries. It was also noted that there was a higher risk of poor quality care with itinerant surgery, which was 8 times the average prevalence in similar hospitals. Seventy percent of the cases reviewed were elective, and 8 percent of those elective surgeries where found to be contraindicated. In 63 percent of the records reviewed, the itinerant surgeons did not provide postoperative care, but billed Medicare anyway for global fees that included this care. Though not every finding applies to oral and maxillofacial surgery, many do.

Many organizations have addressed their stance on itinerancy. The Code of Ethics of the American Society of Plastic Surgeons states that each member may be subject to disciplinary action, including expulsion, if the member performs a surgical operation or operations under circumstances in which the diagnosis or care of the patient is delegated to another who is not qualified to undertake it. The American College of Surgeons state in their Statement of Principles the following: "Discharge of a patient to any location that prohibits in-person postoperative care while early complications can still occur may constitute itinerant surgery. Postoperative care must be rendered by the operating surgeon unless it is delegated to another surgeon equally well qualified to complete that care." At the 2012 AAOMS House of Delegates, the following was adopted as part of the Code on Professional Conduct:

***C.5 Itinerant Surgery:*** Defined as elective oral and maxillofacial surgery performed in non-accredited surgical facilities other than the facility or facilities owned and/or leased by the oral and maxillofacial surgical practice employing the oral and maxillofacial surgeon.

**a.** Fellows and members are strongly discouraged from making itinerant surgery a major part of their practice or component of their training.

**b.** It is unethical if the patient is unfamiliar with the surgeon who performs their surgery. Therefore, if an oral and maxillofacial surgeon performs itinerant surgery, the patient must be provided, in writing, the full name of the surgeon, their state license number, their primary address or main office address, their office telephone number, and their after-hours number prior to their surgical appointment.

**c.** It is unethical for the surgeon to delegate their primary patient responsibility. Therefore, if an

oral and maxillofacial surgeon performs itinerant surgery, they shall comply with the current published AAOMS Parameters of Care for patient assessment and the Office Anesthesia Evaluation Manual for outpatient anesthesia.

1) The surgeon shall perform a patient assessment including a medical history and a physical examination prior to performing surgery,

2) The surgeon shall document the patient's physical status in their record using the American Society of Anesthesiology physical status classification prior to surgery, and

3) The surgeon shall document a diagnosis justifying surgical care.

**d.** It is unethical for the surgeon to perform surgery in an unsafe or unsuitably equipped facility. Therefore, if an oral and maxillofacial surgeon performs itinerant surgery, they shall comply with the current published AAOMS Office Evaluation Manual for facility requirements for each office utilized for itinerant surgery. In addition, the oral and maxillofacial surgeon is required to comply with state laws pertaining to permitting and licensing of any office facility utilizing and providing intravenous sedation and/or general anesthesia. All facilities utilized for such patient care must therefore, comply with state permitting and licensing requirements. As a minimum requirement, each surgeon shall provide their state component an affidavit confirming their compliance with the above standards of care including a list of each facility in which they perform itinerant surgery.

**e.** It is unethical for the surgeon to perform surgery in an unsafe or unsuitably staffed facility. Therefore, if an oral and maxillofacial surgeon performs itinerant surgery, they shall comply with the state laws, rules, and regulations for dental office based anesthesia/sedation procedures regarding staffing requirements. As a minimum requirement, each surgeon shall personally utilize a minimum of two operating room assistants properly trained to assist during itinerant procedures.

**f.** It is unethical for a surgeon to delegate postoperative care to a person who is not similarly qualified to recognize, treat, and manage all surgical complications. This includes the ability and privilege to admit patients to an extended care hospital for surgical care and/or other management. Therefore, if an oral and maxillofacial surgeon performs itinerant surgery, they shall be responsible for the outcome of the postsurgical care and shall maintain communication to ensure the patient receives proper continuity of care.

**g.** The provisions of this *Code* do not apply to the occasional performance by a fellow or member from performing surgery at a facility for the purposes of teaching or charity patient benefit.

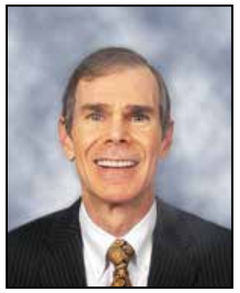
### Where Do We Go From Here?

The issue of itinerant surgery should stimulate a healthy discussion. Should organizations such as the ACS and AAOMS do more to enforce their policies—including loss of membership? Should every office that an OMS works at have a separate permit to ensure that the facility is safe and held to the same standard as the surgeon's own office? What are the outcomes of patients treated by itinerant surgeons compared to those treated by surgeons in their own equipped facility? These are questions that will need to be addressed to continue to provide safe and optimal care for our patients. Oral and maxillofacial surgeons have a strong record using the team model of delivering anesthesia and treatment. Regulation of itinerant practice can originate from organized dentistry, but ideally should have "teeth" provided at the State Board level, thus providing legal oversight and enforcement.

So, yes, I believe it is time to have a discussion about itinerant surgery in order to maintain our specialty's high standard of optimal patient care.







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

# HOW THE LAW REASONS ABOUT BIOETHICAL ISSUES AND THE CRITERIA

## I. INTRODUCTION

The law found itself in a quagmire of unfamiliar territory throughout the twentieth century as man's progression as a species challenged many long-standing beliefs, assumptions and legal tenets. While legal interpretation depends upon those making such determinations, technology has presented some difficult cases before the court for which there is no precedent and the final ruling still leaves room for future debate and potential reversal. Bioethical issues have presented particularly challenging situations for the courts to decide about an otherwise grey that must be transformed into terms of black and white; medicine in particular has been at the forefront of how the law reasons bioethical issues. Notions of liberty, privacy, equal protection, and due process are among the legal safeguards used by attorneys and courts when examining bioethical issues. Global challenges raised by biomedical advances require global responses. Some international organizations have made significant efforts over the last few years to establish common standards that can be regarded as the beginning of an international biomedical law. One of the main features of this new legal discipline is the integration of its principles into a human rights framework.

## II. REDEFINING KNOWLEDGE

If there is one biomedical issue that has stood out above the many others forcing courts everywhere to revisit the ethical components of human progress, the undisputed leader would be when, how, and if to euthanize. The Terri Schiavo case brought this volatile issue right to the forefront of legal focus by forcing the law to re-evaluate the legal meaning of life, when it is over, and how to cease bodily functions all from the combined perspectives of morality, physiology, mercy, technology, and human rights. To sustain one's existence beyond what is widely considered as a reasonable semblance of life quality has sparked an inordinate amount of controversy between those who support or oppose the notion of nutritional withdrawal as a way in which to aide a terminal or comatose patient's demise. Given the global recognition of the Schiavo case where a Florida hospital carried out the task of withholding nutritional sustenance until Schiavo died of dehydration, it is clear how the very essence of life and death has turned into a legal battleground where the critical component of bioethics is at the forefront of close scrutiny.

The Schiavo situation once again sparked heated debate over the legality of euthanasia; most interesting of all, however, is the very state in which Schiavo's non-voluntary/euthanasia by omission occurred upholds laws against exactly what transpired. Florida statutes 765.309, 458.326 and 782.08 all prohibit euthanasia, with the first statute explicitly stating that "nothing in this chapter shall be construed to condone, authorize, or approve mercy killing or euthanasia, or to permit any affirmative or deliberate act of omission to end the life other than to permit the natural process of dying." Within the past several years, the Supreme Court has had to grapple with many controversial issues and decide accordingly the

best way to appease both the law and the public; its decision about whether to include euthanasia within the boundaries of the law has been monumental and unprecedented. The widely awaited decision allowing individual states to conclude for themselves whether to permit doctor-assisted suicides represented a much needed bend in the ever stringent law that heretofore did not allow for an individual to dictate his or her own mortality.

Chief Justice Rehnquist said the court has long recognized the difference between "letting a patient die and making that patient die," and he was not willing to create an entirely separate distinction for the law books. Instead, he opted to have each of the fifty states exercise their own discretion with regard to doctor-assisted suicide. This single historic decision brought forth a great many opportunities for each state to recognize the importance of allowing people to die with dignity. The Supreme Court decision truly opened doors that up until now have been locked tight. With Dr. Jack Kevorkian – the doctor who frequently assisted terminally ill patients with their own suicide – at the forefront of this hotly debated issue, this ruling marked a possible reprieve for the many people suffering with a terminal illness. The Schiavo case brought to light a number of ethical issues not heretofore considered within the boundaries of withholding life-sustaining treatment.

Embedded in the case is a broader controversy than is immediately evident, one involving the definitions by which bioethics judge cases of extreme physical and psychological limits. In its principled form of address, bioethicists who assume the issues involved in the case are settled miss the point of the emotional responses it has brought forth.

Having ruled "there is no constitutional right to die," thus leaving the states to enact their own laws concerning doctor-assisted suicide, the Supreme Court removed itself from any further entanglements surrounding the delicate issue. Doing so did not reflect poorly upon the justices who rendered this decision; rather, it granted each of the fifty states the opportunity to rise to such a level of public awareness necessary with this issue. The impact three prominent cases had upon the issue of euthanasia (Cruzan v Director, Missouri Dept. of Health, Vacco v Quill Supreme Court ruling and Washington v Glucksberg Supreme Court Ruling) helped to set precedents that had not existed where legal implication was concerned. Residing at the core of these new bioethical legal standards was the manner by which the courts ignored the sanctity of life, a foundational element reflected in the Judaic faith. Both Vacco v Quill and Washington v Glucksberg set the stage for concern around which Judaic principles revolve when their respective judges ruled that criminalizing physician-assisted suicide was unconstitutional. Shortly thereafter, the United States Supreme Court overturned these decisions based upon the line of reasoning that while terminally ill individuals do not possess a constitutional right to physician assisted suicide per se, the act of physician assisted suicide is not unconstitutional. Similarly, Cruzan v Director stipulates that terminally ill patients must provide indisputable evidence of their wish to die in order to avoid the inevitable. "Since the life of every human being has inherent worth and dignity, there is no valid category of *lebensunwerten Lebens* [unworthiness]. Any society that supposes that there is such a category has deeply morally compromised itself." (George)

Sade discusses how the very nature of ethics is to abide by a written – or sometimes understood – code of conduct that speaks to moral duty and obligation. Perhaps nowhere is this guiding principle more important than when it comes to the issue of persistent vegetative state (PVS). At what point is a life no longer worth living according to the law? The general consensus to an otherwise interpretive question is that once an individual's quality of life is no longer present - that the person has relinquished every nuance of an existence once lived – the individual becomes a mere shell of his or her previous self. Given the clinical definition of PVS – "the lack of evidence of awareness of the self or the environment, of interaction with others, or of comprehension or expression of language" (Jennett) – it is reasonable to surmise





how this description speaks of an individual who has lost his or her personhood. By contrast, however, is the very verbiage used to portray this wholly observational condition, inasmuch as there is no correlation made between that diagnosis and what is happening with "specific structural pathology." Moreover, PVS is often a temporary state from which people ultimately recover, making the terminology "potentially misleading as it suggests irreversibility."

With the agonizing demise of Schiavo, the question of what defines death has come to the forefront of philosophical, medical and legal debate. When is a person dead? When they can no longer take care of themselves? When they have no quality of life? When there is no hope for reversal of deterioration of brain and other organs should the individual awaken from a coma? Indeed, while one might surmise how the definition of death is quite finite and straightforward, it has proven to be anything but, with the aspect of PVS one of the most focal points of the entire issue. Being that a very vague and indistinct definition of death is the state of no longer being alive in a biological sense, it stands to reason how there is much more to the aspect of demise than meets the eye. For instance, a person might be brain dead but is still alive by virtue of technological advancement in medical application – but is that alive in the human sense or merely artificially? A person who has a heart attack and is not revived for several minutes is agreed to be dead for that brief time period, however, he is ultimately brought back to life and lives another dozen years before finally passing away. He was not breathing during his short absence from mortal existence, which many believe is the primary prerequisite for death, but the fact that he was revived and once again began drawing air into his lungs illustrates how this is not necessarily a definitive component of being dead. As such, "the boundary between life and death is socially created; it cannot be easily ascertained or 'read,' even by the most sophisticated brain imaging technology" (Batchelder), a definition that continues to fuel the debate over PVS and whether a person should be allowed to languish in such a state.

## III. CONCLUSION: WHAT THE FUTURE MAY HOLD

There is no individual health care facility involved with the bioethical issue of withholding life-sustaining treatment in the form of nutritional support, inasmuch as every hospital across the United States stands to be confronted with this concern at one time or another. The Florida hospital where Schiavo ultimately died serves as the precedent-setting facility where much of the issue's legal focus has been placed; however, the growing trend of Futile Care Theory carries with it the potential to forever alter the manner by which all hospitals approach the notion of withholding life-sustaining treatment.

The common denominator of services provided by America's hospitals not only includes standards of care inherent to the protocol of health facilities as mandated by the Hippocratic oath, but also the slowly evolving legal aspect of withholding life-sustaining treatment at which point the respective hospital's bioethics committee deems appropriate. The extent to which the impact of this legal issue has stirred unprecedented concern over the lengths to which hospital bioethics committees can implement futile care at their discretion is both grand and far-reaching; that this budding approach is a "one-way street when it comes to patient autonomy and end-of-life care" (National Right To Life Committee, Inc.) speaks to a discomforting reality of doctors and bioethicists having the last say as to when the patient's life is "worth living and spending medical resources to sustain." Indeed, the changing face of life-sustaining treatment throughout American hospitals gives one pause as to the fundamental properties of patient wishes and how those desires may one day be completely overlooked in exchange for a more utilitarian form of health care amidst the broader spectrum of bioethical issues.

### References Consulted

Andorno, Roberto (2002, December). Biomedicine and international human rights law: in search of a global consensus. *Bulletin of the World Health Organization 80.12*, 959(5).

***Continued on page 27***

# CAPNOGRAPHY AND BOTOX IN CALIFORNIA, AN UPDATE

The AAOMS Board of Trustees approved the following guidelines requiring capnography equipment in the OMS office beginning in 2014:

*During moderate or deep sedation and general anesthesia the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs and monitoring for the presence of exhaled carbon dioxide unless precluded or invalidated by the nature of the patient, procedure, or equipment.*

*Improvements in monitoring exhaled $CO_2$ during anesthesia continue to evolve. Beginning in 2014, AAOMS Office Anesthesia Evaluations will require capnography for moderate sedation, deep sedation, and general anesthesia unless precluded or invalidated by the nature of the patient, procedure, or equipment.*

These statements appear in the *2012 Parameters of Care: Clinical Practice Guidelines for Oral and Maxillofacial Surgery (AAOMS ParCare 12), version 5.0*, which is also a component of the revised *Office Anesthesia Evaluation Manual, 8th edition*.

Successful completion of the office anesthesia evaluation every 5 years is a requirement for membership in the AAOMS.

The Dental Board of California has discussed the need to update the laws that apply to general anesthesia and conscious sedation at several of its meetings. The revision of general anesthesia and conscious sedation laws were not among the priorities set for 2013.

As a condition for issuance of a general anesthesia permit, California Law requires an on-site inspection and evaluation of the dental licensee, the facility, equipment, personnel, and procedures utilized. This evaluation must be completed at least once every 5 years.

California Code of Regulations Section 1043.3 (7) (k) describes the equipment which must include a capnograph and temperature measuring device for intubated patients receiving general anesthesia. This equipment is not, however, required for moderate conscious sedation. Onsite inspection and evaluations completed by Board-approved evaluators must be consistent with existing statues and regulations.

**To summarize:**

There is presently **no** California state requirement for the use of capnography in non-intubated patients or patients undergoing (moderate) conscious sedation. Failure to use capnography in a non-intubated patient is not sufficient grounds for failing the California onsite inspection and evaluation.

The Board welcomes suggestions for legislation or regulations from all interested parties. These may be submitted in person at our meetings or in writing to the Executive Officer.

**Regarding the use of neurotoxins (Botox) and dermal fillers:**

The Board heard extensive testimony regarding the use of Botox and dermal fillers by dentists at its August and November 2011 meetings. After extensive discussion, the Board directed staff to prepare a notice for the website on this topic. The message is as follows:

**Notice Of Existing Law Relating To The Use Of Botox And Dermal Fillers**

The Board has received many inquiries regarding the use of Botox and similar drugs. Under California law, dentistry is defined, in pertinent part, as "diagnosis or treatment, by surgery or other method, of diseases and lesions and the correction of malpositions of the human teeth, alveolar process, gums, jaws, or associated structures; and such diagnosis or treatment may include all necessary related procedures as well as the use of drugs, anesthetic agents, and physical evaluation…" (Business and Professions Code section 1625). A dentist may, therefore, use any legally prescribed drugs to treat patients as long as the treatment is within the aforementioned scope of practice.

A licensed California dentist who has been granted a permit to perform elective facial cosmetic surgery may utilize Botox and similar drugs purely for cosmetic purposes as long as it is legally prescribed and within the scope of practice for their permit (see Business and Professions Code section 1638.1). Please note that some permit holders may not be authorized to perform all cosmetic surgery procedures within the scope of the elective facial cosmetic surgery permit.

Additionally, it should be noted that all procedures authorized under the Elective Facial Cosmetic Surgery permit must be performed in an acute care hospital or a certified surgical center as defined in Business and Professions Code section 1638.1(f).





# CALAOMS Members of the 2013 ABOMS Oral Examination Committee

***California OMSs who are members of the American Board of Oral and Maxillofacial Surgery Examination Committee for 2013 are L to R: David Cummings, William Clark, Mary Delsol (ABOMS Immediate Past President), Larry Lytle (CALAOMS Past President), Sanford Ratner, Alan Herford (CALAOMS President), Earl Freymiller, Bruce Whitcher, Milan Jugan, Fred Stephens (CALAOMS Immediate Past President), Robert Relle, and Vincent Farhood.***

## Helistat

- Soft, white, absorbant sponge
- Measures 1" x 1/2"
- Made from deep flexor tendon
- Sterile and non-pyrogenic

## Cordless Curing Light

- Compact, cordless curing light, with 5 watt LED
- Various curing modes with times settable to 5-50 seconds

## Cytoplast Membranes

- Cost effective for common applications
- High-quality PTFE material
- Variety of sizes available

## Implant Presentation Kit

- Choose from five available options
- Improved patient education and higher treatment acceptance

***Xemax has a wide variety of innovative and time-saving products, as well as excellent prices on your favorite burs, membranes and other essential items!***

***Call for an updated catalog!***

**1.800.257.9470**

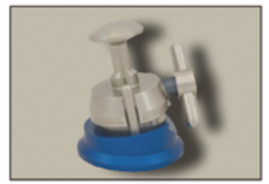
**www.xemax.com**

XEMAX
SURGICAL PRODUCTS, INC.

## Para Drill Aid

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

## Xemax Bone Mill



- Simple disassembly and cleaning
- Easily mills cortical bone

## Cusp-Lok Impacted Cuspid Brackets

- Strong 14k gold chain attached to orthodontic bracket
- Variety of styles available (Mesh, Swivel, Low Profile)

## C-Sponge Pharyngeal Barrier

- The common sense alternative to a gauze throat pack
- Highly absorbent; can be drained while remaining in place


# CALAOMS

CALIFORNIA ASSOCIATION OF ORAL & MAXILLOFACIAL SURGEONS

# 13TH ANNUAL MEETING

## THE WESTIN SAN FRANCISCO MARKET STREET

## MAY 3 - 5, 2013

*Posthumously Dedicated to Philip J Boyne, DMD, MS, DSc*

**SATURDAY SPEAKER: PAUL S. PETRUNGARO, DDS, MS**

"Creating Natural Soft Tissue Emergence Profiles Around Dental Implants in the Esthetic Zone through the Immediate Restoration/ Loading of Dental Implants at Placement"

~ A Periodontist's Perspective ~

**SUNDAY SPEAKER: RITA ZAMORA**

"Social Media Marketing Success Strategies for Oral & Maxillofacial Surgeons"

# VELscope: Update

*Lee Slater, DDS, MS*
*Scripps Oral Pathology Service, San Diego, California*
*Lecturer, Department of Oral & Maxillofacial Surgery, Loma Linda University School of Dentistry*

Is the surgeon who fails to use a VELscope to detect oral premalignant lesions providing substandard care? No. Does evidence from the current literature support the contention that VELscope should now be regarded a standard of care? No.

In 2008, Lingen and colleagues reviewed the literature on aids to identifying oral premalignancy and early cancer, and they concluded that the contention that VELscope improves diagnostic detection/accuracy had yet to be rigorously confirmed.(2) They pointed out that VELscope had been evaluated predominantly in high-risk individuals in cancer centers. It had not yet been evaluated in a low risk dental office setting. If kindergartners were evaluated with the VELscope, several youngsters would probably demonstrate "black" lesions, but they would almost certainly be false positives because oral cancer has an extremely low prevalence in five-year olds. The population tested matters.

In a biased study partially funded by the device's manufacturer, Truelove and associates designed a study to prove that the VELscope can identify lesions that cannot be seen by white light conventional oral examination.(6) The dental school study was biased because it used "clinical judgment" in 551 of 620 cases to determine the nature of lesions, rather than the "gold standard" biopsy; they did not test for false negatives. Of the biopsied nine cases identifiable by VELscope only, five showed mild or mild to moderate epithelial dysplasia.

Before concluding that the VELscope "saved the lives" of these five individuals, one should consider

*The Visually Enhanced Lesion scope (VELscope) illuminates oral mucosa with blue light but permits only green light to reach the observer's eye. Normal mucosa appears green; lesions appear black. The current cordless VELscope Vx model is more convenient than this older bulkier version.*

the significance of a diagnosis of mild epithelial dysplasia. Biopsy is the "gold standard" for assessing premalignant lesions, but histopathologic interpretation is rather subjective,(9) particularly the diagnosis of mild dysplasia. Van der Waal, an astute clinician from the Netherlands, acknowledges this by recognizing pathologic grades of P0 ("no or perhaps mild epithelia dysplasia"), P1 (mild to moderate dysplasia) and P2 (severe epithelial dysplasia).(15) There is evidence that mild epithelial dysplasia, with a malignant transformation rate of about 5%, has a more favorable prognosis than moderate epithelial dysplasia, and that moderate dysplasia has a malignant transformation rate similar to that of severe epithelial dysplasia. (10,16,17) The proposition that patients who have their epithelial dysplasia excised fare better than those who do not ("wait and see" follow up only) remains controversial.(8,11,12,15) In short, patients with mild





epithelial dysplasia have perhaps a 95% chance of never developing oral cancer.(10,16,17)

Farah and colleagues, in a well designed study that should be the model for future VELscope efficacy investigations, also found that VELscope identified 5 lesions undetectable by conventional oral exam, one of which revealed moderate epithelial dysplasia.(1) But they also identified 8 false negative cases (7 mild dysplasias and 1 moderate dysplasia). They found that conventional oral examination alone was superior to VELscope alone in identifying dysplastic lesions, and they concluded that VELscope is not useful in diagnosing epithelial dysplasia.(1)

In the Ohio State University study, the VELscope did not identify any lesions not already recognizable by conventional oral exam, and the VELscope resulted in an unacceptable number of false positives (94%).(4) The authors concluded that the VELscope adds little to conventional oral examination in diagnosing oral epithelial dysplasia.

Therefore, based on information currently available, the VELscope should not be regarded a standard of care. However, clinicians who use the VELscope in their daily practices are encouraged to acquire data and publish their findings so that we may all benefit from their experience.

## Bibliography VELscope

1. Farah CS, et al: Efficacy of tissue autofluorescence imaging (VELscope) in the visualization of oral mucosal lesions. Head Neck 34:856, 2012.
2. Lingen MW, et al: Critical evaluation of diagnostic aids for the detection of oral cancer. Oral Oncol 44:10, 2008. This is a position paper of the American Academy of Oral and Maxillofacial Pathology.
3. Morgan D: Oral surgeons and the VELscope system: Partners in early detection and diagnosis. Available free Online at: http://velscope.com/upload/VELscopeVX_Oral_Surgeons.pdf. Accessed February 25, 2013.
4. McNamara KK, et al: The role of direct visual fluorescent examination (VELscope) in routine screening for potentially malignant oral mucosal lesions. Oral Surg 114:636, 2012.
5. Sweeny L, et al: Assessment of tissue autofluorescence and reflectance for oral cavity cancer screening. Otolaryngol Head Neck Surg 145:956, 2011. Assessment of the Identafi 3000 Ultra device, manufactured by Trimira, Houston, Texas.
6. Truelove EL, et al: Narrow band (light) imaging of oral mucosa in routine dental patients. Part 1: Assessment of value in detection of mucosal changes. Gen Dent 59:281, 2011. University of Washington, Seattle, Oral Diagnosis-Urgent Care Clinic; study made possible with funding from NIH grant #T32 DE07132 and LED Dental Inc.
7. VELscope Vx step-by-step examination guide. Available free Online at: http://www.velscope.com/upload/VELscopeVX_Step-by-Step2.pdf. Accessed February 25, 2013.

**Malignant transformation of epithelial dysplasia**

8. Arduino PG, et al: [7% of dysplasias undergo malignant transformation; excising the dysplasia apparently of little help.] J Oral Pathol Med 38:540, 2009.
9. Fleskens SA, et al: [Interobserver variability in grading laryngeal epithelial dysplasia.] Mod Pathol 24:892, 2011.
10. Gale N, et al: [The malignant transformation rate of moderate dysplasia is approximately 10-20%, see Table 1, laryngeal mucosa.] Histopathol 54:639, 2009.
11. Holmstrup P, et al: Long-term treatment outcome of oral premalignant lesions [excising the dysplasia apparently of little help.] Oral Oncol 42:461, 2006.
12. Holmstrup P: Can we prevent malignancy by treating premalignant lesions? [Editorial]. Oral Oncol 45:549, 2009.
13. Mehanna HM, et al: [12% of oral dysplasias undergo malignant transformation by 4.3 years; excision appears to reduce risk.] Head Neck 31:1600, 2009.
14. Tilakaratne WM, et al: [Grading oral epithelial dysplasia.] J Oral Pathol Med 40:533, 2011.
15. van der Waal I: Potentially malignant disorders of the oral and oropharyngeal mucosa; terminology, classification and present concepts of management. Oral Oncol 45:317, 2009. See Table 8.
16. Warnakulasuriya S, et al: [Moderate epithelial dysplasia has a malignant transformation rate of 16%; mild dysplasia has a 5% rate.] J Oral Pathol Med 40:677, 2011.
17. Wenig BM: Keratinizing dysplasia of the upper aerodigestive tract [The malignant transformation rate of mild, moderate, and severe dysplasia is approximately 5%, 23%, and 28%, respectively]. Pathol Case Rev 13:9, 2008.

# Technical Articles

*Peter Krakowiak, DMD, FRCD(C)*

## Mini-screw anchorage for accelerated second molar uprighting and extrusion of high risk and deeply impacted third molar dentition

By the nature of our practice, we are continuously involved in the management of impacted teeth—third molars, canines, incisors, as well as bicuspids. Most often in molar cases—particularly third molars—patients are treated with removal of the impacted tooth. However, cases invariably arise where there are adjacent molars involved at the given site. Decisions have to be made in these cases how to best treat the impactions so that opposing dentition can be maintained in function and normal occlusal relationship as much as possible. This is especially true in growing patients who may not be good candidates for implant therapy for several more years.

Second molar impactions are reported to have a 0.03% incidence of occurrence. In most of these cases, there is also a concurrent impaction of the third molar. Here, the arch space does not allow for retention and functional hygienic eruption of both teeth. The choice must be made as to which tooth is to be retained and uprighted, and which is recommended/indicated for extraction.

Disturbances in second molar eruption are multifactorial. The growth and eruption of the molar often starts with pre-existing angulations, and it self-corrects as it erupts and follows the distal root inclination of the first molar. The anterior border of the ramus is often resorbed to create space for eruption. In cases where a third molar bud either forms anterior or cephalad to the second molar bud and develops out of sequence, the result is most often a disturbance in second molar eruption. This is especially evident in cases of mandibular hypoplasia or delayed growth.

In some cases, iatrogenic placement of the molar band on the first molar, past sagittal orthodontic expansion, or even lip bumper-based obstruction to the mesial shifting of the first molar can compound the problem. Varied levels of impaction develop depending on space and timing. There are also some instances of third molar and second molar impactions where the teeth are very deeply impacted in the mandible with a significantly increased risk of surgically-induced fractures and/or paresthesias. Over the past few years, the application of limited TAD (temporary anchorage device)-based orthodontics has become a potential avenue for successful management of these complex cases in oral and maxillofacial surgical practice. Many of the less-complex cases of molar tipping or even shallow impactions can be routinely managed by conventional orthodontics and concurrent third molar removal (Figure 1).

In the cases of partial (exposed crown surface) or minimal (2-3mm depth) of mesioangular impactions, a fixed edgewise dental anchorage full arch approach can be considered. The dental segment would serve as anchorage and either a helical uprighting .018 x .025 spring or reversed loops can be applied. Lingual bonded auxiliaries with distal arm anchorage can also be used. The limitations of these non-surgical approaches include difficulty in gaining attachment to deeper impacted teeth and also relatively greater length of time required to achieve the desired correction. In many non-banded cases, the old brass wire techniques can be quite useful in uprighting the tooth in question as well (Figure 2).

There are, however, those complex cases that may need extra-dental or skeletal anchorage especially in patients who do not desire, or cannot afford, full arch orthodontics. Extra-dental anchorage using a TAD mini-screw allows for pure rotation by application of a coupled force system with a higher movement-to force ratio. The active force values cited in the literature needed to support active movement in the dense mandibular angle/body area are in the ranges of 800-1500g/mm. My experience had been that 400-600 gram forces will allow for movement in most cases. The TAD-based rotation will yield some distal-buccal rotation with minimal extrusion. Since no dental anchorage is used, the undesired reactive forces are not applied to the dentition. Limited vector control is present, however, due to limited anchorage positions available at the mandibular angle for the TAD if just simple elastic or coil mechanics are applied.

The basic technique for second molar uprighting involves exposure of the impacted tooth to the extent so that a bracket or a cleat can be applied to either the distal or buccal aspect of the crown structure. More lateral (buccal) placement of the anchor reduces the unwanted vector of lateral pull to some extent, but it will require greater depth of ostectomy to be completed prior to bonding the bracket. Once the bracket is bonded, either Ni-Ti coil mechanics can be applied or a power chain can be used to attach to the bracket. The TAD mini-screw is then applied distally (posteriorly) and as much as possible in line with the buccal aspect of the dental arch. Often a more buccal position is selected due to bone stock availability and orientation. However, the more lateral the TAD is placed, the greater the chances of developing a cross-bite orientation of the occluding teeth. The TAD screw is usually placed 1 to 2.5cm distal to the anchorage attachment on the impacted tooth. Placement closer than 1cm will limit the ability to use coil springs; while placement further than 2.5cm will often create more soft tissue irritation with longer active component dimensions being embedded in the tissues. Also, further

*Figure 1. Conventional orthodontic uprighting utilizing FEA anchorage (courtesy of Dr. Adrian Becker, Jerusalem, Israel)*

*Figure 2. Brass wire technique*

*Figure 3. TAD square head and corresponding Ni-Ti coil attachment*

*Figure 4. Power chain with new link being advanced over buccal cleat attachment*

*Figure 5a. Over-distalization of tooth #18 due to lack of timely follow-up*

*Figure 5b. Spontaneous auto-correction of overdistalized #18 with no active orthodontics*

distanced placement will often increase the vertical vector of pull and may cause unwanted hypereruption of the uprighted tooth. The ascending ramus will normally be able to accommodate a 6-10mm TAD screw superior to the roof of the inferior alveolar canal. A CBCT (cone beam computed tomography) scan is highly recommended to ensure a proper size selection of the mini-implant as to minimize any potential neurovascular structure encroachment.

The TAD screw is then connected to the active component of the device. The 200g Ni-Ti coil springs we use have a rectangular cut out which nicely co-adapt to the rectangular profile of the mini-screw anchor (Figure 3). Once passed over the head of the TAD fixture, it will remain very stable during the captive phase of treatment. In cases where the impaction is deep or bone density is gauged to be greater, a second or even third Ni-Ti coil can be connected to the anchor on the tooth and the mini-screw to increase the forces applied. The coil will have the advantage of continuous traction over its functional length after it is stretched. Once it fully recoils, either a shorter coil can be applied or the fixation point on the tooth can be relocated to a more anterior position on the uprighted tooth. In some cases, if additional distilization or uprighting is needed, we have applied a power chain elastic to get continuous and re-applicable mechanics by advancing the elastic to the next loop hole at every follow-up visit (Figure 4).

The power chain has the advantage of being able to deliver a greater force to the anchor and be sequentially re-stretched at the anterior point of attachment. Even though the power chain appears to be more efficacious than coil springs, it does require more frequent positional correction. Also, the activity and position of the Ni-Ti coil can be best and most easily followed by radiographic evaluation if the appliance is fully submerged in the tissue. The elastic power chain needs to be visually inspected for integrity and tension which, of course, would be difficult if the entire appliance is submerged. Therefore, it is most common (for me) to start with the coils and later switch to a power chain once the tooth-based anchorage is exposed intraorally. At that point, the TAD can be accessed via local anesthesia infiltration and the Ni-Ti coils removed and replaced with a power chain which is then stretched anteriorly and attached to the cleat (or the bracket) on the tooth. The power chain does not need to be ligated in most cases with any wires as long as adequate retention is achieved by the head of the TAD and the cleat or bracket's undercut features.





The site is then re-inspected at 2-4 weeks for movement and if the tooth appears to be moving, the tooth-based anchor can be advanced to the next loop of the power chain to maintain the active forces. This and subsequent advances will not require any anesthesia, in most cases. Once the tooth has cleared the distal undercut of the anterior molar, the active forces are discontinued and the tooth can be either allowed to erupt axially on its own or it can be added to the orthodontic arch wire for final correction of tooth position in all vectors (including further occlusal eruption).

It is very important to follow these patients closely to ensure that overcorrection does not occur (Figure 5a). If the teeth are over corrected, often the tooth will relapse mesially after release of the active forces (Figure 5b). In our experience of molar uprighting, there have not been any significant incidents of hypererupted of the molars above the occlusal plane, especially if opposing dentition was present. In fact, a simultaneous correction of hypererupted opposing molars was observed due to the lower tooth uprighting into its anatomical space without any other active forces being applied to the opposing upper second molar (Figures 6a and 6b).

The mean time for corrections that I have observed for most typical molar cases has been between 3-6 months with proper patient compliance and follow-up visits. Once the teeth have been uprighted, some orthodontic correction may still be required to ensure the ideal fit into the arch and occlusal scheme.

### Mini-Screw Based Forced Extrusion Of Deeply Impacted Teeth

I have also found another limited application for TADs—aiding in the treatment of deeply impacted third molar impactions. These are the few cases that are procedurally difficult due to limited access and carry the highest risk of either nerve injury or intraoperative or post-treatment (iatrogenic) fracture. The TAD application has been successfully applied in these cases to improve the tooth position for surgical access prior to surgical removal. It has also allowed for bone mass increase at the inferior border of the mandible prior to extractions to help aid in post-operative functional loading.

In cases where the third molar is located past the confines of the lingual border of the mandible (Figure 7) and below roots of the second molar, and where the mandibular cross-section is

*Figure 6a. Over-erupted #15; before molar uprighting #18*

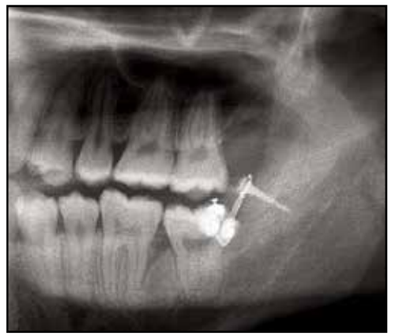


*Figure 6b. Spontaneous intrusion of #15 as #18 is fully uprighted*

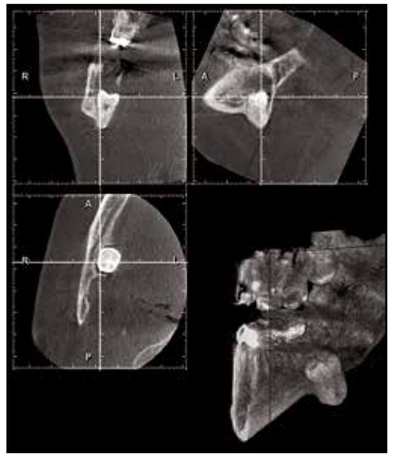


*Figure 7. Extracorporeal position of #17 causing challenging surgical access*


*Figure 8a. Parasagittal CBCT scan showing #17 occupying entire intramedullary area of mandible in cross section*

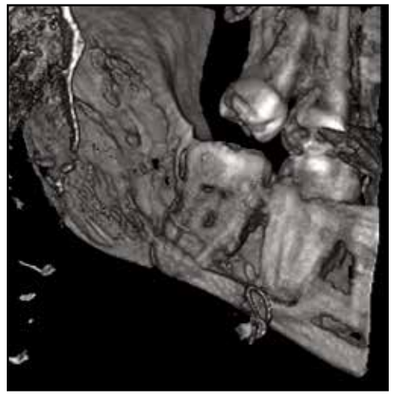


*Figure 8b. CBCT scan reconstructed image of the 3rd molar tooth showing lack of inferior border bone integrity*

extremely hypoplastic with the tooth occupying (essentially) the entire cross dimension of the mandibular angle area (Figures 8a and 8b), this technique is something to consider. These approaches have provided somewhat time-consuming but very predictable and relatively complication-free results.

The mechanics in these cases are based on axial vector pull only as most often the desired tooth movement is only to erupt a tooth. One or two TADs can be placed—one on the mesial and the other on the distal-buccal aspect of the impacted tooth (Figures 9a and 9b). The wide ascending ramus ridge is ideal for this application. Ni-Ti coils are applied in tandem to either one or both of the TADs after they are all ligated to a single bracket that is bonded to the most easily accessible point on the crown of the impacted tooth. In cases involving very deep impactions, some bone removal may be needed to gain this access. If distal movement is needed to bypass the second molar, distal bone removal can be accomplished and anchorage should be placed similar to that for uprighting. Once the tooth has been moved into the confines of the mandibular body (or at least more coronally), surgical access will be greatly improved and standard sectioning of the tooth, followed by removal, can be delivered analogous to treating a partially impacted tooth. In cases where limited bone girth is present apical to the third molar, it is prudent to erupt the tooth and allow for post-distraction osteoid consolidation (Figures 10a and 10b) for 2-3 months prior to removal to further reduce the chance of fracture.

This application of TAD use is a bit technique sensitive and does warrant patience on the parts of both the surgeon and the

*Figure 9a. Dual coils in tandem application for vertical forced eruption of #32*

*Figure 9b. Final tooth position of #32 prior to removal after the application of quad Ni-Ti coils in tandem*

*Figure 10a. Pre-treatment position of #17 with significant lack of inferior border bone integrity and mass*

*Figure 10b. #17 after forced eruption and 2-month consolidation period showing distinct formation of solid inferior border bone volume and structural dimension*





patient. The most common issues we have encountered are local gingival irritations and some hygiene challenges around the hardware. Peridex irrigation of the site has allowed for continued therapy with relative patient comfort in all cases. The removal of the TADs can be accomplished with local anesthesia, and the tissue irritations usually resolve in several weeks. Another potential issue that may surface may be some vertical bone defects that may be present radiographically early on after the uprighting of the second molar on the distal aspect of the first molar roots. In most cases, the radiolucency is related to the lack of calcification in the early osteoid being formed (Figures 11a and 11b). As time progresses, the area will become more radiodense on radiographic projections (Figure 11c). If, however, the defect continues to be evident six months after completion of the movement, a periodontal attachment level should be further evaluated and GBR may need to be considered. This has only been the case in a very small percentage of the cases; however, it would be prudent to discuss the remote possibility of using this additional regenerative care prior to commencement on any uprighting treatment.

## Conclusion

The technique of mini-screw-based molar uprighting is a valuable tool and treatment option for the management of molar impactions where the salvage of the impacted tooth and its retention in the arch are desired. Oral and maxillofacial surgeons should be versed in, and capable of, delivery of this therapeutic modality, and our expertise in this area is very helpful to our orthodontist colleagues and their patients in their efforts to correct complex cases of ectopic tooth development and retarded eruption.

*Figure 11a. Pre-treatment intra-osseous defect along distal root #19*

*Figure 11b. Defect's appearance during active treatment*

*Figure 11c. Consolidation of the regenerated defect at the end of the active treatment phase*

*Risk Management Corner*

# Make Certain Electronic Communications Ensure Patient Privacy

***By Julie Song, MPH, Patient Safety/Risk Management Account Executive, The Doctors Company***

E-mailing and texting are efficient, convenient, and direct methods to communicate in the dental and health care world, but they can be fraught with inadvertent security breaches. When e-mailing or texting replaces direct consultations and communication with dental colleagues, the dental provider must take steps to ensure the e-mails and texts are secure. Without appropriate safeguards, e-mailing and texting can lead to violations of the Health Insurance Portability and Accountability Act (HIPAA).

Health care providers are smartphone "superusers." According to Manhattan Research, over 81 percent of health care providers use a smartphone to communicate and access health information. The attractions are obvious: Texting and e-mailing reduce time waiting for colleagues to call back and may expedite dental care by allowing necessary patient data to be sent and received quickly.

## Safeguard Against HIPAA Violations

The very convenience that makes electronic communications so inviting may create privacy and security violations if messages containing protected health information (PHI) are not properly safeguarded. Electronic messages among dental colleagues should be encrypted and exchanged in a closed, secure network.

However, according to a member survey conducted by the College of Healthcare Information Management Executives, 57.6 percent of those surveyed did not use encryption software. The underlying reasons for poor compliance with encryption could be due to lack of technical knowledge or to avoid the inconvenience of sending a message to someone who may not be able to unencrypt it.

With penalties starting at $50,000 per HIPAA violation, safeguarding electronic messages should be of utmost priority. In addition to encrypting the messages, consider installing autolock and remote wiping programs on smartphones and computers. Autolock will lock the device when it is not in use, and it requires a password to unlock it. Wiping programs can erase data, texts, and e-mail remotely. Both types of safeguards provide additional protection if a device is lost or stolen.

## Ensure Accuracy to Avoid Liability Concerns

A cavalier attitude when composing an electronic message can pose a legal risk. The informal nature of some messages may at times lead to using shorthand, which can increase miscommunication. Additionally, deleted messages are never fully deleted, as metadata (the "data behind the data") is also producible in a lawsuit. It's important to ensure accuracy—particularly with consultations, personal health information, or any other important text communication.

Finally, electronic messages cannot substitute for a dialogue with a colleague concerning a patient. If there is a critical matter or any doubt about the communication, pick up the phone.

## Use Available Safeguards

In some cases, an electronic record vendor may offer a secure e-mail network option to clients. If this is the case, be certain that the e-mail recipient is also utilizing encryption in response to your messages. Be aware that some vendor contracts attempt to shift liability risks resulting from faulty software design or decision support data onto the provider. The contract may also give rights to the vendor to utilize patient or provider data.

## Take Steps to Protect Your Practice

Consider the following steps to safeguard your practice:

- Enable encryption on your electronic devices.
- Have a texting policy that outlines the acceptable types of text communication and situations when a phone call is warranted.
- Report to the practice's privacy officer any incidents of lost devices or data breaches.
- Install autolock and remote wiping programs to prevent lost devices from becoming data breaches.
- Know your recipient, and double-check the "send" field to prevent sending confidential information to the wrong person.
- Ensure the metadata retention policy of the device is consistent with the dental record retention policy, and/or in accordance with a legal preservation order.
- Ensure that your system has a secure method to verify provider authorization.
- When conducting your HIPAA risk analysis, include text message content and capability.

More information on e-communications risks can be found at bit.ly/WuEqj3.

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

©2013 The Doctors Company (www.thedoctors.com).






***Continued from page 13***

Batchelder, Tim (2005, December). An anthropology of death. *Townsend Letter for Doctors and Patients 269*, 123(3).

George, Robert P. (2005, Winter). Always to care, never to kill. *The Human Life Review 31.1*, 101(5).

Horrigan, Bryan (2004). *Adventures in Law and Justice: Exploring Big Legal Questions in Everyday Life*. UNSW Press.

Jennett, B. (2002, October). The vegetative state: the definition, diagnosis, prognosis and pathology of this state are discussed, together with the legal implications. *Journal of Neurology, Neurosurgery and Psychiatry 73.4*, 355(3).

Koch, T. (2005, July). The challenge of Terri Schiavo: lessons for bioethics. *Journal of Medical Ethics 31.7*, 376(3).

Kock Brison, Jule. (2005). *Days of Infamy and Horror*. http://www.newsweb.ca/2005/April_7/DAys_of_Infamy_and_Horror.

Richards, Edward P., Ph.D., J.D., M.P.H. *Supreme Court Upholds Prohibitions on Assisted Suicide*. //biotech.law.lsu.edu/cases/pro_lic/vacco_glucks_brief

Sade, Robert M. (2006, Spring). Defining the beginning and the end of human life: Implications for ethics, policy, and law. *Journal of Law, Medicine & Ethics 34.1*, 6(2).

# In Memorium

## David L. Baker
## 1957-2013

***by Michael P. Morrissette, DDS***

My partner, David Baker, recently passed away after a brief battle with cancer. He was initially diagnosed in April 2012. David was 55 years old.

David and I first met on a flight to Hawaii attending a meeting just a few years out of oral surgery residency. We were both in private practice (David opened an office in Palmdale). We finished residency within one year of each other, and shared similar philosophies in regards to the practice of oral surgery. We became partners in Camarillo in 2000.

He went to high school in Simi Valley and attended Moorpark College then Cal State Northridge. He was accepted to the University of the Pacific School of Dentistry where he graduated first in his class. He completed his OMS residency at the University of Washington. As part of that program, he spent a year in the Netherlands performing complex orthognathic and reconstructive surgery.

David had great hands and was a very talented dental student and later, surgeon. In fact, he was the most skilled and gifted oral surgeon I have ever seen perform oral surgery. He was at his best when the cases were the most difficult. He was so capable under the most stressful of conditions. He loved oral surgery; he realized and understood what a privilege it was to treat patients and be a dentist.

David practiced in Camarillo for 12 years. He was on call for St. John's Pleasant Valley Hospital and treated many in the community who sustained maxillofacial injuries. He was an active staff member at the Ventura County Medical Center which is our local trauma center, and served the county by treating some of the most severely injured patients with head and neck trauma.

He used his extensive experience in orthognathic surgery to support our Ventura County Cleft Lip and Palate Team on a volunteer basis. He would visit an inner city Los Angeles dental clinic on select Saturdays and perform oral surgery for the orthodontists who were providing free orthodontic care.

He enjoyed traveling to third world countries to perform oral surgery. He traveled to Honduras and Peru. He was conversationally fluent in Spanish. In Peru, he gave lectures to the Peruvian dental students and taught the oral surgery residents in the hospital about complex oral surgery cases and infections. One year, he traveled to Cusco, Peru to oversee a group of dental students from the University of the Pacific.

David was an active member of the Church of Jesus Christ of Latter Day Saints. He enjoyed teaching and being involved in the church community. He was an expert skier, enjoyed fishing in the Sierras, and liked to drive and discuss fast cars. He is survived by his wife, Leslie, and his 4 children—David, Eric, Kelly, and Nicholas. His infectious smile, generosity, and compassion for others will be greatly missed.

## Edward E. Black
## July 25, 1937 – October 1, 2010

Dr. Edward E. Black, a prominent Los Angeles oral and maxillofacial surgeon, lost his battle to cancer on October 1, 2010. Dr. Black owned and operated a hospital-based oral and maxillofacial surgery practice within the Crenshaw community for approximately forty years.

Not only did he continue to build his practice, he trained numerous residents in the field of oral and maxillofacial surgery at Martin Luther King, Jr. hospital for 20 years, published numerous journal articles, and was the recipient of the prestigious Daniel Laskin Award in Toronto, Canada in 2009.

Dr. Black was an avid tennis player, workout fanatic, jazz connoisseur, and enjoyed storming up and down the Pacific Coast on his beloved boat called "Jaws Fixer."

Dr. Black leaves to mourn his passing three daughters—Joshlyn Black, Jeanna Black, and Dr. Misty Michelle Black—all living in the Los Angeles area. Dr. Black is survived by a sister—Gladys Black Pierce, two brothers—Dr. James Tillman Black, Sr. of Los Angeles, and William Robert Black of Santa Ana, CA.



## *Upcoming 2013-14*
## *CALAOMS CE Events*

| | | | |
|---|---|---|---|
| **13th Annual Meeting**<br>May 4-5, 2013 | **San Francisco** | **Medical Emergencies***<br>November 6, 2013 | **Northern CA** |
| **Residents' Night Presentations**<br>September 11, 2013 | **Southern CA** | **January Meeting**<br>January 17-19, 2014 | **San Francisco** |
| **OMSA North 2013**<br>September 28-29, 2013 | **Foster City** | **14th Annual Meeting**<br>May 3-4, 2014 | **Newport Beach** |
| **OMSA South 2013**<br>October 19-20 | **Santa Ana** | | |
| **ACLS**<br>Oct./Nov. 2013 - TBD | **Solano** | | |

**OMSA Online Classes - Status Still Unknown**
**We will update the membership when we have more information.**

** The Medical Emergencies course will be alternating between Northern and Southern California Locations each year.*

BRADY PRICE & ASSOCIATES
Experienced, Reliable

Practice Sales ⚜ Associate Recruitment ⚜ Partnership Formation

CEDRIC T "RIC" BRADY
SCOTT A PRICE

Representing Sellers and Buyers
Call For A Consultation (925) 935-0890

OVER 150 OMS REFERENCES AVAILABLE

# Classified Ads

## Equipment For Sale

**Reduced! iCAT Excellent Condition**, used Next Generation Platinum with Extended Field of View. Includes monitors, Codonics medical printer and supplies. Warranty available and selling due to lack of utilization. Asking $95,000. Please contact Frank A. Portale DDS at 209-481-9307.

## Practices for Sale

**Looking to purchase** an OMFS office in Southern California (LA and surrounding areas). Please email me at omfsbuyer@gmail.com if interested.

**San Diego** office based OMS practice available for sale. 2250 sq. ft ground floor suite contains one consult room and four operatories. Fully equipped including an extensive computer network and digital x-ray. Seller will assist new surgeon in transition. Contact Brady Price & Associates (925) 935-0890) or email Scott Price at scottp_brady@sbcglobal.net. All inquired held strictly confidential.

**Premier Oral and Maxillofacial Surgery Practice** available in a highly desirable and prosperous community of the San Francisco North Bay Area. Practice historically produces $1.7 Million with excellent net income. Excellent opportunity for a new practitioner, or a seasoned professional wishing to build his or her professional career. If buyer wishes, owner will remain available on a regular basis to introduce to referring doctors, and to mentor the new owner, but will not be available to contribute any significant amount of surgical time due to disability. For additional details, interested parties please contact Jay M. Hislop, DDS, Esq., who represents the owner, at jayhislop@mac.com, or leave a voice mail message at 209-406-6314. A confidentiality and non-disclosure agreement will be required before release of practice information.

## Associate/Partnership Opportunities

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

**Greater Sacramento** multi-specialty office seeks associate Oral Surgeon for 1 day a month to start; eventually trying to expand program to 2-3 days per month. Dental Practice has great modern facilities and equipment, with an experienced support staff. Please email CV to smiles4abetterlife@gmail.com or fax to 916-817-4376.

**Sacramento** Kids Care Dental Group is looking for a talented oral surgeon to join our team 3-4 days a month. With six offices and TONS of maturing kids (LOTS of 3rds) we have way too many referrals for our one doctor to handle. Private patients, an amazing team, and a proven recipe for success. Please email Derek Boyes at dboyes@kidscaredentalgroup.com to discuss the opportunity in more detail.

## Doctors Seeking Positions

No listings at this time.




Breathe Easy.


nCompass Model 8100H w/ $CO_2$


nGenuity Model 8100EP1 w/ $CO_2$

Add $CO_2$ patient monitoring to your oral surgery practice

More and more oral surgery practices are utilizing our nCompass® and nGenuity® patient monitors with $CO_2$. *Practices like yours need effective capnography monitoring for all moderate sedations, deep sedations, and general anesthetics, effective January 1, 2014.* You'll appreciate our monitors' large color display, intuitive buttonology and rugged design, that ensures satisfaction years after installation.

Now is the time to take advantage of the new $CO_2$ monitoring requirement to update your old monitors. Criticare® monitor configurations include ST-arrhythmia analysis, touchscreen functionality, and EMR compatibility with all major oral surgery EMR programs.

www.onerepinc.com • 888.273.0656

*Criticare, nCompass and nGenuity are trademarks of Criticare Systems, Inc. © 2013 Criticare Systems, Inc. All Rights reserved. MKT-04626-01r4*

CSI CRITICARE SYSTEMS, INC

*Your Criticare Representative Since 1996*

ONE REP incorporated

Toll Free 888-273-0656 **Mark Thrasher** 951-237-3333

# *Could a* LAWSUIT *hit you* OUT *of the* BLUE?

Statistics say Yes. Every year nearly one in ten OMS is sued. For over 20 years, OMSNIC has provided the most powerful claims defense in the industry. Our unparalleled professional liability coverage and risk management program are designed to help protect OMS.

Owned and operated by OMS, OMSNIC has a deep understanding of the specialty and only insures Oral and Maxillofacial Surgeons. The OMSNIC Advantage is our single-minded dedication to protecting, defending and strengthening your OMS practice. For more information call 800-522-6670 or visit our website.

OMSNIC
DEFENDING THE SPECIALTY

*25 Years Serving OMS*
*1988 – 2013*

omsnic.com

AAOMS
Exclusively Endorsed by AAOMS