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The Compass
Staying the Course Through Service and Education
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California CareForce Supported by a Strong Showing of CALAOMS Members

by Pamela Congdon, CAE, IOM, President CCF, CALAOMS Executive Director

Featured left to right - top row: Drs. Julia Townsend, Aaron Adamson, Michael Knutson, Alan Kaye, Kurt Hummeldorf, Leonard Tyko, Moris Aynechi, Larry Lytle, Russ Webb, Murray Jacobs, Monty Wilson, bottom row: Drs. Spencer Anderson, Nathan Latimer, Chan Park, Shaun Daneshgar, Albert Lin, Daniel Witcher, Milan Jugan.

In 2011, CALAOMS, as an organization, involved our specialty in community outreach. The 2010 and 2011 Board of Directors voted to allow CALAOMS staff to work with Remote Area Medical (RAM) to host two free health clinics in Sacramento and Oakland. After the clinics in April 2011, it became apparent that there was a need in California to provide these services to the non- and under-insured on a more frequent basis. With CALAOMS' blessing, CALAOMS staff and a dedicated core team of volunteers formed RAM CA – an affiliate of Remote Area Medical. In 2012, we once again teamed up with RAM to host two more clinics in Oakland and Sacramento.

The promoter of the Coachella Music Festival, Goldenvoice, invited us to hold a clinic in the Coachella Valley at the Indio-Riverside County Fairgrounds in

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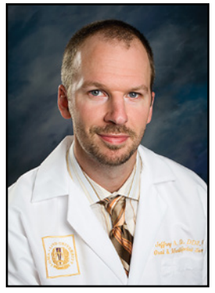
Compass Direction

Editor's Corner



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

Employees and Social Media

In any OMS or group dental office, internal and external conflicts are usually unavoidable and can trigger staff members to "post" or "tweet" their thoughts online to their many real- and cyber- friends. This can have the possible effect of negatively impacting the reputation of the doctor, or the office itself. How can we ensure that our employees will uphold the reputation of the office and prevent such occurrences?

I guess the short answer is, "*we can't.*"

None of us are old enough to know for sure, but I can imagine that office and company managers had the same conversations when the first telephones arrived. "How will we control our communications? What if something bad is said over the phone lines? Is privacy over? Can't our employees steal our information and spread it anywhere with one phone call?"

When email arrived, I remember my boss at the time fighting it tooth and nail. He wanted "the old fashioned means of communication"—everything on paper—documented—and saw this development as the inevitable end of employee discretion and the precursor to an era of scandal; and in some ways it probably was.

At each stage of our technological evolution, managers and leaders have had to *adapt* and *adopt*. This is no different. Social media is an evolution in how we communicate. We can't control the message just like you couldn't control an employee phone call or email message. And yes, employee communications on social media can be subjective, unexpected, and even unfair. But we have all gone through residency and know that *so is life*.

Offices and other businesses are going to have to learn to deal with it, as they always have. Social media is like a Darwinian catalyst which will force rapid change in many office functions. It will expose the solid foundations of the office culture, as well as highlight uncomfortable vulnerabilities. In some ways this may be a gift to the ever-unchanging office (*you all know who you are!*). Those with the best ability to adapt and adopt will certainly have an advantage in the long-term.

But how does this happen? The first step is to have a meaningful social media policy in your office. Employees should understand the office's positions, policies, and consequences. But it also must be a living document and associated with relevant employee training. The policy should be reviewed by an office manager every six months to ensure it still reflects reality and that it's doing its job. It should be part of employee training and on-boarding just like any policy to guide the appropriate use of technology.

If your company does not have a social media policy, here is a website with hundreds of public examples: http://socialmediagovernance.com/policies.php. Perhaps one of them will fit your office. Seek legal counsel if deemed appropriate to do so.

Unfortunately, many doctors and offices don't understand social media; and most are annoyed at the thought of trying to learn it. Many are still trying to control messages and employees in unrealistic ways. Even if you outlaw social media activity in your office, it's still going to happen over personal smartphones on employee breaks. So be realistic and fair. Encourage only positive communication to your staff. Be the leader of the positive message. Chances are that if your staff is constantly negative, they may be mirroring what is given to them as the example.

I read of a couple pretty good examples illustrating why *every* organization needs a social media policy. A local T.V. station was promoting a college scholarship competition on its website. A student posted on the station's Facebook page a claim that the contest was rigged. A teacher responded to the student, wondering if he was just upset because he had been suspended from school that week. Oops. The teacher violated the student's privacy in a very public way. Her post was not on a social media site belonging to her, the student, or the school. It was on her time and on her computer. And yet she ended up being suspended from her job and the school was red-faced because they had no social media policy in place. Or take what happened to a 23-year-old model admitted to Chicago's Northwestern Memorial Hospital last June for excessive alcohol consumption. An E.R. doc allegedly took photos of her in which she appeared anxious and disheveled. He's accused of having posted the unbecoming shots on Facebook and Instagram.

Despite the flak over these and other indiscretions, a recent Harris Interactive poll indicates that 79% of Americans trust health care professionals to safeguard sensitive information. Providers will have to be more cautious than ever, though, as new crowdsourcing apps are introduced.

Most social media pundits will say that if you don't trust your employees to use social media you have a *hiring problem*, not a social media problem. That may be a bit naive and idealistic. You know what? Doctors make mistakes. Patients complain. Employees get upset. Employees go crazy over personal stuff that may have nothing to do with their jobs. And if they take out their frustrations on social media, it doesn't mean the company has a hiring problem.

The American Nurses Association, American Medical Association, and other trade groups have tried to soften administrators' hard line by setting standards for social media use in the workplace. They've published guidelines packed with nuggets like "*Pause before you post*" and "*Be aware that any information [you] post on a social networking site may be disseminated (whether intended or not) to a larger audience*." In addition, the AMA urges its members to maintain separate personal and professional identities, a strategy that's likely to work as well for doctors as it has for Anthony Weiner.

Friends, social media is here to stay; please don't make the risky mistake of continuing to view it the way many of us regard twerking—if we ignore it long enough, surely it will just go away. Nearly 60 percent of the health care professionals surveyed by InCrowd report having no social media access in clinical settings at work.

So just like any other HR issue, you need to have a well-communicated policy which explains the consequences when an employee drags its employer into a mess.

References

Anecdotes reviewed and taken from Future Tense, a collaboration among Arizona State University, the New America Foundation, and Slate; author Melissa Jayne Kinsey.

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2013. As RAM California, we ran all the logistics for the clinic, and RAM USA brought the equipment from Tennessee for us to use as they had the previous two years. This arrangement was not ideal as it only allowed RAM CA to put on clinics in California once a year. Although the clinic in Coachella was successful, it still left us with the feeling that we could be doing more. Realizing that we were not going to get the immediate help we wanted from RAM USA in purchasing our own equipment, we felt that it was time to disassociate with RAM and become our own organization. With the financial support and encouragement from a few dedicated donors, we set out to purchase 70 dental stations, equipment for 10 vision lanes, vision lab equipment to make prescription glasses, 20 medical tents, and the various supplies and instruments needed to run a clinic.

Thus, California CareForce was born. The core team we had developed with RAM CA remained the same; however, we changed our name to better reflect who we are and what we do. By changing our name and philosophy, CALAOMS can now proudly boast that California CareForce is its charitable arm. CareForce is one of two organizations that are sponsored, maintained, and championed by California organized dentistry.

At this time, CareForce has a part-time executive director, Casey Collins. Since CareForce is housed in the CALAOMS office at this time, Steve Krantzman and I oversee the organization and fund-raising duties. Steve, as a board member of CareForce, as well as Director of Operations, researched and ordered all of the equipment needed to hold the clinics.

California CareForce hosted its first four-day clinic April 3-6, 2014 at the Indio/Riverside County Fairgrounds. At first, it seemed like a long shot that in just four short months our CareForce team could do what RAM had been doing for 36 years. And that was to not only organize, but acquire all of the equipment necessary to hold a clinic. With a lot of prayer, hard work, and team effort, a few tears (mine, not Steve's) and equipment assembly weekends, we were ready for Coachella when the time came.

Throughout the four day clinic, we treated just over 2,000 patients with the help of many volunteers that had been with us the previous year and others that were volunteering for their first time. I personally love meeting the volunteers. They may not be getting services, but they are rewarded in so many ways, as well. If you have a patient hug you, bless you, give you a smile, shake your hand, or gratefully cry in your arms then you will understand the power and compassion of volunteering.

A special thank you to the 31 CALAOMS oral and maxillofacial surgeons and 10 oms residents that volunteered over the four days of the clinic! You came from all over the state to support CALAOMS and CareForce. We have been asked to return to Coachella next year before the Festival. We are also hoping to have a clinic this fall in San Francisco or Merced, and three clinics the following year.

We hope that you will consider volunteering at our CareForce clinics, and make California CareForce your go-to volunteer destination.

CCF Coachella 2014 OMS Volunteers

CALAOMS Members				
Moris Aynechi	Milan Jugan	Marc Salomone	Stephen Vaughan	Spencer Anderson
Rick Berrios	Alan Kaye	Peter Scheer	Ashok Veeranki	Nicholas Breig
Shaun Daneshgar	Stephen Kreizenbeck	Todd Sumner	Russ Webb	Ryan Falke
Jeffrey Elo	Steve Leighty	Charles Syers	Monty Wilson	Andre Fernandes
Loretta Gilmore	Albert Lin	Craig Thiede	Daniel Witcher	Michael Knutson
Kurt Hummeldorf	Larry Lytle	Louis Tieu		Nathan Latimer
Murray Jacobs	Robert Mraule	Lonnie Tiner	***OMS Residents***	Ayleen Rojhani
Art Johnson	George Oatis, Jr	Julia Townsend	Aaron Adamson	Rahul Tandon
	Chan Park	Leonard Tyko	Chad Allen	

President's Message

Albert W. Lin, DDS
President, CALAOMS

It's My Honor

Dear Members and Colleagues,

It is my distinct honor to be your CALAOMS President for 2014. As a director of the board and chair of various CALAOMS committees throughout the last 6 years, it has been a privilege to work with both past and present board members and staff. I have never been more impressed with the time spent, commitment to, and passion for service that everyone at the CALAOMS board brings to the table. There is a certain wisdom that long-term board members provide that helps guide newer board members through the often complex, sometimes delicate, and time-consuming process of navigating the board. A strong blend of experience balanced with new ideas—and hopefully more current perspectives and concerns—results from the wide range of backgrounds, interests, and types of practice. Each board member infuses the collective thought process that ultimately becomes the position and spoken word of CALAOMS. This is always done with careful and thoughtful consideration of our specialty, and most importantly, its members!

After spending much time at the beginning of my tenure watching, listening, and learning about the functions and responsibility of the CALAOMS board, I have been enlightened by my experience. When I first began private practice some years ago, my opinions of the board were quite different. I thought board members were politicians interested more in their egos and trying to ensure their historical presence. To my pleasant surprise, I couldn't have been further from the truth! I discovered a group of colleagues that all had one thing in common—a genuine interest and concern in the well-being of our specialty and its members on ALL levels of practice. Issues ranging from topics such as office permits, anesthesia exams, OMSA curriculum, CE courses, managing unforeseen office situations, itinerancy, legislation, insurance, and scope of practice, to name a few. This was truly eye opening and inspiring for me to see firsthand and gave me a completely new appreciation and level of respect for those who had been there before me. There is a rich history in our specialty when it comes to organized OMS. The fusion of the Northern Society and Southern Society to become unified came out of an interesting and challenging time that ultimately led to what is CALAOMS today.

Much thanks and credit to the foresight of the many past and present board members. The other thing I soon realized was that board members come and go, but the ever vigilant and dedicated staff at CALAOMS remain the true backbone and foundation of CALAOMS. The captain of our ship is our executive director, Pam Congdon; and we as board members are inspired by her unwavering passion and dedication to keeping CALAOMS on course. Thank you, Pam!

Just to give you, my friends, a little bit about me…a native of California, I grew up in Chicago where I attended University of Illinois Dental School and then completed my OMS residency training at Northwestern University Medical Center. I spent a

couple of years on staff at Loma Linda University in the OMS department before going into full-time, full-scope private practice. In my spare time, I enjoy spending time with my family, going to the gym, and snowboarding.

I am truly excited this year about our California CareForce program, formerly known as RAM California, an innovative program that provides free health, dental, and vision services to thousands of Californians throughout the state. The new organization will allow volunteers to provide services exclusively to Californians. The landscape of healthcare is changing quickly under the Affordable Care Act and people continue to be affected by the economy. California CareForce will help provide many of these people with healthcare services they can't otherwise afford. California CareForce will continue the large-scale, four-day clinics, and in addition, utilize mobile equipment to provide care on a smaller scale.

In conjunction with Goldenvoice, California CareForce held their first clinic April 3-6, 2014 in Coachella Valley (Indio). We plan to continue holding clinics throughout the state in sites that may include Oakland, Sacramento, and Los Angeles, to name a few. This year in Coachella, we provided approximately 2,000 patients over a nine hundred thousand dollars in free health care services! This program represents CALAOMS' commitment to the advancement of Oral and Maxillofacial Surgery through public service and at the same time will educate the public about our specialty. Our specialty is unique in that it is the link between dentistry and medicine because of our training in both fields. We have the ability to bring both together and help bring healthcare as a whole to people in need. This is what California CareForce is all about, and it belongs to us! It is our endeavor, we own it!! So please come help us promote our great specialty through public service at California CareForce! I look forward to serving as your president this year and am excited about moving this great organization forward!

Advocacy Update

Bryce Docherty, CALAOMS Lobbyist

LEGISLATIVE UPDATE

CALAOMS is currently tracking 22 bills. This year there were a total of 2,028 bills introduced (1,361 Assembly bills and 667 Senate bills).

AB 1174 (Bocanegra) - Teledentistry: This bill establishes "teledentistry" as a billable and reimbursed service in the California Medi-Cal Program. It also inappropriately expands scope of practice for dental assistants and dental hygienists by allowing them to perform "interim therapeutic restorations" or ITR. CALAOMS is working with the author to remove the ITR provisions. CALAOMS POSITION: SUPPORT IF AMENDED

AB 1805 (Skinner-Pan) – Medi-Cal Reimbursement: This bill will bolster provider participation in California's Medicaid (Medi-Cal) program as the State implements the rollout of healthcare reform. AB 1805 will restore the 10 percent cut to Medi-Cal provider reimbursement rates that were enacted as part of the 2011 State Budget Act. CALAOMS POSITION: SUPPORT

AB 1962 (Skinner) – Dental Plan Medical Loss Ratio (MLR): This bill requires dental health insurers to spend at least 80 percent of collected premiums on actual dental care. The percentage rises to at least 85 percent of premiums for employees covered by plans through companies with 50 or more employees. Health insurance companies already have those medical loss ratios in place for healthcare services but dental insurers do not face the same requirement. CALAOMS POSITION: SUPPORT

SB 1429 (Steinberg) – MICRA: This "spot bill" simply declares the intent of the Legislature to bring interested partied together to develop a legislative solution to issues around the MICRA cap on non-economic damages of $250,000. Rest assured there will be absolutely NO negotiations on MICRA in the Legislature. The trial attorneys have picked their path which is the ballot box in November. In fact, according to Jim DeBoo who is leading our campaign effort against the initiative has stated, "In the current healthcare environment, any proposal certain to cause more lawsuits, increase costs, and reduce access is simply a nonstarter. Our health system can't afford it and the people of California don't want it." (Los Angeles Times, February 24, 2014). CALAOMS POSITION: OPPOSE

REGULATORY UPDATE

The Dental Board of California (DBC) recently adopted regulations that take effect on July 1, 2014 to increase your biennial licensure fees from $365 to $450. There has not been a fee increase since 1998. However, the DBC is still operating at a deficit even with this forthcoming fee increase.

On March 12, 2014, I attended a teleconference at the DBC office in Sacramento to further discuss the licensure fee issue. DBC staff reported that the initial analysis conducted by the Budget Office indicated that the licensure fees should currently be at $525 to enable their fund balance to support expenditures. However, the DBC was only able to increase fees to the maximum allowed by statute, which is currently $450. Nonetheless, using $525 as the current "break even" baseline, the DBC projects the needed licensure fees to be $706 by 2025 after adjusting for a rate of inflation annualized by 3 percent.

The DBC has gotten Senator Marty Block (D-San Diego) to introduce a "spot bill" SB 1416 to address further increases in licensure fees. Originally, the DBC was asking for authorization to increase the fee up to $700. However, Senator Block agreed to carry the legislation with the caveat that the licensure fee be pegged at $525 in statute. The DBC is undergoing sunset review next year at which point, Senator Block feels the licensure fee increase issue can be discussed in a broader context.

Therefore, the DBC has voted unanimously to support SB 1416 (Block) as proposed to be amended to increase licensure fees to $525 effective January 1, 2015. Those amendments are forthcoming.

MICRA BALLOT INITIATIVE UPDATE

Consumer Watchdog (i.e. trial lawyers) is technically "off the street." This means they have called in all their signature gatherers and have the requisite number of signatures (i.e. 800,000) to qualify their ballot measure for November. This now means we head into campaign mode. Therefore, all media efforts and external communications regarding the initiative going forward will be handled by the campaign. The campaign led by CDA and CMA has assembled a top-notch campaign team to lead this effort. On your behalf, I am in constant contact with the campaign and their efforts.

The Changing Face of General Dentistry Has Altered Specialty Practice

Charles D. Hasse, DDS, MD
President, American College of Oral and Maxillofacial Surgeons

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This is not intended as a "doom and gloom" editorial, but rather as a commentary on what is happening in southern California and what is about to happen across the nation. Given that traditionally the west coast and east coast set the trends as to practice policy, the wise will pay heed. There is no doubt that specialty practice in the southland is in a state of flux, and that the changing face of general dentistry is at the core of the change. An informal recent survey found that the average oral and maxillofacial surgery practice in southern California is down anywhere from 18% to 35% (survey of 16 specialty practices in Orange County, California, June 2013, *personal communication*). What is the reason for such a significant decrease in productivity? As this author sees it, there are at least 5 readily identifiable causes, which will be discussed:

- Economic pressures
- The weekend education "specialist"
- Difference in the model of general dentistry practice
- Itinerant specialty practice
- Emergence of corporate dentistry

It should be recognized that these 5 causes are not necessarily independent of each other, but in many ways are tied together.

ECONOMIC PRESSURES

Let us begin with economic pressures. It has been reported that the average dental student graduating in this day and age is in debt several hundreds of thousands of dollars.[1] Combine this massive debt with the desire to set up a state-of-the-art modern-day practice, and the cost expenditures and indebtedness can be staggering. When one does set up practice, which is typically slow at the start, the economic pressure of repaying the debt frequently becomes a reality. Does one refer a set of third molars to the oral and maxillofacial surgeon, or does one take the teeth out oneself under local anesthesia, often to the detriment of the patient and the patient's best interest? The same can be true for the other specialties, including periodontists, endodontists, or orthodontists. Regarding orthodontic care, how easy is it to take a set of impressions and place Invisalign trays rather than refer a patient to the orthodontist for the proper management of a malocclusion? Unfortunately, economic pressures can cloud one's judgment and lead one to employ a mode of practice or a method of treatment that is not technically wrong, but is also not necessarily optimal and in the patient's best interest.

THE WEEKEND EDUCATION "SPECIALIST"

In southern California, it is extremely unusual to see a dental practice listed by the traditional moniker of "General Dentistry." Instead, every dental office is listed as "Cosmetic Dentistry and Implant Dentistry." Furthermore, when one looks at the website associated with such practices, it can be most enlightening to learn that these practices are not only "specialists" in implants, but also bone grafting, sleep apnea, orthodontic treatment, Botox and fillers, temporomandibular joint function, and on and on. Far too often, the true nature of this advanced patient care is based on attending a weekend course with rudimentary primers in dental/medical education. Furthermore, the main focus often is centered on teaching how one can bill for such treatment. Since continuing education in dentistry or medicine is mandatory for licensure, no one should argue against the importance of weekend courses as being a mainstay to augment professional education. However, it should be recognized that the intent of such courses is not to bypass the specialist in the management of more complex cases. The ability to take a set of models and place a sleep appliance, mandibular orthotic repositioning appliance, Invisalign trays, and other appliances does not equate to a meaningful understanding of a disease process or condition that requires the benefits of years of specialty education, training, and experience.

DIFFERENCE IN THE MODEL OF GENERAL DENTISTRY PRACTICE: ONE-STOP SHOPPING

There is an emerging phenomenon in southern Californian general dental practices whereby the general dentist controls (and profits from) all aspects of the patient's dental care. All dental care is provided under one roof—the one-stop shop practice. It could be argued that the generalist is the gatekeeper for the care of his or her patients' care, and, accordingly, this mode of practice is proper and makes good sense. However, the growing practice of employing part-time, itinerant specialists in general dentistry offices presents with many limitations for patient care, and ultimately is a detriment to the care of our patients. The most common argument given for itinerant specialists working in the general dentists' office is familiarity and convenience for the patient. In most of these settings, however, the general dentist and most of his/her staff are not present on the day that the specialist is there. Moreover, the convenience factor is not an issue in southern California, which abounds with specialists only mere blocks from each other. How troublesome can it really be to travel 2 or 3 more blocks down the road to see the specialist?

The real issue is financial. The dentist typically keeps 60-65% of the fee that is generated and pays the specialist the remainder of the fee. Close scrutiny will show that this is nothing more than carefully guised "fee splitting"—obviously a breach of longstanding dental ethics, but nevertheless lucrative for all concerned. The specialist makes a good payday for his/her one day of work, and the dentist pockets money that otherwise would have gone out of his/her office with a routine referral. Additionally, those that champion itinerant care will often cite the "access to care" argument. However, the majority of itinerant care is not taking place in underserved areas of California. Rather, it is being done in Orange County and other suburbs of Los Angeles that already have a wealth of established specialty practices in their communities.

ITINERANT SPECIALTY PRACTICE

As previously noted, itinerant dental practice can be 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 available to manage patient problems, complications, or emergencies should they arise (or at least not until their next monthly visit). Alan S. Herford, DDS, MD, FACS, Immediate Past-President of the California Association of Oral and Maxillofacial Surgeons, recently addressed the issue of itinerant surgical practice head-on, noting that not only is this practice rampant in California, but that it is increasing dramatically and that it is likely here to stay. Why? "Because resident doctors who finish their specialty training are not finding as many opportunities to join associates, and the increased debt that they face from student loans makes starting their own practice a daunting endeavor."[2] Dr. Herford goes on to say that the model of the itinerant oral and maxillofacial surgeon has some unique concerns. Specifically, the reliance on the general dentist to "set up" the case can result in substandard evaluation and practice; the preoperative consultation is frequently not done in advance of the surgery—negating the need to obtain appropriate lab work or appropriate medical consultations. Additionally, when a surgeon operates or delivers anesthesia in a setting that they are not familiar with, or without the necessary trained personnel, the optimal

management of surgical or anesthesia emergencies is at serious risk. Furthermore, just as the preoperative evaluation should not be relegated to someone other than the specialist, neither should the postoperative care. It is unethical to delegate post-operative care to a person who is not similarly qualified to recognize, treat, and manage all surgical or treatment complications. Ask yourself this question: do you as the patient want to wait until the next month that the specialist returns if you have an endodontic treatment for a hot tooth go south? Similarly, do you want to wait until the next visit if your third molar extraction requires "dry socket treatment," or more importantly, intravenous antibiotics and drainage in a hospital setting? The answer is obviously a resounding "no," but itinerancy is currently alive and well in California, and it accounts for much of the decline in the specialty practices of oral and maxillofacial surgery.

EMERGENCE OF CORPORATE DENTISTRY

Corporate dental practices have grown dramatically in California, and there does not appear to be an end in sight. Entrepreneurial individuals (who may not even be dentists) purchase practices in an area, advertise heavily, and pay (mostly) young recent graduates to work at bottom-of-the-scale wages to provide every facet of dental care. It can be a very lucrative enterprise. The young dentists are under great pressure to perform; and in a scenario such as this, the pressure and the pace are often too severe to provide optimal care. It becomes "survival of the fittest," and, as previously mentioned, economic pressures frequently win out over ethical practice. This is not to imply that all corporate dental practices are unethical or substandard. However, it must be recognized that this mode of practice has been around for a long time and is likely here to stay. It has its limitations, particularly with reference to the quality of specialty services provided in such a high-volume setting. As Americans anxiously await the effect on health care reform from Obamacare, it is not inconceivable that corporate dental practices may be better prepared to assimilate the changes more readily than an individual practice of 1 or 2 individuals. Government contracts may go to large group corporate practices, accounting for another hit on the individual specialty practice.

In the beginning of this editorial, I stressed that I was not undertaking this piece as a "doom and gloom" message, but rather as an appraisal of what one specialist is currently witnessing in one region of the country. I expect that this editorial should stimulate and foster healthy discussions about the changing face of general dentistry and its effects on specialty practices. I reiterate that the wise will indeed pay heed and begin to look for a solution before the future of specialty practice becomes obsolete. The solutions from the specialist standpoint will not be easy. I would be remiss if I did not stress the fact that all of us pledged ourselves to the Hippocratic Oath upon graduation, and the well- being of the patient must always be paramount in our practice. Balancing this commitment with the realities of a capitalistic economy will indeed be challenging.

REFERENCES

1. Author unknown. Harsh Reality of Dental School Debt. The Dental School Forum; July 2009.

2. Herford AS. Itinerant surgery: is it time to have a discussion? The Compass. 2013; XV(1).

Ethics

Steve Leighty, DDS
CALAOMS Director

Back to the Basics: Ethics 101

It's a Saturday night and I'm in seat 10A at 34,000' with a groundspeed of 505 mph over Grand Junction, CO. I've been in a reflective mood, enjoying what has been the longest sunset of my life (we departed from JFK at 5:30 pm).

My wife, Karen, is sitting next to me. Four general dentists, three of their wives, one PT, one boyfriend, and a dental assistant are sprinkled around the rest of this Airbus 320 as we head back to SFO. We are returning from a week in Ile a Vache, a small island off the coast of SW Haiti, where we held a dental clinic in a church building. We treated about 245 patients with over $140,000 worth of dentistry.

My surgical chair for the past week has been a wooden desk with a door (from the pastor's own house) nailed to the top with multiple wooden shims for balance. My suction was a Home Depot Shop-Vac® that I shared with our two hygienists. My operating light was from REI. I assume I'll be pretty mellow with my staff, as I have been working in shorts and running shoes and sweating all during daylight hours without seeing an a/c, flush toilets, or ice cubes. I won't miss sleeping under a mosquito net, either.

Over the last year, my view about ethics in dentistry has been all over the map. I had been somewhat discouraged with organized dentistry's treatment of ethics and found myself wanting to just remove myself from the whole process. Then, I had the honor of being inducted into the American College of Dentists, where I met a new group of DDSs and OMSs who share many of my same thoughts. I found out that ethics is not dead after all!

Finally, I find myself on another ethics committee at the California Dental Association (CDA) component level again. We are working with real time complaints from and/or concerning our members at the Sacramento District Dental Society (SDDS). Again, I have mixed feelings about the system (mostly the ***written*** codes, by-laws, rules, etc.) and yet I am encouraged by the quality of the volunteer dentists I work with who are also trying to make things better and who believe in ethics. They (my peers and colleagues) are why I keep coming back and why I get engaged.

In a little over a year, Brad, our D2 son at UOP, will advance into the group of other young dentists I meet at meetings, at offices, and at the CDA House of Delegates. Full of energy and in possession of a newly-minted license to practice dentistry, wondering what it will be like to work on patients without a professor or attending in the room, saddled with over $500,000 in dental school debt with no office, no military assignment, or work contract. Did you have the same financial pressures on you when you graduated? I had a quarter of Brad's debt in 1995 dollars, which is not incrementally the same.

My hypothesis is that our present graduates are under greater pressure to perform in a medical/dental world that is rapidly shape-shifting, and with greatly increased scrutiny (from the public, on the internet, and in the media), and loss of control of the business models (corporate business models, increased government and regulatory activity).

Without a developed and integrated sense of ethics (including morals, sense of fairness, or internal guidance systems), I think the profession of dentistry runs the risk of imploding into a technical trade or group of para-professional service workers.

I'm not an alarmist and I don't think the sky is falling. Dentistry and Oral and Maxillofacial Surgery has gotten to where we are, and made our accomplishments, by being pro-active rather than reactionary. I propose that we continue to challenge not only ourselves but our colleagues to be ethical in our lives and career.

One of the questions I wonder about is our response to ethical dilemmas. Those of us in leadership or who have been given responsibility to work with ethics problems face the challenge of alerting others or correcting behavior that is not up to ethical standards. Some religions have developed spiritual police that have been given power for extreme discipline.

In dentistry, someone involved in unethical behavior may endanger his membership status. In more serious examples, the matter may be referred to a judicial council who communicates with the Dental Board, which could lead to substantial legal problems.

The answers about whether the important thing is to discuss ethics or enforce ethics are beyond the scope of this article, but are included for consideration. For justification about the importance of ethics in the medical/dental profession, one doesn't have to look too far.

The American Society of Anesthesiologists Newsletter, March 2014 has several articles about ethics in anesthesia:

1. Protecting patients from physician incompetence
2. Moral hazards presented within the anesthesia company (corporate) model
3. Ethical and legal implications of special relationships among health care providers (i.e., surgeon and anesthesiologists who are married to each other)

The March 2014 issue of SDDS Nugget addresses debt and ethical practice questions:

1. Ethics Corner discussion of patients who are doctor shopping to get a discount for services
2. Multiple articles from young and mature dentists who relate their personal stories and struggles with student debt
3. Young dentists learning to deal with third-party payers who routinely downgrade procedures

CDA Journal (Feb 2014) has several more:

1. Dentistry at the Crossroads (discussion regarding corporate dentistry models)
2. The Perfect Storm (Is solo practice on the way out?)
3. Decision dilemmas and decisions for the new graduates
4. Development of a new Trade Guild? (discussion of dental education)

What are the standards? That is one of the hardest questions to answer. Our favorite attorney from San Francisco says the standard of care is what a reasonable clinician would do in the same or similar circumstances.

Wouldn't it be simple if we could just follow the Golden Rule—do unto others how they would do unto you?" Sometimes we disagree on how we would like to be treated. Certainly there is room for interpretation

about how our "treatment" is received, no matter our best intentions.

What about Rotary's 4-Way Test:

1. Is it the truth?
2. Is it fair to all concerned?
3. Will it bring goodwill and better friendships?
4. Is it beneficial to all concerned?

Again, there is much room for interpretation and argument, although it has served Rotary well for over 100 years.

Those of us familiar with the ADA Code of Ethics, as well as our various state, regional, and/or specialty codes, know that they can change. Not much and not quickly, but they do change over time.

When I was a dental student (UCSF 1991) the definition of a specialist was a dentist who "limited his practice to…one of the ADA recognized specialties." That verbiage is, of course, no longer in use. Because of legal battles with the FTC and other regulatory bodies and legal challenges, the landscape has changed.

Oral and Maxillofacial Surgeons now are free to advertise that they are "implant specialists." GPs can claim to be "cosmetic dentists," "TMJ experts," or "practice limited to or specializing in wisdom teeth extractions and IV anesthesia." Is this confusing to patients? Absolutely. What really is the difference between a specialist and a generalist? Since I don't understand it completely, I have a hard time explaining it to others. Is organized dentistry on the same page with this? Come to the CDA House of Delegates and see for yourself.

My father, Richard Leighty, DDS, was a GP who opened his practice in Augusta, KS in 1960. Back then it was considered unethical to 'advertise' in the newspaper or the yellow pages—a new dentist could "announce" his practice for a short time or be "listed" in the phone book, but was not supposed to have an "advertisement." The height of the letters in inches of your name on the office sign was limited. Otherwise you were unethical.

Fast forward to today where we all have our own websites and we ask our patients to "Like" us on certain websites in order to maximize our Google search engine optimization.

In this issue's article, I've shared some personal stories and struggles with the way we work with ethics. I've given some examples of the multiple levels within organized dentistry that explores ethical issues. I've listed a few examples of published standards of ethical behavior or standards. I remain frustrated with the continual and recurring ethical dilemmas that have surfaced throughout my career. I remain puzzled by the blurring of the generalist versus specialist definition in dentistry. And finally, I question the need for revising and changing written codes of ethics.

Will you agree with me that ethics is not dead? Will you agree that ethics is one of the cornerstones of our profession that needs to be jealously guarded? Will you continue to challenge yourself and your peers about the importance of ethical behavior?

Please address any questions, challenges, or ethical dilemmas from your practice to the editor.

What's Happening in California?

by Jeffrey A. Elo, DDS, MS

Denti-Cal benefits being restored

Medi-Cal will partially restore dental benefits to three million low-income California residents on May 1.

Background

In 2009, state officials cut Medi-Cal services for individuals in rural and other underserved areas, including eliminating coverage for adult dental care.

The California Association of Rural Health Clinics and a community health center in Kings County sued the California Department of Health Care Services and state officials over the cuts, alleging that the Medi-Cal changes conflicted with federal law. A court order reinstated the coverage in October 2010.

The state resumed payments for such services until May 2011, when it received Centers for Medicare and Medicaid Services (CMS) approval to eliminate coverage of benefits considered optional under Medi-Cal.

In July 2013, the 9th U.S. Circuit Court of Appeals ruled that cuts made by state officials "impermissibly eliminate[d] mandatory services from coverage" (California Healthline, 7/8/13).

Gov. Jerry Brown's (D) fiscal year 2013-2014 spending plan included a total of $93.9 million over two years to help partially restore Denti-Cal benefits for adults. Denti-Cal is the Medi-Cal dental program.

Details of Restored Benefits

The restored benefits will include coverage for:

- Cleanings
- Fillings
- Full sets of dentures
- Root canals

California Dental Association President James Stephens said the organization is "delighted" with the decision to restore Denti-Cal benefits but expressed concern over the state's decision not to cover periodontal treatment and partial sets of dentures.

Failing to cover periodontal treatment could have significant effects on patients with diabetes who often have chronically inflamed gums. In addition, not offering coverage for partial dentures could encourage patients with a few missing teeth to have more teeth removed in order to qualify for a full set of dentures.

A spokesperson for state Senate President Pro Tempore Darrell Steinberg (D-Los Angeles) said it is too early in the budget process to decide whether to advocate for restoring additional dental coverage.

DEA Proposes to Reschedule Hydrocodone Combination Products

On February 27, the Drug Enforcement Agency (DEA) officially released a proposed rule to reschedule hydrocodone combination products from Schedule III to Schedule II. This proposal was based on a prior recommendation from the Food and Drug Administration's (FDA) Drug Safety and Risk Management Advisory Committee. The AAOMS will be submitting coalition comments with the ADA and other dental specialties to the DEA on their proposal similar to the coalition comments the AAOMS submitted to the Department of Health and Human Services (HHS) in early February. The AAOMS continues to follow this issue very closely. Unfortunately, it is widely expected that the DEA will finalize its proposed rule and reclassify hydrocodone-containing compounds following the close of the open comment period in late April. Implementation will take place sometime before the end of the year.

Morals and Ethics

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

The Medical-Legal Aspects of Medical Futility

Part 1 of 3

The legal issue of medical futility has arisen in the presence of increasingly complex medical technology, exorbitant medical costs, and state and national debates on assisted suicide. The concept of medical futility refers to the belief that at some point, no amount of continued medical intervention will result in positive health outcomes. The decision to prolong life in the presence of medical futility reflects complex elements debated both in medical communities and in the law about the role of medical professionals, patients or their appointed decision-makers and the courts. Defining futility and reflecting on the legal parameters set for determining futility and for making decisions around prolonged care in situations where medical futility has been determined provides a foundation for understanding this complex legal issue.

Background of the Issue

About a half century ago, the focus of the medical community was on the process of saving lives. The directive embraced by most medical professionals was not only "do no harm," but also "do everything that can be done." At the time, medical technology was burgeoning and the first thoughts of technology advancing past utility emerged in the form of the earliest forms of advanced directive or living will legislation in the 1970s. This was the first glimpse at the problem that would emerge from a zealous research community and the desire to advance medical technologies: the issue of whether individuals should live past their ability to sustain their own lives.

Less than a half century later, advanced directives, living wills and/or do-not-resuscitate orders are regularly recognized documents that apply the perspectives of the patient on the use of life-prolonging technologies. While it has been accepted that patients can exert autonomy by utilizing these documents to demonstrate their will or decision-making in the absence of their ability to communicate those decisions, the flip side has emerged as a more significant legal dilemma: What does the medical community do in the absence of an advanced directive when a patient has no hope of recovery and decision-makers want to continue to sustain life? The concept of medical futility has emerged in an attempt to put parameters on what defines the end of responsibility for care and also as a foundation for policies related to the obligation of health care providers and hospitals to continue to provide costly care in absence of hope of a positive outcome. There are a range of legal and ethical issues that emerge in this debate, including the methods of defining futility in specific cases, the role of decision-makers in regards to futility, and the role of the courts in decision-making in the absence of a clearly defined medical directive.

The focus of the medical community has clearly shifted since the 1970s towards placing the decision-making in the hands of the patients or their loved ones and/or designated (surrogate) decision-maker.

Surrogate decision-makers and medical professionals do not always agree, though, on the appropriate length of time for an intervention and when or if to withdraw life-sustaining treatment. While the legal regulations are clear about how to proceed when a person has left an advance directive prohibiting the use of life-sustaining treatments, it is much less clear when to stop those interventions once they have started. Some of the central legal arguments in relation to this debate include issues of medical malpractice against clinicians who end life-sustaining treatment, and the issue of causation, whether the specific acts of the clinician result in the death of the patient. In order to fully evaluate this complex medical and legal issue, it is important to understand the concept of futility and the different approaches to determining futility within the scope of medical practice.

The Concept of Medical Futility

The concept of medical futility can simply be stated in regards to an essential fact of human life: at some time in every life, disability or death will exceed our medical powers. Regardless of extensive medical efforts, mortality is a reality for each human and medical futility is the belief that mortality is imminent for an individual's patient. Even in the presence of life-sustaining technologies, decisions sometimes have to be made that "enough is enough." Though medical futility can be discussed utilizing a range of different terms and theories, this is the fundamental perspective that has to be utilized when considering the overall issue.

Schneiderman (2011) maintained the value of creating a quantitative (in addition to qualitative) approach to determining whether a patient has the likelihood of recovering from the condition within the scope of the medical practice being utilized. Essentially, Schneiderman maintained that a condition can be deemed medically futile if in the past 100 cases (related through practitioner experience or research) a patient has not successfully recovered in relation to the parameters of the current patient situation. A physician, then, can conclude that a patient's condition is medically futile because it is reasonable to assume that if recovery has not occurred in the past 100 incidences, it is not likely to occur in the next 100 incidences. Subsequently, though, qualitative views of futility have also been the focus of evaluations of practitioner process because of the lack of a full body of empirical data that can support the decision-making in each patient case.

The issue of medical futility has not only brought up discussions about mortality and the nature of medical interventions, but also the legal parameters of medical care. If a doctor perceives the continuation of treatments as medically futile and discontinues those treatments even in the presence of opposition by the surrogate decision-makers, has the doctor crossed a line that physicians should not cross? Who is responsible for determining when treatments stop? Can a physician be held legally responsible (malpractice) for the death of patient who was going to die anyway? All of these questions come into play when considering how to define medical futility and the legal issues around creating this definition.

Schneiderman maintained that the first approach to defining of medical futility should be within the scope of end-of-life care. He utilizes the example of a patient who has end-stage metastatic lung cancer and family members who want to take heroic measures in hopes of a miracle. Though medical personnel may believe that emergency CPR to restore cardiac function would be medically futile, the patient's family may not wish to sign a do-not-resuscitate order because they are hoping for a miraculous cure. A number of rationales have been used when clinicians decide to go against the statements of surrogate decision-makers in these types of situations, including the clinician's belief that continued life sustaining measures cause patient suffering and that continuation of life sustaining measures goes against the central goals of medicine. If the clinician goes against the statement of surrogate decision-makers and does not resuscitate when the patient's heart stops, is the clinician guilty of causation of death or of medical malpractice? These

questions are rooted in methods of defining medical futility.

The definition of futility is the "failing of a desired end" and in the case of medical futility, the desired end becomes the restoration of health. When attempting to define medical futility, though, one of the most problematic elements is the fact that nothing is a certainty and that medical "miracles" and medical failures occur without concern for the specific treatment paradigm or the expectations of medical professionals. Though clinicians can cite hundreds or thousands of medical examples of when a set of circumstances are true, just one example of when the opposite occurs disproves the belief in any kind of medical certainty. At the same time, the more likely an outcome, the greater the likelihood, and clinicians and medical practitioners have to use this kind of standard to assess patient situations and determine their judgments.

An issue that has emerged in attempts to litigate cases in regards to the question of futility is that these cases often have a limited applicable time frame and the lack of action or delays related to court process can create cases that are no longer relevant. The case of Betancourt v. Trinitas Hospitals, for example, was heard by the Superior Court of New Jersey's Appellate Division after Reuben Betancourt's treatment was deemed medically futile and a DNR order placed on his chart and his daughter challenged the action. Betancourt's daughter was successful in preventing the defendant hospital from withholding treatment, but during the appeal process, Rueben died. Though the court did identify the need for a legal process to determine whether continued treatment could be deemed futile, thereby warranting the DNR order, Reuben's death led the court to maintain that the case itself was moot, and so no decision had to be made. This type of case, in which individuals challenge medical decisions, reflects the conflict that has emerged between medical professionals and decision-makers. A conflict that emerged and fueled the continuation of this case even in the unlikelihood of Betancourt's survival was that theorists, including medical ethicist Thaddeus Pope, maintained the importance of recognizing the precedent set from this kind of case, which could be used to support decisions of medical futility applied to similar cases of patients with Betancourt's condition, in this case anoxic encephalopathy. Colleagues have argued that increasingly, clinicians are seeking an empirical basis to support their decisions regarding medical futility.

In addressing the legal and policy ramifications of a definition of medical futility, it is essential to recognize that the definition cannot simply be based on the belief that the goal of medicine is to preserve life, but instead to ensure the preservation of a quality of life and an autonomous capacity for life. Even adding these terms to a definition, though, create specific challenges in terms of who decides when to end treatment and how that decision is made. Assessing factors like the use of advance directives, the causation of death related to treatment completion, and medical malpractice issues, as well as the state and federal regulations around medical practices and assisted suicide need to be brought into a view of this issue.

References

Betancourt v. Trinitas Hospitals. (2010). Superior Court of New Jersey, Appellate Division.

Schneiderman, L. (2011). Defining medical futility and improving medical care. Journal of Bioethical Inquiry, 8(2).

In Memoriam

Sheldon I. Brockett
9/11/1913 – 1/17/2014

As Published in Union Tribune San Diego on Jan. 26, 2014

SAN DIEGO -- Defined by his positive and generous spirit, Shelly Brockett served as a dear friend to a multitude of San Diegans during his vibrant 100 years of life. Shelly's magnetic personality inspired smiles and laughter from family and friends. Shelly died peacefully at his Mission Hills home on Friday, January 17th, surrounded by family.

A San Diego native, Shelly was born in 1913 to Irving T. and Anna (Sheldon) Brockett. As a student at San Diego High School, Shelly was actively involved in music and dramatic extracurricular activities. A love for singing inspired him throughout his life, even resulting in a serenade at his 100th birthday party.

He attended San Diego State University and graduated from the USC School of Dentistry in 1937. Following his graduation, he pursued a post graduate degree in oral surgery.

While at USC he fell in love with another San Diegan, Helen Eastman, who would become his wife of 64 years. Following their time at USC, the young couple returned to San Diego to start their life together.

Shelly was a leader in the San Diego dental community during his professional career which spanned over fifty years. He worked as a maxillofacial surgeon with offices in San Diego and El Cajon, and removed the wisdom teeth of countless San Diegans. He also served as the Chief of Dental Staff at University Hospital, Mercy Hospital, and Grossmont Hospital. He served as president of the San Diego County Dental Society and the Southern California Society of Oral Surgeons. He was also a Fellow in the American College of Dentists.

Shelly was also an engaged civic leader passionately dedicated to the improvement of San Diego - the city his family came to in 1883. He was an active member of San Diego Rotary (president from 1959-1960), and an active volunteer with the San Diego Historical Society where he helped to organize and catalog their photographic archive. He was also an active "social cowboy," with membership in both the DeAnza Trail Caballeros and the Los Senderos Trail Riders horseback groups.

During his later years, Shelly lost much of his eyesight to glaucoma. As his eyesight worsened, Shelly wasn't able to participate in all the activities he once enjoyed; but he found new joy in "books on tape" provided by the Braille Institute. Despite the freedom he lost due to this ailment, he maintained his positive outlook on life and his jovial spirit.

Shelly was preceded in death by his wife Helen, son Lawrence, and granddaughter Kristin. He is survived by a large family: his daughter Kathy (John) of Del Mar, son David (Sonja) of Del Mar, and daughter-in-law Claire of Palm Springs, as well as nine grandchildren and nine great grandchildren. He is also survived by his wonderful caregivers Maggie, Connie, Ali, and Ralph, and his faithful companion Luckie the Maltese.

Technical Articles

Peter Krakowiak, DMD, FRCD(C)

Pharmacotherapy Agent Updates 2014

In the past four years, we have witnessed the entry of several new pharmaceutical agents into the marketplace with distinct clinical relevance to our practice. As always, after initial clinical trials, the actual real world delineation of their positive and unwanted side-effects becomes apparent. This section of technology update will be devoted to a brief review of these agents and how they are fitting into today's OMS practice.

In June 2010, the initial FDA approval of denosumab for treatment of osteoporosis arrived in the USA. In November 2010, a more potent dosing of denosumab was also approved for prophylaxis against SRE (skeletal-related events) in patients inflicted with metastatic bone lesions from solid tumors. Up to this time, bisphosphonates (Zometa, Aredia, Fosamax, Reclast, Skelid, and Actonel) have been primarily used to treat these bone resorption-related conditions with seemingly great levels of therapeutic success. Over the past decade, these agents have also demonstrated potential side effects including delayed or poor hard tissue healing. RANKL inhibitors are the newest wave of the anti-resorptive pharmaceuticals in the US. They show promise but also may have similar clinical pitfalls as the bisphosphonates.

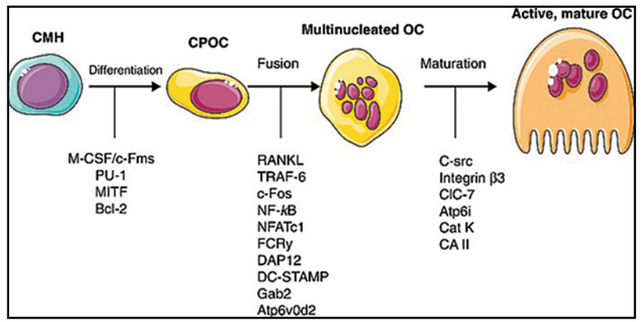
Amgen developed Prolia as well as Xgeva which are two of the currently available RANKL (RANK ligand) inhibitors. The ligand inhibition works by reduction of cell signaling for osteoclast maturation similar to the endogenous effects of osteoprotegerin. In normal tissues, this natural RANKL inhibitor keeps osteoclasts from over-destruction of the hard matrix and depletion of calcium stores. In osteoporotic patients, the levels of oseteoprotegrin are normally reduced. Denosumab is thought to counter this decline and supports the function of osseous homeostasis.

Since 2011, a couple more clinical trials have been conducted to determine dosing, efficacy, and safety in applying denosumab in treatment of multiple myeloma, giant cell tumors, hypercalcemia of malignancy, and prostatic cancer. On June 13, 2013, the US FDA also approved denosumab for treatment of adults and skeletally mature adolescents with giant cell tumors of bone that are unresectable or where resection would result in significant morbidity. Since then, it has been only several months but there have already been several authors (including Aghaloo, Taylor, and Marx) who have published case reports of osteonecrosis occurring in post-drug trial patients taking denosumab. A report of two clinical head-to-head trials by Kyrgidis and Toulis also has indicated a potential parity in the incidence of ONJ occurrences in bisphosphonate and denosumab patient populations being treated for metastatic cancer.

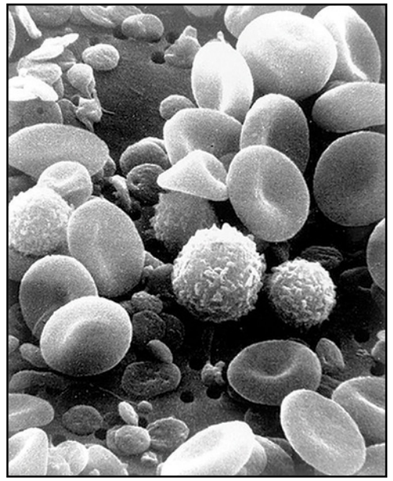
AAOMS has officially noted that a high risk of osteonecrosis can be present in this patient population. The definitive, qualified, and quantified dose/exposure causative relationship has not been yet established, however. Approaching from the standpoint of the overabundance of caution of mind, it is important to develop structured guidelines for treatment of this

now ever-growing segment of our patient population. AAOMS has recently published the Medication-Related Osteonecrosis of the Jaw—2014 Update; however, practitioners still must use their clinical judgment to mange these patients. The new guidelines come with extensive disclaimers and are meant to be "informative in nature." The new position paper can be found at AAOMS.org. Here, also, is some food for thought…

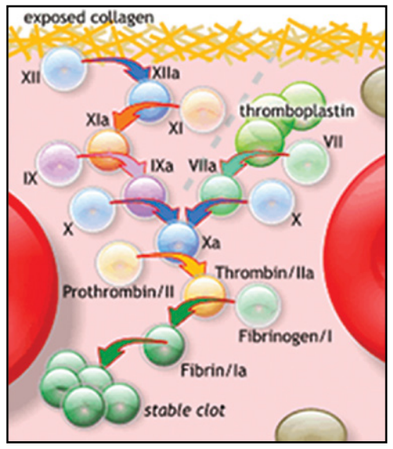
Prolia, the older denosumab counter-osteoporosis agent, is usually given 60mg SC q6 months for osteoporosis; and Xgeva, the anti-cancer formulation, is given 120mg SC q1 month for metastatic cancers. The half-life of denosumab in bone is thought to be longer than most agents but limited to approximately less than one month. It may be therefore prudent to also delay any elective surgical therapy for several months after the last dose of Prolia, as is currently applied to oral bisphosphonates. Since Xgeva is delivered at higher per interval dosage and is more frequently administered, the approach to management of the denosumab cancer patient is more complicated and may be best based mirrored on the contemporary approach to IV bisphosphonate patients' care. In the absence of any solid science, a cautious approach is likely warranted. As such, the performance of elective surgical procedures (such as implant placement) would be contraindicated and non-restorable teeth should be endodontically treated to reduce any direct osseous injury until we know more. Patients with established lesions can potentially also be treated using the established stage 0-3 protocols for bisphosphonates. However, it is hoped that due to different pharmacokinetics and pharmacodynamics of RANKL inhibitors from those of other anti-resorptive agents, the developing ONJ lesions may resolve more rapidly with passage of time and drug holiday therapies if allowed by the patent's underlying osteopetrosis or oncological condition. This entire area of our knowledge is unfortunately in need of additional research as to best develop sound judgment about exact



osteoclast maturation



Red blood cells as seen on scanning electron microscope



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and case-specific risk, prognosis, preventions, and before treatment options can be postulated.

The second group of medications that warrant some notable mention and knowledge-base-updating on our part are the new-age anticoagulants that were introduced in North America over the past four years. These agents were introduced to replace the primary oral anticoagulant—warfarin—and short-term bridging heparin injections. The inhibition of factor Xa directly or indirectly with vitamin K antagonism have been the mainstays of affecting coagulation mechanisms in the past several decades. A new approach with the point of effect on thrombin (factor II) itself has also yielded similar anti-coagulation effects. In recent years, a new series of oral, direct-acting inhibitors of factor Xa have entered clinical development as well. These include rivaroxaban, apixaban, betrixaban, LY517717, darexaban (YM150), and DU-176b edoxaban. The three current FDA approved agents from the above list include rivaroxaban, apixaban, and dabigatran. Despite much higher costs than older anticoagulants, the US patients have been increasingly placed on these agents over the past three years and there have been large direct-to-consumer campaigns put forth by their manufacturers.

We have already seen numerous patients in our southern California practices as the local community medical practices slowly convert to using these agents. My personal experience has been somewhat limited but overall positive with their use and safety when the (below) cited manufacturer guidelines and recommendations are followed. However, there have been several reported bleeding episodes associated with oral surgery published in the literature. I also recently did see a rivaroxaban patient who received extractions in a general practice setting and developed persistent significant bleeding which no one (including me) could control with futile local measures and the patient had to be promptly referred for blood product transfusion due to significant worsening of her baseline anemia. Notably, the patient also had impaired renal function and never adjusted her medication dosage (renal dosing); and to make the situation more difficult, she was erroneously advised by her physician to take her medication despite continued post-op bleeding the night of her extraction. I will start the review with the most notorious and controversial of the three agents.

Pradaxa (dabigatran) is a direct thrombin inhibitor (DTI) approved for stroke prevention in atrial fibrillation. Its off label uses may include DVT prophylaxis and MI care. Dosages are 7mg-150mg BID. Dabigatran exerts its maximum anticoagulation effect within 2-3 h after ingestion. It has, however, a 24-hour window of clinical activity. Unlike warfarin, there is no reversal agent and measurement of the anticoagulant effect is not 'routine.' PT/INR are of limited value and should not be measured when assessing a patient who is bleeding or needs emergency surgery. The APTT may provide the best qualitative measurement of the anticoagulant effect of Pradaxa. Alternatively, a plasma level of the medication can be assayed to determine active dabigatran concentration in the plasma. If a patient receiving dabigatran presents with post-operative bleeding, it is reasonable to delay the next dose of dabigatran. If the ingestion has been recent within 2 hours, it may be possible to administer activated charcoal with sorbitol to reduce its effect. Tranexamic acid (1g intravenously) can be given if significant bleeding persists. Fortunately, dabigatran exhibits low protein binding and may be easily excreted with good renal function or removed by dialysis. If bleeding is life/limb threatening, one should consider an additional hemostatic agent and blood product replacement. The best method to reduce the incidence of post-op bleeding is to consider stopping the medication 1-2 days pre-extraction. In renal impaired patients, this number of days may need to be further extended based on the level of renal impairment. A thorough consultation with the prescribing practitioner is required. Potentially bridging therapy with Lovenox (enoxaparin) is possible to reduce thrombotic events associated with medication withdrawal.

The two other newer anticoagulation agents are factor Xa antagonists, Xarelto (rivaroxaban) and Eliquis (apixaban). Xarelto, an orally active factor Xa inhibitor, is well absorbed from the gut, and maximum

inhibition of factor Xa occurs four hours after a dose. Initial dosing is at 15mg BID for 21 days, then 20mg qd thereafter. The effects last 8 to 12 hours, but factor Xa activity does not return to normal within 24 hours, so risk of bleeding may be elevated for 24hrs or more, and in some cases once-daily dosing is possible. In 2011, the FDA approved Xarelto for the following: prophylaxis of deep vein thrombosis in an attempt to reduce the incidence of pulmonary embolism (PE), adults undergoing hip and knee replacement surgery, and for stroke prophylaxis in patients with non-valvular atrial fibrillation. In 2012, the FDA approved rivaroxaban for the treatment of patients with DVT-related PE as long-term treatment to prevent recurrence.

Eliquis (apixaban) is the other contemporary factor Xa inhibitor indicated to reduce the risk of CVA and systemic embolism in patients suffering from non-valvular atrial fibrillation. Dosages range from 2.5-5mg QD. The bioavailability of apixaban is 50%. After oral intake, the maximum blood level is reached after 3 to 4 hours. The duration of action is around 24 hours allowing for once daily dosing. Plasma protein binding in humans is very high, and the majority of its excretion is via metabolite recovery in feces; hence it is less renal dependent for excretion. This medication should be discontinued for 48 hours prior to surgeries that carry a significant risk of bleeding, and 24 hours for less hemorrhagic procedures. As with any anticoagulant protocol, adjustments and a thorough consultation with the prescribing practitioner are required. There are now well-known and documented significant risks for rebound thrombotic events cited in the literature just as in the traditional VKA (vitamin K antagonist) medication withdrawal. Again, potential bridging therapy with Lovenox is advised in higher risk cases to reduce thrombotic events associated with withdrawal from both Factor Xa inhibitors.

Similar to direct thrombin inhibitor, Pradaxa, there are currently no FDA approved reversal agents for Factor Xa inhibitors Xarelto and Eliquis, and also no standardized test values are readily available to quantitatively and accurately note the level of activity or anti-coagulation. Changes in APTT have been noted, but are as of yet are not standardized. Recently, however, an accelerated approval pathway for andexanet alfa, which is the only agent that has demonstrated reversal of the anticoagulation activity of factor Xa inhibitors, has been filed with the FDA. It may become approved and be available in the near future to mange bleeding complications, and in cases of need for emergent procedures in the factor Xa inhibitor patients. This would make these agents a lot more attractive due to increased safety margins when dealing with acute bleeding episodes.

Finally, there are also some notable interactions of these factor Xa inhibitors which we need to keep in mind in patients who are taking Kenalog (triamcinolone), erythromycin, and clarithromycin—all prolong the duration of action, as well as the increased risk of bleeding with any concurrent NSAID use.

In summary, the new categories of antiresorptive and anticoagulation agents are, regardless of their high costs, becoming more common in our patient populations. As time goes forward, we as a specialty need to develop evidence-based understanding of their therapeutic principles, safety, and peri-operative patient optimization, and of course, formulate new corresponding OMS/dental-specific position papers to best protect and serve the needs of our patients.

Point

ITR in AB1174: The Entry Drug to Mid-Level Providers

Guy E. Acheson, DDS, MAGD

This article is intended to present one side to a much debated topic within organized dentistry. It is intended to inform CALAOMS members who might be CDA delegates or those who are actively involved in their district dental societies as to ongoing discussions happening within organized dentistry.

This article does not represent the opinions or positions of any dental organizations. I am a general dentist who has spent my entire career in a continuous pursuit of learning everything about dentistry. My practice includes conscious sedation and hospital dentistry. I work extensively with special needs patients and enjoy the help of Registered Dental Hygienists in Alternative Practice to meet the needs of these patients. I am the messenger. If you don't like this article, complain to me.

As of this writing, AB1174 has passed the California Assembly and is about to enter its journey through the California Senate. I expect that the bill will pass with virtually no resistance. The legislation has three parts, two of which I believe are very beneficial to the people of California. The third part spells the death of what has been a defining element of what a surgeon is and removes a key element of protection of patient safety.

The good parts of AB1174 allow the implementation of the dental outreach program known as The Virtual Dental Home. The Virtual Dental Home is where dental auxiliaries go to remote sites such as schools, nursing homes, residential facilities, and federally designated underserved areas to complete dental examinations and create dental records on patients who can then have the records examined by a licensed dentist via computer/internet connections. The dentist can then diagnose problems, create treatment plans, and instruct the dental auxiliaries at the remote site to complete preventive and therapeutic procedures as needed and to identify those patients who require the services of a dentist.

The first positive part of AB1174 is that it permits the duty needed by the auxiliaries to allow this to be viable. That is for them to determine which radiographs are needed for the examination and then take them without the prior examination and order of a dentist. The dental chart created by the auxiliaries includes radiographs, photographs, medical and dental histories, as well as the usual dental and periodontal charting. With this model, a dentist can make virtual contact with many patients who otherwise might never travel to a dentist. The dentist can identify those patients who truly need the services of a dentist.

The second positive part of AB1174 is that it requires the Medi-Cal/Denti-Cal system to reimburse the dentist for these examinations that are done without the dentist being in the physical presence of the patient. Payment for these virtual examinations recognizes that remote supervision and examination is as viable and valuable as an in-person encounter with a dentist. This payment for services should be expanded to allow compensation for collaboration between dentists and specialists as part of developing appropriate treatment plans for patients.

Now we come to the part that I disagree with, which is allowing non-dentists to remove carious tooth structure prior to placing a temporary restoration, a technique called an Interim Therapeutic Restoration, or ITR. The restoration is specified to be done with an adhesive material, usually glass ionomer. This is to be presented to the patient and/or parents as a temporary restoration that requires an evaluation by a dentist for consideration for a more definitive restoration. At this time, the proposed legislation requires ITRs to be done only upon the order of the supervising dentist. Dental hygienists are already demanding that at least the Registered Dental Hygienists in Alternative Practice (RDHAP) should be able to do this without a dentist's order. I object to this new duty on several points.

First, these restorations are going to be placed at remote locations on people who are unlikely to seek care from a dentist. These restorations are very likely to be considered final restorations by the patients/parents because they don't intend to see a dentist and they tend to consider any treatment to be final treatment. How many of us (general dentists) have had patients who came to our office with an abscessed tooth that we completed a pulpectomy on as our palliative treatment? We carefully explained to the patient that this treatment is only temporary and that they require definitive endodontic treatment or extraction as the final treatment. The pain goes away and the patient does not return. Months or years later they return complaining of pain from the tooth that "you did a root canal on."

Second, as the oral surgeon who was my instructor during my dental residency told me, "you are allowed to do any dental procedures permitted under law, but you should not start any procedure that you are not prepared to finish…including any foreseeable complications." How many of us have started the excavation of caries only to end up with a pulp exposure? Even when I try to be very conservative, to approach a carious tooth with the idea of doing minimal dentistry, to utilize caution on the side of being too conservative, to excavate the minimal amount of soft dentin and hope for the remineralization of the soft dentin once a well-sealed restoration is placed, only to remove just one more tiny piece of dentin and there it is, the pulp. As a dentist, I can go forward with pulp capping, or pulpotomy, or pulpectomy to stabilize the situation. What will the non-dentist do? Remember, the non-dentist is working remotely without a dentist present. They will be considering doing ITRs on root caries where the pulp is very close to the surface. They are working on people who have difficulty getting to a dentist and now a very urgent or emergent situation is easily created.

Dental auxiliaries already have the duty to place temporary/sedative restorations. They could just as easily debride the lesion with water, a cotton pellet, and the glass ionomer conditioning agent and place the glass ionomer over the lesion as a temporary without running the risks inherent in physically removing diseased tooth structure.

I had the privilege of being a site examiner for HWPP172 that evaluated dental auxiliaries doing ITRs. These pilot projects are always set-up to maximize success and to minimize the chance of failure. I saw dozens of examples of ITRs placed in this pilot project and not one example presented to me demonstrated the removal of tooth structure. In every case presented to me they used glass ionomer as a sealant over questionable pits and fissures, and just painted over facial decalcifications or minimal facial cavitations. In no case did I see evidence of any removal of carious tooth structure. Also, the sole criteria for judging the ITR to be successful was that the patient did not complain of pain in the immediate post-op period. That post-op period was a couple of months at the most. There was no long-term follow-up.

My third point of objection is the historical definition of what differentiates a surgeon from everyone else. That definition has been that a surgeon is given the privilege of removing and altering human tissue in the process of affecting a cure. For physicians and dentists, the doctorate degree is the mark of a surgeon. However, I do not live under a rock and do understand that society has been changing its concept of what a surgeon is.

One example of this was recognized in my many meetings and discussions with legislators and their staffs. They just do not consider teeth to be human tissue; at least not on the level of lungs, kidneys, livers, or feet. They seem to consider teeth to be an appendage that is primarily cosmetic in nature like hair and fingernails. How else could they justify allowing non-dentists to extract teeth on children! This is the most common duty that legislators around the country are beginning to allow non-dentists to do (mid-level providers, dental nurses, dental therapists, etc.).

I really believe that the license to practice dentistry is a privilege extended to me by the citizens of the country in which I live and practice. This privilege is extended in exchange for the duty to consider the safety and well-being of the patient above all else. The citizens' opinion of what types of treatment are allowed and by whom and with what level of training is expressed through their legislators and ultimately by the laws that those legislators pass. The critical tipping point of rejecting the historical definition of what a surgeon is and what non-surgeons are allowed to do was crossed when the California legislature passed laws allowing nurses in remote settings, without the presence of a physician, to complete aspirational abortions (AB154). If that is not surgery, then extraction of teeth and removing carious tooth structure certainly is not. The people are speaking.

I am upset that our major dental organizations have not recognized the significance of allowing non-dentists to remove tooth structure. I suspect the trouble is that our largest dental organizations represent more than just dentists and risk alienating their non-dentist members by opposing this expansion of scope. I am upset that the dentist members do not recognize the significance of allowing the organization to support this expansion of scope. There are so many ways to improve the oral health of the public without putting the most vulnerable patients in our population at risk of harm by justifying it as "doing something." It also keeps chipping away at what distinguishes a dentist from everyone else.

These incremental decisions are chipping away at the value of a doctorate level education in healthcare. The great push for universal healthcare coverage and efficiencies demanded by corporate healthcare systems will increasingly push for the lowest cost of providing services. We have seen the Tulip Bubble, the Dot-Com Bubble, the Housing Bubble, and the great economic non-recovery. With dental schools graduating ever increasing numbers of dental students who are paying whatever it costs to obtain their dental degrees we are creating a professional population that is forced to take whatever employment they can find upon graduation just to service their debts. Their choices for professional growth are severely restricted because they cannot obtain loans to buy or build practices, much less buy a home. The corporate entities that provide the jobs for these new dentists are motivated to keep down costs by utilizing non-dentists to do as much billable treatment as possible and reduce the overhead of expensive dentists. The economics of providing universal healthcare will keep driving down the price point for all services which reinforces the corporate provider model and limits the ability of new dentists to service their debts and grow both professionally and personally.

I don't see organized dentistry taking a serious look at this whole picture. The future of the entire dental profession is at great risk due to the overproduction of dentists at great personal cost and risk to these new dentists. The economics are all wrong. Why are we allowing the slanted statistics and arguments of outside organizations like Pew and Kellogg and The Children's Partnership to create a false impression of shortages of dental providers when the reality is that we are over-expanding our provider population in relation to both the number of providers per population and the economics it takes to educate and support dentists?

By allowing non-dentists to remove human tissue as part of the ITR procedure the primary distinction between the dentist/surgeon and non-dentists is broken. The push to allow more surgical/irreversible procedures to be done by non-dentists will become easier and easier to accomplish. The value of the dentist in being able to provide the most complete treatment for patients is eroded. Eventually, the dentist is no longer the leader of a dental treatment team, they are just another member.

Why should I encourage my children to become dentists?

Counter Point

ITR in AB1174: Response to Article by Dr. Guy Acheson

by Paul Glassman DDS, MA, MBA
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This article is a response to the article submitted by Dr. Guy E Acheson about AB1174, a bill now in the California legislature.

I want to thank Dr. Jeffrey Elo, editor of the CALAOMS *The Compass* for the opportunity to respond to the article by Dr. Acheson. As Dr. Acheson has indicated AB 1174 is a bill currently in the California legislature designed to support the Virtual Dental Home system of care that is being demonstrated throughout California. I want to thank Dr. Acheson for his recognition of the importance of the Virtual Dental Home system of care as a means of reaching currently underserved populations, bringing diagnostic and prevention services to them, and connecting them to dental care and to dentists. The name indicates that this system provides all of the services of a true "dental home" using a geographically distributed, telehealth connected team. More information is available in a number of publications

about this system.[1,2]

I also want to thank Dr. Acheson for his recognition of the value of allowing allied dental personnel to follow a dentist protocol in determining which radiographs to perform prior to initial dental examination by a dentist. As he indicated, this procedure allows dentists to make virtual contact with many patients who might otherwise never travel to a dentist, and facilitates a review of patients oral conditions that can help get patients with advanced disease into dental offices. Dr. Acheson also recognizes the importance of a corollary component of AB1174 which will require the Medi-Cal system to reimburse dentists under this system.

While Dr. Acheson states his support for the components of AB 1174 described above, he indicates concern about one additional component of the legislation. That is the ability for designated allied dental personnel to place Interim Therapeutic Restorations (ITR). I will organize this response to Dr. Acheson's article by addressing each of the points he makes concerning this additional component of the Virtual Dental Home system of care.

First a little background about the ITR. The term "Interim Therapeutic Restoration" was described by the American Association of Pediatric Dentists in a policy statement in which they indicate that the procedure is technically the same as the "Atraumatic Restorative Technique" but with a different name to emphasize the interim nature of the restoration.[3] A recent review of the literature describes the evidence for "sealing caries" using glass ionomer adhesive restorative materials, the efficacy of stabilizing teeth using ITRs, and the ability to reduce pulpal symptoms and reduce patient fear and anxiety using this technique.[4] I should note that the idea of "sealing caries" is new to many dentists who were trained that all infected material needed to be removed from teeth prior to placing restorations. However, it's important to realize that this training is based on a more than century-old tradition with no scientific basis. In fact, these early concepts for managing caries were developed prior to an understanding of the microbiological basis of the disease and the advent of modern adhesive restorative materials. The current high level of scientific evidence indicates that this procedure can be safely performed by dentists and allied dental personnel and has better outcomes than conventional restorations in certain circumstances.

Dr. Acheson describes his concern that, in spite of written and verbal instructions to a patient that an ITR procedure needs follow-up and monitoring, the patient may incorrectly decide that this is not the case and not return for further visits. He cites as an example occasions when he, and other general dentists, perform a pulpectomy and explain to the patient that further treatment is required, and yet the patient does not follow through on a referral for further care. While a similar thing could happen when an allied dental professional places an ITR and recommends follow-up by a dentist, I have trouble coming to the conclusion that Dr. Acheson does that they should therefore not be allowed to perform this procedure. By this logic, and the example Dr. Acheson sites, he and other general dentists should not be allowed to perform pulpectomies. Clearly such a conclusion is unwarranted in that it would deny therapeutic interventions for many people who benefit from them. The benefit of allowing Dr. Acheson and other general dentists to perform a pulpectomy procedure, even when they may not be able to complete the treatment, far outweighs any adverse consequences from a few patients not following through on recommendations for follow-up.

Dr. Acheson's second concern is similar to the first. He raises the possibility of a pulp exposure resulting from what started out as an attempt to excavate caries. I suspect that this concern comes from a misunderstanding about the technique being used by allied dental personnel when placing ITRs in the Virtual Dental Home system. First, the very conservative selection criteria for the ITR include the supervising dentist deciding that the depth of the decay is well away from the pulp. The technique is to remove only soft material from the tooth with an emphasis on obtaining clean margins and not to excavate material from the pulpal floor of the tooth. While we can all imagine horrible outcomes from almost any circumstance, the best way to decide the likelihood of adverse outcomes is to look at actual data for what has happened in the Virtual Dental Home system demonstration. Over 550 ITRs have been placed and evaluated by two separate dentists. All 550 were deemed acceptable by the evaluating dentists and there have been no adverse consequences such as toothaches, broken teeth, or need for immediate or unexpected referral to a dentist. The Virtual Dental Home system has protocols in place to deal with pinpoint and larger pulp exposures but they have never been employed. Again I don't think it would make sense to conclude that general dentists should never start a root canal procedure because occasionally they can't finish them and need to refer the patient to endodontic specialists. By the same logic the ability of allied personnel to stabilize teeth in severely underserved populations in community settings and subsequently get them into dental offices and clinics far outweighs any imagined concerns unsupported by actual experience.

Dr. Acheson describes his role in the Health Workforce Pilot Project (HWPP) #172 evaluation team. He indicates that the ITRs he reviewed "used glass ionomer as a sealant over questionable pits and fissures, and just painted over facial decalcifications or minimal facial cavitations." I am at a loss to understand this statement. First, all the ITRs placed in the HWPP were placed after a dentist determined the indication for doing so. ITRs are not used to treat facial decalcifications unless there is an actual loss of tooth structure with cavitation. A variety of sizes of cavitation have been treated with ITRs, ranging from small to medium-size. It is important to recognize that even small holes in teeth get bigger. The ITR is an important tool to use in a population of children and adults who typically do not seek dental treatment until they have advanced disease. By stabilizing teeth with the ITR procedure, instituting prevention services, gaining the patient or caregiver's confidence, and engaging dentists in monitoring these teeth, progression of disease has stopped in many teeth that would have otherwise led to advanced disease, toothaches, or outright infection. The HWPP results indicate that this procedure can be done effectively and safely by allied dental personnel under the direction of dentists.

The next point raised by Dr. Acheson concerns the "definition of what a surgeon is." It appears to be more of a philosophical concern than one based on evidence. I believe we have come to realize that health care, including oral health care, can best be delivered by well-trained and well-managed teams. We employ allied personnel in dental offices. They perform a variety of duties under direct and general supervision, and all of this results in the ability to provide more oral health care to more people at lower cost. There is nothing philosophically different from this model which allows allied dental personnel to place ITRs under general supervision of dentists.

The last point raised by Dr. Acheson relates to the economics of dental practice. He is apparently concerned that allowing allied dental personnel to place ITRs under general supervision of dentists will result in economic hardship for dentists. I believe the truth could not be more different than this supposition. Traditional dental practice is declining. The ADA Health Policy Resources Center has summarized data indicating that dentist's income and visits to dental offices have been declining for over a decade. The

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1 ***Glassman P, Harrington M, Namakian, M, Subar P. The Virtual Dental Home: Bringing Oral Health to Vulnerable and Underserved Populations. CDA Journal: 2012: 40(7)569-577.***

2 ***Pacific Center for Special Care.*** http://www.virtualdentalhome.org.

3 ***American Academy of Pediatric Dentistry. Policy on Interim Therapeutic Restorations (ITR). Adopted 2001. Revised 2004, 2008. http://www.aapd.org/media/Policies_Guidelines/P_ITR.pdf.***

4 ***Glassman P, Subar P, Budenz A. Managing Caries in Virtual Dental Homes Using Interim Therapeutic Restorations. CDA 2013:41(10):745-752***

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ADA characterizes these trends as the "new normal."[5] At the same time, there is good evidence that dentists are increasingly seeing the wealthiest and the healthiest segments of the population in dental offices while those segments of the population with the majority of dental disease do not visit dental offices on a regular basis.[6] The largely unrealized opportunity is to engage those segments of the population that do not traditionally receive dental care in the current dental care system. The Virtual Dental Home system demonstration has clearly revealed that it is possible to do so by bringing prevention and early intervention services into community settings and connecting underserved people in those locations with dentists and dental practices. The potential for improving the health of the population while at the same time increasing the demand for dental care in dental offices and clinics is significant. While understandable, the impulse to want to resist change in the face of declining reach of the traditional system is not the wisest path for the profession. We have the opportunity to do well for the population and the profession through innovative models of care such as the Virtual Dental Home and it is imperative that we do so and do so now.

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5 American Dental Association Health Policy Resources Center. A Profession in Transition. http://www.ada.org/sections/professionalResources/pdfs/Escan2013_ADA_Full.pdf.

6 Medical Expenditures Panel Survey. Dental Services by Source of Payment, 2010.

AAOMS issues position paper expanding the scope of Medication Related Osteonecrosis of the Jaw (MRONJ)

April 2014

A new position paper on Medication Related Osteonecrosis of the Jaw (MRONJ) released by the American Association of Oral and Maxillofacial Surgeons expands the scope of the condition previously referred to as Bisphosphonate-Related Osteonecrosis of the Jaw (BRONJ) and changes its name to reflect the antiresorptive (denosumab) and antiangiogenic therapies that have recently been associated with the condition.

In addition to changing the name of the condition, the MRONJ position paper provides guidance to:

1. physicians, dentists, dental specialists, and patients in making medical decisions relating to the risk of developing MRONJ, as well as the risks and benefits of those medications related to osteonecrosis of the jaw (ONJ);

2. clinicians regarding diagnosis of MRONJ in patients with a history of exposure to antiresorptive and/or antiangiogenic agents; and to

3. clinicians regarding MRONJ prevention measures and management strategies for patients with MRONJ, based on their disease stage.

MRONJ appears as a non-healing exposed bone in the mouth and may affect patients undergoing intravenous cancer-related therapy, or more rarely, patients treated with oral or IV bisphosphonates for osteoporosis.

Written by the members of the distinguished AAOMS Special Committee that prepared previous position papers on BRONJ in 2006 and 2009, the new MRONJ paper contains revisions to diagnosis, staging, and management strategies, and highlights the status of current research relating to this condition.

In order to distinguish Medication Related ONJ from other delayed healing conditions and to address concerns about under-reporting of the disease, the new position paper redefines the diagnosis characteristics of MRONJ as follows:

Patients may be considered to have MRONJ if all of the following characteristics are present:

1. Current or previous treatment with antiresorptive or antiangiogenic agents;

2. Exposed bone or bone that can be probed through an intraoral or extraoral fistula(e) in the maxillofacial region that has persisted for more than eight weeks; and

3. No history of radiation therapy to the jaws or obvious metastatic disease to the jaws.

The majority of patients on antiresorptive or antiangiogenic therapy who experience MRONJ do so following a dental procedure, such as a tooth extraction. Therefore if systemic conditions permit, the position paper suggests that the start of antiresorptive therapy should be delayed until the patient's dental health is optimized. The MRONJ position paper further recommends that patients who are about to be prescribed antiresorptive or antiangiogenic therapy should undergo a thorough oral examination and a radiographic assessment when indicated in order to identify both acute infection and sites of potential infection that could worsen once drug therapy begins. The paper cautions that any decisions relating to drug therapy must be made in conjunction with the treating physician, dentist and other specialists involved in caring for the patient.

MRONJ is painful and difficult to treat. While osteonecrosis of the jaw has been recognized by dental and medical practitioners for many years, the identification of bisphosphonates as a contributory factor to the condition was first reported by oral and maxillofacial surgeons about 10 years ago when they noticed an increase in the number of patients exhibiting the signs of ONJ. A review of these cases indicated that bisphosphonate therapy was a common thread.

In 2006, the AAOMS appointed the Special Committee on BRONJ to review the existing literature and prepare a position paper that synthesized the findings for the dental and medical communities. This Special Committee was reconstituted in 2009 and again in 2013 to review current research findings. The 2014 Position Paper on Medication Related Osteonecrosis of the Jaws offers the most recent and up to date diagnosis and treatment information to dental and medical professionals, clinicians and patients.

The complete 2014 MRONJ Position Paper is available at aaoms.org.

For further information contact:
Janice Teplitz, AED,
Communication & Publications
847/678-6200, ext. 4336

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Upcoming CALAOMS CE Events

2014

Residents' Night — **Southern CA**
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October 1, 2014

Practice Management — **Southern CA**
October 2, 2014

Medical Emergencies — **Southern CA**
November 5, 2014

ACLS — **Northern CA**
Novermber 15, 2014

2015

January Anesthesia Meeting — **Southern CA**
January 16-18, 2015

15th Annual Meeting — **Northern CA**
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Chapa-De Health, a non-profit community clinic providing outpatient care to Native Americans and other low social-economic group, is currently seeking a Part-time Oral & Maxillofacial Surgeon to initially work on Tuesdays at their clinic located in Grass Valley, CA. Go to: www.chapa-de.org or submit your resume to HR@chapa-de.org. EOE

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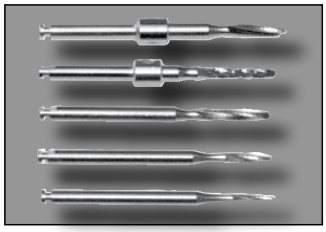

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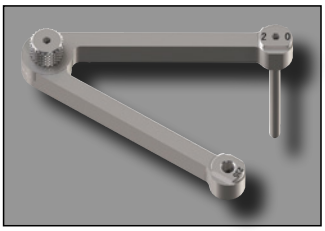

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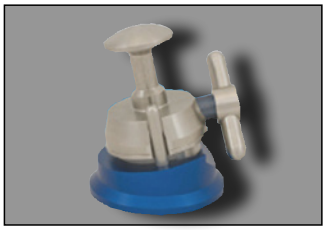

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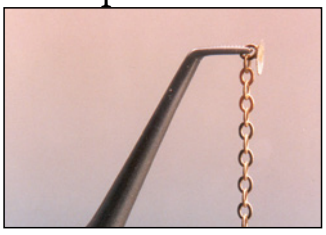

- Strong 14k gold chain attached to orthodontic bracket
- Variety of styles available (Mesh, Swivel, Low Profile)

C-Sponge Pharyngeal Barrier

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