



A PUBLICATION OF THE CALIFORNIA ASSOCIATION OF ORAL & MAXILLOFACIAL SURGEONS

## California CareForce and CALAOMS Deliver Smiles to Indio/Coachella Valley

California CareForce (CCF) held its fifth Indio/Coachella Valley free medical/dental/vision mobile clinic over the March 31-April 2, 2017 weekend where several of our fellow CALAOMS members joined with other medical professionals and volunteers to provide free health care. For many patients, it was their first visit to a health care provider of any sort in several years.

Even with the full implementation of the Affordable Care Act, 1 in 10 Americans remain without health insurance. An even greater number report going years without seeing a dental or vision professional because of cost. CCF is a group of volunteer medical professionals, community leaders, and

general volunteers who provide free medical, dental, and vision care to those in need at mobile health clinics across California. CCF makes no restrictions based on income, employment, or immigration status. CCF volunteers believe that everyone, regardless of their background, deserves access to basic healthcare. CCF does not require insurance or ID to serve patients, and all services are free.

Since 2011, over 10,000 volunteers have provided health care services to over 22,500 individuals, delivering over \$9,000,000 worth of care. Of that, \$2.99 million worth of dental and oral surgical services have been rendered to over 6,000 patients.

**CONTINUED ON PAGE 10**



*Family affair: several CALAOMS members and their families volunteer their time and talents helping others at the CCF clinic in Indio.*

**THE CALIFORNIA JOURNAL OF  
ORAL & MAXILLOFACIAL SURGERY**

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## EDITORIAL



### Humbly lead others with happiness and optimism

by Jeffrey A. Elo, DDS, MS, FACS

*True humility is not thinking less of yourself; it is thinking of yourself less. – C. S. Lewis*

Some people, regardless of what they lack – money, fame, beauty, social connections, etc. – always radiate charismatic attracting energy and confidence. Even their most dubious critics find themselves smitten with these charming folks. They're the ones you turn to for help, advice, and companionship. You can't get enough of them. They make you ask yourself, "What do they have that I don't?"

The difference is that their sense of self-worth comes from within. Irresistible people aren't constantly searching for validation, they're confident enough to find it in themselves.

In a society dominated by antagonism, looking for the positive is not always easy; but I believe it's well worth the time and effort. The challenge for many of us is proactively seeking out positive moments and people in our day-to-day lives. Make looking for them a new habit.

How can we create a more positive and productive work or life environment? Well, of course, I have a few suggestions. Start the day with a conscientious and deliberate decision to be positive each day. Many hundreds of years of philosophical discourse and decades of academic research have arrived at the same conclusion: happiness is a choice. It starts with a positive mindset. I'm not a naïve hippy. I understand that bad things happen to us and to those we care about. And with the constant barrage of negative news stories dominating our social media feeds, entering into a positive state of mind can be quite difficult; but it's not impossible.

How you begin your day is really up to you, and it will set the tone for how positive your day will go and how others around you will act based on your demeanor. Behind my back (*though I know about it!*), my staff laughs at the fact that each morning when I walk into the clinic I'm always whistling or humming. To me, I've been doing it so long I don't even notice; but they tell me that it puts them in a good mood because they think I must be in a good mood. I like that. Begin each day by looking for something positive, funny, or kind, and then share that with someone else. The idea is to get in a good state of mind at the onset of your new day. Then comes the more difficult task of developing a ritual where you begin every conversation or interpersonal interaction on a positive note. It might be as simple as sharing a positive story you just heard or read with your staff. It doesn't really matter what it is as long as it's positive and encouraging. As OMSs we are used to being leaders of our offices, but sometimes we forget what it's like to be led. Regular words of encouragement go a long way with those we work with.

Establishing social relationships produces predictable positive results. According to researchers in the journal *Psychiatry*, "The effect of social support on life expectancy appears to be as strong as the effects of obesity, cigarette smoking, hypertension, or level of physical activity."

It is important to make an effort to reach out and cultivate relationships that are important to you and your well-being. This can be a simple text message, email, or a quick phone call during your commute (*after all, this is California, who doesn't have time to chat – albeit hands-free – while sitting in the car moving 5 miles per hour on the freeway?*) The best way to keep these relationships engaged and productive is to schedule regular get-togethers. Make time on your calendar, if needed. If it's on your calendar, it's more likely to get done. Reconnect with old friends, or make a point to meet one new person this year. Act like your health and happiness depends on it. Research shows it just might!

Confirm the good; don't just condemn the bad or disagreeable. Many times we are quick to point out something wrong; but we are silent when things go well. Give words of encouragement or praise when something goes well. Giving of our time or talents to others can be just as powerful and rewarding as receiving. Parents...grandparents, can I get an 'Amen'? Take notice when someone does something kind for you or for someone you know and spread the word. It will ultimately come back around or be carried forward. It's just as important to reinforce the kind act as it is to perform the kind act.

Harvard researcher Francesca Gino stated, "Receiving expressions of gratitude makes us feel a heightened sense of self-worth, and that in turn triggers other helpful behaviors

toward both the person we are helping and other people, too." Gino found that bosses who expressed gratitude to employees saw a 50% increase in productivity from the employees.

Each day look for the positive. Seek out those kind people who go out of their way to make the lives of others better (i.e., your spouse or your staff members), yet they go unrecognized. When you see a kind act performed commend them for it. They'll be more likely to do it again. Make this a year of good news.

### E-Cigarettes: Educate your young patients about the risks of e-cigarettes

Jeffrey A. Elo, DDS, MS, FACS  
President-Elect, CALAOMS

If your practice is anything like mine, you've been steadily seeing an increase in alternative nicotine- and tobacco-delivery devices: e-cigarettes. Many of the terms are new and they continue to change as new products hit the market. You've also probably taken notice that the patient population that uses these alternative devices is getting younger. As doctors and surgeons – and even more so as parents – this gives us great cause to be concerned for these young kids. The purpose of this article is to provide oral and maxillofacial surgeons with some background and current information on e-cigarettes to help us improve patient care delivery and to potentially reach young patients who desperately need to know the potential risks.

Though it seems hard to believe, teenagers are more likely to get information on health issues from their parents and their health care providers than from peers, the Internet, or social media. Findings from a 2015 Northwestern University study confirm that the Internet is a supplement – not a replacement – for parents, teachers, and doctors as sources of credible health information.

#### What are e-cigarettes?

E-cigarettes are known by a variety of names, including vape pens, e-hookahs, mods, tank systems, and e-cigs. E-cigarettes are electronic devices that use a battery to aerosolize a liquid, usually containing nicotine, flavoring, and other additives, which is inhaled by the user through a mouthpiece. They can also be used to deliver marijuana and other substances.

E-cigarette use among young people has increased over the last five years, and the use of these devices is now more common than the use of regular cigarettes among middle and high school students. Many of our patients and their parents are unaware that nicotine is a common ingredient in e-cigarettes.

Nicotine in any form, including from e-cigarettes, is unsafe for youth. Nicotine is highly addictive and can harm the developing adolescent brain.

#### What are the risks of e-cigarettes for young people?

- The brain continues to develop through the early to mid-twenties. Because the adolescent brain is still developing, nicotine use during this critical period can disrupt the formation of brain circuits that control attention, learning, and susceptibility to addiction.
- Young people are uniquely at risk for long-term effects of exposing their developing brains to nicotine, including mood disorders and permanent lowering of impulse control.
- Nicotine activates the limbic system more strongly in the adolescent brain than in the adult brain, making addiction a greater risk for youth who use nicotine.
- E-cigarette use is strongly associated with other tobacco product use, including regular cigarettes.
- Besides nicotine, e-cigarettes can contain harmful and potentially harmful ingredients, including:
  - Ultrafine particles that can be inhaled deep into the lungs
  - Flavorants such as diacetyl, a chemical linked to bronchiolitis obliterans ("popcorn lung," so identified because of the incidence of the disease in workers at plants that used flavorants containing diacetyl in microwave popcorn)
  - Volatile organic compounds
  - Heavy metals, including nickel, tin, chromium, and lead.
- The aerosol from e-cigarettes is not harmless, either for users or for others who are exposed to secondhand aerosol. It can contain harmful and potentially harmful ingredients, including nicotine.

## PRESIDENT'S MESSAGE



Alan H. Kaye, DDS  
CALAOMS President

In the book "A Tale of Two Cities" we read, "It was the worst of times, it was the best of times."

And so it is for us! Remember, every problem has opportunity attached. My presidency will be consumed with old issues: Anesthesia, legislation and strains being placed on the practice model we have enjoyed for decades. I believe we need to finally flex our muscle and get our story out about who we are, the training we have and the fact that we are the real McCoy! We are not half-baked wannabees, we did not get our credentials out of a Kellogg's Corn Flakes box and the public must continue to hear that truth continuously.

I believe the organizations that have attempted to support us have tried; but it's not enough! It could be too little too late. They may have meant well, but, unfortunately, we specialists do not represent a large enough number of dues-paying members so our loss will not frighten them. All it takes is a few media-advertising dentists, or dental corporations for that matter, to twist the heads of consumers who tend to believe everything they see or read. They are literally brainwashing the public. No one is watching the

store. Our dental organizations are either in shock or unwilling to buck the trend for fear of the Federal Trade Commission (FTC) and the first amendment. The big losers are not only the legitimately trained specialists, but the consumers as well.

Since organized dentistry appears to be in fear of the FTC, we Oral and Maxillofacial Surgeons need to carry our own water and rise to the occasion.

Emergency rooms have become the dumping grounds for surgical complications with patients who are being remotely treated by roving dentists who are hoodwinking general practitioners into grabbing a few extra bucks instead of referring a patient to legitimate specialists who stay in their offices, see their own patients, treat complications and answers phone calls promptly; even at night.

Is the new paradigm? I am off at 5:30pm and you are now someone else's problem? Is this where Oral and Maxillofacial Surgery is being driven? If you are comfortable with that scenario, then the future is bright. If you want to control your own business and deliver superior care to your patients, then there is very little time left to change course. We are entering a dangerous period of change, not only in the White House, but in our healthcare delivery system as well. We need to prevent shortchanging the public, especially when they don't even realize what's happening.

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*It was the worst of times, was the best of times...*

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But, I believe we can turn the tide to some extent. It will take money and dedication. If the Oral and Maxillofacial Surgeons of this state and country are up to the task and are willing to put their money where their mouths are, then there is no telling how much we will be able to accomplish. Time is not on our side. Kaiser Permanente and other corporates are entering the California market. The thought process among corporates is becoming very clear. They see us as tradespeople, not doctors; just another business. *Hey doc, be grateful for having a job....* will be the new mantra.

So, what's finally left of our specialty is up to us. We alone, at this moment in time, will hopefully determine the future of Oral and Maxillofacial Surgery and whether or not we will be able to continue to deliver superior care to our patients. There is no substitute for real specialty care!

When the letter arrives asking for Political Action Committee (PAC) money, pay attention! This may be your last chance to defend your specialty and, as many of you hopefully realize, the rest of the country looks toward California knowing full well that what happens here will happen to them eventually! This is serious business if you want a future. It's all well and good to come to meetings, but if we lose anesthesia you won't need the CE credit.

Raise your right hand and repeat after me: "I am a CALAOMS ambassador who wishes to protect the future of my specialty."

Legislation will be the cornerstone of our survival and it takes money to educate, just ask dental students about their loans. We Oral and Maxillofacial Surgeons need the gasoline to get things done, and unfortunately I now need to include our commercial exhibitors as well. Contribute to our PAC; you vendors can't sell anesthesia medication and machines to doctors who will be prohibited from using them! If we surgeons lose anesthesia you vendors will also lose...big time! Dying in a hospital results in LITIGATION; dying in a dental office results in LEGISLATION!

In my opinion, I believe the average Oral and Maxillofacial Surgeon will agree with these words and is ready to act. Don't let me down.



## E-CIGARETTES CONTINUED FROM PAGE 5

### Conclusion

As oral and maxillofacial surgeons whose primary patient population is in this age group, we have unique opportunities to reach these kids and their parents with credible, correct information about e-cigarettes.

### Reference:

U.S. Department of Health and Human Services. E-Cigarette Use Among Youth and Young Adults. A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2016.



## VENDOR SPOTLIGHT

**CALAOMS WISHES TO THANK THE VENDORS THAT GRACIOUSLY SPONSORED  
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## AAOMS DISTRICT VI TRUSTEE REPORT



Mark Egbert, DDS, FACS

Dentistry, and especially oral and maxillofacial surgery, has always been in the forefront of anesthesia and pain control. The pioneering works of Horace Wells and William Morton with inhalational anesthesia; Ed Staffney in advancing the use of IV pentothal; and Donald Mehlich in researching the efficacy of analgesic alternatives to opioid medications are a few examples. One of the great things that continues to set oral and maxillofacial surgery (OMS) apart is our training in, and our provision of, anesthesia services for our patients. These services span the breadth of the anesthesia continuum from light sedation, or Anxiolysis, to deep general anesthesia with airway instrumentation and intubation, all augmented by the appropriate use of local anesthesia.

Many factors have come to play on the transition over time to the place where we are today. These have included advances in sedation and anesthetic medications, advances in anesthesia equipment, monitoring methods and devices, and advances or changes in regulatory oversight and licensing requirements. Through all of this we have brought to the public services of unparalleled quality and safety and in a most cost-effective manner.

Our model of anesthesia services has evolved under the influences mentioned above. The operator anesthetist model has evolved for most to be a team model of anesthesia delivery with highly trained support staff integrated into the delivery of safe and efficient care. Now, owing to several high profile and sensationalized (due in part to being pediatric) cases around the country we find ourselves under the microscope of public scrutiny. The OMS anesthesia team model is being called to question not only by legislators and regulators, but also by other providers of anesthesia services within and outside of dentistry. The motivations for this scrutiny are many,

but public safety will always be the touted standard. From our perspective, the motivation of the AAOMS has ALWAYS been to support and advance measures to increase the safety and quality of anesthesia services in dentistry while maintaining access for the public to these necessary services at reasonable cost.

The AAOMS DAANCE (Dental Anesthesia Assistant National Certification Examination) Program is but one example of these efforts. This intense five-part curriculum instructs on aspects of anatomy and physiology, pharmacology, monitoring techniques and emergency preparedness followed by a certification examination that has been commended by independent agencies. Many surgeons employ nurses to assist with patient management. DAANCE-certified assistants or nurses are more highly trained than the average dental assistant. The OMS team working together in a stable office environment and utilizing appropriate medical knowledge and experience translates to unparalleled safety for patients.

The AAOMS Board of Trustees has recently taken the following actions:

- Accumulated supporting anesthesia safety data from OMSNIC, CODA Annual Survey of OMS residency programs, and OMSQOR as possible,
- Summarized OMS anesthesia cost data from recent AAOMS practice expense survey information,
- Recommended changes in OMS CODA Standards that would increase the medical anesthesia rotation to 6 months and increase pediatric anesthesia requirements,
- Charged the AAOMS Committee on Anesthesia to develop a standardized new section of the OAE devoted to pediatric anesthesia, and
- Developed recommendations on OMS anesthesia safety strategy that focus on residency training, continuing education, trained office anesthesia assistants, office anesthesia evaluation and regular mock emergency drills with and without our newly developed simulation program.

The AAOMS monitors and recommends appropriate OMS residency CODA Standards in anesthesia training, and offers extensive anesthesia continuing education and advanced simulation courses in emergency preparedness. At the most recent ADA annual session, the AAOMS successfully supported improved training standards based on the level of anesthesia rather than the route of administration, as well as capnography for moderate sedation in dentistry. Capnography, which

is mandated by the American Society of Anesthesiologists (ASA) for moderate sedation, provides the earliest detection of apnea and intervention before desaturation. Any rejection of this technology does seem to place economic benefit over patient safety.

Surprisingly there was significant resistance to accepting this obvious patient safety improvement at the ADA. These detractors remain vocal in the face of the recent change. In a recently published JADA article by Dr. Dionne titled, "Raise the bar for safe sedation, not barriers for access to care" (JADA 2017;148[03]:133-137), false assertions are made that needed to be challenged. The author failed to grasp how the ADA's Committee on Anesthesiology and the ADA Council on Scientific Affairs had labored to produce a revised guideline for the use of anesthesia and sedation that has raised the bar for safety. This was accomplished by increasing the level of training, expanding the requirements to include recent advancements in monitoring ventilation and eliminating the artificial distinction between moderate sedation achieved by different routes of administration. This author goes further to indict the operator anesthetist model of anesthesia delivery as a risk factor to overall safety. He compares this model to that of the distracted driver who is texting while driving and further states that distracted driving is worse than being inebriated. Really? Comparing an operator anesthetist who is working in the very airway that is being monitored with a distracted driver? Or with an inebriated one?

A more appropriate analogy would be that of the jet fighter pilot, who having gone through his or her safety inspections

(pre-surgical work up and timeout) then proceeds to deftly fly the plane while monitoring all systems and communications via heads-up displays and other assorted safety equipment. The fact that our area of procedural focus is precisely in the midst of the airway brings a heads-up perspective to our monitoring. I can tell you with certainty that even with intubated operating room patients under full general anesthesia with a dedicated anesthesia team that I am the first one aware of an airway problem, disconnect or otherwise, nearly every time. Why is this? I would like to say it is because I am just that good, but more likely it is because I am working in the airway, as we all do. Being aware and in tune with not only the procedure at hand, but also with the airway and all the other monitoring data continuously communicated visually and aurally. It is what we do.

In this era of evidence-based medicine, only data driven, scientifically valid decisions should prevail in the provision of safe, effective, efficient, and cost contained healthcare. Sensationalism and emotion have no place in these decisions. We must all commit therefore to providing access to our numbers, and to participating in these data collection efforts when we are asked. Only through these successful registries and data repositories will we be able to support and prove to the public and their appointed regulators that the OMS team model of anesthesia delivery is scientifically sound, ultimately safe, and absolutely cost effective as we all currently believe.

(Portions of this commentary are excerpted from an In Press JOMS Perspectives article authored by the AAOMS Board of Trustees)

### CALAOMS REVAMPS ITS OMSA COURSE



As of the first of this year, CALAOMS completed a 5-year project to completely overhaul its OMSA (Oral & Maxillofacial Surgery Assistant) Course. The course material that was once part of the weekend seminar has been completely updated and transformed into videos of PowerPoint presentations narrated by OMSA Instructors. These videos are delivered to students online via CALAOMS' new online CE portal (<https://ce.calaoms.org>). In addition, new presentations were created for reviewing the course content at the weekend seminars prior to the final exam being given.

Students must successfully navigate the online portion of the course which consists of 9 modules comprised of a number video presentations, each followed by a quiz, which cumulates with a practice final exam. There is a total of 20 video presentations and 20 quizzes.

Initial certification students must successfully complete the online portion prior to attending the weekend seminar. Re-certification students are given the option, during course registration, to be given access to the online portion for review prior to attending the weekend seminar but are not required to complete any/all modules.

This is just one of several CE courses that CALAOMS offers to better equip OMS assistants and office staff with the knowledge needed to be an effective part of the anesthesia team. It should be noted that the OMSA course is part of the required curriculum for the Dental Board of California's Dental Sedation Assistant (DSA) permit.

**CCF CONTINUED FROM PAGE 1**

CCF wishes to offer a big *Thank You* to the over 800 volunteers who donated a combined 8,500 volunteer hours as well as his or her skills at the recent 5th Annual Coachella Clinic. In just three days, CCF volunteers provided over \$750,000 worth of care to 1,693 patients, all at no cost to patients. It is fantastic to know that so many dental, vision, medical, and general volunteers can come together to help bring people out of pain, help them see clearly again, and put them on the path to better health.

The quality of the work put into these CCF clinics has earned official proclamations from officials from Riverside County and the city of Indio with such inspiring stories as a woman being able to cheer out loud because she's able to smile again thanks to the hard work of oral and maxillofacial surgeons.

For those of you interested in learning more about how you can get involved in this effort, please visit <https://www.californiacareforce.org/volunteer/> or contact Pamela Congdon, CAE, IOM at CALAOMS headquarters (Phone: 800-500-1332). Be sure to also mark your calendars later this summer for the next CCF clinic in Sacramento at Cal Expo over the weekend of September 22-24, 2017.

We hope you had fun and found it a rewarding experience. We hope to see you at another CCF clinic soon.

On behalf of every patient who was touched by your generosity and kindness, thank you!

**2017 Coachella Clinic- By the Numbers**

**Total Patients: 1,693**

**Total Value of Services: \$761,838**

**Dental - 952 patients - \$510,186**

613 fillings | 635 teeth extracted | 764 x-rays taken | 56 prophies

**Medical - 609 patients - \$23,472**

274 exams | 51 referrals | 32 acupuncture treatments | 56 chiropractic procedures

**Vision - 745 patients - \$228,180**

669 pairs of eyeglasses made on site | 165 pairs to be made off-site (for free)



CALAOMS member Robert Bass, DDS (left) with assistant Eddie Mendoza.

**Some comments from volunteers at the 2017 CCF clinic in Coachella:**

*My team and I had an awesome time at the Care Force event last weekend – I've got additional teammates asking about next year's event already! – Sean Sullivan, General Manager, Patterson Dental Supply, Inc.*

*I had a wonderful time! I cannot wait until the next one! I am there! Thanks again for everything! - Dr. Darryl L. Morris*

*It was great to participate in the Coachella Clinic this last Sunday. Thank you for your vision and hard work in making California CareForce such a great organization. It is truly a good work! It is a blessing and opportunity to serve in it. All of the volunteers have been great to work with and the patients are truly amazing also. – Dr. Brian Blatter*



WesternU dental faculty member Dr. Hardev Singh (center) with Loma Linda University OMS residents Dr. Ashish Sharma (left) and Dr. Kirolos Zakhary (right).

CALAOMS Members left to right.

*back row: Alexei Mizin, DDS  
Darryl Morris, DDS  
Nader Salib, DDS  
Shama Currimbhoy DDS, Director CALAOMS  
Peter Scheer, DDS, MS  
Alan Kaye, DDS, President, CALAOMS  
Nima Massoomi, DMD, MD*

*front row: Charles Syers, DDS  
Monty Wilson, DDS, Past President CALAOMS  
Julia Townsend, DDS  
Craig Bloom, DMD  
Rick Berrios, DDS  
Sharo Fatehi, DDS  
Pamela Congdon, Executive Director CALAOMS*



CALAOMS member Rick J. Berrios, DDS with a volunteer dental assistant and his family.



Fourth-year dental students from Western University of Health Sciences College of Dental Medicine with WesternU OMS professor and CALAOMS president-elect, Jeff Elo



## The Mycobacterium Outbreak in Orange County

by Solomon Poyourow, DDS, MD, MPH

Last September, I consulted on a 4-year old girl with a facial infection at Children's Hospital of Orange County (CHOC). She had received pulpotomies and stainless steel crowns on teeth S and T in May. Two months later, she developed facial swelling and was referred to a local OMS for treatment of the infection. Teeth S and T were extracted and an incision and drainage was performed followed by antibiotic therapy. The drain was subsequently removed. Three weeks later, the patient developed fever and swelling resulting in referral to CHOC.

This was an unusual clinical course in an otherwise healthy pediatric patient. One would expect odontogenic infection in a child to resolve after extraction, drainage, and antibiotic therapy.

When I saw her there was extensive right submandibular swelling and lymphadenopathy. The skin overlying the swelling had a coin-sized area of erythematous dry skin and was firm, but not particularly painful when palpated. Oral examination showed absence of teeth S and T, along with edematous, fungating gingiva. I was surprised there was not more pain given the size of the neck swelling.

Computed Tomography (CT) of the head and neck was performed, which fortuitously captured the lung apices. Numerous radiopaque nodules and flecks were noted in apical lung fields. A follow-up CT of the chest discovered diffuse radiopaque nodules throughout the lungs. An infectious disease specialist was consulted and atypical mycobacterium was

suspected because of the pulmonary involvement. The patient was taken to surgery for selective cervical lymphadenectomy and debridement of the mandible. Acid fast bacillus stains were positive and cultures yielded mycobacterium abscessus. A PICC line was placed and the patient was started on amikacin, azithromycin, and imipenem. Clofazamine would be added at a later date after applying for special FDA approval.

I had no prior knowledge of mycobacterium abscessus and had never seen a patient with mycobacterium infection of the jaws. After some reading, I learned that mycobacterium abscessus is one of over a hundred different species of nontuberculous mycobacterium (NTM), differentiating it from tuberculosis and leprosy. NTM are ubiquitous in the environment, especially water (municipal, pools, environmental). Mycobacterium are aerobic bacilli with a thick, waxy cell wall that is resistant to acid, alkali, and detergents thereby making it extremely hearty and difficult to kill. In addition, it takes longer to culture than most other bacteria leading to false negative cultures. In fact, most patients treated at CHOC during this outbreak never grew out positive cultures despite having severe osteomyelitis.

Mycobacterium abscessus can infect the lymphatics, bone, soft tissue, lungs, joints, gastrointestinal tract, brain, and eye. It is particularly serious in cystic fibrosis and immunocompromised patients, but is becoming an increasing risk for community- and hospital-acquired infections. It has been documented as a result of cosmetic surgery/injections, acupuncture, and endodontic therapy. In the dental setting, infection primarily results from contaminated dental water lines and development of a slime layer due to inadequate maintenance. Mycobacterium abscessus has multidrug resistance requiring high doses of multiple antibiotics for 4-6 months. Therapy is a combination of surgery and long-term antibiotics.

Scores of similar cases began to inundate the CHOC emergency department (ED) and were seen by each of the OMSs on call at CHOC. These were children ages 18 months to 9 years treated with pulpotomy and stainless steel crown, followed by delayed onset of swelling, pain, and fever. The infectious disease specialists at CHOC linked the cases to a common pediatric dental clinic, notified the OC health department, and developed an antibiotic regimen where there were no prior evidence-based guidelines. Surgical treatment was a team approach by ENT and OMS.

The volume of cases that presented to the CHOC ED was substantial. In total, 105 cases were admitted and worked up at CHOC with head/neck/chest CT. Sixty-eight children were taken to the OR for surgery, ranging from extraction and bone biopsy to cervical lymphadenectomy and extensive

debridement requiring reconstruction plate to prevent post-operative fracture. Twenty-two children had multiple surgeries due to recurrence of infection. Twenty-eight received long-term antibiotic therapy. Antibiotic therapy was used when the surgeon felt debridement was unlikely to eradicate infected bone.

Developing antibiotic and surgical protocols presented a challenge, as there was very little prior experience with this type of infection. A smaller outbreak occurred in Atlanta in 2015, which saw twenty-two cases. Multidisciplinary conferences were held between ID, ENT, and OMS. Each doctor weighed the pros and cons to the respective therapies. Long-term antibiotic treatment carried risk of PICC line complications, hearing loss, and neutropenia. Surgical treatment carried risk of repeat surgery, loss of permanent teeth, nerve injury, sinus involvement, mandible fracture, continuity defect, among other less severe issues. As time went on the medical and surgical protocols were fine tuned.

At this time it appears the number of new cases has slowed to almost a stop. However, I talked with one of the infectious disease doctors last week and she said she still sees a case once in a while. There is also concern about those patients who had multiple pulpotomies but only the ones with evidence of infection were removed. Some children presented with stainless steel crowns on nearly all of their teeth and the surgeon was left with the decision to edentulate a 3-year old or remove only the involved teeth. It is possible therefore that another tooth could be brewing a slow-growing infection.

One cannot help but wonder what the future will be like for these children. Many of them lost significant portions of their maxilla and mandible along with the permanent teeth in the area. Will they develop malocclusion or growth asymmetry? Most of the children are treated under Denti-Cal and their families do not have resources for complex or costly dental rehabilitation. Even if these children are financially compensated for their suffering, it may not be sufficient or available in 15 years when they reach adulthood to provide complex dental rehabilitation.

I am hopeful this experience will encourage every dentist, physician, and surgeon to examine the conditions under which they operate and look for vulnerabilities in sterile technique and cleanliness, as well as to revisit the guidelines established by their respective governing body. The ADA website has excellent information on maintenance of dental unit water lines as well as recommendations for acceptable irrigation sources for surgical treatment.



## IN REMEMBRANCE

### David N. McIntire, DDS



David Nicholas McIntire passed away peacefully on Wednesday, March 15, 2017, after a brief illness, with family at his side. He is survived by his beloved wife, Carla; four children, Grace, James, Arianna Garcia and

Aizza Garcia; two sisters, Cathy Patterson (Larry) and Debbie McIntire; step-brother, Beau Young; mother, Doris McIntire; father, Jim McIntire (Betty); and numerous cousins, aunts, uncles, nieces and nephews. He was preceded in death by his sister, Sharon.

David was born in Chico, Calif. The family moved to Placerville, Calif., in 1964. He graduated from El Dorado High School in 1977, where he excelled in many sports. He went on to graduate from Yuba Community College in 1979.

David then began his dental schooling. He graduated from the University of the Pacific Dental School in 1984, Summa Cum Laude, followed by UCLA School of Oral and Maxillofacial Surgery in 1987.

After practicing in Sacramento, Calif., for a number of years, David decided to move back to Placerville, where he opened his own oral surgery office in 2008. He loved being back in his hometown and near his many friends and family. But his most favorite time was spent with his wife and children.

Services were held at the Green Valley Mortuary on Friday, March 31 at 11 a.m., In lieu of flowers, donations may be made to St. Jude Children's Research Hospital at stjude.org.

As Published by the Mountain Democrat,  
Placerville CA, on March 27, 2017  
written by "Contributor" photo by Pat Dollins

# CALIFORNIA ASSOCIATION OF ORAL & MAXILLOFACIAL SURGEONS UPCOMING CE EVENTS

## 2017 Meetings

- 17th Annual Meeting - Grand California Disney, Anaheim May 6 – 7
- OMSA Fall - (San Ramon) September 9 – 10
- ACLS - (Solano) October 21
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## OMS Techniques



### Modification of active skeletal growth utilizing skeletal fixation – an invaluable tool for early interceptive treatment of maxillary hypoplasia-based Class III disharmony and apertognathia

by Peter Krakowiak, DMD, FRCD(C)

As OMS specialists, we are well versed in the surgical management of growth deformities utilizing open osteotomies and repositioning of the facial skeleton with ridged fixation. As such, these techniques have served as the mainstays of therapy for craniofacial growth disturbances and disharmony in the past century. Most orthognathic surgical therapy is delivered in this approach after complete cessation of growth especially in class III skeletal deformities related to mandibular hyperplasia to prevent or reduce relapse.

About seven years ago I was invited by one of my orthodontic colleagues to hear Dr. Hugo De Clerck, a Belgian orthodontist, present his contemporary interceptive approach to treatment of growth abnormalities that tapped into the principles of the protracted facemask techniques, but uniquely utilized facial skeletal anchorage instead of the typical mask-type headgear. Traditional reverse pull facemasks have been used extensively - often with limited success - to treat predominantly maxillary hypoplasia and mandibular vertical and horizontal hyperplasia. The results of this orthopedic therapy are, unfortunately, often accompanied by adverse dentoalveolar effects due to reactive forces being applied to alveolar bone and dentition. Most facemask appliances apply forces to teeth for

up to 16 hours day for around 1-2 years. Most studies have noted the technique to pose a limited effect on mandibular advancement and posterior mandibular rotation, but introduce undesired proclination of maxillary incisors, intrusion of maxillary molars, and retroinclination of lower incisors. The facemask technique results are often short-lived as a large portion of patients treated for negative overjet relapse in as many as one-third of the cases. Ultimately, the patients who fail this treatment will likely require definitive orthognathic surgical correction. The traditional orthognathic corrective management has well-known surgical risks, morbidity, cost, and, in some cases, still the same relapse potential is present.

Professor Hugo De Clerck proposed a skeletal-based anchorage approach that utilizes customized temporary anchorage devices (TADs) known as bollards to direct distraction forces to the skeletal sutural complex directly via traction of the basal bone bypassing the dental segment and alveolar hard tissues (Figure 1). The approach taps into the active growth potential of the immature facial skeleton in patients typically around 12-16 years of age. De Clerck protocols build on the work of Kokich, Smalley, and Singer who all have attempted to use intraoral dental and TAD-based skeletal anchorage to distract immature periorbital and maxillary growth sutures to improve maxillary projection (Figure 2).

In the De Clerck protocol, two maxillary plates are placed on the maxillary buttress (Figure 3) - strut areas and two mandibular plates are placed in the mandibular parasymphysis (Figure 4). The plates are placed into basal facial skeleton, not alveolus like most screw-type TADs. Their application requires careful intraoral dissection, exposure, and placement of 2-3 fixation screws to each footplate that supports and anchors the transmucosal bollard attachment.

In Europe, the procedures have been performed under local anesthesia and/or IV sedation. My personal experience has been that these procedures are more predictable if done under IV sedation/GA so that we can ensure optimal patient comfort and safety. An average case of placement of four plates can be performed in an outpatient setting in 30-45 minutes when the patient is fully sedated and comfortable.

Case selection is the key, as in most technique-sensitive therapies, to having success. Patients must be under continued care of a qualified and experienced orthodontist with a background in treatment of complicated and surgical cases. The patients, themselves, have to be at a reasonable level of maturity and desire to be actively involved in their care. Although the De Clerck protocol works well and is now backed by some independent peer-reviewed scientific literature, there are cases that will not fully respond to this therapy. Most often such is due to the patient being past their optimal growth period or

patients being non-compliant with the use of traction elastics and postsurgical care and maintenance of the fixation hardware. If compliance is an issue, this therapy will not succeed and conventional orthognathic approaches can be considered after cessation of growth.

Earliest intervention seems to be most beneficial. The dentist and an orthodontist must make a diagnosis of the maxillary hypoplasia early on and refer the patient for evaluation before the age of 12 in all cases. We try to place plates at 11-12 years of age, if possible. The contraindication to an even earlier placement is the presence of unerupted or partially erupted mandibular canines at the mandibular fixation sites. A secondary variable that is not under our control is the patient's level of compliance with daily and ongoing replacement of class III elastics. Some patients need a lot of parental and orthodontic support with vigilant monitoring for their adherence to the daily regimen.

Because the class III elastics (Figure 5 following page) are worn all day and night unlike mask appliances, changes can be achieved quicker and traction of the midface is more predictable. The elastic orthopedic forces are used to move the maxilla forward and downward, and the mandible is held back and upwards. The initial lighter-pull elastics have to apply at least 150 grams of force to the plates, and after the first two-to-three weeks are replaced with heavier elastics of at least 250 gram magnitude per each side.

The length of therapy generally varies, but is determined by the orthodontist and may be up to two years of active elastic use. Bollards are typically left on in case of a later mandibular growth spurt, and if such is noted they can be re-engaged with class II elastics to prevent development of a class III relationship in later teen years. I will typically remove them along with the third molars in patients when they reach around 17-18 years of age.

The bollards can also function as superior anchorage for other dental corrections, such as molar distalization in the maxilla, in crowding cases to bring in the blocked out canines, or molar intrusions when attempting correction of apertognathia. Unlike orthognathic surgery, the changes come at a much lesser level of discomfort and are psychologically easier to adapt to as they are gradual over several months versus the orthognathic changes that occur immediately. There is less of an issue with paresthesia, and there is little chance of segment necrosis or infection noted with this technique. Because this is a sutural-based distraction similar to rapid palatal expansion, the relapse is minimal.

With this technique, there is a bit of a learning curve in the placement and adaptation of the plates. The bollard attachment part of the plates is to emerge in the maxilla approximately at the mid-facial of the first molar - at the mucosal and keratinized tissue junction. The key to achieving maximum anchorage stability is to pre-bend the footplate and connecting arm to the bollards to allow for intimate contact of the plate, as well as the connecting arm, with the subjacent buttress and alveolar bone along the entire length of the plate. Failure to achieve this intimate plate adaptation will result in plates emerging prematurely from the soft tissues and being subject to greater parafunctional forces and manipulation by the patient outside of vectors of the orthodontic traction forces. This often results in plate loosening and, in some cases, they will need to be relocated, if possible.



Figure 1. Bollard plate placement sites

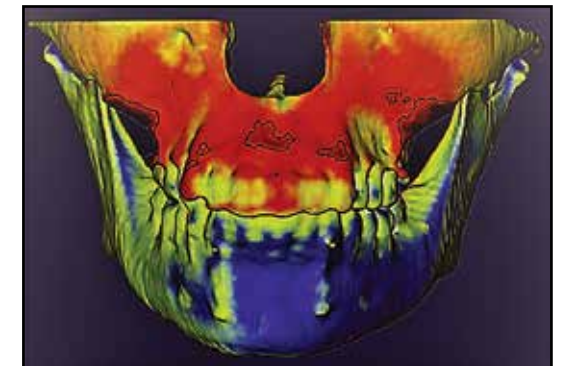


Figure 2. Areas of greatest distraction A-P changes highlighted in red

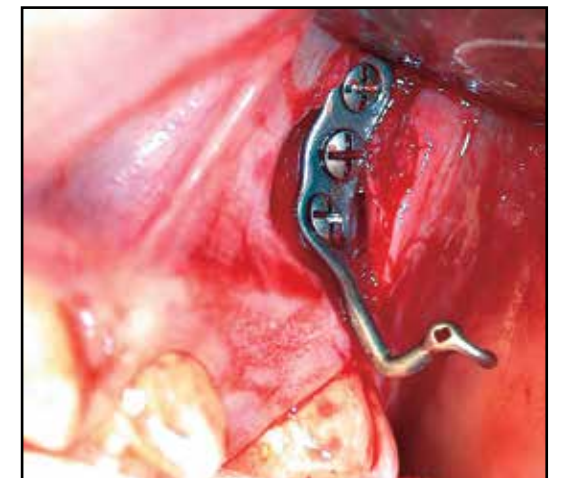


Figure 3. Maxillary plate adapted to the buttress contour



Figure 4. Mandibular bollard plates



Figure 5. Class III elastics



Figure 6A. Pre-De Clerck malocclusion



Figure 6B. Final post-De Clerck positive overjet and canine position



Figure 7A. Mid-treatment mild class III



Figure 7B. Corrected molar and canine and A-P relationships

In the maxilla, the early-teen patient will have limited bone stock and, often, lower bone density limiting the sites available for plate fixation. If the plate becomes loose and the bone around the screws becomes eroded at the vertical buttress site, it may be necessary to return to the site in 3-4 months and replace the plate into the re-healed bone. Moving the plate further forward or backward is limited by the thinness of the maxillary sinus walls outside the buttress and piriform rim sites.

I have found that self-drilling screws were the best in achieving plate fixation. I initially used Sythes micro fixation screws, but have been more successful with the screw line offered by Tita-link specifically for bollard plates. In the mandible, the plates are placed in the depression between the roots of the canine and lateral incisor with the screws and footplate situated below the roots of the laterals and canine when possible. A slight bend is also needed to adapt the plate, but I have found very few of the cases develop plate loosening or fixation failures in the mandible.

In the mandible, only two fixation screws are needed, while in the maxilla the plates require three screws in most soft bone cases. The common issue with the lower bollards is that they can be overgrown by vestibular soft tissues if they are placed too deep. Conversely, if they are placed too superficial they can cause pressure and recession of the cervical gingiva especially over the canine eminence once the elastics are connected to them.

Once the plates are installed the incisions are closed around the bollards and the patient can have elastics applied within 1-2 weeks. I like to get elastics on very quickly as, in my experience, this stabilizes the plates and reduces concerns of plates being manipulated in multiple vectors by the patient's curious tongue. The patient is then appointed with the orthodontist and we will usually follow them along with their orthodontist on 2-3 month intervals during their orthopedic treatment. Once the orthodontic treatment is completed, the plates can be removed. In a few cases, the mandibular footplates can become overgrown by bone and can be retained if their removal requires significant resection of the mandibular symphysis. The connecting arm and bollards are removed from the footplate at their connection on the end of the footplate.

In the past seven years, we have performed around a dozen of these treatments for maxillary hypoplasia with overall great results (Figures 6A, 6B, 7A, 7B). We have also corrected severe apertognathia and class III cases simultaneously by intruding the molars against a maxillary bollard plate all while protracting the maxilla (figures 8A, 8B). In my series of around one dozen patients, one patient was totally non-compliant and no improvement was obviously to be seen in his case. In all but two other cases, positive overjet was achieved and maintained. The two cases that did not correct fully were older (>14 years) female patients. They will likely undergo conventional orthognathic therapy. One of these patients had also limited use of her elastics as she developed TMJ symptoms of capsulitis and joint pain with the class III elastics overloading her joint mid-treatment. She had a concurrent blunt trauma to her joint from a sports-related injury. Once the elastics were removed she returned to a normal joint comfort level, but, of course, did not have adequate corrective effects due to stop in traction forces. The other patient may have also been less than compliant with her elastic use based on the report received from her orthodontist.

The real potential for therapy failure is always disclosed and discussed with the patient and their parents as part of a pretreatment consultation. Most patients, when given an option to intercept the growth issues and likely reduce need for and the extent of any needed orthognathic surgical correction, are happy to have this option presented and easily agree to pursue the treatment in most cases. Even some A-P improvement with incomplete overjet correction may still mean that potentially a two-jaw surgical correction is turned into a single jaw surgery through the sutural distraction therapy.

I have also utilized the maxillary bollards as anchorage for intrusion of maxillary molars to develop restorative space prior to implant placement in the posterior mandible. In adults, I have added corticotomies and buccal plate perforation to enhance the rapid osteogenic remodeling of alveolar bone (Figure 9) in assisting the orthodontist's attempts at tooth intrusion. Usually, we will place two bollard plates in the maxillary buttress areas and, in some cases, add a TAD on the palate as well to give ample intrusion anchorage.

The De Clerck interceptive approach to growth modification has been well received by our community of local orthodontists and has allowed us to get more involved in this unique aspect of dentofacial orthopedics. As such, it has opened up an alternative, and perhaps a better, pathway for treatment of developing skeletal class III patients with maxillary hypoplasia and apertognathia by reducing their treatment costs, morbidity, and recovery times. The key to our success in integration of this clinical protocol into our OMS practice has been a solid collaborative partnership with our local orthodontic colleagues. They, like us, must be progressive in their craft and be aware of this alternative methodology and, most importantly, be especially capable of very early diagnosis of the developing maxillary hypoplasias. The De Clerck techniques are effective and most surgeons can easily add them to their standard armamentarium of procedures even in contemporary office-based OMS practice.



Figure 8A. Pre-treatment class III apertognathia



Figure 8B. Post-treatment open bite correction



Figure 9. Corticotomies and bollard use for molar intrusion

## NEW ABOMS DIPLOMATES

CALAOMS would like to recognize and congratulate these members who recently passed their board exams and are the newest ABOMS Diplomates

Rachel L. Appelblatt, DDS, MD

Heena Chandra, DDS

Ryan J. Colletta, DDS

Marc Dentico-Olin, DMD, MD

Andre V. Guerrero Fernandes, DDS, MD

Samantha B. Jones, DDS, MD

Derek S. Park, DDS, MD, MA

Jennifer D. Perkins Chen, DDS, MD

Kirsten J. Rittenbach, DDS, MD

Olga P. Smutko, DDS

Suzin Um, DDS

Benjamin Yagoubian, DDS MD

## LEGISLATIVE UPDATE



### Spring 2017 Update

by Gary Cooper  
Legislative Advocate, CALAOMS

### Pediatric Dental Anesthesia Issue Continues into 2017

In 2016, due to the tragic death of a six year old under general anesthesia in an OMS's office, pediatric dental anesthesia was a high priority legislative issue for CALAOMS. The new legislative session started in January with the same issue taking center stage once again.

With the Governor's approval of AB 2235 (Thurmond) last year, the Dental Board of California was mandated to generate an in-depth study of the pediatric dental anesthesia statutes in California and a study of adverse reactions that may or may not have occurred as a result of the use of anesthesia in pediatric dental cases. After months of research, the Dental Board Subcommittee that was assigned to do the study concluded that with the exception of a few minor changes, the statutes governing pediatric anesthesia in California are sufficient to provide protection to patients during dental sedation. This conclusion was presented to the full Dental Board on December 1, 2016.

However, at the last minute, to the surprise of most stakeholders involved, the Dental Board chair, Dr. Steven Morrow, proposed a new amendment to the report. He proposed to recommend that for general anesthesia given to patients 7 years of age or younger there shall be at least three people present

during the procedure - which is standard procedure for OMSs already. However, his recommendation was that one of those people be a dedicated general anesthesia permit holder regardless of the fact the provider already has a general anesthesia permit. In addition, the recommendation was to have an additional anesthesia support staff present. So in practical terms, for the OMS, it means *two* general anesthesia permit holders *plus* an anesthesia assistant, *plus* a surgical assistant would be required. This recommendation was accepted by the Dental Board and included in the report submitted to the legislature.

Subsequently, the Senate Business and Professions Committee held a hearing in February to review the Dental Board's report. Various stakeholders presented, including CALAOMS. As expected, this issue has escalated into a competitive scope of practice debate on the safest and most cost effective means of providing anesthesia to pediatric patients.

In February, Assemblyman Thurmond introduced his bill AB 224, which has now been amended to include the Dental Board recommendations. Because these recommendations clearly negatively impact access to pediatric dental care, CALAOMS is taking a strong position of OPPOSE UNLESS AMENDED when the bill is heard in the Assembly Business and Professions Committee on April 25, 2017.

In addition, CALAOMS is sponsoring two bills on the subject. One bill, SB 501 (Glazer) gives the legislature the option of complying with most of the Dental Board's positive recommendations. SB 392 (Bates) requires the Board to study how their recommendation of a second general anesthesia permit holder affects access to care.

Both bills will be heard in the Senate Business and Professions Committee on Monday April 24.

### CALAOMS Legislative Day at the Capitol

On March 1, 2017, several members of the CALAOMS board of directors and legislative committee, along with Mr. Gary Cooper (lobbyist for CALAOMS), and CALAOMS Executive Director Pam Congdon, convened in Sacramento to meet with several key state legislators. The purpose of the day was to introduce ourselves as a specialty and an organization, and to educate lawmakers on our training, standards of care, and everyday practice as it relates to us addressing patient safety and access to care.

The day's busy schedule included meetings with several key Assemblymembers and Senators, including:

- Assemblymember Sebastian Ridley-Thomas (D-Los Angeles) – author of CALAOMS' AB 880 that was signed into law on October 1, 2015
- Assemblymember Marc Steinorth (R-Rancho Cucamonga)
- Assemblymember Jim Wood, DDS (D-Eureka) – Assembly Health Committee Chairman
- (R-Dana Point) – Vice Chair, Assembly Business and Professions
- Assemblymember Kevin Mullin (D-San Mateo) – Assembly Speaker pro Tem
- Assemblymember Mike Gipson (D-Carson)
- Assemblymember Tony Thurmond (D-Oakland) – author of AB 2235
- Assemblymember Brian Dahle (R-Bieber)
- Senator Richard Pan, MD (D-Sacramento)
- Senator Ben Allen (D-Santa Monica)
- Senator Pat Bates (R-Laguna Niguel)—CALAOMS bill author
- Senator Steve Glazer (D-Orinda)—CALAOMS bill author
- Senator Anthony Portantino (D – La Cañada Flintridge)
- Melinda McClain from Governor Jerry Brown's office

Staff from the offices of:

- Senator Bill Dodd (D-Napa)
- Assemblymember Chris Holden (D-Pasadena)
- Assemblymember Catherine Baker (R-Dublin)
- Assemblymember Richard Bloom (D-Santa Monica)
- Assemblymember Tom Daly (D-Anaheim)



Left to right: Dr. Edward Balasanian, Dr. Leonard Tyko, Gary Cooper, Senator Pat Bates, Dr. Larry Moore



Left to right: Dr. Leonard Tyko, Dr. Edward Balasanian, Dr. George Maranon, Dr. James Jensvold, Dr. Alan Kaye, Assemblymember Kevin Mullin, Dr. Larry Moore, Gary Cooper



Left to right: Dr. James Jensvold, Gary Cooper, Dr. Leonard Tyko, Dr. Edward Balasanian, Dr. Alan Kaye, Dr. Larry Moore, Dr. George Maranon



Left to right: Dr. Edward Balasanian, Dr. George Maranon, Dr. Leonard Tyko, Gary Cooper, Assemblymember Brian Dahle, Dr. Alan Kaye, Dr. Larry Moore

## MEANING IN ETHICS



### ETHICAL DIALOGUE REFLECTION

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

**A**s health care practitioners, we have a duty to reflect on our ethical behavior, and it is relevant for us to be aware about the effects of ethics and meaning within the context of our challenging byzantine 'post-modern' world.

The source for truth and reality was primarily religion during the pre-modern era and science during the modern era; in our post-modern era there is no single defining source for truth and reality beyond individual preference. In fact, many observers vociferously opine that post-modernity wallows in nihilistic angst, mysticism, relativism, and the incapacity to know anything with certainty. The difficulty of an ethical dialogue reflection dealing with serious questions of meaning is due in part to epistemic and moral

complexities defining our post-modern condition. Otherwise stated, post-modernity entails definitively overcoming modern philosophical and scientific agendas characterized by the optimism of reason. It also requires recognition of potential structural fragmentation forcing the inevitability of contextual interpretations; thus, defying the illusion of totality and pursuit of a meaningful truth.

Theoretical indeterminacy of post-modernism can be characterized as a philosophical label which contrasts with the clear dimensions of the problems it creates in practice. Two are particularly worthy of reflection: bringing together a plurality of lived moralities (moral pluralism) under a shared common denominator ethos (common morality), and difficulty finding

a level of discourse engaging dissimilarities among moral traditions regarding questions of substance. Whereas the former issue concerns a moral climate that structures all practical spheres of reality, the latter permits the possibility of theoretical reconstruction of a moral climate in terms of ethical discourse and public policy.

Relying upon an analysis of different typologies or moral argumentation, political philosopher and ethicist Alasdair MacIntyre observes: "Debate between fundamentally opposed standpoints does occur; but it is inevitably inconclusive. Each warring position characteristically appears irrefutable to its own adherents; indeed, in its own standards of arguments it is in practice irrefutable. But each warring position equally seems to its opponents to be insufficiently warranted by rational arguments."

One way to reconcile this predicament is bridging the gap of cultural fragmentation and unconvincing nature of arguments between moral agents by surreptitiously reducing ethics to a purely regulatory task; hence, progressively diluting the distinction between legal and moral. The tendency to sublate ethics under the law rests upon the assumption that dialogue on moral convictions separates people; only the law, now invested with a kind of soteriological meaning can bring moral differences under a banner of unifying social rules.

Such a notion of ethics not only discourages meaningful exchange across different traditions; it ultimately has a neutralizing effect on the content of moral conversations as such. An ethical discourse capable of laying out a territory of discussion where differences can meet and confront each other will be expunged from the theoretical agenda of ethics. The latter will, then, provide a grammar of procedural conditions upon which differences among moral traditions may co-exist, without ever coming into contact with one another. Rather than focusing on questions of intrinsic value, moral discussion is expected to articulate rules of reciprocal engagement – the a priori of communication – permitting each moral participant to remain in a safely protected and separated moral universe.

British psychotherapist and essayist Adam Phillips insists that any ethical boundaries are "a form of pontification and imperial self-aggrandizement....no adult can know what's best for another adult; and, by the same token, no group or society can know what's best for another group or society." Phillips' position appears consistent with a post-modernity mindset that does not allow anyone to be "right" on any particular issue including ethics.

In order to overcome problems posed by post-modern conditions, it seems a logical imperative to rethink the meaning

and purpose of ethical dialogue across different traditions within the public realm of 'secular' society. Metaphorically, one must move between Homer's idiomatic sea monsters (Scylla and Charybdis) presenting a dual impasse: the reduction of ethical rationality to a purely procedural function of political regulation and the intellectual impotence toward an incommensurable pluralism that legitimizes the relativity of different points of view.

Our post modernistic movements have created obstacles in the evolution of ethics both in practice and dialogue. This can be traced from the 20th century where there evolved a cynical and rather inflexible belief by many regarding the authenticity of meaning, reality and truth; indeed, ethics and lively dialogue appertaining thereto have been subjugated in large part to the law. Change is required, because this manner of contemplation has put a damper on transparent discussions concerning morality and its relevance. We should defend and live by the doctor's true ethical obligation - to the patient.



Left to right: Gary Cooper, Dr. Leonard Tyko, Assemblymember Bill Brough, Dr. Larry Moore, Dr. James Jensvold, Dr. George Maranon, Dr. Edward Balasarian, Dr. Alan Kaye

### DAY AT THE CAPITAL CONTINUED FROM PAGE 21



Left to right: Dr. Edward Balasarian, Pamela Congdon, Dr. Alan Kaye, Dr. George Maranon, Gary Cooper, Dr. Leonard Tyko, Senator Richard Pan, MD, Dr. Larry Moore, Dr. James Jensvold



Left to right: Dr. James Jensvold, Dr. Alan Kaye, Dr. Edward Balasarian, Assemblymember Marc Steinorth



Left to right: Assemblymember Sebastian Ridley-Thomas, Dr. Alan Kaye, Dr. James Jensvold, Julie Hooper, Dr. Larry Moore



Left to right: Dr. Larry Moore, Dr. Edward Balasarian, Dr. Leonard Tyko, Senator Steve Glazer, Gary Cooper

## RISK MANAGEMENT



### Perspectives on the Future of Medicine

By Richard E. Anderson, MD, FACP,  
Chairman and CEO of The Doctors Company

In just the past few years, the healthcare system has undergone a remarkable transformation from a paper-based system to a digital one. On top of that, healthcare organizations and physicians are under intense pressure to improve value—measured as safety, access, efficiency, cost, and patient experience.

*Robert M. Wachter, MD, professor and chair of the Department of Medicine at the University of California, San Francisco, and bestselling author of The Digital Doctor: Hope, Hype, and Harm at the Dawn of Medicine's Computer Age, discussed this unprecedented change in the healthcare environment—and how it will affect both doctors and patients—during his keynote speech at The Doctors Company's 2016 Executive Advisory Board. In the following conversation with Dr. Wachter, I asked him to share his thoughts on the challenges and opportunities ahead.*

**Q:** Health technology, including mobile apps and wearables, has led to a large increase in the amount of patient data that doctors have to deal with. How will this new data play a role in healthcare?

**Dr. Wachter:** In the future, our healthcare system will be primarily digital, and there will be a far more fluid flow of information than there is today. The patient's information will be available to the patient, to the family, and to the clinicians, whether the patient is at home or in a clinic or being seen in a

hospital. Patients will have the information that they need to manage themselves. And clinicians will have the information they need. And so will the system—in fact, ours will truly become a learning healthcare system, one that makes itself iteratively better as it takes advantage of the experience of prior patients. Up until now, most of the investments have been in enterprise systems like EHRs in hospitals. I think the next big wave in healthcare investment is in consumer-facing technologies that allow patients to monitor their own health.

**Q:** Startups in big cities have attempted to bring back house calls, although there is concern that this will not scale for large populations of patients, particularly in rural areas. Telemedicine has also exploded in use and popularity, although reimbursement and liability issues have not been resolved. How do you see these alternate avenues of care evolving in the future?

**Dr. Wachter:** If we can resolve these issues about telemedicine, I see patients getting most of their care from home, managing their chronic conditions like diabetes, high blood pressure, and heart failure through information provided by the computer through a series of smart algorithms. And when they need to see clinicians, it will be largely through televisions. The idea that a patient would have to take off a day from work and drive to a hospital or to a doctor's office, park, and then see a doctor for a 20-minute visit—people will look back at that and say, “You did that 15 years ago?” I think this vision is quite inspiring. I think that when we get to that place, we will be providing care that's better and safer and cheaper and more patient centric than what we do today.

**Q:** What do you think a hospital visit will look like in the future?

**Dr. Wachter:** First of all, just in terms of the national marketplace, there will be far fewer hospitals and those that exist will be fairly large, will be bristling with technology, and will really be one big ICU. The notion of a separate ICU will go away. Patients will have single rooms. When I walk into the patient's room, the patient will see on their screen who I am, along with my background and bio. The nature of consultation will also change. Right now, when I see a patient in the hospital, if the patient needs the help of a cardiologist or a nephrologist, I'll call them for a consult and they may come and see the patient later in the day, and then they'll leave a note for me and I'll read it and go back and see the patient. In the future, I'll go in and see the patient and if I need a nephrology consult, I'll pull him or her up on the screen in the patient's room and we'll have a three-way conversation. That ability to integrate our care and talk to one another facilitated by technology will make things much better and more efficient than they are today.

$$\text{Value} = \frac{\text{Access} \times \text{Patient Experience}}{(\text{Efficiency} - \sqrt{\text{Cost}})} + \text{Safety}^2$$

**Q:** The idea of patient engagement—encouraging patients to be actively involved in their healthcare—has become a common discussion in medicine. This concept, including ideas such as giving patients open access to doctors' notes, nudges patients to be involved, but it also means that patients will be expected to live up to a different level of responsibility for their health. How do you see the patient role in future years?

**Dr. Wachter:** The role of the patient in their own healthcare is going to be utterly transformed. Patients have been passive in the healthcare system up to now. Technology democratizes everything, and it will elevate the role of the patient by giving them new tools and access to information. The doctor will no longer be the only expert in the room. We'll see patients who are able to partner with their doctors in ways that they're not able to today—through computer tools, smart algorithms, and linkage to online communities where they meet other patients with similar problems. But we have to be careful because patients also may try to take care of themselves and be their own doctors. We have to figure out how to get this right—how to allow technology to permit our patients to manage themselves better on their own or with the assistance of the healthcare system, but also to recognize there are times where patients really need to see a doctor or someone that's part of the healthcare system.

**Q:** While EHRs have brought many positives, they have also created new risks and frustrations for doctors and patients. The Doctors Company did a study of our closed malpractice claims in which EHRs were a contributing factor, finding that 64 percent of these claims were caused by system factors like lack of alerts or clinical decision support and 42 percent of claims were caused by user factors like inputting incorrect information. What are your thoughts on current EHR issues?

**Dr. Wachter:** EHRs are really important because we can't possibly take care of patients using paper and pencil and fax machines. But today's versions of EHRs are not very good, because they were built to serve too many masters. If they were built simply to help the doctor take care of his or her patients, they would look one way. But they weren't. They

were also built to make billing more efficient. They were built for malpractice prevention, to meet regulatory requirements, and for quality measurement. And the problem is that when you build a digital system for 10 different masters, you come up with something that isn't very good for any of those goals. We'll have to do three main things to make the EHR the vehicle that we want it to be. First is promoting for more use of user-centered design. The second is dealing with too many alerts—alert fatigue is overwhelming and dangerous, and we simply have to figure out how to prevent it. And the third is interoperability, to ensure that patient medical records can be shared easily between doctors, hospitals, and other healthcare providers at any time. Technology has brought great things to healthcare, but it always brings unanticipated consequences. It's dangerous to believe that technology will solve all problems—we must instead view it as just another tool to help us improve how we care for patients.

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*Photo: Monty C. Wilson, DDS, oral and maxillofacial surgeon at Ratner & Wilson DDS, Orange and Santa Ana, California*