



## CALAOMS Congratulates Pamela Congdon on 25 Years with the Association

*By Paul Congdon*



**T**his year, Pam Congdon, CALAOMS' Executive Director, will celebrate her 25<sup>th</sup> anniversary with CALAOMS. I was given the honor of writing an article about this remarkable woman so you might come to know more about her beyond her duties as the Executive Director of CALAOMS. I am uniquely positioned to give you this narrative because I found her first and married her 31 years ago. I am more than happy to share the details about her unique personality, passion, and dedication as the amazing person I've come to know, respect, and love.

In short summary, here are a few things you might not know about Pam that have occurred over the last 25 years. These include the fact that she has raised two wonderful children, vacationed in 16 different countries around the world, was run over by a pizza delivery truck, ran two marathons, swam from Alcatraz Island to San Francisco twice, orchestrated the construction of a custom home, obtained her Certified Association Executive (CAE) degree, obtained her Institute on Management (IOM) degree for the certification of chambers and non-profit management, supported her husband (both financially and emotionally) while he obtained his Master of Science and PhD degrees in Computer Science, assisted in the creation of seven legislative bills supporting Oral and Maxillofacial Surgeons, created and led a volunteer organization with over 13,000 volunteers that have provided health services to over 28,500 individuals and have delivered more than \$11,600,000 in services thus far; she has been awarded Proclamations from the city of Indio, the county of Riverside and the congressman from the 36<sup>th</sup> district of California for providing services to the needy. She has been interviewed on TV, radio, and newspaper over 40 times. Oh, and she is a great cook and makes a gourmet dinner every night for her co-dependent husband. Oh again, she does the laundry, cleans the house, and has been known to chop down trees and initiate major projects in the back yard on her own accord. I know I'm missing something, but that was the short summary for the last 25 years.

Here are some more details. In 1993, Pam started working for NCSOMS, the Northern California Society of Oral and Maxillofacial Surgeons. Our son, Cameron, was 1-year

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## in this issue:

- CALAOMS Surgeon Participates in Care of Pamela Congdon - 25 Years of Service .... pg. 1 ■
- Editorial ..... pg. 4 ■
- President's Message ..... pg. 6 ■
- Coronectomy ..... pg. 8 ■
- Marijuana and Anesthesia ..... pg. 11 ■
- Legislative Update ..... pg. 14 ■
- P.R. Update ..... pg. 15 ■
- Complexity in Bioethics ..... pg. 16 ■
- Disaster Preparedness for Your Medical Practice ..... pg. 18 ■
- California CareForce ..... pg. 21 ■
- Upcoming Events ..... pg. 22 ■
- Classified Ads ..... pg. 23 ■

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## EDITORIAL



### Successful Failures In Leadership

by Jeffrey A. Elo, DDS, MS, FACS

Regardless of the individual type of practice, as oral and maxillofacial surgeons, we are all called to be leaders in some way, shape, or form. This may not always be a naturally occurring process – or even an easy one; but it is a necessary one in order for us to be successful in our work environments and professional and personal lives. Recent graduates coming out of OMS residency often question their ability to be good leaders in their offices. They have been accustomed to following orders given by their attendings and senior residents for the past several years; but now find themselves thrust into a position of leadership. I consider that good news. Why? Well, a good leader is first a good follower.

Leaders demonstrate humility. Good leaders know they do not possess all the answers. There is a difference between dreamers and leaders. Dreamers dream about things being different. Leaders determine and act to make a difference. There is a place for prayer, planning, and quiet reflection; and there is a place and time for action. Another way to say it: there is a place for the spiritual as well as the practical in your life.

The demands of leadership are not always easy. These demands can take several forms and can present themselves in various ways – with varying levels of difficulty – over the course of our professional practices and personal lives. Every one of us is going to have a moment where we come to a fork in the road; one road leads to comfort, and the other road leads to sacrifice.

Leaders often must show patience. This is a foreign concept to most of us. Let me illustrate. We do not like to wait. We like everything now. Everything fast. In the past, we used to

have to wait for stuff. Do you remember when we first started being able to access movies? We would go to Blockbuster video stores and could rent something called a videotape (all the millennials say, “What’s a videotape?”). Remember the little sign at the checkout: *Be Kind, Rewind*. Sometimes you would go down to the Blockbuster store and they wouldn’t have the videotape for the movie you wanted. Then, we went to DVD technology. So we would rent the DVD. Then, Netflix came along and they would mail you the DVD. Okay, so you would order the movie you wanted online and then it came in the mail, but it took a day or two for it to get to you. Well, now we just stream it. We don’t have to wait for anything. We just click it and we stream it. Everything comes fast to us. When we hear about waiting, that’s an alien concept in a culture that is used to immediate gratification. Waiting time doesn’t have to be wasting time. Developing leadership skills takes a lifetime. All of us continue to learn and improve, and this process takes time. We need patience to allow the process of maturity to develop.

Leaders take initiative and risks. One good definition of a leader I’ve heard is *the leader is someone who takes people where they don’t necessarily want to go, but when they get there they’re glad they went*.

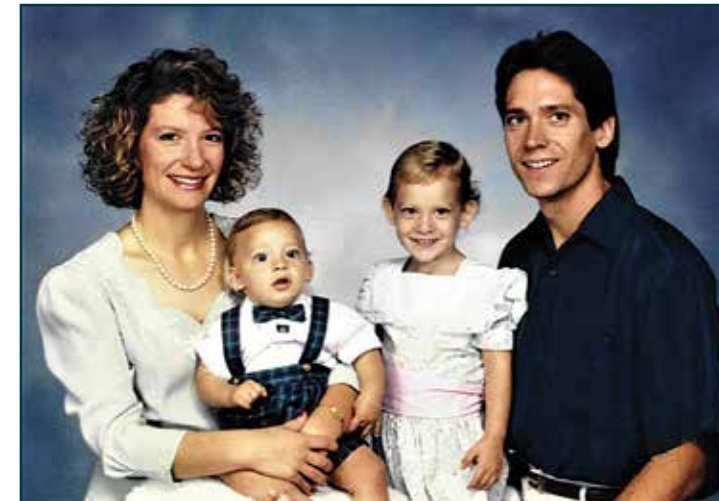
Leaders will face opposition. Sometimes, leaders are put in a place or a situation they don’t want to be and that can be frustrating and upsetting. Did you ever stop to think, though, that this could be for a bigger purpose? There can be a cost to being a leader. Sometimes leaders suffer for others. Does anyone get a free pass on pain? No. Leaders suffer in every way that everyone else does. A leader is going to be accountable for what they do and for what they say. Being a leader is challenging. Leaders are second-guessed. They are gossiped about. Sometimes they are slandered. They face challenges. It is, however, a great privilege to lead. I, personally, am thankful for it. There is a great responsibility attached to it. It’s been said that the leader needs the mind of a scholar, the heart of a child, and the height of a rhinoceros. It’s not easy, but if you’re called to do it, you have to do it. And then if you do it, it’s one of the most wonderful things ever to be used in this way. It’s such a privilege. It’s such a joy. Alan Redpath once said, “There is no winning without warfare, no opportunity without opposition, no victory without vigilance.”

*Houston, we have a problem.* Those are the words from Apollo 13. Two thousand miles from earth; five-sixths the distance to the moon. They had leaked fuel and gas - oxygen - into the atmosphere, and so NASA changed the mission. The original mission was for them to go land on the moon. The new mission was to get the astronauts back to earth alive. Houston began to work with those aboard Apollo 13, and thankfully they were able to get back to the earth alive. It’s interesting

because NASA classified that mission as a “successful failure.” Why? Because they gained much needed experience in rescuing a crew, and the crew survived. The original mission was not successful, but the new mission was.

### 25 YEARS CONTINUED FROM PAGE 1

old and our daughter, Samantha, was 3-years old when Pam returned to work. Pam was a passionate mother and provider for the children in their critical early years. She was also anxious to have a career and demonstrate that she could have an impact on both the family’s future as well as others. So, in 1993, she returned to work at the NCSOMS in Sacramento as an administrative assistant. Pam played the classic “Superwoman” role of working full time and still being an attentive and loving mother and wife.



Pam quickly found herself in a role of authority at the NCSOMS as their needs grew. Her leadership and passion for building a team was apparent in her early renditions of this ‘mission impossible.’ Pam has always brought life and energy to the work environment. It can be fun working with Pam. NCSOMS relocated their office to Roseville and supported the membership while the OMS membership evolved in California.

Pam was recognized for her assistance in the merger of the SCSOMS (Southern California Society of Oral and Maxillofacial Surgeons) and the NCSOMS into today’s better known



Sometimes as leaders we mess up. We make bad decisions. But we learn from these mistakes and do better the next time. That’s called a successful failure.



CALAOMS. This was a critical time for the association and Pam’s compassion, dedication, hard work, and willingness to make things succeed were instrumental in easing the merger of these two organizations. Perhaps it was the persistence and dedication of the California OMSs during this time that inspired Pam; but nonetheless, she began a phase in life where there was no stopping her once she put her mind to something. In the early 2000s, Pam began a series of personal challenges.



Pam’s first challenge to herself was to run a marathon. This required dedicated training in the spare time that she really didn’t have. The thought of completing the task was always harder for Pam than actually doing it. She completed the marathon two years in a row.



CONTINUED ON PAGE 7

## PRESIDENT'S MESSAGE



by Jeffrey A. Elo, DDS, MS, FACS  
CALAOMS President

### California Oral and Maxillofacial Surgeons – A Strong Record of Providing Safe Access to Care

**D**elivering high quality, safe surgical procedures requiring anesthesia in an office setting takes significant specialty training and a firm commitment to patient safety. As oral and maxillofacial surgeons (OMSs), we have achieved and are extremely proud of our long record of safe and effective care. We also know that proposed legislation to mandate a second anesthesia provider during these procedures – although well intended – is an emotional reaction that will not improve safety but will hamper access to care for those who need it. Limiting access to these procedures will significantly affect the most vulnerable among us, including thousands of low-income children, and is exactly the wrong thing to do.

In 2016, the California legislature passed AB 2235, calling for the Dental Board to appoint a special committee to study the safety and effectiveness of office-based anesthesia on pediatric dental patients.

In January 2017, the special committee concluded the anesthesia delivery system is safe, consistent with, and compares favorably to accepted practices across the country. Recommendations were included and aimed at enhancing anesthesia safety in the dental office setting. Most of these recommendations are already required for California OMSs. Significantly, the committee found no evidence that a second anesthesia provider for children under seven years of age would guarantee greater safety.

As OMSs, our mission is to assure the public of safe, comfortable, and optimal care that is affordable and accessible. We have accomplished this with the development and implementation

of mandatory standards of practice, which are more robust than what is currently required by California law.

Our training is extensive. Oral and maxillofacial surgeons undergo a hospital-based residency of no less than 48 months with strong emphasis on anesthesia training; 5 months of which is alongside medical anesthesia residents, and an additional 25+ months of in-clinic anesthesia procedures throughout residency. We must renew our permits to administer anesthesia on a regular basis. A minimum of three individuals are involved in our procedures. These individuals are certified in Basic Life Support and are trained in monitoring and in emergency airway management for deep sedation/general anesthesia. One team member is dedicated to monitoring the patient and the airway and has no additional duties involving the surgical procedure. The supervising OMS must also maintain Advanced Cardiac Life Support certification every two years and must complete 24 hours of graduate-level continuing education specific to anesthesia every two years. Most OMSs also complete training in Pediatric Advanced Life Support.

Unlike most surgeries, the OMS, along with two other highly trained staff, are positioned at the patient's head and can observe and manage the airway quickly in response to any changes. In addition, the level of anesthesia for our surgeries is somewhat lighter because we use profound local anesthesia.

Under this model of care, the safety record for moderate and deep sedation/general anesthesia administration in the OMS office is unmatched by anything in medicine. Statistical evaluation of this fact is undeniable. And the Dental Board study confirmed this.

Any unplanned and untoward event in a dental office is a tragedy. No one disputes that. But we have to consider the facts. The Dental Board study confirms that our model of care delivers a safety record that is remarkable in the health care world. In light of that, mandating a second anesthesia provider – one that will not make the procedures safer and passes on high costs directly to the patient – is a feel-good step that is unnecessary and would be costly and devastating to patient access to care.

Patient safety will always be our number one priority, and that commitment – along with the system of training and accountability we now have – adds up to a reassurance of safe care. Hasty decisions not based on facts will lead to a crisis in access to care for all Californians, but particularly those most vulnerable – the poor, the dental phobic, and our state's children. CALAOMS has been and remains an integral and active part of the solution needed in order to make sure that all children (and adults, alike) — poor and wealthy, rural, and urban — receive the dental health care they need to survive and thrive.



## 25 YEARS CONTINUED FROM PAGE 6

While training, she met someone who triggered another wild idea – swimming from Alcatraz Island. Again, demonstrating that once Pam sets her mind to something, it is not possible to change it until the task is completed. Swimming was not something that Pam had done a lot in the past, so the training was extensive and instructional. She basically had to learn how to swim long distance. She got herself comfortable in the pool and eventually in open water and then finally the San Francisco Bay. Not being satisfied with her results the first time, Pam decided to do this more than once. Two months later, Pam completed the crossing to San Francisco again.



Nothing demonstrates Pam's passion and dedication more than her next project: to find a philanthropic avenue for CALAOMS. In 2010, Pam attended a Remote Area Medical (RAM) event in Los Angeles where she met Stan Brock of Mutual of Omaha Wild Kingdom fame.

Pam volunteered in all areas of the clinic and quickly came to understand the significance and magnitude of the



operation. She convinced Stan Brock to bring his clinic to Northern California and successfully hosted her first medical expedition. Doing everything from raising funds to finding volunteers, food, and a venue, Pam launched a philanthropic arm of CALAOMS and there was no turning back.

As Pam can do so well with her charm and excitement, she pulled in colleagues, friends, family, and new acquaintances into the organization and eventually built its independence as California CareForce. Pam secured and has maintained very loyal sponsors of the clinics over the last five years and the organization continues to provide critical health services to thousands of people in need.



I can't stress how lucky I am to have Pam in my life. Bless her heart and soul. She makes such a difference to those around her and I'm sure she has made the last 25 years at CALAOMS memorable. Please join me in congratulating her on these accomplishments and acknowledging her dedication over the last 25 years.

Congratulations, Pam!!!



## Technical Articles



### Coronectomy A “viable” treatment option for high-risk third molars

by Peter Krakowiak, DMD, FRCD(C)

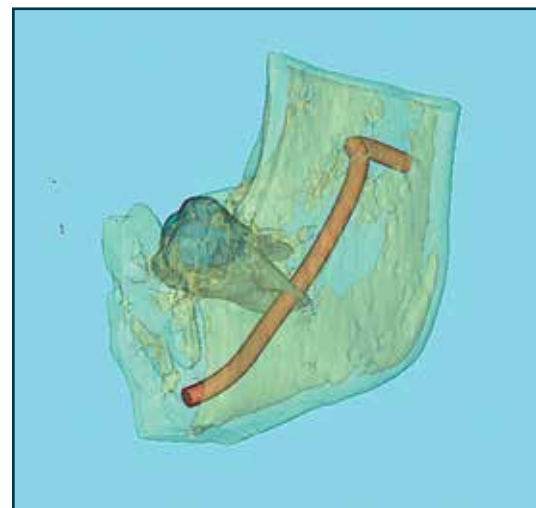


Figure 1. 3-dimensional root-nerve relationship imagery.



Figure 2. Actual root anatomy as compared to the image seen in Figure 1.

As I enter the third decade of my practice, I am becoming more appreciative of conservatism. Not just socially or politically, but also in my approach to clinical concepts. As a resident and novice surgeon, I had the monoptic desire to take on challenges and overcome them surgically at all cost. It is still very gratifying to overcome significant obstacles and achieve therapeutic success. However, a more balanced cost versus benefit approach, as I hopefully mature professionally, is becoming more worthy of consideration in all my surgical endeavors. Certainly, orthognathic surgeries and temporomandibular joint procedures are two such areas of practice, but even in traditional dentoalveolar settings conservatism versus radicalism can be pondered. *Primum Non Nocere* (Latin: “above all, do no harm”). Above all, let us remember it is “What’s in it for our patient?” and *not* “What’s in it for us, our ego, or the bottom line?”

Our well-known and respected California-based OMS, Dr. Tony Pogrel, initially presented the contemporary partial odontectomy in 2004 to our U.S. specialty through the Journal of Oral and Maxillofacial Surgery (JOMS), and it has since become increasingly accepted as a viable alternative solution for dealing with otherwise pathology free – but deeply impacted – high-risk third molars with radiographically evident proximity to the inferior alveolar nerve (IAN). The technique has many proponents especially in Europe where it is thought to have originated in 1980s and was published on initially in Sweden in 1989 by Knutsson. In Europe, it is quite popular and some practitioners have ventured to use this technique routinely for cases where there is a mere two-dimensional panoramic- or even periapical (PA)-based evidence of nerve-root proximity. That *carte blanche* approach is probably not correct.

I believe that rudimentary selection criteria and 2-dimensional (2D)-based risk stratification paradigm are not theoretically supported by clinical outcomes, as there is limited spatial diagnostic value of even the most detailed contemporary digital 2D imaging. It is well understood that PA images or even the panoramic view are distorted and not truly predictive of the actual case specific nerve injury risk and actual 3D anatomy relationships of the site. The high resolution, artifact-free reconstructed (Figure 1) or multiplanar 3D view are superb at delineating the actual site’s spatial correlations (Figure 2). Hence all work-ups and decisions for choosing this modality in 2018, in my opinion, ought to be based on the analysis of type of radiological data to ensure that patients truly receive the accurate and case-appropriate care and

not just a “best guess” based on conceptually flawed or spatially incomplete data.

Fortunately, the past two decades have seen a tremendous increase in our profession’s ability to have real time in-office access and to visualize the exact spatial relationship of the root and the IAN. I routinely acquire CBCT views of third molar cases where panoramic radiographs demonstrate potential vertical overlap in the 2D views. After 12 years of using this protocol and having viewed over three thousand CBCTs, I have noted that it is rare that the nerve actually penetrates the root structure as it transits past it; however, it commonly will produce grooves (Figure 3) in the outside root surface and have roots curve under the nerve canal outline in many cases. In some cases, the buccal and lingual roots can diverge and then entrap the bundle as they grow past it and re-approximate apically themselves below the canal. Once a thorough review of the images in multiple cuts is made, a realistic assessment of actual risk of nerve injury can be completed based on its course. Then that risk stratification can be communicated to the patient.

Recent articles have now expanded on Dr. Tony Pogrel’s work and have given further insight into the rates and type of complications associated with coronectomy. A more recent meta-analysis of contemporary literature on coronectomies selected for 12 of 57 available published studies with the highest level of scientific evidence and firmly supported the use of this technique for cases that are considered at being *high* in the risk for IAN injury. Drs. Juan Cerver-Espert and Sara Perez Martinez’s 2016 systematic review and meta-analysis of world’s literature on the coronectomy subject concluded that coronectomy results in a significantly lesser incidence of both sensitivity loss of the inferior alveolar nerve and no surprise dry socket incidence. Interestingly, no statistically significant differences were observed in the incidence of pain and infection between coronectomy and complete third molar removal. The reduction in rates of nerve injury was noted to be 89% when compared to full traditional exodontia techniques. That is quite a noteworthy statistic when communicating this treatment option to the patient. Additional considerations noted in the studied literature were frequent, but limited in the extent of, distance the root fragment migrated and the need for reoperation, which was actually found to be low.

This concern of root migration was recently addressed in a 2017 JOMS article by none other than our SoCal colleague and editor of this very publication, Dr. Jeff Elo. His study looked at rates of migration of root fragments and the effects of grafting these sites (Figure 4) at the time of coronectomy. His results of retrospectively studying 78 patients over 5- to 9-years showed improved levels of periodontal attachment at the distal of adjacent second molars and no evidence of root structure migrations with grafted sites as compared to non-grafted cases.

With all this said, it is quite rare that I intentionally embark on offering a coronectomy to the third molar patients even with higher risk radiographic correlations. I have employed forced extrusion techniques using TADs and coils to elevate teeth off the nerve bundles (Figure 5) in some cases. This is usually followed by an extraction once the tooth clears the high-risk relationship. I have also removed teeth completely as well. Since I know the exact position of the nerve and root curvature direction in all plains, I usually *plan*

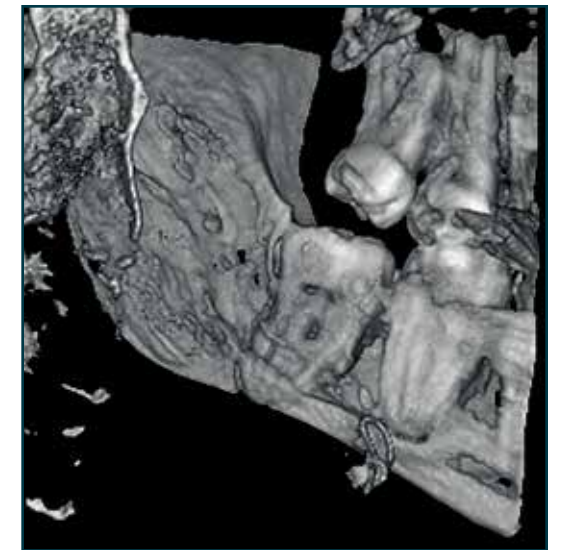


Figure 3. Root grooves from the IAN bundle.



Figure 4. Bone graft material placed over retained roots following coronectomy.



Figure 5. Coils transporting impacted right mandibular third molars.



Figure 6. Curved root fragments.

to remove the entire tooth by careful sectioning of the roots and individual elevation of the root fragment cognizant of their curvature and the needed arc of rotation for their terminal root fragments (Figure 6).

In all cases with complicated anatomy, it is prudent to educate the patients about their specific individual anatomy and the potential need for retention of root fragment(s) if their access and manipulation will likely place unacceptable pressure or disturbance on the IAN bundle structures. This is not a coronectomy, however. It is retention of residual root fragments or can be called partial odontectomy – quasi intentional. And such an approach would have been considered the standard of care up to this decade or so.

The coronectomy technique outlined by Dr. Pogrel and many subsequent authors indicate the removal of the crown of impacted teeth below the level of the CEJ and at least 2-3mm below the level of the adjacent buccal and lingual walls (Figure 7). The technique works best in either vertical or mesioangular impactions and may be more risk prone in horizontal impactions as the CEJ is located in those teeth closest to the IAN bundles. This is a critical technical point, as complete removal of all enamel is paramount in prevention of enamel matrix-induced reactions in the bone matrix during healing. The remaining pulpal stump tissues are left exposed by the coronectomy through the pulp chamber or coronal root section (Figure 8). No endodontic pulp therapy is indicated. The residual root stump usually will not develop a necrotic pulp, as the blood supply at the apex is not disturbed. In the 1990s while working in Canada, Dr. Tony Haskell David and I had a chance to perform and document a series of resections of fused and geminated teeth. We also noted the maintenance of viability in teeth with resections extending into vital pulp as long as that pulp was located subjacent to crestal bone at the site (Figure 9) and it was allowed to fully heal over with secondary reparative bone formation. It was quite surprising initially to see this. Primary closure of the site (Figure 10) is always recommended when working with exposed pulp, and antibiotics are given preoperatively. The grafting of the defect created by the crown removal with either xeno- or allograft is considered to help with initial wound healing as well as demonstrated by Dr. Elo's JOMS article - provides reduction of potential root migration; hence reducing the need for reoperation.

The CDT code for this procedure has been established and accepted in 2011 as D7251 coronectomy - intentional partial tooth removal. Many U.S. insurances do not cover this code; hence, the patients often have to cover the cost of this procedure outside the limitations of their insurance policies. The associated grafts and anesthesia fees may also not be covered for this advanced technique if the primary procedure code is not covered; but the procedure is clearly the optimal surgical treatment for the truly high-risk cases.

As it is now clearly documented by research and meta-analysis of the world's scientific literature, the partial odontectomy protocol can be offered by us to our patients. For those patients with an extreme risk of nerve injury, partial odontectomy or coronectomy is their best and safest treatment option and should be included in our informed consent discussions once nerve risk is properly ascertained and documented by a 3D imaging work-up. The patients can ultimately best make the treatment decision based on knowing all the pertinent risks and benefits as well as our current and accurate understanding of



Figure 7. Subcrestal coronectomy odontotomy.



Figure 8. Coronectomy completed with crown removed and exposed pulp.

the complication rates and outcomes as presented in this brief technique article.



Figure 9. Subcrestal retention of root structure with overlying bone graft.



Figure 10. Primary soft tissue closure at time of coronectomy surgery.



by Solomon Poyourow, DDS, MD, MPH

## Marijuana and Anesthesia

A difficult anesthetic can put a damper on anyone's morning. Each of us has learned to identify the clues that predict a challenging anesthetic. Marijuana use has an unpredictable association with the flailing, combative sedation. Depending on the surgeon's mood, we may call in another staff person or two to control the patient's legs and arms and then try to finish the case as quickly as possible. However, I am reminded of my attending, Dr. Alan Felsenfeld, admonishing me with, "Elegance!" I figured he was saying this because whatever I was doing in that moment was the opposite of elegance. This is how I view these anesthetic rodeos. They lack elegance and are less than gratifying.

For most of us, there does not seem to be a magic bullet to manage these challenging cases. Options include: (1) a lighter level of sedation to enable a more cooperative patient, (2) trying adjunctive medications like phenergan or precdex, (3) bolus propofol for a brief period of calm or apnea followed by return of agitation, (4) bolus ketamine for pharmacologic restraint followed by a long recovery - perhaps accompanied by nausea and delirium, (5) deepening the anesthetic with propofol or propofol/remifentanil infusion, or (6) establishing an advanced airway with an LMA or ETT and running the patient on an inhalational agent. Each option has its pros and cons in light of our need for timeliness, patient safety, simplicity, cost effectiveness, path to a speedy recovery, and avoidance of post-operative nausea. What is certain is as we are pushed out of our comfort zones with these patients, the need for referral arises.

I read an interesting case report from Germany that demonstrated the ability of marijuana to increase tolerance to anesthetic drugs. A 37-year old, 93kg man is scheduled for



orthopedic surgery. He is a regular cannabis user, reporting consumption of 1g per week. In the operating room he receives 200mcg of fentanyl. He then receives 200mg of propofol and remains conscious, talking with the O.R. staff. He receives two boluses of 100mg propofol with no observed clinical effect. IV placement is confirmed. Loss of consciousness is finally achieved with 500mg thiopental, but the patient is still uncooperative to facemask ventilation. 4% Forane® is introduced. Ventilation improves but tidal volumes are limited to 200mL with high peak inspiratory pressures. 200mg of propofol is again given and he is paralyzed with succinylcholine. Tidal volumes improve to 650mL. Sufficient anesthetic depth is reached with the addition of nitrous oxide to sevoflurane.<sup>1</sup> This is an extreme example, but would almost certainly push any of us out of our comfort zone for in-office anesthesia and necessitate an alternative plan.

One mechanistic theory proposed by the authors of this report is that the cannabinoid (CB-1) receptor interacts with the GABA-A receptor, decreasing the efficacy of GABA transmission and reducing neurologic inhibition. GABA-A is the target of propofol, pentothal, benzodiazepines, and volatile anesthetics. There is evidence to support this theory. The CB-1 receptor is a G protein coupled receptor which has been observed to form a complex with GABA-A receptors resulting in decreased transmission of GABA.<sup>2</sup> The case report authors further theorize the addition of nitrous oxide improved anesthetic depth because N<sub>2</sub>O targets the NMDA receptor instead of GABA-A.

If only things were that simple. Another case report<sup>3</sup> describes the difficult-to-anesthetize marijuana user undergoing third molar extraction under intubated general anesthesia. The patient is induced, paralyzed, and intubated but is “difficult to settle” even with high concentrations of volatile anesthetic. The addition of nitrous oxide is ineffective at increasing anesthetic depth, and results in a significant drop in oxygen saturation. The patient is managed by quickly finishing the



surgery and giving additional midazolam and three 50mg boluses of propofol.

I think what I’m trying to convey, and what is already understood by all of you, is that neuropharmacology is complex. I can certainly remember the patient who presented for surgery with a profound odor of marijuana and ends up being the most pleasant, well-behaved anesthetic case you could ask for. Also interesting is the female teenager with extreme pre-operative anxiety who has no history of drug use, but ends up exhausting my staff and me. I am no longer surprised by these patients and lump them in with the marijuana users when it comes time to anticipate a difficult anesthetic.

Perhaps one small bit of comfort is that we are all in the same boat, unless someone does have that magic bullet. In which case, please submit a reply – we would all love to know! However, I doubt that magic bullet exists because there is so much patient variability. As we have just seen, one anesthesiologist attributed his success to nitrous oxide, while another found it counterproductive.

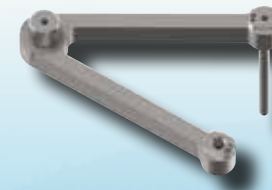
I have had increased success by talking to other OMSs and anesthesiologists about how they care for these patients. Thank you to those who have been gracious and free with your knowledge. I have found personally that increasing narcotic dose can be very effective as well as titrating a baseline propofol infusion. I have found very little benefit from increasing the dose of midazolam.

As I mentioned at the beginning, difficult cases can test us and push us to the edge of our comfort zone. Unfortunately, anesthesia carries such consequences that it is difficult to accept being thrust out of that zone. I think that by mentoring and learning from one another we will increase our common knowledge base and create new standards of management.

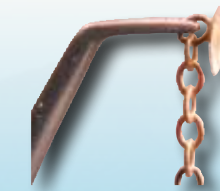
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2. Liu F, Wan Q, Pristupa ZB, et al. Direct protein-protein coupling enables cross-talk between dopamine D5 and gamma-aminobutyric acid A receptors. *Nature*. 2000;403(6767):274-80.
3. Symons IE. Cannabis smoking and anaesthesia. *Anaesthesia*. 2002;57(11):1142-3.

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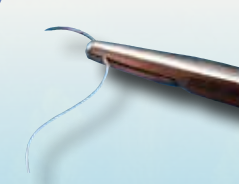
**Para-Drill Aid 2**  
New and improved intuitive implant paralleling device



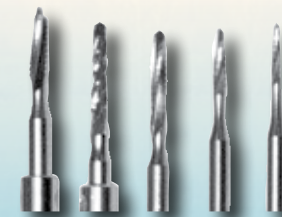
**Cusp-Lok Cuspid Traction System**  
A surgically placed orthodontic appliance, the Cusp-Lok offers variety, quality, and range of treatment for impacted cuspids



**C-Sponge Pharyngeal Barrier**  
Highly absorbent alternative to gauze throat pack



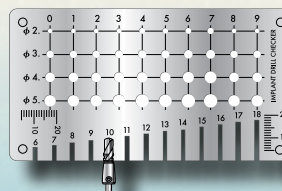
**PTFE Suture**  
A non-absorbable, monofilament suture that produces a minimal pore size while maintaining integrity and tensile strength



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## LEGISLATIVE UPDATE



by Gary Cooper  
Legislative Advocate, CALAOMS

### Spring 2018 Update

January 2018 was the beginning of the second year of the 2017-18 legislative session. It also was the start of the 2018 election year season, which usually is the rationale for higher profile proposed legislation. 2018 is no exception to that phenomenon.

As of this writing, the pediatric dental anesthesia issue remains active. However, any legislative resolution to the matter that was brought to light by the tragic death of young Caleb Sears in 2015 remains in a state of flux. The three pieces of legislation addressing pediatric dental anesthesia safety (AB 224 Thurmond; SB 501 Glazer; and SB 392 Bates) are currently housed in various policy and fiscal committees awaiting some consensus from the involved stakeholders. While CALAOMS, as a major stakeholder, continues to put forth strong safety proposals on the issue, the fact that no legislation that would impede access to dental care to the most vulnerable pediatric patients has been successful and should be considered a positive result. The legislative session remains young and CALAOMS remains vigilant.

In an effort to introduce affordable healthcare legislation in a contentious election year, organized labor is sponsoring AB 3087 (Kalra). This measure would create and authorize a state mandated commission to set prices and rates for health procedures provided by hospitals and most healthcare providers. It is not surprising that there are strong feelings on both sides of this bill. Supporters contend that

government-provided price setting would lower costs and offer greater access to healthcare. Opponents fervently argue that noncompetitive price regulation would seriously disrupt the healthcare system. Most healthcare providers and insurers, including the California Medical Association, California Dental Association, California Hospital Association, and the California Health Plans are actively opposing AB 3087. While CALAOMS certainly advocates for affordable and accessible healthcare, the association has joined with the associations representing providers in OPPOSING AB 3087. CALAOMS agrees that neither the healthcare marketplace nor patients will be better served by a commission setting arbitrary rates. This bill will be heard in the Assembly Health Committee on Tuesday, April 24.

California Dental Association has sponsored AB 2643 (Irwin) that would remove statutory language that limits medical insurance plan coverage of general anesthesia for dental procedures on specific vulnerable populations to only those performed in a hospital or surgery center. This restriction in today's dental landscape puts many young vulnerable patients at risk of not receiving timely, accessible, and affordable care. CALAOMS is supporting AB 2643 when it is heard in Assembly Health Committee on Tuesday, April 24.

Unfortunately, there is no denying that there exists an opioid crisis in this country. This year the legislature is taking on the issue with a vengeance. There are multiple pieces of legislation that have been introduced on a bipartisan basis by members of both the Senate and Assembly. Some of these bills will move all the way through the legislative process. Many of them will either be morphed into other bills or dropped. At this time, CALAOMS is monitoring the myriad of bills and will start engaging in the discussion as the session continues. Since OMSs do prescribe opioids for post-operative surgical pain management, this issue will remain on our radar screen.



## P.R. UPDATE

### CALAOMS is On Social Media and You Should Be Too

By Perry Communications Group

In the last decade, the percentage of Americans with a social media profile has grown from 24 percent to 81 percent, and we've seen the increased use affect society. We've witnessed everything from individuals using the platform to organize protests, to companies using social media to market products, to a president using Twitter in his diplomacy efforts—and policymakers are catching on to this dynamic.

Did you know that in California alone, 119 out of 120 legislators use social media? This shows the importance of these channels to gathering information and interacting with constituents—and if we don't utilize this avenue in our communications efforts, we are missing out on an opportunity. Where meeting with a member of Congress in-person can be a daunting task, we can share information and educate our audiences instantly with a simple click of a button.

Organizations like CALAOMS are committed to furthering the oral and maxillofacial surgery profession and the safety of patients through legislation, making interaction with California's legislators vital. California's oral surgeons can expand their influence by taking advantage of these un-tapped resources and utilizing simple social media techniques to educate our state's highest influencers on issues surrounding oral and maxillofacial surgery.

In a profession relying heavily on word-of-mouth and referrals, social media also creates a great way to interact with other members of the dental industry, increase engagement, and grow your practice.

So how do you get started with integrating social media into your practice? Here are some tips for your social media use and how to best engage with California's legislators:

- **Keep your content short.** Social media users are often scrolling through content on mobile devices, so the shorter and more straightforward the content, the better. Adding a photo or video to the mix will also help grab attention.

- **Schedule posts.** Scheduling your posts through Facebook or a social media aggregator like Hootsuite will allow you to target your audiences at peak times. For legislators, this is often sometime during the workday, but for oral surgeons this could be in the evenings when doctors have a break from seeing patients.

- **Tag individuals and organizations you want to reach.** With legislators especially, you want to reach out to them directly. Tag senators and representatives in your posts by using the @ symbol and including their social media handle. This ensures each legislator at least receives your content. You can also mention individuals by using .@ before a social handle to simply include them in a post you want your entire audience to see.

- **Include hashtags in your posts.** Hashtags are a great way to join conversations and reach a wider audience. Include hashtags specific to your organization or cause in all of your posts. Think: #CAoralsurgeon.

- **Like, Share, Retweet.** Liking, sharing, and retweeting other users' content is an easy way to join conversations and engage with broader audiences. Consider liking and re-sharing content from your target legislators or fellow oral surgeons to increase your interaction.

- **Show the world the important work you do.** Social media is an important tool for interacting with legislators, but it's also a perfect way to get the word out about the work you do in your practice. Whether you're participating in a charity clinic, holding a fundraiser in your community, or simply celebrating a major milestone, social media is an excellent place to share the news with your audience. Social media channels are also useful for posting patient testimonials and other before-and-after content—with patient consent.

Putting these tips into practice, CALAOMS is working to improve its own social media presence. Like CALAOMS on Facebook or follow the group on Twitter here: @CALAOMS. CALAOMS can't wait to engage with you!





## MEANING IN ETHICS



### Complexity in Bioethics

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

Complexity (L-complexitas) is perhaps the most essential characteristic of our present day global networking interdependent society. The traditional scientific method, which is based on analysis, isolation, and the gathering of complete information about a phenomenon, falls short when dealing with such complex interdependencies. Belgian cyberneticist Francis Paul Heylighen proffers use of the emerging science of ‘complexity’ as an alternative methodology capable of tackling such problems.

In philosophical context, the science of complexity is based on a new way of thinking standing in contrast to Newtonian science which is primarily based on reductionism, determinism and objective knowledge. Newton believed his laws provided an inductive scientific methodology and constituted a paradigm shift from both Aristotelian syllogistic logic and the deductive tendencies of Descartes.

Philosopher and epistemologist Carlos Eduardo Maldonado argues for the ‘complexification’ of bioethics and widening the bioethics working spectrum from a limited anthropocentric view to a larger and deeper comprehension. I share his belief that we should consider the ongoing complexity in bioethics as an opportunity to enrich the ethical, political, social and philosophical ‘spectrum of life.’

Bioethics undoubtedly represents a complex intellectual multifaceted phenomenon. Although an established scholarly academic field, it still struggles to find a clear methodology and the coherence of an epistemological canon. Because it rests upon the contribution of different disciplines, bioethics

can be described as an ‘open system’ whose questions can never be settled on the basis of one perspective alone; interdisciplinary enterprises are, by definition, continuous efforts.

Yet the lack of a sense of finality in bioethics can hardly be understood as the result of only methodological instability. Such a position would implicitly entail the idea that ethical reflection operates with theoretical resources of a purely formal nature, whose meaning can be determined independently of contextual variables and historical presuppositions.

We can look at the complexity of American bioethics as the necessary result of the general cultural framework within which it operates. More specifically, paying attention to the fact that the difficulty in coming to conclusive convictions about complex ethical issues depend upon larger notions of a social and, ultimately, political nature. For example: whether to allocate public funding for research on stem cells; allowing experimentation on embryos obtained through cloning techniques; enacting provisions at a state level legalizing physician assisted suicide.

Such a framework can be called the ‘climate’ of American bioethics. Unlike other metaphors, the climate conveys a sense of a condition that molds and defines the nature of a place or even the personality of a people, as Kant noticed so clearly and wittingly in his ‘Anthropology.’ And yet it does so without a sense of necessity. Other traditional metaphors exist to convey the meaning of such a general framework. However, categories like the “ground” or the “foundation,” have fallen under intense scrutiny in contemporary philosophical debate, because they seem to convey a sense of ideological dogmatism.

Perhaps American bioethics can be better understood when seen within a larger conceptual web. The presupposition here is that we never think about the morality of our actions or about criteria for conduct in a vacuum. Terms that circulate within ordinary discourse such as “justice” and “freedom” are also within social and political thinking. This has practical implications for bioethics. No matter how strenuously bioethicists may hope to isolate their perspectives from wider civic imperatives, social and political theory frame and penetrate all bioethical considerations. Indeed, to reiterate the point made by political philosopher Jean-Jacques Rousseau, to separate politics from ethics is to fail to understand both.

In Western bioethics, the notion of solidarity has recently emerged as the category able to strike a balance between the alternatives of collectivism and individualism. Such a notion plays an important function in a variety of issues spanning from reproductive rights to fair distribution of health care resources to medical research and experimentation.

A bioethics inspired by the notion of solidarity calls for a genuinely pluralist normative system that recognizes and sustains a mode of thinking equally distant from excessive privatization, on the one hand, and overweening state control on the other. Solidarity thinking pleads for a notion of democracy that entails a vision of tolerance and understanding of the importance of cultural traditions, the realization that the essence of democracy is the freedom which belongs to citizens endowed with a conscience.

In the ethical voice of political theorist and philosopher Vaclav Havel: “We must trust the voice of our conscience more than that of all abstract speculations and not invent other responsibilities than the one to which the voice calls us. We must not be ashamed that we are capable of love, friendship, solidarity, sympathy and tolerance, but just the opposite: we must see these fundamental dimensions of our humanity free from

their ‘private’ exile and accept them as the only genuine starting point of meaningful human community.” This is the voice of an ethical polity. Were such voice to prevail, the way in which our ethical dilemmas are adjudicated, including those emerging from bioethics, would be rich and complex enough to enable us to see the public and civic consequences of our private choices, even as it would guard against intrusion into our intimate lives.

Ethical dilemmas are inescapably political and political questions are unavoidably ethical. Bioethical dilemmas can never be insulated from politics, nor should they be. But the way in which such complex matters are addressed will very much turn on the social and political framework to which the ethicist, the doctor, the patient, and the wider interested community are indebted.

## Legislative Day 2018

CALAOMS had a successful Legislative Day on March 7, 2018 in our discussions about patient safety and advocacy. Those attending were (from left to right): Dr. Jeff Elo, Dr. Milan Jugan, Dr. Ed Balasanian, Dr. Monty Wilson, Dr. Alan Kaye, Dr. Shama Currimbhoy, Mrs. Pamela Congdon, Dr. Larry Moore, Mr. Gary Cooper, Dr. James Jensvold, and Dr. Abhishek Mogre



Dr. Ed Balasanian, Assemblymember William (Bill) Brough, Dr. Shama Currimbhoy, Dr. Abhishek Mogre, and Dr. Milan Jugan tour the California State Assembly floor and discuss patient safety and opioid prescription safety.



Dr. Ed Balasanian, Dr. Shama Currimbhoy, Senator Patricia Bates, and Dr. Jeff Elo meet to discuss patient safety, public service, ethics, education, and advocacy.

## RISK MANAGEMENT



### Disaster Preparedness for Your Medical Practice

by Julie Brightwell, JD, RN  
The Doctors Company

**R**ecent fires, hurricanes, and floods nationwide have highlighted the importance of planning for disasters. Wildfires in California forced several physicians to quickly relocate their practices some permanently and to move scheduled procedures to different facilities. Hurricane and flood damage in Texas and Florida left practices without power for days or even weeks. Is your practice prepared for this type of situation?

A disaster can overwhelm a medical practice, with damage that can include shattered windows, flood debris, power outages, disrupted telephone systems, computer and system outages, unsafe drinking water, destroyed medical records, medication exposure to temperature and humidity extremes, contaminated instruments, and building structure failure.

Disaster preparedness requires a continuous cycle of planning, organizing, training, equipping, rehearsing, and evaluating. Physicians are critical participants in disaster preparedness, ensuring that patient care and critical services are not interrupted—especially for at-risk individuals who may have special medical needs.

#### Plan Ahead Now

Before the next disaster strikes, make sure your practice has a plan in place. A checklist, ordered by priority and customized to specific types of disasters, can provide the framework for a comprehensive plan. The checklist should include these elements:

- A full-circle call tree that outlines who contacts whom.
- Instructions for setting up instant messaging technology that enables staff to communicate without a wireless network or cellular data connection.
- Instructions for securing records of patients undergoing diagnostic testing and a list of outstanding diagnostic studies.
- Guidelines for maintaining Health Insurance Portability and Accountability Act (HIPAA) compliance. Although the HIPAA Privacy Rule is not suspended during a natural disaster or other emergency, the Secretary of Health and Human Services may waive certain provisions of the Privacy Rule.
- A Certificate of Insurance for your medical malpractice coverage, or instructions for contacting your agent or insurer directly to obtain proof of coverage. This document will be necessary if you are forced to temporarily relocate your practice or procedures.
- Verification that home health agencies caring for your patients have plans in place to provide adequate services in a disaster.
- Steps to follow upon returning from evacuation.

#### When Disaster Strikes

Planning today makes accomplishing the following tasks more feasible during a disaster:

##### Communication

- Contact staff immediately to determine realistic return-to-work time frames.
- Notify external vendors and business associates of your practice interruption and targeted resumption of operation.
- Implement staff briefings at the beginning and end of each day.
- Create temporary phone, fax, and answering services.
- Establish patient telephone triage.
- Implement temporary controls to ensure HIPAA compliance.

##### Computers and systems

- Contact computer service vendors to ensure integrity and recovery.

- Verify insurance coverage for repair or replacement costs and losses.
- Evaluate applicable warranties and consider an information technology restoration service contract.
- Inventory and document hardware and software.
- Document the type and extent of both lost electronic and paper data.
- Ensure data back-up and periodically test compliance.
- Reestablish filing systems and internal programs.

##### Medical records

- Determine the extent of damage to, or loss of, patient records and filing systems.
- Attempt to restore all damaged charts and document inventory findings.
- Notify the state medical board for specific guidance pertaining to lost or damaged records.
- Document all efforts to restore and protect existing records.
- Reconstruct lost charts at the next patient encounter.
- Contact your insurance carrier for restorative services and/or claim procedures.

- Reestablish a filing system and temporary storage if necessary.
- Obtain legal guidance for patient notification during recovery efforts.
- Contemporaneously date and initial all late entries and duplicate information in context of recovery efforts.

In addition, create an inventory of all equipment and medications that may have been exposed to water or extremes in temperature. Repair, replace, or discard damaged items appropriately.

Once your plan is in place, regularly reevaluate its steps and update all contact information. Practice and rehearse the plan's protocols. An effective disaster preparedness plan will help keep your practice focused on delivering care during an emergency.

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



# 2018 COACHELLA CLINIC BY THE NUMBERS



- 542 Dental X-Rays
- 540 Fillings
- 611 Extractions
- 29 Partial Dentures
- 1,523 Individuals Served
- 7,871 Procedures Completed
- \$668,672 in Critical Care Provided

Thank you again to all CALAOMS Members who participated in our 2018 Coachella Clinic at the Riverside County Fairgrounds from March 23 - 25. Because of your efforts, we were able to meet ALL our goals this year!



## California CareForce and CALAOMS Shine in Coachella Valley

California CareForce (CCF) held its free medical/dental/vision mobile clinic in Indio over the March 23-25, 2018 weekend where several of our fellow CALAOMS members and dental students joined with other medical, dental, and vision 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. CCF is so thankful to all of our volunteers and sponsors who work so hard to make these events so successful.

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 12,000 professional and general volunteers have provided health care services to over 28,500+ individuals, delivering \$11,500,000 worth of care.

CCF wishes to offer a big **Thank You** to the 940 volunteers who donated their time, energy, and talents in Indio. In just three days, CCF volunteers provided \$668,672 worth of care to 1,657 patients, all at no cost to the 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.

There is nothing to compare to the joy of a patient receiving care that they so desperately needed by could not afford. And, not to mention the first-time volunteer who said that the weekend was the best of her life.

*If you were not able to make it to this clinic, there are other ways to help make a difference. Until December 31, 2018, a generous foundation will match every dollar donated to California CareForce up to \$25,000. We just starting to acquire monies towards this goal. If you would like to help us reach this goal, please think about donating or sponsoring a dental chair at the September 21-23, 2018 clinic in Sacramento at Cal Expo. Registration for this clinic opens soon!*

*If you really believe in our mission of providing basic medical, dental, and vision care to those without access, now is the time to donate and make the biggest impact with your tax-deductible gift.*

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).

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!



Students and faculty from Western University of Health Sciences attended the California CareForce clinic in the Coachella Valley.



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# CALIFORNIA ASSOCIATION OF ORAL & MAXILLOFACIAL SURGEONS UPCOMING CE EVENTS

## 2018 Meetings

- **OMSA Summer** - Renaissance LAX Hotel July 28 – 29
- **OMSA Fall** - Walnut Creek Marriott September 15 – 16
- **ACLS & BLS** - Murrieta Springs Conference Center October 20
- **ACLS & BLS** - Solano Community College October 27
- **Medical Emergencies** - (Southern California) November 7

## 2019 Meetings

- **2019 January Meeting** - Palace Hotel, San Francisco January 19 – 20
- **19th Annual Meeting** - Island Hotel, Newport Beach May 4 – 5

## VENDOR SPOTLIGHT

*CALAOMS WISHES TO THANK THE VENDORS THAT GRACIOUSLY SPONSORED THE JANUARY 2018 ANESTHESIA SYMPOSIUM & SIMWARS™ LITE PROGRAM AT THE RITZ-CARLTON, RANCHO MIRAGE*

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**DIXON:** Thriving full scope group OMS practice seeks single/dual degree surgeon for associateship leading to potential opportunity to purchase practice. Current opening is 2 days per week with potential opportunity to expand. Ideal candidate must have strong communication skills and quality surgical training. Contact: Dr. Tyler Nelson DMD MD Email: nelsonimplants@gmail.com

**INLAND EMPIRE:** Immediate full-time oral maxillofacial surgeon wanted in Southern California's Inland Empire. We promote a workplace with a supportive and efficient staff, individual growth and personal achievement. The right individual should demonstrate creativity, interpersonal skill and have a team player attitude. We emphasize dentoalveolar surgery, dental implants and pathology but also practice orthognathic, TMJ and trauma surgery. Compensation includes competitive salary, incentive bonus system, health insurance stipend and relocation advancement. Interested applicants should call (909) 331-0227 or email MDudziak@inlandempireomfs.com.

**LOS ANGELES:** Opportunity for full-time associate / future partner to join highly productive modern Los Angeles area OMS practice. Desired candidate is board certified/ eligible with motivation and interpersonal skills to complement surgical abilities. Interested parties please contact Scott Price of Brady Price & Associates @ 925-935-0890 or email CV to scott@bradyprice.net. All inquires strictly confidential.

**PLACERVILLE (NORTHERN CALIFORNIA)** Premier full scope OMS practice, has partnership or associate, opportunity available. State of the art CBCT, EMR Practice Management software. This is an established practice with continued growth and a wide referral base. Routine office based practice that includes: dentoalveolar surgery, bone grafting, implants, IV general anes., orthognathic surgery, and All on four/five implant cases. Located at the base of the Sierra foothills. Please contact: jstraw@edoralsurgery.com 916-990-3644

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

**TUSTIN:** We offer an excellent opportunity for a board certified/eligible surgeon to join our well-established, well-respected, full scope modern Oral and Maxillofacial surgical practice. We are seeking a full time, energetic and motivated surgeon, who is personable and caring with excellent communication and interpersonal skills, who wants to practice a full-scope of oral and maxillofacial surgery. Our practice, established over 20 years ago, has a very wide referral base and is considered a cornerstone in the dental community. For more information about our office, please visit our website at drjeffreyleemddmd.com. If you would like to be part of an elite OMS practice, please contact Beth Bushling @ hr@drleoms.com.

**NORTHERN CALIFORNIA** Premier OMS practice for sale. Partnership leading to full ownership. Motivated and flexible. Seller will stay on to facilitate a smooth transition. This is a prominent OMS practice in one of Northern California's most desirable communities. Our long-established practice enjoys an excellent reputation and exclusive referrals from the majority of dental practitioners in our community, and the region. Collections \$1.75M, pre-tax income \$1.2M. Full scope oral surgery practice that includes all phases of dentoalveolar surgery, implants, orthognathic surgery, and pathology. CBCT imaging on site. State of the art care for full arch rehabilitation implant/prosthetic treatments. Seller intends to immediately reduce his work load sufficiently to allow the new associate adequate patient flow, and sufficient net earnings to afford the purchase, to fulfill lifestyle requirements and student loan obligations, while facilitating a handoff of the important community and professional goodwill. Opportunities abound for an active outdoor lifestyle including, hiking, cycling, boating, skiing, and more. Send inquiries with a letter of interest and a C.V. to: bizdocjay@mac.com.



## PRACTICES FOR SALE

**SAN FRANCISCO:** Longstanding OMFS practice available for sale with transition. Well-maintained 2,272 sq.ft. +/- office in distinguished medical/dental building. Collections average approx. \$500K/yr. based on 4 half-days per week. 3-year average net income of \$300K/yr. with unlimited potential for growth. Interested parties please contact Brady Price & Associates @ 925-935-0890 or email scott@bradyprice.net.

**LOS ANGELES:** Upscale Los Angeles area OMS practice available for sale with transition. Collections average \$700K/yr. on 3.5 days of services per week of services. +/- 1,700 sq.ft. office contains 2 Exam, 2 OPs, Interested parties please contact Brady Price & Associates @ 925-935-0890 or email scott@bradyprice.net

## WOULD LIKE TO BUY

**SOUTHERN CALIFORNIA:** I am currently out-of-state and would like to relocate to California. I am looking for an OMS practice for purchase with transition. Southern California preferred (Greater Los Angeles, Inland Empire or Greater San Diego) / mid-size city or suburban community. 1,500-2,000 sq. ft. 2-3 operatories. Please email me @ surgeryoms@gmail.com

## OMS SEEKING WORK

**LOOKING FOR PT WORK:** Retired OMS Seeking Part Time OMS Job Between San Francisco and Sacramento. Oral and maxillofacial surgeon with 40 years of experience in private practice seeing part time job. Grad of UOP and Highland Hospital. Reason, full time retirement is boring. Experience includes teaching at Highland Hospital. Contact John Kiesselbach at (530) 613-7833 or email jekiesselbach@gmail.com



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*Photo: Gregory D. Segraves, DDS and Heath H. Evans, DDS, oral and maxillofacial surgeons at Eastern Oklahoma Oral & Maxillofacial Surgery, Broken Arrow and Owasso, Oklahoma*

