THE CALIFORNIA
JOURNAL
OF ORAL & MAXILLOFACIAL SURGERY

VOLUME XXIII
ISSUE I
SPRING 2021

www.calaoms.org

A PUBLICATION OF THE CALIFORNIA ASSOCIATION OF ORAL & MAXILLOFACIAL SURGEONS

CALAOMS Advocacy Initiative Involves Educating Lawmakers About Patient Safety

by Jeffrey A. Elo, DDS, MS, FACS

3-Person OMS Anesthesia Team Delivery Model with surgeon in command, a dedicated anesthesia monitor, and a surgical assistant performing a deep sedation.

When legislative efforts are in full swing, the CALAOMS board often receives requests for how members can help offer support. The best way to do so is to help educate legislators and their staff. Reaching out to your local state Assembly member and local state Senator to educate them on who oral and maxillofacial surgeons are, what we do, our safe practices in anesthesia delivery, etc. is extremely valuable. Education can help lead to action. Unless these lawmakers or their family members have been patients in our offices, many don't know what we do and are hearing about us for the first time when we are promoting legislation.

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THE CALIFORNIA JOURNAL OF
ORAL & MAXILLOFACIAL SURGERY
A PUBLICATION OF THE CALIFORNIA ASSOCIATION OF ORAL & MAXILLOFACIAL SURGEONS

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in this issue:

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

EDITORIAL

by Jeffrey A. Elo, DDS, MS, FACS

12 years, 11 months, 30 days + one day

The issue of anesthesia administration in a dental office is once again in front of us. As one who's been working behind the scenes for the past several years on anesthesia safety legislation, I am intimately aware of the players (medical and dental specialty organizations) involved, where each of them stand on issues, who in the dental profession – specifically, in this state – is serious about improving patient safety, and who is interested in simply being heard as promoting patient safety instead of actually taking substantive action to do so. As oral and maxillofacial surgeons, it's in our nature to act swiftly and definitively in the right direction; we have no other choice – the stakes are high in our practices.

CALAOMS's sponsored adult anesthesia legislation, SB 652 (Bates), is the vehicle currently in the Senate Appropriations Committee being discussed. The aim of this bill is to put in statute those items that serious providers – i.e., CALAOMS leadership and our members – know enhance patient safety. These items include a three-person team for deep sedation/general anesthesia, with the surgeon in command, a dedicated monitor trained to assist in the anesthesia, and a dedicated surgical assistant. This has been and is the current standard of care for AAOMS and CALAOMS members. The CALAOMS board recognized that this practice model needed to be written into statute and made mandatory by law to align the law to the current standards to ensure it's being implemented uniformly.

Just as SB 501 (pediatric [under 13 years old] anesthesia bill sponsored by CALAOMS and signed into law in 2018 and set to be implemented in 2022) put in place anesthesia team guidelines and training requirements – 3-person team with anesthesia permit holder in command, a dedicated anesthesia monitor (both the permit holder and dedicated anesthesia monitor will require PALS or equivalent life support training), and a dedicated procedural assistant – so, too, does SB 652, but for patients 13 and older.

Currently, the law does not call for the use of capnography for moderate and deep sedation for patients 13 years and older (starting in 2022, capnography will be required for patients 12 and under in accordance with SB 501). Neither does the law call for a 3-person team with a dedicated anesthesia monitor. Once SB 501 is implemented and if SB 652 is not passed (which is always possible), it seems silly to think that for a child who's 12 years, 11 months, and 30 days old there will be one standard for moderate and deep sedation/general anesthesia delivery in a dental office: a 3-person team, capnography, and PALS/advanced life support training for the anesthesia provider and at least one additional staff person. But just one day later when that child turns 13 years old, the current law will otherwise allow quite a different set-up: no required capnography, no requirement for staff to have enhanced life support training (ACLS), and only one person in the office to have anesthesia training, plus a 2-person team is sufficient (law does not require 3 currently).

SB 652's goal is to complete the process and establish one standard for deep sedation/general anesthesia delivery in dental offices for patients of all ages: a 3-person team consisting of surgeon in command, a dedicated anesthesia monitor, and a surgical assistant; with the anesthesia provider and the dedicated anesthesia monitor both having advanced life support training (PALS or equivalent for under 13; ACLS for 13 and over).

Literally, one day in a child's life can make quite a difference!

Recently, the CALAOMS Legislative Task Force put together a short PowerPoint presentation for our Legislative Advocate, Mr. Gary Cooper, and CALAOMS members to use to help educate lawmakers and their staff about the OMS Anesthesia Team Delivery Model. The focus of this short article is to demonstrate what information is in this presentation so that the information and messaging coming from all CALAOMS members is consistent. We will be posting the PowerPoint presentation to the CALAOMS website so that members can access it if they choose.

The Oral and Maxillofacial Surgery (OMS) Anesthesia Team Delivery Model consists of a 3-person team for in-office deep sedation/general anesthesia, with the surgeon in command, a dedicated monitor trained to assist in the anesthesia, and a dedicated surgical assistant (Figure 1). This is the standard for anesthesia safety in dentistry.
(Anesthesia and Sedation in the Dental Office. NIH Consensus Statement. 1985 Apr 22-24;5:1-18. Available at: consensus.nih.gov/1985/1985AnesthesiaDental050html.htm); (https://www.aaoms.org/docs/govt_affairs/advocacy_white_papers/advocacy_office_based_anesthesia_whitepaper.pdf)

Figure 1. *3-person OMS Anesthesia Team Delivery Model.*

The 3-person Anesthesia Team is continuously in physical contact with the patient (Figure 2):

- Keeping open the patient's airway
- Directly observing and listening to the patient's breathing throughout the entire procedure
- Directly observing the vital signs monitor which is positioned just a few feet away

Figure 2. *All 3 members of the Anesthesia Team are in close physical contact with the patient.*

The Dental Sedation Assistant (DSA) was specifically created in 2010 to provide didactic education and hands-on training in office-based anesthesia – assisting in and recovery of patients from deep sedation/general anesthesia.

Successful completion of the DSA curriculum and the psychometrically validated examination results in a Dental Board of California (DBC)-issued permit (license) that requires renewal every 2 years and completion of 25 hours of DBC-approved continuing education every 2 years for renewal.

SB 652 seeks to enhance the training of anesthesia assistants (Figure 3) who assist in anesthesia delivery for adult patients by requiring Advanced Cardiac Life Support (ACLS) training.
(Business and Professions Code Division 2, Chapter 4, Article 7, Sections 1750.4-1750.5);
(Sodhi K, et al. Impact of advanced cardiac life support training program on the outcome of cardiopulmonary resuscitation in a tertiary care hospital. Indian J Crit Care Med. 2011;15(4):209-212.)

Figure 3. *Pre-tracheal stethoscope used by dedicated anesthesia assistant to listen to patient breathing while also directly observing patient breathing.*

Oral and Maxillofacial Surgeons (OMSs) have been providing safe anesthesia to their patients using the Anesthesia Team Delivery Model which has allowed access to care for patients that have significant dental anxiety.

The hallmarks of the Anesthesia Team Delivery Model include communication, checks and balances, monitoring, team dynamics, protocols, emergency scenario preparation and rehearsal, and crisis resource management during an emergent situation.

This system contributes to and continually supports a culture of safety for in-office deep sedation in dentistry.

OMSs strive to maintain the excellent safety record of the Anesthesia Team Delivery Model by creating simulation programs in anesthesia, regularly updating the office anesthesia evaluation program, convening anesthesia safety conferences, and strengthening standards in training programs. OMSs are committed to the safe and effective delivery of in-office sedation and anesthesia (Figures 4-6).
(Fain DW, et al. The Oral and Maxillofacial Surgery Anesthesia Team Model. J Oral Maxillofac Surg. 2017;75(6):1097-1100.);
(Drew SJ. Oral and Maxillofacial Surgery Team Anesthesia Model and Anesthesia Assistant Training. Oral Maxillofac Surg Clin North Am. 2018;30(2):145-153.)

Figure 4. *Trained anesthesia assistant continuously holding the airway open, listening to and observing the patient breathing, and watching the vital signs monitor.*

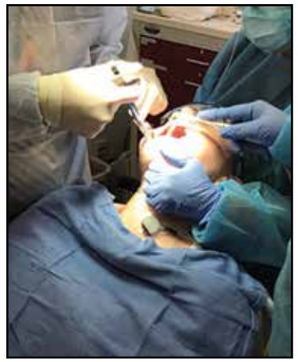


Figure 5*. Pre-tracheal stethoscope used to listen to the patient breathing in real time.*

Figure 6. *Trained anesthesia assistant continuously holding the airway open, listening to and observing the patient breathing, and watching the vital signs monitor.*

The key to reducing procedural sedation risk is detailed and thorough monitoring of the patient during the procedure. Electrocardiogram (EKG heart rate and rhythm monitor), respiratory rate, blood pressure, and pulse oximetry are commonly monitored; but these do not reliably identify airway and ventilation compromise.

Capnography (Figures 7a-7d) measures exhaled carbon dioxide in real-time and provides early identification of airway obstruction and hypoventilation during procedural sedation.

Implementation of this technology provides an additional layer of safety, reducing risk of respiratory compromise in patients receiving procedural sedation.
(Waugh JB, et al. Capnography enhances surveillance of respiratory events during procedural sedation: a meta-analysis. J Clin Anesth. 2011;23(3):189-196.);
(Krauss B, Hess DR. Capnography for procedural sedation and analgesia in the emergency department. Ann Emerg Med. 2007;50(2):172-181.);
(Gallagher JJ. Capnography monitoring during procedural sedation and analgesia. AACN Adv Crit Care. 2018;29(4):405-414.)

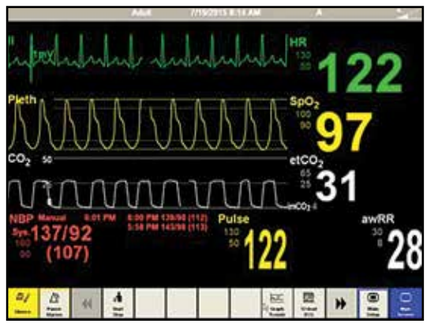


Figure 7a*. Patient breathing rapidly (tachypnea)*

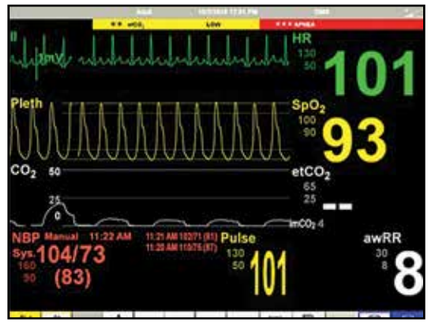


Figure 7b*. Airway obstruction/laryngospasm*

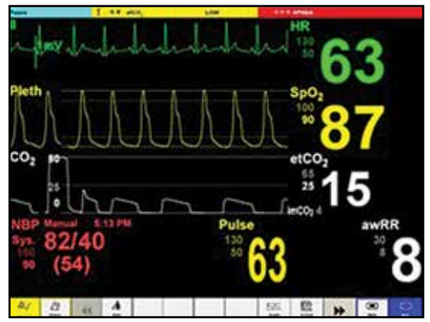


Figure 7c*. Respiratory depression*

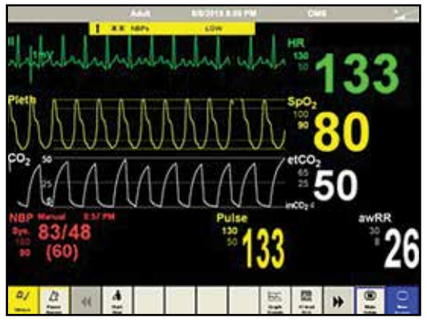


Figure 7d. *Bronchospasm*

OMS FOUNDATION

First Quarter 2021 Member Update

The OMS Foundation extends its sincere thanks to EVERY donor who contributed to the Annual Fund or GIVE in 2020. Your generosity was a lifeline during this complicated year.

Special thanks to Treloar & Heisel for launching the OMSFIRE (OMS for Innovation, Research and Education) campaign with a $100,000 Platinum commitment in January 2020 and to OMS Partners, LLC (Gold) and U.S. Oral Surgery Management (Silver) for their lead OMSFIRE Corporate gifts in 2021. More than 60 Charter OMSFIRE donors collectively committed to $250,000/year to support the Annual Fund through 2024. Many thanks to OMSFIRE Society donors Colorado (Gold), Delaware Valley, Pennsylvania and Ohio (Silver) and Rhode Island (Bronze) for their 5-year commitments. The steadfast support of the Foundation's OMSFIRE and other recurring donors was deeply appreciated in a year in which overall fundraising dropped by 30%.

Included in the Foundation's 2021 research and education funding are two Student Research Training Awards, offering opportunities for promising dental students at Loma Linda University and the University of Alabama at Birmingham to explore careers in research and the OMS profession. The Foundation has invested more than $650,000 in the SRTA program since 1992; its return on that investment is a steady influx of top talent into the specialty. Read more about the University of Pennsylvania's successful SRTA program here, and contact Mary DiCarlo at mdicarlo@omsfoundation.org to share your SRTA story.

Did circumstances compel you to postpone your annual giving in 2020? If you're able, please help us recover from last year's shortfall with a gift in the first quarter. **For the Foundation to continue to serve the specialty effectively, every OMS must treat investment in research and education as a cost of doing business**. A recurring gift of just $209/month contributes $2,500 annually to support the Foundation's work and qualifies you for recognition as a Bronze OMSFIRE donor. Enroll before Feb. 28 for recognition in the Foundation's inaugural issue of *Torchlight*, its e-newsletter debuting in March 2021. Thank you!

PRESIDENT'S MESSAGE

by Shama Currimbhoy, DDS, MS
CALAOMS President

Dear Members,

As 2021 began, many hoped it would bring with it a new outlook on our lives as we reflected on the past year of a historic global pandemic. For many, I think it has. It's taken a little time, but with perseverance there is light at the end of the tunnel. Hospitalizations are decreasing, vaccinations are increasing, and we are slowly working our way back to the somewhat normal. Along with that, the board is back to focusing on the issues that were present before the pandemic outbreak and subsequent shutdown; specifically, the same issues that never went away surrounding our profession.

CALAOMS continues to advocate for the specialty and for our patients. We constantly promote education and advanced training to our members; and have always sought opportunities to further increase patient safety. Sometimes this means getting involved with educating legislators and even promoting statutory and regulatory changes. It's not always easy – in fact, it's actually never easy – but it is the correct thing to do for our patients and our team members; so, the results are worth the struggle.

We are renewing our efforts to promote enhanced training for our anesthesia assistants. As a critical member of the OMS Anesthesia Team Model, our anesthesia assistants' didactic and clinical education can be further improved. Doing so only enhances their professionalism and improves the anesthesia team. Finally, CALAOMS desires to continue the great work of giving back to our communities through our charitable arm, California CareForce. It's easy for all of us to do so, but we should never overlook the great work that California CareForce has done and continues to do. Please look for opportunities to volunteer and give back to your communities. Please visit CaliforniaCareForce.org for more information and to sign up to volunteer at an upcoming clinic in your area. You will not regret this opportunity to serve others. I would like to take the opportunity to thank Dr. Chan Park, CALAOMS's President in 2020. Though we were unable to meet in-person for our May 2020 Annual Meeting and had to conduct all of our business over Zoom, Dr. Park worked tirelessly to provide leadership on a wide variety of unexpected topics, such as obtaining PPE – no easy task since, as you might remember, it was scarce to come by and pricing became ridiculously expensive; new safety protocols for seeing and treating emergency dental patients when so much uncertainty loomed; and providing resources to our members in a rapidly-changing environment where each county had a different set of rules to play by. We all can thank him for his contributions and dedication to our association and profession.

This year, we have hit the ground running. Several committees and task forces have been at it since the beginning. For several months, CALAOMS' Delta Dental Task Force has been working with our Legislative Advocate, Mr. Gary Cooper, on this important issue. The Task Force sought to collaborate with leaders from the California Society of Periodontists and the California State Association of Endodontists to hold discussions with senior management members of Delta Dental of California regarding proposed fee reductions that were scheduled to become effective July 1, 2021. Thanks to their great work and professionalism – manifested concretely through numerous calls, Zoom meetings, conference calls, emails, advocacy, and letter-writing, Delta Dental recently announced they will not be moving forward with implementing the proposed fee reductions and have put these on hold indefinitely. CALAOMS will continue to monitor for any new developments. We also plan on keeping lines of communication open with Delta Dental. We especially want to thank Mr. Cooper for his incredible work in gathering all parties together and facilitating discussions with Delta Dental.

The CALAOMS Legislative Task Force has (re)introduced legislation that was withdrawn in 2020 due to the pandemic. Senate Bill (**SB) 652 (Bates)** proactively promotes the anesthesia team model that contains the same safety measures we successfully advocated for in SB 501 (*pediatric anesthesia safety bill passed in 2018*) to also apply to patients 13 years and older.

As oral and maxillofacial surgeons, our primary concern is always anesthesia safety for patients of all ages. The greatest privilege we are afforded as OMSs is the ability to administer in-office sedation to our patients. This privilege is not taken lightly; and we constantly strive to make it safer through various efforts, including simulation training, didactic and clinical training, and enhanced staff anesthesia/advanced life support training, among others. The OMS Anesthesia Team Delivery Model, consisting of a three-person team for deep sedation/general anesthesia (DS/GA), with the surgeon in command, a dedicated monitor trained to assist in the anesthesia, and a dedicated surgical assistant, is the standard for DS/GA anesthesia safety in dentistry. While it is the current standard of care for AAOMS and CALAOMS members to provide deep sedation/general anesthesia utilizing a three-person anesthesia team, the CALAOMS board recognized that this practice model needed to be written into statute and made mandatory by law to align the law to the current standards.

Some have questioned why we are promoting this legislation now when they perceive that the political landscape might be fairly quiet at this time. That's very simple. CALAOMS does not just react to politics; the current political climate should not preclude the profession from doing the right thing for patients of all ages. We will be asking for CALAOMS members to get involved with a letter-writing campaign soon. Some of you may even be asked to offer testimony at legislative hearings; currently these are being held over Zoom. We hope you will enthusiastically support this effort.

In 2020, CALAOMS successfully launched - for the first time ever - the online OMSA (OMS Anesthesia Assistant) course. Now that the OMSA course is completely online, the CALAOMS board is promoting and encouraging all OMSs and their OMS anesthesia assistants to renew their OMSA training every *two* years instead of every five years. This past September (2020), the AAOMS House of Delegates voted to pass a similar requirement as a condition for membership – this proposal still requires one year for policy and language review before returning to the House in 2021 for final vote. So, just as we have always done in California, we are once again taking the lead on this very important anesthesia-related item designed to enhance the training and readiness of our anesthesia team members. We believe the 5-year interval between recertification of the anesthesia assistants is too long for meaningful retention of skills needed. OMSA recertification every 2 years coincides with the renewal of all other state healthcare licenses and permits on a two-year cycle. Bringing OMSA training and recertification into line with professional licensing norms enhances the professionalism of the OMSA program.

In accordance with SB 501, California Law will require, beginning in 2022, that OMSAs who assist in Moderate Sedation and Deep Sedation/General Anesthesia (DS/GA) on children under 13 years of age must be currently certified in PALS (or a Dental Board-approved course of equal or superior quality). With our proposed legislation, SB 652, the board also desires to enhance the training of OMSAs who assist in anesthesia delivery for patients 13 and older by requiring ACLS certification. If passed, SB 652 will not take effect until 2023.

It is critically important for every OMS in California to understand that the training we provide to our anesthesia assistants is really the point of attack being used by our competitors to demean our team model for the delivery of office-based anesthesia. The majority of CALAOMS members provide anesthesia training to their assistants through CALAOMS' OMSA program. Alternatively, members may provide Dental Anesthesia Assistants National Certifying Examination (DAANCE) training through AAOMS. Unfortunately, these programs are not recognized by the Dental Board of California as a license or permit that would legally empower our assistants to monitor patients during, or recover patients from, deep sedation/general anesthesia.

Fortunately, there is a program in California Statute (Law) that **is** recognized by the Dental Board of California: the Dental Sedation Assistant (DSA). The DSA was specifically created to provide both didactic education and hands-on training in OMS office-based anesthesia assisting in, and recovery of patients from, deep sedation/general anesthesia. Successful completion of the DSA curriculum and the psychometrically validated examination results in a state-issued permit. This permit is exactly analogous to your general anesthesia permit. The DSA permit requires renewal every 2 years and requires the completion of 25 hours of DBC-approved continuing education every 2 years for renewal.

The CALAOMS board has been urging our members to offer DSA training to their assistants. The first step is to fill out the document "*Dental Sedation Assistant Course, Application for Approval by the Dental Board of California*." This process empowers you to train your assistants to become DSAs and be permitted (licensed) providers of monitoring and recovery assisting services in California. CALAOMS stands ready to assist you in this important endeavor. Contact CALAOMS Executive Director Pamela Congdon at (800) 500-1332 and ask for the DSA Application materials.

I want to thank you all for your commitment to our profession. Practicing ethically and safely, at the highest level of care, and treating patients with respect is what we stand for. Our mission statement will always ring clear.

Sincerely,

Shama Currimbhoy, DDS, MS
President, CALAOMS

AAOMS DISTRICT VI TRUSTEE REPORT

by Mark Egbert, DDS, FACS
AAOMS District VI Trustee

Greetings from the District VI Trustee

"Thank you" to CALAOMS – and to all of District VI – for the support and confidence shown me as your AAOMS Trustee. Now running for AAOMS Vice President, more than ever, I am grateful.

Two recent AAOMS events stand out and are mentioned here.

First: Those who have read the most recent President's message will know that we have a new AAOMS Executive Director beginning June 1. After conducting a national search, interviewing many candidates on virtual platforms and then conducting in-person interviews with the selected finalists, the Executive Director Search Committee unanimously approved the selection of Karin Wittich, CAE, as the new Executive Director of AAOMS.

Ms. Wittich has served as AAOMS Associate Executive Director of Practice Management and Governmental Affairs since 2004. Her accomplishments and plans for advancing the Association impressed the Search Committee, which met with one other finalist at AAOMS headquarters last week.

Ms. Wittich replaces the retiring Mr. Scott Farrell, MBA, CPA. AAOMS thanks Mr. Farrell for his hard work and dedication the last five years as Executive Director after serving as Chief Financial Officer and Associate Executive Director of Business and Operations for 18 years.

Second: AAOMS officers, trustees, and senior management team recently met to revisit the AAOMS strategic plan. This review was one year past-due owing to meeting limitations imposed during the pandemic. The plan will now be fit into the AAOMS working documents and will be presented to the 2021 AAOMS house of delegates for approval and adoption. There are six major areas of focus included in the plan. Added together these provide the direction and framework for all AAOMS activities going forward in the next three years. The six important implementation domains are:

ADVOCACY - Advocate at federal and state levels; form strategic alliances.

COMMUNICATIONS - Promote the brand, mission, vision and values of AAOMS.

EDUCATION - Set standards of excellence in education and training for AAOMS fellows,

members and their staff as well as OMS residents.

PRACTICE - Advance and optimize the practice of AAOMS members.

RESEARCH - Catalyze advances in the specialty of OMS and promote scholarships.

FINANCIAL - Ensure the financial sustainability of AAOMS.

As always, I encourage you to read the AAOMS Member Alerts and President's Message, and to visit the AAOMS website frequently for new information as it comes available. Please do not hesitate to reach out with your suggestions, comments, or concerns.

Mark A. Egbert, DDS, FACD, FACS
AAOMS District VI Trustee

LEGISLATIVE UPDATE

by Gary Cooper
Legislative Advocate, CALAOMS

Spring 2021 Legislative Report

While the COVID-19 pandemic has drastically altered how business is conducted under the golden dome of the Capitol, those of us involved in conducting that business have learned to adapt. The first few months of the 2021-22 legislative session has been a very active period for CALAOMS on several fronts.

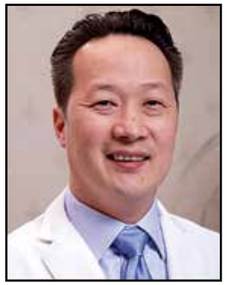
CALAOMS continues to emphasize and promote patient safety during in-office dental procedures requiring anesthesia. When the anesthesia issue was at its peak in 2016 and 2017 due to the very unfortunate death of Caleb Sears in a dental office, CALAOMS remained steadfast in the belief that the three-person anesthesia team method was extremely safe and should be the standard of care for patients of all ages. While it IS the current standard of care for AAOMS and CALAOMS members, the leadership of the association believes it should be written into statute and made mandatory by California state law. In 2018, SB 501 (Glazer) addressed the safety of anesthesia for pediatric patients but was silent on patients 13 years of age and above. In 2021, CALAOMS made the determination to close the loop on the general anesthesia/deep sedation safety issue by sponsoring SB 652 by Senator Patricia Bates.

SB 652 requires that if any age patient is undergoing a procedure requiring general anesthesia or deep sedation, the operating dentist and at least 2 additional personnel shall be present throughout the procedure. The dentist and at least one of the assisting personnel shall maintain current certification in Advanced Cardiac Life Support (ACLS). In addition, for all general anesthesia and deep sedation procedures, capnography technology continues to be mandated. While the legislative process will continue through September 2021, at this writing SB 652 (Bates) has passed its first hurdle, Senate Business and Professions Committee, by a vote of 12-0 on April 19, 2021. The bill now moves on to the Senate Appropriations Committee on Monday, May 3, 2021.

DELTA DENTAL

As most CALAOMS members are aware, Delta Dental had announced in early 2020 that it would be reducing provider rates to the three dental specialties: oral and maxillofacial surgeons, periodontists, and endodontists by July 1, 2020. Obviously, this news was not received well by the specialty providers. The rate reduction decision was especially difficult to accept during the pandemic that had already caused hardships to so many specialty practices. In March 2020, leaders from CALAOMS got actively involved in the process of mitigating the negative impact of Delta Dental's decision. CALAOMS established a Delta Dental Task Force and called together leaders of the periodontist and endodontist associations. Together, the three specialty association representatives met multiple times over a period of a year with the corporate leadership of Delta Dental. Very meaningful, substantive, and transparent discussions ensued. Fortunately, on April 5, 2021, Delta Dental announced an indefinite postponement of fee structure adjustments for California endodontists, periodontists, and oral and maxillofacial surgeons. Delta acknowledged that their decision was indeed based on the "impactful conversations" with the three specialty groups. While this decision is positive for now, these discussions should continue to ensure that these positive results are maintained.

During the remainder of the 2021 legislative session, other bills dealing with issues related to the dental profession will be discussed, debated, and acted upon. CALAOMS will be involved in many of them as the year progresses. CALAOMS believes it is important to make our voice heard when oral and maxillofacial surgeons are impacted. That will continue.



by David Y. Park, DDS, MD

Perception is Reality

Lee Atwater, a political consultant and strategist, once said that "perception is reality." We are living in a world that is controlled by perception every single day. Looking at the stock market with its ups and downs is a vivid reminder that perception has power. In contrast, as doctors and practice owners, we are constantly searching for reality or truth through very different means. We test it through research and experimentation - the crucibles that shape our reality. We are constantly in search of truth and reality in the natural world that help shape our perception. The political world and the scientific world are polar opposites of process; in one, reality helps guide perception, and in the other, perception helps shape reality.

As the OMS Anesthesia Team Delivery Model is challenged in the political realm, we must be mindful that although this model – as delivered by current standards of practice – has enjoyed a proven track record of safety for decades, we must continue to battle the perception that it is subpar; an idea promulgated by those who do not know even what we do. This reckless language threatens access for patients to receive safe, comfortable, and affordable care.

As doctors, we have an obligation to do everything within our power to ensure that we provide affordable, safe, and effective treatment to patients of all ages. Without any prompting from the Legislature or any other organization, CALAOMS established required, regular in-office anesthesia evaluations as well as anesthesia training for OMS anesthesia assistants. These are significant proactive efforts. Yet, for some outsiders, the perception still exists that our team delivery model is an inferior model. If we continue to assert that that perception is incorrect (and it is), we must then try to establish truth through different means. We must guide perception and help to establish truth because this discussion is being brought out in the realm of public perception, not in the realm of established science.

The primary attack against the anesthesia team delivery model has been aimed at the training and certification of our anesthesia assistants. To defend this model, we must also defend and enhance the training of our anesthesia assistants. We must strive to not only meet a safety standard but set a standard for training to guide perception.

One of the unforeseen positive outcomes of the COVID pandemic has been an expedited move to online education for our current OMSA training course. The efforts of the volunteer OMSs and CALAOMS staff (Steve, Teri, and Pam) have established an online training course that can be delivered more efficiently than an in-person course. Online education and training have also been much more widely accepted as an education vehicle as we all sheltered at home and socially distanced.

If we are to continue to defend the anesthesia team delivery model, we – as the experts in anesthesia in dentistry – must become more passionate about enhancing the education, professionalism, and training of our anesthesia assistants. We must set a standard of training that not only satisfies reality but also the perception of reality.

As CALAOMS and AAOMS continue to defend our privilege to provide anesthesia for patients of all ages, there will be recommended changes to enhance the training and professionalism of our anesthesia assistants.

On May 5, 2021, an online webinar hosted by CALAOMS will be presented to discuss and answer questions about the Dental Sedation Assistant (DSA) permit that is recommended for anesthesia assistants. The DSA is a Dental Board-issued license/permit that satisfies the requirement to have a "licensed health professional experienced in the care and resuscitation of patients recovering from moderate sedation, deep sedation, or general anesthesia." It is encouraged that all anesthesia assistants obtain the DSA permit in addition to PALS training if patients under 13 years old are being sedated in-office, and ACLS if sedating patients 13 and older.

Our specialty must move in united fashion in order for the defense of our anesthesia team model to succeed. We must all passionately stand together in defense of the safe, effective, and accessible anesthesia team delivery model; but also realize that we can continue to enhance the training and professionalism of our anesthesia team members.

RISK MANAGEMENT

Before COVID-19, Outlier Medical Malpractice Verdicts Were Rising What's Next?

by Richard E. Anderson, MD, FACP, Chairman and Chief Executive Officer, The Doctors Company,

Severity—the average cost of a medical malpractice claim—continues its relentless increase. Though severity has been rising since at least the 1970s, in recent years we have seen a sharp increase in outlier verdicts, which exceed common policy limits and often set records for their venues: From 2014 to 2018, the number of verdicts in excess of $25 million more than tripled.[1] Similarly, from 2010 to 2019, the average of the top 100 jury awards for medical malpractice cases rose by almost half.[2] This disturbing trend threatens the viability of smaller medical malpractice insurers, who may not have the resources to cover such large verdicts, and portends medical malpractice rate increases while adding to burgeoning healthcare costs.

Before the pandemic, nearly all states had seen these extraordinarily large awards, but whether the pace of these awards will be affected by the pandemic is unknown. Some U.S. states have adopted limited liability protections for physicians during COVID-19, but those protections may be tested in the courts. Alternately, because physicians may be seen as heroes, pandemic-related malpractice cases may be less likely to result in large plaintiffs' awards. Nevertheless, outsized awards to plaintiffs are part of an ongoing long-term trend.

Clinicians may well ask why severity is increasing at the same time the medical community has made important strides in patient safety and the overall frequency of claims has dropped. At The Doctors Company, we've seen a drop from a high of 17 claims per 100 physicians in 2000 to fewer than seven claims per 100 physicians today.

The consolidation of healthcare is one driver of high verdicts. Large corporate defendants, almost always with very high policy limits, make attractive deep pockets in the eyes of sympathetic juries.

Monetary desensitization is another important factor. Our national debt exceeds $22 trillion, our annual budget is over $4 trillion, companies with no profits have valuations in the billions, and top athletes commonly sign contracts worth hundreds of millions of dollars. Though paid indemnities in average malpractice claims average many hundreds of thousands of dollars, and typically cover 100 percent of economic losses, these numbers may appear less impressive in an era where nine- and 13-digit numbers are commonly used. A.M. Best, which rates insurance companies, has expressed concerns about the impact of monetary desensitization, also known as social inflation, on severity.[3]

Batch claims, lawsuits in which plaintiffs bring multiple claims against one defendant based on the same behavior, are another contributor. Examples include the claims brought against compounding pharmacies alleging that breaches in sterile technique affected many individual patients.

Social media is a potent facilitator of batch claims. A patient with an unexpected adverse outcome from a particular operation may post, "Dr. X botched my surgery." Others who believe they have had a similar experience respond, and an attorney gathers them all into a batch claim. Claims of this kind were distinctly unusual in the past, but are now an annual occurrence.

States lacking caps on noneconomic damages are particularly vulnerable to these factors. Without caps, awards for pain and suffering are unlimited and are almost always present in outlier cases.

The increase in severity adds to the costs of healthcare, which already account for 18 percent of our gross national product.[4] At The Doctors Company, we saw a 55 percent increase in severity—the cost of the average claim—from 2000 to 2018. This drives increases in insurance rates: The average payment for a closed medical malpractice case has been growing well beyond the pace of inflation since 2014—and this spike in claims losses necessarily drives the rate increases that insurers are implementing in 2020.[5] (Such increases are sometimes falsely attributed to COVID-19 which is too recent to have driven claims costs.) Ultimately, added costs are passed down to patients in their bills for healthcare.

The rise in severity negatively affects us all, but unless jurors' attitudes change, batch claims decrease, and caps on noneconomic damages are protected, outlier verdicts will continue to become more commonplace.

(Endnotes)

1 Burns B. MedPL market updates. Oral presentation at: PLUS Symposium Series, Healthcare and Medical PL; March 12, 2019; Chicago, IL.

2 Strategic Study Series Insurance Research. 2020: Medical professional liability insurance—years of plenty, years of famine. Hartford, CT: Conning;2019:22.

3 A.M. Best Company. U S medical professional liability market remains in flux. Best's Market Segment Report. Published April 29, 2020. Accessed December 8, 2020. http://news.ambest.com/newscontent.aspx?refnum=224903

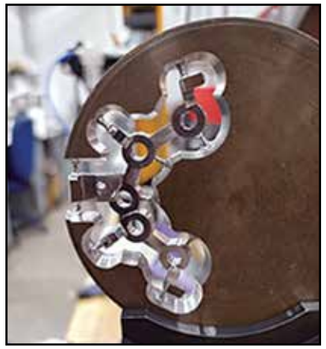
4 Centers for Medicare and Medicaid Services. National health expenditure data. Published December 11, 2018. Accessed November 23, 2020. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html.

5 Karls C. Paid indemnity severity, countrywide by closed year. In oral presentation: What is that light at the end of the tunnel? At: MPL Association CEO/COO Workshop; March 11-14, 2020; Scottsdale, AZ.

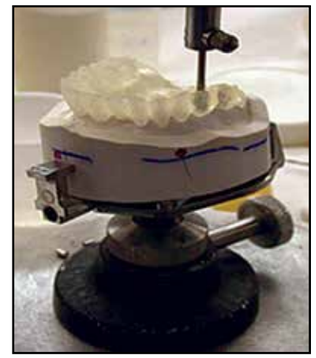
TECHNICAL ARTICLES

Dental implants' next frontier - milled titanium surgical guides and facially generated digital workflow

by Peter Krakowiak, DMD, FRCD(C)

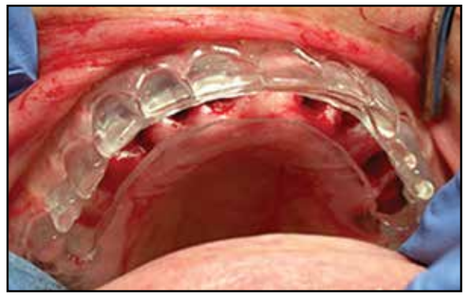


As with most clinical techniques, there is excitement and skepticism when they are initially introduced. There are trials and tribulations and always the inherent need for refinement and advancement of technology as time goes by. So has been the path for technology in the realm of all surgical guide applications and manufacturing. Surgical guides used in orthognathic, craniofacial, and oncological/reconstructive OMS have proven to improve our outcomes and substantially deliver cost and time savings. The era of full dental arch implant-supported reconstruction with immediately loaded restorations has certainly provided ample opportunity for the advancement of the design and use of surgical implant guides and milled restorations.

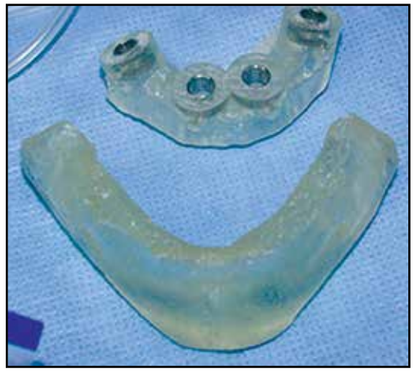


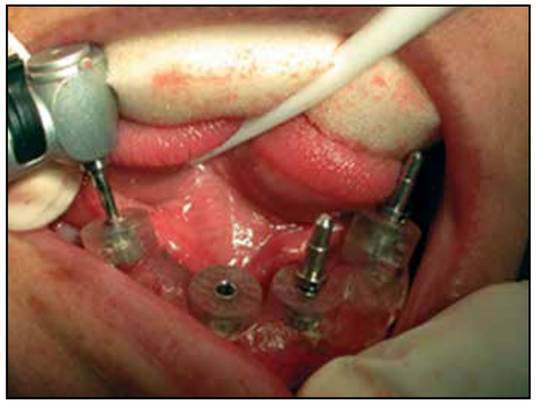
Without these guiding adjuncts, complicated cases often will fail; if not intraoperatively, then in the near future after prosthesis delivery. This is especially evident in cases with minimum bone stock, highly animated lip envelope, and a lack of vertical restorative space. The often-overlooked requirement of the full arch hybrid/overdenture reconstruction paradigm is the creation of additional restorative space for connections and maintenance of structural integrity of the restorative solutions. Canting and skeletal disharmony are often overlooked or ignored, as well, if not identified in planning. Fully digital based planning and workflow can address all these considerations.

Analog paradigm, used for many decades, still has merit and certainly has allowed us to deliver adequate results when properly applied. Wax up stone models and suck-down guides still work well in most cases. Often, however, the planning aspect of these analog cases is either unevenly weighted on the prosthetic/occlusal-driven track or, conversely, based on supporting bone availability with hopes that these two constructs would intersect optimally in the end. Hybrid of analog and digital workflows have attempted to improve the accuracy of planning with varied results. At each transition point, more imprecision was often introduced into the solution process as distorted analog data was mixed with often erroneous digital information subsets. Our initial attempts to deliver guided surgery were mostly based on wax-ups being converted into acrylic guides or duplicates of dentures serving as axial inclination boundary references and even sometimes reduction guides for alveolar ridges. It was certainly an attempt to improve the accuracy of fixture placement, but it certainly was far from being what is considered precise by our current standards.

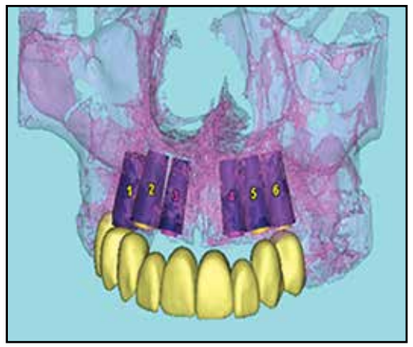


In the mid-2000s, software applications like Simplant® opened our doors to almost full digital planning and surgical guide fabrications. Often, we still needed stone models to be used in cases where teeth or soft tissues were to be used as support for the guides. These guides were printed in resins and allowed for either hard or soft tissue support to increase placement precision. They were bulky and hard to precisely seat in some cases. Desired prosthetic designs could be scanned into the 3D modeling software and used to plan final fixture positions based on the final tooth position. To increase the guide placement accuracy, pinning techniques were developed with varying degrees of orientation precision. Sometimes poorly seated guides created more issues if not recognized than analog or even free hand fixture placement.

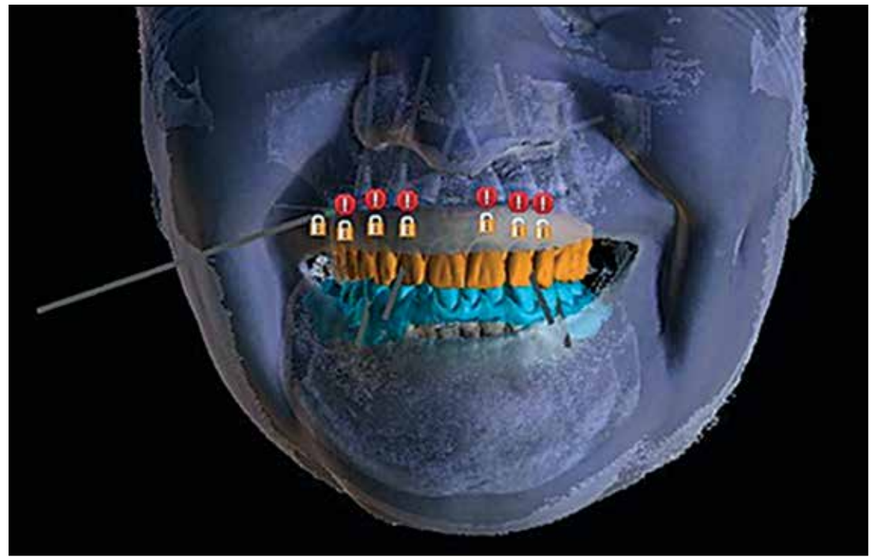




During the last decade, and greatly due to dental post-grad CE centers like Spear, Kois, and Pankey, facially generated treatment planning constructs and smile design concepts have fully come into the forefront of what contemporary dentistry aims to offer. Before this era, the aspect of extraoral or truly facially driven restorative design was not routinely considered. Until the recent introduction of extraoral facial digital analyzers and photogrammetry imaging, there was still a missing link in creating a fully digital surgical guide workflow.



We are now in the position to routinely integrate the virtual perioral animated facial skin drape records (STL-based), dental intraoral hard and soft tissue structure position relations (STL-based), and 3-D CBCT (DICOM-based) hard tissue anatomy into a powerful single format planning platform.



Fully digital workflow and surgical and prosthetic guidance is now available for those desiring to use this 100% digital and facially driven approach. Our experience with this emerging planning and treatment paradigm has been very positive, but it still requires good case selection and an accurate and refined level of planning and surgical expertise to predictably deliver this mode of implant care.

The surgical success aspect of these treatments is based on an application of a surgical guide that serves two main purposes. One is to precisely plan and allow for bone reduction, and the second is for implant position in the alveolar and/or basal bone housing. Additionally, the current stacking surgical guides allow for the seating of the transitional prosthesis in all vectors of space and so it may be captured optimally with chairside pick-up resins. With this control of platform position and depth, the transitional prosthesis occlusal plane location and opposing occlusal coupling can be ensured. This was always a challenge in the analog workflow based on tissue support of the palate or loose teeth to determine VDO and the A-P incisal position.

Our new bone-based implant guides are milled, not printed. The earlier versions of the implant guides were either soft tissue-supported or tooth-based guides where acrylic denture duplicates or later-printed acrylic guides were based off CT scans of the bone and a barium coated denture.

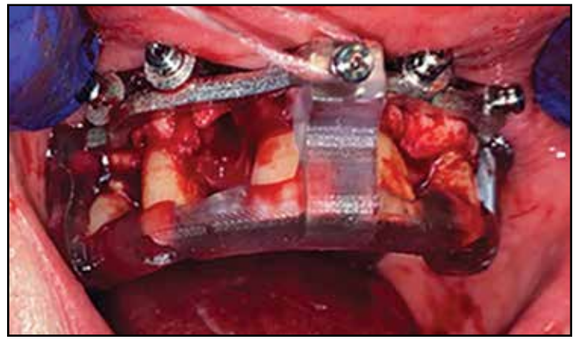
Currently, our surgical and restorative component designs are fully based on virtual final prosthesis design from data sets in facial topography scans, STL-based intraoral scans coupled with our CBCT data all-in-one planning software. This final all-encompassing design algorithm allows for CAD-CAM milling and printing of all related surgical guides, scan appliances (when needed),

seating jigs, reduction wafers, and actual prosthetics, both provisional and final.

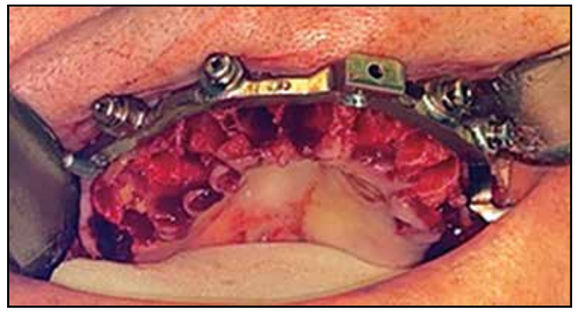
Typical records needed for our current fully digital workflow include extraoral tissue drape scan with facial analyzer(the-digitalface.dental) in repose and in full exaggerated animation. Second intraoral digital scans using Medit scanner are completed to develop the current baseline hard and soft tissue positions. If needed, current removable restorations can be scanned as separate segmentable components of the global data set and placed in their respective anatomical setting. In some cases, we can also print scan appliances based on the intraoral scans so that we can best orient the arches when patients are fully edentulous or without stable restorative reference points. The last, but not the least, layer of data comes from our high resolution CBCT scanner (Carestream 8100 mid volume).

All STL files and DICOM files are integrated and merged into a single planning file with the ability to filter and overlap tissue, implants, and prosthetic components in layers on one single platform by Blue Sky Bio software. The planning software allows for a CAD-CAM process that builds virtual models and develops the needed designs for fabrication of all components required to execute the prosthetic fabrication.

The maximum precision of placement and delivery of implants and transitional prosthesis which this workflow offers is based on a titanium milled pinable foundation base guide. The custom foundation base guide is oriented over basal alveolar bone using a printed seating jig referenced to existing dentition or hard tissue anatomy prior to being pinned by 4 bicortical pins. The dentition is then removed, and the foundation utilizes several swing locking overlays that can be interchangeably applied. The overlays include reduction verification components, implant drill guides, and indexed prosthetic seating wafers.



The foundation base guide is initially used as a reduction guide for any osseous recontouring. As it is pinned only to the facial bone, it does not require the same palatal flap reflection as the earlier and bulkier acrylic guides.



All implant placement is then delivered via either fully guided or partially guided approach. Fully guided approach controls for not only angulation but depth of fixture placement. Our newest C-shaped guide design has been helping to gain access to the tight posterior sites by allowing lateral tilting of implant drills into the osteotomy site.

As the milled guides are titanium, they are much thinner but stronger and less likely to be distorted. The guides are locked into the foundation guide at the back with swing lock design and in the front by a central locking pin. These features allow for great stability and rigidity of the guide but also for ease of placement and removal.

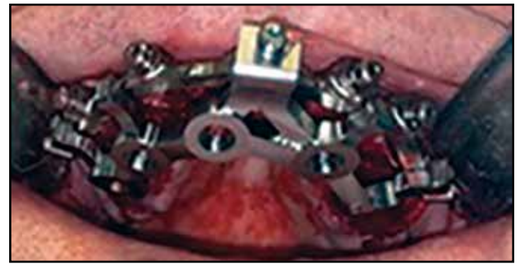
The foundation base plate guide also serves to seat an acrylic wafer that performs two functions. One is to ensure achievement of a flat plane of bone reduction and then the verification of the full seating of the transitional prosthesis. The wafer employs keyed projections that mate with internal receivers in the transitional prosthesis to achieve the planned 3-dimensional position. Once in this position, the attachment to the prosthetic support elements-based multiunit abutment can be ensured with pick-up resins.

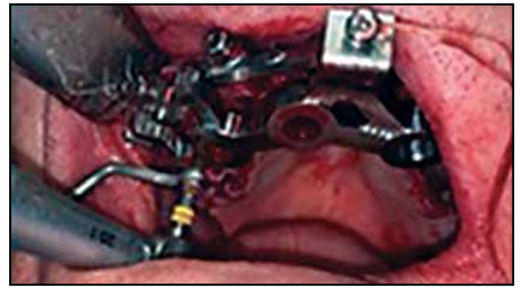
The application of this new workflow and milling technology has proven to be effective at increasing fixture placement accuracy and prosthetic positioning, all while reducing operative and conversion times. The need for occlusal adjustments is minimal and transitional prosthetics made with milled PMMA and nano-ceramics are much more compact and esthetic than traditional denture conversions.

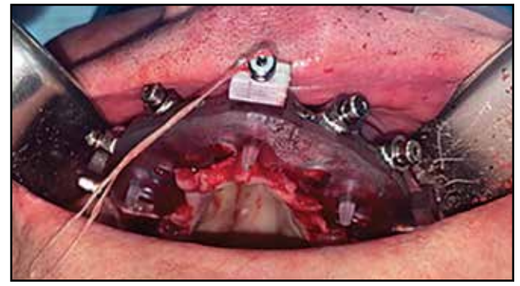
Our post implant placement CBCT analysis has showed that fixture placement is within 0.5 mm of the desired and planned position in most fully guided sites. That is certainly a huge improvement over the free hand or partially guided approaches.

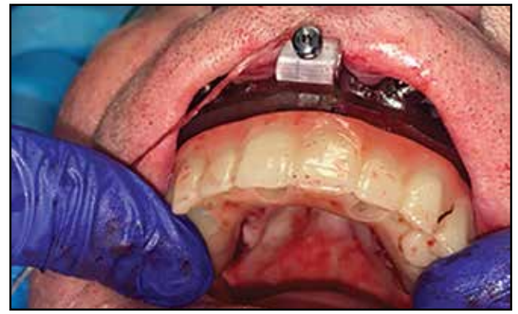
Final prosthesis is made in 4 months after fixture integration using intraoral scans utilizing custom milled scan bodies to ensure accuracy of the intraoral scan in the setting of full arch rehabilitation.

The digital workflow we are using has been developed and continuously perfected by our international digital laboratory team under expert leadership of Mr. Daniel Nowak. Daniel is an exceptional thinker and always encourages us to look for new avenues for achieving excellence and finding new solutions to clinical challenges. Our collaborative approach has been the foundation of our success and the treatment successes of our patients. This is the newest frontier for us but certainly not the last frontier.









by Solomon Poyourow, DDS, MD, MPH

Second Molar Impactions

As I look back on my own experiences with dentistry, I cannot help but feel there is a trend toward earlier orthodontic treatment. This is distinct from a two-phase approach where phase one is growth modification and phase two is leveling, alignment, and coordination of the arches.

It seems that patients are completing orthodontic treatment at a younger age than when I was in high school 30 years ago. I recall having bicuspid and third molar extractions when I turned 15 and getting my braces off 18 months later after passing my driver's license test.

Now, many patients start orthodontic treatment at ages 10, 11, or 12, and finish before the end of junior high. This early treatment can create an interesting situation when second molar eruption is delayed and there is insufficient arch length. This sometimes results in a patient who has completed orthodontic treatment but still has impacted second molars.

It is difficult to do a third molar consultation on a teenager who has finished orthodontics but still has impacted second molars. I am referring to the vertically positioned mandibular second molar with the mesial marginal ridge at the occlusal plane and the distal half of the crown abutting the ascending ramus, covered in mucosa. There is inadequate arch length. How did this happen? What can we do? The patient is clearly not going to jump headfirst into second premolar extractions and another year of orthodontics. Maybe we can remove the third molars and the mandible will grow, thereby resolving the impactions. Or will surgical removal of third molars disturb the mucosal seal around the impacted second molars, leading to chronic pericoronitis and eventual second molar removal? It seems to be a no-win situation.

Wanting to educate myself a bit more about this conundrum, I sought the expertise of fellow surgeons and orthodontists. I was expecting there to be a special cephalometric analysis that would indicate if it were reasonable to start orthodontic treatment prior to eruption of second molars. Perhaps the mesiodistal length of the unerupted teeth could be summed and compared to the projected arch length. The answer I got is that there is no such analysis. It is generally safer to wait until second molars erupt prior to starting final phase orthodontic treatment.

Clearly, there are some exceptions; and cases where the second molars are mesioangular impactions are one of those. These cases may call for earlier extraction of third molars and uprighting of second molars. Surgical uprighting of second molars is something we do with some regularity. We may not have an appreciation for the frequency of complications because they can appear long after the patient has left our care.

Second molar impactions are relatively common, having a published incidence of 0.65%.[1] However, some studies quote rates as high as 2%. Certainly, there are mild impactions that oral and maxillofacial surgeons never see because they are addressed orthodontically. The angles of impaction are usually 30-60 degrees and depth of impaction from 9-12 mm.[2]

The primary etiology of second molar impaction is thought to be inadequate space between the distal of the first molar and the ascending ramus. It can be expected that the space between the ascending ramus and distal of first molar will increase an average of 4-5 mm from age 13 to 18.[1] Interestingly, orthodontic literature has found a 10-20 fold increase in second molar impaction with the use of lingual holding arches to maintain the E-space in the mixed dentition.[4] (E-space is the difference in the mesiodistal width of deciduous second molar and permanent second premolar which is 2.3 mm in the maxillary arch and 2.5 mm in the mandibular arch.)

When contemplating treatment for impacted second molars, there are three choices: surgery, orthodontics, or a combination of the two. Surgical uprighting has the advantage of speed; however, there are increased risks of root resorption, loss of vitality, pulpal obliteration, and ankylosis.[1]

Periodontal complications were nonexistent in the study by Padwa et al. They found periodontal bone levels recovered very well after surgical uprighting, having probing values less than 3 mm. However, pulpal obliteration, periapical radiolucency, and root resorption occurred 31%, 10%, and 5%, respectively. 10% of surgically uprighted second molars were subsequently extracted. Nearly half of all surgically uprighted teeth demonstrated radiographic abnormalities on follow-up; however, most of these did not have a clinical correlation that indicated a need for extraction.[1]

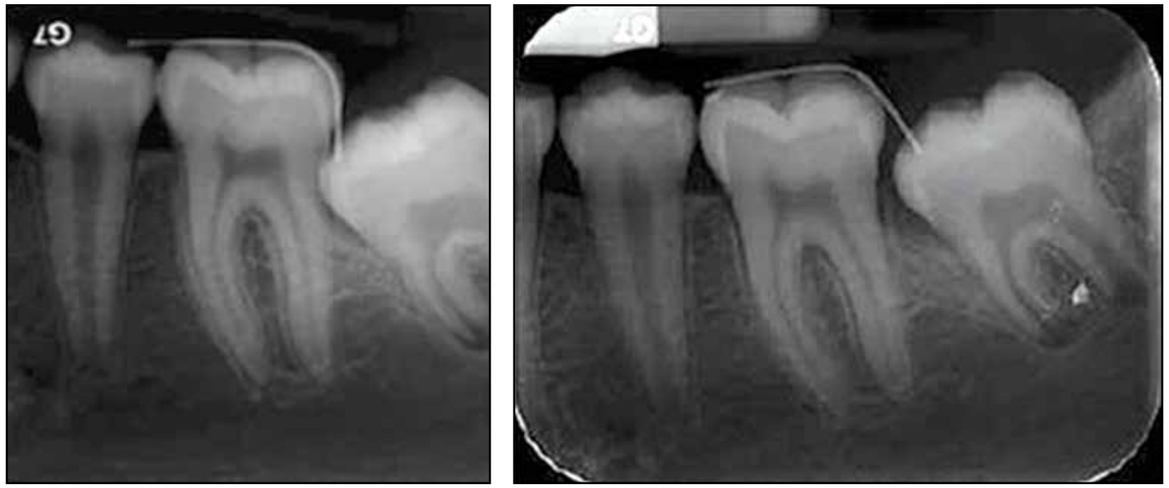
It is worth noting that in the study by Padwa et al, there were no reported cases of root fracture despite having several cases with complete root formation and severe angle of impaction. I suspect root fracture would be the first complication most surgeons would think of when discussing surgical uprighting.

There are numerous orthodontic approaches to uprighting impacted second molars. Surgical exposure followed by orthodontic uprighting had the highest success rate at 71%.[3] Other approaches include the placement of a temporary anchorage device or bone plate, lingual arch with a loop superior to the impacted second molar, and the Bach or pole wire.

The Bach method is simple and elegant, being applicable to patients in or out of orthodontic brackets. Figures 1 and 2 demonstrate positional change over a 3-week period.[5]

A final management approach is extraction of second molars and permitting eruption of third molars. This has the lowest rate of success at 11%.[3]

Having talked to several orthodontists about second molars, they appear to be a thorny subject – sometimes the bane of the orthodontic treatment. The patient has been in braces for 2, 3, or 4 years and the darn second molars are still not in. Patients can get burnt out and demand to wrap up treatment, leaving second molars impacted or unfinished. One change I have made when I see a patient with impacted second molars – whether in orthodontic treatment or recently de-bonded – is to spend a little more time talking about prognosis so they have realistic expectations.



Figures 1 and 2: *Pre-op radiograph demonstrating impacted mandibular second molar; 3-week positional change using the Bach method for second molar uprighting.*

References:

1. Padwa BL, Dang RR, Resnick CM. Surgical uprighting is a successful procedure for management of impacted mandibular second molars. J Oral Maxillofac Surg. 2017;75(8):1581-1590.
2. Fu P-S, Wang J-C, Wu Y-M, et al. Impacted mandibular second molars: A retrospective study of prevalence and treatment outcome. Angle Orthod. 2012;82(4):670–675.
3. Magnusson C, Kjellberg H. Impaction and retention of second molars: diagnosis, treatment and outcome. A retrospective follow-up study. Angle Orthod. 2009;79(3):422-427.
4. Rubin RL, Baccetti T, McNamara JA Jr. Mandibular second molar eruption difficulties related to the maintenance of arch perimeter in the mixed dentition. Am J Orthod Dentofacial Orthop. 2012;141(2):146-152.
5. https://orthopracticeus.com/industry-news/uprighting-impacted-mandibular-second-molars-using-niti-wire/. Accessed April 12, 2021.

MEANING IN ETHICS

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

Morality & Happiness - Part II

While Veatch wrote a text entitled *Rational Man*, there was another philosopher by the name of William Christopher Barrett who wrote a book entitled *Irrational Man*. Rather than support an ethical viewpoint, Barrett delves into existentialism. He mentions Aristotle as the hero of anti-Platonists. But then he remarks that "there is an existential aspect to Plato's thought."

Of course, existentialism is hard to define, so it is not surprising that there are some ideas of existentialism that linger in a variety of writings. Veatch's view of Aristotle's moral theory is aligned with doing the right thing, and Barrett's ideas go more to existentialists who see morality, or doing what a human being should be doing as equated more with individuality. Hence, an existentialist is concerned not only with what things 'mean' but what they 'mean for me.'

In some way, the books *Rational Man* and *Irrational Man* by Veatch and Barrett respectively are at odds, but there are similarities. Indeed, there is deep thought on morality that enters the picture in the context of each work. In some way then, ironically, Barrett is fostering a contemplative life; something that Aristotle claimed is good. Yet, it is important to note that the theorists were at odds. In order to understand a different point of view, as Barrett entertains, the subject of existentialism must be understood.

Existentialism helps to explain why the only practical way of living is to live for one's personal desires and existence. It sounds like a selfish proposition, and in some way it is, but what does anybody really know about existence except for what they experience? Many people have beliefs or theories, but there are no proofs. A thought experiment is to perhaps imagine oneself as creating the whole world. Is the individual God in his own universe? Is there anything beyond the realm of the individual thinker or observer?

What if everything that happens is made simply for the benefit of the individual and no one else really exists. Ironically, the opposite of existentialist thought, or the idea that everything is connected instead, relies on the idea of meaningful coincidences. But what if coincidences are meaningless activities created by the individual thinker who indeed creates his personal universe? It is really difficult to prove otherwise because everyone has an individual mind. Ideas of existentialism abound and a blanket is sometimes used to explain how all human beings are connected to one another.

The idea that everyone is connected by some grand plan, and force that aligns people together, is something that is integrated into the concepts discussed. How are human beings connected? What makes them different? How can one's personal philosophy be correct if it is not aligned with the general mode of thinking? As existentialist theory contends, people just exist and they can define that existence as they see fit. The idea is that people have free choice. They decide their own fate.

Existence is the thing that is the beginning, unlike other theories that first claim there is something more and then human beings are created. This position is reminiscent of Descartes' notion that the proof of existence is thinking, as well as Eckhart Tolle's emphasis on the idea that the thinker is just a mind and not really the soul. Either way, the human being is at the center of things. Perhaps it was the Freudian emphasis in society that would come about to change ideas. Egoism is viewed as negative. Still, the existence of the ego good or bad does provide a sense of detachment. Ironically, it also provides a sense of connectedness or humanness. Sartre seems to see the cogito as something that does not connect people.

The act of thinking, in some way, is not the answer to the problems life presents. This is clearly the opposite of the Aristotelian view that thinking, or contemplating morality, is key to a good and happy life. While the positions are clearly juxtaposed, they are also in same way congruent. That is, one can live a contemplative life, look at morality, mull things over, and still be an existentialist because of the broad interpretation of the latter position.

Existentialists are not necessarily hedonists, although the possibility is there. Still, existentialism does not really prelude contemplation. The fact that Veatch and Barrett's book contain titles that are antonyms *Rational Man* and *Irrational Man* does not mean that there is no meeting of the minds, at least some of the time. The Veatch text is useful in answering the question as to why someone should be moral. Morality is after all important in the scheme of things and allows people to have full, more satisfying lives.

Living a moral life is the key to happiness, which is not necessarily the blissful fleeting feeling one gets from indulgence, but rather a satisfaction the human feels when he or she is doing the right thing. The existentialist view does not incorporate correctness or virtue into the mix. Although individuals are making decisions in either case, there is a difference. The existentialist sees connections, but not the existence of a black and white set of codes for which the human must decipher.

While Barrett and others are not in agreement with such sentiments, and vie for a life only existentialists would think proper, each of the positions can lead to greater personal fulfillment. It seems that what matters is one's perspective. For example, the existentialist is contemplating life by his own rules, whereas the contemplation Aristotle speaks of suggests that there will be a meeting of the minds and that individualism is not desirable.

SERVING THOSE THAT SERVE US

by George M. Yellich, DDS, MS

Dentistry4Vets Changing Veteran's Lives… One Smile at A Time

The Mission of Dentistry4Vets is to provide quality dental care and dental hygiene to eligible veterans living in Monterey, Santa Cruz, and San Benito Counties. There are over 30,000 veterans in our tri-county, most of whom do not qualify for dental care or dental hygiene under the VA guidelines. This gap in their care has had a devasting effect on the well-being and overall health of our veteran population at large. The VA does not include dental care in the veteran benefits package unless very specific requirements are met, such as having been a POW, having sustained injuries during service that resulted in the dental care needed, and/or being permanently disabled. Most veterans do not meet these requirements and thus, are left with either no dental care or intermittent dental care as can be financially afforded.

Within the first two years of establishing the 501(c)(3) nonprofit in 2018, Dentistry4Vets has treated over 150 veterans in the respective offices of the volunteer practitioners. While this was a start, it was cumbersome, and it became clear that the organization needed a designated clinic to satisfy the broad goals of the organization. These goals include: 1) Quality Care for our veterans; 2) Continuity of Care for long-term, overall good health; 3) Comprehensive Care to include specialists; 4) Cost-Benefit of Care with a discounted fee schedule to assist in making the treatment affordable for most; and 5) Ease of Care because we only serve veterans – we understand them and strive to make our clinic a safe and caring environment for them.

Through the generosity of the CHOMP (Community Hospital of the Monterey Peninsula) Montage Foundation, Dentistry4Vets now has a new clinic at the Montage Wellness Center in Marina. The clinic is currently open three days per week providing: 1) Comprehensive dental exams with x-rays; 2) Dental treatment that includes fillings, crowns, root canals, dental bridges, and dentures; 3) Dental hygiene; and 4) Oral Surgery provided by the founders, Dr. George Yellich and his wife, Patricia Yellich.

Origin

Dr. George Yellich (Oral and Maxillofacial Surgeon, Retired Navy Commander, Dental Corps) and his wife, Patricia Yellich, founded Dentistry4Vets based on the number of veterans whom Dr. Yellich saw in his private office that simply could not afford dental care and were suffering from years of dental neglect. Many were missing teeth and suffering from the infection and pain associated with abscessed teeth. When Dr. and Mrs. Yellich contacted the Veteran Transition Center in Marina, they were presented with seven veterans needing dental care. Much to their surprise and dismay, six of the

seven had no teeth at all. This was the turning point. The presiding feedback from these seven veterans was the resulting reclusiveness that stems from having no teeth or very few. They were embarrassed to engage in society, professionally and personally. One such veteran from the Vietnam War era needed open heart surgery and could not afford the dental treatment required prior to his open-heart surgery. The solution to this obstacle was to extract all his teeth. His open-heart surgery was successful, but he was left with a very dismal existence – he no longer felt comfortable around people, including his own family, without any teeth. Eating in public was embarrassing. Applying for employment became a struggle.

This feeling of embarrassment and reclusiveness clearly is an unhealthy existence. Some suffer from depression and turn to alcohol and drug abuse. Many suffer from poor nutrition leading to other physical illnesses and conditions.

Dentistry4Vets has established a solid dental and business model to manage the needs of our veteran population. The clinic staff includes: four volunteer dentists, Dr. Yellich - the volunteer oral surgeon, Patricia Yellich - volunteer surgery assistant and clinic administrator, one paid dentist (2 days per month), and 3 staff personnel - one of whom is the office manager. A partnership with the Cabrillo College School of Dental Hygiene will soon launch, providing more days of dental hygiene. Dentistry4Vets has an established network of dental specialists. There is an office manager who ensures that all OSHA, HIPAA, Infection Control, CPR, Emergency preparedness, COVID-19 guidelines, and other required protocols are current. Safety is a top priority.

Our goal for 2021 is to achieve a 5-day per week clinic providing dental exams, treatment, and hygiene. While the clinic has a business model that aims to cover immediate monthly operating expenses with the fees collected from patients, funding is needed to cover the costs of supplies, an “anchor” dentist, and a “scholarship” program. Even with the discounted fees, there are many veterans who have no ability to pay, and for these patients we have established a scholarship program. Our budget is $3,000.00 per month for this program and these patents will require board approval for their dental treatment. An “anchor” dentist is needed to meet the demands of a 5-day clinical treatment week.

The presiding response from our patients is a very heartfelt appreciation that someone cared enough about their dental needs to do something about it! Dentistry4Vets gives veterans a sense of security and hope for their future. For more information, please visit our website: https://www.dentistry4vets.org/

New 800 sq. ft. facility in Marina donated by Montage/CHOMP Foundation

Dr. Yellich (right) and team deliver a prosthesis for a veteran who is happy to receive the gift of a new smile.

A happy Veteran (center) enjoys her new smile thanks to the great work of the team at Dentistry4Vets.

CALIFORNIA ASSOCIATION OF ORAL & MAXILLOFACIAL SURGEONS UPCOMING CE EVENTS

2021 Meetings

21st Annual Meeting - Webinar	May 19
OMSA Course Opens On-line	July (TBD)
ACLS & BLS Provider Recertification	October (TBD)
Medical Emergencies (South)	November (TBD)

Vendor Spotlight

CALAOMS Wishes to Thank the Following Vendors That Graciously Sponsored CALAOMS' January Anesthesia Webinar Held on January 16th, 2021

- *The Doctors Company - “Speaker Sponsor”*
- *Boyd Industries*
- *Brady Price & Associates*
- *H & H Company*
- *Maxxeus*
- *Provide, Inc.*
- *Xemax Surgical Products*

ASSOCIATE/PARTNERSHIP OPPORTUNITIES

Bay Area, California: Well respected, busy and established oral surgery practice in search of a board certified or board eligible, motivated, hard-working and efficient oral surgeon for a full time position in the Bay Area, CA. Our office provides a full scope of Oral & Maxillofacial surgery including IV-sedation, Extractions, Bone Grafting and PRP, Implant placement, Biopsies and more. Applicant should have CA license, GA permit and Medical Malpractice Insurance. Medical Degree is a plus. Candidate must be able to provide excellent surgical services, establish and maintain relationships with existing and new referring doctors and be interested in growing the practice. Candidates should reply via email with their CV attached to: apply.oralsurgery@gmail.com

High-end Northern California Oral and Maxillofacial Surgery practice is seeking an associate. Full or part time position available. Stunning newly built building on waterfront property with state-of-the-art equipment, CBCT imaging, digital scanners, and more. Full scope office is grossing $2.2 million on 3 days a week with 50% of procedures from implants. Excellent opportunity for growth and buy-in option is available. Hard-working, experienced auxiliary staff currently employed with good referral rapport. Candidates should reply via email with their attached CV to: drdan73@protonmail.com.

Bay Area: OMS practice in search of associate or partner oral surgeon. The scope of practice includes dentoalveolar surgery, implants, bone grafting and oral pathology. Applicant should have a CA license, GA permit, and malpractice insurance. Please contact via email with CV at bayarea.ospractice@gmail.com

Northern California: Well Established and busy/wide referral base Oral Surgery Office in Rural Northern California looking for Full time associate leading to partnership. Practice is established over 30 years with state of art facilities with 3D CT scan. We have two offices where the senior partner is looking forward to retirement. The offices provide full scope Oral and Maxillofacial surgery including IV-sedation/ general anesthetic, extraction, bone grafting, pathology and implant surgery where candidate will have autonomy to "run" the practice but also has the benefit of a partnership with another surgeon. Applicant must have California license where we can assist in obtaining a GA permit. Candidate should reply via email with their CV to wtsb2021@yahoo.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 hand-off 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.

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

Roseville, CA: Immediate full-time oral surgeon needed to join our team. Practices a full scope of oral and maxillofacial surgery with expertise ranging from corrective jaw surgery to wisdom teeth extraction to teeth-in-an-hour/ Dental Implants. Diagnoses and treats facial pain, facial injuries and TMJ disorders, and performs a full range of dental implant and bone grafting procedures. Please call Courtney at 916-783-2110, or email courtney@drantipov.com

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

San Diego Well-respected oral surgery practice located in central San Diego. 25 years in practice and one of the most successful, busy practices in the city. Very active Seattle study club sponsor for over 21 years with 50 members. Scope of practice includes all dentoalveolar surgery, implants, bone grafting, PRF/PRP active use, orthognathic and TMJ surgery, sleep apnea treatment with MRD and bi-maxillary advancement and facial trauma. In house OR capable of supporting single jaw orthognathic/TMJ surgeries. Active hospital practice for more complex cases.

We are looking for a board certified/eligible surgeon with active skills in orthognathic/ TMJ/Trauma surgery comfortable with outpatient anesthesia and dentoalveolar surgery that is interested in becoming a partner in this practice. Comfort with public speaking is a big plus. Outgoing personality with excellent patient care skills is mandatory. Interested parties, please contact via email at info@mvoms.com, or office phone at 619-298-2200 and ask for Kim, office manager

San Francisco We are seeking an OMFS single or dual degree for a part/full time position. Our practice is located in the heart of San Francisco Peninsula. The practice has been established over 50 years with excellent reputation in the community. The facility is state of the art with the latest technology. Our practice emphasizes office-based dental-alveolar and implant surgery but can expand to full scope if desired. Ideal candidate should have excellent interpersonal skills with good patient care and ethics. Salary will be negotiable and competitive. Reply with CV to sfpeninsulaomfs@gmail.com

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

San Francisco: Established oral surgery office in San Francisco is looking for a part time oral and maxillofacial surgeon to join our practice with the possibility of partnership. Our practice is a state-of-the-art facility with advanced technology like digital X-Ray, 3D Scanner and CT scan machine.

The ideal candidate must be a team player looking for a long-term position with the desire to grow professionally. We are seeking someone who works independently, has excellent clinical skills, great chair-side manners and high ethical standards. Candidates should be able to perform the full scope of oral maxillofacial surgery.

Please respond to this ad with your cover letter and resume.
Faces of The Mission
2480 Mission Suite 219
San Francisco, CA 94110
Phone 415.285.0526

OMS SEEKING WORK

UCSF Fresno OMFS Graduate looking for an associateship/partnership position in Southern California, with potential for buy-out down the road. omidniav@gmail.com 714-624-7634

Seeking Part Time OMS Job Between San Francisco and Sacramento. Oral and maxillofacial surgeon retired with 40 years of experience in private practice seeking 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

PRACTICE FOR SALE

Los Angeles: Turn-key oral and maxillofacial surgery practice available for sale, with transition if buyer desires, in west Los Angeles. 1200 sq. ft. office in quality hi rise medical/dental building. Newer CBCT, centrifuge, two surgical operatories, consultation room, recovery room. On 3 ½ days per week, collections averaged 500K for the past three years. Owner selling to return to teaching. Interested parties please contact cell phone 310 415-7816

West Los Angeles oral surgery practice. Well Established, Excellent reputation and relationships within the community and amongst the Dental referral base. The office is 2,200 square feet in a multi-tenant building and has been remodeled with updated equipment and technology, including Cone Beam. 2 Consult Rooms, 3 Surgical Suites, Full surgical Area with Recovery, Nurses Station and Sterilization Center. Very well designed for Oral Surgery flow. This practice has been in the same location for 20+ years. $2.1M Annual Revenue, Operating Expense below 55%, with $1.0M net. Please contact Jason Owens at 855-546-0044 or jowens@ddsmatch.com for a confidential conversation about this opportunity.

Southern California: Well established OMS practice in desirable location in sunny suburb of Southern California for sale. Same location in a professional medical building close to hospital and freeways for over 20 years with great referral base. The owner surgeon is moving out of State and is motivated but will stay for a smooth and stress free transition as long as desired by the prospective buyer surgeon to insure continuation of great service to referral base and community. The owner surgeon has a study club that meets 4 t o5 time a year providing CE credit for referral doctors. The gross Production for the last year was over $1M (break down for each procedure is available) with collection of $900K on 3 ½ days a week! The practice procedures is summarized as full scope of implantology, dentoalveolar, pathology, TMJ. No HMO insurance. There is a lot of potential for expansion of services for an enthusiastic new surgeon. The office has a fully equipped and functional operating room in full operation for general anesthesia with intubation and anesthesiologist. The office was certified as surgery center. It only needs renewal. If you love great climate and outdoor activities, great schooling system, safety, close to airport, beach life style in Southern California, this is your opportunity. For confidential detailed information please contact us at sylviamini@hotmail.com.

WOULD LIKE TO BUY

Greater Sacramento Area. I am looking to purchase a practice with transition in Sacramento or surrounding areas. I am currently practicing in Northern California and I am looking for an OMFS practice with an emphasis on Dentoalveolar and implant surgery. Please contact me at omfspractice43@gmail.com if interested

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

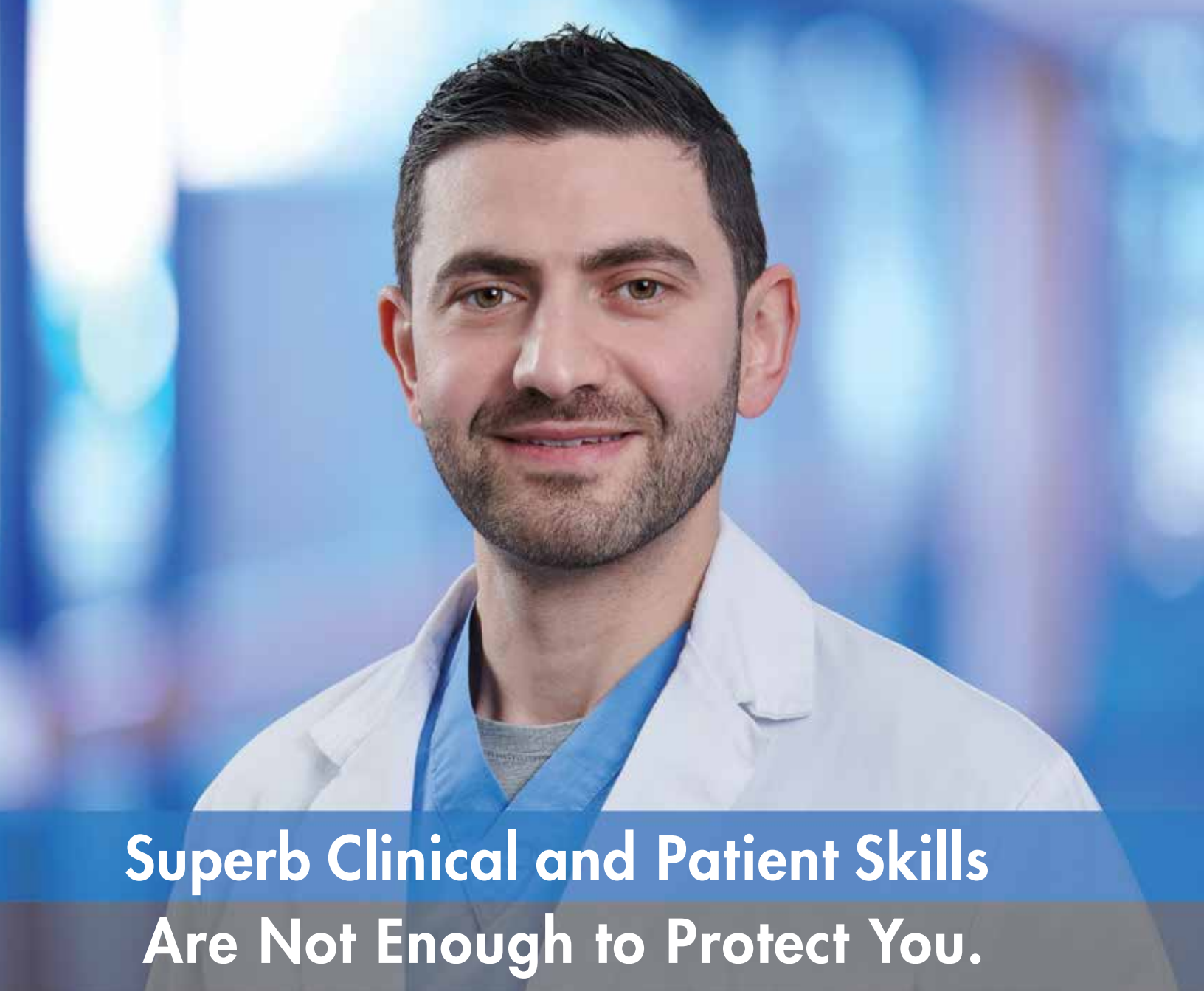


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Photo: Fadi N. Kosa, DMD, oral and maxillofacial surgeon at The Christiana Center for Oral & Maxillofacial Surgery, Newark, Delaware