



DEA Announces MATE Act Training Requirement

MATE ACT



New DEA training requirements affecting oral and maxillofacial surgeons licensed to prescribe controlled substances take effect this summer. All DEA-registered practitioners must complete a one-time eight-hour training requirement of coursework addressing substance use disorders as part of the [Medication Access and Training Expansion \(MATE\) Act](#).

The Medication Access and Training Expansion (MATE) Act, passed by Congress as part of the Omnibus Bill of 2022, mandates most practitioners – including oral and maxillofacial surgeons – licensed to prescribe controlled substances or who hold DEA licenses to complete eight hours of coursework on substance use disorders.

While early drafts of the legislation required coursework to be in the treatment of substance use disorders, AAOMS worked with the ADA to advocate successfully to allow for coursework to be on the safe pharmacological management of dental pain with a referral for the treatment of substance

use disorders, and to allow for the ADA and AAOMS as approved organizations through which training is received. The eight hours is a one-time requirement.

Practitioners who complete their next scheduled DEA renewal registration or an initial application on or after June 27 must check a box on their online DEA registration form affirming they have completed the training. The DEA clarifies that past training – including continuing education received through AAOMS or the ADA prior to Dec. 29, 2022 – counts toward meeting this requirement and that the eight hours does not need to be completed as a single session.

Training may be on the management of patients with opioid or other substance use disorders and not necessarily the treatment of these patients. AAOMS offers qualifying online CE courses to meet the requirement.

While AAOMS continues its communications with the DEA and the Substance Abuse and Mental Health Services

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- * Southern California Oral and Maxillofacial Surgeons

EDITORIAL



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

Don't Get Bored With The Basics

I'm a rather simple guy. Give me jeans, a t-shirt, and a cup of coffee (Original Blend, Dunkin Donuts), and I'm content. I pretty much eat the same thing every day for lunch and have done so for several years. In other words, you could say I like to keep things simple.

My day job is spent in faculty practice at a dental school. We don't have an OMS residency program, but the volume of patients and surgical needs are still there for specialist-level oral surgery services, so that's what I do every day.

The way our school clinic is set up, most nonsurgical extractions are performed by dental students with their general dentist clinical faculty oversight; but on occasion, I'll oversee a student wishing to perform an extraction with my supervision. Though rare, I do enjoy those opportunities to share some of the basic helpful tips that we, as OMSs, know so well that it's almost like operating on autopilot for us.

Some examples of these helpful tips might be teaching students the simple things such as proper patient positioning at an appropriate height so that our shoulders are not raised or slouched but arms kept at a 90 degree position, a patient hairnet to keep their hair out of the mouth and interfering in our procedures, shaded sunglasses to block the bright surgery suite lights, petroleum jelly applied to the lips to prevent the corners of the mouth and the lips from drying out, and the use of a bite block, among others (Figure 1).

We then continue the discussion about the importance of using *soft* hands with our instruments; that since we're using



Figure 1.

steel instruments, in the battle of steel vs. mucosal epithelium, steel has an unbeaten record and will cause undesired and embarrassing (*for us*) tissue trauma if we're not careful and intentional about using *soft* hands.

We'll then discuss the *slow injection* technique with the use of *gentle* retraction of the lips as I remind the student that "we're not mad at this patient, and we aren't trying to hurt them" (Figure 2).



Figure 2.

Since I'm a big proponent of the use of periotomes for all erupted maxillary teeth, I then describe and demonstrate the process of proper positioning and use of the periotomes along with the reminder that we only use *gentle* tapping to advance the periotome to accomplish its task (Figure 3).

And once the use of the periotomes is completed, the forceps can then be used to *gently* deliver the tooth (Figure 4).

We then discuss how to place a figure-of-eight suture and tie the knot (Figure 5). After that comes gauze, post-op instructions, and patient dismissal. Students are often amazed and how quick and *simple* this all looks.



Figure 3.

But why?

What I enjoy most about these not-too-frequent, but very important, individual encounters with the students is the opportunity to show them just how an OMS is attentive to the very *basic* and small details of patient care; and how if they similarly attend to these *basic* details, they, too, can be successful in performing a smooth procedure for their patients.



Figure 4.

I greatly enjoy one of my self-imposed roles and responsibilities as an OMS "ambassador." I want our students to know that when they graduate and join the dental community somewhere, they will find an OMS who will take excellent care of their patients in a gentle and similar manner as what they witnessed while in dental school. I reinforce to them that they can have confidence in their local OMSs and should utilize them as often as possible to care for their patients' oral and maxillofacial surgical needs.

Once their patients have been dismissed, we often engage in a post-procedure "debriefing" at which time I usually ask them



Figure 5.

what they learned that maybe they've never seen before (keep in mind, most students have spent countless hours shadowing or working in dental offices prior to attending dental school, so many believe they're already familiar with how to manage patients). The answer is invariably, "the profound attention to the *basics*." Students often wonder how or why "seasoned" surgeons would still pay attention to the *small things*.

Simple: the *basics* never change.

I heard a story told by someone that got to watch one of Kobe Bryant's private workouts several years ago. Now, being from the Chicagoland area, I've always been more of a Michael Jordan fan (*feel free to disagree with me, but you're wrong!*); but this story well illustrates the point I'm trying to make here.

By many accounts, Kobe's workouts were legendary, not necessarily for the intensity but for the meticulous attention to detail in everything he did. In this particular workout, Kobe spent 45 minutes working on basic footwork. For the basketball-playing readers in the audience, as you all know, this would include pivoting, crossing over, etc....simple stuff that we probably learned in grade school or junior high. Afterwards, he was asked, "Kobe, you're the best player in the world; why would you spend 45 minutes of your workout doing such basic footwork?" Kobe smiled and raised an eyebrow, "Why do you think I'm the best player in the world?"

Excellence in anything can feel boring at times. Doing the same things over and over – for only small, almost imperceptible levels of improvement. At times, we even might start to question what we're doing, if we're doing it right, if we should be doing more, and if it matters.

It does matter.

But if we believe that it doesn't, we either give up on what we're doing or chase the latest, newest shiny object, not realizing that we were on the precipice of what we wanted by

PRESIDENT'S MESSAGE



David Cummings, DDS
CALAOMS President



It is both an honor and a pleasure to serve as CALAOMS President this year. Having participated in national and regional meetings for the past several years, it's very clear that CALAOMS is considered among the strongest oral and maxillofacial surgery associations in the country. Our members are leaders in private practice, in the academic world, and in organizational volunteerism. Our reputation as pioneers on many fronts is unquestionable. We truly have great surgeons.

I want to extend my gratitude to the CALAOMS board and committee members who frequently work behind the scenes to answer calls, respond promptly to emails, participate in last-minute Zoom meetings (usually on inconvenient nights and weekends), etc. in selfless efforts to promote, educate, and advance the specialty of oral and maxillofacial surgery. I can assure you that the CALAOMS board is steadily working hard in all the ways that we can to advocate for and protect our specialty and members.

The CALAOMS board, along with the Continuing Education (CE) Committee, are extremely excited about the 23rd Annual Meeting program taking place at Hayes Mansion in San Jose at one of California's most iconic luxury hotels. The CE Committee continues to work toward ways in which we can bring the highest levels of education to our members. We have coordinated with AAOMS to bring the Office-Based Emergency Airway Management (OBEAM) course to our Annual Meeting – a monumental logistical effort with the goal of saving our members from having to travel to Chicago to take this soon-to-be-required simulation course.

AAOMS developed the OBEAM anesthesia simulation modules. OBEAM uses intensive, real-life experiences to allow participants to practice and master critical techniques for administering and monitoring office-based anesthesia. AAOMS separately offers CE units for registration, attendance, and completion of the OBEAM course. Unlike previous anesthesia emergency simulation courses, OBEAM is standardized to ensure every participant experiences the same simulated events. Its state-of-the-art technology enables AAOMS to automatically evaluate the performance of every participant and pinpoint those areas that may benefit from additional training. In short, this program offers oral and maxillofacial surgeons an effective method of assessing their readiness to meet an office anesthesia emergency. By 2026, AAOMS members who provide office-based moderate, deep, and/or general anesthesia must successfully complete an AAOMS-approved anesthesia simulation training course every five years.

Advocacy

CALAOMS continues to advocate for our anesthesia team model and promote our outstanding safety record to state legislators and the Dental Board. With the influx of new legislators and new administrative staff at the Dental Board, education efforts are timely and valuable.

OMSA

We strongly recommend and advise that all Oral and Maxillofacial Surgery Assistants (OMSA) renew their critically important OMSA training every *two* years – this is more easily accessible now that OMSA has been taken completely online. The board believes the 5-year interval between the recertification of the anesthesia assistants is too long for meaningful retention of skills and information needed to be the most valuable team member possible. OMSA recertification every two years is compatible with the renewal of all other state healthcare licenses and permits, as well as Basic Life Support.

SB 501 is now in effect

Dentists who hold an existing general anesthesia permit are still able to practice under the terms of that permit until it expires, at which point they will need to apply for one of the new permits. The general anesthesia (GA) permit remains in place but is now a GA/deep sedation (DS) permit with deep sedation and GA redefined by the regulations.

Dentists are newly required to obtain a pediatric endorsement prior to administering or ordering GA/DS to patients **under age 7**.

Dentists must have patients continuously monitored during a DS/GA procedure with a pulse oximeter and ventilation using precordial stethoscope and capnography.

Additional staffing is required for patients **under age 13**: the operating dentist and two additional personnel must be present for the procedure. Of the three personnel, **two** must be certified in pediatric advanced life support (PALS) or a Dental Board-approved course in pediatric life support and airway management.

To obtain the pediatric endorsement, dentists must have: (1) completed at least 20 deep sedation/general anesthesia cases of patients under age 7 at the time of license application and renewal, and (2) certification in advanced cardiovascular life support and PALS.

Permit-holders who have insufficient cases to receive a pediatric endorsement can administer DS/GA to patients under age 7 under the direct supervision of a permit-holder with a pediatric endorsement to fulfill the 20-case requirement.

SB 501 does NOT change anything in terms of how OMSs and their staff members provide moderate sedation, deep sedation, or general anesthesia to patients **13 years old and older**. SB 501 only changes the way moderate and DS/GA are administered to patients 12 years old and younger.

If a separate medical or dental anesthesiologist is used, either the operating dentist OR the additional staff personnel (the 3rd person who is required to be present during the sedation) must have PALS for moderate sedation, deep sedation, or general anesthesia for patients 12 years old and younger.

I want to thank you all for your continued support of our specialty.

Most sincerely,

David Cummings, DDS
President, CALAOMS



MATE-Act CONTINUED FROM PAGE 1

Administration (SAMHSA), we also would strongly suggest contacting the DEA with questions regarding qualifying courses or other matters. Email questions to the Diversion Control Division Policy Section at odlp@dea.gov or call 571-362-3260.

Among notable points:

- Training may be on the management of patients with opioid or other substance use disorders and not necessarily the treatment of these patients.
- Past training – including continuing education received through one of the approved organizations prior to the Dec. 29, 2022 – counts toward meeting this requirement.
- Approved organizations include the ADA and AAOMS as well as any other organization accredited by ACCME or CCEPR, among other organizations listed in the DEA and SAMHSA materials.
- Training could be in any of various formats, including classroom, seminars at professional association meetings, or virtual offerings. The DEA recommends retaining some verification of completion of relevant courses. The DEA also has clarified that reading journal articles does not qualify as meeting the training requirement.
- Training does not have to occur in a single eight-hour session but can be cumulative over various sessions totaling at least eight hours.
- For practitioners who “graduated in good standing from a medical (allopathic or osteopathic), dental, physical assistant, or advanced practice nursing school within five years of June 27, 2023,” completion of a comprehensive curriculum that included the eight hours of training would satisfy the requirement. Graduation from an OMS residency within the past five years counts for the requirement. Completion of the curriculum prior to the past five years (e.g., predoctoral studies) would satisfy the requirement as long as graduation from residency was within that five-year period.
- While SAMHSA has *recommended* various core curricular training elements in its recommendations, these are not requirements.
- Beginning on June 27, 2023, practitioners will be required to check a box on their online DEA registration form affirming they have completed the new training requirement when completing their initial registration application or renewing their registration.

For more information about the MATE-Act view our [FAQ MATE-Act](#) document. Also visit [AAOMS's CE section](#) and [ADA's CE section](#) to explore CE opportunities.



AAOMS DISTRICT VI TRUSTEE REPORT



by W. Frederick Stephens, DDS, FACD, FICD
AAOMS District VI Trustee

Due to the efforts of the CALAOMS Board with the assistance of the AAOMS and CAN, this simulation course will also be offered at the CALAOMS Annual Meeting April 29-30, 2023, in San Jose, and will be increasingly available at other regional meetings. It also will be available at the AAOMS Annual Meeting in San Diego later this year.

As of this date, OBEAM has trained a significant number of surgeons, but many more have yet to attend. I strongly suggest not waiting to the last minute to attend, for the course venues can only accommodate so many participants at a time. **Don't wait for the rush!**

One final note on this topic. If you have encountered challenges or obstacles scheduling or obtaining this simulation training or have concerns about the requirement directed by the House of Delegates, I would greatly appreciate your input and comments.

Remember, I am your portal of communication to the AAOMS Board and your national association. Please utilize me! You can contact me via e-mail at dr.wfstephens@gmail.com or call me at (626) 440-0099.

To update you on other current topics and relevant issues to our specialty, I present the following:

Anesthesia

- We continue to follow the **CRNAs** who have become emboldened by recent successes in **achieving independent practice** and relative autonomy afforded during the pandemic. Many states are seeking to make these changes permanent. CRNAs also are **looking for ways to enter dental practices and eliminate** the need for the dental practitioner to hold any form of sedation permit or dental board-based office anesthesia inspection. We are monitoring this push.
- The AAOMS continues to gather essential data from third party entities such as privately billed insurance claims to be utilized to advocate for the safety of the OMS anesthesia team model. The **AAOMS also promotes submission of anesthesia incident reports** from all dental anesthesia and sedation providers to the **Dental Anesthesia Incident Reporting System (DAIRS)**, a **centralized registry** where information related to adverse events in anesthesia may be examined and quantified at a national level.

I am beginning this report while sitting at O'Hare International Airport (*ok ... at the bar*) in Chicago, waiting for a flight back to LAX. I just finished one of our several scheduled 2023 face-to-face AAOMS Board of Trustee meetings this weekend of March 18-20. We accomplished a tremendous amount during this two-day meeting under the leadership of AAOMS President Dr. Paul Schwartz, who was assisted by our own District VI President-elect, Dr. Mark Egbert. We have a very strong Board whose **primary directive is to serve the AAOMS membership**.

I also attended a scheduled **OBEAM (Office Based Emergency Airway Management)** course on Friday March 17th at *The Laskin Institute for OMS Education and Innovation*, located in the AAOMS headquarters. As I hope you are aware, the House of Delegates - through resolution - mandated the completion of this simulation course by the beginning of 2026.

The simulation training program was initiated at the order of the House of Delegates, and with our Board's guidance, developed at great effort, by the Committee on Anesthesia (CAN). This House of Delegates directive was promoted to support and justify our "*perpetually in jeopardy*" team anesthesia model and, ultimately, promote patient safety and surgeon proficiency. This type of simulation training mirrors simulation training required of all commercial pilots to maintain their proficiency in the cockpit. It is imperative that we all maintain our anesthesia and emergency proficiency, ultimately with the best interest and safety of our patients as the goal.

• The American Society of Dentist Anesthesiologists (ASDA) and AAOMS have developed model anesthesia regulations through a joint working group. The model regulations preserve the OMS model of anesthesia delivery. While the model regulations have been approved by the boards of ASDA and AAOMS, use of the model regulations is pending review at ASDA's general assembly in April 2023.

- **OBEAM ... I think I have addressed this enough above. Please visit aaoms.org or calaoms.org to find a date that works for you to take the OBEAM course. Remember, as per the 2021 House of Delegate's resolution, simulation training is now required to be completed for all AAOMS Members and Fellows by the beginning of 2026.**

Advocacy

- **AAOMS Fellows and Members** are **encouraged** to download the **Voter Voice application**. Multiple grassroots campaigns have been initiated over the course of the current Congress and several states have taken advantage of our ability to assist them with their grassroots efforts. The **Voter Voice app** make it easy to participate in the grassroots political process and advocate for your specialty.
- The **State Legislative Tracking Map** on the AAOMS website provides quick access to the status of all issues impacting OMS. You can access these issues at: **AAOMS.org/TrackingMap**.
- We continue to monitor a wide range of issues being introduced at the **state level** that would impact the specialty. **Areas of focus continue to be anesthesia, insurance, and scope of practice.** Activity has been robust as many states rebound from the pandemic.
- **At the federal level**, our first in-person Day on the Hill since COVID, was held April 7-8 this year. It was very successful event. The Committee on Governmental Affairs (CGA) recommended, and the Board of Trustees approved, the **2023 Day on the Hill priorities**, which include support for the following:
 - **Ensuring Lasting Smiles Act.** This Act did not make it through the Senate last year but will be brought back in the House.
 - **Support for the Resident Education Deferred Interest (REDI) Act;**
 - **Dental Insurance Reform / Dental & Optometric Care (DOC) Act;**

◦ *Efforts to address supply and drug shortages.*

Ninety-four attendees participated, including 88 OMSs from 30 states, plus Washington, D.C., 16 of whom were residents and 48 of whom were first-time attendees, defined as those who haven't attended an in-person meeting since 2018. Attendees met with approximately 150 congressional representatives and staff.

Please consider attending next year. It will open your eyes as to who is really in charge of our profession and why we need to be involved.

- We continue to *closely monitor legislative activity* that could result in the *expansion of dental benefits under Medicare Part B. Nothing was passed in the 117th Congress.* This topic, though, will likely return in the future. We are partnering with the ADA and others with respect to this issue and will have an AAOMS position paper available shortly.
- AAOMS continues to monitor efforts to expand Medicare coverage for medically necessary dental services and submitted recommendations to CMS supporting coverage of dental exams and treatment essential for successful medical outcomes, including for patients with MRONJ, post radiation for head and neck cancers, and prior to cardiac or joint replacement surgeries.
- AAOMS will participate in an ADA *ad hoc* workgroup to address and advocate against CMS's assignment of payment adjustment indicators and global periods to certain CDT codes in anticipation of coverage of additional medically necessary dental services.
- Having successfully collaborated with the ADA and AAPD (*American Academy of Pediatric Dentistry*) for CMS to create a HCPCS code (G0330) to increase facility fees for outpatient hospital services nearly **ten-fold**, AAOMS continues to collaborate with the coalition to support Medicaid adoption of the Medicare payment rate and to expand the facility fee increase to ambulatory surgery centers (ASCs). A new infographic for members to promote the new code and higher rate to their hospitals is now available on aaoms.org and has been shared with members via AAOMS e-newsletters.
- AAOMS will participate in a multi-specialty practice expense survey of Medicare providers with the intent to provide updated practice expense data to CMS for purposes of updating the practice expense component of a procedure's relative value unit.
- AAOMS continues to monitor the recently enacted No Surprises Act (NSA) and its impact on OMS. AAOMS

has posted several summaries and FAQs on aaoms.org. A new infographic on the NSA is also available.

Informational Campaign

- **MyOMS.org** has been redesigned to feature more graphics/videos, increase search engine optimization, and be responsive on mobile devices.
- **Seven sets** of patient videos have been developed and are available for **members to download**.
- **18 infographics** have been added to the MyOMS.org website and for **members to download** and use on their practice sites.
- **WebMD** includes an **AAOMS microsite** that continues to generate about 1/3 of the monthly referral traffic to the **MyOMS** website.

Education and Events

- The AAOMS is now offering a **Clinical CE Subscription** service that will allow OMS members to access the entire on-demand Clinical CE Online Library courses for a full year. This 24/7 access to the AAOMS clinical course catalog includes over 100 hours of content and is updated with at least 20 new courses annually. The Clinical CE Subscription is \$249 for a full year. More information can be found at aaoms.org/ceonline.
- The **2023 AAOMS Educational Weekend will be hosted in Rosemont, Ill., April 29-30**. Three courses will be offered:
 - *Advanced Protocols for Medical Emergencies in the Oral and Maxillofacial Surgery Office (APME)*
 - Practice Management Stand-Alone: Practice Performance Indicators – Influence Your Outcomes (one day only)
 - Beyond the Basics Coding Workshop.
- Full course information is available at AAOMS.org/EduWeekend.
- A new online Implant and Bone Graft coding course launched in early 2023.
- The 2023 Coding & Billing webinar series continues with Coding Insights: Tools to Achieve Coding Compliance and Optimal Reimbursement on April 12th presented by CHPCR members Dr. Joshua Everts and Dr. Adam Pitts.

- Upcoming practice management webinars include “Making Dollars and Sense of Your Financials” on April 19 and “Keys to Successful Retirement Planning” on May 10.
- The **105th AAOMS Annual Meeting, Scientific Sessions and Exhibition will be held Sept. 18-23 in San Diego**. Registration will open in the spring. Up-to-date information can be found at aaoms.org/SanDiego.
- The **AAOMS Dental Implant Conference** will be held **Nov. 30-Dec. 2, 2023**, once again at the Sheraton Grand Chicago in Chicago, Ill.
- To see upcoming AAOMS meetings, webinars, and other educational opportunities available, please visit <https://www.aaoms.org/meetings-exhibitions/upcoming-events>.

Communications

A new member-facing podcast series – called **AAOMS On the Go** – launched in November and is publishing new podcasts twice a month. The podcasts can be downloaded or listened to on AAOMS.org/podcasts or popular podcast platforms such as Spotify. Topics cover research, affiliate organization news, JOMS, practice management improvements, and more.

OMS Foundation

- Resident spouses interested in attending the Annual Meeting are encouraged to apply now for the Alliance’s Norma L. Kelly resident spouse scholarship, which offers reimbursement of up to \$1,000 in documented travel expenses plus support and networking opportunities for new AAOMS families.
- Most OMSs have neither the time nor the expertise to actively engage in the research that sustains our specialty. But, through the generosity of its donors, the Foundation can engage those who are most qualified to do this important work. Without these resources, our capacity to evolve and advance will inevitably decline, and the OMS specialty will become indistinguishable from its competitors.
- Please consider supporting the Foundation as an OMSFIRE donor with an annual gift of \$2,500 or more for five years. Or include a gift in your estate plan to help sustain Dr. Walker’s vision for the future of the specialty.
- OMSFIRE donors, Walker Society members, and Foundation volunteers are invited to the Foundation’s

exclusive R.V. Walker Donor Recognition Reception aboard the **USS Midway on September 22 in San Diego**.

- Visit OMSFoundation.org or email Mary DiCarlo at mdicarlo@omsfoundation.org to learn more about OMSFIRE, legacy giving, and the Foundation’s R.V. Walker Society.

AAOMS History Book

- The history book commemorating the AAOMS’s 100th anniversary is available for purchase at AAOMSstore.com.
- This publication – with more than 300 pages – features a 100-year timeline noting the important milestones of our specialty as well as hundreds of photos, a recap of the centennial year, our Annual Meetings, and our leadership and award winners.

Western Society of Oral & Maxillofacial Surgeon (WSOMS)

- I strongly encourage all CALAOMS members, and for that matter, all *District VI* members to join the Western Society of OMS (WSOMS). In past years, WSOMS was a respected component society known for its great CE and comradery, with meetings usually located in great venues throughout the western states. Recent times have changed the demand for such CE and the travel, but this component society is still a very important legislative arm for District VI. **Its current primary role now is to support our Western (District VI) caucus and our representation nationally.** The WSOMS is our regional conduit, providing important two-way communication for national issues and national support.
- Dr. Randal Blazic, the current president of the WSOMS, has done a great job reorganizing the Society and establishing an efficient budget and governing structure to maintain the important role of this component Society. **He and I are asking that all Western District Members join the WSOMS for a mere \$50.00/year.** This will keep the Society healthy and functional, providing support for its members. Society dues can be paid through CALAOMS for California members.

Recognition & Thank You:

Finally, thank you for all your contributors to **OMSPAC** and **the OMS Foundation**. Visit OMSPAC.org and OMSFoundation.org to view the names of all our contributors and learn more about how these important entities help

maintain and advance our specialty and ultimately, our ability to practice.

I have an open-door policy for all District VI members to voice questions, concerns, and suggestions. As mentioned earlier, I would welcome any input about any challenges or obstacles in obtaining your required simulation training. As such, please do not hesitate to contact me via e-mail or phone, as necessary.

Hope this report finds you all well.



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DON'T GET BORED... CONTINUED FROM PAGE 5

staying the course. One way out-performers remain engaged is by separating the “lead” and “lag” measures. In basketball, a lead measure is the time spent on footwork. A lag measure is your season stats as a basketball player. Lead is controllable. Lag is less so.

On a daily basis, we, as OMSs, are engaged in doing something that matters to patients. This, stacked up over time, becomes motivational by itself. When it’s coupled with the lagging performance improvements, it’s even more empowering.

I have no idea where this finds you all today, but whatever your aspirations are for this month, this quarter, or this year, stick with it. And never get bored with the basics.



LEGISLATIVE UPDATE



by Gary Cooper
Legislative Advocate, CALAOMS



Spring 2023 Legislative Report

As of this writing, the 2023/24 Legislative session is completing its fourth month. Nearly 2,700 bills are moving their way through the arduous process. This year is somewhat unique because there are 35 new legislators in both the Senate and Assembly combined. This large influx of newly-elected members is the result of term limits and redistricting. Invariably, a large class of legislators means a larger quantity of “new ideas” being brought forth in new bills.

This year, CALAOMS is collaborating with Western University of Health Sciences College of Dental Medicine to sponsor **AB 936 (Wood)**. This bill expands on the provisions of CALAOMS’ sponsored **AB 880 (Ridley-Thomas)** that was signed in 2015. **AB 880** permits students enrolled their final year of completion in dental schools approved by the Dental Board of California to treat patients without compensation and under supervision at sponsored free healthcare and dental events. **AB 936** allows dental students enrolled in their clinical years to treat patients under the same faculty supervision as they would in their dental school clinics.

The purpose of the legislation is threefold: First, to increase the volunteer workforce at free healthcare clinics. Second,

hands-on training and experience has proven to be very beneficial to the dental students. Finally, exposing dental students to volunteerism early will hopefully inspire them to give back to their communities once they are licensed.

AB 936 is widely supported and has passed the Assembly Business and Professions Committee unanimously. CALAOMS has been successful in adding an urgency clause to the bill to allow it to take effect immediately upon signature by the Governor. The bill continues to move through the legislative process.

CALAOMS continues to believe that addressing the Medical Loss Ratio (MLR) issue as it relates to dental insurance plans is of utmost importance. Medical Loss Ratio is the percentage of patients’ premiums that is actually spent by the plans on healthcare as opposed to administrative costs. Under the federal Affordable Care Act (“Obamacare”), insurance companies are required to spend between 80%-85% on actual healthcare.

In November 2022, Massachusetts overwhelmingly passed an MLR initiative relating to dental plans. The required 83% ratio was passed by the voters with 72% of Massachusetts voters supporting it. The initiative was very strongly supported by dental professional organizations including the American Dental Association (ADA) and the California Dental Association (CDA). Subsequent to the passage of the Massachusetts initiative, at least ten other states have introduced Dental Loss Ratio (DLR) bills. CALAOMS strongly believes that California should introduce DLR legislation. Unfortunately, CDA is unwilling to support such a bill at this time. CALAOMS will continue to advocate that a DLR bill is the right thing to do to enhance patient care.

CALAOMS has offered **SUPPORT** to CDA for three of their sponsored bills:

AB 481 (Carrillo) – Revises and recasts provisions that regulate the requirements for licensure as a registered dental assistant and registered dental assistant in extended functions.

AB 1048 (Wicks) – Prohibits a health plan or health insurer that covers dental services from issuing, amending, renewing, or offering a plan contract or policy that imposes a dental waiting period provision or preexisting condition provision, as defined upon an enrollee or insured.

AB 952 (Wood) – Requires dental plans to disclose whether or not an enrollee’s or insured’s dental coverage is subject to regulation by the appropriate department at the time a treatment plan is communicated to the plan or insurer. The bill also requires that a plan or insurer includes whether or not an

enrollee’s or insured’s dental coverage is subject to regulation by the appropriate department on an identification card, membership card, coverage card, or other documentation of coverage.

All the aforementioned bills are moving forward through the legislature at this time.



CALAOMS members participate in AAOMS Day on the Hill

On March 8, 2023, 90 OMSs – including AAOMS leaders, members, residents and staff – gathered in Washington, D.C., to meet with lawmakers and advocate on behalf of the specialty and patients during AAOMS’s Day on the Hill. This marked the first return to in-person attendance since 2019. Among the attendees were seven CALAOMS representatives.

Priority issues addressed included dental insurance reform, student loan repayment reform, and health insurance coverage for patients with craniofacial anomalies.

Day on the Hill provides members with the opportunity to learn about federal healthcare policy, experience the federal legislative process first-hand, build relationships with members of Congress and staff, as well as network with AAOMS leaders. This is a unique opportunity for OMSs to influence federal policymakers, explain how federal legislation and regulation impacts our practices and patients, and be a voice for the specialty.

No political or advocacy experience is necessary. AAOMS welcomes first-time attendees and will ensure all are effectively prepared for their congressional meetings.



(Left to right): Dr. Preston Fong, OMS intern; Dr. Caitlyn McGue, OMS resident; Dr. D. Allen Pulsipher; Dr. W. Frederick Stephens; Dr. Ashok Veeranki; Dr. David Cummings; Dr. Jeff Elo

IN MEMORIAM

James F. Colburn, DDS



Dr. James (Jim) Colburn passed away in Reno, Nevada on February 23, 2023 after a prolonged illness. Following graduation from the University of California Dental School, Jim practiced general dentistry for several years before completing a residency in Oral and Maxillofacial Surgery at the University of Texas Southwestern Medical Center in Dallas, Texas. After a stint in the Air Force, he practiced in Pleasanton, California for many years. As an avid hunter and fisherman, upon retiring he and his wife, Jan, moved to the Kalispell-Whitefish, Montana area. They later relocated to Middleton, Idaho, and recently, to Reno to be closer to family and friends. He is survived by his wife, Jan, twin daughters Heather and Dawn, and his step-daughter Arin.

Gerry MacDonald

OMS & TECHNOLOGY



by Peter A. Krakowiak, DMD, FRCD(C), FACD

AI - All the right moves? or a Risky Business? My Interview with the AI Vampire

Vampires - fictional constructs of human imagination - have intrigued and horrified us for centuries. The lifeless creatures which extract energy, powers, and life from living humans to sustain themselves in strength and influence have been part of folk culture for centuries in Europe. Artificial intelligence (AI) concepts were also conceptualized in Europe in the 1930s by a British logician and polymath, Alan Mathison Turing. The machine learning technology was defined, and foundations were laid. The AI concepts were sidelined for decades as electronic hardware needed to catch up to the concepts. Many other scientific and technological advancements followed - changing the world into what it is today. Some changes have been very positive, and many have been quite deleterious.

Shortly before the onset of the covid pandemic, I first became briefly introduced to the capabilities of Diagnocat™ AI radiology interpretive software as it entered the global market. AI began to appear in the healthcare field over a decade earlier. European Union members were looking at approving this specific AI-based information technology (IT) application into their mainstream medicine practice. Now, this autonomous interpretive technology is available in North America as well as in Israel, Oceania, Europe, and even Russia. The global interest and desire for AI technology is exploding. Bill Gates, Microsoft, and Google have been embedding AI into their products. There are, however, many that feel very cautious when jumping into AI with both feet. Elon Musk (CEO of SpaceX, Tesla, and Twitter; founder of the Boring Company, Neuralink, and OpenAI) and Steve Wozniak (co-founder of Apple Computer) recently issued somewhat of

a *Minority Report* which suggested a pause in development of machine learning. At this point, a pause may prove to be *Mission Impossible*.

In the 1994 movie *Interview with a Vampire*, Tom Cruise played a vampire named Lestat de Lioncourt who served up a prophetic line: “No one could resist me, not even you...” This may be an unavoidable reality with the looming widespread integration of AI and machine learning in the coming years into our society. Resistance may be futile. There may be no going back. Such a dramatic existential paradigm shift will likely prove to be both a blessing and a curse for humanity as it may lead us into oblivion. Time will tell, ultimately, how much of each outcome will be realized.

AI potential seems infinite as its applications are virtually boundless. *Artificial Intelligence* is defined as intelligence perceiving, synthesizing, and inferring information as demonstrated by machines. These intellectual processes were, until now, present only in the human species. This “thought”-based ability has extended now to also control the movement of objects such as, for example, autonomous driving modes in cars. Also, the advancing robotics and emerging nanotechnology will yield novel research and development of technical processes and applications of future technologies, new art forms, and even the creation of whole new areas of science. The possibilities are, quite frankly, astounding and overwhelming for us with the current level of human cognition, and AI may entirely surpass our imagination and divergent thinking as we know it.

Hopefully, this somewhat dramatic prelude sparked your interest in the topic. With the new reality of conceptual thinking, I have tried a different approach to writing the Journal’s technology section article. It includes a lot of play on words and, hopefully, a bit of quirky human humor. But not all the content which follows is human-derived. I decided to go right to the source and interview AI itself about the topic I was writing about just to give you - the readers - some insight into where we are today with capabilities and thought processes of AI. I figured I would reach out to the AI communication platform - the autonomous ChatGPT software - with two questions so it could give us a glance into some of its thought-forming and self-expression abilities. First, I asked ChatGPT to describe “What are the potential current and future applications of AI in oral and maxillofacial surgery and anesthesia?” I bolded and highlighted the AI answers for the clarity of authorship. Here below is the AI chatbot answer:

“Artificial Intelligence (AI) has been increasingly applied in healthcare to assist healthcare professionals in making accurate diagnoses, optimizing treatment plans, and improving patient outcomes. Oral and Maxillofacial

Surgery (OMS) and anesthesia are two areas in healthcare where AI is being applied to improve patient care. Here are some current and future applications of AI in OMS and anesthesia:

Image recognition: AI can analyze and interpret images from radiological studies and provide accurate diagnoses. In OMS, AI can assist in diagnosing and identifying pathologies, such as tumors or cysts, and help to plan surgical procedures. In anesthesia, AI can assist in interpreting ultrasound images and identifying the correct location for nerve blocks.

Surgical planning: AI can assist in planning surgeries by using algorithms to predict surgical outcomes and plan the surgical approach. In OMS, AI can help to identify the best location for surgical incisions and predict the need for bone grafting or implant placement. In anesthesia, AI can help to optimize patient positioning and identify the best anesthetic approach.

Patient monitoring: AI can be used to monitor patients during surgery and detect any adverse events in real-time. In OMS, AI can monitor the patient’s vital signs and alert the surgeon to any changes in blood pressure or heart rate. In anesthesia, AI can monitor the patient’s oxygen saturation and alert the anesthesiologist to any changes in respiratory function.

Predictive modeling: AI can use patient data to predict the likelihood of complications and assist in developing personalized treatment plans. In OMS, AI can predict the likelihood of implant failure or bone graft rejection. In anesthesia, AI can predict the likelihood of postoperative nausea and vomiting or other complications.

Robotics: AI can be used to control surgical robots and assist surgeons in performing complex procedures. In OMS, AI can assist in performing oral surgeries, such as wisdom tooth extraction or implant placement. In anesthesia, AI can assist in controlling robotic anesthesia machines and delivering precise doses of anesthesia.

Overall, AI has the potential to revolutionize OMS and anesthesia by improving accuracy, efficiency, and patient outcomes. As AI technology advances, we can expect to see even more sophisticated applications in these areas of

network error

It’s important to note that while AI can provide assistance to healthcare professionals, it is not intended to replace human expertise and judgment. AI should be seen as a

tool that can enhance the work of healthcare professionals and improve patient care.”

Interestingly, the response transcript suddenly paused mid-sentence and a network error indicator appeared (in red). The AI chat platforms have been up and running for a while, but they seem to still have a lot of glitches, and there have been reports of odd and even mean-spirited responses. This is a bit concerning and certainly will require human oversight to keep a good level of supervision on the applications for numerous safety and accuracy issues.

Another error which I came across was more conceptual: AI chat remarked, specifically, that its ultrasound image interpretation was a benefit to an anesthesiologist. It failed to list CT imaging, MRI, or even plain film imaging as areas of interest. Clearly, the AI platform still has not learned about the most common and applicable modes of imaging used in anesthesia especially as it pertains to OMS practice. Machine-learning and AI “learn” via supervised learning, unsupervised learning, and reinforcement learning. Once this article is published online, it will have a chance to improve its information database and potentially change its response to the same question the next time it is asked.

Since the AI had a message error, I thought it may be worthwhile to ask it another question. My follow-up question was: “What are potential problems and risks that come with the use of AI in our field?” The following is the AI chatbot’s response:

“The use of AI in oral and maxillofacial surgery can provide many benefits, such as improved accuracy, faster diagnosis, and personalized treatment plans. However, there are also potential risks that need to be considered. Some of the risks of using AI in oral and maxillofacial surgery include:

Data quality: The accuracy of AI systems depends on the quality of the data they are trained on. If the data used to train the system is biased or inaccurate, the AI system will produce biased or inaccurate results.

Safety concerns: AI systems are not perfect and can make mistakes, which could result in serious harm to patients. Therefore, it is crucial to ensure that the AI system is thoroughly tested and validated before it is used in clinical settings.

Lack of human oversight: AI systems are designed to make decisions based on algorithms and data, but they lack the human judgment and intuition that is necessary in complex surgical procedures. Therefore, it is important

to ensure that AI is used in conjunction with human oversight to ensure patient safety.

Ethical considerations: The use of AI in healthcare raises ethical concerns, such as patient privacy and the potential for AI to replace human healthcare providers. It is important to address these concerns to ensure that AI is used ethically and responsibly in healthcare.

Cost: The implementation of AI systems can be expensive, and there may be additional costs associated with maintaining and updating the technology. These costs need to be carefully weighed against the potential benefits of using AI in oral and maxillofacial surgery.

In summary, the use of AI in oral and maxillofacial surgery can provide many benefits, but it is important to carefully consider and address the potential risks to ensure patient safety and ethical use of the technology.”

At this juncture in time, the AI chatbot seemed to give credence to the need for human oversight to ensure patient safety. It also noted specifically the ethical responsibility in healthcare. Finally, the issues of poor data influencing the algorithm was brought up as potentially being dangerous to the process. I will be curious how this dynamic internal AI-based analysis will change with time as data subsets are increased and the analysis of human-error factors versus machine-error analysis may affect the degree of the autonomy that the systems may propose or even self-implement. Humans make errors. That will certainly be considered by these analytical machines.

All in all, my first intentional exchange communication experience with ChatGPT was a real eye opener to the AI’s unlimited didactic and clinical possibilities. However, I have unknowingly been communicating with AI many times - just not realizing it or maybe not being fully cognizant that a machine was communicating with me on an autonomous basis. The extent of AI use is already wider than we think in many industries and financial markets. In fact, including it in the content for this article was a very limited and superficial example of today’s AI capabilities. From creating illustration artwork (Figures 1 and 2), booking patient appointments, business key performance indicator evaluations, malpractice liability stratifications, completing medical records, and developing evidence-based validation of care protocols to diagnose and treat disease patterns, there are limitless applications for the healthcare field. AI technology will revolutionize the world unlike anything we have seen since the invention of the wheel or even the harnessing of fire. I am certain of that - pause or no pause. Great benefit and progress

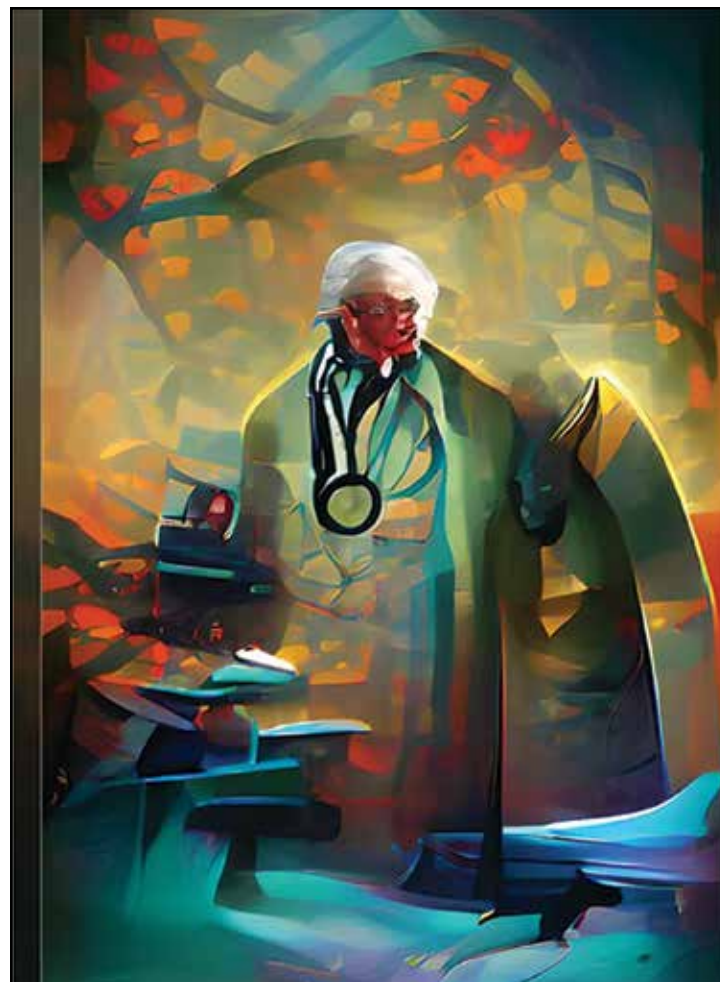


Figure 1. AI-constructed image of a “doctor.”

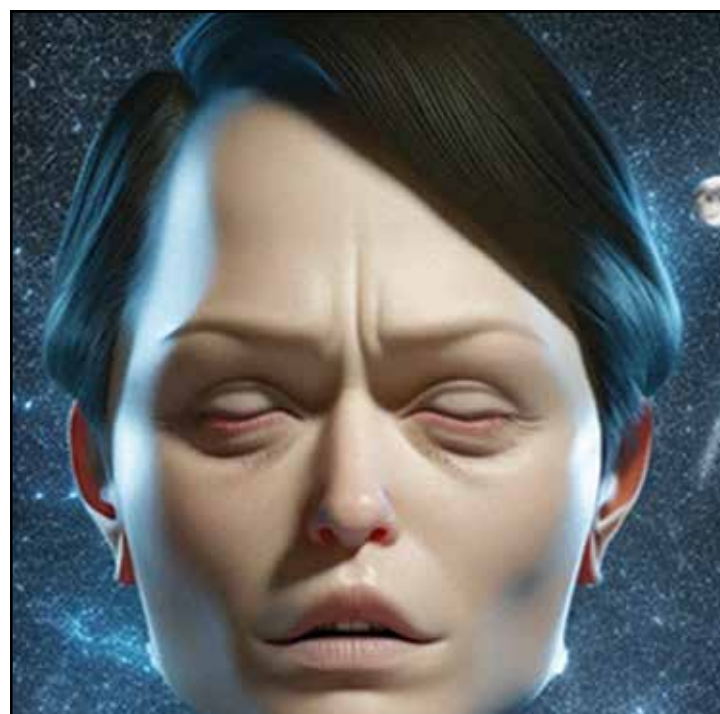


Figure 2. AI-constructed image of “oral surgery.”

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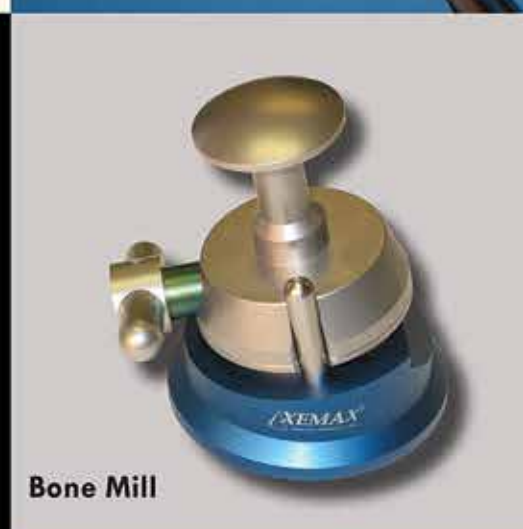
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AI All The Right Moves - CONTINUED FROM PAGE 18

to our society are likely to come. But there may be a catch or two, as there always is.

The main perturbation for us is how will AI net positively impact everyone's life and activity. For example, the editorial oversight and writing of articles for various publications may no longer be needed as all information and its interpretation will be readily available to all with access to an AI chatbot app. This will include experts in the field, but also the layperson. "Dr. Google" has created a lot of issues with lack of relevance and applicability of concepts derived from available internet databases. This problem will almost certainly be furthered as some people (e.g., patients, insurance companies, politicians, and those in the legal world) may feel that medical decisions will have to be AI-approved or validated. Perhaps medical malpractice and all court decisions will no longer be assigned to juries. Many jobs and even professions may become obsolete and, frankly, fully eliminated. Rules and regulations will be altered. Protocols will likely need to be changed for most daily functions and activities.

This paradigm change will present numerous serious ethical and philosophical issues that will need to be carefully considered before we all jump in with both feet. We have one foot down already. This will be a great challenge for us all. I am afraid that even the number of days for contributors like me who write sub-par articles for the technical section of the California Journal of Oral and Maxillofacial Surgery may be already numbered, but in the words of Tom Cruise's Top Gun II character, Lt. Pete "Maverick" Mitchell: "That may be so ...but not today."



CALAOMS Member One of ADA's 2023 "10 Under 10" Honorees



Dr. Sapna Lohiya, Hermosa Beach, California
Univ. of California - Los Angeles School of Dentistry - 2013

The American Dental Association (ADA) recently announced the honorees for their 2023 10 Under 10 Award which recognizes new dentists who are demonstrating excellence in their work and inspiring others. Among the recipients is CALAOMS member Dr. Sapna Lohiya. Founder and President of Women in Dentistry South Bay Chapter, an organized group that provides social and wellness events and dental practice discussions to better strengthen and empower, Dr. Sapna Lohiya was described as a true servant leader. Dr. Lohiya received her Bachelors of Science degree with Honors in Anthropology from University of California, Los Angeles and her Doctor of Dental Surgery degree from the University of California, Los Angeles School of Dentistry. During her time in dental school, Dr. Lohiya developed an interest in surgery and participated in volunteer trips to provide dental and medical care abroad. She went on to complete her oral and maxillofacial surgery residency at the University of Washington in Seattle while simultaneously authoring several abstracts, book chapters, and journal articles and is now a board certified oral and maxillofacial surgeon practicing in Los Angeles. Dr. Lohiya has been recognized for her commitment to teaching and providing excellent patient care by receiving the Top Dentist Award in 2021 and 2022 and the Southern California Super Doctors "Rising Star" Award in 2021 and 2022, in addition to several other honors. In addition to working in her private practice, she serves as a Clinical Instructor for the UCLA School of Dentistry and is active in local leadership as the President-Elect of the Western Los Angeles Dental Society. In her free time, she enjoys outdoor activities, traveling, and spending time with her family and friends. CALAOMS congratulates Dr. Lohiya.



by Mahr Elder, DDS, MD

Review of Anti-clotting Medications

Oral and maxillofacial surgeons (OMSs) are often faced with patients who have simple surgical needs but complicated medical co-morbidities. These are fragile patients that require a delicate balance in terms of surgical and medical management. OMSs serve as a unique link between dentistry, medicine, anesthesia, and surgery. Managing these patients demonstrates our niche skill set the loudest.

A common group of medically challenging patients are those taking blood thinners. Blood thinners fall into two main groups: anticoagulant and antiplatelet medications. These medications aim to prevent blood clots in patients who are at risk for stroke, heart attack, or pulmonary embolism. High-risk patients have a history of atrial fibrillation, deep vein thrombosis, heart valve replacement, and congenital heart defects. Patients with atrial fibrillation are five times more likely to have a stroke, and this group of stroke patients are more likely to have a permanent disability. (1)

There are several different types of anticoagulant medications. Each type works at a different level on the blood coagulation pathway. These can be divided into four main groups: (2)

- *Warfarin* – limits the availability of vitamin K.
- *Heparins* – inhibit thrombin and factor Xa.
- *Factor Xa inhibitors* – affect factor Xa within the blood and within a pre-existing clot; do not require routine monitoring. Examples include: apixaban (Eliquis®), edoxaban (Savaysa®), fondaparinux (Arixtra®), and rivaroxaban (Xarelto®).

- *Direct thrombin inhibitors* – bind directly to thrombin inhibiting its action. Examples include: argatroban (Acova®), bivalirudin (Angiomax®), dabigatran (Pradaxa®), and desirudin (Iprivask®).

Antiplatelet medications reduce platelet aggregation and clot formation, and can be divided into three main groups: (3)

- *Glycoprotein platelet inhibitors* – bind to the glycoprotein IIb/IIIa receptors on the plasma membrane of platelets inhibiting thrombus formation. Examples include: abciximab (Reopro®), eptifibatid (Integrilin®), and tirofiban (Aggrastat®).
- *Platelet aggregation inhibitors* – prevent platelet adhesion in various places on the clotting cascade. Examples include: aspirin, ticagrelor (Brilinta®), clopidogrel (Plavix®), prasugrel (Effient®), aspirin/dipyridamole (Aggrenox®), cilostazol (Pletal®), ticlopidine (Ticlid®), dipyridamole (Persantine®), cangrelor (Kengreal®), and caplacizumab (Cablivi®).
- *Protease activated receptor-1 antagonists* – antiplatelet effect by inhibiting thrombin-related platelet aggregation. Examples include vorapaxar (Zontivity®).

Direct oral anticoagulants (DOACs) are a group name for the anticoagulant medications that target Factor Xa and thrombin, including apixaban (Eliquis®), dabigatran (Pradaxa®), and rivaroxaban (Xarelto®). Dabigatran was the first DOAC approved by the FDA in 2010. These are relatively new medications which reduce thromboembolic complications and have a reduced bleeding risk compared to warfarin or heparin. Advantages include fewer monitoring requirements, more immediate drug onset and offset (important for acute bleeding and procedural management), and fewer drug and food interactions. (4) These significant advantages are the main reason why DOAC prescriptions have quickly exceeded those of warfarin. The approximate number of patient prescriptions in the United States for warfarin is 2.4 million while apixaban (Eliquis®) is 3.3 million, rivaroxaban (Xarelto®) is 2.1 million, and dabigatran (Pradaxa®) is 220 thousand. Contemporary national clinical practice guidelines recommend DOACs as the first-line anticoagulant strategy over warfarin for most indications. (5) DOACs are increasingly prescribed instead of warfarin for chronic anticoagulation due to the ease of dosing, fewer interactions, and less stringent monitoring. (6) Indications and co-morbidities exist for which warfarin remains the preferred anticoagulant. Evidence for the use of warfarin over DOACs is strongest for patients with prosthetic heart valves, antiphospholipid syndrome, or those with a high risk of gastrointestinal bleeding.

Antiplatelet medications are not used for patients with existing blood clots, but instead as a preventive medication for those at higher risk of developing clots. Aspirin remains the most prescribed antiplatelet medication. These medications are usually indicated for coronary artery disease, heart attack, angina, stroke, and peripheral vascular disease. Antiplatelet medications are effective in the arterial circulation where classical vitamin K antagonist anticoagulants have minimal effect. (7) *Antiplatelet* medications interfere with platelet binding while *anticoagulants* interfere with the proteins in the clotting pathway. Approximately 4.3 million patients are prescribed clopidogrel (Plavix®). Over 30 million Americans take daily aspirin, and it is one of the most prescribed medications. Antiplatelet medications are usually indicated in patients with atherosclerosis.

Dual antiplatelet therapy is a combination of aspirin and a P2Y12 inhibitor (irreversible platelet aggregation inhibitor – e.g., clopidogrel, prasugrel, and ticagrelor). This approach is used in patients who have a high-risk thrombotic condition, unstable angina, and peripheral vascular diseases. It has been shown to reduce cardiovascular death and to enhance clinical outcomes in patients with acute coronary disease, but it significantly increases the risk of major bleeding.

Elimination half-life is a significant factor when pausing medication prior to a surgical procedure. It takes 5.5x the elimination half-life for a medication to leave the body. This degree of clearance is not necessary for all oral and maxillofacial surgery procedures. The effects of aspirin, clopidogrel (Plavix®), and other antiplatelet medications last the lifetime of the platelet (7-10 days). It is recommended that antiplatelet medications are held 5-7 days prior to surgeries that carry a considerable risk of bleeding. But for most oral and maxillofacial surgery procedures, two days (*the day before and the day of surgery*) should be adequate and is a balance between hemodynamic control and maintaining the thromboembolic benefits. The short half-life of these medications allows significant platelet repopulation within a short amount of time to aid hemostasis while continuing systemic therapeutic benefits. The short half-life and rapid onset of DOACs simplifies their use and adjustment for surgical procedures. I have found that the same 2-day protocol is effective for these patients. In my practice, I have patients hold their *anticoagulant* and *antiplatelet* medications the day before and morning of surgery. The patient then resumes the evening after surgery or the following morning depending on postoperative bleeding.

I feel that the significance of postoperative bleeding following oral surgery is minimized and under-reported. I have had

Comparison of Oral Anticoagulants and Antiplatelets (8, 9, 10)					
Medication	Onset of action	Elimination half-life	Monitoring	Reversibility after cessation	Antidote
warfarin	36-72 hours	20-60 hours	INR every 1-2 weeks	Several days	Within hours using vitamin K
rivaroxaban (Xarelto®)	< 30 minutes	~ 12 hours	No routine monitoring	~ 24 hours	None available
dabigatran (Pradaxa®)	< 30 minutes	~ 12 hours	No routine monitoring	24-36 hours	None available
aspirin	< 60 minutes	20 minutes, platelets 5 days	No routine monitoring	Antiplatelet effects disappeared > 96 hours	DDAVP, tranexamic acid (<i>not widely recommended</i>)
clopidogrel (Plavix®)	< 2 hours	7-8 hours, platelets 5 days	No routine monitoring	3-5 days	DDAVP, tranexamic acid (<i>not widely recommended</i>)

several patients experience significant bleeding following oral surgery even 1-2 weeks later. Many of these patients are medically fragile, and persistent bleeding following surgery may not be well tolerated due to their delicate cardiac status. I also feel that holding anticoagulant and antiplatelet medications for 5-7 days is not necessary for oral surgery procedures where local measures can be helpful. The risk of stroke and thromboembolism is significant, and this drug pause is not necessary for most oral surgery/dentoalveolar procedures. Numerous studies have been published in the medical literature that have dismissed oral surgery postoperative bleeding as minimal and non-life threatening. Sadly, and unfortunately, I am aware of several patients who have died from postoperative bleeding following oral surgery while on some type of “blood thinner.”

Oral surgery is still surgery; just ask our patients. “Minor” procedures like noncomplicated extractions are usually well tolerated with no medication interruptions and with meticulous local hemostatic measures. But the more complex/major surgical procedures require consideration for medication interruption to ensure positive hemostasis outcomes.

The risks of thromboembolic events are significant and increase the longer a patient withholds their blood-thinning medications. A balance between avoiding a thromboembolic event and significant postoperative bleeding must be struck. There is a lack of high-quality evidence to establish best practices for every clinical scenario, but I have found that holding the day before and day of surgery is a good balance. This is supported by the short half-lives of most “blood thinners.” The lack of consensus amongst physicians on DOAC discontinuation may reflect conflicting best practice advice. (11) Discretion needs to be made when treating patients on blood thinners, and a single approach for every patient is not an advisable approach. A short interruption of medication has a low associated risk but may provide a significant benefit to preventing excessive local bleeding.

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BOARD MATTERS MAY 2023



Changes to Anesthesia and Sedation Permits Introduced by Senate Bill 501

On January 1, 2022, Senate Bill (SB) 501 (Glazer, Chapter 929, Statutes of 2018) significantly changed how the Board issues anesthesia and sedation permits. The Board implemented these statutory changes through the

SB 501 Anesthesia and Sedation Regulatory File, which took effect on August 16, 2022. The changes include:

- There are new patient monitoring requirements when administering moderate sedation, deep sedation, or general anesthesia to patients under age 13.
- General Anesthesia (GA) and Medical General Anesthesia (MGA) permit holders must apply for a new Pediatric Endorsement to administer deep sedation or general anesthesia to patients under age 7.
- Conscious Sedation (CS) permits are no longer issued or renewed. You must apply for a new Moderate Sedation (MS) permit to administer or order the administration of moderate sedation.
- MS permit holders must apply for a new Pediatric Endorsement to administer moderate sedation to pediatric patients. There are two categories of MS Pediatric Endorsement: for all patients under age 13; and for patients ages 7–12 only.

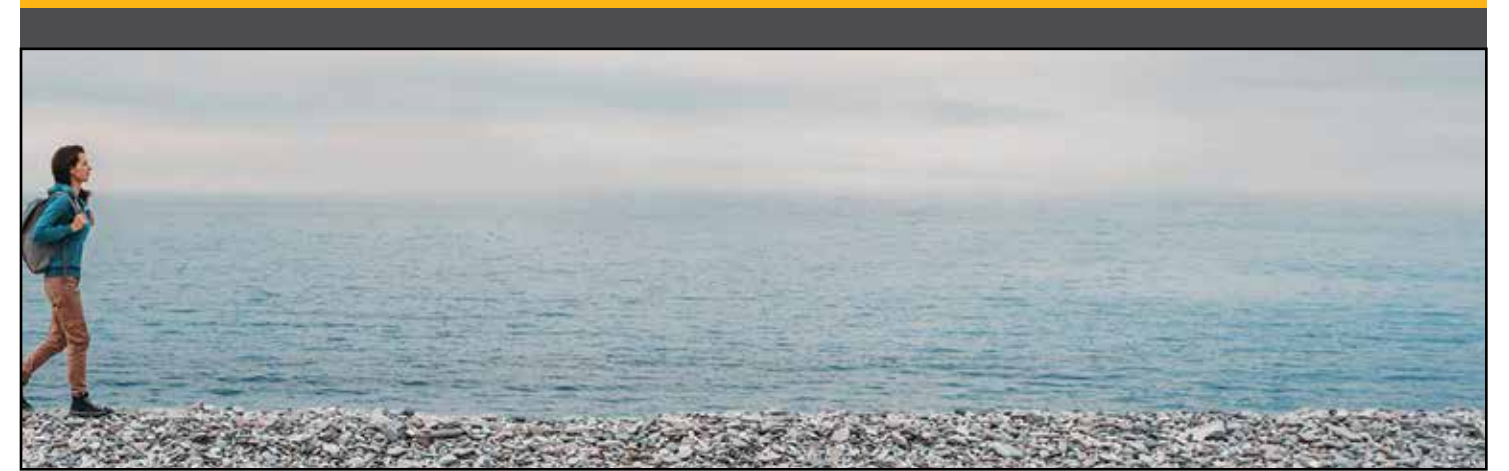
- Oral Conscious Sedation for Minors (OCS-M) permits are no longer issued or renewed. You must apply for a new Pediatric Minimal Sedation (PMS) permit to administer or order the administration of pediatric minimal sedation to patients under age 13.

Permitholders and new applicants can review [Senate Bill \(SB\) 501 Anesthesia and Sedation Regulations Approval](#) for additional information. For applications and details on each permit, go to [Information for Applicants](#) on the Board's website. If you have additional questions, please contact Anesthesia Unit staff at (916) 263-2300 or AU.Program@dca.ca.gov.



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Optum



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Are Your Finances Stressing You Out?

Financial health is a significant factor in a person's overall well-being. While some stress is "good" – in healthy doses, it can help protect us from illnesses, build resiliency, and spark survival instincts into action to avoid danger, among other benefits – ongoing stress can negatively affect your health.

Under "bad" stress, you may experience physical ailments, such as headaches, muscle tension, chest pain, digestive issues, or fatigue, as well as mental health concerns, like sadness, irritability, lack of motivation, or anger. If your financial stress persists, it can become chronic stress, which can lead to serious health conditions, including high blood pressure, heart disease, obesity, diabetes, depression, and anxiety.

Whatever your personal situation is, talking to someone you trust, such as a family member, friend, health care provider, or financial counselor, can be helpful. So can taking measures to reduce your financial stress and working toward financial health and wellness. While everyone's situation is unique, here are some strategies to consider to gain more control over your finances.

Reduce overall stress

You've likely heard it before, but it remains true: Taking care of yourself is an important factor in taking care of everything else in your life. Exercising regularly, eating healthy foods, getting enough sleep, giving yourself time to relax, connecting with others, practicing gratitude, getting outside — they all help combat stress. And none of these have to cost you more or any money. Taking a walk counts. So, does switching from junk food to healthy food, sitting still in a park, reading, etc. The key is to actively nourish your body and spirit.

Figure out how you feel about money

In many cultures around the world, talking about money or one's personal financial situation, be it good or bad, is taboo. On a more individual level, people can have a lot of different emotions associated with money, ranging from guilt or shame for having it or not having enough of it, to exhaustion from the constant struggle of earning and/or managing it, to the joy of having achieved a financial goal, and everything in between.

Understanding how you feel about and view money can help you be more aware of your relationship with it, and take more control of your own behaviors. Keep in mind, your background or current situation does not necessarily define your emotional relationship with money. The key is knowing your relationship with it so you can get a realistic view of your behaviors in relation to your priorities, commitments, and essential needs.

To figure it out, take stock of the money you have coming in and what money you are spending. This will help you identify correlations. For example, if you're generally on a strict budget, but once in a while splurge beyond your own resources, ask yourself why that is and when it happens. Is it when a friend visits and you're ashamed to admit you cannot afford to eat out? Is it when you treat your children to a new toy or activity that you cannot afford because you don't want to disappoint them? Something else?

Do the math

Write down all your sources of income and financial responsibilities, including recurring commitments, such as bills and debts. Also, track your spending. If you have records, you can take a look backward and see where your money has gone. If you haven't kept records, start. You may soon realize that you're spending money on arguably unnecessary items.

Create a budget that includes the essential expenses — like nutritious food, affordable shelter, weather-appropriate clothing and, depending on where you live, things like insurance, medication, etc. Then look at what you need versus what you're spending. Identify problem areas and make decisions about cutting or curtailing non-essentials. Even small changes can add up to a big difference.

Also, consider ways to lower your essential expenses. For example, if you have more than one credit card, consider whether you can consolidate the debt onto the one with the lowest interest rate, and then cut up the rest. Do you have anything of value that you arguably don't need or wouldn't have to replace that you can sell, such as the bicycle your child has outgrown?

Be ready to make tough choices

While it may seem like, and in some cases may be, an oversimplification, making decisions to generally live within your means can go a long way in promoting and providing financial security. For many people, this can mean making difficult decisions.

Depending on the choices you're already making, there may be a variety of ways to curtail your spending and recurring financial responsibilities. An ideal place to start is with lifestyle comforts that are less likely to impact your health and wellness. It all depends on where you live and what resources you have, but it could mean choosing to rent or buy a smaller home, skipping the morning trip to the café in favor of home brew, keeping your smartphone for as long as it works and gets automatic updates, etc.

If you live with family members, it's okay to explain to them the need to cut back and why. If you have children, sharing the situation can also become a teaching moment for them, so they better understand how money works and how to set realistic financial expectations for themselves.

Prepare for the unexpected

It depends on where you live, but consider if you or your partner loses their job or has a health scare, or something else, do you have enough money saved to cover your essential expenses? Financial counselors often recommend having at least 3 months' worth of cash saved to protect yourself against the unforeseeable.

If your balance sheet shows you're in a healthy financial place, protect it by stowing away resources for what could happen. If it doesn't, work toward this as a goal.

Give yourself a break — and a pep talk

Keep in mind, if the numbers seem very imbalanced between what's coming in and what's going out, give yourself a break. Berating yourself (or your partner) will not be helpful. You cannot change your past, but you can take measures to better control how you handle your financial future by making a financial plan and following through. Also, create achievable financial goals. Paying off your debt and creating a cash reserve won't happen overnight, but over time, many people successfully work toward a more financially sound life.

Consider your mental health

A strong link exists between financial stress and mental health. Mental illness affects the way a person thinks, feels, and behaves. People who are living with a mental health condition are more likely to experience financial difficulties, as it often is more difficult to find or keep a job, earn enough income, or manage finances.

Conversely, people with financial stress are more likely to develop mental health concerns, as noted above.

Mental health conditions are treatable. They also are more common than you might believe. An estimated 1 in 8 people globally live with a mental disorder. If you think you may be coping with a mental health concern or illness, connect with a health care provider, community support group, or another qualified resource for help.

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New infographic: Access to hospital-based dental procedures

AAOMS members are encouraged to download and distribute an [infographic](#) to their hospitals to help spread the word and encourage hospitals to accept dental cases now that a new method is available to report facility fees at a significantly improved Medicare reimbursement rate for costs associated with hospital-based dental procedures.

Beginning Jan. 1, CMS implemented a new facility code G0330 for hospitals to report dental services that require monitored anesthesia and the use of a hospital's operating room. Hospitals now may receive \$1,722 per case – up from \$200 that was previously paid for hospital-based dental procedures. This new code and increased payment rate should ensure better access to hospital ORs for rendering complex dental procedures to pediatric, adult or disabled patients.

AAOMS will continue to advocate with the ADA and AAPD for Medicaid coverage as well as coverage in the ambulatory surgical center setting.

Increase in Facility Fees for Hospitals

Effective 2023, hospitals have a method to report facility fees to significantly improve reimbursement for costs associated with hospital-based dental procedures.

Why is facility access to dental surgical care necessary?

- Thousands of children, adults with special needs and disabilities, and the frail elderly disproportionately still suffer from significant dental decay and require extensive dental treatment.
- The complexity of the dental work – combined with the fragile condition of the patient – often requires these services to be conducted in a hospital or ambulatory surgical center (ASC).
- Medicare coverage for dental procedures has been expanded to allow coverage for oral exams and treatment of detected infections for certain medically compromised patients. For example, Medicare will now cover an oral exam for patients prior to undergoing a Medicare-covered kidney transplant or a cardiac valve replacement – as well as the treatment required to eliminate infection prior to the transplant to help ensure the success of the procedure. Coverage will be extended to those diagnosed with head and neck cancers beginning in 2024.
- There also are many states that mandate medical coverage for anesthesia rendered in conjunction with dental procedures in a hospital setting for children, those who are developmentally disabled or those who are medically compromised.

What has changed to enable hospitals to be reimbursed for medically necessary dental treatments?

- Effective Jan 1, 2023, CMS created a new HCPCS code G0330 for hospitals to report dental services that require monitored anesthesia and the use of a hospital's operating room.
- The average Medicare facility fee paid to a hospital will be \$1,722.43 when a dental procedure is rendered in the outpatient setting, which is a significant increase compared to the previous facility fee of approximately \$200. Some state Medicaid plans also have reported they will accept this code.

Ask of hospitals

Utilize G0330

to enable oral and maxillofacial surgeons and pediatric dentists much-needed access to hospital outpatient services while **increasing facility payment to a hospital nearly ninefold from \$200 to over \$1,722** per case.

- AAOMS believes successful outcomes for patients is dependent upon hospital access for oral and maxillofacial surgeons and pediatric dentists.
- A coalition of organizations – including AAOMS, the American Dental Association and the American Academy of Pediatric Dentistry – lobbied CMS for establishment of the new HCPCS code.
- The coalition continues to work with state Medicaid agencies for implementation of Medicaid adoption of the facility code and with CMS for inclusion of the facility code in ambulatory surgical centers.

AAOMS.org/Advocacy

American Association of Oral and Maxillofacial Surgeons
For oral and maxillofacial surgeons
For dentists in New York and New Jersey

RISK MANAGEMENT

Curbside Consultations: Patient Safety and Legal Risks

by Richard Cahill, JD, Vice President
and Associate General Counsel, The Doctors Company



Informal, or “curbside,” consultations among healthcare practitioners represent an important part of clinical practice and help to promote a collegial relationship in both the clinic and hospital settings. These types of informal consultations can increase knowledge among practitioners and may also improve the care and treatment of patients who present with complex comorbidities, often resulting in more favorable outcomes. Informal consultations do, however, include inherent risks for the consulting practitioner. This article answers questions that our patient safety risk managers routinely address about the potential liability of unofficial professional consultations.

Do practitioners who provide curbside consultations risk being sued?

Risks are involved if the expectations between the practitioners are not clearly communicated at the outset of the dialogue. In a classic scenario, the consulting practitioner is sued by a patient the practitioner has neither met nor

examined—and certainly doesn't remember months or years later after a problem has developed and litigation has been initiated.

Invariably, the consulting practitioner who offered the informal advice made no written record of the encounter that could later support the basis for the recommendations. As a result, the consulting practitioner has little evidence to defend the care other than possibly relying on an established routine or habit and practice when attempting to explain the recommendations discussed. The risk of being named in litigation increases significantly if the requesting practitioner identifies the consulting practitioner by name in the patient's record and summarizes the general nature of the conversation.

What are the legal issues raised by curbside consultations?

A consulting practitioner who provides informal advice could be named in a lawsuit if a patient suffers harm because the requesting practitioner relied on the consultant's information to make a treatment decision. Both practitioners could be liable if the information failed to conform to community standards and was a proximate cause of the patient's injury. The probability that both would be named as defendants would depend on the content of the documentation made regarding the consultation, the nature and extent of the patient's injury, and the information revealed during litigation.

The preliminary legal questions to be evaluated in cases involving curbside consultations are: (1) Did a practitioner-patient relationship exist between the consulting practitioner and the patient, and (2) did the consulting practitioner, therefore, owe a duty of due care to the patient consistent with what similarly trained practitioners would have done under the same or similar circumstances?

For each affirmative response to the questions below, the likelihood increases that a curbside consulting practitioner could be named as a defendant and face possible monetary exposure for civil damages should the matter proceed to trial or arbitration:

- Did the requesting practitioner provide detailed facts that included the patient's history, comorbidities, and laboratory data?
- Did the consultant personally review any portion of the patient's record?
- Did the consultant speak directly with the patient or conduct even a cursory physical examination at bedside?

- Did the consultant recommend or order any specific tests, therapies, medications, or other treatment modalities?
- Did the consultant follow up with either the requesting practitioner or the patient?
- Most importantly, did the consultant submit a bill for services rendered?

What kinds of informal consultation cases have been litigated?

Our closed claims analyses revealed multiple cases in which informal consultations took place between practitioners and the patient ultimately suffered serious cardiac, obstetric, neurologic, hemodynamic, or other untoward sequelae. Both practitioners were named in the subsequent malpractice action. In some cases, the consulting practitioner shared in liability for the final outcome based on the degree of involvement. (See the factors outlined in the question above.)

Curbside consults have also moved to electronic communications. Does a practitioner's professional liability insurance cover consulting with other practitioners through electronic means?

It does not matter if the curbside consultation is electronic (via email, text, or telephone) or an in-person, face-to-face encounter. Due to the advent of metadata technology, the electronic footprint of the interaction exists virtually forever. The issues with informal consultations, regardless of the mode, remain the same. The fact that an email, text, or other electronic format allows practitioners who are miles—or states—apart to communicate can, however, also lead to other issues, such as privileging, credentialing, and licensure in the state where the patient resides. Professional liability insurance does not typically cover a practitioner for practice in a state where the practitioner is not licensed.

What patient safety issues are raised by curbside consultations?

From a patient safety standpoint, a verbal or electronic exchange between practitioners may lack the patient's complete clinical picture (which should include a detailed history, an explanation of presenting signs and symptoms, identification of prescription and nonprescription medications, comorbidities, findings on physical examination, and related issues).

By responding without having all the pertinent information, the consulting practitioner may provide advice that is not in the best interests of the patient. It may result in an incorrect diagnosis, the formulation of an incorrect treatment plan, or

a delay in ordering and implementing appropriate therapies. If the patient is harmed as a result, the consulting practitioner could be named as a defendant in a claim.

In analyzing closed claims, we have learned that incomplete or poor communication among practitioners is one of the leading causes of bad outcomes. This represents a major risk with informal consultations: Communication of all the necessary information to obtain and provide good clinical advice is critical.

What criteria can be used to determine whether a situation is low risk or one that requires a formal consultation?

If the requesting practitioner's questions go beyond the low-risk scenarios described below, a formal consult should be obtained instead.

- Questions are for the general education of the requesting practitioner and are not specific to the patient.
- No request is made to confirm or make a diagnosis.
- No record review is required.
- No questions are raised about ordering specific tests or studies.
- The questions are straightforward and require only simple answers and nonspecific advice.

What can practitioners do to protect themselves?

At the outset of the encounter, clear communication must take place between the practitioners that identifies the nature of the inquiry and the type of guidance being solicited. Curbside consultations are tempting to busy practitioners because they are convenient and speedy—the very reasons to avoid engaging in this practice. Also, consulting practitioners are not compensated for the time, expertise, and potential liability exposure involved. If you decide to assume this risk, consider the following strategies:

- Clarify the nature of the consult; advise the requesting practitioner that a curbside consultation should not be considered a formal consultation.
- Consider the facts *not* provided.
- Keep the consultation brief.
- Make sure the requesting practitioner is aware that the advice given is not a treatment decision.

CONTINUED ON PAGE 29

MEANING IN ETHICS



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

Meaning in Ethics & Existentialism

Though existentialism as a concept goes back to the authorship of 19th century philosophers including Friedrich Schelling, Soren Kierkegaard, Franz Kafka, and Friedrich Nietzsche, Martin Heidegger's evaluation of the philosophical principles of existentialism have been applied to the development of a science of the mind constructed around the concept of man's essential questioning. Heidegger (1889-1976) was born in Messkirch, Germany, and was influenced as a student by the writings of Kierkegaard and Nietzsche, as well as the mentorship of Edmund Husserl. Heidegger identified the significance of exploring essential questions of existence but reflected on the contextual nature of human experience and the correlation between experiential and temporal components.

Heidegger's philosophical principles regarding the nature of human experience and the analytical views of how man self-assesses in the presence of specific conditions become elements of a psychological existential process. Heidegger maintained that man continually tries to understand the

purpose or meaning of existence within the scope of man's experiences in a temporal world. Heidegger described his views of being, or in his case "Dasein," as a central entity in direct contrast with "non-existence." Because of the purposeful nature of existence and the belief in man's capacity, Dasein is constantly driven by the question of wholeness and approaches that help to determine both potential and meaning within man's experiential perspective. As long as Dasein is as an entity, it has reached its 'wholeness'. Subsequently, man is driven to continually create and recreate a sense of true self and to apply an authentic and experiential view of self within the world.

Heidegger's views are especially important when considering the nature of man's development within a world and his belief in the temporality of experience or the immediacy of the need for answers to central questions. Man seeks a greater understanding of his existence in a specific environment, and the "meaning of existence," as well as the meaning of non-existence. "Within the horizon of time the projection of a meaning of Being in general can be accomplished." More completely, it is plausible to maintain that existential conundrums emerge from a very real assessment that Dasein exists temporally, and that man's time on earth, or within any conscious existence, will someday end. As man explores his understanding of Being-in-time, he must also recognize the significance of exploring a closer understanding of Being-towards-death.

Heidegger also recognized that existential exploration and the seeking of answers to fundamental questions of purpose and meaning frequently occurred in relation to dramatic events or the progression towards death. Individuals consciously explore existential concerns when pervasive factors, including the aging, provide an impetus or a temporal directive for scrutinizing life experiences. Subsequently, Heidegger's existentialism stood as a foundation for understanding the contextual nature of experience and the importance of defining influencing factors that support answer-seeking behaviors.



Curbside Consultation - CONTINUED FROM PAGE 28

- Refrain from using email or text messages as a method of informal consultation. (For more information, see our article "[Smartphones, Texts, and HIPAA: Strategies to Protect Patient Privacy.](#)")

If the requesting practitioner continues to insist that you render a treatment decision or makes serial inquiries about the same patient, we advise that you firmly but respectfully request making a formal and documented consultation instead. This approach helps to promote optimum patient care and protects

the practitioners from possibly frivolous malpractice claims in the event of an unexpected or adverse outcome.

For additional information, contact the Department of Patient Safety and Risk Management at [\(800\) 421-2368](tel:8004212368) or [by email](#).

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 considering the circumstances of the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.

CALIFORNIA ASSOCIATION OF ORAL & MAXILLOFACIAL SURGEONS UPCOMING CE EVENTS

2023 Meetings

■ OMSA Course On-line

■ Medical Emergencies Course

Open Year Round

November (TBD)

2024 Meetings

■ January Meeting Webinar

■ 24th Annual Meeting (Anesthesia)

January 13, 2024

Southern CA - April or May 2024

VENDOR SPOTLIGHT

CALAOMS WISHES TO THANK THE FOLLOWING VENDORS THAT
GRACIOUSLY SPONSORED CALAOMS' MEETINGS IN 2023

- **The Doctors Company** - Webinar Sponsor, January 2023 Meeting.
- **The Doctors Company** - Speaker Sponsor, 23rd Annual Meeting.
- **OMSNIC/HUB International** - Residents Sponsor, 23rd Annual Meeting.
- **US Oral Surgery Management** - Luncheon Sponsor, 23rd Annual Mgt.
- **H & H Company** - WiFi Sponsor, 23rd Annual Meeting.



ASSOCIATE/PARTNERSHIP OPPORTUNITIES

BAY AREA: Oral & Maxillofacial Surgeon California Partner Opportunity. Part-time or Full-time Oral Surgeon in Northern California. IMMEDIATE OPENING! We are a well-established, high-tech, modern dental practice in the prestigious area of San Jose/Milpitas with excellent patient population, fee-for-service, and looking for a licensed, outstanding Oral Surgeon. Offering option to buy and room for growth, excellent income, flexible schedule, sign-on bonus and competitive base salary. Please contact via email at: bayarea.ospractice@gmail.com

CENTRAL VALLEY & BAY AREA: Kids Care Dental & Orthodontics is on the move... come join our incredible Doctor Group!! KCD&O has part-time and full-time opportunities for oral and maxillofacial surgeons in the Sacramento, Stockton, and San Francisco East Bay regions.

KCD&O is a doctor-led and patient-centered pediatric practice that offers multi-disciplinary services across pediatric dentistry, orthodontics, and OMFS. We are the premier pediatric group in the state of California and currently have practices throughout Northern California. You will work with an experienced practice management staff, PALS-certified assistants, and have the opportunity to collaborate and share insight with our orthodontists and pediatric dentists. The scope of practice includes routine dentoalveolar surgery, benign pathology, etc. We can assist with hospital privileges for those interested. We accept fee-for-service or PPO's. This is a phenomenal opportunity, our surgeons enjoy competitive compensation with high earning potential, a path to equity/ownership for full-time pro-

viders, and group benefits including health, dental, vision, life/AD&D and professional liability insurance, and a 401(k) savings plan. Requirements are a CA license and a GA permit. If you are interested, please contact us at 916-661-5754 and send your CV to drtalent@kidscaresdental.com

CENTRAL CALIFORNIA: Successful, established practice with the latest technology: optical scanning, 3D CBCT, etc.. Wonderful staff and support. Full time associate with quick path to partnership. We will assist with GA permit, etc. Email: rahnoms@yahoo.com

LAKE TAHOE: Dream opportunity to build an oral surgery career in the Lake Tahoe area. Our thriving, two-office practice has a reputation for taking great care of people and has excellent relationships with our referring offices in Truckee and Lake Tahoe. The practice scope is primarily dentoalveolar and implant-based, with very occasional trauma and hospital cases. Current doctors work three days a week with full-time income. Offices are all-digital with CBCT, X-NAVs, intraoral scanners, and updated equipment in both locations. Looking for an ABOMS certified (or active candidate for certification) associate leading to partnership. Must be personable, caring, and interested in making this area your forever home. Tahoe Oral Surgery is a proud supporter of 1% for the planet. Please email inquiries to rachel@tahooral-surgery.com

NORTHERN CALIFORNIA: Sierra Foothills, well established practice seeking an associate leading to partnership. Very desirable community with opportunities for an active outdoor lifestyle. Send inquiries with letter of interest and CV to bizdocjay@mac.com and nfantovrn@aol.com

NORTHERN CALIFORNIA/WINE COUNTRY: Part-time or Full-time Oral Surgeon Position - IMMEDIATE OPENING!

Offices are state of the art, with a solid patient base, fee-for-service and have full-time staff and leadership. Seeking motivated and hard-working OMS with excellent interpersonal skills. We have a well-established dentoalveolar/implant practice with room for growth and opportunity for additional procedures such as trauma and orthognathics. Candidates would be expected to establish and maintain relationships with existing and potential referring doctors in the community. This is a great opportunity for new graduates or experienced Oral Surgeons to join our established, very busy and profitable practice. Contact: 1161732OMFS@gmail.com

ORANGE COUNTY: We are currently seeking a motivated, compassionate surgeon to join our growing practice in the greater Orange County area. We have a two in one oral surgery office fully equipped in the beautiful city of Huntington Beach, CA. All current staff surgeons are board-certified with extensive experience in Dentoalveolar, implant, orthognathic, and trauma surgery. Currently both in the past and present all surgeons held or hold leadership positions in the local dental societies as well as local academic appointments. Primary surgeon is on staff at 3 local hospitals but no ER coverage is required with this position unless associated prefers. The scope of the practice includes but not limited to: dentoalveolar, orthognathic surgery, trauma, pathology, grafting, IV sedation.

Our position is for a unique individual who is caring of patients with exceptional interpersonal skills. Included with employment: salary, health coverage, 401K, CME reimbursement, mentorship with other surgeons, and more. All single or double degreed candidates will be considered as well as BE and BC. Currently this practice only has one doctor owner and seeking a well-qualified and skilled colleague with eventual partnership opportunity. Please contact Ofc managers- Rod or Mary 714-766-6560 or 949-514-8714 or send us an email: social-omfsdds@gmail.com



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 contact- Courtney
Phone: 916-783-2110
Email: courtney@drantipov.com

SACRAMENTO: Exciting Associate Opportunity! Sacramento Surgical Arts is looking to add a surgeon, seeking a partnership track, to support the growth of 3 practice locations!

We are a full scope oral surgery private practice, providing a variety of services from advanced oral and maxillofacial surgery to non-surgical cosmetic procedures.

Sign on bonus; competitive base annual salary; quarterly production bonus; partnership opportunity; benefits; retirement. CV's and inquires can be directed to tkackley@mosaicdentalcollective.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

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

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.

TEMECULA: Oral & Maxillofacial Surgeon In Temecula, CA Seeking Associate Leading To Partnership. We are offering an excellent private practice opportunity in the highly sought after Temecula Wine Country in California. This is a well-established, respected, and busy practice with an 18-year history of providing the highest level of oral and maxillofacial surgical care. We are located in the heart of Southern California that offers great weather year-round and suburban living with wineries and golf courses. Temecula is within travel distance to San Diego beaches and Big Bear ski slopes as well. Along with all these great assets, the Temecula Valley School District is ranked as one of the top school districts in California.

We are currently seeking a motivated and compassionate surgeon with exceptional interpersonal skills to join our high producing practice. Benefits of Joining the Practice:

Working with a friendly and hardworking team
Competitive compensation with bonus opportunity
Associateship that leads to Partnership opportunity
Benefits package – includes medical, dental, vision, and 401K
For Inquiries, Please Contact: Alexa Arcaira at alexa@innovativeimplant.com

SANTA CLARA: We're a group of 2 GP offices located in Santa Clara in the heart of Silicon Valley. We've been in business for over 20 years, and have been referring all OS procedures out. We recently moved to a brand new 4200 sqft, state of the art facility with 12 operatories. We're looking for a surgeon to join our team and to launch our in house speciality department. With an average of 100+ new patients a month, a great team of supporting staff, and an amazing 7 general dentists, there is so much potential for us to grow together. Please contact our manager Tim Dang by text at 408-655-4873 or email tim@PerfectSmileDentalCare.com

DOCTOR SEEKING POSITION

SAN DIEGO: An Army OMS looking to join a well-rounded practice as a partner or associate to partner.

Currently, I am the Chief of Oral and Maxillofacial surgery at Winn Army Community Hospital on Fort Stewart, GA and have a very active dent-alveolar practice as an independent contractor.

I am separating this coming summer and would love an opportunity to come back home to San Diego. Please contact me for a CV or to schedule an interview. Sergey Gazarov, DDS sgsergey@gmail.com or 858-382-2254

PRACTICE FOR SALE

IRVINE: Newly renovated oral surgery practice located in Irvine, CA. Located in a very desirable area near Hoag Health Center in a high rise medical building. The office is large enough to support multiple doctors with 3 operating suites and 3 consult rooms. All new state of the art equipment was added during the top to bottom renovation. The practice is currently in growth mode, which makes this a perfect time to purchase and turn this into a thriving practice for many years to come! Will provide transition support.

Located in Southern Orange County, Irvine is one of the nation's largest planned urban communities and encompasses more than 65 square miles. Irvine's central location—45 miles from Los Angeles, 85 from San Diego, and 15 minutes from Disneyland Resort—makes it a popular hub for Southern California travelers. There's a lot to love right in Irvine proper. From kid-friendly outdoor activities to full-service shopping, the little big city has something for everyone. Please contact:

jstraw@edoralsurgery.com 916-990-3644

SOUTH SAN FRANCISCO BAY AREA: Excellent private practice opportunity in a very attractive South San Francisco Bay Area community. This is a well-known and respected practice with a 32-year history of providing the highest level of patient care. Our facility is a free-standing, 3,000+ square foot building located in a very desirable location. We are accredited by the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF). Anesthesia services are readily available as part our close, 11-year, relationship with the premier anesthesia group in our area.

Our surgeon is looking to transition his practice to a highly competent and deeply committed doctor who is willing to do what it takes to provide the standard of care our patients deserve. Practice transition options are available including clinical and/or business mentoring as desired. Please send preliminary inquiries to: oms.transition.2022@gmail.com

WOULD LIKE TO BUY

SILICON VALLEY: Oral Surgery Practice seeks buyer to continue a decades long tradition of providing quality OMS services to a traditional referral base in San Jose, Los Gatos and Saratoga. Interested prospects can send a CV to molinelli@aol.com or call 650-347-5346.

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.

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



Dr. Anthony Spina and Dr. Victor Cimino
Chicago Surgical Specialists, Chicago, IL

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