

# The Compass

Staying the Course Through Service and Education



Volume XIV, Issue 2, Summer 2012

## Capnography - The New Standard Of Monitoring In The OMS Operator

by Peter Krakowiak, DMD, FRCD(C)

**I**t is safe to assume that most of us enjoy keeping up-to-date with ongoing progress in our field. As of January 2014, the (new) updated national standards of anesthesia practice will provide us with such an opportunity to further advance our caliber of care through integration of the newly-mandated capnography monitoring protocol. It will no doubt, just as with past advancements, be readily adopted by our OMS community. Capnography will further maximize effectiveness and our already superior procedural safety of patient monitoring which we have so diligently and continuously worked toward since the early monitoring standards were introduced over forty years ago. The application of capnography has already been an advanced airway device confirmation standard introduced by the AHA as part of their 2010 revamped ACLS protocol. Of course, as with any procedural update, the new monitoring standard will increase the need for the surgeon/anesthetist's and their supporting auxiliary staffs' education in this area. For many of us, it will also require the introduction of some additional equipment to our facilities. The new guidelines dictate the application of capnography to the routine monitoring of all sedation and general anesthesia cases.



The following has been provided to The Compass from the AAOMS and is included for your consideration prior to further discussion of capnography:

*“Since 1991, capnography has been required for intubated anesthetics, but the early technology did not make it practical as a reliable monitoring device in OMS office-based surgeries. Much has changed in the last 20 years, and today’s capnography equipment has become a more accurate and dependable source of data. Based on a review of closed claim data, the American Society of Anesthesiologists has recognized the value of capnography and mandated its use in all anesthetics including open airway moderate sedation, deep sedation, and general anesthesia.*”

*AAOMS believes that promoting a culture of patient safety in office-based anesthesia is a dynamic process that should have as its ultimate goal the elimination of all serious morbidity or mortality. In that spirit, the AAOMS Committee on Anesthesia and the Board of Trustees have approved the **mandatory use of capnography** on all moderate sedations, deep sedations, and general anesthetics **effective***

*Continued on page 16*

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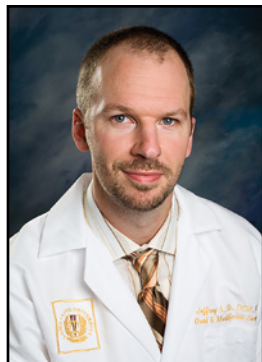
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## Editor's Corner



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

### Good posture in the office can help reduce back pain

Chronic neck and lower back pain seems to be an epidemic among dental providers, especially OMSs. We are used to standing on our feet all day long and (literally) bending over backwards (in the cases of palatally-impacted mesiodens or canines that need exposure and bonding. But are we, in the long-run, hurting our posture and spine for the future? Is there anything we can do to help prolong our careers and add quality to our lives as we age in this profession?

Correct posture is a simple, but very important, way to keep the many intricate structures in the back and spine healthy. It is much more than cosmetic—good posture and back support are critical to reducing the incidence and levels of back pain and neck pain. Back support is especially important for doctors and surgeons who spend many hours sitting in an office chair or standing throughout the day, as many of us do routinely.

### PROBLEMS CAUSED BY POOR BACK SUPPORT AND POSTURE

Not maintaining good posture and adequate back support can add strain to muscles and put stress on the spine. Over time, the stress of poor posture can change the anatomical characteristics of the spine, leading to the possibility of constricted blood vessels and nerves, as well as problems with muscles, discs, and joints. All of these can be major contributors to back and neck pain, as well as headaches, fatigue, and possibly even concerns with major organs and breathing.

### IDENTIFYING GOOD POSTURE

Basically, having correct posture means keeping each part of the body in alignment with the neighboring parts. Proper posture keeps all parts balanced and supported. With appropriate posture (when standing) it should be possible to draw a straight line from the earlobe, through the shoulder, hip, knee, and into the middle of the ankle.

Because people find themselves in several positions throughout the day (sitting, standing, bending, stooping, and lying down) it's important to learn how to attain and keep correct posture in each position for good back support, which will result in less back pain. When moving from one position to another, the ideal situation is that one's posture is adjusted smoothly and fluidly. After initial correction of bad posture habits, these movements tend to become automatic and require very little effort to maintain.

### ERGONOMIC OFFICE CHAIRS FOR BACK SUPPORT

Office work often results in poor posture and strain to the lower back. Many people work sitting in an office chair that is not properly fitted to their body and does not provide enough lower back support. One strategy is to choose an ergonomic office chair that provides better support than a regular chair and may be more comfortable, as well.

### TAKE A BREAK FROM SITTING IN AN OFFICE CHAIR

In addition, the spine is made for motion, and when sitting in any type of office chair (even an ergonomic office chair) for long periods of time, it is best to get up, stretch, and move around regularly throughout the day to recharge stiff muscles.

### STANDING POSTURE

- Stand with weight mostly on the balls of the feet, not with weight on the heels
- Keep feet slightly apart, about shoulder-width
- Let arms hang naturally down the sides of the body
- Avoid locking the knees
- Tuck the chin in a little to keep the head level
- Be sure the head is square on top of the neck and spine, not pushed out forward
- Stand straight and tall, with shoulders upright

- If standing for a long period of time, shift weight from one foot to the other, or rock from heels to toes
- Stand against a wall with shoulders and bottom touching the wall. In this position, the back of the head should also touch the wall—if it does not, the head is carried too far forward.

It is important to note that an overall cause of bad posture is tense muscles, which will pull the body out of alignment. There are a number of specific exercises that will help stretch and relax the major back muscles. Some people find that meditation or other forms of mental relaxation are effective in helping relax the back muscles. And many people find treatments and activities such as massage therapy, yoga, tai chi, or other regular exercise routines, or treatments such as chiropractic or osteopathic manipulation, etc., to be helpful with both muscle relaxation and posture awareness and improvement.

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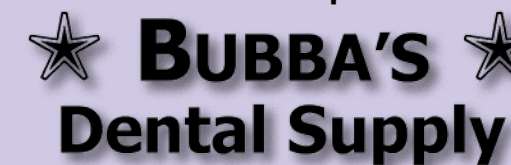
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## President's Message



W. Frederick Stephens, DDS  
President, CALAOMS

## Trial by Fire

Well, believe it or not, we are over half way through 2012 and deep into the months of summer. Hopefully, everyone is experiencing the welcome summer bump in office production and it helps compensate for the slower times we have all seen. Considering how our Board entered 2012 with the issues surrounding SB-694, the last several months have been relatively calm around the Association.

Senate Bill-694, authored by Senator Alex Padilla, continues to progress through state legislative committees. As you all know, it calls for the creation of a Statewide Department of Oral Health within the State Department of Public Health, directed by a "State Dental Director," which would be appointed by gubernatorial appointment. In addition, it orders a study to ascertain the potential for, and ability of, traditional and non-traditional dental providers to provide safe and effective dental care for children in California. The procedures performed would include irreversible dental procedures, such as tooth preparation and placement of direct

restorations, therapeutic pulpotomy, and the extraction of deciduous teeth.

As a result of this highly contentious subject and the CDA's support for this bill, a special session of the House of Delegates was called for in March. At this special session, The House voted to modify the CDA's support of the study to now include only registered dental hygienists and expanded duty registered dental assistants, and omitted other previously delineated, lesser-trained individuals. Senator Padilla has since modified his bill to reflect the CDA's new support position on the study. As this bill continues to progress through the State's legislative committees, it has largely had bipartisan support. Ultimately, and in my opinion, funding of this project will perhaps be the bigger issue for the bill.

After numerous personal conversations with CDA leaders, and as a result of the special session of the HOD's vote, the CALAOMS Board of Directors felt that we should revisit the contentious subject of our opposition to the CDA's position and SB-694. With significant discussion and debate, we as a Board subsequently voted to modify our position of "opposition" to a "watch" position at this time. This new position was chosen for a number of reasons, some of which, at least for the time being, must be kept within our leadership and out of publication. Rest assured though, this does not mean that we are comfortable with this bill. With the combined depth of our leadership experience, each member of our Board examined this issue and arrived at this position change only after much discussion and debate and ultimately based it upon what we felt was "the better play at this time."

Our relationship with the CDA is of considerable importance. As a Board, we felt that simply watching the progress of this bill at this time, especially considering its continual evolution, was the most optimal course and would best improve and establish our position with the CDA. We remain deeply concerned about the concept of any non-dentist providing irreversible care to anyone, much less children. In spite of that fact, we also respect the concept of a "cooperative association" with the CDA, and as a result have established this current position.

Please understand, a "watch" position can be changed at any time. We are monitoring this bill closely through our lobbyist and will make every effort to keep our membership up-to-date as to any changes in our position. We are here to represent and serve you—the members. Your individual opinions are highly valuable and are very important to us. As a result, we always welcome and appreciate your input on this issue.

On a lighter note, and as a segway into another aspect pertaining to perhaps a more proper way to "access care," I want to publicly recognize the hard work and expertise of our own Executive Director, Pam Congdon. As many of you know, Pam has been closely involved with RAM (Remote Area Medical) for the last couple of years. This endeavor is something that has become quite dear to her heart and important to our Association. Pam currently is the RAM California Host Coordinator and President. She organized two events earlier this year in Oakland and Sacramento, which together treated 4,893 patients and provided just short of \$1.8 million worth of dental care. Many of you participated in these events, and I also want to personally thank you for your efforts in this worthy

cause. CALAOMS' association with RAM certainly places us in a very favorable light in terms of access to dental care issues in California. As a result, no one can say that we don't care about "access to care" issues in this population of patients. Great job, Pam, and great job to those who participated!

Also and finally, I hope to see yawl at the upcoming Annual Meeting of the AAOMS in San Diego, September 10 – 15, 2012. The annual meeting is always a great time to get together with our colleagues and friends and learn from some of the best in our specialty. We all know San Diego's reputation as an exciting destination to visit, and for many of us, at least in southern California, it will be just a short drive. It also can be a welcome get-a-way after that busy summer. Hope yawl can clear your schedules for this event, for it will be very worthwhile.

I wish you a great and productive rest of the summer. Hopefully, you will also be able to find a bit of time for some rest and relaxation with family and friends...and don't forget the sunscreen!

## CALAOMS Launches "Value Added Program" As a Benefit of Membership

This August, CALAOMS is adding a new benefit of membership, "The CALAOMS Value Added Program." CALAOMS has established a group purchase program through McKesson Medical Corporation, tailored to the OMS practice.

CALAOMS member will be able to purchase items listed in the program formulary at discounts ranging from 5% to 50%. The program features on-line medical supply ordering, cost management programs, and weekly updates on Rx Medication status. This program is offered exclusively to CALAOMS and its members.

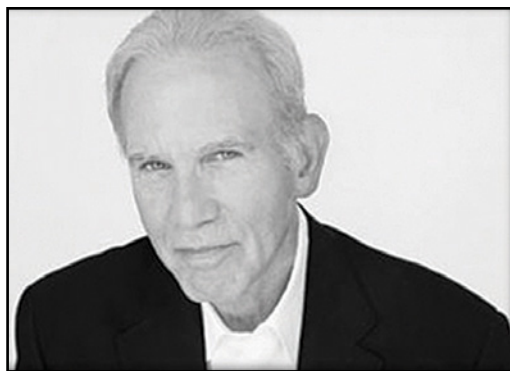
By now you should have received a flyer in the mail outlining this program. If you did not receive

the flyer you may contact CALAOMS to find out more, or better yet, go to [www.calaoms.org](http://www.calaoms.org) and look for the "Value Added Program" link.

To take advantage of the program, all you will have to do is setup a "Ship To" account under the CALAOMS parent account. You will then be able to make purchases online and pay for them with your credit card.

Members who took part in the pilot program were able to see average savings of 27.5% on their purchases. Enough to recoup your annual CALAOMS dues in as little as a few months.

Do yourself a favor and look into this program!



## THE UNCERTAIN FUTURE OF OMS

by Dr. Marc B. Cooper

*“When it comes to the future, there are three kinds of people: those who let it happen, those who make it happen, and those who wonder what happened.”*

*John M. Richardson Jr. Professor of International Development, American University*

### INTRODUCTION

Over the years, you have gotten the job done both as a clinician and a business owner. As a clinician, you continuously worked to improve your skills and stay updated on the most advanced technologies. You spent hundreds of hours and thousands of dollars on continuing education and state-of-the-art equipment to provide the best surgical care possible. You took excellent care of your patients and provided exceptional customer service.

As a business owner, you ran a good ship. You worked at being a leader, manager, and marketer so your practice would operate efficiently and profitably. You managed by the numbers. You took care of your

referrals and they took care of you. You generated a substantial personal income.

But the world has changed, and dentistry has changed along with it. What worked for your practice in the past is not working now, and clearly will not succeed in the future. What are these changes? Why are they occurring now? What actions are you considering to succeed in the future?

### CONTEXT IS DECISIVE

Context decides what wins and loses within it. The context of dentistry has changed. That which succeeded within the old context will no longer succeed in the new context. Evidence for this contextual shift is abundant. Here is a partial list of the changes that have occurred over the last few years due to this contextual shift:

- The emergence of midlevel providers
- Loss of individual state licensing
- Easy access and licensing of foreign dentists
- Significant increase in number, size, and territory of MSOs / DSOs
- Itinerant specialists, particularly in periodontics and oral and maxillofacial surgery (OMS)
- Significant reduction of available associateships in private practices
- Solo practice negotiable values decreasing
- Significant infusion of capital into MSOs/DSOs by venture capitalists and private equity firms
- A rapidly declining number of dental graduates and residents seeking ownership in dental practices
- Seven new dental schools, three of which are for-profit
- New third parties
- Acquisitions, mergers, and consolidation of suppliers
- Consolidation of 3<sup>rd</sup> parties

- Increasing number and size of Retail Corporate Dental Companies
- National specialty corporate entities focusing on implants and prosthetics
- Substantial increase in percent of PPO contracts from less than 20% a decade ago to nearly 80% today
- Emergence of state “exchange” programs and the Affordable Healthcare Plan covering some domains of dentistry
- Diminishing private practice revenues and decreasing personal income

It’s undeniable. These changes, and many more, are proof that the context of dentistry has shifted. Context is conclusive; and in today’s context, solo or small partnered specialty practices no longer have the potential for success they once had. In fact, many specialty practices are in jeopardy.

### SYSTEM CHANGES

System success and failure is context dependent. The system that is operating within this new context is distinctly different from the system that had been in place for the careers of most oral and maxillofacial surgeons. The four components of the dental system are the Purchaser (employer, government, or unions), Payer/Plan (insurance companies, capitated organizations), Provider (solo, partnered, group, DSO), and Patient (Diagram 1).

When most OMSs went to school and opened their practices, the axis of power ran from the Provider (driver) to the Patient (decision maker). The Purchaser and Payer/Plan were basically passive in this system. In this system, following the universal rule of 80/20, solo practice or small partnered practices flourished (Diagram 2).

But the system has changed inside the new context. The Purchaser has emerged as the driver and the Payer/Plan as the decision maker, while the Provider and the Patient have become more passive. Solo and small partnered practices within this system struggle whereas group practices flourish (Diagram 3).

### YOUR CHOICES

There are numerous choices which OMSs are facing today. Each one of these choices has benefits and costs, and each one carries its own set of risks and rewards (Diagram 4).

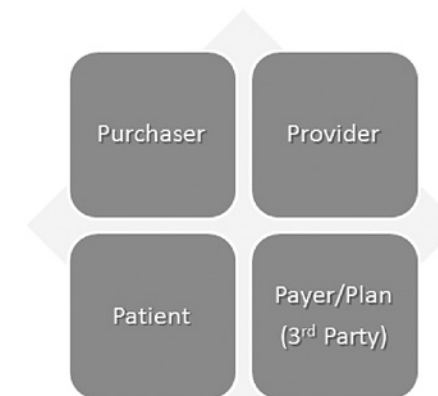


DIAGRAM 1

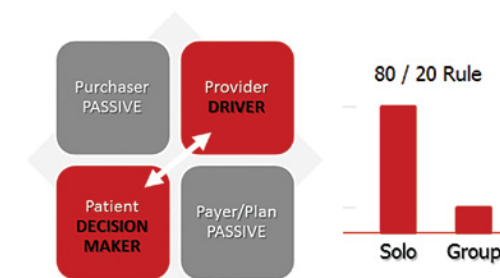


DIAGRAM 2

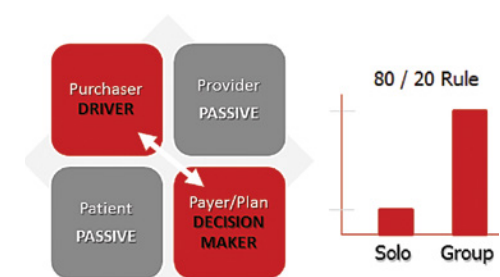


DIAGRAM 3



DIAGRAM 4

*SOLO – CONCIERGE PRACTICE*

A number of OMSs will attempt to reinvent themselves as *conciierge* practitioners. They will add a host of cosmetic and plastic surgery procedures, marketing themselves nearly 24/7 in upscale niches, building offices in exclusive locations, hiring extremely well-trained and expensive staff, developing themselves as a personality “brand,” and will be totally fee-for-service. This market is very narrow, but certainly available. Few will make it, though many will try.

*SOLO – FAMILY PRACTICE*

Solo family practice is the type of practice most OMSs have now. Unfortunately, this will be a very tough place to reside given the dwindling numbers of referrals and the downward trend of 3<sup>rd</sup> party payments. Efforts to work harder, work more efficiently, reduce costs via downsizing, expand marketing efforts via *lunch and learns*, running study clubs, doing *cookie runs*, and speaking at study clubs and conferences will not result in sustainable growth. Practice revenues will remain flat or continue to shrink. This is a *no-win* position. Older practitioners may be able to ride it out, but younger OMSs will need to seriously consider other practice models and make uncomfortable choices about which direction to pursue.

*ITINERANT PROVIDERS*

New graduate residents, or OMSs preferring not to deal with the business end of a practice, will work as independent contractors in large multiple GP/specialty enterprises such as Clear Choice, and/or group practices. The number of days per location per month will depend on the practice’s needs. The OMS usually is paid on commission.

However, as large GP practices become absorbed by expanding MSOs/DSOs, the itinerant OMS’ position in these enterprises will become highly vulnerable. Many will be replaced by existing employee OMSs of the MSO/DSO, although some of the itinerant OMSs will be offered employee positions and some stock

in the acquiring MSO/DSO. Nevertheless, in today’s dentistry, itinerant OMS is still a reasonable option for young OMSs beginning their career for the foreseeable future.

*MULTI-PROVIDER ORAL SURGERY ENTERPRISES*

Joining with other OMSs may be a viable option to counter the onslaught of decreasing revenues of solo practice. Reducing overhead and sharing management and ownership accountabilities will make use of scale. But dentists notoriously make bad partners. The majority of dental partnerships ultimately fail. Conscious and committed work which needs to be done to develop the capacity to be strong partners is discounted by most OMSs, labeled as *soft*. Choosing not to work on partnership issues and communication, not surprisingly, leads to disarray. However, as economic pressures increase, more OMSs will form partnerships with two to five doctors. The success rate of these partnerships will increase because the outside economic pressures will directly reduce their individual needs and concerns.

The successful multi-provider OMS practices most often have a strong senior doctor who leads and manages through a command and control model. In nearly every case, these multi-provider practices eventually expand into multi-provider/multi-location entities through opening new offices and/or acquiring existing OMS offices.

Currently these multi-provider partnered practices, both single office and multiple offices, are gaining popularity and becoming more present on the OMS landscape. These partnered entities will be able to make a small number of associateships available.

*MULTI-PROVIDER/MULTI-LOCATION*

Multi-provider/multi-location practices are currently experiencing moderate success. One major competitive advantage is access and coverage for their market. Again, these practices typically have a very

strong senior doctor who is in command and carries most of the weight in the decision making process.

The majority of multi-provider/multi-location practices in the U.S. are not constituted with OMSs only, but a mix of dentists, predominantly GPs, with multiple specialists. These practices are classified as multi-specialty practices. They don’t operate as a true corporate business with clear lines of leadership accountability, and rarely have a functional board of directors. It’s usually the strength of one or two of the senior doctors that generate the intention and focus of the business. These lead doctors are rarely specialists.

Successful multi-provider/multi-location practices have strong internal management, usually in the form of a *super* office manager, though many of these practices have seasoned professional management executives who come from a corporate background. A limited number of positions for OMSs are available in these entities at this time. Positions for an OMS will become available as these multi-provider/multi-location practices come into existence.

*DSOs & MSOs (DENTAL SERVICE ORGANIZATIONS & MANAGED SERVICE ORGANIZATIONS)*

DSOs function much like multi-provider/multi-location practices, but on a much larger scale. They have a number of practice locations varying from 20 to hundreds. The DSOs contract with MSOs who supply asset and personnel management, as well as other business functions, such as human resources, finance, and marketing.

The MSO owns the physical assets of the practices and have typically acquired the dental practices as part of the contract. The acquisitions are carried out with cash and stock. Currently, DSOs-MSOs are the fastest growing entities in dentistry. Both the DSO and the MSO have a corporate architecture, with a board of directors at the helm, senior executives, professional managers, and administrative support staff.

Oral and maxillofacial surgeons function in the same manner as in a multi-provider/multi-location, although they may have stock in the DSO and possibly in the MSO depending on their contractual agreements. In the DSO-MSO model, the OMS gets paid on commission, but in addition, receives a pre-determined portion of the profits defined in their contracts. The characteristics of their stock are also defined in their contracts.

The force behind the rapid growth of MSOs-DSOs is the increasing force of consolidation and acquisition which is pervading every industry. The DSO-MSO model has the greatest capacity to utilize these forces. With size comes economies of scale which defray the money lost in insurance write offs. The ability to negotiate with 3<sup>rd</sup> parties, suppliers, labs, personnel, advisers, and consultants is noteworthy given the volume of business that can be promised.

In terms of entrance strategies for OMSs, MSOs/DSOs offer some powerful opportunities. Unfortunately, for exit strategies, the need to acquire OMS practices is absent since they can find an adequate supply of OMSs from residency programs, or failing or underperforming associateships.

**CONCLUSION**

The context of dental practice has changed, that is undeniable. It isn’t going to go back ‘to the way it was.’ Solo or small-partnered OMS practices are under great duress and will have difficulty surviving in the new context.

There are many choices available to OMSs to forward their careers and maintain a portion, or all, of their assets. But every choice has a consequence. And certainly ‘doing nothing’ is a choice. But I strongly urge OMSs to investigate the choices presented in this article.

My recommendation is to form regional groups of OMSs; regional because every region is different in terms of the conditions, market, and players. Establish

leadership, set up subcommittees to explore and report on the choices described in this article - their benefits and costs, their availability for employment and ownership. Perform site visits, attend conferences, and get yourself educated in each of these choices. Then, when you have sufficient knowledge to thoughtfully consider which choice would work best, make a selection, create a strategy, and move forward with intent.

It is never going back to the way it was, so complaining and hoping won't do any good. Figure out what is best for you, which choice fits your strengths and weaknesses, consider your risks and rewards, consider access and availability, consider personal income and retirement, consider your core values, and then make a commitment and move forward into the future.

Dr. Marc Cooper's professional career includes periodontist, private practice, academician, researcher, associate professor, practice management consultant, corporate consultant, business coach, life coach, seminar director, futurist, board director, author, entrepreneur, and inventor.

The Mastery Company has been in existence since 1984. Dr. Cooper's client experience in the dental industry includes over 2,000 solo private dental practices, small partnered practices, group practices, MSOs-DSOs, suppliers, vendors, disease management companies, Think Tanks, IT Companies, Insurance Companies, and biotechnical firms. He has also worked in large hospital systems, the NASA/AMES Business Incubator in Silicon Valley, and several Fortune 500 companies. Dr. Cooper is the author of seven books, two of which, *Mastering the Business of Practice* and *Partnerships in Dental Practice*, are top-selling practice management books.

Dr. Cooper can be reached at [info@masterycompany.com](mailto:info@masterycompany.com) or through the Mastery Company Website [www.masterycompany.com](http://www.masterycompany.com)

## Ethics Debate



Steve M. Leighty, DDS  
Chair, CALAOMS Ethics Committee

### "I was just thinking about whether it was ethical to have hospital privileges..."

From my past nine years of serving on the CALAOMS Ethics Committee, the most common complaint I've received has been "poor after hours' service." Here's an example: Through a series of circumstances, Dr. A's patient, "Mr. Jones," suffers some sort of complication over the weekend and ends up seeing Dr. B for an incision and drainage, prescription medication, or some other form of minor treatment. Come Monday morning, Dr. B calls Dr. A to explain what transpired over the weekend. Instead of being grateful for the assistance, Dr. A fires back that "The patient should have followed the post-op instructions, protocol, etc.," and therefore, Dr. A has been out of the loop and can't be considered as having done anything wrong.

I have a couple of similar stories. I've had a couple of patients over the years that got worried about some oozing or a broken suture, or maybe they ran out of their pain medicine. Instead of reading their printed post-op instruction sheet or simply calling our office, they push the 'panic button' and go to the nearest emergency room/urgent care center, or they start calling other dentists and end up in another OMS' office. In a strict sense, this situation could be interpreted as abandonment, which is unethical. In reality, if Dr. A is communicative and appreciative to Dr. B, the matter is over and it doesn't come to the attention of the Ethics Committee.

What do *ethics* and *hospital privileges* have in common? This topic came up at the Western Society of OMS meeting recently in Cle Elum, Washington. About one dozen CALAOMS members attended the meeting at the Suncadia Resort, among the 75 total attendees. The featured speaker was Dr. Ole Jensen, who lectured about implant surgery in a very unique and thought-provoking manner. The Tuesday morning lecture was a demonstration of the SimMan program by Dr. David Todd.

While waiting for our Board meeting to begin, a few of us started talking about being on call and having hospital privileges. Out of that discussion arose a number of questions that might be good to discuss. *Do you have hospital privileges? At how many hospitals do you have privileges? Do you participate in trauma call? At how many hospitals do you have courtesy privileges? Do you have greater or fewer hospital cases now than at the beginning of your career?*

I'll admit I was shocked to learn this week that having hospital privileges was not required to obtain medical liability insurance coverage. I've always had operating privileges, often at multiple locations, since I've been in practice. I can't imagine not having a venue in which to perform

orthognathic surgery, treat a severe facial/odontogenic infection, or a trauma case.

None of us have identical caseloads, and we obviously utilize varying scopes of practice, but how can we be sure we will *never* need the O.R.? In my practice, 50% of my O.R. cases are *not elective*. I would feel pretty inadequate if a third molar patient developed an infection that I needed to drain, and I didn't have hospital privileges. In fact, one of my colleagues told me about a situation he knew of that played out just like that. The OMS told the patient that they "should go to the nearest emergency department," which they did. Another OMS from the community was called in (due to his on-call responsibility) and he provided the necessary treatment.

Somehow it seems to me that being without privileges would not be 'best practice,' and would not position me in the strongest arrangement with which to care for my patients, and that, in turn, makes the situation seem unethical. Am I overthinking the situation? Apparently, I'm the last to know about the changes in the requirements connecting liability insurance to hospital privileges.

We've all seen the pleas from organized OMS groups to "encourage us to take ED call to help preserve the OMS presence in the medical community and the hospitals." I thought, for the most part, that turf wars were what that issue was about; but now I'm not so sure. I wonder if we are shedding some of the ethical responsibility in providing the best care we can for the patients that are entrusted to us. Doesn't 'best practice' imply continuous and coordinated care?

Bottom line is, as modern day OMSs, we don't have to take hospital call or even have privileges to be an OMS in good standing. Are you okay with that? Is it ethical to avoid having hospital privileges since we're not required to? I invite your responses—positive or negative.

## Anesthesiology

### Ending the Era of Surgical "Clearance"

By Mona Kotecha, MD

In preparation for my next day's cases at the large academic medical center where I work, I reviewed a chart for a 90-year-old with severe spinal cord stenosis who was scheduled for extensive spine surgery to alleviate debilitating neurologic symptoms.

She suffered from a myotonic dystrophy and mild dementia. Her history was complicated by severe mitral regurgitation with severely elevated pulmonary artery pressures and a heart failure-related hospital admission the prior year, although she had not had an echocardiogram for nearly two years. Afflicted with long-standing cardiac conduction disease, she had a pacemaker placed decades ago. It had been subject to many revisions since then but had not been interrogated for a year. Her spinal cord symptoms had progressed with such severity that for the past year that she was wheelchair bound.

Her primary care provider, a clinic nurse practitioner, had seen the patient recently. "The patient is stable and she is cleared for her upcoming surgery," read her note.

What a relief, I thought to myself.

Then I rolled my eyes.

I shared my frustration with a colleague across the country who practices in a private practice. He recounted a recent case in which a primary care team "cleared" a patient with unstable angina for surgery (it seems the patient's unstable angina presented so reliably, it was "stable" unstable angina). We together recounted our favorite themes from these pre-operative "clearance" notes. "Avoid hypoxemia and hypercarbia," read several. "Recommend albuterol if patient develops asthma" read another. "Recommend spinal anesthesia," read another, referencing an anti-coagulated cardiac cripple. And my personal favorite, "recommend an LMA instead of general anesthesia."

We both laughed at what Karen Sibert eloquently describes as the ever-present "disconnect between medicine and surgery."

Why do primary care doctors and cardiologists "clear" our patients for surgery, and what does pre-operative "clearance" really mean? In "clearing" a patient, do they imply a promise of a good outcome?

I think the answer to the first question is a simple one. They "clear" patients because surgeons—and we—ask them to. Somewhere in our professional lives as peri-operative doctors, we hung up our white coats in favor of wearing scrubs full-time. Save the fortunate anesthesiology practices that have a fully integrated pre-operative clinic led by the department of anesthesiology, we defer important workups to other physicians and mid-level providers who, at times, make promises we cannot keep and operate on assumptions about the surgical experience that are not true.

And so we are faced with the common frustration of assessing patients the day of surgery who have received far too many needless tests (chest x-rays and coagulation studies where none are indicated) and some who have received

far too few (the absence of an echocardiogram in a patient with a blowing murmur and syncope).

I soldiered on with the spine case. I arrived extra early the next morning, prepared to perform a meticulous history and physical, engage in a family discussion and consult the electrophysiology service. I met the patient in the pre-operative area, where she arrived with a DNR order. My history and physical revealed that she had been aggressively titrated on calcium channel blockers for treatment for hypertension, and despite profound mitral regurgitation, she was fully paced at the rate of 50. We rescinded the DNR after a lengthy family meeting. I requested reprogramming of the pacemaker. I prepared my infusions, invasive monitors and had a heartfelt conversation with the surgeon, who I think partially hoped I'd put the brakes on the 7:30 wheels-up entirely. We planned together how we would approach the day ahead of us.

Fortunately, thanks to the patient's physical resilience and plenty of good luck, the case proceeded uneventfully.

Unfortunately, it won't be the last time I read the words, "your patient is cleared for surgery."

This is a defining time in the profession of anesthesiology. It's time to capitalize on the changes in our profession and proceed fearlessly on with the establishment of the "surgical home." If we don't take ownership of the pre-operative experience, medical and surgical hospitalists, cardiologists, primary care physicians and even mid-level providers will step up and do so. The decision to start or expand an anesthesiology-run pre-operative clinic is not without cost. It may be expensive, burdensome and temporarily take physicians out of more profitable roles. It is complicated to determine who needs to be seen, who needs a phone call,

and what tests really need to be ordered and for whom. Sometimes a pre-operative visit will save money and help a patient avoid a cancelled surgery or it may even reveal a life-changing condition. And sometimes the visit will add cost but little value. In our attempts to streamline the experience, unnecessary tests will be ordered and vice versa. But we must work through these challenges, not avoid embracing them entirely.

Let's end the era of surgical "clearance," and do what we do best, personally assess the patient's fitness for anesthesia as soon as the decision has been made by our surgical colleagues to operate. Our primary care and cardiology colleagues are invaluable team members who can best *optimize* patients well-known to them for their upcoming procedures. They can share their histories, physicals, study results and assessments of the patient's medical condition. They can share the wisdom and insight about a patient's condition that come from seeing a patient month after month. But they themselves do not personally deliver anesthetics that have the capacity to induce respiratory and hemodynamic mayhem in the operating room day after day. So they should not promise patients outcomes we cannot guarantee to deliver. Instead of asking them to "clear" our patients, let's ask for their honest assessment of just how optimally managed a patient's co-morbidities are. Because we don't really need or want a "green light" to anesthetize someone; no such "green light" exists. We can leave the long-term medical management to the experts but still take ownership of the pre-operative workup. We are, after all, the architects of the "surgical home."

**Notes:**

*Details of the cases described have been changed to protect patient privacy.*

*Views expressed are those of the individual author, not those of the California Society of Anesthesiologists.*

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*Continued from page 1*

**January 1, 2014.** This position will be reflected in the 2012 AAOMS Parameters of Care.”

Several books and countless chapters have been written on capnography in the global anesthesia literature. I will attempt to provide a fairly succinct “elementary” overview of capnography with its reference specifically to the open airway technique, as that is the direct focus of the forthcoming mandate. The open airway technique is, after all, the most common anesthetic technique in our contemporary outpatient office-based Oral & Maxillofacial Surgery practice. Recent surveys of our specialty membership have noted a very limited number of offices routinely using closed circuit intubated anesthesia care and these practices are already under more comprehensive and previously mandated standards of monitoring. I will attempt to cover the topic at a depth that is appropriate for all members of the anesthesia/surgical team and hopefully this article will be suitable as an in-service reference to all your back and front office personnel.

A good starting point in our discussion is the review of the current sentinel monitoring for open airway cases of moderate sedation/general anesthesia. All patients require pulse oximetry, EKG, NIBP, and visual airway observation. The precordial stethoscope monitor has also been included in our standards as part of office equipment requirements. It is not, however, based on my own experiences as a state examiner, a standard part of every office’s protocol and in such use for each and every case. The precordial is a great adjunct if used appropriately, but it requires active application and a greater degree of vigilance than an automated “alarmed” sentinel device such as a pulse oximeter or a capnograph. The ear piece and stethoscope connection tubing can be sometimes uncomfortable to wear and tends to restrict surgeon movements without disconnection. Cross contamination can also become an issue. Most recently, the addition of wireless technology has made the monitoring more comfortable with either a blue tooth connectable ear piece or a remote speaker.

The applications of pulse oximetry are very well established as a cardiopulmonary monitoring technique although there are significant problems with its inherent

lack of real-time sensitivity to early changes in ventilation. It is a monitoring technique based on measuring of reserve oxygenation of the blood on the hemoglobin carrier molecule, and as such does not show real-time ventilation and pulmonary perfusion issues as these surface. Only once a significant protracted ventilatory arrest has occurred and depletion of stored oxygen has taken place, the oxygen saturation changes will be detected by a pulse oximeter. The indicator response time will often lag over 2 minutes behind the actual ventilatory event depending on the individual and their level of supplemental oxygen and pre-oxygenation. It is well documented that brain injury will occur after 2-8 minutes of sustained hypoxia. Also, limited sensitivity is present with pulse oximetry to detect hypopneas or reduced ventilations, airway obstructions, or airway flow dynamics.

Capnography does provide these unique data subsets which can enhance the existing monitoring standards. These include information regarding carbon dioxide (CO<sub>2</sub>) production, respiratory patterns, and alveolar ventilation. Hence new subsets of data will be provided which can help in the differential diagnosis of any hypoxias. In a closed circuit, capnography can give more specific and direct insight into ventilation and perfusion. One of the greatest advantages of CO<sub>2</sub> monitoring over pulse oximetry is that it is stable and measurable even in low-perfusion patients or cold extremity (vasoconstricted) or low volumetric situations. Patient movements also will not affect its sampling or interpretation. There are, however, some instances where pulse oximetry will show desaturations of hemoglobin without alarm-triggering changes being registered by a capnography unit. It really depends on the default alarm setting of each type of monitoring apparatus. Most often, this will occur in cases where hypopnea and very low tidal volumes are present—not sufficient enough to maintain good saturation—but enough to register as ventilations and yield CO<sub>2</sub> output on a capnogram. So do not think that capnography will make the pulse oximeter obsolete. It cannot do this at this point. It will, however, become in our practices a great sentinel technique capable of readily identifying adverse respiratory events and, in synergism with pulse oximetry, has already been shown to be capable of preventing over 90% of adverse patient outcomes based on a recent ASA closed claim study.

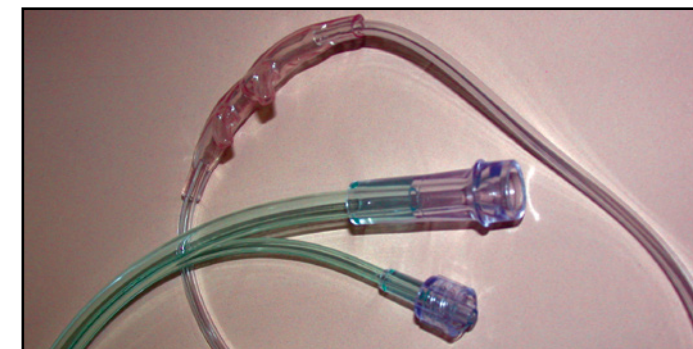
The flow by open-circuit capnography has some limitations, particularly when it utilizes nasal sampling. This limitation should be understood. Many interpretations of values possible in closed-circuit sampling are impossible due to some inaccuracy of measured waveforms and ET<sub>CO</sub><sub>2</sub>. However, there are newer devices that have improved sampling of CO<sub>2</sub> in expired air and, thus, decrease most previous artifacts. It is reasonable to use ET<sub>CO</sub><sub>2</sub> data from an open-circuit sampling to generate a baseline waveform, respiratory rate, and ET<sub>CO</sub><sub>2</sub> values, and focus attention to any changes from these baseline values. It is prudent to assume that any changes in ET<sub>CO</sub><sub>2</sub> from the baseline are due to depression of ventilation or airway obstruction until otherwise proven by close examination.

At this point, let’s take a step back and review the processes that are responsible for generation of variable levels of CO<sub>2</sub> in the sampling line. At the end of inspiration, the airway and the lungs are filled with CO<sub>2</sub>-free gases. Carbon dioxide then slowly diffuses into the alveoli, and in seconds equilibrates with the end-alveolar capillary blood ( $P_a\text{CO}_2 = P_c\text{CO}_2 = 40\text{ mm Hg}$ ). The final concentration of CO<sub>2</sub> in the alveoli is determined by the extent of ventilation and perfusion of the alveoli, known as the V/Q ratio. The alveoli, with a higher V/Q ratio, tend to have lower CO<sub>2</sub> compared to alveoli with a lower V/Q ratio that normally have higher CO<sub>2</sub> levels. As gases are analyzed at more proximal locations in the respiratory tract, the concentration of CO<sub>2</sub> decreases gradually to zero at some point. The volume of CO<sub>2</sub>-free gas is termed *respiratory dead space* and here there is no exchange of oxygen (O<sub>2</sub>) and CO<sub>2</sub> between the inspired gases and the blood. As

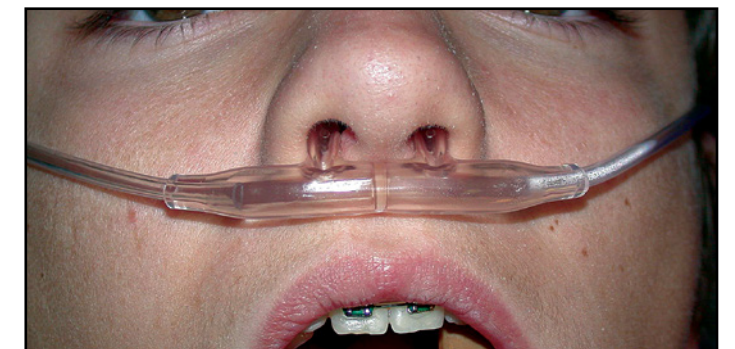
the patient exhales, a CO<sub>2</sub> sensor will not sense CO<sub>2</sub> as the initial gas sampled will be the CO<sub>2</sub>-free gas from the aforementioned dead space. However, as exhalation continues, CO<sub>2</sub> concentration will rise and then will reach a peak as the CO<sub>2</sub>-rich gases from the alveoli make their way to the CO<sub>2</sub> sensing point. At the end of exhalation, the CO<sub>2</sub> concentration again falls to zero or baseline as the patient starts to inhale some CO<sub>2</sub>-free gases. The evolution of CO<sub>2</sub> from the alveoli to the mouth during exhalation, and inhalation of CO<sub>2</sub>-free gases during inspiration gives the characteristic shape to the CO<sub>2</sub> curve that is identical in all humans with healthy lungs. This will be expanded further in the text.

Two main continuous sampling techniques are used in linear time-based capnography. The one that lends itself best to our OMS outpatient practice is a side-stream method of sampling where a sampling tube is attached to a nasal canula (Figure 1), a facemask, or a nasal hood and is connected to the CO<sub>2</sub> sensor. Usually, a pump will aspirate the gases through the sampling capillary tube. The medical gases flow to the patient via a separate line. If medical gases in addition to oxygen are used, a scavenging system may also be required for the sampling line. As an alternative, a mainstream sensor can also be placed on the main line, but this is not possible in non-closed circuit cases. The downside of the side-sampling technique is a small (2-3 second) delay in sampling due to the connection line length. Also, side-sampling lines are subject to condensation (Figure 2) and contamination, and require additional filtering and moisture trap use. The contaminants enter the sampling tubes and increase flow resistance in the

*Continued on page 18*



**Figure 1.** Combination tidal air sampling/O<sub>2</sub> delivery nasal canula circuit



**Figure 2.** Condensation is evident in the sampling line (on the patient’s left side)

Continued from page 17

tubing, thus affecting accuracy of the CO<sub>2</sub> measurements. The sampling tubes may also become occluded. Some units either increase the sampling flow or reverse the flow (purge) when a drop in pressure from a flow restriction is sensed. This will help to clear the secretions from the tube. If the occlusion is not cleared, the sampling tube must be replaced. Sometimes, liquids can enter the main unit of the analyzer despite the presence of water traps where they can cause corrosion and form residues. This can degrade the performance of the CO<sub>2</sub> analyzer. Positioning the sampling tube upwards away from the patient decreases the frequency with which liquids are drawn into the tubes (Figure 3). Interposing filters at either ends of the sampling tube can also minimize the contamination of the CO<sub>2</sub> monitor. Once the sample has been collected, the CO<sub>2</sub> concentration is analyzed through one of several methods.

The most frequently utilized CO<sub>2</sub> measuring technology involves application of infrared (IR) spectrographs. Non-elementary polyatomic gases such as CO<sub>2</sub>, N<sub>2</sub>O, or H<sub>2</sub>O vapor absorb the IR rays. CO<sub>2</sub> absorbs specifically at 4.26 microns of IR light. The amount of light absorbed is directly proportional to the concentration of the gas and the absorbance of the



Figure 3. Portable Capnograph is mounted above the patient's body height on an LCD panel monitor

sample can be compared to a known standard. The resultant data can be expressed and reported as partial pressure in mmHg or as FCO<sub>2</sub>, percentage of partial pressure over atmospheric pressure. The advancements in laser-based technology have allowed for use of narrow spectrum laser emissions to analyze very small volumes of gases with greater precision. Even small flow rates of a side-stream capillary appliance can generate very precise results using this technique—known as *molecular correlation spectrography*. Other methods of CO<sub>2</sub> analysis include Raman spectroscopy, which uses an argon laser beam and induces substance-specific scattering of particles that can then be used to identify each gas including the concentrations of inhalation agents, as well. The last two current methods of CO<sub>2</sub> measurement are mass spectrometry and photoacoustic spectroscopy. They are less common in current monitors and use principles as delineated by their names. Mass spectrometry uses mass-to-charge ratio to identify substances, and photoacoustic spectroscopy uses IR beams to cause particle-specific sound wave generation that can be measured. Finally, a colorimetric litmus based qualitative detector has been used in the past for CO<sub>2</sub> detection when the device is exposed to airway gases coming from an ET tube. The device would turn a different color (from room air color) if exposed to CO<sub>2</sub>-rich gas mixture. The colorimetric device has been predominantly advocated to verify endotracheal tube placement in emergency or field applications.

Once the data is sampled and analyzed, it is displayed on a digital screen. It will normally have that characteristic broad hump curve, as mentioned earlier, when presented in a time-based recording method. In the late 1940s, first such time-based curves were introduced to monitor nitrogen SBT-N<sub>2</sub> (single-breath test for nitrogen) and to study uneven ventilation in the lungs where instantaneous nitrogen concentrations were plotted against expired volume. The same principles were then used to follow the CO<sub>2</sub> concentration as it is plotted against expired volume. The resulting curve resembles an SBT-N<sub>2</sub> curve in shape and is called an SBT-CO<sub>2</sub> curve. An SBT-CO<sub>2</sub> curve is traditionally divided into phases: I, II, and III; and

occasionally, a phase IV, if present. These phases correspond to the limbs of the time-based tracing (Figure 4). There are distinct physiologic mechanisms which correlate for phases I, II, and III. This graphic representation of gas flow is known as a *time capnogram*. The phases correlate to inspiration (phase 0), and expiratory segments I, II, III, and possibly IV. There are also important angle measurements that are made as the phases transition, and these are known as the alpha angle (between phases II and III) and beta angle (between phase III and the descending limb). The alpha angle provides information about flow dynamics including obstructions in the airway, and the beta angle gives an indication of re-breathing in closed-circuit cases.

A standard capnogram for all healthy patients with normal breathing patterns will contain an initial CO<sub>2</sub> value of zero that will rise during the cycle and then return to zero (Figure 5). Each normal breath will be associated with a maximum ET-CO<sub>2</sub> value achievement. The absolute peak ET-CO<sub>2</sub> will correlate to the expired CO<sub>2</sub> concentration. The shape of the tracing curve will change with the length of each expiration and repeat itself based on the frequency of the respiratory rate.

General pattern recognition is adequate for OMS practice scenarios in which assessment is based on the presence or absence of the normal capnogram waveform (verification of endotracheal tube placement, apnea, upper airway obstruction, laryngospasm), or in which the abnormal capnogram shape is

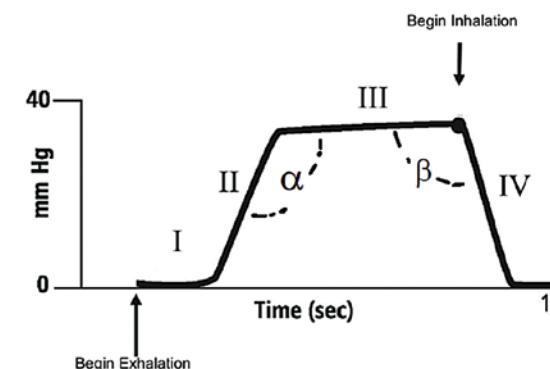


Figure 4. Anatomy of the standard time based Capnography curve

characteristic of a specific condition or disease entity (obstructive lung disease/ bronchospasm, hypoventilation, hyperventilation).

Although the surgeon/anesthetist's eye can discern gross changes in waveform amplitude and shape, it cannot recognize small, yet diagnostically significant, changes in the angles and slopes of segments of the capnogram. Without the ability to discern minor graduations in shape, open airway capnogram results may only be categorized as *normal* or *abnormal*. EKG tracings have been structured to reflect a standard suite of amplitude and interval measurements, facilitating quantitative research and operator, as well as automated, interpretation. Similar quantitative features of the capnogram would need to be available to maximize its utility as a diagnostic adjunct.

The only quantitative values provided by a contemporary capnogram are respiratory rate and ET-CO<sub>2</sub>. The respiratory rates will directly correlate to the patient's level of sedation, anxiety, and metabolic functions. Normal levels for a sedated patient are between 10-16 breaths per minute; lower rates are indicative of respiratory depression or hypopnea, and higher rates correlate to hyperventilation. Normal ET-CO<sub>2</sub> levels are usually 35 to 45 mmHg, and in the absence of COPD/obstructive airway disease correlate to adequate perfusion. In cases of respiratory depression, the ET-CO<sub>2</sub> values will tend to *increase* to over 50 mmHg. Often this value will be reached prior to any onset of hypoxemia that would be normally reflected by a drop below 90% of the SpO<sub>2</sub> value. In a (small) 2006 emergency department patient study by Burton et al., the detection of subclinical respiratory

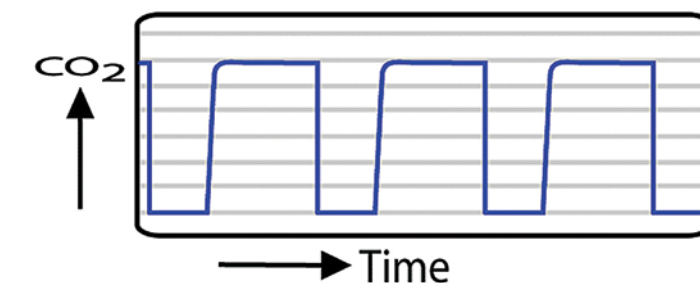


Figure 5. Normal cycles of ventilations returning to baseline of ET-CO<sub>2</sub>

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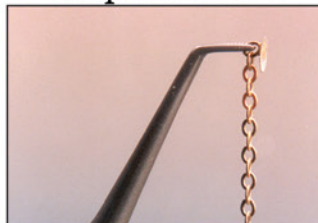
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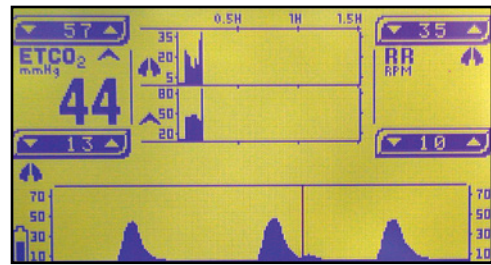


Figure 6. Normal interval breathing pattern with rate and depth variations

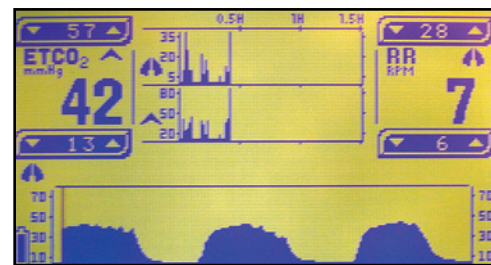


Figure 7. Bradypnea with slow expirations and elevated ETCO<sub>2</sub> levels

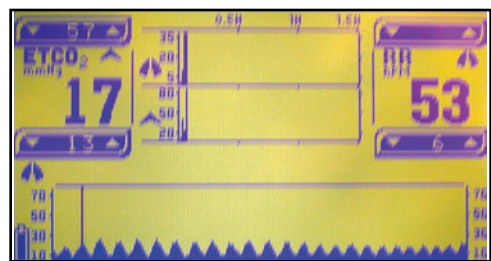


Figure 8. Hyperventilation is evident with rapid shallow breathing and fall in ETCO<sub>2</sub>

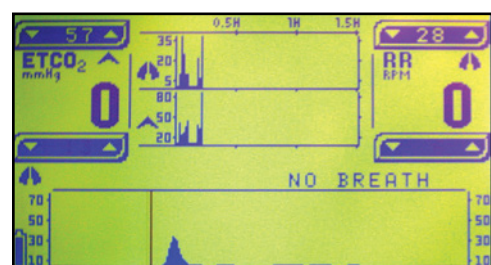


Figure 9. Full apnea or complete laryngospasm will appear as no tidal volumes and ETCO<sub>2</sub>

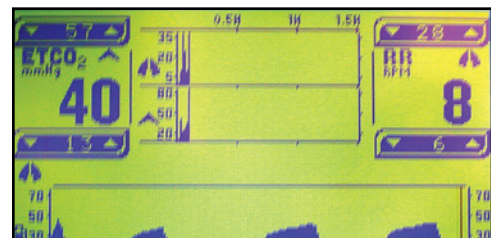


Figure 10. Pathognomonic "Shark fin" waveform indicative of obstructive respiratory flow pattern

depression lagged between 12 to (as much as) 271 seconds before being recognized by a subjective clinical interpretation of respiratory rate changes and objective SpO<sub>2</sub> monitoring.

Many commonly encountered ventilatory patterns will have corresponding presentations on a standard time-based capnograph. Their appearances can be identified and will further aid in the management of the patient. Normal physiologic variability is clinically evident between patients, as well as within the same individual over any period of time. Breath-to-breath intervals and depth will vary—especially in awake, talking patients, or ones with greater anxiety, as well as children. As the depth of anesthesia increases, these variations tend to equilibrate and become more mesomorphic on the time-based ETCO<sub>2</sub> tracing.

Some of the more common patterns noted on a capnogram in our office settings will include the pharmacologically induced ventilatory patterns such as interval breathing, bradypnea, hyperventilation, apnea, laryngospasm, upper airway blockage, bronchospasm, and full respiratory arrest. Interval breathing is a normal pattern associated with deep sedation where respiratory efforts are briefly paused and resumed at irregular intervals (Figure 6). In drug-induced bradypnea, the ETCO<sub>2</sub> will have higher amplitude and the width of each waveform will be longer. Of course, the respiratory rate will be diminished (Figure 7). The opposite will be evident in hyperventilation with much shorter waveforms but at a higher frequency of occurrence (Figure 8). Also, the ETCO<sub>2</sub> amplitude will be diminished. Apnea is obviously a full cessation of ventilation due to lack of mechanized muscle function which is centrally mediated. It will appear as no waveform (Figure 9). Partial laryngospasm can be detected by auscultation of high-pitched airway noises that fail to resolve with airway manipulation. It may not be readily identifiable by the capnogram if airway flow is still present. However, its complete variant will be evident as an apnea-like flat line when ETCO<sub>2</sub> levels are not produced, but the patient will still exhibit chest wall movement with no breath sounds on a physical examination—which will differentiate it from the standard apnea.

The capnogram is also capable of detecting bronchospasms and obstructive lung conditions. The shape of each CO<sub>2</sub> waveform will have a curved ascending phase and an up-sloping alveolar plateau (Figure 10). This characteristic "shark fin" appearance of the curve will have a wide alpha angle and is indicative of a bronchospasm or obstructive airway disease airway flow dynamic.

I wanted to end the article with some thoughts and potential solutions for updating the monitoring armamentarium in our offices to the new standards. For offices that already have multiparameter monitors that are capnography-capable, this change will mean that you will need to start using and connecting the sampling lines with your existing airway adjuncts, such as a nasal hood or nasal cannula to these full parameter monitors (Figure 11). There will also be a need to order filters or moisture traps depending on your sampling device. *That is a big consideration.* These items carry a considerable cost and may be a deciding factor for which machine is best for your practice setting. Some multifunction or pure capnography monitors do not include the needed filtering hardware. They require that additional component with each airway adjunct use. These combination sampling line/filter/moisture trap nasal cannulas are available for as much as up to \$16 per item. Having a monitor with a built-in trap (Figure 12) and filter may mean that a less expensive \$2 stand-alone sampling line will suffice. In a busy OMS office, this may translate to a \$75,000-100,000 purchasing line item over (as little as) five years of use. With the current levels of limited insurance reimbursement for this type of care, this new additional cost will certainly be a consideration for both patients and doctors.

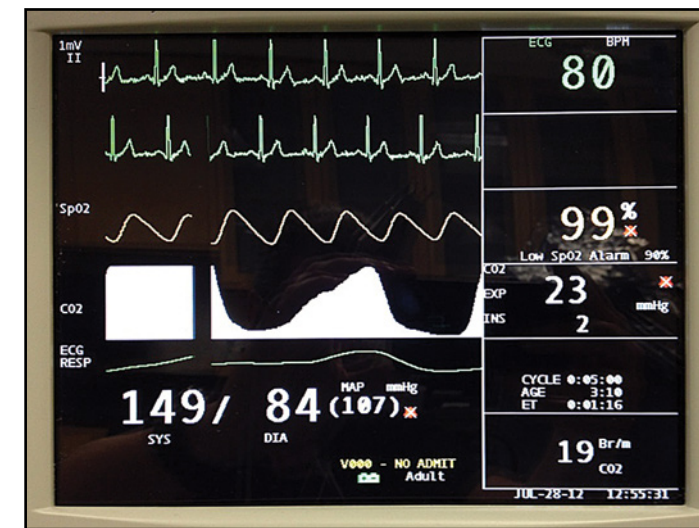


Figure 11. Multiple parameter monitor displaying all pertinent patient vital data

For those who already have equipment capable of monitoring EKG, SpO<sub>2</sub>, NIBP, respiratory rate, and temperature, and do not want to replace their existing monitor there are several small inexpensive stand-alone capnographs available to meet their needs. These are currently available for around \$1,500-\$2,000. The important factor to consider when purchasing one of these "add-ons" is once again their need for external filtering and vapor trap devices, as this will affect the long-term cost of their operations. Sometimes, buying a whole new monitor with built-in filtering technology and the ability to download all monitoring data to a digital electronic medical records base (coming to us all in 2014, as well) for a few thousand dollars more will save a bundle in the long-term. The biggest upside to these small stand-alone capnographs is their relative small size and weight making them very portable and easily moved from room to room—reducing the need for having multiple units in the office. Some of these newer portable units also do offer data transfer capabilities, as well, making them EMR compliant for 2014.

The practice of anesthetic care for Oral & Maxillofacial Surgeons is continuously evolving with constant enhancements centering on patient safety and comfort. The addition of capnography is just another of our steps in this progression. In the future, most certainly many other monitoring and anesthetic techniques will be added and adapted for our clinical use. It is incumbent on us and our staff as leaders in outpatient anesthesia to keep ourselves well-positioned to embrace these developments as they surface.



Figure 12. Built in moisture trap and filtering capnography coupler on a multiparameter monitor



Larry J. Moore, DDS, MS, FACD, FICD

## Anesthesia Belongs to All of Dentistry

*The following letter was written in response to Dr. Daniel Orr's article in the TCDS Bulletin; CALAOMS believed our members would appreciate reading Dr. Moore's response*

In his July/August TCDS (Tri-County Dental Society) Bulletin article "Pain and Anxiety are not a Joke," Dr. Daniel L. Orr, II envisions a utopia where patients of all ages and medical conditions are relieved of pain and anxiety during dental procedures by the use of anesthetic agents administered by a specialist in dental anesthesiology. Dr. Orr's opinion is grounded in the belief that should the 2012 ADA House of Delegates approve a recommendation propagated by the American Society of Dentist Anesthesiologists (ASDA) to establish a new specialty in dental anesthesiology, patients will have greater access to anesthesia services in their dental offices.

But wait! Is a new dental specialty necessary? Dr. Orr's vision is alive and well right now in every dental practice in the United States! Dentistry is different than medicine; the truth is every dentist is permitted to administer anesthesia commensurate with their

training and scope of practice. In medicine where a specialty of anesthesia exists, only medical anesthesiologists and nurse anesthetists receive training and are allowed to administer anesthesia for most procedures. These medical specialists have supported policies that prohibit the delivery of anesthesia by the same person who performs the surgical procedure, thus requiring a separate doctor or CRNA for what amounts to every significant procedure in medicine. Dentistry is different: for more than 168 years, dentists have used their model of anesthesia delivery to successfully manage the pain and anxiety of patients with a variety of health concerns.

### Who Supports a New Specialty?

Dr. Orr's article also requires some clarification. The American Dental Society of Anesthesiology (ADSA) and the American Society of Dentist Anesthesiologists (ASDA) are two separate organizations. The ADSA has around 5,000 members<sup>1</sup>, all of whom practice dental anesthesia to the full extent of their training and experience, including approximately 200 dentist anesthesiologists. The ASDA has around 200 members, and the proposed new specialty would apparently exclude everyone who does not qualify for ASDA voting membership, just as the ASDA excludes all 4,800 other members of the ADSA from its current voting membership<sup>2</sup>. It should be noted that Dr. Orr is a member of the ASDA<sup>3</sup>, the group requesting specialty recognition, and to my knowledge, the ADSA, for its part has not made any statement of support for specialty recognition for this small group of dentists<sup>4</sup>.

I am personally fully supportive of dental anesthesiology, and I respect the excellent training these dentists receive. I believe they, like other dentists, should be free to practice to the full extent of their training and experience. There are, however, important reasons not to give specialty recognition for anesthesia in dentistry to any one group, just as there are compelling reasons not to create a specialty of implantology in dentistry, or to require specialty qualification of a general dentist who chooses to extract wisdom teeth.

More to the point, Dr. Orr's utopian dream may actually be imperiled by the advent of a specialty in dental anesthesiology. Here's why:

- In the US and Canada there are approximately 200 dentist anesthesiologists (DA's), 30% of whom do not practice anesthesiology full time, and there are only 10 DA training programs<sup>5</sup>. In the interest of access to care, it would seem improbable that 200 individuals could meet the needs of the 180,000 dentists in the USA to manage developmentally-disabled, phobic, medically-compromised and pediatric patients. As a concrete example of this, each of the 6,000 actively practicing Oral and Maxillofacial Surgeons (OMS) performs an average of about 684 general anesthetics a year on their own patients for an annual total of 4.1 million cases<sup>6</sup>. In contrast, the 200 dentist anesthesiologists are estimated to perform about the same number of cases per person for an annual total of about 136,600 general anesthetics (3.2% of the current case load). At the ASDA projected rate of growth of fully trained dentist anesthesiologists, it would take over 50 years to produce a workforce capable of making a meaningful impact on the existing demand from OMS alone.
- An ADA recognized specialty of dental anesthesiology will apparently entitle only around 200 individuals to speak for all of dentistry nationally and on the level of state legislatures and dental boards regarding dental anesthesia. Will your privileges to give nitrous oxide, oral conscious sedation, and intravenous sedation be vigorously defended? Or, will dentistry go the way of medicine?
- Medicine has approximately 48,000 MD anesthesiologists and 40,000 nurse anesthetists who do a combined 40 million cases a year in hospitals, ambulatory surgery centers, and more recently in doctor's offices (including dental offices).
- There is no evidence that a specialty in dental anesthesiology will reduce patient costs. Indeed, it is likely that the anesthesia charges will be billed

separately and may not be considered covered services at a time when many patients are staying away from dental treatment for cost reasons. For example, in medicine, gastroenterologists recently lost a regulatory battle with the medical anesthesiologists and their privileges to administer deep sedation/general anesthesia using propofol. The cost per procedure rose 50% to 100% due to the need for a separate MD or CRNA anesthesia provider<sup>7</sup>.

Dr. Orr is correct in stating that pain and anxiety are not a joke – not for the dental profession or for our patients. The creation of a dental anesthesiology specialty is not a decision to make in the spirit of goodwill. All of dentistry will live with the outcome for decades to come. On their website, the ASDA states, "It is time." But is it really? Don't let the control of your practice slip through your fingers. Anesthesia belongs to all of dentistry, and every dentist can administer this therapy to their patients within the scope of their training and practice – even dentist anesthesiologists.

Larry J. Moore, DDS, MS, FACD, FICD  
Immediate Past President, AAOMS

Diplomate, American Board of Oral and Maxillofacial Surgery and the National Dental Board of Anesthesiology  
Chino Hills, CA

### Endnotes

1. American Dental Society of Anesthesiology web site, [www.adsahome.org](http://www.adsahome.org), July 30, 2012.
2. Author's personal opinion based on several face to face meetings with the leadership of the ASDA.
3. ASDA website, "Find a Member", Las Vegas, Nevada, [www.asdahq.org](http://www.asdahq.org).
4. The author is a member of the ADSA
5. ASDA Application for Specialty Recognition in Dental Anesthesiology.
6. Data provided by OMSNIC, professional liability carrier for 85% of all practicing OMS.
7. Waking up to major colonoscopy bills, NY Times, May 28, 2012, Roni Caryn Rabin.



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

## MEDICAL ERROR DISCLOSURE: IS IT SAFE TO SAY YOU'RE SORRY?

With respect to error, the practice of medicine/dentistry is a business no different from any other industry; when mistakes are made by an operator, they are both acknowledged and rectified. Most times an apology accompanies the correction, such as with an overcharge at a retail store or an incomplete repair at the mechanic. However, when a health care practitioner makes an error, the corrective measure is not as simple as a refund or redoing the procedure; rather, mistakes are not readily accounted for and even hidden with the hopes no one will find out. The extent to which medical errors can maim or otherwise compromise the patient's quality of life is both grand and far-reaching; that disclosure is not always forthcoming speaks to multitude of personal and legal trouble the responsible party seeks to avoid. Given today's litigious social climate, the propensity for medical errors to remain undocumented is a risk factor that stands to detrimentally impact not only the practitioner but also all those who were even remotely involved, including the hospital or clinic.

Weighing this risk while at the same time respecting the patient's ethical right to know the truth presents a dichotomy that may be equally resolved with a simple two-word phrase: I'm sorry.

Health care providers must focus on the overriding purpose of disclosure: to provide patients and families complete information about their care. Appropriate treatment decisions and planning require this level of honest communication. The decision to disclose shouldn't revolve around efforts to avert litigation, but rather around the shared goal of providing patients and families information needed to make decisions about next actions. Now compelled to disclose, health care providers are learning that the practice may be less detrimental to malpractice outcomes than predicted and that it may be beneficial to reasonable claim management efforts. In spite of earlier fears, experience is demonstrating that disclosure actually may be viewed favorably by jurors and the community.

Determining when an apology is warranted and when to issue one is an ongoing process throughout much of the country as hospitals and other health care facilities grapple with producing such policy. We can learn much on this subject from internist Albert Wu, M.D., M.P.H., Professor of Health Policy and Management and Medicine at the Johns Hopkins School of Public Health. His teachings focus on patient outcomes and quality of care, and he is widely published in the field. Wu has illustrated variants with which said procedure is developed, which typically occurs on the heels of research data showing a utterly low percentage of respondents who say they report medical errors to their supervisors, much less the patient or his/her family. Wu notes that patient demands were far more reasonable and less litigious than what the medical industry as a whole believed them to be, inasmuch the top four requests they wanted fulfilled in relation to an error were 1) being told what occurred; 2) having the guilty party assume responsibility; 3) being assured enough was being done to prevent the same thing from happening to someone else; and 4) given an apology.

Wu is quick to point out, however, that each situation presents its own set of circumstances where an apology may or may not be warranted and then how it should be accomplished. Also of consideration is the type of apology - of which there are three - to use in a given situation: complete and genuine that assumes liability, non-specific that does not accept or deny blame, and the absence of any apology whatsoever; the noncommittal nature of the latter able to be construed either way as being culpable or not. Apologies have long been linked to automatic blame; however, Wu notes how the trend is shifting to an entirely different perspective that actually now considers a sincere apology as a bridge between a remorseful health care provider and a patient who simply wants to be involved with the problem pertaining to his or her own body. There's a worry that apology is tantamount to an admission of guilt, but it appears that patients do not seem to see it that way. Observers have noted they don't think there has ever been a case where the fact that the physician apologized wound up figuring into a lawsuit; and if it did, it was only to the positive: patients observing that the physician was honest and sincere seemed to understand that they had suffered and thought better of the physician as a result.

A model for establishing an effective error disclosure program includes some basic concepts such as coming right out and admitting wrongdoing at the first disclosure meeting and keeping things clear and concise by not adding or subtracting any pertinent details. Speculation of what should have occurred only serves to place the health care provider in a greater position of potential harm, inasmuch as he or she cannot veer off into 'what ifs.' The announcement of something bad happening, but no details, are yet available to say exactly what brings the patient into the situation rather than isolating and keeping it a secret. That the details are not confirmed is offset by the patient's appreciation for being respected and informed. This discussion is most appropriate as soon after the occurrence as possible. Wu points out how the more that discussion occurs in real time, the more it really is part of the normal discourse between physicians and patients informing them about their

condition, and the less it seems like something that ought to merit a malpractice suit.

When used appropriately, an apology holds a number of benefits for diffusing an otherwise complex situation, such as negating emotion and thereby neutralizing communication, downgrading the inherent anger associated with the occurrence of medical error, and affording the simple gesture of respect toward the patient. Whether it was a system or personal error, apologies can be tailored to reflect the genuine intent of the speaker is trying to convey: 1) I am sorry for doing that/not doing this; 2) I apologize for the system's application failure; or 3) for an undetermined reason why the error occurred--this happened while I was on duty, and as such, I accept onus for the outcome.

Effectively tailoring a medical error disclosure involves a number of elements, not the least of which includes utilizing understandable policies and procedures attuned to the needs of both patient and family; open communication that incorporates the critical components of compassion, commitment, and concerned; mediation that opens communication; venting; flexibility in how conflict resolution is approached; and last, but certainly not least, an apology.

Decisions regarding selection of judicial review/venue (e.g. settlement, arbitration, jury trial) are between the attorney and doctor. For eighty percent of the cases brought before mediators under the auspices of Alternative Dispute Resolution (ADR), the ability for a positive, mutually workable outcome for all parties involved precludes the need for the more time-consuming and costly aspects of litigation; for the other twenty percent, formal litigation is typically the next step for resolution. However, taking the requisite steps through the mediation process - even if the absence of a satisfactory resolution ultimately leads to legal action - helps to establish a necessary foundation upon which to narrow the issues, making formal litigation more manageable. Several situations pertaining to may deem ADR an unsatisfactory choice for resolving an issue, not the least of which includes:

- A definitive or authorized resolution of the matter is required
- The matter significantly affects other parties not part of the same mediation process
- A full public record of the proceeding is important
- The Agency requires continuing jurisdiction over the matter in dispute
- The dispute involves certain very sensitive issues

The ADR approach – a method by which a neutral party oversees the resolution process of problems and conflicts – has long been considered an effective method of defusing unproductive situations. Inasmuch as conflict is not without its value within the scope of ethical concerns in the medical community, it stands to reason how no two people will always come to agree upon a single solution – especially if they are on opposing sides of the issue. For the most part, encountering positive resolutions is not the norm, inasmuch as conflicts over medical error too often manifest themselves in the form of destructive tendencies. This is why ADR has continued to be a most sought after method of resolve. Interestingly, most people do not understand what it takes to successfully manage their conflicts in a productive manner when emotions reach such a high level, which is why the situation often gets out of hand before it is resolved. ADR equips all parties involved with this knowledge, ultimately teaching them how to address the situation through calm and constructive negotiation.

Error and apology are part of a cultural change that is really necessary in institutions. There needs to be greater acknowledgement all around that we are fallible, that the mistakes are inevitable, and they will happen even in the best institutions and even involving the best and most well-meaning clinicians. I think patients need to understand, too, that the people who are taking care of them are human, and things can and do go wrong. I think that increased awareness of the inevitability of errors allows institutions to place appropriate emphasis on managing their institutions with that reality. Errors will always happen; the trick

is to manage those risks, manage that uncertainty, manage those errors, and to still come out in the end with the best outcomes for patients.

Given that a medical malpractice lawsuit can damage and even destroy the health caregiver's career, it is not difficult to understand why errors are not readily disclosed even when the practitioner knows it is his or her ethical duty to do so. Weighing the risks of disclosing the mistake impacts many others besides the practitioner, which is why the notion of enterprise risk management (ERM) is taken into consideration where apologizing is concerned.

The disclosure of adverse events, or unanticipated outcomes, is an evolving process in health care. Difficult issues center on when, how, and what to say during disclosure. Concerns persist about the legal damage that can result from a poorly conducted disclosure discussion. Hearsay may become 'fact' by virtue of thoughtless comment or patient misunderstanding. Apology may be misinterpreted as culpability. Discloser discomfort may be seen as dishonesty. Careful education, process development, and training can overcome these concerns.

The primary components of ERM are to look at the dangers and benefits from a holistic vantage point rather than merely draw upon the negative and try to figure a way to avoid culpability. This structured analytical process incorporates the objective of identifying and eliminating the financial impact and volatility of a portfolio of risks rather than on risk avoidance alone. Ultimately, enterprise risk management seeks to empower practitioners with the understanding that disclosure is not the career ending action it has long had the reputation of being, as well as to fortify a greater competitive benefit inherent to telling the truth.

The six primary domains of ERM include: 1) operational: brought forth directly from the organization's core business systems and practices, not the least of which includes outpatient care and clinical services; 2) financial: impact to the organization's

potential for earning, raising, and/or accessing capital. Additional risks include relationship to risk transfer, as with insurance premiums and bonds; 3) human: recruiting, retaining, and managing staff which include worker's compensation, absenteeism, turnover, discrimination, and unionization; 4) strategic: ability to achieve growth and expansion as with mergers, profitability, and joint ventures, financial performance, and customer satisfaction; 5) legal/regulatory: health care regulatory and statutory compliance, accreditation, and licensure that includes OSHA policies, Medicare-related status, HIPAA conformity, and JCAHO accreditation; and 6) technological: risk associated with biomedical and information technologies, equipment, devices, and telemedicine [such as] clinical information systems such as computerized physician order entry and radiology picture archiving and communication systems and off-site monitoring of critical care units.

While it is true people in the position of caregiver are bound to make mistakes for no more sinister a reason than simple human error, there are also times when ill-conceived deeds - even with the intent of doing good - need to reflect just as high a level of accountability for the ensuing mistakes; to remain quiet is not only a breach of personal and medical ethics, but it defies the growing trend toward the incorporation of enterprise risk management where upholding onus is concerned.

The phrase "no one is perfect" takes on an entirely different meaning when applied to the health care industry, particularly when it comes to the prevalent nature of medical errors; with recent data illustrating how accepting culpability through full disclosure and apology can - in many situations - actually fend off litigation rather than encourage it, health care providers who are more inclined to look the patient directly in the eye and offer a genuine "I'm sorry" stand to empower themselves with a renewed ethical and professional conscience.

Apology and disclosure has ethical implications (i.e. professional and personal moral duties)

to the patient/family, and medical situation. These concerns directly affect the best interests of patients. If a physician makes a mistake which injures the patient, it is an ethical duty to tell the patient. The doctor should not keep silent and hope the patient doesn't discover the error. And even if there was no error, the patient needs to be fully informed as to how an adverse outcome occurred. The physician must not treat the patient as a potential legal adversary, and couch his or her statements accordingly. They must be honest and forthright and always act in the patient's best interests. Moreover, expressions such as "I'm sorry," whether or not they convey an admission of responsibility, demonstrate caring and empathy. Such a demonstration of concern is an essential part of the physician-patient relationship.

The physician has several personal duties paralleling physician duties, to wit: always practicing with veracity; honoring patient autonomy in managing the patient's medical situation; thorough informed consent for procedures; respecting personal dignity; enhancing human flourishing; promoting the common good and social justice; maintaining beneficence and nonmaleficence; curbing paternalism; respecting persons/personhood; maintaining patient's right of privacy.

In sum, the mission of the physician includes both professional and personal duties to their patients. Respecting these duties increases quality of life for all concerned. The ethical approach for the physician is to specify what is best for her patient and for the patient to be completely involved in that decision. Should an error occur, the physician should be sensitive to both professional and personal moral duties, and act accordingly.

This paper really just takes a snapshot observation at a complex subject, and it is my intention to bring a sensitive issue to the fore, in hopes that the reader considers all relevant possibilities and perspectives, prior to coming to a plan of action when faced with medical error disclosure.

## My First Years After OMS Residency

*submitted for The Compass by a 2010 California OMS residency program graduate*

Confidence in the economy was at the lowest in the final two quarters of 2009. Unfortunately, this was the exact time that I was trying to find a job—the completion of my OMS residency training being June, 2010. My co-resident and I had no idea where we were going after residency was over. He had student loans for both he and his wife to pay off, as well as two kids to provide for, not to mention housing, car payments, and insurance coverage. I had student loans for both medical and dental school that would rival most average mortgages. We both felt that once residency was over there was a ticking time bomb of loan payments that we needed to take care of. He decided that he would take his family anywhere in the country that would make him financially secure, and I decided that I wanted to stay in southern California to be closer to my family.

At the time we finished residency in June, we were both in limbo. There were interviews and “talks” for both of us, but nothing solid had yet materialized. There were people calling that were “interested in adding an associate.” There were dinners and office tours, but in the end all those interviews and talks fell through—people just weren’t as ready as they thought they were. We both got the same disappointing phone calls. The practices we hoped to join never ended up hiring anyone due to the decrease in production the economy caused. My co-resident ended up finding work out of state, and I ended up planning to build a practice in a crippled economy against all reason.

During the planning and building of my practice, I had to support myself. I found whatever work I could and said yes to it. I covered for a sick OMS for a reasonable daily rate. Friends who were general dentists brought me into their practices to work. I checked every classified ad on 3-4 websites on a daily basis looking for work. I drove 2 hours (each way) for work on some days. Needless to say, it wasn’t what I had dreamed how my career would start when I was in residency, but in a lot of ways, I was lucky—I had found consistent work. Regular work and practices that were decent to both their patients and doctors were, many times, not easy to find. One practice I worked for didn’t pay me for three months, and sent a letter from a lawyer when I refused to schedule work with them. I quit working for a few practices when I didn’t agree with their practice philosophy.

Other surgeons that finished residency at the same time I did have very similar experiences. We bonded over trying to make ends meet. One friend would call and ask if I had any leads on work because he was only working two days a week. Another friend would call to vent about the practice policies in an office, or the difficulties of working with new staff every day. We all felt the pressures of our student loans and bills piling up. Invariably, we all planned to stop traveling and build our own practices someday.

I look back into the recent past and know that it was a struggle. It’s not easy training new staff or arranging assistants to work with you. It’s not easy dealing with new equipment or chairs and lights on a regular basis. Now, thankfully, most of my time is spent in my own practice. I still do work outside of my office, but do so with an established specialty group instead of just walking into a dental office and working.

I still get calls every now and then either from a surgeon looking for work or a dental practice looking for a surgeon. I don’t hesitate to help them out because although I am not looking for work anymore, I know what it felt like when I was.

## 2013 January Meeting and Anesthesia Symposium

Friday, Jan. 18 - Sunday, Jan. 20, 2013

Saturday Topic: “Meeting Today’s Challenges in Anesthesia for Oral & Maxillofacial Surgery”  
Speaker: Andrew Herlich, DMD, MD, FAAP



“Office-based Ambulatory Anesthesia: Benchmarks and Outcomes”  
Speaker: Thomas B. Dodson, DMD, MPH

### Sunday Topics

“LMA’s as a Routine Airway”  
Speaker: Frank L. Pavel, DMD





## New Cleft Treatment Clinic Opens in Los Cabos, Mexico, April 2012

by Jeffrey J Moses DDS, FAACS

Between the dates of April 22-29, 2012, CALAOMS member Dr. Jeff Moses began a new project entitled, “Sonrisas de Los Cabos,” where surgical, speech/audiology, ENT, and dental services were performed on some of the hundreds of children afflicted with facial cleft deformities living in the 500 mile region north of Los Cabos, Baja Sur, Mexico. A special note of thanks is given to KLS Martin USA, Inc., for making the acquisition of \$12,000 worth of surgical instrumentation possible through a discounted donation. KLS Martin also donated a \$5,000 travel grant to the University of Michigan’s craniofacial division—managed by surgeon, Sharon (Ron) Aronovich, to assist in this project.

The Rotary Club of Cabo San Lucas arranged for the local charitable service organization, DIF, to bring children to the pilot clinic organized and run by the Smiles International Foundation. Some of these families were given transportation by the DIF, traveling as far as 12 hours by van and bus to be able to be screened and given treatment plans for surgery which will be performed twice annually in the months of April and October from this time forward. One “poster-child” was selected, along with his facially-clefted stepfather, to be the first two cases operated at the site in order to fully test the facilities and ensure safety, and to identify the future needs for equipment procurement for ongoing projects.

The father declined surgery on the operation day due to his many concerns over the large family he had brought with him, and to give additional assurance—in his thinking—that his son would not be postponed

or cancelled. After questioning the father in translation, it appeared that he had been offered surgical correction as a child and was extremely disappointed when his surgery was cancelled, which led to a lifetime of ridicule by his classmates and others who tortured him growing up about his facial deformity. After successful counseling, the father agreed to complete his surgery this upcoming October.

Little Alexis was successfully operated on, and the hospital—owned by one of the local Rotarians—was beautifully equipped to allow safe anesthesia and perioperative support. Additional ambassadorial benefits were added to this pilot mission through the surgical assistance of several of the doctors, psychologists, and dentists who are members of the Rotary Club of Cabo San Lucas; they are able to provide ongoing follow-up.



*Alexis pre-operation*



*Dr. Moses takes Alexis back for surgery*



*Alexis post-operation*



*Alexis' mother holds Alexis after surgery*

The overall monetary service of the April mission, “Sonrisas de Los Cabos” totaled **\$18,430.00**

All travel, housing, and professional expenses were completely (personally) donated by the team participants. We anticipate that this region’s patients and their parents will be delighted to see the group members return season

after season, which will give their families the comfort of longitudinal care and a feeling of “growing within the clinic family.” It also will give our volunteers the pleasure of watching these children grow up healthy and enter society functionally. Interested volunteers can visit the website, [www.SmilesInternationalFoundation.org](http://www.SmilesInternationalFoundation.org)



### American Board of Oral and Maxillofacial Surgery

Congratulations to the following CALAOMS members who recently completed their certification to become a Diplomate of the American Board of Oral and Maxillofacial Surgery:

*Hector A. Caballero, DDS*

*Daniel Y. Hsu, DDS, MD*

*Gabriella M. Tehrany, DDS, MD*

*Tina I. Chang, DMD, MD*

*James O. Jacobs, DDS*

*John E. Tillner, DDS*

*Allen T. Chien, DDS*

*Jae H. Jun, DDS, MD*

*Richard Ting, DDS, MD*

*Adam T. Clark, DDS*

*Adel S. Khalil, DDS, MD*

*Stephen T. Wat, DDS*

*Nikhil K. Desai, DMD, MD*

*Eric Kim, DDS, MD*

*Ian Woo, DDS, MD*

*Bao-Thy N. Grant, DDS*

*Yuko C. Nakamura, DMD, MD*

CALAOMS recognizes the significant time, energy, and dedication that went into achieving this professional status and commends these doctors for their efforts.

## Legislative Update

### “Under the Dome”

by CALAOMS Legislative Advocate Bryce Docherty

With nearly 3,000 pieces of legislation introduced annually, CALAOMS has identified approximately a dozen bills that are being actively tracked. CALAOMS has adopted “hard” positions of Support or Oppose on many of these bills.

Below is a brief look at some of the more noteworthy legislation CALAOMS is actively tracking this year that either have an impact on dentistry in general and/or oral and maxillofacial surgery specifically.

**AB 2214 (MONNING):  
HEALTH WORKFORCE DEVELOPMENT**

**CALAOMS Position: Support**

**Status: Senate Appropriations Committee**

**Summary:** This bill would require, until January 1, 2019, the California Workforce Investment Board to establish the Health Workforce Development Council to help expand California’s health workforce in order to provide access to quality health care for all Californians. The bill would also require the council to perform certain duties, including seeking expertise from multi-sector representatives to enhance the understanding of the issues and policies needed to

ensure that California has the necessary workforce to provide access to quality, and culturally and linguistically appropriate health care. Lastly, the bill would require the council to inform the Legislature of its health initiatives and progress.

**AB 2252 (GORDON): DENTAL COVERAGE – PROVIDER NOTICE OF CHANGES**

**CALAOMS Position: Support**

**Status: Senate Appropriations Committee**

**Summary:** This bill would require a plan providing dental coverage that automatically renews dental provider contracts to, upon renewal or on an annual basis no later than July 1 of each year, make available to the provider, upon request by the provider, a copy of its current contract and a summary of all of those changes made since the contract was issued or last renewed, whichever is later. The bill would also require a plan providing dental coverage to provide at least 45 business day notice to dentists providing services under its plan contracts of any material change to the plan’s rules, guidelines, policies, or procedures concerning dental provider contracting or coverage of or payment for dental services.

**SB 694 (PADILLA):**

**CALAOMS Position: Neutral/Watch**

**Status: Assembly Appropriations Committee**

**Summary:** This politically charged and highly controversial bill within dentistry would create the Statewide Office of Oral Health within the California State Department of Public Health with a licensed dentist who shall serve as the Dental Director. The bill would also establish the framework for a dental workforce study identical to the elements adopted by the CDA Special HOD Resolution (1S6) to address access to care and unmet oral health needs of children in underserved areas of California. After much

### New Course Added for CALAOMS Members

Managing the OMS Practice Beyond 2012 – How the Affordable Care Act Will Impact Your Practice.

CALAOMS leaders attended the AAOMS Leadership Conference this past June at AAOMS Headquarters in Rosemont.

Karin Wittich, AAOMS Associate Director for Practice Management and Government Affairs shared information, both federal and state related, on pending legislation and regulation. Karin discussed issues related to reimbursement, coding, billing and alternative payment models.

After Karin conveyed issues that OMS will be facing in the future, the CALAOMS Board felt it would be timely and beneficial to have Karin come address our membership and provide information on upcoming possible concerns of Managing our practices.

Karin will provide two courses in California from 9:00am – 4:00pm on:

**September 26, 2012 at the Hilton Oakland Airport Hotel**

And

**October 10, 2012 at The Hotel Hanford in Costa Mesa**

We encourage all CALAOMS members to attend and bring their office manager. Please go on to [www.calaoms.org](http://www.calaoms.org) to register for the course, or call CALAOMS headquarters at 800-500-1332 to request an emailed or faxed registration.

deliberation, CALAOMS has reluctantly removed its opposition to this bill.

Notwithstanding the positive elements of this bill, such as creating the Dental Director for the Statewide Office of Oral Health, it would also unfortunately seek to study expanding the current scope of practice of mid-level dental providers rendering specific services on children under the supervision of a licensed California dentist.

CALAOMS applauds the author for his commitment to the stakeholder process where several concerns from many dentists regarding the study portion of this bill were discussed. Furthermore, CALAOMS greatly respects the process undertaken by CDA to try and assuage these concerns as well.

CALAOMS continues to closely monitor and review ongoing amendments to this bill and reserved the right to change its position at any time.

**SB 1528 (STEINBERG): MEDICAL MALPRACTICE COMPENSATION**

**CALAOMS Position: Oppose**

**Status: Assembly Floor – Third Reading File**

**Summary:** This bill would express the intent of the Legislature to establish a framework for compensating persons with injuries due to the fault of third parties. The bill would also specify that when a person is compensated for an injury due to the fault of another, the lien rights and other rights of the parties provided in specified provisions should be maintained. A prior version of this bill included provisions that would have weakened MICRA. Senator Steinberg intends to rework some of those provisions but CALAOMS continues to work with CAPP in opposing the bill until an agreement that does not weaken MICRA can be reached.

*“If you miss a day “Under the Dome” – you miss a lot!”*

## Risk Management Corner

### When the Unthinkable Happens: Steps to Take in the Event of a Treatment-Related Death

By Pamela Willis, RN, JD, Patient Safety/Risk Manager,  
The Doctors Company

The treatment-related death of an oral and maxillofacial surgery (OMS) patient is a rare but distressing situation. During the immediate aftermath of a patient's death, although emotions and anxiety are running high, there are specific reporting requirements that the practitioner must meet.

The first step is to immediately contact your professional liability insurance carrier. As the endorsed carrier of CALAOMS, The Doctors Company offers assistance to its OMS members in these difficult times. Our Claims and Patient Safety Departments are dedicated to protecting members. The incident must be reported in writing as soon as possible to your regional claims office. For assistance with this process in Northern California, call (800) 321-3242, and in Southern California, call (800) 328-8831. Be prepared to relate the facts of the event to the claims specialist when you call.

You may also wish to discuss the incident with a patient safety/risk manager at The Doctors Company. Such a discussion does not constitute notice to the company of a potential claim, but the patient safety experts can provide

helpful resources. For example, if there is disclosure of circumstances that must be shared with the patient's family or next of kin, patient safety/risk managers have expertise in disclosure and will gladly assist with this process. Contact the Patient Safety Department at (800) 421-2368, extension 1243, to be connected with a patient safety/risk manager anytime, day or night.

California Business and Professions Code 1950.5 outlines the requirements that an oral and maxillofacial surgeon must fulfill in the event of a patient's death:

*...report to the board in writing within seven days any of the following:*

*(1) the death of [a] patient during the performance of any dental or dental hygiene procedure;*

*(2) the discovery of the death of a patient whose death is related to a dental or dental hygiene procedure...*

*Upon receipt of a report pursuant to this subdivision the board may conduct an inspection of the dental office if the board finds that it is necessary. A dentist shall report to the board all deaths occurring in his or her practice with a copy sent to the Dental Hygiene Committee of California if the death was the result of treatment by a registered dental hygienist, registered dental hygienist in alternative practice, or registered dental hygienist in extended functions...<sup>1</sup>*

A claims specialist may be able to help you ensure that this required written report to the Dental Board is well formulated, so contact

your carrier as soon as possible after the event occurs.

In the event of a patient death, the following recommendations may assist in the defensibility of any possible claim:

- Do not add to, delete from, or otherwise alter a medical record.
- Place the medical record in a safe place.
- After making a report to your liability carrier, keep copies of your correspondence in a safe place—not in the patient's chart—for future consultation.
- Always require the patient's legal representative's signature to release a copy of the medical record or any information within it.
- Do not discuss the event with anyone other than your claims specialist, patient safety/risk manager, or defense attorney.
- Do not make contact with anyone associated with the case except your claims specialist, patient safety/risk manager, or defense attorney.

Practitioners with dual licenses should be aware that the Medical Board of California does not usually require patient death reporting if the incident has already been reported to the Dental Board. However, if you experience an incident involving a treatment-related death, it is important to check with the Medical Board of California to ensure that these requirements have not changed.

Although the treatment-related death of an OMS patient is never an expected situation, assistance is available. The Doctors Company's experienced, professional claims experts and patient safety/risk managers are

dedicated to your protection and are with you every step of the way.

#### Endnotes

- 1 CAL.BPS SECTION 1900-1966. 6 page. California Business and Professions Code Web site. <http://www.leginfo.ca.gov/cgi-bin/displaycode?section=bpc&group=01001-02000&file=1900-1966.6>. Accessed August 2, 2012.



**RAM**  
*California*

SAVE THE DATE

CALAOMS Once again will work with RAM California in 2013 to provide care to the under and uninsured people in our state.

The clinic will be held in Coachella Valley at the Indio/Riverside Fairgrounds in Indio, CA on April 4-7, 2013.

Please mark your calendars. We will let you know when volunteer registration is open for this clinic.

## Upcoming 2012-13 CALAOMS CE Events

<p><b>Residents' Night</b> September 5, 2012 - "New Date"</p> <p><b>Practice Management</b> September 26, 2012</p> <p><b>Practice Management</b> October 10, 2012</p> <p><b>ACLS</b> October 13, 2012</p> <p><b>Medical Emergencies*</b> November 7, 2012</p>	<p><b>Burbank</b></p> <p><b>Oakland</b></p> <p><b>Costa Mesa</b></p> <p><b>Solano</b></p> <p><b>Irvine</b></p>	<p><b>OMSA</b> September 29-30, 2012</p> <p><b>OMSA</b> November 17-18, 2012</p> <p><b>Jan. 2013 Anesthesia Symp.</b> January 18-20, 2013</p> <p><b>13th Annual Meeting</b> May 3-5, 2013</p>	<p><b>Oakland</b></p> <p><b>Glendale</b></p> <p><b>La Quinta</b></p> <p><b>San Francisco</b></p>
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*\* The Medical Emergencies course will be alternating between Northern and Southern California Locations. This year it will be held in Southern California.*

### Classified



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#### ASSOCIATE/PARTNERSHIP OPPORTUNITIES

**CALIFORNIA**, Full time position with opportunity for buy-in. Position includes two practice locations. Clear Choice Dental is located in San Jose and our private practice is located in beautiful Santa Cruz. Full scope practice specializing in Orthognathic surgery, implants and wisdom teeth. Please e-mail resume to Dr. George M. Yellich at gmyell@aol.com, or call Dr. Yellich at Clear Choice Dental (408) 556-9587, or Santa Cruz Oral and Maxillofacial Surgery at (831) 475-0221.

**LOS ANGELES**, Immediate opening in a busy, well-established Los Angeles-area OMS practice. Amazing opportunity for a hard-working and outgoing OMS to develop a successful career. We are seeking an associate who is passionate about their work and strives for excellence. Position will lead to partnership and/or practice buy-out. Please email jobopp@live.com with inquires.

**NORTHERN CALIFORNIA** Oral Surgery office north of the Golden Gate Bridge with easy access from Highway 101 seeks full time associate for this high-volume practice leading to buyout and/or partnership. Interested prospects should send a CV and cover letter to molinelli@aol.com or call Stephen Molinelli of Northern California Practice Sales at 650-347-5346.

**RIVERSIDE COUNTY**, Oral Surgery Practice. Nicely appointed, 3 operatory oral surgery practice in a prime location with easy freeway access. The spacious facility is efficiently designed. A well trained, dedicated staff work with the oral surgeon and patients in this long established business. 2011 collections exceeded \$900,000. The seller is retiring. Contact Practice Transition Partners: (888) 789-1085, contact@practicetransitions.com, www.practicetransitions.com.

#### FACULTY POSITION

**ORAL MAXILLOFACIAL SURGERY FACULTY** Western University of Health Sciences College of Dental Medicine in Pomona, California is seeking full and part-time Oral Maxillofacial Surgery faculty for the didactic and clinical instruction of students in the DMD program. The College of Dental Medicine aspires to be a premier center for integrative educational innovation.

*To read the full Ad, please go to [www.calaoms.org/ClassifiedAds/AvailablePartnerAssociatePositions.aspx](http://www.calaoms.org/ClassifiedAds/AvailablePartnerAssociatePositions.aspx)*

#### DOCTORS SEEKING POSITIONS

NO LISTINGS AT THIS TIME.

**TO PLACE AN AD IN THE COMPASS, PLEASE CONTACT STEVE VIA EMAIL AT [STEVE@CALAOMS.ORG](mailto:STEVE@CALAOMS.ORG). CLASSIFIED ADS ARE FREE OF CHARGE TO CALAOMS MEMBERS**

#### EQUIPMENT FOR SALE

**iCAT EXCELLENT CONDITION**, used Next Generation Platinum with Extended Field of View. Includes monitors, Codonics medical printer and supplies. Warranty available and selling due to lack of utilization. Asking \$105,000. Please contact Frank A. Portale DDS at 209-481-9307.

**REDUCED! RITTER SURGICAL TABLE**, Model F-Type 75, \$500. Call Doug Fortney at 858-485-1783 or email doctorfortney@hotmail.com

**BAXTER INFUSO.R. SYRINGE PUMP** w/ Propofol Smart Label. Like new. New \$1800, Sale \$500. If interested, email roger.kingston@att.net.

#### PRACTICES FOR SALE

**LOOKING TO PURCHASE** an OMFS office in Southern California (LA and surrounding areas). Please email me at omfsbuyer@gmail.com if interested.

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Owned and operated by OMS, OMSNIC has a deep understanding of the specialty and only insures Oral and Maxillofacial Surgeons. The OMSNIC Advantage is our single-minded dedication to protecting, defending and strengthening your OMS practice. For more information call 800-522-6670 or visit our website.



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