

# The Compass

Staying the Course Through Service and Education



Volume XVI, Issue 2, Summer 2014

## Western Society of Oral and Maxillofacial Surgeons (WSOMS) – You do belong, don't you?

**Y**ou already belong to AAOMS and CALAOMS. WSOMS needs your membership, too. More to the point, you need District VI, and WSOMS is the conduit.

My predecessors have made this pitch before, but there has never been a greater need for representation with AAOMS and with Washington, D.C. I recently attended a leadership conference in Rosemont, IL and heard a frightening list of issues and topics that will continue to affect our practices, whether private or academic. Changes in reimbursement, licensing, privileges, and interaction with the medical world are all in a state of flux.

Dr. Don Devlin wrote in the spring 2014 *Westerner* (WSOMS' newsletter) about Dr. DeWayne Briscoe—the first WSOMS president in 1973—and Dr. Terry Slaughter and their observation that our district was poorly and inconsistently represented at the annual national

House of Delegates (then known as the American Society of Oral Surgeons). Despite this district's efforts in providing safe and effective outpatient anesthesia, we were looked down upon by the rest of the country for our so-called "pentothal parlors."

WSOMS member benefits include sponsoring one of the premier OMS events of the year. Our meetings have been conducted in many beautiful locations, such as Colorado Springs, Lake Tahoe, Sun Valley, Alaska, and Acapulco, to name a few. The next two meetings will be in Portland (July 2015) and Whistler, BC (July 2016). Fabulous food, world-renowned speakers, social events, and yes, politics await you.

Alaska, Arizona, California, Washington, Oregon, Hawaii, Utah, Idaho, and Nevada: you need WSOMS/District VI and we need you. Our

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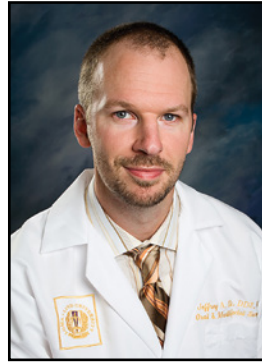
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## Editor's Corner



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

### "It's just a tooth..."

I have no doubt that I'm among great company when I say that I really and truly enjoy my job. My wife will tell you that in a dozen years she's never really heard my alarm clock go off in the morning. I always seem to get up about 5 minutes before it should go off. I suppose that's because I really don't mind getting up to go to work. I also suppose my job is a little unique; on average I spend 4 days a week treating patients in the clinic as the sole OMS at a dental school setting, and 1 day a week working with OMS residents at my residency alma mater 30 miles away.

As much fun as our jobs can be, there are always stories we hear that, if even for a second, inject fear into the fun. Last week, I heard such a story. I was talking to a colleague from out of state and they shared how they get a kick out of hearing patients talk about general anesthesia and down-play the experience as, "well, it's just a tooth."

A 48-year-old man, ASA IV, presented for elective tooth removal. Comorbidities included end stage renal disease (ESRD) on regular hemodialysis, type 2 diabetes mellitus, hypertension, hyperlipidemia, gastroesophageal reflux disease, chronic obstructive pulmonary disease, and a history of cocaine abuse (red flag #1). Preoperative laboratory investigations were all unremarkable except for a serum creatinine of 9.8 mg/dl, though expected with ESRD. The patient was on regular dialysis and he was scheduled for another session on the day of surgery after the surgical procedure (possibly red flag #2). In the preoperative period, he was very anxious and refused all the methods of a topical or local/regional anesthetic offered to him (red flag #3). A decision was thus made to proceed under in-office (accredited ambulatory surgery center) intubated general anesthesia with a balanced anesthetic (possibly red flag #4).

After adequate preoxygenation, he was induced with intravenous midazolam and titrated increments of propofol. After obtaining adequate sedation, the trachea was intubated in an atraumatic fashion (grade 1 view) with a size 7.5mm oral RAE tube. Intraoperatively, anesthesia was maintained with air-oxygen (1:1) and sevoflurane titrated to maintain a MAC of 0.7-1. The intraoperative period was short (15-20 minutes) and uneventful. Just prior to extubation, the patient had good neuromuscular function and was breathing spontaneously. At this time, there was a sudden onset large volume hemoptysis, and the patient coughed up about 100cc of frank blood into the endotracheal tube and breathing circuit. A gentle suction was done, and after ensuring that there was no more active hemoptysis, the trachea was gently extubated under watchful conditions.

Immediately after extubation, his oxygen saturation dropped into the low 80s despite 100% oxygen via a tight sealing facemask. Along with this, his blood pressure increased, ranging between 225 - 250 mmHg systolic. Poor oxygenation and hemodynamic instability necessitated emergent re-intubation. A video laryngoscope was now used which showed a heavily congested oropharyngeal and laryngeal space;

however, there was no evidence of active bleeding. The patient was emergently transferred to the E.R. where he continued to deteriorate hemodynamically and had poor oxygenation. Chest x-rays showed bilateral upper and mid predominant air space consolidation. Lab studies revealed a significant drop in the hematocrit compared with baseline along with normal coagulation parameters. However, an emergent bronchoscopy did not show active airway bleeding or obstructive mucous plugs. A diagnosis of diffuse alveolar hemorrhage was made and the patient was transferred to the medical ICU. A bedside echo in the E.R. and a formal transthoracic echo in the ICU were unremarkable, and the suspicion of this being a cardiac event was also thus ruled out. In addition, there was no evidence of ischemia on the EKG or with serial cardiac enzymes. Further management was similar to treatment for ARDS including high positive end expiratory pressure (PEEP) and permissive hypercapnea. His chest radiology showed a slow improvement, and he oxygenated better over the course of the next week in the ICU. The patient was successfully weaned off the ventilator and made a complete recovery at the end of this period.

When I heard this story, I felt the fun get sucked right out of the room. Much like when I attend the Anesthetic Complications sessions at the AAOMS meetings. A straightforward procedure does not always equate with straightforward anesthesia.

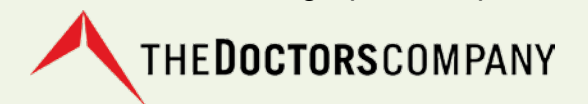
In-office sedation/general anesthesia in the adult age group is typically based on regional blocks in combination with some titrated IV anesthetics for light-moderate-deep sedation. The goals of anesthesia for such a case are amnesia, analgesia, akinesia, and hypotonia in varying degrees. The advent of numerous adjuvants to the available local anesthetics for dentoalveolar surgery has given the OMS flexibility of choices, as well as reliability of anesthesia for these procedures. This might suffice for most patients; however, those who suffer from comorbidities which prevent them from lying flat, or suffer from additional anxiety, tremor, and restlessness may have to be considered for general anesthesia.

Thankfully, the majority of time, dentoalveolar surgery is generally associated with minimal systemic effects and a low risk of major morbidity or mortality. However, patients presenting for this type of procedure vary widely in body habitus and can have multiple comorbidities. The stress response of surgery combined with the immunomodulatory responses of a general anesthetic might complicate some of these relatively benign coexisting disease states, and present the operator/anesthetist with problems postoperatively.

In our heavily populated state of California, with an ever-aging population and with an expanding group of patients with varied recreational habits, it never hurts to be kept afresh that bad things can and do happen. Though not always expected, all we can do is try to be as prepared as possible; and hopefully react accordingly and properly. Securing the airway without any delay and diagnosing and managing the underlying cause are all part of the practice of good perioperative medicine. It's my hope that this story will remain in your minds the next time your ASA IV patient tells you, "it's just a tooth..."

### CALAOMS Exhibitor Recognition

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## Letter to the Editor

I just read Dr. Richard Boudreau's article in The Compass. It is an excellent article. Thank you for expressing so eloquently such a difficult topic.

I have often debated with my own colleagues, especially while doing my General Surgery residency, about this very same issue. So much of care given in the last few weeks to months of someone's imminent death is driven by fear. Fear of lawsuits. Fear of medical malpractice. Fear of letting go (with family). Fear. Fear. And there, lying in an ICU bed is a patient who will die—probably soon.

For the family, life is not priceless. There is an endpoint to what medicine should and can do. I can guarantee that the greatest doctors in the universe cannot keep someone alive indefinitely. Death is a part of life. That sick family member's quality of life is to be valued above all, even above other family member "issues."

For the doctor, life is still not priceless. Take into account what medical interventions are of real value to the patient. Important and sometimes very difficult confrontations and medical decisions should not be put off until your ICU shift is over because you don't want to deal with it. Please don't let surgeons bully you into doing futile surgeries. Also, as a group, are critical care doctors given the resources and support to adequately handle the family, hospital, and surgeons all vying for their patients?

To the hospital: Please honor advance directives even in the threat of lawsuits from family. If the patient doesn't want intervention, then don't do it! If you trust the same doctors who work to save the life of your patients then trust them when they tell you continued medical intervention is futile. Why does it sometimes take weeks to months to make a definitive decision on a suffering human being? If only there were lawyers in the afterlife....oh boy!! Please invest

in easily accessible, educated, and robust end-of-life teams. Let's find realistic and practical solutions where dignity is maintained for all; solutions, without the dirty hand of politics.

Enough with the fear.

Thanks again for the great article. I look forward to parts 2 and 3.

*Tania Nelson-Chrystal, DDS, MD  
Sacramento Oral Surgery*

## Reply

Dear Dr. Nelson-Chrystal,  
Thank you for your insightful 'firsthand' comments aptly expressed within the context of patients, families, doctors, hospitals, and lawyers. For many different reasons, the 'fear factor' is inherent for both doctors and patients, and requires understanding and compassion on both sides of the aisle. I agree that there is an "endpoint" at which time to conclude 'enough is enough,' life-sustaining technologies notwithstanding. Value based practice, including autonomy and dignity, necessarily includes honoring advanced directives which, fortunately, is legally required by hospitals. Lawyers also need to be cognizant of avoiding undue judicial delay in their role managing end-of-life cases, as you well point out. *Beneficence* is the central moral principle in the ethics of medicine and entails all the aforementioned components packed into the complex notion of acting for the patient's 'good.'

*Richard Boudreau, MA, MBA, DDS, MD, JD, PhD  
Attorney at Law & Faculty Loyola Marymount Univ.  
Bioethics Institute  
Member Calif. Bar, Wash. DC Bar & US Supreme  
Court Bar*

## CALAOMS and California CareForce – A Lasting Partnership and A Relationship with Benefits

*by Pamela Congdon, CAE, IOM,  
CALAOMS Executive Director  
President, California CareForce and Volunteer*

Members of CALAOMS and volunteers of California CareForce are working together to help the underinsured and noninsured residents of California. It's a partnership that the CALAOMS Board and the California CareForce (CCF) Board wanted formalized. At the CCF Board meeting in June, the CCF Board voted to reserve two Board positions for a CALAOMS Board Director and the CALAOMS Executive Director. This is a relationship that will benefit both organizations. California CareForce is one of two organizations in California that is sponsored by organized dentistry; CDA Cares is the other. *Please see the Preamble to the CCF Bylaws below.*

WHEREAS, the Board recognizes and appreciates the value of the support of California Association of Oral and Maxillofacial Surgeons (CALAOMS);

WHEREAS, the Board desires to continue its existing auspicious relationship with CALAOMS;

WHEREAS, the Board desires to further develop its relationship with CALAOMS;

WHEREAS CALAOMS has dedicated its full support to the Board from the inception of California CareForce;

WHEREAS, CALAOMS desires to continue its existing auspicious relationship with California CareForce;

WHEREAS, CALAOMS desires to further evolve its relationship with California CareForce;

NOW, THEREFORE, BE IT RESOLVED, that the following preamble shall be entered into the California CareForce Bylaws:

### PREAMBLE

In recognition and appreciation of California Association of Oral and Maxillofacial Surgeons' invaluable assistance in the creation of California CareForce, the California CareForce Board of Directors declares the following: California CareForce does hereby reserve one board of director position permanently to be filled by a California Association of Oral and Maxillofacial Surgeons Representative. Said representative shall serve as a liaison Between California CareForce and California Association of Oral and Maxillofacial Surgeons.

### BE IT SO RESOLVED.

If you have volunteered for one of our clinics, you know that "dental" is a large part of the clinic; and specifically oral surgical services, and those being primarily provided by oral and maxillofacial surgeons—you! Dental and vision insurance are not typically included with general medical insurance plans. Therefore, 80% of the patients we see need dental and vision services.

CCF's next clinic is working with the organization, Stand Down, providing services to homeless veterans in Sacramento on September 12 and 13. We are proud and honored to be able to give back to these men and women who have fought for all of us.

After that, we will be back in the Coachella Valley March 27-29, 2015 for our third clinic in this area. It was at this clinic that we started a referral service with the local clinics helping provide appointments to patients that needed further care. Our annual clinic

*Continued on page 21*

## President's Message



*Albert W. Lin, DDS  
President, CALAOMS*

### On the Horizon

**D**ear CALAOMS members,  
The year is moving by fast, and I hope everyone has had an enjoyable and busy summer! The first half of the year has been filled with various projects for the board. Earlier in the year, CALAOMS brought in a full-spectrum consulting firm, Elmet Communications. The purpose of this was to help CALAOMS create seamless public relations through traditional communications, social media, webpage design, crisis management, reputation enhancement, rebranding and community relations, to name a few.

As a board, we are continually monitoring and discussing possible solutions to the many issues that affect our specialty, such as itinerancy practice, threats from medicine about anesthesia and cosmetics, general dentists placing implants, and corporate dentistry/implant centers. Currently, there are ongoing projects that involve all of these topics which I

strongly believe will help carry CALAOMS and our members well into our future!

In April of this year, California CareForce provided over \$900,000 in free medical and dental care during the Coachella Valley Health Expedition. CALAOMS strongly supports and will continue to have a strong relationship with CareForce. We will have two board positions on the CareForce board of directors. One will be a CALAOMS board member and one will be the Executive Director of CALAOMS. On September 12-14th, we will have our next clinic at Mathar Field working with Stand Down providing care to approximately 300 homeless veterans and their families. We have also committed to having at least three clinics next year starting with Coachella Valley on March 27-29th, Grass Valley, and hopefully, Oracle Arena in Oakland. The hosts and dates for these sites are being worked on currently. This continues to be spearheaded by our very own Executive Director, Pamela Congdon, CAE, IOM.

On the legislative front, CALAOMSPAC continues to monitor politics and legislation that affects our specialty specifically, and dentistry as a whole. We are now utilizing Capitol Track analysis which gives us background information and opens the actual language so you can read the entire bill, where it is in the legislative process, and the current analysis. One of the more prominent pieces of legislation that is currently on all healthcare providers' radar screens is Prop 46, the ANTI-MIRCA ballot proposal. CALAOMS and CDA, along with many others in the healthcare industry, are in opposition to Prop 46 and are supporting the campaign to bring down this legislation. A new video released in August for the online campaign entitled, "The Truth about Proposition 46" is available now! It features physicians and medical students discussing the potential harmful consequences to patients and the California health care system should Prop 46 pass. PLEASE use Twitter (@NoOn46) and retweet the video, "like" NO on 46 on Facebook, and embed the YouTube video on your website or blog! We need to

get the word out. Please remember to Vote NO on 46 on November 4th!

In other statewide news, a big Congratulations to Colonel/Dr. Bob Hale, one of our members for his recent publication in the September 2014 Discover Magazine! His article entitled, "Face of Hope, New Skin, New Bone, New Promise for Soldiers disfigured in War" is just one great example of how we can and should promote positive news stories about CALAOMS and its members in the news media.

I would also like to congratulate, and thank on behalf of the entire board, Ms. Teri Travis for her 10-year anniversary with CALAOMS and decade of excellent service to our organization and its members. We couldn't do what we do without your help and guidance. We look forward to many more years with you, Teri!

On the national level, AAOMS President, Dr. Eric Geist, has presented the Practitioner Based Research Network (PBRN) and changed the protocol from random selection to accepting volunteer clinicians. To participate, one needs to read an NIH study guide, take a couple of short exams online, and submit a current C.V., dental or medical license, and proof of liability insurance coverage. Here is an opportunity to help support OMS research, especially since we are always being accused in the public of lacking it. Please check out the AAOMS website, [aaoms.org](http://aaoms.org), or call/write Randi Andreasen at AAOMS for details.

Last, but not least, I would like to thank CALAOMS members for your continued support of CALAOMS. Your commitment to retain membership and attend our meetings helps us continue to represent and fight for our great specialty. There IS power in numbers. I am ever grateful for the opportunity to serve as your President this year and will continue to serve in every capacity for the rest of the year. I look forward to seeing you at the AAOMS annual meeting in Oahu. Aloha!

### *WSOMS Continued from page 1*

present annual dues are \$175, but with increased membership we would be able to reduce this figure through economy of scale and still offer the same benefits. However, we need a critical mass of members in order to put the dues decrease into effect.

I'm only asking for two action items from District VI members. First, please join WSOMS if you haven't already done so (thank you to those of you who have). Second, become engaged in the conversation about our membership goals by discussing with your colleagues and through your state society. WSOMS is open to assisting or organizing and collecting your state dues along with WSOMS dues if that would be beneficial to you.

Questions? Problems? Concerns? Check us out – write, call, or email us with your ideas. Whatever you do, do not ignore the reality of the changes in our evolving health care system. The changes are here and now. We will assuredly be affected more in the future, not less. A strong coalition is our best defense. We are better at being proactive, so let's band together while the getting is good.

### **Steve Leighty, DDS**

*President-elect, Western Society of Oral and Maxillofacial Surgeons*

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## Technical Articles



Peter Krakowiak, DMD, FRCD(C)

### Virtual Orthognathic Surgical Planning – A pathway to superior level of efficiency, precision and team communications.

The current economic climate for delivery of orthognathic care in most private practice settings has not been favorable in California over the past decade. Growth in HMO based medical care and decreased level of PPO compensation as our health care systems try to become “affordable” versus “exceptional” are attributable to this slowly progressive change. A few of our more dedicated colleagues still however make efforts to maintain orthognathic care as part of their clinical practice. It is one of those gifts that our training uniquely affords us and it should remain a part of our array of clinical services. As many of you are as well, I

as a solo private practice provider am often confronted with complexity of maintaining my somewhat limited hospital practice and at the same time make time for part time faculty involvement while supporting the salaries and functionality of a full time referral based OMS practice all in a very competitive and demanding Southern California environment. Did I mention trying to get home by 8pm so I can tuck the kids in for bed? It is a tasking endeavor and any help with efficiency and systems is certainly welcomed.

Virtual surgical planning, a more recent application of digital craniofacial 3-D imaging, may be one such wonderful development. Along with greater ability to perform outpatient orthognathic and reconstructive surgery the medical modeling and virtual planning can potentially help us to maintain this area of practice even in these most challenging conditions. The approaches that can reduce planning and surgical time and increase the precision of procedures are of essence. I believe that virtual surgical planning and guide fabrications are now adequately developed and have been tested sufficiently to help us with the large scope procedures. The application of these concepts have already have been a huge asset in large implant cases by significantly reducing procedure times involved in full arch or multiple fixture placement cases. Having a very favorable experience with implant virtual planning and seeing our residents effectively apply virtual reconstructive and orthognathic software in planning the larger cases at our LAC+USC and CHLA residency training sites I have recently started to switch from my own traditional planning protocols based on painstaking integration of cephalometric tracings, photographic analysis and stone articulated study model based case planning, followed by arduous, lengthy and often frustrating Erikson table based model surgery protocols to now using virtual surgical planning in the orthognathic case preparation and execution (fig.1.). My initial experiences have been quite positive. As with any new technology or technique there is always the need for abundance of healthy skepticism and extra degree of caution. Our professional literature now includes data that supports and documents the accuracy and efficacy of this application of virtual surgical planning.

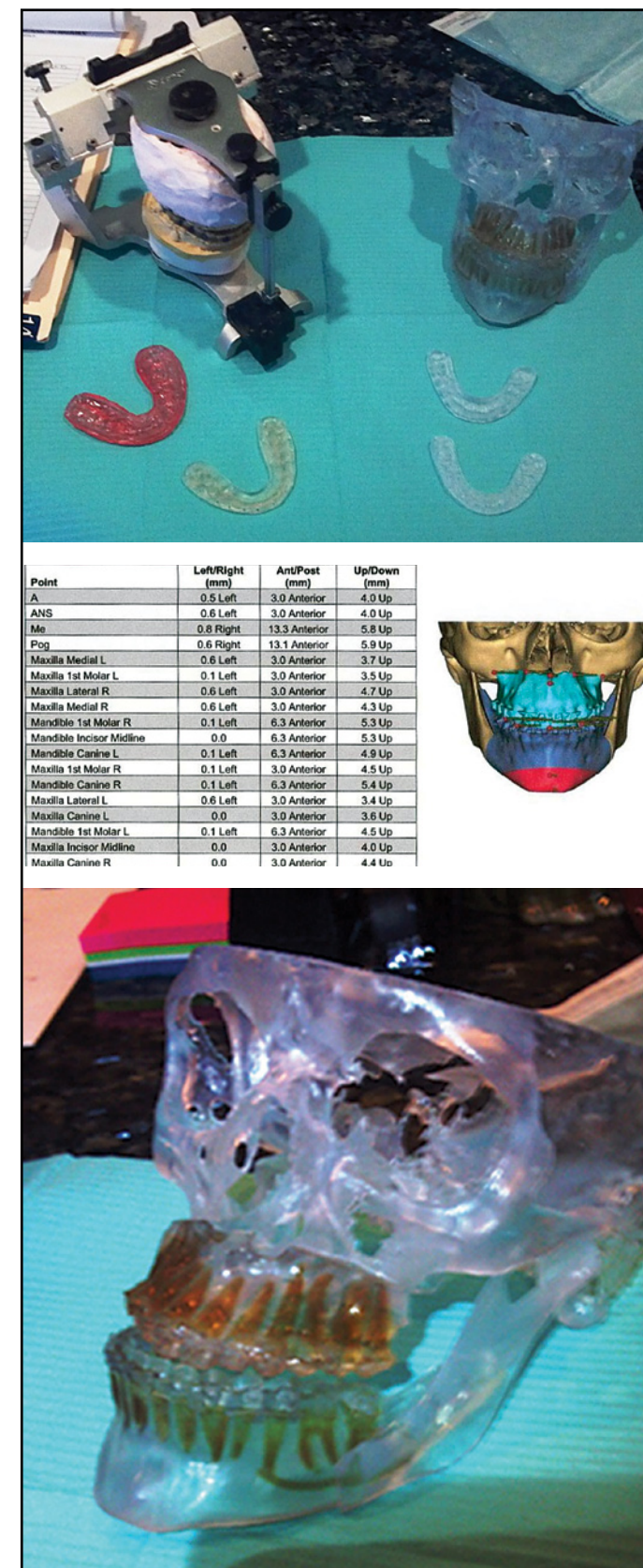


Figure 1. Traditional and Virtual surgery planning.

There are hundreds of scientific articles on this topic now in most OMS journals. A recent European systematic literature review published in the IJOMS looked specifically at the accuracy of three-dimensional (3D) virtual surgical planning of orthognathic procedures compared with the actual post surgical outcome of orthognathic surgery. Over 400 of the most current articles were reviewed by the Scandinavian authors and seven statically significant articles were selected, with a combined sample size of 149 patients. Success criteria of precision and reproducibility were set at less than 2 mm mean difference in six of the articles. High degree of precision was noted in 125 of the 133 patients included in these articles who were regarded as having had a successful outcome. However due to differences in the limited presentation of data, meta-analysis was not attempted by the Danish author. Virtual planning however proved to be an accurate and reproducible method for orthognathic treatment planning. Suggestions were made that a more uniform presentation of the data is still necessary in future literature to allow the performance of a valid meta-analysis. We will await that.

The currently applicable OMS virtual planning is available for implant, orthognathic and reconstructive surgical applications. This edition of the technology update will focus specifically on the orthognathic application. The application in micro vascular reconstructions, including cutting guides, are amazing and truly groundbreaking but that is a topic for another edition.

The current virtual Orthognathic presurgical protocol is similar to the traditional work up in that radiographic data and physical models are used to analyze and plan the case. However the radiography is now fully 3-Dimensional and the dental models are virtual. Patient’s CT medical or dental CBCT imaging with FOV(field of view) large enough to visualize superior orbital skeleton down to the inferior most mandibular border including anteriorly the soft tissue Pogonion point and Porion posteriorly is obtained (fig 2.). Soft tissue including the lips and nasal structures need to be included for lips and nasal tip as well. The

images are uploaded to the Materialize or Medical modeling software. Due to limited current image detail and accuracy of the occlusal dental surfaces transfer from CT imaging additional optical scan of either the dentition or stone models of the dentition must be fused with the CT images. Also a final occlusal (set up) relationship must be generated using polymeric bite registration material and submitted with the rest of the data. Once the digital data is gathered the entire planning process occurs on a server of a modeling company. This affords the ability for such to be performed online with participation of multiple remotely connected parties. This really came in handy on my most recent case where the patient's orthodontist Dr. Quinn, a San Francisco based orthodontist was able to actively participate in the session with me in my North San Diego County office all while receiving software use and planning guidance by a Materialise software engineer in Michigan. It took us less than 20 minutes for a two jaw case. Same model surgery could take me 2-3 hours and another 1hr is usually spent making and polishing splints. Quite a difference in time, isn't it? Not too mention no messy stone work and acrylic dust clouds to savor.

The CBCT with fused/integrated dental arch structure scans are first oriented to achieve natural head position and correct any errors in CT data positioning.

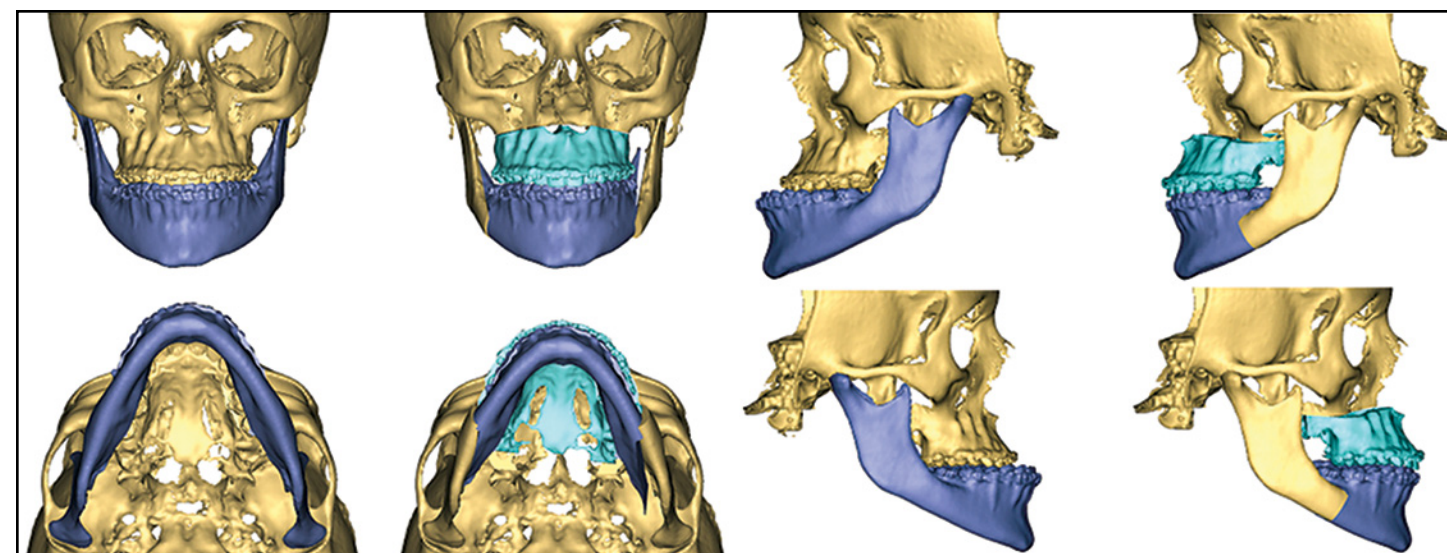


Figure 2. Pre-treatment and planned treatment images

Photographs of natural head position are useful in developing this orientation. The surgical plan is then formulated to address the yaw, pitch and roll of the needed movements and point of rotation is selected for each axis. The level of planned Lefort osteotomy is also chosen and marked virtually. Segmental arrangements are formulated. Movements in the vertical, transverse and horizontal planes of the maxilla are made using a mouse. Precise numerical anatomical points are assigned and measurements are automatically made by the software in multiple vectors and standard analysis angles computed to ensure the accuracy and efficacy of the planned movement (fig.3). The corrected maxillary position is then registered against original mandibular position with use of computer simulated autorotation around the condylar hinge axis into the new maxillary position. This is where the Intermin splint is generated, of course virtually. The thickness of the splint, degree of cuspal overlay and position of wire pass through portals are planned. Then the lower jaw distal segment position is generated based on the desired final bite registration (set up) position. The mandibular osteotomy cuts are chosen and the proximal segments are then rotated or derotated around the joint hinge axis to ensure maintenance of the ramus orientation. Areas of potential bone reduction can be then roughly identified in the proximal segment buccal extension and distal lingual segments to allow for ideal approximation of

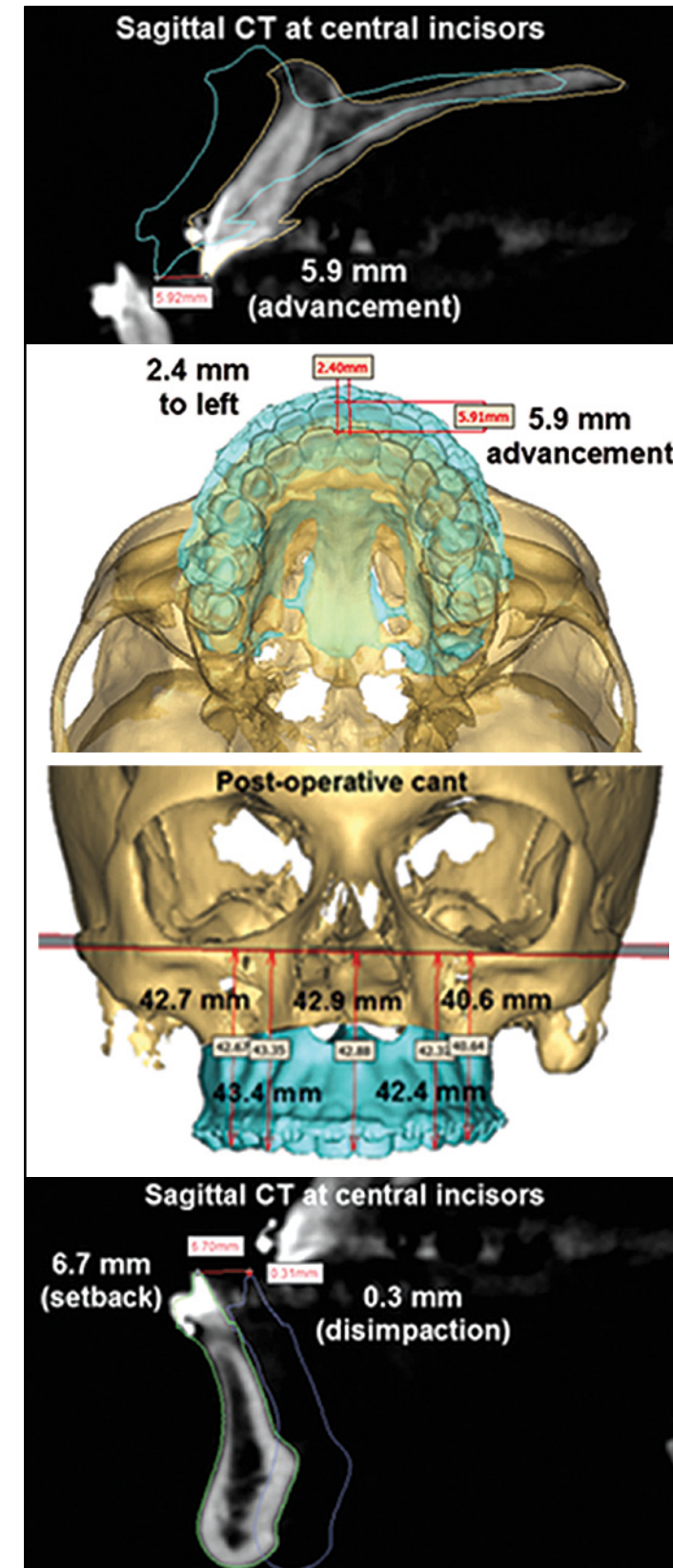


Figure3. AP and maxillary cant correction view superimpositions

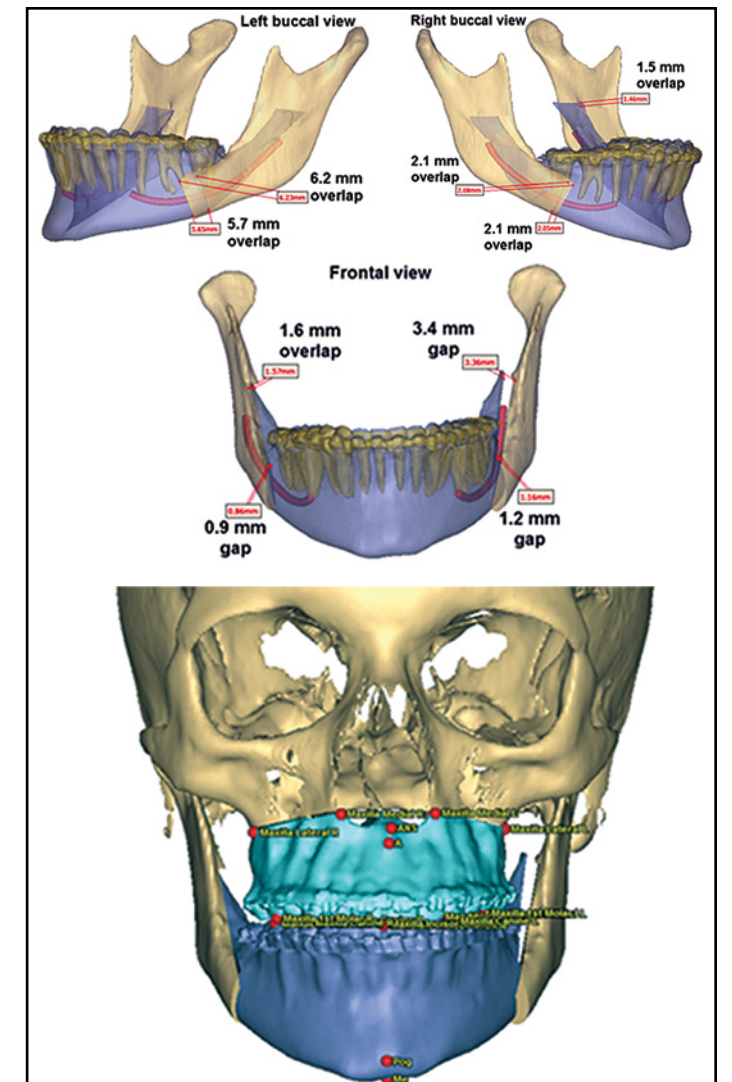


Figure 4. Planned osteotomy cuts with anticipated segment overlaps

the sagittal osteotomies prior to fixation (fig 4.). At this juncture, all hard tissue positions are approved this 3-D jaw and dental relationship is then used to generate virtually the final splint (fig.5). Once again the final splint can be customized such as the interim splint. An option is available to mate the splints for those who like the splint in splint technique. Various additional modifications such as transpalatal strut or thickened palatal flange designs are possible especially in stabilizing transverse maxillary expansions. At this point the surgical planning is completed for the dental segments and additional planning including the genioplasty procedures can be incorporated into the plan. Both a cutting guide and positioning guides can be created for

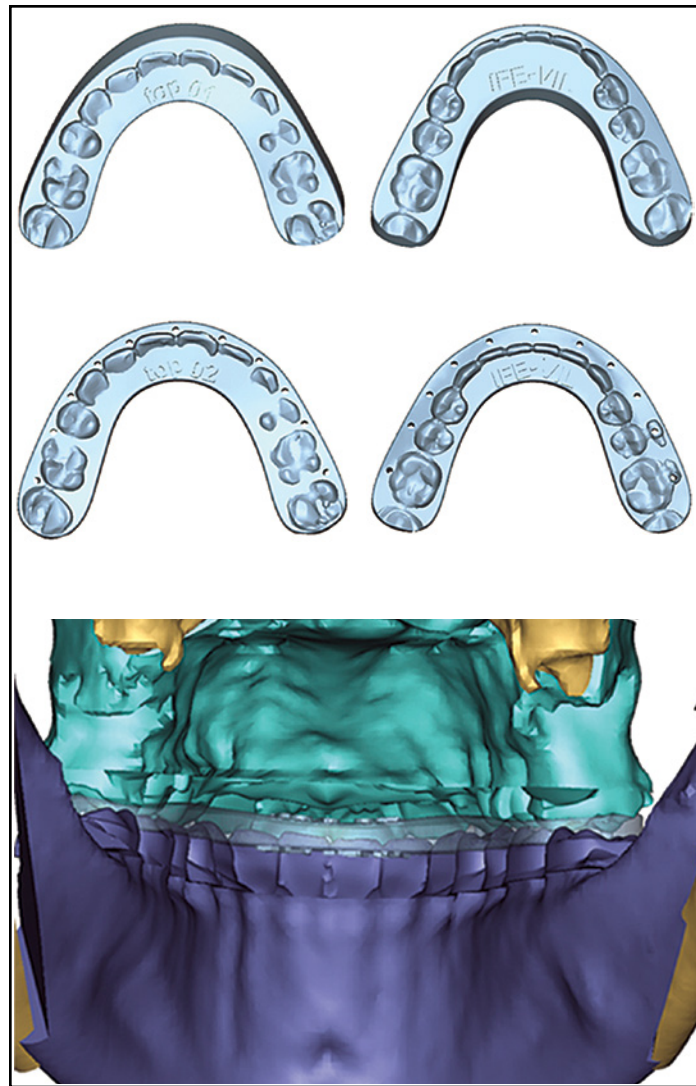


Figure 5. Interim and Final splint designs

any planned genioplasty if so desired. The plan is then used to mill the surgical guides from acrylic plates and the “real” surgical guides are ready to be shipped out in just a few days. The guides are usually ordered through a surgical plating representative and as such can be usually billed out directly to the hospital as part of our hardware requirements similar to custom cheek implants or plating and fixation hardware. This new protocol has kept our clinical and surgical provider time expense and material cost to a relative minimum. It has also allowed us to precisely communicate with the referring orthodontist and have them participate remotely in real time virtual surgery and truly such level of collaboration is invaluable to maintaining our working relationships with our colleagues. It allows

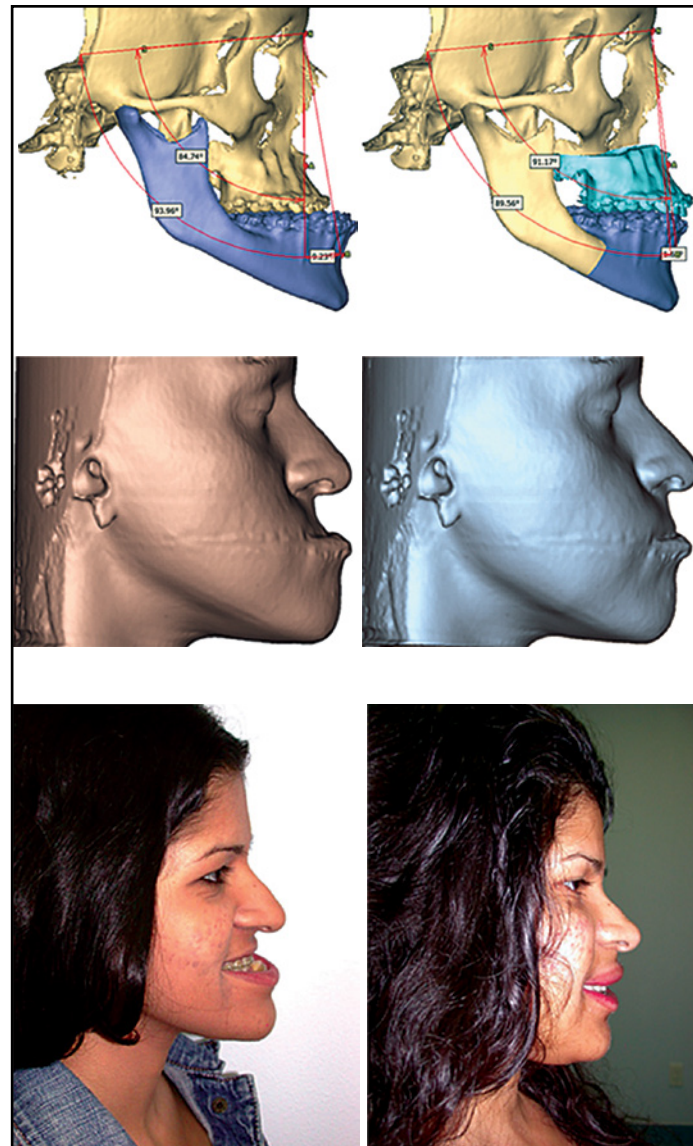
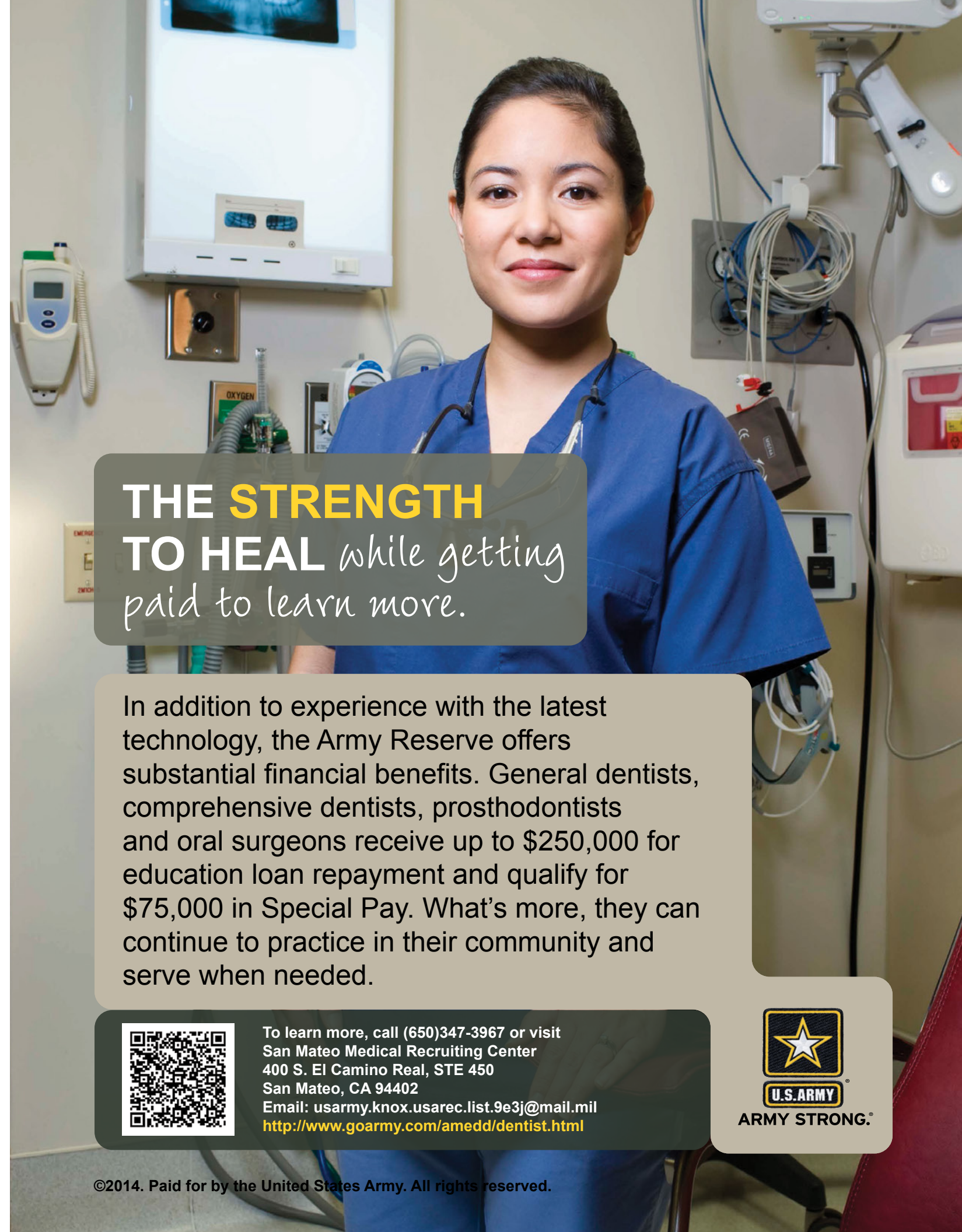


Figure 6. Planned Cephalometric, virtual soft tissue predictions and our actual case results

us to not only to deliver the best of our skills but be exceptional at presentation and communication of our desired treatment outcomes (fig 6.). I highly recommend that, if you have not already been exposed to this modality, you contact your surgical plating company to help you integrate this into your practice. It is a very worthwhile addition to our armamentarium. DePuy-Synthes CMF and Medical Modeling are currently the two premier providers of these services and can be contacted for further help with getting your practice into the next level of efficiency and precision of orthognathic surgical care.



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Tony Chu DDS, MD, FACS

## A Better Approach to Integrating Trauma into Private OMS Practice

Whether you have an abiding interest in trauma care but have given up on it or never really signed on in the first place, you should take another look at whether a new approach may work for you. As oral and maxillofacial surgeons, we are experts in maxillofacial trauma. They were often the most attractive cases during residency for most, something to anticipate, seek out, and treat. Our specialty worked hard over several decades to earn the right to offer top-flight hospital trauma care. Why have we nearly given that up now across the nation, causing concern at OMS societies and in journal editorials for many years now? And what solution can there be to this conundrum? I believe the following is a better approach to the integration of trauma care into the private OMS practice.

Many private practice OMSs would still offer maxillofacial trauma care in their communities if just one or two major conditions were improved. But they've 'burned out' from a morbid combination of very low and/or difficult reimbursement, calls that are disruptive during office-hours and inconvenient in the off-hours, irritating hospital bureaucracy or systems, operating room scheduling frustrations and poor equipment support with lack of appropriately trained ancillary personnel. The list goes on, including

the well-documented challenges of providing care to the large numbers of facial trauma patients in our communities who are socio-economically disadvantaged. From my recent discussions, military OMSs with extra wartime trauma experience post-residency also have problems transitioning to private practice trauma care, such are the hurdles to surmount.

Moreover, recent graduates struggling with high debt loads, who are less willing to accept the almost universally low teaching position salaries offered, are just as intolerant of the negatives of trauma surgery. They are also suffering from what I call 'delayed gratification syndrome', and don't have the patience or wherewithal to tolerate jumping through fire-ringed hoops for the often laughable fees paid by mostly federally-sourced coverage. And though freshly trained in the newest techniques and instrumentation that compensate for their relative inexperience, they simply are not fast enough usually in the O.R. nor are their office protocols efficient enough, to make a buck and feel good doing it. For that matter, neither do most private practitioners of any longevity, unless they have years of frequent and consistent experience to become greatly efficient managing and processing trauma patients in a proficient enough manner to allow one to truly enjoy it.

So let's face it, you actually need to be induced back or start to do trauma cases in your practice. There has got to be a better way for offering maxillofacial trauma services in your practice. I've found that there are three key components to make integrating regular trauma cases into our daily practice fun, exciting and profitable again. These involve the Payment of maximum fees you can depend on for every case, setting up the Logistics for efficiency (and profitability) with less stress, and executing Treatments adeptly:

### 1. Payment.

All oral and maxillofacial surgeons deserve to be paid for their skills, knowledge, training and experience. Until you are paid appropriately, you will never consider integrating trauma into your practice, period. Even if you had great intentions initially, one would likely drop from trauma call fairly soon after

discovering that poor reimbursements leaves you "bitter" and unable to continue that service to your community. There is no question that being solidly profitable on every case will make the inevitable challenges to trauma call, care and commitment much more palatable in the long run.

How can this be achieved? You must start by negotiating immediately with your hospital to pay you a stipend of at least \$1,000 per consult in return for being on continuous call, irrespective of whether or not you end up operating on that patient. Every hospital has the funds for this, but it must be negotiated. Once the trauma stipend for coverage agreement is in place, I recommend concluding a second agreement to pay you a stipend for dental pain and infection calls, in furthering your commitment to the hospital and community. The physician director of trauma at your institution is a great person to start engaging and impressing with your responsiveness and professionalism that you bring to their service. After your reputation is established over a period of six to nine months, you and the trauma director should approach the hospital CEO or COO directly and begin negotiations. Don't waste time with non-executives who can't make the necessary financial investment decisions, and may have an unknown interest in stalling or blocking your initiative. And don't sell yourself short with timidity. You are an invaluable resource to them, and they always have budgetary discretion, usually through extra federal grants available yearly to Level I, Level II and most Level III trauma hospitals, that can easily be fractionally allotted to you. This same tactic applies for ER directors' budgets for infection call coverage, and is often easier to discuss if your reputation is already established with hospital executives.

I was able to get a per-consult \$1,000+ trauma stipend, and a per-consult \$500 dental infection stipend approved by the CEO, through working diligently to build great relationships at my community Trauma Level II hospital, and subsequently demonstrating my value to them. To capitalize onward, have your financial staff trained to handle all or part of the billing process. I recommend the latter and adding a flat-fee

specialized medical billing service for maximum payments from all funding sources. The byzantine nature of medical insurance payers' claims processing is just too labor-intensive and error-prone for the OMS practice to handle completely in-house; yet keeping a partial trauma billing capability allows you to carefully track and coordinate it to keep your finger on its pulse. Though the average of these collections can total only about 30% of billed fees, if you can deliver outstanding outcomes efficiently as is likely after the first couple of years to get 'fast and good', you will still be quite profitable as demonstrated below.

Actual representative case example of mine in 2012: I was paid ~30% of my fees, or \$1,500, on a \$5,000 zygoma ORIF case. Add \$1,000 from the stipend equals \$2,500. For a 90-minute case plus 90-minutes for consult and after-care time by me, means I was paid \$2,500 for 3 hours of work, or \$833/hour – and this is typical. Since there is minimal office overhead of about 10% for trauma patient care (yes!), you are 'taking home' 90% of all trauma revenue pre-tax. That is equal to or better than office implant or dentoalveolar surgery (I averaged \$500/hr, including consultation & after-care by the doctor) for the vast majority of oral surgeons. Even if you are limited in some ways for your particular situation, you are still quite profitable. The point is that you are certainly nowhere near losing money on trauma cases set up this way. Still interested? Read on.

### 2. Logistics.

Going in to the hospital or seeing a trauma consult at your office needs to be quick, smooth and relatively painless for maximum efficiency. You need to be able to bring up imaging and charting instantly from home or office or between hitting the ski slopes and biking/hiking trails while away. Whether or not that patient has been seen yet, you should be able to virtually complete your diagnosis and have a concise plan in your mind to come up with a plan of attack. You will then be able to effectively communicate your tentative plan to the ER doc, trauma general surgeon, trauma team nurse practitioner or physician's assistant, your staff and of course the patient: do not keep them waiting unreasonably beyond two to three hours (except if notified late

evening – see below) past your initial response to their call, fax or text. Stick to your promised timeline and they will love you; update them if delays creep up and they will love you more and return the courtesy. Following confirmatory consultation and succinct discussion with the patient, all that remains is to make final arrangements in getting to the O.R.

There is very rarely a need to see the patient immediately or otherwise stress out, if you work with and ‘train’ your colleagues to the patient management approach you want (especially the trauma surgeons and ER docs). Utilize your ancillary teams and physician colleagues that are already in-house as necessary to defer temporarily, yet benefit the patient’s progression of care. That gives you plenty of time to get a good night’s rest if the call was first received late evening (9-11PM for me), or to leisurely respond after surgery or dinner etc. With great relationships and mutual respect, late night calls virtually become a thing of the past. Also taken to an extreme, if I’m vacationing and reachable on my smartphone worldwide, finishing the last few runs or lounging at the beach, then getting to a desktop to access the patient’s imaging helps me plan and relate it to the O.R. and others once I get back into town. I’m always clear about my un/availability during vacation, and the trauma team will tee up the patient otherwise as usual, explaining to them that “Dr. Chu does all of our facial trauma cases, and will be in to see you once your swelling goes down”. It is the exception that we have to transfer a patient out for maxillofacial care, unless it’s at the beginning of a two-week absence, or the patient is impatient.

The fastest and least disruptive way to reach you should be by texting key information needed to keep you efficient. All of the important folks listed above and the page operators, both at the hospital and for your office privately, must be able to reach you at anytime by texting: I had standing orders to avoid contacting me between the hours of 11PM to 6AM unless it was a dire emergency that the in-house trauma, ER or hospitalist doctors couldn’t handle, otherwise I’d answer them back ASAP. Great customer service always keeps them coming back and works both ways. Think of the

trauma team as you do your dental referrers... both of them are your true client bases without a doubt, and you (and they) will be much more willing to overlook any glitches that neither can control.

The key here is that the foregoing efficiencies allow you to gather up and go tentatively with 90% of needed diagnostic information, leading to a 90% clear plan of action, that allows you to schedule and plan appropriately 90% of the time, even before seeing the patient. Thus the rare 1 in 10 cases that need further clarification or further arrangements can’t critically detract from your streak of stress-free trauma profitability; and usually these adjustments to timing or care are so minor they barely rate a mention. With some experience and refinement, you would likely get to a 95% ratio of pre-consultation predictability in diagnosing and planning, as I was able to achieve after several years, with just 1 case in 20 giving me an unexpected headache. Mistakes are reduced with constant communication. Keeping things moving allows for smoother and timely care progression despite being busy at the office or away. Profitability rises, stress melts.

### 3. Treatment.

Actual treatment and follow up must be properly planned, focused on best practices using simple or straightforward surgical approaches that are supported in the literature for optimal patient outcomes. Why attempt ORIF or endoscopic repair of 98% of routine subcondylar/condylar fractures, when research and experience demonstrates that closed reduction is faster, easier, cheaper plus stress-free to you, while providing excellent patient outcomes by all measures? Why continue to limit yourself to the traditional arch bar wiring, when hybridized arch bars allow for vastly more efficient application and post-treatment removal? And why not train and ‘privilege’ your RDA/OMSA to come with you and assist in the O.R.? The right person properly motivated (time and a half pay after hours) often relishes the excitement of the hospital, assists the O.R. tech and you to be more efficient especially on tough cases, and helps more effectively with after-care, while singing your praises to others – that’s a triple play in my book.

During the ICU and ward pre- and post-op day(s), you must appropriately utilize trauma team personnel, taking advantage of a beneficial trend to having 24-hour hospital and trauma team physicians and even some ancillary sub-specialists in-house, who extend your efficient care for the patient exponentially. These must be properly set up to avoid confusion and require good and efficient communication (texting!) to ensure proper patient hand offs. I often chatted/texted about patient care concerns or responded to questions between office patients. For anything more involved, I would either put in a quick call, or explain and delegate to my RDA/OMSA to resolve. With the usual and unusual always handled with aplomb, your good reputation spreads like wild-fire, and can only help build and maintain your standing in the community as the ‘go-to’ oral and maxillofacial surgeon!

Later office follow-ups must adhere to this same model. By training to employ the greatest competencies amongst your own staff, this allows for truly efficient and stressless post-op care through maximal delegation of repetitiously routine things, ranging from clipping wires and changing rubber bands, to removal of hybridized arch bars (often without even local anesthetic needed, yes!) and patient education at all phases in the weeks that follow hospital discharge. Your time is precious. The staff meanwhile often cherish a change in their routines, and are usually enthusiastic at being given higher level responsibilities in something that is as ‘cool and exciting’ as maxillofacial trauma and reconstruction that their doctor is performing weekly, if not more frequently.

What a pleasure it became, to fully practice what I trained in competently delivering as a maxillofacial trauma surgeon, not to mention being a welcome complement to a busy implant and dentoalveolar practice. Too many of you harbor equal love for the basic and profitable scope of OMS and resentment from the boredom of uni-dimensional or narrow focus of your practices, yet you can’t bring yourself to consider trauma as a viable source of surgical diversity and income. I hope that I have convinced those that are so interested and inclined, to take a harder, deeper look

(again, for many out there) at how the much-maligned area of trauma care for the vast majority of oral surgeons in private practice can be a sustainable and rich source of professional pride, community recognition, collegial relations with hospital staff, and overall surgical career satisfaction, further contributing to a thriving practice life for you.

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### Take care when choosing new vendors for scarce IV saline

The ongoing shortage of IV saline solution has led many OMSs to seek out vendors with available product. AAOMS recommends that OMSs very carefully check all saline solution products received from vendors - especially those who may be new to the practice. The shortage of IV saline solution is very real and according to a recent issue of *Kaiser Health Care News*, manufacturers report they will not be able to catch up with demand until sometime next year. The Board of Trustees has approved the topic of drug and IV fluid shortages as a 2014 legislative priority issue. ASI partner Southern Anesthesia & Surgical, Inc. has been able to obtain some FDA-approved saline solution from Spain. Although there are some minor differences between the products imported from Spain and saline solution manufactured by Hospira in the US, the products are similarly priced.

## CALAOMS member Dr. Tara Aghaloo among first Osteo Science Foundation grant recipients

The Board of Directors of the Osteo Science Foundation has awarded its first four research grants, totaling close to \$200,000 to researchers at Columbia University, Indiana University, Rutgers University and UCLA. The research projects, which focus on applied developments and treatment concepts in regenerative medicine for clinical application in oral, cranial, and maxillofacial surgery, align with the vision of Osteo Science Foundation, which is to advance hard and soft tissue regeneration in oral, cranial, and maxillofacial surgery through research and education.

Grantees from this first grant cycle are:

Dr. Tara Aghaloo, UCLA: *"Hard and Soft Tissue Engineering to Regenerate Mandibular Segmental Defects;"*

Dr. Tienmin Chu, Indiana University: *"Thrombopoietin in Cranial Regeneration"*

Dr. Sidney Eisig, Columbia University: *"Tracking cells and biomaterial remodeling in tissue engineered bone graft;"*

Dr. Hilton Kaplan, Rutgers University: *"Decellularized neurovascular bundle for craniomaxillofacial reconstruction."*

Tara Aghaloo is Associate Professor in Oral and Maxillofacial Surgery at the UCLA School of Dentistry. She completed dental school at UMKC, as well as Oral and Maxillofacial Surgery residency, a medical degree, and PhD in oral biology at UCLA. Her research is in bone biology and regeneration, while maintaining an active clinical practice focusing on implants and hard and soft tissue regeneration. She is also active in professional organizations where she is a board member of the Academy of Osseointegration

and section editor of the International Journal of Oral and Maxillofacial Implants.

The Osteo Science Foundation will be offering grants on a semi-annual basis. The next submission period for grant proposals is October 1 - December 1, 2014. All grant proposals must be submitted online at <http://www.osteoscience.org/index.php/grants>.



### Osteo Science Foundation

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*The Osteo Science Foundation provides a platform for scientific studies and an exchange of ideas in regenerative medicine. The Osteo Science Foundation will support the next generation of clinicians and bring together clinical research with industry leaders in Oral, Cranial and Maxillofacial Surgery.*

*Dr. Geistlich of Geistlich Pharma established the foundation to honor Dr. Philip Boyne's surgical excellence and outstanding research and to make his vision of bone and tissue regeneration a reality. Dr. Geistlich formally launched the Osteo Science Foundation in 2013.*

*To learn more about the Osteo Science Foundation, please visit their website at: <http://www.osteoscience.org/>*

## Ethics



Steve Leighty, DDS  
CALAOMS Director

### Is Success Enough?

I recently heard Michael Josephson speak at a Rotary convention in Reno. I borrowed most of this column's thoughts from a commentary of his.

I know a lot of highly successful people. They are at the top of their field and enjoy many of the comforts that wealth can afford. Most of them seem to enjoy their success. Let's turn our view slightly then and consider the difference between success and significance.

Alfred Nobel was greatly disappointed when he read his own obituary which had been printed by mistake when his brother died. The obituary was certainly complementary, describing him as a brilliant chemist who had made his fortune by inventing dynamite. However, he was struck by how hollow and inconsequential his accomplishments seemed as the total summation of his life. Determined to leave a much more meaningful legacy, he went on to establish the Nobel Prizes to acknowledge truly great human achievements.

Alfred Nobel realized that there's a transitory quality to success, while significance can be immortal and

ageless. A life devoted to attaining personal goals can be satisfying, but how much more enriching when we use our talents and time to improve the lives of others.

In the book *Living a Life that Matters*, Harold Kushner wrote, "Our souls are not hungry for fame, comfort, wealth, or power. Our souls are hungry for meaning, for the sense that we have figured out how to live so that our lives matter, so the world will be at least a little bit different for our having passed through it."

If we realize this before it's too late, we're less likely to dishonor our families and our legacies with dishonesty or selfishness. I challenge us to consider: Success isn't enough.

Opportunities abound in the dental and oral surgery community for service projects. Please consider joining with California CareForce, CDA Cares, or other charity projects in the dental community. Rotary and other service clubs, as well as other church and community outreach needs are all around us. Volunteer service on the Board of Directors for CALAOMS or WSOMS offer other avenues of service.

#### CALAOMS and CCF Continued from page 7

in the area also assists these local clinics by relieving some of their patient back log.

We are working with groups in Grass Valley and the Santa Barbara/Santa Maria area to schedule future clinics. We will keep you posted on dates as they become available.

Please consider volunteering at any or all of our clinics. We, along with the people of California, really need you. The rewards for you and the patients are immeasurable. It really is a great feeling to volunteer and help others.

## Morals and Ethics



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

with care. Theorists like Robert Burt have argued that there are distinct ethical issues in end-of-life decision-making that can impact how practitioners perceive their roles. While Burt argued that no practitioner should make choices that inflict death on another person, there is a fine line in defining causation when a person's life support systems are shut off by a practitioner. From a legal perspective, concepts like causation and intent become pertinent to the argument of how to approach medical futility. From a legal perspective, a medical practitioner's intent in relation to causation can play a significant role in determining an individual's culpability for bringing about a particular consequence or state of affairs. More particularly, if a practitioner injects a patient with a high dose of morphine with the intent of causing death and the patient dies immediately, the practitioner can be perceived as introducing the causative factor that resulted in death.

If the practitioner ends life-sustaining treatment because there is no chance, from the practitioner's perspective, that autonomy or health can be achieved, and their actions result in cardiac arrest, this is not perceived as caused directly by the actions of the practitioner. In each case, the patient dies, but in each case, the intent and actions differ, creating a call to delineate these kinds of behaviors through terminology like medical futility. Because of this fine line, legal comparisons have been made between views of medical futility and assessments of practitioner's behaviors in relation to both medical futility and assisted suicide.

### Hastening Death for Other Purposes

There are times when the actions of practitioners can cross a significant line. For example, hospitals and medical centers sometimes struggle with limited resources and limited amounts of technology to be utilized in their facilities. Keeping a patient alive on a set of equipment when that person has little or no hope of recovery while other patients go without necessary equipment or treatment can lead practitioners to make decisions about the futility of a person's medical status based on competing interests. The costs of treatments and the ability of family members to pay

## Legal Views of Causation

### Part 2 of 3

There seems to be a fine line between the actions of a medical practitioner to end the life of an individual based on the argument that continued life-sustaining interventions are medically futile and the introduction of approaches to end life when treatment is medically futile but life sustaining interventions have not yet been introduced. It appears medically acceptable to pull the plug on a patient who has been receiving medically futile treatment, but it is not acceptable to provide a patient with medication to terminate life even in the presence of the same odds of successful intervention. The legal concept of causation has to be considered when reflecting on the role of practitioners and the difference between ending medically futile care and participating in assisted suicide.

It has been argued that this kind of problem extends from the level of technology that has emerged in end-of-life care and the problems that practitioners face when making decisions about whether to continue

for long-duration hospital stays can also influence perceptions of futility. Because the costs of long-term treatment in the hospital setting is so excessive, the limit of treatment for critically ill patients who may not have the capacity to survive often reflects the culmination of information provided to practitioners, who take financial and practical issues into account.

There are distinct empirical assessments that go into decision-making regarding medical futility, and practitioners often turn to the medical organization to support a decision of futility. These individuals may take into account a much broader range of elements rather than just if the patient will survive or achieve a level of health or function; medical facilities frequently look at factors like the cost of treatment and the ability of patients to pay for that treatment. Medical decisions around futility are determined by what colleagues refer to as "outcome data" and this kind of data can lack a level of statistical confidence necessary for clinical decision-making. As a result, other types of outcome data, including the costs of treatment and the perspectives, goals or views of the medical facility can come into play when groups attempt to determine the futility of a treatment paradigm for a given patient.

Flexibility in the assessment of futility can be seen as both a positive element in allowing practitioners leeway in deciding individual cases, but can also create some conflicts when applied to creating legal directives. It is clear from what has been stated that medical decision-makers, especially surrogate decision-makers for patients, can clearly determine when life should end and identify when interventions should stop. They are less able to take part in an active dialogue with medical professionals in the presence of claims that medical futility exists. The state of Texas, for example, in a measure to protect the decision-making capabilities of medical professionals and to support hospital ethics committees, has created a procedure by which family demands for treatment can be reviewed. The outcomes of these committees, though, can also support the decision of medical professionals to withdraw life support, and this gives the

family members little recourse because they have followed the procedure outlined by the state lawmakers. Because there is no tried and true definition of what constitutes futility, the general disposition of those placed in a decision-making capacity determines the outcomes for both patient and the family.

This can create considerable issues, especially when families perceive significant violations of their rights. For example, in the Alabama Supreme Court case of Newsome and Newsome v. Gunnells, the appellants maintained that Dr. Drew Gunnells delivered their premature infant twins at 24 weeks and then refused to provide treatment, maintaining that it was medically futile to provide care for the neonates, who would inevitably, in his opinion, die (Pope, 2012). Though the infants were born alive, it was Dr. Gunnells' view that they were born too prematurely to survive and any intervention would only prolong their inevitable deaths. The Newsomes' babies cried for more than four hours while their parents watched unable to convince anyone to provide them with care, and before they could pursue any other course of action, their infants died. This type of case demonstrates the worst case scenario of the treatment of a patient, in this case two patients who could not speak for themselves, who had surrogate decision-makers, their parents, who sought treatment, and the decision of a physician to refuse treatment based on his own experiences in the neonatal intensive care and the unlikelyhood that infants born at 24 weeks gestation would survive outside the womb (Pope, 2012).

Within the scope of cases like the Newsomes, it is necessary to consider what might have been the competing interests or perspectives that supported Dr. Gunnells' decision. From the perspective of the parents, every effort was not made to ensure that their newborn children would survive, but this was based on Dr. Gunnells' medical perspective, which linked his own views of their condition to the belief that infants born before 24 weeks gestation would be considered a "miscarriage" rather than a live birth. It was also based on his early assessment that the infants would not be born alive, his decision not to contact a neonatologist

to be present at the birth, and his expert opinion about the length of time they would survive when they were born alive. In each case, his experience worked against the Newsomes, but these beliefs were based on his experience and the fact that in the past 100 cases, it was likely those infants born before 24 weeks would not survive and his quantitative assessment of medical futility. In addition, though, Dr. Gunnells may have also been asserting his belief that the infants, if they lived, would require a level of care that the Newsomes could not provide, that their care would be costly, and that they would be reliant on the care of others for their lives. This kind of assessment, though not often a part of the discourse of medical futility, sometimes comes into play as a part of medical decision-making. Researchers have argued that the concept of medical futility does not have fully defined criteria and is not structured in order to allow the application of both quantitative and qualitative elements in the justification of medical decision-making.

From a legal perspective, the issue of competing interests becomes a factor when assessing the approaches that practitioners take to addressing care for a variety of different types of patients, but most distinctly in reference to end-of-life care. One specific issue that had emerged references the decisions that practitioners make in regards to both the living and the dead and has to do with the use of organ transplants. The need for live organ transplants and the number of people waiting on transplant lists has created a medical imperative to convince the families of individuals who may be receiving treatment in the presence of medical futility to give up the fight for life in order to allow for the use of the live organs. The process of harvesting organs for organ transplantation has become a legal consideration when assessing the intent of practitioners in hastening the death of individuals rather than prolonging the use of life sustaining technologies. Because organs can deteriorate the longer a person is on mechanical ventilation and other forms of life support, cases have emerged when family members suspect that practitioners have hastened death in order to secure these organs for other patients.

In the case of *Jacobs v. Center for Organ Recovery and Education (CORE)*, Jonathan Coleman, the Hamot Medical Center and Dr. Pahapill, Jacobs claimed wrongful death, fraudulent misrepresentation and medical malpractice after the death of Michael Jacobs' son, Gregory. Mr. Jacobs maintained that Dr. Pahapill told him that his son Gregory was "brain dead" and had no chance of recovery, and communicated this to Mr. Jacobs knowing it to be false in order to encourage Mr. Jacobs to donate his son's organs. Mr. Jacobs relied on the misrepresented information presented by the doctors to make his decision to terminate life-sustaining technologies and turn his son's body over to the physicians in order to be harvested for organ donation. Mr. Jacobs maintained that the doctors made compelling arguments for the benefits that others could obtain from his son's organs, and Mr. Jacobs wanted "some good" to come of his son's death. In the case filed in the United States District Court of the Western District of Pennsylvania by Mr. Jacobs against CORE and the participating physicians at the Hamot Medical Center, Mr. Jacobs maintained that the physicians argued that subsequent treatments would be medically futile and then misrepresented the level of his son's condition in order to secure the donated organs.

This kind of issue and the lack of a solid legal response suggest the need for greater structure to the decision-making regarding medical futility. This is true both in cases like the Jacobs, where unclear messages were provided in order to ensure the harvesting of organs, and in cases where clinicians and family members' conflict over decisions in terminating services in which the patient may want to die (e.g. assisted suicide). There is a need for a functional structure through which these types of decisions can be both made and defended.

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## Risk Management

### Rising Number of Infectious Disease Cases Creates Patient Safety Issues

Physicians are reporting communicable, or infectious, diseases that were thought to have been controlled in the United States. New cases of whooping cough (pertussis) and, most recently, measles (rubeola) are making headlines. During the first half of 2014, there were more reported cases of measles than for any year since the disease was eliminated from the country in 2000.<sup>1</sup> In addition, newly classified infectious diseases are emerging, like Middle East Respiratory Syndrome.

To protect staff and patients, medical offices need to have established protocols that limit the exposure risk from individuals who come into the office with one of these debilitating, if not fatal, conditions. Medical malpractice liability risk may grow as reports of infectious diseases continue.

Your practice can reduce liability risks and promote patient safety by:

- Documenting all discussions with patients and parents of minors regarding infectious diseases, including the risks and benefits of inoculation.
- Documenting all discussions about serologic evaluations with patients who are unsure of their immunity status.
- Ensuring that all immunization tracking is up to date so that patients remain on a timely immunization schedule.
- When possible, allowing only staff members who have demonstrated evidence of immunity to work

with patients suspected of having a communicable or infectious disease.

- Complying with state laws for the provision of vaccines to healthcare workers. For more information, go to <http://www2a.cdc.gov/nip/statevaccapp/statevaccsapp/default.asp>.
- Notifying those who may have come in contact with an infected individual that they should see a physician.
- Ensuring that all office staff members are trained in the use of personal protective equipment and on proper isolation techniques when working with patients who present with symptoms of an infectious disease.

Follow these tips if you or your staff suspects a patient has an infectious disease:

- Minimize risk of exposure by moving the patient from the waiting area and isolating him or her in an exam room.
- For airborne diseases, place a surgical mask on the patient and ensure that all office staff members wear protective equipment, including gloves, eye protection, masks, or an N-95 particulate respirator, if needed.
- Follow standard disinfection and sterilization procedures for exam rooms.
- Report suspected cases to the local health department and obtain specimens for disease testing.
- Consider making post-exposure prophylaxis available to those who have been exposed.

Contributed by The Doctors Company. For more patient safety articles and practice tips, visit [www.thedoctors.com/patientsafety](http://www.thedoctors.com/patientsafety).

#### (Endnotes)

<sup>1</sup> CDC: Highest number of U.S. measles cases since 2000. *CNN Health*. <http://www.cnn.com/2014/05/29/health/cdc-measles/>. Published May 30, 2014. Accessed June 5, 2014.

## Upcoming CALAOMS CE Events

2014

**Residents' Night**                      **Anaheim**  
September 24, 2014

**Practice Management**            **Santa Clara**  
October 1, 2014

**Practice Management**            **Long Beach**  
October 2, 2014

**ACLS**                                      **Solano**  
October 25, 2014

**Medical Emergencies**              **Los Angeles**  
November 5, 2014

2015

**January Anesthesia Meeting**      **La Quinta**  
January 16-18, 2015

**Residents' Night**                      **Northern CA**  
January 28, 2015

**Risk Management**                      **Northern CA**  
February 11, 2015

**Risk Management**                      **Southern CA**  
February 25, 2015

**OMSA Spring 2015**                      **Los Angeles**  
March 7-8, 2015

**15th Annual Meeting**                      **Berkeley**  
April 24-26, 2015

*\* The Medical Emergencies course will be alternating between Northern and Southern California Locations each year.*

## Classified



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d  
S

### 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 gmyell1@aol.com, or call Dr. Yellich at Clear Choice Dental (408) 556-9587, or Santa Cruz Oral and Maxillofacial Surgery at (831) 475-0221.

**SACRAMENTO**: Kids Care Dental Group is looking for a talented oral surgeon to join our team 3-4 days a month. With six offices and TONS of maturing kids (LOTS of 3rds) we have way too many referrals for our one doctor to handle. Private patients, an amazing team, and a proven recipe for success. Please email Derek Boyes at dboyes@kidscaredentalgroup.com to discuss the opportunity in more detail.

**CHAPA-DE HEALTH**, a non-profit community clinic providing outpatient care to Native Americans and other low social-economic group, is currently seeking a Part-time Oral & Maxillofacial Surgeon to initially work on Tuesdays at their clinic located in Grass Valley, CA. Go to: [www.chapa-de.org](http://www.chapa-de.org) or submit your resume to [HR@chapa-de.org](mailto:HR@chapa-de.org). EOE

### PRACTICES FOR SALE

**ORAL SURGERY PRACTICE FOR SALE**--Sonoma County--High quality and high volume oral surgery practice seeks buyer to carry on an excellent tradition of providing oral surgery services to patients and a strong referral base of general dentists. This practice has consistently collected in excess of \$1,000,000 with an owner's net in excess of \$450,000. Seller is willing to assist buyer in a short or long-term transition and 100% financing is available. Interested prospects should send a cover letter and current CV by email to [molinelli@aol.com](mailto:molinelli@aol.com) or by calling Steve Molinelli at 650-347-5346.

**GREATER SACRAMENTO** multi-specialty office seeks associate Oral Surgeon for 1 day a month to start; eventually trying to expand program to 2-3 days per month. Dental Practice has great modern facilities and equipment, with an experienced support staff. Please email CV to [smiles4abetterlife@gmail.com](mailto:smiles4abetterlife@gmail.com) or fax to 916-817-4376.

**ORANGE COUNTY**, Excellent opportunity for a board certified/board eligible surgeon to join our well-established, well-respected, full scope modern Oral and Maxillofacial surgical practice. We are seeking a full-time or part-time energetic and motivated surgeon, who is personable and caring with excellent communication and interpersonal skills, who wants to practice a full scope of oral and maxillofacial surgery. For more information on our office please visit our website at [drjeffreyleedmddmd.com](http://drjeffreyleedmddmd.com). Please call Beth Bushling (714) 734-9363 or email [drleehr@gmail.com](mailto:drleehr@gmail.com).

### OMS ASSISTANT WANTED

**MOUNTAIN VIEW**, A highly service oriented oral surgery practice is looking for a surgical assistant. This position would require professionalism, motivation, reliability, multi-tasking and positive customer service skills. Oral surgery experience is required, and includes: Dental Implantsm Hard and Soft Tissue Grafting, Extractions and Biopsies, Taking Radiographs, Great Sterile Technique. Please include a cover letter with your qualifications and current resume. Fax to 650-938-9282

**SAN DIEGO** Well-established practice in North San Diego County grosses \$900K+ on 28 hours/week, 50% profit, freestanding professional building, gorgeous facility, 3 ops, 2 exam, digital pano/PAs, 27 years goodwill, outstanding reputation, broad referral base, dependable staff. Call 760 716-3199.

**LOOKING TO PURCHASE AN OMFS OFFICE** in Southern California (LA and surrounding areas). Please email me at [omfsbuyer@gmail.com](mailto:omfsbuyer@gmail.com) if interested.

**SACRAMENTO** Thriving full scope group OMS practice seeks single/dual degree surgeon for associateship leading to partnership position. Ideal candidate must have strong communication skills and quality surgical training. For more information please send cover letter and CV to [scott@bradyprice.net](mailto:scott@bradyprice.net) or contact Scott Price of Brady Price & Associates (925) 935-0890.

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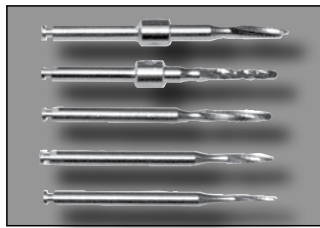
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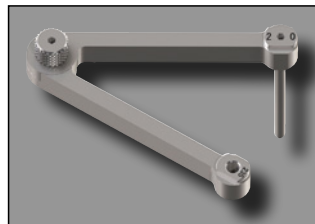
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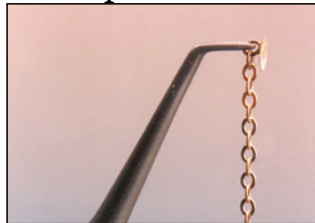
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