The California Legislature recognized California CareForce (CCF) on Thursday, August 29, 2019 by presenting the leadership of CCF with a joint resolution authored by Senator Jim Nielsen and Assemblymember James Gallagher. Both legislators represent the city of Paradise, California and the surrounding communities. The framed resolution was presented by Senator Nielsen in his Capitol office and on the Senate floor.

Legislative resolutions are presented to acknowledge extraordinary accomplishments by individuals or organizations. CCF was honored for the incredible work done by CCF and the California Association of Oral and Maxillofacial Surgeons (CALAOMS) volunteers in organizing the Chico health clinic held August 2-4, 2019. Senator Nielsen specifically noted the tremendous outpouring of support shown for the victims of the 2018 Paradise fire, and included CCF as a major part of that support.

Continued on Page 6
EDITORIAL

The Moral Pursuit Of Happiness

In California, we are blessed with the abundant opportunities that come with nice weather and ample public attractions; however, we also live in a pathetically dumb-ed-down culture. The levels of literacy and numeracy continue to plummet (California public schools rank 38th nationally in quality), while levels of unintelligence keep rising. Accurate knowledge of events from the past evaporates with its hard lessons unlearned, as the present culture demonstrates its contempt for the wisdom of the ages. In short, we are living in a time that is characterized by the arrogance of ignorance, which knows nothing but is certain nonetheless that it’s smarter than you. All one needs to do is spend five minutes with our Founding Fathers reading their exquisitely worded, meticulously drafted nation-forming documents to confirm that we all know less than we think, or, for that matter, spend five minutes with Dante or Shakespeare or C. S. Lewis (insert a teenager’s voice/Tweet here that says, “Who?”). Students are also no longer being taught to ask the big life questions: Who? What? When? Where else on this great earth is happiness as a core principle of government? America has developed quite differently than other countries and anti-social. It is yet another example of the divine wisdom of America’s Founders to include “Life, Liberty and the pursuit of Happiness” in the Declaration of Independence. Where else on this great earth is happiness as a core principle so enshrined? The American belief in the societal merit in pursuing happiness is in no small way responsible for why America has developed quite differently than other countries of the world.

Most people who are unhappy don’t engage in evil doings; however, most evil doings are performed by unhappy people.

Pleasure for the hedonist is a drug. But the pursuit of happiness is not the pursuit of pleasure. The pursuit of pleasure is hedonism, and hedonists are not happy because the intensity and amount of pleasure must constantly be increased in order for hedonism to work. Pleasure for the hedonist is a drug. But the pursuit of happiness is not the pursuit of pleasure. The pursuit of pleasure is hedonism, and hedonists are not happy because the intensity and amount of pleasure must constantly be increased in order for hedonism to work. Pleasure for the hedonist is a drug. But the pursuit of happiness is not the pursuit of pleasure. The pursuit of pleasure is hedonism, and hedonists are not happy because the intensity and amount of pleasure must constantly be increased in order for hedonism to work. Pleasure for the hedonist is a drug. But the pursuit of happiness is not the pursuit of pleasure. The pursuit of pleasure is hedonism, and hedonists are not happy because the intensity and amount of pleasure must constantly be increased in order for hedonism to work. Pleasure for the hedonist is a drug. But the pursuit of happiness is not the pursuit of pleasure. The pursuit of pleasure is hedonism, and hedonists are not happy because the intensity and amount of pleasure must constantly be increased in order for hedonism to work. Pleasure for the hedonist is a drug. But the pursuit of happiness is not the pursuit of pleasure. The pursuit of pleasure is hedonism, and hedonists are not happy because the intensity and amount of pleasure must constantly be increased in order for hedonism to work. Pleasure for the hedonist is a drug. But the pursuit of happiness is not the pursuit of pleasure. The pursuit of pleasure is hedonism, and hedonists are not happy because the intensity and amount of pleasure must constantly be increased in order for hedonism to work. Pleasure for the hedonist is a drug. But the pursuit of happiness is not the pursuit of pleasure. The pursuit of pleasure is hedonism, and hedonists are not happy because the intensity and amount of pleasure must constantly be increased in order for hedonism to work. Pleasure for the hedonist is a drug. But the pursuit of happiness is not the pursuit of pleasure. The pursuit of pleasure is hedonism, and hedonists are not happy because the intensity and amount of pleasure must constantly be increased in order for hedonism to work. Pleasure for the hedonist is a drug. But the pursuit of happiness is not the pursuit of pleasure. The pursuit of pleasure is hedonism, and hedonists are not happy because the intensity and amount of pleasure must constantly be increased in order for hedonism to work. Pleasure for the hedonist is a drug. But the pursuit of happiness is not the pursuit of pleasure. The pursuit of pleasure is hedonism, and hedonists are not happy because the intensity and amount of pleasure must constantly be increased in order for hedonism to work. Pleasure for the hedonist is a drug. But the pursuit of happiness is not the pursuit of pleasure. The pursuit of pleasure is hedonism, and hedonists are not happy because the intensity and amount of pleasure must constantly be increased in order for hedonism to work. Pleasure for the hedonist is a drug. But the pursuit of happiness is not the pursuit of pleasure. The pursuit of pleasure is hedonism, and hedonists are not happy because the intensity and amount of pleasure must constantly be increased in order for hedonism to work. Pleasure for the hedonist is a drug. But the pursuit of happiness is not the pursuit of pleasure. The pursuit of pleasure is hedonism, and hedonists are not happy because the intensity and amount of pleasure must constantly be increased in order for hedonism to work. Pleasure for the hedonist is a drug. But the pursuit of happiness is not the pursuit of pleasure. The pursuit of pleasure is hedonism, and hedonists are not happy because the intensity and amount of pleasure must constantly be increased in order for hedonism to work. Pleasure for the hedonist is a drug. But the pursuit of happiness is not the pursuit of pleasure. The pursuit of pleasure is hedonism, and hedonists are not happy because the intensity and amount of pleasure must constantly be increased in order for hedonism to work. Pleasure for the hedonist is a drug. But the pursuit of happiness is not the pursuit of pleasure. The pursuit of pleasure is hedonism, and hedonists are not happy because the intensity and amount of pleasure must constantly be increased in order for hedonism to work. Pleasure for the hedonist is a drug. But the pursuit of happiness is not the pursuit of pleasure. The pursuit of pleasure is hedonism, and hedonists are not happy because the intensity and amount of pleasure must constantly be increased in order for hedonism to work. Pleasure for the hedonist is a drug. But the pursuit of happiness is not the pursuit of pleasure. The pursuit of pleasure is hedonism, and hedonists are not happy because the intensity...
Legislative resolutions are prestigious and should be cherished by their recipients. The fact that Senator Nielsen, the Dean of the Senate, enthusiastically presented the resolution says a great deal about his respect for both California CareForce and CALAOMS. That respect will go a long way as we enter a new legislative year with many new issues to face. Members of CALAOMS have reason to be proud of their leadership and of the organization as a whole. View the Resolution on the opposite page.

RESOLUTION
CALIFORNIA LEGISLATURE
By the Honorable Jim Nielsen, 46th Senatorial District, and the Honorable James Gallagher, 3rd Assembly District; Relative to Commending

California CareForce

WHEREAS, The relationship between a community and nonprofit organization is a vital and interdependent one, deriving strength from the civic involvement and dedication of those who engage with such organizations, the many positive outcomes these organizations make possible, and the spirit of cooperation and respect they foster within the community; and

WHEREAS, One such dedicated nonprofit organization is California CareForce, which has offered health care services to medically underserved communities for nearly a decade, and it is appropriate at this time to highlight its many achievements and underscore the positive impact it has made in the local community and beyond; and

WHEREAS, Senate Bill 5 in its mission to promote the health and well-being of those in need through volunteer-supported, no-cost health care clinics across the State of California, California CareForce brings together health care professionals, community leaders, and engaged citizens to sponsor temporary clinics where free care is provided; and

WHEREAS, As the philanthropic arm of California Association of Oral and Maxillofacial Surgeons, California CareForce serves thousands of patients who lack the resources for much-needed health care, providing educational opportunities for those patients to learn about the importance of good nutrition, strong oral health, and disease awareness and management and helping them establish a medical, dental, and vision home, in addition to offering students, such as those seeking professional health care degrees, vital hands-on experience; and

WHEREAS, Since its inception in 2011, California CareForce has sponsored 21 clinics in a variety of locations, including the Coachella Valley, San Joaquin, Oakland, Gold Country, and the greater Los Angeles area, bringing together 13,000 volunteers to provide vital healthcare services valued at more than $30 million to 32,000 patients; and

WHEREAS, On August 3 and 4, 2019, California CareForce will hold a health clinic in Chico to offer services at no charge to hundreds of Northern California residents who are in serious need due to a variety of circumstances, but with the most specifically those affected by the Paradise fire; and

WHEREAS, The invaluable contributions California CareForce has made toward increasing access to quality health care services in the State of California reflect an organization devoted to the highest ideals of community service; now, therefore, be it

RESOLVED BY SENATOR JIM NIELSEN AND ASSEMBLY MEMBER JAMES GALLAGHER, That California CareForce be commended for the outstanding contributions it has made across the State through its health care clinics and extended services that foster success in the future.
The concern expressed in the Joint Statement about the OMS anesthesia model is not the education, training, and capabilities of the Oral and Maxillofacial Surgeon, but rather, the Joint Statement’s concern focuses on the need for “…an appropriately qualified, dedicated monitor who is prepared to unambiguously help in the event of a patient emergency” for patients undergoing deep sedation/general anesthesia. It has long been the position of the ASA – the people who provide medical anesthesia training in our residencies – that the surgeon cannot also be the monitor.

While the Joint Statement focuses on pediatric patients without defining a specific age range for pediatrics, based on my personal experience as an AAOMS officer with multiple face-to-face meetings with the leadership of the ASA, the ultimate position of the ASA is not to train pediatric assistants. The unprecedented and unjustified attacks we are experiencing are likely only the beginning of a long-term plan to completely strip OMS of the team model of office-based anesthesia delivery.

Earlier this year, the American Academy of Pediatrics (AAP) and the American Academy of Pediatric Dentistry (AAPD) issued joint guidelines for monitoring and management of pediatric patients undergoing procedural sedation (2019 AAP/AAPD Guidelines). These guidelines specifically targeted the specialty of Oral and Maxillofacial Surgery and our use of the team model of anesthesia delivery. On July 29, 2019 the American Society of Anesthesiologists (ASA) issued a statement titled “The Joint Statement from the American Society of Anesthesiologists, the Society for Pediatric Anesthesiology, the American Society of Dentist Anesthesiologists, and the Society for Pediatric Sedation Regarding the Use of Deep Sedation/General Anesthesia for Pediatric Dental Procedures Using the Single-Provider/Operator Model.” [Emphasis added] The power of an evidence-based legislative campaign was proved in 2018 by the passage of CALAOMS-sponsored bill SB 501. This landmark pediatric dental anesthesia safety bill is now in California law, but it does not take effect until 2022. There is plenty of time for our enemies to take action that could undo SB 501 before it has a chance to take effect. CALAOMS fully expects legislative challenges to our anesthesia model in the next year or two. The power of an emotion-driven legislative campaign against us cannot be underestimated. In spite of evidence and reason, emotion sells; and media – especially social media – thrives on it.

As the storm clouds gather, remember that Oral and Maxillofacial Surgery is a legislated specialty. The content of California Law directly determines everything we do as Oral and Maxillofacial Surgeons. What we may have believed to be entitlements have always been privileges subject to the wisdom, or the whim, of our legislators. It has never been more important to be politically active than now. Get to know your state Senators and Assembly Members. Show up at their district events and show support. Invite them to see your offices and ambulatory surgery centers. At a minimum, give generously to the California Association of Oral and Maxillofacial Surgeons Political Action Committee (CALAOMSPAC). Go to www.calaoms.org, Member Resources, Donations and Contributions, calaoms."

" Defense Against the Perfect Storm Part 3 Take action now. Train your anesthesia assistants to become DSAs. Give to CALAOMSPAC to assure we have a strong voice in the legislature. Most importantly, adhere to the Culture of Safety that has always been the foundation of OMS office-based anesthesia. Patient safety is our first priority. Take personal responsibility for the future of OMS office-based anesthesia. Rethink and redefine your parameters for patients who qualify for office-based deep sedation/general anesthesia. Not every patient is a candidate for deep sedation/general anesthesia in the office setting. Develop guidelines for your office based on patient age, weight (BMI), and health – with regard to who can be treated in your office based on your training, experience, and comfort level. Know when to say no; and say no when you know it is best."

As your CALAOMS President in 2019, I have been urging our members to offer DSA training to their assistants. The first step is to fill out the document “Dental Sedation Assistant Course, Application for Approval by the Dental Board of California.” This process empowers you to train your assistants to become DSAs and be licensed (permitted) providers of monitoring and recovery assisting services in California. CALAOMS stands ready to assist you in this important endeavor. Contact CALAOMS Executive Director Pamela Congdon at (800) 500-1332 and ask for the DSA Application materials.

DEFENSE AGAINST THE PERFECT STORM
Part 2

The power of an evidence-based legislative campaign was proved in 2018 by the passage of CALAOMS-sponsored bill SB 501. This landmark pediatric dental anesthesia safety bill is now in California law, but it does not take effect until 2022. There is plenty of time for our enemies to take action that could undo SB 501 before it has a chance to take effect. CALAOMS fully expects legislative challenges to our anesthesia model in the next year or two. The power of an emotion-driven legislative campaign against us cannot be underestimated. In spite of evidence and reason, emotion sells; and media – especially social media – thrives on it.

As the storm clouds gather, remember that Oral and Maxillofacial Surgery is a legislated specialty. The content of California Law directly determines everything we do as Oral and Maxillofacial Surgeons. What we may have believed to be entitlements have always been privileges subject to the wisdom, or the whim, of our legislators. It has never been more important to be politically active than now. Get to know your state Senators and Assembly Members. Show up at their district events and show support. Invite them to see your offices and ambulatory surgery centers. At a minimum, give generously to the California Association of Oral and Maxillofacial Surgeons Political Action Committee (CALAOMSPAC). Go to www.calaoms.org, Member Resources, Donations and Contributions, calaoms."

" Defense Against the Perfect Storm Part 2 The power of an evidence-based legislative campaign was proved in 2018 by the passage of CALAOMS-sponsored bill SB 501. This landmark pediatric dental anesthesia safety bill is now in California law, but it does not take effect until 2022. There is plenty of time for our enemies to take action that could undo SB 501 before it has a chance to take effect. CALAOMS fully expects legislative challenges to our anesthesia model in the next year or two. The power of an emotion-driven legislative campaign against us cannot be underestimated. In spite of evidence and reason, emotion sells; and media – especially social media – thrives on it.

As the storm clouds gather, remember that Oral and Maxillofacial Surgery is a legislated specialty. The content of California Law directly determines everything we do as Oral and Maxillofacial Surgeons. What we may have believed to be entitlements have always been privileges subject to the wisdom, or the whim, of our legislators. It has never been more important to be politically active than now. Get to know your state Senators and Assembly Members. Show up at their district events and show support. Invite them to see your offices and ambulatory surgery centers. At a minimum, give generously to the California Association of Oral and Maxillofacial Surgeons Political Action Committee (CALAOMSPAC). Go to www.calaoms.org, Member Resources, Donations and Contributions, calaoms."

" President’s Farewell It has been an honor being your President in 2019. I wish to extend my profound and sincere thanks to your CALAOMS Board of Directors: Dr. Jeff Elo, Immediate Past President; Dr. Chan Park, President Elect; Dr. Shama Currimbhoy, Vice President; Dr. Ed Bedrossian, Treasurer; Dr. Sam Khosary, Senior Director; Dr. Dave Cummings, Directors; Dr. Ashok Veeranki, Director; Dr. Jayini Thakker, Director; and Long-Term Delegates, Dr. Frederick Stephens and Dr. Alan Kaye. Special thanks to Jeff Elo who does double duty as our Journal editor and emergency ghost writer for yours truly.

It would be impossible to execute the duties of CALAOMS President without the dedicated services of our loyal and capable staff, led by the incomparable Pamela Congdon, CAE, IOM, Executive Director. Pam is the hardest working and most effective association executive I have had the pleasure of working with. Steve Krantzman, Associate Director, has been invaluable in supporting the technology needs of CALAOMS and is the creative genius behind the CALAOMS Opioid Education Presentation. Teri Travis, CMPD Director of Continuing Education Services, is the backbone of CALAOMS’s CE from OMSA to the Annual Meeting. We are fortunate to have such talented individuals on our Senior Management Team.

Thank you to the loyal CALAOMS Fellows and Members who serve on our Committees. Thanks to all who have maintained faithful attendance at our continuing education events.

Thanks to California CareForce for being the conscience of CALAOMS and for enabling us to give back to the victims of unfortunate events and circumstances in California.

Sincerely,
Larry J. Moore
Greetings from the District VI Trustee,

I am grateful to CALAOMS – and to all of District VI – for the support and confidence shown me as your AAOMS Trustee. As Dr. Tom Indresano has done, and Drs. Larry Moore, Jay Malmquist, Elgan Stamper, and Terry Slaughter before him, I will continue to bring hard work, dedication, and a love for the specialty to the AAOMS Board table from our district. That four of these five past AAOMS Presidents are from California speaks to the importance of CALAOMS in leading the district and AAOMS.

We have just returned from our 101st AAOMS Annual Meeting in Boston. We had a successful meeting! The House of Delegates completed the work of the association and elected a new slate of officers. Dr. Victor Nannini (New York) is AAOMS’ new President, Dr. B.D. Tiner (San Antonio, TX) ascended to President-Elect, and Dr. J. David Johnson (Oak Ridge, TN) was elected Vice President. Dr. Robert Clark (Lexington, KY) – previously District III’s Trustee – is now AAOMS Treasurer, and our own Dr. Tom Indresano has moved to the Immediate Past President office where he will continue to provide wise counsel to the AAOMS Board. On a historic note, District III has elected the first woman to sit as District Trustee. Congratulations to you and thank you for your diligence.

In the long run, data will be the key to maintaining the safe OMS anesthesia team model of safe anesthesia delivery. AAOMS has responded to both publications, as neither the above guidelines nor statement provided any scientific evidence supporting these recommendations. AAOMS criticized the OMS anesthesia team model of safe anesthesia delivery. The Dental Anesthesia Incident Reporting System (DAIRS) has been live for over a year now and links to DAIRS are available on the AAOMS website (https://www.aaoms.org/member-center/dental-anesthesia-incident-reporting-system). Members are asked to report any anesthetic event. State dental boards are being petitioned to accept DAIRS reporting to satisfy state requirements. The information is not identifiable, but will assist in the understanding of anesthetic events. In addition, this data will be used to guide and direct the development of future educational programs.

AAP’s revised guidelines. The statement specifically criticized the OMS anesthesia team model of safe anesthesia delivery. AAOMS has responded to both publications, as neither the above guidelines nor statement provided any scientific evidence supporting these recommendations. AAOMS sent a letter to the editor of the AAP journal, and submitted a rebuttal in the Journal of Oral and Maxillofacial Surgery (JOMS) to the Joint Statement which has been posted online (https://www.aaoms.org/member-center/member-news) and will appear in the December 2019 issue of the JOMS.

In the long run, data will be the key to maintaining the safe OMS anesthesia team model of sedation and anesthesia delivery. The OMS Quality Outcomes Registry is accepting enrollment and has been well received by participating members (https://www.aaoms.org/member-center/oms-quality-outcomes-registry). A March/April AAOMS Today article reviewed and explained this initiative in detail.

To best advocate for our specialty, we need all members to participate with OMSQOR. Obtaining the total number of procedures performed – with and without anesthesia – and on what patient demographic is critical to providing stakeholders with evidence of the safety of the services that OMS practices provide. Visit www.aaoms.org/member-center/omsqor to review the FAQs and Resource Guide to help with participation.

The Dental Anesthesia Incident Reporting System (DAIRS) has been live for over a year now and links to DAIRS are available on the AAOMS website (https://www.aaoms.org/member-center/dental-anesthesia-incident-reporting-system). Members are asked to report any anesthetic event. State dental boards are being petitioned to accept DAIRS reporting to satisfy state requirements. The information is not identifiable, but will assist in the understanding of anesthetic events. In addition, this data will be used to guide and direct the development of future educational programs.

Advocacy

The importance of monitoring legislative and regulatory proposals that could affect patient safety and access to care remains high. AAOMS remains dedicated to assisting each state with managing issues that may arise affecting your ability to provide safe and affordable care to your patients. CALAOMS remains a model for the rest of the nation in this regard. In the area of advocacy and surveillance – and with proactive legislative initiatives – you are the leaders. Congratulations to you and thank you for your diligence.

By the time you read this, I will have attended the CALAOMS Board meeting in late October, and I look forward to attending the next CALAOMS meeting this winter. I hope to meet many of you there.

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

VENDOR SPOTLIGHT

CALAOMS Wishes to Thank the Vendors That Graciously Sponsored CALAOMS’ 19th Annual Meeting at the Island Hotel Newport Beach

Speaker Sponsor: The Doctors Company

Attendee Gift Sponsor: tlicc

Membership Luncheon Sponsor: HALS Med Dent Supply

Breakfast & Breaks Sponsor: Boyd Industries
MEANING IN ETHICS

Latent Meanings and Nuances in Bioethics

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

The study and value of etymology (G- etumologia “true sense”) in bioethics cannot be overstated. It is fair to say that use of explicit language when joined to the sense (“what is done or made on behalf of the community as a whole.”) One can draw the meaning of the terms “public” and “private.” The boundaries between the public and private help to create a moral environment for individuals, to establish norms for what is appropriate or worthy actions, and to establish barriers to action in different areas, particularly in areas such as the taking of human life, promulgation of familial duties and obligations, and the arena of political responsibility. Public and private, therefore, are embedded within a dense conceptual web of meanings and implications linked to other basic notions, including nature and culture, male and female, individuality and community, and so on.

According to political theorist Brian Fay, these notions are conditioned on “society’s understanding of the meaning and role of work; its view of nature; its concept of agency; its ideas about authority, the community, the family; its beliefs about God and death, and so on” (Contemporary Philosophy of Social Science: A Multicultural Approach). The content, meaning, and range of public and private vary within each society, defining the virtues of political and private life and their normative significance.

In the history of Western political thought, public and private imperatives, concepts, and symbols have been ordered in a number of ways. They include: the demand that the private world be integrated fully within the public arena; the insistence that the public sphere be “privatized,” with politics controlled by standards, ideals, and purposes emerging from a particular vision of the private sphere; or, finally, a continued differentiation and bifurcation between the two spheres.

Bioethics is deeply implicated in each of these broad, general theoretical tendencies that often touch on the private and the public. Consider the example of a couple who decides to conceive a child through artificial insemination by donor. One could wonder: What happens to a society’s view of the family and inter-generational ties if more couples resort to artificial insemination? What is the effect on the psycho-social development of donor children? What are the responsibilities, if any, of the donor father beyond the point of sperm donation for a fee? Do contractual agreements suffice to “cover” not just the legal but also the ethical implications of such agreements?

All these questions could be solved simply by an appeal to privacy. In such a view, those questions are the exclusive business of the individuals involved in the contractual transaction at stake. And yet other questions loom large: Does society have a legitimate interest in such “private” choices, given the potential social consequences of private arrangements? Or should such procedures be covered by health insurance?

There is widespread disagreement over the respective meaning of public and private within societies. The boundaries between the public and private help to create a moral environment for individuals, to establish norms for what is appropriate or worthy actions, and to establish barriers to action in different areas, particularly in areas such as the taking of human life, promulgation of familial duties and obligations, and the arena of political responsibility. Public and private, therefore, are embedded within a dense conceptual web of meanings and implications linked to other basic notions, including nature and culture, male and female, individuality and community, and so on.

According to political theorist Brian Fay, these notions are conditioned on “society’s understanding of the meaning and role of work; its view of nature; its concept of agency; its ideas about authority, the community, the family; its beliefs about God and death, and so on” (Contemporary Philosophy of Social Science: A Multicultural Approach). The content, meaning, and range of public and private vary within each society, defining the virtues of political and private life and their normative significance.

In the history of Western political thought, public and private imperatives, concepts, and symbols have been ordered in a number of ways. They include: the demand that the private world be integrated fully within the public arena; the insistence that the public sphere be “privatized,” with politics controlled by standards, ideals, and purposes emerging from a particular vision of the private sphere; or, finally, a continued differentiation and bifurcation between the two spheres.

Bioethics is deeply implicated in each of these broad, general theoretical tendencies that often touch on the private and the public. Consider the example of a couple who decides to conceive a child through artificial insemination by donor. One could wonder: What happens to a society’s view of the family and inter-generational ties if more couples resort to artificial insemination? What is the effect on the psycho-social development of donor children? What are the responsibilities, if any, of the donor father beyond the point of sperm donation for a fee? Do contractual agreements suffice to “cover” not just the legal but also the ethical implications of such agreements?

All these questions could be solved simply by an appeal to privacy. In such a view, those questions are the exclusive business of the individuals involved in the contractual transaction at stake. And yet other questions loom large: Does society have a legitimate interest in such “private” choices, given the potential social consequences of private arrangements? Or should such procedures be covered by health insurance?
Since 2011, California CareForce has held 24 clinics. With the assistance of 15,000 dedicated volunteers, we have served 32,000 individual patients for a total of $14,000,000 worth of care. You’ll enjoy being part of our community of caring, dedicated healthcare professionals. Don’t hesitate to ask your referring dentist to join us too! By the end of the weekend, our volunteers are smiling even wider than our patients. Visit www.californiacareforce.org to sign up.

Attention CALAOMS Members. Save the Date for an Upcoming California CareForce free clinic.
- Grass Valley on January 11 - 12, 2020
- Coachella Valley end of March, 2020

Since 2011, California CareForce has held 24 clinics. With the assistance of 15,000 dedicated volunteers, we have served 32,000 individual patients for a total of $14,000,000 worth of care. You’ll enjoy being part of our community of caring, dedicated healthcare professionals. Don’t hesitate to ask your referring dentist to join us too! By the end of the weekend, our volunteers are smiling even wider than our patients. Visit www.californiacareforce.org to sign up.

Visit Xemax online for our full product line, or call for an updated catalog!

1-800-257-9470 • www.xemax.com
Fall 2019 Legislative Report

The first year of the 2019-2020 legislative session ended on Sunday, October 13, 2019 with Governor Gavin Newsom taking action on the final group of bills that reached his desk this year. 2019 was Governor Newsom’s first year as governor, and the pattern of his signing and vetoing legislation will become much more apparent in the coming years. He is, however, demonstrating an active interest in healthcare legislation, which should prove to be very positive as his administration moves forward.

While the pediatric anesthesia issue was not a front-and-center issue in 2019, the governor signed one bill - AB 1622 (Carrillo) - that added the requirement to the Dental Practice Act that the informed consent form used prior to administering general anesthesia to a pediatric dental patient encourage the parents to consult with the patient’s dentist, pediatrician, or family physician. The fact that the pediatric anesthesia issue was not on the legislative radar screen in 2019 belies the fact that the issue is just under the surface.

CALAOMS has every reason to believe it will be a very hot and emotional legislative topic once again in 2020. Since the American Academy of Pediatrics (AAP) and the American Academy of Pediatric Dentistry (AAPD) issued their guidelines recommending a second anesthesia provider be present during pediatric general anesthesia, the American Society of Anesthesiologists (ASA) and the American Society of Dental Anesthesiologists have added their support. This has the potential to reintroduce the issue to the California legislature and could undermine the very positive legislation enacted in the CALAOMS-sponsored SB 501 (Glazer) that was signed into law in 2018 but does not take effect until January 2022.

One of the more relevant bills to be signed (October 13, 2019) was AB 1519 by Assemblymember Evan Low. This measure is the traditionally non-controversial legislation that extends the operation of the Dental Board of California (DBC) after the legislative Sunset Review process. While AB 1519 did extend the operation of the DBC, other provisions were added to the bill as well. Specifically, the bill requires that dentists who provide orthodontic services either in a dental office or via telehealth shall meet the accepted standard of care of reviewing the patient’s recent radiographs prior to the movement of teeth. While these provisions are beneficial to patients and CALAOMS agrees with the policy, Governor Newsom indicated his displeasure of including non-related DBC policy language used for “over 50 years by the OMS profession is safe and should not be changed; only strengthened.

The fact that the pediatric anesthesia issue was not on the legislative radar screen in 2019 belies the fact that the issue is just under the surface.

What is Vaping?

Recently, I introduced my 18-year-old niece to the concept of renting a movie. And by renting a movie I mean really renting a movie, as in getting off the couch, getting in a car, driving to the store, picking up a movie, watching it, and then returning it back to the store (yes, people still do this). For most young people in her generation, the art of renting a movie is carried out simply by pushing a button on her smartphone, computer, or smart tv. There is a distinct generational gap in how each of us sees the world. Unfortunately, this gap doesn’t extend just one way. I’m also clearly unable to see how her generation views the world.

As an oral and maxillofacial surgeon in private practice, a large percentage of my patient population is near my niece’s age. It doesn’t take long to find evidence that I am out of touch with people this age in my practice. That evidence is present on one of the first forms that our patients complete as they enter our waiting room – the health history. Like yours, our health history queries about smoking and tobacco products – what is used; how much is used, etc. From our experience, many patients in this age group “smoke” by vaping, but they don’t check that box. They often view smoking and vaping as separate and distinctly different things.

What is vaping? Vaping is a rapidly growing trend especially in the high school-aged population. A recent study showed that 37% of high school seniors reported vaping in 2018, an approximate ten percent increase from just the year prior. There are many challenges to this growing trend for health care providers. We simply don’t have the long-term data on the negative health effects of vaping. We also don’t have an adequate way to measure dose when patients vape.

Newer-generation devices are able to deliver a higher concentration of nicotine to users than previous devices. The lack of a strong odor or lasting residue allows vapers to use the products more often in a multitude of settings. Vaping per nicotine dose is also cheaper than equivalent tobacco products in California. Medicine has always measured tobacco use by the number of packs consumed over a period of time. This simple dose and frequency calculation cannot be similarly or accurately applied to vaping. The variables of vaping dose and frequency of vaping are extremely difficult to adequately measure.

Many young teens view vaping as a safe alternative to smoking. People believe that vaping is inhaling a water vapor that carries nicotine; yet the truth is that the device heats propylene glycol and glycerol to produce a hypersmolar aerosol that is deposited deep within the lungs along with nicotine and harmful byproducts of the process. Some of these byproducts are formaldehydes and acetaldehydes that can cause lung disease as well as cardiovascular disease. The devices can also contain acrolein – a commercial herbicide – that is known to cause asthma and lung cancer.

Vaping devices can also vary on what type of consumables are being used. Some patients may be using wax-based or oil-based devices to inhale tetrahydrocannabinol (THC) products. The contents and byproducts of these consumables are also difficult to measure due to lack of standardization and regulation. Many cases of severe lung damage are from oil-based vaping devices.

We are finally seeing that vaping is not as harmless as previously believed and promoted. The U.S. Surgeon General has issued a warning about the risk of secondhand vape smoke and some cities have subsequently outlawed and regulated the use of vaping devices. Most recently, the Centers for Disease Control and Prevention (CDC) has been investigating an outbreak involving 1,808 patients with severe lung injuries that have been reported from 48 states and resulted in the confirmed deaths of 18 patients.

If the numbers are correct, more than one-third of patients in this prevalent age for undergoing wisdom tooth removal surgery may be vaping (and not admitting to it). While many people use nicotine, there is also a population of users that vape THC and marijuana products. A recent study found that patients using marijuana and THC products can require up to three times the dose of propofol to achieve similar levels anesthesia as control patients.

The negative implications of vaping in our patient population are evident. THC use can adversely affect anesthesia delivery and nicotine’s potent vasoconstrictive effects are known to delay wound healing. These ramifications and challenges must be addressed, but the first step in facing those challenges is awareness and understanding so that we can be a part of the conversation to standardize and regulate this new trend.

by Gary Cooper
Legislative Advocate, CALAOMS

by David Y. Park, DDS, MD
E-cigarettes and Youth: What Health Care Providers Need to Know

WHAT ARE E-CIGARETTES?
Electronic cigarettes (e-cigarettes) are battery-powered devices that deliver nicotine, flavorings, and other ingredients to the user. Using e-cigarettes is sometimes called “vaping.” E-cigarettes do not create harmless “water vapor” – they create an aerosol that can contain harmful chemicals.

HOW MANY YOUTH ARE USING E-CIGARETTES?
- E-cigarettes have been the most commonly used tobacco product among U.S. youth since 2014.
- In 2018, CDC and FDA data showed that more than 3.6 million U.S. youth, including 1 in 5 high school students and 1 in 20 middle school students, were past-month e-cigarette users.
- During 2017 and 2018, e-cigarette use skyrocketed among youth, leading the U.S. Surgeon General to call the use of these products among youth an epidemic in the United States.

WHAT ARE THE RISKS FOR YOUTH?
- Most e-cigarettes contain nicotine, which is highly addictive. Nicotine exposure during adolescence can:
  » Harm brain development, which continues until about age 25.
  » Impact learning, memory, and attention.
  » Increase risk for future addiction to other drugs.
- Young people who use e-cigarettes may be more likely to go on to use regular cigarettes.
- Many e-cigarettes come in kid-friendly flavors – including mango, fruit, and crème – which make e-cigarettes more appealing to young people.
- E-cigarette aerosol is not harmless. It can contain harmful substances, including:
  » Nicotine
  » Ultrafine particles
  » Cancer-causing chemicals
  » Flavorings that have been linked to lung disease
  » Volatile organic compounds
  » Heavy metals such as nickel, tin, and lead

WHAT DO E-CIGARETTES LOOK LIKE?
- E-cigarettes come in many shapes and sizes. Some look like regular cigarettes, cigars, or pipes. Larger e-cigarettes such as tank systems – or “mods” – do not look like other tobacco products.
- Some e-cigarettes look like other items commonly used by youth, such as pens and other everyday items. New e-cigarettes shaped like USB flash drives are popular among youth, including JUUL and the PAX Era, which looks like JUUL and delivers marijuana.

WHAT CAN YOU DO AS A HEALTH CARE PROVIDER?
As a health care provider, you have an important role in addressing this epidemic among youth.
- Ask about e-cigarettes and vaping - including discreet devices such as JUUL - when screening patients for tobacco product use.
- Educate patients about the risks of tobacco product use, including e-cigarettes for young people, and counsel youth and young adults to quit.
- Learn about the different shapes and types of e-cigarettes and the risks of e-cigarette use for young people at www.CDC.gov/e-cigarettes.

ABOUT USB FLASH DRIVE-SHAPED E-CIGARETTES
As a health care provider, you may have heard about the use of USB flash drive-shaped e-cigarettes, including JUUL (pronounced “jewel”). JUUL is the top-selling e-cigarette brand in the United States.
JUUL is being used by students in schools, including in classrooms and bathrooms. JUUL’s nicotine liquid refills are called “pods.” According to the manufacturer, a single JUUL pod can contain as much nicotine as a pack of 20 regular cigarettes.
JUUL delivers nicotine in a new form called “nicotine salts,” which can make it less harsh on the throat and easier to use by youth. JUUL also comes in flavors that can appeal to youth.
Platelet Rich Fibrin – What is it Good For?

After years of sitting on the sidelines listening to other clinicians extoll the virtues of platelet rich plasma/ fibrin (PRP/PRF), I decided to give it a try. It seemed worthwhile to first perform a literature search and learn what PRF can improve and where it might fall short. Platelet concentrates have been reported about in medical and dental literature for decades. The term “PRF” was first coined in 1954 during coagulation experiments. In the 1970s, researchers developed an appreciation for the ability of platelet concentrates to aid in wound healing and adhesion of tissues. “Fibrin glue” was found to improve skin healing in rats. From 1975 - 1978, several studies reported on the use of platelet-fibrin mixtures to facilitate closure of epithelial wounds.1 PRF entered the dental literature in 1984 with an article entitled, “Use of PRF in bone volume augmentations” in the Belgian Review of Medicine and Dentistry.2 PRF gained popularity in oral and maxillofacial surgery (OMS) after 1997 when researchers developed an appreciation for the ability of platelet-rich fibrin (PRF) to improve and where it might fall short.

Platelet concentrates have been reported about in medical and dental literature for decades. The term “PRF” was first coined in 1954 during coagulation experiments. In the 1970s, researchers developed an appreciation for the ability of platelet concentrates to aid in wound healing and adhesion of tissues. “Fibrin glue” was found to improve skin healing in rats. From 1975 - 1978, several studies reported on the use of platelet-fibrin mixtures to facilitate closure of epithelial wounds.1 PRF entered the dental literature in 1984 with an article entitled, “Use of PRF in bone volume augmentations” in the Belgian Review of Medicine and Dentistry.2 PRF gained popularity in oral and maxillofacial surgery (OMS) after 1997 when researchers developed an appreciation for the ability of platelet-rich fibrin (PRF) to improve and where it might fall short.

A significant advance came in 2001 when French anesthesiologist Joseph Choukroun and his team developed PRF. PRF had the following advantages over PRP: easier preparation, completely autologous, more gradual release of cytokines and growth factors, and antimicrobial properties due to neutrophil chemotaxis and the presence of leukocytes. The protocol for

making PRF has changed and several types of PRF have been described, including L-PRF (leukocyte-free), A-PRF (advanced), T-PRF (titanium prepared), and i-PRF (injectable).8 Different researchers have claimed their discovery of slightly different PRF subtypes based on centrifuge protocol. Choukroun markets the only FDA-certified centrifuge for making L-PRF (IntraSpin®). The original PRF centrifuge protocol called for 3000 rpm for 10 minutes. This changed to 2700 rpm for 12 minutes to make standard or leukocyte-rich PRF (L-PRF). Advanced PRF (A-PRF) is spun at 1500 rpm for 14 minutes.9 T-PRF simply uses titanium blood collection tubes instead of glass or plastic. i-PRF is made by spinning at 700 rpm for 3 minutes.

A variation on PRF – named concentrated growth factor (CGF) – was touted by Sacco in 2006. He claimed the fibrin matrix was larger and possessed more cytokines.4 CGF is made in a proprietary centrifuge (Medifuge®) which accelerates for 30 seconds, spins at 2700 rpm for 2 minutes, 2400 rpm for 4 minutes, 3000 rpm for 3 minutes, and finally followed by a 36-second deceleration.10 Interestingly, a group of researchers tested the mechanical and degradation properties of A-PRF compared to CGF and found no difference in microstructure, water content, tensile strength, or degradation rate. However, CGF was distinct to PRF and it is questionable whether there is any meaningful difference.

Regarding clinical benefit, many studies have evaluated the impact of PRF on third molar extraction outcomes. There is substantial evidence to support reductions in pain, swelling, trismus, and alveolar osteitis (AO). A double-blind study from 2004 found a decrease in AO from 15% to 7.6%.11 The incidence of AO seems high, but the results were statistically significant and indicative of a strong benefit. A systematic review from 2015 showed a greater than 60% reduction in AO as well as a decrease in pain and swelling after third molar surgery.12 Another study looked at the incidence of AO as well as periodontal healing. This study used a split-mouth design where PRF was randomly placed in one of the mandibular sites but not the other. Pain, AO, and periodontal probing depths on the distal of the adjacent second molars were assessed. Similar to the first study cited above, 18% of non-PRF sites developed AO compared to none of the PRF sites. Pain was improved in the PRF sites. However, no difference was noted in periodontal healing.13

Regarding bone healing, study results are mixed on the ability of PRF to improve bone healing.14 Many studies have been conducted analyzing the effects of adding PRF to allograft, xenograft, and alloplast. A great number indicate no benefit

or worsening of outcomes with the addition of PRF in sinus grafts.13,14 Some are those studies that indicate quicker sinus graft healing and less residual graft particles; however, this did not affect clinical outcomes. Several studies have examined using PRF alone as a graft material. One such study compared L-PRF to no graft in socket preservation. PRF was found to be superior to no graft. The PRF group yielded decreased vertical and buccal resorption and increased bone mineralization compared to the no graft.15 However, the real question is how does PRF alone compare to allograft or xenograft in bone augmentation and preservation?16 De Angelis et al. evaluated three groups for socket preservation: L-PRF, L-PRF plus xenograft, and xenograft. The L-PRF group was found to have greater horizontal and vertical bone resorption than the xenograft groups.17 This finding was echoed by another study which found greater horizontal bone loss with the use of PRF alone compared to alloplast. However, other studies commented that PRF sites showed greater cellularity and more mineralized bone despite greater resorption.18 One study showed no difference in bone volume between PRF-augmented extraction sockets and those without a graft.19 Thus, the value of PRF as a sole bone grafting material is questionable. Some clinicians are skeptical in utilizing PRF alone in sinus augmentation.20 However, it is known that simply lifting the Schneiderian membrane and keeping it elevated will result in bone formation. It would be interesting to see how PRF compares to allograft/xenograft without simultaneous implant placement in the sinus.

In conjunction with traditional bone grafting, PRF can be used as a barrier membrane. Multiple studies support the use of PRF as a membrane in guided bone regeneration. In fact, one study indicated greater bone formation with the use of PRF membrane compared to resorbable collagen membrane or non-resorbable membrane.21

PRF is a readily available technique with multiple applications and low cost. I find myself integrating it into more aspects of clinical practice as I streamline the workflow and observe the clinical benefit to my patients. It can be fun to try different things and PRF is an easy, not-so-new thing to try.

References

17. Temmerman A, Vandenbroucke M, Casters A, et al. Use of leukocyte and platelet-rich fibrin in socket management and ridge preservation:
For 8 years, claims in which the use of electronic health records (EHRs) contributed to patient injury have been on the rise.

The Doctors Company’s analysis of claims in which EHRs contributed to injury show a total of 216 claims closed from 2010-2018. The pace of these claims grew, from a low of 7 cases in 2010 to an average of 22.5 cases per year in 2017 and 2018. EHRs are typically contributing factors rather than the primary cause of claims, and the frequency of claims with an EHR factor continues to be low (1.1 percent of all claims closed since 2010). Still, as EHRs approach near-universal adoption, they may become a more prevalent source of risk.

### Top System Technology and Design Issues

<table>
<thead>
<tr>
<th>Claim</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>30</td>
<td>14%</td>
</tr>
<tr>
<td>Electronic systems/technology failure-EHR</td>
<td>26</td>
<td>12%</td>
</tr>
<tr>
<td>Lack of or failure of EHR alert or alarm</td>
<td>15</td>
<td>7%</td>
</tr>
<tr>
<td>Fragmented record</td>
<td>14</td>
<td>6%</td>
</tr>
<tr>
<td>Failure/lack of electronic routing of data</td>
<td>10</td>
<td>5%</td>
</tr>
<tr>
<td>Insufficient scope/area for documentation in EHR</td>
<td>8</td>
<td>4%</td>
</tr>
<tr>
<td>Lack of integration/incompatible systems</td>
<td>5</td>
<td>2%</td>
</tr>
<tr>
<td>Failure to ensure information security</td>
<td>1</td>
<td>0%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>104*</td>
<td>48%</td>
</tr>
</tbody>
</table>

*Note that the percentages are of the total number of electronic health record claims (n=216).

### Top User-Related Issues

<table>
<thead>
<tr>
<th>Claim</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incorrect information</td>
<td>29</td>
<td>13%</td>
</tr>
<tr>
<td>Pre-populating/copy &amp; paste</td>
<td>29</td>
<td>13%</td>
</tr>
<tr>
<td>Hybrid health records/EHR conversion issues</td>
<td>27</td>
<td>13%</td>
</tr>
<tr>
<td>User error-other</td>
<td>25</td>
<td>12%</td>
</tr>
<tr>
<td>Training and/or education</td>
<td>16</td>
<td>7%</td>
</tr>
<tr>
<td>Alert issues/fatigue, user-related</td>
<td>5</td>
<td>2%</td>
</tr>
<tr>
<td>Computer order entry workarounds</td>
<td>4</td>
<td>2%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>129*</td>
<td>60%</td>
</tr>
</tbody>
</table>

*Note that the percentages are of the total number of electronic health record claims (n=216).

Here are the top five risks and suggestions to avoid an EHR-related malpractice claim:

1. **Risk:** Copy/paste may perpetuate incorrect or outdated information.
   **Solution:** Avoid copying and pasting except when describing the patient’s past medical history.

2. **Risk:** Many EHRs auto-populate fields in the patient’s history and physical exam and in procedure notes, causing the entering of erroneous or outdated clinical information
   **Solution:** Contact your organization’s IT department or your vendor if you notice that the auto-populated information is incorrect, note it and document the correct information.

The EHR-related claims closed from 2010-2018 were caused by either system technology and design issues or by user-related issues.

The CALIFORNIA JOURNAL OF ORAL & MAXILLOFACIAL SURGERY

### Top System Technology and Design Issues

<table>
<thead>
<tr>
<th>Claim</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>30</td>
<td>14%</td>
</tr>
<tr>
<td>Electronic systems/technology failure-EHR</td>
<td>26</td>
<td>12%</td>
</tr>
<tr>
<td>Lack of or failure of EHR alert or alarm</td>
<td>15</td>
<td>7%</td>
</tr>
<tr>
<td>Fragmented record</td>
<td>14</td>
<td>6%</td>
</tr>
<tr>
<td>Failure/lack of electronic routing of data</td>
<td>10</td>
<td>5%</td>
</tr>
<tr>
<td>Insufficient scope/area for documentation in EHR</td>
<td>8</td>
<td>4%</td>
</tr>
<tr>
<td>Lack of integration/incompatible systems</td>
<td>5</td>
<td>2%</td>
</tr>
<tr>
<td>Failure to ensure information security</td>
<td>1</td>
<td>0%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>104*</td>
<td>48%</td>
</tr>
</tbody>
</table>

*Note that the percentages are of the total number of electronic health record claims (n=216).

Here are the top five risks and suggestions to avoid an EHR-related malpractice claim:

1. **Risk:** Copy/paste may perpetuate incorrect or outdated information.
   **Solution:** Avoid copying and pasting except when describing the patient’s past medical history.

2. **Risk:** Many EHRs auto-populate fields in the patient’s history and physical exam and in procedure notes, causing the entering of erroneous or outdated clinical information
   **Solution:** Contact your organization’s IT department or your vendor if you notice that the auto-populated information is incorrect, note it and document the correct information.

The EHR-related claims closed from 2010-2018 were caused by either system technology and design issues or by user-related issues.

### RISK MANAGEMENT

Electronic Health Record Continues to Lead to Medical Malpractice Suits

by Darrell Ranum, JD, Vice President of Patient Safety and Risk Management

For 8 years, claims in which the use of electronic health records (EHRs) contributed to patient injury have been on the rise.

The Doctors Company’s analysis of claims in which EHRs contributed to injury show a total of 216 claims closed from 2010-2018. The pace of these claims grew, from a low of 7 cases in 2010 to an average of 22.5 cases per year in 2017 and 2018. EHRs are typically contributing factors rather than the primary cause of claims, and the frequency of claims with an EHR factor continues to be low (1.1 percent of all claims closed since 2010). Still, as EHRs approach near-universal adoption, they may become a more prevalent source of risk.

### Top System Technology and Design Issues

<table>
<thead>
<tr>
<th>Claim</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>30</td>
<td>14%</td>
</tr>
<tr>
<td>Electronic systems/technology failure-EHR</td>
<td>26</td>
<td>12%</td>
</tr>
<tr>
<td>Lack of or failure of EHR alert or alarm</td>
<td>15</td>
<td>7%</td>
</tr>
<tr>
<td>Fragmented record</td>
<td>14</td>
<td>6%</td>
</tr>
<tr>
<td>Failure/lack of electronic routing of data</td>
<td>10</td>
<td>5%</td>
</tr>
<tr>
<td>Insufficient scope/area for documentation in EHR</td>
<td>8</td>
<td>4%</td>
</tr>
<tr>
<td>Lack of integration/incompatible systems</td>
<td>5</td>
<td>2%</td>
</tr>
<tr>
<td>Failure to ensure information security</td>
<td>1</td>
<td>0%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>104*</td>
<td>48%</td>
</tr>
</tbody>
</table>

*Note that the percentages are of the total number of electronic health record claims (n=216).

Here are the top five risks and suggestions to avoid an EHR-related malpractice claim:

1. **Risk:** Copy/paste may perpetuate incorrect or outdated information.
   **Solution:** Avoid copying and pasting except when describing the patient’s past medical history.

2. **Risk:** Many EHRs auto-populate fields in the patient’s history and physical exam and in procedure notes, causing the entering of erroneous or outdated clinical information
   **Solution:** Contact your organization’s IT department or your vendor if you notice that the auto-populated information is incorrect, note it and document the correct information.

The EHR-related claims closed from 2010-2018 were caused by either system technology and design issues or by user-related issues.
What would you do if you saw a TV ad about a lawsuit against a drug company over a medication prescribed by your physician that you were currently taking? In 2017, the U.S. Chamber Institute for Legal Reform (ILR) asked that question of 1,335 adults—500 of whom were currently taking or had taken one of 12 prescription drugs frequently targeted by personal injury lawyers. Nearly half of the survey respondents said they would definitely or probably stop taking the drug immediately after seeing the ad. When shown an actual TV lawsuit ad about a medication they or a household member had taken, more than half said they would reduce the dosage to below the prescribed amount.

Problems with litigation advertising are not new. The ILR study reinforces the findings of an earlier survey commissioned in 2007 by the National Council for Community Behavioral Healthcare. Its poll of 400 psychiatrists found that 97 percent had patients who stopped taking their medications or reduced their dosages. More than half of the respondents believed that their patients had reacted to litigation advertising. Another ILR poll found that, in 2003, one-third of surveyed physicians had prescribed drugs to patients who then refused to take them because of litigation.

The malignant effects of attorney advertising are significant enough that the American Medical Association (AMA) House of Delegates adopted a policy during its 2016 annual meeting: The AMA would advocate to require warnings in attorney ads, cautioning patients to not stop taking their medicines without discussing it first with their healthcare providers. Predictably, attorneys have a different view. When interviewed about the AMA’s new policy, Philadelphia plaintiffs’ lawyer Max Kennerly told Legal Newsline (an ILR publication) that the warnings are unnecessary: “Attorney advertisements are one of the primary ways that the public learns about new dangers of drugs and medical devices.” Although Mr. Kennerly lists medical malpractice and drug class actions among his areas of special expertise, he also stated, “I don’t know of a single instance of a patient stopping a medication and being hurt because they saw an attorney’s advertisement.”

Contrary to Mr. Kennerly’s statement, ILR’s study notes that MedWatch, the U.S. Food and Drug Administration’s Safety Information and Adverse Event Reporting Program, received reports that 31 patients quit taking prescribed blood thinners after seeing litigation advertising and then suffered injuries that included stroke, pulmonary embolism, paralysis, and death. These incidents occurred between September 2014 and December 2015. Another 61 reports through December 2016 described patients who had stopped taking blood thinners in response to attorney ads and suffered injuries that included cardiac arrest, stroke, deep vein thrombosis, transient ischemic attack, and death.

In an informational hearing on the subject in June 2017, the U.S. House of Representatives Judiciary Committee heard from practicing physicians whose patients had been negatively affected by attorney advertising—including one moving example of a patient who died because she stopped taking her prescribed anticoagulant after receiving a pamphlet in the mail from a plaintiffs’ attorney targeting the medication. The committee also heard from a law professor who explained that much of the drug litigation advertising is funded by so-called “aggereators”—law firms that do not try cases but merely recruit plaintiffs. The aggregators then pass the plaintiffs to other law firms, often in jurisdictions far from the patients and their healthcare providers, where courts and juries are sympathetic to class action plaintiffs. The committee’s final witness was a lawyer who counsels other lawyers on their ethical responsibilities. This witness felt that regulation of attorney advertising on drug litigation is unwise and unnecessary.

In Texas, the Senate passed SB 1189, Deceptive Advertising Practices. The bill precludes legal advertising from being presented as a medical alert, health alert, consumer alert, or public service announcement. It also prevents ads from using federal or state government logos to suggest an affiliation and prohibit ads from falsely claiming that a product has been recalled or is under investigation by the FDA. The legislation mandates specific warnings and disclaimers—including a warning that patients should consult a physician before stopping a prescribed medication. The governor is expected to sign this bill. Similarly, the California State Assembly passed AB 3217 with bipartisan support, to see it die in the California State Senate under pressure from the plaintiffs’ ads’ opposition. Although it will be difficult to enact this kind of important legislation, it is essential that the healthcare community join us in supporting these measures when they are introduced at the state level.

Lawsuit advertising continues to grow. The American Tort Reform Association issues periodic updates on trial lawyer ad spending. While not all of the ads are related to drug litigation, the expenditures are staggering. In the third quarter of 2018, trial lawyers spent $226 million to air ads on local broadcast networks, up $50 million from the second quarter of 2018. That figure includes 23,000 ads in New York City alone, at a cost of nearly $9 million in three months. Those figures do not include local cable, national cable, or national broadcast networks. The ILR estimates that trial lawyer advertising in 2017 amounted to $1 billion nationwide.

Physician advocates continue to grapple with trial lawyer advertising—including concerns that misleading advertising may affect the objectivity of potential jurors—as evidence mounts that deceptive ads hinder a physician’s ability to provide effective treatment. Providers may wish to add the pernicious effects of attorney advertising to the factors influencing when and how to assist patients in following their prescribed therapies.

We will continue to monitor legislative developments and advocate on behalf of our members and the medical profession. Look for updates in future issues of The Doctor’s Advocate.

Track Legislation in Your State

Keep up to date on bills and regulations we’re tracking in your state. Find our interactive Legislative Activity map at thedoctors.com/advocacy.

References

American Tort Reform Association. White papers and reports on advertising spending. www.atra.org/resources/white-papers-and-reports/


Reprinted with permission. ©2019 The Doctors Company (www.thedoctors.com).

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

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

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

We are looking for a board certified/eligible surgeon with active skills in orthognathic/TMJ/Trauma surgery comfortable with outpatient anesthesia and dentoalveolar surgery that is interested in becoming a partner in this practice. Comfort with public speaking is a big plus. Outgoing personality with excellent patient care skills is mandatory. Interested parties, please contact via email at info@mvoms.com, or office phone at 619-298-2200 and ask for Kim, office manager info@mvoms.com or 714-624-7634

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

Seeking Oral & Maxillofacial Surgeon Established oral surgery office in San Francisco is looking for a part time oral and maxillofacial surgeon to join our practice with the possibility of partnership. Our practice is a state-of-the-art facility with advanced technology like digital X-Ray, 3D Scanner and CT scan machine. The ideal candidate must be a team player looking for a long-term position with the desire to grow professionally. We are seeking someone who works independently, has excellent clinical skills, great chair-side manners and high ethical standards. Candidates should be able to perform the full scope of oral maxillofacial surgery.

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

 seekin G P a r t t i m e O M S J o b B etw een San Francisco and Sacramento. Oral and maxillofacial surgeon retired with 40 years of experience in private practice seeking part time job. Grad of UOP and Highland Hospital. Reason, full time retirement is boring. Experience includes teaching at Highland Hospital. Contact John Kiesselbach at (530) 613-7833 or email jkietivelbach@gmail.com

Seeking Oral & Maxillofacial Surgeon Established oral surgery office in San Francisco is looking for a part time oral and maxillofacial surgeon to join our practice with the possibility of partnership. Our practice is a state-of-the-art facility with advanced technology like digital X-Ray, 3D Scanner and CT scan machine. The ideal candidate must be a team player looking for a long-term position with the desire to grow professionally. We are seeking someone who works independently, has excellent clinical skills, great chair-side manners and high ethical standards. Candidates should be able to perform the full scope of oral maxillofacial surgery.

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

OMS SEEKING WORK

Omidi NiaSar, DDS. Currently in last year of residency at UCSF Fresno OMFS. Looking for an associatehip/partnership position in Southern California, with potential for buyout down the road. omidniasar@gmail.com 714-624-7634

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

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

Would Like to Buy

Seeking OMS Practice Owner in San Francisco. Established in 1982, this 1000+ practicing site includes digital X-ray machine, digital records, and implant patient database. Full range of OMS services. Asking price under $1,000,000.

Seeking Oral Surgery Practice. Established Oral Surgery practice in Northern California. 2018 gross over $1,000,000. Asking price $1,000,000. Please email for more information.

OMS Practice for Sale. Currently working 15 hours. Practice 3 years old. No dental lab in place. Great opportunity for retired dentist.

OMS Associateship/Partnership Available. Established Oral Surgery Practice. Reduced Hours.

OMS Practice for Sale. Full scope oral surgery practice for sale. Located in a 1,500 sq. ft. office building. 1,500 sq. ft. office with 3 operatories. Privately owned, no debt.

OMS Practice for sale. Small fee-for-service oral surgery practice in Central California.

OMS Practice for Sale. Oral Surgery practice in Oakland, CA. 1,750 square feet.

Over 150 OMS References Available

As autumn arrives and the holiday season approaches, spend some time with those that matter most in your life.
Private practice oral and maxillofacial surgery depends on OMS taking ownership of our future. Participating in organized oral and maxillofacial surgery is vital, as is controlling the protection of your practice by being an owner of OMSNIC. Every OMS we insure owns shares in the company, and the capital contribution you make upon joining entitles you to your share of profits upon retirement. In a world of faceless insurance companies, OMSNIC has faces you know and trust, those of your colleagues. When we stay together, we keep the Specialty strong. 800-522-6670 omsnic.com