CALAOMS Fellow Dr. W. Frederick Stephens Named AAOMS District VI Trustee

At the Business Sessions for the 103rd AAOMS Annual Meeting in Nashville, TN, on September 27-29, 2021, CALAOMS Fellow W. Frederick Stephens, DDS, FACD, FICD was elected to become the next District VI Trustee for AAOMS.

There are six AAOMS Trustee districts. District VI consists of the following Western states: Alaska, Arizona, California, Hawaii, Idaho, Nevada, Oregon, Utah, and Washington.

Dr. Stephens was born and raised in an Idaho farming community and later moved with his family to Seattle, Washington. He attended the University of Washington, completing an undergraduate degree in Zoology. He subsequently graduated with honors from the University of Washington School of Dentistry.

Dr. Stephens was then accepted into the oral and maxillofacial surgery training program at The University of Texas

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With yet another of California’s medical liability insurers selling out to Wall Street, there’s an important question to ask. Do you want an insurer that’s driven by investors? Or do you want an insurer that focuses on you, and has already paid more than $120 million in awards to its members when they retire from the practice of medicine?

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Drug-related overdose and death epidemic continues to worsen

According to data from the Centers for Disease Control and Prevention (CDC), 93,331 people died of a drug overdose in 2020—a record number that reflects a rise of nearly 30% from 2019 (72,151). This amounts to 255 overdose deaths per day—every day of the year. For context, a Southwest Airlines 737-700 airplane holds a maximum of 143 passengers. We all would certainly take notice if one or two of these planes went down every day.

Some in the medical community have said that the increase in overdose deaths was driven by the lethal prevalence of fentanyl, as well as switch-related stressors and difficulties in accessing supportive care. Those aged 20-34 years old died more from fentanyl overdoses than from other types of drugs. The director of the National Institute on Drug Abuse, Dr. Nora Volkow, commented that, “This is the highest number of overdose deaths ever recorded in a 12-month period, and it is our home state of California. This is chilling. It seems to be a wave that is not done cresting. It does not appear that the epidemic continues to worsen.

In October 2017, President Trump declared the opioid crisis a public health emergency, formally recognizing what had long been understood to be a growing epidemic responsible for devastation in communities across the United States. Just 3 years later, in October 2020, the opioid epidemic reached a record high, with 40,727 opioid overdose deaths in just 1 month, a 13% increase from the same month in 2019.

While most dentists are not as likely to be approached by patients addicted to opioids who seek out multiple prescribers, oral and maxillofacial surgeons can easily be placed at the intersection of addiction for many patients who seek their first prescription for legitimate pain management (i.e., first exposure). The role of oral and maxillofacial surgeons in preventing addiction and abuse of opioids has risen to the heights of the dental profession’s national dialogue.

California prescribers of controlled substances are required to register with the Department of Justice’s Prescription Drug Monitoring Program – CURES 2.0—and as of October 2018, have been required to consult a patient’s prescription history in CURES prior to writing a Schedule II–IV drug for the first time. According to data provided by the Attorney General, between October 2014 and October 2018, dentists prescribed an average of 700,000 controlled substances per month out of the approximate four million prescriptions that traditionally get entered into CURES each month. Meanwhile, dentists requested a total of 33,597 activity reports from CURES during that four-year time frame. This suggests that dentists were not regular users of CURES prior to the October 2018 mandate despite being significant prescribers of controlled substances.

In support of its commitment to finding a solution to prescription drug abuse, during the 2018 California legislative session, the Dental Board of California (DBC) supported the passage of Senate Bill 1109, authored by Senator Patricia Bates, which adds “risks of addiction associated with the use of schedule II drugs” to the DBC’s area of continuing education. The California Board of Dental Examiners (BDE) approved this regulatory language that would require dentists to take 2 units of mandatory continuing education every two years upon license renewal. The continuing education course should cover pain management, the identification of addiction, and the practices by which opioids are prescribed or dispensed.

Addiction, misuse, and overdose of prescription opioids is a public health crisis affecting both adults and children. Urgent measures are needed to better inform the public of the risks associated with both the long-term and short-term use of opioids in an effort to tackle this problem. Oral and maxillofacial surgeons play a pivotal role in providing quality care, ensuring patient safety, and supporting the improvement of public health. As potential prescribers of opioids for perioperative dental and maxillofacial pain management, oral and maxillofacial surgeons have a professional responsibility to reduce the misuse and abuse of opioids.

DISTRICT VI CONTINUED FROM PAGE 1

Southwestern Medical Center/Parkland Memorial and affiliated hospitals in Dallas. There, he completed both an anesthesiology residency and a surgical residency with special concentration in orthognathic and facial reconstructive surgery, temporomandibular joint surgery, and all aspects of maxillofacial trauma.

Upon completion of his residency training, Dr. Stephens began private practice in Dallas. Four years later, he and his wife relocated to southern California and subsequently opened offices in the communities of South Pasadena, Arcadia, and La Cañada. After building his practice in both the San Gabriel and San Fernando Valleys, he ultimately established The Pacific Coast Center for Oral, Facial, and Cosmetic Surgery in 1999 as the next and highest generation of his practice.

Dr. Stephens is a Past President of CALAOMS, a current and former member of numerous AAOMS committees, a member and chair of state and national OMS political action committees and OMS foundation boards, and was a long-serving member of the ABOMS examination committee.

CALAOMS is very proud and thankful to have Dr. Stephens represent California and District VI at the AAOMS Board of Trustees. Congratulations and best wishes for a successful tenure on the AAOMS Board, Dr. Stephens!

Update from California CareForce

The California CareForce 2021 Chico Clinic is right around the corner (November 12-14, 2021) and we’re in great need of Oral and Maxillofacial Surgeons!

As one of the largest sections of our clinics and our most requested service by patients, our dental volunteers are crucial in supporting our mission. At our last clinic in Chico in 2019, roughly 600 volunteers came together to provide over half a million dollars’ worth of free healthcare services to more than 1,200 patients. Of those 1,247 patients served, 562 of them were dental patients.

This year we anticipate seeing 650 people per day over the two and a half clinic days, but we can only base the number of patients we see off the number of providers we have volunteering. Right now, we’re still in need of eight Oral and Maxillofacial Surgeons each day. From relieving dental pain to lessening the burden of financial stress for those who are uninsured, the services you provide can mean a world of difference to the hundreds of individuals, families, and seniors visiting our clinics each day. Please spread the word and consider joining us in serving those that need it most.
Dear Members,

It is my pleasure to address you all as I mark the Fall season. It was a busy year! Not just on our CALAOMS committees, but also in our members’ private practices, surgical centers, and academic institutions. While COVID is still here with us, we are trying to get back to providing the safest treatment we can. The COVID effects are still being felt and likely will be for many years to come. We have continued to persevere, pushing for increased quality and safety measures for our patients, encouraging training and education for our assistants, and standing on a national platform to do so.

Delta Dental Fee Reductions
One of our notable victories for the year was the indefinite postponement of the Delta Dental specialty fee reductions. These fee reductions were proposed by Delta Dental to affect the dental specialties of endodontics, periodontics, and oral and maxillofacial surgery. This would have been devastating to our members. The CALAOMS Board believes the 5-year interval has always done in California, we are once again taking the lead on this very important anesthesia-related item designed to promote the DSA curriculum and the MAXSA Renewal Every Two Years
The AAOMS House of Delegates passed a few very important resolutions. One of these resolutions requires all dental assistants assisting in oral surgery be required to complete an anesthesia assistant certification course. The criteria of these courses and programs will be made clear to AAOMS members after collaboration among the AAOMS Board of Trustees (BOT), the Committee on Practice Management and Professional Development (CPMPD), and the Committee on Anesthesia (CAN). This will be a condition for membership in AAOMS to be completed by 2026.

OMSA Renewal Every Two Years
CALAOMS is promoting and encouraging all OMSs and their OMS anesthesia assistants to renew their OMSA training every two years instead of every five years. So, just as we have always done in California, we are once again taking the lead on this very important anesthesia-related item designed to enhance the training and readiness of our anesthesia team members. The CALAOMS Board believes the 5-year interval between recertification of the anesthesia assistants is too long for meaningful retention of skills needed. OMSA recertification every two years coincides with the renewal of all other state healthcare licenses and permits on a two-year cycle. Bringing OMSA training and recertification into line with professional licensing norms enhances the professionalism of the OMSA program and now will be standardized across the country.

SB 501 No Longer Set to Take Effect on January 1, 2022
Senate Bill 501 (Glazer) was signed into California law in 2018, and was set to take effect on January 1, 2022. However, CALAOMS was recently informed by the Dental Board of California that regulations have not yet been finalized; and therefore, the Dental Board is not ready to implement the requirements of the law. As such, the Dental Board is exploring possible legislation to postpone the implementation date for the provisions of SB 501, possibly to January 1, 2023. CALAOMS will continue to communicate with the Dental Board and will closely monitor this situation, and we will continue to provide updates to the membership as they become available to us.

AAOMS Recognition for CALAOMS’ Efforts
AAOMS is very proud of what California has accomplished with regard to training and credentialing of anesthesia. The OMS Anesthesia Team Delivery Model, consisting of a three-person team for DS/GA, with the surgeon in command, a dedicated monitor trained to assist in the anesthesia, and a dedicated surgical assistant, is the standard for anesthesia safety in dentistry. AAOMS recognizes this and is advocating for this and higher standards of care when performing procedures under anesthesia. It is critically important for every OMS in California to understand that the training we provide to our anesthesia assistants is really the point of attack being used by our competitors to demean our team model for the delivery of office-based anesthesia.

The majority of CALAOMS members provide anesthesia training to their assistants through CALAOMS’ OMSA program. Alternatively, our members may provide Dental Assistant Professional Staff Development (DAPS) and the American Association of Anesthesiology (AAAAM) training through AAOMS. Unfortunately, these programs are not recognized by the Dental Board of California (DBC) as a license or permit that would legally empower our assistants to monitor patients during, or recover patients from, deep sedation/general anesthesia.

Dental Sedation Assistant
And that leads me to my final point. With the risk of sounding like a broken record, I will repeat myself once more. We, in California, are so lucky and privileged to have a recognized permit/license program by the Dental Board of California. The Dental Sedation Assistant (DSA) permit program is in California Statute (law). The DSA was specifically created to provide both didactic education and hands-on training in OMS office-based anesthesia, and receive a recognized permit/license program by the Dental Board of California. The DSA permit program is in California Statute (law). The DSA was specifically created to provide both didactic education and hands-on training in OMS office-based anesthesia. I am honored and grateful to have had the opportunity to serve with you all.

Practicing ethically and safely, at the highest level of care, and treating patients with respect is what we stand for. CALAOMS will always stand by our mission statement: to promote the advancement of the specialty of oral and maxillofacial surgery and the interests of its members through the protection of patient safety, public service, ethics, education, and advocacy.

Sincerely,
Shama Currimbhoy, DDS, MS
President, CALAOMS
RESOLUTION 21-B-1
RESOLVED, that the Board of Trustees gather essential data from third party entities such as privately billed insurance claims, which will be utilized to advocate for the safety of the OMS anesthesia team model, and be it further, RESOLVED, that AAOMS members be encouraged to participate in the Anesthesia Prospective Study supported by the OMS Foundation to assist in gathering essential information on the practice and safety of OMS office-based anesthesia, and be it further, RESOLVED, that AAOMS members be encouraged to report any unintended event related to the delivery of anesthesia for a patient through the Dental Anesthesia Incident Reporting System (DAIRS), an anonymous self-reporting system used to collect and analyze anesthesia incidents in order to improve the quality of dental anesthesia care.

RESOLUTION 21-B-3
RESOLVED, that Chapter XII, Finances, Section 20. Dues and Assessments, of the Bylaws be amended as follows with all conflicting bylaws, policies, etc. amended accordingly (strikethrough = deletion; bold underline = addition):

Dues of fellows and members shall be $695,000 and $1,550; dues of affiliate members shall be $422; and dues of allied staff members shall be $55 due January 1 of the ensuing year. Exceptions to this shall be at the discretion of the Board of Trustees in accordance with policy.

The amount of annual dues and assessments shall be recommended to the House of Delegates by the Board of Trustees and be fixed by the House of Delegates by a two-thirds (2/3) affirmative vote to the delegates present and voting with a 60-day prior notice.

RESOLUTION 21-B-4
RESOLVED, that the final year of the $350 informational campaign assessment adopted by the House of Delegates by way of Resolution 19-B-3 be rescinded.
Prevent, Communicate, Document: Medical Malpractice Data Help Us Manage Risk

by David L. Feldman, MD, MBA, FACS, Chief Medical Officer, The Doctors Company and TDC Group

The good news about medical malpractice is that there isn’t very much of it—which is the classic oxymoron of drawing insights from medical malpractice claims to improve patient safety. Nevertheless, medical malpractice data can focus our search for ways to succeed at three key aims of physicians, practices, and health systems: (1) prevent adverse events, (2) prevent lawsuits if adverse events do occur, and (3) prevail in lawsuits when all else fails.

Still, the advantages of medical malpractice data come with obvious downsides. For one, many undesirable outcomes, adverse events, and near misses never result in a claim, so the claim data set, relative to the quantity of care provided that does not proceed optimally (or is perceived as not proceeding optimally) is quite small. And when compared to the total volume of care, it is minuscule. Further, if we wish to study closed claims, we must wait: By the time an event becomes a claim that completes the legal process, it is typically four to five years out from the originating event.

Still, the advantages of medical malpractice data as a source data are indisputable—and powerful enough to overcome the drawbacks.

1. Relative to alternatives like peer review or root cause analysis, medical malpractice claims provide a much richer source of data. It is a sad yet helpful truth that people bare their souls when they are sued.

2. Because medical malpractice data have a direct correlation to large sums of money, it is easier to use medical malpractice claim-related findings to drive tangible, system-wide improvements to patient safety that no one wants to pay for.

Prevent, Preclude, Prevail

Prevent adverse events. “We can’t fix what we can’t see,” says Dana Siegal, RN, CPHRM, CPPS, director of Patient Safety Services for CRICO Strategies. The Doctors Company employs CRICO’s Comparative Benchmark System when we code medical malpractice claims for our closed claims studies. She continues, “When we view that data across collective and comparative data sets, we validate the repeated patterns and trends across the care system, allowing us to focus resources and improvement initiatives on the most vulnerable risks.”

P. Divya Parikh, MPH, CAE, vice president of Research and Education for the MPL Association, agrees: “Medical malpractice data offer insight into high-risk specialties, medical conditions, and procedures that result in claims, allowing physicians and healthcare systems to direct their risk management programs for safer delivery of care.”

This last point is key—that healthcare systems can and do direct resources to improving patient safety based on insights derived from medical malpractice data—because it is easier to convince large systems to change when they can see not only a patient safety benefit, but also a strong financial incentive.

Preclude lawsuits with good communication. “Communication issues are a great example of the power of studying malpractice data to shed light on the multiple factors contributing to errors and harm,” says Ms. Siegal. When we analyze closed medical malpractice claims across specialties and settings, communication gaps crop up again and again. Those gaps can stem from medical team members miscommunicating with each other or with families. While the former may result in an adverse event (see the first P: Prevent), the latter may result in a lawsuit. A patient’s desire to pursue litigation after the aftermath of an adverse event or undesirable outcome is both low it carefully when responding to adverse events. A swift, compassionate, effective response to a patient’s needs in the aftermath of an adverse event or undesirable outcome is both ethically superior and practically advantageous for all parties, when compared to a lawsuit as the likely alternative.

Prevent when there are lawsuits via documentation. While undesired outcomes—even those that fall within the realm of a known complication for the treatment or procedure—may motivate patients to sue, it is often poor documentation that motivates a plaintiff’s attorney to take a case. The Doctors Company’s Vice President and Associate General Counsel Richard F. Cahill, JD, addresses this potential pitfall in “The Defensible Medical Record”.

Patient grievances may be filed based on an individual’s faulty recollection of events, or a failure to understand the course of treatment or the underlying reason that an adverse consequence occurred. When a medical record is well documented, many allegations are often easily resolved—frequently before a formal administrative process is even initiated.

All of this is otherwise phrased as:

Prevent, Communicate, Document

Experience has taught us that patients may bring suit either in the presence of actual medical error or in their perception of medical error. Either way, we have an opportunity to learn how to prevent the next claim. Ms. Parikh summarizes: “Every claim is, in essence, a patient complaint, and therefore an opportunity to learn where improvements can be made.”

The guidelines suggested here are not rules, do not constitute legal advice, and do not ensure a successful outcome. The ultimate decision regarding the appropriateness of any treatment must be made by each healthcare provider considering the circumstances of the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.

If your institution participates in a disclosure program, follow it carefully when responding to adverse events. A swift, compassionate, effective response to a patient’s needs in the aftermath of an adverse event or undesirable outcome is both ethically superior and practically advantageous for all parties, when compared to a lawsuit as the likely alternative.

Current reconciliation proposal excludes Medicare dental benefits expansion

Legislation to expand dental benefits under the Medicare program was not included in the latest version of the Build Back Better Act (HR 5376), legislation to carry out many of President Joe Biden’s domestic policy priorities.

Most Democrats came to agreement on October 28, 2021, on the roughly $1.75 trillion package they expect to pass in the coming weeks via the budget reconciliation process, which can pass without bipartisan support. Progressive Democrats fought hard to include Medicare Part B coverage for hearing, vision, and dental in the final agreement; however, only hearing services is currently included. Senator Bernie Sanders (I-Vt.) is stillpledging to get two out of the three benefits included but a comprehensive dental expansion in Part B is a longshot at this point.

Language to significantly expand the number of dental services covered under the Medicare Part B program was included in the original House reconciliation bill that made its way through the committee process last month. Instead, the House is expected to vote on the new negotiated version—which does not include dental expansion—before sending it to the Senate for passage.

AAOMS has been advocating against a Part B expansion for several months alongside other dental stakeholders, including the American Dental Association. AAOMS members have participated in numerous meetings with their members of Congress and sent more than 2,300 letters to nearly 400 members of Congress on the issue.

Should this agreement become law, this would be only a temporary victory as advocacy groups will continue to push Congress for legislative solutions—including an expansion of dentistry in Medicare. AAOMS will continue to advocate for solutions that provide affordable oral healthcare to both the senior and low-income populations that best serve OMSs and patients. Please consider joining AAOMS advocacy efforts if you are not already involved. Visit AAOMS.org/action to learn more.
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Beginning January 1, 2022, all prescriptions—both for controlled and non-controlled substances—issued by a licensed healthcare practitioner to a California pharmacy must be submitted electronically. All pharmacies across the state must be capable of accepting those prescriptions and are required to immediately notify prescribers if the electronic transmission fails or is incomplete.

Healthcare practitioners who fail to meet the requirements of AB 2789 may be subject to disciplinary action.

By now most of us are aware of the new prescribing requirements which will take effect January 1, 2022. When I initially heard of this law, I misunderstood it. My initial interpretation was that providers only needed to be able to transmit prescriptions electronically but were not mandated to do so.

I went ahead and downloaded an app on my phone, spent an exorbitant amount of time setting it up, and getting two-factor authentication established. Then I had my chance to write my first E-prescription! It took approximately 20 minutes; and at the conclusion, I decided I would keep writing and calling in prescriptions. I loved the speed at which I could rattle off my name, DEA number, patient name, DOB, and prescription in prescriptions. I loved the speed at which I could rattle off my name, DEA number, patient name, DOB, and prescription on a pharmacy voicemail. I was like an auctioneer. Then my bubble burst.

Upon careful review of AB 2789, clinicians are mandated to transmit all prescriptions electronically with some exceptions. The exceptions include:

1. An electronic data transmission prescription is not available due to a temporary technological or electrical failure. For purposes of this paragraph, “temporary technological or electrical failure” means failure of a computer system, application, or device, or the loss of electrical power to that system, application, or device, or any other service interruption affecting the certified electronic data transmission prescription application used to transmit the prescription.

2. The prescribing health care practitioner is issuing a prescription to be dispensed by a pharmacy located outside California.

3. The prescription is issued in a hospital emergency department or urgent care clinic and one or more of the following conditions are present:
   i. The patient resides outside California.
   ii. The patient resides outside the geographic area of the hospital.
   iii. The patient is homeless or indigent and does not have a preferred pharmacy.
   iv. The prescription is issued at a time when a patient’s regular or preferred pharmacy is likely to be closed.

4. The prescription is issued by a veterinarian.

5. The prescription is for eyeglasses or contact lenses.

6. The prescribing health care practitioner and the dispenser are the same entity.

7. The prescription is issued by a prescribing health care practitioner under circumstances whereby the practitioner reasonably determines that it would be impractical for the patient to obtain substances prescribed by an electronic data transmission prescription in a timely manner, and the delay would adversely impact the patient’s medical condition.

8. The prescription is for a controlled substance for use by a patient who has a terminal illness.

Prescribers can also call in prescriptions for noncontrolled substances in situations that qualify as exceptions under the state law; but only in emergency situations can prescribers call in prescriptions for schedule II drugs.

According to this new law, a clinician who fails to give a prescription as an electronic transmission must document the reason in the patient chart as soon as possible, and within 72 hours of the resolution of the technical or electrical failure. Clinicians who do not adhere to this law are to be referred to the appropriate board for administrative sanctions.

Prescribers can choose to purchase a standalone prescribing software or a software application associated with an electronic health record. Prescribers should consider several factors before purchasing prescribing software, including whether they need to use the software on mobile platforms and whether they want enhanced software that provides additional features, such as the ability to check for drug interactions or a patient’s drug allergies.

Electronic Prescribing For Controlled And Uncontrolled Substances Becomes Mandatory In California In January 2022

The Dental Board of California is reminding prescribers of the upcoming e-prescribing requirements established by Assembly Bill (AB) 2789 (Wood, 2018). AB 2789 was proposed as a solution to reduce opportunities for diversion of controlled substances by eliminating the use of paper forms, which can be lost, stolen, and used illegally.
LEGISLATIVE UPDATE

As always, CALAOMS continues to stress and support patient safety during in-office dental procedures requiring anesthesia. Which is why it should not be a surprise to anyone that the association would sponsor and support legislation that mandates the three-person team anesthesia method for adults as well as pediatric patients. While AAOMS and CALAOMS members are required to utilize the team method for patients of all ages, it is NOT required for all ages under California statute. Senate Bill 501, passed in 2018, does mandate the 3-person team method for those patients under 13 years of age.

“In Senate Bill 501 (Glazer) was signed into California Law in 2018 and was set to take effect on January 1, 2022. However, CALAOMS was recently informed by the Dental Board of California that regulations have not yet been finalized; and therefore, the Dental Board is not ready to implement the requirements of the law. As such, the Dental Board is exploring possible legislation to postpone the implementation date for the provisions of SB 501, possibly to January 1, 2023. CALAOMS will continue to communicate with the Dental Board and will closely monitor this situation, and we will continue to provide updates to the membership as they become available to us.”

In the April Legislative Report, it was reported that CALAOMS leadership decided to enhance safety for dental patients of all ages undergoing procedures requiring anesthesia. In February 2021, SB 652 by Senator Patricia Bates of Orange County was introduced and sponsored by CALAOMS. The bill enjoyed strong support from both the Senate Business and Professions Committee and Appropriations Committee. At its May meeting, the Dental Board of California voted overwhelmingly to SUPPORT SB 652 (Bates). In late May, just prior to the full Senate voting on SB 652, the California Dental Association submitted a letter of OPPOSITION to SB 652 to the Senate. CALAOMS strongly believes the bill would have secured the required 21 votes to pass. However, a lengthy acrimonious debate over the merits of patient anesthesia safety would have clouded the issue and possibly impeded the bill’s continued movement. Therefore, with Senator Bates’ consent, the bill was put over until the legislature reconvenes in January 2022. During the next few months, discussions will be held with Senator Bates and all stakeholders on how to move forward.

California Department of Public Health (CDPH)

CALAOMS recommends that members follow COVID-19 mandates as prescribed by the California Department of Public Health (CDPH). All mandates and recommendations can be found on their website, covid19.ca.gov. In addition, all members should be aware of the requirements issued by individual county public health officials. These orders can be more restrictive than CDPH mandates.

MEANING IN ETHICS

In brief contextual overview: pre-modern era was one in which religion was primarily the source for truth and reality; during the modern era science became the source for truth and reality; in the post-modern era there is no single defining source for truth and reality beyond individual preference. In fact, many observers have opined that post-modernism wallows in nihilistic angst, mysticism, relativism, and the incapacity to know anything with certainty. The difficulty of a moral reflection that deals with serious questions of meaning can be blamed on the complexity, both epistemic and moral, defining our post-modern condition. Post-modernity entails the definitive overcoming of the modern philosophical and scientific agenda characterized by the optimism of reason; also, the recognition of a structural fragmentation that, forcing us to the inevitability of contextual interpretations, defies any illusion of totality and, with it, the very pursuit of truth as meaningful.

The theoretical indeterminacy of post-modernism as a philosophical label contrasts with the clear dimensions of the problems it creates in practice. Two are particularly important and worthy of reflection. First, the problem of bringing together the plurality of lived moralities, what we call moral pluralism, under the common denominator of a shared ethos, or a ‘common morality’ in bioethical jargon. Secondly, the difficulty of finding a level of discourse that engages differences among moral agents by surreptitiously reducing ethics to a purely regulatory task, thus progressively diluting the distinction between the legal and the moral. The tendency to sublate ethics under the law rests upon the assumption that dialogue on moral convictions separates people; only the law, now invested with a kind of soteriological meaning, can bring moral differences under the banner of unifying social rules.

Such a notion of ethics not only discourages meaningful exchange across different traditions; it actually entails, in the long run, a neutralizing effect upon the content of moral conversations as such. An ethical discourse capable of laying out a territory of discussion, where differences can meet and confront each other, will be expunged from the theoretical agenda of ethics. The latter will, at best, provide a grammar of procedural conditions upon which differences among moral traditions may co-exist, without ever coming into contact with one another. Rather than focusing on questions of intrinsic value, moral discussion is expected to articulate, at best, rules of reciprocal engagement – the a priori of the communication – that will allow each moral participant to remain in a safely protected, yet totally separated, moral universe.

In order to overcome the problems posed by our post-modern condition, it seems imperative to rethink the meaning and purpose of ethical dialogue across different traditions and within the public realm of ‘secular’ society. One must move here between the Scylla and Charybdis of a twofold dead end; the former problem concerns the moral climate that structures all practical spheres of reality, the latter permits, more specifically, to the possibility of a theoretical reconstruction of such moral climate, both in terms of ethical discourse and public policy.

Relying upon an analysis of different typologies or moral argumentation, political philosopher and ethicist Alasdair Maclntyre observes: “Debate between fundamentally opposed standpoints does occur; but it is inevitably inconclusive. Each warring position characteristically appears irreducible to its own adherents; indeed, in its own standards of arguments it is in practice irreducible. But each warring position equally seems to its opponents to be insufficiently warranted by rational arguments.”

A way of solving this predicament is to bridge the gap of cultural fragmentation and the unconvincing nature of arguments between moral agents by surreptitiously reducing ethics to a purely regulatory task, thus progressively diluting the distinction between the legal and the moral. The tendency to sublate ethics under the law rests upon the assumption that dialogue on moral convictions separates people; only the law, now invested with a kind of soteriological meaning, can bring moral differences under the banner of unifying social rules.

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

Post-Modernity Re-Thinking of Moral Meaning

by Gary Cooper

Legislative Advocate, CALAOMS
DEA Warns that International and Domestic Criminal Drug Networks are Flooding the United States with Lethal Counterfeit Pills

September 27, 2021 – The Drug Enforcement Administration warns the American public of the alarming increase in the lethality and availability of fake prescription pills containing fentanyl and methamphetamine. International and domestic criminal drug networks are mass-producing fake pills, falsely marketing them as legitimate prescription pills, and killing unsuspecting Americans. These counterfeit pills are easy to purchase, widely available, and often contain deadly doses of fentanyl. Pills purchased outside of a licensed pharmacy are illegal, dangerous, and potentially lethal. This alert does not apply to legitimate pharmaceutical medications prescribed by medical professionals and dispensed by pharmacists.

DEA and its law enforcement partners are seizing deadly fake pills at record rates. More than 9.5 million counterfeit pills were seized so far this year, which is more than the last two years combined. Officials report a dramatic rise in the number of counterfeit pills containing at least two milligrams of fentanyl, which is considered a deadly dose. The number of DEA-seized counterfeit pills with fentanyl has jumped nearly 430 percent since 2019, a staggering increase. DEA laboratory testing further reveals that today, two out of every five pills with fentanyl contain a potentially lethal dose. Additionally, methamphetamine is increasingly being pressed into counterfeit pills.

Some of the most common counterfeit pills are made to look like prescription opioids such as oxycodone (Oxycontin®, Percocet®), hydrocodone (Vicidin®), and alprazolam (Xanax®); or stimulants like amphetamines (Adderall®). Fake prescription pills are widely accessible and often sold on social media and e-commerce platforms – making them available to anyone with a smartphone, including teens and young adults. These counterfeit pills have been seized by DEA in every U.S. state, and in unprecedented quantities.

Drug traffickers are using fake pills to exploit the opioid crisis and prescription drug misuse in the United States, bringing overdose deaths and violence to American communities. According to the Centers for Disease Control and Prevention, last year more than 93,000 people died of drug overdoses in the United States, marking the largest number of drug-related deaths ever recorded in a year. Fentanyl, the synthetic opioid most commonly found in counterfeit pills, is the primary driver of this alarming increase in overdose deaths. Drug trafficking is also inextricably linked with violence. This year alone, DEA seized more than 2,700 firearms in connection with drug trafficking investigations – a 30 percent increase since 2019. DEA remains steadfast in its mission to protect our communities, enforce U.S. drug laws, and bring to justice the foreign and domestic criminals sourcing, producing, and distributing these deadly fake pills.

The only safe medications are ones prescribed by a trusted medical professional and dispensed by a licensed pharmacist. Any pills that do not meet this standard are unsafe and potentially deadly. DEA has launched the public awareness campaign, One Pill Can Kill, to educate the public on dangers of counterfeit pills and how to keep Americans safe. For more information, visit DEA.gov/onepill.

The Drug Enforcement Administration ensures the safety and health of the American public by fighting against violent criminal drug networks and foreign cartels trafficking in illicit drugs. To accomplish that mission, the Drug Enforcement Administration employs approximately 10,000 men and women throughout the world – Special Agents, diversion investigators, intelligence analysts, and chemists – across 239 domestic offices in 23 U.S. divisions and 91 foreign offices in 68 countries.

For more information about counterfeit pills, go to www.DEA.gov/onepill.

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Vendor Spotlight

CALAOMS Wishes to Thank the Following Vendors That Graciously Sponsored CALAOMS’ Meetings In 2021

- The Doctors Company (Speaker)
- H & H Company
- Boyd Industries, Inc.
- Brady Price & Assoc
- Maxxeus
- Provide, Inc.
- Xemax Surgical Products
- OMS Partners
- Treloar & Heisel
- KLS Martin
- Geistlich Biomaterials
- OMSNIC
- MedPro OMS
- Acumed/OsteoMed

2022 Meetings

- January 2022 Anesthesia Meeting - San Francisco
  January 15 -16
- 22nd Annual Meeting - San Diego
  April 30 - May 1
- OMSA Course On-line
  Open Year Round
- ACLS & BLS Provider Recertification
  March (TBD)
- ACLS & BLS Provider Recertification
  October (TBD)
- Medical Emergencies (South)
  November (TBD)
NORTHERN CALIFORNIA: Well Established and busy/wide referral base Oral Surgery Office in Redding, Northern California is for sale. Full time associate leading to partnership opportunity. Practice is established over 30 years with state of art facilities with 3D CT scan. We have two offices where the new associate will be expected to work with one office being in Redding as the Principal is looking forward to retirement. The office provides full scope Oral and Maxillofacial surgery including IV-sedation, general anesthetic, extraction, bone grafting, pathology and implant surgery where candidate will have autonomy to “run” the practice but also has the benefit of a partnership with another surgeon. Applicant must have California license where we can assist in obtaining a GA permit. Candidate should reply via email with their CV to wtsb2021@yahoo.com

Northern California: Oral Surgery Group located in Stockton/Modesto California is seeking Board Eligible or Certified Oral and Maxillofacial surgeons to join our well-established team.

Full scope practices specializing in standard oral surgery, implants, orthognathic surgery, and trauma. Offices are fully equipped, including full-time staff and leadership. Seeking motivated and hard-working OMS with excellent interpersonal skills. Exceptional opportunity for new graduates and experienced Oral Surgeons to join our established, very busy, profitable group. Competitive pay and benefit package. Inquire and include CV. Interested candidates, please email: jgutierrez@bayareaospractice@gmail.com

Bay Area: Oral Surgery Group located in Pinole California is seeking Board Eligible or Certified Oral & Maxillofacial Surgeons to join our well-established team.

Irvine (Southern California): Premier full scope OMS practice, has partnership opportunity available. State of the art CBCT, EMR Practice Management software. This is an growing practice with enormous growth potential. Routine office based practice that includes: dentoalveolar surgery, bone grafting, implants, IV general anesthetics, orthognathic surgery, and All on four/five implant cases. Local candidates preferred. Please contact: jstraw@edoralsurgery.com 916-990-3644

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

Santa Barbara OMS: Associate wanted to practice in Santa Barbara. Leading to Full Partnership. Please contact Yvonne at 805-692-8500 or Email at drwelsh.oms@gmail.com

San Diego: Well respected oral surgery practice located in central San Diego. Full time in practice and one of the most successful practices in the region. Inactive Seattle study club sponsor for over 21 years with 50 members. Scope of practice includes all dentoalveolar surgery, implant/plant/PRP use, orthognathic and TMJ surgery, sleep apnea treatment with MRD and bi-maxillary advancement and facial trauma. In house OR available. Complete office with all equipment and technology, including Cone Beam and Sterilization Center. Very well established office. Owner retiring. Very busy practice. Please contact: jstraw@edoralsurgery.com

Southern California: Oral & Maxillofacial surgery practice including IV-sedation, Extractions, Bone Grafting and PRP, Implant Placement, Biopsies and more. Applicant should have CA license, GA permit and Medical Malpractice Insurance. Medical Degree is a plus. Candidate must be able to provide excellent surgical services, establish and maintain relationships with existing and new referring doctors and be interested in growing the practice. Candidate should reply via email with their CV attached to: apply@oral-surgery-gmail.com

San Francisco: We are seeking an OMS full or dual degree for a part/full time position in Oakland. Practice is located in San Francisco Peninsula. The practice has been established over 50 years with excellent reputation in the community. Facility is state of the art with the latest technology. Our practice emphasizes office-based dental-implant and implant surgery but can expand scope if desire exists. Full scope oral candidate should have excellent interpersonal skills with good patient care and ethics. Salary will be negotiable and competitive. Reply with CV to sfr peninsulaoms@gmail.com

San Francisco: Established oral surgery office in San Francisco is looking for a part time oral and maxillofacial surgeon to join our practice with the possibility of partnership. Our practice is a state-of-the-art facility with advanced technology like digital X-Ray, 3D Scanner and CT scan machine. The ideal candidate must be a team player looking for a long-term position with the desire to grow professionally. We are seeking someone who works independently, has excellent interpersonal skills, great chairside 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. For confidential contact: Courtney@drantipov.com 2480 Mission Street 219 San Francisco, CA 94110 Phone: 415 285 0525

Southern California’s Inland Empire: Immediate full-time oral maxillofacial surgeon wanted in Southern California’s Inland Empire. This is a growing OMS practice with emphasis on Dentoalveolar and implant surgery. Please contact me at omfspractice434@gmail.com if interested

San Francisco: Oral Surgery Group located in desirable location in sunny San Francisco Peninsula with an established practice. The location is state of the art and is motivated but will stay for a smooth and stress free transition as long as desired by the candidate. The practice is looking for a qualified professional that is interested in a continuation of great service to referal base and community. The owner surgeon has a study club that meets 4 or 5 times a year and has an established practice. The office is located in the heart of SF Peninsula with the possibility of buy in. Email: drwelsh.oms@gmail.com for a confidential conversation about this opportunity.
The tradition of OMS working together has been part of OMSNIC’s DNA since our founding. In fact, the very formation of the company was the result of oral and maxillofacial surgeons coming together to confront a crisis. When a new crisis arrived in the form of the pandemic, OMSNIC partnered with AAOMS and OMS advisors to help OMS practices around the country survive the financial strains and safety challenges.

OMSNIC is the only professional liability insurance company owned by oral and maxillofacial surgeons where practicing colleagues represent your interests. As part of your OMS community, OMSNIC is committed to the safety and success of every OMS practice.  800-522-6670  omsnic.com