When legislative efforts are in full swing, the CALAOMS board often receives requests for how members can help offer support. The best way to do so is to help educate legislators and their staff. Reaching out to your local state Assembly member and local state Senator to educate them on who oral and maxillofacial surgeons are, what we do, our safe practices in anesthesia delivery, etc. is extremely valuable. Education can help lead to action. Unless these lawmakers or their family members have been patients in our offices, many don’t know what we do and are hearing about us for the first time when we are promoting legislation.

CONTINUED ON PAGE 5
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EDITORIAL

12 years, 11 months, 30 days + one day

The issue of anesthesia administration in a dental office is once again in front of us. As one who’s been working behind the scenes for the past several years on anesthesia safety legislation, I am intimately aware of the players (medical and dental specialty organizations) involved, where each of them stand on issues, who in the dental profession – specifically, in this state – is serious about improving patient safety, and who is interested in simply being heard as proponents for anesthesia safety in dentistry.

CALAOMS’s sponsored adult anesthesia legislation, SB 652 (Bates), is the vehicle currently in the Senate Appropriations Committee being discussed. The aim of this bill is to put in statute those items that are serious about improving patient safety, and who is interested in simply being heard as proponents for anesthesia instead of actually taking substantive action to do so. As oral and maxillofacial surgeons, it’s in our nature to act swiftly and definitively in the right direction; we have no other choice – the stakes are high in our practices.

CALAOMS leadership and our members – know enhance patient safety. These items include a 3-person team for deep sedation/general anesthesia delivery in dental offices for patients of all ages: a 3-person team consisting of a surgeon in command, a dedicated anesthesia monitor, and a surgical assistant; with the anesthesia provider and the dedicated anesthesia provider both having advanced life support training (PALS or equivalent for under 13; ACLS for 13 and over).

Literally, one day in a child’s life can make quite a difference!

Just as SB 501 (pediatric [under 13 years old] anesthesia bill sponsored by CALAOMS and signed into law in 2018 and set to be implemented in 2022) put in place anesthesia team guidelines and training requirements – 3-person team with anesthesia permit holder in command, a dedicated anesthesia monitor (both the permit holder and dedicated anesthesia monitor will require PALS or equivalent life support training), and a dedicated procedural assistant – so, too, does SB 652, but for patients 13 and older.

Currently, the law does not call for the use of capnography for moderate and deep sedation for patients 13 years and older (starting in 2022, capnography will be required for patients 12 and under in accordance with SB 501). Neither does the law call for a 3-person team with a dedicated anesthesia monitor. Once SB 501 is implemented and if SB 652 is not passed (which is always possible), it seems silly to think that for a child who’s 12 years, 11 months, and 30 days old there will be one standard for moderate and deep sedation/general anesthesia delivery in a dental office: a 3-person team, capnography, and PALS/Advanced Life Support (ALS) training for the anesthesia provider and at least one additional staff person. But just one day later when that child turns 13 years old, the current law will otherwise allow quite a different set-up: no required capnography, no requirement for staff to have enhanced life support training (PALS or equivalent for under 13; ACLS for 13 and over).

SB 652’s goal is to complete the process and establish one standard for deep sedation/general anesthesia delivery in dental offices for patients of all ages: a 3-person team consisting of a surgeon in command, a dedicated anesthesia monitor, and a surgical assistant; with the anesthesia provider and the dedicated anesthesia monitor both having advanced life support training (PALS or equivalent for under 13; ACLS for 13 and over).

Recently, the CALAOMS Legislative Task Force put together a short PowerPoint presentation for our Legislative Advocate, Mr. Gary Cooper, and CALAOMS members to use to help educate lawmakers and their staff about the OMS Anesthesia Team Delivery Model. The focus of this short article is to demonstrate what information is in this presentation so that the information and messaging coming from all CALAOMS members is consistent. We will be posting the PowerPoint presentation to the CALAOMS website so that members can access it if they choose.

The Oral and Maxillofacial Surgery (OMS) Anesthesia Team Delivery Model consists of a 3-person team for in-office deep sedation/general anesthesia, with the surgeon in command, a dedicated monitor trained to assist in the anesthesia, and a dedicated surgical assistant (Figure 1). This is the standard for anesthesia safety in dentistry.


The 3-person Anesthesia Team is continuously in physical contact with the patient (Figure 2):

- Keeping open the patient’s airway
- Directly observing and listening to the patient’s breathing throughout the entire procedure
- Directly observing the vital signs monitor which is positioned just a few feet away

Successful completion of the DSA curriculum and the psychometrically validated examination results in a Dental Board of California (DBC)-issued permit (license) that requires renewal every 2 years and completion of 25 hours of DBC-approved continuing education every 2 years for renewal.

SB 652 seeks to enhance the training of anesthesia assistants (Figure 3) who assist in anesthesia delivery for adults by requiring Advanced Cardiac Life Support (ACLS) training. (Business and Professional Code Division 2, Chapter 4, Article 7, Sections 1730.4-1750.3; (Sodhi K, et al. Impact of advanced cardiac life support training program on the outcome of cardiopulmonary resuscitation in a tertiary care hospital. Indian J Crit Care Med. 2011;15(4):209-212.)

The Dental Sedation Assistant (DSA) was specifically created in 2010 to provide didactic education and hands-on training in office-based anesthesia – assisting in and recovery of patients from deep sedation/general anesthesia.

The Oral and Maxillofacial Surgery (OMS) Anesthesia Team Delivery Model consists of a 3-person team in-office deep sedation/general anesthesia, with the surgeon in command, a dedicated monitor trained to assist in the anesthesia, and a dedicated surgical assistant (Figure 1). This is the standard for anesthesia safety in dentistry.
Oral and Maxillofacial Surgeons (OMSs) have been providing safe anesthesia to their patients using the Anesthesia Team Delivery Model which has allowed access to care for patients that have significant dental anxiety.

The hallmarks of the Anesthesia Team Delivery Model include communication, checks and balances, monitoring, team dynamics, protocols, emergency scenario preparation and rehearsal, and crisis resource management during an emergent situation.

This system contributes to and continually supports a culture of safety for in-office deep sedation in dentistry.

OMSs strive to maintain the excellent safety record of the Anesthesia Team Delivery Model by creating simulation programs in anesthesia, regularly updating the office anesthesia evaluation program, convening anesthesia safety conferences, and strengthening standards in training programs. OMSs are committed to the safe and effective delivery of in-office sedation and anesthesia (Figures 4-6).


The key to reducing procedural sedation risk is detailed and thorough monitoring of the patient during the procedure. Electrocardiogram (EKG heart rate and rhythm monitor), respiratory rate, blood pressure, and pulse oximetry are commonly monitored; but these do not reliably identify airway and ventilation compromise.

Capnography (Figures 7a-7d) measures exhaled carbon dioxide in real-time and provides early identification of airway obstruction and hypoventilation during procedural sedation.

Implementation of this technology provides an additional layer of safety, reducing risk of respiratory compromise in patients receiving procedural sedation.


First Quarter 2021 Member Update

The OMS Foundation extends its sincere thanks to EVERY donor who contributed to the Annual Fund or GIVE in 2020. Your generosity was a lifeline during this complicat-ed year.

Special thanks to Treloar & Heisel for launching the OMS-FIRE (OMS for Innovation, Research and Education) campaign with a $100,000 Platinum commitment in January 2020 and to OMS Partners, LLC (Gold) and U.S. Oral Surgery Management (Silver) for their lead OMS-FIRE corporate gifts in 2021. More than 60 Charter OMS-FIRE donors collectively committed to $250,000/year to support the Annual Fund through 2024. Many thanks to OMSFIRE Society donors Colorado (Gold), Delaware Valley, Pennsylvania and Ohio (Silver) and Rhode Island (Bronze) for their 5-year commitments. The steadfast support of the Foundation’s OMSFIRE and other recurring donors was deeply appreciated in a year in which overall fundraising dropped by 30%.

Included in the Foundation’s 2021 research and education funding are two Student Research Training Awards, offering opportunities for promising dental students at Loma Linda University and the University of Alabama at Birmingham to explore careers in research and the OMS profession. The Foundation has invested more than $650,000 in the SRTA program since 1992; its return on that investment is a steady influx of top talent into the specialty. Read more about the University of Pennsylvania’s successful SRTA program here, and contact Mary DiCarlo at mdi-carlo@omsfoundation.org to share your SRTA story.

Did circumstances compel you to postpone your annual giving in 2020? If you’re able, please help us recover from last year’s shortfall with a gift in the first quarter. For the Foundation to continue to serve the specialty effectively, every OMS must treat investment in research and education as a cost of doing business. A recurring gift of just $209/month contributes $2,500 annually to support the Foundation’s work and qualifies you for recognition as a Bronze OMS-FIRE donor. Enroll before Feb. 28 for recognition in the Foundation’s inaugural issue of Torchlight, its e-newsletter debuting in March 2021. Thank you!
A s 2021 began, many hoped it would bring with it a new outlook on our lives as we reflected on the past year of a historic global pandemic. For many, I think it has. It’s taken a little time, but with perseverance there is light at the end of the tunnel. Hospitalizations are decreasing, vaccinations are increasing, and we are slowly working our way back to the somewhat normal. Along with that, the board is back to focusing on the issues that were present before the pandemic outbreak and subsequent shutdown; specifically, the same issues that never went away surrounding our profession. CALAOMS continues to advocate for the specialty and for our patients. We constantly promote education and advanced training to our members; and have always sought opportunities to further increase patient safety. Sometimes this means getting involved with educating legislators and even promoting statutory and regulatory changes. It’s not always easy—in fact, it’s actually never easy—but it is the correct thing to do for our patients and our team members; so, the results are worth the struggle.

We are renewing our efforts to promote enhanced training for our anesthesia assistants. As a critical member of the OMS Anesthesia Team Model, our anesthesia assistants’ didactic and clinical education can be further improved. Doing so only enhances their professionalism and improves the anesthesia team. Finally, CALAOMS desires to continue the great work of giving back to our communities through our OMSA training, among others. The OMS Anesthesia Team Delivery Model, consisting of a three-person team for deep sedation/general anesthesia (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 DS/GA anesthesia safety in dentistry. While it is the current standard of care for AAOMS and CALAOMS members to provide deep sedation/general anesthesia utilizing a three-person anesthesia team, the CALAOMS board recognized that this practice model needed to be written into statute and made mandatory by law to align the law to the current standards.

Some have questioned why we are promoting this legislation now when they perceive that the political landscape might be fairly quiet at this time. That’s very simple. CALAOMS does not just react to politics; the current political climate should not preclude the profession from doing the right thing for patients of all ages. We will be asking for CALAOMS members to get involved with a letter-writing campaign soon. Some of you may even be asked to offer testimony at legislative hearings; currently these are being held over Zoom. We hope you will enthusiastically support this effort.

In 2020, CALAOMS successfully launched - for the first time ever - the online OMSA (OMS Anesthesia Assistant) curriculum. Successful completion of the OMSA course is completed for providers who are scheduled to become effective July 1, 2021. Thanks to their great work and professionalism—manifested concretely through numerous calls, Zoom meetings, conference calls, emails, advocacy, and letter-writing, Delta Dental recently announced they will not be moving forward with implementing the proposed fee reductions and have put these on hold indefinitely. CALAOMS will continue to monitor for any new developments. We also plan on keeping lines of communication open with Delta Dental. We especially want to thank Mr. Cooper for his incredible work in gathering all parties together and facilitating discussions with Delta Dental.

The CALAOMS Legislative Task Force has (re)introduced legislation that was withdrawn in 2020 due to the pandemic. Specifically, SB 652 (Rates) proactively promotes the anesthesia team model that contains the same safety measures we successfully advocated for in SB 501 (pediatric anesthesia safety bill passed in 2018) to also apply to patients 13 years and older.

As oral and maxillofacial surgeons, our primary concern is always anesthesia safety for patients of all ages. The greatest privilege we are afforded as OMSs is the ability to administer in-office sedation to our patients. This privilege is not taken lightly; and our board is continuously working hard through various efforts, including simulation training, didactic and clinical training, and enhanced staff anesthesia/advanced life support training, among others. The OMS Anesthesia Team Delivery Model, consisting of a three-person team for deep sedation/general anesthesia (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 DS/GA anesthesia safety in dentistry. While it is the current standard of care for AAOMS and CALAOMS members to provide deep sedation/general anesthesia utilizing a three-person anesthesia team, the CALAOMS board recognized that this practice model needed to be written into statute and made mandatory by law to align the law to the current standards.

Sincerely,
Shama Currimbhoy, DDS, MS President, CALAOMS
AAOMS DISTRICT VI TRUSTEE REPORT

Greetings from the District VI Trustee

Thank you” to CALAOMS – and to all of District VI – for the support and confidence shown me as your AAOMS Trustee. Now running for AAOMS Vice President, more than ever, I am grateful.

Two recent AAOMS events stand out and are mentioned here.

First: Those who have read the most recent President’s message will know that we have a new AAOMS Executive Director beginning June 1. After conducting a national search, interviewing many candidates on virtual platforms and then conducting in-person interviews with the selected finalists, the Executive Director Search Committee unanimously approved the selection of Karin Wittich, CAE, as the new Executive Director of AAOMS.

Ms. Wittich has served as AAOMS Associate Executive Director of Practice Management and Governmental Affairs since 2004. Her accomplishments and plans for advancing the Association impressed the Search Committee, which met with one other finalist at AAOMS headquarters last week.

Ms. Wittich replaces the retiring Mr. Scott Farrell, MBA, CPA. AAOMS thanks Mr. Farrell for his hard work and dedication the last five years as Executive Director after serving as Chief Financial Officer and Associate Executive Director of Business and Operations for 18 years.

Second: AAOMS officers, trustees, and senior management team recently met to revisit the AAOMS strategic plan. This review was one year past-due owing to meeting limitations imposed during the pandemic. The plan will now be fit into the AAOMS working documents and will be presented to the 2021 AAOMS house of delegates for approval and adoption. There are six major areas of focus included in the plan. Added together these provide the direction and framework for all AAOMS activities going forward in the next three years. The six important implementation domains are:

- ADVOCACY - Advocate at federal and state levels; form strategic alliances.
- COMMUNICATIONS - Promote the brand, mission, vision and values of AAOMS.
- EDUCATION - Set standards of excellence in education and training for AAOMS fellows, members and their staff as well as OMS residents.
- PRACTICE - Advance and optimize the practice of AAOMS members.
- RESEARCH - Catalyze advances in the specialty of OMS and promote scholarships.
- FINANCIAL - Ensure the financial sustainability of AAOMS.

As always, I encourage you to read the AAOMS Member Alerts and President’s Message, and to visit the AAOMS website frequently for new information as it comes available. Please do not hesitate to reach out with your suggestions, comments, or concerns.

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

LEGISLATIVE UPDATE

Spring 2021 Legislative Report

While the COVID-19 pandemic has drastically altered how business is conducted under the golden dome of the Capitol, those of us involved in conducting that business have learned to adapt. The first few months of the 2021-22 legislative session has been a very active period for CALAOMS on several fronts.

CALAOMS continues to emphasize and promote patient safety during in-office dental procedures requiring anesthesia. When the anesthesia issue was at its peak in 2016 and 2017 due to the unfortunate death of Caleb Sears in a dental office, CALAOMS remained steadfast in the belief that the three-person anesthesia team method was extremely safe and should be the standard of care for patients of all ages. While it is the current standard of care for AAOMS and CALAOMS members, the leadership of the association believes it should be written into statute and made mandatory by California state law. In 2018, SB 501 (Glazer) addressed the safety of anesthesia for pediatric patients but was silent on patients 13 years of age and above. In 2021, CALAOMS made the determination to close the loop on the general anesthesia/deep sedation safety issue by sponsoring SB 652 by Senator Patricia Bates.

SB 652 requires that if any age patient is undergoing a procedure requiring general anesthesia or deep sedation, the operating dentist and at least 2 additional personnel shall be present throughout the procedure. The dentist and at least one of the assisting personnel shall maintain current certification in Advanced Cardiac Life Support (ACLS). In addition, for all general anesthesia and deep sedation procedures, certification technology continues to be mandated. While the legislative process will continue through September 2021, at this writing SB 652 (Bates) has passed its first hurdle, Senate Business and Professions Committee, by a vote of 12-0 on April 19, 2021. The bill now moves on to the Senate Appropriations Committee on Monday, May 3, 2021.

DELTA DENTAL

As most CALAOMS members are aware, Delta Dental had announced in early 2020 that it would be reducing provider rates to the three dental specialties: oral and maxillofacial surgeons, periodontists, and endodontists by July 1, 2020. Obviously, this news was not received well by the specialty providers. The rate reduction decision was especially difficult to accept during the pandemic that had already caused hardships to so many specialty practices. In March 2020, leaders from CALAOMS got actively involved in the process of mitigating the negative impact of Delta Dental’s decision. CALAOMS established a Delta Dental Task Force and called together leaders of the periodontist and endodontist associations. Together, the three specialty association representatives met multiple times over a period of a year with the corporate leadership of Delta Dental. Very meaningful, substantive, and transparent discussions ensued. Fortunately, on April 5, 2021, Delta Dental announced an indefinite postponement of fee structure adjustments for California endodontists, periodontists, and oral and maxillofacial surgeons. Delta acknowledged that their decision was indeed based on the “impactful conversations” with the three specialty groups. While this decision is positive for now, these discussions should continue to ensure that these positive results are maintained.

During the remainder of the 2021 legislative session, other bills dealing with issues related to the dental profession will be discussed, debated, and acted upon. CALAOMS will be involved in many of them as the year progresses. CALAOMS believes it is important to make our voice heard when oral and maxillofacial surgeons are impacted. That will continue.
Perception is Reality

by David Y. Park, DDS, MD

Looking at the stock market with its ups and downs is a vivid reminder that perception has power. In contrast, as doctors and practice owners, we are constantly searching for reality or truth through very different means. We test it through research and experimentation - the crucibles that shape our reality. We are constantly in search of truth and reality in the natural world that help shape our perception. The political world and the scientific world are polar opposites of process; in one, reality helps guide perception, and in the other, perception helps shape reality.

As the OMS Anesthesia Team Delivery Model is challenged in the political realm, we must be mindful that although this model - as delivered by current standards of practice - has enjoyed a proven track record of safety for decades, we must continue to battle the perception that it is subpar; an idea promoted by those who do not know even what we do. This reckless language threatens access for patients to receive safe, comfortable, and affordable care.

As doctors, we have an obligation to do everything within our power to ensure that we provide affordable, safe, and effective treatment to patients of all ages. Without any prompting from the Legislature or any other organization, CALAOMS established required, regular in-office anesthesia evaluations as well as anesthesia training for OMS anesthesia assistants. This has proven to be a significant proactive effort. Yet, for some outsiders, the perception still exists that our team delivery model is an inferior model. If we continue to assert that that perception is incorrect (and it is), we must then try to establish truth through different means. We must guide perception and help to establish truth because this discussion is being brought out in the realm of public perception, not in the realm of established science.

The primary attack against the anesthesia team delivery model has been aimed at the training and certification of our anesthesia assistants. To defend this model, we must also defend and enhance the training of our anesthesia assistants. We must strive to not only meet a safety standard but set a standard for training to guide perception.

One of the unforeseen positive outcomes of the COVID pandemic has been an expedited move to online education for our current OMSA training course. The efforts of the volunteer OMs and CALAOMS staff (Steve, Terri, and Pam) have established an online training course that can be delivered more efficiently than an in-person course. Online education and training have also been much more widely accepted as an educational vehicle as we all sheltered at home and socially distanced.

If we are to continue to defend the anesthesia team delivery model, we – as the experts in anesthesia in dentistry – must become more passionate about enhancing the education, professionalism, and training of our anesthesia assistants. We must set a standard of training that not only satisfies reality but also the perception of reality.

As CALAOMS and AAOMS continue to defend our privilege to provide anesthesia for patients of all ages, there will be recommended changes to enhance the training and professionalism of our anesthesia assistants.

On May 5, 2021, an online webinar hosted by CALAOMS will be presented to discuss and answer questions about the Dental Sedation Assistant (DSA) permit that is recommended for anesthesia assistants. The DSA is a Dental Board-issued license/permit that satisfies the requirement to have a “licensed health professional experienced in the care and resuscitation of patients recovering from moderate sedation, deep sedation, or general anesthesia.” It is encouraged that all anesthesia assistants obtain the DSA permit in addition to PALS training if patients under 13 years old are being sedated in-office, and ACLS if sedating patients 13 and older.

Our specialty must move in unified fashion in order for the defense of our anesthesia team model to succeed. We must all passionately stand together in defense of the safe, effective, and accessible anesthesia team delivery model; but also realize that we can continue to enhance the training and professionalism of our anesthesia team members.

RISK MANAGEMENT

Before COVID-19, Outlier Medical Malpractice Verdicts Were Rising

by Richard E. Anderson, MD, FAC9, Chairman and Chief Executive Officer, The Doctors Company

Severity—the average cost of a medical malpractice claim—continues its relentless increase. Though severity has been rising since at least the 1970s, in recent years we have seen a sharp increase in outlier verdicts, which exceed common policy limits and often set records for their venues. From 2014 to 2018, the number of verdicts in excess of $25 million more than tripled.1 Similarly, from 2010 to 2019, the average of the top 100 jury awards for medical malpractice cases rose by almost half.2 This disturbing trend threatens the viability of smaller medical malpractice insurers, who may not have the resources to cover such large verdicts, and portends medical malpractice rate increases while adding to burgeoning healthcare costs.

Before the pandemic, nearly all states had seen these extraordinarily large awards, but whether the pace of these awards will be affected by the pandemic is unknown. Some U.S. states have adopted limited liability protections for physicians during COVID-19, but those protections may be tested in the courts. Alternately, because physicians may be seen as heroes, pandemic-related malpractice cases may be less likely to result in large plaintiffs’ awards. Nevertheless, outsized awards to plaintiffs are part of an ongoing long-term trend.

Clinicians may well ask why severity is increasing at the same time the medical community has made important strides in patient safety and the overall frequency of claims has dropped. At The Doctors Company, we’ve seen a drop from a high of 17 claims per 100 physicians in 2000 to fewer than seven claims per 100 physicians today.

The consolidation of healthcare is one driver of high verdicts. Large corporate defendants, almost always with very high policy limits, make attractive deep pockets in the eyes of sympathetic juries.

Monetary desensitization is another important factor. Our national debt exceeds $22 trillion, our annual budget is over $4 trillion, and the overall frequency of claims has dropped. At The Doctors Company, we saw a 55 percent increase in severity—the cost of the average claim—from 2000 to 2018. This drives increases in insurance rates: The average payment for a closed medical malpractice case has been growing well beyond the pace of inflation since 2014—and this spike in claims losses necessarily drives the rate increases that insurers are implementing in 2020.3 (Such increases are sometimes falsely attributed to COVID-19 which is too recent to have driven claims costs.) Ultimately, added costs are passed down to patients in their bills for healthcare.

The rise in severity negatively affects us all, but unless jurors’ attitudes change, batch claims decrease, and caps on noneconomic damages are protected, outlier verdicts will continue to become more commonplace. (Endnotes)

1 Burns B. MedPL market updates. Oral presentation at: PLUS Symposium Series, Healthcare and Medical PL; March 11, 2019; Chicago, IL.
5 Karl’s C. Paid indemnity severity, countrywide by closed year. In oral presentation: What is that light at the end of the tunnel? At: MPL Association CEO/COO Workshop; March 11-14, 2020; Scottsdale, AZ.
As with most clinical techniques, there is excitement and skepticism when they are initially introduced. There are trials and tribulations and always the inherent need for refinement and advancement of technology as time goes by. So has been the path for technology in the realm of all surgical guide applications and manufacturing. Surgical guides used in orthognathic, craniofacial, and oncological/reconstructive OMS have proven to improve our outcomes and substantially deliver cost and time savings. The era of full dental arch implant-supported reconstructions has certainly provided ample opportunity for the advancement of the design and use of surgical implant guides and milled restorations. Without these guiding adjuncts, complicated cases often will fail; if not intraoperatively, then in the near future after prosthesis delivery. This is especially evident in cases with minimum bone stock, highly animated lip envelope, and a lack of vertical restorative space. The often-overlooked requirement of the full arch hybrid/overdenture reconstruction paradigm is the creation of additional restorative space for connections and maintenance of structural integrity of the restorative solutions. Canting and skeletal disharmony are often overlooked or ignored, as well, if not identified in planning. Fully digital based planning and workflow can address all these considerations.

Analog paradigm, used for many decades, still has merit and certainly has allowed us to deliver adequate results when properly applied. Wax up stone models and suck-down guides still work well in most cases. Often, however, the planning aspect of these analog cases is either unevenly weighted on the prosthetic/occlusal-driven track or, conversely, based on supporting bone availability with hopes that these two constructs would intersect optimally in the end. Hybrid of analog and digital workflows have attempted to improve the accuracy of planning with varied results. At each transition point, more imprecision was often introduced into the solution process as distorted analog data was mixed with often erroneous digital information subsets. Our initial attempts to deliver guided surgery were mostly based on wax-ups being converted into acrylic guides or duplicates of dentures serving as axial inclination boundary references and even sometimes reduction guides for alveolar ridges. It was certainly an attempt to improve the accuracy of fixture placement, but it certainly was far from being what is considered precise by our current standards.
In the mid-2000s, software applications like Simplant® opened our doors to almost full digital planning and surgical guide fabrications. Often, we still needed stone models to be used in cases where teeth or soft tissues were to be used as support for the guides. These guides were printed in resins and allowed for either hard or soft tissue support to increase placement precision. They were bulky and hard to precisely seat in some cases. Desired prosthetic designs could be scanned into the 3D modeling software and used to plan final fixture positions based on the final tooth position. To increase the guide placement accuracy, pinning techniques were developed with varying degrees of orientation precision. Sometimes poorly seated guides created more issues if not recognized than analog or even free hand fixture placement.

During the last decade, and greatly due to dental post-grad CE centers like Spear, Kois, and Pankey, facially generated treatment planning constructs and smile design concepts have fully come into the forefront of what contemporary dentistry aims to offer. Before this era, the aspect of extraoral or truly facially driven restorative design was not routinely considered. Until the recent introduction of extraoral facial digital analyzers and photogrammetry imaging, there was still a missing link in creating a fully digital surgical guide workflow.

We are now in the position to routinely integrate the virtual perioral animated facial skin drape records (STL-based), dental intraoral hard and soft tissue structure position relations (STL-based), and 3-D CBCT (DICOM-based) hard tissue anatomy into a powerful single format planning platform.

Fully digital workflow and surgical and prosthetic guidance is now available for those desiring to use this 100% digital and facially driven approach. Our experience with this emerging planning and treatment paradigm has been very positive, but it still requires good case selection and an accurate and refined level of planning and surgical expertise to predictably deliver this mode of implant care.

The surgical success aspect of these treatments is based on an application of a surgical guide that serves two main purposes. One is to precisely plan and allow for bone reduction, and the second is for implant position in the alveolar and/or basal bone housing. Additionally, the current stacking surgical guides allow for the seating of the transitional prosthesis in all vectors of space and so it may be captured optimally with chairside pick-up resins. With this control of platform position and depth, the transitional prosthesis occlusal plane location and opposing occlusal coupling can be ensured. This was always a challenge in the analog workflow based on tissue support of the palate or loose teeth to determine VDO and the A-P incisal position.

Our new bone-based implant guides are milled, not printed. The earlier versions of the implant guides were either soft tissue-supported or tooth-based guides where acrylic denture duplicates or later-printed acrylic guides were based off CT scans of the bone and a barium coated denture.

Currently, our surgical and restorative component designs are fully based on virtual final prosthesis design from data sets in facial topography scans, STL-based intraoral scans coupled with our CBCT data all-in-one planning software. This final all-encompassing design algorithm allows for CAD-CAM milling and printing of all related surgical guides, scan appliances (when needed),
seating jigs, reduction wafers, and actual prosthetics, both provisional and final.

Typical records needed for our current fully digital workflow include extraoral tissue drape scan with facial analyzer (digitalface.dental) in repose and in full exaggerated animation. Second intraoral digital scans using Medit scanner are completed to develop the current baseline hard and soft tissue positions. If needed, current removable restorations can be scanned as separate segmentable components of the global data set and placed in their respective anatomical setting. In some cases, we can also print scan appliances based on the intraoral scans so that we can best orient the arches when patients are fully edentulous or without stable restorative reference points. The last, but not the least, layer of data comes from our high resolution CBCT scanner (Carestream 8100 mid volume).

All STL files and DICOM files are integrated and merged into a single planning file with the ability to filter and overlap tissue, implants, and prosthetic components in layers on one single platform by Blue Sky Bio software. The planning software allows for a CAD-CAM process that builds virtual models and develops the needed designs for fabrication of all components required to execute the prosthetic fabrication.

The maximum precision of placement and delivery of implants and transitional prosthesis which this workflow offers is based on a titanium milled pinable foundation base guide. The custom foundation base guide is oriented over basal alveolar bone using a printed seating jig referenced to existing dentition or hard tissue anatomy prior to being pinned by 4 bicortical pins. The dentition is then removed, and the foundation utilizes several swing locking overlays that can be interchangeably applied. The overlays include reduction verification components, implant drill guides, and indexed prosthetic seating wafers.

The foundation base guide is initially used as a reduction guide for any osseous recontouring. As it is pinned only to the facial bone, it does not require the same palatal flap reflection as the earlier and bulkier acrylic guides. All implant placement is then delivered via either fully guided or partially guided approach. Fully guided approach controls for not only angulation but depth of fixture placement. Our newest C-shaped guide design has been helping to gain access to the tight posterior sites by allowing lateral tilting of implant drills into the osteotomy site.

As the milled guides are titanium, they are much thinner but stronger and less likely to be distorted. The guides are locked into the foundation guide at the back with swing lock design and in the front by a central locking pin. These features allow for great stability and rigidity of the guide but also for ease of placement and removal.

The foundation base plate guide also serves to seat an acrylic wafer that performs two functions. One is to ensure achievement of a flat plane of bone reduction and then the verification of the full seating of the transitional prosthesis. The wafer employs keyed projections that mate with internal receivers in the transitional prosthesis to achieve the planned 3-dimensional position. Once in this position, the attachment to the prosthetic support elements-based multunit abutment can be ensured with pick-up resins.

The application of this new workflow and milling technology has proven to be effective at increasing fixture placement accuracy and prosthetic positioning, all while reducing operative and conversion times. The need for occlusal adjustments is minimal and transitional prosthetics made with milled PMMA and nano-ceramics are much more compact and esthetic than traditional denture conversions.

Our post implant placement CBCT analysis has showed that fixture placement is within 0.5 mm of the desired and planned position in most fully guided sites. That is certainly a huge improvement over the free hand or partially guided approaches.

Final prosthesis is made in 4 months after fixture integration using intraoral scans utilizing custom milled scan bodies to ensure accuracy of the intraoral scan in the setting of full arch rehabilitation.

The digital workflow we are using has been developed and continuously perfected by our international digital laboratory team under expert leadership of Mr. Daniel Nowak. Daniel is an exceptional thinker and always encourages us to look for new avenues for achieving excellence and finding new solutions to clinical challenges. Our collaborative approach has been the foundation of our success and the treatment successes of our patients. This is the newest frontier for us but certainly not the last frontier.
Second Molar Impactions

A lthough I look back on my own experiences with dentistry, I cannot help but feel there is a trend toward earlier orthodontic treatment. This is distinct from a two-phase approach where phase one is growth modification and phase two is leveling, alignment, and coordination of the arches.

It seems that patients are completing orthodontic treatment at a younger age than when I was in high school 30 years ago. I recall having bicuspid and third molar extractions when I turned 15 and getting my braces off 18 months later after passing my driver’s license test.

Now, many patients start orthodontic treatment at ages 10, 11, or 12, and finish before the end of junior high. This early treatment can create an interesting situation when second molar eruption is delayed and there is insufficient arch length. The primary etiology of second molar impaction is thought to be inadequate space between the distal of the first molar and the ascending ramus. It can be expected that the space between the ascending ramus and distal of first molar will increase an average of 4-5 mm from age 13 to 18.1 Interestingly, orthodontic literature has found a 10-20 fold increase in second molar impaction with the use of lingual holding arches to maintain the E-space in the mixed dentition.4 (E-space is the difference in the mesiodistal width of deciduous second molar and permanent second premolar which is 2.3 mm in the maxillary arch and 2.5 mm in the mandibular arch.)

When contemplating treatment for impacted second molars, there are three choices: surgery, orthodontics, or a combination of the two. Surgical uprighting has the advantage of speed; however, there are increased risks of root resorption, loss of vitality, pulpal obliteration, and ankylosis.1 Periodontal complications were nonexistent in the study by Padwa et al. They found periodontal bone levels recovered very well after surgical uprighting, having probing values less than 3 mm. However, pulpal obliteration, periradicular radiolucency, and root resorption occurred 31%, 10%, and 5%, respectively. 10% of surgically uprighted second molars were subsequently extracted. Nearly half of all surgically uprighted teeth demonstrated radiographic abnormalities on follow-up; however, most of these did not have a clinical correlation that indicated a need for extraction.1

It is worth noting that in the study by Padwa et al, there were no reported cases of root fracture despite having several cases with complete root formation and severe angle of impaction. I suspect root fracture would be the first complication most surgeons would think of when discussing surgical uprighting. There are numerous orthodontic approaches to uprighting impacted second molars. Surgical exposure followed by orthodontic uprighting had the highest success rate at 71%.2 Other approaches include the placement of a temporary anchorage device or bone plate, lingual arch with a loop supra- rior to the impacted second molar, and the Bach or pole wire.

References:
MEANING IN ETHICS

Morality & Happiness - Part II

While Veatch wrote a text entitled Rational Man, there was another philosopher by the name of William Christopher Barrett who wrote a book entitled Irrational Man. Rather than support an ethical viewpoint, Barrett delves into existentialism. He mentions Aristotle as the hero of anti-Platonists. But then he remarks that “there is an existential aspect to Plato’s thought.” Of course, existentialism is hard to define, so it is not surprising that there are some ideas of existentialism that linger in a variety of writings. Veatch’s view of Aristotle’s moral theory is aligned with doing the right thing, and Barrett’s ideas go more to existentialists who see morality, or doing what a variety of writings. Veatch’s view of Aristotle’s moral theory that there are some ideas of existentialism that linger in existence. What if everything that happens is made simply for the benefit of the individual and no one else really exists. Ironically, the opposite of existentialist thought, or the idea that everything is connected instead, relies on the idea of meaningful coincidences. But what if coincidences are meaningless activities created by the individual thinker who indeed creates his personal universe? It is really difficult to prove otherwise because everyone has an individual mind. Ideas of existentialism abound and a blanket is sometimes used to explain how all human beings are connected to one another.

The idea that everyone is connected by some grand plan, and force that aligns people together, is something that is integrated into the concepts discussed. How are human beings connected? What makes them different? How can one’s personal philosophy be correct if it is not aligned with the general mode of thinking? As existentialist theory contends, people just exist and they can define that existence as they see fit. The idea is that people have free choice. They decide their own fate.

Existence is the thing that is the beginning, unlike other theories that first claim there is something more and then human beings are created. This position is reminiscent of Descartes’ notion that the proof of existence is thinking, as Eckhart Tolle’s emphasis on the idea that the thinker is just a mind and not really the soul. Either way, the human being is at the center of things. Perhaps it was the Freudian emphasis in society that would come about to change ideas. Egoism is viewed as negative. Still, the existence of the ego good or bad does provide a sense of detachment. Ironically, it also provides a sense of connectedness or humanness. Sartre seems to see the cogito as something that does not connect people.

The act of thinking, in some way, is not the answer to the problems life presents. This is clearly the opposite of the Aristotelian view that thinking, or contemplating morality, is key to a good and happy life. While the positions are clearly juxtaposed, they are also in some way congruent. That is, one can live a contemplative life, look at morality, mull things over, and still be an existentialist because of the broad interpretation of the latter position.

Existentialists are not necessarily hedonists, although the possibility is there. Still, existentialism does not really preclude contemplation. The fact that Veatch and Barrett’s book contains titles that at first appear antonymous Rational Man and Irrational Man does not mean that there is no meeting of the minds, at least some of the time. The Veatch text is useful in answering the question as to why someone should be moral. Morality is after all important in the scheme of things and allows people to have full, more satisfying lives.

Living a moral life is the key to happiness, which is not necessarily the blissful fleeting feeling one gets from indulgence, but rather a satisfaction the human feels when he or she is doing the right thing. The existentialist view does not incorporate correctness or virtue into the mix. Although individuals are making decisions in either case, there is a difference. The existentialist sees connections, but not the existence of a black and white set of codes for which the human must decipher.

Within the first two years of establishing the 501(c)(3) nonprofit in 2018, Dentistry4Vets has treated over 150 veterans in the respective offices of the volunteer practitioners. While this was a start, it was cumbersome, and it became clear that the organization needed a designated clinic to satisfy the broad goals of the organization. These goals include: 1) Quality Care for our veterans; 2) Continuity of Care for long-term, overall good health; 3) Comprehensive Care to include specialists; 4) Cost-Benefit of Care with a discounted fee schedule to assist in making the treatment affordable for most; and 5) Ease of Care because we only serve veterans – we understand them and strive to make our clinic a safe and caring environment for them.

Through the generosity of the CHOMP (Community Hospital of the Monterey Peninsula) Monterey Foundation, Dentistry4Vets now has a new clinic at the Monterey Wellness Center in Marina. The clinic is currently open three days per week providing: 1) Comprehensive dental exams with x-rays; 2) Dental treatment that includes fillings, crowns, root canals, dental bridges, and dentures; 3) Dental hygiene; and 4) Oral Surgery provided by the founders, Dr. George Yellich and his wife, Patricia Yellich.

The Mission of Dentistry4Vets is to provide quality dental care and dental hygiene to eligible veterans living in Monterey, Santa Cruz, and San Benito Counties. There are over 30,000 veterans in our tri-county, most of whom do not qualify for dental care or dental hygiene under the VA guidelines. This gap in their care has had a devasting effect on the well-being and overall health of our veteran population at large. The VA does not include dental care in the veteran benefits package unless very specific requirements are met, such as having been a POW, having sustained injuries during service that resulted in the dental care needed, and/or being permanently disabled. Most veterans do not meet these requirements and thus, are left with either no dental care or intermittent dental care as can be financially afforded.
seven had no teeth at all. This was the turning point. The presiding feedback from these seven veterans was the resulting reclusiveness that stems from having no teeth or very few. They were embarrassed to engage in society, professionally and personally. One such veteran from the Vietnam War era needed open heart surgery and could not afford the dental treatment required prior to his open-heart surgery. The solution to this obstacle was to extract all his teeth. His open-heart surgery was successful, but he was left with a very dismal existence – he no longer felt comfortable around people, including his own family, without any teeth. Eating in public was embarrassing. Applying for employment became a struggle.

This feeling of embarrassment and reclusiveness clearly is an unhealthy existence. Some suffer from depression and turn to alcohol and drug abuse. Many suffer from poor nutrition leading to other physical illnesses and conditions.

Dentistry4Vets has established a solid dental and business model to manage the needs of our veteran population. The clinic staff includes: four volunteer dentists, Dr. Yellich - the volunteer oral surgeon, Patricia Yellich - volunteer surgery assistant and clinic administrator, one paid dentist (2 days per month), and 3 staff personnel - one of whom is the office manager. A partnership with the Cabrillo College School of Dental Hygiene will soon launch, providing more days of dental hygiene. Dentistry4Vets has an established network of dental specialists. There is an office manager who ensures that all OSHA, HIPAA, Infection Control, CPR, Emergency preparedness, COVID-19 guidelines, and other required protocols are current. Safety is a top priority.

Our goal for 2021 is to achieve a 5-day per week clinic providing dental exams, treatment, and hygiene. While the clinic has a business model that aims to cover immediate monthly operating expenses with the fees collected from patients, funding is needed to cover the costs of supplies, an “anchor” dentist, and a “scholarship” program. Even with the discounted fees, there are many veterans who have no ability to pay, and for these patients we have established a scholarship program. Our budget is $3,000.00 per month for this program and these patients will require board approval for their dental treatment. An “anchor” dentist is needed to meet the demands of a 5-day clinical treatment week.

The presiding response from our patients is a very heartfelt appreciation that someone cared enough about their dental needs to do something about it! Dentistry4Vets gives veterans a sense of security and hope for their future. For more information, please visit our website: https://www.dentistry4vets.org/
BAY AREA: OMS practice in search of a associate or partner oral surgeon. The scope of practice includes dentofacial surgery, implant bone grafting and oral pathology. Applicant should have a CA license, GA permit, and malpractice insurance. Please contact via email with CV at bayarea.om-practice@gmail.com

NORTHERN CALIFORNIA: Well established and busy Oral and Maxillofacial Surgery Office in Rural Northern California looking for Full time associate leading to partnership. Practice is established over 30 years with state of art facilities with 3D CT scan. We have two offices where the senior partner is looking forward to retirement. The offices provide 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 with GA permit. Please contact Candidate should reply via email with their CV to wtsh2001@yahoo.com

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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 high volume practice capable of supporting general anesthesia with intubation and functional operating room in full operation. The ideal candidate must be a team player looking for a long-term position with the desire to grow professionally. We are seeking an individual with 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. For further information 415.285.0526

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BAY AREA, CALIFORNIA: Well respected, busy and established oral surgery practice in search of a board certified or board eligible, motivated, hard-working and efficient oral surgeon for a full time position in the Bay Area, CA. Our office provides a full scope of 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 with GA permit. Please contact Candidate should reply via email with their CV to wtsh2001@yahoo.com.

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