Early in the morning on April 6th, a group of us volunteers left the parking lot from the headquarter offices of the OFSOC and CCF with a box truck and a semi fully loaded with equipment for 70 dental stations, sterilization, dental, vision, and medical supplies, along with enough equipment for 10 vision lanes and production of 250 pairs of glasses per day. We were headed for Coachella Valley to set up our free health clinic. This would be our fourth clinic in Indio. As it turned out, it would also be our best one yet.

Why was this clinic the best, to date? Here are my top 5 reasons:

1. On October 1, 2015, Governor Jerry Brown signed into law AB 880. This bill was sponsored by Assemblymember Sebastian Ridley-Thomas at the request of OFSOC to allow California dental students, in their final year of training, the privilege of participating and providing dental treatment under indirect faculty supervision at free health clinics.

CONTINUED ON PAGE 5
WE ARE UNRELENTING IN OUR DEFENSE OF GOOD MEDICINE

We stand with doctors. When shady litigants challenge the good name of one of our members, we are fierce and uncompromising. Our powerful attorneys have well-earned reputations for unyielding defense and aggressive counter-action. Our relentless defense of the practice of good medicine is just one of the reasons we are the nation’s largest physician-owned medical malpractice insurer, with 78,000 members.

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RELENTLESS
A good name should be esteemed higher than riches

by Jeffrey A. Elo, DDS, MS

Who we are matters. It matters to us as individuals. It matters to our spouses. It matters to our kids. It matters to our patients. It matters to our staff. What is the status of your name in the circles you belong to? Would you, or others, say it is good? Do you even care how those around you view your name? I’m not talking about the actual name. There is nothing fancy about my actual name as nearly one million people in the U.S. share it. Statistically, my name is the 46th most popular first name.

I’m talking about what your name implies. When people in your community hear it what do they think of you? A good name really speaks to your integrity. It’s about your reputation and the character you have inside. It identifies who you are from a moral and ethical standpoint. Essentially, it’s what you are all about.

A well-known Proverb states that “a good name is to be chosen rather than great riches…” “Let’s think about that—a good name is better than riches. Better than all the money in the world is what people think when your name comes up. Does that seem odd or even possible? I mean I’m pretty sure that I could find some pretty positive ways to use great riches. It seems like there are often strings attached? That there might be an ulterior motive for using their money?

While that might be true, a good name, I believe, still provides more value. I can think of a few reasons why a good name is better than great riches: A good name provides stability. When you have a good name people can trust you, and that trust is a stabilizing factor in your relationship with them. They know what to expect from you and can lean on your decisions with absolute surety, knowing they were made with pure motives. Those whose good name has been tarnished have a difficult time building trust. Their motives will always be questioned as insincere. They are often seen as looking out for themselves only and taking little consideration for the needs of others. And how often do you question the motives of those who throw their great wealth around? Doesn’t it seem like there are often strings attached? That there might be an ulterior motive for using their money?

A good name is eternal. Riches are fleeting. Money could be with you one minute and gone the next. And of course we know that we can’t take riches with us once we leave this world. A good name, however, can be eternal. How many great men and women of history are still being spoken of in a positive light? Wouldn’t you agree that you know more people of history for who they are and what they did rather than what they owned or how much money they had? Wouldn’t it be special if that could be you? How will your legacy be remembered and portrayed by family, friends, or colleagues once you are gone? Will they focus on the value of your good name or only remember that you cared about money? One of those will provide fonder memories and produce more positive future dialogue than the other.

A good name brings loving favor. The ending phrase of the above mentioned well-known Proverb continues with “...loving favor rather than silver and gold.” As we are to seek a good name instead of riches, so we are also to seek loving favor over riches. And I can think of no better way to garner loving favor than to have a good name. People will favor you for having integrity. They will appreciate you for showing kindness, mercy, and attention to their needs. They will stand up and support you when you are bombarded with unwarranted attacks.

And let’s be honest...wouldn’t we all prefer to be favored first and foremost? Riches we could live without. A life that doesn’t experience favor would be devastating. Riches are not evil and there is nothing wrong with having them. But a good name is better than riches—that all the riches of the world. It provides more value in the present and the future. Do you need to start working on yours today?
Dr. Leonard M Tyko II, DDS, MD, FACS

OFSOC is confident that OMS deliver anesthesia safely. The evidence shows this - as does our long history. Dentistry is the pioneer of pain and anxiety control.

A great deal of work lies ahead of us. Though we have an anesthetic model with an exemplary record, we face confusion within the legislature, with many of our medical colleagues, and with the average citizen about who we are and what we do. If we are to maintain the ability to care for our patients, we must also maintain our anesthetic abilities. If the Dental Practice Act changes, as some would desire, we will be forced to adopt the medical model of anesthesia. Imagine if all of your patients who require sedation or general anesthesia are funneled into the medical system.

Imagine how unprepared the medical system will be to care for so many more patients. Imagine the skyrocketing costs and the delay or refusal of care. Imagine the catastrophic effect on oral health in your communities.

Members of OFSOC, this is a call to action. We need each of you to rally to protect the autonomy of dentistry and the autonomy of your specialty. Please make appointments to speak with your state assembly member and senator. Endeavor to educate them about who we are, how we are trained, and our safety record. OFSOC can provide you with talking points and scripts. And once you’ve done that, call other dentists in your area and ask them to advocate on our behalf as well. It is only through a loud and united effort that we can make our voices heard.

Respectfully yours,

Leonard M Tyko II, DDS, MD, FACS
Fellowship in the American College of Dentists is by invitation and is based on a proven, confidential, peer-review system that has remained intact since the inception of the College in 1920. The College was founded by the president, vice president, and secretary of the American Dental Association (then called the National Dental Association) and by the president of the National Association of Dental Faculties (forerunner of the American Dental Education Association). At the time of its founding, dentistry was plagued with a variety of problems, particularly in the areas of education, journalism, and research. The College was specifically conceived “to elevate the standards of dentistry, to encourage graduate study, and to grant Fellowship to those who have done meritorious work.” Fellowship was specifically conceived “to elevate the standards of dentistry, to encourage graduate study, and to grant Fellowship to those who have done meritorious work.” Fellowship was bestowed only if the accomplishments of the nominee are truly outstanding and epitomize excellence.

Congratulations, Fellows, on a job well done! OFSOC is proud of you!

MEANING IN ETHICS

While preparing for a lecture involving Kantian epistemological ethical decision making, I had a moment of anamnesis triggering reflection on the ‘meaning’ in medicine. Most of us recall reading Frankl’s ‘Man’s Search for Meaning’ while in college; the same philosophical principles can translate to medicine which has historical roots, including epistemology, ontology, metaphysics, and, more recently, bioethics. According to Plato, anamnesis is the closest that human minds can come to experiencing the freedom of the soul prior to its being encumbered by matter. Health care clinical ethics can be viewed through the prism of the anamnesis of meaning, not only for medicine per se, but, more importantly, for ethical decision making itself.

Moral reflection, especially in the existentially charged realm of clinical ethics, does not necessarily begin with the application of normative principles, nor can it be sustained by an attitude of resignation strictly toward the pursuit of ‘the good’; rather, it begins with a free and open confrontation with the meaning of the experiences we all face as a continuum in day-to-day life. Attending to the moral meaning of concrete situations entails recognizing that formal modes of logical argumentation are only derivative functions of the moral language; thus, an ethicist’s involvement is a work of ongoing circumstantial understanding.

Clinical ethics can also be viewed as a form of mindfulness that impels the practice of medicine towards its own telos; to wit, the ends to proper ethical decision making. Because it articulates the ends of medicine in the context of a communal ethos, with attendant needs, values, and priorities, clinical ethics is perhaps better understood as a function of critical analysis that borrows from the anthropological and epistemological milieu in which it operates.

Therefore, the function of clinical ethics can be viewed as articulating a commitment to the search for ‘meaning’; a search that is hindered by the limited vision of positivist natural sciences, and by excessive preoccupation with normative dimensions. The former is a recurring temptation of medicine, most visible, of late, in discussions regarding, for example, aid-in-dying and genetic research. It is not enough to keep such a conversation open to the latest normative integration in an endless exercise of reflective equilibrium if this paradigm fails to address the deepest matters of humanity. Indeed, without an appreciation for the profound nature of humanity and meaning, one will not be able to fully comprehend how caring is an integral part of medicine when caring is not an option.

According to philosopher Edmund Husserl, “Fact minded science excludes in principle precisely the questions which man finds the most burning: questions of meaning or meaningless of the whole of human existence.” Similarly, bioethicist Leon Kass insightfully opined that “Brilliant moral theories might come too late, when ethics has already lost its soul.” My message is that we should be mindful that strategies for solving moral problems need to be addressed beyond the scope of normative principles and, in fact, rely on the larger questions of humanity and ‘meaning’.

The Relevance of ‘meaning’ in Clinical Ethics

by Richard Boudreau, MA, MBA, DDS, MD, JD, PHD

“Brilliant moral theories might come too late, when ethics has already lost its soul.”

NEATEST ACD FELLOWS

Oral and Facial Surgeons of California congratulates its newest ACD Fellows!

On November 5, 2015 in Washington, D.C., the American College of Dentists inducted into Fellowship the following OFSOC members:

• John M. Allen, DMD, FACD (Pomona)
• Simona C. Arcan, DMD, MD, FACD (Huntington Beach)
• Charles D. Hasse, DDS, FACD, FICD (Irvine)

Fellowship in the American College of Dentists is by invitation and is based on a proven, confidential, peer-review system that has remained intact since the inception of the College in 1920. The College was founded by the president, vice president, and secretary of the American Dental Association (then called the National Dental Association) and by the president of the National Association of Dental Faculties (forerunner of the American Dental Education Association). At the time of its founding, dentistry was plagued with a variety of problems, particularly in the areas of education, journalism, and research. The College was specifically conceived “to elevate the standards of dentistry, to encourage graduate study, and to grant Fellowship to those who have done meritorious work.” Fellowship was not designed to circulate honors among a small clique.

Fellowship in the American College of Dentists is a distinct honor and it is often the high point in a dental career. Only about 3.5% of dentists in the United States have been granted Fellowship in the College. Fellows of the American College of Dentists truly are an elite group. Fellowship is bestowed only if the accomplishments of the nominee are truly outstanding and epitomize excellence.
Legislative Update

O

The California Journal of Oral & Facial Surgeons

OFSOC joined with CDA, California Medical Association, and other provider groups to oppose the current version of the bill. OFSOC asked AAOMS president Dr. Lou Rafetto to come to California to speak in opposition of the bill in this form. Dr. Rafetto, along with OFSOC president Len Tyko, met with many members of the legislature. These meetings were very beneficial in educating the legislators on the complexities of the current practice of oral and maxillofacial surgery in California. This proved to be necessary and very timely due to an Assembly bill moving through the legislature, AB 2235 (Thurmond).

AB 2235 (Thurmond) is a bill that was introduced at the request of a family whose six-year old son tragically died while under anesthesia in the office of an oral and maxillofacial surgeon (OMS). Originally, the intent of the bill was to require two anesthesia providers in the room while an OMS performed any procedure requiring anesthesia. The bill was originally introduced to require the Dental Board of California to create a committee to evaluate the use of anesthesia by dental professionals and report back to the legislature. OFSOC supported that version of the bill. However, the family of the young boy wanted more and the bill was amended to require an informed consent form language and with a more robust data collecting process by the California Dental Board.

While the bill passed with more moderate provisions, it is very evident that there are many healthcare providers who would like see the current oral and maxillofacial surgery team anesthesia delivery model altered. This was made clear by testimony at the Assembly hearing. At the time of this writing, AB 2235 (Thurmond) is moving through the Assembly with the requirement that a comprehensive study of the dental professions’ delivery model of anesthesia to juveniles be completed before any scope of practice changes be enacted. That is the strong position of OFSOC. However, as the bill continues to move, the bill could change in an undesirable way and OFSOC will continue to be very engaged.

SB 994 (Hill) specifies that a covered licensee, which includes dental professionals, must adopt and implement an antimicrobial stewardship policy before applying for a renewal license. This policy is defined as efforts to promote the appropriate and optimal selection, dosage, and duration of antimicrobials for patients. The stated goal of the bill is to reduce antimicrobial overuse and misuse and minimize the development of antimicrobial-resistant infections. OFSOC will continue to monitor this measure as it moves forward.

AB 533 (Bonta) remains a “well intentioned” bill sponsored by several of the healthcare insurance plans with the stated goal of addressing the long-standing balance billing issue. Under the balance billing scenario, patients may receive unexpected billing amounts after receiving care at a facility that is part of their insurance plan’s network but from an out-of-network provider who contracts with the facility. OFSOC, along with CDA, continued to watch this bill until the last week of the session last year. Amendments added to the bill over the Labor Day weekend would have limited payments over the Labor Day weekend would have limited payments to Medicare rates for out-of-network providers. In addition, providers would be required to adhere to a dispute resolution process that has yet to be determined to collect additional payments. AB 533 would apply to dentists and OMSs practicing in hospitals, surgery centers, or offices that provide care under general anesthesia. The Medicare rates amendment raised enough concerns, particularly in the dental care arena, that OFSOC joined with CDA, California Medical Association, and other provider groups to oppose the current version of the bill. Ongoing discussions continue among the stake holders, including OFSOC, to get the bill into an acceptable position.

OFSOC Day at the Capitol

On March 2, 2016, several members of the OFSOC board of directors and legislative committee, along with Mr. Gary Cooper (lobbyist for OFSOC) and Executive Director Pam Congdon, convened in Sacramento to meet with several key state legislators. The purpose of the day was to introduce ourselves as a specialty and an organization, and to educate lawmakers on our training, standards, and everyday practice. The day’s busy schedule included meetings with the following Assemblymembers and Senators:

- Assemblymember Sebastian Ridley-Thomas (D-Los Angeles)—the author of OFSOC’s AB 880 which was signed into law on October 1, 2015
- Senator Ed Hernandez, OD (D-West Covina)—Senate Health Committee Chairman
- Senator Jerry Hill (D-San Mateo)—Senate Business and Professions Committee Chairman
- Senator Hannah-Beth Jackson (D-Santa Barbara)
- Assemblymember Matt Dababneh (D-Van Nuys)
- Assemblymember Jim Wood, DDS (D-Eureka)—Assembly Health Committee Chairman
- Assemblymember Dave Hadley (R-Torrance)
- Assemblymember Marc Steinorth (R-Rancho Cucamonga)
- Assemblymember Marc Levine (D-Santa Rosa)
- Assemblymember Tony Thurmond (D-Oakland)
- Assemblymember Susan Eggman (D-Stockton)
- Assemblymember Mike Gatto (D-Burbank)
- Senator Hannah-Beth Jackson (D-Santa Barbara)
- Assemblymember Matt Dababneh (D-Van Nuys)
- Assemblymember Jim Wood, DDS (D-Eureka)—Assembly Health Committee Chairman

Save the Date

2017 January Anesthesia Meeting
January 14 & 15, 2017
Claremont, Berkeley

Speakers:
Norman Betts, DDS, MS
Kathryn Rouine-Rapp, MD
 Gurpreet Dhallawal, MD

www.ofsoc.org

OFSOC legislative committee chair Jim Jensvold, OFSOC lobbyist Gary Cooper, president Len Tyko, president-elect Alan Kaye, and vice president Jeff Elo pause to take a photo in the state capitol rotunda.
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Incorporating digital intraoral scanning technology into surgical implant practice
by Peter Krakowiak, DMD, FRCD(C)

Every few years I find that we inevitably introduce new technology into our practices, and after several years the new technology becomes both a routine and an indispensable part of our everyday operations. This is not to say that it is always a seamless process. The typical tribulations of most new technology implementation are usually the initial financial expenditures, especially if you are one of the early users in the market, the ongoing and recurring need for training of operators and support staff, and connecting the capabilities of the technology into a therapeutic collaborative with our referring doctors. The cost issues of new technology usually become less pronounced after the first two to three years after product entry as competition for the marketplace quickly occurs and multiple vendor companies will rapidly provide similar products and technology. The second hurdle is likely the most difficult to overcome as it truly does take the commitment of the entire team to embrace the new technology. Surgeons, assistants, ancillary support staff have to be enthusiastic, motivated, and excited with the implementation strategies and show commitment to getting the technology in place. No small task at hand. Finally, getting our referring partners to take advantage of the technology was the staff/operator need to take traditional impressions is over 10 minutes per case, not including the time generated to set up, pour, set, trim, and mount the models. 

Currenty, my new scanner-based impression appointments involve an easy setup of my plug and play scanner wand into any of my workstations' dedicated gaming-caliber laptops. Having 4 office locations, my scanner readily travels with me and can easily go from operator to operator in a small hand-gun-sized case. Since the scanner is powderless there is no need for dusting which is a huge plus when working in surgical fields.

The first CBCT imaging device we purchased in 2002 was a Carestream product and they were not alone. We were one of the early implant fixture compatible scanners in 2011. The early players included Biomet Embed, Lava COS from 3M, iTeero from Cadent, IOS FastScan, Sirona’s Cerec, and newer True Definition from 3M, E4D Dentist from D4D Technologies and Carestream CS3500, amongst the few. Early versions of the systems were priced upward of $45k (so around a baseline Ski Nautique boat).

In 2006 as now an OMS owner/practitioner I started with my CBCT imaging collection (at $180k it was my first “pre-owned” Ferrari 512TR that I did not buy). Since then I have acquired two additional CBCT scanners in 2013 and 2015 for our new satellite offices. These were a bit less costly by that time ($58k so maybe an E class Mercedes and the other for $55k or a 5 series BMW). Then in 2007 we added implant-based CBCT-guided surgical implant planning.

In current OMS practice, the optical scanners allow us to get intraoral impressions technology appeared on the dental market in 1997 with Siemens and Cerec. Having learned from my CBCT purchases I waited till early 2015 to get some skin in this game as I wanted to have some better and more cost effective options to choose from. I started looking at the early implant fixture compatible scanners in 2011. The early players included Biomet Embed, Lava COS from 3M, iTeero from Cadent, IOS FastScan, Sirona’s Cerec, and newer True Definition from 3M, E4D Dentist from D4D Technologies and Carestream CS3500, amongst the few. Early versions of the systems were priced upward of $45k (so around a baseline Ski Nautique boat).

When it comes to buying things for the office, I like to price items in terms of things I could have bought with the same funds but did not. Fortunately, the price point is now south of $15k for even the more advanced scanning systems. When choosing my system I wanted an open platform scanner which was free to work with all premier implant systems and all commercial milling sites so that I would not be limited to any one specific implant line by my scanner. I wanted something that would not charge me for each product use or have maintenance fees up the wazo. Also, I waited for refinements that would allow for much faster scan times, the smallest camera size, defogging capabilities, portability of the unit to multiple work stations, smaller unit/CPUs size, and the ability to capture structures without “dusting” in the normal wet/humid intraoral environment. I also looked for a scanner that would be most compatible with my existing CBCT software. I finally settled on a Carestream product CS3500.

Part of my decision was course based on already owning two of their CBCT scanners and having great support and software familiarity with Carestream software. The company has so far provided us with tremendous support and repeated a la carte training of our team for the past year (all-inclusive in the product price). This ongoing chairside support feature has been critical to us being able to implement the technology since its capture involves all of our team members. Also, as new members joined our team they had access to this training opportunity as well, courtesy of our Carestream representative.

In current OMS practice, the optical scanners allow us to get cost effective, rapid, and highly precise renditions of soft tissues, dental structures, and implant position circumventing the need for traditional elastomeric PVS, polyether, or alginate-based impressions and stone cast modalities. The scanners, together with all the ongoing updates and advances. Choosing someone that has years of experience with early CAD/CAM technologies such as John, has been paramount to our success in incorporating the new scanner data acquisition into the surgical implant practice mix. His sound knowledge and ability to communicate with our entire collaborative care team, especially our restorative team, has been invaluable.
Currently, our typical scans are mostly used to generate custom restorative abutments and milled screw-retained restorations. I will briefly present a simple single unit case to illustrate the basic workflow which can also be similarly applied to a multi-unit case or even a full arch restoration with small adaptations for occlusal coupling.

Essentially, just as with stone models, we will generate two virtual soft tissue and teeth models of the areas of interest. For most single unit restorations we aim to capture at least three teeth (facial, occlusal, and lingual) on either side of our implant fixture and the majority of soft tissues extending on the facial into the vestibule. We then will capture the opposing dentition and facial soft tissues in the corresponding sextant. Our staff will perform this part of the data acquisition in most cases (Figure 1). Once the scans are completed, a bite relationship capture is made which relates the arches and occlusal schemes of the two virtual segment models together. This occlusion/bite registration is completed by the doctor to ensure the highest precision of record. In my experience, this modality of bite correlation is much more accurate than traditional wax owlers or flowable bite registration material technique as the exact fit of the bite is directly verifiable and maximal intercuspation is readily visible without impression materials in the way of our eyesight. Also patients are most intercuspated without intervening materials this way.

If the virtual model is to be made ahead of surgical placement, the digital impression can be sent to the lab or to an in-office milling unit to manufacture the planned surgical guide, abutment, temporary, or even the final restoration. Alternatively, it can be used to plan the implant position as well as the abutment on non-immediate load cases. To capture the implant position the technique requires two separate scans. The initial scan will visualize the soft tissue contour of an exposed implant with its tissue molding/healing abutment removed. The immediately captured sulcular contour image will provide the lab with the desired emergence profile information for the abutment/restoration contours as they were developed by the healing abutment. Alternatively, these images can be altered in CAD/CAM design software rendition of the restoration if needed during production to change the desired tissue contour. Subsequent to the initial image capture, a system specific scan body (Figs. 2 and 3) is placed into the implant for a second scan of the site (Fig. 4). This part of the process is completed by a licensed dentist as it is analogous to the final impression (Fig. 5). A shade selection is taken to assist with restoration of the site (Fig. 6). It is important to use scan bodies that are manufacturer specific and can be readily identified by third party software used by the milling labs (Fig. 7). Some labs can supply you with their preferred implant scan bodies. They can be sterilized and used several times, further reducing the cost of providing this service. Once the scan body is captured with the scanner, the software will then marry the image of the scan body with the initial virtual scan of the arches in their articulated setting (Fig. 8). The files are then approved by the restorative practitioner and can be utilized in the exchange to plan the subgingival connecting elements of the abutment (Fig. 9) and restoration (Fig. 13). From there the standard CAD/CAM process is completed and the

models, abutment, and/or crowns are milled or printed (Fig. 14). In some cases labs can create virtual models of tissues and implant connections and then use this hybrid approach to design and/or fabricate any components in standard lab top fashion, if so desired. The traditional layered ceramic restorations may still be desired by some in high esthetic demand cases.

In our community, many of our referring GP doctors already have a vast expertise with the use of Cerec milling technology and have been using the Cerec scanners to mill their inlays, onlays, and crowns for well over a decade. They have also been able to scan prefab and custom abutments and crown crowns over these components over the past several years (Figs. 15 and 16). Most recently, with the introduction of implant specific titanium connected zirconia milling blocks for custom abutments, they have also been able to use technology to mill all prosthetic based components and crowns in their own offices. Even multiunit restorations are possible with the newer Cerec machine paradigms.

Not all offices and doctors, however, have embraced this technology and we still have the ability to assist the other restorative practitioners with the delivery of advanced prosthetic and implant care in the virtual paradigm to their patients using our own scanners. We are always relying on our partner laboratories to provide the milling/casting and crown restoration fabrication capabilities which employ optimal collaboration and will result in the highest caliber of outcomes for their referred patients. The optical scan is now also a base for developing occlusal appliances, surgical guides, and orthognathic splints in our practice. The scans are capable of registering arches for denture fabrication and tray fabrication for aligner-based orthodontic therapy.

Virtual study models do not occupy room on shelves and are not subject to chipping when moved around. Of course as anything in digital media they are prone to file loss or corruption if not stored properly. Since there are multiple companies in the market place there is always some concern about compatibility. However the majority of systems use an open platform STL file analogous to DICOM files for CT scanners which allow for extrapolation and application of the data in numerous settings and third party software applications. The savings in materials, staff time, two-way shipping costs, and improvement in accuracy of the working models is significant when using digital impressions. The elastomeric impressions can always be distorted, are subject to time-based deterioration, and stone model materials experience setting and thermal distortions as well. These are not the case with digital impressions. Recent literature on the use of digital fixature level impressions in implant cases has shown them to be superior to the traditional open tray and closed tray impression techniques. With a lot of products on the market this may be a very good time to consider adding optical scanning capabilities to your practice if you have not done so, or implement them now if you have had this technology on board but have not implemented it to its full potential.
The news made national headlines: Hollywood Presbyterian Medical Center’s computer systems were down for more than a week as the Southern California hospital became yet another victim of ransomware—an attack where a business or individual’s computer system is held hostage by cybercriminals until a ransom is paid. Hollywood Presbyterian Medical Center ended up paying $17,000 to restore its systems and administrative functions.

Once ransomware is in your medical practice or hospital system, there are only three basic options:

1. If you have performed frequent backups, restore your system.
2. If you have not performed frequent backups, pay the ransom.
3. Put your system back to the default setting—and lose everything.

If before the attack you’ve performed incremental backups, you can restore the areas affected, with minimal data loss (for example, an hour). If you have point-in-time backups, you can restore with increased data loss (for example, a week). If you have no reliable backups, you can reset the technology back to its “out-of-box,” or default, state and lose all the data, if no paper records exist. The only other option would be to pay the ransom.

Besides loss of business, inconvenience to patients, and damage to reputation, a ransomware attack also poses liability risks. The possibility of adverse events and subsequent claims for professional negligence increases when computerized systems necessary for various functions such as CT scans, documentation, lab work, and pharmacy needs are offline. If hospital systems are down for any significant period of time, certain patients should be transported to other hospitals.

Adverse events can occur when healthcare workers do not have access to EHR systems. However, if this type of case was litigated, the patient would have to prove that something in the records may have had a bearing on the treatment being provided. In the case of emergency care, the claimant would have to successfully argue that the staff should not have undertaken the care until the medical records could be accessed.

Hospitals, medical practices, and businesses should take full precautions to prevent a hack that results in ransomware being installed. Prevention strategies include:

• Provide security awareness for all employees. Over 80 percent of attacks are made possible by human error or human involvement. Train staff members to avoid downloading, clicking on links, or running unknown USB on computer systems.

• Block the malware at the firewall, by using intelligent firewalls to stop the malware from downloading.

• Install intrusion detection software to monitor illegal activities on computer networks.

• Stop the malware from executing on desktop computers by installing application whitelisting software, anti-virus, or anti-malware.
There’s an App for That: Benefits and Risks of Using Mobile Apps for Healthcare
by Robin Diamond, MSN, JD, RN, Senior Vice President, Patient Safety and Risk Management, The Doctors Company

With over 100,000 mobile health apps now available—in addition to many new tools that allow physicians to remotely monitor their patients’ conditions—physicians now have to handle an increasing amount of constant data and patient information that they did not have in the past. Patients are using mobile apps to monitor their activity levels, track weight loss, improve medication adherence, and even track their blood pressure or blood sugar levels. Only 16 percent of healthcare professionals currently use mobile apps with their patients, but 46 percent plan to do so in the next five years.¹

Mobile apps offer many potential benefits to doctors and patients:

- Mobile apps can help patients self-monitor their conditions and alert them and their physicians to problems before they become serious medical issues.
- Some of these apps are regulated by the FDA. For example, patients can monitor their heart rhythms with an FDA-approved device that wraps around their iPhone.
- Mobile apps can be a tool for patient education:
  - A better-informed patient is more likely to understand risks and, if there is an adverse event, may be less likely to file a lawsuit.
  - Mobile apps help patients remember important information about their healthcare. Patient pamphlets and other educational materials are often lost or forgotten. Patients forget 80 percent of the information they are told and inaccurately remember an additional 10 percent, leaving patients with just 10 percent of the information remembered correctly.
- Mobile apps can engage patients in their healthcare:
  - Many patients today are interested in becoming as involved in their care as possible.
  - One patient engagement platform that connects patients and physicians, Healthloop, markets its FDA-approved device that wraps around their iPhone.
- Mobile apps can help patients self-monitor their conditions and alert them and their physicians to problems before they become serious medical issues.
- Some of these apps are regulated by the FDA. For example, patients can monitor their heart rhythms with an FDA-approved device that wraps around their iPhone.

However, these apps bring with them many potential risks and limitations. They have not yet seen malpractice suits that involve mobile apps because the use of these apps to monitor patients is fairly new. Malpractice lawsuits may not be filed for several years after the adverse event, so with the increased use of mobile apps for healthcare, we expect there will be lawsuits involving mobile apps in the future.

Physicians could face allegations of failing to educate the patient/family about the risks and limitations of the app or failing to act appropriately if the app goes offline or malfunctions. Product liability, negligence, contract law, and even malpractice tort law could be applied to possible causes of action in lawsuits brought because of an injured connection to use of a mobile app. Injuries could occur if:

- The physician receives information from a mobile app and does not act on this information. Physicians have a legal duty to review real-time data directly from the patient and respond. Mobile apps raise patient’s expectations of how a physician will act—the patient/family expect that the physician’s response “within a moment’s notice.” When an adverse event occurs, if a patient believes the physician failed to act on information from a mobile device, the patient might sue. If physicians don’t respond to information from an app, this will be recorded in the metadata, which can be used in court.
- The readings received from a mobile device are wrong and is prescribed based on the wrong data. There are a lot of untested apps on the market that may be unreliable or even dangerous. Apps are also vulnerable to being hacked, resulting not only in potential loss of personal health information (PHI) but also in potential malfunctioning of the app.
- Patients rely on technology alone, leading to decreased phone contact with the physician when symptoms arise or there are changes in the condition that require immediate action.
- These apps can be useful tools to support a comprehensive care plan, but physicians need to be knowledgeable about these apps so they can educate their patients about the apps’ limitations and potential risks.

Consider limiting your patients to one mobile app that you agree to monitor. This will make it easier to control the incoming data and help make the best use of the app. Other important considerations include:

- Consider whether the two-way communication between you and your patient is secure and, therefore, HIPAA/HITECH compliant. Ask the vendor for assurance that the app is HIPAA-compliant and that data is encrypted for security.
- Know the app:
  - Vendor information, such as updates, downtime, and critical value alerts.
  - How will it interface with your EHR?
  - Is the device regulated by the FDA as a medical device?
  - Will you get alerts by e-mail or a phone call from the vendor when the app isn’t working?
- Beware of the possibility of lack of security when using public Wi-Fi with the app.
- Clearly communicate and educate the patient/family about the purpose of the app and how and when the data is transmitted to the clinician.
- Avoid assuring the patient that the app will “take care of everything.” Educate the patient/family about the limitations of apps, with specific examples of instructions for the patient to follow. For example, can the algorithm be changed for specific patient needs?
- Identify a contact person within your organization to troubleshoot and be available to address technical problems.
- Have the patient/family sign a consent form that describes the risks, benefits, and purpose of the app.
- Do not do this alone! Avoid utilizing medical apps without support from your organization.

References

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THE CALIFORNIA JOURNAL OF ORAL & FACIAL SURGEONS
Upcoming CE Events

2016 Meetings
- ACLS - Solano October TBD
- OMSA Fall 2016 - Foster City October 15 – 16
- Medical Emergencies - Southern CA TBD November 2
- January Anesthesia Meeting - Berkeley January 14 – 15
- 17th Annual Meeting - Anaheim May 6 – 7

2017 Meetings
- January Anesthesia Meeting - Foster City TBD
- OMSA - Southern CA TBD
- Medical Emergencies - Solano TBD
- 22nd Annual Meeting - Berkeley January 14 – 15
- 9th Annual Meeting - Anaheim May 6 – 7
- 18th Annual Meeting - Berkeley January 14 – 15

Events

PRACTICES FOR SALE

LOS ANGELES: Upscale Los Angeles area OMS practice available for sale with transition. Collections average $570K/yr. on 3.5 days of services per week of services. +/- 1,700 sq. ft. office contains 2 Exam, 2 OPs. Interested parties please contact Brady Price & Associates @ 925-935-0890 or email cvp@bradyprice.net.  All inquiries strictly confidential.

SILICON VALLEY: OMS practice available for immediate sale in highly regarded Silicon Valley suburban community. Full scope practice collects approx. $1.2 Million/yr. on 4 days/wk. Seller will assist after sale as requested. Interested parties please contact Brady Price & Associates @ 925-935-0890 or email cvp@bradyprice.net.

LOS ANGELES: Los Angeles area OMS practice seeks full-time associate / future partner to join highly productive and modern two office based OMS practice commencing summer 2016. Desired candidate is board certified/eligible with motivation and interpersonal skills to complement surgical abilities. Interested parties please phone Brady Price & Associates @ 925-935-0890 or email CV to scott@bradyprice.net. All inquiries strictly confidential.

Placerville: Solo Oral and Maxillofacial Surgery practice seeks Board Certified, eligible Oral and Maxillofacial surgeon. Well established and growing OMS practice in Placerville (Northern California) looking for a Part-Time associate. Our office is mostly focused on dentoalveolar surgery with special emphasis on dental implants. The practice has experienced tremendous growth and will be continually growing. This is an excellent opportunity for a motivated surgeon who wants to excel in private practice. The compensation is competitive. Please email qualifications to placervilleoral surgery@gmail.com

Dixon: Thriving full scope group OMS practice seeks single/dual degree surgeon for associatehip leading to potential opportunity to purchase practice. Current opening is 2 days per week with potential opportunity to expand. Ideal candidate must have strong communication skills and quality surgical training. Contact Dr. Tyler Nelson DMD MD Email: nelsonimplants@gmail.com

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Representing Sellers and Buyers Call For A Consultation (925) 935-0890

Over 150 OMS References Available

ASSOCIATE/PARTNERSHIP OPPORTUNITIES

CALIFORNIA: Full time position with opportunity for buy-in. Position includes two practice locations. Clear Choice Dental is located in San Jose and our private practice is located in beautiful Santa Cruz. Full scope practice specializing in Orthognathic surgery, implants and wisdom teeth. Please e-mail resume to Dr. George M. Yellich at gmyel1@aol.com, or call Dr. Yellich at Clear Choice Dental (408) 556-9587, or Santa Cruz Oral and Maxillofacial Surgery at (831) 475-0221.

SILICON VALLEY: Job opening for associatehip with buy-in opportunity for the right person. A very well-established 30 year old practice in the heart of Silicon Valley (San Jose area). Requires a gentle, caring surgeon with an emphasis toward quality patient care. We are focused on wisdom teeth, dentoalveolar, bone grafting, and implant surgeries. Send CV to: wayneichikawaddis@sbcglobal.net

TESTS: We offer an excellent opportunity for a board certified/eligible surgeon to join our well-established, well-respected, full scope modern Oral and Maxillofacial surgical practice. We are seeking a full time, energetic and motivated surgeon, who is personable and caring with excellent communication and interpersonal skills, who wants to practice a full-scope of oral and maxillofacial surgery. Our practice, established over 20 years ago, has a very wide referral base and is considered a cornerstone in the dental community. For more information about our office, please visit our website at drjeffreyleemddmd.com. If you would like to be part of an elite OMS practice, please contact Beth Bushling @ br@drfeylems.com.

Los Angeles: Los Angeles area OMS practice seeks full-time associate/future partner to join highly productive and modern two office based OMS practice commencing summer 2016. Desired candidate is board certified/eligible with motivation and interpersonal skills to complement surgical abilities. Interested parties please phone Brady Price & Associates @ 925-935-0890 or email CV to scott@bradyprice.net. All inquiries strictly confidential.

Looking for PT Work: Retired OMS Seeking Part Time OMS Job Between San Francisco and Sacramento. Oral and maxillofacial surgeon with 40 years of experience in private practice seeking part-time job. Grad of UOP and Highland Hospital. Reason, full time retirement is boring. Experience includes teaching at Highland Hospital. Contact John Kiesselbach at (530) 613-7833 or email jkiesselbach@gmail.com

WOULD LIKE TO BUY

Looking To Buy: Are you looking to buy an OMS practice? Place your ad here by emailing steve@calaooms.org.

EQUIPMENT FOR SALE

ATTENTION: New or established oral surgeons looking to develop an independent contractor PT work; equipment and instruments packaged to travel and guidance to get started. Excellent way to generate income as starter with no serious overhead expenses. Call retired OMS at 650-544-5297 for more information.
OMSGlobal™ is the only liability insurance program designed specifically for oral and maxillofacial surgeons, and it's only available from OMSNIC. Since OMSNIC is owned by OMS, member claims are overseen by practicing OMS. Claims defense is aggressive and effective. OMSGuard has three essential components: the OMSGuard Professional Liability Policy, OMSGuard Claims Defense, and the OMSGuard Risk Management Program. Get the standard of excellence in OMS practice protection, 800-522-6670.

Photo: Monty C. Wilson, DDS, board certified OMS at Ratner & Wilson DDS, Orange and Santa Ana, California