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The Compass
Staying the Course Through Service and Education
Volume X, Issue 3, Fall 2008

Larry J. Moore, DDS, MS Wins Race for AAOMS Vice Presidency

Dr. Larry J. Moore, of Chino Hills, California and our most recent District VI Trustee, was elected Vice President of the American Association of Oral and Maxillofacial Surgeons at the AAOMS Annual Meeting in Seattle, Washington on Friday September 19, 2008. Dr. Moore defeated Dr. Lanny Garver of Florida from District III. Dr. Moore will ascend to the AAOMS Presidency in 2010 - 2011. Larry will become only the seventh OMFS from California to serve as AAOMS President since 1918. Previous Californians who have served as AAOMS President were: Frank L. Warren - 1923; Stanley Rice - 1955; Lyall O. Bishop - 1962; Bernerd C. Kingsbury, Jr. - 1971; Terry W. Slaughter - 1978; and Elgan P. Stamper - 2004.

Dr. Moore identified four areas which he believes face immediate and persistent challenges to the ongoing success of our specialty: research, education, advocacy, and legislation. In his well received speech to the AAOMS House of Delegates at the "Meet the Candidates Forum," Larry outlined his strategies for dealing with these challenges. The full text of Dr. Moore's excellent speech may be found on the CALAOMS website at www.calaoms.org.

Larry is now busy performing his duties as AAOMS Vice President. His duties include: assisting and supporting the new AAOMS President, Dr. R. Lynn White of Austin, Texas and Dr. White's goals for this next year; serving on the AAOMS Board of Trustees and Executive Committee; functioning as

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Compass Direction

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* Northern California Society of Maxillofacial Surgeons
* California Society of Oral and Maxillofacial Surgeons
* Southern California Oral and Maxillofacial Surgeons

Editor's Corner

Leonard M. Tyko, DDS, MD
Editor of the Compass

I LIKE BEER!

I like beer. Now, least you think your humble editor has a drinking problem, allow me to elaborate. My beer consumption is limited to family visits (especially with my dad), BBQ'ing, and those occasional nights out with the boys. I also enjoy a beer at the end of a tough day, or with a nice meal, or simply to prevent a good bottle of beer from aging past its prime. Mind you, we are not talking about binge drinking, watered-down, lowbrow, mass-produced pilsners. I am not a Bud-man. Rather, I liken myself a connoisseur of well-crafted brew. I especially enjoy a good India Pale Ale (IPA). The hopp-ier the IPA the better. Right now, I'm imagining the wonderful freshness and slight bitterness of the hops balanced off with just the slightest sweetness of the malt. Body counts a lot, too. Thin, flimsy, watery beer never packs enough initial flavor and always finishes disappointedly. I waste no belly fat on drinking them.

It turns out that Northern California is more than a great place for wine; it also is a great place for beer. I'm certain you all recall Fritz Maytag, the great grandson of the appliance manufacturer, who rescued the Anchor Brewery in 1965 and kicked off the craft brew movement. Surely, you have all tried Anchor Steam beer, their most famous brew. The next professional meeting that you attend in San Francisco, make sure you tour the Anchor Brewing Company. The building is beautiful, the brewery's history is fascinating, and the beer is free. You usually need to make reservation 6 weeks in advance, so plan ahead. North of San Francisco

lie several more excellent breweries. All of which make excellent IPAs. What a place to practice!

Several of my friends share my feelings for beer. We get together every so often and go out for dinner at a brewery or restaurant with a good beer list. This group of friends is comprised mostly of dentists, physicians and businessmen. We are all roughly the same age and at the same point in our careers and family lives. On several occasions, usually after the third beer, interesting topics arise: School is a distant memory, our practices/careers are running smoothly, the kids are doing well, and we all have the same question, "So, what's next?"

I firmly believe that we all need goals. I also firmly believe that after focusing on personal goals through school, residency, and the launching of a career, there comes a time to begin serving a greater cause. This cause could be many different things. Possibly, one could serve their religious organizaiton, those less fortunate in their community, or ones profession. This change of focus from individual goals to the larger community is what fills the "what's next" void. Looking to help others shifts our thoughts to an endless supply of worthy things to do.

For me, however, one personal goal remains – having a building with a brewery on the first floor, and my professional practice on the second.

Balanced Billing

On Friday, September 26, CMA and a coalition of health care providers filed a petition with the Superior Court of California in Sacramento seeking an injunction against a regulation recently finalized by the Department of Managed Health Care (DMHC). The regulation expands the definition of "unfair billing pattern" to include a practice commonly known as "balance billing," which DMHC asserts would provide it with the authority to bring enforcement actions against providers.

"Balance billing" occurs when HMOs refuse to pay in full for emergency services provided to their policyholders by doctors or hospitals with whom the insurance companies do not contract. Faced with the refusal by a giant financial corporation to pay the bill, providers are forced to send part of the bill to the patients to whom they provided the emergency care in order to recoup their costs.

HMOs make hundreds of millions of dollars shorting the health care providers who take care of Californians in need of emergency care through these denials.

CMA's legal petition argues that the regulation is unlawful and unenforceable for the following reasons.

DMHC lacks the authority to regulate doctors. DMHC was created in order to protect Californians from health insurance companies, not allow insurance companies to underpay their policyholders' bills, sticking them with the tab for emergency services. The regulation runs counter to the Knox Keene Act's intent to ensure that HMOs provide adequate networks of care for their policyholders. Instead of ensuring adequate provider networks for Californians with HMO plans, the regulation would shrink provider networks by transferring hundreds of millions of dollars from emergency services to insurance companies. DMHC did not meet the procedural requirements of the Administrative Services Act, which requires it to analyze the potential anti-competitive impacts of the regulation. The Legislature, not DMHC, has the sole authority to regulate this issue.

The DMHC regulation took effect on October 15. CMA anticipates that we will not receive resolution on our request for an injunction until a few weeks after that. To help physicians deal with the uncertainty caused by this regulation and to answer any questions they have about their rights and responsibilities under the regulation, For those CALAOMS members who are also CMA members, CMA has prepared a provider toolkit, which is at their website and can be found under "CMA Spotlight" on the home page.

As appeared in the weekly CMA e-newsletter early October 2008

President's Message

Bruce L. Whitcher, DDS
President, CALAOMS

The Year in Review

By the time everyone reads this message the presidential election will have been decided and we'll be hearing about the new administration's plans for the future of the nation and the future of health care. There will be important changes, but for those of us in clinical practice caring for our patients still remains our foremost concern.

- **Dr. Larry J. Moore Elected Vice President of AAOMS**

Certainly, one of the most exciting events of the year was the election of Dr. Larry Moore, District VI AAOMS Trustee, as AAOMS Vice President. Not unlike the national race for president, Larry ran on a platform of new ideas and energy in contrast to his opponent's many years of experience. No one could predict the outcome of the election until the very end, but after his candidate's speech, I think nearly everyone was convinced he was the best man for the job. We should all be grateful that Larry is willing to take up the substantial commitment this office requires. It is vitally important that District VI and California fields candidates for this national office. Congratulations, Larry!

- **Professional Liability Insurance – nothing to take for granted**

The year started off with the sale of our professional liability carrier to the Doctor's Company and questions about the future of our coverage with SCPIE. We have enjoyed stable affordable coverage with SCPIE ever since I began practice over 20 years ago, but nothing remains secure forever. Fortunately, CALAOMS leadership responded promptly and negotiated a 2 year contract that maintains our unique ability to participate in claims review, have choice of defense counsel, receive free tail coverage after 5 years, and other important provisions with the Doctor's Company.

Recognizing the changing nature of the professional liability marketplace CALAOMS leadership has, from time to time, conducted a review of available policies. Our Insurance Task Force recently met with the representatives of six leading professional liability carriers to determine the best available coverage. Our specialty is seen as an important book of business by these companies. This gives us considerable leverage when negotiating terms, particularly because nearly the entire membership of CALAOMS has remained with our endorsed carrier.

- **Advocacy takes consistent effort by a team**

As President of CALAOMS, it has been my charge to advocate for our ability to care for our patients and to maintain the unique practice environment that allows us to deliver safe and cost effective services, sometimes in spite of the external forces that always seem to be present. The partnership with our CDA lobbyist has been extraordinarily effective. Throughout the year, our legislative committee has been engaged and active and CALAOMSPAC has been ramping up grass roots activities in anticipation of the election.

- **Tissue Banks**

This year we saw a bill passed by the legislature at the last possible moment that removes the little known requirement that all dental practices handling allograft materials must register as tissue banks. The cost savings as well as the elimination of onerous record keeping was some very good news and one of the single most important legislative accomplishments of the year.

- **Licensure of OMS assistants**

Another important bill also became law that will allow OMS anesthesia assistants to receive a license to perform new duties. The existing scope of the OMS assistant remains unchanged, but the new duties include addition of meds to an IV line, more independence in monitoring sedated patients, and the ability to remove an IV line. The most important aspect of this bill is that it establishes a license for our anesthesia assistants and gives them legal standing. We all know that it is virtually impossible to administer anesthesia or manage an emergency without highly trained staff. By establishing a uniform standard for the education and training of the anesthesia assistant we have done much to protect our preferred mode of practice from criticism by other groups.

- **Dental Bureau to resume scheduling of GA/CS evaluations**

As expected, anesthesia related issues have surfaced this year, although in an unexpected form. The Dental Bureau recently announced to CALAOMS that they intend to resume scheduling of office anesthesia evaluations. CALAOMS has been scheduling evaluations for over the past 15 years, a function allowed under the applicable laws. Although CALAOMS has a staff person dedicated to this function and our program has been running very smoothly, CALAOMS will work with the Bureau to assure a smooth transition for this

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GENERAL ANESTHESIA FOR ORAL SURGERY

By Mark L. Monson, DDS. Private practice, Oceanside, CA Staff surgeon, Chief of implant dentistry, VAMC Sepulveda Lecturer, Section of Oral and Maxillofacial Surgery, UCLA

I have been concerned that fewer American Oral and Maxillofacial Surgeons are comfortable with outpatient general anesthesia. More of our members are choosing deep sedation rather than general anesthesia for their patients. Deep sedation is an excellent technique that works well for many patients, but there remain some that prefer or require general anesthesia. I frequently see patients that come to me for surgery because their original oral surgeon would not "put them completely to sleep" or required that an anesthesiologist be present to administer general anesthesia. A great part of our heritage lies in the operator-anesthetist model, and I would hate to see us lose the ability and privilege to provide this service for our patients.

My impression is that many surgeons shy away from administering general anesthesia due to the patient management problems it can present. I have utilized a few techniques that make administering general anesthesia a more enjoyable and less stressful experience. When I have shared these techniques with other surgeons, many of them have encouraged me to publish them for our entire specialty. Hence the genesis of this paper.

The three biggest improvements to the technique I learned in residency are the nasal airway, propofol, and ketamine. The nasal airway, used in the way I will describe, decreases the incidence of hypoxia. Propofol provides a smoother anesthetic than methohexital with less nausea. Ketamine in 25 to 50mg intravenous doses is useful in the "propofol resistant" patient. I will describe a routine anesthetic for removal of third molar teeth on a healthy young adult.

The patient is brought to the operating room and lies supine on the bed/chair. Blood pressure cuff, EKG, and pulse oximeter monitors are attached and pre-operative vital signs are recorded. I will auscultate the heart and lungs. An intravenous line is established with a catheter, administration set and bag so a continuous infusion can be utilized. 100% oxygen is administered via nasal mask. A stopcock is inserted into the intravenous administration port and 100ug of fentanyl and 2mg of midazolam is administered and its effect evaluated.

While the effect of the initial sedation is being evaluated, initial surgical preparation takes place. Gloves are donned. The patient is draped. A mouth prop is placed. The surgical handpiece is setup. The suture, scalpel and local anesthetic are prepared. Prior to induction of general anesthesia, the suction is tested once again.

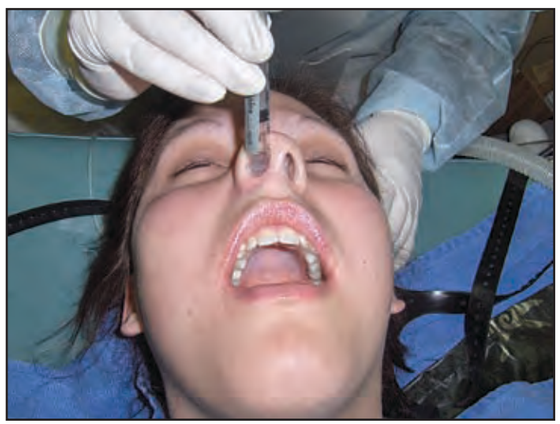

Figure 1 - Intra nasal topical anesthesia being applied

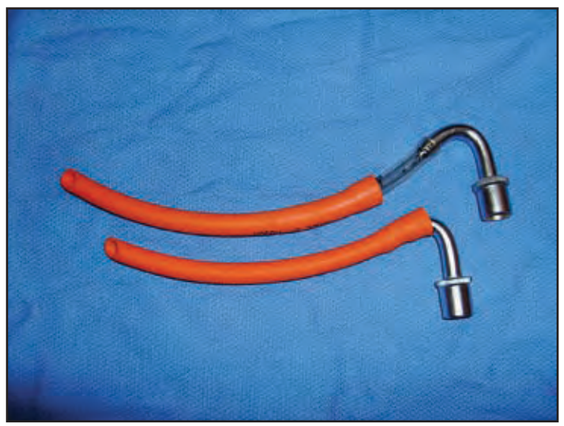

Figure 2 - Nasal airway with acute angle connector

An induction/test dose of 50mg of propofol is given. Once the patient's eyes close or glaze over and become unresponsive to verbal stimuli, 2cc of 2% lidocaine jelly is placed in the right nostril (Fig. 1) and 1cc is placed in the left nostril. If the patient responds to this, then another 50mg bolus of propofol is administered. Local anesthesia is administered.

The nasal airway is placed at this time. The nasal airway has proven to be a major advantage over nasal mask gas administration. In residency, I was taught that a nasal airway could be placed to remedy an obstructed airway. The airway was placed and the nasal mask placed over the nasal airway. An improvement to this technique is to connect the airway directly to the anesthesia machine similar to an endotracheal tube. I have found that red rubber nasal airways (Figure 2) with acute angle metal endotracheal tube adapters work best. If a patient is latex allergic then I use a non-latex airway in similar fashion. The non-latex airway is not as durable as the red rubber airway and collapses more easily. If the airway is not long enough to extend beyond the base of the tongue, a section of endotracheal tube is used as an extender. I used to use a cut non-cuffed endotracheal tube for the entire airway, but I have found that the red rubber airway is much kinder to the tissues than an endotracheal tube, even when the endotracheal tube is softened by soaking it in warm water.

Prior to insertion of the nasal airway, a second dose of 50mg of propofol is given if needed. The usual dosage of propofol is 50mg every five minutes. The dosage is modified by the usual factors such as age, weight, anxiety, and is titrated as needed. The nasal mask is removed. Lubricating jelly is applied to the right nostril and the nasal airway is coated in the lubrication (Figure 3). The nasal airway is then inserted. If the airway does not insert easily then it is withdrawn and placed in the left nostril.

The acute angle connector is then connected to the anesthesia machine tubing (Figure 4). The end tidal CO_2 monitor is attached as if the nasal airway was an endotracheal tube. Experience demonstrates that the end tidal CO_2 monitor works much better in this fashion than attached to a nasal hood or nasal canula. A Weider tongue retractor is used to retract the tongue and visualize the position of the airway. If the airway is too short, a longer one is placed. A tonsil suction is used to suction the pharynx. A throat pack is then placed.

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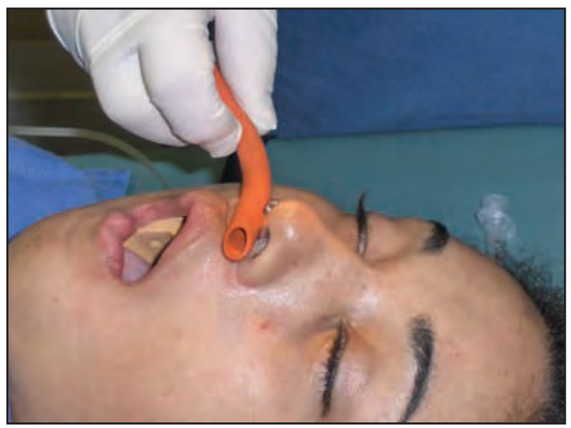

Figure 3 - Right nostril lubrication

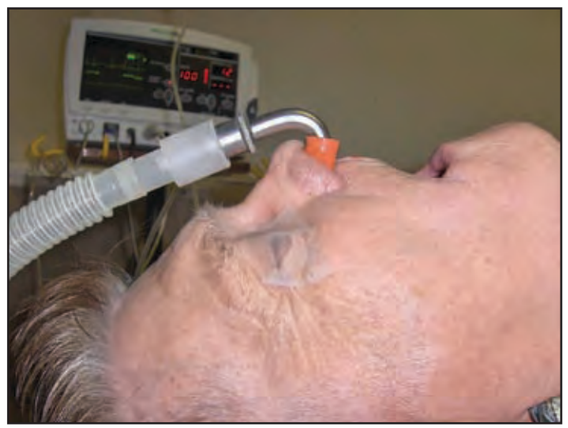

Figure 4 - Nasal airway connected to anesthesia machine

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Some surgeons are concerned that insertion of a nasal airway is too invasive to be performed on a routine basis. I have found that when the airway is placed in the manner that I have described, it is less invasive than intravenous cannulation.

After the nasal airway is functional, a decision is made whether or not to administer positive pressure oxygen. I have found that approximately 50% of patients experience induction apnea where positive pressure ventillation is beneficial. This situation demonstrates another advantage of the nasal airway. Rather than having to hook up a full face mask to ventillate the patient, it can be done with the existing airway. The surgeon pinches the nose with one hand and covers the mouth with his other hand. The surgical assistant performs a chin lift manuver. The anesthesia assistant compresses the bag (Figure 5).

The surgery then proceeds in conventional fashion. It is much easier for the anesthesia assistant to maintain the airway with the nasal airway in place. The nasal airway is left in place until the patient is responsive after surgery. The topical anesthesia allows most patients to tolerate the airway very well even when nearly awake. Once the surgeon is confident that the patient can easily maintain their airway on their own, the nasal airway is removed and the nasal mask replaced. If the patient becomes combative during emergence then the airway is left in place but disconnected from the oxygen tubing until he relaxes or no longer needs the airway.

Occasionally a patient will obstruct in spite of the nasal airway. This is most commonly caused by the nasal airway not being long enough and being occluded by the posterior tongue or the airway being trapped anterior to the epiglottis. In this situation, I will reposition the airway posterior to the epiglottis or insert a longer airway as previously described. I will frequently use a laryngoscope to verify the position of the airway in this situation.

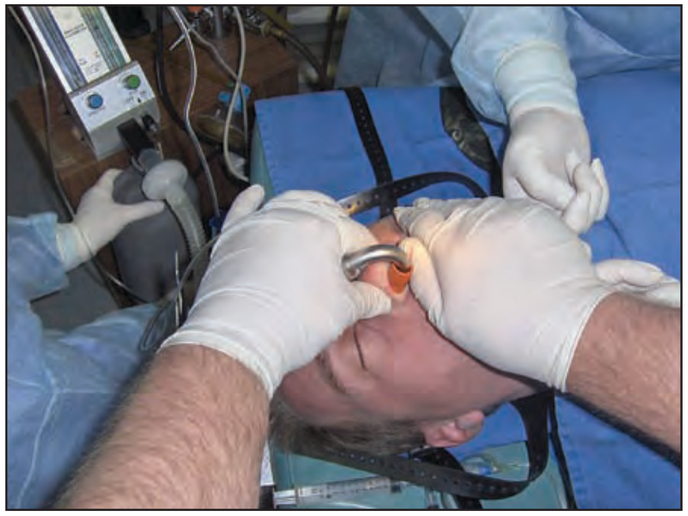

Figure 5 - Positive pressure ventilation

The techniques I have described have made the delivery of general anesthesia in the oral and maxillofacial surgery office safer for the patient and less stressful for the surgeon.

CALAOMS Sends Out First Email Newsletter

On October 24, 2008 CALAOMS sent out its first email newsletter. We provided a link to review CALAOMS Bylaw changes, and another link to vote on whether to approve those changes.

For those members who opened their emails, the percent that voted was quite good. The problem is that out of 612 emails sent, only 302 were opened. That is only a 50% open rate.

We are hoping that this was due to an oversight or error. For those of you who have staff reviewing your emails, please make sure they do not delete emails from CALAOMS. Also, all members should ***add CALAOMS.ORG to your safe senders list,*** so that the emails are not inadvertently flagged as junk email or spam.

Cover Story - Larry J. Moore, AAOMS VP

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President Elect in the event of a vacancy; and serving as Secretary of the AAOMS Services, Inc. (ASI) Board of Directors. Larry is also serving as the AAOMS Board of Trustees liaison to the Committee on Continuing Education and Professional Development, the Committee on Residency Education and Training, the Commission on Professional Conduct and the Residency Organization of AAOMS. Larry must attend all of these committees' meetings and conference calls.

Dr. Moore was also recently a California Delegate to the American Dental Association House of Delegates in San Antonio, Texas. Larry worked within the California delegation to help bring two important resolutions forward that benefit organized dentistry. California introduced Resolution 70RC,S1, which urges the Joint Commission on National Dental Examinations to maintain standardized scores in the Dental National Boards Part I and Part II. The Joint Commission had planned to make the Dental Boards pass-fail. The California delegation also supported Resolution 37RC which provides a task force to assist the Commission on Dental Accreditation (CODA) in making substantial changes in its culture and structure to better serve its communities of interest. Both of these resolutions are important to oral and maxillofacial surgery, all other dental specialties and advanced education programs in general dentistry.

We congratulate Larry on his recent victory, and wish him much success! Please give him your support as he represents us nationally and internationally.

P. Thomas Hiser, D.D.S., M.S.
CALAOMS Past President
CALAOMS Long Term Delegate to the AAOMS House of Delegates.

"Are You Interpreting X-rays for other Practitioners?"

At the AAOMS State Advocates meeting in San Antonio, Texas, attendees discussed a growing trend of oral and maxillofacial surgeons reading x-rays and CAT scans obtained by other practitioners. The concern is about findings not recognized by the oms. If there were an untoward event which could have been prevented by timely diagnosis with the x-ray, the oms may be liable. Malpractice coverage may prohibit the oms from being a radiologist, and therefore no protection is present for missed diagnoses. CALAOMS suggests the oms should check with their malpractice insurance carrier to make sure they are covered for this type of assistance.

John L. Lytle, DDS, MD
CALAOMS Director

Presidents Message - Year in Review

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important function. The Bureau has indicated that they feel that OMSs are, without question, the best qualified to perform office anesthesia evaluations, and that the evaluators are a critical aspect of this important function. We plan to offer improved evaluator calibration courses in 2009 in an effort to refine our successful program.

- **CALAOMS staff – better than ever!**

All of these issues have been dealt with against the backdrop of the usual functions undertaken by CALAOMS including publication of the Compass, our extensive continuing education program, the handling of memberships, and daily inquiries by the public and our members. None of this would be possible without the support of CALAOMS staff under the leadership of our executive director. As President, I have had the privilege of working closely with all of them, and every CALAOMS member should be proud of their team. Their mission is to support all of you in your practices in every way they can, and to always go the extra mile on your behalf.

Bruce Whitcher, DDS
President, CALAOMS

SCPIE's Risk Management Corner

Medical Record Retention

By Laura A. Dixon, BS, JD, RN, CPHRM,
Director, Department of Patient Safety, Western Region

Physicians have many responsibilities with respect to retaining medical records. A number of variables affect the length of time a physician should keep a medical record, such as state and federal laws, medical board and association policies, and the type of record (for example, an adult patient versus a pediatric patient record). The following information can guide physicians in developing their medical record retention policies.

Basis for Keeping Medical Records

The most important reason for keeping medical records is to provide information on a patient's care to other health care professionals. Another major rationale is that a medical record that is well documented provides support for the physician's defense in the event of a medical malpractice action. Without the medical record, the physician might not be able to show that the care he or she provided was appropriate and met the standard of care.

State and Federal Laws

For the most part, state and federal laws regarding mandatory record retention time frames apply to hospitals or similar facilities rather than to a physician's clinic. The Medicare Conditions of Participation (COP) require hospitals to retain records for five years (six years for critical access hospitals),[1] whereas OSHA requires an employer to retain medical records for 30 years for employees who have been exposed to toxic substances and harmful agents.[2] HIPAA privacy regulations have a six-year retention requirement,[3] which follows the federal statute for limitations for civil penalties.[4]

Medical Board and Medical Association Policies and Recommendations

When state or federal laws are silent on medical record retention, medical boards may have policies or recommendations on how long a physician should keep records. For example, the Colorado State Board of Medical Examiners Policy 40-07 recommends retaining medical records for a minimum of seven years after the last date of treatment for an adult and for seven years after a minor has reached the age of majority, or age 25.[5] The California Medical Association has concluded that while a retention period of at least 10 years may be sufficient, it recommends that all medical records

be retained indefinitely or, in the alternative, for 25 years.[6]

Case Law

A decision by the California Court of Appeals[7] challenged the protection traditionally afforded to physicians by the statute of limitations. The court held that when an injury or abnormality did not manifest itself within the statute of limitation or if the patient could not have discovered the problem within the required time frame, the statute of limitations was suspended until the injury became apparent. As such, the time frame for the patient to bring a malpractice action was several years after the care was provided.

Recommendations

The Doctors Company recommends that physicians retain medical records for at least 10 years after the last visit for adult patients and up to age 28 for minors, or 10 years after the patient reaches majority. For California physicians, medical records should be retained for 25 years after the patient's last visit. Some states allow records to be retained in an electronic format. For example, a paper record may be scanned to a computer or kept in another electronic format, such as microfilm. Paper records should be stored with a reputable document storage company.

Such companies may offer alternative methods for document management, such as electronic scanning and storage, which physicians may want to consider. Storing closed or archived records at your residence puts you at risk of damage from fire or flood, loss due to theft, or other unauthorized access. You should also check state statutes and professional licensing agencies for state-specific requirements or recommendations.

What Records Should You Retain?

Retain all records that reflect the clinical care provided to a patient, including provider notes, nurses' notes, diagnostic testing, and medication lists. Retain records obtained from another provider for the same length of time as those in your record. This is especially true if you have relied on any of the previous records or information when making current clinical decisions.

As to billing records, physicians should review bills for any reference to care provided. For example, review the bill to determine if it shows a limited examination or an annual physical with diagnostic tests obtained or requested. If the billing document shows that care was provided, it may be in your best interest to keep the bill for as long as you retain the medical record. Otherwise, you need to retain it for the same length of time as other business records and in accordance with federal and state income tax requirements.

The Doctors Company understands that there are financial implications behind these recommendations. However, given the importance of the medical record in defense of a malpractice action, it is vital for the physician to have the record available to defend proper care.

References:

1. 42 CFR § 482.24(b)(1) and 42 CFR § 485.638(c).
2 .29 CFR § 1910.1020(d)(1).
3. 45 CFR § 164.530(j)(2).
4. 42 CFR Part 1003.
5. Colorado State Board of Medical Examiners Policy 40-07.
6. Hanson CI, Meghrigian AG, Penney SL, Abrams GM. California Physician's Legal Handbook. Vol. 4. San Francisco: California Medical Association; 2007:27:10.
7. Brown v. Bleiberg, 32 Cal. 3rd 426, 186 Cal. Rptr. 228 (1982)

The guidelines suggested here are not rules, do not constitute legal advice, and they do not ensure a successful outcome. They attempt to define principles of practice for providing appropriate care. The principles are not inclusive of all proper methods of care nor exclusive of other methods reasonably directed at obtaining the same results. The ultimate decision regarding the appropriateness of any treatment must be made by each health care provider in light of all circumstances prevailing in the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.

Spotlight on Members

Although Dean Chalios is not a member of CALAOMS, his work with the CDA and CALAOMS on behalf of organized dentistry, merits putting him in this issue's spotlight.

By Pamela Congdon, CAE
CALAOMS, Executive Director

Dean Chalios is Vice President of Public Policy for the California Dental Association. In this capacity, he is responsible for all matters related to policy, legislation, regulation, federal affairs, grassroots advocacy, and related issues. Prior to joining the CDA team, he served for 16 years as a legislative and political advocate with the California Medical Association. He has also served as a campaign finance director, special assistant to a U.S. Senator and assistant to a state assembly member. He has extensive experience in association management, as well as legislative, grassroots and political advocacy. Dean is a graduate of San Jose State University and holds a masters degree from the University of San Francisco. Dean joined CALAOMS' legislative efforts as our lobbyist in October 2007.

Dean grew up in a Greek-American family in San Francisco. Dean's priorities in life were shaped by his upbringing with an emphasis on family, education and public service. He states that these are the great traditions of his Hellenic origins.

Dean's passion for politics started at a very young age. He worked at his first campaign when he was 14. Dean's mom volunteered him to help out a "nice Greek guy" running for City Council in Daly City. Dean shares that it was something about the process of government working together to make things happen that intrigued him. He is interested in the concept of when government can be helpful and when to stay away. He said that a good example of this was with the Tissue Bank Licensure issue.

The Executive branch proposed that dentists needed to be licensed as a tissue bank because of their use of allograft. However, dentists know how to handle allograft and for the government to come out and say that an individual practitioner needs a license is absurd.

Dean, as our lobbyist, approached the Legislature and asked that oral and maxillofacial surgeons be statutorily exempted from this law. We were successful in that effort.

Another issue was the Denti-Cal reimbursement rate was slated for a 10 percent reduction. The CDA went to the Judicial branch to stop this from being implemented.

This is an example of Dean's job, to address whether branches of government are working together on issues related to dentistry. If these entities are not working together, he works with us to protect the profession from any adverse actions that may result. If this happens, he must develop a strategy to alleviate the problem.

Since Dean is so passionate about government and politics, I asked him if this year's election had any extra impression on him. Dean believes that Senator McCain, President Elect Obama and President Bush all love this country. He said that seeing pictures of President Elect Obama and President Bush at the White House warmed his heart and reaffirmed his deep faith in American Government. Dean feels that very few societies would have a smooth transition from one political philosophy to another.

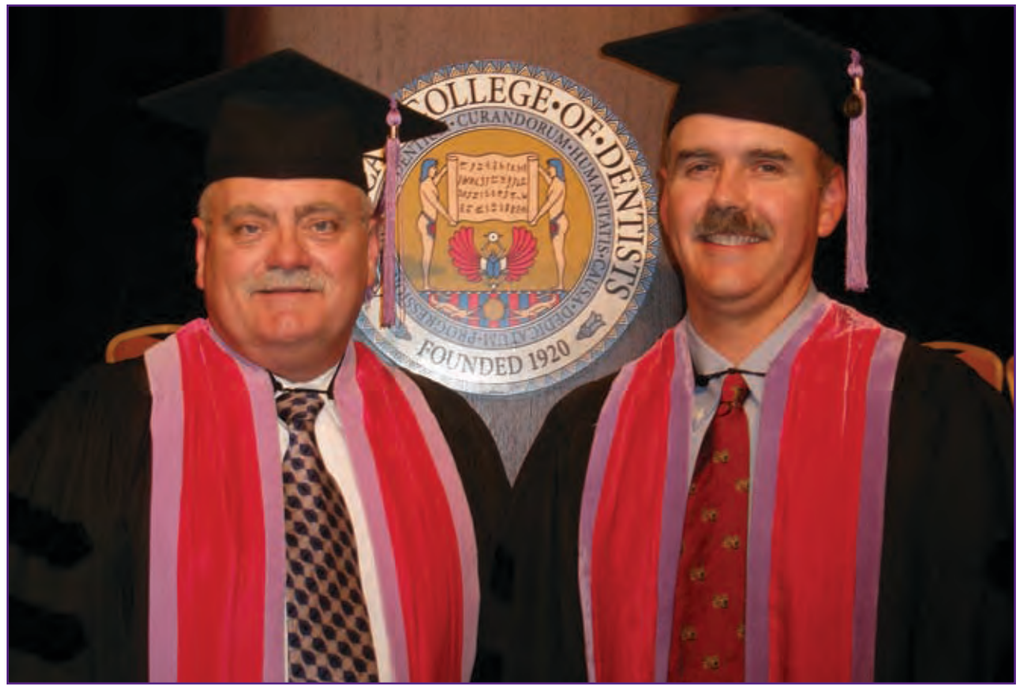
Before becoming CALAOMS' lobbyist and Vice President for Public Policy at CDA, Dean was a legislative and political advocate for the California Medical Association. Dean says that the difference representing physicians vs. dentists is that physicians have become beleaguered over the years by the proliferation of managed care. Dentistry has been able to keep managed care at bay. It is important for dentistry to advocate for the continuance of private practice with no undo influence from insurance companies.

Dean says there are a lot of issues that affect oral and maxillofacial surgeons that might not affect most dentists. He enjoys working with CALAOMS on those issues. His years representing the medical profession have been invaluable in dealing with issues that have arisen for OMS. One example of this, is the matter of balanced billing. Dean is able to recognize the unique nature of how OMSs deal with the issue. Because of the knowledge he already has these issues, he can advise us on the best course of action to take.

When asked if Dean has any hobbies, he happily replies that his job demands a lot of time and he loves what he does. His spare time though, is spent with his wife, Shannon, 7 year old daughter, Mikayla, and border terrier, Charley. In closing, Dean reiterates that he works in a wonderful profession and was afforded the education that has provided him these wonderful opportunities.

CALAOMS Members Inducted as Fellows of the American College of Dentists.

In conjunction with the ADA Annual Meeting, the American College of Dentists held their 2008 induction ceremony on October 16th, at the Marriott River Center, San Antonio, Texas. During the ceremony, 318 dentists were inducted into the American College of Dentists as new Fellows. Among the inductees were Michael E. Cadra, DMD, MD, CALAOMS Past President, and Ned L. Nix, DDS, CALAOMS President Elect. Dr. Cadra and Dr Nix are pictured below following the ceremony.



Dr. William H. Ware, Longtime UCSF Dentistry Faculty Member and former OMFS Chair, Passes Away (1926-2008)

It is with deep regret that the School of Dentistry records the death of William H. Ware, D.D.S., M.D.S., former professor and chairman of the Division of Oral and Maxillofacial Surgery who gave a lifetime of service to UCSF.

Dr. Ware was a graduate of the University of California, Berkeley and the University of California San Francisco School of Dentistry in 1954 and the UCSF Oral and Maxillofacial Surgery Program in 1957. He began his 51-year academic career as instructor in Dental Medicine and Oral Surgery at UCSF in 1957, and culminated as professor and chairman of the Division of Oral and Maxillofacial Surgery from 1976-1983. He remained on the faculty as Professor Emeritus of Oral and Maxillofacial Surgery.

Dr. Ware made many contributions to the specialty of Oral and Maxillofacial Surgery during his distinguished career. Among the most important was his pioneering effort in the field of growth center costochondral graft transplant for temporomandibular joint reconstruction in children. He was also an internationally recognized expert in the fields of orthognathic and temporomandibular joint surgery.

Throughout his career, Dr. Ware was a dedicated teacher beloved by students, residents, and faculty alike. He was a recipient of the UCSF Dental Alumni Medal of Honor, and in recognition of his contributions, his former residents, patients, and friends established the William Ware Visiting Professorship in the Department of Oral and Maxillofacial Surgery in 1990, and this continues as an annual event, now part of the main alumni meeting. In 2007, an appeal was launched to raise the funds to establish a William Ware Endowed Chair in Orthognathic and Reconstructive Surgery, and the necessary funds were raised in a record time of three months with many of his former students, residents, and colleagues contributing.

Our sympathies extend to his wife, Carmen, and his family including his brother, Robert, also a dentist, his sister, Betty, and children, Bill, Julie and Nancy, from his first marriage to Elise. UCSF will be arranging a service of remembrance in the near future.

Republished courtesy of UCSF Newsbrief. This article and more about Dr. Ware can be found at http://williamhware.com

The late Dr. William H. Ware (center) with former Dean, Charles Bertolami (to the immediate left of Dr. Ware), OMFS Chair, Tony Pogrel (to Dean Bertolami's left), and OMFS faculty, Taken at the William Ware lecture in January 2007

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Technology Corner

Let's Just Back-Up One Moment.

By Steve Krantzman
Director of Information Systems, CALAOMS

Today's computer technology has come a long way since the computers with Intel 286 processors and 256 KB of RAM, of the early 1990's. As a matter of fact, a very basic home computer using today's technology is far more powerful than the combined computing power of all of the computers NASA used to send the first man to the moon.

Not only has hardware improved over the years, software has improved as well. The oral and maxillofacial surgeon of today can use one of the many brands of Practice Management software to effectively and efficiently manage their practice. Most of the better brands will allow you to keep records on your patients (even include scanned or digitally taken x-rays), scheduling of patients, and even accounting for billing and bookkeeping. You truly can have a paperless office (save for the walk-out invoices that may be needed) if you choose. There are many other benefits to using Practice Management software, which you are aware of, if you are using it to manage your practice.

One of the bigger benefits is the storage of records. Quickly, the room sized medical record storage systems are becoming a thing of the past. With Practice Management software, you can store all of the records for your entire patient list, for the life of your practice on a single hard drive. There is a tremendous savings involved in this. You no longer have to archive your older case files in storage facilities or convert them to microfiche. You have also freed up valuable space in your office for much needed equipment.

As is almost always the case, there are downsides to this technology. The downside here is the volatility of the data. If your hard drive were to crash, you could potentially lose your entire practice's records. If you are lucky, you could send your hard drive out to a data recovery specialist, and for a considerable cost you might be able to recover your data. Data is also susceptible to corruption from a bad hard drive or viruses. The hard drive works, but the data becomes unreadable, and essentially useless. These are in addition to various other maladies that can cause data loss.

There are two methods out there to help protect your valuable patient records/data. The first is a form of what we in the industry call fault tolerance, and that is RAID. RAID stands for Redundant Array of Inexpensive Drives, and has been around for 15 years or more. There are many levels of RAID which affect a cost to efficiency/reliability ratio. Near the middle of this ratio lies RAID 5, and is the one that would benefit most OMS offices. How this works is that typically on a server (a computer on steroids that delivers services to workstations) you have a number of hard discs that make up a RAID. A typical number of drives is 4 but can be as little as 3 or as many as 6 or more. Using 4 drives as an example, data is written in blocks and in

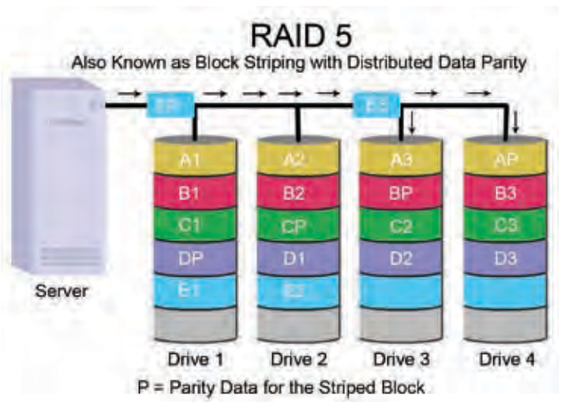

figure 1

RAID 5 a block is split between three of the four drives with parity data written to the fourth. The next block gets written to three different drives with the parity data written to the fourth drive which is different than the one used for the first block of data (see figure 1).

There are three benefits to RAID 5. The first is that if one of the four hard drives fails, depending on how the server is set up, you may continue to work without interruption until the bad drive can be replaced. Second, the data on the bad drive can be recreated using the remaining 3 drive and the parity data on those drives. You can swap out the bad drive for a new blank drive of the same size or larger, and the data will be recreated on the new drive. You have not lost data, and you may not have even seen an interruption of access to that data. The third benefit to RAID 5 is that data is written to multiple drives, therefore multiple drives are used to retrieve the data, which translates to faster data retrieval/improved performance.

The second method of protecting data, is to simply backup the data. Backing up data basically means making a copy of the data. You can store that copy on the same hard drive as your data, but that is not a good solution. If your hard drive were to fail, you would lose your data, and the backup copy. The best solution is to store the backup copy on different media. You can store the backup data on data tapes using tape drives, on CD/DVDs using CD\DVD writers (also known as optical drives), on a group of hard drives called a NAS device (network area storage device), or other available media. It does not particularly matter what type of media you use, the most important feature is that the media is portable. You do not want to store all of your backups at the office. If there was a fire that totally destroyed your office, you would lose your computer systems, and have no way to recreate the data, as the backups were stored on-site as well.

In my opinion, the best media to use are the new portable USB hard drives. They have become inexpensive, can hold a tremendous amount of data, and usually are the fastest at writing the backups (and restoring if needed). You would also need, at a bare minimum, two of these drives. One that backs up the data for a week kept at the office, and the other kept off site, such as your home. You would then rotate out these backup drives on a weekly basis. Some backup schemas require as many as 23 drives. One for the year, one for each month and ten for the daily backups with, five kept at the office and the previous week's five kept off site. The daily drives are then rotated out on a weekly basis.

How often should you backup and how may drives do you need? That depends on the answer to a question that you ask of yourself. How much data can I afford to lose? Can I lose a month's, a week's, a couple of days', or only one day's worth of data. Basically, the more critical your data is to your practice, the more frequently you should back up that data. I would recommend daily backups, but that decision is yours. Also by having numerous drives you do not put all your eggs into one basket, so to speak. If your last backup failed due to a defective drive or disk error, you could restore your data from the drive that holds the previous day's backup data. This way, you may only lose one day's worth of data as opposed to a week or more.

There is a myriad of software and schema for backing up data. You should consult with a computer professional to see what the best match is for your practice. Yes this take time and money to setup, but can you afford not to have a back up strategy in place? Where would you be if you lost all of your data? Here at the CALAOMS central office I use a combination of both methods. I have servers with RAID 5 that receive regular backups to removable discs (Dell RD1000 with 80/160 GB cartridges). This way I have fault tolerance and additional backups kept off site to protect against the unforeseen.

Do yourself a favor, if you are not already doing this, take one moment and backup your data!

If you have a computer related question and the answer may benefit your fellow members, please feel free to ask it, and I will do my best to deliver a clear concise answer. Feel free to email me at steve@calaoms.org.

Alert Regarding General Anesthesia and Conscious Sedation Evaluation Scheduling.

For the past 5 years, CALAOMS has been scheduling General Anesthesia and Conscious Sedation evaluations for The Dental Bureau of California (formally the Dental Board of California). CALAOMS membership coordinator, Barbara Holt, has done an excellent job on the scheduling and has fine-tuned the process in coordination with the DBC.

In October, the Dental Bureau informed CALAOMS that the scheduling of GA/CS evaluations should be a DBC function. Their plan is to schedule 100% of the evaluations by February 1, 2009. In the meantime, Barbara will continue to schedule the evaluations and will work closely with the DBC to make the transition of these duties as smooth as possible.

The majority of the evaluators that the Dental Bureau has at its disposal are CALAOMS members. The Bureau recognizes their expertise in the field of anesthesia, and will continue to utilize their services to perform the much needed evaluations.

As of February 1, 2009, all questions regarding the scheduling of evaluations for GA/CS Permits should be directed to the Dental Bureau of California. The DBC staff member in charge of scheduling is:

Jessica Olney
Phone: (916) 263-2373
Email: jessica_olney@dca.ca.gov

Upcoming Events For Fall 2008

January Meeting - Anesthesia
January 17-18, 2009 — Westlake Village

Residents' Night
February 11, 2009 — Foster City

Risk Management - Inf Control - CA DPA
March 4, 2009 — Santa Ana

Risk Management - Inf Control - CA DPA
March 11, 2009 — San Francisco

ACLS
March 21, 2009 — Solano

Annual Meeting
April 25-26, 2009 — Las Vegas

Residents' Night
September 23, 2009 — Southern CA

ACLS
October/November (TBD), 2009 — Solano

Medical Emergencies
November 4, 2009 — Northern CA

Medical Emergencies
November 18, 2009 — Southern CA

A Golden Opportunity for OMSF's Golden Anniversary… A Million Reasons to Give!

In 2009, the Oral and Maxillofacial Surgery Foundation celebrates its 50th anniversary. For 50 years, OMSF has been supporting research and education in the specialty. To help celebrate this monumental year, AAOMS has made a generous gift of $200,000 to the REAP Annual Campaign. In addition, when OMSF raises $600,000 for REAP by October 1, 2009, AAOMS will contribute an additional $200,000. That's $1 million to address the research and education needs of our specialty!

REAP, which stands for Research and Education Advance Patient care, was initiated in 2005 to meet the growing needs of our specialty. Since its inception, REAP has raised nearly $1.1 million, all of which supports research and education in our specialty. The research we fund today makes up the building blocks of future patient care. OMSF is proud to have provided more than $8.5 million in support for more than 200 research awards and fellowships. With the success of the REAP Annual Campaign, OMSF looks forward to much more future support.

How can you celebrate OMSF's 50th anniversary? Make your REAP gift today! Your gift will honor the past 50 years and take a step forward into the future. The possibilities for REAP are enormous: if each oral and maxillofacial surgeon invested just $1,500 to $2,000 a year, this would provide $6 to $12 million for OMSF's research fund on an annual basis.

With the AAOMS Challenge, there are a million reasons to make a REAP gift. Celebrate OMSF's golden anniversary in 2009-- take advantage of this golden opportunity to make an anniversary gift to REAP. Use the REAP Donation Form to the right or visit the OMSF web site at www.omsfoundation.org

Donate online at www.omsfoundation.org

REAP Donation Form

❍ I want to celebrate OMSF's 50th Anniversary with a $2,000 REAP gift.

❍ I am proud to participate in REAP by contributing a gift in the range of $1,500 to $1,999 to OMSF.

❍ Enclosed is my check for: $_____.

❍ Please charge my card $_____

❍Monthly ❍Annually ❍One Time

❍Visa ❍Mastercard

Name on card:_____

Card number: _____

Expiration date: _____

Security code *(on back of card):* _____

Signature: _____

❍I'm interested in volunteering. Please contact me to be an Ambassador.

AAOMS I.D. #_____

Name:

Address: _____

City, State, Zip: _____

Phone:_____

E-Mail:_____

This donation is in ❍honor ❍memory of:

Name: _____

Please notify the following about the gift:

Name:_____

Address:_____

City, State, Zip:_____

Mail to:
9700 W. Bryn Mawr Avenue
Rosemont, IL 60018
-OR-
Fax: 847.678.6254
Fax for credit card payments only.

Thank You!

As Always CALAOMS' ACLS Course Remains A Big Draw

Year after year CALAOMS' ACLS courses fill to capacity for both the doctor's course as well as the assistant's course. Pictured below, Dr. Michael Mullen and Dr. Newton Gordon demonstrate megacode to oms assistants.

Classified Ads

Doctors Seeking Positions

Dual degree OMFS chief resident at the University of Michigan looking for associate position or office that is available for sale starting December of 2008 in California. Please email me at armkotik@gmail.com for further information and CV.

Retired Oral Surgeon of 1 year is bored. Looking for part-time and/or vacation fill-in work. Central Southern California preferred, open for Northern California as well. Contact Greg Welsh @ (805) 680-4887

Equipment For Sale

New overhead diagnostic lights by Burton. Outpatient II models used 1 month. Paid $1700.00 each will sell for 1200.00 each or buy all 3 for $3000.00 (530) 622-4800

Job Opportunities/ Practices for Sale

Lake Arrowhead, CA

Price Reduced
Highly Motivated to Sell

Satellite office located in beautiful Lake Arrowhead Resort. Looking for someone interested in working part-time at your convenience and or to purchase. Please call Dr. Stuart Green at (949) 872-5664.

North Orange County, CA

Multi-office Oral Surgery Practice has an associate position available with partnership potential. Start date flexible. Main services provided are Dentoalveolar and Dental Implants. Contact Melissa @ (714) 534-5588.

Northern California

Well-established OMS practice seeks a Board Certified/ Ed. qualified Oral and Maxillofacial Surgeon to fill an immediate position in the East Bay region of San Francisco. Newly retired senior partner leaves an opening for the right candidate with an emphasis on quality care and building and maintaining relationships.

- Associate position leading to partnership.
- Two office practice with newly opened facility.
- Seattle Study Club component club for 11 years.
- Great communities for families with excellent schools, entertainment, restaurants, and cultural events.

Please send inquiries to Dr. Gronbach at krgronbach@yahoo.com or 510.551.5165.

Oregon-Central

Cascade Mountain views-clear blue sky. Winter and Summer sports in your backyard. Fast-growing, family-friendly area. Direct flight from LA to Edmond now available. Extremely busy practice established for nearly 11 years with large referral base and low overhead. Assumable lease. A turn-key situation. Put on our scrubs and work. Will stay for transition if desired. Contact elsurgeon@gmail.com.

Oregon-Southern

Practice Opportunity: Our growing community needs additional BE/BC OMF Surgeons. Ideal area to live with beautiful mountains and outstanding recreational, educational and cultural opportunities. Modern oral surgery building located adjacent to expanding regional medical center was made available for lease Spring '06. Excellent opportunity for OMS desiring to relocate or recent graduate. Please call (541) 944-2140 or e-mail glksabre@aol.com.

San Francisco, East Bay

Immediate opening for OMS associate leading to buy-in/partnership. Two doctor practice with senior doctor retiring. New office construction currently underway. Long-standing practice with excellent referral base. Ideal place for young families with great schools. Request more information from and send CV to eastbaysfoms@yahoo.com.

Santa Monica, CA

Associateship with potential for partnership. Seeking well-trained, motivated and personable OMS to join established 3 surgeon practice in Santa Monica. New office facility, full scope OMS with emphasis on implants. Call Dawn (310) 315-1034.

Notice

- Has an insurance carrier forced you to get a medical exclusion prior to paying a dental claim?
- Has a dental insurance company sent your dental claim to a medical insurance, then paid it at a much reduced rate?

CALAOMS is gathering data on this problem. Please submit cases to the Home Office.

Need Space for Meeting?

CALAOMS' Central Office Conference Room may be your answer. If you have a study club, component dental society meeting or other event and are looking for space, CALAOMS's Conference Room is available to members. Call the Central Office to find out more. 800-500-1332

"Going paperless: There's no better time than now, and no better company than Windent."

Phuong C. Huynh, D.D.S.
Mission Oral & Maxillofacial Surgery
Riverside, California

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"No file cabinets. No walls of records.

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I like being able to see a patient's entire chart in front of me in the operatory. In fact, I can also see my entire practice in front of me at all times. There is never any need to call the front office to get information.

There's no better time than now to go paperless, and there is no better company than Windent to help you do it. I am absolutely content with their service and support."

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A portion of each Windent sale is put into a scholarship fund for OMS residents.

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For details on how a paperless practice can work, get the free pamphlet *"How Dr. Phuong C. Huynh Operates a Paperless OMS Practice."* Call Windent at 800.466.9218 or go to www.windent.com.

800.466.9218

*The only papers at Dr. Huynh's office are occasional personal notes between staff, insurance forms that come into his office (and are shredded after being entered into the Windent system), and patient walk-out statements.