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The Compass
Staying the Course Through Service and Education
Volume XII, Issue 3, Fall 2010

CALAOMS Members Shine at the AAOMS Meeting in Chicago

The 2010 AAOMS Annual Meeting in Chicago was very successful and well attended. It was also well represented by CALAOMS members, as three distinguished AAOMS awards were bestowed on three of our outstanding members in recognition of their hard work and dedication to the specialty, Dr. Larry Moore, Dr. Gerald Gelfand, and Dr. Timothy Shahbazian. Also recognized at the AAOMS meeting was the generosity of the members of our state association in our efforts to donate to the Oral and Maxillofacial Surgery Foundation (OMSF) REAP 5 campaign. At the conclusion of the REAP 5 campaign, the OMSF presented awards for the districts and states that excelled. California was recognized as the state that gave the most total dollars in the country. Participation from California OMSs was up from 6% to 8%, a noteworthy accomplishment in this down economy. Congratulations to the awardees and to all the CALAOMS members who donated to the campaign!

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Compass Direction

We reward loyalty. We applaud dedication. We believe doctors deserve more than a little gratitude. We do what no other insurer does. We proudly present the Tribute® Plan. We honor years spent practicing good medicine. We salute a great career. We give a standing ovation. We are your biggest fans. We are The Doctors Company.

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CALIFORNIA ASSOCIATION OF ORAL & MAXILLOFACIAL SURGEONS

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THE DOCTORS COMPANY

The COMPASS

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Your CALAOMS Central Office Staff

Your staff is here to help you with any questions about membership, continuing education courses, certification, and events. Please do not hesitate to contact us with questions or concerns at:

950 Reserve Drive, Suite 120
Roseville, CA 95678
Office: (916) 783-1332
Office: (800) 500-1332
Fax: (916) 772-9220
Web Site: www.calaoms.org

Executive Director
Pamela Congdon, CAE, IOM
Phone Extension: 12
email: pamela@calaoms.org

Associate Director
Steve Krantzman
Phone Extension: 11
email: steve@calaoms.org

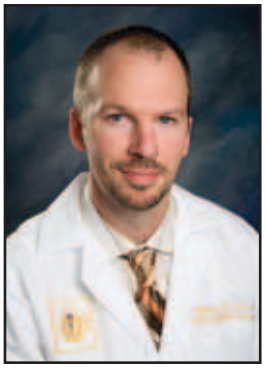
Continuing Education Services
Teri Mandella
Phone Extension: 13
email: teri@calaoms.org

Membership Services
Barbara Holt
Phone Extension: 10
email: barbara@calaoms.org

CALAOMS also does business as:

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

Editor's Corner



Jeffrey A. Elo, DDS, MS
Editor of the Compass

Self Neglect--Don't Do It

Why is the physical and mental health of oral and maxillofacial surgeons (OMS) important? What can we do when we know we're not at our best? What is the best protection against physical or mental impairment?

"Old Doc Rivers," by physician-poet W.C. Williams, portrayed the tension between a physician's dedication to patients and his inability to recognize and respond to his own health-related impairments. Doc Rivers would "go anywhere, anytime, for anybody," and his flashes of brilliance in diagnosis and therapy made him a local legend. Yet his punishing schedule exacted an immense toll, and he ended up ruined by alcohol and drugs. Throughout the story, Williams confronts physicians with a vital question: Where is the appropriate balance point between caring for patients and caring for self?

Dedication to patients is necessary and appropriate, but not to such a degree that it prevents us from attending to our own needs. Good health plays an important role in enabling us to perform at our best, and poor health may undermine fitness to practice surgery.

Patients, communities, and the profession of dentistry have a legitimate interest in the health of those in whom they place their trust. And as oral and maxillofacial surgeons, we bear a duty to recognize our own health-related limitations, and take appropriate steps to safeguard those who depend on us. No patient should be harmed because an OMS is sleep-deprived, febrile, intoxicated, or, simply, in too much distress to perform adequately.

Depending on circumstances, ensuring our patients' safe, quality care may entail rescheduling a patient visit or arranging for a colleague to provide care. What might seem at first glance an admission of weakness turns out to offer powerful testimony to the strength of an OMS's dedication to patients. We must be prepared to assume the role of recipients, not just providers, of care. Some people prefer to view doctors as impervious to the injuries and ailments that beset them, regarding the white coat, at times, as a cloak of invulnerability.

The vitality of surgeons and the wholeness of the profession, itself, depend more than anything else on our ability to reconnect with the inherently inspiring aspects of the practice of oral and maxillofacial surgery.

Yet doctors' mortality rates are no lower than those of patients. By recognizing that we are cut from the same mortal cloth as our patients, we lay the groundwork for a deeper doctor-patient relation-

ship, putting the welfare of patients above our own determination and pride.

How well do we succeed at recognizing our own vulnerability? Are we sufficiently in touch with the connection between our own health needs and the interests of our patients to discern when the former jeopardizes the latter, and take the necessary steps to ensure that patient needs are met?

Equally important, are we mindful of signs of impairment in colleagues and willing to intervene as needed on patients' behalf? Dentistry remains a profession only so long as it monitors its own ranks. OMSs have a duty to watch out for one another and to subordinate the understandable desire to avoid embarrassment or confrontation to the good of patients. Yet we should be careful, lest we forget the limits of health as a medical priority.

Reasonable patients do not choose an OMS solely on the basis of his or her health status. We cannot infer a high degree of medical knowledge, skill, or dedication from a slim waistline, a low blood pressure, or an ideal serum lipid profile. In fact, an excessive preoccupation with personal health might prevent doctors from devoting sufficient time and attention to the needs of patients.

From the patient's point of view, there is comfort in knowing that their OMS is prepared to skip meals, sacrifice sleep, or miss a workout at the gym to attend to their needs. Attention to our health has other limits. A system that does a good job of protecting patients from doctors' impairments may not fare so well at promoting excellence in medical service.

Excellence in practice

The most worthy aim of a life in oral and maxillofacial surgery is not to satisfy minimal standards of safety and competence, but to excel. Focusing too much attention on impairment and its remediation may distract us from performing at our best. We should not ignore our health, but we need to attend to it in a way that recognizes the prevention, diagnosis, and treatment of impairment as a byproduct of a higher pursuit.

The best protection against impairment is not an infallible system of detection and enforcement, but an approach to the practice of surgery that promotes genuine fulfillment, enabling OMSs to do to the best of our abilities those things that are most worth doing. We do better work when we have good work to do. Such work is characterized much less by extrinsic rewards, such as power, fame, and money, than by the intrinsic rewards of the work itself.

Are we growing and developing through our labors? Are we performing surgery in a way that accords with the ideals that drew us to a career in dentistry in the first place and have animated this venerable profession throughout its history? And, most importantly, do we sincerely believe that we are making a significant difference in the lives of the patients, families, and communities we serve? If the answer is yes, then impairment is much less likely to become an issue.

From my vantage point, doctors who derive genuine fulfillment from the pursuit of dentistry's highest aspirations are less likely to become discouraged, suffer burnout, and neglect themselves. Far from finding their work a burden, they cherish it as a privilege. They need not flog themselves from day to day to keep going, because they are drawing from one of the most invigorating wellsprings of inspiration available to human beings: the sense that they are achieving their full potential and enriching the lives of others.

We may make a living by what we get, but we make a life by what we give. The word "health" derives from an Old English word that means whole. To become and remain whole, we need to approach health like a symphonist. Merely getting each piece in perfect working order is not enough. We need to be virtuoso musicians who know how to play their parts well, in ways that harmonize with every other

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CALAOMS Members Shine... Continued from page 1

Dr. Larry J. Moore named 2010-2011 President of the American Association of Oral and Maxillofacial Surgeons

Dr. Larry J. Moore, DDS, MS, of Altadena, assumed the Presidency of the American Association of Oral and Maxillofacial Surgeons (AAOMS) during the 92nd Annual Meeting in Chicago, September 27 – October 2, 2010. Dr. Moore comes to this position following one-year terms as AAOMS' President-elect and Vice President. Prior to his election as an officer of AAOMS, he served three years as a trustee on the AAOMS Board of Trustees, representing fellows and members practicing in the District VI jurisdictions of Alaska, Arizona, California, Hawaii, Idaho, Nevada, Oregon, Utah, and Washington.

"I am grateful to my colleagues for the confidence they have placed in me and look forward to leading the Board of Trustees of this illustrious organization in the coming year," says Dr. Moore. "As the healthcare landscape continues to shift, the patient care delivery system is striving to adapt to the ongoing evolution. Oral and maxillofacial surgeons, with our extensive dental/surgical training, are vital members of the healthcare team and AAOMS' immediate focus will be to ensure that the specialty's practitioners remain best prepared and positioned for this changing environment."

Dr. Moore is a Diplomate of the American Board of Oral and Maxillofacial Surgery and a fellow of AAOMS, the American College of Dentists, and the International College of Dentists. In addition to AAOMS, he is a member of several professional organizations, including the California Association of Oral and Maxillofacial Surgeons, American Dental Association, California Dental Association, American Society of Temporomandibular Joint Surgeons, and the American Dental Society of Anesthesiology.

Dr. Moore maintains a private practice in Chino Hills, CA. He is also a lecturer in the oral and maxillofacial surgery residency program at King/Harbor-UCLA Medical Center. He received his dental degree and a master's degree in oral biology at the UCLA School of Dentistry, and completed his surgical residency at Harbor-UCLA Medical Center. Dr. Moore and his wife, Jill, reside in Altadena, CA.

Dr. Gerald Gelfand Receives AAOMS Presidential Achievement Award

Dr. Gerald Gelfand, DMD, of Woodland Hills, received the Presidential Achievement Award during the opening ceremony of the 92nd Annual Meeting of the American Association of Oral and Maxillofacial Surgeons (AAOMS), September 29, 2010, in Chicago. The award is presented to AAOMS fellows and members who have made significant long-term contributions to the specialty.

For nearly a decade, Dr. Gelfand has worked tirelessly with the AAOMS Committee on Governmental Affairs and the Oral and Maxillofacial Surgeons Political Action Committee (OMSPAC) to inform colleagues of the importance of legislative and regulatory advocacy and to raise the specialty's profile with legislative bodies at all levels. As chair of both committees, he led

the development of cohesive and focused national and grassroots advocacy initiatives to monitor and respond to issues of importance to the specialty.

Dr. Gelfand received his dental degree from the University of Medicine and Dentistry of New Jersey in Newark, and completed his oral and maxillofacial surgery residency at Michael Reese Hospital and Medical Center in Chicago, IL.

Dr. Gelfand is an active participant in numerous professional organizations, frequently focusing his energies on legislative and advocacy issues. He is a past president of the California Association of Oral and Maxillofacial Surgeons, Southern California Society of Oral and Maxillofacial Surgeons, and San Fernando Valley Dental Society. Dr. Gelfand has been a delegate to the American Dental Association House of Delegates since 2000, and an alternate delegate and delegate to the AAOMS House of Delegates since 1994.

Dr. Timothy S. Shahbazian Named AAOMS Committee Person of the Year

Dr. Timothy S. Shahbazian, DDS, of Fremont, received the 2010 AAOMS Committee Person of the Year award during the opening ceremony of the 92nd Annual Meeting of the American Association of Oral and Maxillofacial Surgeons (AAOMS), September 29, 2010, in Chicago. He was recognized for his leadership of the AAOMS Committee on Health Care and Advocacy. He has been a member of the committee, which monitors and advocates for equitable insurance reimbursement levels, since its inception in 2001.

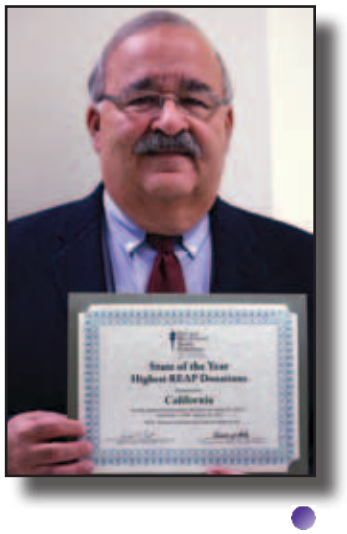
While serving on the committee, Dr. Shahbazian represented AAOMS and the American Dental Association on the American Medical Association's Relative Value Update Committee for nine years. During that time, he advocated for the best possible reimbursement for oral and maxillofacial surgeons by participating in the development of relative value recommendations for new and revised OMS procedure codes, and by developing strong rapport with various dental directors and carrier consultants.

Dr. Shahbazian received his dental degree from the UCLA School of Dentistry, and completed his oral and maxillofacial surgery residency at Louisiana State University.

A Diplomate of the American Board of Oral and Maxillofacial Surgery, Dr. Shahbazian maintains a private practice in Fremont, CA. He is a director of the California Dental Society of Anesthesiology, and is a member and lecturer on the OMS National Insurance Company Risk Management Committee.

CALAOMS Receives an Award of Recognition From the OMSF

Dr. Thomas Indresano, DMD, President of CALAOMS, accepts a certificate of recognition awarded by the OMSF for "State of the Year - Highest REAP Donations." California has always been a leader with an economy that is ranked among nations, not just states. It is progressive, and until recently, has always attracted the best and brightest minds. Therefore, it is not a far stretch to believe that California should also be a leader in giving back. This has not always been the case with the OMSF's REAP campaign, but we hope that it will become a standard for the future.



From the President's Desk

A. Thomas Indresano, DMD
President, CALAOMS

Farewell

It's coming to the end of the time entrusted to me as your CALAOMS President. A lot has happened over this past year.

I am particularly proud of CALAOMS' efforts to promote the oral health of the citizens of California. This is much of what our organization is all about. Also, we have enhanced the way we manage our oral and maxillofacial surgery (OMS) office anesthesia team model by implementing AB2367.

Several OMS training programs throughout the state have begun to teach higher level practice skills to OMS assistants, and more sites are being added to do the same. The results of this concerted effort will benefit the people of California who entrust their anesthesia-related care to OMSs on a daily basis.

We have arranged two more Remote Area Medical (RAM) events to take place in our state-this time in northern California. The first will be held in Sacramento, while the second will be held in Oakland to benefit the greater Bay Area. This medical/dental multi-specialty event is offered to help those who can't afford to seek treatment elsewhere, but sorely need our help in optimizing their oral health. In this time of severe economic decline, CALAOMS is helping to provide a great benefit for the people of California.

Yet with all that we have accomplished, there are many challenges still left for Dr. John L. Lytle, our incoming CALAOMS President. We are so fortunate to have a strong organization that produces many great leaders. To them, I leave the tasks of increasing the Oral and Maxillofacial Surgery Foundation corpus to $100,000,000.00, and producing enough educators to perpetuate the training of our specialty. I do suppose, however, that there will be a few other issues that pop up from time to time. There always are. Farewell.

Editorial... Continued from page 5

performer. We may get the cells and organs in good working order, but if the body is not aligned with the mind and the soul, the result will be cacophony.

The greatest threat facing us today is not a deficit of sleep, nutrition, or longevity. Nor is it a deficiency in health care payment or even the erosion of professional autonomy. The greatest threat facing our practice today is a deficit of inspiration, what we might call inspiration deficit disorder.

To recapture, sustain, and augment inspiration, we need to see our lives as part of a larger story of healing. It is our privilege, for a time, to breathe new life into healing's timeless aspirations in our daily work. The vitality of surgeons and the wholeness of the profession, itself, depend more than anything else on our ability to reconnect with the inherently inspiring aspects of the practice of oral and maxillofacial surgery. If we can position ourselves on the appropriate trajectory toward this higher end, the lesser goals--including the health of OMSs--will find their proper orientation.

CALAOMS 2011 Board of Directors

CALAOMS would like to congratulate the newly elected 2011 CALAOMS Board of Directors. These officers will start their term in office January 1, 2011.

- **President:** *John L. Lytle, DDS, MD*
- **President-Elect:** *W. Frederick Stephens, DDS*
- **V.P./Secretary:** *Alan S. Herford, DDS, MD, FACS*
- **Treasurer:** *Alan H. Kaye, DDS*
- **Immediate Past President:** *A. Thomas Indresano, DMD*
- **Director:** *Albert W. Lin, DDS*
- **Director**: *Monty C. Wilson, DDS*
- **Director**: *Leonard M. Tyko II, DDS, MD*
- **Director**: *Steve M. Leighty, DDS*
- **Long Term Delegate:** *P. Thomas Hiser, DDS, MS*
- **Long Term Delegate**: *Michael E. Cadra, DMD, MD*

American Board of Oral and Maxillofacial Surgery

Congratulations to the following CALAOMS members who completed their certification earlier this year to become a Diplomate of the American Board of Oral and Maxillofacial Surgery (ABOMS).

CALAOMS recognizes the significant time, energy and dedication that went into achieving this professional status and commends these doctors for their efforts.

Junil Ahn, DDS, MD
Christopher S. Daniel,DDS, MD
Fariborz A. Farnad,DMD
Robert Ferdowsmakan, DMD, MD
Mirwais Hussainy, DDS
Alexander Y. Kim, DDS, MD
Don Kim, DDS, MD
Wendy P. Liao, DDS
Jennifer J. Liu, DDS, MD
Grant B. McGann, DDS
Alexei I. Mizin, DDS
Quoc L. Nguyen, DDS
John R. Rayher, DDS, MD

Legislative Update

by Legislative Committee

Governor Schwarzenegger and the Superior Court of California have upheld a provision that exempts nurse anesthetists from physician supervision.

Last February, the California Society of Anesthesiologists (CSA) and the California Medical Association (CMA) filed suit against Governor Schwarzenegger in response to the Governor's letter to the Centers for Medicare and Medicaid Services (CMS) requesting that the state be allowed to opt out of the requirement that a physician be present to either administer or supervise anesthesia for Medicare patients. Under federal law, the CMS has the authority to approve the Governor's request for a Medicare "opt out" of this requirement.

A motion filed by the CSA and the CMA to require Governor Schwarzenegger to withdraw his request to "opt out" has been denied. The ruling was based on the presiding judge's opinion that, given the absence of a state statute that specifically stipulates physician supervision of nurse anesthetists who administer anesthesia, federal regulations allow the Governor discretion to conclude that opting out of the Medicare supervision requirement is consistent with California state law. Furthermore, the judge opined that with respect to the physician supervision issue, current California state law does not refer to supervision, and judicially interjecting a supervision requirement into the law would create ambiguity. The judge went on to state that the legislature has the ability to impose a supervision requirement into state law, should it wish to do so.

With physicians claiming that the specialty of anesthesia is the practice of medicine, and Certified Registered Nurse Anesthetists (CRNAs) claiming that the specialty of anesthesia is also the practice of nursing, dentists, including oral and maxillofacial surgeons, dentist anesthesiologists, and others who have advanced training in anesthesia-- but no recognized anesthesia specialty--must pay particular attention to new legislative efforts in individual states, lest we be lost in the turmoil.

We all know that dentists have historically been anesthesia providers. In Spain v Burch (154 S.W. 172, 169 Mo. App. 94, 1913), the plaintiff sued a physician for malpractice in administering an anesthetic. The court said that "where, as in this case, physicians and dentists are ... used as experts on the question of the proper use of this anesthetic, and it is shown that dentists use it more often than physicians, and are often more proficient and skilled in its use than an ordinary practitioner of medicine, that the usual and customary methods of using it by dentists, skilled in that respect, is a legitimate source of inquiry, and such evidence should not be excluded. The skill and proficiency by which a physician administering an anesthetic is to be judged is not to be measured by the usual and ordinary skill possessed by other physicians only, but extends to that possessed by other persons, whose occupation and study give them an equal or better knowledge of the right methods of its use than is possessed by a general practitioner of medicine."

There is always the potential for some dentists, or the entire dental profession, to lose sedation and anesthesia privileges.

The American Dental Association's (ADA's) guidelines for the use of conscious sedation, deep sedation, and general anesthesia for dentists advises that a CRNA should only work under the supervision

of a dentist who also has been trained in the sedation and anesthesia procedures that the CRNA will be administering. At present, California law does not allow CRNAs to administer anesthesia unless the dentist holds a general anesthesia permit. Physicians who provide anesthesia in a dental office must also have a Dental Board-issued anesthesia permit.

What are the implications for the dental profession as this battle unfolds at the state level? First, if one counted every dentist who administers sedation or general anesthesia who might be affected by a change in state anesthesia rules or laws that this struggle might produce, the numbers would be small in comparison to the "big 2." The 700 oral and maxillofacial surgeons, the handful of dentist anesthesiologists, and the few periodontists and general dentists who administer intravenous conscious sedation, deep sedation, and/or general anesthesia pale in comparison to the thousands of anesthesiologists and CRNAs who have flexed their massive political muscle to control who can be responsible for administering anesthesia.

It would not be surprising that the concept of the operator-anesthetist supervising a team of self-trained, nonprofessional auxiliaries in any type of private medical/dental office would be viewed unfavorably by both MD-anesthesiologists and CRNAs, as well as the legislators whom they will both lobby for their individual causes. In fact, Medicare rules, and virtually all medical insurance policies, already prohibit separate billing for sedation services provided simultaneously by the operating surgeon.

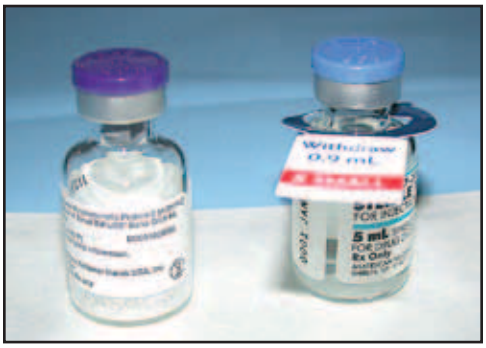
When issues such as physician oversight of CRNAs incite legal and legislative battles over which provider may deliver anesthesia, it behooves us to pay close attention. There is always the potential for some dentists, or the entire dental profession, to lose sedation and anesthesia privileges. State board rules should be fair to all dentists who give sedation and anesthesia. We need to work together for the common good of preserving our individual privileges to provide anesthesia care, whether we use the operator-anesthetist team concept in a single office, or practice as a mobile dentist anesthesiologist who can transform any dental office into a safe operating room-like environment.

References:

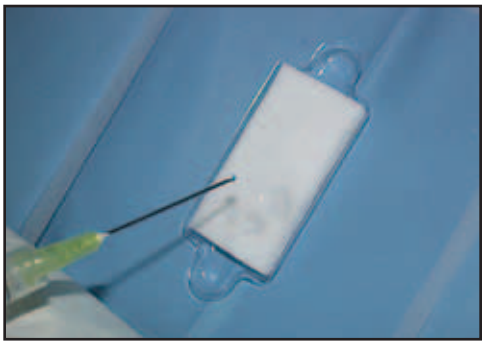
Medical Anesthesiologists Keep CRNA Supervision Rules Intact.. Anesthesia Progress, Vol. 20, Nov. 2009

Anesthesia -- It's finally the practice of medicine. Gene A. Blumenreich, JD, AANA General Counsel 1999. http://www.aana.com/Resources

CMA Says Court Ruling on Nurse Anesthetists Is Off Base. CMA Press Release, October 13, 2010. http://www.csahq.org/files/CMA_Release_13Oct10.pdf

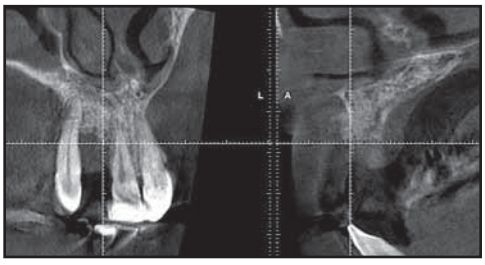


rhBMP powder and sterile water solvent vials.



rhBMP solution being applied to the collagen sponge.

rhBMP soaked sponge with xenograft expander added (off-label technique).



CBCT image of vertical ridge defect before treatment.

Technical Articles

Peter Krakowiak, DMD, FRCD(C)

The rhBMP Applications in Contemporary Office-Based OMS Practice

A group of bone morphogenetic proteins (BMPs), naturally occurring messenger peptide sequences, have been actively researched over the past five decades since it became apparent that they possess a remarkable ability to heal bone. It has become evident over the past few years that they may, in many cases, eliminate the necessity for bone harvesting from other parts of the body. The growth factors belong to the TGF-β super family of extracellular matrix proteins. Initially discovered by Marshall Urist, they have been researched by numerous academic surgical centers in the world, and notably, in our specialty field by past CALAOMS pioneer, Dr. Phil Boyne.

Currently, over 20 BMPs have been identified and labeled; six of them appear to be capable of initiating ectopic bone growth. Of these, rhBMP-2 and rhBMP-7 have been studied to the greatest extent, and are FDA-approved for use in certain orthopedic (rhBMP-2 and rhBMP-7) and maxillofacial (rhBMP-2) surgical

applications. BMPs act by binding the pluripotent stem cell's exterior and signaling the nucleus via intracellular proteins called SMADs, which, in turn, induce transcription of several osteogenic genes. Additionally, the proteins allow for increased angiogenesis and chemotaxis at the sites where they are applied.

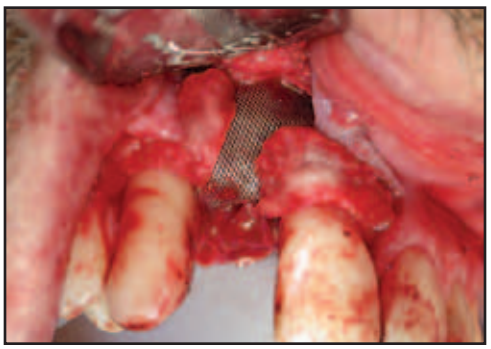
BMP is a naturally-occurring substance found within the bone itself, but mostly in limited amounts. To provide clinically useful and reproducible amounts of isolated human BMP, it must be produced in a specialized bioengineering facility.

The isolated gene for the BMP protein from bone tissue has been used to create genetically-engineered producer cells, applying well-established molecular biology techniques. These producer cells can synthesize large quantities of rhBMP. A similar process is used to manufacture other biologically important proteins, such as insulin. The recombinant form of rhBMP is identical to the natural human form in both its chemistry and in its ability to generate de novo bone.

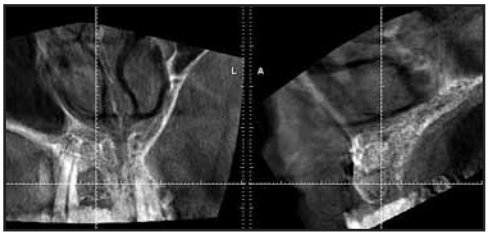
Current U.S. Food and Drug Administration (FDA)-approved maxillofacial protocols utilize techniques where rhBMP-2 is soaked onto, and binds with, an absorbable collagen sponge that is designed to reabsorb over several weeks. During this time, the bound rhBMP-2 stimulates the circulating stem cells to produce new bone at the site of sponge placement.

BMPs may be used to promote bone growth in several areas of the body. In the spine, BMP-2 and BMP-7 grow bone in the disc space to join or fuse the vertebrae, often reducing back pain as they stabilize the spine. In certain long bone fractures, such as tibial fractures, BMPs have been shown to help heal broken bones, especially in cases where traditional approaches for repair have fallen short. In maxillofacial applications for jaw bone resorption, rhBMP-2 may be placed in a section, or sections, of the jaw that need to be augmented in preparation for dental implants.

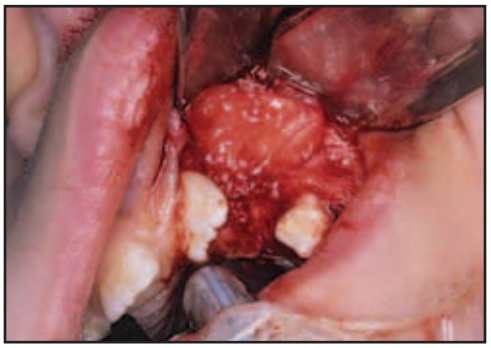
Currently, only INFUSE® Bone Graft contains a synthetic (manufactured) bone graft material that has been approved by the FDA for use in oral and maxillofacial bone grafting procedures; specifically, sinus augmentation and localized alveolar ridge augmentation. However, the product has been utilized off-label in many other maxillofacial applications, including cleft alveolar ridge repair, discontinuity defect reconstruction, and maxillofacial fracture repair.



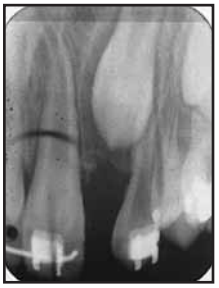
Defect with titanium membrane filled with BMP sponges, which are also applied to the adjacent root surfaces.



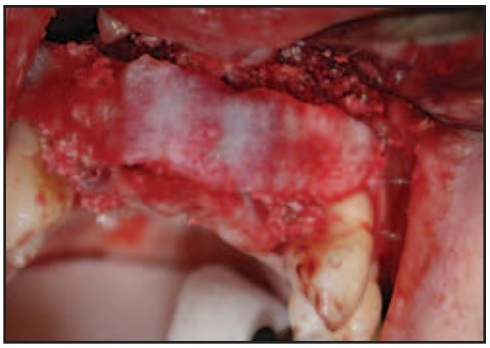
CBCT of the same site six months after GBR using rhBMP and titanium membrane.



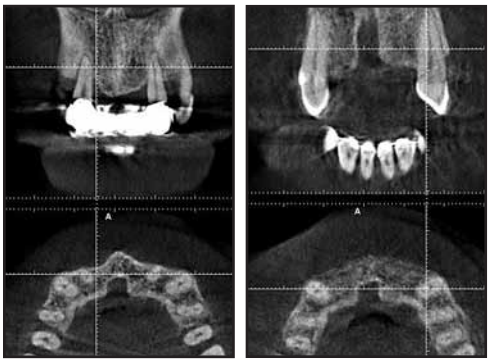
Left alveolar cleft defect repair using rhBMP/sponge (Courtesy of Dr. W.K. Tom and Dr. M. Chin).



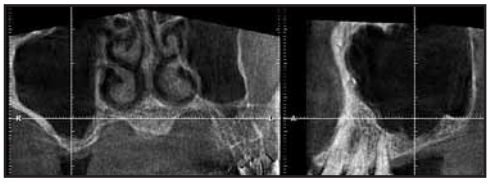
Canine shown erupting through the grafted and repaired cleft (Courtesy of Dr. W.K. Tom and Dr. M. Chin).



Surgical view of BMP-soaked collagen sponge onlayed over the defect.



Left: Pre-treatment ridge CBCT of maxillary anterior sextant with active vertical periodontal attachment loss and horizontal ridge atrophy.
Right: Six months post-op CBCT of the site showing over a 30% increase in horizontal ridge dimensions.



CBCT of pneumatized sinus and severely atrophied posterior maxillary ridge.

The use of rhBMP in lieu of autogenous hip bone harvesting offers an alternative with lower morbidity, and is more suitable in the office-based outpatient environment. Some potential for use in bisphosphonate-related osteonecrosis of the jaws (BRONJ) defects has also been contemplated as other traditional options, such as hyperbaric oxygen (HBO) and free tissue transfer, have proven to have limited success. Defects associated with peri-implantitis and periodontitis have also been successfully treated using rhBMP-2 sponges.

In addition to the off-label applications, the FDA-approved techniques have been evolving with new emphasis given to maintaining spatial volume for osteogenesis, in addition to the limited support offered by the collagen sponge. Traditional graft expanders, such xenografts and allografts, have been used with good results. In discontinuity defects of the mandible, additional fixation hardware along both the superior and inferior aspects of the defect have been utilized. Cadaveric mandibular cribs filled with BMP-soaked sponges have also produced excellent results.

The obvious advantage of using rhBMP-2 is the ability to bypass harvesting autogenous iliac crest or tibial bone, reducing both cost and morbidity associated with these reconstructive efforts. Also, the cost of additional hospitalization and longer anesthesia times required for a separate harvest, physiotherapy, and additional follow-up care has been eliminated. Currently, only rhBMP-2 is FDA-approved for treatment of maxillofacial defects and is distributed by Medtronics.

Medtronics has developed several sizes of packages with incremental doses of the rhBMP-2 proteins. The kits range in size from XXS-L. Most localized alveolar defects can be treated with an XXS package at a cost of around $800. Sinus augmentation requires small or even medium kits which are significantly more costly, up to around $4,500.00. In our hospital practice, we have access to rhBMP-2 and the hospital usually is able to bill the patient's medical insurance for such pharmaceutical and hardware costs. Most of my implant patients, however, once made aware of the potential benefits of the BMP treatment--and ability to circumvent autogenous harvesting--have elected to have the procedure performed in an outpatient setting in our office due to reduced costs compared to hospital admission and anesthesia fees.

Few contraindications exist to application of this surgical technique and related materials. Patients with a known hypersensitivity

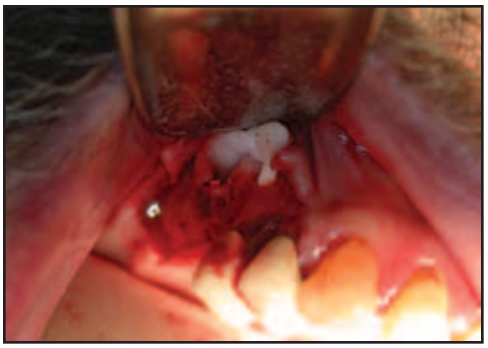
to either rhBMP-2 or carrier vehicle should not have the material used. Other contraindications include: pregnant females, skeletally immature individuals, active infections at the surgical sites, recent or adjacent tumor resection sites, and patients with active malignancies. Moreover, it is recommended to inform women of child-bearing age not to become pregnant for one year post-therapy. Also, the safety of this therapy has not been established in nursing mothers.

The most significant and common side effects have been protracted extensive edema, mucosal and facial erythema, and local pain. The edema has been significant, especially when large volumes of rhBMP have been used in repair of mandibular discontinuity defects and spinal fusions, requiring the re-admission of patients for airway observation and even active management.

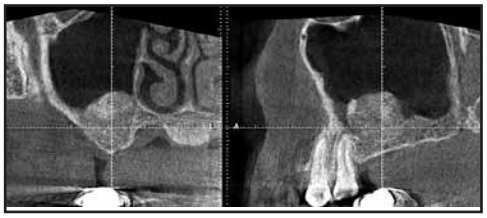
There are some patients that may not respond to rhBMP therapy at all; but that number appears to be less than 10%. This treatment failure should be included in the informed consent process. To date, no other adverse issues have been noted, such as ectopic bone formation or induction of oncogenesis.

My personal experience with BMP has been very positive so far, and I have now completely discontinued the use of tibial and iliac harvests for sinus and ridge augmentation in my practice. I still believe that large-span defects can be treated with iliac crest marrow grafts and/or cortical grafts, but as our skills with cadaveric cribs increase, I may consider that also a technique of the past. Most of my cases have involved sinus augmentation and local ridge reconstruction in compromised or multiply-operated alveolar defects. To maintain more stable graft and site dimensions, I, as many others, have incorporated xenograft particulate and, recently, allograft trabecular marrow sponges.

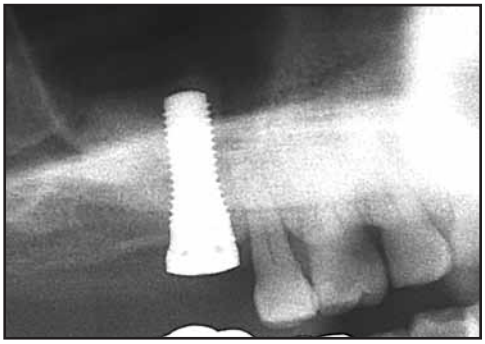
The use of titanium tray mesh-protected rhBMP/xenograft particulate has allowed us to gain vertical ridge height in the pre-maxilla without cortical block use or alveolar distraction. Other practitioners using the material have had similar results in the posterior mandible and maxilla, as well. Interestingly, so far I have had only one infection since using BMP, and it occurred in a sinus augmentation case of a smoker. The infection involved the particulate graft expander over the lateral window. It was loose and encased in draining purulent exudate. After very delicate irrigation of loose particles, but retention of the remainder of the BMP-soaked sponges in the cavern of the antral space, the patient was placed on oral antibiotics.



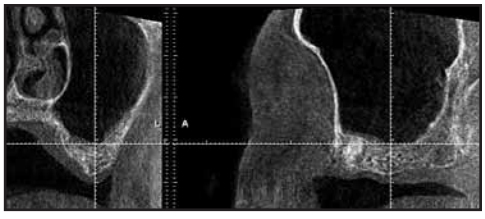
Placement of rhBMP-soaked collagen sponge via the standard lateral window sinusotomy.



CBCT showing the same site at eight months with good mineralization of the planned implant site.

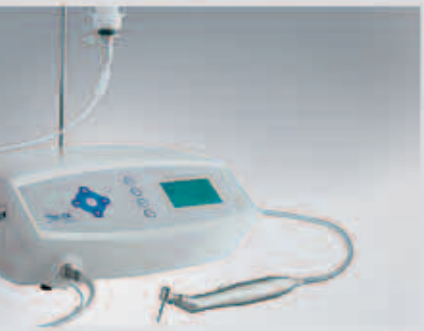


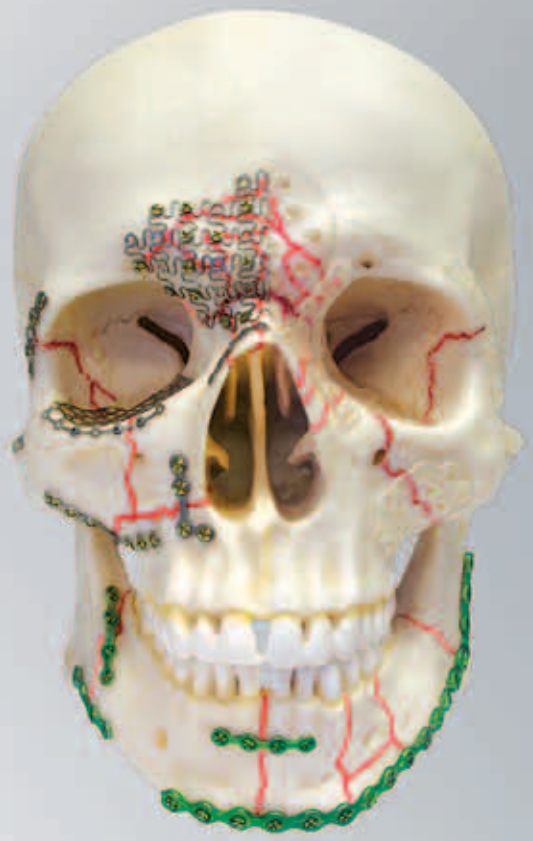
Panoramic view showing adequate dimensions for placement of a 14mm Straumann Tapered Wide Neck fixture.



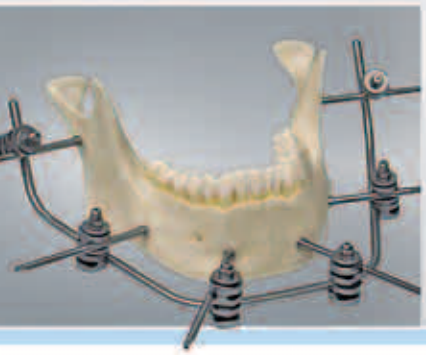
CBCT of another pneumatized sinus with atrophied posterior maxillary ridge.

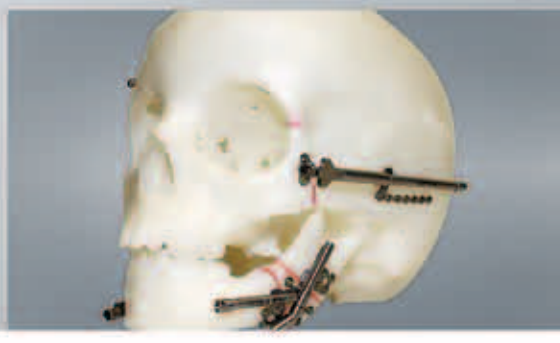
Products for Oral & Maxillofacial Surgery





Surgical Innovation is our Passion





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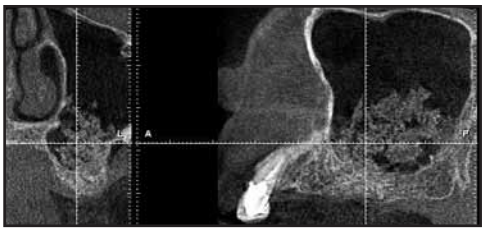
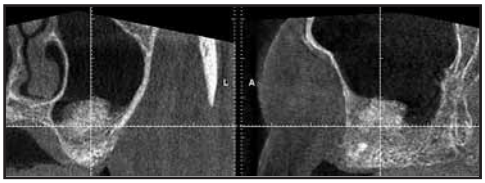
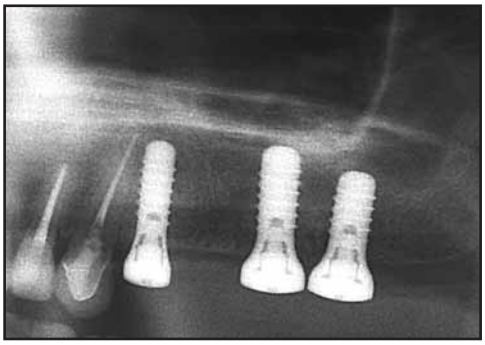


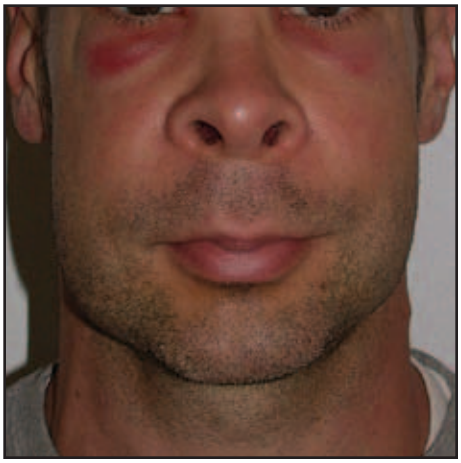
CBCT of xenograft expander matrix and rhBMP sponges placed in antrum immediately after material placement.



CBCT at six months showing excellent consolidation of the graft materials with enhanced mineral density of the site.



Three fixtures placed per fixed prosthodontic restorative plan utilizing guided surgery techniques.



Interestingly, the patient went on to full healing with no evidence of any graft loss or even decreased bone formation in the sinus.

Similar events with hip/tibia autograft or allograft/xenografts have always resulted in significant or a total loss of the graft volume. That, in itself, aside from the lack of need to harvest autogenous bone, has really got me exited about offering the therapy to our patients. The increased cost of the material is offset by the time savings of no second site surgery and decreased associated morbidity. The follow-up and management of those additional complications can be extensive, as we all know. The one thing that I always stress to my patients is the extent and duration of facial and gingival edema. In most cases, the edema peaks at 72 hours after placement of the BMP-laced graft, after the initial surgically-induced edema starts to resolve. It can be worrisome and sometimes mistaken as a sign of wound infection. However, unless it involves airway compromise, it should be allowed to run its protracted course. Several of my patients remained swollen externally for two weeks before any reduction in size of edema was noted. Also, periorbital edema and erythema from vascular congestion were present. This was quite concerning to the patients, and required continuous supportive reassurance from our team.

The second decade of the 21st century will really be the period when rhBMP will reach its full clinical potential and become fully integrated in our reconstructive treatment efforts. The work of pioneers like Dr. Phil Boyne has laid a foundation for possibly the greatest surgical advancement in the reconstructive surgical techniques we will use in our lifetime.

On November 13th, the Marsh Robinson Academy of Oral Surgeons is hosting Dr. Jay Malmquist, who is considered to be one of the world's OMS opinion leaders and a principal national clinician with significant experience with BMP-based maxillofacial reconstruction. All interested in this topic are enthusiastically invited to join us at the Downtown Los Angeles Marriott for this exceptional West Coast CE event on this exciting topic. For your registration materials, please feel free to email me directly at pkoms@sbcglobal.net. If you have not looked into adding rhBMP to your practice yet, this is a great local opportunity to get to hear more about it.

Left: Significant facial edema and infraorbital erythema are present one week after anterior maxillary ridge atrophy repair using only one XS Medtronics Infuse kit. Also, note the extension of edema to buccal spaces and angle of the jaw on the right side. Edema such as this can persist for over 2 weeks with very slow and limited improvement.

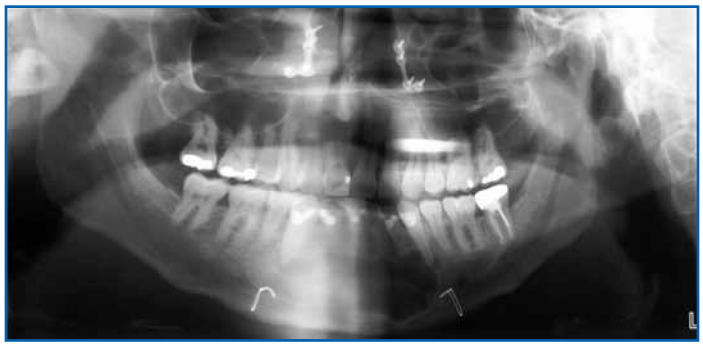
Surgical Ciliated Implantation Cyst of the Mandible or Glabella

by Lee Slater, DDS, MS, Scripps Oral Pathology Service, San Diego, California; voluntary adjunct faculty, Department of Oral & Maxillofacial Surgery, Loma Linda University School of Dentistry

If a mandibular cyst arises in a patient years after he/she had orthognathic surgery, the possibility of an iatrogenic implantation cyst should be considered (see Figure 1). That is, in addition to the usual "culprits" (radicular cyst, dentigerous cyst, lateral periodontal cyst, odontogenic keratocyst, ameloblastoma), the uncommon surgical ciliated implantation cyst (SCIC) of the mandible should be included in the differential diagnosis.

The reciprocating saw used for a Le Fort 1 osteotomy can potentially carry fragments of antral or nasal respiratory mucosa to a mandibular sagittal split or sliding genioplasty osteotomy site. Such implanted ciliated mucosa can slowly proliferate and years later form a unilocular or multilocular mandibular cyst or a chin extraosseous cyst. Histologically, the surgical ciliated implantation cyst (SCIC) is lined by ciliated pseudostratified columnar respiratory epithelium with goblet cells. The SCIC can be distinguished from a glandular odontogenic cyst (GOC) because the implantation cyst has: cilia (an unusual finding in GOC); edematous mucoid stroma often containing eosinophils (features typical of maxillary sinus respiratory mucosa); and sometimes hyaline cartilage of nasal septal origin. Thorough curettage is the initial treatment of choice. Because long-term follow-up on SCICs is presently unavailable, the recurrence rate following curettage is unknown.

A similar ciliated cyst of the glabella or superior nasal dorsum may occur years after rhinoplasty. Meticulous removal of bony, cartilaginous, and mucosal remnants from the surgical site may prevent such glabellar implantation cyst formation.



Panoramic radiograph of surgical ciliated implantation cyst (SCIC). A 4 x 2 cm cyst developed in the anterior mandible of a 29 year-old male following orthognathic surgery. The cyst was lined by ciliated pseudostratified columnar respiratory epithelium with goblet cells.

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Risk Management Corner

by Barbara Worsley
Regional Assistant Vice President
Patient Safety/Risk Management
The Doctors Company

WHO IS THE DOCTOR?

The doctor-patient relationship is at the heart of healthcare delivery, but this relationship is at a crossroads in the 21st century,. Today's patient is no longer simply a passive recipient of a provider's care. Yes, some patients still have an "I'll do whatever you say, doctor" attitude, but they are in the minority. Frustrated after dealing with a demanding patient, have you ever asked yourself the question "Who is the doctor here?"

While patients have the right to make their own healthcare decisions, the doctor must never lose sight of the duty to exercise reasonable care in managing a patient's condition and course of treatment. Never assume that things you know to be true are obvious to the patient. Although a patient may make requests for specific treatments and/or medications and state, "I'll sign any informed consent form you want --- just do it," this doesn't eliminate your liability when patient injury results.

While seemingly obvious, doctors should remember that their patients do not have the same knowledge as they do. Patients, therefore, can't appreciate the risks they are creating. Consider the following liability scenario:

A 25-year-old male patient was referred to Dr. A by the patient's general dentist for evaluation of a wisdom tooth extraction. There was a request that Dr. A perform an extraction of tooth #16, but in discussing this extraction with the patient and reviewing the patient's Panorex taken at Dr. A's office, it was apparent that the other wisdom teeth were also impacted. The decision was made by the patient to have all four wisdom teeth extracted that very day.

Dr. A obtained a detailed history from the patient which revealed no contraindications to proceeding with the extractions. The patient suffered from no allergies, no asthma, no bleeding problems, was not diabetic, and suffered no other chronic illnesses. Dr. A's notes indicated that the patient was informed of alternative treatments, including no treatment at all or treatment involving removal of less than four wisdom teeth at one time.

All doctors are faced with the difficulties of trying to adhere to patient or patient family directives and are many times unduly swayed into making judgments that are increasing their risks of trouble.

As the roots were curved, the insured recommended that surgery be performed under general anesthetic. The patient rejected the idea. He did not wish to defer the surgery to another date when he could be prepared for general anesthesia. Evidently, the patient had recently eaten and general anesthesia was not possible at that time. Dr. A later acknowledged that had the procedure been done under general anesthesia, it was likely that a nurse would have assisted and there would have been less risk of the patient inadvertently moving his head during the extractions.

The first tooth to be extracted was tooth #32. Four carpules of Lidocaine, two on each side, were injected and approximately 15 minutes elapsed to achieve an adequate anesthetic result. Dr. A was half-way through the procedure going in a lingual direction when the patient suddenly jerked his head, causing the

drill bur to perforate the lingual plate, thereby causing injury to the lingual nerve. Immediately upon recognizing that the drill had gone deeper than anticipated, Dr. A informed the patient of what had happened and advised the patient that he must remain still. The remainder of the procedure on tooth #32, as well as the extractions of teeth #1, #16, and #17, proceeded without complication.

The dental assistant at the time of the patient's extractions testified that Dr. A tried to convince the patient to undergo general anesthesia for quite some time, but the patient refused. She stated that Dr. A preferred utilizing general anesthesia for wisdom teeth extractions, especially in cases where there were four impacted wisdom teeth.

The patient, a life insurance salesman, suffered severance of the lingual nerve, resulting in anesthesia.

Every day you are faced with situations in which patient expectations or demands are possibly contrary to your opinions. Have you experienced the following?

A 52 year old male patient wants to have his asymptomatic wisdom teeth extracted because "it's something I should have done long ago." Do you proceed?

Upon examination of a 54 year old morbidly obese female with very large lingual tori, you suggest that they be removed in a hospital due to concerns about potential airway problems. Because of insurance/financial concerns, the patient insists the surgery be performed in the office. What would you do?

A 12 year old shows up for a scheduled extraction of tooth #22 but you discover that he has been suffering from a cold for five days. Do you reschedule the procedure per your office protocol or proceed with the extraction due to the mother's insistence that this be done because the child is going off to camp in a couple of weeks and she wants to get this done now?

A family dentist refers a patient for a wisdom tooth extraction although the tooth is causing no pain. Cone imaging indicates high risk potential due to the position of the roots and adjacent nerve. Do you go ahead with the procedure or, despite the dentist's recommendation and patient's wishes, advise that you "will watch" for an indefinite period of time?

All doctors are faced with the difficulties of trying to adhere to patient or patient family directives and are many times unduly swayed into making judgments that are increasing their risks of trouble. Such influences cannot get in the way of sound medical judgment. In the end, keep asking yourself the question, "Who is the Doctor?"

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THE DOCTORS COMPANY

Press Release

The Doctors Company Acquires American Physicians Capital, Inc. — October 22, 2010 —

The Doctors Company, the largest national insurer of physician and surgeon medical liability has completed its acquisition of American Physicians Capital, Inc., the parent company of American Physicians Assurance Corporation (American Physicians), a major provider of health care liability insurance in Michigan, Ohio, Illinois, and New Mexico.

With the addition of more than 7,000 physician policyholders, The Doctors Company Further extends its position as the largest national insurer of physician and surgeon medical liability to almost 55,000 insureds.

To find out more, go to www.thedoctors.com

Advanced Program in Oral and Maxillofacial Surgery

The Herman Ostrow School of Dentistry of the University of Southern California LAC + USC Medical Center

by Kyle Yip, DDS and Peter Krakowiak, DMD, FRCD(C)

Program overview

Inaugurated in 1954, the oral and maxillofacial surgery (OMS) training program at The Herman Ostrow School of Dentistry of the University of Southern California (USC) has served the Los Angeles County population for over fifty years. Over those years, the program has trained some of the current leaders in the field, including many past ABOMS presidents, ABOMS examiners, and nationally recognized experts in oral and maxillofacial surgery, as well as craniofacial surgery. Primarily based at the Los Angeles County (LAC) + USC Medical Center, OMS residents train in one of the busiest, most intense clinical environments, characteristic of a major metropolitan Level I trauma center and tertiary care facility. Exposure includes didactic and clinical training in all aspects of oral and maxillofacial surgery, with emphases on advanced maxillofacial trauma, maxillofacial pathology, orthognathic surgery planning and treatment, cranio-maxillofacial surgery, temporomandibular joint surgery, and dento-alveolar surgery, including reconstruction, rehabilitation, dental implants, and pre-prosthetic surgery. Fifteen residents and two interns provide services at the brand new, state-of-the-art LAC + USC Medical Center, mostly on an outpatient basis. They also provide consultant and treatment services for acute trauma patients and medically compromised inpatients. Additionally, residents receive in-depth clinical and hands-on operative training at Children's Hospital of Los Angeles, where the USC OMS service is an integral member of the world-renowned craniofacial and cleft palate team. Additional surgical training is provided at USC University Hospital and its affiliated Norris Cancer Center, Long Beach Memorial Medical Center, Ranchos Los Amigos National Rehabilitation Center, and the Herman Ostrow School of Dentistry of USC. Residents participating in the 6-year dual-degree program receive MD training at the Keck School of Medicine of USC.

Faculty

Dr. Dennis-Duke Yamashita, DDS, Chairman and Program Director

An alumnus of the program and native to Southern California, Dr. Dennis-Duke Yamashita has been intimately involved in resident training as Chairman and Program Director since 1992. Dr. Yamashita is board certified in oral and maxillofacial surgery and formerly served as an ABOMS board examiner. Dr. Yamashita oversees training in the full scope of OMS of his residents; and under his guidance, many graduates have returned as part-time and full-time faculty. During his tenure, Dr. Yamashita also developed and integrated the dual-degree MD program at USC.

Dr. Yamashita, the current director of the department of dentistry, as well as our former department director, Dr. Joseph Anselmo, have been involved over the past decade in the development and planning

of the newly-completed OMS clinic at the LAC+USC Trauma Center. The clinic is considered one of the most advanced county hospital clinics in the country, and includes a dedicated full general anesthesia suite/operating room, 3-D CBCT imaging equipment, and virtual software-based orthognathic and implant planning facilities. The main core of OMS residency faculty members includes an all-board certified attending staff consisting of:

Dr. Thomas AuYong, Dr. Paul Bohman, Dr. David Cummings, Dr. David Hochwald, Dr. Peter Krakowiak, Dr. Anh Le, Dr. Bach Le, Dr. John Lytle, Dr. James McAndrews, Dr. Dieu Pham, Dr. Steven Yen, and Dr. Mark Urata

Many other local surgeons and alumni, including Dr. Ted Tanabe, Dr. Willie Baugh, and Dr. Michael Clark have volunteered to help coordinate the activities of the program. The program also has faculty members, including Dr. Zaw Tun, Dr. Stan Hanes, Dr. Jettie Uyanne, Dr. Richard Polachek, and the new dental school clinic director, Dr. Fariborz Farnod, who teach the undergraduate curriculum at the USC School of Dentistry. There are 15 residents on service, many of whom are graduates of premier dental schools from all over the United States and Canada. Four residents are enrolled in the four-year program, and 11 are enrolled in the six-year curriculum. Two highly coveted one-year internship spots are also available each year for graduate level residency experience in oral and maxillofacial surgery. Most of our interns go on to complete full residency training at USC or other accredited program in the United States.

Current Residents

The USC OMS program is rich in heritage and tradition, and continues to thrive. The program has advanced under the current chairman and has been able to attract top recruits from across the nation. Unlike the USC football program, it has not been subject to any scholarship restrictions or bowl appearance exclusions! A list of the current residents in the various programs is listed on the right.

4-year Program

- Dr. Jack Hardy, DDS – Chief Resident (University of Louisville)
- Dr. Brent Ramsey, DDS – Senior Resident (Herman Ostrow School of Dentistry of USC)
- Dr. Troy Follmar, DDS – Junior Resident (University of Pacific Arthur A. Dugoni School of Dentistry)
- Dr. Simon Choyee, DDS – 1st year Resident (Herman Ostrow School of Dentistry of USC)

6-year Program

- Dr. Nam Cho, DDS, MD – Chief Resident (Herman Ostrow School of Dentistry of USC)
- Dr. Ivan Marks, DDS, MD – Senior Resident (University of California, Los Angeles)
- Dr. Jenny Wong, DDS, MD – Senior Resident (University of Saskatchewan)
- Dr. Cynthia Au-Yeung, DDS, MD – Junior Resident (University of California, Los Angeles)
- Dr. Allan Leung, DDS, MD – Junior Resident (Herman Ostrow School of Dentistry of USC)
- Dr. Shadi Boutrous, DDS – 3rd year resident (University of California, San Francisco)
- Dr. James Keobounma, DDS – 3rd year resident (New York University)
- Dr. Vinela Bakllamaja, DDS – 2nd year resident (University of California, San Francisco)
- Dr. Ryan Kriwanek, DDS – 2nd year resident (University of California, Los Angeles)
- Dr. F. Kyle Yip, DDS – 1st year resident (University of California, Los Angeles)
- Dr. Tae Youn, DDS – 1st year resident (Herman Ostrow School of Dentistry of USC)

1-year Internship

- Dr. Shawn Hofkes, DDS – Intern (Herman Ostrow School of Dentistry of USC)
- Dr. Parshan Namiranian, DDS – Intern (University of California, Los Angeles)

CALAOMS Invites Remote Area Medical (RAM) to Northern California

by Pamela Congdon, CAE, IOM
Executive Director, CALAOMS
RAM Volunteer

In May, 2010, Remote Area Medical (RAM) hosted a free medical/dental clinic in Los Angeles at the L.A. Sports Arena. Last year, a similar event took place at the Forum in Los Angeles. Los Angeles district supervisor, Mark Ridley Thomas, championed the event. At the L.A. Sports Arena event, RAM volunteers provided free medical and dental services for over 7,000 patients, who received more than 15,000 services.

At CALAOMS' request and coordination, RAM is bringing their expedition to northern California. The first event will take place in Sacramento at Cal Expo, April 1-4, 2011, and the second event is scheduled, tentatively, to take place in Oakland at the Coliseum, April 9-12, 2011, to provide attention to all those in need of free dental, medical, and vision care.

I had the pleasure of attending and working all 7 days at the RAM clinic held at the Sports Arena, where I witnessed all walks of people receiving care--homeless, jobless, and those under-insured. That expedition was the most rewarding experience, not only for the thousands of patients who received care, but for the hundreds of volunteers who helped provide it. As that event had such a transforming effect on me, I invited RAM to northern California to help those in our (local) communities. This expedition will complement services provided by Smiles for Kids and Smiles for Big Kids.

For those of you interested, you can view a "60 Minutes" segment on RAM's mission presented by their founder, Stan Brock. Visit www.ramusa.org and click on the link at the top of the page. After watching this video, I was moved to work with RAM so that I, too, could provide help to others. I know that many of you were moved to do the same, as well, as evidenced by the incredible turnout of CALAOMS members at the L.A.-based events. Our last issue of the Compass highlighted the inspiration and hope which RAM brought to the communities of the greater Los Angeles area. Many of you contacted the CALAOMS office after reading about the event to volunteer for RAM's expeditions in northern California.

CALAOMS is working with Senator Sam Aanestad, DDS, on these future RAM expeditions scheduled to take place in northern California in April, 2011. Our leadership team will be hosting fundraisers to raise money to help abate the costs for food, supplies, equipment rental, security, maintenance, housing of RAM staff, etc. Evaluating the expenditures from the L.A. Sports Arena RAM event, it is estimated that each expedition costs about $150,000 to produce. This could be higher or lower depending on food and/or services donations.

If you would like to participate on a committee to prepare for the upcoming RAM expeditions, please contact me by calling the CALAOMS office at (800) 500-1332. The committees include: Leadership, Lodging, Food, Communications, and Volunteer.

In the next few weeks, I will be emailing and faxing more information on these events, along with sign-up requests for committees, fundraising, and volunteers.

Thank you, in advance, for your help with this amazing project hosted by CALAOMS!

2011 January Anesthesia Meeting

January 15-16, 2011

Saturday: "Preoperative Evaluation of Medically Compromised Patients and Recognition and Management of Anesthetic Emergencies"

O. Ross Beirne, DMD, PhD

Sunday: "Simple Facial Cosmetic Procedures as an Adjunct to Your Existing Practice"

Jacob Haiavy, DDS, MD

CALAOMS

CALIFORNIA ASSOCIATION OF ORAL & MAXILLOFACIAL SURGEONS

800 500 1332 www.calaoms.org

In Memoriam

A GIANT

by Leon E. Pappanastos

Kenneth E. Follmar, DDS, MSD
December 15, 1923 – October 7, 2010

"Giants" is a word on the tip of our tongues these days, since the San Francisco Giants won the World Series this year. However, there is a "giant" of oral and maxillofacial surgery who will be remembered by all of us, Ken Follmar.

Ken passed away in October, and his passing was celebrated on October 16th, at his son, Ken, Jr.'s, home in Saratoga, FL. In attendance were many of his friends, family, and fellow professionals to celebrate the life of this loving, generous, and hard-working "giant."

Ken was THE oral surgeon in the San Jose/Los Gatos area. He began his years of service to the profession he loved in 1957. He went through the chairmanships of the Santa Clara County Dental Society and became president. I'd say that he was responsible for upgrading the society by selecting outstanding speakers and committee chairmen.

On the local level, he worked very hard to establish a department of dentistry at the local hospitals; specifically, Good Samaritan. He was chairman of that department for many years. He also championed the upgrade of privileges for dentists on the medical staff.

His prominence extended to the Northern California Society of Oral Surgeons. Oh, how he enjoyed going up to the Leopard Cafe in San Francisco to meet with his fellow oral and maxillofacial surgeons. He became president of that society, as well.

Because he cared so much for our profession, he devoted much effort to peer review and ethics. These standards are still around today, but probably not practiced as steadfastly as originally intended.

After being nominated by Don Devlin to the American College of Dentists, he proceeded to do for that organization what he had accomplished for all of the other professional organizations, leaving them better than he found them. Toward the end of his career, he became president of the American College of Dentists, and was responsible for nominating many of our local dentists.

While Ken was in oral and maxillofacial surgery residency at the University of Alabama, I was in dental school there. We met up with each other, again, during my tour of duty in the United States Air Force in California. He invited me to visit him at his practice in San Jose as an observer. That was when I decided to specialize in oral and maxillofacial surgery. He invited me to join his practice in San Jose.

I was not the only one he influenced. For the record, his son, Ken, Jr., has taken over his practice. His

son-in-law, Bill Eddie, is a dentist. His son, Michael, is a prosthodontist. He has two grandchildren, Troy (Ken, Jr.'s son), who is an oral and maxillofacial surgery resident, and Alicia (Ken, Jr.'s daughter), is a dental student at Harvard. Then, there are two physicians, Keith and Ken, siblings of Troy and Alicia, who are finishing up residencies in the medical field. There are 5 other grandchildren that I would classify as mavericks in the eyes of Ken. I think all of them are college graduates, though.

Ken's curriculum vitae is quite lengthy and impressive, but there are two positions he held which most people are not aware of. He was a marine in World War II, and was stationed at a Navy hospital in the Korean war.

He was a staunch supporter of both the Northwestern University Dental School and the University of Pacific, Dugoni School of Dentistry, giving of his time and providing financial aid. He contributed to the character of the students by sponsoring those he thought were qualified.

I would like to share with you two of Ken's favorite quotes: "Remember - there is a patient attached to every tooth," and "A banker is a business man who offers to loan his umbrella...when it is not raining. As soon as the rain begins to fall, he wants his umbrella back...in dentistry, professionalism and commercialism are not compatible."

We will miss this "giant" of a man...if each of us could follow in his footsteps, the world would be a better place.

Wisdom Gone

by Alison K. Paolini,
Recient California OMS Patient

I lost some wisdom the other day.
I lost it in an unusual way.
It wasn't that I forgot or such.
it was a tooth that was too much.

My Wisdom tooth, it had to go.
Most lose them when they're young you know.
But now at seventy three I was told
That mine was now decrepit and old.

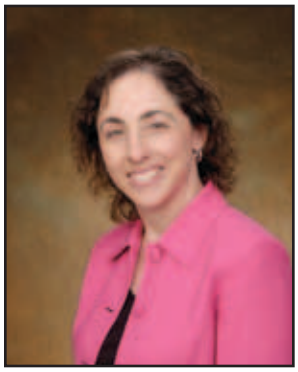
It broke and then was in the way.
I had to be careful of it every day.
The filling popped right out I guess.
It made my mouth a downright mess.

So off to Dr. W. I went
Well if truth be told I was summarily sent.
And he said it would not be hard,
And wrote a date down on a card.

Again I traveled to his place.
Hoping to keep a dignified face.
In short time and with gentle care
I was done and out of there.

so here I am, some wisdom gone.
But not too bad, and life goes on.
And after all is said and done
I still have some in wisdom, one.

CAPP, CALAOMS, and MICRA



by Lisa Maas
Executive Director
Californians Allied for Patient Protection

Dentists, other healthcare providers, and the California Association of Oral and Maxillofacial Surgeons (CALAOMS) understand that California's landmark Medical Injury Compensation Reform Act (MICRA) is a national model that has controlled healthcare costs and improved access to care while protecting patients' rights for over 30 years.

Californians Allied for Patient Protection (CAPP) was created in 1991 as a broad-based organization of dentists, physicians, hospitals, healthcare facilities, doctor-owned liability carriers, nurses, and other healthcare professionals whose sole purpose is to protect access to care and patient safety through California's MICRA legislation. The California Medical Association, the California Dental Association, The Dentists Insurance Company, and CALAOMS work together with CAPP on legislative, political, and legal issues related to MICRA.

MICRA is a critical component of California's fragile safety net for access to healthcare. It was enacted by overwhelming bipartisan support in response to a crisis of runaway medical liability costs and the resulting shortage of doctors, most predominantly in high-risk specialties.

While there are seven provisions of MICRA, the two most often discussed are the cap on non-economic damages and the limits on attorneys' fees. When an injured patient receives an award, he or she is entitled to: (1) UNLIMITED economic damages for past and future medical costs; (2) UNLIMITED economic damages for all lost wages and lifetime earning potential; (3) UNLIMITED punitive damages, which seek to punish the defendant and (4) speculative non-economic damages, sometimes called pain and suffering awards, which are capped at $250,000. In addition, MICRA's limits on attorney contingency fees offers a descending fee schedule to allow for a greater share of the award to go the patient instead of the lawyer.

California doctors pay significantly less for professional liability insurance than doctors in other states – at a rate of one-third the rest of the nation.

Today, MICRA saves the healthcare system billions of dollars each year and increases patients' access to healthcare by keeping healthcare providers in practice and hospitals and clinics open.

Most importantly, MICRA works in California. California doctors pay significantly less for professional liability insurance than doctors in other states – at a rate of one-third the rest of the nation. With rates particularly higher among specialty doctors, MICRA is crucial in keeping rates reasonable so that doctors can afford to practice in California.

MICRA provides increased access to healthcare for all Californians, but particularly for the most vulnerable populations, including women, children, seniors, and those in rural areas. Understandably,

many of these providers are less able to absorb increased costs. The safety net providers who serve these populations would be forced to close their doors and require patients to utilize the emergency room as their source of primary care, further exacerbating the system and increasing costs for all.

CAPP continues to work with CALAOMS to ensure that MICRA remains intact and viable in California. CAPP's website at www.micra.org includes many articles, studies, and other facts regarding access to care, and MICRA's importance in protecting both patients and doctors. CAPP also invites CALAOMS members to attend fundraisers for legislative members in their districts on a monthly basis.

For questions or additional information about MICRA or Californians Allied for Patient Protection, please contact Lisa Maas at LMaas@micra.org or (916) 448-7992.

Editorial Correction

The editorial staff would like to correct errors in the Summer 2010 edition of the Compass. The caption for the photo on the cover (article "RAM LA"), had a two of our members' names listed incorrectly. Second from the left, for Moris Aynechi, DMD, MD, we mistakenly used Michael Morrissettee DDS, and fourth from the left, for Ted Feder, we mistakenly used DDS, Kenneth Fader, DMD. Our apologies to both Drs. Aynechi and Feder, who selflessly donated their time to this worthy event.

Classified Ads

Equipment For Sale

Ritter Surgical Table, Model F-Type 75, $1500.00. Call Doug Fortney at 858-485-1783 or cell at 858-254-8461 or doctorfortney@hotmail.com

iCAT Cone Beam Unit
Take over lease purchase plan for $150,000. If interested, contact: 800-955-4765

Brand New Boyd S2615 oral surgery chair purchased 8/10. Never used. Beige, aseptic upholstery. Putty-colored base. Flat, articulating headrest (AH-64) with magnetic pillow and forearm supports. Comes with two 6-way IV arm board, RAIL mount, and putty trim. Retail cost, $7,500. Asking $6,800 OBO. If interested, please contact Jeff @ 949-679-3470.

Doctors Seeking Positions

Experienced, Board Certified OMS seeks work for 3 to 3 ½ days per week in quality office, group or institution. Currently Associate Prof. of OMS at major residency program. Might consider locum tenens for 6 mo+. Call 303-328-1863 or e-mail eos@cftinet.com. CV on request.

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

Associate/Partnership Opportunities

Bellflower, OMS position available. Full scope, group OMS practice in Bellflower, CA is seeking a full time associate; future partnership potential. For more information email resume to: Carolyn@oralsurgerycenters.com

Los Angles, Immediate opening in a busy, well-established Los Angeles-area OMS practice. Amazing opportunity for a hard-working and outgoing OMS to develop a successful career. We are seeking an associate who is passionate about their work and strives for excellence. Position will lead to partnership and/or practice buy-out. Please email jobopp@live.com with inquires.

Email steve@calaoms.org to place an ad in the Compass. *No cost for CALAOMS Members

Job Opportunities/ Practices for Sale

San Francisco Bay Area, Prestigious Practice, Busy Commercial District, 7 Years of Excellent Marketing Techniques to Capture a Unique Patient Base (30% of Practice), Unlimited Dental Coverage, 14 Ops, Includes $800K Equipment, 2009 Gross $2.7 Mil with $350K oral surgery business referred out, 80% Financing Available. 2010 Forecast $2.6 mil. Asking $1.95 Mil. Contact ProMed (888) 277-6633 info@promed-financial.com

the Compass is published three times a year in the Spring, Summer and Fall.

CS/GA Evaluator Calibration Course

The Dental Board of California will be holding CS/GA Evaluator Calibration courses in March of 2011. If you are an existing evaluator, the Dental Board recommends you take this course to keep up with new updates to the program. If you would like to become an evaluator, you must attend this course. The courses will be on March 16 in Northern California, and on March 23 in Southern California.

You should receive registration material in the mail shortly, but if you do not, please do not hesitate to contact the Dental Board at (916) 263-2300.

Upcoming 2011 CE Events

For Doctors

January Anesthesia Meeting — **Monterey CA**
January 14-16, 2011

Residents' Night — **Solano CA**
February 2, 2011

Risk Management — **Northern CA**
March 2, 2011

Risk Management — **Southern CA**
March 9, 2011

ACLS — **Solano CA**
March/April

11th Annual Meeting — **Rancho Palos Verdes**
May 21-22, 2011

For Staff

OMSA Winter — **Santa Clara CA**
February, 2011 — ***Weekend Seminar***

OMSA Winter — **Anaheim CA**
January 15, 2011 — ***Start of Home Study***
April 30 - May 1, 2011 — ***Weekend Seminar***

ACLS — **Solano CA**
November 6, 2010

Medical Emergencies — **Northern CA**
October/November

Medical Emergencies — **Southern CA**
October/November

THE OMSNIC ADVANTAGE

At OMSNIC, we are dedicated to meeting the professional liability insurance needs of members of the American Association of Oral and Maxillofacial Surgeons across the country. Owned and operated by oral surgeons, our specialized knowledge of the field helps to ensure the best possible return on the preferred stock investment made by each policyholder. As an OMSNIC policyholder, you have full access to all aspects of the OMSNIC Advantage:

- Comprehensive yet affordable professional liability coverage and other valuable products
- Aggressive defense tailored to the OMS specialty to protect your practice, your reputation and your future
- Risk Management to help you deliver a higher quality of care and reduce the potential for claims

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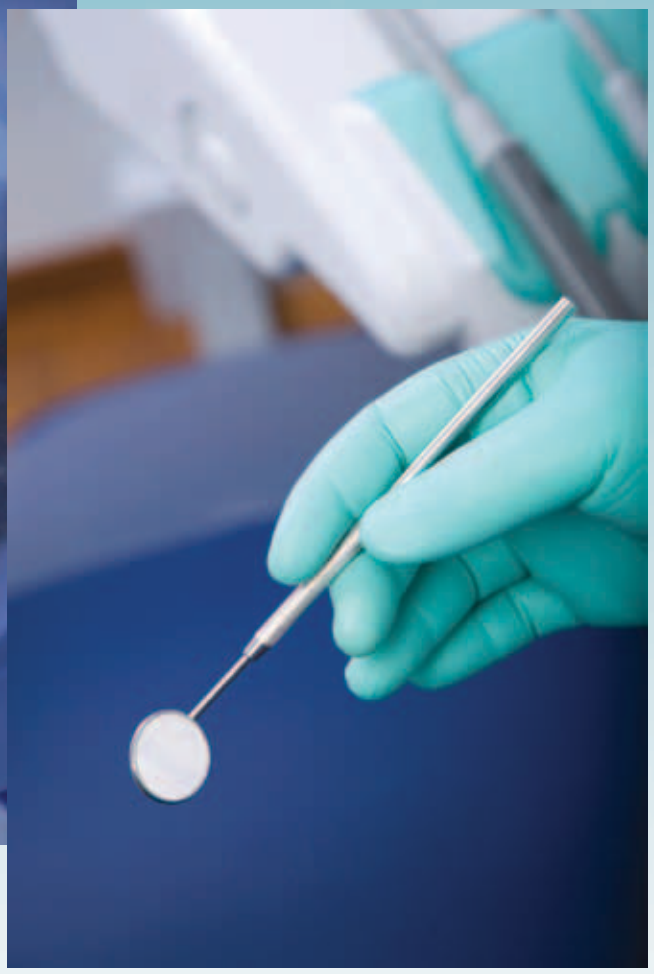

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