The Compass
Staying the Course Through Service and Education
Volume XV, Issue 3, Winter 2013

CALAOMS Says Goodbye to Two of our Members - They will be Missed

Dr. George Gamboa - 12/17/23 - 10/22/13

Dr. Gerald Gelfand - 10/4/45 - 10/23/13

George C. Gamboa, DDS, MS, EdD

by John J. Lytle, DDS, MD – Editor
(reprinted with permission from** SCOA Proceedings**, Summer 2012)

He was interested in two things in school: sports and studies.

I remember that George was an attending in 1960 and 1961 when I was a resident in oral surgery at the USC School of Dentistry. George was the attending on Wednesdays taking Dr. Marsh Robinson's place when Dr. Robinson was in surgery.

The Gamboas had just built their home in Arcadia in 1961. They often invited residents over for dinner. These were special evenings with Dr. and Mrs. Gamboa, and included Drs. Charles Yoon, Leland Reeve, and Charles Petty. George said that Mrs. Petty always baked the bread and organized the food with Mrs. Gamboa.

George is a third-generation Californian. His great grandfather came from Spain around the Horn with a stop in Chile where a large Spanish colony was located. The vessel from Chile was to land in Monterey, but a storm forced them to land in Yerba Buena. George's great grandfather, Jacinto Gamboa, was on the passenger list.

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The COMPASS

Published by the

California Association of Oral and Maxillofacial Surgeons

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Compass Direction

Editor's Corner

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

Change No Longer On the Horizon, but Here

As I've no doubt stated here many times in the past, I'm a news buff. I love to follow politics and see where things are headed. I like to ponder the issues and mull over ideas. As we turn on the news, we see a cacophonous passel of issues surrounding us in the healthcare arena. Recently, in a sit-down discussion with some similar-minded out-of-state ADA members, we reviewed some of the ADA reports and briefs to consider just what some of the current issues affecting dentistry are and to consider what, if anything, can be done about them. I'll attempt to be 'brief'—pun intended.

The U.S. population is increasing in size and is older and more diverse. Consumer habits are changing with more Americans relying on technology in healthcare decision-making and demanding greater value for their spending.

Utilization. I think we all would agree that routine dental care is an important component of oral and overall health. But is it being utilized? Reports show us that dental care utilization for children increased more than 9% over the last decade. The increase was driven entirely by low-income children, however. Children below the poverty line experienced a 38% increase in dental care utilization from 2000 to 2010, while those between 100-200% of poverty saw a 35% increase. Adult dental care utilization peaked in 2002-2003 before declining 10% over the remaining part of the decade.

The decline in utilization was consistent among all non-elderly adults, but was more pronounced for younger adults. Adults ages 19-34—the least likely group to visit the dentist—experienced the largest decrease in utilization. Among seniors, utilization held steady. The decline in adult utilization occurred across all income groups. Adults below the poverty line experienced an almost 14% decline in utilization between 2003 and 2010. By contrast, high-income adults, who were more than twice as likely to have an annual dental visit as low income adults, experienced a 6% decline during that same period. Low-income adults and young adults are seeing increased financial barriers to dental care, resulting in decreased utilization.

Safety net. Adults do not have access to the same dental care safety net as children. The past decade has seen significant reductions and eliminations of adult dental benefits in Medicaid programs like Denti-Cal. Unlike dental benefits for children in Medicaid, adult dental benefits are optional and often subject to cuts during lean economic times as we saw in California (though some adult dental benefits are due to be restored in May 2014, thanks to tax increases last year). We are seeing the effect of a steady disinvestment in adult dental benefits within state Medicaid programs, along with a reduction in employer-sponsored dental benefits. The Affordable Care Act (ACA) includes pediatric oral care as an essential health benefit, but does not address adult dental care. This omission is likely to have long-term consequences. Dental benefits are a major predictor of dental care utilization, and the ACA represents a missed opportunity to address the financial barriers issue.

Down economy. The dental economy is in transition. After decades of growth, dental expenditures have flattened. Public programs are a small, but growing source of dental financing, while the percentage of out-of-pocket financing has declined. In 1990, only 2% of dental expenditures were financed by public programs. By 2011, it grew to 8%. The trade-off for increased public spending has been reduced out-of-pocket spending (the more in taxes one has to pay, the less likely they are willing and/or able to spend more in co-pays at the provider's office).

Consider also the decrease in utilization—the percentage of adults with a dental visit in the past year has declined steadily since the early 2000s. While children have had an increase in annual dental visits over that time, it is not enough to offset the decline among adults. In addition, the growth in utilization is most prevalent among low-income children who are likely to be covered by public programs (which many providers do not accept). The decline in utilization has not being offset by an increase in per-patient expenditures. In order to make up for the decline in utilization, expenses for patients who visit the dentist must increase significantly if total expenditures are to hold steady. Since 2008, per-patient expenditures have been flat, contributing to the slowdown in national dental expenditures.

The small, but growing shift in payer mix has likely contributed to the flattened growth in dental expenditures. Public programs reimburse at a significantly lower rate than private insurance, although there is evidence private insurers are reducing payment rates as well (Delta, anyone?). Both pay less than private-pay patients. If this trend in payer mix continues, the growth in dental expenditures is unlikely to rebound to earlier levels.

Population shift. The U.S. population is growing and becoming more racially and ethnically diverse than ever before. Baby boomers are retiring at increasing rates. Changing demographics play an important role in dental use as some groups are more likely than others to have dental needs, have dental benefits, and visit the dentist. The growing racial and ethnic diversity of the population will likely have an effect on dental utilization trends. Racial and ethnic minorities are less likely to use dental care than whites.

From 2000 to 2050, the percentage of the white population is projected to drop from 81% to 74%. The percentage of the population identifying themselves as Hispanic is expected to grow from 12.6% in 2000 to just over 30% in 2050. Hispanics are less likely than the general population to visit the dentist regularly and more likely to view regular dental care as unimportant. Hispanics are also more likely to be uninsured for dental benefits than whites. We are unlikely to see a return to the fast growth in dental expenditures of previous decades. The growing number of adults without benefits, the growth in public financing at the expense of private insurance, and the increasing diversity of the population all point to very slow growth of expenditures over the coming decades. The near stagnant growth seen in the last few years may be the "new normal."

ACA implementation. The health care system is on the verge of major reform as the ACA is fully implemented in the coming months. As stated previously, dental benefits are included as an essential health benefit for children, but not for adults. Although almost 17 million adults are expected to gain some level of dental benefits through the Medicaid expansion, only a small share of this will be 'extensive' coverage.

Adult dental benefits are optional within Medicaid. Only 800,000 adults are expected to gain private dental benefits through purchases on health insurance exchanges. This expansion is expected to generate 9.2 million dental visits, *more than 80% of which will be through Medicaid*. The increase in children and adults gaining dental benefits through Medicaid will put significant pressure on the safety net delivery system. Along with other issues, Medicaid reimbursement for

dental care in most states is inadequate to entice the majority of dentists to participate. Research shows that reforming Medicaid, including increasing reimbursement rates closer to market levels, is associated with an increase in dental care utilization—though this is unlikely to happen. The ACA does not address the critical issues of dental care reimbursement and other program inefficiencies within Medicaid.

Dental schools. Significant increases in dental school enrollment are planned or underway, in part due to a perceived shortage of dentists, but also due to the presence of a significant excess demand for dental education. The supply of dentists, on a per capita basis, has been fairly stable the past few decades. According to the most comprehensive data, the number of professionally active dentists in the United States was between 59 and 60 per 100,000 population since 1990.

Given the dental economy is expected to remain sluggish, any further major ramping up of the supply of dentists could potentially have negative effects on dentist earnings. As a result, policy makers need to give careful consideration to any further expansion of dental school capacity or increase in foreign dentists in the face of what appears to be decades of very modest growth in dental spending and demand for dental care.

Moreover, for various reasons, and pure economic reality being one of them, dentists will likely, and already are, expanding their scope of practice beyond traditional dentistry. While the most optimistic glowing picture for the near future does not seem readily apparent, what we can do is maintain our high clinical skills, apply our deep knowledge base, and hold fast to treating patients with unmatched integrity.

The Board of Directors at CALAOMS will continue to stay on top of emerging issues and will continue to promote policies that will benefit our patients, our specialty, and the field of dentistry. Stay tuned.

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Gamboa/Gelfand Continued from page 1

With an eighth grade education in a little red schoolhouse, George's father, George Angel Gamboa, became a successful rancher. George Charles Gamboa was born in King City. He attended the Lodi Academy, a boarding school, where he excelled in baseball and football. He had many friends at school from South Monterey County as well as from the coast, King City, and the Lodi area.

George took pre-dental at Pacific Union College in the Napa Valley city of Angwin. His undergraduate interest was zoology. George was interested in two things in school: sports and studies.

When he returned to Pacific Union College for his second year of pre-dental, all of a sudden draft boards were kings of the hill. George had a roommate who was drafted 10 days before entering medical school. George applied to dental school at the College of Physicians and Surgeons in San Francisco one year early and was accepted. By being accepted early, he was placed in the Medical Administrative Corps (MAC) as a Second Lieutenant in the U.S. Army; thereby out of the authority of the Draft Board.

George had not been taken into the Army Specialized Training Program (ASTP) in his first year of dental school because of a benign heart rhythm. His class at P&S was the largest in the history of the college with 53 students.

After just four weeks in dental school, George was called in by Dean Sloman at P&S where the dean questioned George. Because of his background in ranching and baseball, and because he could not carve properly, Sloman wondered if George thought he had the hands for dentistry. Dean Sloman told him that catchers don't do dentistry; pitchers do. Dean Sloman assigned George to a classmate who was an excellent carver for an additional 12 hours, to learn how to carve. George followed Dean Sloman's advice with help on Sunday mornings. George re-did his carving at home and improved his carving of plaster teeth.

P&S was on a war schedule; the dental course was scheduled for 36 months, but finished in 35 months. George graduated from dental school when he was 22 years old.

George met Winona Collins in San Francisco. Her aunt owned the boarding house where he lived; her uncle was in charge of bellhops at the Fairmont Hotel. Winona studied nursing at White Memorial Hospital in Boyle Heights in Los Angeles.The Gamboas have three children: Cheryl was born in Glendale in 1948; John followed in 1952, and Judy in 1953—both born at St. Mary's in Rochester, Minnesota.

In 1946, before graduation from dental school, George was called to two years of active duty because of his one year in the ASTP. He joined the Navy as a LT (jg) dental officer, and in October 1946 was stationed at the Naval Training Center in San Diego. There were 190 dental officers during the war; Unit One worked 7 am to 3 pm; Unit Two worked 3 pm to 11 pm. There were seven dental clinics with several ensign dental officers; they could not practice dentistry because they were not 21 years old; they did the dental lab work until they came of age.

George finished dentistry in 1946 after two years in the Navy. He spent two years as a general dentist in Rosemead then went to the Mayo Clinic in 1950 where he received a MS in oral and maxillofacial surgery. Drs. Frank Pavel, Bill Kaplan, and Lowell Pincock were at Mayo at the same time. Six Fellows at a time rotated through Mayo Clinic's three-year OMS program.

George received a degree in Zoology and later his Doctorate in Higher Education at USC. He opened his practice in San Gabriel in 1953. When he retired, he sold the practice to Dr. George Chew.

In 1999 he wanted to teach full-time because he enjoyed working with students. He was asked by Dr. Richard Oliver to teach full-time at USC. This would mean teaching half-time and developing systems half-time, but he wasn't interested in the administrative side.

George remembers Mondays and Wednesdays were big operating days at County Hospital. Dr. Robinson started the OMS program. OMS instructors were not treated well at that time. They operated from 7 am to 3 pm, but the ENTs resisted having oral and maxillofacial surgeons come in; the OMS always signed their patients in as malocclusions.

George was invited to teach in the oral surgery section at Loma Linda University School of Dentistry by Dean Smith. He was chairman of the oral surgery department from 1960 to 1964 and worked at USC during the summers.

George took the American Boards at Loma Linda in 1964 with Dr. Petty. He joined the American Association of Oral and Maxillofacial Surgeons in 1964 and the Southern California Society of Oral and Maxillofacial Surgeons in 1965.

George has received many honors. He received the Distinguished Service Award from SCSOMS where he was membership chairman and education chairman. George was president of the Southern California Academy of Oral Pathology and the California Dental Society of Anesthesiology. CDSA also awarded him the Distinguished Service Award.

George was recently recognized by USC as a faculty member for over 45 years. He wanted everyone to know that he is proud of dentistry and all dental specialties.

Dr. Bob Huntington wrote in his president's message in the summer 2010 issue of SCOA Proceedings: "Dr. George Gamboa took the bull by the horns in November 2001 as the first president of SCOA and led the struggles during those early fledgling years." Bob continued: "Dr. Gamboa initially wrote 'The objectives of SCOA are to be professional camaraderie and continuing education at a reasonable cost.' Those objectives remain to this day."

Gerald Gelfand, DMD

by P. Thomas Hiser, DDS, MS, Past President, CALAOMS

Jerry was born in Newark, New Jersey. He graduated from Rutgers University in 1967 and The University of Medicine and Dentistry of New Jersey—New Jersey Dental School in 1971. He completed his oral and maxillofacial surgery residency at Michael Reese Hospital and Medical Center in Chicago in 1974. Following residency, Jerry spent two years of active military duty in the U.S. Air Force as a Major and Chief of oral and maxillofacial surgery at George Air Force Base in Victorville, California. He had practiced in Woodland Hills since 1976, and had volunteered tirelessly his entire career for the betterment of dentistry and oral and maxillofacial surgery.

Jerry has been an important figure in helping to guide California and national dental and oral and maxillofacial surgery organizations for many years. His counsel has been sought by many in these organizations because of his clear and logical thinking, his mild manner, his flawless integrity, and his willingness to work and follow through with projects.

Recognizing the importance of oral and maxillofacial surgery being a specialty of dentistry, Jerry has—throughout his career—participated in leadership positions in both organized dentistry and oral and maxillofacial surgery. He has helped bring the perspective of occasional opposing viewpoints to the table to help resolve conflicts—to the benefit of all. Among the many leadership positions held by Jerry over the years include:

- President of CALAOMS
- President of the WSOMS
- President of the SCSOMS
- President of the San Fernando Dental Society
- President of the CALAOMS Health Foundation
- Chairman of the CDA Council on Legislation
- Chairman of the CDA Screening Committee
- Chairman of SCSOMS Anesthesia Committee
- Chairman of OMSPAC Board of Directors
- Chairman of AAOMS Committee on Governmental Affairs
- Co-Chair of CALAOMS Council on Government Affairs
- CDA Trustee
- Delegate to the CDA House of Delegates
- Delegate to the ADA House of Delegates
- Cal-D-PAC Board of Trustees
- ADA Council on Government Affairs
- CALAOMSPAC Board of Directors
- Delegate to the AAOMS House of Delegates
- CALAOMS Long-Term Delegate to the AAOMS House of Delegates
- Fellow, American College of Dentists
- Fellow, International College of Dentists
- Fellow, Pierre Fauchard Academy

The CALAOMS Board of Directors dedicated the 2013 January Membership Meeting to Jerry as a tribute to him and to celebrate all of his accomplishments to the specialty. Jerry was also the recipient of the 2009 CALAOMS Distinguished Service Award and the recipient of the AAOMS 2010 Presidential Achievement Award in Oral and Maxillofacial Surgery for his work in the political and governmental affairs arena. At the recent October, 2013 AAOMS Annual Meeting in Orlando, FL, Jerry made the long trip to receive the AAOMS 2013 John F. Freihaut Outstanding Political Activist of the Year Award in recognition for his outstanding efforts to advocate legislative and regulatory initiatives that have advanced and supported the specialty of oral and maxillofacial surgery. Though he traveled so far in a weakened state just days before his passing, we were all so happy to see Jerry this last time.

In addition to the many organizational leadership positions held by Jerry and running a successful private practice these many years, he also found time to volunteer at the UCLA School of Dentistry Department of Oral and Maxillofacial Surgery teaching residents and students about our specialty. He did this for over 30 years. Jerry volunteered at the Los Angeles Free Clinic and also coached Little League for the L.A. County Department of Parks and Recreation for over 20 years. Jerry received the Woodland Hills Small Business Person of the Month Award by the Woodland Hills Chamber of Commerce in 1993. He was always a humble man who was never too busy to take on more for the betterment of others.

Despite all of the above, Jerry's greatest accomplishment is his loving family who would likely just as soon describe him as a great family man and wonderful father and terrific husband. Jerry is survived by his beloved wife, Marilyn, of 32 years and three children, Julie (Rick) Cornejo, Joshua, and Mitchell (Naomi). Jerry has 2 grandchildren, Vincent (12), and Alexa (7) who no doubt were loved and adored by their grandfather. Jerry will be greatly missed by his many friends, relatives, and professional colleagues. Two older brothers, Marty and Lenny, preceded him in death.

Jerry and Marilyn were loving partners. He spent time relaxing as an avid stamp collector and member of the National Philatelic Society. Never did a day go by without completing his L.A. Times crossword puzzle, reading the Sports sections, and watching Jeopardy. But, what he really enjoyed most was just being with his wife and family.

Personally, I first met Jerry in 1993 when we served together as rookies on the Board of Directors of the Southern California Society of Oral and Maxillofacial Surgeons. It has truly been my great honor to have him as my close friend all these years and to watch him serve our profession and his community with great distinction. I know I speak for many when I say Thank you, Jerry, for a life well-lived and for all that you have done for us! You will be missed.

COSMETIC SURGERY IS IT FOR YOUR PRACTICE?

by Michael P. Morrissette, DDS
Chairman Cosmetic Credentialing Committee

In the 1980s cosmetic facial surgery became a part of residency training for oral & maxillofacial surgeons. To some degree, residents were to be exposed to different aspects of facial cosmetic surgery (and this certainly varied from program to program), and were required to be tested over this area in order to become Board Certified.

Though our national organization acknowledged cosmetic surgery as part of our scope of practice, what was taught in residency did not translate into what was legally allowed by state dental boards (including California). This lead to legislative changes promoted by AAOMS and our state organization. As you are aware, in 2006, SB 438 was approved and became an avenue for oral & maxillofacial surgeons to legally perform elective facial cosmetic surgery.

Fast forward 7 years. Currently, there are only 26 oral & maxillofacial surgeons in California who have been issued a permit to perform elective facial cosmetic surgery. This number includes several members who have medical licenses, and could otherwise already legally perform cosmetic surgery.

Is the membership at large disinterested in cosmetic facial surgery? Do members feel that it is cost prohibitive to go through the process of obtaining a permit? Does the added necessity of becoming an accredited facility seem overwhelming? Is it too difficult for older practitioners to obtain proctored cases and therefore a permit? Do members feel that facial cosmetic surgery is outside the scope of practice for non plastic surgeons?

As a general trend, cosmetic surgery is on the rise for both men and women throughout the country. These surgeries are not just being performed by plastic surgeons. Many of you are aware of organizations such as the American Academy of Cosmetic Surgeons, which are composed of members from other specialties, including Dermatology, Otolaryngology, Obstetric and Gynecology, Oral & Maxillofacial Surgery, and even Family Practice trained doctors and general medical physicians. At their annual meetings, these different specialties blend together to promote safe cosmetic surgery and provide an opportunity to learn from colleagues who were exposed to different residency experiences. There is a mutual respect among members and an understanding that there are many ways to achieve excellent cosmetic results.

In addition, the interest of general dentists concerning the use of both cosmetic and therapeutic Botox is increasing. There are many states where general dentists can legally perform Botox injections and inject dermal fillers. The American Academy of Facial Esthetics, a dental organization, provides training for general dentists to perform Botox and dermal fillers for esthetic and pain therapeutic uses (TMJ, headache and facial pain). In the state of California, nurses can inject Botox and dermal fillers under the direction of a physician.

Concerning the cost surrounding the permit process, there are several considerations. Much depends upon previous training and exposure to cosmetic facial surgery, as well as to what extent a surgeon wants to provide cosmetic surgery. For example, it is possible for oral & maxillofacial surgeons to obtain a limited cosmetic permit solely to provide Botox and dermal fillers in their practice. Dentists and Surgeons inject the face daily, we understand the anatomy, and have the greatest understanding of facial pain control. These considerations together potentially make us the best candidates to provide these services (and an added benefit of making our office staffs and spouses very happy!). The addition of just this aspect of cosmetic surgery requires some additional training and costs about $2,000 for a training course, but no more

training than adding any other procedure (like zygoma implants for example). As far as proctoring, there are many practitioners willing to teach these non-surgical cosmetic procedures. Many practitioners begin by performing their proctored procedures on friends and relatives and staff (for a non-surgical procedure, you may be surprised by how many people volunteer).

Lastly, I'd like to discuss office accreditation. This is a requirement for elective cosmetic surgery permit holders in order to provide this service in their office. Many of you who have already gone through the process hopefully will agree that it is a very positive experience. Whether you feel that your office is already extremely prepared for office emergencies, the process makes you re-examine your office procedures and protocols, office sterility, anesthesia monitoring, and record keeping. I certainly feel that the delivery of care and potential to manage an anesthetic emergency has significantly improved after undergoing an office accreditation.

There are several accreditation agencies approved by the California Medical Board to provide this service including the Joint Commission, Accreditation Association for Ambulatory Health Care (AAAHC), and the Institute for Medical Quality (IMQ). We elected to use IMQ and found this organization to be helpful and efficient in guiding us through the accreditation process. As an example of time and costs, the entire process from the time of completion of an application to the actual on-site inspection and acknowledgement of approval was 3 months at a cost of $4,500.

We, as oral & maxillofacial surgeons, are fortunate to have such a broad scope of practice that allows us to select which areas of oral surgery we care to focus on. As with trauma, implants, orthognathic surgery, pathology, and cleft lip and palate, cosmetic surgery is another viable and rewarding area of our specialty. The incorporation of certain aspects of cosmetic surgery into an oral & maxillofacial practice is neither too difficult nor expensive.

The CALAOMS 2014 Board of Directors

Here are the CALAOMS 2014 Board of Directors. We extend a warm welcome to the newest Director Chan Park, DDS, MD.

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President's Message

Alan S. Herford, DDS, MD, FACS
President, CALAOMS

At the Years End

As we come to the end of the year, and as I come to the end of my presidency of CALAOMS, I would like to reflect back on some of the highlights of the year. Your association has been working hard to represent your interests. To that end, I would like to thank all of the CALAOMS members who completed the survey that was sent out in recent months. This information was extremely helpful in revisiting and updating our Strategic Plan.

CALAOMS lost one of our great advocates and leaders when Dr. Gerald Gelfand passed away in October. His contributions to organized dentistry were many. He was a strong advocate for our specialty and a fierce defender of CALAOMS. He will truly be missed. The Board initiated a project to create a document chronicling the history of CALAOMS. Dr. Gelfand was working on this prior to his passing, and we hope to complete the project by next year. There is an importance in preserving our history and documenting it for future generations of CALAOMS members.

One of the goals for the year was to continue to promote our involvement in helping to increase access to care for the many needing care in California. The Board coalesced in voicing your concerns regarding AB 694 which would have led to irreversible procedures being performed by non-dentists on pediatric patients. CALAOMS chose to support and align ourselves with the Remote Area Medical (RAM) team. The support from our members in volunteering their time to make a difference in the lives of many patients who would not have been able to receive care otherwise was incredible. The RAM California 2013 Expedition held in Indio, CA in April was a huge success. With the collaborative efforts of RAM USA, RAM-CA (which has been renamed California CareForce, see pg. 15), Goldenvoice, CALAOMS, and all of the professional and non-professional volunteers, the Expedition in Indio was able to provide 12,210 much needed services to 2,770 patients for a total cost of services provided estimated at 1.05 million dollars. Our Executive Director, Mrs. Pam Congdon, CAE, IOM, deserves a special "Thank You" for all she does in helping to organize and promote our association's involvement with RAM California. Thank you, Pam, for all you do for us!

Earlier in the year, our Board was approached by members of the media regarding the safety of anesthesia delivered in the oral and maxillofacial surgery office. As president, I felt it was important to send out to our members some information regarding the exemplary safety record of the team anesthesia model as practiced by our members, as well as information regarding the extensive anesthesia training of OMSs. Oral and maxillofacial surgeons have, and will continue to, lead healthcare in this area. We train oral and maxillofacial surgeons in the safe and effective delivery of high quality care to our patients. As a Board, we developed a CALAOMS Crisis Management Policy and Procedures plan which includes media training, a crisis management team, as well as a communication chain.

The continuing education (CE) committee continues to do great work. The speakers this year were outstanding and included such names as Dr. Thomas Dodson, Dr. Paul Petrungaro, and Ms. Rita Zamora. The CE committee continues to listen to what topics you find helpful and have been successful in attracting highly sought after speakers. The January Anesthesia Meeting is always a highlight of the year. Our Board felt that it is important to add a simulation component to the meeting. I am happy to report that we will have our first "SIM Man wars-lite" competition on January 19, 2014 at the beautiful Ritz-Carlton in San Francisco. This type of technology is emerging as a fantastic aid in the review and practice management of anesthetic emergencies.

The OMSA training course is undergoing significant updates as well. Under the unmatched leadership of Dr. Vivian Jui and Dr. Bryan Krey, this important educational component has helped to maintain the strong team model of delivering anesthesia as practiced by our OMSs. The course has been updated and will contain an online component and feature more case discussions and interactions at the face to face meetings. We look forward to seeing this course continue to evolve.

Strategic Plan Update

On October 26, 2013 the Board of Directors met at the CALAOMS headquarters in Roseville to participate in a strategic planning session. A special thanks to Dr. Tom Hiser who facilitated the planning process. There were 6 goals that were identified from the membership survey that was sent in October. I would like to briefly discuss some of these. The first goal was to Preserve the Viability of the OMS Practice. Other goals included Advocacy and Public Awareness/Relations, Education, and Membership Recruitment, Retention, and Participation. Included in the first goal—Preservation of the Viability of the OMS Practice—are things like 3rd party reimbursement—managed care, public education on who OMSs are and what we do, marketing—dealing with competitors, advancement of clinical/practice management of OMSs and staff through CE, and changing models of OMS practice. Included in the changing model of OMS practice were items such as the increasing debt burden that graduating residents accumulate, the issue of increasing itinerant surgeons in some areas, and the changing corporate model for dental offices.

Once the areas of concern were identified, specific strategies were made to address each area. For example, there was a need identified by many of our members that referring dentists—as well as the public in general—should be educated on the importance of OMSs and what OMSs do. To that end, the decision was made to begin work with Elmets Communications firm to aid us in our public relations and education of the public. This also includes being able to assist in getting our message out and providing media training to specific spokespeople who are available to address the media in times of emergency. Our goal is to increase the awareness of the importance of OMSs. Another concern addressed by our members is the unknown regarding the Affordable Care Act and how this will affect their practices. To that end, we are planning on having a program on how to survive "Obamacare." We are looking form more information on this topic to bring to our membership

Finally, I would like to say Thank You to the CALAOMS Board of Directors and Executive Director for their support and assistance during this busy year. I would also like to thank the membership for their support, encouragement, and suggestions throughout the year. CALAOMS is in good hands and I know that Dr. Albert Lin will do an outstanding job as president in the upcoming year. It was truly a privilege and an honor to serve you as president of our association. We are truly blessed to be involved with such a great specialty. My best wishes to you all for a safe and fantastic holiday season!

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AAOMS Member Alert

FDA To Submit Formal Recommendation to Reclassify Hydrocodone Combination Products Into Schedule II

October 25, 2013

Janet Woodcock, MD, Director, FDA Center for Drug Evaluation and Research, has released a statement that, "by early December, FDA plans to submit our formal recommendation package to HHS to reclassify hydrocodone combination products [including Vicodin] into Schedule II. We anticipate that the National Institute on Drug Abuse (NIDA) will concur with our recommendation. This will begin a process that will lead to a final decision by the DEA on the appropriate scheduling of these products."

Director Woodcock's statement further notes that "the FDA has become increasingly concerned about the abuse and misuse of opioid products, which have sadly reached epidemic proportions in certain parts of the United States. While the value of and access to these drugs has been a consistent source of public debate, the FDA has been challenged with determining how to balance the need to ensure continued access to those patients who rely on continuous pain relief while addressing the ongoing concerns about abuse and misuse."

The FDA's decision comes in response to a 2009 request from the Drug Enforcement Administration to reschedule hydrocodone from Schedule III to Schedule II. As of today, there is no opportunity for AAOMS to provide official comment; however, we have commented on this specific issue several times in the past and will continue to seek opportunities to comment on this latest action.

The AAOMS has worked closely with the ADA and others to alert the agencies about the benefits of hydrocodone for oral and maxillofacial surgery patients and the difficulties involved in making legitimate pain prescriptions available for these individuals should hydrocodone combination products be rescheduled. On October 16, 2012 the AAOMS and the ADA provided joint comments to the FDA and in January of 2013, the FDA accepted our joint testimony during a hearing on this important matter.

We recognize that the FDA's announcement will create a potential burden to the practicing oral and maxillofacial surgeon. AAOMS will continue to monitor the situation closely and advocate for the specialty.

For further information contact:
Janice Teplitz, AED
Communication & Publications
847/678-6200, ext. 4336

AAOMS News

Key Resolutions Addressed by AAOMS House of Delegates, October 2013, Orlando, Fl

Following are some of the actions taken by the 2013 AAOMS House of Delegates

Approved a dues increase of $200 for AAOMS fellow and member categories with pro-rata increases for all other dues categories, with the exception of allied staff dues.

Adopted a resolution enabling two OMS residents representing the Executive Committee of the Resident Organization of AAOMS to serve as at-large members of the House of Delegates where they may caucus and vote on all issues with the exception of the election of AAOMS officers/trustees, ABOMS directors, and district caucus officers.

Approved that AAOMS initiate an informational campaign with $1.1 million allocated from operating reserves to fund the initial phase of the campaign. A formal, annual report on the campaign's outcomes, as well as ongoing progress reports will be made to the House. Principals of Athorn Clark and Partners attended the Reference Committee hearings to provide background for the resolution and to respond to members' questions.

California Association of Oral and Maxillofacial Surgeons Announces RAM California Renamed to California CareForce

Sacramento, CA – The California Association of Oral and Maxillofacial Surgeons announced today that starting in 2014 the innovative program that provides free health care to thousands of Californians each year will change its name to California CareForce. The program was formerly known as the California affiliate of Remote Area Medical.

The new organization will allow volunteers to focus exclusively on providing vital services to people in California. The new website at www.CaliforniaCareForce.org has more information about the organization, upcoming events, and how to get involved.

"California CareForce will continue to provide the highest quality in medical, dental, and vision care to residents all over California," said Pam Congdon, Executive Director of the California Association of Oral and Maxillofacial Surgeons and President of California CareForce. "With healthcare policies changing and many people still struggling financially, California CareForce will ensure as many people as possible get the services they need."

California CareForce will continue the large-scale, four-day weekend events that it is most known for, but will also expand its services with additional mobile equipment to provide care on a smaller scale.

California CareForce and Goldenvoice are already planning the first clinic of 2014 on April 3-6 in Coachella Valley. They will continue holding events all over California including Oakland, Sacramento, and Los Angeles among others. The most recent clinic in Coachella Valley in 2013 was estimated to have provided almost 3,000 patients over a million dollars in free health care services.

Registration for the Coachella Clinic 2014 is now open!

California CareForce is a 501(c)(3) non-profit dedicated to providing free health, dental, vision, and veterinary services to residents all over California. California CareForce partners with individual volunteers, professional organizations, universities, and businesses with the mission of ensuring a healthy California for all people regardless of income, status, or education. For more information go to www.CaliforniaCareForce.org and like us on Facebook at www.facebook.com/CaliforniaCareForce.

Advocacy Update

Bryce Docherty, CALAOMS Lobbyist

LEGISLATIVE UPDATE

AB 916 (Eggman) – False or Misleading Advertising: This California Society of Plastic Surgeons bill is intended to ensure patients are not misled by their physician and surgeon when seeking specialty medical care. CALAOMS wants to make sure this bill doesn't also disavow patients of valuable information as it pertains to knowing what specific credentials their dual-degreed oral and maxillofacial surgeon (OMS) also licensed by the Medical Board of California (MBC) may possess. For example, a dual-degreed OMS also licensed by the MBC would be prohibited by this bill from advertising or disclosing to patients that they are a Diplomate, Fellow (or any other derivative descriptor) of the American Board of Cosmetic Surgery (ABCS). CALAOMS feels strongly that patients need more information regarding the credentials of their healthcare providers – not less. CALAOMS is closely monitoring this bill, which stalled this year in the Senate Business & Profession Committee. CALAOMS POSITION: WATCH

AB 1174 (Bocanegra) - Teledentistry: This bill establishes "teledentistry" as a billable and reimbursed service in the California Medi-Cal Program. It also inappropriately expands scope of practice for dental assistants and dental hygienists by allowing them to perform "interim therapeutic restorations" or ITR. CALAOMS is working with the author and CDA on amendments to provide appropriate dental supervision of ITR by mid-level dental providers. CALAOMS anticipates this bill, which stalled this year in the Assembly Health Committee, will be heard in early 2014. CALAOMS POSITION: SUPPORT IF AMENDED

SB 809 (DeSaulnier) - Controlled Substances Reporting: This California Attorney General Kamala Harris sponsored bill was passed, signed by Governor Brown and takes effect on 1/1/14. This bill fully restores the ongoing funding of the Controlled Substance Utilization Review and Evaluation System (CURES). This funding primarily comes from an assessment ($6) on prescriber and dispenser licensing fees. According to the sponsor and author, this bill is intended to curb prescription drug abuse of controlled substances. CALAOMS was successful in seeking amendments that removed the mandate that OMSs and other prescribers check the CURES database prior to prescribing a controlled substance. CALAOMS then supported SB 809. CALAOMS POSITION: SUPPORT

2014 LEGISLATIVE FORECAST

Dental Anesthesia: CALAOMS anticipates legislative and/or regulatory action to update dental office-based sedation terminology. The goal is to have consistency with nationally recognized terminology and corresponding standards. As would be expected there have been some differences of opinion among various communities of interest within dentistry but the ADA Guidelines will serve as a tool to finding common ground.

Dental Hygienists: The Dental Hygiene Committee of California (DHCC) will be undergoing "sunset review" in 2014. This requires the Legislature to review their regulatory oversight of dental hygienists and debate statutory changes requested by the DHCC. Based on a recent report by the DHCC, CALAOMS expects proposed legislation that would make the DHCC an independent board and seek scope of practice expansion for dental hygienists. Such scope of practice expansion will include removing supervision restrictions to allow dental hygienists to independently perform a full range of services such as administering local anesthesia, nitrous oxide-oxygen analgesia, and soft tissue curettage. Dental hygienists will also be seeking independent reimbursement for those services.

FEDERAL HEALTHCARE REFORM UPDATE

California has aggressively implemented all facets of the Affordable Care Act (ACA) (i.e. Obamacare). Our state exchange (Covered California) is open for business and continues to enroll a passel of new patients. California has also implemented expanded eligibility in the Medi-Cal Program and restored much of the optional adult dental services as part of prior state budget actions eliminating Denti-Cal. California has also excluded pediatric dental services from the 10% Medi-Cal provider rate reductions and recoupment process. Medi-Cal providers finally lost a lengthy legal battle with the State of California to prevent implementation of rate reductions and recoupment of these previously anticipated general fund savings. CALAOMS will continue to monitor all of these activities well into 2014.

MICRA BALLOT INITIATIVE FILED

CALAOMS also anticipates a statewide ballot initiative in 2014 to overturn portions of the California landmark medical malpractice award caps (aka MICRA) for non-economic "pain and suffering" damages. This effort is being led by an advocacy group named Consumer Watchdog with strong financial support from the California trial attorneys. This effort would raise the current cap from $250K to $1.2M. CDA, CMA, CHA, and others have formed Patients & Providers to Protect Access and Contain Health Costs, the "NO" committee to fight the trial attorney initiative to change MICRA. This group has already risen $30M to fight this effort.

The campaign to lift the MICRA cap is well underway. Recently, according to the "NO" committee, the Consumer Attorneys of California kicked in hundreds of thousands of dollars to bankroll the initiative. In turn, expect to see signature gatherers at your local grocery stores.

From the early stages of this campaign the trial attorneys intend to mislead voters. They already have attempted to make this initiative about patient safety and have tried to gloss over lifting the MICRA cap by adding the window dressing of drug testing doctors. They know if voters understand the dire consequences associated with lifting the cap, voters will oppose the measure. The nonpartisan Legislative Analyst's Office estimates that lifting the MICRA cap would cost local governments and the state hundreds of millions of dollars annually. These dollars are currently spent on public safety, protecting the safety net and clinical care. This amount doesn't take into consideration the hit to taxpayers. Overall, lifting the cap would cost Californian's billions of dollars.

The MICRA cap was put into place by a wave of frivolous lawsuits that drove healthcare costs to unprecedented levels and now that battle is being fought again.

Go to http://micra.org/about-capp/sign-up.php to join the fight with CALAOMS!

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Continuing Education And General Meetings

CALAOMS 2014 January Anesthesia Meeting & SimWars™ Lite Program

January 18-19, 2014
The Ritz-Carlton, San Francisco, CA

Saturday Topic: "Comprehensive Airway Management and Anesthetic Management of Special Patient Groups for the Office-Based OMS"
Speaker: Michael K. Rollert, DDS

Sunday Program: "SimWars™ Lite"
Introduction: Ned Nix, DDS
Sr. Lead Education Specialist, Laerdal Medical Corporation: Rick Ritt EMT-P, MA
Facilitated by your CALAOMS SimWars Task Force: Dr. Michael Cadra, Dr. Margaret Delmore, Dr. Rich Robert, and Dr. Len Tyko

Residents' Night Presentations (North)

January 29, 2014
Hilton Pleasanton at the Club

"Clinical Pathology Conference"

CALAOMS/The Doctors Company Risk Management Seminar (North)

February 5, 2014
Holiday Inn & Suites Oakland Airport Hotel

CALAOMS/The Doctors Company Risk Management Seminar (South)

February 19 2014
Hilton Irvine/Orange County Airport Hotel

ACLS Spring 2014

March 15, 2014
Solano Community College, Suisun, CA

OMSA Winter 2014 (North)

March 22-23, 2014
Hilton Oakland Airport Hotel

OMSA Spring 2014 (South)

April 26-27, 2014
Hilton Irvine/Orange County Airport Hotel

CALAOMS 14th Annual Meeting

May 3-4, 2014
Island Hotel, Newport Beach, CA

Saturday Topic: "The Power of Digital Dentistry: It's Impact on Implant Dentistry and What Every Surgeon Needs to Know"
Speakers: Lee R. Walker, MD, DDS and Gary Morris, DDS

Sunday Topic: "AAAHC Accreditation for Office Based Surgery" and "OMS Office Based Facial Cosmetic Surgery"
Speaker: Edmund Braly, DDS

Residents' Night Presentations (South)

September 17, 2014
Location to be determined

ACLS Fall

October/November 2014 (TBD)
Solano Community College, Suisun, CA

Medical Emergencies (South)

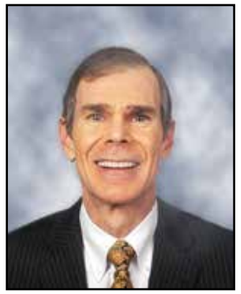
November 5, 2014
Location to be determined

CALAOMS 2014 CE At A Glance

- 2014 January Anesthesia Meeting **January 18-19, 2014**
- Residents' Night Presentations (North) **January 29, 2014**
- Risk Management (north) **February 5, 2014**
- Risk Management (south) **February 19, 2014**
- ACLS Spring 2014 **March 15, 2014**
- OMSA Winter 2014 (North) **March 22-23, 2014**
- OMSA Spring 2014 (South) **April 26-27, 2014**
- 14th Annual Meeting **May 3-4, 2014**
- Residents' Night Presentations (South) **September 17, 2014**
- ACLS Fall **October/November 2014 - (TBD)**
- Medical Emergencies (South) **November 5, 2014**

- We invite you to visit our website for current, up-to-date information on Continuing Education course offerings and to register online at: www.calaoms.org/events

Morals and Ethics



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

What We Do and Why We Do It: Distinguishing Between Morals and Ethics

To glibly speak of morals and ethics without saying exactly what we are suggesting by these terms is how many people, groups, governments, and religions get themselves into trouble. Let us, at least, be clear in our usage and in our prejudices. I understand "ethics" to be reflections upon or, if you will, ideas about "morality," which, in turn, is behavior. Reflection upon action constitutes the matrix of morals and ethics. Morality is behavior answering the human quandary, "What to do?" whereas ethics are reflections upon the question of "Why do it?" The difference between saying a person is "moral" and saying a person is "ethical" is the difference between saying a person has "done" the right thing and a person has "thought" he has done the right thing.

The relationship between morals and ethics is very close, but distinct, even though many people discussing right and wrong behavior will, unfortunately, and to the detriment of linguistic acuity, use them interchangeably. When a person is called moral and ethical in the same breath, chaos and confusion reign. What I am suggesting here is that "morality has to do with behavior," whereas "ethics has to do with thinking" about and reflecting upon an idea of what is right and wrong. A moral person responds to the challenge of "what to do," whereas an ethical person responds to the challenge of "what to do" with a reflective understanding of "why do it."

We might argue that a moral person is not necessarily "ethical," nor is an "ethical" person necessarily "moral." It is quite possible for a person to "do the right thing" without ever reflecting upon "why it was done," whereas it is equally possible for an individual to think about or reflect upon "why a thing should be done" without actually doing it. It can be argued, though some will dispute it, that an individual who does the right thing without reflecting upon why to do it is not necessarily a moral person at all because the act of "doing the right thing" is integrally tied to an understanding of or reflection upon "why it is the right thing to do." In other words, is "doing the right thing" without thinking about the "doing of it" really moral behavior?

The relationship between behavior and ideology, therefore, is central to our discussion. Let us consider "behavior" itself. Behavior as judged in human terms is "action," whether that action is intentional, accidental, or reflexive. We will avoid the use of the term "instinctual" because today it is fraught with psychological and political baggage which I will not unpack here. But to say a human act falls within one of these three categories of actuation, namely, intentional, accidental, or reflexive, is quite defensible. An act, we are saying, is either "on purpose," "inadvertent," or "a biogenic response" to a stimulus introduced either externally or internally to the human person.

We are here, then, faced in our discussion of "morality as behavior" with the prospects of an act done either (1) on purpose, (2) unintentionally and inadvertently, or (3) as a mere biological response to a stimulus. In this case, it is conceivable that a moral act may occur without "reflection," by which we mean "intention." To do the right thing, the moral act, without intending to do it, as in the case of (2) and (3) above, hardly makes for a moral act at all. The right thing was done but not on purpose, not intentionally, but merely by accident or reflex. So, we have the possibility of an individual doing the "moral" thing without thereby being characterized as a "moral" person. In the instances of (2) and (3), that is, accidentally or reflexively, the right things were done but the doing of them was not moral because "intention" was not present in the acts.

There are, of course, "gradations" of moral behavior or actions related to right and wrong, namely, moral, immoral, and amoral. Moral acts are those in which the "intent" is to do the right thing. Immoral acts are those in which the "intent" is NOT to do the right thing. Amoral acts are those in which there is no intent to do either the right or the wrong thing. In the case of "moral" acts, they are done on purpose intending the right. In the case of "immoral" acts, they are done on purpose intending the wrong. In the case of amoral acts, they are done with no intention of either right or wrong.

Ethics, on the other hand, has nothing directly to do with "acts" or "behavior," but rather with "intentionality," for intentionality necessitates an address to the "why" of an act without it being the act itself. The idea of doing the right thing is quite different from actually doing the right thing. The former is of the nature of "ethics," whereas the latter is of the nature of "morals." One can be an outstandingly ethical person without being a moral person for one can reflect upon moral action without engaging in that action. However, one cannot be an outstandingly moral person without being an ethical person, for moral action necessarily requires reflection upon moral action. One can have ethics without morality, but not morality without ethics. *Ethics, then, is ideology; morality is behavior.*

Technical Articles

Peter Krakowiak, DMD, FRCD(C)

Current Management Options for OSA Patients in Oral and Maxillofacial Surgical Specialty Care – A Review and Evidence Based Approach

This year concluded my first decade in private OMS practice and also the 20th year being involved in clinical dentistry. I was recently attending a lecture on digital and virtual treatment surgical planning when I came to a sudden realization that in reality not only dentistry but also oral surgery as a whole, has really struggled to dramatically grow and expand into new areas of practice or profoundly transition into new surgical paradigms in the past few years. Even when we critically look at the entire past decade or so we have only been able to just refine some of the earlier-developed and already existing clinical concepts such as rigid fixation, distraction osteogenesis, rh-BMP and allograft use, full arch and esthetic zone implant reconstruction, digital 3D imaging, and of course now CAD-CAM/imaging/impression amalgamations. I will not even mention piezosurgery, as such would, well, just take way too much time…Seriously, though, even important clinical areas such as our treatment outcomes for oral cancer have been somewhat static despite billions of dollars spent in research. The promising 1980-90s' TMJ surgical corrections have become somewhat irrelevant outside of the few dedicated centers (thank you for keeping up the good fight!) that still practice joint replacement and perform open joint procedures. Makes you want to give more to our OMS research foundations, doesn't it?

One area which perhaps has not gotten much attention but is still a very viable and likely area where significant and growing impacts can still be made on our patients' well-being is the area of sleep apnea and sleep disorder therapy. Personally, eating and sleeping are my most cherished activities. And now we all can get to help others with both. Interestingly, the general dentistry community and even periodontists have started to expand their scope of sleep medicine care and corresponding revenue flow to a much greater degree than most OMS practitioners. So I thought that maybe it's time that we also look at this growing area of therapeutic need in this edition of The Compass.

As a uniquely cross-trained blend of head and neck surgeons, dentists, and anesthesiologists, we are perhaps best positioned to evaluate, diagnose, and treat the obstructive sleep apnea (OSA) subset of sleep disorder patients with both surgical and dental appliance-based care. No one can do this better outside of our specialty on either the medical or dental side. After all, most of our "routine" care involves management of the airway in a variably depressed state of consciousness (the patient's, of course!). The precipitating vector which makes this area of care a growing sector is directly related to the growing waist line (and neck line) of most of our society. Obesity trends have been increasing at astronomical rates with projections of having all 50 states (57 if you are a sitting president) having greater than 44% obesity rates by 2030. Currently, more than 15 states have rates of more than 30% with California (in 2010) being in the 20-24% bracket based on the CDC data.

It may be hard to imagine, but this progressive medical condition potentially shortens its victim's lives by 12-20 years compared to 7-10 decreased life expectancy in smokers and 5 year decrease in Type II diabetics.

The most popular non-surgical current treatment for obstructive sleep apnea is CPAP (Continuous Positive Airway Pressure), with a small segment of the population getting surgical correction of their airways, and an even smaller segment receiving dental appliance therapy. Approximately 40 million adult Americans suffer from OSA, yet only a small number (2-3%) have received successful treatment. That leaves several million patients untreated. The main reason is lack of compliance with CPAP. That lack of compliance can be attributed to the bulkiness of the CPAP facemask and the discomfort of continuous positive pressure on the airway. There are also significant costs associated with continued CPAP machinery and supplies.

Figure 1

With the growing focus of cost and affordability of treatment options, oral appliance therapy is becoming a more appealing option to more and more patients and their insurers. Although a previously marginalized therapy, the dental based appliances have gained a first-line acceptance, and in 2006 were mandated by parameters of sleep medicine care as a bona fide alternative to CPAP for mild and moderate sleep apnea care.

CPAP was developed in 1981 by an Australian doctor, Collin Sullivan, and has been significantly improved over the years; however, it still carries the disadvantages of size, discomfort, and most often convoluted follow-up. Multiple parties are involved with the treatment, such as primary care doctors, sleep medicine doctors, as well as durable medical equipment providers. Patients often will report mask (Figure 1.) discomfort, air leaks, rhinitis, claustrophobias, aerophobias, subcutaneous air penetration, and even chest discomfort from continued positive pressure barotraumas. The compliance stats range from 10-60% in long-term follow-up studies. Hence, clearly there is still a need for alternative therapy and this is where surgical treatment and oral anterior positioners (for the mandible) are great therapeutic modalities.

To get involved in management of sleep apnea cases is not very difficult for an oral and maxillofacial surgeon. Surgeons who practice orthognathics and splint therapy for TMD consideration already have the necessary surgical expertise, clinical materials, and staff needed to help with the treatment modalities at hand. Our knowledge of airway and anesthesia-learned assessment terminology is already part of our practice. The critical steps will be to add diagnostic equipment such as a pharyngometer, positioning gauges, and home sleep study equipment; and then develop ways to screen and identify the patients who are already coming to our offices for dental or other surgical procedures.

The first step is to identify potential patients who may have undiagnosed Sleep-related Breathing Disorders (SBD) or have been diagnosed with OSA and are having problems with their current CPAP compliance. These patients will usually have several risk factors such snoring/gasping during sleep, larger neck sizes, obesity, male predilection, enlarged airway obstacles, hypothyroidism, cardiovascular disease, and allergy or asthma issues. The most common symptoms of OSA are snoring, excessive daytime sleepiness, and hypertension. Other sentinel features include morning headaches, diabetes, social and sexual dysfunction, memory lapses, dental occlusal trauma, and nocturia. The Epworth Sleepiness Scale (ESS) is routinely used to help identify patients by asking them questions indicative of their level of daytime sleepiness.

Often pediatric patients may also be suffering from sleep apnea. Most often enlarged tonsils and adenoids are the culprits, as well as narrow arches and mouth breathing patterns are recognized as co-factors. The affected children tend to be smaller than average due to decreased sleep time and secretion of related growth hormones. The development of ADD/ADHD has now been linked to pediatric OSA and many cases have been treated by treatment of the underlying OSA. It has been postulated that early correction of pediatric OSA will improve growth patterns of the maxillofacial skeleton and reduce adult incidence of OSA. Most predictably, maxillary expansion and tonsillectomy are curative for many of these patents. The specific pediatric OSA care is beyond the scope of this article, but is an important consideration for oral maxillofacial surgeons and orthodontists.

Snoring, a common presenting sign, in itself is not pathognemonic of the OSA condition, but is usually a part of the OSA patient presentation and can be effectively treated by the same techniques. The most concerning problem of OSA is related to development of apneic states that lead to long-term sympathetic outflow (in the fight or flight mode) which increases heart rate and creates hypertension. Moreover, the lack of adequate O_2 levels induces reduction in nitric acid production which is needed to maintain vasodilatation and protection of endothelial vessel linings. Such, in turn, cause greater incidence of endothelial injuries and atherosclerotic plaque formations. These, of course, increase stroke and heart attack incidence by up to 45%. Another serious side effect of apnea is the potential to develop insulin resistance due to the continuous hyper-sympathetic state. This will result in diabetic conditions and their systemic sequelae. Finally, GERD tends to accompany efforts to generate diaphragm and accessory respiratory musculature function in OSA and allows negative pressure to advance gastric contents into esophageal recesses.

Figure 2

So where do we start with our care? In my practice we evaluate all patients for airway stability, TMD, neck circumference, rough BMI, and specifically ask if they snore or experience daytime somnolence. If they are positive in findings for any of these, we will have them fill out an Epworth (ESS) questionnaire. Patients who reach a high score on the questionnaire are counseled regarding their potential for having or developing OSA. Also any patients who have undergone sedation procedures and had significant apnea or hypopneas on our capnography readings also receive the ESS questionnaires during their follow-up visits.

If patients express interest in further follow-up, we will then have the patients take a portable sleep study unit (Figure 2) home to gather at-home sleep study data for subsequent analysis by our local board-certified sleep medicine expert. There is also an option to have the patient have a sleep study done at a formal sleep lab. For most patients, the at-home route is less costly and is more likely to be a realistic sleep experience; hence, we prefer that route. The unit we use provides an acceptable range of data to make a diagnosis and determine the severity and have our sleep medicine expert issue a prescription for either CPAP and/or an oral-mandibular-advancement appliance. CPAP and orthognathic surgery are the only acceptable options for treatment of severe OSA (tracheostomy is also an approved treatment for severe OSA, but is uncommonly accepted by patients). Oral appliance therapy can be considered an adjunct to CPAP or equivalent intervention in mild to moderate OSA. Obtaining a study interpretation by a board-certified specialist in sleep medicine with indications of OSA severity interpretation and actual treatment prescription meet the requirement of current standards and parameters of care published in 2005 by the American Academy of Sleep Medicine which state "oral appliances are indicated for use in patients with mild to moderate OSA who prefer them to continuous positive airway pressure (CPAP) therapy or who do not respond

to, are not appropriate candidates for, or fail treatment attempts with CPAP."

Since we are a surgical specialty, I will start by addressing the surgical methods of airway correction. These techniques are certainly now very well researched and thoroughly documented, and for most of the techniques with the exception of maxillomandibular advancement (MMA), they have by themselves limited long term improvement data on Respiratory Disturbance Index (RDI) and AHI (Apnea Hypopnea Index)—the main indices of sleep apnea and hypopnea.

The uvulopalatopharyngoplasty (UPPP), tongue reduction, genioglossus advancement/suspension(GGA), and the Pillar procedure have demonstrated marked improvement in snoring scores, but all respectively fail to match up to the MMA procedure with its cure rate of 95%. Unfortunately, not all patients are candidates for the orthognathic correction secondary to systemic health and financial limitations. For those patients, CPAP and/or oral appliance therapy can rapidly and predictably offer effective therapy approaching 100% correction of their apnea—as long as there is compliance.

Radiographic evaluation—which at one point was considered a diagnostic standard for OSA diagnosis based on the retropharyngeal airway dimensions—consisted of either plain cephalometric films or CT projections. However, these are no longer considered to be significantly useful in diagnosis and pathophysiological correlation. They can, however, show post-operative anatomical changes. The airway diameter will usually be altered when patients are asleep and supine. However, cephalometric studies focusing on the distance between the hyoid bone and the inferior border of the mandible can be somewhat corroborative to understanding the basis and pathophysiology for the OSA diagnosis. The greater the distance from mandibular plane to superior crest of the hyoid beyond the normal 1.6mm the greater is the effect of the tongue on the available airway dimensions. The other anatomical dimensions that were considered are the posterior airspace diameters that are also co-relatable to OSA. A distance of less than 11mm suggested lesser airway diameter in adults. Retromandibular skeletal growth patterns clearly establish unfavorable space considerations in the cervico-mandibular ring. The smaller that space and greater the soft tissue contents, the lesser is the residual airway. Large tongue size and the overall percentage of fat, as well as neck circumference, have been shown to correlate with increased episodes of apnea. However, somewhat paradoxical is the external neck size of over 17 inches in males and 15 inches in females, large waists of 42 inches or greater, elevated BMI (greater than 30), prominent tonsils, and uvular edema are predictors of increased risk for OSA. Medical history of hypertension, diabetes, GERD, or heart disease is also contributory as all of these conditions are known to be the most common comorbidities with OSA. Clinical history, interpreted polysomnography data (sleep study), and pharyngometry are the most accurate modalities used to confirm a suspected case of OSA.

Home sleep study tests or sleep lab testing have been the standard of diagnosis and are required for coverage for any care from most insurance plans. The studies are usually interpreted by a board-certified sleep medicine physician and consist of sleep values for several parameters. Blood pressure, heart rate, oxygen saturation, EEG-based sleep cycle depth, EMG-based peripheral mobility, respiratory rate, and airway noise levels are all monitored and recorded during the sleep state of the patient (Figure 3). As noted before, the

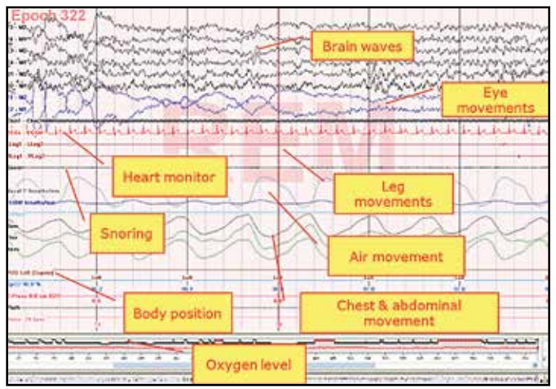


Figure 3

benefit of home sleep studies is that these more closely correlate to normal environmental surroundings and give patients a more natural state of sleep versus a sleep study center. Both approaches, however, are considered to be accurate for the development of diagnosis and gauging of the severity of the disease. New interpretive software applications and capnography are now available to improve the interpretation of the home study data to make them equivalent to the comprehensive lab-based testing.

The sleep study gives several key elements that are used to evaluate and monitor the management of the patient. Some split sleep studies can also be used to titrate the CPAP therapy for optimal levels of vent settings. RDI and AHI are the key elements which relate to Respiratory Disturbance Index and Apnea/Hypopnea index. Mean and minimal oxygen saturations are also suggestive of the severity of the condition and its systemic ramifications.

Once a diagnosis has been made the issue that needs to be addressed is the optimal treatment selection. The first step for all patients is a thorough education and counseling session that addresses the habits and behaviors that contribute to the development of the condition. Most patients are not fully aware about the mortality and deleterious effects of sleep apnea on their systemic heath and quality of life. Patients should be counseled to avoid narcotic use, alcohol consumption, and sedative intake. Their risk for increased incidence of death after general anesthesia should be highlighted. Short-acting agents are preferred if they must undergo general anesthesia, or Monitored Anesthesia Care (MAC) sedation may be a better option if possible. In most patients, obesity control will significantly improve the severity of their disease. Bariatric procedures have been shown to be of value in severe OSA cases.

As already alluded to, the mainstay of nonsurgical treatment in contemporary practice is CPAP. It has been repeatedly shown to significantly reduce the risk of mortality and morbidity in the OSA population. CPAP has the ability to keep the airway open at multiple levels of potential obstruction from the nasal passages to the lower airway. Airway humidification is also a potential benefit of this form of therapy. Compliance is probably the biggest issue with this therapy, and if the appliance is not used due to lack of comfort, CPAP has obviously no success in treating these patients. It should be always, however, the starting point in our care.

Surgical options will often solve the problems of compliance but do require surgical intervention and risks of surgical and anesthesia care. The most predictable and patient compliance independent correction of anatomically-based OSA is the MMA procedure. Long-term improvement of outcomes has been noted in several current randomized clinical trials. This is universally considered as the definitive procedure.

Of course tracheostomy is fundamentally the most successful OSA treatment as it completely allows for bypass of all the structures and levels of obstruction of the upper airway. The tracheal cannula can be capped during the day to allow for normal speech and function. It is a drastic treatment, but quite useful in craniofacial and developmental syndromal cases—especially pediatric patients—where the compliance issues can be circumvented and growth is still occurring. It is, however, not a problem-free solution.

The other options for surgical care (different from the MMA) include specific airway level surgical corrections. When paired in a multi-level approach they can also be considered as a comprehensive correction but have not been as effective as the MMA procedure. These level-specific treatment approaches are aimed at a single level of obstruction; hence, often they fail to address all areas of consideration, especially lower level obstructions.

Proceeding from top to bottom, nasal valve reconstruction involves failed cartilaginous portion repairs, nasal isthmus (smallest area) corrections, septoplasties, and turbinectomy.

Uvulopalatopharyngoplasty (UPPP) (Figure 4) removes the palatal-uvular complex as the obstruction,

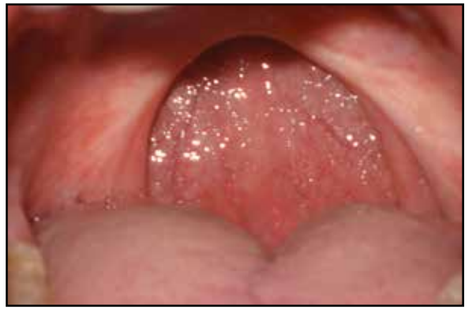


Figure 4

but causes intense scarring and is very painful while offering limited immediate improvement in severe OSA disease. Its long-term effects are questionable based on current literature evidence. Lateral pharyngoplasty approach removes lateral wall musculature to widen and re-suspend the soft palate. Few clinical trials and their efficacy are documented on this approach. Laser-assisted uvulopalatoplasties (LAUP) and radiofrequency ablations (RFA) are also employed to treat obstruction at the soft palate/oropharynx level. RFA procedures scar the palatal tissues to stiffen the palate. This allows for minimal uvula reduction and thins out the dimensions of the soft palate. Interestingly, these procedures can, in some cases, increase the AHI in certain subjects. The Pillar procedure also has low yields in correction of the AHI. The Pillar procedure firms up the soft palate by interstitial implant placement. These upper airway pharyngeal procedures are often successful in treatment of snoring. They can be combined with lower level procedures to improve OSA cure rates in mild to moderate severity patients. In those combined approaches, they are often considered phase I treatments which can later be followed by a MMA procedure if they fail to improve the AHI to less than 30. Lower level corrections include base of the tongue RFA, lingual tonsillectomy, lingual suspension, and glossoplasty. Genial tubercle/genioglossus advancement (GGA) osteotomy with or without hyoid suspension is used to suspend the musculature and advance the epiglottis and the base of the tongue for more of a multilevel treatment. Combined upper and lower level corrections including UPPP, GGA, and hyoid advancement have all been employed. Evaluation of true surgical success rates is difficult due to the lack of therapeutic homogeneity in approaches in most of the cases. Overall phase I procedures have had success rates of up to 61%, whereas phase II (MMA) has success rates of 90% cited. Interestingly, phase II treatment following phase I has lesser success rates than straight MMA, likely secondary to circumferential scarring of the airway. Distraction osteogenesis can also be considered in cases of very severe congenital micrognathia or midface hypoplasia as a prologue or definitive therapy. It is, however, a complex process especially when dealing with two jaw corrections.

The most effective surgical correction is MMA as it is a true stand-alone procedure with multilevel correction (Figure 5). Not surprisingly, it yields the greatest results and offers the most long-term cure in young patients. At the time of standard orthognathic advancement surgery, the surgeons can strategically widen the piriform bony aspect with ostectomy/osteoplasty and address the turbinates and any septum deviation. A counter-clockwise rotation of the maxillofacial complex is attempted by most surgeons to improve the posterior airway and minimize incisal tooth exposure associated with large advancements. MMA treats multiple levels and expands the airway in A/P and transverse vectors. Simply put, increasing craniofacial size increases the airway. Meta-analyses of 53 recent clinical reports looking at MMA noted maxillary advancements to have a mean value of 8.3mm, and 10.3mm advancement in the mandible as

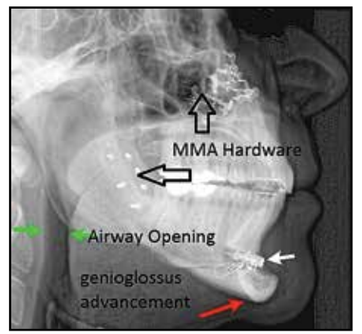


Figure 5

measured at the incisors. The pre-op AHI mean value was 63, while post-op was 9.5. Pre-op SpO_2 levels of 79% increased to 87% post-op. The ESS scores were statistically improved and BMI decreased slightly, as well—not surprisingly after the period of "wired jaw" cuisine. These numbers were analyzed by Holty and were recently published in Sleep Medicine Reviews, where the journal cited an overall surgical success rate of 86%. The best results were in younger patients. The mean AHI reductions went from a mean of 66 to 7 for patients under 30. It was noted that factors for success included younger patients with lower pre-op AHI and more extensive maxillary segment movement (at least 10mm). Major complications of MMA therapy were noted to be present in 1% of the cases, including cardiac arrest, dysrhythmias, and unfavorable fractures; while minor complications occurred in 3% of cases. There were also other untoward outcomes not included in either of the categories, including malocclusion (44%) and facial paresthesias (100%). No differences in short-term and long-term success within 3 years of follow-up were noted. 89% were happy with their choice of surgery-based therapy for OSA.

Cost and morbidity/mortality of surgical services often makes it a second line treatment modality after CPAP and/or mandibular positioner appliance therapy especially in mild and moderate severity cases. When the patient presents with mild-moderate OSA, the splint therapy has many potential benefits and applications. It can be used alone as the mainstay of therapy, or can be used as an adjunct to CPAP/BPAP where it reduces the end-tidal pressures, making it more comfortable for the user.

Unlike other treatment modalities formerly mentioned, appliance therapy is limited for delivery only by licensed dentists. Physician sleep practitioners cannot prescribe or manufacture these types of appliances. Physicians can serve as a valuable referral source for their patients who either fail CPAP or who are not candidates for surgical corrections.

The initial step to developing appliance-based therapy is to gain the results of a sleep study and secure a prescription for a mandibular advancement oral sleep appliance from either the sleep physician or a primary provider based on a formally read out sleep study. The patient then undergoes a consultation session which covers the application of this modality, risk factors, benefits, and treatment options. Considerations such as appliance longevity, repairs and maintenance, adjustments, and potential untoward effects on dentition, occlusion, and TMD should be included. A thorough oral exam and TMJ evaluation should be completed, and any pathology, dental restoration issues, periodontal condition, and TMD stabilized and optimized.

The next step includes evaluation of the nasal passages and upper airway patency. Acoustic rhinometry is used to ensure nasal patency. If nasal airway diameter is compromised, these sites can be identified by the study and can be surgically corrected by septoplasty or turbinectomy procedures. If the nasal passages are adequately patent, an assay of lower airway collapsibility is made using sonar pharyngometry. These studies will demonstrate the ability and location of greatest airway collapse. Highly collapsible airways are ones which tend to respond best to mandibular repositioned

Figure 6

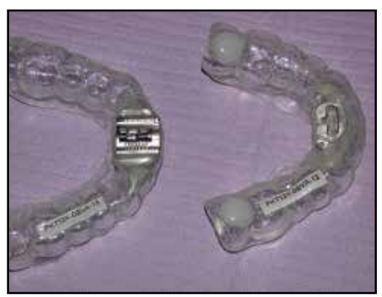


Figure 7

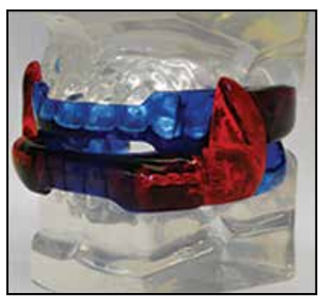


Figure 8

appliance therapy. The airway diameters can be volumetrically mapped (Figure 6) descending from the oro- to the hypopharynx and recorded for reference and to assess the efficacy of the repositioning appliance to control the airway diameter after its application.

The patient then will undergo standard dental elastomeric, or now optical, impressions of the upper and lower arches to develop standard dental working casts and to fabricate the desired oral appliance. The final and most critical step is to set the inter-arch position. In the past, before the availability and application of pharyngometric reference measures, the position was usually set somewhat arbitrarily and often it was less than ideal. In fact, in most cases the chosen protrusive position was often actually deleterious to maintenance of maximal airway diameter. Using airway gauges which progressively set the interincisal opening and protrusive set point, we can serially move the mandible as to establish vertical and A-P relationship and maximally correct the collapse of the lower airway. The acoustic pharyngometer is used to make these serial comparative assessments of airway diameter while using different progressive bite jigs. In most cases, a "sweet spot" exists where the least airway collapse and greatest diameter is achieved. Advancing the patient further anteriorly or increasing the vertical component of incisor correlation beyond this point will cause greater airway collapse.

Once the position of the mandible is made, it can be registered so that a working cast can be mounted on an articulator using transfer face bow techniques or standard bite registration over gauge techniques.

The laboratories can generate several different FDA-approved appliances including TAP (Figure 7), Respire Blue (Figure 8), Herbst (Figure 9) and quick-fit Norad appliances. Some designs are better for use with CPAP while others afford greater range of mobility for patients with parafunctional habits. Once delivered, their occlusal fit must be tested (Figure 10) and the A-P setting titrated if needed (Figure 11) after a follow-up home sleep study.

Medical insurances often provide coverage for many components of the OSA work-up and care once the sleep study interpretation is indicative for OSA. Ironically, today their coverage for splint-based therapy often coincides, or in most cases significantly exceeds, the reimbursement level for our MMA procedures.

As our profession continues on a path of progress, leadership, and innovation, the clinical area of sleep apnea care is certainly one worthy of further exploration and engagement. A strong scientific basis exists now for most treatment modalities and the standards of care are normalizing. In our practice, the addition of appliance therapy to surgical correction options has been an exciting facet for all of us to be involved with, including my staff who really enjoys their direct participation in the diagnosis, portable sleep study applications, diagnostic pharyngometry and rhinometry, as well as titration of the jaw relationships for optimal appliance design. I strongly recommend that all OMS specialists entertain the idea of adding this to their practices if they are not already involved in this care.

Figure 9

Figure 10

Figure 11

Social Media and Your Professional Reputation

(originally published on DrBicuspid.com, October 14, 2013)

by Rita Zamora

Many new dentists find themselves at a crossroads with social media. Some feel they'd like to erase their social media past and start over, while others never used social media and dread doing so for their practice. The good news is there's a solution.

The key to success in social media from a professional standpoint is to find a balance between being personable and visible online, yet maintaining your personal privacy.

Note the difference between the words "personable" and "personal." You don't have to reveal your private personal life to be successful in social media professionally. And no, it's not a good idea to be an online hermit.

In fact, research shows how important availability of professional information has become. In 2011, Google commissioned a study about how people search for products and services online. People's search patterns today show an increase in the number of sites they reference, as well as the type and level of information they want to see.

For example, in addition to your website bio, a potential new patient may want to see your video on YouTube, what people say about you on Yelp, and the photos on your Facebook business page. As a dentist your online reputation impacts the perception of many -- including patients, employees, associates, and more. Further, your online persona should match your in-person persona. Congruence of online reputation and your authentic self helps build trust and grow relationships.

Protecting your reputation

Another important reason to have a robust online presence is for reputation protection. Whether you want an online reputation or not, you will have one. In fact, you have an online reputation already -- just Google yourself and see what the story tells. Maybe you don't have a story yet? As a public health professional, you will at some point. If you don't take control and lead your online presence, in time the public will.

In some cases, it may be one disgruntled patient's review. And you certainly don't want that one grumpy patient's review to be the sole piece of information that pops up when someone Googles your name. On the other hand, consider a pediatric dentist who disliked the thought of social media. Over the course of several years, his patients' mothers took the liberty of opening Facebook pages on the doctor's behalf. They left glowing, wonderful reviews about the doctor, and some uploaded photos of their kids smiling and having fun at their dental appointments.

One day the pediatric dentist decided to give Facebook a chance. He was delighted to find an amazing business page filled with incredible testimonials -- all initiated by his patient's parents! That was a happy ending. However, there are often many not-so-happy endings. So take the initiative, be proactive, and grow a positive, authentic online reputation for yourself.

Where to start

When it comes to social media, where do you begin as a new dentist? Rest assured, you don't have to go it alone. There are ways to delegate parts of creating and managing your online persona. However, the more informed you are the better you'll be able to delegate and make good business decisions regarding social media marketing and online reputation building.

Start by making sure you have a business page on Facebook and Google+ to represent your practice. Individuals can have personal profiles on Facebook and Google+, and those should be for personal use. Friending patients via personal profiles is not recommended because, among other potential risks, it can blur the lines of the doctor-patient relationship.

Once you have your accounts for Facebook, Google Plus, Twitter, etc. set up, what's next? The main thing you need to consider is social media content. In other words, what will you post about? You can best leverage social media by keeping an open mind. For example, rather than posting strictly dental-related topics on your Facebook page, you could also build trust and grow relationships via "personality" topics to show your human side. Examples of personality topics include the following:

- Nonprofits you believe in
- Local businesses you support
- Hobbies you enjoy

In other words, share a little bit about your personality, your authentic self and values, and people will find something in common with you. Like attracts like. By showing a bit of personality, coming across as personable, you in turn build trust and valuable relationships -- keys to attracting new patients, improving case acceptance, and expressing leadership.

Learn to delegate

If all of this sounds appealing yet overwhelming, you aren't alone. Note that like many other practice duties, you can delegate the management of your social media. Below are a few tips to keep in mind for effective delegation:

- Appoint an internal team member for social media management.
- Make sure your social media manager has good communication and people skills.
- Implement an editorial calendar system that will allow you to preapprove posts.
- Allow your team access to seminars, webinars, or one-on-one coaching to keep up to date and motivated.
- Hold your manager accountable for keeping you informed on what is being said about you online.

Avoid the temptation to delegate all of your social media management to an external source. Over the years, many social-media-avoiding dentists subscribed to monthly programs that "managed" the practice's social media entirely. In some cases, the doctor would discover they disliked the content being posted about them and found patient interaction nonexistent. This being "social" media, patients can often tell what is generic and what is genuine. Patients respond better to the occasional, personable post rather than a constant flow of generic content.

A final component in growing a positive online reputation is to support your social media manager's efforts. You can do this by understanding and acknowledging the value of social media for your practice. Be open to discovering and sharing your core values. Show some of your human side and a bit of personality -- and by all means have some fun while you are at it! This in turn will result in the attraction of new patients, better case acceptance, referrals, and valuable trust and relationships within your community.

Rita Zamora is an authority in social media marketing for dental professionals. She and her team specialize in training clients for independence so they can manage social media themselves. Rita is a highly sought after speaker (recently presented at a CALAOMS meeting) and is published frequently in the U.S. and internationally. She graduated magna cum laude from the University of Colorado with a bachelor's degree in business and marketing and has more than 18 years of experience working hands-on in the business of dentistry. She can be reached at rita@ritazamora.com.

The Compass - Winter 2013

CALAOMS Congratulates its Newest ACD Fellows!

On October 30-31, 2013 in New Orleans, the American College of Dentists inducted into Fellowship the following CALAOMS members:

- ***Dr. Peter A. Krakowiak (Lake Elsinore)***
- ***Dr. Steve M. Leighty (Auburn)***
- ***Dr. Suzanne U. McCormick (Encinitas)***
- ***Dr. W. Frederick Stephens (Pasadena)***

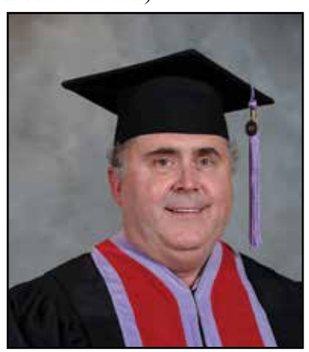
CALAOMS also congratulates Dr. M. Edmund Braly (Norman, OK) on his induction into Fellowship with the American College of Dentists. Dr. Braly will be a featured speaker at an upcoming CALAOMS meeting in 2014.

Fellowship in the American College of Dentists is by invitation and is based on a proven, confidential, peer-review system that has remained intact since the inception of the College in 1920. The College was founded by the president, vice president, and secretary of the American Dental Association (then called the National Dental Association) and by the president of the National Association of Dental Faculties (forerunner of the American Dental Education Association). At the time of its founding, dentistry was plagued with a variety of problems, particularly in the areas of education, journalism, and research. The College was specifically conceived "to elevate the standards of dentistry, to encourage graduate study, and to grant Fellowship to those who have done meritorious work." Fellowship was instituted to promote excellence within the profession by recognizing it. Outstanding dentists were singled out and honored as positive role models to the profession. Fellowship reinforced the highest ideals of dentistry. Fellowship was not designed to circulate honors among a small clique.

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

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

Dr. W. Frederick Stephens (L)
Dr. Peter Krakowiak (R)



Dr. Steve Leighty

Dr. Suzanne McCormick with Dr. Huong Le, past president of the Dental Board of CA

Risk Management Corner

Malpractice Case Shows Risk from Physician Not Dating and Initialing Reports

By Julie Song, MPH, Patient Safety/Risk Management Account Executive, The Doctors Company

Physicians must be certain that there is a process in place to ensure that no imaging, laboratory, or consultant's report is ever filed unless it has been dated and initialed by the physician as proof that it was reviewed. Many medical liability claims would be prevented by this simple policy.

It is also important to create a suspense file or electronic health record (EHR) follow-up list for all ordered imaging studies, laboratory tests, diagnostic procedures, and consultations—to ensure that they were completed and that the physician reviewed the reports.

The following case is an example of a "perfect storm" that led to a malpractice claim:

A patient over the age of 50 was referred by the primary care physician to an orthopedist for evaluation of a two-year history of low back pain. The orthopedist ordered x-rays, which showed a questionable lytic lesion measuring 6 cm in diameter in the right iliac bone just superior to the acetabulum. The orthopedist's routine was to personally review his patients' x-rays, which he did in this case, but he focused on the lumbar spine and did not see the lytic lesion. The radiology report was sent to the orthopedist's office and filed without his review. No office policy existed to ensure that reports were filed only after he had initialed and dated them.

An x-ray taken eight months later again showed the large lytic lesion in the pelvis. The orthopedist reviewed the films and again missed the lytic lesion. The radiology report was not found in the orthopedist's file.

Four months later, the orthopedist performed an L5 laminectomy. Follow-up x-rays again noted the expansile lytic lesion. These films were reviewed by the orthopedist, who focused on the operative site in the lumbar spine and failed to see the lesion. The radiologist's report was faxed to his office and filed; it had not been brought to his attention.

An MRI done one month later showed a lobulated, expansile lesion in the pelvis, suspicious for low-grade chondrosarcoma. The radiologist phoned the orthopedist to discuss the findings—it was the first time the orthopedist realized that an abnormality was present.

The patient was immediately referred to a major medical center, where the patient underwent partial resection of the pelvis and hip with amputation of the right leg. A claim was filed alleging failure to appreciate the presence and significance of a lesion diagnosed as chondrosarcoma more than three-and-a-half years after it was first noted in the filed radiology reports.

Contributed by The Doctors Company. For more patient safety articles and practice tips, visit www.thedoctors.com/patientsafety.

THE DOCTORS COMPANY

Upcoming 2014 CALAOMS CE Events

January Meeting January 17-19, 2014	**San Francisco**	**OMSA Winter** March 22-23, 2014	**Oakland**
Residents' Night Presentations January 29, 2014	**Pleasanton**	**OMSA Spring** April 26-27, 2014	**Irvine/Orange County**
Risk Management February 5, 2014	**Oakland**	**14th Annual Meeting** May 3-4, 2014	**Newport Beach**
Risk Management February 19, 2014	**Irvine/Orange County**	**Residents' Night** September 17, 2014	**Southern CA**
ACLS March 15, 2014	**Solano**		

Classified Ads

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Reduced! iCAT Excellent Condition, used Next Generation Platinum with Extended Field of View. Includes monitors, Codonics medical printer and supplies. Warranty available and selling due to lack of utilization. Asking $95,000. Please contact Frank A. Portale DDS at 209-481-9307.

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

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Oral and Maxillofacial Surgeon San Francisco East Bay Area Half Time or Full Time Position. BC/BE oral surgeon sought by UC San Francisco affiliated public hospital system in Contra Costa County. Located 30 miles east of San Francisco, with excellent weather, and close to outstanding cultural, recreational and natural attractions. One hour to the Napa Valley wine country or beach. 2 ½ hours to skiing. Martinez sits on San Francisco Bay, at the gateway to the Sacramento River Delta, for superb boating and fishing. New hospital & surgical facilities serve needs of ethnically and culturally diverse population, who have a fascinating variety of clinical problems. Excellent compensation package includes health care, vacation & sick leave, disability insurance, paid CME, defined benefit pension and more. Malpractice insurance provided. Position available immediately. California License required. Contact Domenic Cavallaro, DDS at 510-918-2159 or at nickcav@comcast.net.

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