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The Compass

Staying the Course Through Service and Education

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Volume VIII, Issue 1, Spring 2006

Building For The Future

CALAOMS' new central office is going to occupy a prominent 3,500 sqft of this a 20,900 sqft condominium building located in a new business/office park in the heart of Roseville, CA. It is sourrounded by upscale shopping, entertainment, and dining.

On March 9, 2006, CALAOMS closed escrow on 3,500 square feet of prime office space in a beautiful new office condominium building on Reserve Drive in Roseville. This is the first piece of real property that CALAOMS has ever purchased and it represents a huge development in the history of our association.

The process started last year as an idea from the Finance Committee. We had significant cash reserves, an office space inadequate for our needs, and the prospect of rising rents for the foreseeable future. Our Executive Director, Pam Congdon, conducted a needs assessment outlining the space requirements of CALAOMS for the next twenty years. She projected that we would spend about $800,000 over the next

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Compass Direction

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The COMPASS

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Your CALAOMS Central Office Staff

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CALAOMS also does business as:

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

Editor's Corner

Tim Silegy, DDS
Editor, of the Compass

My friend and colleague, CALAOMS Past President, Terry McCarthy, once told me that the secret to success as an oral and maxillofacial surgeon can be found in the three A's: Affability, Availability and Affordability. If you subscribe to this belief, as I do, you know that as a specialty we are dependent on our referring doctors for our livelihood. However, as competition for the "dental dollar" becomes more intense, we must add another "A" if our practices are to continue to thrive. That "A" is **authority**.

I think it's safe to say that the lay public and health care professionals alike consider us the unequivocal authority when it comes to pulling teeth. To a lesser extent, in part due to the overlap of skills between oral and maxillofacial surgeons, ENTs and plastic surgeons, we are also recognized as experts at jaw surgery and repairing facial fractures. Public and professional perception wanes however, if we broach the subject of dental implants, anesthesia and facial cosmetic surgery.

As surgeons, we all think highly of ourselves and of our abilities. Justifiably so, as we are arguably the most highly trained and developed specialists in Dentistry, and perhaps in all of healthcare. This matters little, however, if we are not recognized for our abilities. It's all about perception. Take for example the case of our periodontal colleagues.

At the CALAOMS winter meeting in San Francisco, my friend and fellow CALAOMS member, John Boghossian, approached me about Vision 2020. For those of you who are unaware, Vision 2020 is The American Academy of Periodontology's strategic plan- - the intent of which is to grab the lion's share of the dental implant market. In it they state, among other things, that by the year 2020…

- We (Periodontists) will be known as the premier providers of periodontal plastic surgery, oral reconstructive surgery, regeneration, tissue engineering, and implant therapy as well as leaders in the coordination of interdisciplinary care.
- We will be the preferred partners of industry to advance innovations for patient care.

Not long ago, periodontists saw the writing on the wall. As the literature (much of it published by oral and maxillofacial surgeons) began to demonstrate the overall success of dental implants, they recognized that traditional periodontal surgery was rapidly becoming obsolete and that implantology would be the way of the future. Consequently, they began to emphasize dental implant education in their training programs.

While most of us were spending sleepless nights putting Humpty Dumpty back together again, they were treatment planning full arch implant cases with their dental colleagues. I completed my training in 1995 having placed 4 implants. Many of my friends in periodontal programs had placed more than 50. Additionally, because many OMS programs are hospital based, and almost all periodontal programs are university based, dentists in training tend to have more interaction with periodontists.

Finally, the dynamic between the general dentist and periodontist is one where the general dentist will often refer a patient to determine if a tooth is salvageable. With implants now at their disposal, doomed teeth once removed by oral surgeons, are removed by the periodontist and replaced with dental implants. We are simply out of the loop. Given the emphasis placed on implant training and the nature of their relationship with the general practitioner, periodontists are well on their way to accomplishing their goal.

On the national level AAOMS has worked hard to provide outstanding continuing education in dental implantology. The December Implant meeting in Chicago has become one of the preeminent implant meetings in the country. In an effort to increase public awareness, AAOMS has created a national implant campaign. A special "pull-out" section appeared in *USA Today*, and an in-flight video designed to educate the general public as to the oral surgeon's role in implant dentistry has appeared on a major carrier.

Marketing directly to the general public, while effective, is not enough. AAOMS must reach out to general dentists and be an educational resource for those who wish to learn how to place dental implants. Regardless of your personal feelings on this issue, it is important to understand that many general dentists have already begun placing their own implants. Truth be known, they are placing and restoring the majority of dental implants worldwide. Positioning ourselves as the authority on implants and sharing our wealth of information with others will have numerous positive effects. It will increase the number of implants being placed (a benefit to surgeons, dentists and patients) and we can promote evidence-based techniques, which will insure the success of the technology. Counterintuitive as it may sound, it will also generate more implant referrals for oral and maxillofacial surgeons.

In March, the CALAOMS board of directors, committee chairs and staff gathered in Marina del Rey to refine the strategic plan. While the plan is not yet ready to be released to the membership, it closely parallels the one set forth by AAOMS, and among other things, addresses the issue of implant dentistry.

Organized oral and maxillofacial surgery is ever vigilant in protecting our profession so that we can deliver quality care to our patients. Perhaps this is the greatest value of membership. I caution you, however, not to become complacent. While the interests of our members are well represented on the state and national level, it is important for you to utilize the "four A-s" independently. Share your knowledge with family, friends and most importantly, other healthcare professionals. Show them before and after pictures of orthognathic and implant cases. Practice to the scope of your training. Attend AAOMS, CALAOMS and CDA sponsored continuing educational programs so that you can garner the most up to date information available. In so doing you can perpetuate the excellent reputation that those who have come before us worked so hard to establish.

Spotlight on our Sponsors

CALAOMS would like to thank the following companies for their sponsorship of events at the Palm Springs Meeting

Speaker Sponsor:

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President's Message

By Gerald Gelfand, DDS
President, CALAOMS

I hate to write. Well, maybe "hate" is too strong a word but I really dislike writing and envy those who possess such a talent. Those who know me would readily agree that I'm a talker, not a writer. Though I am obligated to write a number of reports and messages similar to this one, it's always an effort. There are few things about which I procrastinate but writing is one of them. However, my editor has given me a deadline so I have to get it done. In an effort to have everything going for me when I finally get to it, I'm writing this where I do my best work, at 39,000 feet in the air on my way to Washington, D.C., for a meeting of the American Dental Association Council on Government Affairs. (Yes, I do a few other things in addition to serving as the president of CALAOMS).

For my first President's Message I could take the easy way out and thank a few people for moving the association forward this past year. People like Immediate Past President Mike Cadra, the Board of Directors, Executive Director Pam Congdon and her staff, and the committees, councils and task forces that keep CALAOMS functioning efficiently and effectively. But that's what everybody writes about in that first message, and I prefer to do something a bit different.

One potential crisis we could face and that would be a legislative attempt to attack our operator/ anesthetist model of delivering care

I could write about the new office space which we have purchased and are in the process of building out, and how that will help to stabilize our rent and help hold the line on future dues increases (I didn't say there'd never be any) while establishing an equity position for the association. I could write about our frustration as we wait for the final report of the occupational analysis so that we might move our scope bill forward and once again get it to the Governor's desk. Perhaps it's actually happened before you read this. I could write about the continued organization of our committee structure and the fine work of our chairs and committee members in advancing the goals of CALAOMS. I could write about the outstanding continuing education programs we sponsor and present all over California and beyond (our annual meeting this year is in Las Vegas in May) and the continued success of the OMSA course. I could write about the newly proposed regulations for Registered Surgical Assistants and all the work Bruce Whitcher has done on our behalf in helping to shape these regulations. I could write about the excellent relationship CALAOMS enjoys with AAOMS and CDA and the cooperative efforts we share in dealing with national as well as statewide issues. I could go on, of course, but all of these things have been written about before so I'll have to find something else to write about.

I could write about the apathy that exists among many of our members. As is usually the case, most of the work of the association is done by a handful of our almost 600 active members. As I came into this position, I made a lot of phone calls all across the state seeking people to chair and serve on committees. I heard "no" a lot more than "yes." I certainly don't expect all our members to get involved but I'd sure like to see more of you take a role in leading CALAOMS. But apathy is an old story, so I'll need to find something else to write about.

Crisis is a word I dislike because we overuse it about all sorts of things. F or me, there's truly only one potential crisis we could face and that would be a legislative attempt to attack our operator/ anesthetist model of delivering care. I truly love this specialty. It's the most unique specialty of medicine or dentistry and different from any other specialty because we are the only ones who put our patients to sleep and operate on them at the same time. We do it thousands of times every day. We do it safely, efficiently, skillfully, cost effectively, and we've been doing it that way for years. But everybody knows that already.

Unfortunately, general anesthesia carries with it a potential for risk. Though the chance of a patient dieing in one of our offices is about 1 in 800,000, it's always a tragic event whenever it occurs. One such tragic event in West Virginia has resulted in the usual knee jerk reaction. Legislators appealing to public hysteria, which they and the media help create, are contemplating legislation that would require a separate anesthetist/anesthesiologist be present for all out-patient general anesthesia. I sincerely hope this doesn't happen.

The unintended consequences of such legislation, a reaction to one tragic incident, is much farther reaching than those state legislators could possibly imagine. The cost of OMS services would rise dramatically, and access to care would be effected adversely. What would you do with those 10 year olds with swollen faces who need a primary tooth removed as an emergency at 3pm and the anesthesiologist in your office is gone for the day? Do you admit the child to the hospital just to remove one primary molar (a very expensive, time consuming and just plain silly action in my estimation)? The increased cost of hospitizaltion is prohibative. Do you bring the patient back to the office the next day or maybe two days later, when the anesthesiologist is back? Regardless, we've had so much written about anesthesia issues that anything I'd write about would just be redundant. You've heard it all before, so I won't go there.

I might write about the need to support CALAOMSPAC, especially so that we might be fully prepared to fend off any challenge like that described above. Our surveys tell us that advocacy is very important to you but still only about one third of you (the third that obviously gets it) contribute to the PAC. When, not if, we do have our delivery system challenged we need to be ready to protect ourselves immediately. That's not the time to start raising funds. We need to be proactive, not reactive, in protecting our right to administer outpatient general anesthesia. Remember, it takes money to wage the good battle. However, there's been so much written about anesthesia, and the need to support the PAC, that there's no point in my writing about that yet again.

I could write about the CALAOMS Health Foundation and the vision of the Foundation chairman Len Tyko and his Board. Community service and public welfare in my opinion are important aspects of CALAOMS and through our Foundation we can benefit many who need our services. Support for the Foundation, like the PAC, should be something we expect from all our members and yet the participation levels are low. I could write about the Foundation but I've been doing that for the past two years so no need to rehash it here yet again.

I could write abut the important relationship we have with SCPIE in California and how the royalty agreement as the CALAOMS endorsed liability carrier provides significant monetary benefit to the association as a source of non dues revenue. Equally important is the support from our meeting sponsors and vendors, which contribute to non-dues revenue and helps us to hold the line on dues. But you've heard it all before so there's no sense in writing about that again.

So since I can't think of anything to write about for my inaugural president's message, I guess I just won't write one at all.

Please Don't Skip This Article!

How do I know that most CALAOMS members gloss over information about the CALAOMS Health Foundation? The Board conducted a study. Non-profit consultants, J.G. Pettey & Associates, interviewed CALAOMS members and asked questions regarding the membership's familiarity with the Health Foundation, the Foundation's perceived strengths and weaknesses, and the general philanthropic spirit of our members. What did we find? Despite a year's worth of Compass articles regarding our Mission and Vision statements, most of our members still say "What? We have a foundation?"

Although disappointed by our continued obscurity, we were encouraged by one fact: 100% of the survey participants believed that the Health Foundation was a credible and worthwhile endeavor.

Empowered by this belief, we at the CALAOMS Health Foundation announce a year-long campaign to raise the awareness and visibility of our organization. In this spirit, let me start with the basic FAQ's regarding the Foundation.

Who runs the Foundation?

This year the Health Foundation's Board of Directors includes Drs. Bob Allen, John Scaramella, David Milder, Fred Stephens, Lester Machado, and Leonard Tyko. These members donate their time and energy to guiding the Foundation's activities. No one receives compensation or financial gain from their work on the Board. Several positions remain unfilled on the Board, and we welcome anyone interested in joining us.

What does the Foundation do?

The CALAOMS Health Foundation is a philanthropic organization primarally dedicated to supporting California OMS resident training programs. Secondarally we want to provide care and assistance to Californian's under served population in need of OMS care. This year, the Board has three planned activities: Sponsor Resident Table Clinics at the Annual Meeting in Las Vegas, provide travel grants to Las Vegas for participating resident researchers, and support Grand Rounds at California training programs.

Where does the Foundation get money?

The Foundation solicits and receives donations from the CALAOMS membership at large. We currently are developing plans for larger fund-raising campaigns. Again, we welcome input and leadership for these activities.

Where does the money go?

Last year the Foundation funded the resident table clinic competition, supported grand rounds at UCSF, and raised funds to help with hurricane Katrina relief efforts. The organization runs efficiently and a small sum goes toward administrative staff salaries. Our long-term aspiration is to raise enough money to help indigent Californians in need of OMS care, as well as, expand our support of resident research and training programs.

In the following months, a complete financial statement will be available for all those interested in examining the Foundation's financial base. My goal is to make our Foundation's financial situation totally transparent. After all, the Foundation's money belongs to all of us.

How much money is needed for this year?

8750 dollars has been bugeted by the Health Foundation to support resident table clinic competition, travel grants, and grand rounds. It is our goal to raise significantly more than our budgeted expenses in order to build our financial principle and expand the Foundation's philanthropic activities.

The CALAOMS Health Foundation cannot thrive without the support of CALAOMS members. Please consider giving back to your profession so that we may help others. We sincerely thank you for your support.

Respectfully yours,
Leonard M. Tyko II, DDS, MD
President, CALAOMS Health Foundation

SCPIE's Risk Management Corner

Documentation Is Patient Care

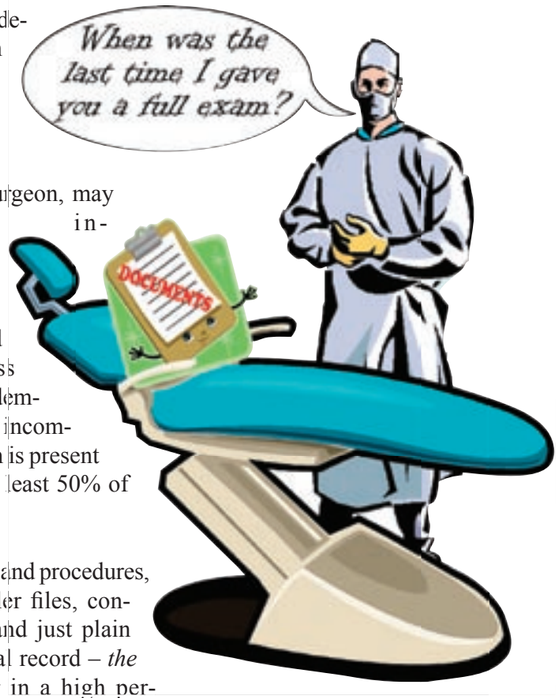
By Barbara Worsley

Of all the risk management education topics, none produces quite the same degree of eye-rolling and sighing as documentation. Oral surgeons or staff who arrive at a meeting and find documentation on the agenda secretly – and sometimes not so secretly – wish they had called in sick.

Are we caring for the paper instead of caring for the patient? Hardly.

But in order to treat patients effectively, you must hear their story, both from them and their family/support network. Then that story is transmitted to other involved parties. Good documentation is the way to communicate the story efficiently and accurately.

A thorough assessment of any patient begins with the patient's or family's description of what is going on. The plan of care — with its goals, strategies, time frame and measures of success — flows from this thorough assessment. For all members of the healthcare team to be able to do their part, they must have access to the detailed information generated through the assessment and plan of care.



You, the oral surgeon, may believe — even insist — that your documentation is comprehensive and complete, but closed claims reviews across medical specialties demonstrate that poor or incomplete documentation is present as a risk issue in at least 50% of cases.

Despite policies and procedures, checklists and tickler files, continuing education and just plain nagging, the medical record – *the* determining factor in a high percentage of all medical malpractice lawsuits – can be a woefully inadequate witness to the medical care provided.

In reviewing SCPIE closed claims, the following were some of the deficiencies in multiple medical records:

- Altered documentation
- Incomplete or missing documentation
- Allergy history not documented
- Lack of documentation of phone advice
- Missing progress notes and lab reports
- Illegible notes
- Incomplete informed consent
- Informed refusal not documented
- Patient education not documented.

Lack of good documentation not only reflects less-than-optimal patient care but is also a prime factor in liability loss. The following table summarizes some claims, both for oral surgeons and other specialists, in which documentation — or lack of it — played a key role in the resolution of the claim.

Indemnity Paid	Allegations	Comments
$100,000	Negligent bridgework in 53-year-old female, resulting in work needing to be redone.	Doctor produced a written chart as being an original. He lost or destroyed the original chart and then rewrote it. The doctor's appointment book, lab and billing records contradicted information in the rewritten chart.
$150,000	Negligent mandible osteotomy, resulting in facial deformities of a 43-year-old male.	The medical record was incomplete regarding treatment dates and there was inadequate documentation of the patient's complaints; little written in record of informed consent. In addition, the insured admitted liability in a letter to the patient.
$500,000	Failure to diagnose and treat melanoma, resulting in wrongful death of a 38-year-old female.	The physician's entire documented record for this patient, who was seen over a period of several months, consisted of six scant entries. The doctor said that because he was the only physician treating the patient the need for "excessive" documentation was unnecessary. The case was completely defensible from a causation point of view if there had been good documentation in the medical record.
$200,000	Negligent treatment of dry socket and failure to diagnose osteomyelitis, resulting in trigeminal neuralgia.	The patient's medical record consisted of two pages of notes for four months of treatment. The oral surgeon never took any radiographs, including CT scans, bone scans or even a Panorex.
$275,000	Acute airway obstruction following IV anesthesia, resulting in death of 63-year-old male.	Testimony of staff contradicted the chart, which had been "reconstructed" following the acute event in the office. Temporary chart notations on tray paper linings had been discarded post-incident.
$233,000	Wrongful death of a 48-year-old woman.	A non-English-speaking patient signed the Consent for Surgery, which was entirely in English. It was believed that the patient brought along her own interpreter, but none of the records contained a notation to this effect.

In the absence of complete, consistent, comprehensible documentation, how can oral surgeons possibly explain what they did, why they did it and what they expected to achieve?

What more is there to say? Documentation – caring for the medical record – *is* patient care.

New Office

Continued from page 1

twenty years in rent if we stayed in the rented office space, and even more if we moved to a larger, newer facility.

Having experience in land development, architecture, space design and contract negotiation, and a keen devotion to our association, Steve Krantzman, Director of Information Systems, worked through the myriad of details in the negotiations with the developer and realtor, ensuring a successful close of escrow that concluded in a contract that is favorable to our interests and within our budget. We owe a huge debt of gratitude to Pam for her vision, and Steve for his diligent effort on our behalf. Pam and Steve are now in the process of designing the space to best suit the needs of our association.

Jerry Gelfand and Mike Cadra have appointed a committee to garner donations towards the costs of development of the space. We project a cost of approximately $300,000 to fully develop the office. Exciting opportunities are now open for us, our colleagues and some of our vendors to participate in the office development project.

This is an endeavor that has showcased the talent of many of our members and the dedication, vision and talent of our amazing staff. We can all be proud of this accomplishment.

Together, we have set the stage for the growth of our association in a way that helps ensure our financial strength for years to come!

Editor's Note: This article was excerpted from a letter sent to the Board of Directors from Dr. Lester Machado, Treasurer. Lester played no small part in this project, and is to be commended.

The 13th International Symposium of OMS

The 13th International Symposium of OMS sponsored by UCSF was held at Kauai, Hawaii (where else) from January 23-27, 2006. As you might expect a great time was had by all. Below is a photo of some of the doctors in attendance provided by attendee and CALAOMS Member Vince Farhood, DDS.

Pictured from left to right Dr. Radhika Chigurupati (CA), Art Curley Esq. (CA), Robert Campbell (VA), Anthony Pogrel (CA), R. T. Myhall (OR), Moghees Baig, Roger Meyer (GA), Paul Thomas (Cardiff, Wales), Salvatore Ruggiero (NY), David Hatcher (CA), Philip Worthington (WA), Michael Pikos (Fl), Michael Lewis (Cardiff, Wales), Raymond White (NC), Brian Schmidt (CA), Charles Bertolami (CA) Not Picutred - Vince Farhood (CA).

District VI Trustee Report

Although it seems only a short time since I was elected trustee at the annual meeting in Boston, I have already come to appreciate the long hours and hard work Rick Crinzi has given to District VI for the past 4 years as our trustee. We all owe Rick a heartfelt "thank you" for a job well done. I am pleased to say I am enjoying my service to District VI. The Board of Trustees and Officers of AAOMS share a common goal of advancing the specialty of OMS, and I feel privileged to work with such a talented and dedicated group.

The annual meeting in Boston was a great success for AAOMS, attracting the second largest attendance in our history, and producing non-dues revenue to the association that surpassed budget estimates. The continuing education programs were well received and provided opportunities for CE credit and networking unmatched by any other event. The Committee on Continuing Education and Professional Development, and the Committee on Practice Management/ Professional and Allied Staff should be congratulated for the excellent quality of the program. We are looking forward to another highly successful program in San Diego this fall, and I hope to see all of you there. The San Diego 2006 annual meeting will be extended, with a two day anesthesia review course offered prior to the start of the scientific sessions and exhibits.

The annual Dental Implant Conference was held in Chicago the first weekend in December, and registered an all time record attendance. This implant program is rapidly becoming the preeminent venue for hands on and didactic implant training in the United States. Mark your calendars for the first weekend in December 2006, invite your referrals, and register early, as the conference will most likely sell-out.

Your AAOMS Board of Trustees met at the American Dental Association annual session in Philadelphia October 6-11, 2005. The board attended ADA District Caucuses as well as the ADA House of Delegates, and identified one issue of importance to oral and maxillofacial surgery: The restructuring of Dental Specialty Residency Review Committees by CODA (the Commission on Dental Accreditation) would result in a majority of the members of Residency Review Committees being nonspecialists and public members. AAOMS supported a compromise restructuring plan that would maintain specialists as the majority of members on their RRC, while incorporating public members for oversight.

As BOT liaison to the Committee on Government Affairs, I attended the 10th annual State Advocates Forum in Tucson, Arizona on November 11 and 12, 2005. This meeting brings together the executive directors and lobbyists who represent OMS around the country for a roundtable discussion of the legislative issues that are of importance to OMS both regionally and nationally. The highly successful meeting was also attended by your AAOMS President Dr. Jay Malmquist, President Elect Dr. Mark Tucker, Vice President Dr. Lee Pollan, President of the Dental Board of California Dr. Newt Gordon, and CALAOMS President and Chairman of the Committee on Government Affairs Dr. Gerald Gelfand.

The issues that seemed to generate the most interest and discussion were scope of practice, especially relating to elective cosmetic procedures, the use of botulinum toxin by dentists, and general anesthesia/conscious sedation. Of these issues, I think the vast majority of us would view the general anesthesia/conscious sedation issues as the most critical to the practice of OMS, but all these issues are important.

It is crucial that our members understand that OMS is a small specialty that is presently enjoying relatively good times when compared to our colleagues in medicine. We simply cannot afford <u>not</u> to be politically active and astute in our state and national legislatures. Presently there are 2 trains figuratively coming down the track, and many of our members seem unaware of the impending problems. A growing problem of massive importance to us is preservation of the single operator/anesthetist model utilizing a team of OMS assistants and the surgeon.

Pressure from nurse anesthetists and other groups have the potential to threaten our pattern of practice if we do not remain constantly vigilant. Compliance with office anesthesia inspection and re-inspection programs mandated by the AAOMS Bylaws has never been more important to safeguard our anesthesia privileges. In West Virginia, the WVSOMS expects in 2006 to see the third attempt in as many years to change the WV dental practice act to require an additional anesthesia provider to administer general anesthesia in the dental office setting. State OMS societies in other states are reporting similar challenges to the OMS anesthesia team concept. As always, the answers to these challenges are better handled proactively than reactively.

In Idaho, the ISSOMS is fighting a move from the Oral Conscious Sedation group to legislate a separate standard for sedation when given by the oral route. As we all know, sedation and general anesthesia are a destination, not a method of transportation. It makes no difference if you drive or fly to Sacramento, you are still in Sacramento. So far the ISSOMS has successfully argued that the education and training required to safely administer sedation is not diminished by the method one uses to create the sedated state in a patient. The battle is not yet won; the legislation was rejected in the upper house, but remains active in the lower house of the Idaho legislature.

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The training of OMS assistants who compromise part of the anesthesia team has become an issue of great importance. The AAOMS Committee on Anesthesia has proposed a voluntary certification program for OMS anesthesia assistants, and AAOMS President Jay Malmquist has appointed a taskforce to work out the methodology whereby such a program could be developed. I was pleased to be appointed BOT liaison to this taskforce as I have been closely involved in OMS anesthesia assistant training for 11 years; 5 years as co-chair of the CALAOMS OMSA program, and 6 years with AAOMS's OMAAP program as a member and chair of the Committee on Practice Management and Professional and Allied Staff. I would encourage all our members in District VI to make use of these excellent training programs to help train anesthesia assistants, and to periodically update their skills and knowledge base.

What is it worth to practice Oral and Maxillofacial Surgery?

The best way to insure proactive management of the legislative issues impacting OMS is to support your state and national OMSPACs. Contributions of time and money are needed, and one of my goals as district VI trustee is to see district VI become the leader in contributions to OMSPAC, both in terms of total contributions, and in the percent of our members participating. Presently we rank 3rd in percent participating, and second in total contributions. Only 36% of OMSs in California contributed anything to OMSPAC last year. This means about a third of our members are doing the heavy lifting, and two thirds are getting a free ride. Encourage all your colleagues to step up and contribute to defend their practices against the adversaries of OMS. If all you want to do is run your practice, and you are not interested in politics, you owe it to the volunteers who work to preserve your privilege to practice to support the efforts that make your lifestyle a reality.

Dr. Lynn White, District V Trustee, and many other AAOMS staff, members, and fellows are to be congratulated for efforts that eventually led to passage of an amendment proposed by Senator Kay Bailey Hutchison of Texas. The amended bill (S. 1042) will provide incentive special pay to military OMSs. As a specialty, we must maintain close contact with our federal and state legislators to preserve our scope of practice, and to correct discrimination based on degree. Our new lobbyists in Washington DC have informed us the military may resist rapid implementation of the new ISP provisions, but they are well positioned to press for attention to this matter through good relationships with congressmen in the appropriations committee for the military.

On a personal note, I attended the CALAOMS board and membership meeting in San Francisco, October 28-30, 2005. After 5 years as a director and officer, this was my last official meeting as a member of the board of directors of CALAOMS. I have deep appreciation and respect for the leadership of the California Association, and I know the time commitment required, therefore I declined nomination for Vice President of CALAOMS in order to focus on the job of being District VI Trustee. I take the responsibilities of trustee very seriously, and my goal is to evenly and resolutely represent the entire Western District.

Best wishes and warm personal regards to all,

Larry J. Moore, DDS, MS
AAOMS District VI Trustee

Compass Interview: Gerald Gelfand

A candid conversation with the dynamic and energetic President about CALAOMS, organized dentistry, his practice and sweat pants.

Compass: You have been involved with organized dentistry for a number of years. What has been your motivation?

Gelfand: I have always been self motivated. It's my natural inclination to be a "doer" and get involved. I've always been an activist and enjoy being in leadership positions and being part of the solution.

Compass: In recent years, CALAOMS and CDA have developed a strong relationship. How important is this relationship? Do you think it's important for OMSs to be members?

Gelfand: The relationship between CALAOMS and CDA is extremely important. CDA represents all of dentistry in California and we're a part of that. But they are a much larger and stronger organization than ours and in order for us to have any success with those issues which are unique to OMS we will need the support of CDA. When legislative and regulatory bodies want information concerning dental/OMS issues, they turn to CDA, not CALAOMS. I'd like to see that changed but, regardless, a close and open alliance with CDA is critical for us.

By the same respect, all OMS's should be CDA members. CDA and CALAOMS provide very important benefits for members and non-members alike. Unfortunately non-members enjoy those benefits without paying for them. I think that's wrong.

Compass: What are the major issues facing oral and maxillofacial surgeons in the next five years?

Gelfand: The most important issue, of course, is any encroachment upon our operator/anesthetist model.

Other issues are nothing new, e.g. insurance control of fees, reduced trauma call and lack of remuneration for ER work, the shortage of OMS educators and the ripple effect on training programs, dental schools, and access to care issues, licensure issues, especially specialty licensure, the high cost of health care (everybody's problem), entitlement programs and lack of appropriate remuneration and on and on...

Compass: Even though CALAOMS has a strategic plan, most presidents have an agenda for their term. Is there anything you really want to get accomplished this year?

Gelfand: Comming into office, I wanted to do a couple of things. I wanted to make the Board meetings more relevant. I have decreased committee/officer reports and added an issues discussion as well as other more meaningful reports or outside guests.

I wanted to engage the Board more, so I have increased the amount of communication between the President and the Board members.

I wanted to make sure all committees were working at an optimum level so I spoke with each chair, suggested goals for the year, spoke about ways to make sure all committee members were engaged and active on the committee and it was not a committee of one (the chair), invited the chairs to our board meeting and strategic planning. I think it's had a positive effect and the committees seem to be doing very well at this time.

There are a number of other things which are taking place some through the work of task forces which I have initiated for CALAOMS but enough for now.

It's my natural inclination to be a "doer" and get involved

Compass: As President, you are obviously aware of the many benefits of membership. What do you see as the biggest CALAOMS member benefit?

Gelfand: The biggest benefit is protection, but not in the sinister sense. I mean that only organized OMS (and organized dentistry) is there to watch out for our best interests and though one derives this same benefit as a non member, it's really unfair to not pay one's share. That's a really important benefit. Due diligence and vigilance on the part of CALAOMS and AAOMS has saved the average OMS thousands of dollars over the years but many don't realize it. So protection is the biggest benefit.

Compass: Tell us a bit about your practice. Major vs. Minor cases. Do you take call? Do you hire cute girls? How much do you make? Ever dipped into the Fentanyl?

Gelfand: I have practiced for 32 years, the past 28 at the same location in Woodland Hills. I practice alone in a primarily office based dentoalveolar practice. I still do trauma, have never done TMJ surgery and have pretty much given up orthognathic surgery.

I make enough, don't hire "girls", only "women" and have never dipped into the Fentanyl.

Compass: How many pair of sweat pants do you own?

Gelfand: I own a lot of sweat pants.

Our Presence Amongst the Medical Community

Mike Cadra and myself are members of the AAOMS Scope Advocacy Task Force. You may well ask what this is, and I have to tell you that it is an ad hoc committee established by AAOMS to look into the issues concerning our declining presence in the medical community, and therefore our perceived declining influence and possible standing in the medical community, and certainly our inability to be able to institute change through the medical community.

It is felt to be important that both ourselves and our policies and positions should be known in our local medical communities. We may need to rely on help from our anesthesia colleagues and also our plastic and ENT colleagues, and even our orthopedic and dermatology colleagues. It appears we have a declining presence in our local hospitals and medical centers around the state in that we are rarely in the hospital for breakfast to chat with the other physicians and are seen less often in the emergency rooms and operating rooms of our local hospitals.

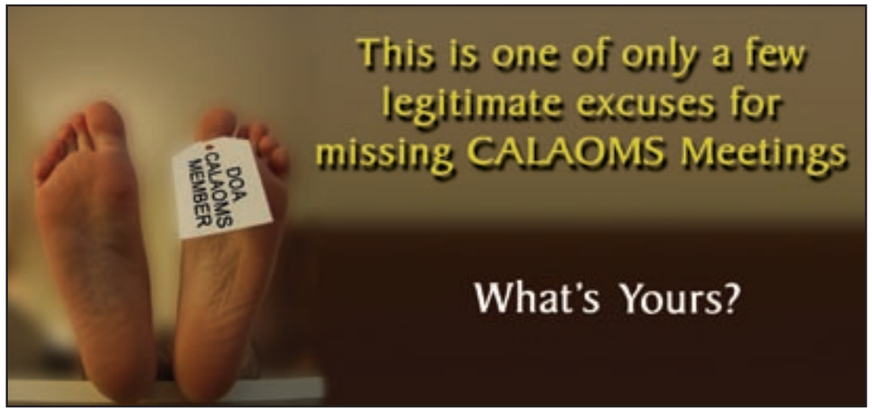
The Scope Advocacy Task Force has been tasked to look at ways of reversing this trend and therefore increasing our presence and influence amongst our medical colleagues. Suggestions so far include the following:

- Oral and maxillofacial surgeons should spend time cultivating relationships with medical colleagues both inside and outside our local hospitals.
- We should attempt to have a continued presence in our local hospitals including a presence in the emergency room, the operating rooms, at social events, and political events.
- We should seek office within the administrative structure of our local medical centers including being the Chair of the Department of Dentistry within our hospitals and also accepting appointments on the Credentials Committee and Medical Staff Committees including becoming officeholders amongst these groups.
- Double-degree oral and maxillofacial surgeons should strongly consider becoming members of the American Medical Association, the California Medical Association, and the local constituent group. Unlike the ADA, the AMA does not have a tripartite structure so that you can join one without the others. Within these bodies we should consider standing for committees and seeking officeholder positions.
- Double-degree oral and maxillofacial surgeons should apply for fellowship in the American College of Surgeons so that we can build up a solid presence within this group to have influence at a national level.

I am sure some of you feel that these goals are either unattainable or irrelevant to our specialty as it exists today in private practice, but there is great value in maintaining a strong presence within the medical community particularly if the scope of the specialty and the operator/anesthetist model remain issues.

If you have any other suggestions to add or other comments please contact Mike Cadra or myself.

Tony Pogrel



It's Not too Late! Sign up for the 6th Annual Meeting in Las Vegas, May 5-7 Call 800-500-1332 for Details

General Announcements

A Warm Welcome

CALAOMS would like to take a moment to extend a warm welcome to the following oral and maxillofacial surgeons who became a full member of our organization over the last year. We will continue to recognize new members as they obtain full membership in subsequent issues.

Approved August 2005
Peyman Hedayati, DDS, MD
Victor Pak, DDS
Jeffrey Payne, DDS, MD

Approved October 2005
Patrick Duffy, DDS, MD
David Montes, DDS
Anil Punjabi, DDS, MD
Anthony Rega, DDS
David Salehani, DDS, MD
Kenneth Wong, DDS
Thomas Ying, DDS

Approved January 2006
Richard Bae, DDS
Holly Hatt, DMD, MD
Stjepan Podstreleny, DDS
Sudheer Surpure, DDS, MD

Approved March 2006
Keyoumars Izadi, DDS, MD
Jettie Uyanne, DDS
Robert Wagner, DMD, MD

Upcoming Events For 2006

OMSA Home Study Course Begins		**OMSA Home Study Course Begins**	
April 15, 2006	Summer Course	October 15, 2006	Winter Course
CALAOMS 6th Annual Meeting		**Infection Control and Risk Mngt**	
May 5-7, 2006	Las Vegas	October 25, 2006	North - TBD
OMSA Expanded		**ACLS**	
May 17, 2006	South - TBD	Oct/Nov - TBD	Solano
OMSA Home Study Course Begins		**Infection Control and Risk Mngt**	
July 1, 2006	Fall Course	November 1, 2006	Los Angeles
Residents' Night		**Fall Membership Meeting**	
September 27, 2006	Los Angeles	November 3-5, 2006	Sonoma

Call for Publication Committee Members

- Do you like to be a contributor?
- Do you have something to say about your profession?
- Do you think the Newsletter could use improvement?
- Do you think the Web-Site needs improvement?
- Do you like seeing your name in print?

If you answered "Yes" to any of the above questions, then you need to seriously consider becoming a member of the CALAOMS Publications Committee.

We are looking for energetic members who love their profession and want to make a difference.

Call Tim Silegy, Committee Chairperson to discuss signing up for the 2006 committee year.
(562) 496-1978

Classified Ads

Equipment For Sale

Mid Summer Cleanup!
Steve M. Leighty, DDS, Grass Valley, would appreciate any (new or used in good repair) common surgical instruments (forceps, elevators, needle drivers) to help outfit the new dental clinic at the Community Hospital in Ilam, Nepal. This project is sponsored by the 49er Rotary Club in Nevada City. 1364 Whispering Pines Lane, Grass Valley, CA 95945. Call 530.272.8871 for details.

STRYKER HANDPIECES – Microroto –osteotome # 277-01 8 @$2400 each.
STRYKER Foot switch – round . # 277-07 2@ $600 each.
IBM SELECTRIC II Typewriters $200.
BACKUP CPU POWER SUPPLY $300.
HP SCANJET 4 C/T –Scanner with transparency adaptor $600.
COMPUTER – NORTHGATE PENTIUM II -450 MG Htz,128 MB Ram, 8.3 Gig HD 13" Monitor, Windows '98, MS Word, MS Office $695.
Printer – OKIDATA Dot Matrix $150
NETWORK HUB - 10 Base T $45
Call (559) 447-0544

Baxter InfusO.R. Suringe Pump for Propfol. Used Once $1200.00
Harvest PRP Centrifuge Used about 10 times $3500.00. **Call 760-365-0658**

Doctor Seeking Position

Opportunity Wanted. Young Board Certified OMS looking for an associate position leading to partnership or buy-out. Please email dromsca@yahoo.com

Job Opportunities/ Practices for Sale

Concord, CA
Existing specialty group practice with established management looking for a quality oriented specialist with long term goals to join a highly profitable situation as a 100% owner of your practice. Our practice has been established since 1989 and currently consists of OS, Pedo and Endo. This is truly a unique opportunity that provides the income and quality of life unlike any other. Income for the current OS is approximately $650,000 on an annualized basis. Please call 925-680-0220 or fax resume to (925) 680-8087 or email me at hrezapour@aol.com.

Glendale, CA
OS practice in a multispecialty office (endo, ortho, pedo, perio, OS) seeks new OS for routine exts, wisdoms, implants, IV. Current OS moving out of area. Grossing 300k/yr and growing, Wed&Fri ~8/9am-1/2/3pm. Ready to take over, keep 35-45%, 0 investment, 0 overhead. Glendale, CA. (818) 547-2804 Pgr:(818) 410-2426 email: lexme2003@yahoo.com

Hayward, CA
Well established, busy solo practice in Hayward looking for personable/capable OMS for associateship leading to partnership. Please call Dr. Jim Mossop 510-582-7191 or fax resume to 510-582-8147.

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

Salinas/Monterey, CA
Associate With Immediate Partnership Potential**.** Practice in Northern California's premier coastal area. Well-established, highly successful, multi-office, high-income OMS practice seeking a single/dual degree OMS who is board certified or an active candidate for board certification, for associate/early buy-in. Excellent salary, benefits and opportunity to assume leadership. Full-scope office/hospital practice with emphasis on implants and related grafting, orthognathic and cosmetic. Recreation opportunities and Lifestyle amenities abound. Please send CV to Dr. Terry W. Slaughter @ 420 E. Romie Ln., Salinas, CA 93901.

San Jose
San Jose Oral Surgeon, in desirable area, retiring after 8 years. 3-op office, single-story Professional building. Working 4 days/week, FFS netting $600,000, collections over $1million. FP $635K Western Practice Sales 800-641-4179

San Diego, CA
Well established full-scope OMFS practice. Fully accredited JCAHO Surgery Center. Seeking an Associate, Board Certified or eligible. Please send your Resume to (619)420-6645.

Sierra Foothills
OMFS PRACTICE : Purchase/Buy-in. Located in the Sierra Nevada foothills--Gold Country. Outdoor recreation abounds, awesome place to live and practice. Get out of the rat race without giving up income. Well established practice. For more info. darlene4paws@msn.com

Turlock, CA
We are currently looking for an experienced Oral Surgeon to join our wonderful clinical team. The office is located in Turlock, California in the Central Valley. Full scope office including trauma and implant surgery. Excellent salary, and benefits. Flexible days. If you are interested in joining our team, fax your resume to (209) 669-8123 or email to aileen@valley-dental.com.

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

Vallejo, CA
Looking for an oral surgeon, one day a week, can earn up to $2000 a day, for more info call (925) 325- 2293 or send email to Nazilaedalati@aol.com .

Front Office Staff/ OMS Assistants Wanted

West Los Angeles
Front office position available for bright, outgoing individual with previous experience with billing, insurance and collections, and good communication skills. Please call (310) 614-9557

Wanted..
Experienced Oral Surgical Assistant, x-ray and CPR licensed, anesthesia, surgical assisting, inventory and supply control, fluent English mandatory, second languages helpful. Full time position, leadership role. Office mainly does dento-alveolar and implant surgery, local and general anesthesia. Salary and benefits generous. Unique office in Alameda, a great office to work in. Call Tina if interested 510-522-7010.

Office Space For Sale or Lease

Established Oral Surgery office suite for lease in Castro Valley, 1150 +/- sq ft in a professional building, close to freeway and hospital. 4 ops, newly remodelled with some equipment available for purchase. 510-420-8888

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Being a mountaineer involves serious risk to your physical well-being. Being an oral/maxillofacial surgeon—especially in today's highly litigious environment—involves serious risk to your professional reputation and financial security.

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