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The Compass

Staying the Course Through Service and Education

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Volume IX, Issue 1, Spring 2007

Mead Heads CDA: Emphasizes Importance of Professional Involvement

On November 12, 2006, one of our own, Dr. Ronald Mead, was elected president of the California Dental Association. Dr. Mead, a native Californian and father of 2, received his dental degree from Loma Linda University and completed his OMS training at Highland General Hospital. After a short stint in Vallejo, Dr Mead began his private practice in San Luis Obispo. In 1981, the same year he opened his practice, Dr. Mead began his service to organized dentistry in the Central Coast Dental Society. He attributes his start in organized dentistry to early professional mentoring that stressed the importance of community and professional involvement. Since that time, Dr. Mead has held offices within organizations spanning from the Central Coast Dental Society to the American Association of Oral & Maxillofacial Surgeons.

In his new capacity, Dr. Mead shared a few moments to discuss his presidency and vision for CDA.

You were CALAOMS President in 1997. How are the 2 Presidencies different?

I hoped to serve in both organizations; it just happened that I began with CALAOMS. CALAOMS, being a smaller and a less formal organization, was less intimidating and easier in which to participate. For me, it was a learning ground for parliamentary procedures and the ends-and-outs of organized, professional action.

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Compass Direction

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

Editor's Corner

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

Tyko Beats Silegy in Momentous Struggle for Power

At the Annual CALAOMS meeting in Palm Springs, Dr. Leonard Tyko surprisingly beat Dr. Tim Silegy in three, straight, arm wrestling matches. Up for grabs was the prestigious leadership of the Compass newsletter. In victory, Dr. Tyko now ascends to the editorship of the Compass in this, first issue of 2007….

OK, well, maybe that's not what really happened. In fact, those of you who know Dr. Silegy know of his tremendous biceps and therefore his upper body strength. It is possible, actually, probable, that I accepted the position of editor of the Compass because Dr. Silegy simply asked. Tim and I have known each other for over 10 years. He has been an active and involved member of our organization and is responsible for my involvement over the last 3 years. I am indebted to Tim for expanding my professional role and for the dedicated service he gave as editor over the last two years. In light of this (and his bicep size), how could I say, "no"?

Under Dr. Silegy's guidance, the Compass has expanded and improved. I hope to continue this progress over the next year as we work to make the Compass a viable source of information and education. This goal however, requires more than good organization, word processing, and shiny paper. Continuing the progress of the Compass and CALAOMS in general requires the attention and involvement of the membership at large—you.

CALAOMS is but a mouthpiece for our profession. The members who work diligently to educate, legislate and protect our profession are amazing people. Sitting in my first Board Meeting, I was overwhelmed by the dedication of the members *volunteering* their time to plan meetings, publications, and political action. Honestly, and embarrassingly, I had taken all this work for granted, and I was struck at that moment by how lucky I (and we) are.

Come steer a course toward leadership

Frankly, getting involved with CALAOMS was not an easy decision for me. I was worried about being over-extended. I was too busy; when would I find the time? But sitting in that Board Meeting, I realized that these are smart, educated, and devoted people, but they are also just regular people. They have practices, families, and lives outside the profession. If they could do it, why couldn't I? I accepted my first role within CALAOMS and was surprised to discover that the rewards I received easily outweighed the constraints on my time.

It is no secret that national volunteerism is down. Some members of our Board feel that the general membership lacks interest in volunteerism. I don't believe that we are indifferent. I believe that we are scared—scared of being stressed, overworked, unappreciated.

Seven years ago, I finished my residency and moved to Northern California. My professional focus was different then. I was focused on buying and growing a practice and providing for my family. My dad sat me down and stressed to me the importance of community and professional involvement. As a man who served 34 years as a LA County Sheriff, I admired his life-long devotion to professional service. He reminded me that a true professional does more than just go to work. A professional donates his time and talents to the betterment of the profession and the community. He assured me that in doing so, I would become a better dentist/physician, a better provider, and a better man. It turns out, as in most things, my dad was right.

So, I charge you to get involved with CALAOMS. This involvement doesn't have to be extreme. Volunteer for a committee, write an article for the Compass, arrange a speaker for a meeting, judge a poster presentation. Call and ask; we will find something that will fit into your time frame. ***This organization is for you. Use it!***

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What do you feel being an OMS brings to your presidency?

Simply, I have a different prospective - but nothing else. It is important for me to focus on dentistry as a whole, not on our specialty. I rely on CALAOMS to bring forth issues pertinent to OMS. It is critical that as oral surgeons, we take an active role in issues that are pertinent not only to our specialty, but to general dentistry, as well. We must rely on one another to protect and advance the entire profession—not just one branch.

What is it like being CDA president?

Though the workload takes a toll on my practice and personal life, the office is interesting, exciting and, of course, enjoyable. I have minimal personal time - all of my spare time is CDA time. I am amazed by some aspects of the job, like the daunting number of emails I receive. But, I am energized by the commitment of California dentists I encounter while traveling about the state to various meetings.

What are your goals for your presidency?

Issues of access to care, dental student debt reduction and scope of practice are my main focus. I have great interest in the CDA Foundation and how it can be used to ease the debt load of the newly graduated dentist. Like in other states, many Californians have difficulty accessing care. I would like to see new graduates be able to minimize their debt while working with this underserved population.

Do you see any upcoming issues particularly important to OMS?

The main issue for OMS's was SB 438, scope of practice. This is an excellent example of how the CDA and specialty organization worked together for the good of the whole profession. Our work now involves the safe and organized implementation of this law—an arena where we can and will continue our collaborative efforts.

How well represented do you feel OMS's are within the CDA?

We are well represented. There are OMS's at various levels of the CDA who are very good and working hard. Our specialty gains strength by having representation throughout the organization. As I have said before, it is important for others to see OMS's working on issues that don't specifically affect our specialty. This insures that when issues specific to OMS arise, we will be more likely to have the support of organized dentistry. OMS's need to actively maintain visible roles and representation at all levels.

What is your next step after your presidency?

Retirement.

By: Leonard M, Tyko, DDS, MD

President's Message

Murray K. Jacobs, DDS
President, CALAOMS

Civility Communication Community

Three words that I hope can provide some degree of direction as we enter 2007 and attempt to strengthen and advance our specialty are civility, communication, and community.

At 4'11" as an entering freshman at Hughson Union High School, I was not highly recruited by the varsity basketball coaches. Not withstanding, I had a burning desire to participate in the game for which, it appeared, I was not well suited. On the first day of practice, some of the larger, more respected players on the team actually attempted to stuff me in the basket (unsuccessfully might I add). Undaunted, I spent evenings, Saturdays, weekends, and summers trying to improve my skills and wishing for an infusion of growth hormone.

By the start of my junior year, I had actually grown a little (5'6") and had managed an invitation to try out for the varsity basketball team. Three weeks later the coach rewarded my effort with the last jersey for the first home game. I was going to play (or at least suit up with the varsity basketball team!) I could not contain my excitement and invited my two best friends from Modesto to attend the game.

For those of you who have played high school basketball you will know that one of the great "macho" traditions is to raise from your seat at half-time of the junior varsity game, your duffel bag in hand, to enter the locker room to put on your uniform with the rest of the "jocks." I awaited the moment with great anticipation, with my best friends at my side. However, it was not to be. Three minutes before the great migration to the locker room, the coach instructed Tommy Manning, a senior, to take my uniform. The coach had changed his mind and Tommy was going to play!

I was stunned. I sat nearly motionless for the remainder of the J.V. game, carefully holding back the anger and the tears. I left the gym quietly prior to the start of the varsity game. I arrived home and boldly announced to my parents that I was quitting basketball and would not play anymore. My decision was made in haste and was certainly motivated out of feelings of embarrassment and disappointment.

Three words that should be etched in stone, if not in our minds

Fortunately, my parents were wise enough to counsel me and convinced me to reverse my decision. As a result, I continued to follow my passion for basketball and the following year, not only did I make the varsity team, but also I was voted on to the All-Conference team!

I learned two great lessons that night.

1. Decisions made in haste because of embarrassment or anger are often wrong.

2. Seemingly small decisions now can have an impact on our future experiences in life for many years.

During this past year, we have dealt with a number of important issues in our specialty that have had significant implications with regards to our ability to continue to practice in the manner we would like. We have had a number of great successes, not the least of which included the passage of SB 438 and the purchase of a new office building for CALAOMS, which will provide much benefit for years into the future. As these issues and many others were discussed, I would like to commend Dr. Jerry Gelfand for the professional and competent manner in which he handled the discussions. Decisions were not made in haste or because we were angry or embarrassed about some issue. Dr. Gelfand understood that the decisions that we were making could have an impact on our specialty long into the future. So, ideas were weighed carefully. I would also like to thank so many of you who donated your time and energy for the betterment of our great profession. The advancements we make do not just happen. They require effort.

Now, as we enter a new year there remains much to be done. We continue to deal with insurance issues, anesthesia certification issues, increasing competition with our C.E. programs, recruitment of new members, faculty retention issues, implementation of our scope bill, advocacy and many, many more challenges.

May I encourage the members of the board and members of our society generally that as we discuss and debate these issues that an atmosphere of CIVILITY will prevail. It's okay to have varying opinions and ideas.

Additionally I would encourage you to COMMUNICATE your ideas and concerns to the board. We are anxious to hear from the membership. After all, this is your professional society.

Finally, we have all been fortunate to be members of this great COMMUNITY of oral and maxillofacial surgery. We need to view ourselves as a part of a great organization with nearly unlimited potential for growth and development. Giving back should occupy a portion of our time. We encourage everyone to participate and add your particular talents to the mix.

None of what we accomplish could be done without the great work of the dedicated and loyal people in the central office. Thank you Pam, Steve, Barbara, Debbie, and Teri.

May we all have a prosperous and successful 2007.

NOMINATING/LEADERSHIP DEVELOPMENT COMMITTEE

Gerald Gelfand, DMD, Chair

In the first, and perhaps last installment, reviewing the CALAOMS committees, let's talk about leadership. (Just when I thought I was done writing articles for a while, one of my least favorite endeavors, I'm back at it again).

Where does our leadership come from? How do they apply for positions on our Board and committees? Who makes the decision about appointments and how is our slate of officers developed each year prior to being sent out to the membership for a vote? The answer, in short, is the Nominating/Leadership Development Committee.

The Nominating/Leadership Development Committee consists of seven CALAOMS Fellows and is chaired by the Immediate Past President. This year, that's me. The committee is charged with the following duties:

- To study and address the problems and leadership requirements of the Association.
- To select nominees who have the experience and the qualities that meet the needs of the Association.
- To interview prospective nominees personally, by telephone or by mail and secure their consent to serve if elected.
- To prepare a report containing the committee analysis of the leadership needs of the Association and to recommend a slate of candidates with their experience and qualifications and the reasons that the committee feels the candidates named can meet these needs.
- To submit its report to the Board of Directors.

Of paramount importance to the committee is the identification of the future leaders of CALAOMS, knowing that visionary leadership is the key to the future success of CALAOMS in protecting and representing our specialty in California as well as providing national leadership.

You have all recently received the newly expanded application forms for all leadership positions, i.e. committees and the Board of Directors. If you have ever entertained the idea of "getting involved," what better time to do so than now? By filling out and returning the application, you will declare that you are interested in being part of the solution of the many issues we face. It will validate your commitment to keeping oral and maxillofacial surgery strong and independent. Beyond that, you will no doubt receive more than you give. You will have the satisfaction of knowing that you are part of the debate when it comes to protecting OMS, especially our operator/anesthetist model, and that you got involved and didn't leave it for someone else to do as so often happens. Perhaps most important, you will be astonished at the many well informed and committed oral and maxillofacial surgeons in California who work tirelessly on behalf of this specialty. You will have the opportunity to call these incredible people your friends, people whom you would otherwise probably never even know.

Experience counts, but it's not an absolute prerequisite. If you've never been involved in leadership within the dental profession, you may want to consider getting active with your local component dental society or the California Dental Association in order to gain valuable experience. There are also many organizations outside of dentistry where you can develop leadership skills and gain experience. However, even without such a background, all you really need is the ability to analyze and articulate and you, too, can contribute to the future protection and expansion of our specialty. Actually, if you can think and talk at the same time, you're probably qualified.

So don't delay. No more lame excuses. Put down the remote and get up off the couch and please fill out the application form now. Together we can continue to build on the momentum established by CALAOMS as we play an ever increasing role as health care providers in California. If there is a missing piece in your professional fulfillment this may just be it.

SCPIE's Risk Management Corner

Risk Tips to Prevent Wrong Tooth Extraction

By Barbara Worsley
of The SCPIE Companies

Extraction of the wrong tooth occurs with surprisingly high frequency—about 10% to 15% of malpractice claims against oral and maxillofacial surgeons are due to this error. In most cases, wrong tooth extraction is preventable.

Could this happen to you? A 38-year-old patient was seen by Dr. B for extraction of supernumerary teeth #1A and #16A. On the day of the procedure, Dr. B's assistant clipped a white surgical slip on the cover of the patient's file and wrote down the procedure that the doctor was to perform, which was standard practice. However, the assistant thought that the #1A and #16A from the consultation notes actually said 1⍓ and 16⍓. The assistant assumed that the arrows were pointing up to the words surgical extraction that appeared in the line above so he wrote surgical extraction of teeth #1 and #16.

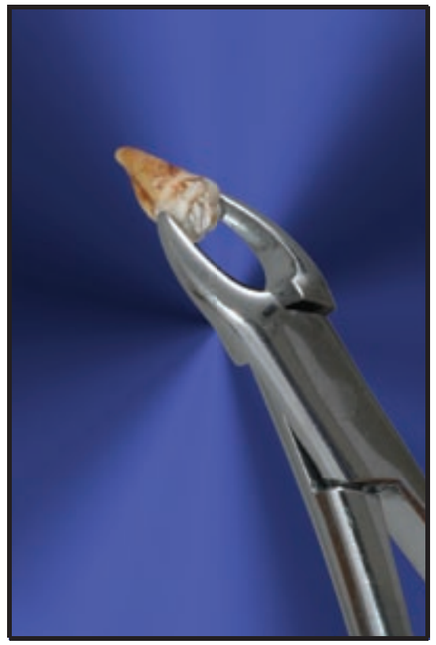
Using only the surgical slip as his guide, Dr. B extracted tooth #16. When the doctor was removing #16's root tip, the patient commented that he thought he was "just having an extra tooth extracted." Dr. B then went back to the consultation notes and realized that he was supposed to extract #16A and #1A.

While extraction risks are real, most of the risk factors can be diminished by paying careful attention to documentation, informed consent and careful treatment. A high proportion of extraction-related allegations involve skilled oral surgeons who simply failed to exercise good judgment.

When mistakes are made, one of the most common reasons is vague or misunderstood communication between the oral surgeon, the staff or the referring doctor. For example, the use of several different numbering systems for identifying teeth appears to be a major cause of the communication breakdown. Another potential source of breakdown is verbal communication carried from the referral office by the patient to the oral surgeon's office.

The informed consent process is also vital to managing extraction risks. The consent form should specify what tooth or teeth are to be extracted; it should not simply state that "extractions" are to be performed. Do not extract any teeth for which you do not have consent.

One of the Joint Commission's 2004 patient safety goals is to "eliminate wrong-site, wrong patient, wrong procedure surgery." Echoing the Joint Commission, the American Dental Association recommends the following to avoid wrong tooth extraction: 1) Review the dental record, including the medical history, laboratory findings, appropriate charts and dental radiographs; 2) indicate the tooth number(s) or mark the surgical site on the diagram or radiograph to be included as part of the patient record; 3) ensure that radiographs are properly oriented and visually confirm that the correct teeth or tissues have been charted; 4) conduct a "time out" to verify the patient, tooth and procedure to be performed with the assistant present at the time of the extraction (the two-person rule).



Preventing mistakes are easier than repairing them, and the guidelines below warrant close and careful review. Consider the following risk management suggestions:

- Always document why the extraction is warranted—include subjective patient complaints and objective clinical findings (e.g., results of periodontal probing), as well as written radiographic findings.
- Double check the tooth number as indicated on the referral form letter and on the copy of the X-ray films. Look at any appliance sent with the patient to be sure it matches up with the teeth to be removed.
- Confirm that you have the patient's informed consent for the removal of that tooth. Consent should be specific and not simply state that "extractions" will be performed. Only extract teeth for which you have consent. If possible, obtain a signed informed consent from the patient in advance of his/her appointment.
- Develop a standardized referral form (insist on name and number of the tooth/ teeth). This improves the communication between the referring dentist and the surgeon and also reduces ambiguities.
- Contact the referring dentist and document the discussion if there are any questions regarding the extraction request.
- Place any fax transmissions of an updated treatment request in the medical record. Also, updated emails (in cases of non-electronic records) should be printed and put in the chart.
- Verify twice the correct tooth to be extracted, using your written and radiographic records, before you pick up the forceps. Encourage staff to not hesitate in suggesting a potential problem in tooth selection.
- Describe the tooth/teeth to be extracted in longhand (e.g., upper right first premolar) since there are different tooth numbering systems.
- Develop and utilize an extraction check-off list incorporating the Joint Commission's "Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery."
- Slow down and be careful. Use the old carpentry rule, "Measure twice, cut once."

We Have Moved!

It has been just over a year an a half from concept to reality, to realize the dream. The California Association of Oral and Maxillofacial Surgeons now have a home they can literally call their own.

With insight from our Treasurer, the CALAOMS Board, and Building Committee, we accomplished this without assessing the membership. We were able to do this by tapping into funds from our reserves, and with the help of generous donations from our members and vendors.

By owning our office outright, we will reduce our yearly operating expenses, allowing us to keep rising dues at bay.

Although we fell short of our goal for donations, it is still not too late for those of you that have not contributed to do so. We asked for each member to contribute the amount you would receive for a case of third molar extractions, but any amount will help.

Please Note our New Address
950 Reserve Drive, Suite 120
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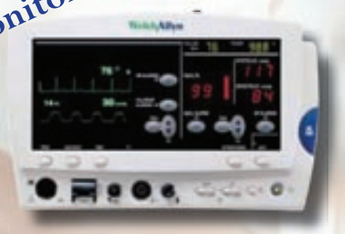

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Come Join us for a Weekend in Beautiful Monterey

The California Association of Oral and Maxillofacial Surgeons is Hosting its 7th Annual Meeting. It is to be Held in Monterey April 27-28, 2007

Featured Speaker Thomas R. Flynn, DMD lectures on the topics of "Anatomy and Surgery of Oral and Maxillofacial Infections" and "Microbiology and Antibiotic Therapy of Oral and Maxillofacial Infections"

It is still not too late to register, so call now! 800-500-1332

Meeting Dedicated to W. Howard Davis, DDS

I'm Mad as Hell, and I don't want to take it anymore!

By Daniel E. Levin, DDS

It's getting harder and harder to come up with catchy titles for these articles and now I am even reverting a little bit to Hollywood for ideas. I really want to say I won't take it any more, but unfortunately, I am stuck for now. About two weeks ago I had to go to the local emergency room to control the bleeding of a recent extraction socket on an 86 year old female. Her daughter gave a history of having the extraction around noon. She called her dental office on two occasions during the afternoon and was told ultimately to go to the emergency room since the oral surgeon working in the office would not be back for 1 week. She was dumped. No direction, no contact name, just go to the emergency room. At 2 AM I was not interested in talking politics about the merits (or lack thereof) of itinerant oral surgeons. I just wanted to control the bleeding and go home. What is so outrageous about this incident is that it could have been easily controlled in the early evening when it became apparent that the bleeding would not stop by gauze pressure alone. Did I also mention that this lady was 86 years old with limited reserve?

This is just one of several typical incidents that I have with the itinerant surgeons. They get paid for providing the care, but are either unable or unwilling to provide adequate after-hours emergency care. Certainly, a number of us had to supplement our income working outside our offices in the early years, especially those of us who started a practice from scratch. But the colleagues I have discussed this with, all said that they covered their after hour issues, including seeing these patients in their own offices and or making special arrangements to see these patients elsewhere.

I do realize that the dynamics of hospitalizations have changed, especially where medical insurance comes into play. The patient has to go to this hospital and can only be treated by these providers ad nauseum. Nevertheless, this affects us permanents as well, and we seem to handle it. When we come across a situation we cannot handle, we make the arrangements. An itinerant needs to make these arrangements with the local oral surgeons for after-hours coverage, even if he has to pay him out of his own pocket. This may require more than one surgeon since not everyone goes to all of the local hospitals. The itinerant needs to be made aware of the emergency so he can personally elect to either treat the patient or direct him to the appropriate place. And finally, he must give the patient a contact name so care can occur in an expedient manner.

Working outside your office used to be an additional way to supplement your income while building your practice. It now seems that this is an industry unto itself., driven partly by large HMO dental practices who are reluctant to refer out patients. However, I'm not sure why large populated urban and suburban areas even need itinerants. They make the most sense in areas where oral surgical care is spotty at best and this can be a huge convenience for the patients.

The issue of itinerant oral surgeons has come up several times in the past. I think it is time to create policies within our own society to deal with them. Hospital emergency rooms cannot legally dump patients, but must find a doctor willing to accept the transfer. This is a model that we as an organization can pursue. Persistent violations should be considered unprofessional conduct and a reportable Dental Board offense. It should affect membership standing in CALAOMS, AAOMS and even filter down to ABOMS. I guess if he doesn't care about these organizations, then he doesn't care about oral surgery.

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I have often said that I believe that most oral surgeons are generous and cooperative individuals that can work closely with their colleagues and I would strongly encourage all itinerant oral surgeons to make the appropriate arrangements. It's good dental practice, and it is good for the patients.

By the way, I am not so mad anymore…I got it off my chest. But if you are mad, let us know what your thoughts and possible solutions are and perhaps we can find an equitable solution. dl

What Has CALAOMS Done For Me Lately?

Members call the CALAOMS Central Office everyday asking when our next course on emergencies will be held, if we have room for 3 new recently hired assistants in the ACLS course, questions regarding SB438 or sometimes even just to say hi and to thank the CALAOMS staff for all that CALAOMS does for them.

In all truth, those last calls aren't the most common we receive, but they are commonly asked by members who are involved. If you aren't involved in a volunteer position, on a committee, task force, as a lecturer for OMSA or the Board, most likely you don't know everything that CALAOMS does for you and for your specialty.

If you were the Anesthesia Chairman, you would know that your ability to provide anesthesia in an office setting is under attack every day. The committee works with the Dental Board of California and with legislators regarding this access to care and to help retain this as part of the scope of what you do. If you were an anesthesia evaluator, you would know that we schedule about 25 anesthesia evaluations a month. It takes 2 OMS's for every evaluation and this can sometimes take 8-15 calls to members to schedule just one evaluation.

If you were part of the Nominating/Leadership Development Committee, you would have been working on new protocols and applications on how to find the best, most qualified members to lead your association in the future.

If you were part of the CE committee you would be amazed at what goes into preparing just one meeting. Starting with deciding on the most timely up to date subjects to present, expert speakers to deliver the presentation, dates that don't conflict with other meetings and ending with the administration details by the central office, locating and contracting with hotels in the most convenient parts of the state with ample meeting space, developing the registration material and mailing to members.

If you've been involved or at least read the Compass, you know how diligently our Board, grass roots members, lobbyist, CALAOMS staff and CDA worked tirelessly to succeed with the passing of SB438. CALAOMS continues to work with the Dental Board of California to assure that the application process along with the protocols for SB438 are proceeding so that our members who want to include cosmetics in their practice can.

Unfortunately, due to limited space for this article I can not actually put here everything that CALAOMS offers. However, my hope is that all of you will know that the CALAOMS Central office is here for its members and the Board of Directors makes every decision with the best interest of the membership in mind.

By Pamela Congdon
Executive Director, CALAOMS

NEWS ANNOUNCEMENT

SURGEONS UNITE INITIATING CHILDREN'S DEFORMITY HOSPITAL

Surgeons and Dentists from the United States joined forces with those located in Baja California on March 9-10, 2007 to " initiate and cut the ribbon" on the first children's facial- deformity surgical clinic performing complex surgical procedures under general anesthesia with the Mexican town of Tecate's state-of-art facility built specifically for the Centennial Anniversary of Rotary.

Dr. Jeff Moses, retired Carlsbad Maxillofacial Surgeon, Rotarian, and Founder of the Smiles International Foundation along with his wife, Maribel worked closely with Rotarians, doctors and local officials from both sides of the border during the previous year to locate patients and arrange supplies and provide the clinic with critical organizational logistics.

"Without the full support and involvement of the wonderful Rotarians and doctors in the Clubs from California, Oklahoma, and Mexico, this would not have been possible" said Moses. "Many seemingly insurmountable hurdles were transformed into small bumps in the road through their efforts."

The first screening clinic ran in early November of 2006 and the preparations were made for the tri-annually held surgical-dental treatment clinics to begin in March of 2007. Out of the first dozen patients screened and treated, there were four selected for general anesthesia and, in order to benefit the children most, 2-4 surgeries for each child was performed at the same setting ending the Saturday Surgical Day with a total of 12 facial cleft surgical procedures.

The operating team surgeon, Dr. Kevin Smith, also a Rotarian, was accompanied by his co-team leader, Dr. B.J. Costello and their colleagues Drs. Shawne Higashi and Matthew Dudziak from Oklahoma and Pennsylvania respectively.

Drs. Marcos Ramirez, Elizabeth Salinas and Yolanda Villa-Torres from Mexico, worked side-by side with the surgical-dental dental team with Drs. Gary Godward and Bob Fleming providing much-needed dental treatments for the children. Dr. Ramirez also headed the follow-up clinic for the operated children assuring a successful continuity of treatment care.

The official name for this project is
"Smiles of Tecate" or more appropriately in Spanish: "Sonrisas de Tecate"

Clinic Founder, Dr. Jeff Moses stands (far right) stands in the hall with Craniomaxillofacial surgeon B.J. Costello (far left) and Surgical Technician, Rotarian and Former Vietnam Veteran P.O.W. Neil Black in center

Ribbon Cutting Ceremony of First Facial Deformity Hospital Clinic in Tecate, Mexico

Clinic's First Cleft Surgical Case Recuperating in Recovery: From right to left, Drs. Kevin Smith, Paula Rawls J., and Shawne Higashi

Dentistry Not Included In Early Health Care Reform Proposals

As the 2007 legislative year begins, it has quickly become clear that health care reform is going to be a major topic of discussion. Comprehensive proposals are being announced or introduced by the Governor and legislative leaders from both parties. Although dental coverage was not specifically included in any of the early proposals, CDA is preparing to be an active participant in discussions as they unfold in the weeks and months ahead.

"We had anticipated last year that health care reform would move into the legislative spotlight, and clearly that is now happening," said Santos Cortez, DDS, chair of CDA's Government Affairs Council. "While the Governor vetoed a bill last year that would have created a state-run, single-payer health care system, he stated at that time that increasing coverage for the uninsured would be a top priority for him after the election, and that he would be proposing his own plan as part of his 2007 budget proposal."

Although many legislators have introduced health care reform bills already, much of the early attention has been focused on the Governor's comprehensive proposal, which was released in early January. This sweeping package proposes to provide health care coverage for every Californian, including undocumented immigrants, by combining a mandate that employers with 10 or more employees provide coverage or pay a 4 percent payroll tax to help fund coverage. It contains a requirement that all individuals obtain coverage with no more than a $5,000 annual deductible. The Governor's plan would require health insurers to guarantee coverage to all individuals regardless of preexisting conditions, would increase Medi-Cal provider reimbursement rates in exchange for charging physicians and hospitals a 2 percent and 4 percent annual fee, respectively, and would expand Medi-Cal (to adults without children) as well as the Healthy Families Program. It would also create a purchasing pool for low-income uninsured adults. Although the proposal would not include dental coverage as a mandatory benefit, it would make dental benefits available through the pool as an optional purchase.

"The Governor's proposal has not yet been introduced in legislative form, so many of the details remain to be seen," said Dr. Cortez. "However, we have been assured by key staff in the Governor's office that the proposed provider fee currently would not include dentists. Dental offices with more than 10 employees that do not provide coverage for their employees would be subject to the 4 percent payroll tax. The proposal would expand the availability of dental coverage through the Healthy Families Program and through the new purchasing pool. The Governor's advisors have met with CDA and are interested in discussing dentistry's role further as the legislative session continues."

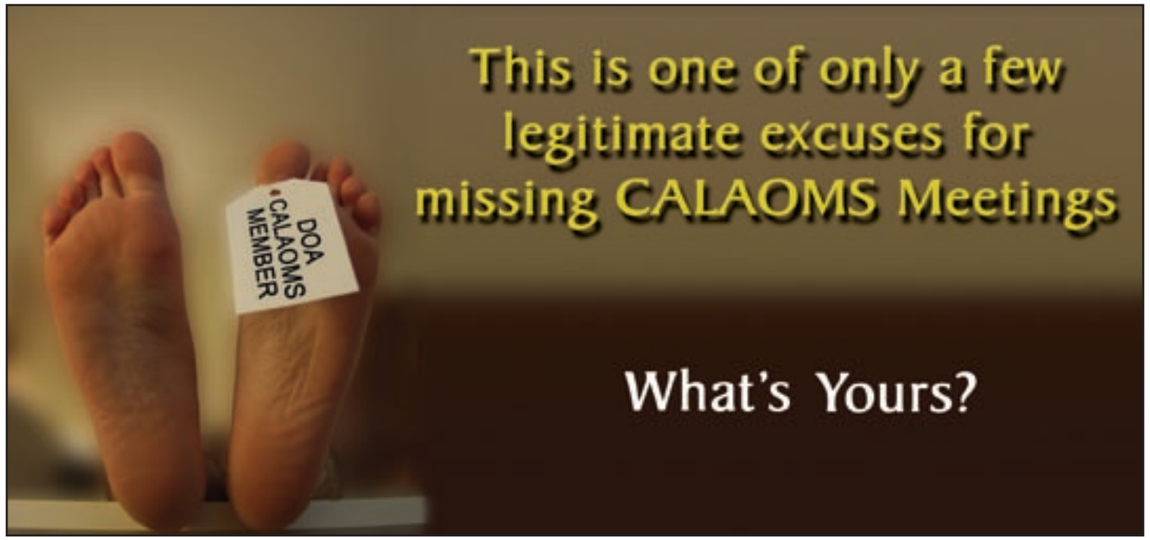
Prior to the release of the Governor's plan, Assembly Speaker Fabian Nunez and Senate President Pro Tem Don Perata each had announced their own health care reform proposals. In broad outline, they are very similar to the Governor's proposal, encompassing varying degrees of employer mandates to provide coverage, requiring insurers to guarantee coverage to individuals, and expanding Medi-Cal and Healthy Families eligibility; Speaker Nunez's proposal, however, does not contain a mandate that individuals obtain health coverage. Neither proposal currently includes dental coverage.

In addition to the leaders of the Assembly and Senate, other legislators have or are expected to introduce significant reform proposals as well. Senator Sheila Kuehl (D-Santa Monica) has re-introduced her proposal to create a statewide, government-run, "single-payer" health care system that essentially would replace the current private health insurance market. Senator Kuehl's proposal, which would include dental care, was vetoed by the Governor last year. On the other side of the political spectrum, the Senate Republican Caucus in late January released its own reform package, which would emphasize tax incentives, rather than mandates, for employers and individuals to purchase health care coverage, and would create incentives for expanding the use of primary care clinics in underserved areas. The Assembly Republican Caucus also has introduced an 18-bill package of reform proposals, with a similar emphasis on individual incentives.

In anticipation that health care reform would be a major subject in 2007, CDA's 2006 House of Delegates adopted a policy statement on "Expanding Access to Oral Health Care Coverage." The statement begins by declaring that "oral health is integral to general health and is essential to the overall health and well-being of all individuals," and expresses CDA's support for "expansion of access to oral health care, including extending systems of oral health care coverage to groups that have traditionally been uninsured…" The statement also makes clear, however, that any inclusion of oral health care benefits in a reform package must assure the integrity of the dentist-patient relationship, be funded and administered separately from the medical side, prioritize fundamental treatment objectives, and be funded adequately to "cover the actual cost of treatment and reasonable overhead."

"CDA already has begun incorporating the principles set forth in last year's House resolution into our lobbying efforts," said Cathy Mudge, CDA Vice President of Public Policy. "Although most of the proposals we have seen so far do not include dental in any substantial way, we nevertheless intend to be very active in the legislative discussions this year. Based on early conversations, we anticipate that Assembly and Senate leaders' bills eventually will be consolidated into a single proposal, most likely in a joint legislative conference committee. The Governor's proposal, because it is not being introduced in formal legislative language, simply provides a negotiating point for his office to be engaged in these ongoing discussions. We will keep our members informed of any significant developments."

By Liz Snow,
Chief Strategy Officer, CDA



Just Do it, but Do it Right

By Joe Niamtu, III DMD
Richmond, Virginia

Congratulations to oral and maxillofacial surgeons in the beautiful state of California. You have banded together and fought and won one of the toughest battles ever waged against our specialty. Your membership, leadership and supporting dental boards and societies deserve a huge pat on the back for your efforts and a big thank you from states that have not yet fought this battle. California is a bellwether state on many national issues and I believe this victory will set a precedent for many other states.

Although it is appropriate to bask in your victory, it is imperative that you do not lose sight of the path ahead. Although neither a politician or expert on the subject, my partners and I were directly involved with the same situation in the State of Virginia in 1999 and I can speak from some experience.

To provide some Cliff Notes, I began performing cosmetic facial surgery procedures in 1997 and became passionate about that aspect of our specialty. Each year I began doing more and more cosmetic facial surgery and as of 2004 limited my practice to this arena. In 1999 my practice was sued by the Virginia Medical Society for "the illegal practice of medicine" and we countersued for defamation. Like your state, the dental profession banded together and fought this issue. Both of these suits were dropped when the Virginia General Assembly ruled in favor of the amended Dental Practice Act which the Governor of Virginia signed into law in 2000. This was the end of many problems but the beginning of others and I want to pass on some words of wisdom to my California colleagues.

First off is the fact that the prejudice will never go away. It is unfortunate that grown men and women from other specialties cannot admit that other specialties are adequately trained to perform cosmetic facial surgery. I whole heartedly feel that our training in the head and neck is comparable or superior to any specialty. For this reason, I feel well trained to perform cosmetic facial surgery. I believe that the competition actually believes this as well, but will never admit it. In fact, I think the reason that they fear our scope of practice so much is that we have proven many times that we are competent in this arena and can step up to the cosmetic plate easier that most other specialties.

There will always be derogatory statements and negative publicity from the competition so don't expect that to change, in fact, expect it to get worse. Although it continues to surprise me how small some competing specialties make themselves look when they demean others, it is very commonplace in all states. People are going to say bad things about you. The way to get them back is to prove them wrong. It is said that the best means of driving your competition crazy is to simply succeed. Detractors can say all the bad stuff they want and at first it may impact your business. Don't fall into their trap. Keep you head high, get great training, do great work, treat your patients great and after a while it all catches up with you. "If this guy is so bad, how come he is so busy and has such a great reputation" is the what patients will eventually say when someone levels their barrels at you in a thinly veiled, self serving attempt to garner referrals and dollars. If you are going to dabble in minor cosmetic procedures, i.e. Botox, fillers, microdermabrasion, skin care, mole removal, etc. then you will probably stay beneath the radar screen of your detractors. If, however, you intend to make cosmetic facial surgery a large part of your practice and intend on marketing this aspect of your practice, plan on losing friends. Your competing specialties will be detractors and unfortunately some of your OMS colleagues will "downtalk" you to your dental referrals. If you have "the fire" for cosmetic facial surgery then it does not matter as it is no different than having a passion for implants, TMJ, orthognathics, etc. If you love what you do and do what you love, your reputation will catch up to you. You just have to navigate the bumpy road in the beginning. When I first began doing cosmetic

procedures a decade ago, many of my dental and OMS colleagues found it amusing, but ten years later, I am routinely performing cosmetic facial surgery procedures on the dentists and their wives. I proved over the years that I was serious and good at what I did. I personally decided to limit my practice to cosmetic facial surgery which most people won't. It is important to maintain a good balance with your referring sources so they know that you still have a passion for routine OMS and that the cosmetic facial surgery is your "crown and bridge". In other words the icing on your cake, a part of your practice that you enjoy.

The world is watching you and half of it wants to see you succeed and half of it wants to see you fail.

The biggest mistake any California OMS can do to set back our entire specialty is to make the competition right; to screw up and allow them to say "I told you so!" It is your primary concern to make sure this does not happen and to police your ranks to make sure there are no loose cannons that ruin things for everyone. Cosmetic facial surgery is fun and it can be lucrative. It is cash up front, there is no billing, no collections, no bad debt, and no insurance. Sounds great, and it is, but I still cannot out produce my partners that do mostly third molars and implants. Routine OMS is still in my opinion the best deal going for remuneration and lifestyle. Also important is the fact that the patient populations between dentoalveolar and cosmetic facial practices are vastly different. You go from performing short procedures on young health patients to long procedures on older patients. This takes a lot or rethinking and sometimes retraining. Most dentoalveolar patients present to you because they have to, not because they want to. It is the opposite with cosmetic facial surgery patients. This is an upper class luxury and these are darn demanding and finicky patients. If you hate working with TMJ patients then reconsider cosmetic facial surgery as these patients take much hand holding and are very demanding. I am on call 24/7 and all my patients get my cell number. The last thing I want is for one of them to not be able to reach me in an emergency or perceived emergency and end up in a hostile competing office. If you have other head and neck specialties that are friendly it truly pays to forge that relationship as you can assist each other and sooner or later you will need it.

Back to the loose cannon. If you had cosmetic facial training in your programs then operate to your skill and experience level. If you did not have formal cosmetic training then the responsibility is on you to get it. Remember, many plastic surgery programs have weak cosmetic training and the same can be said about other specialties that perform cosmetic surgery. Just because someone is residency trained or board certified does not guarantee competence in cosmetic surgery. The moral here is to get the proper training before you operate. Performing TMJ surgery, orbital trauma and salivary gland surgery is very similar to many cosmetic facial surgery procedures, in fact harder than many. Your OMS surgical training has set the stage for your ability to readily learn and perform cosmetic facial surgery. That training does not come overnight and is a significant personal commitment to obtain. It is intense and it is not cheap. Training usually takes the direction of multiple didactic courses, multiple cadaver dissection courses, multiple observation courses and finally proctoring. You, in California, are not done bickering with the detractors. You will have to sit down with them and define what training is necessary and what constitutes proficiency, so don't relax or let your guard down. You need to set the bar high and submit to the same standards as the competition. The standards it would take them to obtain hospital privileges for cosmetic facial surgery procedures should be the same for you. If you are residency trained in cosmetic surgery then op reports and a sign off letter from your chairman and proof of malpractice should do. If you were not residency trained then a reasonable number of didactic and clinical course hours and reasonable proctoring (similar to what a general surgeon may need for laparoscopic privileges) should be established. Another

Continued on Page 23

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means of determining "adequate basic training" is to look at the standards required by malpractice companies to perform specific procedures. The educational and clinical standards are frequently spelled out in terms of course hours and proctored cases. You absolutely, positively do not want that loose cannon to have complications before your plane gets off the runway. Don't allow that to happen. You will have complications at some point, all surgeons do, just make sure they are not from ill training or negligence.

Always put the patient first. Again cosmetic facial surgery is fun and some of you are going to want to jump in. Primo non nocere (first no harm), never forget that. Get trained, always put the patient's safety and welfare first and success will come. You at some time will be tempted to try some new procedure because it is new or cool or what ever. Always be careful, always be paranoid and always put your patient and your specialty first. Never give the detractors ammo, they have enough already. Never hold out to be anything other than an OMS that performs cosmetic facial surgery. If you market cosmetic procedures, state your degree and specialty in your materials. If you mention board certification, make sure to say what board. Internal marketing is very powerful. All of us have families of all ages passing through our offices every day. This is your best initial target market.

Find a mentor and work with them. This is essential. You will have questions, problems, complications and celebrations concerning cosmetic patients. Having an experienced colleague (OMS or other specialty) that is not in competition is invaluable and makes life easier.

Think like a surgeon! Always make sure you realize the standard of care for your community and uphold it. If facelift patients get M.D. history and physical exams, lab studies and EKG at local surgery centers, then they should get the same at your office. Seek AAAHC or JACHO accreditation. It is not as hard as most of you think and it has made me a better surgeon with a safer office. It is also a great marketing tool and lets your patients know you are in pursuit of excellence.

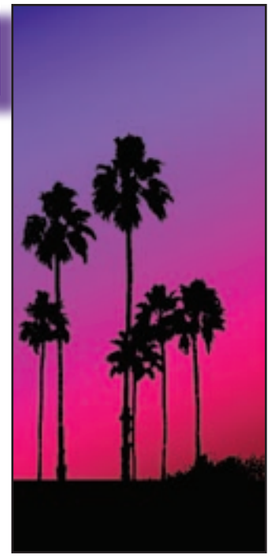
I love cosmetic facial surgery; it has become the defining theme in my life and my life's work. As stated earlier, there are downsides as I have had many sleepless nights and faced many stresses that my partners did not. I feel that I pursued cosmetic facial surgery in the correct manner. I spent a lot of money and many, many hundreds of CME hours learning cosmetic facial surgery. I have written over 150 articles and find myself on the international lecture circuit. I don't say this to brag, because I am an average OMS with an above average passion for what I do. I had the same passion about routine OMS for most of my career. We are so lucky to do what we do. Protect it, don't mess it up, don't jeopardize what we have all worked so hard to achieve. Don't be a loose cannon; the wolf is always at your back door.

You have every right to perform cosmetic facial surgery. It is part of contemporary OMS, it is taught in our residency programs, it is part of our board exams and it is covered by our malpractice insurance. Initially some patients may find it unusual that an OMS performs cosmetic facial surgery. It is easily explainable and makes perfect sense. What other specialty has the unique an intense training in the head and neck as does ours. In fact, we are ultra specialists. I explain to my patients that I do not do breasts and tummy tucks, that I concentrate on the area I have studied all my life and I am a specialist in that area. I explain that no single specialty "owns" the face and that there are multiple specialties that are well trained in this area and that I will put my facial training up against any of them. Every practitioner has the obligation to offer his or her patients the latest advances in their specialty and if your motivation is to include cosmetic facial surgery then you have every right and qualification.

The world is watching you and half of it wants to see you succeed and half of it wants to see you fail. Don't assist the later half.

Just do it, but just do it right!

Palm Springs Meeting in Review



It was a beautifully clear but cold winter day in the desert as I walked to our first CALAOMS educational meeting of the new year. This two day meeting, which was held at the magnificent *Hyatt Grand Champions Resort & Spa* in Indian Wells January 13th - 14th, was headlined by Dr. Steven M. Roser from Emory University School of Medicine. Dr. Roser did a superb job covering a potentially marginally exciting topic of *"Surgical Management of the Medically Compromised Patient."* After two mornings of interactive lecture, we all came away from Dr. Roser's presentation with a renewed appreciation of our medically compromised patients and a better comfort level in evaluating them for surgical care.

As usual, an important part of these meetings is our membership luncheon. This well attended luncheon gave all participants an opportunity to mingle with colleagues, but just as importantly, allowed our CALAOMS leadership to update our membership on current topics of interest to our specialty. We were especially fortunate at this luncheon to have several current AAOMS dignitaries present including Dr. W. Mark Tucker, AAOMS President; Dr. Lee Pollan, AAOMS President-elect; Dr. R. Lynn White, AAOMS Vice-President and our own District VI Trustee, Dr. Larry Moore. In addition to current AAOMS leaders, we also had the opportunity to meet and speak with candidates running this year for AAOMS offices including, Dr. Ira Cheifetz, current AAOMS Treasurer running for Vice-President; Dr. Thomas Skiba, District IV Trustee running for Vice-President; and Dr. Edwin Slade, running unopposed for Treasurer. Finally, your new CALAOMS officers were also graciously inducted by Dr. Tucker.

One of CALAOMS's most recent and celebrated achievements is the passage of our Cosmetic Surgery Bill, SB-438. Many people were influential in the passage of this bill, including all of you who wrote letters to the Governor. Two special people were honored though at this luncheon. Dr. Frank Ercoli from Desert Regional Medical Center Trauma Services and California 64th District Assemblyman John Benoit, addressed the audience and related their experiences with this process and their working relationships with the Oral & Maxillofacial Surgery Community. Without the dedication of our specialty particularly in the area of facial trauma and reconstructive surgery we would not have been as well respected and represented by our medical colleagues in this endeavor.

As with all of our educational meetings, our colleagues who support our practices with equipment, supplies, and services were present and accounted for sponsoring our continental breakfasts and showing us the latest of their wares. They also donated a number of great raffle gifts (none of which I won). Our vendors have always been supportive of our specialty. SCPIE though was especially generous, donating a check for $ 10,000.00 to our new building fund. This allows us to get very close to our fund raising goal, but lets not stop there. For those who have yet to donate, any amount is an investment in your specialty and professional organization and is greatly appreciated.

This years desert meeting was well attended and proved to be a great educational opportunity. It also was simply a chance to get away for the weekend. For those of you who could not attend, we hope to see you next year, or at our other meetings this year.

By
W. Frederick Stephens, DDS

General Announcements

On Wednesday, May 23, 2007, CALAOMS invites you to attend the Open House for the new CALAOMS Headquarters in Roseville. We hope that you will be able to join us. The Open House will be held from 4:00pm – 8:00pm. Formal invitations will be sent in the next few weeks.

This day was chosen because CDA will also be hosting their Legislative Day at the CDA building and state capitol in Sacramento. A lot of our members attend Legislative Day to learn about how CDA and the other professions of dentistry are involved in state advocacy. If you want more information on attending this event please contact your local dental society or the CDA.

Also, please plan to join us at the CALAOMS Annual Meeting being held in one of our membership's favorite destinations – The Monterey Plaza Hotel. The meeting will be held April 27-29, 2007. Thomas Flynn as our host will present "Updates of Oral and Maxillofacial Infections". Please join us at our banquet on Saturday evening being held at the Monterey Bay Aquarium where we will honor, Dr. Howard Davis who has received the dedication of this year's Annual meeting. Dr. Lee Heldt will receive the committee person of the year award for his dedication to the CALAOMS ACLS program which he has chaired for over 20 years. We will also honor Mr. Mark Rakich for his tremendous efforts and support of CALAOMS as our lobbyist in the success of SB438.

CALAOMS welcomes your suggestions on how the CALAOMS Board and staff can meet our member's needs. Please feel free to call on your Board or the CALAOMS staff.

Upcoming Events For 2007

OMSA Summer Course Begins		**OMSA Fall Course Begins**	
April 15, 2007	North State	June 15, 2007	South State
Annual Membership Meeting		**Residents' Night Presentations**	
April 27-29, 2007	Monterey	September 26, 2007	South State
Medical Emergencies		**ACLS**	
The May 16 and June 6 courses listed in the CE booklet have been rescheduled ! The new dates are as follow:		Oct./Nov.	Solano
October 24, 2007	Location TBD	**Fall Membership Meeting**	
November 7, 2007	Location TBD	November 10-11, 2007	La Jolla

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 the Central Office to discuss signing up for the 2007 committee year. (800) 500-1332

Classified Ads

Equipment For Sale

Mid Summer Cleanup!
Dr. Steve Leighty is looking for oral surgery instruments and/or equipment in good repair to help outfit several dental clinics in Mexico, Nepal, and Uganda. These projects are operated by Rotary International. For more information: Steve M. Leighty, DDS, 1364 Whispering Pines Lane, Grass Valley, CA 95945. Telephone: 530.272.8871 or email: smlzenos@pacbell.net.

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IBM SELECTRIC II Typewriters $200.
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HP SCANJET 4 C/T –Scanner with transparency adaptor $600.
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Printer – OKIDATA Dot Matrix $150
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Job Opportunities/ Practices for Sale

Contra Costa County, CA
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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.

Lake Arrowhead, CA
Satellite office located in beautiful Lake Arrowhead Resort. Looking for someone interested in working part-time at your convenience and or to purchase. Please call Dr. Stewart Green at (949) 701-4488

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 Francisco, CA
Part-time associate needed for the Stonestown Surgery Center and it's satellite office. Terms open to negotiations. 415-664-5060.

San Francisco Bay Area
Oral surgeon sought by UC Davis affiliated primary care hospital system in Contra Costa County. Located in San Francisco's East Bay close to outstanding cultural and outdoor recreational opportunities. New hospital & surgical facilities in Martinez serve needs of ethnically and culturally diverse population. Part-time intermittent work to start, possibly leading to full time position. Contact Nick Cavallaro DDS at 925-370-5200 x 4388, 510-918-2159, or at NCavallaro@hsd.cccounty.us

San Jose
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San Diego, CA
OMS position available. Comprehensive three doctor OMS practice in central San Diego is seeking a full time associate; future partnership potential; full scope practice with surgery center. For more information email resume to: mstaple@mvoms.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 was made available for lease Spring '06. Excellent opportunity for OMS desiring to relocate or recent graduate. Please call 541 944-2140 or e-mail glksabre@aol.com.

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 .

How To Place A Classified AD
If you a member of CALAOMS, please email your ad to steve@calaoms.org and indicate how long you would like the ad to run. If you are not a member of CALAOMS, please call 800-500-1332 and ask for Steve

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