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The Compass

Staying the Course Through Service and Education

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Volume X, Issue 1, Spring 2008

OMS Treats Injured LAPD SWAT Officer

On 7 February 2008, one of our own CALAOMS members treated an injured LAPD Swat team member. Emergency room doctors at Northridge Medical Center called in OMS, Dr. Gabriel Aslanian, to operate on a 51-year-old injured officer. Earlier in the day, a major police action occurred after a violent suspect barricaded himself in a San Fernando Valley residence. After a prolonged standoff, a gun battle between LAPD SWAT members and the suspect ensued. Officer Randal Simmons, age 51, was killed, the first in the line of duty fatality for LAPD SWAT, and Officer James Veenstra, was shot in the face.

Left: LAPD Photo of Officer Veenstra taken sometime prior to the shooting. Right: Veenstra appeared at a press conference approximately 2 months after the shooting. Although his jaw is still wired shut, his soft tissue is healing nicely.

Officer Veenstra was transported to Northridge Medical Center where Dr. Aslanian was called to care for Officer Veenstra's injuries. Mr. Veenstra suffered a gunshot wound to the left mandible, resulting in severe comminution of the mandible body and significant soft tissue injury involving the lips and tongue. Luckily, no life-threatening trauma was sustained. Under the care of Dr. Aslanian, Officer Veenstra was taken to the operating room for closure of his soft tissue injuries and a closed reduction of the mandible fracture. The surgery took 3 hours and lasted into the early hours of the morning. In reference to the surgery, Dr. Aslanian says, "Can you imagine the havoc that all these fragmented

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Compass Direction

Official Publication of the California Association of Oral and Maxillofacial Surgeons

The COMPASS
Published by the
California Association of Oral and Maxillofacial Surgeons

Published 3 times a year by the California Association of Oral and Maxillofacial Surgeons. The Association solicits essays, letters, opinions, abstracts and publishes reports of the various committees; however, all expressions of opinion and all statements of supposed fact are published on the authority of the writer over whose signature they appear, and are not regarded as expressing the view of the California Association of Oral and Maxillofacial Surgeons unless such statement of opinions have been adopted by its representatives. Acceptance of advertising in no way constitutes professional approval or endorsement.

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CALAOMS also does business as:
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* Northern California Society of Maxillofacial Surgeons
* California Society of Oral and Maxillofacial Surgeons
* Southern California Oral and Maxillofacial Surgeons

Editor's Corner

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

CALAOMS Health Foundation Closing

Welcome to a new year and my second go-around as editor of The Compass. I am grateful for the opportunity to serve in this capacity again. I would like to thank the staff at our main office, namely Steve Krantzman and Pamela Congdon. They shoulder the lion's share of the work publishing the Compass, and they do a tremendous job. I wouldn't be as successful as editor without them.

As with last year's editions, I will continue to champion the theme of giving back to our community, practice, and profession. However, this year's call to action will take on a different tone. Our specialty is filled with a wealth of diversity – not just age, gender, and ethnicity, but also diversity in training, mode of practice, and professional style. It is human nature to look at differences and make judgments, but often, these judgments are made in a vacuum, outside of a meaningful context and without full knowledge of the pros and cons of each position. As such, our judgments rarely are accurate, nor are they constructive.

This year, I call you all to a debate. I challenge us to look at the divisive issues within our ranks, and hold an honest, detailed, and respectful debate of these issues. The goal of this debate is to educate ourselves; to identify our strengths; and, hopefully, to use our differences to find solutions to our professional problems.

The first area that we shall scrutinize is the itinerant oral surgeon. This debate will take place over the next 2 editions of the Compass. On the following pages, you will find articles detailing the pros and cons of this professional role. I invite you to study each position; consider it within your community and from your unique professional perspective. Undoubtedly, each of you has either worked with, as, or near an itinerant OMS. I call on you to add your experiences to the argument and submit a respectful reply. The next edition of the Compass will publish these responses.

Our membership is intelligent, caring, and sophisticated. We are also opinionated and passionate. I call on you all to share your passion and vocalize your opinion. Let's engage in a meaningful conversation about the challenges we face as a profession. In doing so, we give back to ourselves the gifts of our diversity.

As a reminder, we've been at our new location for over a year now. For those of you that use accounting software such as QuickBooks, Quicken or the like, please change the Central ***Offices Address to:***

CALAOMS
950 Reserve Drive, Suite 120
Roseville, CA 95678

Numerous Checks were addressed to the old office location. As our request with the United States Postal Service to forward mail has expired, we would hate for your check to get lost.

Point

The Case For Itinerant Oral Surgeons

As the dental specialty climate in California evolves, itinerant oral and maxillofacial surgery has become more prevalent. Currently, most oral surgery patients are treated in private, single surgeon or group surgery practices and this will still predominate. But, now there is an increase of practices where the oral surgeon works with general practitioners and other specialists all in the same office. Recently, large dental companies have been actively involved in establishing multi-specialty practices.

Reasons for surgeons choosing to work in a multi-specialty clinic vary. For many, contracting one's services to a multi-specialty clinic or company gives them greater flexibility with when and how often they work. Although most offices request a certain number of days per month depending on the number of patients, scheduling is typically according to the surgeon's preferences. Because the surgeon is not in the office every day, the office administration is motivated to keep the specialist busy when they are there.

Starting contracted work is usually easy. Depending on the company, the surgeon can begin work at an office and have a busy schedule early on. Busy is not necessarily good, but typically contracted oral surgeons don't experience the lag-time it takes to acquire the referral patterns needed when someone joins or starts their own private practice.

For the itinerant surgeon, the administrative burden is greatly diminished. Office staff are usually trained to obtain necessary medical consults, insurance authorization, referrals and organize the day so the doctor can spend more time in treatment, thus increasing production. The surgeon's overhead is lower because the contracted offices purchase and stock the necessary surgical supplies. Some companies even provide equipment and will compensate for the IV medications. Much of the routine post-op work is lessened as most initial checks are performed by the general dentist. Also, for some surgeons, it's nice not to be in the same office every day. There's more variety with whom they work. They also tend to be more removed from the oft times strenuous daily office politics.

In a state the size of California, there are large numbers of patients who need oral surgery treatment. Unfortunately, for many, their dental insurance company limits where they can go. Most successful private oral surgery offices

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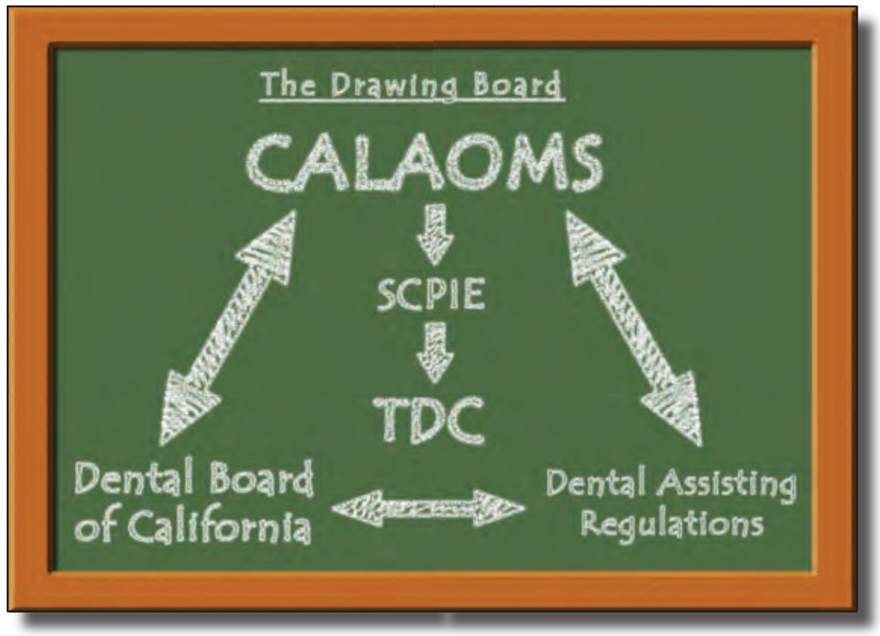
President's Message

Bruce L. Whitcher, DDS
President, CALAOMS

As CALAOMS enters the second quarter of 2008 I'd like to offer some reflections on the state of the specialty and the dental profession. As many of you know, CALAOMS got off to a busy start this year with our usual continuing education programs for doctors and staff. There is plenty happening behind the scenes as well.

First, we successfully negotiated our way through the impending sale of our endorsed professional liability insurance carrier SCPIE. Jason Sexton of SCPIE worked very closely with CALAOMS representatives to assure any transition in ownership would maintain the favorable terms offered to our members. This led to the company offering a 2 year contract to insureds. We also formalized our special arrangements with the company including closed claims review, underwriting and our royalty agreement that helps keep membership dues down. Almost all SCPIE policy holders renewed coverage for 2008. This is a major accomplishment that preserves the OMS book of business and gives us an advantage in future negotiations. This did not happen without a considerable amount of hard work over the holiday season by Tom Hiser, Gerald Gelfand, Rich Robert, and the members of the Insurance Committee.

A second major issue surfaced with the Governor's veto of SB 534 that effectively set a date for the sunset of the Dental Board as of June 30, 2008. CALAOMS has a critical working relationship with the Dental Board through our general anesthesia and conscious sedation permit evaluation program. The sunset of the Dental Board also called into question the future of the Cosmetic Credentialing Committee established under SB 438, the regulations affecting the scope of surgical assistants, and a number of other issues. Although efforts to pass new legislation that would extend the sunset date failed, we have had positive assurances that the Dental Board will continue to function as an advisory committee and that all Board functions will be preserved. The present Executive Officer Rick Wallinder has been given the position of Bureau Chief and most of the staff will stay on. Although there will undoubtedly be a period of adjustment with the Board now under the authority of the Director of Consumer Affairs, this is the best possible outcome given the circumstances.



The general anesthesia and conscious sedation on-site inspection and evaluation program is the cornerstone of office anesthesia in California. CALAOMS has administered this program for many years but we have never had a formal contract with the state. In order for the Dental Board to issue us a contract they must develop a "Request for Proposals" (RFP) and solicit bids from any interested parties. Although it seems unlikely that an organization other than CALAOMS could submit an effective bid for this contract, we are taking this matter very seriously and plan to enter the bidding process as though it were a highly competitive situation. As leaders in the field of ambulatory anesthesia this program is critical to our specialty. In order to bolster our credentials in this area we are offering calibration courses again this year. Maintaining our pool of evaluators requires constant effort. Please plan to attend one of the courses and become an evaluator if you have not done so already.

Regarding Dental Board regulations, the Board passed a motion at their January meeting to postpone implementation of the new dental assisting regulations until 2012, and to study alternative regulations. The Dental Board, CDA, CALAOMS, and other stakeholders are now developing a new approach to the dental assisting scope of practice. We hope this will be simpler and easier to understand. All agree that there is a tremendous need to get dental assistants into the workforce. It is fortuitous that AAOMS is presently conducting a job analysis for the anesthesia assistants. This should lead to more formal recognition nationwide for the important role our assistants play in the delivery of anesthesia care. We hope to include the AAOMS job analysis as new regulations for dental assisting are drafted.

Regarding the Cosmetic Credentialing Committee, a CALAOMS ad hoc committee has taken on the task of making the credentialing process more user friendly to members, especially those interested in minor procedures such as injectable fillers and botox. These simple procedures are being offered by medical practitioners with little if any surgical training and are trivial for the OMS to perform, however they gained popularity following the passage of SB 438 and do not fit neatly into the procedure list outlined in the bill. We hope to encourage a teaching center in California to offer an opportunity for our members to obtain the required operative reports for the cosmetic surgery permit. In the interim, we are very pleased to offer a course designed to help you incorporate cosmetic procedures into your practice presented by Joe Niamtu April 19 in San Francisco.

As your President, I have been attending all California Dental Board meetings. Although some of the Board discussion items are more relevant to OMS than others, this has given me the opportunity to get to know the individual members of the Board on a more personal basis. They are very appreciative of dentists who take the time to attend their meetings and are very attentive to the comments they make. The Dental Board is very accessible to the profession. I frequently call individual board members regarding issues and I find that I can reach them quite easily. They have respect for our specialty especially on anesthesia issues, but they can only act if they have our input. Please consider increasing your awareness of the Dental Board. They are the ones who issue your license to practice, but they also need your help and direction.

I attended the ABOMS Oral Certifying Exam this year. We had an excellent contingent from California including Alan Felsenfeld, Vince Farhood, and Rob Relle. You may have heard that the Oral Exam has moved to Dallas and now uses the testing center of the American Board of Obstetrics and Gynecology. We all agreed that the weather was a great improvement

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President's Message
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over mid winter Chicago, but that something was lost by not being at the Drake. Despite being in a completely new venue, the exams went very smoothly and the candidates, staff, and examiners all felt the process was much more uniform in the new setting.

On the broader front of the dental profession as a whole, we are starting to hear more about "mid level practitioners". Although this term can mean lots of different things, I define this as a dental care professional who is the equivalent of a nurse practitioner or physician's assistant. The ADA is developing such an entity as a "community dental health coordinator", a hygienist who works independently in under served areas under the direction of a dentist. Also, there are the Dental Health Aide Therapists in Alaska who perform some irreversible dental procedures including some extractions. The Minnesota State Legislature is presently considering a bill that would create an expanded duties hygienist who could do some tooth preparation, place restorations, simple extractions, and prescribe medications. The ADA predicts we will see similar legislation in California in the next 3 years. This is clearly being driven by "access to care" issues as politicians seek to provide care of some sort to underserved areas and populations. I think we all would agree that substandard care can be worse than no care, but this is seen as an arguable point with the various legislative proposals for expanded health care having failed this year in California. We would all do well to remember that what is good for dentistry is also good for oral and maxillofacial surgery, and to become more aware of issues such as these that will affect the entire dental profession.

Spotlight on our Sponsors

CALAOMS would like to thank the following sponsors of our 2008 Palm Springs Anesthesia Symposium that was held in February of this year.

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We greatly appreciate their continued support of our association over the years

Point / Counter Point
Continued from Page 5

remove low compensating insurance plans from their practices early on. It's more likely that patients with these plans will be treated in an office where an itinerant oral surgeon works. The niceties and ambiance of a higher end office may be lacking, but patients can receive the treatment they need. Also, as in most states, in California there tends to be a disproportionately higher number of surgeons living and practicing in more desirable neighborhoods. Itinerant surgeons can find a niche traveling to offices in locations that are underserved.

So, in general terms, the itinerant surgeon fills a gap. While the work is not glamorous, the itinerant surgeon can earn a living utilizing their specialty skills while serving the public in an area of need.

by Samuel Clemmons

Counter Point

The Case Against Itinerant Oral Surgeons

Several months ago, I wrote an article on itinerant oral surgeons ("I'm mad as hell…"). I received several calls and e-mails agreeing with my opinion. I also did hear a few who adamantly disagreed.

As in most controversial issues, there are always two sides to this story and *The Compass* is the perfect venue in which to express an opinion. Hopefully, these Point/Counter-Point articles will stimulate others to contribute to this dialog.

I want to make myself clear. I do not want to interfere with anyone's ability to make a living. We have all had to start somewhere. Rather than making a case against itinerants, I strongly believe that our society should establish standards for itinerant practice that should be followed by those surgeons who wish to be CALAOMS members. Just as they did when anesthesia was in its infancy, these standards will insure patient safety and preserve the integrity of our specialty.

Most commonly, itinerant oral surgeons are employed by metropolitan HMO or group dental practices. They are hired as independent contractors and paid a percentage of the fee. The advantage to the itinerant is that he or she has no overhead or office to manage. The advantage to the dental office is the ability to capture revenue that would otherwise be referred out. With the exception of not having to drive to a different office, there is no advantage to the patient without standards.

These practices schedule patients for an oral surgeon who is on site infrequently. He or she removes third molars on a patient on that day and does not see the patient again. Follow-up is performed by a general practitioner in the same office.

This works great, assuming that there are no major issues. It falls apart if the patient experiences a significant complication. When faced with a problem he or she cannot manage, such as prolonged bleeding or a deep space infection, the knee-jerk response from the general dentist is to send the patient to the emergency room. You gotta love getting up in the middle of the night to treat someone else's bleeding socket!

Few of us would have any problem assisting our non-oral surgeon colleagues on request, but these patients are just turfed out of the office, often times having no clue as to who treated them or what direction they should take. This creates a great deal of anxiety for the patient, overloads our emergency rooms, creates a significant expense to the patient and puts an extreme burden on an ever decreasing number or oral surgeons who take call. In essence, the itinerant oral surgeon has been paid but there are no funds available for the permanent oral surgeons.

These patients become frustrated and angry which may lead to litigation, not only against the original oral surgeon, but to the surgeon taking call as well.

As I stated, the premise of this column is to establish uniform practices. The membership can agree on incorporating this into the CALAOMS code of ethics. To get the ball rolling, I suggest the following items be considered for all itinerant oral surgeons.

1. It is the responsibility of the itinerant oral surgeon to provide the same quality of care as any other oral surgeon. This means not only the surgical care but after care as well. It is not acceptable for a patient paying for specialty oral surgical care to have anything less than the equivalent specialist for the post-operative care.

2. Emergency follow-up care should not be designated to anyone else other than an oral surgeon. If the itinerant surgeon is not available, he should make arrangements with a local oral surgeon to see these emergencies.

3. Itinerant oral surgeons should become members of a local hospital or make arrangements with a local oral surgeon to see any patient that may require hospitalization including an emergency room visit. Patients should not be referred to the hospital or ERs without direction.

There is no doubt that there are well trained, competent and responsible oral surgeons working outside their own offices. These standards would ensure quality patient care which is good for the patients, the oral surgeon and for our profession.

by Daniel Levin, DDS

The opinions expressed in the "Point - Counter Point" sections, are the views of the authors and only the authors. These are not the views of CALAOMS, nor does CALAOMS endorse these views. Nor should any assumptions be made about endorsements of views and opinions, by CALAOMS as an organization, by its Board of Directors as a governing body, by its General Membership as a whole, or by its Editor.

SCPIE's Risk Management Corner

Identifying and Managing Risks for Office-Based Procedures

Although there has been an increase in the last few years of doctors performing surgical procedures outside of the acute care environment, office-based procedures are nothing new for oral and maxillofacial surgeons. The majority of your procedures are conducted in an office setting instead of at a hospital. While most procedures are safely conducted without an adverse event, doctors must recognize that each case has the potential for complications and be prepared to manage it. The following examples occurred as a result of failure to anticipate and prepare for complications.

• A 66-year-old male suffered cardiac arrest and subsequent death while undergoing multiple tooth extractions. Liability issues included lack of adequate pre-op clearance for a patient with chronic history of heart disease.

• An alleged adverse reaction to IV anesthetic for tooth extraction resulted in the death of a 63-year-old male. Multiple liability issues included incomplete chart documentation and the inappropriate handling of the office code blue.

• The alleged negligent use of anesthetic medications and failure to respond appropriately to an emergency resulted in the death of a 5-year-old male. The child was being treated for multiple caries repair.

By recognizing and managing the potential risks associated with office-based procedures in the preoperative, intraoperative and postoperative stages, doctors can minimize their liability and improve patient safety.

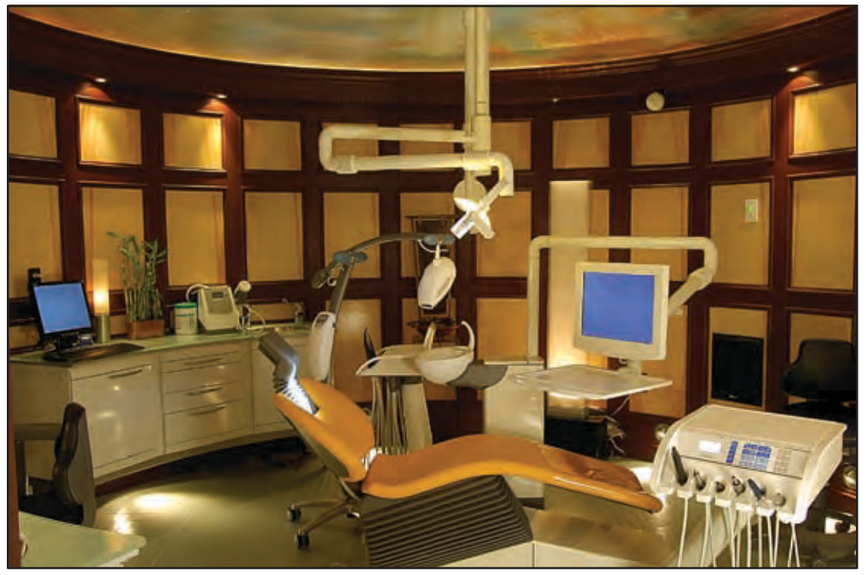
Preoperative Stage

When assessing the risks of office-based surgery, there are several factors to consider: the health of the surgical candidate, the office facility's capacity to handle emergencies, and the training of the medical personnel.

Patient Selection

Not all of the patients who come to a doctor's office for oral surgery are appropriate candidates. To identify these high-risk candidates, a preoperative history and physical examination must be completed. Particular attention should be given to factors such as age; weight; and history of other illnesses, including diabetes, cardiac disease and respiratory conditions.

The American Society of Anesthesiologists (ASA) recommends that clinicians administering sedation/analgesia should be familiar with sedation-oriented aspects of patient's medical history, including 1) abnormalities of the major organ systems; 2) previous adverse experience with sedation/analgesia as well as regional and general anesthesia; 3) drug allergies, current medications, and potential drug interactions; 4) time and nature of last oral intake; and 5) history of tobacco, alcohol, or substance abuse. The doctor should also evaluate the patient for a history of venous thromboembolism and be knowledgeable about its risk factors and management. Oral surgeons are encouraged to consult with appropriate subspecialists and/or an anesthesiologist for patients at increased risk of experiencing sedation events due to pre-existing conditions.



The majority of OMS procedures are conduct ed in an office setting instead of a hospital.

The ASA has a patient classification system (available at www.asahq.org) to assist with the selection of patients for office-based surgery using moderate sedation/analgesia, deep sedation/analgesia or general anesthesia.

Patient Education

It is essential to manage expectations by educating the patient about the nature of the procedure and the risks and complications that could occur.

Complete the informed consent process well in advance of the procedure to ensure that the patient has enough time to read through the materials and ask questions prior to the surgery. The documentation in the patient's chart should include the discussion with the patient that outlines the specific risks, complications, and alternatives to the proposed procedure.

Anesthesia carries distinct risks, so a separate discussion about the risks and complications of anesthesia should be documented and an informed consent form specific to the risks of anesthesia included in the chart.

Facility and Equipment

There are stringent federal and state requirements that hospitals must follow in maintaining their facilities, but very little regulation pertains specifically to a doctor's office.

To maintain patient safety, the office must comply with 1) all applicable federal, state and local laws; 2) codes and regulations relating to fire prevention, building construction and occupancy; 3) accommodations for the disabled; 4) occupational safety and health statutes; and 5) disposal of medical and hazardous waste guidelines. The building also must have sufficient back-up power should there be a power outage during the procedure.

Age-and-size-appropriate equipment necessary to conduct the procedure should be checked and maintained regularly between uses.

Personnel

California state law requires that oral and maxillofacial surgeons procure a permit to administer anesthesia based on documented education, training and competence. Permit holders must undergo reevaluation every five years and complete at least 24 hours of continuing education courses in general anesthesia every two years to renew their permit.

All personnel must be competent, trained and licensed to assist with the procedure. The oral surgeon who is performing the procedure must provide adequate supervision to both licensed and unlicensed staff in the room. In addition, California Business and Professions Code §2216 requires that there be a minimum of two staff persons on the premises, one of whom should be either a licensed doctor or a licensed healthcare professional with current certification in advanced cardiac life support.

Intraoperative Stage

Even with a thorough preoperative plan and screening process, a patient emergency may arise and the office must be prepared to handle any intraoperative complications. At a minimum, facilities should have a reliable source of oxygen, suction, age-and-size-appropriate resuscitation equipment and emergency drugs. Enough space should be available for immediate access to the patient, accommodating the personnel, resuscitative equipment, anesthesia machine and all monitoring equipment.

Although the office may have the required number of personnel and the necessary equipment, without a written emergency plan a patient emergency could be devastating. Staff should be educated about the plan so that each person knows what is expected of him or her. Always be aware that when a medical or anesthetic emergency

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Bylaws Committee Update

Ned L. Nix, D.D.S.,
CALAOMS President-Elect

Our bylaws are reviewed and updated by your board of directors on a regular basis. Board approved bylaws changes must be voted on and approved by the general membership. The AAOMS distributes standing rules and bylaws to all members and charges the respective component societies to keep their bylaws in line with those of our national organization.

Over my five years serving as a director, we have had issues discussions including the topic of itinerant oral and maxillofacial surgical care. Webster defines itinerant as, "Traveling from place to place." The AAOMS Code of Professional Conduct (section C.3) states, "Oral and maxillofacial surgeons should treat their patients as they would like to be treated in like circumstances. Their independent judgment should not be compromised."

AAOMS' advisory opinion follows, as to the practice of itinerant oral and maxillofacial surgery:

> C.3.00 An oral and maxillofacial surgeon must not practice oral and maxillofacial surgery on a scheduled basis in locations other than suitably equipped and staffed facilities, such as oral and maxillofacial surgery offices (as defined in C.3.01 and C.3.02), accredited hospitals, surgery centers, academic institutions, state or federal institutions, or in the military service. This provision should not prevent or discourage oral and maxillofacial surgeons from providing unscheduled urgent or emergency care as needed in any type of setting.
>
> C.3.01 An oral and maxillofacial surgery office is defined as a non-mobile facility that has passed the state general anesthesia or conscious sedation evaluation where required by state law, is represented by trained staff persons, displays the attending oral and maxillofacial surgeon's name, and provides 24-hour coverage by an oral and maxillofacial surgeon who is within a reasonable distance and/or response time of the facility for the administration of emergency care.
>
> C.3.02 Facilities meeting these criteria may be a part of an associated medical or dental clinic. Each oral and maxillofacial surgery facility must meet the appropriate statutes as set forth in the state Dental Practice Acts and comply with current AAOMS office anesthesia regulations, including the maintenance of drugs and equipment on the premises, and be subject to on-site evaluation where required.
>
> C.3.03 Itinerant Surgery: In all conduct regarding their performance of elective treatment away from their usual clinical or training location, oral and maxillofacial surgeons shall uphold the standards of the profession, its standards of care, and the provisions of this Code, including but not limited to the provisions of Advisory Opinions 3.00 and 3.02 herein.
>
> a. Fellows and members are strongly discouraged from making itinerant surgery a major part of their practice or component of their training. An oral and maxillofacial surgeon must not perform elective surgery at a distance from the usual location where he or she operates without direct or at minimum supervisory determination of the diagnosis and of the adequacy of preoperative preparation. Postoperative care must be rendered by the operating surgeon unless it is delegated to another practitioner who is qualified to continue this essential aspect of total surgical care. It is the responsibility of the operating surgeon to establish communication to ensure that the patient receives proper continuity of care.
>
> b. This Code provision shall not prohibit the occasional performance by a fellow or member of surgery at a distant U.S. or foreign facility for the purposes of teaching, or treatment of a patient in need of care or procedures in which the fellow or member is particularly expert, provided the continuity of care requirements set forth in paragraph a. above are fulfilled.
>
> c. For purpose of this advisory opinion, the term "occasional performance" means the uncommon or infrequent occurrence of performing surgery at a distant U.S. or foreign facility. An "itinerant surgeon" is defined as a surgeon who travels from place to place to act as a primary surgeon in locations at a distance from his or her usual place of primary practice. The phrase "at a distance" is defined as a location so far removed from his or her primary practice location that a more local provider would be called upon to provide emergency coverage.
>
> d. The above provisions are not meant to prohibit or interfere with the ability of an oral and maxillofacial surgeon practicing in a less populated area to treat patients where no local surgeon is available.

I hope by reviewing this advisory opinion that CALAOMS members are better able to provide the best care possible for our patients.

Identifying and Managing Risks, Continued From Page 11

occurs, an effective team response is essential to prevent serious morbidity or even death.

Medical record documentation in the intraoperative stage should detail the surgery with a description of the operation and findings as well as vital signs throughout the procedure. The American Association of Oral and Maxillofacial Surgeons (AAOMS) recommends that the following indicators be monitored continuously or at regular intervals during sedation and general anesthetic procedures: blood pressure; heart rate and rhythm (ECG); and monitoring oxygenation by continuous use of pulse oximetry, monitoring ventilation by auscultation of breath sounds or other methods.

Anesthesia records must indicate the type, amount and route of administration of the medication. To accurately capture the events in case of an emergency, it is recommended that a scribe be available to assist in the documentation. Above all, do not consider the paper lining of your surgical tray to be a substitute record.

Postoperative Stage

Due to numerous issues that may arise postoperatively, close monitoring must be done in the recovery period. The doctor should be immediately available until the patient has been discharged from anesthesia care. Discharge of the patient is an oral surgeon's responsibility and should not be delegated to other personnel.

Patients should be sufficiently recovered from the procedure and sedation before discharge and accompanied home by a responsible adult. Providing postoperative instructions in writing will increase compliance.

Since no two cases are alike, doctors are encouraged to prepare for procedures keeping in mind that each patient brings a different set of risks with him or her. Awareness and good preparation during each stage of the surgical procedure will improve patient safety, which, in turn, will decrease your liability risk.

Dental Auxiliary Corner

New Law to Affect Surgical Assistants

At its January meeting, the Dental Board of California requested development of a new proposal for the regulation of dental assistants. The Board indicated that current legislation, passed in 2005 and due for implementation in 2010, was difficult to understand and overly complex. Included in this current legislation was the Registered Surgical Assistant, a career pathway designed to address the needs of the OMS assistant.

The California Dental Association immediately began holding discussions with representatives of dental assisting and the dental specialties in order to develop a new proposal. CDA already had a bill in place, AB 2637, that would delay the implementation of the dental assisting regulations until 2012. CDA initially proposed that all advanced surgical assisting duties would be reserved for the Registered Dental Assistant (RDA). CALAOMS representatives told CDA that this was not ideal from our perspective as completion of the RDA requires extensive training in restorative assisting our assistants would never use.

CALAOMS proposed creation of a certificate that would focus on certifying our staff members for anesthesia related duties as these are most critical for our specialty. Most OMS practices employ dental assistants who are not licensed to perform the duties allowed for the RDA. A certificate in anesthesia assisting would allow them to legally perform most anesthesia related duties.

The duties for the "Certified Sedation Assistant" include:

1) Monitor patients during the preoperative, intraoperative, and postoperative phases, using noninvasive instrumentation such as pulse oximeters, electrocardiograms, and capnography, limited to selection and validation of monitoring sensors, selecting menus and default settings and analysis for electrocardiogram, pulse oximeter and capnograph, continuous blood pressure, pulse, and respiration rates; interpretation of data from noninvasive patient monitors including readings from continuous blood pressure and information from the monitor display for electrocardiogram waveform, carbon dioxide and end tidal carbon dioxide concentration, respiratory cycle data, continuous noninvasive blood pressure data, and pulse arterial oxygen saturation measurements, for the purpose of evaluating the condition of the patient during preoperative, intraoperative, and postoperative treatment.

2) Drug identification and draw, limited to identification of appropriate medications, identification of specific drug groups used in surgical settings, ampule and vial preparation and draw techniques, pulling drugs of correct amount verified from dentist's request.

3) Add drugs, medications, and fluids to intravenous lines using a syringe, provided that a licensed dentist is present at the patient's chairside, limited to determining patency of IV line, selection of injection port, syringe insertion into injection port, occlusion of IV line and blood aspiration, line release and injection of drugs for appropriate time interval, infusion recheck.

4) Removal of intravenous lines.

Training for certification will require completion of 12 months work experience, board approved course of 110 hours, and a final examination.

Dental assistants would retain their present duties including removing sutures, placing monitors, reading and repeating monitor readings for interpretation by the dentist. The new law would also include a section that specifies that assistants may perform certain "extraoral duties" delegated by the dentist.

The AAOMS is presently developing a national program for certification of anesthesia assistants very similar to the CDA proposal. The AAOMS proposal also focuses exclusively on anesthesia related duties.

Although the Certified Sedation Assistant will not be able to place a socket dressing as that duty is reserved for the RDA, we gain a simplified certification process with fewer hours of required training with this new proposal.

We are continuing to hold discussions with CDA on this important issue. We still need to develop the educational requirements for the board approved course for example. We anticipate that CALAOMS will offer such a course to the membership as a new version of OMSA. This will involve a combination of distance learning via the internet, classroom exercises, and office based clinical training. We have until 2012 to get this in place and our assistants may continue to function as they always have in the mean time.

I would like to thank Dr. Lou Gallia, Dr. Ned Nix, and Gayle Mathe of CDA for their help with this issue. Please contact me if you have any questions. The CALAOMS Board of Directors and Legislative Committee will continue to address this matter.

Bruce Whitcher, DDS
President, CALAOMS

OMS Treats Injured LAPD SWAT Officer

Continued From Cover Page

Dr. Gabriel Aslanian updating the press on the condition and prognosis of Officer Veenstra following the surgery.

pieces of shrapnel wreaked on his soft tissues? …That was the most challenging part, to be able to put all the little pieces back together again and decide what the correct course of action was considering the severity of the injury." Officer Veenstra is recovering well, however, Dr. Aslanian estimates that he will need several reconstructive surgeries before his deficits are minimized.

Dr. Aslanian earned his DDS degree from the University of Southern California in 1996, completed his MD and residency at State University of New York, Stony Brook, and obtained his OMS training at Long Island Jewish Medical Center in 2002. He shares private practice offices in Glendale and Northridge with his brother Yervant G. Aslanian, DDS, MD, who was his inspiration for pursuing a career in OMS.

Dr. Aslanian was happy to be involved in the care of Officer Veenstra, who he calls a dedicated civil servant, in his time of need. Dr. Aslanian's actions serve to illustrate the need for OMS trauma call. After all, what other service could provide such care?

-CALAOMS Staff

Spotlight On Members

Photos and Captions By Vincent Farhood, DDS

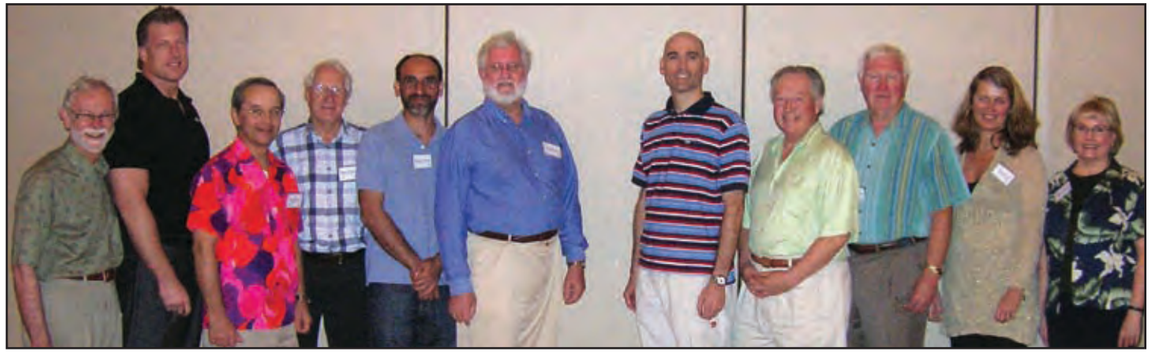
American Board of Oral and Maxillofacial Surgery oral examinations in Dallas

CALAOMS members on ABOMS Examination Committee who took part in oral examination held this year in Dallas, Tx. include (left to right) Drs. Herford, Relle, Whitcher, Felsenfeld, Farhood. Missing from this photo is Dr. Delsol ABOMS Director.

CALAOMS President, Dr. Bruce Whitcher reviews questions for the written ABOMS examination.

The UCSF 15th International Symposium In Oral And Maxillofacial Surgery

Contemporary Clinical Care in Oral and Maxillofacial Surgery, January. 14-18



The participants at the meeting are left to right: Drs. David Whittaker (Forensic Odontology), Craig Misch (Implant Problems in the Esthetic Zone), Martin Bogetz (Outpatient Anesthesia and Sedation), Ross Bierne (Bone Grafting), Mehran Hossaini (UCSF OMS Staff), M. Anthony Pogrel (UCSF OMS Program Chairman), Brian Schmidt (UCSF OMS Program Director), Robert Myall (Osteomyelitis in Children), Lewis Estabrooks (Implant related Medicologal Issues), Tara Renton (Dento-Alveolar Surgery), Dorothy Perry (UCSF staff). Not pictured are Arthur Curley (Implant related Issues), Michael Pikos (Digitally Guided Augmentation), Vincent Kokich (Emerging Technology and Implants), Joel Weaver (Improving Margin of Safety of Office Anesthesia), missing from the center of the photograph is Dr. Charles Bertolami (meeting founder).

ACLS Course Held at Solano Community College on March 8th

Dr. Mike Mullens demonstrated AED procedures to OMS.

Dr. John Bond supervises 'Mega Code' exercises.

The CALAOMS Spring ACLS re-certification course was well attended once again this year! Dr. Michael Mullen and Dr. Newton Gordon instructed on the use of the AED while Dr. John Bond and Dr. William K. Tom presented the mega code demonstration. This course will be returning in November of this year. Be sure to visit the CALAOMS website (www.calaoms.org/events) the first part of September for registration information. Don't wait too long though as this course always fills to capacity rather quickly. We look forward to seeing you in the fall.

Upcoming Events For 2008

Cosmetics		**Medical Emergencies**	
April, 19 2008	San Francisco	October 8, 2008	Northern, CA
GA/CS Evaluators' Calibration Course		**Medical Emergencies**	
April 30, 2008	Anaheim	October 22, 2008	Southern, CA
GA/CS Evaluators' Calibration Course		**ACLS**	
May 7, 2008	San Ramon	November, 2008	Solano
CALAOMS Annual Membership Meeting		**Anesthesia**	
May 17-18, 2008	San Diego	November 5, 2008	Orange County
Residents' Presentations			
September 24, 2008	Santa Ana		

Volunteering: No Pay, But High In Rewards

Steve M. Leighty, DDS
CALAOMS Member

Growing up as a dentist's son I heard many times that being a dentist was a privilege few people ever realized. Along with that privilege of being a professional came demands of: continuing education, leadership, higher ethical standards and service. I believe we can 'give back' through service to a variety of civic clubs, our church, or professional organizations.

What is true about dentistry goes double for those of us who have been able to attain a certificate of Oral and Maxillofacial Surgery. I have yet to discover a career I would trade for among my friends and associates in the medical profession, the business world, and even the greater dental community.

When I first moved to Grass Valley to purchase Dr. Sam Aanestad's practice, I joined Rotary for two reasons. First, I noticed that a lot of people I looked up to were involved in service. Secondly, I assumed I might pick up some casual referrals. I quickly learned that, like the dental community, it takes years to obtain, cultivate, and retain good referrals, so there were no quick business upticks from my new membership. However, I did slowly get an understanding of how service clubs work to create a better world a few projects at a time.

In February of 2004, I accompanied a general dentist, a copier salesman, and two retired women from publishing and printing careers on a scouting trip to Ensenada, Mexico. We planned to visit a cleft lip and palate clinic operated by Thousand Smiles Foundation (formed in the 1980s by a group of San Diego area Rotarians). When we learned that their modern clinic was being utilized only one weekend each quarter, I got a vision about 'borrowing' their facilities and staffing the clinic with dental professionals and lay volunteers from Northern California.

After establishing a relationship with Thousand Smiles over multiple visits during the next 18 months, we held our first clinic in October 2005. Staffed with three dentists and one oral surgeon (yours truly), we registered and obtained screening x-rays for 70 patients and performed dental treatment on 35.

49er Breakfast Rotary of Nevada City organized and operates NorCal Dental Clinic twice yearly (April and October) in Ensenada, BC, Mexico. We just returned

Cucapah Ensenada 2007: The NorCal dental team enjoys taking a break on the awning covered veranda.

from our 6th trip in which we treated 116 patients. We usually take 3-4 general dentists, one or two RDHs, along with a few translators and some administrative staff to operate the clinic. After flying to San Diego, most of us rent vans and cars to travel the 75 miles south of the border. Some members of our group fly their single engine airplanes directly to the Ensenada airport (no commercial flights).

Hotels and restaurants are plentiful and reasonably priced in Ensenada. Most of us arrange to arrive Thursday evening. After a 7:00 am breakfast, we arrive at the clinic at 8:00 and perform equipment setup and volunteer orientation. The two story dental clinic, operated by Thousand Smiles (Foundacion Mil Sonrisas) looks like a dental equipment showcase with modern dental chairs, lights, and autoclaves. Nearly all equipment, materials, and barriers are provided. Our volunteers are responsible to bring their own scrubs, glasses, and any special equipment they require. For instance, I bring a headlight, my Stryker handpiece (the clinic provides standard highspeed/lowspeed dental handpieces) and a couple of instrument setups for extractions, as well as a Nomad x-ray unit. Traditional intraoral films and processor are available and a new panoramic unit will be installed soon.

I usually perform triage duties, order x-rays, and help to keep the professional volunteers working smoothly. Pre-Dent students from UCSD perform many

A portion of the modern 8-chair clinic where volunteers work side by side to fulfill the needs of some of the underprivileged citizens of Ensenada and surrounding communities.

of the assisting duties, alongside RDAs and RDHs. For the last several clinics, we have been able to recruit local dentists and one oral and maxillofacial surgeon to join in our effort. We try to get the patients treated by 6:00 pm so we can have dinner and some relaxation before repeating the same process on Saturday. At the end of the day, the chairs are raised up for cleaning and plastic wrap, all supplies are returned to storage, and countertops are sanitized.

We partner with local Rotary clubs and other non-profit healthcare related groups to bring patients, to provide food for our volunteer team, and assist with translation throughout the weekend.

What does it take to be a volunteer? First of all, it is not necessary to be a Rotarian. Professional volunteers need to provide a notarized copy of their dental license, along with copies of their professional liability policy face page, and passport.

I perform extractions and the occasional biopsy. I also get to do some teaching with the students as well as the dental colleagues. We occasionally have a specialist, but the great majority of our dentists are GPs. We are not allowed to utilize any anesthesia other than local anesthetic. As per our agreement with the cleft palate group is that we perform only general dental procedures at our clinic.

We plan to continue our clinic for the forseeable future; in fact Thousand Smiles has asked us to consider increasing our frequency. We have also worked in a smaller clinic in Mexicali and are involved in a building project at Casa Hogar located in Beuna Vista, 10 miles south of Ensenada.

For more information, or to be included on my distribution list for future clinic dates, contact Steve M. Leighty, DDS smlzenos@pacbell.net at 1364 Whispering Pines Lane, Grass Valley, CA (530) 272-8871.

Try It! You may just find the rewards you have been looking for.

Article by Albert W. Lin, DDS

Our first 2008 CALAOMS meeting held in Rancho Mirage on January 19-20th was a great way to start the new year! The anesthesia symposium for providers of dental conscious sedation and general anesthesia utilized wireless keyboards and interactive media to actively integrate audience participation and obtain real time feedback. Answers to questions relating to anesthesia care were immediately tabulated, assessed and then commented on by an interdisciplinary panel. The panel was monitored by our own Dr. Tim Silegy and Dr. Martin Bogetz (M.D. anesthesiologist) who both helped summarize the topics along with evidence based research. Overall, the results of the questions and feedback from the panel were supportive of the fact that OMS surgeons continue to provide a high standard of care in delivering in-office general anesthesia. I am confident that our specialty is committed to the constant research effort needed in evidence based techniques to continually raise our parameters of care. A consistent priority among OMS colleagues that I spoke with at the meeting was a thorough pre-op evaluation, effective management of a patient's medical history if necessary, and patient safety in the intra-op and post-op phases of general anesthesia. I think that this is reflective of the fact that OMS surgeons are trained to evaluate the patient as a whole, not just the oral cavity.

Eye opening at the symposium was the difference in parameters of care in other dental specialties aside from dental anesthesiologists. This was an important topic of discussion at our first CALAOMS board meeting for 2008. Two separate task forces, one formed by OMS residency programs in California and one by AAOMS have been submitted to the ADA foundation to participate in the formation of standardized training programs for other dental specialties. The general consensus at the board meeting was that other dental specialties and general dentists were going to start programs to learn conscious sedation; and that we should become actively involved in the development of and accreditation of their training requirements. I agree that this is not only prudent, but essential. Remember, in the event of an in-office anesthesia emergency, we will all be lumped into the category of "dentist". There will be no distinction between the training in various specialties, and we will all be held to the standards set by the American Association of Anesthesiologists.

All in all, the anesthesia symposium was presented in an excellent format that was appropriate and addressed the needs of both OMS surgeons and other dental specialties. It helped stimulate the obligation that we have as health care professionals to provide the highest level of care possible to our patients.

California Surgeon Secures $1.86 million from the NIH

Dr. Vivek Shetty, professor of oral and maxillofacial surgery at the UCLA School of Dentistry, has been awarded a $1.86 million grant from the National Institute on Drug Use, a branch of the National Institutes of Health. Funded through NIH's Genetics, Environment and Health Initiative, the four-year research grant will allow the development and refinement of hand-held salivary biosensors to rapidly and precisely measure psychological stress reactions subsequent to facial injury. The development of portable biosensors for detecting stress reactions to injury builds upon Dr. Shetty's ongoing research study, funded by a $3.7 million grant from the National Institute on Drug Use, on collaborative care strategies for facial injury patients. Beyond increasing awareness of the psychosocial antecedents and sequelae of facial injuries, the technologies being developed by Dr. Shetty's research team will lead to improved comprehensive care by all trauma care specialists.

A recipient of a $35,000 Research Support Grant from OMSF in 1993, Dr. Shetty has parlayed the starter funds into one of the largest, and most successful, facial injury research programs in the US. As Director of Research for the Section of Oral and Maxillofacial Surgery at UCLA, Dr. Shetty directs the Facial Injury Research Center, a multidisciplinary team of oral and maxillofacial surgeons, psychologists, addiction specialists, health service researchers and social scientists.

Dr. Shetty is an example of how gifts to OMSF lead to bigger and better things for the specialty. Without gifts to OMSF, there would be no research grants, and subsequently, less opportunity for surgeons to apply for more funding for their research from other sources, such as the NIH. There are a variety of ways to support the work of OMSF, such as an annual membership gift, a REAP contribution, or an estate gift.

Making an estate gift is a decision that requires thought and caring. Certainly, planned charitable gifts enable you to contribute significantly to the future of the specialty. In most cases, they also allow you to increase or stabilize income and moderate capital gains, income and estate tax obligations. Literally, charitable estate gift planning can help you retain more resources for your family. Many think you need considerable wealth to make a charitable estate gift. This is simply not true.

To help you navigate through the many estate giving options, OMSF has a special planned giving website--GiftLegacy, at www.omsfgift.org. Gift Legacy familiarizes visitors with many planned giving vehicles, the way they work, and their tax advantages. After visiting the site, plan on attending one of the Foundation's Estate Planning Seminars at the AAOMS Annual Meeting. There you can learn up-to-date information on financial and estate planning. Both seminars include a presentation and question and answer period.

If you make an estate gift of $10,000 or more to OMSF, you will be honored with a membership in the Robert V. Walker Society. Members of this prestigious society are recognized with an elegant reception each year at the AAOMS Annual Meeting.

Please feel free to contact OMSF Executive Director Frank J. Kurtz, PhD, at 847-233-4361 or fkurtz@aaoms.org with any questions.

Yes! I want to support the OMSF

Name: _____ Address: _____

City, State, Zip: _____ Phone: _____

❍ **Foundation membership: $165** ❍ **A gift to REAP of $** _____ ❍**Alliance membership $75**

List member name: _____ ❍**Please send me information on planned giving**

Method of Payment:

❍Check ❍Visa ❍Mastercard

Name on card: _____ Card number: _____

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

Signature: _____

Mail to: 9700 W. Bryn Mawr Avenue Rosemont, IL 60018

OR- Fax: 847.678.6254 *Fax for credit card payments only.*

Remember to include signature above. ***Thank You!***

Oral and Maxillofacial Surgery Foundation

Leading the specialty through support of research and education

Special Recognition

HALS Med-Dent Supply Company, Inc.

HALS Med-Dent will be presented "The Exhibitor of the Year" award at our Annual Meeting in San Diego on May 17, 2008 for their exceptional and continued support of CALAOMS and our members. HAL's continued dedication to CALAOMS over the years has prompted us to create this award to recognize vendors who's generous contributions help make our events possible.

Classified Ads

Job Opportunities/ Practices for Sale

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

Lake Arrowhead, CA

Price Reduced
Highly Motivated to Sell

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

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

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

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

Palmdale
Respected, thriving practice for sale. Excellent staff and efficient systems in place. Fee for service yields high net with untapped hospital cases and a growing population in family oriented Palmdale. You may choose to live in Santa Clarita. Seller will assist transition as requested. View www.transdent.com or call (800) 588-0098 and ask for ID#OSCA003.

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

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 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.

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.

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

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.

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.

Notice

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

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

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