

The Compass

Staying the Course Through Service and Education



Volume XI, Issue 1, Spring 2009

CALAOMS Enhances Professional Liability Insurance Program for Members

SCPPIE Insurance and The Doctors Company recently joined forces. The combination of two of California's leading medical liability insurers has not only enabled the company to continue a long-standing tradition of exceptional service, but it has strengthened its ability to go even further in protecting California oral and maxillofacial surgeons (OMS).

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surgeon, and oral surgeon medical liability.

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Donald J. Palmisano, MD, JD, FACS
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Editor's Corner



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

"Pulse Oximetry" Rubbish!

I am sorry to report that the pulse oximeter, a true cornerstone of our anesthetic monitoring equipment, is rubbish. The random numbers displayed on these machines have duped us. What do they really mean? Do they really help us? We are a crowd of overachievers. Not only do we constantly push ourselves to give a 100%, we push our patients to give us a 100% too. While connected to our pulse-oximeters, patients must score high marks, or we send them off to remediate the basics of oxygenation and ventilation - even if that means forcefully chinning, inserting various devices into noses or mouths, or squeezing small, compliant oxygen-rich bags into large, non-compliant, oxygen-poor patients.

Now, I know you have bought into the notion that the pulse oximeter is critical to insure patient safety. Further, you think, after reading my last article, that I have lost too many brain cells to good microbrew. It's okay if you find my denouncement of the pulse-oximeter heretical; trust me, it was difficult for me to accept this

truth, especially after years of school, residency, and continuing education courses, all touting the merits of the pulse oximeter. How did I come to this realization you ask? Well it was a slow, evolutionary process that began on the side of a mountain.

Recently, I vacationed in Tanzania and climbed the tallest peak in Africa, Mount Kilimanjaro. I hiked with a safety conscious outfit. At 11,300 feet everyone underwent a pulse oximeter reading. This was our baseline reading, just in case we had a problem at higher altitude. My initial reading was pulse 113 bpm and SaO₂ 93%. Out of morbid curiosity, I did repeat



measurements at higher altitudes. At 15,200 feet my pulse again was 113 bpm, but my S_aO₂ dropped to 84%.

Our highest camp, Upper Glacier Camp, was at 18,500 feet. Here my reading was 74% and pulse of 122 bpm. "Hmmm..." I thought, as I tried to stay warm in my tent, "a pulse-ox of 74% and I am not dead." In fact, I was so far from death that I acutely felt the bitter

cold penetrating through my tent, sleeping bag, layers of long underwear and into my bones. I contemplated my 74% saturation. Would I fail my office anesthesia evaluation if I kept my patient at 74%? Certainly if one of my patients had such a reading, I would try to fix it. So, did I need supplemental oxygen? Was my little brain or heart at risk? If I were at 74% now, what would my saturation be at the summit? How long could I survive at this saturation? I pondered (obsessed?) throughout the night, arose the next morning and continued to climb. As the last 800 feet of the mountain loomed ahead of me, I pushed these questions to the back of my mind and concentrated on placing one foot in front of the other. Once I had my feet organized and set my lungs to heavy breathing, my brain figured out that, clearly, I was OK.

This pulse oximetry issue continued to bother me and, upon returning home, it prompted me to do a little research. The next time you're at your desk, do a quick bit of research. Type in a few key words: "outcome" and "pulse oximetry." I was quite surprised by the results. Pederson, *et al* (Pulse oximetry for perioperative monitoring. *Cochrane Database of Systematic*

Reviews 2003, Issue 2. Art. No.: CD002013. DOI: 10.1002/14651858.CD002013) found "No statistically significant differences were detected in cardiovascular, respiratory, neurologic, or infectious complications" between the oximetry and control groups. So, my lived experience was validated by science. Makes you wonder what else we have bought into over the years; devices, products, procedures... what is the evidence for

their routine use? Now, I'm not advocating that we all throw out our pulse oximeters. I'm just suggesting that you read, question, and research. And, I'm suggesting you challenge yourself, for example, to climb a mountain, or to become the next Compass editor.

The bottom line is that I did summit, and I did survive. In fact, I have great memories of the climb: the wonderful Tanzanian people, the companionship (& shared misery) of my fellow trekkers, the view of a thunderstorm from above the clouds, and the feeling of ascending a great mountain. But then again, maybe it was the lack of oxygen that influenced my recollection of those events. Maybe my patients would find my surgical acumen, jokes, and bed-side manner more appealing if I kept their saturation at 74%!

SPOTLIGHT ON OUR SPONSORS



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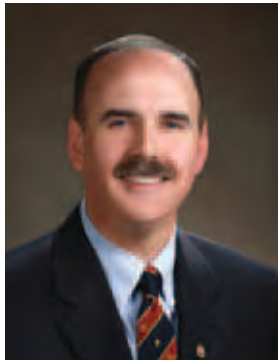
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President's Message

“History (and physical) repeats itself” Hospital Privileges and Credentialing



Ned L. Nix, DDS
President, CALAOMS

Hospital privileges are an important part of the full scope oral and maxillofacial surgeon's curriculum vitae. The leadership at the American Association of Oral and Maxillofacial Surgeons (AAOMS) has consistently advocated for active hospital privileges for its members and fellows. Hospitals provide a center to treat the medically compromised dental patient, the trauma patient, the reconstruction patient, and also serve as a center for the admission of in-office patients that may have surgical or medical complications. The OMS also needs to be at the table with the physi-

cians to educate these allied health care colleagues about the practice of oral and maxillofacial surgery (OMS). AAOMS has reported in recent years that the percentage of Fellows and Members obtaining hospital privileges is declining.

I am writing today to report about a recent discussion regarding the Active-Affiliate status for the medical staff at one of the San Jose area hospitals. I believe hospital centers need a way to establish competency among its staff members, but the Active-Affiliate category as described by Good Samaritan Hospital (GSH) is not the answer. Take a look at the GSH bylaws example. My concern is that it is flawed, and it could be applied to physicians and surgeons unknowingly and inappropriately.

Quoting section 3.6-1 of the GSH medical staff bylaws regarding active affiliate status, “This category is for office-based physicians who require hospital affiliation but do not admit or consult on patients. Physicians in this category have no admitting privileges and cannot perform any

procedures, consultations or otherwise attend to patients.” Why would a physician or surgeon want to be credentialed in this category? I would assume the physician still pays hospital staff dues. Maybe this physician attends hospital functions and has access to the library or the individual comes to the hospital to interact professionally with colleagues. Maybe they just show up to get a free lunch. I am sure insurance companies and



As history has shown us, hospital privileges are not cast in iron, and we must continually fight the battle to maintain them if we are not active and present on hospital staffs and on their committees.

certifying boards require some type of active staff classification to maintain their privilege to provide diagnostic and surgical services.

During a discussion at the Executive Committee meeting of another hospital where I serve as the

Chief of Dentistry, I appreciated the fact that hospitals must protect themselves in credentialing physicians and surgeons that are able to show current competency. The question is how can the hospital do this? I would recommend each department establish criteria acceptable to the medical staff and incorporate them into the hospital bylaws and standing rules. Only the specific doctors within a specialty or emphasis know which

processes or procedures are pertinent to the modern contemporary practice of their area of medicine or surgery. We continue to fight the scope of practice and admitting history and physical battles in hospital centers as oral and maxillofacial surgeons.

As an example, I was re-credentialed at GSH from Active to Active –Affiliate without being previously notified. I believe this was done due to either lack of surgical activity, or it was due to the fact that without an active department of oral and maxillofacial surgery the credentialing committee does not understand what I do. Due to budget cuts at GSH, the department of oral and maxillofacial surgery and dentistry was dissolved five years ago. We were lumped into the department of surgery, and we have lost our independence among the medical staff at that hospital. Like plastic surgeons or ENT surgeons, many of the surgical procedures we do can be done in the office under non-intubated general anesthesia, local anesthesia, or in surgical centers. In my specific case, I had asked for reconsideration based upon my activity at other centers in the community.

I am an attending surgeon for OMS residents at the Highland General Hospital in Oakland. I am active in teaching residents maxillofacial trauma management, and I do a jaw fracture every month in the operating room. For reconstruction and orthognathic surgery, a colleague and I use the Valley Care Hospital in Livermore because they have a fee schedule for overnight ambulatory surgery admission that is thousands of dollars less than traditional hospital operating rooms. I also have privilege at Kaiser-San Jose Hospital, where dental anesthesia is covered

under the member's insurance plan. I admit, operate and attend to my patients there as an active member of the department of head and neck surgery (ENT-HNS). I had assumed that submitting documentation of these cases to the GSH credentials committee would suffice to reinstate me to Active status. Fortunately when my request for re-appointment to the Active staff was reviewed, my activity as an attending at Highland General Hospital qualified me for an Active-Courtesy privilege.

I will ask you the question, what are the hospital centers trying to accomplish with this Active-Affiliate status? Active-Courtesy status at some centers gives the physician or surgeon the privilege to still admit and operate on their patients on a limited basis. I would promote each individual department establishing acceptable criteria for which current competency can be assessed, leading to credentialing active staff members. If the hospital wants to create a class for inactive physicians to remain on staffs, let us make sure an Active-Affiliate (for which no admitting or surgical privileges are granted) is the correct category for these doctors.

Let's talk about credentialing. While serving as Chief of Dentistry at Community Hospital of Los Gatos, I was involved in reviewing the bylaws for a recent adoption and approval by the medical staff. I was told by the Chair of the

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Bylaws Committee that a California Medical Association (CMA) template was used to 'update' the bylaws. The bylaws referred to a "Qualified Oral Surgeon" meaning, "an individual with a currently valid license to practice dentistry in the state of California who has successfully completed a post-graduate program in oral surgery accredited by a nationally recognized accrediting body approved by the U.S. Office of Education, and who has been determined by this Medical Staff to be currently competent to perform a complete history and physical examination to determine the ability of each of his patients to undergo the procedure the oral surgeon proposes to perform." I did not mind this definition, but I felt it was incomplete, and I lobbied to have it modified. I had "Qualified Oral Surgeon" changed to Oral and Maxillofacial Surgeon. I also had the word "admission" placed in front of history and physical. I felt "to determine the ability of each of his patients to undergo the surgical procedure the oral surgeon proposes to perform" did not clarify that a patient with surgical complications or an infection may be admitted for observation and treatment. The bylaws committee approved the following modification, "... to perform a complete admission history and physical examination and determine the course of treatment for their patients within the limits of their licensure...."

While reviewing the section of the bylaws referring to dental privileges, we were lumped into a category called "limited license practitioners." There was certain ambiguity. Section 6.3.2 (Dental Privileges) of the Community Hospital of Los Gatos bylaws stated, "Admission of a dental patient shall be the dual responsibility of the dentist and a physician member of the medical staff." Section 6.4 (Limited License Practitioners) stated, "patients admitted to the hospital for dental care shall receive the same basic medical appraisal as patients admitted for other services.... this includes having a physician member of the medical staff perform an admission history and physical examination and record the findings in the medical record. The limited license practitioner is responsible for the part of the history and physical examination related to his specialty." I was able to have it clarified that based upon the revised definition of oral and maxillofacial surgeon, OMSs would not be treated as other limited license practitioners such as general and pediatric dentists. The OMS will be viewed independently and be able to admit patients without a physician co-admit as well as be credentialed to do H&Ps if qualified.

The bottom line is if we are not present in the hospital and are not active on hospital staffs and committees we are going to have to repeat fighting the battles that were fought years ago. Beginning April 10, 2007, El Camino Hospital of

Mountain View takes ownership of the Community Hospital of Los Gatos (CHLG) by way of a merger. CHLG closes and the bylaws in effect at El Camino Hospital will govern the medical staff. During my review of the bylaws of the El Camino Hospital, I noticed that the history and physical privilege was included on the credentials list. It was noted that OMSs could apply for the H&P privilege "for ASA I and II patients only." Did we take our physical diagnosis courses in residency to only treat ASA I and II patients? I think not. I hope to be involved in lobbying for our full privileges at this new hospital center. I would suggest the following language, "Oral and maxillofacial surgeons who have completed training at accredited institutions possess the privilege to perform admission history and physical examinations, and will collaborate with physicians when appropriate for the comprehensive care of their dental patients." I would charge all CALAOMS members to maintain Active staff privileges at one's hospital. This will be very important moving forward as some of us expand our scope of practice to cosmetic maxillofacial surgery. The specific credentialing battle will go way beyond just admission history and physical examinations. We will have to hear again and again, "Dentists doing facelifts?" We are all charged to advocate for our specialty. The education of our medical colleagues as to our education, training and scope of practice is an ongoing process. The fight will certainly continue.

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Tribute® Plan—An Unrivaled Financial Career Reward

Members of The Doctors Company/SCPIE Insurance are eligible to participate in the company's one-of-a-kind Tribute Plan, a breakthrough financial benefit that rewards doctors for their loyalty to the company and their dedication to the practice of good medicine. The Doctors Company/SCPIE Insurance is the only national insurer to offer such a significant benefit.

The Tribute Plan utilizes a financial loyalty pool to reward its members. A portion of this loyalty pool money is allocated annually to each doctor based on his or her premium. Eligible members receive their reward when they meet three simple requirements:

- Reach age 55 or older,
- Retire permanently from medicine, and
- Have five or more years of continuous coverage with The Doctors Company/SCPIE Insurance at retirement.

CALAOMS Program Discounts

The Doctors Company/SCPIE Insurance offers members of CALAOMS a multitude of exclusive discounts and programs, including an expanded claims-free discount of up to 12.5 percent. These discounts are in addition to the average premium rate reduction of 20.2 percent for oral and maxillofacial surgeons in California.

Coverage Terms

Coverage terms for CALAOMS members currently insured by The Doctors Company/SCPIE Insurance remain unchanged, including

CALAOMS Members Program Discounts and Credits:

Claims-free credit—CALAOMS members who remain claims free may receive an additional credit of up to 12.5 percent.

Risk Management/Patient Safety resources—The Doctors Company/SCPIE Insurance offers innovative tools designed for OMS, as well as premium discounts and free CME credits.

Tribute Plan contributions—members can receive credits of up to 10 percent a year available as a career award at retirement.

New to practice discount—doctors recently out of training or new to claims-made insurance may qualify for lower initial premiums.

coverage limits and terms of "tail vesting." Moreover, upon renewal, policyholders will become eligible for all the unique benefits offered by The Doctors Company/SCPIE Insurance.

Expanded Service and Support

The company expanded its California service operations, including the addition of a prominent CALAOMS member for internal claims review and increased claims management, underwriting, patient safety, and policyholder services staff. This is in addition to the team that has been dedicated to servicing CALAOMS members for more than 22 years.

"As the largest oral surgeon carrier in California, we are well positioned to anticipate and meet the needs of oral and maxillofacial surgeons," said Jason Sexton, VP of Member Direct at The Doctors Company/SCPIE Insurance. "By combining two great companies, our member insureds will receive even more competitive rates and expanded services tailored to meet the unique needs of the dental surgeon."

The dedicated CALAOMS team at The Doctors Company/SCPIE Insurance can be reached at:

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Jason Sexton, Vice President, Member Direct
Phone: (800) 717-5333

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Barbara Freed, Claims Supervisor, Claim Department
Phone: (800) 328-8831

Department of Patient Safety:

Barbara Worsley, Regional Assistant Vice President, Department of Patient Safety
Phone: (800) 421-2368, ext. 4347

Spotlight on Members

by Pamela Congdon, CAE with excerpts from Howard Davis' Speech

Frank McCarthy MD, DDS Honored at CALAOMS 2009 January Membership Meeting, at the Westlake Four Seasons

CALAOMS had the honor of hosting Dr. Frank McCarthy and his wife, Judy at our membership luncheon at the Westlake Four Seasons on Saturday, January 17, 2009.

Dr. Frank McCarthy had been chosen as the recipient to receive the dedication award of the CALAOMS 2009 Annual Meeting. Unfortunately, due to the location of the Annual meeting being held in Las Vegas, Dr. McCarthy would not be able to attend that meeting. CALAOMS felt it was important for Dr. McCarthy to receive the award and recognition in person and in front of all his peers. It was arranged that Dr. McCarthy would accept his award at the CALAOMS Membership Meeting in Westlake. Dr. W. Howard Davis and his wife, Jane attended the meeting in which Dr. Davis presented Dr. McCarthy with his dedication plaque.

Dr. Davis first shared with the audience Dr. McCarthy's accomplishments. Although, Dr. McCarthy accomplished much in many areas, it was his achieve-

ment in standardizing a program for evaluating office anesthesia that allows oral and maxillofacial surgeons to provide excellent anesthesia care throughout the entire nation. The program stated that every member practicing office general anesthesia must allow a visit from the committee. This became a change for the society's bylaws and a breakthrough of direct office examination. These regulations were adopted by California; and then through AAOMS, these standards were brought to the United States.

At the meeting, peers, past students and colleagues offered their congratulations and thanks to a gentleman that enhanced the specialty of oral and maxillofacial surgery. Old friends, Don and Beatrice Devlin brought pictures memorilizing past meetings held throughout Dr. McCarthy's history with the oms society. Many members, who had never met Dr. Frank McCarthy, were amazed and impressed by his intelligence and incredible sense of humor as he graciously accepted his award as the honoree for the dedication of the CALAOMS Annual Meeting.



Howard Davis, DDS reads the CALAOMS 9th Annual Meeting dedicatee plaque to recipient Frank McCarthy, MD, DDS.



Dr. McCarthy flanked on the left by CALAOMS President Ned Nix, DDS, and on the right by Howard Davis, DDS, Past President of SCSOMS.



Dr. McCarthy with his wife Judy, and Bernard Levin, DDS. Dr. Levin purchased Dr. McCarthy's practice upon his retirement.



Dr. McCarthy with long time friend and one of his many mentees, Terrance McCarthy, DDS.



Dr. McCarthy with Harrison Fortney DDS spend some time talking during the luncheon

2009 Board of Directors Installed at January Meeting.

At the January Meeting, the members of the CALAOMS 2009 Board of Directors were inducted. After the ceremonies, newly inducted CALAOMS President Ned Nix, DDS, presented Immediate Past President, Bruce Whitcher, DDS his Past President's pin in addition to a plaque recognizing his dedication and service to CALAOMS and the profession of OMS.

We would also like to mention that Dr. Whitcher was recently appointed to the Dental Board of California. So as to not have the appearance of any improprieties, Dr. Whitcher has resigned from his position on the CALAOMS Board. We would like to congratulate him on his appointment, and would also like to let him know that his presence on the Board will surely be missed. 2007 Past President, Murray Jacobs DDS, will be filling the vacated Immediate Past President position.



CALAOMS President, Ned Nix, DDS presenting plaque to CALAOMS Immediate Past President, Bruce Whitcher, DDS.

2009 ABOMS Oral Examinations - Dallas, Texas



California Members of the American Board of Oral and Maxillofacial Surgery Examination Committee who participated in the Oral Examinations in Dallas are as follows: Drs. Farhood, Machado, Webb, Pogrel, Felsenfeld, Delsol, Herford, Relle, Ratner, Whitcher. This was the largest California representation ever.

UCSF 16th International Symposium in Oral and Maxillofacial Surgery



The faculty of the UCSF 16th International Symposium in Oral and Maxillofacial Surgery held at the island of Kauai (this explains the casual dress). Standing are Drs. Tarnow, Lewis, Bast, Lloyd, Machado, Spagnoli, Mr. Curley, Esq., Dr. Pogrel. Seated are Drs. Lee, Jahangiri, Niamtu, and Eversole. Not Pictured - Dr. Farhood.

Spotlight on CA OMS Training Programs

Loma Linda University Department of Oral and Maxillofacial Surgery

by Jeffrey A. Elo, DDS, MS, and Alan S. Herford, DDS, MD

Located in California's Inland Empire, containing 2 of the largest counties in the United States (San Bernardino and Riverside), the Department of Oral and Maxillofacial Surgery (OMS) at Loma Linda University (LLU) provides an extensive array of maxillofacial services to a wide variety of patients.



Figure 1.
Dr. Bernard Byrd (1926-2001).

In 1964, Dr. Bernard Byrd (Figure 1) was approached by Dr. Irv Rappaport, an oral and maxillofacial surgeon, who was then Chief of Surgery at the University of California, Irvine, with a request that consideration be given to establishing a graduate program in OMS. With the assistance of Elmer Kelln, an LLU OMS residency program was established, primarily situated at the Orange County Regional Medical Center, with the first resident finishing in 1968.



Figure 2.
Dr. Philip J. Boyne, Former Emeritus Professor.

The current Residency Program in Oral and Maxillofacial Surgery was established under the leadership of Dr. Philip J. Boyne (Figure 2) and became accredited in 1978. Today, our department is chaired by Alan S. Herford, DDS, MD (Figure 3), who also serves as the Residency Program Director. Dr. Wayne Tanaka serves as the Pre-doctoral Program Director.



Figure 3.
Dr. Alan S. Herford, Chairman and Program Director

The OMS department is currently staffed by numerous board-certified faculty members: Drs. Alan Herford, Liviu Eftimie, Wayne Tanaka, Dale Stringer, Jeffrey Dean, Wilson Baugh, Ed Marshall, Harvey Zalsman, Jr., D. Allen Pulsipher, Jacob Haiavy, Hooman Zarrinkelk, David Gilbert, and Jeffrey Elo. These full-time and part-time faculty OMSs take an active role in the training of residents at LLU.

The LLU OMS department serves 3 major hospitals (1 University-based and 2 county-based facilities): LLU Medical Center in Loma Linda, Arrowhead Regional Medical Center in Colton (formerly San Bernardino County Medical Center), and Riverside County Regional Medical Center in Moreno Valley (Figure 4, Figure 5, Figure 6).



Figure 4.
LLU Medical Center



Figure 5.
Riverside County



Figure 6.
Arrowhead Hospital

These 3 hospitals are the only major trauma care institutions in the entire Inland Empire, servicing 6 million people. The OMS department provides full-scope elective maxillofacial services, as well as complex trauma services at each of these hospitals. At Arrowhead Regional Medical Center, the most expensive county hospital constructed west of the Mississippi River, the OMS department is the sole provider of facial trauma surgical care and treats hundreds of patients each year. In addition to providing coverage to these hospitals, the OMS department runs a busy outpatient surgery center at the LLU School of Dentistry (Figure 7). The OMS faculty practice is also based intramurally in the LLU School of Dentistry.



Figure 7.
LLU School of Dentistry

The Inland Empire has been the fastest growing area in Southern California over the past 20 years. With the increase in population, the amount of surgical exposure has increased dramatically. For many years, the LLU OMS department was a 1 resident-per-year training program, but as a result of an incredibly enhanced case load, the program began

accepting 2 residents per year in 2002; and in 2009, the department will have 5 incoming first year residents.

In 2003, a 6-year dual-degree residency track affiliated with the LLU School of Medicine was started. An OMS scholarship was established and funded by Dr. and Mrs. Philip Boyne to assist residents with their medical school tuition.

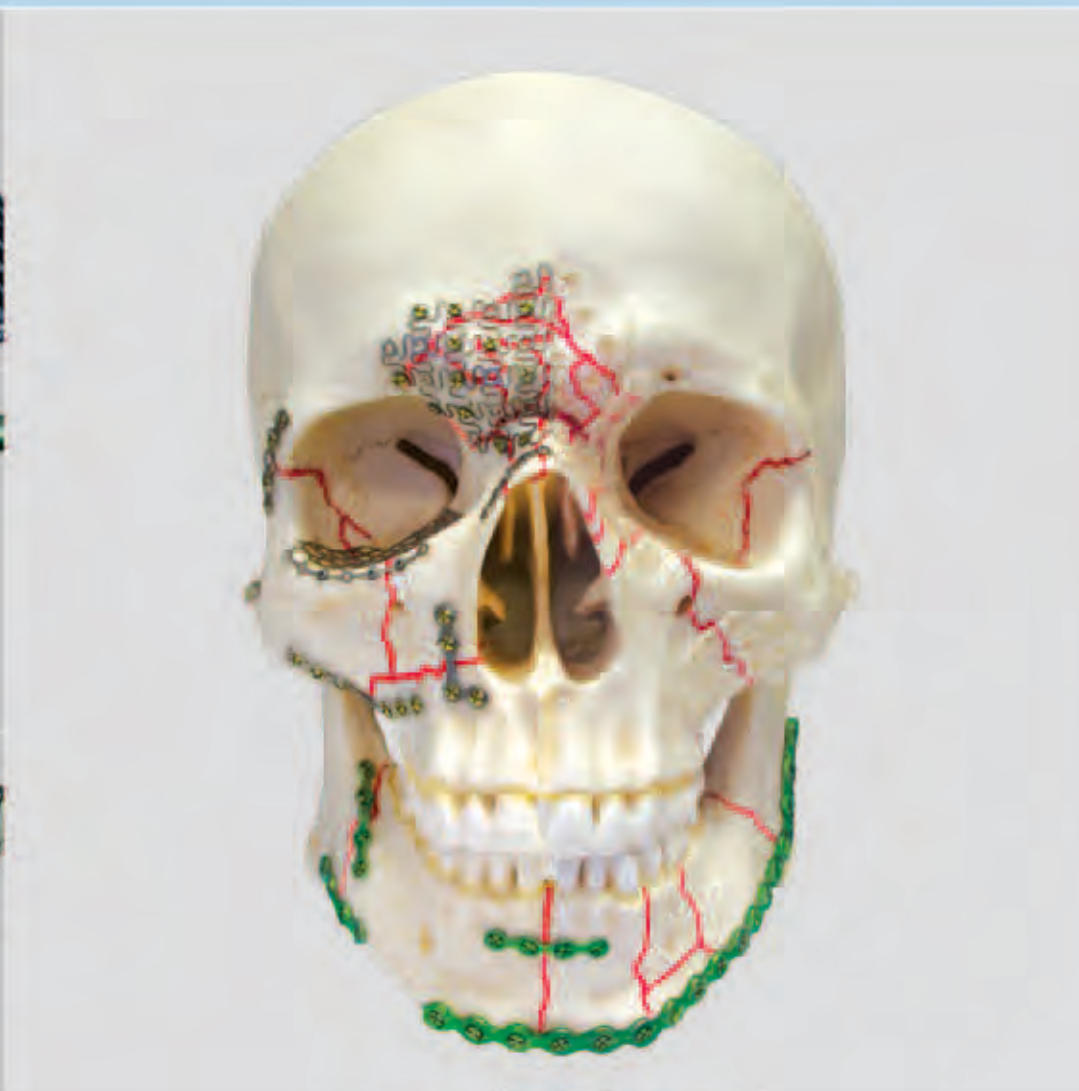
Residents are from diverse ethnic backgrounds, nationally and internationally. The LLU program currently accepts 3 residents each year who are graduates of dental schools throughout the country. The present group of residents includes graduates of the University of Colorado, UCSF, UCLA, University of Washington, University of Southern California, and LLU, among others. Residents are accepted into the LLU School of Medicine and are given advanced standing. The residents in the OMS department at LLU experience the full scope of OMS each week of their training.

The OMS department is an active participant on the LLU Children's Hospital Craniofacial Deformities Team. All residents are also involved in teaching of undergraduate dental students at the LLU School of Dentistry.

In addition to an extensive and varied surgical case load presenting a large number of various clinical problems, the OMS department is actively involved in a number of research projects. Dr. Boyne was a leader in research involving bone grafting and applications of bone morphogenetic proteins in maxillofacial surgery and had published over 230 peer-reviewed articles and textbook chapters. These included landmark articles reporting initial work on OMS hyperbaric oxygen therapy, anterior maxillary cleft bone grafting, maxillary sinus lift grafting, and clinical application of guided tissue regeneration. Dr. Herford has published numerous articles during his tenure at LLU and has designed a plate-guided transport distraction osteogenesis device that is currently available commercially. All LLU OMS residents are involved in research as well, and

Continued on page 20

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In Memoriam

Dirk R. Payne, DDS

A few weeks ago, a good friend and colleague passed away, Dirk R. Payne. I knew Dirk for 10 years before his unexpected passing at only 44 years of age and in prime shape, at least compared to me though I could say that of most people, but especially of Dirk. Dirk was the consummate family man and a loving father. We were not socially active together but we were all each other had, you know--call partners, that second marriage that freed you up to have a life outside of dry sockets, infections and preserve your first marriage. He was the person I called to vent frustrations, discuss cases, and just tell those great stories of everyday occurrences; an oral surgeon's wingman. Dirk was as good as it got for a call partner, always willing to come in, treat your patients as his own, driving to my office to see my patients, and actually caring how someone was doing; that was the man he was.

Dirk's free time was consumed by his love of his family and the time spent with them: coaching sports, counseling for their sorrows, and shaping their lives. Dirk is survived

by his lovely wife, Brenda, and 5 equally wonderful girls. He was a great father and friend to them as this became very evident while listening to his two oldest daughters speak at his funeral. Imagine that, a man devoted to his family at the expense of his personal time and work; that was the man he was.

Talking with his staff after his death was very informing of an individual's character. He was the kind of man which gave the discounts to any senior citizen without their asking (guilty of not doing this myself) and taking care of those in need without charge. While on call one weekend, I had the opportunity to meet a woman he was caring for with no money or insurance with post surgical osteoradionecrosis (not of his doing either). I asked him why he hadn't referred her out to one of the teaching hospitals. He explained it was because she had nowhere else to go, no institution would take on the case yet he had enough compassion to carry the burden, that was just his nature. I



had the unfortunate task to see the patient the day after his death on a check up visit and it was heart breaking to tell her that he had died the night before. I watched her cry for his passing and not because of the loss of a doctor willing to take care of her but because of the loss of the person who cared. Not many patients would do that for their oral surgeon; that was the man he was.

We should all wish we lived like Dirk with integrity and caring. I myself know that I am looking at life differently as I just celebrated the 10th anniversary of turning 43, you know the time in life when you see your kids going off to college, your wife starts turning the heat down for a change and you now want it up. I realize more than ever that life can take sudden turns and preparing for these is as simple as hugging your own family every chance you get. That was the man he was, and for those of us who knew him, the man we will miss.

Kurt W. Thompson DDS

Gerald E. Hanson D.D.S., M.P.H.

7/18/47 – 1/23/09



Gerald E. Hanson of Las Vegas, Nevada and Clarks Fork, Idaho left this world behind to claim his greater reward after a courageous battle against malignant melanoma. Following his childhood in Minnesota, and a short detour to serve Uncle Sam in Washington D.C. in the late '60's, Gerry found his calling in dentistry and ultimately, in oral and maxillofacial surgery. His practice on Jones Boulevard in Las Vegas grew to be one of the most successful in the Western states, not only because of his fine surgical skills, but because of his uncompromising standards of excellence and compassionate care of his patients. Gerry loved his chosen career path and was determined to give back what it had given him. He spent countless hours in selfless service to organized dentistry and oral/maxillofacial surgery --- serv-

ing as President of the Clark County Dental Society 1982-83, President of the Nevada State Society of Oral and Maxillofacial Surgeons 1983-85, President of the Nevada Dental Association 1987, Secretary-Treasurer of the American Association of Oral and Maxillofacial Surgeons 1988-91, and President of the Western Association of Oral and Maxillofacial Surgeons 1995-96. He served his adopted home state on the Nevada State Board of Health from 1990-95, and acted as Chief of Oral and Maxillofacial Surgery at Sunrise Hospital 1984-94 and Sunrise Mountain View Hospital 1995-2001. His final, and most enduring, tenure was on the Board of the Oral and Maxillofacial Surgery Foundation, where as Chairman from 2005 to 2007, he created and spearheaded an innovative annual giving campaign that brought unheralded success in funding research for the specialty.

As impressive as Gerry's professional accomplishments were, they were only a small part of the man. He acquired a love of aviation at an early age and became a talented pilot. His superb restoration of antique and classic airplanes was legend and the list of awards too numerous to mention. He often said that flying was less expensive than hours on a psychiatrist's couch, and his perspective on this earthly life was most easily restored by looking down

from the heavens. Gerry was an accomplished singer with an incredible voice that graced numerous church choirs and, on occasion, a fortunate karaoke bar. His appetite for reading and learning was endless --- he was a student of history, of aviation, and of religion. His studies brought him into the fold of Christianity in his later years, a source of strength and comfort during the trials of his illness.

Because of his great character, Gerry garnered friends from all aspects of his extraordinary life. He was a cherished and loyal son, brother, cousin, friend, and mentor to countless individuals who had the privilege of being touched by this exemplary human being. He will be forever missed.

He is survived by his father Gerald S. Hanson of Lincoln, Nebraska and his sister Cleora Bently of Mankato, Minnesota as well as numerous extended family members. In lieu of flowers, donations can be made to the Oral and Maxillofacial Surgery Foundation (www.omsfoundation.org) or to the Loma Linda University School of Dentistry (www.llu.edu/llu/dentistry)

by Mary Delsol, DDS



Continued from page 15

annually present papers at national and international meetings, as well as to the *Journal of Oral and Maxillofacial Surgery*.

The mission of Loma Linda University is "to make man whole." In addition, it is the mission of the Department of Oral and Maxillofacial Surgery to instill in our graduates a spirit of life-long learning and professional improvement, as well as service above self. As such, the department is involved in international mission service. Recently, this has included trips to Guatemala, Bangladesh, and Vietnam.

The LLU OMS program continues to strive to provide excellent service to those patients who entrust us with their care. We train residents to become not only good clinicians but also good doctors. Our department is grateful for the dedication of our attending surgeons and the commitment that they have given to the residents, our medical centers, and most importantly, our patients. We look forward to continuing to grow and develop as a department, and foresee an exciting and rewarding future for OMS at LLU.



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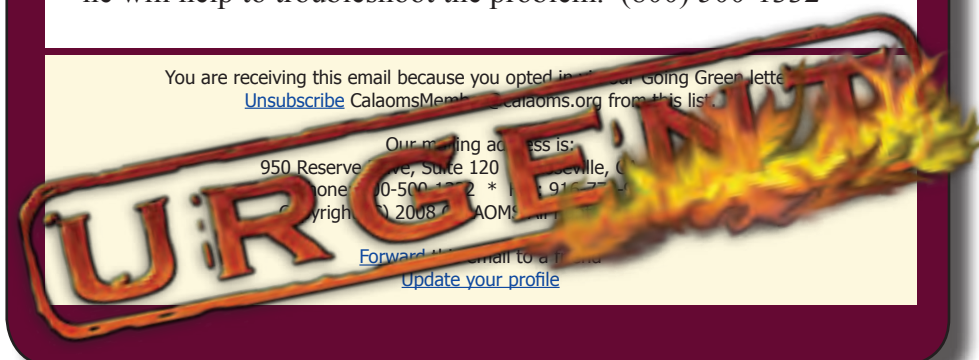
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Tummy-tucks

By Walter F. Lamacki, DDS

As Originally Published in the December 2008 Issue of the CDS Review, the official publication of the Chicago Dental Society, and subsequently reprinted in the ADA News "View Point" February 2009. Reprinted here with permission of Dr. Lamacki, and the CDS.

I thought I had seen it all. . . that is, until a new (?) wrinkle (pun intended) reared its ugly head.

Two ads for dental seminars on injectible botulinum toxin (Botox) therapeutics recently crossed my desk.



The subjects cited in the ads included: how to smooth lines and eliminate wrinkles; lip sculpting; volume enhancement and lifting the corners of the mouth, among a litany of other questionable treatments.

One course offers direction on how to partner with a physician in a medical-dental spa and "legally" bill through a medical corporation. Another promises help in securing liability insurance. And another guarantees making the practice compliant with the Dental Practice Act.

You are promised a 156-page manual, handy detailed technique sheets to use during procedures and a telephone number to call if you get stuck in the middle of a procedure.

You can tape the assembly (oops I meant treatment sheets) on a nearby wall in the operatory to refer to during procedures. I would also suggest that you wear a Bluetooth telephone while blissfully injecting because you may need to be talked down, reminiscent of bad movies in which an airport traffic controller safely talks down a hysterical passenger thrown into the pilot's seat by fate.

The courses don't come cheap. They range from \$2,195 to \$4,580. But again, it's less costly than a medi-

cal education, not to mention specialty training.

All of this would be laughable if it were not for these courses receiving Program Approval for Continuing Education (PACE) from the Academy of General Dentistry (AGD). I am assured by Illinois leaders of AGD that they are addressing the problem.

Barbara Mousel, State of Illinois Dental Examiner and a CDS member, cautions that course instructors may not demonstrate on live patients unless they hold a valid Illinois license. The state of California Dental Board ruled that the use of Botox was illegal by dentists. They have since modified their ruling to allow the use of Botox by oral surgeons in certain instances, especially trauma.

The course guides the participants in how to comply with practice acts, how to bill through medical plans and how to file insurance claims; that implicitly tells me there are serious legal problems with this practice. There is no point mentioning those nits, morality and ethics; it's likely the entrepreneurs are not familiar with either of them.

Besides offering Botox, aromatherapy, massages, chiropractics and voodoo, I wouldn't be surprised if dental-medical spas are soon offering tummy-tucks. I await anxiously the next exciting expansion of the dental practice.

By the way, there is a moral and ethical pathway to doing plastic surgery: go to medical school.

Way off Base

By Joe Niamtu, III DMD

I was quite concerned to read the recent short sighted editorial on Botox in Dentistry by Walter F. Lamacki, DDS (Tummy Tucks, Pg 4, ADA News, 2-16-09).

These comments are obviously somewhat tongue in cheek in an attempt to add humor, but

many of them are extremely bothersome, especially for someone who is an ADA committee chair and hence should understand contemporary Dentistry.

If Dr. Lamacki thinks that the perioral changes of Botox and Injectable fillers ("smoothing lines, eliminating wrinkles, elevating the corners of the mouth, sculpting lips and volume enhancement") are "a litany of questionable treatments" I suggest that he spend a day in my practice to see the role of perioral soft tissue aesthetics, so he can familiarize himself with some of the more contemporary aspects of Dentistry.

I do agree with the spirit of Dr. Lamacki's article in that some of the promotional courses available to dentists are filled with hype and may be insufficient training by unqualified doctors. I also agree and personally disdain attempts to promote these procedures under the guise of pure profit, flying below the radar screen in a spa situation and trying to obtain insurance coverage for obviously elective cosmetic surgery. Yes, the entrepreneurial side of aesthetics (and many other aspects of dentistry and medicine) is often passed off as CME and not to enhance the patient but the pocket book. No argument here.

The truly misplaced comment in this editorial is the closing line "By the way, there is a moral and ethical pathway to doing plastic surgery: go to medical school." Are you kidding me? Did an ADA committee chair really make that statement? Does this dentist not realize that cosmetic facial surgery is well integrated in Oral and Maxillofacial Surgery which is in fact a part of Dentistry? Does he not realize that the ADA definition of Dentistry includes the aesthetic treatment of the face and neck by qualified dentists? Does he not realize that many State Dental boards have waged huge turf wars with competing specialties in order for Oral and Maxillofacial Surgeons to have the right to perform cosmetic facial surgery procedures including Botox, injectable facial fillers, facelifts, eyelid surgery, skin resurfacing, facial implants, brow lifting procedures, etc.? Does he realize that cosmetic facial surgery is part of the core curriculum of Oral and Maxillofacial Surgery training programs, is part

of our board exams and is covered by our malpractice insurance?

The closing statement in this editorial is so ignorant of what the wide scope of Dentistry represents that it somewhat scares me that there may be other individuals in ADA leadership positions with similar bias. Perhaps Dr. Lamacki, was only referring to General Dentists and not Oral and Maxillofacial Surgeons and for those reasons his statements were not inclusive of our entire profession. In the United Kingdom, much of Botox and Filler injection is performed by General Dentists and I believe this will gain popularity in this country as well. It is likely to become integrated in "cosmetic dentistry".

I am a board certified Oral and Maxillofacial Surgeon and I have limited my practice to cosmetic facial surgery. That is all I do and yes, I am a dentist. I am the largest user (in any specialty including Plastic Surgery) of cosmetic Botox and fillers in the central part of my state. I am also the Oral and Maxillofacial Surgery Member on the Allergan (makers of Botox) Medical Aesthetics Training Bureau and a certified Botox Training Center for Allergan and several other filler companies. I have taught hundreds of physicians and dentists (nationally and internationally) on the safe and effective use of Botox and fillers and cosmetic facial surgery in general over the last 12 years. Although most of the dentists I have trained are Oral and Maxillofacial Surgeons, I have also lectured and instructed to numerous General Dentists and other Dental specialists. I believe that education should be seamless and available for all and it is up to the State Dental Boards to decide who is qualified to deliver these services.

I hope that this information will assist Dr. Lamacki in understanding the contemporary scope of cosmetic facial surgery in dentistry in the United States.

Joe Niamtu, III DMD
Cosmetic Facial Surgery
Richmond, Virginia
niamtu@niamtu.com

Technology Corner

A Case for Strong Passwords

Open Sesame is probably the most famous password (actually passphrase) ever used and evokes thoughts of warm Arabian Nights and of Ali Baba and the Forty Thieves. This passphrase was used by the thieves to gain access to their secret cave that held their looted treasure, the mouth of which was sealed by magic. Upon uttering the passphrase, "Open Sesame," any one of the select group of thieves could gain entrance to the cave.

Historically, passwords and passphrases have been used by secret societies and military units to allow only selected few with the correct password or passphrase to gain entrance into the society's secret chambers or to allow passage by the guards of a militarily occupied area.

Today, passwords are a way of life for many of us, and are used to secure personal information in our computers, computer networks, applications, files, and in many types of websites that we visit on

the internet. As opposed to the thieves in the story who needed to protect their looted treasure from others, we need to protect our private information from the thieves. Even if you have not stored personal/sensitive information that can be used against you, your email or other electronic messaging accounts can be used in an attempt to swindle money from your friends and family.

You may have heard about "Facebook" (a free-access social networking website) and the troubles that they have had recently. Thieves are hacking into and taking control of user accounts on Facebook. Once they have control, pretending to be the owner of the account, they then send out emails to all of the friends and family members linked to the account. The emails usually state that while traveling on business or pleasure their wallets/purses were stolen and that they have no credit cards or money which to use to return home. They then ask that money be sent to help them in their time of need and that they will repay the loan once they return home.

As an Oral Surgeon, you may use email to send or receive patient information to or from a referring dentist, or to a colleague for a second opinion. If you do, you may be at risk of violating

HIPPA Regulations, unless you take precautions so that this information is not compromised. To minimize your exposure, you need to password protect your email accounts so that only you and your staff have access to them. You would also want to encrypt emails that contain patient information so that they cannot be read if intercepted during transmission across the internet. Encrypted emails require a unique key (a type of password) to decrypt them so that they may be viewed.



Most people use the names of their children, pet names, names of street they grew up on, names of schools attended, or some other easily remembered name as their password. The problem with this is that as the amount of information on the internet grows, so is the likelihood that information about you will become available. Facebook is a great example of

this. Members post information about themselves so that friends and family are kept up to date as to what they are up to or doing. They also post other information about themselves in order to connect with long lost friends of their childhood. Often, this information is the name of the schools attended, the names of their children, the names of their pets,... So you can see that it is very easy for a thief looking at the public profile of a member on Facebook to hack into an account using the information provided by the member.

Even if there is not information about you on the internet that can be used to guess your passwords, hackers can still gain entry to your password protected areas by using what is called a "Brute Force Attack." By using a specifically designed program (which can be found and downloaded from the internet) that contains a dictionary, a hacker can run this against your

account until the correct word in the dictionary allows access to your account. So, you still need to take extra measures to protect yourself.

The types of passwords that I have mentioned which are name or words found in dictionaries are called "Weak Passwords." They are weak in the sense that they are easy to break or hack. To protect yourself from having a computer, network, email or website account hacked, you need to use "Strong Passwords."

Strong passwords are a minimum of 8 characters long, and contain at least two of the following:

- letters of the alphabet of which one or more are capital letters but not all;
- one or more Arabic numbers;
- one or more special characters such as ! @ # \$ % ^ & * ? ...

Even still, care needs to be taken on how it is constructed. As an example, you might think that "Terrible1" would be a strong password as it contains at least 8 characters, of which there are lowercase letters, a capital letter, and a number. In reality, it is not. The use of strong passwords that start with capitalizing the first letter of a word and ending with a number is very common. Brute force applications are therefore programmed in a way that once the program runs through the dictionary without success, it will start over, but it will capitalize the first letter of the words. If that does

not work, it will start over again, this time adding numbers to the end of the words, and so on.

A better example of a strong password would be "teRRible", where I have replaced the letter "l" with the Arabic numeral "1." The strongest passwords do not even resemble a word and look something like this "S3ij9#bD", a random arrangement of all items that can be used to create a strong password. The only problem with this password is that it is often difficult for even the creator to remember.

You might be thinking to yourself right now that you have a hard enough time remembering all of the weak passwords that you use for all of your accounts. There is no way you are going to change all of your passwords to strong ones, because the likelihood of being hacked is minimal. You might want to rethink that, as one of our members just recently had one of their email accounts hacked and taken control of. The perpetrator then sent messages out to everyone in their address book requesting financial aid. So if it can happen to one of our members, it can happen to you.

Whether or not I have made a strong case for using strong passwords, do not be surprised if thieves are casing your computer and accounts as you read this.

by Steve Krantzman

Help OMSF Celebrate 50 Years

In 2009, the Oral and Maxillofacial Surgery Foundation celebrates its 50th anniversary. Since 1959, OMSF has been supporting research and education, the cornerstones of the future of our specialty. OMSF has given more than \$9.1 million back to the specialty, through more than 200 research awards, fellowships, and specialty-related projects.

Part of this support includes two of the most groundbreaking studies in our specialty's history. The Outcomes Assessment Project was created to validate the quality and appropriate care provided by oral and maxillofacial surgeons. The Third Molar Study has investigated the health effects of patients who have not had their third molars removed. OMSF has supported these projects with \$500,000 and \$1.2 million, respectively.

Each and every oral and maxillofacial surgeon is a part of the history of this specialty. And each one of you can be a part of its future, too, with an anniversary gift to OMSF. In 2005, OMSF launched a new annual program, Research and Education Advance Patient care (REAP), to involve every OMS in the future of the specialty and the improvement of patient care. Gifts to REAP provide annual support for research and education. Thanks to the generous response from donors, REAP has raised more than \$1.1 million for research and education since its establishment.

In 2008, AAOMS made a generous gift of \$200,000 to the REAP annual program to celebrate OMSF's 50th Anniversary. In addition to the gift, AAOMS made a unique challenge: if OMSF raises an additional \$600,000 for REAP by October 1, 2009, AAOMS will contribute an additional \$200,000. That's \$1 million to address the research and education needs of our specialty!

Celebrate OMSF's 50th anniversary with a REAP gift today! Your gift will honor the past 50 years and help the Foundation take an important first step into the future. To make a gift, visit the OMSF website at www.omsfoundation.org.

OMSF supports research and education with more than \$600,000 in 2008

The Oral and Maxillofacial Surgery Foundation approved more than \$600,000 in funding for research awards, fellowships and other specialty-related projects in 2008. Since 1985, more than \$9.1 million has been provided to the specialty from the OMSF and the Alliance in support of research and education. Thanks to our donors who made this possible.

2008 Research & Fellowship Awards

Stephen B. Milam Research Support Grant

- *Dental pulp stem cell-mediated functional skeletal regeneration*

University of California, San Francisco

Janice Lee, DDS, MD, MS

\$75,000

Supported by KLS-Martin

Research Support Grants

- *Non-invasive therapies for altered facial sensation following orthognathic surgery*

University of North Carolina

Ceib Phillips, PhD, MPH
CO-PI: George Blakey, BA, DDS
\$73,360

Supported by Nobel Biocare

- *Alveolar and long bone response to bisphosphonates in vitro and in vivo*

University of California, Los Angeles

Tara Aghaloo, DDS, MD, PhD

\$74,000

- *TMJ pain diagnosis through EMG*

Physical Medicine Institute, Fort Worth, Texas

Schrawan Kumar, PhD, DSc, FRSC
CO-PI: John Zuniga, DMD, MS, PhD
\$69,500

- *Novel biomaterial for osteochondral regeneration in the TMJ*

University of Kansas Center for Research, Inc

Michael Detamore, PhD
CO-PI: Kamal Busaidy, BDS, FDSRCS
\$75,000

Clinical Surgery Fellowships - \$60,000 each

- University of Pittsburg School of Dental Medicine

Program Director: Bernard J. Costello, DMD, MD

- Arnold Palmer Hospital for Children

Program Director: Ramon L. Ruiz, DMD, MD

- Nova Southeastern University/Broward General Medical Center Department of OMS

Program Director: Joseph P. McCain, DMD

Synthes CMF Award

- University of Alabama at Birmingham

Peter D. Waite, MPH, DDS, MD

\$15,000



Upcoming CE Events For 2009-10

OMSA Fall 09 Home Study Begins

June 15, 2009 Southern CA

Residents' Night

September 23, 2009 Southern CA

OMSA Winter 10 Home Study Begins

October 15, 2009 Northern CA

OMSA Fall 09 Weekend Seminar

October 24-25, 2009 Southern CA

Medical Emergencies

November 4, 2009 Northern CA

ACLS

November 7, 2009 Solano

Medical Emergencies

November 18, 2009 Southern CA

January 2010 Meeting

January 15-17, 2010 Southern CA

OMSA Winter 10 Weekend Seminar

February 20-21, 2010 Northern CA

10th Annual Meeting

May 21-23, 2010 San Francisco

Crest Widening by Distraction: Case Study

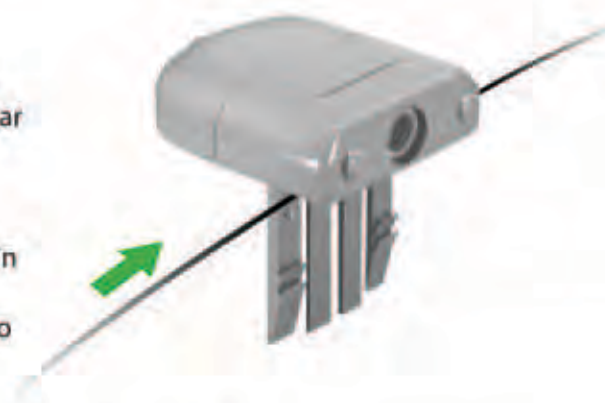
By Dr. Zvi Laster, Department Head of Oral Maxillofacial Surgery, Poriya Hospital, Tiberias, Israel.



Introduction

The MIS "Laster" Crest Widener (MIS Implants Technologies, Fair Lawn, N.J.) utilizes distraction osteogenesis (DO) for the correction of horizontal alveolar width deficiency in order to widen the narrow alveolar crest that has sufficient height for implantation.

The Crest Widener consists of four arms making up two couples (two arms in each couple). Each couple moves apart when activating the key counter-clockwise. There are very sharp, small spikes on the outer side of the arms to stabilize the device while engaging the cortical bone.



This technique has the following advantages over bone grafting:

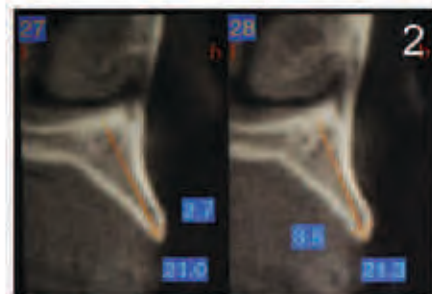
- ▶ Simultaneous expansion of the soft tissue leading to sufficient attached gingival and soft tissue cover.
- ▶ The transported bone is not stripped from the periostium, therefore there is no post-operative bone loss resorption.
- ▶ The process is a short, minimally traumatic procedure with no swelling.
- ▶ Less technique sensitive and easily performed under local anesthesia in the dental office.
- ▶ Implant placement is possible after an extremely short post-operative period (five to eight weeks).
- ▶ Very short time for final rehabilitation.
- ▶ Predictability of the final crestal width.

Case Study:

An 18-year-old female was referred for implants at the area of tooth numbers 9,10, and 11. A C.T. scan revealed a knife-edged crest. (Fig. 1), (Fig. 2)



Pre-Op



C.T. Scan



Under local anesthesia, three trans-periosteal incisions were cut: two vertical and one crestal defining the area to be distracted. (Fig - 3)



A piezo-machine was used for vertical bone cuts through the incisions half the distance of the crestal width without stripping the periostium, thus avoiding compromised blood supply to the transported buccal cortical plate. (Fig - 4)



The piezo machine was used to cut along the crest to a depth of 8-10mm. (Fig -5)



The buccal plate was then split gently (incomplete fracture) by using a thin osteotome. (Fig - 6)



The Crest Widener was tapped into the crestal cut and soft tissue sutured on both sides. (Fig - 7)



The low profile of the widener enables one to prepare an Omnivac over the teeth and the device, so esthetics is not compromised. Care should be taken to ensure that the slightly flexible omnivac does not touch the device when biting on the front teeth. (Fig - 8)



The patient was sent home for one week (latency period) and was given 500mg of Ampicillin three times a day. A week later, the patient was instructed in how to activate the device in front of a mirror. The rate was 1/4 of a turn three times a day (0.3mm). (Fig - 9)



The patient was checked every five days. After 15 days of activation, the patient was asked to stop the activation for two weeks (consolidation period) and return to the clinic for removal of the device under local anesthesia. (Note the arm's marks.) (Fig - 10)



The Omnivac is used for marking the ideal location of the implants. In the same session, after the removal of the device, the Omnivac was replaced and was used as a guide to mark the ideal location for the implants. (Fig - 11)



Three "Seven" MIS implants were implanted transmucosally on the day of device removal. (Fig - 12)



The implants were inserted deep with the healing caps sunk in the callus. (Fig - 13)



The healing period was uneventful and the implants were osseointegrated. Four months after the implantation, the final bridge was constructed and cemented by the patient's dentist. (Fig - 14)

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