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The Compass

Staying the Course Through Service and Education

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Volume XII, Issue 1, Spring 2010

"What 'Health Care Reform' Means to OMS"

Following more than a year of negotiations, hearings, markups, town hall meetings, and speeches, large-scale health reform legislation is now the law of the land. To keep our members apprised of what this will mean to us as practicing oral and maxillofacial surgeons, CALAOMS, with the aid of AAOMS Governmental Affairs, has put together key points for your review. It is our goal to keep our members updated, as some changes start immediately, while others are delayed. We have outlined some key health reform provisions and implementation deadlines that impact us as oral and maxillofacial surgeons.

Is the healthcare bill the proverbial dagger through the heart of the American healthcare system? Only time will tell!

Individual Mandate

• All U.S. citizens and legal residents will be required to have 'qualifying' health coverage (hardship exemptions made) by 2014. Those not in compliance will face a maximum tax penalty of $325 in 2015 per adult per year, and $695 starting in 2016. Beginning after 2016, the penalty will be increased annually by the cost-of-living adjustment. *[Effective January 1, 2014]*

Employer Mandate/ Small Business Tax Credit

• Requires employers with more than 50 employees to offer health insurance coverage. Employers that do not offer such coverage and have at least one full-time employee who receives a premium assistance tax credit will be fined $2,000 per total full-time employee. The first 30 employees will not be counted for the penalty calculation. Employers with more than 50 employees that offer coverage, but have at least one full-time employee receiving a premium assistance tax credit, will pay

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Compass Direction

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Your CALAOMS Central Office Staff

Your staff is here to help you with any questions about membership, continuing education courses, certification, and events. Please do not hesitate to contact us with questions or concerns at:

950 Reserve Drive, Suite 120
Roseville, CA 95678
Office: (916) 783-1332
Office: (800) 500-1332
Fax: (916) 772-9220
Web Site: www.calaoms.org

Executive Director
Pamela Congdon, CAE
Phone Extension: 12
email: pamela@calaoms.org

Associate Director
Steve Krantzman
Phone Extension: 11
email: steve@calaoms.org

Continuing Education Services
Teri Mandella
Phone Extension: 13
email: teri@calaoms.org

Membership Services
Barbara Holt
Phone Extension: 10
email: barbara@calaoms.org

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

Editor's Corner

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

The Strength of a Leader

2010. The winter Olympics. Health care overhaul. Economic depression. Domestic terrorism. I feel like a mosquito at a nudist colony…I'm not sure where to begin! The winter Olympics are over, the NCAA basketball tournament has crowned a champion, and it's back to watching the professionals compete. It's always a bit of a let-down watching professionals compete, though, because they lost their competitive drive when they signed for millions—they almost look bored now. Not long before these guys struck it rich they were like little kids—winning meant everything, even getting a shiny trophy!

But I really will miss watching the Olympics. I mean, who doesn't love the sport of curling? What's not to love about this "perfectly ridiculous, agonizingly slow" (*Charles Krauthammer quote*) Olympic sport? It's a sport no one knows the rules of, it's a hybrid between horseshoes and housecleaning, and everyone wears funny shoes. It involves sliding large rocks over ice and then SCREAMING at them…but there we were, hypnotized by it!

But what I really enjoy about the Olympics is the purity of the athletes and the sport. With few exceptions, the athletes are raw and purely talented, and they actually *listen* to the advice of their coaches. OMS residents are our specialty's equivalent of Olympic athletes. They are our raw and talented athletes, and they are willing to listen to their coaches. The problem is, we have a shortage of coaches.

As oral and maxillofacial surgeons, we have deeply ingrained in our DNA the drive to excel. And we succeed. The reality is that if we look back on our lives, both professional and personal, we would see some familiar traits common to most, if not all, OMSs: hard working, responsible, diligent, committed, successful, and passionate, to name a few.

Right now, our OMS training programs need people like you: well-trained, passionate, knowledgeable oral and maxillofacial surgeons who remember what it was like to be knee-deep in the mess of residency, trying to sift through mounds of information just to make some sense of it all, while feeling overwhelmed. The work of many is being left up to only a few. Teaching residents is hard, but greatly rewarding. I know many great people with good intentions to help, but we are not getting the job done. We are leaving it up to "them" to teach. We need to *join* them. We need to *be* "them."

CALAOMS members should not allow our residents to hurl down such slippery ice without our expert guidance.

Despite popular belief to the contrary, there's absolutely no power in intention. An eagle may *intend* to fly away, he may decide to do so, he may talk with the other eagles about how wonderful it is to fly, but until the eagle flaps his wings and takes to the air, he's still on the ground. There's no difference between that eagle and all the others. Likewise, there is no difference in the person who intends to do things differently and the one who never thinks about it in the first place. Have you ever considered how often we judge ourselves by our intentions while we judge others by their actions? Yet intention without action is an insult to those who expect the best from you.

CALAOMS members are among the elite professionals in the country. We can work together toward solutions that will ensure the future strength of oral and maxillofacial surgery in our state. Each of us can have a role in building a better future for the specialty and the public. We can begin by supporting existing residency programs and volunteering to teach in our local residencies and dental schools—most even pay a small stipend for your service! We can share with prospective health professionals and dental students our well-kept secret, that oral and maxillofacial surgery is the most rewarding dental/surgical specialty. We also must encourage our academic health centers to include oral and maxillofacial surgery in their surgical education programs.

I would imagine that every single OMS whose eyes glaze these pages can remember exactly what it felt like to be on general surgery, wearing the trauma pager and running around the hospital day and night, treating nausea, butt pus, back pus, leg pus, shortness of breath, belly pain, neck pain, back pain, and chest pain. Eventually, you returned to OMS service and life was good again! Not because the service is easier, in fact, quite the opposite—but you actually *wanted* to learn. You'd seen your last butt abscess and longed for the days of draining some pus out of a neck! You'd seen so many pilonidal cysts that you actually longed for the smell of eikenella. Okay, maybe I got carried away, but the point is this…you put in your time, you paid heavy dividends, and you suffered pain. Don't waste your pain. Sweet are the uses of adversity. All of the valuable experience that you gained does mean something; but it is only meaningful when it is shared and passed down.

Residents need people like you to share your stories. You may find it hard to believe, but residents actually do listen to the "old timers" as they share helpful tips. Your time on this earth, and in our specialty, is a gift to be used wisely. Don't squander your words or your thoughts. Consider that even the simplest actions you take for your lives matter beyond measure...and they matter forever in the lives of those you reach.

While it is true that most people never see or understand the difference they make, or sometimes only imagine their actions having a tiny effect, every single action a person takes has far-reaching consequences. Tomorrow, think about every act you perform while in your office, and I am willing to bet that each of you can recall who taught you the exact technique you are performing. Be that influence!

Spotlight on our Sponsors

January 2010 Meeting

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Hals MedDent Supply - *Luncheon Sponsorship*

CALA OMS 10th Annual Meeting

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From the President's Desk

A. Thomas Indresano, DMD

Let's Not Lose Our Moral Compass

These are interesting times, politically, economically, and technologically. In our professional lives, we are encountering changes in traditional practice models. Professional management groups are buying oral and maxillofacial surgery (OMS) offices. Oral and maxillofacial surgeons are practicing in dental group clinics.

Is the single office OMS practice on the way out? Will these changes remain or will we evolve into other models?

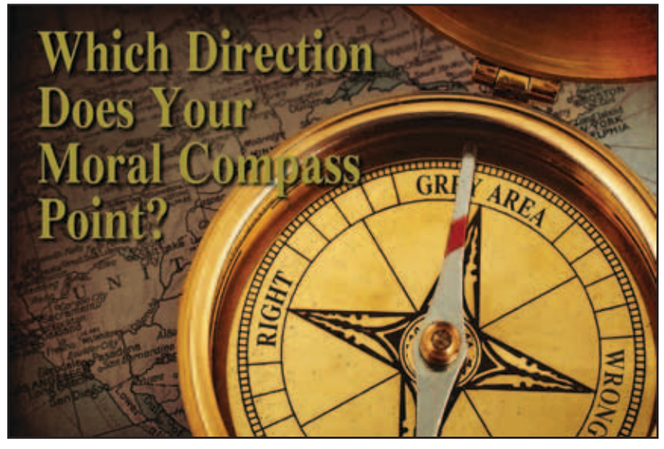
From a business perspective, we can argue the merits of consolidation, reduction of overhead, cost effectiveness, and other management concepts. Only experience and outcomes will guide us in that arena. It is imperative that we maintain our focus. We provide expert consultation and service to our patients. Our care must be safe and appropriate, and hopefully at the highest levels of quality. Our reputation is based on thorough, quality care.

I am dismayed to see OMSs practicing in offices that are not dedicated facilities, without the space and equipment to handle all emergency situations, because the offices are designed for generalists. I am dismayed to see OMSs without hospital appointments to treat sick patients that need advanced care in the hospital setting.

If OMSs have no other options, they get put into the office model, and limited means result in limitations of care; or worse, tragedy. In addition, lack of presence in the hospital will result in a change in the perception of who we are as a specialty.

I understand that recent graduates have had limited opportunities. Many of my own residents have taken jobs in these "factory practices." I am not so naïve to expect people to turn these positions down when there is no other money coming in, but I think the situation gives us, the members of CALAOMS, a new obligation.

We must make ourselves known to these youngsters, helping them to better understand the moral obligation they have to take complete care of their patients. They can't leave it to the clinic in which they work. They must follow their patients, making sure the treatment



they've rendered progresses without any post-operative complications, or manage the complications that do arise.

They must have a hospital affiliation to care for those patients who require additional management; or at least have a working relationship with a colleague who can provide that for them. I know, in most cases, that I am "preaching to the choir," but I think the present situation gives us all a new duty. We need to step up and help our colleagues understand their obligation, not in a punitive way, but as friends and mentors. Hopefully, with better economic times, most of them will eventually find traditional practice settings to be in.

2010 ABOMS Oral Examination - 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 follow: Drs. Vincent Farhood, Lester Machado, Robert Relle, Alan Felsenfeld, William Clark , Bruce Whitcher, Jeffrey Dean, Sanford Ratner, Alan Herford. Not pictured is Mary Delsol, Secretary / Treasurer - ABOMS. This year tied with last year as the largest California representation ever at the Oral Examinations.

In the next issue of the Compass, we will recognize CALAOMS Members who completed their certification this year to become Diplomates of the American Board of Oral and Maxillofacial Surgery.

Legislation

by Dean Chalios
Vice President Public Policy, CDA

New *Dental Sedation Assistant* Permit Category Now Law in California

In 2009, the Legislature passed, and the Governor signed into law, Assembly Bill 2637 (Eng), a comprehensive bill dealing with a wide range of issues related to dental assisting in California. A critical part of that bill for oral and maxillofacial surgery offices was the creation of a Dental Sedation Assistant permit (DSAP) category. In spite of late opposition from the California Nurses Association to the dental sedation permit provisions of the bill, AB 2637 was passed easily by both houses in August, and was signed by the governor. Its provisions, including the new permit category, took effect January 1, 2010.

AB 2637 is the capstone of more than six years of public and intense legislative and regulatory work initiated in response to a sunset review committee recommendation to evaluate the dental assisting structure. While the sunset process was the catalyst for a new structure, CALAOMS partnered with the CDA and used the process as an opportunity to respond to OMS concerns about the difficulty in finding skilled and appropriately trained chairside assistants to meet the unique needs of an OMS practice.

The new DSAP allows a range of duties specific to assisting in the OMS' administration of sedation to a patient, and in the monitoring of patients under sedation. The provisions of this new category expand opportunities within oral surgery assisting without changing the OMS' fundamental oversight responsibilities.

Concerns have been raised about the safety and training of this new category from dentist anesthesiologists, the medical anesthesia community, and the nursing community. The Dental Board will be undertaking a regulatory process this year to place the educational requirements of the new category in regulations. We expect these communities to raise their concerns in the upcoming regulatory hearings and want members to understand the arguments supporting the safety of the new DSAP.

The new law specifically requires a dentist who holds the necessary general anesthesia or conscious sedation permit to be at the patient's chairside, to make all anesthesia decisions, and to instruct and verify the permitted dental assistant's actions. The permitted dental assistant makes no decisions about the administration of medication. The only dosage a permitted dental assistant may add is mid-procedure, upon direct instruction and verification by the dentist.

Nothing in the new law diminishes the dentist's responsibility in the administration of anesthesia to protect a patient's safety, or in any way transfers that responsibility to a permitted dental sedation assistant.

The education requirements for the DSA permit ensure that the permitted dental sedation assistant is familiar with the environment in which he or she is performing the DSA permitted duties per the instruction of the dentist; bringing a more educated assistant into the oral and maxillofacial surgery environment.

While the education requirements were included in AB 2637 to allow for implementation of the new duties by January 1, 2010, these provisions will sunset on January 1, 2011, necessitating the adoption of regulations by the Dental Board of California. This impending regulatory process will continue to be transparent and open to public input, as was made clear by the author of the AB 2637, Assemblymember Mike Eng, who submitted the following in a letter to the Assembly Journal in August 2008:

"Detailed education and training requirements are contained in this legislation to ensure that dental assisting education institutions can modify their programs prior to the effective date of the new duties and permit categories. While the legislation establishes minimum requirements, every student must be trained to competency and must pass a state-administered examination. Additional instruction, experience, repetitions or testing may be necessary for a student to achieve competency to the satisfaction of his or her educational program. All of the education and training provisions will sunset on January 1, 2011, requiring the Dental Board to revisit and evaluate the curricula through regulation. A regulatory process provides the opportunity for re-analysis by those in the dental community and other interested parties to ensure that the requirements are sufficient, accommodate competency in all duties, and make the fullest use of training hours. Likewise, if additional training is deemed necessary, the Assembly Business and Professions Committee reserves the right to revisit the issue."

The DSA permit represents the collective input and agreement of those who have engaged in the formal public processes through our elected Legislature – CALAOMS, CDA, and a number of other dental specialties and interested parties. While strengthening the dental assisting career ladder and providing more targeted help for dentists in their practices, the DSA permit duties and education ultimately recognize and maintain the strong record of patient safety in the dental office.

Dental Sedation Assistant Permit

The new dental sedation assistant permit includes the following duties under the direct supervision of a licensed dentist or other licensed health care professional authorized to administer conscious sedation or general anesthesia in the dental office:

- Monitor patients undergoing conscious sedation or general anesthesia utilizing data from noninvasive instrumentation, such as pulse oximeters, electrocardiograms, capnography, blood pressure, pulse, and respiration rate monitoring devices. Evaluation of the condition of a sedated patient shall remain the responsibility of the dentist or other licensed health care professional authorized to administer conscious sedation or general anesthesia, who shall be at the patient's chairside while conscious sedation or general anesthesia is being administered.
- Drug identification and draw, limited to identification of appropriate medications, ampule and vial preparation, and withdrawing drugs of correct amount as verified by the supervising licensed dentist.
- Add drugs, medications, and fluids to intravenous lines using a syringe, provided that a supervising licensed dentist is present at the patient's chairside, limited to determining patency of intravenous line, selection of injection port, syringe insertion into injection port, occlusion of intravenous line and blood aspiration, line release and injection of drugs for appropriate time interval. The exception to this duty is that the initial dose of a drug or medication shall be administered by the supervising licensed dentist.
- Removal of intravenous lines.

The duties of a dental sedation assistant may only be performed in a dental office or dental clinic.

Permit requirements

In order to obtain the permit, an unlicensed dental assistant must have 12 months of work experience; complete California Dental Practice Act, infection control, and basic life support courses; complete a 110-hour board-approved course specific; and pass a state-administered written examination.

Permit holders will be required to renew their permits every two years and complete continuing education similar to that of the RDA. If the permit holder is an RDA or RDAEF, completion of the continuing education units for the RDA or RDAEF license will satisfy the continuing education requirement for the permit.

Risk Management Corner

Cyberliability: Privacy and Security Challenges

by Barbara Worsley
Regional Assistant VP. Department of Patient Safety
The Doctors Company/SCPIE Insurance

Changing operational processes to accommodate new technology is not an easy task for most doctors. But greater attention must be paid to the subject of legal liabilities associated with new modes of practice, new technologies for sharing information, and new ways of seeking treatment.

Privacy and security challenges in this age of digital record-keeper are dramatically increasing. Failure to comply with strengthened HIPAA regulations plus the new Red Flag rules can mean stiff monetary penalties, lawsuits, audits, loss of reputation, and other costly consequences. Adhering to these new regulations will protect you and your patients.

ARRA

Sweeping changes to the obligations of providers under HIPAA security and privacy rules were included in the American Recovery and Reinvestment Act of 2009 which became effective February 17, 2010. The term "breach" is now defined within ARRA as "the unauthorized acquisition, access, use, or disclosure of patient health information which compromises the security or privacy of said information." Breaches include misdirected paper faxes, mailings to incorrect providers, the loss or theft of data on unencrypted laptops or flash drives, or even a misdirected electronic fax.

Under the new regulations, notice is required to patients whose records were inappropriately accessed. Within 60 days of discovery of a breach, the practice must provide notice via first class mail to the affected person's last known address. Among other things, the notice must include:

- A description of what happened and the date of the breach,
- A description of the information involved in the breach,
- The steps the person should take to protect himself or herself, and
- A description of the practice's investigation and mitigation efforts.

In any case in which 500 or more persons are affected by a breach, the covered entity must provide notice to local media outlets.

Civil penalties for violation of the privacy or security rules are now increased to a range of $100 to $50,000 per violation with maximum penalties for additional violations in any one year ranging from $25,000 to $1.5 million.

Red Flags Rule

In November 2007, the Federal Trade Commission (FTC) issued a set of regulations, known as the "Red Flags Rule" requiring that certain entities develop and implement written identity theft prevention and detection programs to protect consumers from identity theft. Implementation of these laws finally goes into effect June 1, 2010 and any oral surgeon who accepts insurance or allows payment plans is subject to the Red Flags Rule.

Identity theft occurs when one uses another's personal identifying information, i.e. name, Social Security number, credit card number, insurance enrollment or coverage data, to commit fraud or other crimes. In the case of doctor practices, of particular concern is medical identity theft. This occurs when someone uses a person's name and sometimes other parts of their identity, such as insurance information, without that person's knowledge or consent, to obtain or make false claims for medical services or goods.

A Red Flag is a pattern, practice, or specific account activity that indicates the possibility of identity theft. The FTC identifies the following as red flags:

- Alerts, notification, or warnings from a consumer reporting agency.

- Suspicious documents and/or personal identifying information, such as an inconsistent address or nonexistent Social Security number.
- Unusual use of, or suspicious activity relating to, a patient account.
- Notices of possible identity theft from patients or law enforcement authorities.

Any medical or dental practice with 20 or more employees must have a written identity theft program which describes the policies and procedures in place to identify, detect, and respond to these "red flags." Your program should have the following elements:

- Identification of what red flags could occur in your office including occurrences which could be considered a red flag.
- Steps your practice will take to detect red flags.
- Establishment of procedure to respond to red flags
- A review and update of your program at least on an annual basis.
- Incorporation of specific administrative elements into the program.

Stolen Laptops

One of the primary sources of data theft is due to the loss of laptops and other portable electronic devices. Today's laptops are ripe targets for thieves. Anywhere from 600,000 to 1.5 million laptops are stolen or lost each year in the United States, according to law-enforcement and private estimates. And the FBI reports that 97 percent of stolen laptops are never recovered.

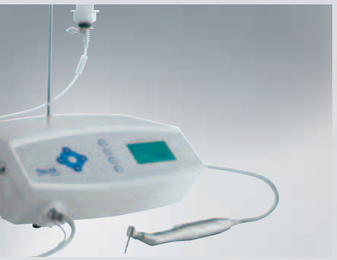
How can you protect yourself and patient information from the theft of your laptop? Keep the following tips in mind:

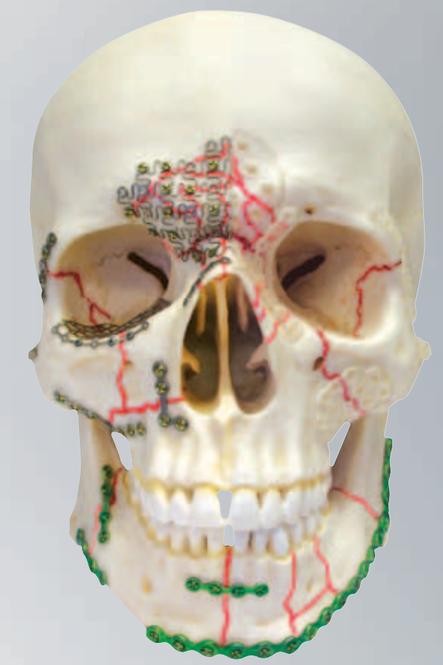
- Treat your laptop like cash. If you had a wad of $100 bills sitting out in a public place, would you turn your back on it --- even for just a minute? Of course not. Keep a careful eye on your laptop just as you would a pile of cash.
- Keep it off the floor. No matter where you are in public, at a conference, a coffee shop, or a registration desk, avoid putting your laptop on the floor. If you must put it down, place it between your feet or at least up against your leg, so that you're aware of it.
- Get it out of the car. Don't leave your laptop in the car, not on the seat, not in the trunk. Parked cars are a favorite target of laptop thieves; don't help them by leaving your laptop unattended.
- Pay attention in airports. Keep your eye on your laptop as you go through security. Once on board your flight, put the computer under the seat in front of you. Try to avoid putting it in the overhead bin. Others will have more access to it there.
- Leave it at the office. Don't carry sensitive data with you if you can do without it. In many cases, data on stolen laptops didn't need to be there. Your practice should have a policy stating what kinds of data can be loaded onto portable devices.

References

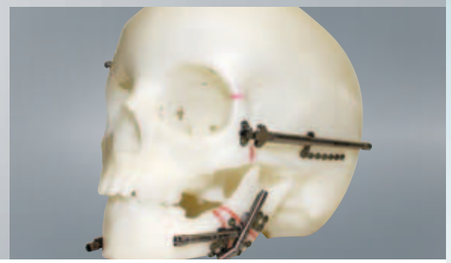
1. "Breach Notification for Unsecured Protected Health Information: Interim Final Rule" August 2009. Department of Health and Human Services.
2. "Guide for Compliance with the New Red Flags Rule" www.ada.org/prof/resources
3. Sample identity theft policy and assorted compliance documents. www.ama-assn.org

Products for Oral & Maxillofacial Surgery





Surgical Innovation is our Passion



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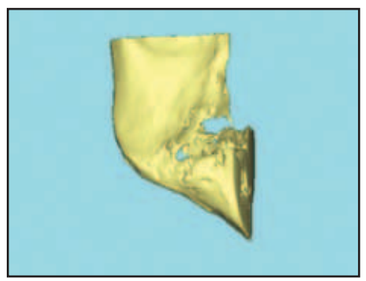
by Peter Krakowiak, DMD., FRCD(C)

Cone Beam Computed Tomography More Than Just Another Perspective

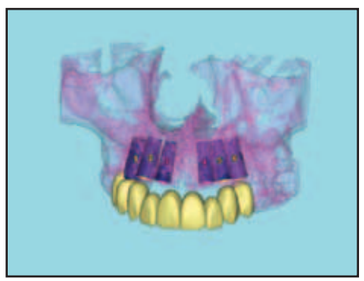
Volumetric 3D imaging is currently approaching that critical point of being recognized in the United States as the standard of care in implant dentistry. The imaging modality has been a standard of care in facial trauma, as well as pathology and reconstructive evaluation and treatment for more than a decade. It is undeniably the shape of things to come in contemporary orthodontic & facial orthopedics, and even good old dentoalveolar surgery. It seems that it is here, and it is here to stay. Unlike fads, such as CO2 lasers, PRP machines, and fancy arthroscopy gadgetry (many of us have these sitting and collecting dust) which had their time and left the stage, CBCT equipment will be around for the next several decades. It is really that useful, and it has phenomenal diagnostic capability in a myriad of applications. I think it will soon be hard to claim that one provides the highest current level of care without having daily access to the data it affords. Yes, there will be those who disagree with that statement but those are fewer and fewer with every passing year.

Perhaps with the downturn in the economy it may be a difficult time to justify the expenditure of $100,000-plus dollars on another "x-ray machine," but at the same time it may be just the adjunct that gives us the edge over our other competitors in the area of oral implantology and facial surgical care. Moreover, it will be a great deduction that can be had in one single fiscal year under the tax code section 179. From my personal experience, my practice has benefited greatly from my scanner. In the past two and a half years, we have taken over 1200 scans. Even with a modest fee of $150 per scan, it has certainly been a solid revenue generator. Most of all, my relative sanity has been the biggest benefactor of the imaging capabilities of my CBCT machine.

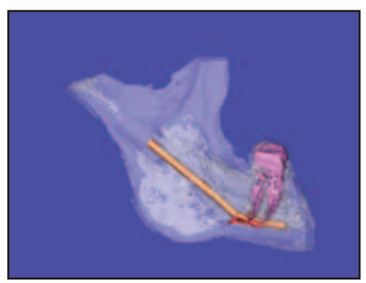
Cases that before were challenging because of the uncertainty in diagnostic parameters, such as exposures, supernumeraries, deep impactions, hard tissue lesions, and nerve-root proximity cases have become more predictable and less stressful during the delivery of care. Knowing exact spatial relations and precise three dimensional coordinates of structures, i.e., lingual bone thickness over impacted teeth, and, of course, of the mandibular nerve adjacent to or through the roots of third molars has allowed me to be more aggressive, but less cavalier, in my case execution. I feel that my ability to inform the patients about their case-specific risks of surgery has also been enhanced, especially in third molar cases.



Lingual Plate Fracture Post Third Molar Removal



Virtual restorative-driven implant treatment planning



Expressed sealer around IAN causing paresthesia

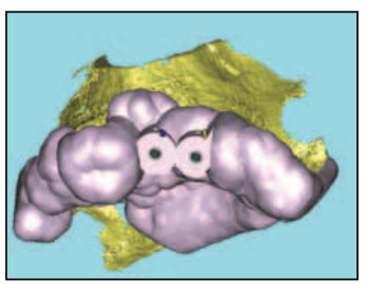
The dental CBCT has great advantages over medical grade CT scanners. For one, the images are more specific for the hard tissues and expose the patients to approximately 10% of the standard dose of radiation compared to medical head and neck, or facial, CT scans. The difference comes from the way data is acquisitioned by a single rotating cone of radiation versus the repeated linear spiral slicing with the medical grade radiation beam. Typical CBCT scan dose is 45-100 mSv (The sievert (Sv) is the SI unit of equivalent dose. Although it has the same units as grays, J/kg, it measures something different. It is the dose of a given type of radiation in Gy that has the same biological effect on a human as 1 Gy of x-rays or gamma radiation). That may be less than a conventional full mouth series or just about three times the exposure of a single panoramic x-ray. With smaller volume scans or targeted scans, the exposure is quite limited. The experience of the operator of the CT scanner has a lot to do with this parameter. In many cases, a 4cm x 4cm x 4cm volume can be obtained on our scanner. The exposure is then less than that of one panoramic survey.

Of course, as with any increase in knowledge there comes a greater sense of responsibility, and the CBCT modality is no exception. In a recent CDA journal article by Art Curley, J.D., the topic of including CBCT data in all complex cases of third molar impactions, mesiodens/supernumeraries, and implants has been touched on. The patients must be informed of the availability of such imaging, and if they refuse to get the studies, it should be documented that the diagnostic modality was offered and the patient declined, knowing that not doing so may increase their risks and complications.

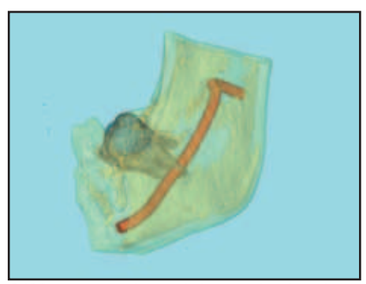
The other medical-legal issue that lies in this arena is the ability and responsibility to interpret the images acquired. Most dentists do not have this expertise and must utilize the services of either a neuroradiologist or an oral & maxillofacial radiologist to interpret the scans. Our specialty is unique given our extensive training in interpretation of these images in trauma and tumor surgery, but often large volume scans will image structures outside our traditional areas of expertise. When this occurs, a radiologist should be involved in the interpreting of the data, including the soft tissues, as well. Having a smaller targeted volume scan or using smaller volume scanners that limit the data to our area of expertise may be the best solution to this issue. Some malpractice insurers have taken note of this issue and now will not cover under the standard policy the OMS who takes images for outside referrals using their in-house scanner. And this brings up the topic of who utilizes this diagnostic modality.

A recent survey commissioned by *conebeam.com* revealed that most scanners in use are the I-Cat (65%) and Newtome (22%) brands. J Morita, Sirona, Hitachi, Planmeca, and E-woo are less common. The same study looked at who uses the scans most in their practices. Interestingly, periodontists had a (slightly) higher rate of usage of scanners than OMS doctors by about 1%. Orthodontists use the scanners one-third less frequently than OMS/perio groups. GPs and prosthodontists use the scanner a third less than the two leading groups. Some use by endodontists was also noted. Most of the users reported they utilize the technology less than five times per week. However, the top 30% utilize it

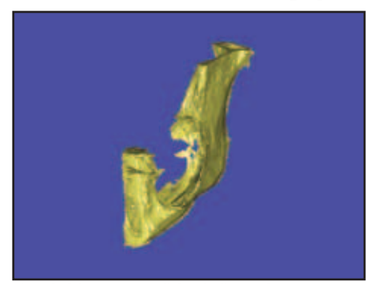
Continued on page 16



Virtual surgical guide design for implants



IAN coursing through lower third molar roots



Ameloblastoma of the left angle

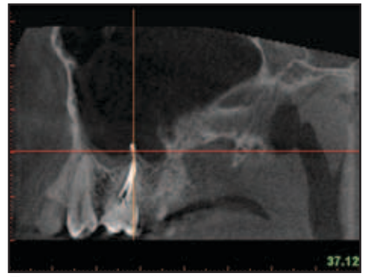
Continued from page 15

over 15 times per week. Finally, the survey looked at software use in the interpretation and planning of the data results. Simplant had a 52% share of the market, followed in a distant second by Nobelvision, and then individual manufacturer's own software.

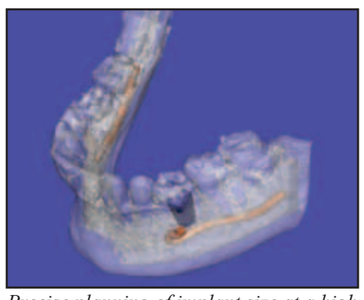
In my practice, I perform a pre-treatment CBCT on all implant cases. I also scan all third molar cases where the nerve runs superior to the apices of the roots. All expose and bond cases, as well as supernumeraries and mesiodens, get scans, as well. Of course, the hard tissue lesions and cysts get scanned, too. There are often cases where apical health of several teeth is questioned, and a lesion's origin can be pinpointed to the exact root of a tooth. Trauma cases are also a great application to delineate alveolar ridge fractures. I have utilized the scanner to diagnose post-extraction osteomyelitis cases, endodontic sealer extravasation into the inferior alveolar nerve canal, overfilled apical stops, root tips in the sinus, maxillary aspergillosis from endo overfill, and implants in the maxillary sinus, nasal floor, and mandibular nerve. My data has now been used in several medical-legal cases.

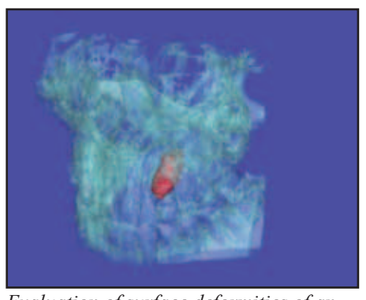
However, what I value the most about CBCT capabilities is that it daily demonstrates how much I can still improve my own surgical cases and results. I am still amazed how a seemingly perfect implant placement on a two-dimensional film or even the best clinically-evident crestal platform position and angulation can be completely misleading as to the actual body of implant position and the extent of bone coverage over the implant itself. As they say, "ignorance is bliss." The ability to verify our surgical results is not limited only to implants. Most recently, a study of bilateral sagittal split osteotomy (BSSO) surgeries revealed that we fall short in our planned objective far more than we think. A CBCT study from a recent JOMS issue showed that fewer than 50% of vertical lingual extensions of transverse cuts run posterior to the lingula. In fact, over 30% are found to be anterior. I scanned my last BSSO, and found myself in the latter group. Before CBCT data, I would have been certain of the opposite.

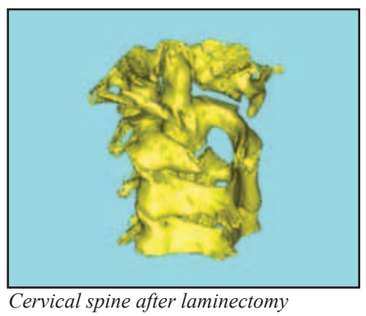
To summarize, I think that there is not much doubt that CBCT imaging is becoming the standard of care. As leaders in the dental field, it is incumbent on us to further develop and expand our own abilities and skills in this diagnostic treatment modality. Most who use it already do find it very exciting and rewarding. Furthermore, staying at the forefront of this soon-to-be universally utilized technology will keep us ahead of other competing dental surgical therapists who often have no real didactic and clinical radiography interpretation experience in their respective post-graduate training programs.



Endodontic overfill of palatal canal with mild mucosal reaction


Precise planning of implant size at a high risk site


Evaluation of surface deformities of an unerupted canine


Cervical spine after laminectomy

On The Cosmetic Side

by Kyle Van Brocklin, DMD

A New Frontier

Nurses do it. Physician assistants (PAs) do it. Gynecologists do it. I am referring to cosmetic procedures on the face. How is it that these disciplines do elective surgical cosmetic procedures on the face and we do not? When I considered this notion, it got my blood boiling. I was trained with a CO2 laser in the late 1980s. I enjoy utilizing a laser in my practice. Now that the state has some knowledge as to our training and true scope of practice, I feel it is time for California Oral and Maxillofacial Surgeons to take advantage of this opportunity. It is time to get the cosmetic license that we have truly earned.

Procedures for rejuvenating the skin and adjacent regions are actively sought by our patients. Numerous major advances, including virtually all cutaneous lasers and light-source based procedures, botulinum exotoxin (Botox), soft tissue augmentation with implants or filling agents are being used by our colleagues in other states. With our training in the head and neck area, oral and maxillofacial surgeons can make facial rejuvenation accessible to risk-averse patients by emphasizing safety and reducing operative trauma. No specialty is better positioned than oral and maxillofacial surgery to lead the field of cutaneous facial surgery while meeting patient needs.

I sought the cosmetic license because I felt that our profession is much more competent in doing facial cosmetic procedures than those listed earlier. Believe me, there are many bureaucratic hurdles to overcome in order to attain the license, but it is worth it. I have limited my cosmetic practice to facial laser, Botox, and soft tissue filler cosmetic facial procedures. As such, I have built an unexpected relationship with plastic surgeons in my area. Why? One example is when I treat a patient with Botox and he/she asks about the excess tissues under their eyes, I refer the patient to a plastic surgeon for a blepharoplasty. Instead of creating animosity with neighboring plastic surgeons, I have established a support mechanism for the procedures that I perform. I realize that some of my fellow oral and maxillofacial surgeon colleagues will perform rhinoplasty and blepharoplasty procedures, and that is a good thing. These are the same patients that may desire breast implants or tummy-tucks, which we, in turn, can refer to our plastic surgery colleagues. It is a win-win for all.

I have implemented the FRAXEL re:store laser in my practice. The laser is a product of Reliant Technologies. The ease in using the laser and the results are very rewarding. The FRAXEL has advanced fractional scanning technology, adjusting for hand speed; it has features for ideal spot density, optical tracking system, all assuring a uniform and safe treatment for the patient. The range of treatments include: acne scarring, sun damage, melasma, wrinkles, and general resurfacing. Performing facial cosmetic procedures in my office has been a nice off-shoot to performing dentoalveolar procedures. It has been fun and the results have been personally rewarding. Should we be doing these procedures? Absolutely! Will doing these procedures educate the public and our medical colleagues as to our trained capacity? Most definitely!

Update on Actions of the Dental Board

Update on the General Anesthesia/Conscious Sedation (GA/CS) Evaluation Program

The number of GA evaluations performed in January (16), February (22), and March (22). The number of CS evaluations for January (5), February (9), and March (6).
There were 3 failed GA evaluations last year.
There were 6 failed CS evaluations last year.
There were 0 MGA failures.

New Training Requirements for Dental Assistants

There is a new requirement for an 8-hour infection control course, C.P.R., and California law if the employee was hired after 1/1/10, if continuously employed for more than 120 days. This training must be completed within one year.

Assistants (DAs) must complete these requirements when changing places of employment after 1/1/10 even if they have prior experience working in a dental office.

The 8-hour infection control course must be given by a DBC-approved provider and must include 4 hours of didactic education, 2 hours of laboratory pre-clinical training, and 2 hours of clinical training. The California Dental Association (CDA) plans to offer this course in the near future. The DBC maintains a list of approved courses on their web site.

"Dental Assistant" (DA) Defined:

A dental assistant (DA) is a person who, without a license, may perform basic supportive dental procedures, as authorized by Section 1750.1 and by regulations adopted by the Board, under the supervision of a licensed dentist. "Basic supportive dental procedures" are those procedures that have technically elementary characteristics, are completely reversible, and are unlikely to precipitate potentially hazardous conditions for the patient being treated. The supervising licensed dentist shall be responsible for determining the competency of the DA to perform the basic supportive dental procedures, as authorized by Section 1750.1.

DA Duties Related to Anesthesia/Sedation

DAs are allowed to perform the following:

- Place patient monitoring sensors
- Monitor patient sedation—limited to reading and transmitting information from the monitor display during the intra-operative phase of surgery for electrocardiogram (ECG) waveform, carbon dioxide (CO_2) and end tidal CO_2 concentrations, respiratory cycle data, continuous non-invasive blood pressure (NIBP) data, or pulse arterial oxygen saturation (SpO_2) measurements, for the purpose of interpretation and evaluation by a supervising licensed dentist who shall be at the patient's chairside during this procedure
- Assist in the administration of nitrous oxide (NO_2) when used for analgesia or sedation
- A DA shall not start the administration of the gases and shall not adjust the flow of the gases unless instructed to do so by the supervising licensed dentist who shall be present at the patient's chairside during the implementation of these instructions. This shall not be construed to prevent any person from taking appropriate action in the event of a medical emergency.

New Fingerprinting Requirement for License Renewal

A licensee who was initially licensed prior to January 1, 1999, or for whom an electronic record of the submission of fingerprints no longer exists, shall furnish to the Department of Justice a full set of fingerprints for the purpose of conducting a criminal history record check and to undergo a state and federal level criminal offender record information search conducted through the Department of Justice.

Wanted: Dental Experts to Review Investigation Cases

The Enforcement Division of the Dental Board of California (Board) is seeking qualified licensees to serve as Dental Experts. Experts are practicing dentists who review investigation cases in an effort to evaluate and/or determine whether violations of the Dental Practice Act can be substantiated.

Dental Experts review cases to determine if the standards of the profession are being met and/or the Board's laws and rules violated. They are required to provide a written report of their expert opinion. The majority of the Board's cases involve quality of care issues. Expert opinions are provided confidentially to the Board. However, experts on Board cases may be required to testify regarding their opinions in court or before an Administrative Law Judge.

You must certify the following before the Board may consider your application to become a Dental Expert:

- You have been a lawful California practitioner of the occupation or profession for which consulting related work is to be performed for a minimum of five years.
- Your renewal fees have been paid as required.
- Your continuing education requirements have been met.
- To your knowledge, no accusation or other legal action has been filed against you by any agency or government.
- You have not been admonished or otherwise disciplined by the agency that regulates your practice.
- If you are a specialist in a particular area, you must be Board Certified or Board Eligible.

Board Experts are paid $100 an hour for case review and report preparation. Travel costs associated with attending meetings are reimbursed. This position and the person performing these expert consulting services is designated as an at-will independent contractor that does not have status as an employee of the State or status as a permanent civil servant of the State. In some instances you are required to testify at Administrative Hearings as an expert in the particular case you have reviewed.

If you are interested, please complete a Consultant Self-Certification form and send it with your most current resume/curriculum vitae to the following address:

Dental Board of California
Attention: Nancy Butler
2005 Evergreen Street, Suite 1450
Sacramento, CA 95815

Welch Allyn/ MRL AED Recall

This is a reminder that Welch Allyn is voluntarilly recalling MRL Jumstart/Welch Allyn AED 10 models purchased between October 30, 2002 and July 11, 2005, or if the unit was serviced in 2007.

If you believe that you may have one of the units being recalled, please check the serial number at:
www.welchallyn.com/AED10Recall,
or call the recall center at 888-345-5356

What "Health Care Reform"'Means to OMS
Continued from page 1

the lesser of $3,000 for each employee receiving a premium assistance credit or $2,000 for each full-time employee. Employers may not have a waiting period for employee enrollment in health coverage that exceeds 90 days. *[Effective January 1, 2014]*

• The law provides for a tax credit for small employers with no more than 25 employees and average annual wages of less than $50,000 that purchase health insurance for employees and contribute up to 50% of their total premium. *[Effective upon enactment]*

• Phase I: For tax years 2010-2013, provides a tax credit of up to 35% of the employer's contribution toward the employee's health insurance premium. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $25,000. The credit phases-out as firm size and average wage increases.

• Phase II: For tax years 2014 and later, eligible small businesses that purchase coverage through the state Exchange, can receive a tax credit for two years of up to 50% of the employer's contribution toward the employee's health insurance premium. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $25,000. The credit phases-out as firm size and average wage increases.

Excise Tax on Health Plans

• Imposes an excise tax (equal to 40% of the value of the plan that exceeds the threshold amount) on insurers of employer-sponsored health plans with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage. The tax is imposed on the issuer of the health insurance policy, which in the case of a self-insured plan is the plan administrator or, in some cases, the employer. *[Effective January 1, 2018]*

• The threshold amounts will be increased for retired individuals age 55 and older who are not eligible for Medicare and for employees engaged in high-risk professions by $1,650 for individual coverage and $3,450 for family coverage. The threshold amounts may be adjusted upwards if health care costs increase more than expected prior to implementation of the tax in 2018. The threshold amounts will be increased for firms that may have higher health care costs because of the age or gender of their workers.

• The aggregate value of the health insurance plan includes reimbursements under a flexible spending account for medical expenses (health FSA) or health reimbursement arrangement (HRA), employer contributions to a health savings account (HSA), and coverage for supplementary health insurance coverage. The aggregate value of the plan will exclude dental and vision coverage.

Medical Device Tax

• Imposes on device manufacturers an excise tax of 2.3% on the sale of any taxable medical device. Exempts from the tax Class I medical devices, eyeglasses, contact lenses, hearing aids, and any device of a type that is generally purchased by the public at retail for individual use. *[Effective for sales after December 31, 2012]*

• While providers are not directly tapped for this tax, it is possible that the increased cost to manufacturers could be passed along to providers through higher prices on non-Class I devices.

Medicare Payroll Tax

• Increases the Medicare Part A (hospital insurance) tax rate on wages by 0.9% (from 1.45% to 2.35%) on earnings over $200,000 for individual taxpayers and $250,000 for married couples filing jointly, and imposes a 3.8% tax on unearned income for higher-income tax-payers. *[Effective January 1, 2013]*

Flexible Spending Accounts (FSA)/Health Savings Accounts (HSA) Limits

• Limits the amount of contributions to a FSA for health-related expenses to $2,500 per year, indexed for inflation. *[Effective January 1, 2013]*

• Increases the tax on distributions from a HSA (prior to age 65) that are not used for qualified medical expenses to 20% (from 10%) of the disbursed amount. *[Effective January 1, 2011]*

• HSA/FSA accounts are used by patients for dental care, which is not always included in employer-provided insurance. These limitations may have a negative effect on access to dental care for patients without dental coverage.

Medicare Independent Payment Advisory Board (IPAB)

• Creates an independent, 15-member Medicare Independent Payment Advisory Board (IPAB) tasked with presenting Congress with "comprehensive proposals to reduce excess cost growth and improve quality of care for Medicare beneficiaries." The Board's proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. The Board would be prohibited from making proposals that ration care, raise taxes or Part B premiums, or change Medicare benefit, eligibility, or cost-sharing standards. *[Effective upon enactment]*

• This provision provides for the addition of an independent commission with the ability to mandate Medicare payment cuts for physicians, who are already subject to cuts due to the flawed sustainable growth rate (SGR) formula.

Claims Submission/Fraud & Abuse

• The maximum period for submission of Medicare claims is reduced to a maximum of 12 months. *[Effective upon enactment]*

• Accelerates Department of Health and Human Services (HHS) adoption of uniform standards and operating rules for the electronic transactions that occur between providers and health plans, such as benefit eligibility verification, prior authorization, and electronic funds transfer payments. Establishes a process to regularly update the standards and operating rules for electronic transactions and requires health plans to certify compliance or face financial penalties collected by the Treasury Secretary. *[Effective upon enactment]*

• Initiates several Medicare and Medicaid fraud and abuse prevention initiatives, including a new enrollment process for providers and suppliers, and a requirement that suppliers and providers implement compliance programs with core elements determined by HHS.

Quality Measures/PQRI

• Extends through 2014 payments under Medicare's Physician Quality Reporting Initiative (PQRI). Physicians voluntarily participating in PQRI in 2011 will see a 1% increase in incentive payments and a 0.5% increase from 2012-2014.

• Beginning in 2014, physicians who do not submit measures to PQRI will have their Medicare payments reduced by 1.5%. The penalty will be increased to 2% in subsequent years. *[Effective upon enactment]*

•The impact on oral and maxillofacial surgery is still being assessed.

Imaging

• Increases the utilization rate assumption for calculating the payment for advanced imaging equipment from 50% to 75% *[Effective January 1, 2011]*

• Physician must disclose ownership interest in imaging equipment to their patients *[Effective upon enactment]*

Insurance Reforms/Definition of Essential Benefits

• Creates state-based exchanges through which individuals can purchase health coverage, with premium and cost-sharing credits available to individuals/families with income between 133-400% of the federal poverty level (FPL). Stand-alone dental coverage available through dental insurers will also be offered through the exchanges. **There is no requirement** for providers to participate in any of the exchanged-based insurance plans. *[Exchange development deadline January 1, 2014]*

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• Provides for insurance reforms that bar insurers from denying coverage for pre-existing conditions, establishing lifetime or annual limits on coverage or rescinding coverage except in cases of fraud or misrepresentation. Further, group health plans that cover dependent children are required to extend coverage to such dependents until age 26 *[Effective beginning 6 months after enactment]*

• States that the Secretary of Health and Human Services (HHS) will define the essential health benefits, but the final definition must include: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative services/devices, laboratory services, preventive and wellness services, and chronic disease management and pediatric services, including oral and vision care.

• Requires all qualified health insurance plans, including those offered through the Exchanges and those offered in the individual and small group markets outside the Exchanges, to offer at least the essential health benefits package. *[Effective January 1, 2014]*

• It will be at the discretion of HHS in creating the definition of pediatric oral services to be included in the essential benefits package – it is unclear at this time whether or not third molar removal will be included.

Prohibition Against Degree of Provider Discrimination

• Prohibits health insurance issuers from discriminating against providers acting within the scope of practice of their professional licensure and in accordance with state law. *[Effective upon enactment]*

Medicaid Expansion

• Expands Medicaid to all individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL based on modified adjusted gross income. All newly eligible adults will be guaranteed a benchmark benefit package that at least provides the essential health benefits as defined for the exchanges which includes pediatric, but not adult, oral health services. *[Effective January 1, 2014]*

• To finance the coverage for the newly eligible, states will receive 100% federal funding for 2014 through 2016, 95% federal financing in 2017, 94% federal financing in 2018, 93% federal financing in 2019, and 90% federal financing for 2020 and subsequent years.

Alternative Dental Health Care Providers

• Authorizes the Secretary to award grants to establish training programs for alternative dental health care providers to increase access to dental health care services in rural, tribal, and underserved communities. The term 'alternative dental health care providers' includes "community dental health coordinators, advance practice dental hygienists, independent dental hygienists, supervised dental hygienists, primary care physicians, dental therapists, dental health aides, and any other health professional that the Secretary determines appropriate." *[Demonstration projects shall begin within 2 years after enactment and shall conclude not later than 7 years after enactment]*

• Incorporated the Indian Health Care Improvement Act (IHCIA), which includes a provision to allow tribes in states that license dental therapists to establish a Dental Health Aide Therapist (DHAT) program.

• These provisions could promote midlevel dental providers to perform surgical dental procedures and expand the availability of the Alaska DHAT model to other tribal areas of the country.

The History of SCPIE and CALAOMS

by George Oatis, DDS

In the mid 1980's there was a malpractice insurance crisis. Several companies would not insure oral and maxillofacial surgeons and The Dentist's Insurance Company (TDIC) premiums were going to increase to $45,000.00 per year. Because of this, several members from CALAOMS decided to form their own off-shore insurance companies.

Lee Reeves, then President of CALAOMS, was not comfortable with the off-shore options and formed a committee to explore companies in California that would insure oral and maxillofacial surgeons as a group, not combined with other specialties of medicine and dentistry. The members were Lee Reeves, Marion Mills, Frank Barbee, Al Steunenberg, Jerry MacDonald and myself. We first approached The Southern California Physicians Insurance Exchange (SCPIE). We met several times with Don Zuk, the President of SCPIE, to discuss what we as OMS wanted in a program.

First, we wanted our own "book of business", meaning we did not want to be commingled with their physician insured. Second, we wanted to have a say in the setting of the premiums, and lastly, we wanted a very active risk management committee to make recommendations to the claims department and add surcharges when necessary. There was a severe learning process on both fronts. SCPIE had no idea what the practice of oral and maxillofacial surgery involved and we knew little about the malpractice insurance business. After several meetings we came up with a program we were both happy with.

We had our own "book of business", rated only within our own group. We had our own risk management committee, which reviewed all claims and made recommendations to the claims department. We had a free "tail" after a certain age or years with SCPIE, a percentage of the claim premiums would go back to CALAOMS and ownership in the company depending on the profits the company made on all their business.

The first year's premiums were arbitrarily set at $15,000.00. Over the years this was adjusted depending on the claims paid. We were fortunate to have Bill Green put in as Vice President in charge of our account shortly after it started. The risk management committee met with SCPIE department managers at least twice a year and an OMS was assigned to review all claims. The program met all of our expectations. Most of the claims were extraction of the wrong tooth and anesthesia of the lip or tongue. Premiums were kept in check. A 5% rebate was given for attending risk management courses. In the 9 years I was involved on the Risk Management Committee, only one OMS was dropped and only one had to be surcharged at the 50% level. At one time, we were given stock that went up to $25,000.00. Also at one time, there were 550 insured in the program. Thanks to the visions of men like Lee Reeves we have had a very successful stable malpractice program for close to 24 years.

The Doctors Company (TDC) purchased SCPIE in 2008. The Doctors Company wanted to continue the relationship with CALAOMS that SCPIE had. In order to make sure that CALAOMS still recommended the best malpractice insurance to our members, The CALAOMS Board commissioned an Insurance Task Force to review the benefits of The Doctors Company. The Task Force also interviewed representatives from OMSNIC, Medical Insurance Exchange of California, The Dentist's Insurance Company, Medical Protective, Dentist's Advantage, and Premier Physicians Insurance Company. After careful consideration and review of the Task Force report, the CALAOMS Board voted to continue the relationship with The Doctors Company.

The Doctors Company continues to support CALAOMS and their members by sponsoring our meetings and by offering low premiums and discounts to our members.

In Memorium

Stuart I. Green, D.D.S.
1940-2009

by Jeffrey A. Elo, D.D.S., M.S.

In August, 2009, CALAOMS, the Orange County Dental Society, the city of Santa Ana, friends, family, and I lost a very dear friend, Dr. Stuart Green. Dr. Green is the very gracious man who sold me his Santa Ana-based oral and maxillofacial surgery practice in 2006. Being from the Midwest, I didn't know anyone in the area. He was my first friend in Orange County.

Though it may seem as such, not every doctor is reclusive, and Stuart Green was proof of that. His office door always remained open. You could find him in conversation with a colleague, friend, sales rep, or drop-in guest discussing topics ranging from general anesthesia to long-storied jokes, history, ballistics, food, racquetball, and traveling—all in one session!

Stuart Ian Green was born in Cleveland, Ohio on May 28, 1940. He lived in Cleveland through high school, graduating in 1958. Being from the Buckeye state, it was a logical choice to join the "scarlet and gray" of Ohio State University.

He attended Ohio State University for three years, at which time he was accepted to Case Western Reserve University School of Dental Medicine. After one year at Case Western Reserve University, he transferred to West Virginia University School of Dentistry, where he completed dental school and obtained his Doctor of Dental Surgery degree.

Following dental school, Stuart then completed one year of oral and maxillofacial surgery residency in Philadelphia at Hahnemann Hospital, followed by

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Upcoming 2010 CE Events

For Doctors

10th Annual Meeting
May 21-23, 2010 — San Francisco

Residents' Night
September 22, 2010 — Southern CA

ACLS
October/November, 2010 — Solano

Medical Emergencies
November 3, 2010 — Northern CA

Medical Emergencies
November 17, 2010 — Southern CA

For Staff

OMSA Summer — Northern CA
Weekend Seminar: August 28-29, 2010

OMSA Fall — Southern CA
Home Study Starts: June 15, 2010
Weekend Seminar: October 23-24, 2010

OMSA Winter — Northern CA
Home Study Starts: October 15, 2010
Weekend Seminar: February, 2011

ACLS
October/November, 2010 — Solano

Medical Emergencies
November 3, 2010 — Northern CA

Medical Emergencies
November 17, 2010 — Southern CA

Continued from page 25

one year in Washington, D.C., and, one final year in Pittsburgh.

After practicing as an associate in Los Angeles, Stuart opened his private practice of oral and maxillofacial surgery in Santa Ana, CA, in 1974, and practiced at the same location until 2006. He was instrumental in developing and promoting standards in providing office-based general anesthesia for OMSs. He also donated his time to teaching part-time at Loma Linda University School of Dentistry.

Stuart had a great passion for playing racquetball, until illness prevented him from enjoying it. A few other CALAOMS members (Neal Freeman, Michael Blum, Howard Winer) and I would take Stuart out for a monthly dinner outing. It was with these men that I learned invaluable information on life, politics, practice, and friendship. Coincidentally, I was always impressed with the vast array of jokes that would be told—incredible how the mind can retain such information, but yet we still forget to pick up milk from the grocery store! Those days will truly be missed.

Stuart and his family greatly enjoyed all that Orange County life has to offer, having taken residence in multiple areas, including Newport Island, Orange Hills, and then Irvine. Stuart leaves behind his beloved wife, Christy, whom he married on October 14, 1979—marking nearly 30 years of marriage, their daughter, Jenae, 26, and son, Hagen, age 29, as well as his beloved sister, Shelly Frank, and her husband, Billy, plus multiple nieces and nephews.

Having spent only limited time with Stuart, it was clear that he truly loved his family and friends, and was so proud of each of them. I saw in him what it truly meant to be a friend to someone else. We will all miss him greatly.

Two are better than one, because they have a good reward for their labor. For if they fall, one will lift up his companion. But woe to him who is alone when he falls, for he has no one to help him up. Ecclesiastes 4:9

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Experienced, Board Certified OMS seeks work for 3 to 3 ½ days per week in quality office, group or institution. Currently Associate Prof. of OMS at major residency program. Might consider locum tenums for 6 mo+. Call 303-328-1863 or e-mail eos@cftinet.com. CV on request.

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Did you know that classified ad placement is free to CALAOMS members? To place a classified ad, email the ad copy to steve@calaoms.org

San Francisco, Oral & Maxillofacial Surgeon Excellent opportunity for board eligible/board certified OMFS to join a dynamic, high volume, solo practice in prime San Francisco location. Must be well trained OMFS with good basic surgical skills and capable of maintaining the quality of this high income practice. Must possess strong communication skills to successfully interact with patients, staff,and colleagues. The practice is focused on Dental Implants and dentoalveolar surgery with opportunity to include the full scope of OMFS. Must possess initiative, and a strong work ethic with a desire to grow and expand a state of the art practice. First year salary negotiable, with buy in starting the second year. Please submit CV and contact information to : Sam J. Poidmore, DDS., 18152 Pamela Place, Villa Park, Ca. 92861, or Fax # 714-921-9667.

CALAOMS

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