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The Compass

Staying the Course Through Service and Education

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Volume XIV, Issue 1, Spring 2012

CALAOMS Hosted 2nd Year of RAM Clinics

by Russ Webb, DDS

The dental floor of the 2012 Sacramento Expedition held at Cal EXPO March 30-April 2. Photo courtesy of Alvin Jornada

Earlier this year, CALAOMS and the Tzu Chi Foundation once again hosted two free dental/medical/vision clinics; one at the Oakland Coliseum, March 22-25 and the second at Cal Expo, March 30-April 2. CALAOMS and Tzu Chi worked closely with RAM California and RAM USA to provide the equipment, infrastructure, and logistical support needed to allow over 2400 volunteer physicians, nurses, dentists, oral surgeons, dental hygienists, dental assistants, ophthalmologists, optometrists, and opticians, as well as general volunteers to provide medical, dental, and vision services to 6100 patients between the two

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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, IOM
Phone Extension: 12
email: pamela@calaoms.org

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

Continuing Education Services
Teri Travis, CMP
Phone Extension: 13
email: teri@calaoms.org

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

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* Southern California Society of Oral and Maxillofacial Surgeons
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Editor's Corner

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

A Case for Teamwork

Building an effective, cohesive surgical team is extremely hard. But it's also simple. Teamwork doesn't require great intellectual insights or masterful tactics. More than anything else, it comes down to courage and persistence. And so, if you're committed to making your team a healthy one, and you can get the rest of the team to share your commitment, you're probably going to make it. And just in case you're not sure this will be worth the time and effort–and risk–there is a case for going forward.

In this day and age of informational ubiquity and nano-second change, teamwork remains the one sustainable competitive advantage that has been largely untapped. Teamwork is almost always lacking within offices and organizations that fail, and is often present within those that succeed.

It is true that teamwork is hard to measure. Why? Because teamwork impacts the outcome of an organization in such comprehensive and invasive ways that it's virtually impossible to isolate it as a single variable. Many organizations prefer solutions that are more easily measurable and verifiable, so they look elsewhere for their competitive advantages

But even if the impact of teamwork were more easily measurable, head surgeons and/or top executives probably would still look elsewhere. Why? Because teamwork is extremely hard to achieve. It can't be bought and it can't be attained by hiring "an intellectual giant" from the world's best dental or medical or business schools. It requires levels of courage and discipline–and emotional energy–that even the most driven doctors and executives don't always possess.

As difficult as teamwork is to measure and achieve, its power cannot be denied. When people come together and set aside their individual needs for the good of the whole, they can accomplish what might have looked impossible on paper. They do this by eliminating the politics and confusion that plague most offices and organizations. As a result, they get more done in less time and with less cost.

Also, when it comes to helping people find fulfillment in their work, there is nothing more important than teamwork. It gives people a sense of connection and belonging, which ultimately makes them better parents, siblings, friends, and neighbors.

As difficult as teamwork can be to achieve, it is not complicated. The true measure of a team is that it accomplishes the results that it sets out to achieve. To do that on a consistent, ongoing basis, a team must overcome the five dysfunctions listed here by embodying the behaviors described for each one.

The Five Dysfunctions of a Team

(adapted from <u>The Five Dysfunctions of a Team</u> by Patrick Lencioni. Jossey-Bass, 2005. Pages 3-7)

Dysfunction #1: Absence of Trust

Members of great teams trust one another on a fundamental, emotional level; and they are

comfortable being vulnerable with each other about their weaknesses, mistakes, fears, and behaviors. They get to a point where they can be completely open with one another, without filters. This is essential because…

Dysfunction #2: Fear of Conflict

Teams that trust one another are not afraid to engage in passionate dialogue around issues and decisions that are key to the office's or organization's success. They do not hesitate to disagree with, challenge, and question one another--all in the spirit of finding the best answers, discovering the truth, and making great decisions. This is important because…

Dysfunction #3: Lack of Commitment

Teams that engage in unfiltered conflict are able to achieve genuine "buy-in" around important decisions even when various members of the team initially disagree. That is because they ensure that all opinions and ideas are put on the table and considered, giving confidence to team members that no stone has been left unturned. This is critical because…

Dysfunction #4: Avoidance of Accountability

Teams that commit to decisions and standards of performance do not hesitate to hold one another accountable for adhering to those decisions and standards. What is more, they don't rely on the team leader as the primary source of accountability; they go directly to their peers. This matters because…

Dysfunction #5: Inattention to Results

Teams that trust one another, engage in conflict, commit to decisions, and hold one another accountable are very likely to set aside their individual needs and agendas and focus almost exclusively on what is best for the team. They do not give in to the temptation to place their departments, career aspirations, or ego-driven status ahead of the collective results that define team success.

Letters to the Editor

The Technical Article "Immediately-loaded fixed transitional full arch prosthetics" by Dr. Peter Krakowiak, published in the Fall 2011 issue of the Compass generated two letters to the editor. The following are those two letters followed up by a response from the author.

Letter One

from Arshiya Sharafi, DDS

I just recently read the article in The Compass, Fall 2011 by Dr. Krakowiak. I truly appreciate his time and effort to write a technical article regarding the immediately loading of fixed full arch prosthesis. His detailed effort to show how to do immediate loading is great. I am also very surprised by the first 2 pages of the article, where instead of truly having a 'technical article;' Dr. Krakowiak takes time to talk about the arrival of large dental implant centers. Is this a technical article or is he relieving aggression towards other doctors? I am truly insulted by what he states and how he categorizes <u>certain</u> dental implant centers with other general dentist promos.

I have a full scope oral and maxillofacial surgery practice and I am the board certified surgeon for the Clearchoice Dental Implant Center in San Diego. Let us make it clear that our center has a full time oral surgeon, a full time prosthodontist and a full time lab technician. We have a state of the art facility that mimics any surgical center with full surgical suites, iCAT, and dental laboratory. Clearchoice centers <u>are not</u> your typical 'general dentist implant centers' and we are not 'the one-stop-shop doctor carousel drive-through setting' (as Dr. Krakowiak describes). Even though Dr. Krakowiak does not mention Clearchoice specifically, I am still offended because Dr. Krakowiak clearly is categorizing us at Clearchoice with competing general dentist or other implant centers that do provide

poor treatments for patients. Let us make it clear that we do not have 'unprofessional and deceitful' advertising, we do not offer treatment to everyone, we do not promise patient teeth in a day (even though that is our goal) and no we do not offer free oil change and free haircuts.

We have done more that 175 full arches since our opening in February of 2011, we have loaded 98% of our cases, we have placed over 850 implants and we use a variety of technique where we place more than four implants per jaw. We also use sinus lift/traditional way of treating patients, we use zygomatic implants and we treatment plan patients appropriately. We follow our patients for more than two years post final prosthesis delivery and we do not tell patients that they can keep their teeth their whole life. Here is Dr. Krakowiak antagonizing 'implant centers,' not knowing what happens in our Clearchoice centers. In fact he talks about working closely with his referrals and how he enjoys the multidisciplinary dentistry, and then he discusses how he makes the provisional prosthesis himself. He is not a prosthodontist or a general dentist to be performing the provisionalization. We have a prosthodontist that does all the immediate loading and final prosthesis. I have many referring doctors whom we work with where the immediate loading is performed at our center and the final prosthesis is made by the general dentist. So we also find it rewarding to work closely with our referring restorative doctors.

Then he discusses the lack of articles on the all on 4 techniques. Let us just look at the most recent articles that are out in publication other than Dr. Malo's ten year study. 1) The All-on-Four Immediate Function Treatment Concept With NobelActive Implants: A Retrospective Study, Charles A. Babbush, DDS, MScD* Gary T. Kutsko, DDS, John Brokloff, DDS; 2) Mandibular all-on-four therapy using angled implants: A three year clinical study of 857 implants in 219 jaws, C. Butura, et al; 3) Maxillary all on four therapy using angled implants: A 16 month clinical study of 1110 implants in 276 jaws; Stuart Graves, et al.

So I believe if The Compass is going to publish a technical article, then let us make it that and not an opinion article. Let us not categorize every center as the same, just like the fact that every oral surgery practice is not the same. We welcome all our OMS colleagues to visit our Clearchoice centers and see the modern, fantastic and gratifying medicine we provide patients.

Arshiya Sharafi, DDS
San Diego, CA

Letter Two
from *Hooman M. Zarrinkelk, DDS*

I wanted to thank you for including the article, "Immediately-Loaded Fixed Transitional Full Arch prosthetics" in the Fall, 2011 Compass. One of the many things that the article stated correctly is that there is a "large volume of buzz about this concept." The question we must ask ourselves is why is there such a buzz? Is it because of the significant amount of money spent on advertising by some implant centers and corporations, or is it because this concept and technique is so remarkable? I think the answer is that they both are true.

Before we go any further, I must state that I am not part of any implant center; and as a matter of fact, my practice name doesn't even have the terms "center" or "institute" in it, which I do realize is against the latest trends. Going back to the reasons for the "buzz," there is no question that there is a lot of money being spent on public advertising--some good and some not so good. But I do not think we can and should expect the advertisers to educate (potential) patients through their advertisements, as your article implied they should. The purpose of the advertisements is to expose the public to the services offered; while we are to inform them of their options and procedural risks when they get to the office. We all know that this is not the case with all centers that advertise (though many

advertise truthfully), and your article was correct in stating that some of the ads can be misleading.

I take another viewpoint on the ads. They, at the very least, expose potential patients to the possibility of treatment because, let's face it, most edentulous patients don't go to a dentist, and those that do see the typical general dentist who is reluctant to offer any options beyond a denture reline for fear of complexity or need for specialty referral, etc. I don't condone misleading advertising, but let's stop looking at direct-to-public marketing as an evil concept undertaken only by shady characters practicing out of their garage. Let's admit that if done correctly and ethically it can have a positive impact on our patients' lives; patients who otherwise would not have known of other options available.

Now on to the topic of the procedure itself. The concept is remarkable because one can take a patient who is edentulous--and most likely has suffered significant atrophy of the jaws--and offer them an immediate full-arch fixed appliance in one visit with no grafting, and in most cases, a 50 percent reduction in cost (or more). Compare that with the traditional approach of: hard/soft tissue grafting procedures, (followed by) 6-month healing/waiting time while wearing a poorly-fitting provisional removable appliance, followed by the implant placement, then another 6-month healing/waiting period while wearing the same removable provisional appliance, and finally after a year getting the final fixed prosthesis at twice the cost or more--you do the math. That is why it's remarkable and more easily accepted by the patients. And the results when performed by an appropriately-trained surgeon and restorative dentist can be beautiful.

The article in The Compass was correct to point out that these treatment modalities are not for every patient, but the reality is that most edentulous patients desiring a fixed appliance can be treated effectively with the graft-less solutions that experts like Paulo Malo and Edmond Bedrossian have been pioneering for many years. In my practice, there have only been one or two patients I could not apply this treatment to effectively, and that was due to the patients' desire not to have artificial gingival show, therefore necessitating grafting procedures. But the rest of my patients just want to stop wearing loose-fitting dentures, or they dread going from a failing dentition to dentures and could care less how many implants they get or what angle or position they occupy--they just want good-looking teeth.

In those patients, an appropriately-trained surgeon can deliver the results the patients desire, sometimes with modifications; but nevertheless, the same outcome. Again taking exception with your article, there is quite a bit of literature suggesting that patients can be treated successfully with an immediately-loaded full-arch appliance including tilted and splinted implants--one just needs to dig a bit deeper in the literature, and some extrapolation from research on other similar concepts is necessary; or just talk to Dr. Bedrossian or Dr. Malo, or you can call me if you are intimidated by those two.

My practice is the typical OMS practice: wisdom teeth removal, 89-year old grandmother with broken #29, etc. For the past few years, I have incorporated the graft-less concepts into our treatment plans as indicated, and the results and benefits to my practice and the patients it serves has been remarkable. Elimination of grafting procedures from my discussion with patients seeking treatment has been the most powerful tool in increasing case acceptance. It is also noteworthy that my results have been more predictable and successful than when I was utilizing the traditional grafting procedures--and did I mention that I trained under Phil Boyne.

I do agree with the author that it does take a team to accomplish this task, and I am fortunate to work with some very skilled professionals that help me witness the transformation of patients through the use of graft-less techniques every day. The author does an admirable job in describing the procedures involved, and we cannot expect a complex treatment concept to be adequately explained in just a few pages. But the article does not do justice to readers by including

innuendos about the success or appropriateness of these treatment protocols. But I don't blame the author. The first time I saw Dr. Bedrossian's presentation on zygoma implants many years ago, I thought to myself that he is out of his mind. Boy, was he and others like Malo and Fortin ahead of everyone else.

I also remember early in my career blaming my implant failures on fixture design or brand only to find out later that the fault was my lack of experience. It is true that in inexperienced hands, techniques such as "All-on-4" can turn into "none-on-3;" but in experienced hands, they can be a very powerful and effective tool to help a lot of patients get rid of their dentures and live a normal life.

So why did I write this letter? Because I don't like the idea of large corporate-run dental implant centers either, and I don't want to see patients be treated inappropriately by other specialists who claim to be "physicians of the mouth." These concepts are and should be in the realm of all OMSs because we are the best trained to perform them, and if we all learned to do them there would not be an incentive for more of these dental implant centers to open.

Hooman M. Zarrinkelk, DDS
Oral & Maxillofacial Surgery of San Buenaventura

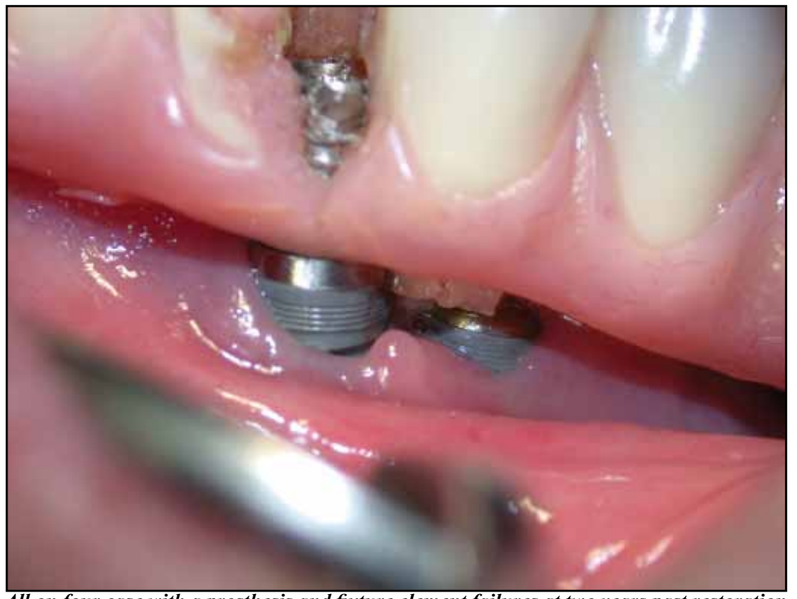
Author's Response
by Peter Krakowiak, DMD, FRCD(C)

I have to admit I was clearly surprised when Jeff (Elo) and John (Allen) contacted me to write a response to two choice letters received by The Compass in regards to my Fall 2011 issue article on the temporization of contemporary immediate full arch rehabilitation. First, it made me quite happy as I realized that perhaps somebody actually does read my articles, and furthermore they have sparked the readers' interest enough to take their highly valuable time and write to the editor about it. So thank you to Dr. Arshiya Sharafi and Dr. Hooman Zarrinkelk for your letters.

The authors of the letters have both expressed my shared enthusiasm for the technique, but did not fully share my personal disenchantment with the rather unprofessional and pathetic advertising methodology used to introduce these in the media, and how such practices can and do often degrade the process and our profession. After reading their responses, I still stand by my impressions on the topic, but their letters both were clearly heartfelt so I am very compelled to at least respond to them. Both doctors also feel that there is now preponderance of standardized scientific literature to support the introduction of concept into everyday practice. I have some issues with this notion.

First, to give you some reference, I wrote this article almost over a year ago, before most of the newly-cited literature was even in the press. However, I did look at the most recent literature Dr. Sharafi cited, and interestingly enough, all of the result literature is authored or coauthored by employees/business affiliates of Clearchoice. No, please do not get me wrong and do not again take things personally, Dr. Arshiya. Until I read your letter, I had not heard of you, never mind knew who you were. I also did not know much about Clearchoice to comment on their business and marketing practices. I was commenting on the local Los Angeles area advertising heard mostly on our local talk stations. There are numerous ads there on this very concept. I do not believe you and your corporate entity have any ads in the L.A. market. Be that as it may, as OMS docs, we are supposed to have a bit thicker epidermis than most. Most of us do. I respect the work and contributions of Dr. Charles Babbush, Dr. Ole Jensen, and Dr. Stuart Graves. They are certainly providing us with some framework and as they themselves indicate their "findings are relatively early, 3 years or fewer;" and from the standpoint of peer review level II or better scientific evidence, they include only retrospective single-center data. This is not uncommon in implant literature. In fact, all other dozen or so 2011 and 2012 published papers on the topic have only data from a couple years' follow-up at most. As I stated in my article, the only long-term data that was available in 2010 for these techniques came from Dr. Paulo Malo.

The completion and publication of independent, non-sponsored 10-year data is very important so that an "apples to apples" comparison can be made versus the other traditional treatment options. These are readily available for graft-based implant procedures. Also, we may get a better sense what the 'real world' success rates are outside the offices of Dr. Paulo Malo and Dr. Babbush. Just to underscore this point, I am showing you a picture of a case I recently inherited from a Colorado-based practice that would meet the criteria of success in some of the articles cited. In my humble judgment, this is not success. Is this the real world success? What it really is, is a failure waiting to materialize fully in the next few years. As time goes on, we will see more of this.



All on four case with a prosthesis and fixture element failures at two years past restoration

Drs. Sharafi and Zarrinkelk, as well as I, entered the specialty after the Proplast era and subperiosteal implants. Both had their day in the sun. Maybe that is why some in our generation of surgeons feel that they want to hang their hat on a few month's worth of biased and scientifically impure follow-up data. Time will prove if that is the wisest approach. Once again, please do not get me wrong, gentlemen, I am not diminishing the potential and benefit of this approach. This technique is a very cost effective and relatively rapid way to deliver great life-changing patient care. That is why I wrote the article about it in the first place.

However, I deeply do care about how we practice our healing art and our patients' care. I deeply care about our specialty. I am certain that most of us do. I come from 3 generations of dentists and have seen dentistry drastically decline into a gimmicky business from a well-respected profession in the last 15 years. The patients are still the same, the diseases have not changed; even our techniques and equipment have not advanced that much considering other fields of science. What has changed is the unchecked allowance by our "professional" community for commercialism, practice efficiency modeling, marketing, up-selling, and all the other things that would make my grandfather turn in his grave and my mother cringe. So pardon my expressions of deep disappointment with the current affairs of our dental implant community--be it dentists, surgeons, or the new dental corporate entities. I was not "relieving aggression" as Dr. Sharafi perceived it. I was voicing my concern and frustration on where we are collectively heading. This concept just seems to be surrounded by those concerning practices.

Also, despite the fact that I mentioned "implant centers" only once and only in one sentence out of the entire six-page article, I did not name any one specific entity by name. Dr. Sharafi seems to feel that my

whole article was all about him and his outfit. Well, the article was not about Clearchoice. As is said, "No animals were harmed in production" of the article, and I had no specific targets to assassinate. Until his letter was received, I had only heard of Clearchoice in passing and have not even seen their ads or their impressive website. However, I took time to educate myself since then and was amazed by the corporate structure, advisory boards, and the whole model of operations. I highly recommend that all our members look up their website and explore the site, especially the pages on Clearchoice Management Services, LLC and Clearchoice Holdings, LLC. The most remarkable part of the Clearchoice entity is the business advisory board made up almost entirely of dental health care outsiders, including the likes of past financial portfolio and investment mangers, lawyers/business and real estate developers, and even former coal mining executives. It is not readily clear to me why they have made a choice in their lives to help fund this very unique niche market. Perhaps it was for the betterment of their fellow mankind's mastication. Regardless, we all may be very thankful for it in the end.

The last point that I wanted to address from Dr. Sharafi's letter is that of my personal involvement in the restorative aspects of implant dentistry. In a successful referral-based practice, we need to be involved to the extent that the general dentists want us to be involved. The old days of slapping on the healing abutment and 'off you go' are gone. We are competing with other very capable and attentive specialists who do deliver custom milled abutments and temporaries, and include the abutment dye and even scan the implant fixtures with Itero or Encode digital scanners in their offices to help the restorative office. I know each surgeon has a different background so each individual's take on this may be different. Before completing my surgery residency in 2003 and becoming a board certified oral and maxillofacial surgeon, I practiced general dentistry for eight years. I placed and restored my own implants since the mid 90's. Many of the dentists I work with are great people and skilled operators, but are not ready to tackle these complex procedures at this time. It is, after all, a brand new technique even to us. Remember that some GP's often struggle with a single solid "snap-on" type abutment. It is imperative that we as the mentors and experts help to ensure that the patient receives the best possible care even if it means that we perform parts of the restorative procedure or directly help with the delivery of these. Everyone benefits from our extra efforts. The referring doctors really do appreciate our help and involvement on these cases until they develop their level of confidence and expertise. The patients get the care they need from their family doctor, but with the extra controls and oversight of a specialty provider.

As per Dr. Zarrinkelk's letter, he very proudly noted "that elimination of grafting procedures from my discussion with patients seeking treatment has been the most powerful tool in increasing case acceptance. It is also noteworthy that my results have been more predictable and successful than when I was utilizing the traditional grafting procedures." My only fear is that a tunnel vision approach may set into our minds where every case gets the full arch immediate rehab with crestal resection no matter what the state of the remaining or opposing dentition is. In many cases that may not be in the patient's best long-term interest. A sinus lift or GBR should still be considered for those patients. Each case should be evaluated and considered based on the basis of its individual merits and the patient should be given all the options, risk benefits, and costs as part of their informed consent process. Failure to do so would be professional negligence…

The immediate full arch rehabilitations procedures are certainly making a good case to be here and stay, but it will be interesting to see how their long-term success will stand up against other more conservative approaches and also how the prosthesis and angled fixture durability will pan out in the open practice on a long-term basis. One thing for certain is that the long success of the dedicated "implant" centers that are purely devoted to delivery of this type of care will be closely tied to the long-term success and reputation of this currently exciting and quite progressive procedure. Let's all revisit this paradigm in a decade.

Risk Management Corner

When the Cabinet is Bare—Importing Medications from Foreign Countries

What happens when you write a prescription that can't be filled? Shortages of Doxil, Adderall, and many more drugs are causing issues for patients with a variety of cancers, attention deficit hyperactivity disorder (ADHD), and other diseases. Many of these drugs are generic injectables in which the drug price doesn't reflect the cost of manufacturing and so has been dropped.

Combine shortages with another common ailment—namely, the patient's financial condition—and importing drugs from foreign countries can seem like a reasonable solution to patients searching for unavailable or expensive medications. Whether from the Internet, trips across the border, or, at least in Florida, from a pharmacy called The Canadian Drugstore, foreign-sourced drugs are seemingly everywhere.

Because drugs imported from foreign countries are not subject to the Food and Drug Administration (FDA) oversight and monitoring, they may lack the quality controls that ensure drug safety. In October 2011, President Obama directed the FDA to take action against the supply shortages, and the agency is reviewing its policy on reimportation.

Consider the following legal issues regarding importation and reimportation:

- It's not legal for you or your patients. Under the Food, Drug, and Cosmetic Act, it is against federal law to import unapproved, misbranded, adulterated, or foreign versions of U.S.-approved medications into the United States.
- Medical professional liability coverage issues may arise, given the exclusionary language of many professional liability policies.

Foreign-sourced drugs may increase safety concerns about drug interactions, may lack tamper-resistant packaging, and may vary in dosage.

Consider the following medical management practices to help manage your patients:

- Ensure you have an updated medication history on each of your patients. Find out if the patient is taking medications that are imported.
- Encourage patients to use one pharmacist as a means to help prevent drug interactions when combining medications. One pharmacist will maintain a current medication profile that lists all medications prescribed from any and all prescribers, thus increasing detection and prevention of potential problems.
- Educate your patients about the risks of obtaining drugs from foreign sources.
- Consult with your local pharmacist on appropriate generic substitutions that are available with the patient's insurance coverage.
- Consider financial concerns and alternatives when prescribing medications. Many pharmaceutical companies offer drug assistance programs. Some pharmacy chain programs offer generic prescriptions at a low cost.
- If you are considering using an off-label drug, have a well-documented informed consent process.

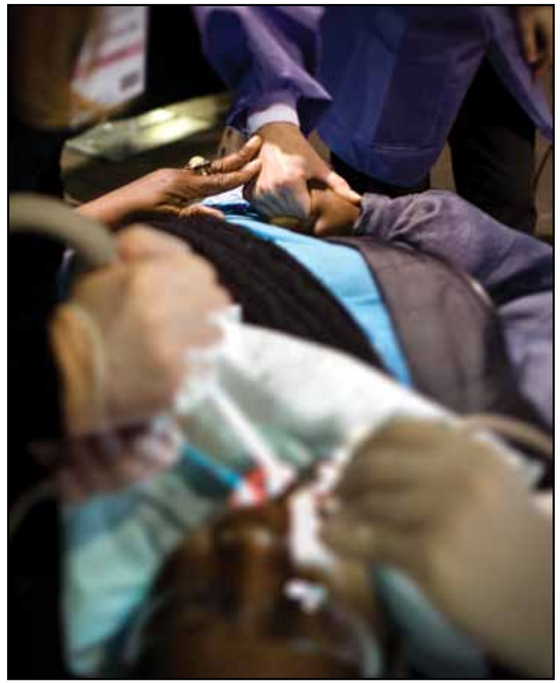
Contributed by The Doctors Company. For online resources, such as interactive guides, National Patient Safety Foundation tools, and more tips, visit www.thedoctors.com/psw.

THE DOCTORS COMPANY

CALAOMS Hosts RAM Continued from page 1

venues. In Oakland, we saw 2086 dental patients; and in Sacramento, we saw 2141 dental patients for a total value of $1,788,347 worth of donated care.

I, again, had the pleasure of helping to organize and help oversee the dental aspect of these two "expeditions" as RAM calls them. The four 12 hour days were exhausting and exhilarating; but also some of the most rewarding projects I have been associated with. Along with our department leads, Dr. Don Rollofson and Dr. Sean Roth in triage, and Cathy DiFrancesco in hygiene, I got to work with many wonderful volunteers who all share the desire to give back to our communities and our wonderful profession. We saw the full range of patients, from those who had routine dental care until recently - for a variety of reasons (mostly from loss of employment and dental benefits) - to those who had not seen a dentist for many years. Treatments included the full range as well, from hygiene to many restorative procedures to full mouth extractions of non-restorable teeth. Regardless of the treatment received, virtually all the patients I dealt with were very appreciative and freely gave out thank you's, hugs, and handshakes.

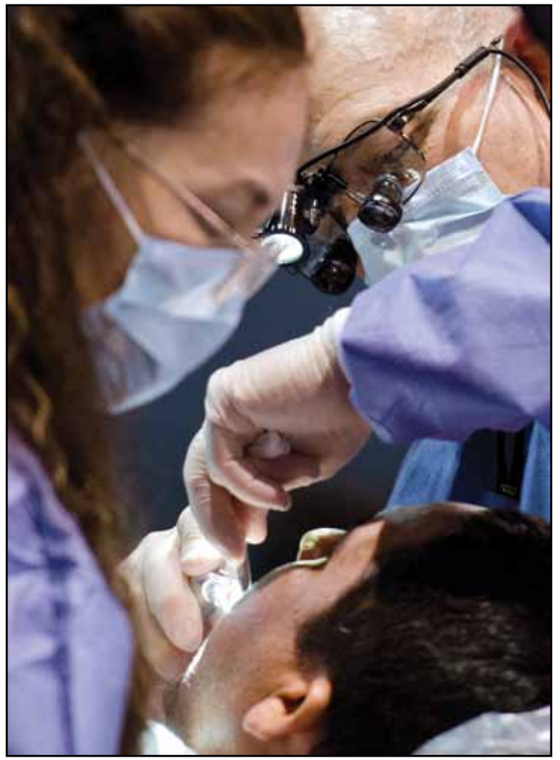


RAM Clinics are not just about providing treatment, they are also about providing compassion and hope to our neighbors.

Many of our dental volunteers were part of the clinics last year and will be involved next year and years to come because of the personal reward and sense of accomplishment. Many of those who joined us for the first time this year will be back next year for the same reasons. There is a certain camaraderie within our group and I must thank each of them for their hard work and I look forward to our next expedition.

Angeline Tamayo, RDH cleans a patient's teeth in the 34 chair hygiene section of the dental floor.

Olga Borodenko (right) demonstrates proper preventative dental care to patients as the clinics also strive to educate and teach preventative care as well.



Dr. Norman Spalding, DDS and his wife Flora are only a few of the husband and wife teams that work together to provide care.

I would be remiss if I did not thank those who were responsible for bringing RAM back to our two venues and to those who helped organize, set up, and maintain the equipment and supplies so that we could do what we do best - providing dental care. Thank you to CALAOMS and Tzu Chi for seeing the need, the awesome RAM volunteers from Tennessee who kept up with the demand for instruments in sterilization, kept our stations supplied, and kept our equipment running. The wonderful Tzu Chi volunteers who always had a smile on their face, and in most cases, anticipated our needs and had them taken care of before we needed to ask. The CALAOMS staff who organized the clinics, recruited volunteers, verified professional credentials, and checked volunteers in and out.

And finally, I must thank my wife, Kathi, for taking on the responsibility of problem solving from finding dental assistants for everyone, chairs for each of our practitioners, solving patient concerns, and tracking down routing slips when questions arose and generally keeping the flow going. Her help was invaluable.

For anyone who has not experienced a RAM event, I highly recommend joining us next year. Regardless of your preconceived ideas, I think you will be greatly surprised and rewarded once you come join our team.

Photos provided courtesy of Alvin Jornada Photography. Alvin Jornada is a freelance editorial and documentary photographer based in Santa Rosa, California. You may view some of his other fine works at www.alvinjornada.com. For questions or comments, you may reach Alvin via email at info@alvinjornada.com

President's Message

W. Frederick Stephens, DDS
President, CALAOMS

Trial by Fire

I would venture to say that at some time or other we have all had the experience of being thrown into a situation in which we had to make quick and decisive choices…a so-called "*trial by fire.*" Residency was certainly full of situations like this for me, as I am sure it was for you. This was, in fact, the case for our not-yet-officially-inducted CALAOMS Board and me this past January.

Just days before our first Board meeting in January, we were made aware of a new state senate bill, SB-694, that was rapidly progressing through the California legislature. The bill, which is sponsored by Senator Alex Padilla and supported by the California Dental Association, is an attempt to address current national political pressures revolving around access to dental care for children.

This bill has two major parts. First, it calls for the creation of a state-wide Office of Oral Health within the state Department of Public Health, and it appoints a new Dental Director to oversee the office. Second, and more importantly, it will design and implement a study to assess the safety, quality, cost effectiveness, and patient satisfaction of irreversible *(surgical)* dental procedures performed by traditional and non-traditional *(mid-level)* providers. These mid-level providers would potentially receive only two years of post-high school training to perform these procedures. Based upon the findings of these studies, a recommendation would subsequently be offered for potential scope of practice changes that would allow these mid-level providers to practice in the state of California. For the purposes of this bill, children are defined as being up to 18 years of age.

At the request of a number of vigilant and concerned CALAOMS members, this bill was brought to the Board's attention, forcing us to rapidly research these proceedings--and leading us to produce a position paper. As a dental specialty association in California, "normal" reflex would be to mirror support of the CDA in such matters. We held lengthy factual and emotional discussions: to not support our parent association could place us in a less-than-desirable position with the CDA, and subsequently could affect CDA's potential support for CALAOMS especially in the inevitable event of future issues affecting our specialty.

In spite of these considerations, our Board analyzed the available information and made a decision; which, in our opinion, was in the best interests of our membership and the patients we serve. ***We collectively did not feel that such minimally-trained individuals would be adequately prepared to perform irreversible and/or surgical care of any type. This was especially true for children, our most difficult patient population.*** As a result, we did not feel that such a study was necessary, thus we documented our opposition to the second part of this bill with our position paper. As a Board, we knew this could create potential backlash from the CDA, but it represented our honest feelings on the subject and perception of our membership's desires.

As more California dental specialty associations and other CDA members voiced their opposition to the concept of such mid-level providers, a special CDA House of Delegates was called to re-address this issue in more depth to see if any changes in CDA's support of the bill were necessary. Based on the many calls and e-mails I personally received, our position paper opposing SB-694 certainly played an important role in bringing this bill, along with the CDA's position, to the attention of dental specialty leaders and others in California.

As your new CALAOMS President, I was extremely impressed with the many members who contributed an immense amount of unsolicited time and effort to this subject. I would like to especially recognize and thank ***Dr. George Maranon, Dr. Steve Leighty, Dr. Lester Machado, Dr. Jeff Elo, Dr. Alan Kaye, Dr. Albert Lin, and Dr. Gerald Gelfand*** for their assistance, efforts, and wisdom on this subject. I also want to thank each of our Board members for their hard work and loyalty to our profession, our communities, and the patients we serve.

These are the individuals that make us what we are--the strongest and most influential dental specialty organization in the great state of California. As a result, I am proud to represent you as President. So, keep up the good work! We are all stronger as a result.

Senate Passes SB 694; Bill Moves to Assembly

This article courtesy of CDA Communications

After three committee hearings held in rapid succession to meet second-year legislative deadlines, SB 694 (Padilla), which calls broadly for the creation of a state office of oral health along with a scientific safety study of potential new dental workforce models, was passed by the Senate on Jan. 26 by a 34-2 vote.

The bill now moves to the Assembly, where further hearings on the bill are not expected until at least March. In the meantime, CDA's support position on the bill is on hold until Senator Padilla decides how he is going to proceed.

As reported in the January *CDA Update* (cda.org/publications), Sen. Alex Padilla in early January amended SB 694 in an effort to begin taking a more comprehensive approach to access to care consistent with the policy direction established by the house.

As passed by the Senate, SB 694 is still only a framework with many details yet to be determined, but it encompasses two central elements: 1) establishment of a new state office of oral health with an appointed state dental director who would be empowered to focus greater state attention and resources on the oral health access needs of Californians, and 2) development of a rigorous scientific study using federal or private funds to examine the safety and cost-effectiveness of allowing non-dentists to perform more advanced procedures.

Having passed its initial House, SB 694 must now go through a similar committee process in the Assembly, but instead of the tight January timetable, the remainder of the 2012 legislative year will be available to continue developing the specific provisions of the bill. The next significant deadline is April 27 for Assembly policy committee hearings. The bill likely will be sent to two policy committees: the Business, Professions, and Consumer Protection Committee and the Health Committee. After that, it would need to be heard in the Assembly Appropriations Committee by Aug. 17, and finally be passed by both the full Assembly and the Senate (to concur on any Assembly amendments) by Aug. 31. The governor would then most likely have until Sept. 30 to sign or veto the bill.

Technical Articles

Peter Krakowiak, DMD, FRCD(C)

Contemporary appliance therapy options for the bruxism patient

Albeit not as cutting edge as BMP, All on Four, TADs or Piezo osteotomes, the care of the TMD patient has continued significance to many practicing Oral & Maxillofacial Surgeons. More patients require this aspect of our care then full arch restoration. In general the scope and volume of surgical care for these maxillofacial complex problems has significantly dropped off in terms of number of surgical procedures performed in the past two decades. At our LAC+USC OMS training program only the most debilitated patients receive open joint procedures in the current care paradigm. However the number of TMD patient being referred to our care has been steady if not on the rise.

It may be a good starting point to review general features of bruxism and then discuss some of our contemporary removable appliance options for patients with history and signs of parafunctional bruxism. The therapy issues associated with management of internal joint derangement or osteoarthritis will not be fully discussed in this review due to space constraints and time. As indicated, bruxism can occur during being awake or during sleep. Bruxism during daytime is commonly referred as clenching or Diurnal Bruxism. It is often precipitated or exacerbated by increased life stress and work pressure. Bruxism during sleep either during daytime or during night is termed as Nocturnal Bruxism. Nocturnal bruxism has been classified as sleep related movement disorder accordingly and is related to OSA spectrum of sleep disorders.

TMD patient care which includes bruxism is a fairly large part of my practice as many of other health practitioners either do not want or do not know how to care for these patients. Often the TMD patient is an unwanted orphan of Medicine and Dentistry and often gets bounced around from dentist to a neurologist to ENT surgeon until being finally referred to hopefully somewhat definitive OMS care. Please notice I did not say cure. I said care. Most surgical residency programs do not devote a large portion of their curriculum to removable splint therapy and its efficacy. Most of my knowledge came from courses taught by prosthodontists and gnathologists as well as some trial and error discovery. No matter what our backgrounds are, it is paramount that we are able to see these folks, professionally examine them, accurately diagnose their condition as well as provide them with appropriate evidence based therapy. Yes there is an evidence based method to treating this “little shop of horrors”. No I did not state cure there either.

We are all very familiar with the common approach of firing off a generic night-guard prescription to the lab after the auxiliary staff sees the patient with the lack of any regard for specifics of the patients TMD presentation. This practice simply does not correlate well with providing the highest level of care. A structured specific review of symptoms and their history, careful examination of head and neck musculature,

movement findings such as MIO, lateral and protrusive movement ranges, deviations in path should be made and documented. For purposes of patient education Doppler auscultation (figure 1) and joint sound generation on translation can be made. Also a careful occlusion of occlusal relationship with wear patterns and working, non-working and guidance patterns should be noted. A radiograph of joint structures either panoramic, CT or MRI imaging as well as less commonly arthrography and scintigraphy can be helpful to evaluate the health of the hard and soft tissues from an imaging stand point.

Clinical correlation however is the most important part of developing a treatment plan. Load test with Leaf gauge (figure 2), Lucia Jig (figure 3) and even a cotton roll should be performed to test for joint pain or referred lateral pterygoid causalgia. Mounted models and occlusal analysis with digital bite force appliances such as Tekscan (T-Scan) can also be helpful but are often considered only after the initial management of the condition with appliance therapy and pharmacological adjuncts and only once the patient is deemed to require redevelopment of their occlusal scheme. In the past attempts to make intraoral bite registry system for bruxism were made. More advanced testing for nocturnal bruxism include the EMG recording. The principal advantage of external EMG’s is that the occurrence of bruxism can be assessed without intraoral devices, which may change natural bruxism activity. However there may be some difficulty in precisely quantifying the data of these observations as they record other coexisting oro-facial activities (e.g. sighing, coughing and talking) which cannot be discriminated from sleep bruxism. Also, other sleep disorders cannot be ruled out or other physiological changes related to sleep bruxism such as micro arousal, tachycardia and sleep-stage shift cannot be well differentiated. The addition of recording of the heart rate was recommended as one of the compensatory measures for improving the accuracy of sleep bruxism recognition. A miniature self-contained EMG detector–analyzer (BiteStrip) was developed as a screening test for moderate to high level bruxers. More recently, a miniature self-contained EMG detector–analyzer with a biofeedback function (Grindcare) was developed as a detector and biofeedback device for sleep bruxism. Both devices comprise of EMG and stimulation electrodes, a microprocessor, a memory for data storage, a display for user interface and light-emitting diodes. The portable EMG recording system enables multiple-night recording in a natural environment for the subject with minimal expense. The self-contained EMG detector–analyzer is the most cost effective and precise

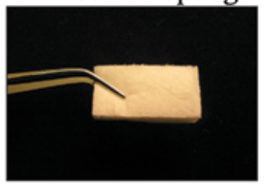
Continued on page 20

Figure 1. Portable doppler ultrasound unit which can be used to help educate patients and better document joint sounds in translation.

Figure 2. A leaf gauge can be used to diagnose painful joint condition and also to eliminate premature contacts in determining the centric record of occlusion.

Figure 3. Lucia Jig is used to determine the most posterior CR joint position and to also elicit pain in retrodiscal or capsular joint tissues on loading. Its’ use for several minutes allows for muscle deprogramming especially that of lateral pterygoids.

Helistat Hemostatic Sponge



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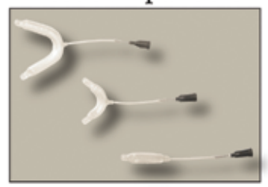

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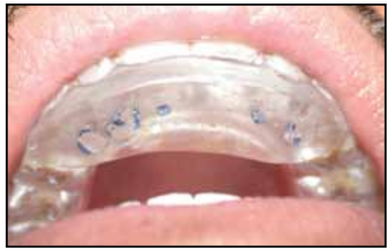

Figure 4. An anterior bite plane needs adjustment to best distribute the anterior contacts over multiple teeth in protrusive and excursive movements at the time of delivery.

Figure 5. An aqualizer is available in different sizes and can be delivered to the patient on the day of initial evaluation. It is both a diagnostic and therapeutic adjunct.

Figure 6. Posterior fluid sacs allow for disclussion of the arches without setting a firm point of contact and hence allow for muscle deprogramming and often quickly relieve symptoms of myospasms.

Figure 7. The flat plane appliance has limited canine rise and allows for group function and balancing contact support in excursion.

Bruxism Continued from page 17

device for detecting sleep bruxism. Finally sleep laboratory based polysomnographic recordings can be ordered for sleep bruxism generally to include electroencephalogram, EMG, electrocardiogram and thermally sensitive resistor (monitoring air flow) signals along with simultaneous audio–video recordings. Sleep bruxism activity is assessed based on EMG activity in the masticatory muscles. Because the sleep laboratory setting offers a controlled recording environment, other sleep disorders (e.g. sleep apnea and insomnia) can be ruled out and sleep bruxism can be discriminated from other orofacial activities such as myoclonus, swallowing and coughing that may also occur during sleep. The major limitation is that a change in the physical environment for sleep can influence the actual nocturnal behavior of bruxer. Another important variable is the expense as multiple night recording need often to be taken as the occurrence of sleep bruxism can vary over a number of nights.

Most contemporary pathophysiologic evidence points to disturbances in central neurotransmitter system as being involved in the etiology of the bruxism. It is hypothesized that the direct and indirect pathways of the basal ganglion, a group of five subcortical nuclei that are involved in the coordination of movements as being affected in patients with bruxism. The direct output pathway goes directly from the stratum to the thalamus from there the afferent signals project to the cerebral cortex. The sleep-related micro-arousal, which is hallmark of rise in autonomic cardiac and respiratory activity, tends to repeat 8-14 time per hour during the sleep. It has been suggested that this activity tends to occur in the onset stages of REM sleep. The sleep stage transitions facilitate the onset of the activity. A strong correlation with OSA has been made and is currently being further investigated.

The increased parafunctional muscle activity can respond to application of anterior occluding devices such as the beleaguered NTI appliance or more preferably anterior bite plane disclussive design based on a full occlusal coverage plate (figure 4) In a study from 2007 by Baad-Hansen, the anterior plane appliances reduced over 50% of bruxism related muscle activity compared to the flat plane appliances. These appliances reduce the elevator muscle activity, release the spasticity of lateral pterygoids and seat the condyles. Many names have been used to refer to the category of this device such as Hawley, Sved, and NTI. In cases where difficulty exists in determining the source of pain symptoms after a full TMD patient exam, this type of appliance can be helpful in further tracing the pain origin as joint or muscle based. The anterior bite plane

device can also work as protective device for porcelain restorations and normal dentition. It has however some limitations. It is to be avoided in patients who have pain in joint loading. Fortunately most bruxers do not fall into that group. The anterior appliances will increase the loads on the TM joints, and hence must be used only in patients who do not have symptomatic joints. These conditions include capsulitis, retrodiscal pain and joint pain on static loading and translation. Sometimes lateral pterygoid spasticity can refer to the joint itself as well. It should be ruled out by deprogramming. If the patient display joint based discomfort when the condyles are seated it will be prudent to fabricate a flat plane appliance and consider making it not in the patient's CR. A bite force test with a Leaf gauge or Lucia Jig is helpful to determine the source of pain when selectively loading the joints in CR. Both tests isolate the joint and remove the occlusal interferences to ensure seating of the condyle into the CR position. Since there are no CO contacts without any teeth touching each other, a true CR is more likely to be located unless the patient is having lateral pterygoid spasticity. The spasticity can be corrected or "deprogrammed" by placing the patient in a Lucia jig or an Aqualizer (figure 5 and 6) for 15-30 minutes and then re-evaluating their anterior points of contacts against baseline contact point on the Jig. Another quick way to rule in or out lateral pterygoid pain referral to joint is to complete a Stabilization test. The test is performed by having the jaw passively restrained by the examiner in patients CR or CO position and asking the patient to try and move their mandible laterally or attempt to open against resistance. If no pain is noted the joint is more likely to be the source of the pain with in movement. However, if pain is elicited without the joint translating the lateral pterygoid muscle contribution to the symptoms is identified. If pain occurs only on one side during excursion it may be still possible to make the appliance with an anterior plane with small modifications. If pain on the working side a group function may need to be incorporated into the design on the symptomatic working side. If non-working side is painful then balancing contacts should be created in the occlusal scheme of the appliance.

In cases where clear joint pain is noted after the pterygoid influence is ruled out the splint design will have to incorporate posterior occlusal stops and reduce any anterior guidance. This scenario is quite rare, however, if not identified these patients are the ones that actually get worse after traditional "splint" therapy with either generic anterior guidance or anterior only appliances. The risks of anterior only appliance use include induction of posterior extrusion or anterior migration with potential of developing aperthognathia. The key to preventing the occurrence of these is to avoid wear of appliances for more than 10 hrs. per day and building full coverage on all splints. Also patients who have a significant difference between CR and MIP or CO may develop postural open bites due to pterygoid posturing when the splint is absent which often results in posterior interference contacts and malocclusion.

The flat plane full arch appliances (figure 7) can be a solution for these patients who may have no pain in CR on loading but these may experience pain on translation or suffer from a lateral pole displacement. The flat plane appliances will still have to build to allow for minimal posterior disclussion during translation but purely due to the condylar movement. Any ramp in the anterior can be reduced to improve the pain in patients who have continued discomfort with performing excursive movements. For those patients who exhibit pain in clenching, a new intercuspal position may need to be developed using the splint. This can sometimes be also provided by constructing an anterior positioning splint that re-establishes the hinge axis for the joint in a more anterior position that its CR location. These appliances are somewhat difficult to make and are controversial in their long term impact on the joint and occlusion. However short term therapy may be beneficial as long as a close follow up is maintained. In patients who are comfortable in clenching but exhibit pain in excursion the anterior ramp of a flat plane appliance may have to be further adjusted. The flat splint is also helpful in the prosthodontic reconstruction to develop the tolerable guidance patterns by reading the ramping features.

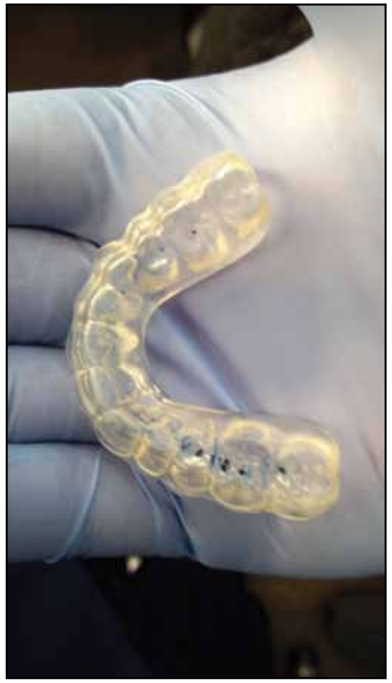

Figure 8. A soft acrylic splint with significant posterior working side contacts needed to establish group function and joint support for patients that are either non-candidates for anterior bite plane due to joint symptoms or use of any hard splints in general.

In patients who are still not able to tolerate the acrylic resin hard splints either flat plate or anterior plane and especially patients with internal joint pathology a trial use of full coverage soft splints is indicated. These splints lack any specific guidance patterns and will mostly function in group function (figure 8) while providing posterior support to unload the condylar head.

To be more complete in our understanding of treatment options we will briefly touch upon Biofeedback therapy and Pharmacological adjuncts. Up until now limited success and efficacy has been offered by various methods of biofeedback therapy. These include stimulation of subjects with motor and taste feedback pathways. Unfortunately due to prevalence of nocturnal bruxism during periods of sleep any consequences of the frequent arousals, like excessive daytime sleepiness will need further attention before these technique can be safely applied in treatment of patients with bruxism.

The pharmacological management of bruxism has been studied increasingly over the past decades. The standard application of muscle relaxants has been very well established and most patient benefit from low dose qhs regimen of either Soma or Flexeril. These are often combined with NSAID therapy and or low dose steroids. Many patients however are not able to take these medications at therapeutic dosages due to significant depressive side effects which inhibit their ability to carry on their daily activities. Newer medications being evaluated are drugs that have paralytic effect on the muscles through an inhibition of acetylcholine release at the neuromuscular junction such as botulinum toxin. These agents have shown to decrease bruxism activity especially in severe cases with such co-morbidities like coma, brain injury, amphetamine abuse, Huntington's disease and now even autism have been evaluated and Botox has been applied with some success. Also the studies on effects of serotonergic and dopaminergic medicines in the treatment of sleep bruxism have been completed. The catecholamine precursor l-dopa exerted a modest but attenuating effect on sleep bruxism. So did the administration of low doses of the dopamine D1/D2 receptor agonist Pergolide in a severe bruxism cases. Most notably the selective alpha-2 agonist clonidine seems a promising medicine for the management of sleep bruxism, although further safety assessments are still required because severe morning hypotension was noted in approximately 20% of the study users. It can be concluded that although some pharmacological approaches for bruxism seem promising, they all need further efficacy and safety assessments before routine and broad based clinical recommendations could be made.

Finally, most TMD patients including bruxers benefit from some psychosocial evaluation and management. The management of psychosocial stressors, coping mechanisms and improvements to deleterious habits and lifestyles should also be considered. Since these problems can often progress or be part of chronic pain care the comprehensive approach utilizing neurologists and in some cases psychiatrists is also advised. Certainly once stable in term of the symptoms, these patients may need occlusal rehabilitation and in some cases orthodontic evaluation to optimize their occlusal schemes. Long term follow up care is indicated even after initial incidence of acute bruxism and the related myofacial pain symptoms.

AAOMS Alert!

EtCO2 Monitoring to be Required in 2014

The AAOMS Committee on Anesthesia and the Board of Trustees have approved the mandatory use of capnography on all moderate sedations, deep sedations, and general anesthetics effective January 1, 2014. This position will be reflected in the 2012 AAOMS Parameters of Care.

California Maintains A large Influence Within ABOMS

Dr. Mary Delsol, who practices in Dana Point and Lake Forest, California, is currently the 2011-2012 President of the American Board of Oral and Maxillofacial Surgery. Dr. Delsol served on the ABOMS Examination Committee from 1998-2005, after which she was elected as a Director of the Board. Dr. Delsol, who has been a long-time proponent of organized dentistry, has also served as President of the Western Society of Oral and Maxillofacial Surgeons in 1999, as well as President the California Association of Oral and Maxillofacial Surgeons in 2002.

California OMS who are members of the American Board of Oral and Maxillofacial Surgery for 2012 are L to R: Vincent Farhood, Doug Johnson, Sanford Ratner, Fred Stephens (CALAOMS President), Larry Lytle (CALAOMS Immediate Past President), Earl Freymiller, Jeff Dean, Mary Delsol (ABOMS President), M. Anthony Pogrel, William Clark, Bruce Whitcher, Robert Relle, Alan Herford.

Ethics Debate

Steve M. Leighty, DDS
Chair, CALAOMS Ethics Committee

"I was just thinking about…"

I have spent a lot of time thinking about ethics and politics recently. 'Access to care' and 'mid-level providers' are issues that are permeating the dental community across the country. Would you believe there are colleagues who are not even aware of these issues? It's true--I talk to them every day. This article is about how I was forced to confront my sense of ethics.

In May 2000, the Surgeon General called attention to access to care deficiencies in dentistry. President Obama made healthcare reform a major policy act early in his administration. Many states either have, or are considering, legislation to allow non-traditional or non-dental providers to provide dental services to underserved patients.

Some of the world's first dental therapists were trained in New Zealand. Alaska has Dental Health Aide Therapists (DHATs) who are allowed to perform a wide range of procedures, including extractions and restorative procedures--using a handpiece. Alaskan DHATs are being trained at the University of Washington, and are currently restricted to working on federal Indian reservations. They have supervising dentists—generally present via phone. In some states, mid-level providers come from within the Registered Dental Hygienist (RDH) ranks.

I serve as a Director with both the CALAOMS board and the Western Society of OMS board, and am a CDA Delegate for Sacramento District Dental Society. I have been a CDA member since my 1st year at UCSF, and have been a strong supporter of organized dentistry.

Since the CDA House of Delegates last November (2011), I have found myself testifying to the California Senate Appropriations Committee, looking at a petition calling for a *special* House of Delegates, and sifting through a barrage of daily emails that dwarfs anything I've ever seen--not to mention conference calls, caucuses, and reading hundreds of pages of background material. In the process, I've struggled internally about whether I was doing the right thing. What if my personal view was in opposition to CDA's support of California's own SB 694? Is it ethical for a dentist to be opposed to CDA's political or policy agenda?

At our CALAOMS meeting in San Francisco in January, the Board of Directors voted to create and publish a position letter in opposition of this bill that CDA supported. There was conflict in that I was a member of both organizations. I testified at the Senate on behalf of CALAOMS…more internal conflict within a week.

When I watch the process of choosing a GOP candidate, I have feelings ranging from laughter to despair. I ask myself whether I'm watching legitimate political discussion or entertainment. The newspaper is full of conflicts: domestic drilling policy, 'Occupy Wall Street', and global warming—to name a few. In ethical terms, where do we draw the line for dental politics?

Recently, *Christianity Today* ran an interesting article asking the question of how a Christian should act in this age of ever-polarizing political activity. Is God honored when people claiming to be followers lash out with outlandish accusations of their opponents?

My follow-up questions for us in the dental community are: *Are our patients (the public) well served when the dental community disagrees so strongly with each other? Is our profession well served when we dentists are divided?*

We dentists are not acting to make policy decisions in a vacuum. CDA, our component societies, CALAOMS, other specialty organizations, the California legislature, the Foundations, our lobbyists, and PACs all have a stake in this argument.

Growing numbers of people are frustrated with government at many levels. Why do politicians battle so much among themselves? Why does the government take so long and seem to be so ineffective in addressing and solving so many problems?

The article in *Christianity Today* (January 2012) is taken from a book by Amy Black entitled *Honoring God in Red or Blue: Approaching Politics with Humility, Grace, and Reason*, to be published soon (Moody, June 2012).

Political scientists categorize political questions in two groups: easy or hard. **Easy** questions are often moral in nature. For instance, gay marriage, abortion, or medical marijuana are issues that most of us quickly and instinctively choose one side or the other. Although the issues may themselves be complex, the focus is on the end goal.

On the other hand, even though virtually every American would say that terrorism is wrong, the solution for the best way to fight terrorism quickly splinters us apart. Should we go to war? Should we institute economic sanctions? How much money should we budget? These are **hard** question**s** because we can't agree on the best means to get to a common endpoint--which we all do agree upon.

I tend to place access to care in the *hard* category since it seems like we would all agree that everyone should have dental care, right? At least the kids, right? Actually, even that statement is controversial. At the federal level, President Obama's healthcare reform policy presupposes that healthcare is a <u>right</u> to all people. Many people question that policy. Similar conflicts are associated with access to care background. For instance, I've seen conflicts among the information and maps that identify 'underserved' dental areas.

I've heard the argument that instead of focusing on the 30% of patients that are underserved, dentistry should celebrate the 70% that are well served. Active discussions among the various stakeholders involve the definition of the terms: provider, non-traditional, alternative, irreversible, expanded, and so on. There are well-developed arguments surrounding even the need for, or design of, research projects involving the study of mid-level providers. I have to conclude that this issue is even more complex than it appears because of the difficulties in defining the problem itself and the potential solutions.

When we disagree on the ends (*easy* questions), the two sides use absolutist and moralistic terms and tend to be judgmental of the opposing view-holders. It is tough to compromise in these situations. When we disagree on the means (*hard* questions), it seems more likely that there could be room for compromise and negotiation.

How should we as dentists conduct ourselves and our discussion about political and policy issues? One option would be to remain neutral and leave this up to "someone else" (leaders and lawmakers). Another option is for <u>all</u> dentists to educate themselves and become engaged on some level. We in representative or leadership roles should already be committed to researching, discussing, and being in dialogue with other stakeholders.

Prompted by this ethics article from the magazine, I offer a few suggestions for those dealing with difficult decisions.

1. Admit the complexity of political issues.
Most of us wish to solve problems quickly and cleanly and get back to the business of dentistry as soon as possible. Access to care may be an issue that will be a longer, multi-step process. Given the stakes of our decisions, it is important to ask questions, expect transparency, and understand the issues, the stakeholders, and the process

2. Play fair with the war of words.
We should not engage in vicious attacks nor support those who do. Overstatement is sometimes necessary to highlight important differences and simplify complex points. Those who use catch phrases or one-liners should not use them to demonize our rivals or distort their positions.

3. Engage hard issues ethically.
Politics has the reputation of being a dirty business. As dental professionals, we should strive to avoid extremism and the fueling of political fires. We should challenge ourselves to find ways to firmly but respectfully disagree with our opponents, utilizing truthful and civil political engagement. If we look at those who disagree with us as enemies, we lose the opportunity for meaningful dialogue and mutual respect.

I have many friends who are on opposing sides of our access to care issues. These are professional colleagues for whom I have great respect. As a general rule, I don't like being confrontational. As I mature (I'm aging for sure, I hope there is some maturation) though, I see that it is wrong to remain silent when I have something to say or contribute to an argument. How do I do that in an ethical manner?

Get informed, act professionally in all of your affairs, and join with your colleagues in solving the issues affecting dentistry. It is only through our combined strength and ethical behavior that we have a chance to make California dentistry even better than it already is.

Since this article was originally written, the special House of Delegates occurred last weekend in Oakland. I was pleased to see that the discussions and floor debate were professionally conducted. Resolution 1S6 was amended and passed. I think it was a good start to some healing and renewed cooperation between the two sides. We now need to roll up our sleeves and continue to represent the dental community in the best, and ethical, way that we can.

Technology: Get on Board or Miss the Train

Inbound Marketing for Oral and Maxillofacial Surgeons

by Adrian Zahid

The Power of the Internet

The internet has revolutionized how we do business with each other. Those who are unable to catch the new shifts in the way we connect are not only falling behind, but are missing out on the great conversations being held online. Consider this fact about the internet and social media tools: Facebook has more than 845 million monthly users (as of December, 2011). If Facebook was a country, it would rank as the 3rd largest country in the world behind China and India. One out of seven people in the world have a Facebook account. A collective 1,333 years, in terms of time, are spent on Facebook every day. Twitter is the preferred communication tool for those of both Generation X and the Millennial generation (Generation Y--those born after 1980).

Studies show Wikipedia to be as accurate as the encyclopedia; and if you were paid $1.00 for every new article added to Wikipedia, you would earn $1,712 per hour. LinkedIn just won $8 billion for its IPO, and its average user earns over $100k per year. Twitter has over 156 million users and has been used as a micro-communication tool by those ranging from celebrities to revolutionaries. 150 million blogs are created each year. Google drives the search business with 64.1% of all internet users preferring to use Google as their search engine.[1] Each person coming to the search engine comes with a question or a desire. Google's success lies in finding what the searcher wants within 1 to 3 clicks.

Old Advertising is Expensive

Direct mail campaigns predate television and radio ads with companies like JCPenney and Sears getting their start using mail order catalogs. The power of direct mail lies in casting as wide a net as possible. The returns are less than 1-2%, which means most of the brightly colored pieces of mail end up in the trash with the rest of the junk mail. With the invention of the radio, and a few years later the television, we embarked on 40 years of the "golden years" in advertising through interruption. Super Bowl ads aside, few consumers enjoy interruptions to their viewing experience by commercial advertising. In the early years of television, we had four channels to choose from, and all that the companies had to do to advertise was purchase air time. The Eisenhower Interstate Highway System gave rise to billboard signs, newspapers started selling more and more ad space to please shareholders, the sporting industry got a huge boost when athletes started endorsing products--hawking everything from shoes to facial and hair products. With the proliferation of cable consumers, viewers were forced to watch 8 minutes of ads for 22 minutes of show content. Not surprisingly, most viewers opt to tune out to the ads.

Trying not to be outdone by social media, older methods of advertising, such as television and radio ads, have increased 10-fold in the last 4 years, bombarding the average consumer with nearly 3,000 ads per day. Unfortunately, the consumer is tuning out. Studies show that nearly 90% of television users and 95% percent of internet users skip ads if they can.[2] It doesn't pay to interrupt people like it used to.

As a health care provider, the cost per acquisition for patients is, in most cases, 4 to 6 times higher using older methods of advertising. On the other hand, more people are "consuming" based on recommendations of their friends through Web 2.0 and social media. Consumers are becoming more interested in seeking out people who have tested out products and

services before buying. This may reflect the changing economy where more consumers would prefer to buy after doing some research and reading some recommendations rather than buying out of impulse. The old adage, "one half of marketing dollars are wasted, but we don't know which half" is increasingly true about older methods of *interruption* marketing.

The return on investment for newer methods of finding patients is sometimes 400x to 800x, and most dental specialists are walking away from huge savings and increases to their bottom line. The best kept secret of Web 2.0 and social media marketing is that unlike older methods of advertising it is personalized, demographically targetable, infinitely measurable, and easily adapted to changing conditions in the marketplace. You can test your way to success in marketing your practice online and offline by allowing your website visitors to tell you what they responded to on your site by analyzing the time they spend on a particular page and the way they click through or away from your site.

Violating Rule Number One

Most in the healthcare community have been slower to adapt to social media than average businesses. This may be due to an over-reliance on direct mailings and generalist referrals. Most dental practice websites violate search engine's number one rule: *no duplicate content*. Having duplicate content--content that is displayed on other websites--is the kiss of death in terms of search engine positioning.[3] Consider what would happen to television viewership if all of the channels displayed the same show on every channel, yet many dental websites display the same FAQ's, exact word-for-word procedure descriptions, images, and, in egregious cases, are not viewable on newer devices, such as iPads and smart phones due to excessive flash media content.

If No One Finds You, Do You Really Exist?

Most doctors who have minimal trust in the effectiveness of online advertising obtain a cheap website that resembles their business card and has poor content quality. Having paid their unemployed brother-in-law's friend to get some presence online, they rest assured that they have done their part, or they sign up for the $39.99 to $79.99/month "all-inclusive" plan that never ends--trusting the website company to host their website (and thousands of others), market them, and rank them and their competitors all on the first page of Google. The result is usually that very few or no patients come through the website, leaving the dentist confirming his belief that "practice websites do not work."

To be found online, you need to have targeted web traffic. People looking for "sofa covers" coming to your website will click away no matter how compelling your content is. The real success lies in positioning your website for searches that reflect your services; for example, a mother looking for an oral and maxillofacial surgeon to remove her child's wisdom teeth searches in Google for "*wisdom teeth removal* in (her city)." If your competitor shows up in the ranking at or near the top of Google, they get the patient and the business. The difference between the percentage of traffic between the first-ranked website on Google and the second ranked web page is 34%.[4] Most people do not click past the first page on Google for their search. It's time to reshape the way we think about marketing. Stop pushing. Start attracting. Stop interrupting. Start engaging.[5]

Savvy Tools and Marketing Principles to Boost Your Earnings

There are some web and social media tools that you can use to increase conversion rates (number of people who contact you online and walk into your office), help you get found online (Search Engine Optimization, or SEO), and analyze behavior-driven communication with potential patients that can help nurture them and turn them in to business leads. These tools are available online and are free.[6] It is worth every dollar, though, to invest in a professional search engine expert or inbound marketing company who can give you measurable results on your investment.

How to Drive the Right Traffic to Your Website (SEO)

Good and relevant content is king. A consumer will search until they find what they are looking for. Invest in quality, original content that is written for the consumer and for the search engines. There are 2 types of visitors that come to your website: search robots and humans. Search robots ignore untagged images and (most) flash content, but read titles, meta tags, search tags, and some written content to index your site. Think of this process of indexing your site by a search engine robot as putting a file with pages in a filing cabinet. The cabinet is the search engine and the file is your website name with the pages being the individual pages in your site. If your site is well tagged with titles and meta tags, it will be easier to find in a stack of literally hundreds of thousands of files in the cabinet drawer labeled "oral surgeons." Humans read words and click on images and watch videos. They are motivated by pleasure, fear, altruism, and money. If your website can demonstrate how you will increase their comfort and decrease their anxiety and costs by getting a certain procedure done, they will be more motivated to consider *you* rather than someone else whose site offers mere procedure descriptions and no personal touch.

Search engines rank websites in order of what they feel is relevant to the searcher. The process of aligning your website with the greatest number of searches and positioning your website to be near or at the top of the search results is called search engine optimization, or SEO. Factors that affect the SEO are search volume, time of the day, and search engine algorithm changes from time to time; it is not a one time effort on your part, but an ongoing process. Since the folks at Google cannot read every website out there, they trust their robots to catalog websites and display them based on user needs and search trends. They also rely on the popularity or relevancy of the content by how many "back-links" (other websites linking to your site) there are. *Beware of linking scams that back-link your website from poor or non-relevant sources as it can earn your website a ban from the search engine if caught*. Well-ranked dental practices on Google often have hundreds, if not thousands, of quality links to their site.

Having a well-written and frequently updated blog (a scheduled set of updates that readers come to expect) can dramatically and inexpensively increase the chances of your website being found. A blog increases your indexed pages, on average, by 30%, thus ensuring your website has an even better chance of dominating the coveted 10 slots on the search engine's first page of search results. Hiring a blogger or a company to produce quality content for your blog is fairly inexpensive; in most cases their fees run not more than $50 per 150 word blog post. Reputable bloggers in your city are usually willing to write for free if you guest blog for them once in a while.[7] You may also receive "bonus point exposure" for writing a short article to post in your city newspaper, or for doing a free interview segment on a local radio station.

Technology today saves you time by allowing you to write or produce content in one social media tool and promote it in every other tool with one click of the mouse. Produce a video on YouTube about your practice and you can easily show it on your company's Facebook page for your patients and fans to "Like," which instantly shows it on their pages to their friends and families. Your Facebook page can be configured so that people can book appointments at your office through the practice page on Facebook. Facebook Ads can be segmented by various socioeconomic factors. More and more users are using their smart phones to pay for and search for services online. By possessing the requisite Mobile SEO, you are ensuring that a Google Maps search for "oral surgeons (in your area)" positions you at the top of the results for directions to your office (and increased revenue for you).

Pay-per-click advertising (PPC) is gaining popularity in some dental circles because of its proven ability and potential to bring you customers the minute you begin running the ads online. As the name suggests, you are paying per click, which means you pay the search engine for every click on your ad which

displays on top of the "organic search results" in the sponsored search section and on the side, as well.[8] You only pay if someone visits your site or landing page. There is no charge if no one clicks on your ad. Most of the time, the search engine charges less than what the full amount would be to position the ad. The best way is to design a specific landing page (it could be a particular page on your site--not necessarily your homepage) that meets the need; for example, a landing page dedicated to wisdom teeth extractions only. After designing the page, you create an ad and include words you feel someone searching for information on wisdom teeth extractions will use; for example, "taking out wisdom teeth." Then, set a maximum bid amount, such as $0.25 per click or $5.25 per click, to set you as high as possible. Keep in mind, though, that relevance trumps money, so keep your ads relevant to your landing page. You might pay $45.75 for a total of 10 clicks, of which 2 visitors convert to patients, each paying you $2,000 for their procedures. Your cost was only $45.75 and your revenue was $3,954.25. Can you see how return on investment (ROI) could be 10x - 100x or more with more targeted clicks?

Web analytics software serves as a crucial hub for measuring the success of your advertising efforts. Google and other search engines provide free web analytics software that is robust enough for dental practice marketing analysis needs. Google Analytics tracks visitors through a line of code that is put into your website to track various data metrics and goals ranging from demographics, such as which surrounding cities your visitors are coming from to content such as the pages visitors are viewing on your site, to measuring the success of your Google Adwords campaigns, to which pages do most visitors leave your website from.[9] By creating goals or paths through which you expect visitors to take through your site, you can see data on how much time they spend on average per page and how they progress through your site. For example, someone might first go to your "Procedures" page, and then check out your "About Us" page to read about you and your team, then they might look at the "Frequently Asked Questions" page, check out your blog, and read a few articles there before filling out the contact form.

According to Avinash Kaushik, a premier web analytics guru, in his book Web Analytics 2.0, he says that key performance indicators (KPI) and actionable insights (AI) are what a busy business owner or, in our case healthcare provider, needs to look at to have sound online and offline marketing strategy.[10] The most telling KPI is the bounce rate on your individual pages--how many people land on your web page and click the "back" button to leave immediately. Reducing your bounce rate by even 10% can raise your conversion rate significantly. AIs are direct actions you can take--based on data--that help you make actionable decisions whose effectiveness can be relentlessly measured.

Test Your Way to Success through A/B Testing and Multivariate Testing

There are various tools online to test how visitors click through your site such as ClickTale that can save and replay up to 10K visitors' behaviors on your site showing you how they arrived on your site, what they looked at, and where they clicked next. Most importantly, it can also give clues as to why they left. A good web analytics professional can help you analyze the visitor logs and help you see which pages are underperforming so that you can replace them with better performing pages.

Website optimizer tools allow you to test various versions of your website to test colors, fonts, layouts, landing pages, pictures, videos, and content to see which combinations attract and get visitors to convert to contacting your office through the contact form. Simple A/B testing compares one website configuration against another, while multivariate testing allows you to test (literally) hundreds of variations by splitting up your website traffic to show you which combinations bring you the best ROI. Small improvements in design, layout, and even the color of buttons on landing pages have shown to increase conversions.

Companies that continually test and improve win consistently over those who keep static pages.

Engage Your Audience

Seth Godin, a former vice president at Yahoo!, whose blog, "Seth's Blog," is the 12th most read blog[11] in the world,[12] writes a blog post 7 days a week and has being doing so for 10 years. He wrote and published a free ebook titled Releasing the Idea Virus which has become the most downloaded ebook of all time. In it, Godin talks about the value of attention. Marketers spend trillions of dollars each year trying to get the most valuable commodity in the world, a consumer's attention. Gaining the attention of somebody is very hard, but losing it just as easy. When visitors come to your website, what is your message trying to convey to them? Do you demonstrate that you are listening to their fears, their concerns, and looking out for their needs?

Social media is just people having conversations online. "Word of mouth" is still the greatest driver of business, and social media allows patients to "remark" about your remarkable practice. The care your team showed at the consultation visit to allay the fears of an aloof teenager, the way you and your staff patiently answered the questions of a worried mother during post-op instructions, the special touch of you, the surgeon, calling the patient at the end of the day to see how they are recovering all go a long way in encouraging your patients to promote you. The old method of advertising was to visualize a funnel and put as many prospects at the top of the funnel and hope they don't leak out. The new way is to turn that funnel sideways and allow your patients to use it as a 'loudspeaker' through social media to let their friends, family members, and co-workers know that your care was exceptional and that they personally recommend your services. Having patients come through your website is great, but having the majority of your patients referring or bringing their friends to you is priceless.

Adrian Zahid is a web analytics professional who co-owns ANM Design & Marketing, a company that positions non-profit, healthcare, and law firms on the internet. For any questions or comments, you can contact him at anmwebdesign@gmail.com. Adrian enjoys building and leading non-profit ventures to make a difference in people's lives around the globe.

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"*New Strategies to Protect Yourself when Negotiating or Renewing* Your Dental Office Lease"

Part Three of a Three Part Series

by Law Offices of Barry H. Josselson, A Professional Law Corporation

In The Compass's prior Summer and Fall 2011 installments in this three-part series, we saw that during challenging economic times (such as that which the dental profession is currently confronting), the terms and provisions of your dental office lease contribute significantly to the financial success of your dental practice. All office leases deal with issues such as (i) annual rent increases, (ii) the right to sublease or assign your dental office lease to another dentist who purchases your practice, (iii) the right to exercise an option to renew to remain in your premises at your election, (iv) the allocation of responsibility between you and the landlord for making and paying for repairs, and (v) the landlord's right to recapture or take back your premises should you decide to sell your dental practice.

Your or your dental real estate attorney's discovering these hidden provisions in the lease, negotiating fairly these critical terms of your lease with the landlord, and being proactive in structuring your lease to address your long term professional and financial needs are a *prerequisite* for securing a fair lease and establishing a satisfactory landlord-tenant relationship

4. Pass through of operating expenses to tenant.

Many leases pass through operating expenses of the building or shopping center to the tenant for reimbursement to the landlord. Study carefully your lease to determine if some, most, or all of the operating expenses are passed through to you and what items remain the landlord's sole responsibility (e.g., repairs to the roof, foundation, or exterior walls). When comparing multiple locations from which to choose your ideal dental office, each prospective landlord needs to provide you with its track record of operating expenses and the amount of costs borne by each tenant throughout the year. Try to "carve out" certain identifiable capital expenditures which remain the landlord's responsibility (e.g., roof, foundation, or exterior walls). Or try to put a cap or ceiling on certain capital expenditures incurred by the landlord and for which you may be responsible (e.g., heating, ventilation, and air conditioning systems). Or you may wish to negotiate a warranty given by the landlord that certain equipment will be and remain in good operating condition for a specified period of time and during such period the landlord shall be financially responsible for repairs. The most important factor is to know in advance what repair items are your financial responsibility, and what expenses remain the landlord's obligation to pay. Then, try either to shift certain repairs back to the landlord or to place a dollar ceiling beyond which you will not be liable when paying for such repairs.

5. Recapture of premises by landlord.

Many leases provide that the landlord may *take back*, *"recapture",* or *reacquire* the premises merely upon your request to the landlord to sublease or assign the office to another dentist. Please note that this right by the landlord to take back the premises is not predicated upon your being in default or in breach of the lease. Instead, even if you are in perfect compliance with the lease, many leases provide the landlord with the right to regain the premises subsequent to your notifying the landlord of your intent to sell your practice or to sublet any part of your office to another dentist. Protect yourself from this onerous provision by deleting it from your document.

All of the recommendations in this three-part series should be employed to make your lease more fair. All leases are drafted in favor of the landlord because they have been prepared by the landlord's legal counsel. The only question is whether such lease has been prepared slightly, moderately, or extremely in favor of the landlord. Your and your dental real estate attorney's responsibility is to make it equitable for both you and the landlord.

Barry H. Josselson serves as an instructor in the UCLA School of Dentistry Graduate Practice Residency program and guest lectures at the UCSF, USC, and Loma Linda Schools of Dentistry and the UNLV School of Dental Medicine. He may be reached at 800-300-3525.

Upcoming 2012 CALAOMS CE Events

Residents' Night
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ACLS
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October 13, 2012

Medical Emergencies
Southern CA
November 7, 2012

OMSA
Southern CA
Fall 2012 - TBD

OMSA
Northern CA
Fall 2012 - TBD

** The Medical Emergencies course will be alternating between Northern and Southern California Locations. This year it will be held in Southern California.*

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iCAT Excellent Condition, used Next Generation Platinum with Extended Field of View. Includes monitors, Codonics medical printer and supplies. Warranty available and selling due to lack of utilization. Asking $120,000. Please contact Frank A. Portale DDS at 209-481-9307.

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Practices for Sale

Looking to purchase an OMFS office in Southern California (LA and surrounding areas). Please email me at omfsbuyer@gmail.com if interested.

California Full time position with opportunity for buy-in. Position includes two practice locations. Clear Choice Dental is located in San Jose and our private practice is located in beautiful Santa Cruz. Full scope practice specializing in Orthognathic surgery, implants and wisdom teeth. Please e-mail resume to Dr. George M. Yellich at gmyel1@aol.com, or call Dr. Yellich at Clear Choice Dental (408) 556-9587, or Santa Cruz Oral and Maxillofacial Surgery at (831) 475-0221.

Associate/Partnership Opportunities

California, Full time position with opportunity for buy-in. Position includes two practice locations. Clear Choice Dental is located in San Jose and our private practice is located in beautiful Santa Cruz. Full scope practice specializing in Orthognathic surgery, implants and wisdom teeth. Please e-mail resume to Dr. George M. Yellich at gmyel1@aol.com, or call Dr. Yellich at Clear Choice Dental (408) 556-9587, or Santa Cruz Oral and Maxillofacial Surgery at (831) 475-0221.

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Northern California Oral Surgery office north of the Golden Gate Bridge with easy access from Highway 101 seeks full time associate for this high-volume practice leading to buyout and/or partnership. Interested prospects should send a CV and cover letter to molinelli@aol.com or call Stephen Molinelli of Northern California Practice Sales at 650-347-5346.

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Faculty Position

Oral Maxillofacial Surgery Faculty Western University of Health Sciences College of Dental Medicine in Pomona, California is seeking full and part-time Oral Maxillofacial Surgery faculty for the didactic and clinical instruction of students in the DMD program. The College of Dental Medicine aspires to be a premier center for integrative educational innovation.

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Comprehensive Dental Fee Schedule 2012

Bone Particulate Grafts*

Product Name	Particulate Size	Item Code	Sizing	Fee
Cortical Bone Demineralized	.125-.850mm	DD025	0.25cc	$29
		DD005	0.5cc	$43
		DD010	1.0cc	$58
		DD020	2.0cc	$90
	0.5-1.0mm	DY025	0.25cc	$29
		DY005	0.5cc	$43
		DY010	1.0cc	$58
		DY020	2.0cc	$90
Cortical Bone	.125-.850mm	DN025	0.25cc	$29
		DN005	0.5cc	$43
		DN010	1.0cc	$58
		DN020	2.0cc	$90
	0.25-1.0mm	DB025	0.25cc	$29
		DB005	0.5cc	$43
		DB010	1.0cc	$58
		DB020	2.0cc	$90
	0.5-1.0mm	DE025	0.25cc	$29
		DE005	0.5cc	$43
		DE010	1.0cc	$58
		DE020	2.0cc	$90
	1.0-2.0mm	DX005	0.5cc	$43
		DX010	1.0cc	$58
		DX020	2.0cc	$90
Cortico Cancellous	0.25-1.0mm	DH025	0.25cc	$30
		DH005	0.5cc	$46
		DH010	1.0cc	$63
		DH020	2.0cc	$96
	0.5-1.0mm	DZ025	0.25cc	$30
		DZ005	0.5cc	$46
		DZ010	1.0cc	$63
		DZ020	2.0cc	$96
Cancellous	0.25-1.0mm	DK025	0.25cc	$31
		DK005	0.5cc	$47
		DK010	1.0cc	$63
		DK020	2.0cc	$96
	0.5-1.0mm	DA025	0.25cc	$31
		DA005	0.5cc	$47
		DA010	1.0cc	$63
		DA020	2.0cc	$96
	1.0-2.0mm	DL005	0.5cc	$47
		DL010	1.0cc	$63
		DL020	2.0cc	$96

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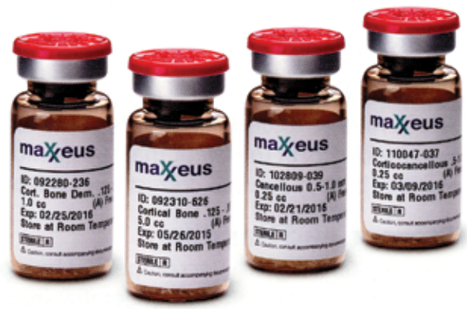

*Additional products and sizes may be available upon request; please consult your Customer Service Representative for details.

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Pericardium

Resorbable Membrane - Natural Barrier Grafts

Product Name	Item Code	Sizing	Fee
Fascia	DF152	1.5 x 2.0cm	$80
	DF202	2.0 x 2.0cm	$90
	DF203	2.0 x 3.0cm	$100
	DF304	3.0 x 4.0cm	$150
Pericardium	DP101	1.0 x 1.0cm	$60
	DP152	1.5 x 2.0cm	$80
	DP202	2.0 x 2.0cm	$90
	DP203	2.0 x 3.0cm	$100
	DP304	3.0 x 4.0cm	$150

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Platform Grafts

Product Name	Item Code	Sizing	Fee
Unicortical Cancellous Platform	DU912	0.9 x 1.2cm	$240
	DU915	0.9 x 1.5cm	$274
J Platform	DJ010	1.0cm	$330
	DJ015	1.5cm	$414

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J Platform

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