THE CALIFORNIA JOURNAL OF ORAL & FACIAL SURGERY

VOLUME XVII
ISSUE I
SPRING 2015

www.OFSOC.org

A PUBLICATION OF ORAL & FACIAL SURGEONS OF CALIFORNIA

What's in a Name Anyway

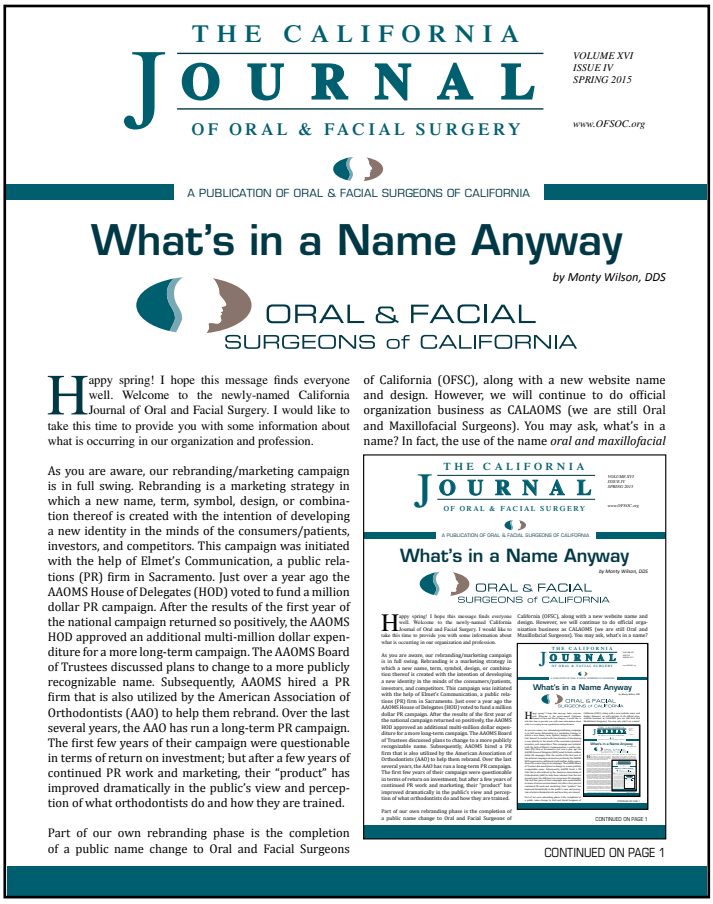
by Monty Wilson, DDS

ORAL & FACIAL SURGEONS of CALIFORNIA

Happy spring! I hope this message finds everyone well. Welcome to the newly-named California Journal of Oral and Facial Surgery. I would like to take this time to provide you with some information about what is occurring in our organization and profession.

As you are aware, our rebranding/marketing campaign is in full swing. Rebranding is a marketing strategy in which a new name, term, symbol, design, or combination thereof is created with the intention of developing a new identity in the minds of the consumers/patients, investors, and competitors. This campaign was initiated with the help of Elmet's Communication, a public relations (PR) firm in Sacramento. Just over a year ago the AAOMS House of Delegates (HOD) voted to fund a million dollar PR campaign. After the results of the first year of the national campaign returned so positively, the AAOMS HOD approved an additional multi-million dollar expenditure for a more long-term campaign. The AAOMS Board of Trustees discussed plans to change to a more publicly recognizable name. Subsequently, AAOMS hired a PR firm that is also utilized by the American Association of Orthodontists (AAO) to help them rebrand. Over the last several years, the AAO has run a long-term PR campaign. The first few years of their campaign were questionable in terms of return on investment; but after a few years of continued PR work and marketing, their "product" has improved dramatically in the public's view and perception of what orthodontists do and how they are trained.

Part of our own rebranding phase is the completion of a public name change to Oral and Facial Surgeons of California (OFSOC), along with a new website name and design. However, we will continue to do official organization business as CALAOMS (we are still Oral and Maxillofacial Surgeons). You may ask, what's in a name? In fact, the use of the name *oral and maxillofacial*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Published 2 times a year by the California Association of Oral and Maxillofacial Surgeons. The Association solicits essays, letters, opinions, abstracts and publishes reports of the various committees and members; however, all expressions of opinion and all statements of supposed fact are published on the authority of the writer over whose signature they appear, and are not regarded as expressing the view of the California Association of Oral and Maxillofacial Surgeons unless such statement of opinions have been adopted by its representatives. Acceptance of advertising in no way constitutes professional approval or endorsement. The Editorial Board reserves the right to control article and ad content as well as placement. Changes may be made without notification.

in this issue:

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

EDITORIAL

You're never too old to say 'thank you'

by Jeffrey A. Elo, DDS, MS

Saying thank you to colleagues, staff members, associates, and others more distantly connected to us might be an annual year-end ritual for many folks in leadership positions. Speeches, memos, and newsletter articles are often filled with lists of names and the actions for which they are receiving thanks. These gestures of appreciation are mostly nice and thoughtful yet they can be accepted with a bit of cynicism by recipients, especially if this is the only time during the year when 'thanks' have been provided.

Why say thank you? Well, we do it partly because we've been taught from a young age that it is the right thing to do. We learn to say thank you to those who offer us help, who give things to us and who provide guidance or support. Yet doing this at a young age is mostly because we are told to, not because we truly understand the power of saying thank you.

In work environments there are many reasons why someone might say thank you. Sometimes words of appreciation are seen as political acts – which is what draws the most cynicism towards end-of-the-year missives. Political thank yous are those perceived as given to cement an alliance, earn brownie points, or position the giver of thanks for some future benefit that he or she anticipates. The appreciation gets lost in the calculated reason behind the words.

Other thank yous can be seen as pro-forma – a thank you that goes back to the childhood lesson of doing it because you are supposed to. When a child does this, it is understood that some of their thank yous may not come off as particularly sincere, yet this is because children are still learning exactly what it does mean to say to someone 'I appreciate what you have done.' From someone older, a pro-forma thank you does not carry much weight and is soon forgotten – or chalked up as just one of those things.

As doctors and leaders of our offices and within the community, we have the opportunity to move beyond doing things because we are supposed to and step away from thank yous that are political. The appreciation we share can be genuine and specific, sincerely conveying the positive emotional impact that someone's actions have had on our own life or on the lives of others.

Trustworthy leaders are great providers of genuine and sincere expressions of thanks. When they say thank you, it benefits the recipient of the thanks yet also benefits themselves. It feels good to share a positive emotion with someone and a heartfelt thank you is definitely a positive emotion.

Saying thank you for a specific act or contribution also helps people to know that their leader knows who they are, is aware of the work that they do, and knows of the value that a specific act has brought to the office/group – whether it was an act of customer/patient service, extra effort to finish a project, service to a colleague needing help, or simply active participation during a brainstorming session.

In an article entitled *A little thanks goes a long way: explaining why gratitude expressions motivate prosocial behavior*, authors Adam Grant and Francesca Ginoi state, "Our research suggests that gratitude expressions may have important theoretical and practical implications for encouraging prosocial behaviors that promote cooperation." Basically, through a series of creative experiments, the authors confirmed that saying thank you contributes to people's sense that they are valuable members of the group and to their willingness to make future contributions that are of benefit to the group. Trustworthy leaders know this, yet it is also nice to have outside confirmation.

What lessons can we take from this?

1. Saying thank you sincerely is powerful.

2. Sharing thanks with the people who provided the service is critical to the appreciation being seen as genuine and to its having a positive impact.

3. Saying thank you can have absolutely no financial cost associated with it yet it can generate significant financial benefits for the office/group in terms of reputation and employee satisfaction.

4. Saying thank you generates positive feelings.

If there is one action you wish to take this year to strengthen your role as a trustworthy leader, try saying thank you more often. Do it with genuine care for those you are thanking, identify specifically the action or contribution you want to praise, and let the person you are thanking know about the broader impact of their actions. All of this will help you to understand deeply the power of saying thank you and will let those you thank know that you see them, know about their contributions, and appreciate their efforts.

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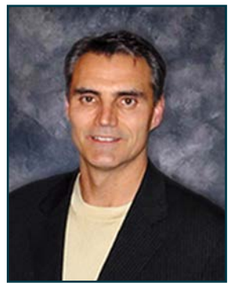
Grant A, Ginoi F. A little thanks goes a long way: explaining why gratitude expressions motivate prosocial behavior. J Pers Soc Psychol. 2010;98(6):946-955.

Lyman A. Say thank you more often. Great Place to Work Institute—Workplace tips and best practices. 2012.

PRESIDENT'S MESSAGE



What's In A Name Anyway?

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surgeon versus *oral surgeon* has been asked in the past by researchers and published in the JOMS in 2013 by OMSs at Loma Linda University. They surveyed undergraduates and dental students and found that the use of *oral and maxillofacial surgeon* increased students' perception of the OMSs' surgical scope compared to *oral surgeon*, alone. More recently, the question was asked by members of the same LLU OMS research team "What name best represents our specialty? *Oral and maxillofacial surgeon* versus *oral and facial surgeon."* This study is pending publication with JOMS, and found that the name *oral and facial surgeon* increased senior dental students' perception of OMSs' surgical scope. Other surgical services have used name changes for the betterment of their profession. An example is *Otorhinolaryngologist* to *Ear, Nose, and Throat (ENT)* to *ENT/Head & Neck Surgery.*

Often, rebranding involves radical changes to a brand's logo, name, image, and marketing strategy. Businesses throughout the world acknowledge the value of brands and brand recognition. Successful rebranding projects can yield a brand better than before…we hope to accomplish this. Marketing develops the awareness and associations in the consumer memory so that customers know and are constantly reminded which brands best serve their needs. As I have mentioned in previous communications with you, our PR/marketing campaign goal is to improve the public's awareness of who Oral and Maxillofacial Surgeons are, and what types of surgeries we perform. One ultimate goal is having the mother of a teenager who may need their wisdom teeth removed know that an OMS is *the* doctor to see for this very technique-sensitive procedure.

In other news, we have retained a new lobbyist, Mr. Gary Cooper. We are introducing a new bill, AB880 (Ridley-Thomas). This bill is designed to allow dental students in the state of California to provide dental care under (faculty) supervision to underserved patients at free health clinics and fairs. This bill has generated significant support within both bodies of the legislature in Sacramento. This bill supports our advocacy efforts with our philanthropy service through California CareForce (CCF).

This past week, I attended the CDA Interdisciplinary Affairs Committee (IAC) in Sacramento. This brought together all the dental specialists in the state to discuss their various concerns. The other specialists in the state are facing similar concerns with itinerant dental practice, as well as general dentists advertising as "specializing in…" certain procedures or processes. Time will tell whether CDA is ready to make any major announcements regarding some of these specialist issues.

We have continued to support and promote Dr. Steve Leighty for appointment to the Dental Board of California. In the past, we have had OMSs appointed to the Dental Board, and our specialty has been well-represented. We know that Dr. Leighty, if appointed, will continue this tradition of excellent representation.

Lastly, I had the opportunity in March to attend the AAOMS Day on the Hill in Washington, D.C. It was an exciting opportunity to meet with California legislators and provide them with our concerns and positions on various topics. I would highly encourage everyone at some point to attend, as I am sure you will find it quite rewarding and beneficial to your practice.

As always, the Board of OFSOC/CALAOMS will continue to work to improve our profession and your practice in the state of California. May you all have a productive summer.

Best regards,

Monty C. Wilson, DDS
President, Oral and Facial Surgeons of California

STUDY CLUBS

Study Club Mentorship – Providing Leadership for Sustainable Patient Centered Dentistry in Your Community

by ***Peter Krakowiak, DMD, FRCD(C)***

The last two decades have turned dentistry on its head and created an erratically changing environment fraught with challenges and struggles for those who truly care about purveying and maintaining exceptionalism and patient focused approach in our traditional healing art. The world of contemporary referral based dental specialist care is under attack and it is difficult to predict if it will still be a viable model of OMS practice in twenty years. The two chief culprits are greed and ego. No surprise there. It is amazing how often I have heard that a procedure can be done better, cheaper and faster by a generalist than a specialist. This misconception is very unique to dentistry. Medical surgical specialist with the exception of plastic surgeons do not experience these delusions. Many have blamed the largely unchecked corporate entry into our profession and the somewhat misguided ideas about taking ones practice to the next level (not having mastered the entry level) for having caused the considerable harm to the quality of care delivered to the patients and our cumulative professional care standards. There are other notable influences to the forthcoming debacle which may include an increase in the number of for-profit dental schools, limited regulatory oversight of standards of the dental profession, insurance control of fee schedules and no credentialing process in the vast majority of specialty care delivery in the dental settings. These challenges are daunting and unlikely to go away. In fact there are new horrific business models based on specialist kickbacks, GP co-ownership of specialty practices and other unethical fee sharing relationships that are already on the horizon if not in fact already here in California. One possible avenue to retard this cataclysm is to re-engage our local dental colleagues and our dental community and demonstrate to our peers that albeit dentistry is a business now more than ever it is still a profession above all and one that can and must affords its members with an opportunity to serve our patients within the framework of ethical, exceptional quality care firmly focused on the individual patient's best interests. Period.

How do we achieve this turn around. Our only hope is by building stronger relationships within our remaining independent provider dental community. As OMS specialists, we all have, due to our rigorous residency based OMS education and vast expertise in most aspects of dentistry an amazing academic background which uniquely qualifies us for this form of educational leadership, clinical support and mentorship. In my over a decade of being in private OMS practice the starting and coordinating a study club has been one of the most rewarding and exciting experiences and non-clinical activities I have undertaken. The Clubs have turned into a central part of our practice and have allowed us to grow as a recognized leader in peer based education in our community and have enhanced all of the participants' practices in so many ways.

A local community based study group is a phenomenal opportunity to demonstrate the advantages of collaborative team care approach that cannot be matched by any other "du jour" business scheme. I have found that our study clubs have allowed us (the member dentists in my community) to take on more complex cases and treat them with optimal outcomes as we have been able to learn from each other and rely on each other's strengths. The study group benefits from multi-specialty presence since even our lengthy education has its limits and we often can lack the full perspective. The old adage that if you do not diagnose a concern you will never be able to treat it has been especially validated in our case discussions as often one specialist or even GP member is able to take note of concerns that the rest of the group failed to identify. It has been eye opening to say the least. Diversity of the study club is very important and it is great to have members at different periods of their career participating. This allows some mentorship in both directions between younger and more seasoned providers. Albeit the differences are important in backgrounds one characteristic must be shared in common by all group members. It is a desire to respectfully discuss and work on patient care together engaging other members of the group especially the available specialists. If the members are looking at the group as a pure source for CE to meet their yearly quota, the core element of collaborative care will be missed and the exceptional opportunity to grow together and share in the care will be lost. We have avoided taking on these minded folks into our groups as they would fail to meet with the true goals of our program. The second characteristic of a successful collaborative group

is that it has a strong social element where all members can have a forum to bring up and share ideas and experiences that are not always clinical in nature. Fun and variety of locale, food and conversation topics are a must to keep things fresh and captivating.

There are many ways to structure and organize a study group or club. The subsequent ideas can be incorporated or not and customized to fit any specific group and setting. They are suggestions only. The key point is not to make the group about you or your practice. The group must not exist as a pure marketing/referral platform that is for example based and centered on the placement of implants or third molar pathology. The growth and development of the members of the group must be the center and focus of the study group and their needs and goals must be the pillars upon which the curriculum and structure of the group is based upon. Some other concepts to keep in mind may include starting to organize a group from your current referrals and every year reach out and add new members as other may retire or change their availability. It is best to keep the group to 8 to 10 members to start. I find that members do best in terms of attendance if they live/practice within 30 minute radius of the location site of the meetings. I have found Wednesday to work well for our group and that day was best for me to have a bit extra time to coordinate the events on a typically slower clinical day. I would strongly recommend prior to organizing the group to reach out to other local dental specialists in the community and ask them to join the group and serve as co-mentors. Our groups have traditionally had a surgeon, prosthodontist, orthodontist, and an endodontist as members. I attempted to engage a periodontist as well but with little success. I also have made one of my most responsible and experienced staff members take task for organizing and communicating all events to all members with reminders and email updates on almost a weekly basis. This continued system of reminders and updates has kept everyone connected and in good attendance. Getting accurate final numbers for each meeting has allowed us to minimize waste in our catering budgets. Since my practice has multiple locations in slightly geographically separate areas we now have two separate discussion groups with two sets of specialist mentors one for each location. I have asked the other specialist mentors as well to invite an additional new member to the group every year, reinforcing the type of participant we felt would be the best fit for the group.

As per location I have been fortunate to have access to two corporate style board rooms in two out of my four office locations each which can comfortably accommodate 12-20 members of each discussion group to meet together. We usually have the meetings catered by local restaurants. That way the quality and variety of the meals is kept high for everyone's enjoyment. Alternatively many restaurants may have private rooms available. I would discourage trying to do the meeting in a regular restaurant that does not offer a separate sound proof room as to keep the distractions to minimum. We have attempted to limit any alcohol consumption in our meetings to a minimum. This policy of no or limited alcohol is a prerequisite for quality interactions, orderly conduct of business at hand and of course liability. We also have identified a separate location where we bimonthly host both groups together for guest speaker presentations. We have a wonderful but low key local country club setting where a

Pankey Pala Mesa Syudy Group

nice large lecture room and in-house catering are available. Usually we attempt to bring in a national level speaker for these joint sessions and often invite some non-study club members to experience our study club curriculum on an "a la carte" format. This allows for new member recruitment as well as serving the CE needs of non-members.

After selecting the right members and logistics, the most important consideration for study group success is its didactic content. One option for the group is to internally generate the cases and present materials from the members. I have found it difficult in our specific group to have the membership consistently generate, document and present their own content. We have been able to do this once per year. In today's very busy lives very few members have the ability to compile high quality cases that are varied in content and are of higher complexity. I also hate to be the "do you have your case ready" Police. The other option is to choose a distant CE provider who has already generated a library of topics and cases. The cases generated by the post grad level educational institutes are extremely convenient and contain usually s high quality of specifically structured content that we use as a springboards for our more broad and customizable group discussions. We now have experience using materials from two separate CE providers who cater to distant education and small group learning. For the previous four years we engaged with Spear Education out of Scottsdale, AZ and this past year we have started working with the Pankey Institute out of Miami, Fl. There are other providers of this type of ready to use educational content such as LVI and Seattle Study Club all with varying cost considerations for the type of content they provide. As mentioned before, in addition to 3-5 cases which are supplied by our affiliate education providers we engage the talents of 3-4 national level lecturers to speak to our two groups in a joint bimonthly session. The bringing of the two groups together is a unique opportunity to have even more interactions and networking of larger number of local doctors and in many cases they are invited to bring their staff to these larger symposium type sessions. Non-member doctors and staff are also welcomed under separate tuition. This structure has allowed us to have additional budgetary means to bring out top tier speakers since we have attendee levels of almost 70-100 members and guests per session.

In addition to our standard locally based meeting schedule we have taken advantage of weekend away trip seminars at Spear education and at Pankey. Both these institutions have an ability to offer highly structured seminars and workshops in different areas of clinical interests and skill level. I have found that Spear has at this point a very highly polished product but we have over the last four years exhausted collectively most of their already developed content. I believe they will be adding more. Their traditional Scottsdale based seminars included treatment planning essentials, diagnosis of TMD and occlusion, esthetics and worn dentition content. The two or three day seminars were held Thursday to Saturday (Not the most favorable to our OS schedule) and were complimented with similarly oriented workshops for those who desired to add hands on learning to their conceptual learning from seminars. From the feedback I received from our membership all GPs felt they really enjoyed and benefitted from the content presented. The Scottsdale Center for dentistry where Spear has offered its courses is well set up to handle the meetings and there are comfortable accommodations nearby. One obstacle to our continued interaction with Spear was a significant and mounting per member cost of the programs and a permeating sense of for profit approach to the center, training offered and some perceived lack of flexibility in customizing its product to best suit our needs from some if its corporate leadership.

With these limitations in mind, we have recently reached other providers and have engaged the true pioneer of postgraduate dental education the Pankey institute. Unlike other providers of similar CE content, Pankey is a non-profit institute. That quality became apparent right off the bat. The institute has been a springboard for many exceptional dental clinicians and educators in US and abroad including the likes of Gordon Christiansen and Frank Spear himself. Also unlike Spear, the Pankey Institute has developed content in numerous areas of clinical practice ranging from the basics like Spear's treatment planning modules to sleep medicine, implants, pain management and even practice management, transitions and financial planning. Its Key Biscayne located training center has excellent

Discussion group

Articulator Case Analysis

didactic and hands on learning facilities for small to medium groups. The institute also owns adjacent condominiums which can be used to stay in during the learning excursions. The institute has so far been very accommodating to help us customize their content to our hybrid study club model of lectures and discussion groups all while keeping the cost of operating the club more reasonable, especially based on our large size. The cases prepared for our use have been available on line and easily accessed by all members. The Pankey distant learning model currently offers both non-facilitated and facilitated learning options. In the non-facilitated content links to virtually presented cases are provided so that the group can review and base their discussion of the cases during group meetings. Members are given prior access to case materials usually two weeks ahead. The material includes virtual models, articulated stone models, and patient pre-treatment records. During the meeting, the local mentors present the cases in a structured format using narrated segmented videos. Each segment is used to spark group discussions about specific topics and concepts presented by the case. One of the most worthwhile elements of the discussion is the underlying notion that there is always more than one way to treat any of the scenarios and this often makes the members of the group appreciate that inherent aspect of our professionalism and helps to grow mutual respect for each other's philosophies and backgrounds.

The facilitated learning pathway includes access to traveling Pankey faculty members who in our case just last month presented a day long weekend program simultaneously to both of our groups focusing on a specific area of our interest. Our groups desired to concentrate on wear case diagnosis and their management during our last meeting. Two senior Pankey faculty flew in for the weekend program and personally lead our day long program. It turned out to be a huge success. Our goal for next year is to develop an actual two day splint and occlusion workshop during the next facilitated session in 2015-16 year. This will require additional equipment but will add another dimension to our hybrid structure of learning by including hands on opportunities. It all goes into keeping the content fresh and having varied learning modalities and activities as the study group matures.

Miami Pankey Meeting 2014

There are differing opinions on the subject of charging tuition for these types of programs. I have set up a moderate $1700 annual fee for all members to contribute. The fees collected have not fully covered the cost of operating our club, however our practice has been able to support the club from our CE budget and marketing funds. It has been a worthwhile investment into our practice and our dental community. We have not used a lot of outside sponsorship from dental vendors but such can always be an avenue to help shoulder the expense of such an undertaking. I am of the opinion that members have better appreciation of the group if they're partially responsible for the operating costs and the clinical direction of the club. It is therefore that we have annually required all members to complete an annual evaluation and future direction forms. We use this feedback to plan each subsequent year's curriculum. At the end of each academic year all members are recognized with wall or desk plaques and certificates.

Our study club membership was also involved in the past few years in helping our local communities less financially privileged families receive toys for Christmas for their kids. As a group, we provided hundreds of helmets to go along with brand new and refurbished bikes donated by the Sheriff's department to the cause known as "Spark of Love Campaign." This notion of group giving has been a year round concept, as we have now delivered thousands of dollars' worth of collaborative care to several truly needy patients in our community. The positive and supportive relationships developed by the members of the group has been getting passed on to the community we serve and practice in. If it was not for our group interactions these several folks would have had a hard time finding a collaborative and caring group of doctors. I look forward to continue to cultivate this benevolent community outreach aspect of our group. Most members of the group have also expressed their appreciation of this unique aspect of our group.

A very successful "bonus" event we added to our discussion/guest lecture format is an annual group trip to Cabo San Lucas. It involved a little bit more planning than our usual meeting as we had to arrange for flights, accommodation and some party planning but we created a unique social opportunity combined with some good CE content for our group. We received generous

Kavo Simlab at Pankey institute

support from one of our corporate implant partners to secure a national level speaker and arrange his travel to speak to us. We stayed at an all-inclusive resort but did set out on some outside nighttime activities including a beach party and some bar hopping. The members were encouraged to bring their spouses. We held morning CE sessions from 8-10 allowing for plenty of time to enjoy the destination. Some of the group took part in an offshore fishing expedition while others enjoyed the SPAs and swimming with dolphins all much closer to the shore. The event was a huge success and we vowed to return. This year a hurricane affected our plans to return to Cabo but we are planning to go to the Pankey National meeting in New Orleans in September. The idea of including the member's spouses in some of our study club activities extends also to our year end function which traditionally is held at one of local Temecula area wineries and helps to put a cap on another year of comradery and collaborative learning and patient care.

For those who have been involved in mentoring study clubs it is a very work intensive but extremely rewarding activity and a key aspect of a dynamic forward looking specialty practice. It allows for development of lasting personal and professional bonds and increases our collective abilities to excel in clinical care. The groups affords its mentors a leadership platform to influence the scope and manner in which dentistry is practiced in their communities, where positive professional patterns can be nurtured and commended and misguided or deleterious practices can be discouraged. If you have been thinking about revitalizing or growing the caliber of your professional specialty OMS practice, this is a great starting point. You will have fun with this creative and worthwhile enterprise. Furthermore, you will be contributing to the preservation of collaborative care by independent members of our dental profession and hopefully, leaving your positive mark on the field of dentistry for future years to come.

Cabo San Lucas Deep sea fishing excursion

New radiation machine fees, forms required

As 2015 began, so began new fees and forms that OMSs should be aware of regarding the use of radiation machines.

Annual radiation machine registration fees went up from $79 to $93 as of Jan. 1, 2015. Machine registration fees for dentists are billed every other year.

The reporting requirements of the California Department of Public Health for installation or receipt, sale, transfer, disposal, or discontinuance of use of any reportable source of radiation have stayed the same, but the way in which it is reported has changed.

To report the discontinuance of use of a radiation machine, dentists should notify the California Department of Public Health by submitting a completed "Radiation Machine Registration for Changes to Registrant or Machine Information – RH 2261C" form.

To report that a dentist is no longer in possession of any functional radiation machine, they should notify the California Department of Public Health by submitting a completed "Radiation Machine Registration for Withdrawal of Registration – RH 2261W" form.

To register a new dental facility with a radiation machine, notify the California Department of Public Health by submitting a completed "Radiation Machine Registration for New Registrants – RH 2261N" form.

Dental providers can download a copy of the new forms by visiting cdph.ca.gov/rhb.

For a radiation machine to be inactivated from the CDPH-RHB registration database, the radiation machine has to be incapable of producing radiation or no longer in the possession of the registrant. Incapable of producing radiation means a radiation machine is no longer functional. Dentists are reminded that unplugging a machine or placing a functional machine in storage on site or off site, for use at a later time, does not mean that a machine has been made incapable of producing radiation.

Failure to report the sale, transfer, disposal, or discontinuance of use of a radiation machine(s) will result in continued registration billing.

For more information, visit cdph.ca.gov/rhb.

Additionally, CDA's Radiation Safety in Dental Practice guide has been revised to provide information inspectors have been requesting. Dental practices have reported that radiation inspectors have requested that written radiation safety programs include a policy on pregnant employees and pregnant patients. The Radiation Safety Guide in Dental Practice includes guidance for managing pregnant employees. Information on pregnant patients and dental X-rays also has been added to the guide.

Information courtesy of the California Dental Association

CALIFORNIA CAREFORCE

California CareForce – The Charitable Arm of CALAOMS/OFSOC

by Pamela Congdon, CAE, IOM
Executive Director, CALAOMS/OFSOC
President and Volunteer California CareForce

Just about five years ago, CALAOMS/OFSOC, a great membership organization – our organization - wanted to invest in our communities and give back to help the people of California. A group called Remote Area Medical (RAM) had been providing free health clinics in 2009 and 2010 in Los Angeles. With professional and general volunteers, they provided free dental, vision, and medical care to the under- and non-insured people who had little or no access to care. With the elimination of the adult dental (Dentical) program in California in 2010, CALAOMS asked if RAM would provide clinics in northern California. With CALAOMS as the host and organizer, successful clinics helped 6,569 people get badly needed care in Sacramento (April 1-4, 2011) and Oakland (April 9-12, 2012). CALAOMS, seeing the need for improvement in access to care in California, agreed to help establish and form RAM CA. In 2014, we changed our name to California CareForce (CCF) so that we could, as an organization, concentrate solely on helping the people in need in California.

With more than six million Californians who are eligible for Medi-Cal and Dentical, but do not get seen for care, CCF, as the charitable arm of OFSOC/CALAOMS, does its part in providing no-cost care to those who do not have access to affordable healthcare. CCF is privileged to be among other great works and organizations that provide care to those who cannot afford it – such as CDA Cares, Care Harbor, Tzu Chi, RAM, and others.

California CareForce and the Oral and Facial Surgeons of California are really a match made in heaven. OFSOC supports California CareForce operations by allowing CCF to maintain an office at OFSOC headquarters. They have allowed OFSOC staff to help with CCF while it is short staffed. Steve Krantzman, the Associate Director of OFSOC, is a board member and Director of Operations for CCF. He has been instrumental in the development of both the office and clinic settings. The CALAOMS/OFSOC Board applauds Steve for all of his hard work and extra efforts on behalf of CCF.

It is hard to believe that in five years and eight clinics, CCF has provided care to over 27,000 people, with care totaling approximately eight million dollars. California CareForce has loyal OMS volunteers who have embraced helping others. Here are what a few of them have to say about their experience at CCF clinics:

"Being good is commendable, but only when it is combined with doing good is it useful. Participating as a provider in California CareForce events is both commendable and useful, and provides a lot of good to many who need it. It's a privilege and an honor to be a part of an organization whose passion has been to develop and see to fruition such well-run large-scale care events. You don't need to travel thousands of miles just to be able to help people. There is great need right here in California." – *Jeffrey A. Elo, DDS, MS*

"I would say that the opportunity to work at the clinics is good for my soul, to just help others and not have to worry about the business of care, just giving the care." – *Kurt Hummeldorf, DMD*

"Patients are not only very appreciative for the treatment, but it is not unusual for some to cry from happiness." – *Alan Kaye, DDS*

"I have had the pleasure of volunteering now for a few years with California CareForce. I LOVE it! It is well organized, a devoted volunteer team, with high quality services. The patients are a delight to treat in that they are so patient, cooperative, and grateful. It is so wonderful seeing my colleagues; it is like a mini reunion. The fellowship in an endeavor of service is a joy for all of us. This is great work of human kindness by all the corporations, volunteers, and the California CareForce team. I am grateful for the opportunity and privilege." – *Loretta Gilmore, DDS*

"Realizing the extreme need for healthcare for so many underserved in our state, and experiencing the overwhelming gratitude of those who received what services California CareForce has been able to provide in the way of dental, medical, and vision, has been inspiring and enriching beyond words." – *Craig Bloom, DMD*

Leonard Tyko, DDS, MD, one of CCF's board members and OFSOC's President-Elect, wrote an article last year about the CCF clinic in Coachella. Please see a reprint (with permission) of his article here.

May 13, 2014 -- As an experienced oral and maxillofacial surgeon, I have the privilege of being involved with the California CareForce (CCF) Clinic, which began through my affiliation with the California Association of Oral and Maxillofacial Surgeons (CALOMS). I have always felt strongly that it is important to help those in need, and organizations like CCF make getting involved easy.

We are incredibly fortunate as Americans to live in a country where we have more than others; however, it's important to keep in mind that there are many people here whose needs are left unmet. In my practice, we often care for patients with limited resources from local hospitals and clinics, and that is why I feel such a close connection to CCF's mission. They set up clinics in areas where people have the greatest unmet needs and deliver healthcare services to patients who would otherwise not have access.

The CCF Clinic, hosted at the Riverside County Fairgrounds from April 3-6, provided a unique platform for Remote Area Medical USA (RAMUSA), California CareForce, Goldenvoice, CALAOMS, the Flying Doctors, and a number of other professional and non-professional volunteers to offer much-needed services to more than 2,000 patients. While more than $1 million in services were provided by hundreds of highly skilled medical professionals, they were complimentary for patients at the clinic thanks to the support of CCF, whose mission is to provide free health, dental, and vision care to Californians.

This particular experience in the Coachella Valley was perhaps one of my most memorable. I left my clinic on a Friday and flew from Oakland to Ontario, CA; rented a car; and drove two hours to Indio -- a remote location in the middle of the desert. When I arrived at the clinic early the next morning at 6 a.m., patients were already waiting in line for services, as they had either camped out overnight or arrived even earlier that morning. "These patients were there simply because they could not afford a new pair of glasses or have their teeth filled or pulled on their own."

As I scanned the crowd, I could see that these patients came from all walks of life, and I found it incredibly rewarding to work with them. They weren't homeless or drug addicts or even terribly underprivileged -- they were just like anyone else. They were simply there because they could not afford a new pair of glasses or have their teeth filled or pulled on their own. These patients quietly suffer, hoping someone will help them get what they need to better themselves and improve their life. Looking at them made it impossible not to take a step back and realize that we are just one major illness or catastrophic event away from being in their exact position!

My primary role at the clinic was to extract teeth, so I spent a majority of my time there pulling the teeth of patients suffering from pain and infections. After a full day of pulling teeth, I drove back to the airport, flew back to Oakland, and drove back home, arriving around 10:30 p.m. that night. As I settled in to my warm bed, visions of the many different faces I saw that day made me realize that we are so fortunate to be in the position we're in. Seeing how a procedure as simple as extracting a tooth truly made a difference in someone's life was incredibly rewarding, and I would go through the same process all over again to get the opportunity to help someone in need. Copyright © 2014 DrBicuspid.com

Our next California CareForce Clinic is in Pomona, July 10-12, 2015 at the Fairplex. Please join us as a volunteer, bring your assistants, your referring dentists, and your family—like a lot of our members do. I promise it will be one of the most rewarding experiences you can have.

Thank you to all who have already volunteered and continue to volunteer in these truly worthwhile causes.

RISK MANAGEMENT

THE DOCTORS COMPANY

Electronic Medical Records May Cast Physicians in Unfavorable Light During Lawsuits

By Keith L. Klein, MD, FACP, FASN

While the electronic medical record (EMR) has advantages, it also has introduced liability risks. EMRs can lead to lawsuits or result in a weak defense by casting the physician in an unfavorable light.

For example, examine these exchanges in a recent malpractice trial:

- *Plaintiff Attorney*: Doctor, if the emergency renal consult was called in at 11:30, why did you wait until 6 PM to see the patient, during which time his kidneys became severely damaged?
- *Doctor*: I did see the patient within 30 minutes.
- *Plaintiff Attorney:* Where does it show that in the chart?
- *Doctor*: Uh…it doesn't, I guess. I saw the patient but wrote the note later.
- *Plaintiff Attorney:* So you claim you saw this critically ill patient in 30 minutes, spent one hour evaluating him, but did not document your findings for another six hours?

And later in the trial:

- *Defense Attorney:* But the lab record shows that the kidney function was declining…
- *Judge: [interrupting]* The physician notes state each day that kidney function was normal. How do you explain that in the face of deteriorating kidney function? Why would a physician write that, unless he hadn't looked at the lab testing or the patient?

EMRs can increase malpractice risk in documentation of clinical findings—copying and pasting previously entered information can perpetuate any mistakes that may have been made earlier.[1] Incorrect information is the most common user-related contributing factor in malpractice cases involving EMRs, according to a study by The Doctors Company of EMR-related closed claims from 2007 to 2013.

In the study, 15 percent of cases involved pre-populating/copy-and-paste as a contributing factor. Copy-and-paste is a necessary evil to save time during documentation of daily notes, but whatever is pasted must also be edited to reflect the current situation. Too often the note makes reference to something that happened "yesterday." For example, the sentence "Patient presented to ED with chest pain yesterday…" is pasted over the next two weeks in the daily progress note. An even more telling example is a sentence like "Patient's admitting lab is normal…" being perpetuated while the actual creatinine levels rise every day.

In one case, the judge commented about copy-and-paste issues: "I cannot trust any of the physician notes in which this occurred and the only conclusion I can reach is that there was no examination of the patient…it means to me that no true thought was given to the content that was going into 'the note.'"

Checkboxes, particularly those that pre-populate, can be a physician's nemesis. It's easy to click on checkboxes, and often they are pre-checked in templates. EMRs have been presented in court that show, through checkboxes, daily breast exams on comatose patients in the ICU, detailed daily neurological exams done by cardiologists, and a complete review of systems done by multiple treating physicians on comatose patients. Questioning in court as to how long it takes to do a review of systems and a physical examination, the patient load of the physician for that day, and how many hours the physician was at work cast doubt on the truthfulness of the testifying physician. A time analysis showed that there was no way the physician could have accomplished all that was charted that day.

In one case that typifies how to impeach a doctor, it was clear that the doctor spent eight hours at work and, accounting for lunch, spent a little over seven hours seeing patients. But the total time it was documented that he spent on each patient would have required his time at work to be 15 hours.

As one judge stated in court: "This medical record is simply not believable. I don't know whether to fault the hospital, the company that wrote the software, or the physician, but the only one on trial here is the physician. In medical malpractice,

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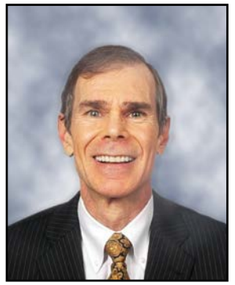
MORALS AND ETHICS



Procedural Structure for Determining Futility Part 3 of 3

by Richard Boudreau, MA, MBA, DDS, MD, JD, PhD

The need for a structure through which medical futility can be understood has been identified through the existing case studies and variations in decision-making process that have become evident. Determining medical futility is not the only element that has to come into play when determining whether to end treatment or to assist in providing relief from prolonged illness. In relation to the process of litigation and the views of the courts, the need for a structure for debating futility and for determining specific actions on the part of medical professionals is clearly in alignment with goals of achieving both a legal and ethical response to this issue. The problem that emerges when trying to script a legal structure is that there is only a fine line between medical futility supporting cessation of life-prolonging procedures and medical futility supporting the pursuit of life-ending procedures. In both cases, intent is the same and the determination of medical futility is the same (Pope, 2009). In these two distinctly different processes, though, causation becomes the procedural issue that sparks expansive legal debates.

The first component of the argument around futility is that there needs to be an understanding that futility defines a medical probability, not a factual certainty. As a result, medical futility can only be incorporated into a procedural structure in determining decision-making if there is an agreed-upon criterion from which futility can be defined. Whether it is Schneiderman's 100 case quantitative perspective or a qualitative outcome-based perspective (the outcome achieved would not be medically desirable), there must be a way to create an operationalized view of medical futility that can be applied to specific medical interventions. There is a clear differentiation, though, between applying medical futility to the cessation of medical procedures or the use of technology when it is already in use and the decision to not even start the use of life-sustaining or potentially life-saving treatments. In the case of the Newsomes and their newborn children, the line blurs around the emotionality involved. It has been maintained that though we have the capacity for treatment, treatment should not always be utilized. It may have been technically possible to prolong lives in this case, but the question that the physician had to consider was: Should everything that can be done be done? In the Newsome's case, the doctor believed that he should not have introduced treatment to the newborns, and instead left the family to deal with the reality that their children would not live. Not every practitioner would have made this same decision, but the question raised in the scope of considering procedure is: Should the doctor have been the sole person to determine the process of care?

There are a range of factors that medical facilities may integrate into a defensible procedure for the application of medical futility in defense of either the denying of treatment or the cessation of treatment. These factors could include potential outcomes, patient welfare, professional standards, experience or evidence-based practices, and the level of authority provided the practitioner. If the emergency room doctor determined the status or potential of neonates without the help or consultation of a neonatologist, the emergency room doctor might have been viewed as negligent in his approach, the outcome of which resulted in the death of two children. The parameters of medical futility and the application within any medical organization needs to reflect adherence to a procedure that ensures that no single individual takes on the responsibility of making decisions that result in the cessation of life-sustaining technologies without consultation of others.

From a procedural perspective, there are variables that come into play that are important when creating a protocol for decision-making that can meet the legal muster. Specifically, physicians need to be encouraged to address the process of care and understand when to stop. At the same time, in facilities where there are limited beds, limited resources and limited service providers, providing medically futile care can actually be harmful to others. This can occur in regards to a broad sense of healthcare resources, health care dollars or in relation to practical matters, including access to medical resources and the use of medical staffing models.

One of the questions driving procedural changes in relation to medical futility is whether medical dollars should determine longevity for individuals receiving life-sustaining care. When there are limited resources in intensive care units and limited access to monetary compensation and staffing, the continuation of care for patients without a chance of recovery becomes problematic for those needing care. Physicians have to balance what they perceive as their responsibility to an existing patient with the resources they have to provide for others. As a result, creating a procedural foundation for decision-making as it relates to medical futility can reduce the chance of problematic responses and claims of medical malpractice for physicians who deny patient care.

Conclusions

Medical futility is a difficult term to define, either qualitatively or quantitatively, though theorists have attempted. Work to create a cohesive view of medical futility extends from continued litigation when physicians either refuse treatment or require the cessation of treatment when patients are deemed to be in a medically futile state. In many cases, disputes between the surrogate decision-makers for the patient and the practitioner making decisions resulted in the pursuit of litigation. Perhaps the most confusing issue is that there is a very fine line between actions by practitioners to end the life of a person in a medically futile state and the continued opposition to assisted suicide.

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the record must speak for itself, but this record is worse than silent. It is egregious."

Notes can also be problematic. One issue that frequently comes up is the actual time the patient was seen. It is the accepted practice, especially on teaching rounds, to see all patients and then write notes at the end of the day. The EMR will automatically date and time-stamp the physician's note as the time the note was created. This gives a misleading impression of when the patient was actually seen, and in a rapidly changing clinical situation, the note may not accurately reflect the patient's clinical condition at the time the physician actually saw him. Therefore, it's important to state in the note the specific date and time that the patient was seen and examined.

Reading an EMR is like taking a drink out of a fire hydrant—it is bloated with repetitive data, and critical findings can easily be missed. Copying information such as entire x-ray reports and lab data into notes only adds to this problem. Because the details of the chest x-ray can easily be looked up, the x-ray should only be summarized in the note, such as, "chest x-ray normal except for right upper lobe infiltrate consistent with a viral pneumonia."

The fundamental mantra when writing a note in an EMR is to show that you put thought into the record. Discrete data, though strongly favored by IT professionals and insurance companies, does not accomplish this. Free-text entry of three or four sentences can convey far more information than several pages of template-driven notes and will reflect that you saw the patient and put thought into the note.

All these common EMR issues—incorrect information, copy-and-paste, and poor note-taking—cast doubt on the integrity of the doctor and the medical record. While the doctor may not have committed a clear-cut act of malpractice, these types of issues in the medical record cast the doctor in an unfavorable light in front of a judge or jury.

Reference

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Contributed by The Doctors Company

Oral and Facial Surgeons of California giving back—a rewarding experience for all involved

by Daniel Witcher, DDS

After separating from the US Navy, Iraq War Veteran Daniel found himself in a position that nearly 30% of our most recent veterans find themselves—a state of unemployment. Daniel struggled with homelessness and substance abuse; and felt as though he had nowhere else to turn. That is, until he found the Veteran's Village of San Diego (VVSD). Here, Daniel was given a warm meal, a place to call home, and most importantly, the tools he needed to get back on his feet and become a productive member of society again. During his 2-year rehabilitation program, Daniel found that even with all his newfound skills and sense of self worth, he was still having difficulty adapting and finding a job. The reason: Daniel felt ashamed to smile due to the poor condition of his mouth. As he put it, "I had a lot of pain. I couldn't speak properly, and I was embarrassed because I knew I would never find a job."

Enter the San Diego Dental Health Foundation (SDDHF). Through collaboration with local volunteer dentists and surgeons, VVSD and SDDHF were able to offer complete oral rehabilitation for Daniel, who now feels as though his life has been changed forever. Said Daniel, "It's been a Godsend. I can speak publicly. I can look at people. I can talk. I can laugh. I don't have to hide my smile anymore. It's fantastic. I can't thank them enough." Daniel now has a job and has reunited with his wife and daughter, with whom he had separated from during his struggles with substance abuse and unemployment.

The SDDH Foundation didn't stop there. Their most recent goal: construct, equip, and staff a permanent dental clinic on the Veteran's Village Campus to provide complete continuity of care to the residents. The SDDHF Board of Directors have been working tirelessly to make this dream a reality. Three of them are our own OFSOC members, and include Dr. David Milder, Dr. Daniel Witcher, and SDDHF President, Dr. Lester Machado. As SDDHF Executive Director Mike Koonce stated, "Oral and maxillofacial surgeons have played a key role in the success of the Foundation, as well as the development of the VVSD Clinic." Lester Machado added, "In the past 8 months, we have raised a total of $318,000 in cash and $55,000 in in-kind gifts. The contractor building the clinic has donated $25,000 in supplies and much of his labor for free. Local equipment vendors have donated over $30,000 in free equipment. The support for this project has been robust and very heart warming. We all believe that our returning service men and women deserve no less than to have their smiles back."

Around the same time that Daniel was entering into treatment with the Veteran's Village, Francisco was awakening from general anesthesia in a small operating room in Tecate, Mexico. And although he doesn't remember his first trip to the team's operating room nearly 18 years prior, OFSOC member Dr. Jeff Moses certainly does. Francisco's case is one that Dr. Moses remembers well. He met his parents at the then fledgling group that became the backbone of the Smiles International Foundation in the waiting room of the clinic. The couple had traveled nearly 800 miles by bus through the back roads of Baja in order to reach the clinic and seek treatment for their son's bilateral cleft lip and palate. At that time, they were considering putting Francisco up for adoption if they could not receive care. When they arrived, they found that the clinic was nearing the end of their operating schedule and were no longer accepting new patients. Dr. Moses remembers, "I saw this beautiful young boy. All that was wrong was a bilateral cleft. But our schedule was full to the point where nurses and doctors would work well into the night and the next day. I asked the team, 'Can we do this?' To their credit, they all pitched in."

Francisco continued to return to the Smiles International Foundation clinic in Tecate for years, undergoing multiple reconstructive surgeries, including most recently, maxillary and mandibular orthognathic surgery. Now retired, Dr. Moses helps organize and secure funding for clinics like Tecate Smiles all over the world, including other parts of Mexico, Costa Rica, Panama, Guatemala, Ecuador, India, and Ukraine. The goal is to provide lasting care for these patients beyond their initial lip and palate repairs through interdisciplinary treatment, as well as collaborations with local dental and medical teams. Said Dr. Moses, "The goal of our organization is to provide long-term longitudinal treatment for these patients that extends far beyond the initial surgeries that we perform. With help from Rotary International, as well as the support from local healthcare providers and educators like the Pierre Fauchard Academy and Universidad Latina, we are able to commit ourselves to a comprehensive professional team approach that supports these children as they progress into adulthood."

The stories of these patients, while inspiring, are not uncommon. Access to care continues to be an issue for underserved populations both in the United States and abroad. According to the American Dental Association (www.ada.org), approximately one-third of Americans are unable to seek regular dental care for a multitude of reasons, many of which revolve around financial constraints. Our very own state organization, OFSOC, recognized this need and, under the guidance of Executive Director Pamela Congdon and the board of directors, founded California Care Force (CCF; formerly RAM California) in 2011 with the goal to provide free care to underserved populations in both northern and southern California. Since its inception, CCF events have treated over 17,000 patients and provided over $6,000,000.00 worth of treatment.

Equally important, however, is the ability for these events to bring people together. As a former OMFS resident and new graduate, I can recall attending volunteer events like California CareForce and Tecate Smiles and being amazed at the camaraderie between the volunteers. Many individuals came from all parts of the United States, and in some cases, the world, excited both by the opportunity to give back to those less fortunate, but also to catch up with old colleagues and friends. Aside from the tremendous sense of fulfillment that comes from taking part in these events, the opportunity to gather with like-minded surgeons can be just as gratifying and entertaining. Whether it's on the city, state, national, or international level, taking time away from the daily grind to give back is something that can often leave you and your staff feeling refreshed and renewed. As one CCF volunteer put it, "If you can help out at one of their clinics, you will have one of the most rewarding days of your life!"

For me, serving others, giving back to my community, and working on projects like the Veteran's Village, Smiles International Foundation, and California CareForce have been incredibly rewarding experiences. I encourage all of our members to continue their charitable efforts and provide an example to all other state organizations as to what it means to give back. Roll up your sleeves and get involved. There is so much need wherever you turn, and together we can continue to make a difference.

For more information on how to get involved, please visit:
www.sddhf.org
www.smilesinternationalfoundation.org
www.californiacareforce.org

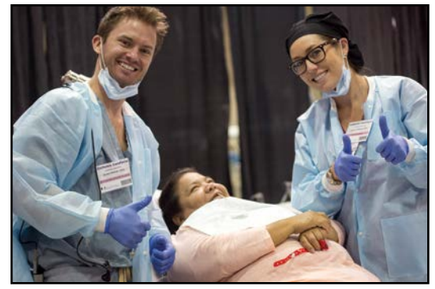
Reference:

http://www.ada.org/en/public-programs/action-for-dental-health/access-to-care

OFSOC member Dr. Jeff Moses (center, with hat) performing a pre-operative exam at a Mayan Smiles clinic in Campeche, Mexico.

A child with a cleft deformity being readied for surgery by a caring volunteer at the Mayan Smiles Clinic.

Dr. Jeff Moses with wife, Maribel (left), pre-operatively visiting with a child at the Mayan Smiles Clinic.



OFSOC member Dr. Daniel Witcher (left) with fiancée, Jouet Peterson (right), and a grateful patient at the March 2015 California CareForce event in Coachella Valley.

TECHNICAL ARTICLE

Stanford MEDICINE Otolaryngology Head and Neck Surgery

Let's Slice and DISE

Drug-induced Sedation Endoscopy for Dynamic Airway Evaluation in Patients with Obstructive Sleep Apnea

by Stanley Yung Liu, DDS, MD
Assistant Professor
Sleep Surgery Division
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When patients are first evaluated for obstructive sleep apnea (OSA) in an oral and maxillofacial surgeon's office, an array of static imaging modalities comes to mind. While polysomnography is the gold standard instrument to diagnose OSA, it does not provide anatomic information about sites of airway vulnerability. To fill that void, two-dimensional lateral cephalometry to three-dimensional cone beam CT—with the latter available for both upright and supine positions—are widely used. To visualize the airway and examine collapsibility of the pharyngeal wall, nasopharyngoscopy with negative pressure maneuvers is available. Nevertheless, to examine dynamic airway activity during sleep is critical for contemporary surgical care providing site-specific treatment other than continuous positive airway pressure (CPAP). Surgeons need to *see* the moving airway during sleep, as it is after all a syndrome of "sleep" and not "awake" apnea.

Researchers have tried to address this limitation using sophisticated imaging techniques such as sleep MRI. Valuable information has been gathered from sleep MRI, but its implementation in routine practice is impractical. There are also studies using sleep CT or even sleep fluoroscopy, which besides the impracticality, come with the hefty price of unwelcomed radiation. What has been determined from these studies, though, is that the airway collapses differently in every OSA patient, and that static imaging or awake nasopharyngoscopy do not reflect dynamic airway activity during sleep.

The intent of this article is to introduce DISE for my OMFS colleagues. DISE is classically known as "drug induced sleep endoscopy," which now the sleep medicine community has preferentially embraced as "drug induced *sedation* endoscopy." Oral and maxillofacial surgeons who routinely sedate patients for procedures in-office can incorporate DISE as part of their work-up for OSA patients. Currently, the vast majority of DISE is performed in operating rooms of major academic centers. Distinct advantages of performing DISE in outpatient oral and maxillofacial surgery sedation suites include a tremendous decrease in cost, the creation of a more ecologically friendly environment for sleep, all the while maintaining the same standards of patient safety.

Dynamic evaluation of airway during natural sleep via endoscopy was first described in 1978. Since sleep endoscopy during spontaneous sleep is not feasible in routine practice, airway endoscopy with pharmacologic sedation evolved in popularity. The re-naming of sleep endoscopy to sedation endoscopy more accurately describes the phenomenon that the examination is not performed under natural sleep.

The additional information that DISE provides over awake nasopharyngoscopy is numerous. An approximate 20-minute observation involving every level of the upper airway conveys information about patterns and grades of collapse more so than a single awake nasopharyngoscopy. There are questions about the accuracy and depth of sedation when different pharmacologic agents are used, and they are certainly determinants of good DISE examinations. Different centers have worked out ways of controlling levels of sedation, where the agents most frequently used are Propofol and Dexmedetomidine. Arguing that differences in sedation levels obviate the usefulness of DISE is like claiming awake endoscopy with Müller's maneuver is not useful because one cannot standardize inspiratory pressure that patients generate. The key take home is: DISE is an adjunct to a thorough physical examination, polysomnography, static airway imaging, and awake fiberoptic. The key then lies in the proper interpretation of the aggregate data.

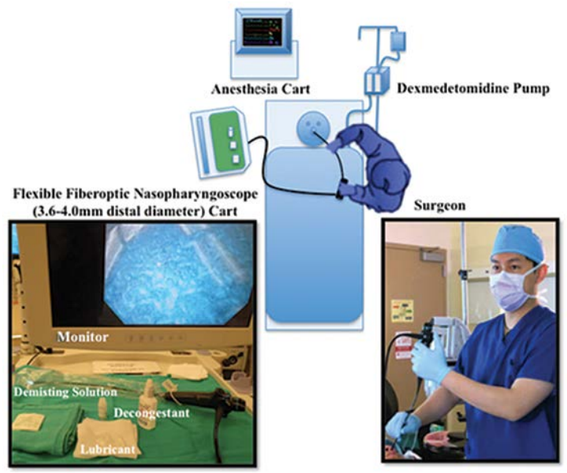

figure 1. Patient and Surgeon Positioning for DISE, with Armamentarium

At Stanford, patients undergoing DISE are placed in a supine position in a dimmed and quieted operating room (Figure 1). The nasal cavity is decongested with phenylephrine half an hour prior to the procedure. Drug-induced sedation is achieved with intravenous administration of Dexmedetomidine via a target-controlled infusion system at a rate of 1.5mcg/kg/hr, after an initial loading dose of 1.5mcg/kg is delivered over 10 minutes. Patients are not pre-oxygenated. The anesthesia team monitors electrocardiography, blood pressure, and oxygen saturation during the procedure. A flexible nasopharyngoscope is used to sequentially observe the nasal cavity, nasopharynx, velum, oropharynx, tongue base, and epiglottis. Degree and pattern of collapse is recorded at each level using the VOTE classification. Mouth closure and jaw thrust maneuvers are performed towards the end of endoscopy and resulting airway changes are documented.

Briefly, the VOTE (Velum-Oropharynx-Tongue-Epiglottis) classification is a system that rates the pattern and grade of collapse at each of the aforementioned airway sites (Figure 2). At the level of the velum, pattern of collapse is classified as circumferential, anterior-posterior, or lateral to medial. At the oropharynx, it is lateral to medial. At the tongue, it is anterior to posterior. At the epiglottis, it is either anterior to posterior or lateral to medial. Grading of collapse is from 0 to 2, where 1 is between 25% to 75% airway obstruction, and 2 is greater than 75% obstruction.

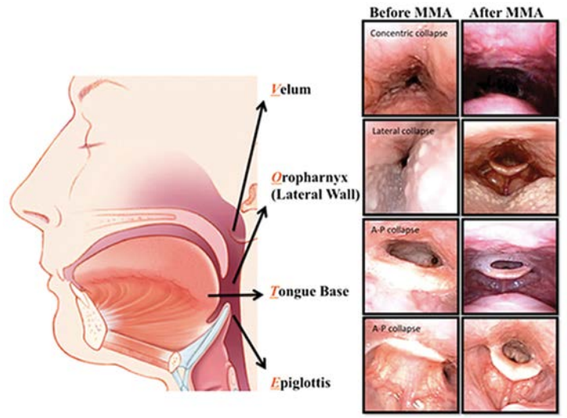

figure 2. Screenshots of DISE images at the four levels of the VOTE (Velum, Oropharynx, Tongue, Epiglottis) Classification

In my current practice, I perform DISE for two groups of patients. The first group includes patients who seek surgical intervention, and I am identifying a site to address for maximal impact. This does not include patients who seek surgery to improve CPAP adherence, where they most often just need nasal surgery (septoplasty or turbinate reduction). This also does not include patients who are candidates for maxillomandibular advancement (MMA), where the entire upper airway needs to be addressed. Common examples of patients in this group where DISE has directed treatment include those whose airway stability is vastly improved with simple jaw closure or jaw thrust. I may recommend either oral appliances or genioglossus advancement. Depending on the type of collapse seen at the velum, an uvulo-palatal flap versus other forms of palatal surgery may be considered. With the advent of hypoglossal nerve stimulation devices, circumferential collapse at the velum needs to be ruled out. The DISE videos also become a valuable educational tool during clinic as I counsel patients about proposed procedures.

I have also been performing DISE perioperatively for MMA patients. MMA remains the most effective surgical intervention for OSA, regardless of age, body habitus, dentofacial relationships, and disease severity. We are all familiar with the sagittal views of the pre- and post-MMA ceph or CT scan, where a larger retroglossal airway is consistently observed. Nevertheless, my group has identified from perioperative DISE that the most marked dynamic airway change after MMA is stability and widening of the lateral pharyngeal wall. This cannot be observed by static imaging alone. Again, this delineates the importance and synergy of both static imaging and dynamic airway observation during sleep or sedation as we strive to accurately phenotype patients for surgical success.

Oral and maxillofacial surgeons have a unique perspective of the upper airway. We manage the upper airway routinely as we perform a vast array of procedures under sedation. Our anesthesia training uniquely prepares us to deliver outpatient sedation and general anesthesia procedures safely. At the same time, we are sensitive to patients who are at risk for OSA. Finally, we are often called upon to perform maxillomandibular advancement for patients who have not found relief with other procedures. Embracing and further improving DISE is part of our continued responsibility in assuming care for patients with this widely prevalent condition.

It's time we slice and DISE.

Acknowledgement

I would like to thank the Stanford ENT Anesthesia team, particularly Dr. Vladimir Nekhendzy and Dr. Jeremy Collins for refinement of the Stanford adult DISE protocol. I also appreciate Dr. Leh Kiong Huon for preparation of the images and figures.

ORAL & FACIAL SURGEONS OF CALIFORNIA
UPCOMING CE EVENTS

2015 Meetings

- **ACLS** - Solano Community College — October 17
  Doctors and Assistants Course
- **OMSA Fall 2015** – DoubleTree by Hilton Sacramento — October 24-25
  Weekend Seminar for both New and Recertification
- **Medical Emergencies** – Northern California Location TBD — November 4
  For Doctors and Staff…Make Sure Your Office is Prepared!

2016 Meetings

- **2016 January Anesthesia Meeting** - San Francisco — January 15 – 17
- **16th Annual Meeting** - San Diego — May 20 – 22

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LOOKING TO PURCHASE AN OMFS OFFICE in Southern California (LA and surrounding areas). Please email me at omfsbuyer@gmail.com if interested.

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OMS PRACTICE IN THE SUBURBS OF SACRAMENTO CALIFORNIA A flourishing OMS private practices at the doorstep of the Sierra Mountains, seeking single/dual degree surgeon for associate with potential partnership. Send CV to dentalimplants4420@gmail.com with earliest date of availability and contact information. . Contact us immediately for an opportunity that will not last long

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.

SACRAMENTO: Thriving full scope group OMS practice seeks single/dual degree surgeon for associateship leading to partnership position. Ideal candidate must have strong communication skills and quality surgical training. For more information please send cover letter and CV to scott@bradyprice.net or contact Scott Price of Brady Price & Associates (925) 935-0890.

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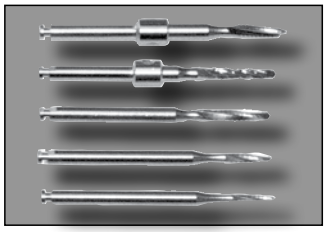

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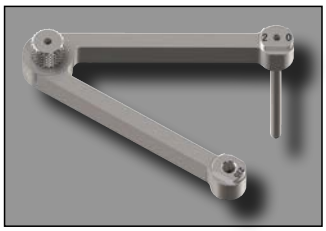

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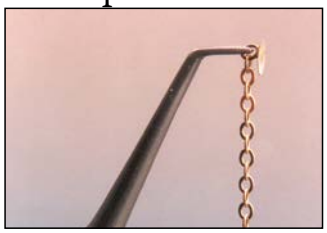

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