



The Compass

Staying the Course Through Service and Education

Volume VII, Issue 2, Summer 2005



CALAOMS Members Storm State Capital



Top Row: Craig McDow, DMD, MS; Craig Alpha, DDS; George Maranon, DDS; Eric Alltucker, DDS, MD; Larry Moore, DDS
Second Row: Russell Web, DDS, President CDA; Ken Wong, DDS; Ronald Mead, DDS; Jeffrey Persons, DDS; Frederick Stephens, DDS
Third Row: Alan Felsenfeld, DDS; Cassey Shimane, DDS; Terrance McCarthy, DDS; Ned Nix, DDS
Bottom Row: Tim Silegy, DDS; Tony Chl, DMD; Tim Shahbazian, DDS; A. Thomas Indresano, DMD; Martin Craven, DDS, MD; Lester Machado, DDS, MD.
Photo Courtesy of Charr Crail - CDA

As evidenced by *The above* cover photo, oral and maxillofacial surgery was well represented at CDA's annual Legislative Day held on May 2, 2005. The event, which takes place annually in Sacramento,

is an opportunity for California dentists to lobby issues relating to dentistry before their district representatives.

The morning session included a briefing by CDA staff on several issues, and a question and answer session with orthodontist turned

assemblyman, Bill Emerson and oral and maxillofacial surgeon turned senator, Sam Aanestad. Several dentists were acknowledged by CDA for their exemplary participation on legislative activities over the past year. Among them were Dr. Larry Moore for his exceptional testimony
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Editor's Corner



Tim Silegy, DDS
Editor, of *The Compass*

PRACTICING BEST PRACTICE

By: Dr. Tim Silegy
Editor

I was saddened last month by the passing of my friend Dan Nakamura. An endodontist, Dan was a pillar of professionalism. Always impeccably dressed, Dan had a knack for being the best. He was an outstanding practitioner and had a chair-side manner that would make Marcus Welby seem insensitive. Dan was active in organized dentistry serving as president of the Harbor Dental Society and as CDA Trustee. He was an excellent gardener, and played classical piano. Above all, Dan enjoyed people. He regularly hosted parties leaving no detail undone and all guests having had the time of their lives. What inspired me most about Dan was his ability to be the best at everything he did.

I thought it would be appropriate then, to dedicate this issue of *The Compass* not to Dan, rather to what

Dan personified—being the best you can be.

It's funny how lessons we learn in early childhood carry forward to our professional lives. When I was in grade-school, one of the highlights of the year was "field day." Usually held in late spring, it was the day when the longest jumper, fastest runner and most nimble potato-sack racer was crowned. Try as I might, I was never the longest, fastest nor most nimble. The cherished blue ribbon eluded me year after year. Once, after having received two seconds and a third place ribbon I sat dejected at the dinner table. I can remember my parents telling me all those years ago, "you can't always be the best, Tim, but you can always do your best." It didn't take the hurt away, but over time I came to realize, that while I could never fully control the final outcome, I could control the effort I put forth. How then, do we define "doing your best" within the context of our profession?

To answer this question, I have enlisted the help of a few CALAOMS members. CALAOMS President, Dr. Mike Cadra, comments on the need to keep abreast of current trends in oral and maxillofacial surgery. He cautions "older doctors" against becoming complacent and encourages them to be dedicated to a lifetime of learning.

At the recent Dental Board of California calibration meeting, CALAOMS Anesthesia Chairman, Mark Grecco and I, had a lengthy conversation about the state of ambulatory anesthesia in California. Mark related to me that his goal as chairman is to enroll everyone in the idea of practicing anesthesia according to the "Parameters of Care" as outlined by the American Association

of Oral and Maxillofacial surgeons. In this issue of *The Compass*, Mark will discuss "best practice" anesthesia within the context of an informal study conducted at this meeting.

In an effort to practice on an even level with our medical colleagues, many oral and maxillofacial surgeons are pursuing office accreditation through outside agencies. Dr. Dan Levin, a veteran of the process, shares his experiences.

I once read that "a professional does his best work when he really doesn't want to." No one likes to lose sleep to attend to a trauma patient in the middle of the night or miss a child's soccer game because a referring general dentist just snapped off a crown and wants you to bail him out at five o'clock on Friday afternoon. Yet we do it because it goes with the territory.

Similarly, as professionals, we are each called to practice to the best of our ability. The drive to do so, must come from within and be supported by our professional associations. CALAOMS is committed to this premise and will continue to support California's oral and maxillofacial surgeons as they endeavor to provide their patients with timely and appropriate care.



SPOTLIGHT ON OUR SPONSORS

CALAOMS is extremely fortunate to have numerous corporate sponsors, many of whom advertise in *The Compass*. Others are well represented as exhibitors at our many educational meetings and some even subsidize our social events. The following companies contributed to the annual meeting: Hals Med Dent – Scientific Sessions, Oral Pathology Associates – Past President's Dinner, Windent OMS – Luncheon and SCPIE– Membership Banquet. In this and subsequent issues, we will highlight these and other contributors to our organization.

With its roots at the University of Southern California, Oral Pathology Associates (OPA) has been serving California's oral and maxillofacial surgeons for over 28 years. In 1997, at the request of Dean, Howard Landesman, Drs. Raymond Melrose and Janice Handlers left the University, establishing a private practice in Los Angeles. Both doctors are Diplomates of the American Board of Oral and Maxillofacial Pathology. Dr. Melrose is a Professor Emeritus and Dr. Handlers is a Former Professor at USC. Additionally, Dr. Melrose continues to teach oral and maxillofacial residents and post-doctoral students at the King/Drew and USC/LAC Medical Centers.

OPA offers tissue diagnosis and consultation for numerous health care professions, but the majority of their referrals come from oral and maxillofacial

surgeons.

A full service pathology lab, OPA prides itself in 24 hour turn around of soft tissue specimens and prompt notification by telephone of all malignant and unusual lesions.

OPA recently upgraded its website to better serve its clients. Biopsy kits and consent forms are now just a click away. Additionally, surgeons can refer their patients to the website if they have questions regarding their diagnosis or to learn more about how tissues are processed and evaluated. Finally, a multitude of cases can be viewed at their "virtual clinicopathologic conference." It is a great way to test your knowledge and to stay abreast of new findings in oral and maxillofacial pathology.

For more information call 310-235-1164 or visit their website at www.oralpathologyassociates.com.

Health Foundation Table Clinics

By, Leonard Tyko, DDS, MD

The CALAOMS Health Foundation sponsored its Second Annual Table Clinic Contest at last month's CALAOMS meeting held in Newport Beach. The Foundation is happy to report that five residents entered the contest. A panel of four judges evaluated the clinics based on the basic tenets of research

methodology and applicability to the field of oral and maxillofacial surgery. Dr. Thomas Ying, resident at Loma Linda University, won the first place prize of \$1000 with his presentation "Repair of Alveolar Cleft Defects with Bone Morphogenic Protein." The second place prize of \$750, went to UOP/Highland General Hospital's Dr. Craig Alpha's work on "Immediate loading of the Edentulous Maxilla." The \$500 third prize went to Dr. Anna Lu's (UOP/Highland General Hospital) presentation on "Unilateral use of the Zygomatic Implant, a Preliminary Report." Dr. Vahid Tabibzadeh, of UCLA, and Dr. Ken Wong, of UOP/Highland General Hospital, put forth impressive research on "Implants in Grafted Bone and Associated Risk Factors" and "Evaluation of Edentulous Maxilla: Graftless Approach to Physiologic Treatment Planning."

The Foundation would like to thank the Table Clinic Contest's panel of judges. Drs. Robert Bass, Daniel Levin, Albert Lin, and Brian Mudd graciously donated their time to evaluate these fine presentations. Also, the Foundation would like to thank the CALAOMS membership who supports the Health Foundation. Their monetary contributions encourage scientific research, which, in turn, benefits our specialty.



Residents Anna Lu, DMD and Ken Wong, DDS pictured with UOP/Highland Program Chairman, A. Thomas Indresano, DMD

Are you an "older doctor"?



By Michael Cadra, DMD, MD
CALAOMS President

Older doctors are not keeping up to date clinically..." read the headline in the American Medical News (AMN). This statement easily grabbed my attention as I have probably passed the midpoint of my career and as such would most likely be considered an "older doctor".

The original article by Choudhry, et. al., published in the Annals of Internal Medicine, was the basis for the "executive summary" found in the AMN. The study is an analysis of previous studies which compared clinical knowledge and health care quality to age and years in practice. The result of the review is certainly counter-intuitive. The majority of the studies demonstrated a negative association between years in practice and several measures of quality of care. This negative association held for medical knowledge, adherence to nationally accepted guidelines and patient outcomes. The negative association was consistent

across multiple medical specialties including surgery, orthopedics, anesthesia, pediatrics and multiple other specialties and sub-specialties.

The authors do acknowledge that attributes not evaluated in the studies, including judgment and humanism may improve with experience.

Oral and maxillofacial surgeons should not ignore these findings, as they most likely apply to our profession as well as our medical colleagues. I did some additional research on a website suggested by Dr. Tom Dodson at our January meeting concerning "evidence-based practice." I found another review of available literature on professional learning which states, "The available Level I evidence indicates that didactic sessions (lectures, even with handouts) do not improve clinicians' performance."

The editors of Annals of Internal Medicine discussed the article at length asking, "What are the implications of this study for the professional development of physicians?" The conclusions are that "professional development" is something that must be committed to early in the professional career. "We must accept that professional maturity not only produce experience and wisdom but also may



harbor the danger that a physician does not keep pace with new knowledge and practice standards, that conceivably a physician's skills and knowledge may eventually decrease over time."

How many of us are doing things just as we did in our first year of practice, even though there may be evidence based literature that suggests we should change? If I were to induce anesthesia as I was taught 20+ years ago, I would still be using a straight needle, Valium, Demerol, Brevital, not using a continuous IV fluid infusion and prescribing antibiotics for practically every surgery.

The study also presents challenges for the organizations that provide continuing education. The question relative to CALAOMS is "how will we facilitate the professional development of our members?" We have just had a very well attended and interesting continuing education (CE) course in Newport Beach with Dr. Michael Block speaking on bone grafting and dental implant surgery. Not every CE course has been as successful. Our CE committee is challenged by several factors. First, when surveys are responded to, the areas that are always noted for more education

include implants, anesthesia and dentoalveolar surgery topics. Second, the revenue from CE is our biggest source of non-dues revenue. Our members vote indirectly by attending or skipping the conference. Are we to provide topics such as orthognathic surgery, TMJ issues, trauma, cosmetics or pathology if the attendance will not support the cost of the course, much less make a profit for CALAOMS?

Oral and maxillofacial surgeons must know the current evidence based standards of care. It has been over ten years since AAOMS published the first edition of "Parameters of Care", and the third edition is due to be replaced in the near future. How many of us have really read and put into use these practice based parameters?

I will also put forward the statement of the editors of the aforementioned article: "...all physicians, not just those with time-limited certification, must embrace the concepts behind maintenance of certification, which provides an opportunity to prevent the outcomes demonstrated in Choudhry and colleagues' study." I suggest to our membership that this applies to oral and maxillofacial surgery also.

ABOMS went to a time-limited certification in 1990. "Older doctors", such as myself, should consider testing our clinical and take the recertification examination or at the very least participate in the ONSITE exam given each Spring. I took the recertification exam in 1997, and

cannot believe that it is nearly time to take it again.

I believe that if we are to maintain our current scope of practice, all our members need to prove to our referral sources that we are the leaders in our areas of practice and that we will not allow this negative correlation of years in practice and clinical outcomes.

In regard to anesthesia, we must remain the leaders in outpatient care of our patients by keeping up with the anesthesia literature, attending anesthesia and medicine "refresher courses" and practicing emergency drills with our staffs on a routine basis. I submit to you, that biennial renewal of your ACLS card is not enough!

In regards to implants, I believe that there are multiple other specialties that will be happy to take over the placement of implants if we do not continually upgrade our surgical skill and knowledge. With dentoalveolar surgery, a domain rarely threatened in the past, we face increased competition from roving GPR trained dentists taking out impacted teeth in the general dentist's office under IV sedation.

We must demonstrate our commitment to excellence in all facets of oral and maxillofacial surgery if we are to thrive in the new millennium. If you too are an "older doctor," I challenge you to set the example, as did the many fine surgeons who established our great specialty.

MENTOR COMMITTEE OUTREACH

By, Gerald Gelfand, DMD
Chairman, Mentor Committee

The Mentor Committee is looking to expand and seeking new members in currently underrepresented geographic areas. We need committee members in the following areas:

- San Bernardino/Riverside
- San Diego
- Los Angeles
- Orange County
- Fresno
- Bakersfield
- Sacramento
- Stockton
- San Luis Obispo
- Ventura/Santa Barbara
- Modesto
- Monterey
- Santa Rosa
- Eureka and points north
- Redding

The responsibilities are not overwhelming and you'll be providing a great service for CALAOMS and for the applicants and new members of CALAOMS. If you're interested, please contact me at (818) 225-8602 or gelfoms@aol.com.



SCPIE's Risk Management Corner

Informed Refusal: When Patients Won't Follow Your Instructions

By Barbara Worsley

We're a long way from the days when oral surgeons told patients what they needed and patients agreed without question. Although some patients still have an "I'll do whatever you say, Doctor" attitude, they're in the minority. In today's world, different people react to proposed treatments or tests differently, often as a result of their varied backgrounds, financial status, values, attitudes and perspectives.

Most patients want information about medications, procedures and alternatives before they take a test or embark on a specific course of treatment. Also, every patient who is mentally competent has the right to refuse any test or treatment option.

In this environment, providers should never provide treatment without first obtaining informed consent from patients (or from individuals legally empowered to give it on their behalf). Our legal system defines treatment without informed consent as battery.

Informed refusal, the other side of informed consent, is equally important. During the informed refusal process, oral surgeons must make sure patients understand the seriousness of their conditions; the full range of possible risks to patients—up to and including death, if applicable—should be discussed. You must also go a step further by disclosing what is likely to happen if patients decline treatment or tests, or do not take other recommended follow-up steps.

Patients benefit from such discussions by becoming more knowledgeable about the pros and cons of recommended treatments and tests. Oral surgeons benefit because informed patients have more realistic expectations and therefore are less likely to sue for malpractice.

The Legal Obligation

In *Truman v. Thomas*, 27 Cal.3d 285 (1980), the California Supreme Court held that doctors are responsible for making sure patients are aware of all significant risks that could result from noncompliance. In Truman, the court reviewed the patient's right to refuse treatment, and the provider's corresponding duty of care, as follows:

"If a patient indicates that he

or she is going to decline a risk-free test or treatment, then the doctor has the additional duty of advising [the patient] of all material risks of which a reasonable person would want to be informed before deciding not to undergo the procedure. On the other hand, if the recommended test or treatment is itself risky, then the doctor should always explain the potential consequences of declining to follow the recommended course of action."

The obligation applies equally to all tests and procedures, from simple, common ones to the most complex and unusual. It also applies to a recommendation that patients see a specialist; oral surgeons must inform patients of the possible consequences of not getting a consultation.

Documentation in a patient's medical record should include the following:

- a notation about the information that the surgeon gave the patient concerning the condition and the proposed treatment or test. Reasons for the treatment or test should be noted.
- a notation that the patient was advised of the possible risks and consequences—including loss of life, if applicable—of failing to undergo treatment or a test.
- a notation about the physician's referral of the patient to a specialist, including the reasons for the referral and possible risks of not seeing the specialist. Also

note any attempts to contact the patient after the referral to a specialist.

- a notation about the patient's refusal of the physician's treatment/testing plan or advice. This should include the patient's signature on a refusal-of-treatment form. (Go to www.scpie.com/forms for a sample form.) Although such forms are optional, they offer the oral surgeon the strongest protection against claims of a lack of informed consent. Make sure an independent witness is present when the patient signs the form.

Maintain an Ongoing Dialogue

Patients may refuse treatment for many reasons. Fear of a biopsy result, disagreement with you over the appropriate treatment plan or lack of insurance coverage may all contribute to a patient's refusal to follow the recommended treatment plan.

You have a duty to respect a patient's decision; however, you should also explore the patient's reasons for refusing treatment and continue discussing your recommendations with him or her. You should maintain an ongoing dialogue concerning:

- what the testing/treatment entails
- why it is the recommended course of action

- the risks and benefits of the proposed testing/treatment
- the risks of delaying or not having the testing/treatment
- possible alternatives.

If a patient fails to return to you for recommended treatment, you should inform the patient of the possible consequences for failure to proceed with that care. The number of letters sent and phone calls made should correspond with the seriousness of failing to obtain care. For example, failure to follow up after routine extractions may require only one telephone call after a missed appointment while refusal to follow up after discovery of a suspicious lesion would warrant several phone calls and strongly worded letters.

Just because patients refuse a particular treatment or test does not necessarily mean they are incompetent or don't know what they're doing. Refusal to comply can be an important cautionary flag, one that alerts the oral surgeon of the need to take a close look at his or her recommendation and at the reasoning behind the patient's refusal to follow it.



New ABOMS Diplomates



Congratulations to the following OMS from California who are new 2005 Diplomates to the American Board of Oral and Maxillofacial Surgery. The list includes:

Michael Beckley, DDS

Marc Bienstock, DDS, MD

Michael Devlin, DDS, MD

Alan Esla, DDS, MD

Evan Gold, DMD, MD

Michael Gunson, DDS, MD

Arthur Johnson, III, DDS, MD

Peter Krakowiak, DMD

James McAndrews, DDS

Phillip Seim, DDS

David Stephens, DDS

Certification by the ABOMS is the "crowning achievement in the educational process because it indicates that an individual who has attained this recognition cares about defining and improving their level of knowledge," stated ABOMS President Dr. Edward Ellis III.

Office Accreditation — Why bother?



By Dan Levin, DDS

Several years ago I received my notice from ABOMS that I had passed the board exam. This day was filled with great relief and exhilaration. As many of you know, it is a very humbling experience to present yourself to a group of professional peers and *voluntarily* let them grill you on your current knowledge of oral and maxillofacial surgery. Since that happy day, I think I can count on one hand the number of patients who have ever asked me if I was board certified. Other than a few insurance companies and hospitals, no one has seemed to care about this accomplishment. Certainly, being board certified does not mean you have better technical skills or that you are going to be more successful than your non-boarded colleagues. So why do it?

I am certain that we each have several profound reasons, but for many of us it all boils down to it being the right and professional thing to do. Board certification

elevates the oral and maxillofacial surgeon in both the eyes of the general public and the dental community. It also elevates our profession.

Office accreditation presents us with another challenge. Simply stated, office accreditation is like board certification, for your office. There are many reasons not to do it such as, the cost, the time commitment, and the general pain in the rear factor. These things considered, I must really be a glutton for punishment since I have been re-certified 3 times and am gearing up for my fourth.

Currently, the Accreditation Association of Ambulatory Health Care, Inc (AAAHC) charges close to \$700 just for the application fee. My last survey fee in December 2003 was about \$3700.00. Next are the costs associated with getting ready for the survey. Typically, you will need an experienced consultant with fees that average around \$75.00/hour. Depending on your degree of readiness, you should expect to spend around 100 hours preparing. There no doubt will be additional miscellaneous fees mainly associated with equipment repair and book keeping items. Finally, once you become accredited, you will need the funds necessary to maintain your accreditation.

Next comes the time involved. Most good consultants will educate you with all the rules and regulations; however, you need to get involved with the entire process since it is you, not the consultant, who will meet with the surveyor.

With this level of difficulty, why would anyone bother with office accreditation? Before that question can be answered, you need to know a little bit more

Office Accreditation and Association Membership are the Building Blocks for a Strong Practice



about accreditation. The two major national organizations that do the majority of our type of offices are the AAAHC and Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Both organizations function independently and are endorsed by the major professional organizations including AAOMS, ADA, AMA, etc. The survey process involves a complete scrutiny

of your office policies including: procedures, protocols, logs, quality assessment, and governance. The attempt is to make an office into an “organization” with bylaws, mission statements, and responsibility to a board of governors (you). In addition, your office will need to document your compliance with a national standard established by the variety of supporting professional organizations with the goal to improve patient safety.

The survey process involves a review of your Operational Policy and Procedures Manual and Continuous Quality Improvement

Program. Next, approximately 25 charts are reviewed in order to demonstrate appropriate document handling including Consults, History and Physical Examinations, signed Consents and Anesthesia Records. Finally, the physical plant is examined and all logs, equipment, crash carts, are inspected. The surveyors may also elect to observe a surgical procedure. Two days are

generally required to complete the inspection.

Most of the organizational factors are a paper chase and there is a huge laundry list of compliance issues. Both AAAHC and JCAHO will provide you with a manual listing all the items to be inspected, but it has been my experience that it is worded in accreditation-speak. This is where a good consultant comes into play. He or she can outline the important issues for you so they can easily be implemented into your office. This will help you to maintain your compliance, making subsequent surveys easier. No doubt by now the pain in the rear factor seems overwhelming. In actuality, it is not as bad as it sounds and it is very doable.

So it still begs the question on why bother? There are several reasons for office accreditation and a few are listed as follows:

1. Risk Management. Your office complies with a national standard and it would be very difficult for an advisory to find fault with your facility.
2. Earning Patient Trust Through Quality. This is the AAAHC credo which demonstrates to patients the high level of commitment you have made. By *voluntarily* allowing your facility to be closely scrutinized and that it meets nationally recognized standards for quality health care services.
3. Additional Income. Technically, you should be

able to bill for your facility charges, however, don't expect to retire just yet. Many insurance carriers are reluctant to pay for the facility if it is within the doctor's office. In addition, many may want you to be Medicare certified as well, which, unto itself, has additional physical plan requirements (smoke walls, fire safety systems, true 90 minute electrical back up and the list goes on).

4. Public Perception. For those that know, office accreditation elevates the status of our outpatient facilities. It makes us at par with any accredited surgical center, hospital based or otherwise, since the standards are the same nationwide. It is good for the individual oral surgeon and it is good for our association.
5. Practice Value. Somewhere down the road, we will all retire from active practice and, though I do not have any particular documentation, common sense would dictate that a fully accredited office would have increased value and/or high interest on the part of a buyer.

I truly believe as the numbers of oral surgeons accrediting their offices increases, the cost will drop and the standards for us as oral surgeons will improve, becoming more specific to our specialty. But ultimately, what it all boils down to is that it is the right and professional thing to do!

The Future of Oral and Maxillofacial Surgery Assisting In California - An Update

By Bruce Witcher, DDS
Chairman, Council on Education

Last year, the Governor signed a bill that would create specialty assisting categories for surgery, orthodontics and restorative dentistry. This law will take effect on January 1, 2007. There has long been a need for specialty assistants who have specific training but who have not completed an RDA. The licensed category for the OMS assistant is known as the registered surgical assistant. CALAOMS had input to this bill, and recommended that the registered surgical assistant have the following duties:

1. taking impressions for surgical splints and occlusal guards
2. placing surgical dressings
3. removing an IV line
4. monitoring of patients in the pre-op, intra-op, and post-op phases
5. giving medications into an IV line with the surgeon at chair side

Under present regulations, the duties the dental assistants (DA's) may perform that apply to the OMS office are:

1. extra oral duties at the direction of the surgeon
2. basic supportive dental procedures that are technically elementary, reversible, and have no potential for patient harm
3. take impressions for study models bleaching trays, and sports guards
4. remove sutures and surgical dressings

Monitoring, as performed by OMS assistants, is conducted as an extra oral duty and basic supportive function.

Registered dental assistants (RDA's) may do all the duties of the dental assistant, but may also:

1. place surgical dressings
2. monitor patients in the post-operative phase according to general anesthesia regulations
3. RDA's must also complete 25 units of CE every two years

Because registered surgical assistants (RSA's) are performing new duties and now have licensed status, they will be required to complete additional training as well as an examination. The length and nature of this training is presently the subject of negotiations.

CALAOMS is taking a strong position that it must be possible to complete this training in a reasonable amount of time, at a reasonable cost, and that assistants (DA's) who have already trained through OMSA and have work experience will receive educational credit toward registered status.

Those who presently have an RDA will have to complete less training than DA assistants, as they can presently perform more duties than the DA. Although this is still the subject of negotiations, current RDA's will almost certainly have to complete a course in giving IV medications if they wish to perform this duty.

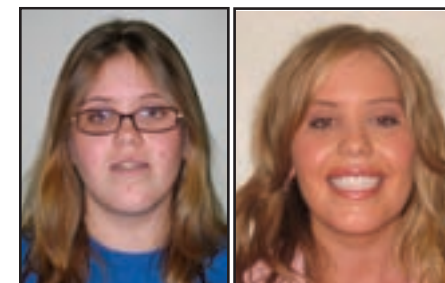
There will always be a role for the OMSA course in the training of our assistants. We will seek to have the OMSA course approved for credit toward licensure although at present the course is for CALAOMS certification only and does not confer licensed status.

CALAOMS will always be a strong advocate for OMS assistants and preservation of the critically important role you play as a member of the anesthesia team. The registered surgical assistant will be able to perform valuable new duties but will not replace the traditional OMS assistant who has functioned as an effective team member for many years.

The Role of OMS and Extreme Makeover

Until recently, the general public had a limited knowledge as to the full scope of oral and maxillofacial surgery. This changed significantly on April 14th when close to 10 million people watched as a young Californian, Katie Cox, underwent a mandibular osteotomy on ABC's hit television show, *Extreme Makeover*. The surgery was performed by *Compass* editor, Dr. Tim Silegy and CALAOMS Fellow, Dr. Rob Relle.

Dr. Silegy was approached to appear on the show by cosmetic dentist, William M. Dorfman, a member of the program's "extreme team" of doctors, trainers, estheticians and others who perform many of the procedures. Dr. Dorfman had read an article on orthognathic surgery published by Drs. Silegy and Relle in the *Journal of the California Dental Association*.



Katie was the youngest person ever to appear on *Extreme Makeover*. "Normally, you have to be 21 to be on the show, but what

interested the producers in her story was that it involved both a functional and cosmetic problem," says Dr. Silegy. "This was a girl who had never moved on to womanhood because her braces kept her 'trapped' as a teenager."



Dr. Silegy spent 15 hours being followed by a camera crew throughout the initial consultation, preoperative appointments, surgery and follow-up appointments after Katie's bandages had been removed.

According to Dr. Silegy, Katie was put on the "fast track" for the show. "We accelerated the process," he says. "Her orthodontist, Dr. Sugiyama, had set up her case so well that she had a perfect bite after surgery. We used rigid fixation, which allowed us to take her braces off just three weeks after surgery."

With her braces off and her osteotomy healing, the rest of the "extreme team" sprang into action. Dr. Ava Shamban improved Katie's complexion, Drs. Ari Rosenblatt and Ziv Simon contoured her gums,

Dr. Anthony Griffin enhanced her upper lip and Dr. Bill Dorfman veneered her maxillary anterior teeth. Contact lenses provided by Dr. Maloney and a new hairstyle, makeup and a fashionable new wardrobe completed Katie's transformation.

"It was great to be able to work with a really good team of professionals to achieve the maximum outcome," Dr. Silegy says. "It was also rewarding to care for a patient who had access to everything needed to achieve optimal results. Often we are limited in what we can do by financial considerations. On *Extreme Makeover*, those limitations disappear."



Katie was one of three patients who joined Dr. Silegy and Dr. Moore as they testified in favor of SB 438 before the Senate Business and Professions Committee on April 18th. As Dr. Moore eloquently stated, "While this procedure was labeled 'extreme' for the purposes of television, this is what we do day in and day out."

Annual Meeting in Review

What do you get when you combine a beautiful venue, a great topic and a nationally known speaker? You get a very successful annual meeting! This year's CALAOMS Annual Meeting was held at the Four Seasons Resort and Spa in Newport Beach, California on May 21st and 22nd. The festivities officially began on Friday evening at the Past President's Dinner which honored Past Presidents from CALAOMS and from the NCSOMS and SCSOMS.

Bright and early the following morning, attendees were greeted by the always cheerful CALAOMS staff, Pamela Congdon and Teri Mandella. As they enjoyed a wonderful continental breakfast, surgeons, family and staff browsed numerous exhibit booths and listened to several very impressive table clinics presented by oral and maxillofacial surgery residents from UOP/Highland, Loma Linda and UCLA.

This year's featured speaker was Dr. Michael Block. His casual demeanor and jovial delivery was well received by those present. Dr. Block showed several examples of particulate bone grafting and astounded the audience with a case showing the effectiveness of BMP impregnated gel foam for sinus augmentation procedures.

The morning session was followed by a wonderful lunch with guest speakers, Dr. Gerald Hanson, Dr. Elgan Stamper and Liz Snow from CDA. Dr. Len Tyco then announced the winner of the Resident's Table Clinic competition sponsored by the CALAOMS Health Foundation.



Thomas Hiser and Dan Levin examine the table clinics, while residents Tim Yang, and Ken Wong stand by to field questions.

Later that evening, following a short cocktail hour sponsored by our exhibitors, members strolled by beautiful Fashion Island to the Orange County Museum of Modern Art for a dinner honoring two of our outstanding members. Dr. Lee Heldt presented the Distinguished Service Award to Dr. Tim Shahbazian. Dr. John J. Lytle honored friend and colleague, Dr. Ross Prout, to whom of this year's Annual Meeting was dedicated.

Attendees were then entertained by David Winston. Amazingly, he correctly identified objects placed by members into velvet bags and more amazing still, read the minds of several members, answering some very interesting questions. Following a rousing applause several members returned to the Four Seasons Bar where they danced the night away.

The following morning, Dr. Block continued his lecture on bone grafting and attendees had a final opportunity to meet with exhibitors. "This was one of the best annual meetings I have attended," remarked many CALAOMS members. "The resort, education and social activities were fantastic. I really enjoyed the camaraderie!"

If you were unable to attend the meeting Newport Beach, don't miss out on what should prove to be another outstanding event. Oral pathologists William Carpenter and Roy Eversole, oral medicine specialist, Sol Silverman, and oral and maxillofacial surgeons, Thomas Indresano and Brian Schmidt, will team up to present a review of mucosal pathology and central lesions. The meeting will be held at San Francisco's beautiful Hotel Niko October 28th through the 30th. A registration form is included as an insert to this newsletter, or, if you prefer, online registration is available at www.calaoms.org.



Annual Meeting Dedicattee Ross Prout, DDS shares a moment with his son Ross Prout, III following the dedication.



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OFFICE ANESTHESIA: Regulatory Guidelines Versus Standard Of Care

The recent Dental Board of California Anesthesia Office Evaluation Calibration Courses, attended by current and incoming evaluators, took place on March 2, 2005 in Costa Mesa and March 9, 2005 in San Jose. Both venues were well attended in Costa Mesa and in San Jose. I conducted an informal survey at these meetings by asking the following questions relative to office General Anesthesia and Intravenous Sedation:

Question 1. In regards to intravenous (IV) access, do you use:

- a. an angiocath
- b. a "butterfly"
- c. a straight needle

Question 2. In regards to IV fluids, do you:

- a. run a continuous infusion
- b. use fluids for drug administration only
- c. not give IV fluids

Question 3. In regards to monitoring, when do you use an ECG:

- a. for GA only
- b. for both GA and IV sedation

Question 4. In regards to monitoring, when do you use capnography:

- a. for GA only
- b. for both GA and IV sedation,
- c. neither

I asked these questions in an effort to gain some insight into practice patterns of oral & maxillofacial surgeons in California. Implicit in these questions is the discrepancy between minimum

requirements as mandated by California law, Parameters of Care as published by the American Association of Oral and Maxillofacial Surgeons, and "standard of care," defined as the level of care, skill and treatment which is recognized as acceptable and appropriate by reasonably prudent similar healthcare providers under similar circumstances.

Why is this important? Simply stated, one can practice within the legal requirements of the state, and yet, still be practicing outside of national and local norms. This is possible because "standards of care," are fluid and change with time in response to accumulated clinical data, research and technology.

Law, on the other hand, is written by legislators, albeit with "expert input," and changes slowly, incrementally, and in response to forces which may ultimately be politically driven rather than patient-care driven.

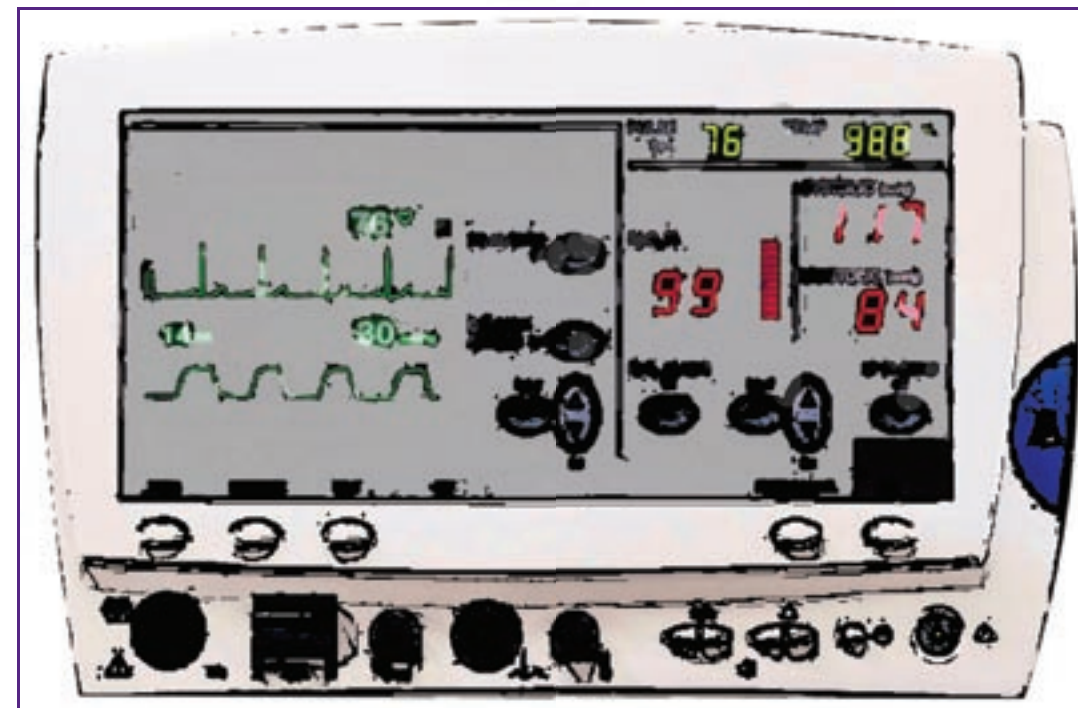
And what about the Parameters of Care? These are described within the AAOMS document as a "... range of accepted patient management strategies...". While this definition is intentionally vague in order to prevent misuse of the document by plaintiff's attorneys, in reality, this document represents those practice elements that the clinical leaders in our profession would ideally like to see implemented universally.

So what separates those who practice at the minimum level from those who practice at the standard of care? And

By Mark Grecco, DMD
Chairman, Anesthesia Committee

what separates the practice elements of "standard of care" from the elements of the AAOMS Parameters of Care? Using examples taken from the survey, let's look first at question number one, IV access.

Of the 142 responses returned on this



question, 107 practitioners place angiocaths for all GA and IV Sedation cases, 31 place butterfly needles and 4 place straight needles. According to California law, the minimum is exceeded in all cases as IV access is not specifically required for GA or IV Sedation. The standard of care as defined by these same numbers is clear, in that approximately 75% of practitioners place angiocaths. In this instance, 75% of practitioners also

practice in parallel with the AAOMS Parameters of Care.

Question two, on infusion of IV fluids shows similar results. Of 142 practitioners, 115 infuse fluids during all cases with 15 practitioners infusing only sufficient fluid to administer drugs and 12 infuse no fluids at all. All meet minimum standards. The 81% response rate makes infusion of IV fluids the de facto "standard of care" which is also consistent with the

AAOMS Parameters of Care.

Question three, concerning ECG placement during both GA and MAC runs at 122 of 140 practitioners, or 87% with 18 practitioners or 13% monitoring during GA only. Again, all meet the minimum, the Standard of Care defines itself and 87% also practice consistent with the Parameters.

Question four, concerning the use of

capnography during GA runs at 27% with 37 of 138 practitioners routinely utilizing this modality. Minimums met by all, "standards" exceeded by 27% and Parameters met by that same 27%

Pretty good numbers, right? Maybe not. The group surveyed consists of those who are vested by the state, with the responsibility of evaluating their peers' practices in outpatient anesthesia. And yet, a strong argument could easily be made that at least 20% of these individuals practice below the "standard of care." The group surveyed does not include non-evaluators and non-CALAOMS members, but likely does represent the larger whole in terms of practice patterns.

Informal questioning of membership reveals a number of reasons for these "non-standard" practices. Many cite the cost of materials. This can only be dismissed as ludicrous in light of the fees and general rates of compensation of the membership. Many state that they practice now the way they always have and it's never been a problem. This group may wish to consider the following: one can do absolutely everything right in clinical practice and still have a bad outcome. Similarly, just because one has NOT had a problem, does NOT lead to the inevitable conclusion that everything has therefore been done right.

The trends in regulatory oversight of outpatient anesthesia are clear. In the vast majority of states, the practice of outpatient anesthesia is regulated at both the level of the practitioner (i.e. appropriate post-graduate education and licensure) and at the level of the facility (i.e. accreditation- AAAHC or JCAHO plus or minus state licensure.) For reasons that vary from state-to-

state, these same requirements have largely spared outpatient anesthesia in dentistry.

It is absolutely imperative that outpatient anesthesia delivery in all settings be held to a single standard and the AAOMS Parameters of Care indirectly acknowledges this. Every element of this document is consistent with, and sufficient to satisfy the requirements for outpatient anesthesia delivery, whether medical or dental, in any state.

A primary goal of the CALAOMS Anesthesia Committee is to maintain our privilege of providing safe office-based anesthesia utilizing the single operator-anesthetist model. If the process of bringing Oral & Maxillofacial Surgery into parallel with the rapidly emerging national standards for outpatient anesthesia is left to one of the many interested outside parties, the operator-anesthetist model will most likely cease to exist. This has already happened in Great Britain.

If, however, we are proactive and take the simple steps to require of ourselves nothing more than what already exists in our own Parameters of Care, we can guide the process logically and dispassionately. Our internal standards will be the equal to, and many times exceed those of any state agency or regulatory body. If we wait until the laws change to meet these same standards, it will be a painful, expensive and quite probably, futile process.

Please support the Anesthesia Committee as we guide the membership towards the voluntary adoption of all aspects of the AAOMS Parameters of Care for outpatient anesthesia.

AAOMS DAY ON THE HILL REPORT

By, Gerald Gelfand, DMD
Chair, AAOMS Committee on Government Affairs
Chair, OMSPAC Board

I am writing on an airplane cruising at 37,000 feet (as the Captain is always compelled to inform us, though I can't imagine why) returning from the annual American Association of Oral and Maxillofacial Surgeons Day on the Hill. The event, as usual, was very informative and a huge success. Approximately 80 oral and maxillofacial surgeons from all over the country were there to represent our views on critical issues of the day to the legislators who significantly control both our professional and private lives. Visiting our Representatives and Senators in their Washington offices to discuss and lobby for our views is the ultimate expression of democracy in a representative government and I, for one, never get tired of the inspiration it brings. Of course, we rarely actually see the legislators but rather we speak with a legislative aide who handles health care issues, but that's another story.

Aside from doing a lot of eating (and there's a bit of drinking, too) the day consisted of a variety of presentations and updates of the three issues which comprised the order of the day prior to our visits to "the hill". Members of the CGA and OMSPAC came in a day early for an extraordinary joint meeting of both groups. Ordinarily these two agencies meet jointly in the morning prior to "Day on the Hill", then break out separately in the afternoon. Since I chair both this year (something that's never happened before), we stayed together for the entire day, which resulted in an excellent exchange of ideas and an extremely productive meeting. It was to be sure a huge success for two AAOMS committees, which often overlap in their function.

The morning of the Day on the Hill was kicked off at breakfast with an update and review of the three main topics of the day: Dental Health Aide Therapists (DHAT) in Alaska, pay equity in the military for dental corps

officers versus medical corps officers and deductibility of student loan interest. By the way, the staff of the AAOMS government relations' office, in particular Karen Wittich and Jeanne Tuerk, do a phenomenal job representing our views and acting as watchdogs on our behalf. I work closely with these people and although most of you may never have an occasion to meet them it's comforting to know that they are there working on our behalf.

The DHAT in Alaska has occupied a lot of our time at CGA both at AAOMS and ADA and was the major focus of the day. In a nutshell, it is a program whereby high school graduates are given 18 to 24 months of training in New Zealand and return to remote Alaskan native villages to provide, in addition to preventive care and nutritional counseling, irreversible dental procedures such as simple extractions (whatever they are), pulpotomies and dental restorations. The details of the program are quite interesting so please call me if you'd like more information but suffice it to say that AAOMS, as well as the ADA, are vehemently opposed to anybody doing irreversible dental procedures other than licensed dentists. It is an excellent example of the new spirit of cooperation, which is taking place between AAOMS and the ADA.

Bob Brandjord, AAOMS Fellow and president-elect of ADA, did a superb job updating the group on this issue prior to our visits with the legislators. Mike Graham, senior congressional lobbyist of ADA, updated the group on the student issue explaining that current law limits the deductibility of interest on student loans. Reforming this and loosening other restraints which limit student/new graduate options will have far reaching effects and hopefully open doors for students who wish to go into teaching positions.

Mike also updated the group on the pay equity issue. There are a variety of special pays available to medical and dental officers in the military but the inequity revolves around what's known as Incentive Special Pay (ISP). This is a yearly bonus offered to medical officers, which ranges from \$6,000 to \$36,000 depending upon specialty. ENT surgeons, most closely

allied to OMS, receive an ISP of \$30,000 per year. That's a lot of money designed to retain people in the military and create more equity with the private sector. Despite how vital OMS is to the military mission, indeed all facial trauma in the middle east theatre is provided by OMS's, dental officers are not eligible for this ISP. We lobbied for OMS's to receive the same \$30,000 per year as ENT surgeons and hopefully the legislators got the message. This will be a long and difficult battle but we're making progress and moving in the right direction. This is another issue with which we have great support from ADA.

The morning ended with a short address from Representative Eric Cantor (R-VA). Congressman Cantor, clearly a friend of dentistry, is the member of Congress who introduced a resolution this past year honoring the dental profession for its Give Kids A Smile program.

You may recall the recent accidental violation of restricted airspace by a small private plane in Washington. This happened as a group of us, including yours truly and AAOMS President Dan Daley were sitting in the office of Senator Orrin Hatch (R-UT). When the alarm went off, the senator's senior aide with whom we were meeting immediately got up and said, "let's go, we have to get out", and proceeded to take off. It was clear that these folks had been well drilled about what to do when this alarm sounded as people came streaming out of the Senate office building at a rapid pace. I mean, they were running like it was a sprint at the Olympics and was taken very seriously. Security came out of the wood work in addition to the obvious uniformed security. Needless to say, it was the end of our meeting with Senator Hatch for whom we were waiting after he cast a vote on the Senate floor. It was not until I arrived home later that night that I was even aware what had occurred. It was clearly the most exciting part of the day.

California was well represented with three attendees in addition to myself. CALAOMS Vice President and state PAC chair Murray Jacobs, AAOMS Immediate Past President Elgan Stamper and resident member

Alex Kassef were all there to support the effort. These are committed AAOMS members who work tirelessly to try and protect our practices and our interests from inappropriate governmental intrusion. The AAOMS Day on the Hill is an annual event open to any AAOMS member. Come join us next year. I'm sure you will find it worthwhile, empowering and invigorating. You can reach me at (818) 225-8602 or gelfoms@aol.com if you have any questions.

CALAOMS HEALTH FOUNDATION REPORT

By, Gerald Gelfand, DMD
President, Health Foundation

In the beginning of 2004, Tom Hiser assumed the position of President of CALAOMS and faced many dilemmas. The one of which I speak, is the CALAOMS Health Foundation. A fledgling organization built from 501(c)3 funds held over from the SCSOMS which could not be combined with the 501(c)6 funds of the NCSOMS to be placed with the general funds of CALAOMS, a new foundation was born. I told Tom that I would take over the chairmanship of the Foundation Board and try to give it a vision and direction and build upon its base--one less problem for him to worry about.

To that end, we expanded the Board with talented and extraordinary people. We have developed both mission and vision statements and embarked on an ambitious fund raising campaign which has resulted in a record year for contributions in 2004 and hopefully a new record in 2005. Yet there is much to be done and we are far short of where we'd like to be.

This is now my second year as Chair of the Foundation and as I approach my CALAOMS presidency in 2006, I realize that with the many obligations I have to CALAOMS, AAOMS, CDA, ADA and other areas, I will not be able to stay on as chair of the Foundation while I sit as the CALAOMS President. Consequently,

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on SB1336, & SB438 and Dr. Jeffrey Persons for his effort in organizing a grass roots campaign for the same bill.

Following a short lunch break, volunteers, grouped by CDA component, trekked across the street to the capital, where they met with their representative assembly members and senators. Their agenda -- to lobby CDA's position on the following Bills:

SB 438 (Migden) – Oral Surgery – Elective Cosmetic Procedures: In 2004, CDA co-sponsored SB 1336 (Burton) with the California Association of Oral and Maxillofacial Surgeons (CALAOMS) in an effort to create a permitting process that would allow oral surgeons who met certain criteria to perform specified elective procedures in accredited outpatient facilities. Presently there is an anomaly in state law, whereby certain oral surgeons are permitted to perform complete facial reconstructions in a hospital trauma care setting, but cannot perform the same or similar procedures on an elective basis in their offices. Rather than trying to broadly redefine "dentistry" in statute for this purpose, the bill as introduced proposed to create a process by which oral surgeons could obtain a permit from the Dental Board of California after having demonstrated and documented specific credentials.

SB 1336 ultimately was passed by the Senate with a final vote of 30-0, after passing out of the Assembly on a 67-2 vote, despite the continuous strong opposition from the California Medical Association, the California Society of Plastic Surgeons, and the California College of Emergency Physicians, who argued that the bill would be an inappropriate and potentially unsafe expansion of oral surgery scope of practice. However, the Governor vetoed the bill on August 27, stating that he was not yet comfortable that these practitioners were sufficiently qualified. In his veto message, the Governor requested his Director of Consumer Affairs to conduct an occupational analysis of the oral and maxillofacial surgeon profession to determine if the procedures in question could be performed safely and competently on an elective basis. That analysis is currently in progress and is expected to be completed later this year. In the meantime, with Senator Burton having left the Legislature last year due to term limits, **Senator Carole Migden (D-San Francisco)**, who was elected to take Senator Burton's seat last November, has agreed to introduce **SB 438**, which is nearly identical to last year's SB 1336, and which can be used as a legislative vehicle to move this issue forward again depending upon the results of the state's analysis. Senator Migden and CDA have made clear to all parties that the bill will not be sent to the Governor prior to the release of that analysis. SB 438 passed the Senate Business, Professions, and

Economic Development Committee on April 25th on a 5-1 vote, and was passed by the full Senate May 16th on a 30-2 vote. The bill now moves to the Assembly.

SB 683 (Aanestad): Licensure – Postgraduate Residency Program Recognition: **Senator Sam Aanestad (R-Grass Valley)** has introduced **SB 683** on CDA's behalf. SB 683 is a continuation of last year's SB 1865 (Aanestad), which gave California dental licensure applicants the option of taking the Western Regional Examining Board (WREB) exam instead of the state clinical exam. California is one of many states that are beginning to develop alternatives to the traditional, one-time only clinical exam that relies on the use of "live patients." SB 683 would provide an additional alternative for licensure applicants, by allowing them to instead complete a clinically based, postdoctoral general dentistry or specialty residency program of at least one year's duration, at a school or facility accredited by the Committee on Dental Accreditation (CODA) of the American Dental Association. The residency program would be required to include a formal outcome assessment evaluation of each resident's competence to practice dentistry. This option would allow licensure applicants to have their clinical competency evaluated over an extended period of time, and would be more in line with the licensure process that has long been in place for physicians. SB 683 passed the Senate Business, Professions, and

Economic Development Committee on April 11th on a 6-0 vote and was passed by the full Senate by a 37-0 vote on May 2nd.

AB 1077 (Chan) -- Children's Oral Health Assessments:

Significant research over many years has demonstrated that poor dental health is one of the leading causes of missed school days for children (which results in lost average daily attendance revenues for schools), and is also one of the most preventable. CDA this year is sponsoring **AB 1077** by **Assembly Member Wilma Chan (D-Oakland)**, which as originally written was modeled after legislation passed in Illinois that would generally require children to provide documentation of an oral health assessment by no later than May of their kindergarten, second, and sixth grade years, unless the child's parent or guardian indicates that they choose not to obtain the assessment, cannot afford the assessment, or cannot find a dentist in their area. AB 1077 was passed by the Assembly Health Committee April 5 on a 10-2 vote, and was passed by the Assembly Education Committee on April 20 on a 10-0 vote. Some school organizations are objecting to the bill as an "unfunded mandate." The bill allows parents to "opt out" by completing a simple form and there is no punitive action for not completing the assessment. This bill is intended to obtain information about the severity of the problem and to build capacity to help children find the dental care they need. Because

legislative staff has estimated an annual cost of \$8 million, the bill is currently on the Assembly Appropriations Committee "suspense file," where high-cost bills are prioritized in conjunction with the budget process. CDA has proposed amendments to limit the assessments to kindergarten only as a starting point, which should reduce the bill's costs significantly, but may still not be enough to keep the bill alive during a difficult budget year. CDA is working with all involved parties, including a close working relationship with the California Society of Pediatric Dentists (CSPD) in an effort to find ways to lower the bill's projected costs while still having a meaningful impact.

AB 966 (Saldana) – Dental Amalgam: CDA is opposed to **AB 966** by **Assembly Member Lori Saldana (D-San Diego)**. AB 966 would phase in a requirement that certain dental offices install amalgam separators by January 1, 2007. This language would essentially give dentists no choice but to install amalgam separators in their offices, regardless whether their local water agencies have detected problems with mercury discharges. CDA already strongly encourages dentists to use well-established best management practices in their handling of dental office wastewater, and local publicly owned treatment works (water treatment facilities) can and sometimes do require the installation of amalgam separators. CDA believes this law is not necessary.

These local regulatory agencies already have the statutory authority to require dentists to implement any pollution prevention strategy, including amalgam separators, and CDA has cooperated with every agency that has developed additional requirements. CDA has also worked effectively with local water agencies to resolve specific local issues involving mercury and amalgam. This state is too big and geographically diverse to require a one-size-fits-all approach. AB 966 was passed by the Assembly Environmental Safety and Toxic Materials Committee April 26th on a 5-2 vote, and will be heard next in the Assembly Appropriations Committee. Amendments taken on May 11th in response to concerns expressed by Environmental Safety Committee members, which exempt various specialists, non-profit practices, and practices where a majority of the patients are Denti-Cal patients, do not change the fundamental objections to the bill, and CDA remains opposed.

These, and many other legislative issues, can have a substantial impact on the entire dental community. The vitality of our association rests directly in the hands of our many volunteers. Members are encouraged to participate in the legislative activities of their local dental societies. Anyone interested in serving on the CALAOMS legislative committee should contact Pamela Congdon or Dr. Jeff Persons for information.

Editor's note

Legislative summaries provided by CDA

General Announcements

CALAOMS Fall Meeting

CALAOMS will be holding its Fall Membership Meeting this year at the Hotel Nikko in beautiful San Francisco. The topic of this meeting will be "Surgical Pathology Seminar" a look into Oral Mucosa (Dysplasia and Carcinoma) and Selected Central Lesions (Diagnosis and Treatment). Guest speakers who are specialists in the field include William M. Carpenter, DDS, MS, Roy Eversole, DDS, MSD, MA, Sol Silverman, DDS, MA, A. Thomas Indresano, DMD, and Brian Schmidt, DDS, MD, PHD.

Educational objectives for the course are as follows:

1. The new factors associated with the etiology and pathogenesis of oral carcinoma and the histopathic changes involved.
2. Premalignant lesions of the oral mucosa as well as various techniques for diagnosis and treatment.
3. A number of selected lesions of the jaws and their new and sometimes-controversial treatments.



8 Continuing Education units will be awarded for attending this weekend meeting.

The Hotel Nikko is located in the heart of San Francisco. It is situated just two blocks from Union Square where shopping, nightlife, and theatrical entertainment abound. The world class ANZU restaurant calls the Nikko its home. The hotels architecturally stunning marble interior is host to artwork from San Francisco's most innovative and established artists.

Please mark your calendar now and call the CALAOMS Central office at 800-500-1332 or go online at: www.calaoms.org/events to register. We as always look forward to seeing you there.

Upcoming Events

2005

OMSA Home Study Course Begins July 1, 2005 Fall Course	Infection Control and Risk Mngt October 19, 2005 Costa Mesa
OMSA Expanded September 14, 2005 Berkeley	Fall Membership Meeting October 28-30, 2005 San Francisco
Residents' Presentations September 28, 2005 Costa Mesa	CALAOMS ACLS November 5, 2005 Suisun
OMSA Home Study Course Begins October 1, 2005 Winter Course	Medical Emergencies in the OMS Office November 9, 2005 Long Beach
Infection Control and Risk Mngt October 12, 2005 TBD	OMSA Expanded November 16, 2005 Long Beach

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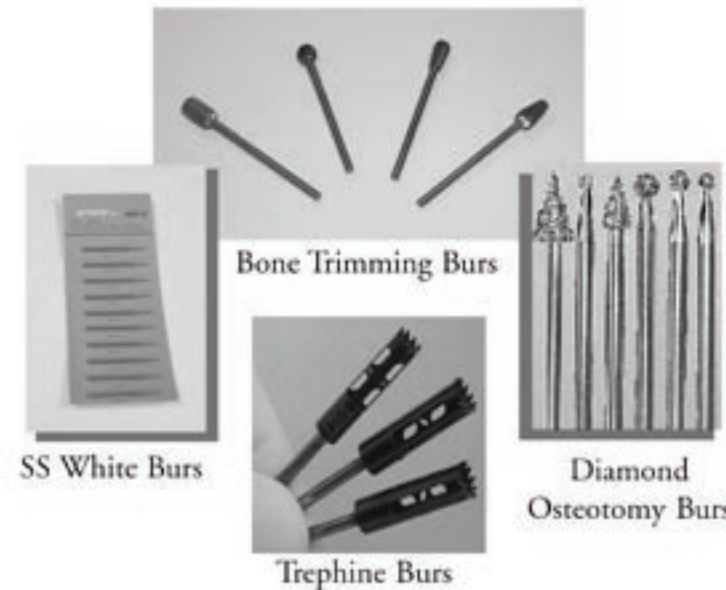


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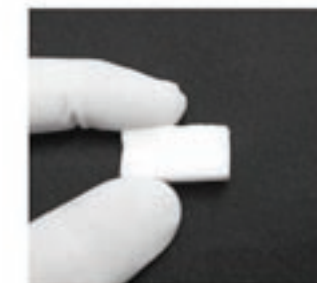
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we are looking for a volunteer to assume the Chair of the Foundation Board. We are looking for a dynamic individual who believes in the positive influence the Foundation can bring to our profession and our community. We are looking for an individual with vision who can support the goals of the Foundation to provide educational programs for our residencies as well as pursue our statewide program of providing OMS services to indigent children and others in need in our own communities. We're looking for a talented, thought provoking individual who can increase our fund raising efforts and help grow our corpus to at least one million dollars in order to be able to provide a positive impact on the lives of those in need. After all, isn't that what a non-profit philanthropic foundation is for? There are so many untapped sources that could be developed for fund raising and we've only just begun. We need an introspective,

thoughtful chairperson who can guide this Foundation into new areas of support and expand our programs. If that individual is you, I need to hear from you.

You don't need a background in Foundation management. I certainly didn't have one, yet we have had some success in building up the Foundation. But we do need someone with more expertise than I as well as more time to devote to the task at hand. The rewards of volunteerism are many, so even if you've been on the sidelines previously, perhaps this is your niche. You won't have to do it all alone. We have a wonderful, hard working Board and excellent support in the central office from Pam and her entire staff.

The Foundation has just completed sponsoring both a residents poster contest at the Annual Meeting in Newport Beach, with the first three prizes of \$1,000, \$750 and

\$500, as well as a silent auction, the first of its kind for the Foundation. We will continue to look for new and innovative ways in order to raise funds. As I've said many times, there's never a wrong time to contribute to the Foundation. On this page you'll find a pledge card to make your contribution to the CALAOMS Health Foundation so please fill it out and support **your** Foundation by sending your donation to the central office.

Well, that's my pitch for this issue. Usually it's about money. This time it's even more important than money. It's about people, i.e. the right person to take this Foundation to the next level. If that person is you; if you ever thought of getting involved with CALAOMS at the highest levels; if you're ready to bring your talents to the arena and have a positive impact on your profession and your community, please let me know at gelfoms@aol.com or (818) 225-8602.

Yes, I want to support My Foundation. Please accept my tax deductible donation of:

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DONALD E. COOKSEY, D.D.S., M.S.
December 3, 1915/January 30, 2005

By Gary Carelsen, DDS



Delta; Los Angeles Dental Society; Omicron Kappa Upsilon; Phi Gamma Delta; Skull & Dagger; SCAOP and SCSOMS.

Dr. Cooksey loved the ocean and joined the Navy in 1940 after attending Occidental College and USC Dental School. He started as a Lt.jg in the dental division. He retired from the navy in 1967 with the rank of Captain after also serving in Korea and Viet Nam. As a Midway survivor, he received many awards for his service and was on the Battleship Wisconsin in Tokyo Bay at the Japanese surrender. Don never tired of telling the entire battle of Midway story from his perspective on site and knew the names of all the participants, American and Japanese. His experience as an oral surgeon during the war was instrumental in his future life as a teacher. He later was Chief of the Dental Clinic of Bethesda Naval Hospital.

Donald married Gwen in 1967 and practiced briefly in Beverly Hills. Dr. Cooksey didn't care much for private practice and decided to take a teaching position at the USC School of Dentistry. I was his student in 1971 and was greatly influenced by his ability to teach, to relate to each of us as a unique individual, and his colorful background. Don was loved by all of his residents and he was a good friend to many of us aside from being our mentor. Don owned a Chris Craft power boat and would take us diving and fishing at Catalina Island. Don had been a great water polo player and an avid scuba diver. Later in life, I reciprocated and took Don fishing on my

boat for albacore and to Bahia Magdalena, where his fluency in Spanish was invaluable. Don also spoke fluent Japanese, was a champion tournament Life Master Bridge player, and could complete any Times Crossword puzzle in 10 minutes. Don and Gwen moved to Poway in 1991 and he was very active in the Stoneridge Country Club, where he played golf and hung out with his buddies playing bridge. Don and Gwen traveled extensively around the world, especially to Africa. They owned a home in Cabo San Lucas so they could be closer to great fishing.

I believe that Donald E. Cooksey has made significant contributions to the Profession of Oral and Maxillofacial Surgery in his many roles as a Navy Oral Surgeon, as a Professor of Oral & Maxillofacial Surgery, as a leader of our great profession, and as a husband, father, grand-father and great-grandfather. I will miss Don very much. He will, I know, be remembered by all whose lives he has touched.

Dr. Cooksey leaves behind his wife Gwen, his daughter Diane Hewitt in South Carolina, 7 grandchildren and 8 great grandchildren.

Please send any donations in his name to The Dr. Donald E. Cooksey Medical Clinic and Outreach Center, 32111 Watergate Road, Westlake Village, CA 91361 www.wpcwestlake.org.



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