

The Compass

Staying the Course Through Service and Education



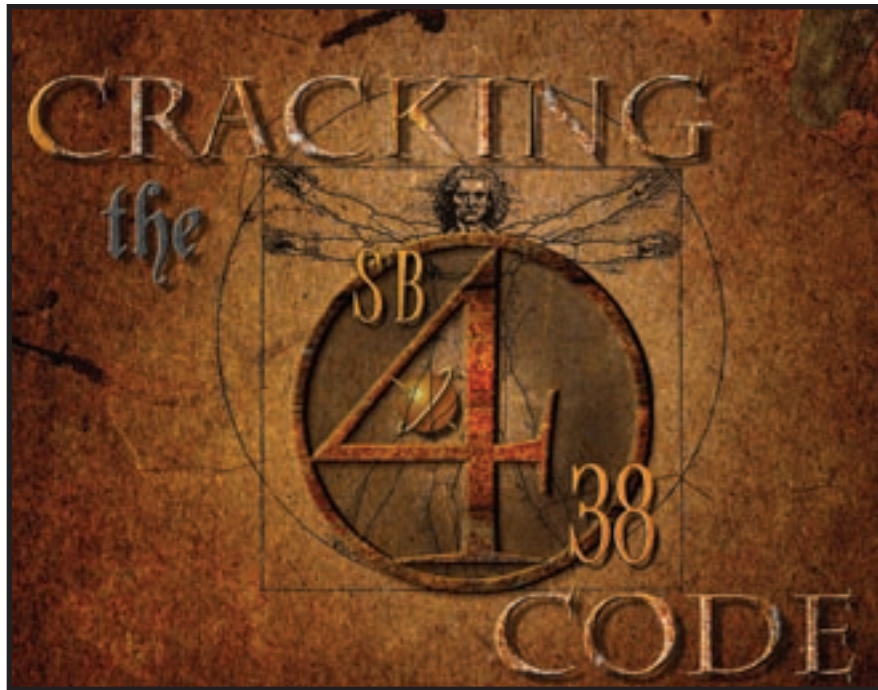
Volume VIII, Issue 2, Summer 2006

Occupational Analysis Favorable

On October 27th, 2004, Senate Bill 1336, which passed almost unanimously through the California State Legislature, was vetoed by newly elected governor Arnold Schwarzenegger. In a message to the legislature the governor wrote:

"I believe this practice needs to be more carefully reviewed and evaluated to fully ensure the safety of California's consumers. Therefore, I am directing the Department of Consumer Affairs to conduct an occupational analysis of the Oral and Maxillofacial Surgeon (OMS) profession.

This analysis will allow the Department of Consumer Affairs to examine the existing training and education requirements and make an assessment as to whether the additional permit standards proposed in the bill would enable the OMS to practice safely and competently in the expanded situations allowed for by the bill."



Are you confused about the Scope of Practice Bills and their course through the California State Legislature? We will clearly spell out the history of these bills in the next issue of the Compass

The department of consumer affairs (DCA) hired HZ Assessments to perform the analysis. The analysis took nearly a year to complete and was given to the DCA in May. The results of the study were glowing! In the mean time SB1336 was reintroduced by Sentaor Migden as SB 438.

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Editor's Corner



Tim Silegy, DDS
Editor, of the Compass

Ah, yet another Fourth of July has come and gone. The day, and frequently the weekend associated with it, is the official kick off to summer. There are chili cook-offs, barbecues, picnics, parades, the year's first sunburn and, of course, fireworks! Across the nation, friends and family get together to have fun. We sure do have it good!

As is typical of most holidays, we frequently find ourselves so caught up in the party, that we forget what we are supposed to be celebrating. On July 4, 1776, a few men risked their lives to take a stand for what they believed in. From this stand, a nation was born. Since that time, countless lives have been lost defending the ideals promulgated by our founding fathers.

The other day I caught the opening scene of Stephen Spielberg's "Saving Private Ryan." For those who have not seen it, the film is a very graphic portrayal of the Normandy invasion on D-Day. Even for

those of us numbed by the trauma we observed first hand in our training programs, the opening sequence is disturbing to say the least. In one day over nine thousand lives were lost. I once read that "these young men gave up their tomorrows so we could have our todays." There is no greater sacrifice. Mine is a lucky generation—too young for Viet Nam and too old for the Persian Gulf.

The motto of the United States Military Academy in West Point, New York, is "Duty, Honor, Country." These words are ingrained in young cadets through the course of their college education. As oral and maxillofacial surgeons, perhaps our motto should be duty, honor, profession.

We truly are members of a wonderful profession. We have the ability to make a significant difference in the lives of our patients. We are trained to correct dentofacial deformities, administer general anesthesia and ameliorate the pain of a toothache. Our post-doctoral training is relatively short and we generally are not faced with the stress of making "life or death" decisions. And, we get paid very well for what we do!

With every great privilege comes an even greater responsibility. As the complexion of health care continues to change, fewer and fewer oral and maxillofacial surgeons are taking hospital call--choosing instead to focus their efforts on the ever lucrative "teeth and titanium" surgical practice. While I certainly believe that we should be compensated for the professional services

we provide, we also have a duty to serve that segment of the population that falls victim to trauma. If we don't, who will?

As my friend and colleague Dan Levin satirizes in this issue of *The Compass*, with fewer and fewer oral and maxillofacial surgeons practicing to the level of their training, perhaps we should eliminate the "maxillofacial" from our title and shorten our residency training programs.

Similarly, fewer and fewer CALAOMS members are willing to serve in our Association's leadership. In this issue, we eulogize Leland Reeve, a true oral surgery mover and shaker. Lee had a vision for our profession and gave much of himself to see this vision become a reality.

Please don't take everything we have gained as a profession for granted. We are where we are today, because of the men and women who came before us. Regardless of your "type" of practice, recognize that these individuals sacrificed many hours of their free-time, fighting for the privileges we have today. Without them, we wouldn't have the freedom to practice as we choose.



Occupational Analysis

Continued from Page 1

The HZ Assessments' analysis titled "Examination Of Existing Educational And Training Requirements For Oral And Maxillofacial Surgeons" is a 79 page document that thoroughly addresses the issues charged by the Governor. The conclusions of the analysis is as follows:

"Our findings indicate that the additional permitted standards and credentialing process proposed in Senate Bill 438 would enable the OMSs to practice safely and competently. Our conclusion is based on a thorough review of OMS education, training, experience, required credentials to be submitted; and, a review of current practice that includes the procedures cited in the bill.

We found that OMSs have sufficient education, training and experience to perform elective facial cosmetic procedures. While there may be some variation in the offerings of the training programs, recent graduates of residency or post-graduate fellowship programs have completed comprehensive programs of study that provide them with a solid foundation to perform cosmetic procedures and the clinical skills to obtain documentation of their skills. Practitioners who are already providing elective facial cosmetic surgical services have proven their clinical competence to perform the procedures. Practitioners who fulfill the requirements in either pathway must submit credentials for medical

staff membership to a credentialing committee which evaluates their fitness for active status.

We were cognizant of the fact that in order to be granted medical staff membership, a credentialing committee of a licensed general acute care hospital would conduct a thorough review of practitioner credentials. Here, OMSs would submit extensive credentials documenting their education, training, surgical privileges, and active status on the staff of a licensed general acute care hospital, to the hospital's credentialing committee. In eight of the nine facilities that we surveyed, OMSs would be required to obtain surgical privileges for facial cosmetic procedures through the same privileging process as other surgeons--after obtaining additional education and training specific to the privilege requested. Documentation of malpractice insurance and professional liability claims history would be a required part of their application for medical staff membership.

We viewed the permitting process as similar to the privileging process at a licensed acute care hospital. Both involve a multidisciplinary committee to make the final check of an applicant's qualifications. Senate Bill 438 clearly specifies that a multidisciplinary credentialing committee comprised of a plastic surgeon; an otolaryngologist; and three board certified OMSs (one OMS must be a physician and surgeon) would be charged with reviewing qualifications of all applicants. Thus, only qualified

OMSs would be authorized to obtain the permit.

It should be noted that the Dental Board of California would be required to solicit input and recommendations regarding members of the credentialing committee from a variety of sources including the Medical Board of California, the California Dental Association, CALAOMS, the California Medical Association, and the California Society of Plastic Surgeons.

In conclusion, we found that the proposed permitting process provides for many checks and balances including reviews by hospital credentialing committees for surgical privileges, reviews by hospital committees for staff membership, and possession of malpractice insurance. The checks and balances ensure that only qualified OMSs would be authorized to obtain the permit."

SB 438 has since passed through the Senate, and the Assembly with an almost unanimous vote. It then went back to the Senate for confirmation with one small change. As *The Compass* goes to print, the Bill once again has reached the Governor's desk for consideration. With the training, experience and scope of oral and maxillofacial surgery substantiated by the study he requested, CALAOMS is hopeful of a positive outcome.

The full HZ Assessments' analysis can be found at:
www.calaoms.org/analysis.pdf

President's Message



By Gerald Gelfand, DDS
President, CALAOMS

A PERFECT (OMS) WORLD: ZZZ...ZZZ...ZZZ!

Wow! What a day I just had.

First of all, the Governor called to say, "My bad". He apologized for doubting the qualifications of credentialed oral and maxillofacial surgeons to do facial cosmetic surgery. He said he had no idea about the type and extent of the training which we receive. As he put it, "Who knew you guys had so much training. Why, you're like real doctors." He confided that he was led astray about us by some medical friends and forgot about the public interest for a moment. He told me he was sincerely sorry for putting us through all this again despite the overwhelming support of the

legislature and he will be making a public comment to that effect.

Following the call, I drove to the airport and flew to Sacramento to sit in as the Speaker of the Assembly read a proclamation adopted unanimously by both houses of the legislature. It said that OMSs are highly trained and uniquely skilled practitioners in the delivery of outpatient anesthesia services. It went on to add that they have been providing anesthesia services in a safe and cost effective manner for many years and are experts in the delivery of outpatient general anesthesia affirming the vital service that they provide to thousands of patients every week. And they police themselves, too, having done so for years. It added that nothing should infringe on the right of OMSs to continue to provide the safe administration of outpatient anesthesia while operating on their patients. In short, they agreed with Carly Simon: Nobody Does It Better.

Then COMDA called to say they had it all wrong and they realize that on-the-job training is an appropriate alternative pathway toward becoming a Registered Surgical Assistant. They have determined that CALAOMS members have done an exemplary job of training OMS assistants and are clearly quite capable of continu-

ing to do so and therefore they've decided to now support SB 1541 (Ducheny). "You guys have been giving successful assistants programs for a very long time in addition to OJT", the caller said. "Who knew? You should have told us." I thought we did.....a lot.

This was turning out to be one of the best days of my life. I even considered buying a lottery ticket but thought a flight to Vegas for the night might be better. Oh well, no hasty decisions since the day's not over yet. Can it get better or will it crash?

A spokesperson for the insurance industry announced today that all dental HMO plans will double their OMS fee allowance effective tomorrow. She said that they have come to understand that the fees are currently much too low and it's not fair to the practitioner. She added that the insurance industry just wants to provide what's best for its insured's and compensate the OMS fairly for his/her services. To that end, prior authorization will no longer be required. The patient and OMS will decide on the best treatment and proceed as soon as they'd like. She went on to say that all PPOs will immediately adjust their fee schedules to the OMSs UCR. Lastly, she reported that they will "slash" their CEO's yearly bonus by 10% to pay for the

additional cost. Though this is not expected to cause a hardship for any of the CEO's, one did complain he may need to get rid of one of his yachts.

Then to top it off, when I got back to the office from Sacramento, my office manger tells me she needs to talk to me. Better hold that lottery ticket since that's usually a precursor to bad news so I figure my karma is about to hit. But lo and behold, she told me we've just been too darn busy and we're making too much money and we need to do something soon. Boy, what a problem. I asked her, don't all OMSs have this problem? Let's call some friends and see what they've done. She just rolled her eyes and told me we need to schedule heavier (NO WAY), or move to a bigger office (yeah, at age 60 at the same location for 28 years I need the stress and hassle of moving my office) or hire an associate or two as well as more staff. If I keep making so much money, she said, I'm going to have a major tax problem next year (and why should next year be different than any other year?) with this unplanned level of additional income. All those patients who tell you how they're buying your next Mercedes may finally be right. She suggested just closing down for a month to keep a lid on the income (only my office manager could come up with that one) but that certainly won't help those hundreds of patients clamoring to get in. Oh, well, I'll just have to deal with that problem.



"Honey, wake up. Jer, you're talking in your sleep. Must be having a dream. I hope she was cute."

"What? What did you say?"

"I said, 'wake up'. Sounds like you were dreaming. Something about the Governor and insurance and all the money you were making. Where's my half? I don't know what else. Just a lot of mumbling."

"Oh, that was all a dream? Too bad. But it was so real. Ah well, it's nice to think of things as they should be in a perfect OMS world even if it is just a dream. Thanks for getting me up, honey: I have to get to the office to check on our legislative battles and fight with insurance companies, which there's plenty of time to do with all the open holes on the schedule."

Someday maybe it doesn't have to be a dream but we'll need everybody's help if we're ever to get there.

New ABOMS Diplomates



Congratulations to the following OMS from California who are new 2006 Diplomates to the American Board of Oral and Maxillofacial Surgery. The list includes:

- Paul Anderson, DDS, MD**
- Brian Bast, DMD, MD**
- Michael Chan, DDS**
- Chien "Brian" Cheng, DDS, MD**
- Tony Chi, DMD**
- Keyoumars Izadi, DDS**
- Grace Lee, DMD, MD**
- Daniel Mobati, DDS, MD**
- Alan Shelhamer, DDS**
- Sharad Sohoni, DDS, MMSc**
- John Tomaich, DDS, MD**
- Robert Wagner, DMD, MD**
- Trent Westernoff, DMD, MD**

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.

Update on CALAOMS' Building Campaign

In February of 2006, the CALAOMS Board of Directors polled you, the CALAOMS members to find out if you felt it was in the best interest of your Association to purchase office condominium space for the CALAOMS Central Office. The response and feedback was overwhelming positive. We have purchased a new office condominium that is large enough to meet our office space needs for the next twenty years.

We paid for the office shell with cash from our reserves. We have enough reserves remaining to meet the challenges ahead. Even though we paid for the building outright, we still have over \$300,000 in tenant improvement costs ahead of us.

It was with our financial security in mind that we initiated the "Case of Thirds" campaign. We ask every member to make a donation to the building. This donation can be made as a pledge and paid in 4-12 monthly payments. Some of the members who have pledged \$10,000 have opted for the extra payment time. Any donation is appreciated and we will work with any payment schedule that is convenient for you. We have had retired members

pledge much less, but their donations demonstrate their faith in our profession and our association, CALAOMS.

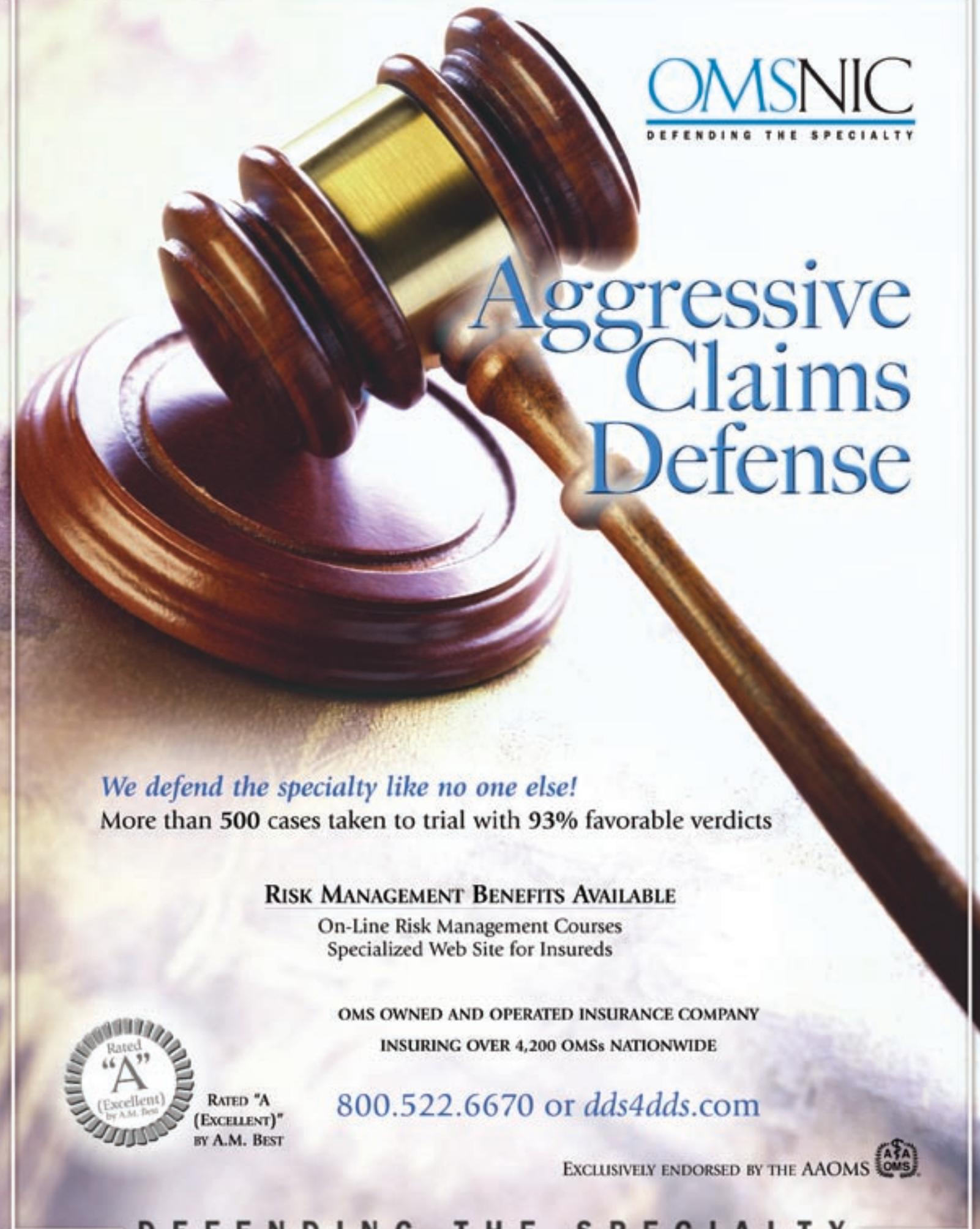
Many members have asked if a donation to the building is tax deductible. According to our accountant, yes; if written from your business account, your building donation can be deducted as a business expense.

We are early in our campaign and have already received \$81,000 with an additional \$31,500 in pledges. Everyone who contributes will have their name engraved on the CALAOMS Sponsorship Plaque that will be displayed in your new central office. You will also receive recognition in the Compass and on your name tag as a sponsor.

We want to thank you for the remarkable response so far. We look forward to serving you from our new office and we invite you to support this forward thinking project and become a part of the "Case of Thirds" campaign today. Please call the central office and make your pledge today.

The CALAOMS would like to recognize and thank the following members for contributing to the Building Fund

- | | | | | |
|------------------------|---------------------|-------------------|---------------------|---------------------|
| Ali Alijanian | David Cummings | Murray Jacobs | Daniel Miller | Elliott A. Smart |
| Robert Allen | Mary Delsol | Robert Jarvis | Rex Moody | Brian Smith |
| Joseph Anthony | Dennis Detomasi | Alan H. Kaye | Larry Moore | Jerold Sorensen |
| Stanley Baker | Craig B. Dever | Nestor Karas | Robert Mower | Albern Spoolstra |
| Richard E. Barsan | Jeff Donlevy | Robert S. Kiken | Michael Mullen | Elgan Stamper |
| Henry Bennett | Michael Doucet | Joseph S. Kim | David Nicholls | Jon Eric Steffensen |
| Richard Berger | Dean L Duncan | Roger Kingston | Ned L. Nix | Edward Stoddard |
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SCPIE's Risk Management Corner

Identity Theft: Why Doctors Should Be Especially Vigilant

By Barbara Worsley

One of the newest and most devastating crimes to come down the information superhighway is identity theft. Oral surgeons may not be at greater risk than anyone else for having their identity stolen, but all doctors make appealing and vulnerable targets for crooks familiar with the medical industry's billing and payment practices.

For example, California's Bureau of Medi-Fraud and Elder Abuse (BMFEA) has uncovered several elaborate schemes in which thieves steal the identities of providers and patients to defraud the Medi-Cal program of millions of dollars.

INCREASINGLY WIDESPREAD PROBLEM

The term identity theft (also known as identity fraud) refers to any crime in which someone wrongfully obtains and uses another individual's personal data to commit a fraud or deception, typically for economic gain. Identity theft usually involves two victims: the person whose information is stolen and used,

and the commercial victim who is cheated out of services, merchandise or money.

In 1998, identity theft was criminalized by federal law through the "Identity Theft and Assumption Deterrence Act." Violations of the measure may be investigated by any federal investigative agency—including, but not limited to, the United States Secret Service, the Federal Bureau of Investigation, the United States Postal Inspection Service and the Office of the Treasury Inspector General for Tax Administration.

Violations are prosecuted by the Department of Justice. In most cases, the crime carries a maximum term of 15 years imprisonment and/or a fine and forfeiture of any personal property used, or intended to be used, to commit the offense.

A large and growing number of people suffer significant financial and emotional harm from the crime. More than half of all complaints the Federal Trade Commission (FTC) tracked in 2003 concerned identity theft. Some 215,000 cases were reported to the FTC in 2003, up from approximately 162,000 the previous year.

The agency estimates that in 2002 alone, the U.S. had nearly 10 million identity theft victims. Over the past five years, the total number in the country has been a staggering 27.3 million.

Between April 2003 and April 2004, "phishing"—one of the newest scams in identity theft—cost victims more than \$1.2 billion. Phishing involves identity thieves sending out e-mails that appear to be from nationally known businesses and



other legitimate-sounding entities, asking the recipients to verify their user name, account number and access code. According to recent research, these scams fool one in 20 people.

In the past, the main ways to carry out identity theft were by stealing purses, retrieving credit card applications from the mail or trash, or engaging in computer hacking. No longer. A 2002 study conducted

by the Chicago-based credit bureau Trans-Union Corp. indicated that most cases now involve the theft of personal information by employees.

In other words, they're likely to be inside jobs committed by dishonest people in positions with access to people's personal information.

According to Joanna Crane, manager of the Identity Theft

program at the FTC, many thefts are committed by individuals who are authorized to be on company property but who should not have access to such sensitive data. Indeed, some temporary workers actually seek to be hired in order to steal personal information. In other cases, long-term employees sell personal data to crime rings, which then use it to commit fraud.

CRIMINAL PROSECUTION UNDER HIPAA

Recently, a medical technician at the Seattle Cancer Care Alliance was sentenced to 16 months in prison, making him the first person to be criminally prosecuted for violating the privacy provisions of the Health Insurance Portability and Accountability Act.

The technician will also be required to pay \$15,000 in restitution to the cancer patient whose name, birth date and Social Security number he used to obtain credit cards, with which he charged more than \$9,000 in purchases.

"To be a vulnerable cancer patient fighting for your life, and have to cope with identity theft, is just unconscionable," said U.S. Attorney John McKay. "This case should serve as a reminder that misuse of patient information may result in criminal prosecution."

MEASURES TO HELP PROTECT YOURSELF

The following are some suggestions on how to protect yourself from identity theft:

- Run background checks on potential employees; implement internal financial controls in your practice.
- Ask patients to tell you if they get statements from insurers for services you did not perform.
- Keep prescription pads in a safe place; protect your Medicare, DEA and employer tax numbers.
- Shred documents containing

personal information when they are no longer needed.

Perhaps most important: Give out your Social Security number only when absolutely necessary. According to the California Department of Consumer Affairs' Office of Privacy Protection:

- You do not need to carry your Social Security card in your wallet or purse; leave it at home.
- If you're uncomfortable giving a particular business your number, ask if they'll accept a different form of identification.
- If a government agency requires you to give your number, the agency must disclose the legal authority underlying the requirement, as well as what the agency will do with the number.

For more information about protecting your Social Security number, log on to:

www.privacy.ca.gov/sheets/cis4english.htm.

California Attorney General Bill Lockyer urges anyone who suspects the unauthorized use of the identities of doctors and/or patients to contact BMFEA's Hotline at 800/722-0432 and the California Department of Health Services' Medi-Cal Fraud Hotline at 800/822-6222.



“What’s a maac sillo facial?”



By Daniel E. Levin, DDS

About a year ago, I attended the annual UCLA Hawaii Ambulatory Oral Surgery Conference. When speaking with one of the program directors, our own Dr. Alan Felsenfeld, he asked me if I was still taking ER backup call at my local hospitals. With some hesitancy, I informed him that

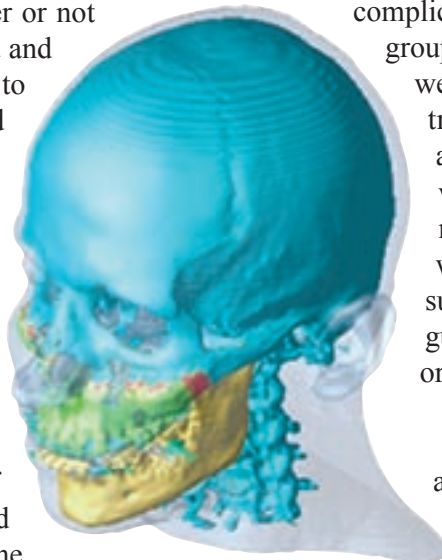
after all of these years, I still was but was planning on cutting back. Alan further asked whether or not I still did orthognathics, TMJ and trauma and again I informed him that I did but began to question why in my mind. He informed me that that was good since most oral surgeons he speaks with just want to pull wisies out and put titanium sticks in. Well that’s a no brainer. Most oral surgeons have a high degree of comfort with dentoalveolar surgery; most of it is done during regular business hours with little if any after hour issues and it pays well for the effort and time! I recently did a second opinion for a colleague of mine for an orthognathic surgery alleged complication. Compared to the pre-op, the result was excellent but the patient lost sight of the big picture and went on and on about miscellaneous minor problems that most likely would resolve themselves with time anyway. I just couldn’t help to think that I was glad I was not the primary surgeon.

The AAOMS has long advocated that oral and maxillofacial surgeons be active in the hospital and hospital emergency rooms. Yet for a lot of obvious reasons, most surgeons have begun to limit their practices to a majority of dentoalveolar procedures. Who needs to go to an ER in the middle of the night or on the weekend, especially since no one including the patient, wants to pay you for it. Orthognathic and TMJ surgery is filled with potential

complications and huge liability combined with a declining insurance reimbursement rate. Fortunately, the greatest general patient need is every day plain old dentoalveolar surgery. So if the greatest need is dentoalveolar surgery and this makes up the majority of procedures for most oral surgeons* then why does it take so long to train us?

A week doesn’t go by when a patient asks me “what’s a maac sillo facial?” I used to go into a lengthy discussion that the AAOMS in the mid seventies changed the official name from oral surgeon to oral and maxillofacial surgeon to reflect the full scope of our services. If this was a PR move, most patients don’t have a clue as to what maxillofacial means. I personally believe that it is a feel good term, but it is certainly much easier to say oral surgeon.

Fortunately for oral and maxillofacial surgery, there are a few surgeons who still enjoy and want to do more complicated surgeries, ER back up etc. For this group, the training time is critical. But perhaps we should have two tiers, those being fully trained oral and maxillofacial surgeons and “exodontists” as a second tier, which would require a much shorter training time, maybe 1-2 years at the most. These guys would do the majority of dentoalveolar surgery, be a new referral source for tier one guys, be somewhat intimidated by the “real” oral surgeons but make out like bandits.



A few weeks ago, the LA Times even did a lead article about the diminishing supply of physicians for the aging and retiring baby boomers. The exodontists could fill that gap in an instant (does it really take 4 years to learn how to take teeth out?)

Sounds good? Yet, maybe we all should rethink again what we are going to say to a patient when they ask what maxillofacial means. Perhaps it will help redefine whom we are as a profession, our responsibilities and more importantly our abilities to treat just about the entire spectrum of oral and maxillofacial surgery. If we as “real” oral surgeons won’t get involved with high-risk patient situations, who will? More importantly, we will need trained people to take care of us in our old age. Have a great summer. DL

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CALAOMS 6th Annual Meeting



CALAOMS President, Gerald Gelfand, DMD Presets the meeting dedicatee plaque to Guest of Honor, Harold Hargis, DDS.



CALAOMS President, Gerald Gelfand, DMD Presets Committee person of the Year Award to Bruce Whitcher, DDS (left), and Distinguished Service Award to Alan Kaye, DDS (right).



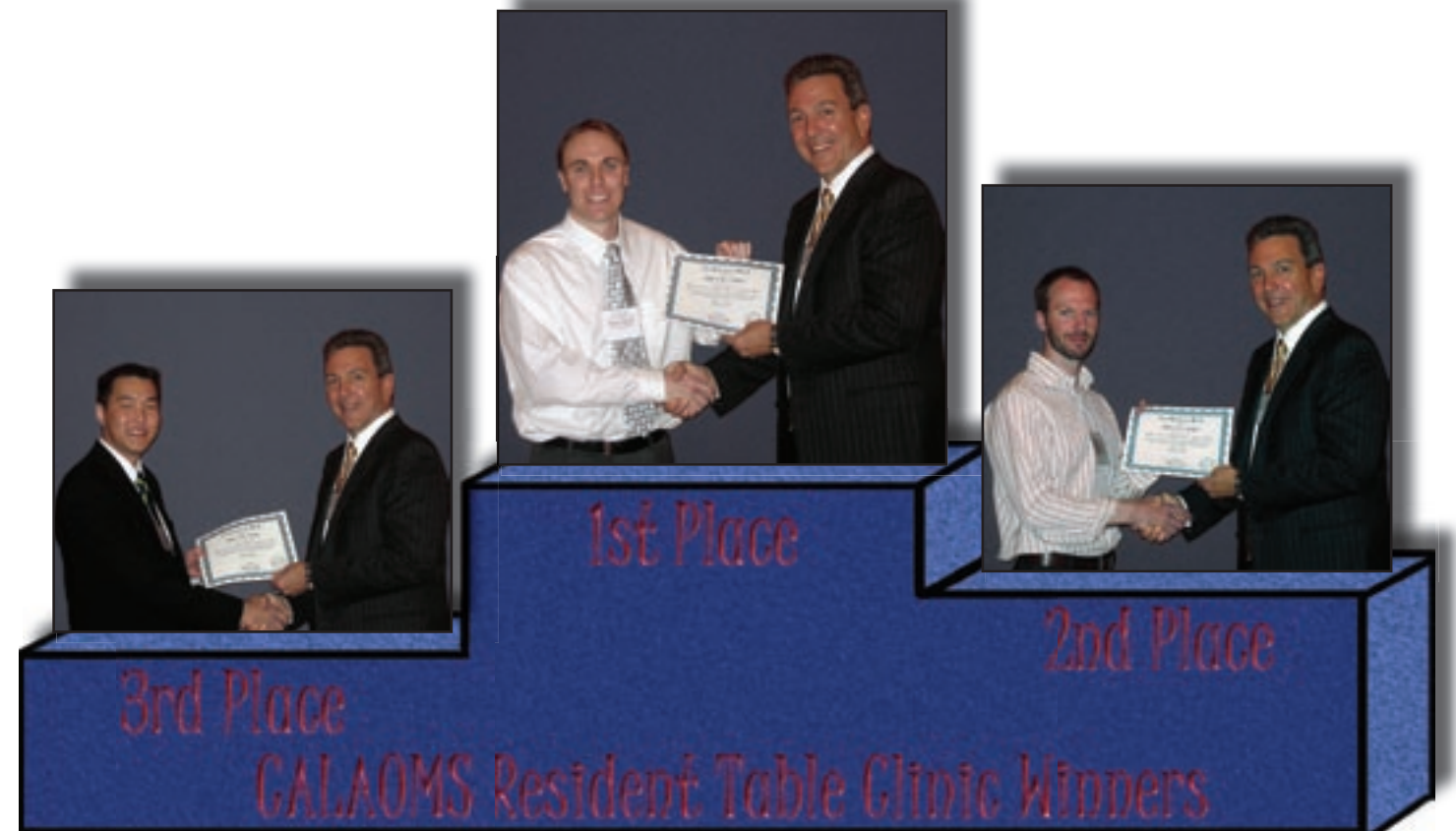
Michael Beckley, DDS discusses the merits of a topic presented by a resident at the Table Clinic, with the Compass Editor, Tim Silegy, DDS.



CALAOMS members enjoy socializing while dining on an outdoor terrace at the Wynn Resort during the Membership Banquet.



California Residents who participated in the Resident Table Clinic competition at the 6th Annual Meeting in Las Vegas from left to right are as follow: Dr. Brandon Brown - Loma Linda, Dr. Jonathan Nakano - Loma Linda, Dr. Rick Rawson - Loma Linda, Dr. Mike Lypka - USC, Dr. Zachary Peacock - UCSF, Dr. Wendy Liao - Highland, Dr. Dennis Song - UCSF, and Dr. Jeffrey Elo - Loma Linda.



Congratulations to the winners of the 3rd Annual CALAOMS Resident Table Clinic. A great effort was made by all participants and the competition was fierce. Our panel of judges had an extremely difficult time choosing the winners. Once the dust cleared the winners were revealed. First Place - Dr. Zachary Peacock, Second Place - Dr. Jeffrey Elo, Third Place - Dr. Dennis Song. Awards were presented by Table Clinic Chairman, Robert Allen, DDS.

NEWS ANNOUNCEMENT

U.S. Maxillofacial Surgeons Aid Cleft Orphans in Ukraine

Between the dates of May 9-21 2006, CALAOMS surgeon, Dr. Jeff Moses, and Craniomaxillofacial surgeons, Dr. Greg Smith, and Dr. John Caccamese, joined with their chief nurse, Patricia Hunter R.N. and their children's self-esteem program director, Maribel Vargas to forge the start of a new Craniofacial Surgical alliance with the surgeons of the Melechor Medical Center located in the city of Dnepropetrovsk, Ukraine. Previous identification by Variety Children's Lifeline of under-served children from three orphanages who were born afflicted with Cleft Lip and Palate deformities led retired surgeon, Jeff Moses to form the team together through his public 501c-3 foundation named Smiles International, a subsidiary of the Pacific Clinical Research Foundation founded in 1987. The team was sponsored by the Variety Children's Lifeline, also a charitable

public 501c-3 foundation dedicated to serving children's un-met medical needs worldwide.

In addition to the continuing education symposiums which were presented to the professionals on Cleft and Craniomaxillofacial Management, the team treatment screened and treatment planned over 37 children and performed approximately 17 procedures on 10 of the children. The Smiles International Foundation sponsored a Surgical Symposium on the Management of Cleft and Craniofacial Deformities for the region's surgeons and medical professionals. Several Rotary Clubs and private clinics received presentations by Dr. Moses in order to help organize matching grants for further equipment purchases and support. Surgical equipment, instrumentation and supplies were donated after the trip. Professional educational exchange programs are



in process for the Ukrainian surgeons in order to acquaint them with our educational facilities. Biannual visits with expanded services are now established. Plans are to increase the visitation's frequency in order to allow continuation of longitudinal surgical care for the children.

Contact Dr. Jeffrey J Moses DDS for further information at:

DrJeffMoses@SmilesInternationalFoundation.org



Left to Right: Dr. Victor, Ukraine Surgeon, Dr. Gregory Smith, Craniomaxillofacial Surgeon, Dr. Yuriy Zozulya, Ukraine Neuro-Surgeon, Dr. Anatoly Komok, Ukraine Chief of Maxillofacial Surgery, Dr. Jeff Moses Team Leader, Patricia Hunter, R. N. Head Nurse, Maribel Vargas, Children's Self-Esteem Programs, Dr. Ala Knesh, Ukraine Chief of Stomatology, Dr. John Caccamese, CranioMaxillofacial Surgeon, Dr. Vladimir, Ukraine Chief of Anesthesia.

In Memoriam

LELAND W REEVE, DMD



Dr. Leland Reeve passed away peacefully in his sleep at his Pasadena home on Friday May 12, 2006. He had been ill with pancreatic cancer since December 2005.

Dr. Reeve was born on November 19, 1926 at St Vincent's Hospital in Los Angeles, California. Dr Reeve graduated from Long Beach Polytechnic High School with honors; Long Beach City College, AA degree; University of Redlands, BS degree with honors.

He served in the US Navy Air Corps as a pilot in World War II. The Navy put him into flight school and sent him to Kansas State Teachers College and Dartmouth. He learned to fly the F4U Corsair and F6F Hellcat. His training period lasted long enough that he was never assigned to service in the Pacific before the war ended in August 1945. He was discharged from the Navy in June 1946.

He attended the University of Southern California Graduate School in Biochemistry and the University of Oregon Graduate School in Biochemistry. He received his DMD degree from the University of Oregon Dental School and completed his Residency in Oral and Maxillofacial Surgery at Los Angeles County-USC Medical Center.

ELMER H. BROWN, JR., DDS

Elmer H. Brown, ("El"), born February 21, 1927 in Trenton, NJ, died May 31, 2006 in Avila Beach, CA from complications of prostate cancer.

El spent his early years in Trenton, the eldest son of Elmer H. Brown, D.D.S. and Anna Walter Brown. During World War II he attended the Merchant Marine Academy in Kings Point, NY and served aboard the Carthage Victory cargo ship in the Pacific theater carrying dynamite for

Dr. Reeve was first associated with Dr. Leroy Knowles, a general dentist in Los Angeles, from 1955 to 1956. He was then a partner with Dr C M Woodward and Dr George Prince, both of whom were oral and maxillofacial surgeons in Pasadena, from 1959 to 1961. He was in solo practice in Pasadena from 1961 to 1991. Dr Reeve suffered a stroke in 1991 after which he retired from his active practice and his passion for aviation.

Dr. Reeve was deeply committed to his alma mater, the University of Southern California, where he taught oral and maxillofacial surgery and anesthesia to students and residents. He also maintained numerous hospital affiliations.

Dr. Reeve was very active in organized oral and maxillofacial surgery serving as President of the Southern California Society of Oral and Maxillofacial Surgeons in 1984 and as the first president of the California Association of Oral and Maxillofacial Surgeons from 1986 to 1989. He was a Fellow in the American Association of Oral and Maxillofacial Surgeons, the California Association of Oral and Maxillofacial Surgeons and the American College of Dentists. Most recently, he was active in the Southern California Orofacial Academy.

Among his many accomplishments, perhaps the most significant was his leadership on the Committee for the Development of the Anesthesia Self Evaluation Program which later evolved into the California State Board General Anesthesia office evaluation.

Dr. Reeve published numerous books, articles and movies, and presented courses nationally and internationally. He was also an accomplished pianist and organist and served on the board of directors of the Los Angeles Theater Organ Society and the American Theater Organ Society.

staging the invasion of Japan. After the war he attended Princeton University as a member of the class of 1948 and went on to study dentistry at Temple University. During the Korean War, he served as an oral surgeon in the Air Force, attaining the rank of captain. After discharge, he attended the University of Pennsylvania Graduate School, and was certified in oral surgery in 1956. He was the first oral surgeon on the Central Coast, practicing in San Luis Obispo from 1957 to 1991, retiring only after he "got it right." He was a lifelong athlete (swimming, running, playing basketball, and

Continued on Page 20

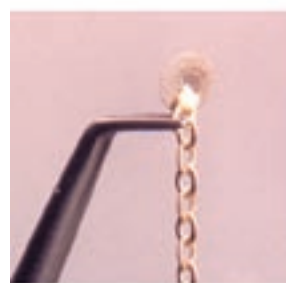
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In Memoriam Continued From Page 17

scuba diving), and a booster of local school athletics. After retirement he enjoyed exercising at the Avila Bay Club with the "Boys of Summer," managing rental properties, traveling, and wine tasting. He was diagnosed with prostate cancer in 1995 and participated in several research programs at institutions around the country with the hope of extending his life and the lives of others. The knowledge of cutting-edge treatment options gained through this process made him a valuable resource for friends who developed the disease.

El served the dental community through his active involvement in the Central Coast Dental Society and the state and national oral surgery societies, and provided leadership as chief of staff at General and Sierra Vista Hospitals. He served his local community as a Rotarian, an usher at the Performing Arts Center, and a board of trustee of the Avila Beach Community Foundation.

El leaves his wife, Anne (Anee McGovney), children Barbara Ramirez (Ralph), Cynthia Brown, Richard Brown (Dale), Marian Bernick (Todd), and grandchildren Justin, Lauren, Christian, Alexandra, Thalia, Gus, and Elise, as well as a brother Bruce W. Brown of Vero Beach, Florida, and nieces and nephews. He is predeceased by his parents and a sister.

In lieu of flowers, donations may be made to the Rotary Scholarship Fund (P.O. Box 833, San Luis Obispo, CA 93406), Foundation for the Performing Arts Center (P.O. Box 1137, SLO, CA 93406), or the Mozart Festival (P.O. Box 311, SLO, CA 93406).

El's family wishes to thank his many friends for their ongoing love and support, and extend a special thanks to Best Care, Hospice Partners, Dick Robb (Hospice volunteer) and Pamela Berry (caregiver) for their care and kindness.

RAYMOND SHEARN, DDS

CALAOMS would also like to recognize the passing of Dr. Raymond Shearn. Dr. Shearn practiced oral surgery from 1948 to the early 1990s, in Northern California where he retired as a Life Member. He served in the United States Navel Reserve in the 1940s, and was President of the NC-

SOMS from 1966-67. He was 84 years old. We would like to extend our condolences to the family and friends of Dr. Shearn as well as those of Dr. Reeve and Dr. Brown.



Upcoming Events For 2006

OMSA Home Study Course Begins June 15, 2006 Fall Course	Infection Control and Risk Mngt October 25, 2006 Concord
Employee Law* September 13, 2006 Los Angeles	Infection Control and Risk Mngt November 1, 2006 Los Angeles
Employee Law* September 20, 2006 Berkeley	Fall Membership Meeting November 3-5, 2006 Sonoma
Residents' Night September 27, 2006 Los Angeles	ACLS November 11, 2006 Solano
OMSA Home Study Course Begins October 15, 2006 Winter Course	<i>* New Course offered this year. Make sure your hiring and employment practices are legally sound.</i>

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