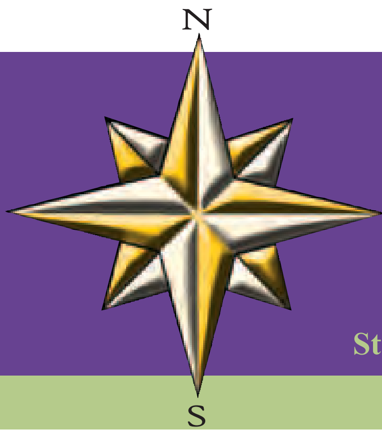

The Compass

Staying the Course Through Service and Education

Volume XI, Issue 2, Summer 2009

CALAOMS Moves To Increase Involvement In Community Service Programs

Denti-Cal used to serve 2.8 million low-income adults in California who would otherwise receive no dental care. With the elimination of the adult dental program, there has been a significant impact on beneficiaries who have no where else to go for dental care. These people who lack access to affordable dental treatment often live in pain, limiting their ability to find and retain work and diminishing their productivity. And when parents do not make at least one dental visit annually, their children are 13 times less likely to visit a dentist that same year.

Poor oral health resulting from the elimination of adult Denti-Cal services in California also increases non-dental medical costs ultimately borne by both the state and counties. When those with severe dental problems end up in hospital emergency rooms ill-equipped to provide full dental services, their dental problems often continue and the cost of treatment in that venue is approximately 10 times greater than the cost of providing preventive care at the dental office. Abolishing the adult Denti-Cal program is going to have a devastating effect on dental school clinics that serve a large portion of this population and are critical to dental education.

It is important for CALAOMS and our members to step up and use the knowledge of our profession to help those in our communities who are affected by these economic cuts, set backs and otherwise just bad luck by participating in community service programs. In addition to making a difference in the lives of people and in our communities, CALAOMS and our members

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

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the lives of *his children...*

and *his grandchildren...*

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Editor's Corner

Leonard M. Tyko, DDS, MD
Editor of the Compass

Baseball Teaches Great Life and Professional Lessons

I have a divided household these days. It is baseball season, and the males in my house (myself and my 2 sons) are enthralled. My wife —well, she is less enamored. I hear her objections: too many practices, too many games, over-zealous parents, the list goes on. But I don't buy it. I am not the first to say it, but I believe it in my heart: Baseball is more than a sport; it is a metaphor for life.

As a kid, I loved to play. I have great baseball memories. Most of my childhood weekends were spent doing yard work with my dad. When we were finished with the work, he would pitch tennis balls and I would practice hitting. My dog was our outfield; he loved chasing those balls, and I loved hitting them. I still remember the feeling of hitting a home run. One home run was a grand slam in a playoff game. It doesn't get much better than that!

But not every play was successful, and certainly not every game was won. In those experiences, baseball taught me some good, old-fashion lessons. All that time my dad spent with me drove home the value of practice and hard work. I learned that success comes to those who work at it, to those who plan for it, and to those who believe they can do it. At the end of practice, one of my coaches would sit us down, have us close our eyes, and have us imagine making a good defensive play or hitting the ball well. I use this technique today when thinking through hard surgical cases.

Many years have past, and I have boys playing baseball. Seeing that I am no longer a player, baseball has given me a new role, that of a coach. I just love it. I love playing and teaching the game, but I also love that baseball still has something to teach me. One such lesson came from simply playing catch with kids. We've all been admonished to look at things from others' prospective. I try to do this, but my size 14 feet rarely allow me to walk in another's moccasins. Baseball helped me with this point. Back to playing catch: why are some kids afraid of the ball? The answer is really simple. If you are young and uncoordinated and don't believe that you can catch the hard object coming at you at a high rate of speed, the most logical coarse of action is to protect yourself and evade a direct hit! Understanding that, it was easy to see the problem and work on remedies for it – to break down each step of the action and boost the players' ability and confidence to perform. Now, it is easier for me to trouble-shoot problems with or between employees or those that come with our patients.

Baseball is truly one of the most amazing sports devised: The spotlight directed onto an individual, amongst his teammates; the spotlight directed onto a surgeon, amongst his support staff. We are only as good as our last pitch, or our last surgery. Despite good action on our fastball or a wicked forkball, we must rely on our defense, our front office personnel and surgical assistants, to back us up. Without our coaches, managers, franchise, and league (mentors, teachers, training programs, and professional organizations), we would lack the necessary skills and even a park to play in. So, batter up and play ball!

Welch Allyn AED 10 & MRL JumpStart AED Voluntary Recall

If you purchased a Welch Allyn AED 10 or MRL Jump-Start AED between the dates of October 30, 2002 and July 11, 2005 or had it serviced in 2007, your defibrilla-tor may be subject to a voluntary recall being issued by Welch Allyn. Depending on the date of manufacture or service, your unit may have a remote chance of having one or more of the following problems:

- Low energy shock
- Electromagnetic noise interference
- Unexpected shutdown during use
- Blown fuse
- Loss of voice prompts
- Shutdown in cold temperatures.

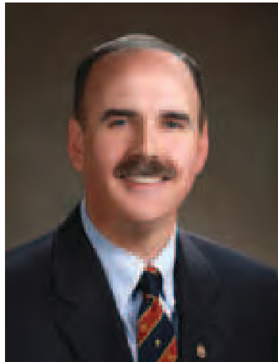
To find out if your unit is affected by this recall, you can compare its serial number to the list of unit serial numbers affected by the recall at ***www.welchallyn.com/AED10Recall***,
Or call the recall center at 888-345-5356.

If your unit is affected by this recall, it is important that you continue to use the device in accordance with its voice prompts and the directions for use, until the device is corrected.

President's Message

A call to future leaders:

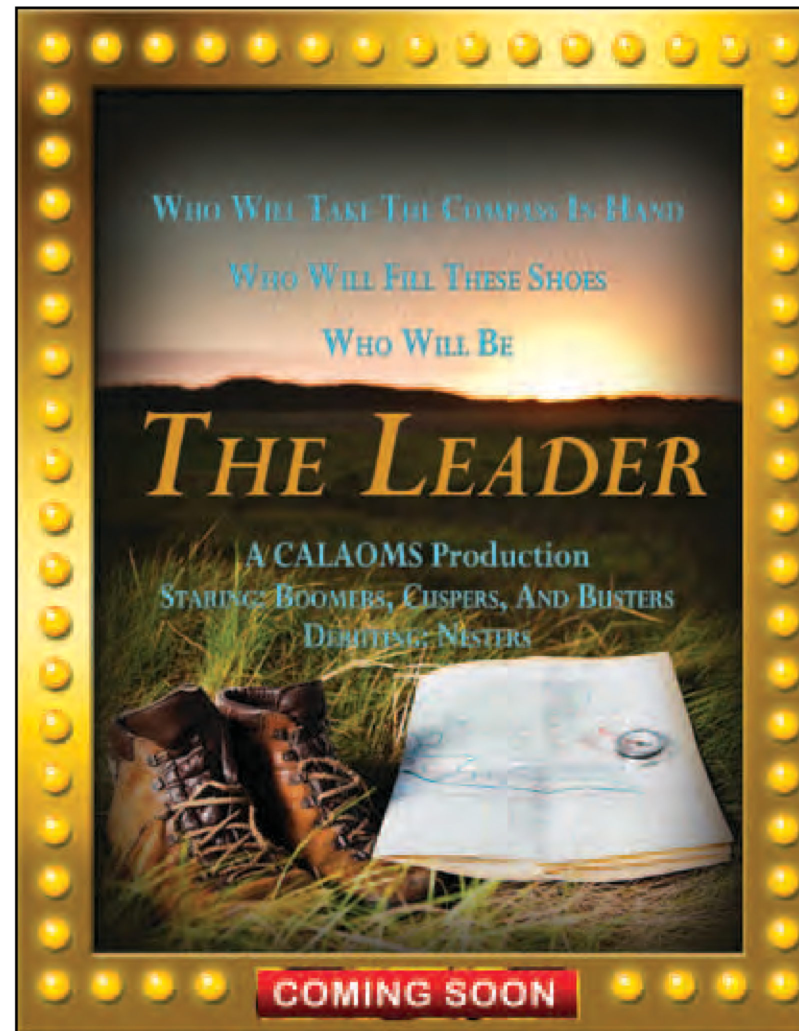
"Giving back to your professional organization yields great returns for your practice!"



Ned L. Nix, DDS
President, CALAOMS

I have always felt that I get so much more in return for what I give back to my profession. I made an eight year commitment to CALAOMS in 2002 to serve on your Board of Directors. It has been a privilege for me to serve as your President this year. In my presidential address to your Board of Directors on January 16, 2009 I said, "My individual goals for the year are to promote ethical behavior, professionalism, and to cultivate young leadership from within our membership." I have always been troubled by the low level of participation of our members in leading the organization. I also have wondered about our member's participation in our meetings and continuing education offerings. Why don't we have better attendance at our major meetings? Let's do the math. We have over 600 active members and fellows of CALAOMS. Average attendance for our January meeting and continuing education offering in Southern California is 60 doctors. Our annual meeting in April or May draws as many as 100 doctors. This comes out to 10% for a meeting with average attendance and 17% for a highly attended meeting. Is this just apathy? I would like all of you to step forward and participate with us!

I heard a great presentation at the AAOMS Leadership Conference in 2008 given by Marilyn Moats Kennedy. She is a demographer and has published and spoken about her theories on generational behavior. She defines groups such as the "Boomers," "Cuspers," "Busters" (also called Generation X), and "Nesters." She described me perfectly! I entered dentistry as a second career. I studied Agricultural and Managerial Economics at UC Davis receiving a Bachelor of Science degree in 1986. I was a four year varsity golf letterman, team captain and an NCAA Division II All-America selection in 1984. I worked in sales and marketing for six years prior to entering dental school. I enrolled at San Jose State University as a biology graduate student to complete my dental school prerequisites in 1991. I was 31 years old when I began my dental studies in 1992 at UOP. I felt dental school was an opportunity of a lifetime! I became interested in oral and maxillofacial surgery early on, and I worked hard to qualify for a residency position after graduation and a subsequent GPR.



Ms. Kennedy places me in the generation of "Cuspers." She said people like me, because we are a little older than typical, have a better sense of what we want. She said such people won't pursue a liberal arts degree (and take on significant school debts) for a lowly job stuck with the same company for a 30 year career. These people will try a few jobs and travel. They are gaining momentum waiting for their big break! When they find what they really love they will go back to professional school and become physicians, dentists, or lawyers. They are not joiners. They are busy with their family and don't have time for long meetings and organizations. They have one or two children, working partners, and probably never plan to retire. They live in or near big cities to enjoy the urban lifestyle. They plan to work more efficiently so they can work less.

I actually don't fit the profile of a "Cusper" perfectly. "Cuspers" are a generation between the "Boomers" and "Nesters." The "Boomers" (the baby boomers) were joiners. They committed themselves to organizations, boards of directors and were company men for life. They did not take risks. They lived in the suburbs, and they had large families. They knew there were long commitments to organizational behavior. I am very much a "Cusper" with characteristics of a "Boomer" and "Buster." The "Boomer" in me respects our organization, CALAOMS, and sees the value in professional relationships, mentoring, and lifetime learning. Ms. Kennedy says I also have characteristics of a "Buster." I enjoy the urban lifestyle, plan to work less and more efficiently, have one child, probably will never retire, take a few risks, and put a high value on not wasting my time.

Most of our active membership falls into the categories of "Boomers" and "Cuspers". Taking into account Ms. Kennedy's description of these groups helps to explain the behavior of our membership. It means we need to engage our members in a variety of activities if we want to build a strong CALAOMS community with participation. Ms. Kennedy looked at workplace, lifestyle, social, motivational, and communication characteristics. We need to understand how all of the generational groups can interact. Let's look at our own demographics at CALAOMS. We have four generations currently practicing. 19% are "Pre-Boomers" (over 65 years old), 37% are "Boomers" (64-50), 30% are "Cuspers" (49-41) and 14% are "Busters" (40-31) (the "Nesters" will join us next). Using myself as an example again, a "Cusper" with characteristics of both a "Boomer" and "Buster," we need to focus on the bridges between generations. We need to find characteristics that are important to each group that work for all of us. Ms. Kennedy calls this "Communicating cross-generationally."

The "Boomers" are motivated by money and work ethic, expected to lead, and care what people think about them. They are socially conservative, enjoy family and friends, and they are into prestige. They are motivated by promotion, public and peer recognition, and loyalty to self. Their communication style is geared to teamwork, and they highly value participation and consensus. The "Cuspers" are motivated by money and principle, lead and follow, want others to work with them, and want to win. They work hard, play hard, and worry about money. They are committed to exercise, and they think community activity is boring. They also spend time with family and friends. They enjoy mentoring others, and they are committed to meeting organizational goals. The "Busters" work for principle and personal satisfaction. They put their personal lifestyle first, and they are not leaders. They don't care what others think, work alone, and are into "win-win" relationships. They are technically savvy as opposed to their "Boomer" and "Cusper" counterparts. Their lifestyle characteristics include not caring about what others think about what they like, they exercise for mental health, and they enjoy the inner city. Socially their friends are their family, and they are all "going green." They are motivated by time off, and they expect to be mentored. They are interested

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Pres. Msg. Continued from Page 7

in gaining new skills, and they are infatuated by new technology. They often work alone. They have a blunt "just do it" style, and they generally don't participate, attend meetings or need to hear other's opinions. In which category do you fall? Are you a true "Cusper" like myself that has characteristics of different generations? Do you want to understand your colleagues and work together for the benefit of our great specialty?

CALAOMS meetings are a beginning. There are always opportunities to enjoy camaraderie and conversation with our members. I have heard of OMSs attending the AAOMS meeting twice in a two year period, collecting 25 units of CEU each meeting, and never attending another meeting. That's not good. I am all for attending the AAOMS meeting, but I would hope our members are exposing themselves to other meeting and CE opportunities beyond their bi-yearly ACLS and BLS re-certification. Current CALAOMS leaders are always willing to inform the membership about leadership opportunities. The experienced leaders are always available for mentoring. Our senior members have a lifetime of professional experience, and they are often available to guide interested members regarding surgical skills and practice management issues. Our meetings offer continuing education units that can be used for California dental license renewal. The current CE requirement is 50 units every 2 years, of which 24 units must be anesthesia related to qualify for GA permit renewal. An example of an involved CALAOMS member's attendance at meetings would be as follows: January Meeting (anesthesia based), 8 CEU; CALAOMS Annual Meeting, 8 CEU; Infection Control/Dental Law/Risk Management Meeting, 8 CEU; two regional meetings (for example Resident's Night, 3 CEU; Medical Emergencies, 8 CEU). This example totals 27 CEU in one year in which 16 are anesthesia based (January Meeting and Medical Emergencies). Two years of attendance at CALAOMS meetings not only will provide you with the required CEU to maintain your dental license and anesthesia permit, it will open up opportunities for you to meet the membership and advance your leadership skills. You will also be able to establish relationships with mentors and create friendships.

I continue to become a better doctor for my patients because of the returns I receive from my participation in CALAOMS. As always, I would like to thank all of my mentors who have guided me and encouraged me to enter leadership. I would also personally like to thank Ms. Marilyn Moats Kennedy who helped with me in this effort, and inspired me to use her theories as they pertain to our organization. It is a lifetime of learning; it's the PRACTICE of oral and maxillofacial surgery. So you say you are a computer whiz? Have you attended an OMS fellowship? Do you frequently participate in dental missionary work providing cleft lip and palate or other services to patients in foreign countries? Are you interested in cosmetic maxillofacial surgery? Do you have a system by which orthognathic surgery is profitable in your practice? Do you have leadership skills in other areas affiliated with your OMS practice such as serving on a bank board of directors (a future CALAOMS Treasurer!) or serving on a city council or committee? If you are willing to share your expertise with us, I am sure our membership would be willing to share some of their expertise with you. I guarantee the formula always works out to be we get back so much more than we give. I am imagining a CALAOMS where 50% of our members attend our meetings, participate in committees and serve on our board. We would be developing future Dental Board of California members, CALAOMS committee chairs, CALAOMS board members, AAOMS committee members, ADA and CDA council members and delegates, and leaders in our local component dental societies. Our organization would be even stronger and our entire membership would be the beneficiary! I look forward to working with all of you at all levels of dental leadership. Please contact me with questions about how you can become a leader for CALAOMS. I will do my best to guide you in the right direction.

By John Bond, DMD
CALOMSPAC Chairman

In these difficult times both politically and economically, not only in California but nationwide, it is easy to throw in the towel, give up and adopt a no more, no how, no way attitude toward anything political, including PAC contributions. I know, because I find that attitude deep within myself. However, as I reflect, sift out the emotion, and remember where we have come from and what we have accomplished, it reduces it down more clearly to reality. Like it or not, it is how business is done politically in Sacramento, Washington D.C. and every other state and local political entity, which in large part, dictates our livelihood. Accordingly, it doesn't makes sense not to play in a game, where hopefully you can influence the outcome rather than merely rolling the dice or flipping the coin. It does matter, and if we cherish our profession, we do have to play.

Historically, prior to establishing our own PAC, CALAOMS made contributions through CDA's PAC. It was sort of a co-PAC for lack of a better description. It became increasingly obvious that while the two organizations in large part shared similar interests, to what degree and to what extent they wished to invest their time, talent and treasure on certain issues did not always coincide. Accordingly, CALOMSPAC came into existence in August 2001. Successes have been many, largely centered around educating legislators and their staff on our training as OMS, our licensure and certification, and our experiences over the years. Additionally, education on Scope of Practice Bills, which affect each and every one of us in our daily practices, has been a major undertaking of the PAC. Contributions have been made to the election of legislators and the Governor who we have deemed largely sympathetic toward our profession and its responsibility to our patients. In addition, we have reached out to some who had no idea of who we were or what we did until contact was made. Contributions are the ticket to enter the arena.

We were positioned well to help Dr. Sam Aanestad win his bid for election to the State Assembly and subsequently to the State Senate, as well as Dr. Bill Emerson's bid and successful election to the State Assembly. It cannot be stressed enough how important this is, and as you all have to know, such campaigns are never cheap. Special interests lie all about to wield their influence with campaign contributions. We must do our part to get the word out relating to those issues affecting us daily. There is no better way to do this than from within and according it has to be a never ending conquest.

In 2006, CALAOMSPAC made a $40,000 contribution to the California Alliance for Progress and Education, reflecting our organizations commitment to the program. Additionally, CALOMSPAC supported two Independent Expenditures in conjunction with CDA in 2004 for $35,000 and again in 2006 for $75,000. Money is always easier to spend than it is too make, as I'm sure you experience in both your practice and personal life. Accordingly, an ongoing function of CALOMSPAC is to raise the necessary funds to turn around and spend on maintaining our right to practice our specialty as we want on our patient's best interests. Otherwise, our specialty will be dictated by the interest of never ending bureaucracies. This can only be done by reaching, educating and convincing our legislators of what is best, not for us, but for our patients. Oddly, the two coincide.

Currently, there is about $100,000 in our PAC Fund. The

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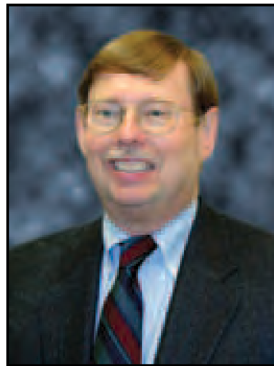
Spotlight on Members



Richard Robert, DDS, MS

By Wendy Liao, DDS

In the April issue of JOMS, Dr. Leon Assael wrote an editorial discussing one of America's national heros - Captain C.B. "Sully" Sullenberger, the pilot who landed the crippled US Airways plane in the Hudson River of New York. Dr. Assael drew a strong parallel from the pilot's readiness to tackle an emergency with confidence and skill to the OMS' skill dealing with emergencies in the office. Dr. Richard Robert's attitude and approach to emergency management makes him a hero within our profession.

From the minute I walked into Dr. Robert's office, I was impressed by the efficiency of his auxiliary staff. While waiting for Dr. Robert to finish seeing a patient, one of his assistants gave me a tour of the office, showing me such items as their airway emergency equipment, and their emergency medications (each clearly labeled with indications, concentration dosage, and expiration dates). Of particular note was his office staff's utilization of a simple systematic computerized inventory of supplies and medications to ensure that nothing has expired.

Just as Captain Sully relied on his well-trained flight crew to evacuate the plane in an orderly manner, each member of Dr. Robert's 10-person staff dedicates a number of hours each month drilling for emergency situations. In addition to their practice drills, the office maintains an up-to-date and well-delineated handbook covering every emergency scenario containing both textual and illustrative points for ease of reviewing.

Dr. Robert grew up in Atlanta, and graduated from Emory University's School of Dentistry before moving to San Francisco to conduct research on bone grafting of bony defects at the Letterman Army Medical Center. With this interest and exposure to bone healing and physiology, he soon signed up for OMS training at the University of Michigan. Due to his experience in San Francisco, he decided to move back West to start his professional career. In addition to his private practice, Dr. Robert is also intimately involved in the teaching program at the UCSF OMS department, working with the residents on surgical anatomy, anesthesia techniques and management of anesthetic emergencies. Throughout his career, he has been involved in almost all of our CALAOMS committees and several AAOMS committees as well. He has been instrumental in the continuing

It does not matter if you purchase a ready made ACLS Airway Kit (as the Banyan Stat Kit 900 on the left), or put one together on your own (as Dr. Robert has on the right.). The important part is that you have one so that you are prepared in the rare event an anesthetic emergency arises in your office.

development of the CALAOMS surgical assistant training course, which has been adopted on a national level. This training course has been expanded by AAOMS to provide certification which will be offered in 2009.

From my short visit with Dr. Robert, I couldn't help but be struck by his passion and dedication to the cause of the development for a safe anesthesia environment. He sees in-office anesthesia procedures as a special privilege given to the OMS specialty, crusading for each generation of OMS surgeon to treasure and protect it wholeheartedly.

While emergencies of any kind are rare, when they arise you want the most prepared team to handle the situation. For every passenger on US Airways flight 1549, the appreciation and respect for Captain Sully and his team is unparalleled for the way they calmly guided the flight to safety. Similarly, for every patient who undergoes anesthesia, one hopes to have a surgical team as prepared and unflappable as Dr. Robert's team.

CALAOMSPAC Continued From Page 9

CALOMSPAC committee periodically receives and reviews requests for contributions from CALAOMS members, our lobbyist, or individual legislators. They are individually reviewed and voted on by the committee after discussion with amounts determined. It is an important function of CALAOMS and I would urge your participation in either this committee or any other area of interest within the organization. We are who we are, and that would be us. Without input and participation we are much less than what we can be with input and participation. This is also most true of CALOMSPAC. I urge your participation by making a contribution if you have not found it within your heart and means to do so in the past. And if you have made contributions in the past, my and CALAOMS's heartfelt thanks goes out to each and every one of you. Please take time to spread the word among your peers. It is easy to dislike the process. However, it is painful to live the consequence of not being involved.

American Board of Oral and Maxillofacial Surgery

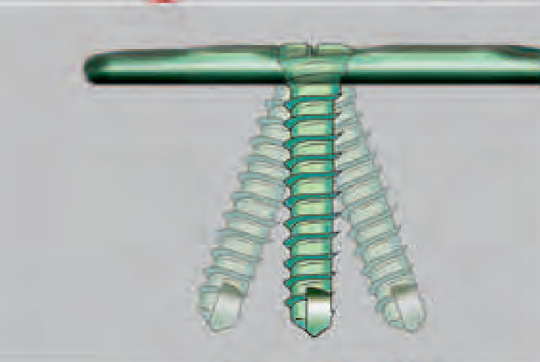
Congratulations to the following CALAOMS members who recently completed their certification to become a Diplomate of the American Board of Oral and Maxillofacial Surgery (ABOMS).

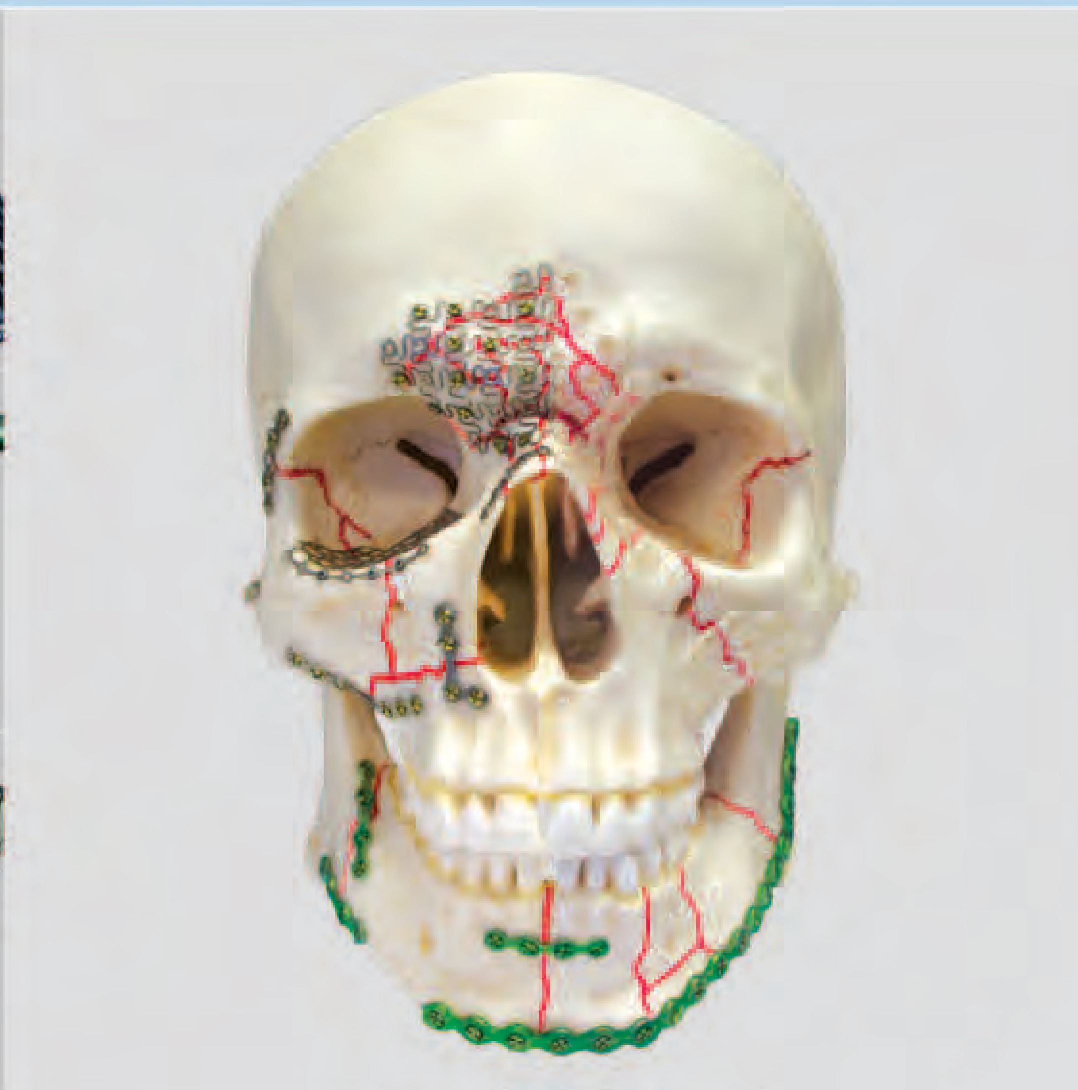
CALAOMS recognizes the significant time, energy and dedication that went into achieving this professional status and commends these doctors for their efforts.

Antonio Arredondo, DDS
Edward Balasanian, DDS, MD
Michael Belton, DDS, MD
Stephen Connelly, DDS, MD
Mahr Elder, DDS, MD
Jeffrey Elo, DDS, MS
David Kim, DDS, MD
Steven Kupferman, DMD, MD
Susan Lee, DMD, MD

Azizollah Maghen, DMD, MD
Diana Medina, DDS
Jonathan Nakano, DMD
Hidemi Oka, DMD, MD, MS
Brian Oleksy, DDS, MD
Alexander Rabinovich, DDS, MD
Ashok Veeranki, DDS
Benjamin Walline, DDS, MD
Brian Yang, DDS, MD

Products for Oral & Maxillofacial Surgery





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Spotlight on California OMS Training Programs

Highland General Hospital
Department of Oral and Maxillofacial Surgery

by Wendy Liao, DDS

The Oral and Maxillofacial Surgery residency program is in its 83rd year at Highland General Hospital. Today's program, however, bears little resemblance to the original one year residency established by Dr. Sadi Fontaine in 1926. The program expanded to PGY I-IV, 48 months in duration while accepting two residents per year in 1967. In 2004, the program further expanded to three residents a year with a total of 12 residents. Supporting and teaching these residents are seven full-time faculty, six part-time faculty, five participating training institutions, and a dynamic curriculum of core surgical training and didactics.

Located in the San Francisco Bay Area, just a few miles east of the Oakland/San Francisco Bay Bridge, Highland General Hospital (HGH) is the main campus of the Alameda County Medical Center and is both the home and primary training institution for the OMS program. This hospital is a high volume, level II trauma center and 240-bed acute care facility, serving a patient population which is largely indigent, inner city and culturally diverse. HGH is the designated trauma center for northern Alameda County, and the only trauma center for the city of Oakland, seeing over 3500 trauma activations per year. In addition to dental and OMS, this hospital also provides a full range of clinical programs and sponsors various hospital based residency training programs including Emergency Medicine, Internal Medicine, Podiatry, Ophthalmology Primary Care Medicine, General Surgery, and Orthopedic Surgery.

At HGH, the OMS team serves as the primary provider of facial trauma surgical care, resulting in a tremendous caseload and experience for the residents. Over the last 8 years the operative caseload combining all 4 hospitals has been 2000 major cases per year(667 per senior resident) of Trauma, Reconstruction, Pathology, Cosmetics and Orthognathic, well over the requirement dictated by the Commission on Dental Accreditation (75 per senior resident). In addition, the OMS team runs a busy outpatient clinic (14000 visits per year) where adult and pediatric dentoalveolar and infection cases are treated with local or intravenous anesthesia.(400 cases per year). About 700 patients per year have their 3rd molars removed in that clinic.

HGH has been a pioneer in complex implant placement, especially for the edentulous maxilla. Under the direction of Dr. Edmond Bedrossian, very complex fixed implant reconstructions are performed every Monday morning. These cases are restored by our restorative dentists with the OMS residents taking part in all of the restorative process. This management gives the resident first hand restorative experience that facilitates the resident's ability to converse with the restorative dentist after the resident begins his/her practice.

Left: The original Highland General Hospital building which officially opened its doors in 1927, featured Spanish baroque architecture.

Opposite: The newest edition of the Highland General Hospital on the left, which was built in 2004, joins in with an addition to the original hospital on the right.

In 2001, Dr. A. Thomas Indresano became the chair of the OMS department as well as the Residency Program Director. At the same time, the hospital program became affiliated with the University of the Pacific Arthur A. Dugoni School of Dentistry providing the residents with an academic setting. Residents also benefit from clinical rotations at a variety of nationally renowned Bay Area hospitals including Kaiser Permanente Medical Center in Oakland, Oakland Children's Hospital and California Pacific Medical Center.

The dental school at the University of the Pacific (UOP) plays a significant role in the overall clinical experience of the residency. Residents spend a significant amount of their clinical time in UOP's oral surgery and implant clinic as part of ongoing university affiliation. On-service second year residents rotate to the dental school every afternoon. They see mostly dentoalveolar and pre-orthodontic patients referred from the main student clinic, orthodontic clinic, and pediatric clinic. For four months of their final year, fourth year residents also rotate to the implant clinic at the dental school every afternoon. Here they have a chance to work in an environment that is not unlike a private practice setting. They work with a senior dental student and prosthodontic faculty in forming a viable surgical and restorative treatment plan. At this implant clinic, they are granted a great deal of independence and benefit from high volume of implant, sinus augmentation, and bone graft surgeries. Residents also spend one month with the oral pathology staff where they learn how to develop and interpret specimens. There is also a once a month joint orthodontic-OMS conference where surgical orthodontic cases are presented by both teams. Senior dental students are scheduled for one or two week HGH oral surgery rotations during which they are exposed to working in a hospital environment. The students attend morning hospital rounds with the OMS team, and observe and assist in treating patients in both inpatient and outpatient surgeries. Combining the university experience with the urban county facility provides the residents with balance and diversity as well as added academic, research and teaching opportunities.

Third year and fourth year residents have valuable four-month rotations through Kaiser Permanente Medical Center in Oakland, CA. Headed by Dr. Felice O'Ryan, the maxillofacial clinic serves as a powerhouse for orthognathic surgeries and cleft alveolus repairs in northern California. Residents are exposed to facial deformities, TMJ diseases and syndromes. Working and training intensely with "mama" (Dr. O'Ryan) and "dad" (Dr. David Poor), residents become familiar with treatment planning, pre-surgical model surgeries and numerous surgical procedures.

Beginning in 2008, the Highland Hospital OMS team became an official member of the Craniofacial Deformity team at the Children's Hospital, Oakland, just minutes from the Highland campus. The team holds clinic sessions weekly to treat cleft lip and palate patients. Many alveolar cleft grafts and orthognathic surgeries are operated. Children's Hospital is a 191 bed pediatric medical center, recognized nationally as a leader in Pediatric Medicine. Children's is the designated pediatric trauma center for all of Alameda County. It is also a major tertiary referral center for Northern California, with patients frequently transferred by helicopter from outlying areas. OMS

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HGH Continued From Page 15

residents are on call for all pediatric mandibular fractures coming via the emergency department. One of the most precious experience for residents is a one-month rotation of pediatric anesthesia where residents work alongside an anesthesiologist at the Children's hospital providing general anesthesia and intravenous sedations.

In addition to the vigorous academic curriculum, the didactic curriculum includes formal courses in head and neck anatomy, physical diagnosis, implantology and oral pathology. Weekly evening conferences with guest speakers from a wide range of specialties and professions are held on an on-going basis. Residents also put together and present interesting or crucial cases formally to a panel of attendings during these evening grand rounds. Rigorous debates and discussions can sometimes turn into quite brutal but memorable experiences for the presenting resident. Journal club is held once a month typically in a less formal setting such as a restaurant or at an attending's home. This provides an opportunity to review the latest articles written on a pre-chosen topic.

The residents come from diverse backgrounds both ethnically and professionally. The current group of residents has graduated from dental schools at the University of Pacific, University of Pittsburgh, USC, UCSF, Temple University, University of Connecticut, Michigan, and Tufts. Several residents also have experiences in internship and general practice residency. The residents are a close-knit and supportive family which boasts a strong sense of camaraderie which continues well after the completion of training. The program alumni have formed the Sadie Fontaine Academy which sponsors a nationally recognized annual education seminar where current residents are honored guests.

We are proud of our nurturing and interactive academic environment at the UOP / Highland Hospital.

AB2637 Creates Two New Permit Categories for Dental Assistants: Dental Sedation Assistant and Orthodontic Assistant

By Corrine Cline-Fortunato, DDS

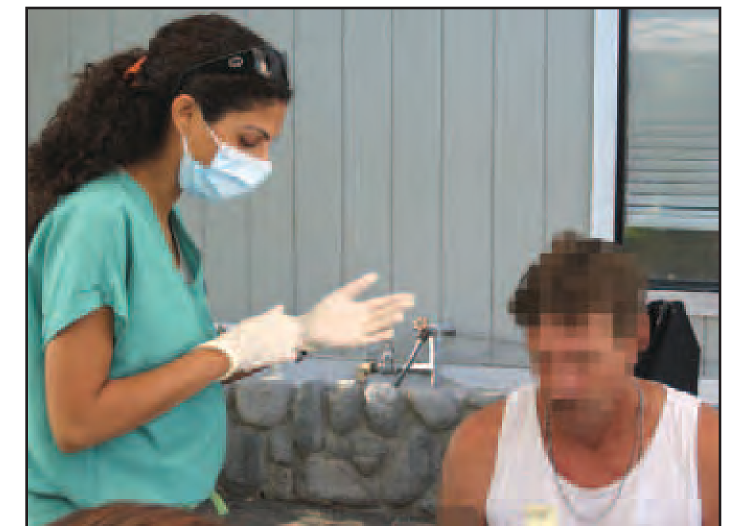
As a result of AB2637, a new dental assisting structure with many new and expanding duties takes effect January 1, 2010. The revised structure preserves the current dental assisting categories (DA, RDA, and RDAEF), establishes the educational requirements for both the renewal of existing RDA/RDAEF licenses and the application for new RDA/RDAEF licenses. It also creates two new "Add-On Permits": Dental Sedation Assistant Permit (DSAP) and Orthodontic Assistant Permit (OAP). The purpose of the legislation is to create a meaningful dental assisting career ladder and increase the capacity of general and specialty practices and clinics to provide care. In a nutshell, AB2637 provides a clear outline of what education, licensing and permits auxiliary dental team members must obtain and maintain in order to perform specific clinical functions. Of particular interest to most of us in the OMS specialty is the Dental Sedation Assistant Permit (DSAP).

The DSAP is an "add-on" permit that allows a DA, RDA or RDAEF to assist a dentist in the administration of sedation and in the monitoring of patients under sedation. Beside the usual DA, RDA, or RDAEF duties, a DSAP can monitor patients undergoing conscious sedation or general anesthesia, draw and place drugs, medications, and fluids into an intravenous line, and remove IV lines. These duties must be preformed under the direct supervision of a licensed dentist, or other licensed healthcare professional authorized to administer conscious sedation or general anesthesia in the dental office.

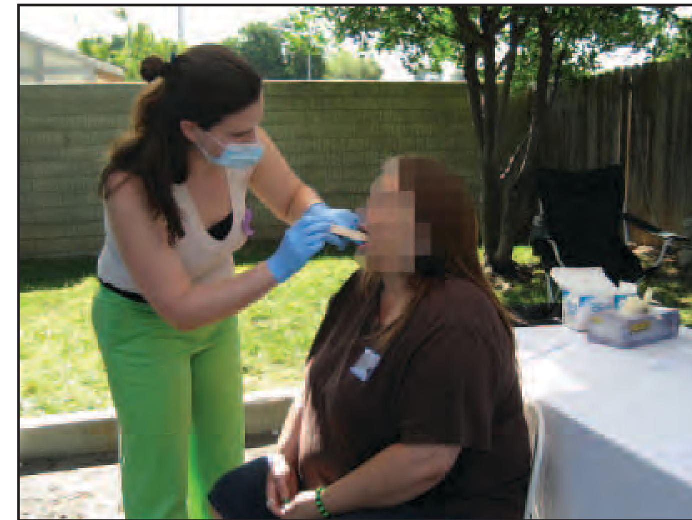
For comprehensive comparison of the current and new DA, RDA, and RDAEF duties and educational requirements, please visit www.CDA.org (New Dental Assisting Duties and Standards in 2010) or contact the CDA Division of Public Policy at (916) 554-4984.

CALAOMS and Community Service Continued from Cover Page.

From Left to Right :Dr. Shama Currimbhoy, Dr. Alexis Kleinman and Dr. Sam Khoury volunteered their time at Up & At It.



Dr. Shama Currimbhoy darns her exam gloves in preparation of a dental screening.



Dr. Alexis Kleinman performs a dental screening on a female participant of Up & At It.

Dr. Sam Khoury performs a dental screening on a male participant of Up & At It.

have the opportunity to educate the public on, and grow awareness of the profession of OMS. It is these reasons that CALAOMS feels the need to ramp up it efforts in the area of community service programs.

One recent program CALAOMS participated in on Saturday, July 11, was Up & At It. This was a community project to work with "Clean and Sober" a Sacramento based nonprofit dedicated to assisting homeless men and women seeking recovery from drug and alcohol addiction.

CALAOMS, in partnership with the Sacramento District Dental Society, offered to provide dental screenings and find follow up care for each individual in the program. The program reached out to sixty plus men and women who have made courageous steps of getting clean and sober and are now reintegrating back into society. Up & At It was a four day event that helped the participants with resume' and interviewing skills, Skill Building in Confidence, Motivation and Communication, as well as Communication in the Workplace.

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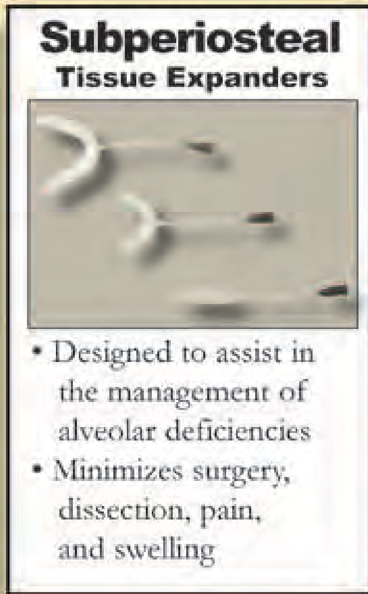

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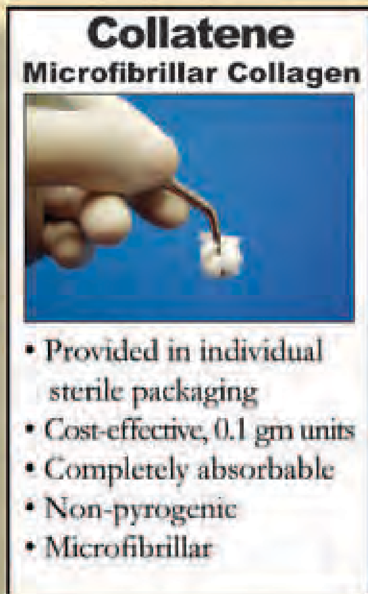
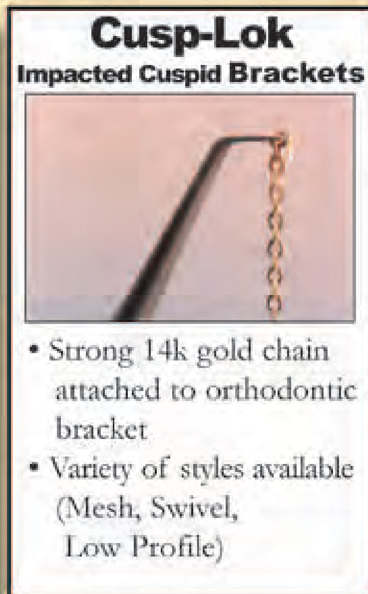




Community Service Continued from Page 19

Dental screenings were done by CALAOMS resident members Dr. Shama Currimbhoy, Dr. Alexis Kleinman and Dr. Sam Khoury from the UOP/Highland Residency Training Program which is under the direction of Dr. A. Thomas Indresano, Director of OMS Training. Drs. Khoury, Currimbhoy and Kleinman took time out of their weekend to drive from Oakland to Sacramento to help with the program. The doctors made the participants feel comfortable and gave them hope as they work to get their lives back on track. I helped our doctors with the screening process, and then helped the participants find clothing to wear for their job interviews.

Another recent program that CALAOMS asked members to donate their time to, was The Los Angeles Dental Expedition. At the request of CALAOMS member Dr. George Maranon, CALAOMS sent emails to its membership urging members to volunteer for the expedition. The expedition is a joint effort of the five Los Angeles County Dental Societies to provide much needed dental care to thousands of individuals of low-income unemployed or indigent circumstances. The event is taking place at The Forum Arena in Inglewood August 11-18, 2009.

With these two previously mentioned events, CALAOMS has joined its efforts with already established programs. In a sense, we have been followers in these programs. CALAOMS however is the premier dental specialty, and as such should take the lead and partner with other organizations in not only the dental community, but the public community at large.

Therefore, on August 3, I have set up a meeting with Cathy Levering, Executive Director for the Sacramento District Dental Society; Suzi Ettin, nurse for Loaves and Fishes (a private sector, faith based, charitable organization dedicated to feeding the hungry and sheltering the homeless), and Dr. Steve Leighty, a CALAOMS member who is passionately involved in dentistry/mission work with Nor-cal and Thousand Smiles. My goal is for CALAOMS to set up a successful project to help the needy, which can then be duplicated in numerous communities across the state. Additionally, I want CALAOMS to be recognized as a compassionate organization giving help and care in the communities in which we live every day. I hope also, that the public will see how passionate oral and maxillofacial surgeons are in helping people in their communities and as a profession.

By Pamela Congdon, CAE
CALAOMS Executive Director

Upcoming CE Events For 2009-10

BMP Program
September 16, 2009 — Southern CA

Residents' Night
September 23, 2009 — Southern CA

OMSA Winter 10 Home Study Begins
October 15, 2009 — Northern CA

OMSA Fall 09 Weekend Seminar
October 24-25, 2009 — Southern CA

Medical Emergencies
November 4, 2009 — Northern CA

ACLS
November 7, 2009 — Solano

Medical Emergencies
November 18, 2009 — Southern CA

January 2010 Meeting
January 15-17, 2010 — Southern CA

OMSA Winter 10 Weekend Seminar
February 20-21, 2010 — Northern CA

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

Risk Management Corner

This article, published in 2007, was written by Jacqueline Ross, PhD(c), MSN, RN, risk management analyst, OHIC Insurance Company. OHIC is the leading physician-owned medical malpractice carrier in Ohio, and a wholly owned subsidiary of The Doctors Company.

Which Tooth?

The case outlined in this article highlights a number of valuable lessons that can help dentists and oral surgeons ensure patient safety and reduce risk in their practices.

The Facts of the Case

The patient in this case came to our insured oral surgeon's office on a referral but did not have x-rays or a referral card.

Our insured oral surgeon noted obvious tooth decays in tooth no. 19, and tooth no. 20 was rotted to the gum line with an unresolved root canal (no crown was ever placed).

The patient gave our insured the names of the referring and previous dentists. The patient was unsure which tooth required extraction, so our insured attempted to contact the referring dentist but was unsuccessful. Our insured then called the patient's previous dentist, who relayed that the patient's last visit had been two years earlier, and at that time, the no. 20 tooth needed extraction and no. 19 could have been saved. Our insured agreed that the no. 20 tooth was most problematic and required extraction, so he removed it.

The patient called the referring dentist the following day, complaining of pain. He was told to come in for evaluation but did not appear in the office until a few days later. The patient later said the dentist told him that the wrong tooth had been pulled, but the notes do not reflect this.

The Allegation

The patient alleged the wrong tooth was extracted without an examination or x-ray.

The Arguments and Outcome

The first dentist's notes reflected instructions to the patient for the need to either return for a crown or have the tooth (no. 20) extracted. The patient had never returned. Although the second (referring) dentist did not document it, he indicated in his deposition that tooth no. 20 was rotted to the gum line and the patient had sought dental care only twice in 10 years.

The referring dentist's record recommended extraction of tooth no. 19. The patient was given the names of two oral surgeons and told to call the office since a referral card was required by his insurance. The patient failed to do this. The omission led to nonpayment.

The patient relied on the opinion of the referring dentist, who simply wrote a letter confirming that the no. 20 tooth had been extracted, but he did not indicate any criticism of our insured's care in this letter or in his deposition. In fact, this dentist commented that the patient had asked him to write that the wrong tooth had been extracted and a breach in the standard of care had occurred. He refused the patient's request.

Our insured oral surgeon refused to settle this case because the tooth in question required extraction. In addition, the patient was never able to produce any expert testimony critical of our insured's standard of care. After the deposition of the referring dentist, the patient's attorney acknowledged the lack of support. In fact, the patient's attorney asked if our insured oral surgeon would be willing to provide additional care for the patient since he was still having pain. The insured declined. This case was closed.

The Lesson

This case provides good examples of the need for better communication and documentation.

The oral surgeon should have delayed the extraction until confirming which tooth was to be extracted. The oral surgeon should have spoken with the referring dentist, documented the correct tooth in the record, and then read back the information to the referring dentist for verification. This small step, although disruptive, would have avoided the allegation.

Additionally, the insured oral surgeon did not provide sufficient documentation on the examination—which should have included a detailed description of the condition of the teeth and the subsequent discussion with the patient on the findings.

This case example also highlights the importance of patients taking a more proactive role in their safety. Patients need to be a partner in patient safety. The patient came to our insured oral surgeon without knowing which tooth required extraction, without a referral card, and with no x-rays.

This patient was also noncompliant. He failed to follow up with the first dentist, and he did not call the referring dentist for a referral card. These oversights resulted in the wrong tooth being pulled (although it was effectively argued that the tooth required extraction anyway) and in the nonpayment. It is through the combined efforts of health care providers and patients that patient safety risks are diminished.

Patient Safety Tips

Effective communication among providers is timely, accurate, complete, unambiguous, and understood by the recipient. If the communication between two providers does not meet these criteria, stop, and take the time to make it effective.

- Write down critical information and read it back.
- Receive confirmation from the individual that you heard correctly.

Have a standardized approach to "hand-off" communication between providers, including the opportunity to ask and respond to questions.

- The process should include the opportunity for questioning between the giver and receiver of patient information.
- The information should include up-to-date status.
- The information should be verified as accurate.

Patients should be encouraged to be actively involved in their own care.

- Educate your patients on their care plan and on what to expect.
- Encourage your patients to speak up if they have concerns.

Prevent wrong-site surgery

- Have a preprocedure process to ensure all of the relevant documents and studies are available prior to the start of the procedure and they have been reviewed and are consistent with each other and with the patient's expectations and with your team's understanding of the intended patient, procedure, and site.
- Mark the procedure site.
- Use a "time out" before starting the procedure to conduct a final verification of the correct patient, procedure, and site.

J4268 10/07

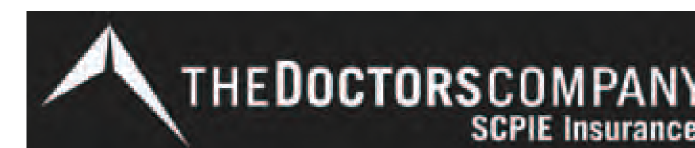
Reference

The Joint Commission. 2008 National Patient Safety Goals. Available at: www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals. Accessed on July 17, 2007.

About the Author

Jacqueline Ross, PhD(c), MSN, RN, risk management analyst, OHIC Insurance Company.

The guidelines suggested here are not rules, do not constitute legal advice, and do not ensure a successful outcome. The ultimate decision regarding the appropriateness of any treatment must be made by each health care provider in light of all circumstances prevailing in the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.



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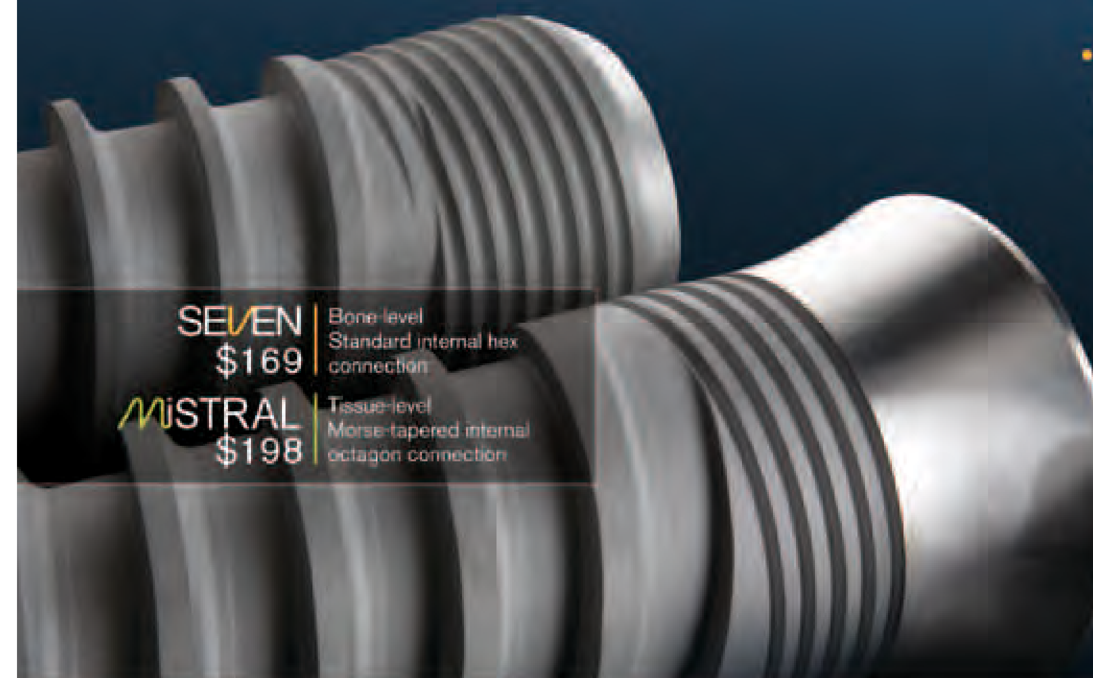

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