

The Compass

Staying the Course Through Service and Education



Volume XIII, Issue 2, Summer 2011

CALAOMS Host To RAM in California

In April of this year, CALAOMS hosted two free health care clinics for Remote Area Medical® (RAM). Our organization invited RAM to provide the clinics in northern California because of the great need we are seeing in our communities for everyday health care. This need has a lot to do with recent budget cuts we have seen in our state causing the elimination of many health care services. CALAOMS took the lead in establishing the clinics and worked directly with Stan Brock, the founder of Remote Area Medical®.



CALAOMS Executive Director, and RAM Volunteer Host Coordinator Pamela Congdon with RAM founder, Stan Brock.

If you were one of the fortunate people to meet Mr. Brock at these or past clinics, you saw firsthand that his compassion and completely unselfish nature to help people is intoxicating. The model he developed for the clinics provides free dental, medical, and

vision services, as well as making eyeglasses on site for patients. All patients are welcome to attend and are seen on a first-come, first-served basis, no questions asked.

The clinics that CALAOMS hosted were held at Cal Expo on April 1-4, and the Oakland Coliseum, April 9-12. Both clinics saw over 3,000 patients and provided over 5,000 services. We also had over 1,100 volunteers at each site. Mr. Brock told me that these two clinics, or “expeditions” as he calls them, were “the best RAM has seen out of 640 expeditions.”

Sacramento was expedition #639 and Oakland was #640. He praised the spirit of our volunteers, the organization of the clinics by CALAOMS as hosts, and the appreciation of the patients. We set records in

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Editor's Corner



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

What Makes a Leader?

Key leadership success secrets set the great leaders apart from the “so-so” leaders in today’s organizations. Leadership style is learned from mentors, learned in seminars, and exists as part of a person’s innate personal leadership skill set developed over years, and existing possibly from birth. Nature or nurture is a question often asked about leadership. I answer, “yes,” because I believe the combination of natural leadership skills and nurture through leadership development defines a person’s leadership style.

From personal experience and research, we can define the characteristics of leadership that make great leaders. Leadership differs from management and supervision, although some people and organizations use the terms interchangeably. While the definitions of the terms differ, an individual may have the ability to provide all three.

- **Supervision** means that an individual is charged with providing direction and oversight for other employees. The successful supervisor provides recognition, appreciation, training, and feedback to reporting employees.
- Management means to conduct the affairs of business, to have work under control, and to provide direction, to guide other employees, to administer and organize work processes and systems, and to handle problems. Managers monitor and control work while helping a group of employees more successfully conduct their work than they would have without the manager. A manager’s job is often described as providing everything the reporting employees need to successfully accomplish their jobs. One famous quote from Warren Bennis, Ph.D.. in *On Becoming a Leader* distinguishes management from leadership: “Managers are people who do things right, while leaders are people who do the right thing.”
- While a supervisor and a manager may also exhibit leadership skill or potential, true leaders are rare. This is because the combination of skills, personality, and ambition essential to leadership are difficult to develop and exhibit. According to Don Clark, in his excellent leadership resource, *Big Dog’s Leadership Page*, “Bernard Bass’ theory of leadership states that there are three basic ways to explain how people become leaders. The first two explain the leadership development for a small number of people. These theories are:
 - Some personality traits may lead people naturally into leadership roles--this is the trait theory.
 - A crisis or important event may cause a person to rise to the occasion, which brings out extraordinary leadership qualities in an ordinary person--this is the great events theory.
 - People can choose to become leaders. People can learn leadership skills--this is the transformational leadership theory.”

The transformational leadership theory is the one (I believe) is correct for most leaders today.

CHARACTERISTICS OF A SUCCESSFUL LEADERSHIP STYLE

Much is written about what makes successful leaders. The characteristics, traits, and actions that are keys to success are:

- Choose to lead
- Be the person others choose to follow
- Provide vision for the future
- Provide inspiration
- Make other people feel important and appreciated
- Live your values and behave ethically
- Set the pace through your expectations and example
- Establish an environment of continuous improvement
- Provide opportunities for people to grow, both personally and professionally
- Care and act with compassion

THE KEY LEADERSHIP TRAIT

The first, and most important characteristic, of a leader is the decision to become a leader. At some point in time, leaders decide that they want to provide others with vision, direct the course of future events, and inspire others to success. Leadership requires the individual to practice dominance and take charge. If you choose to become a leader, whether in your workplace, community, or during an emergency, the discussion of these characteristics will help you formulate the appropriate mix of traits, skills, and ambition. Successful leaders choose to lead. Unlike Keanu Reeves as Neo in 1999’s smash hit, *The Matrix*, you get to decide whether you are “the one.” The first characteristic of a leader is choice - leaders choose to lead. ●

RAM article continued from page 1

the dental section at the Sacramento clinic on Friday, April 1, boasting 22 oral and maxillofacial surgeon volunteers in one day who extracted 649 teeth. The total number of extractions for the four day clinic in Sacramento was 2,134; and 1,356 for the four day clinic in Oakland. I will also mention that at each clinic, over 1,000 pairs of eyeglasses were made.

The stories I’ve heard from volunteers who worked at the clinic, as well as patients who received services, are many and quite touching. It’s hard to describe how it feels to volunteer at these clinics, but to have a patient thank you for giving back his dignity or for caring enough to bring the clinic to their community is a reward that is indescribable.

CALAOMS and RAM also worked closely with the Tzu Chi Foundation who led the medical section of the clinic and provided acupuncture treatments to the patients, as well as set up 30 dental chairs. The Tzu Chi Foundation is a wonderful group of caring and compassionate individuals that distributed food and water to the patients, and also tried to keep boredom at bay with songs and skits that included patient participation.

Continued on page 19



Patients waiting in the early hours of the morning in hopes of getting a number that would enable them to receive one of the many services provided at the Sacramento RAM Expedition

President's Message



*John L. Lytle, DDS, MD
President, CALAOMS*

By all standards this was a very successful event. Now, RAM has focused our attention on public service within CALAOMS and the state of California.

At our annual meeting in Palos Verdes in May, we honored Pam Congdon for her persistence and her success in coordinating these extraordinary events.

Congratulations, Pam, on a job well done! CALAOMS is proud to have you as our executive director.

It was Pam's vision for CALAOMS that made this event such a big success. After participating myself, I saw the positive results of the RAM campaign. I believe we now have a great opportunity to enhance the humanitarian component of CALAOMS by developing our own outreach program. It will have a real and tangible impact on the citizens of our state. With your help it will grow and prosper, and it can only benefit our organization.

Your CALAOMS board of directors has recently voted to be the official hosts of RAM California with Pam as President. This organization will be supported entirely through donations, and CALAOMS will maintain a strong leadership role. RAM California will coordinate events in California and will expand our outreach as an organization. We plan to begin hosting and working with RAM CA on an ongoing basis in the CALAOMS office in the near future. If you are interested in volunteering at the RAM events in Oakland and Sacramento March 2012, please let our staff in Roseville know.

Since RAM California will be a separate organization from CALAOMS, the (CALAOMS) board has nominated Dr. Steve Leighty, our newest director, to be the liaison from CALAOMS to RAM. He will provide the needed input to RAM California, and will fill us in on the progress made. Thank you, Steve! I know you will do a fine job.

I look forward to seeing our mission soar to new heights as this program takes off. It is a proud moment for our organization and I am glad to be a member of CALAOMS.

Expanding Humanitarian Outreach in California

Dear members,

“Our mission is to promote the advancement of the specialty of oral and maxillofacial surgery and the interest of its members through public service, ethics, education, and advocacy”

When you enter the doors of our beautiful central office in Roseville, you immediately see in bold relief our mission statement painted on the wall as written above. It is there for all to see, and most importantly, for our organization to abide by.

This past March and April, CALAOMS successfully hosted the Remote Area Medical® (RAM) clinics in northern California. This was initiated and directed by our own executive director, Pamela Congdon, CAE, IOM. The services provided included dental, medical, and vision care. Many thousands of patients were treated over an 8-day period, all free of charge. Donations poured in for facilities, equipment, food, and incidentals.



*Marwood Stout, DDS
Chair, CALAOMS Legislative Committee*

CALAOMSPAC Needs You!

Our CALAOMSPAC board and legislative committee members are in frequent contact with lobbyists and various legislators. It is through these encounters that we build the friendships and alliances that can become valuable as we promote (and protect) our profession.

As we enter the more intense political season, there will be certain campaign events the board determines are worthy of support. Many of these events can be attended by board members, but there are times where this is not feasible for geographic reasons. In such a case, we need a volunteer surgeon who can attend an event on behalf of CALAOMSPAC, meet the candidate, present a contribution check, and take steps to form a personal relationship with the legislative candidate. It is best that the surgeon attending has either a residence or an office in the district.

As these campaign opportunities arise, we will contact the CALAOMS members in the candidate's

district in an effort to find a volunteer to attend. When this call goes out, I ask that you check your availability and see if you can participate as our representative.

Many CALAOMS members are actively involved in the political process and have developed personal relationships with legislators. We are grateful for their efforts and our profession is better because of it. But we need more members involved.

Many find politics to be frustrating, unpleasant, impure, and to be avoided, if at all possible. This is understandable, but our political opponents are surely not avoiding anything. Our participation is vital, and it is the only way we can accomplish favorable legislation.

You may also have personal feelings of support, condemnation, or indifference for a legislative candidate and his or her positions. But some of our association's most successful legislative efforts have come through the relationships built with legislators many of us would scarcely support at the ballot box. We need legislative support on both sides of the political aisle. And we need surgeons like you participating on behalf of CALAOMS at these kinds of events.

When an event is announced, I hope you take the opportunity to participate. Once confirmed, we can book your attendance and send you the actual check to present. You need not be a political junky, and it is okay if you do not know the status of all the bills in process or when each legislator is termed out. We will prepare some talking points for you to discuss when you have some face time with the candidate or staff members. The campaign events can be busy, and sometimes the face time comes with a separate appointment to meet the candidate.

If you are interested and willing to function as a CALAOMS representative, please contact me at woodymms@gmail.com. We would love to have you participate, and we will give you first opportunity when a local event opportunity arises.



Sunset Review and More

The Dental Board of California (DBC) is in the process of completing sunset review. This is a performance review that is conducted for all boards and bureaus every four years. The review of the DBC is conducted by the Senate Business and Professions Committee and leads to legislation that allows the board to continue operations until the next review is conducted.

The DBC has completed the review process and a bill (SB 540) has been sponsored by the senate committee chair, Senator Price, that will extend operation of the DBC until 2018. This bill has been passed by the senate and is now in assembly committee. The bill must next be passed by the assembly and signed by the governor.

At present, SB 540 contains the following provisions:

1. Addresses unresolved and ongoing litigation regarding specialty advertising by deleting existing limitations on specialty by general dentists; however, advertising must not be materially false or misleading (see B&P Code Section 651(h)5(A) i-iii).
2. Effective January, 1, 2012, the DBC will be reconfigured to eight practicing dentists and seven public members. What remains unchanged is that

of the eight practicing dentists, one shall be a dentist practicing in a non-profit community clinic, and one shall be a member of a faculty of any California dental college.

3. Extends the sunset review date to January 1, 2018.
4. Expands the requirements that licensees give notice to patients that the DBC is the entity that regulates dentists, and provide the telephone number and internet address of the DBC.
5. Establishes the Dental Assisting Council as the sole entity of the board that will provide recommendations to the DBC on all dental assisting matters.
6. The bill establishes that the members of the council shall be appointed by the board president and shall consist of two members of the board and five members who are either registered dental assistants or registered dental assistants in extended functions.
7. Extends the California Dental Corps Loan Repayment Program of 2002 until all the money in the account is expended.
8. Does not include the DBC's request for a specific time limitation on public disclosure for citations issued for less egregious violations and additional enforcement measures for lesser violations of the Dental Practice Act.

GENERAL ANESTHESIA/CONSCIOUS SEDATION (GA/CS) EVALUATOR PROGRAM

All GA/CS permit holders must attend an evaluator calibration course. Courses are held twice a year in two locations. 2011 courses were held March 16 in San Francisco and March 23 in San Diego, and were well attended.

General anesthesia onsite evaluations are now current, but the DBC is having difficulty recruiting conscious sedation evaluators. There has recently been an

increase in conscious sedation permits exacerbating the shortage.

The board needs more evaluators willing to evaluate conscious sedation permit holders!

ELECTIVE FACIAL COSMETIC SURGERY (ECFS) PERMIT PROGRAM

Nineteen (19) ECFS permits have been issued to date.

Dr. Nestor Karas has resigned from the ECFS committee after years of dedicated service. We thank Dr. Karas for his exemplary service on the committee.

This position must be held by a dual-degree OMS licensed by the medical board and board certified by the American Board of Oral and Maxillofacial Surgery, and who maintains privileges at an acute care hospital.

Dr. Lou Gallia of Sacramento has been appointed to fill the open position on the committee. We welcome Dr. Gallia to the committee and thank him for his willingness to serve.

DENTAL SEDATION ASSISTANT (DSA) TRAINING

Eight DSA course providers have been approved to date; however, none are offering the training outside their own practices. New DSA provider courses cannot be approved until new regulations are adopted later this year; however, course provider applications are still being accepted. Please contact Pam Congdon, CAE, IOM (CALAOMS Executive Director) for course provider information.

As of January 1, 2010, dental assistants must have a DSA permit to perform the following duties (see BPC Section 1750.5 for details):

1. Monitor patients undergoing conscious sedation or general anesthesia utilizing data from non-invasive instrumentation.

2. Drug identification and draw, limited to identification of appropriate medications, ampule and vial preparation, and withdrawal of correct amount as verified by the supervising licensed dentist.
3. Add drugs, medications, and fluids to intravenous lines using a syringe, provided that a supervising licensed dentist is present at the patient's chairside. The exception to this duty is that the initial dose of a drug or medication shall be administered by the supervising licensed dentist.
4. Removal of intravenous lines.
5. Non-permitted assistants may place monitoring sensors and read and repeat monitor readings for interpretation by the dentist. ●

THE FIRST DSA PERMITS ARE ISSUED

CALAOMS would like to congratulate the first oral surgery assistants to receive the new DSA (dental sedation assistant) permit issued by the state of California. We commend them on the tremendous effort and time put forward to obtain this new license classification. They are as follows:

Dr. John L. Lytle's assistants:

- Frances Escudero Permit #1
- Alexandra Uribe Permit #2
- Chrystal Rodriguez Permit #3

Dr. Ned L. Nix's assistants:

- Castarina Cardenas
- Jenae Jewett

Dr. Kenneth E. Follmar's assistant:

- Monica Lopez

Dr. Richard Robert's assistants:

- Jason Dela Vega
- Alexis Grey
- Amanda Miller - Pending

Southern Bangladesh Mission Trip

*Kourt Chatelain, DMD
Resident, Dept of OMS Loma Linda University*

*Carlos Moretta, DDS
Clinical Professor, Dept of OMS Loma Linda University*

Recently, a small group of doctors from the Loma Linda University schools of medicine and dentistry completed a mission trip to southern Bangladesh. The team consisted of a faculty oral and maxillofacial surgeon (OMS), a



Drs. Carlos Moretta and Kourt Chatelain remove a forehead mass on a young boy

resident OMS, a few dental and medical students, an optometrist, an internist, a pediatrician, a family practitioner, an ophthalmologist, a physical therapist, and auxiliary personnel.

Bangladesh is ethnically homogeneous. Indeed, its name derives from the Bengali ethnolinguistic group, which comprises 98% of the population. Bengalis, who also predominate in the West Bengal province of India, are one of the most populous ethnic groups in the world. In 2009, the population was estimated at 156 million. Religiously, about 90% of Bangladeshis are Muslims, and the remainder are mostly Hindus.

Bangladesh has the highest population density in the world, excluding a handful of city-states and small countries, such as Malta. The mid-2009 estimate for total population was 156,050,883 which ranks Bangladesh 7th in the world.

The basic social unit in a village is the family (poribar or gushti), generally consisting of a complete or incomplete patrilineally extended household (chula) and residing in a homestead (bari). The individual nuclear family often is submerged in the larger unit and might be known as the house (ghor). Above the bari level, patrilineal kin ties are linked into sequentially larger groups based on real, fictional, or assumed relationships.



Dr. Carlos Moretta and Kourt Chatelain perform facial surgery in an open air operating setting

Groups of homes in a village are called Paras, and each para has its own name. Several paras constitute a mauza, the basic revenue and census survey unit. The traditional character of rural villages was changing in the latter half of the 20th century with the addition of brick structures of one or more stories scattered among the more common thatched bamboo huts.

Although farming has traditionally ranked among the most desirable occupations, villagers in the 1980s began to encourage their children to leave the increasingly overcrowded countryside to seek more secure employment in the towns. Traditional sources of prestige, such as landholding, distinguished lineage, and religious piety were beginning to be replaced by modern education, higher income, and steadier work. These changes, however, did not prevent rural poverty from increasing greatly. In a 1986 survey, 47% of the rural population was below the poverty line, with about 62% of the poor remaining in extreme poverty. The number of landless rural laborers also increased substantially, from 25% in 1970 to 40% in 1987.

During our four and half day trip, approximately 3,500 patients received treatment at no cost. About 1,800 patients were treated in the dental component. Medical treatment consisted



Dr. Kourt Chatelain standing next to a typical housing unit

of the diagnosis and medical management of various illnesses, both common and more endemic to the region. Dental treatment consisted mainly of extractions, with some limited restorative treatment provided. Our faculty OMS, CALAOMS member Dr. Carlos Moretta, not only provided surgical management of difficult extractions, but also utilized his general surgery training by removing various lesions from multiple parts of the bodies of different patients, including scalp and face lesions, back lesions, and shoulder lesions.

All of the patients treated were exceedingly grateful for the services they received. The newly-toothless smiles of many of the children treated provided the fuel to keep us all going. Without the amenities that we've grown accustomed to in our daily lives, this fuel was much needed, and most certainly appreciated by all of us providing care. The locals were most hospitable and welcomed us with open arms, giving generously of all they had to offer.

We encourage all of you, if given the opportunity, to reach out to others less fortunate, whether in a far-off land, or simply in your backyard community. Sure, it may not improve your bottom line, but you will be given something much more than what money can buy.



Dr. Kourt Chatelain (back row, far left) with colleagues and new friends after a long day

Ethics Debate



Steve M. Leighty, DDS
Chair, CALAOMS Ethics Committee

I was just thinkin'

I was just thinking about...some of the provocative thoughts that Jeff Elo stirred in me with his article on professionalism in the Spring 2011 Compass. My father practiced general dentistry in Augusta, Kansas, and was my first role model for a professional. Since then, I've had some other role models and mentors, and I'm proud to say that some of my most respected mentors are listed as fellow CALAOMS members.

Recently, I've come to believe that we who work in health care and enjoy the status and attention of our patients and the public are, effectively, all role models. Some good; some not so good. My staff is one of my biggest reminders that, way more than I realize, my mood, behavior, language, and my activities are noticed by those around me. This is a very sobering thought.

Does this mean that as a professional, we are always "on stage?" Must we always act like we are

moral and ethically bound to be upright, honest, fair, and all the rest? As the ethics chair for CALAOMS, I've had a pretty quiet committee recently. I've spent time with CDA ethics, too, which is also very quiet.

My perception of CDA ethics and its big brother, the judicial council, is that there is never any lack of activity, education, and practice challenges. But the entire process reminds me of the Wizard of Oz who made lots of noise but had no real strength or substance.

Don't misunderstand, I respect the volunteers and staff who work to keep ethics education and training a part of CDA resources. However, sadly, I think ethics is dying in today's world.

Speaking for myself, there are times I feel overwhelmed by the pressures we face as dentists. I travel to Mexico for charity work regularly, and often I take an assistant or two. Recently, I learned that I am required to provide workers' compensation insurance, even though my assistant volunteers her time! Before you travel abroad to donate your services, check your workers' comp policy, I can assure you it does not cover international work. I have been able to find one agency that will cover my staff for a \$2,400 premium (for one weekend). What do I do? Simple. I've stopped taking my assistants to Mexico.

As a CDA delegate, this year the House will be considering "access to care" resolutions in our rush to be a leader and help organized dentistry become "green." Don't get me wrong--rules and regulations, lawyers, special interest, and an ever-expanding cry for dentistry to (kind of) lower the bar a little to allow more dental care by non-dentists makes me feel like I can never keep up on everything I need to or should be.

The last volunteer dentist--a specialist--that I recruited for my component society quit after less than one year. After attending an ethics seminar, he came away completely discouraged. He felt ethics had

become a paper lion. I tend to agree with him, but I feel we must try and regain some ground somehow.

A few years ago, I made a complaint to my component about another OMS in my area that advertised in the Yellow Pages that he was an "implant specialist." The ethics chair kindly wrote back and said that they "had no power to enforce the ADA or CDA Code of Ethics with regard to specialty advertising." CALAOMS had a similar response and suggested that I call AAOMS, which I did. To be honest, I can't remember much of my conversation with the person on the other end of the phone, except that there were "bigger fish to fry," and that lawsuits in southern California and Florida were being watched. The end result (from my understanding) is that the Federal Trade Commission trumps professional ethics.

Didn't we all learn the same stuff in dental school about specialties being tightly regulated, and that one shouldn't pass him- or herself off as a specialist unless they actually graduated from an ADA-recognized specialty program? Well, like in many things in life, the honest people follow the rules and the dishonest ones march to a different tune.

I saw denturism brought into practice in Washington while I was a resident. Fighting denturism in Yuba City nearly broke the collective back of the Butte-Sierra dental component that I was a member of at the time. More attention and resources were later put into place when the same denturism group popped up in Redding and San Francisco.

As an undergraduate philosophy major, I learned that morals are universally held truths that transcend culture, religion, and generations. Ethics are similar, but not the same. Professional societies, churches, and governments adopt codes of ethics that more clearly spell out the parameters of behavior for a more defined group and set of circumstances.

Has the idea of ethics become quaint or old-fashioned? Do ethics require enforcement or more universal acceptance by a group in order to be valid?

Does the lack of ethics complaints at CALAOMS prove that we OMSs are more ethical than OMSs a generation ago?

I have read the old files and there used to be a lot more 'activity' among California oral and maxillofacial surgeons with regard to ethics complaints. Maybe it's time to move on to a new model of ethics which is defined by public interest attorneys and enforced by Department of Consumer Affairs staffers?

If you can forgive my sarcasm, and overlook a few of my *non sequiturs*, I have a challenge for you. Write, call, or email us at CALAOMS with your thoughts. Do you agree with me or do you have a different paradigm we should consider? Reactions to this column--which I've committed to run for at least three issues--will be discussed in the subsequent issue, along with some new ethics topics. I've been saving this for years, and feel the need to get some of it off of my chest.

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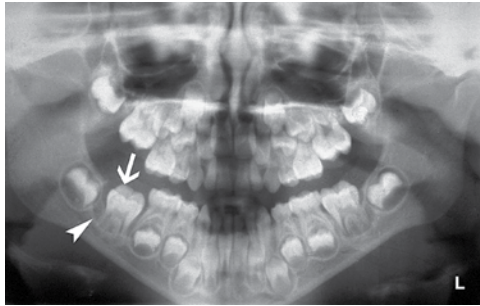


Figure 1. Paradental cysts involving mandibular “6-year” molars bilaterally. A 6 year-old boy had bilateral firm tender swellings buccal to teeth #19 & 30. A corticated “cup-shaped” radiolucency was observed inferior and distal to each mandible first molar (arrowhead). The buccal bifurcation cysts displaced root apices to the lingual, resulting in superior tipping of lingual cusps (arrow). A buccal periosteal reaction was seen on occlusal radiographs. The cyst distally displaced the developing second molar.



Figure 2. Paradental cysts involving mandibular “12-year” molars bilaterally. A 12 year-old girl had swellings of the posterior lower buccal vestibule bilaterally, associated with partially-impacted teeth #18 & 31. Only the left swelling was tender to palpation.



by Lee Slater, DDS, MS, Scripps Oral Pathology Service, San Diego, California; Lecturer, Department of Oral & Maxillofacial Surgery, Loma Linda University School of Dentistry

Bilateral Paradental Cysts

If a child presents with a tender swelling buccal to a mandibular first molar, the possibility of an inflammatory paradental cyst should be considered (Figure 1). Similarly, if an adolescent presents with a painful or tender vestibular swelling buccal to a mandibular second molar, a buccal bifurcation cyst warrants consideration (Figure 2). The surgeon should look for confirmatory radiographic evidence of paradental cyst on the panoramic radiograph (Figure 1): a thin U-shaped or “saucer-shaped” cortex outlining a radiolucency apical and distal to a mandibular molar; and lingual displacement of root apices causing the lingual cusps to be superiorly displaced (the molar appears to be buccally tilted). Approximately 25-35% of buccal bifurcation cysts are bilateral (excluding paradental cysts involving wisdom teeth), although only one side may be symptomatic.(8,9)

Paradental cysts have been reported under several diagnostic appellations including: mandibular infected buccal cyst-molar area, buccal bifurcation cyst, and inflammatory paradental cyst.(8) It is

usually first identified just prior to mandibular molar eruption. So a paradental cyst involving the first molar (“six-year molar”) occurs at age 6 to 8 years, and one affecting the second molar (“twelve-year molar”) presents at age 12 to 14 years. Because paradental cysts are not seen in adults, Pompura and associates hypothesize that they spontaneously resolve.(9)

The cyst can be associated with a deep buccal periodontal pocket (15 mm), particularly when the molar is only partially erupted,(7,11) and such a cyst could appropriately be regarded as an “eruption pocket cyst.” Patients often report a foul-tasting discharge from the area.(9)

This cyst can automarsupialize: the cyst lumen can gain or regain connection to the gingival sulcus and decompress with minimal surgical intervention (such as piercing the cyst with a periodontal probe). (2,7) However, painful, tender or enlarging cysts unresponsive to conservative measures should be treated by curettage/enucleation: a full thickness flap is developed, and the fenestration at the superior aspect of the buccal cortex is enlarged enough to allow enucleation (the cyst is attached to the cemento-enamel junction but not to the bony walls or roots). The associated molar need not be extracted. Within a year of enucleation, periodontal probing depths are normal, bone fills the defect, and the molar fully erupts and “rights itself.”(9,10)

The paradental cyst shows nonspecific histologic features similar to those seen in chronic periodontitis, radicular cyst, or inflamed dentigerous cyst. Therefore the diagnosis of paradental cyst is based on clinical and radiographic findings, not microscopic features. A tender buccal bifurcation cyst should evoke consideration of paradental cyst; inflamed odontogenic keratocysts rarely present with tenderness.

If you see children in your practice, you will certainly encounter patients with paradental cysts; look for them.

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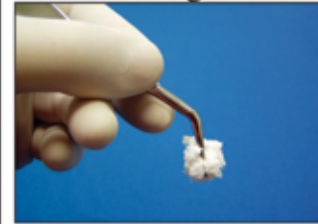
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CALAOMS 11th Annual Meeting a Huge Success

Jeffrey A. Elo, DDS, MS

This past May, the stunning Terranea Resort perched on the Palos Verdes Peninsula in Rancho Palos Verdes hosted the 11th annual CALAOMS meeting. The venue was exquisite, as the resort is surrounded on three sides by the Pacific Ocean, with Catalina visible across the channel. Members were able to reconnect with old friends and colleagues while taking full advantage of a true “working vacation,” as the resort featured challenging recreation and top level relaxation at The Links at Terranea, The Spa at Terranea, three ocean view pools, and a generous collection of restaurants and lounges.

We also received great continuing education from some fantastic speakers, including Dr. Jason Cope, who discussed screw-type transitional anchorage devices (TADs); Dr. L. Douglas Knight, who discussed maxillary zygomatic anchorage plates; and our own Dr. Anders Nattestad, who discussed surgical techniques and complications associated with the use of these products. We also heard from our own Dr. Alan Felsenfeld, who discussed management and complications in dentoalveolar surgery.



Dr. John L Lytle (left) presents the Meeting Dedication Award to Dr. Frank Pavel (right)

AWARDS AND DEDICATIONS

The venue provided the opportunity for us as an organization to recognize outstanding leadership, service, and dedication among our members. The meeting was dedicated to Dr. Frank Pavel, Sr. Frank practiced in San Diego and was an Associate Clinical Professor of Surgery at the School of Medicine, University of California, San Diego. He became the president of the SCSOMS in 1975, and then became the president of the ABOMS in 1982. CALAOMS thanks Dr. Pavel for his many years of service to the profession, his patients, society, and our organization.

The Distinguished Service Award was awarded to Dr. Al Steunenberg. Al served as the president of the NCSOMS in 1986, and then became the president of CALAOMS from 1989 to 1991. He was one of the founders of CALAOMS, and became the second president of the organization. He was instrumental in helping CALAOMS obtain malpractice insurance when premiums were raised to historic heights. He co-wrote the Nerve Injury Protocol with Dr. Tony Pogrel, and was able to promote this as an important document throughout the state and country. Congratulations and many thanks to Dr. Steunenberg for his many years of service to our specialty and our organization!

The Committee Member(s) of the Year Award was presented to both Dr. Kyle Van Brocklin and Dr. Jeffrey Donlevy for their many years of service on the Peer Review Committee. CALAOMS recognizes and greatly appreciates

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Dr. John L Lytle (left) presents the Distinguished Service Award to Dr. Al Steunenberg (right)

RAM Article continued from page 5

Because of the incredible need in the area, as well as success of the clinics, Mr. Brock suggested that we form Remote Area Medical California (RAM California). In doing so, we would become an affiliate under the RAM Foundation, which is headquartered in Tennessee. We will be under RAM’s umbrella and operate as a 501(c)(3) organization. We will start operating small clinics until we can raise enough money to purchase dental chairs, autoclaves, medical and vision equipment, and a vision lab to make the eyeglasses. RAM headquarters will guide us through this process until we are ready to operate fully as RAM CA. The CALAOMS board of directors voted to be the official

hosts of RAM CA and to foster CALAOMS’ outreach and humanitarian efforts in the state of California, with the vision of being leaders and examples in efforts like these across the country.

In 2012, CALAOMS and RAM will provide a repeat of the clinics in northern California. The Oakland Expedition will be held March 20-26, and the Sacramento expedition will be held March 27- April 3. Please consider volunteering at the RAM CA clinics for the patients, for CALAOMS, and for yourself--I promise you that it will be time well spent!

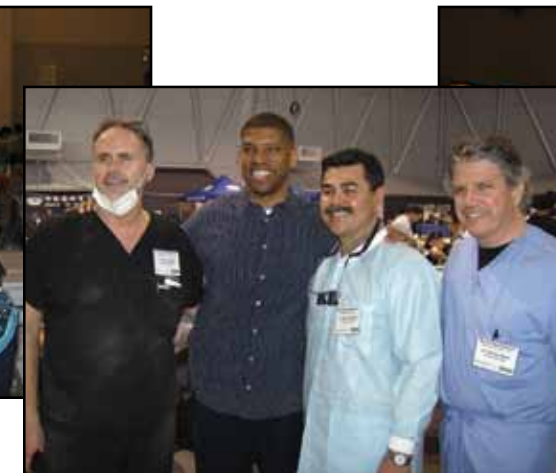
*by Pamela Congdon, CAE, IOM
Executive Director, CALAOMS*



The Dental area of the Sacramento RAM Expedition being readied for the first clinic day. In the background are two mobile dental units provided by the Tzu Chi Foundation. Approximately 60 dental stations are set up in the middle, with approximately 30 hygienist stations in the foreground. A record setting number of dental services were provided at the RAM Sacramento expedition.



Dr. David Rainero with his assistant Erica Beverly at the RAM Oakland expedition.



From left to right: Dr. Steve Leighty, Sacramento Mayor Kevin Johnson, Dr. John Santamaria, and Dr. Nicholas Rotas at the RAM Sacramento expedition.



Dr. Sam Houry (foreground) and Dr. Terrance Rust (background) at the RAM Oakland expedition.

POLST V. DNAR – End of Life



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

The fact is, we are all mortal beings, and despite our best efforts, we're all going to face end of life issues, whether our own, or our immediate family member's. Most are familiar with a standard DNAR form (do not attempt resuscitation) in a patient's chart; however, they fall short. The POLST form (physician orders for life-sustaining treatment) translates advance directives into a physician's order that can be followed when a patient is too sick to speak for themselves. Many patients discuss their code status with their doctor and a "Do Not Attempt Resuscitation" (DNAR) is marked in their chart; however, a missed DNAR chart note is all it takes to start an unwanted journey.

Although widely advocated for their usefulness, advance directives or living wills are not generally helpful in some cases. Aside from evidence that an advance directive often is not followed in any setting, this document typically addresses a hypothetical, medically catastrophic event that may happen sooner or later, or maybe never. As a result, the patient's wishes can be left open to interpretation depending on circumstances. These documents generally speak to a limited number of situations, such as when the patient is imminently dying, suffering in the last stages of

advanced progressive illness or permanently unconscious, and they do not necessarily preclude initiating interventions. This is a good thing for the young person who suddenly has a heart attack. This is not good for those patients whose chronically critical illness or whose advanced illness or frailty makes it unreasonable to think an intervention can offer benefit.

Even when there is a DNAR order in a patient's chart, that order may not be found quickly enough if a patient is rushed to the hospital, or the emergency medical technicians may disregard it if they are not confident the patient had decided on a care plan that took into account this specific event in light of his or her health condition.

In short, something more is needed to assure a way to follow Ethical and Religious Directives for Catholic Health Care Services No. 57 in forgoing by withholding interventions that will not be beneficial and that does not limit forgoing to withdrawing interventions only after they have imposed excessive burden. This "something more" can be the Physician's Order for Life-Sustaining Treatments (POLST).

In brief, the POLST program began in 1991 with the development of a medical order sheet under the leadership of the Center for Ethics in Health Care at the Oregon Health and Sciences University. This form was developed to translate advance directives into a physician's order that could be followed by clinicians directly when a patient is too sick to speak for her/himself. It was created for patients for whom, due to their advanced illness, frailty or status of being chronically critically ill, it was possible to decide in advance whether or not an intervention in response to a clinical event would carry a "reasonable hope of benefit" or whether that intervention would entail "excessive burden."

Key elements:

- Legal standing for emergency medical technicians, who are otherwise obligated to resuscitate any patient they are called to see

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the time and commitment that these two gentlemen volunteers donated to help ensure best practices in our state.

The Exhibitor of the Year Award was presented to KLS Martin for their continued generous support of our membership and organization. We truly do value our relationship with KLS Martin and look forward to many more years of a great partnership!

CALAOMS also wants to recognize all the outstanding contributions put forth by the California OMS residents who submitted table presentations/posters to the Resident Table Clinic. They were all well-received by both the membership and the judges. The Resident Table Clinic winners were:

- 1st Place--Dr. Shama Currimbhoy, University of the Pacific/Highland Hospital
- 2nd Place--Dr. Chan Park, Loma Linda University
- 3rd Place--Dr. Kirsten Rittenbach, University of California, San Francisco

Doctors Pavel, Steunenber, Van Brocklin, Donlevy, Currimbhoy, Park, and Rittenbach were honored at the Annual Membership Luncheon on Saturday, May 21, 2011 at the Terranea Resort.

A big "Thank You" to all who attended the meeting! It truly was a weekend that will not be forgotten.



Dr. John L Lytle (center) presents the Committee Member(s) of the Year Award to Dr. Kyle Van Brocklin (left) and Dr. Jeffrey Donlevy (right)

- Portability, so it would travel with the patient to any point of care in the system to assure that his or her wishes regarding life-sustaining treatment would not be lost in transition
- A greater appreciation that a patient's wishes regarding end-of-life care is more than simply documenting "code status." In addition to indicating CPR or DNAR when a patient has no pulse and is not breathing, the order sheet addresses the benefit or burden of various levels of medical interventions such as IV fluids, hospital admission, ICU care, intubation outside the context of apnea, as well as the use of antibiotics and medically administered nutrition and hydration.

In 1995, this order sheet became what is known today as the POLST, a portable tool that specifies the patient's wishes regarding beneficial and burdensome treatment at end of life and that, as a physician's order, is transferable throughout the health care system.

The literature regarding POLST makes heavy use of the expression "patient wishes." Many articles point out a POLST is better able to assure "patient wishes" than are other tools. This may lead some to see the POLST as exaggerating patient autonomy. Some raise concerns about patient choice of medically assisted suicide and euthanasia. Patient autonomy is certainly a factor with a POLST order, but no more so than it is with any other physician's order requiring patient/surrogate consent. Respecting patient autonomy is important because consent is involved, but subjective desires in health care are necessarily constrained by the parameters of clinically objective facts and professionalism. HIPAA, of course, permits disclosure of POLST to other health care providers as necessary.

I have simply highlighted some key points which are, hopefully, helpful, although the subject matter is understandably sensitive and even disturbing to some. In any event, an advance directive of some sort should exist for us all, and a POLST is currently the recommended choice. Visit www.caPOLST.org for further information/guidance.



Fig 1: Map of states that have legalized marijuana from the National Organization for the Reform of Marijuana Laws website



Fig 2: Advertisements for medical marijuana recommendations from physician websites



Fig 3: Google Maps search of medical marijuana dispensaries in Los Angeles

Marijuana As Medicine?

The growing medical marijuana epidemic in California and its implications for the oral and maxillofacial surgeon



by Nora Kahenasa, DMD
Oral and Maxillofacial Surgeon
Diplomate, American Board of OMS

Marijuana has been legalized for use as medicine in California along with 15 other states (Fig 1), and the District of Columbia, over the past 14 years. In California, sales of medicinal marijuana by California’s “budtenders” have thrived for 13 years and is currently California’s biggest cash crop, with total sales of \$14 billion dollars annually. In Los Angeles alone there are close to 200 medical marijuana dispensaries (Fig 2) that are selling medical marijuana to those patients who possess a recommendation by a licensed physician (Fig 3). It is estimated that between 750,000 and 1,125,000 patients, or 2-3% of California’s population, are medical marijuana users. These numbers are considered estimates since the number of patients who possess medical marijuana recommendations are not required to register directly with the state. Under California’s medical marijuana law, Prop. 215, patients need only a physician’s recommendation to be considered legal. The estimate of approximately 1 million medical marijuana patients represents a substantial increase from 300,000 in 2007; 150,000 in 2005; and 75,000 in 2004. According to the 2009 National Survey on Drug Use and Health, 16.7 million Americans aged 12 or older used marijuana at least once in the month prior to being surveyed, an increase over the rates reported in all years between 2002 and 2008. Estimates also suggest that about 9 percent of users become addicted to marijuana; this number increases among those who start young (to about 17 percent) and among daily users (25-50 percent).¹ With this growing epidemic on our hands, oral and maxillofacial surgeons should be familiar with the effects of marijuana on our patients and the possible risks of treatment in this patient population. The purpose of this article is to provide pertinent information

on the adverse effects of marijuana on the oral and maxillofacial surgery patient and propose potential practice pearls that could help to avoid known complications in these patients.

Although medical marijuana is considered legal in California, the marijuana plant (*cannabis sativa*) is a schedule 1 controlled substance in the US (high abuse potential; no legitimate medical use), and is currently illegal under federal law.² Despite this classification, physicians in California continue to write recommendations for the medicinal use of marijuana, with 94% of those recommendations written for a diagnosis of “severe and chronic pain,” mostly in males under the age of 40.³ The schedule 1 classification of marijuana has made scientific research of the drug, including the optimal dose and delivery routes for the conditions being treated, very difficult to study.⁴ Sophisticated cultivation and plant breeding techniques in recent years have produced high potency cannabis species with THC contents of 60-150mg/ joint compared to those cannabis species in the “flower power” days of 1960’s, which possessed THC contents of only 10 mg/joint (Fig 4). THC, or Δ⁹ -tetrahydrocannabinol, is one of 61 cannabinoids in the cannabis plant along with 340 other chemical compounds that enter the mainstream smoke, are inhaled, absorbed and produce measurable effects for 0.5-2 hours, with a dose as small as 2.5 mg. Initially, the inhaled cannabinoids are distributed in the areas of the body with the highest blood flow (brain, lungs, liver) to cause the acute effects. However, since they are highly fat soluble, the cannabinoids will also accumulate in fatty tissue, allowing them to be slowly released out of the fat and back into the body and brain as time passes. Due to its accumulation in fat and the cumulative effects with repeated doses, the plasma half-life for occasional to chronic marijuana users is 28-56 hours, while the tissue half-life can be 7-30 days.⁵

Although marijuana has been typically referred to as a “soft drug” leading to the belief by some practitioners that its effects are benign, its acute and chronic adverse effects are observed in every body system. The euphoria, or “high” the patient experiences, varies

greatly with the dose, mode of administration, expectation, environment, and personality of the individual. This initial “high” can be experienced with as little as 2.5 mg THC, producing a resultant decrease in anxiety, alertness, tension, and depression along with feelings of detachment, intoxication, and general changes in perception. Greater marijuana doses will increase the euphoric changes experienced by the individual leading to consequent tolerance to those same doses in chronic users. These euphoric changes can also become adverse in some individuals, resulting in anxiety, panic reactions, and psychotic symptoms.⁶ Chronic, frequent marijuana use can then lead to cognitive impairment, shortened memory span, and altered time perception. Chronic users who abstain from marijuana use for long periods may also experience withdrawal symptoms, including anxiety, appetite disturbance, depression, and sleep latency.⁷ Chronic marijuana use with subsequent marijuana dependence is currently reported to be the most common type of drug dependence after alcohol and tobacco in the USA and Canada.⁸

Though marijuana is reported to contain medicinal properties as a potential analgesic, antiemetic, anticonvulsant, and appetite stimulator⁸, as previously mentioned, the adverse affects on each physiologic system can be of significant concern for the oral and maxillofacial surgery patient undergoing surgery and/or anesthesia. Within the autonomic nervous system, low or moderate doses of marijuana will cause an increase in sympathetic activity (increase norepinephrine), with reduction of parasympathetic activity, resulting in an increase in cardiac output (30% or more) and tachycardia.⁹ This tachycardia will cause a 20-100% increase in heart rate that can last 2-3 hours after use. The increase in heart rate and marijuana-associated myocardial depression can cause EKG changes including nonspecific, transient P, ST, or T wave abnormalities.^{9,10} Increases in carboxyhemoglobin and decreases in oxygen associated with smoking marijuana will also produce an increase in myocardial oxygen demand. Overall, these acute cardiovascular changes will increase risk for myocardial infarction,

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which is reported to be 4.8 times over baseline in the first 60 minutes of marijuana use.¹¹ Following repeated marijuana doses, tolerance to the aforementioned cardiovascular effects are evident, resulting in slight decreases in resting heart rate and blood pressure. Only when marijuana cessation is followed for at least 48 hours, will the cardiovascular effects and tolerance to those effects be reversed in the chronic marijuana user.¹²

Taking the significant and possibly fatal cardiovascular effects of marijuana into account, the oral and maxillofacial surgeon should take precautions to avoid increases in myocardial demand and sympathetic activity that can lead to tachycardia in the marijuana user. If it is not possible to postpone surgery and/or anesthesia for the 48 hours needed to reverse the acute cardiovascular events that occur in the marijuana user, then use of those anesthetic agents with tachycardia potential, such as ketamine, atropine, and epinephrine, should be avoided.

Marijuana use also has the potential to cause orthostatic or postural hypotension with resultant dizziness or possible fainting. The effect of postural hypotension with marijuana use is of significant concern in patients with decreased cerebrovascular reserve, since there will be an increased likelihood of falls with associated injuries, and even the possibility of ischemic stroke. Transient cerebral ischemic episodes and ischemic strokes after marijuana use have even been reported in young smokers who had no other contributing factors but heavy marijuana use.¹⁰ Though these risks are rare and underreported, it is important for the oral and maxillofacial surgeon to avoid significant cerebral pressure changes during anesthesia in the marijuana user, particularly with those drugs such as ketamine and nitrous oxide that have the potential to significantly increase cerebral blood flow.¹³

Marijuana cigarettes contain a cocktail of chemicals similar to tobacco, including tar, carbon monoxide, bronchial irritants, and even higher levels

of carcinogens than those found in tobacco smoke.¹⁴ The pulmonary effects of smoking 3-4 marijuana cigarettes per day is equivalent to smoking 20 or more tobacco cigarettes per day.¹⁵ Common adverse pulmonary effects such as coughing, wheezing, sputum production, laryngospasm, bronchospasm, emphysema, and bronchitis can occur in chronic marijuana smokers. Uvular edema causing airway obstruction and prolonged intubation has also been reported secondary to the high temperature at which marijuana burns, and its resultant mucosal irritation when inhaled.¹⁶ The impaired ability of alveolar macrophages to properly provide respiratory defense may also predispose the chronic marijuana user to pulmonary infections.¹⁴ Care must therefore be taken to thoroughly evaluate the patient's pulmonary function as well as the patient's airway for signs of edema or mucosal irritation that may have detrimental repercussions during anesthesia. Reports in the anesthesia literature have made various recommendations for anesthetic management of marijuana users, from administering preoperative dexamethasone as a prophylactic measure for potential laryngeal edema to postponing elective surgical procedures in patients with an acute history of marijuana exposure.¹⁶ Since most oral and maxillofacial surgery procedures are elective, it seems prudent for the oral and maxillofacial surgeon to postpone surgery in patients with signs or symptoms of acute marijuana use for their optimal safety.

The immunosuppressive effects of marijuana on macrophages, natural killer cells, as well as T and B lymphocytes, will result in a decrease of host resistance, potentially causing peri-operative bacterial and viral infections that can significantly affect surgical outcomes in the oral and maxillofacial surgery patient.¹⁷ Various studies in past decades have shown that cannabinoids have significant effects on infectious disease resistance including opportunistic bacteria and viruses.¹⁸ As the major cannabinoid in marijuana, THC can compromise the immune system deeming the host response ineffective against intracellular microorganisms. In addition to these immunosuppressive effects, chronic drug abuse in

general may be associated with behavioral and social practices that can contribute to increased exposure to pathogens and opportunistic infections.¹⁸ The potential for neglectful health practices, and potentially compromised immune system can consequently cause poor oral health in marijuana users which can result in higher rates of plaque, tooth decay, and gingivitis, as well as an increased prevalence of *candida albicans* when compared to non-users.²² Xerostomia, which occurs due to the potent parasympatholytic properties of marijuana, can also commonly occur. In chronic and frequent smokers, there is repeated low-grade irritation of the oral mucosa which can result in leukoedema. Oral premalignant lesions including erythroplakia and leukoplakia are also possible findings, although no direct association has been made between marijuana use and oral cancer. Chronic use will, however, result in chronic mucosal inflammation and leukoplakia that can progress to neoplasia.²¹ By and large, it seems that the present epidemiologic evidence regarding the relationship between marijuana use and the induction of oral cancer is inconsistent and conflicting, but does not seem to contribute to overall incidence of head and neck cancer in the marijuana user population. Given such, it is important for the oral and maxillofacial surgeon to recognize the immunosuppressive effects of marijuana on patients and take appropriate measures to ensure marijuana users are monitored for signs and symptoms of oral and systemic infections or pathology associated with marijuana use. Since these adverse effects are infrequently reported in comparison to other illicit drugs or tobacco, most marijuana users are unaware of their existence. Patient education, in addition to oral cancer screenings and stringent avoidance of known interactions during treatment are important tools the oral and maxillofacial surgeon can use to increase the knowledge and safety of the medicinal marijuana patient.

As previously stated, chronic marijuana use will result in tolerance to its effects. The rate of tolerance is dependent on the dose and frequency of administration so that each individual will have a different degree of tolerance, making predictability of the effects in an individual quite difficult. Repeated marijuana doses

will result in accumulation of the behavioral and pharmacological effects over time, resulting in plasma elimination of up to 50 hours and tissue elimination of up to 30 days. The tolerance observed in chronic marijuana users can also result in cross-tolerance with other drugs. Of utmost importance to the oral and maxillofacial surgeon is the cross-tolerance between marijuana and anesthetic agents such as benzodiazepines, barbiturates, phenothiazines, and opioids.¹⁹ As one of few human studies on anesthetic requirements in marijuana users, a recent study on the induction dose of propofol in marijuana users concluded that marijuana use significantly increases the dose of propofol required for satisfactory clinical induction.²⁰ Anecdotally, it seems that the cross-tolerance with marijuana and these commonly used anesthetic drugs is difficult to predict, but can be clinically evident in patients with a history of marijuana use who fail to reach an adequate anesthetic plane with an otherwise sufficient anesthetic dose. It is the author's experience that these effects can potentially be minimized if marijuana users in need of intravenous conscious or deep sedation are advised to discontinue marijuana use 48 hrs. prior to surgery allowing the acute adverse marijuana effects, including tolerance, to pass. Although mild withdrawal symptoms such as anxiety and insomnia may occur with marijuana cessation, when compared with the acute effects of marijuana use, those potential withdrawal symptoms will pose less overall risk of adverse events for the patient who will undergo anesthesia. The patient can also be advised to speak with the physician who made the medical marijuana recommendation about alternative forms of treatment during the period of marijuana cessation.

Taking into account the significant adverse effects of marijuana on each body system, as well as its continually growing and rampant use in California, the oral and maxillofacial surgeon must be extremely vigilant in properly interviewing the oral and maxillofacial surgery patient. Obtaining a social history can be unreliable since patients may refuse to disclose substance abuse during interviews, particularly teenagers with family members present. To reduce this occurrence,

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social history should be obtained in a non-accusatory fashion while interviewing the patient apart from their family members. Although some authors recommend drug screens, in the oral and maxillofacial surgery practice they are typically costly, time consuming, and not readily available, making reliance on suspicion and regional abuse patterns the only possible methods to assess potential drug use in untruthful patients.²³ Verbal and/or written preoperative instructions advising patients not to use marijuana (or other illicit drugs) 48 hours before surgery may be also added to standard preoperative instructions provided to patients to help prevent the unwanted adverse effects of marijuana during anesthesia. Although this may seem obvious information for most individuals, the marijuana user with a medical marijuana recommendation may not fully know or comprehend the potentially fatal effects of marijuana use during anesthesia and therefore may feel it is safe to use their medicinal marijuana preoperatively. It is the role of the oral and maxillofacial surgeon to take proper precautions to help prevent the adverse effects of marijuana use during treatment.

In conclusion, the legalization of marijuana for medical use has dramatically increased the number of reported marijuana users in California. The potential for cross-tolerance with anesthetic agents along with its adverse pulmonary, cardiovascular, cerebrovascular, and immunosuppressive effects can interfere with the induction of anesthesia, surgical course, and postoperative recovery. These possibilities make it advisable for the oral and maxillofacial surgeon to diligently inquire into the history of marijuana and drug use on our patients, be aware of the potential effects of use, and do our best to prevent untoward adverse events by providing proper instructions for the medical marijuana user.

¹ These data are from the 2009 Monitoring the Future survey, funded by the National Institute on Drug Abuse, National Institutes of Health, Department of Health and Human Services, and conducted annually by the University of Michigan's Institute for Social Research. The survey has tracked 12th-graders' illicit drug use and related attitudes since 1975; in 1991, 8th- and 10th-graders were added to the study.

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“New Strategies to Protect Yourself when Negotiating or Renewing Your Dental Office Lease”

Part One of a Three Part Series

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

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

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

1. Annual rent increases. Your rent payments have a diminished value each year to the landlord because of the eroding effects of inflation. Consequently, landlords provide for annual rent increases to maintain the original dollar value of their rent when the office lease commenced. Request, therefore, that your annual rent increase by the consumer price index and **not** by any fixed amount which exceeds the consumer price index. Many landlords increase rent by an amount that exceeds the inflation rate; however, if your lease provides that repairs and maintenance to your building are passed through to you and the other tenants, there is no compel-

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ling reason for the landlord to seek an annual increase over and above the annual inflation rate.

Be careful, also, of rent increase clauses which state that the annual increase shall be tied to inflation with a certain **minimum** guaranteed increase (e.g., 3%) and a certain maximum cap beyond which the rent shall not increase (e.g., 6%). Some landlords discreetly provide that the “cumulative” annual increases shall not be less than the minimum or greater than the maximum amounts listed in the lease. The word “cumulative” permits the landlord to add up and average all of the annual increases and, therefore, the maximum number stated in your lease does not provide you as much protection as you might think. For example, let's say your lease prohibits increases above 6% per year. In year 1, inflation is 2%; year 2, inflation is 2%; and in year 3, inflation explodes to 12%. You might think that your 6% ceiling would protect you; however, because the “cumulative” sum of the 3 years of inflation equals 16% (2% + 2% + 12%), the landlord could still increase your rent by 12% because the “cumulative” sum in the lease has averaged less than 6% per year (a total “cumulative” increase of 18% for the 3 year period in question is permitted). **Review carefully your annual rent increase provisions.**

The next issue will address your right to assign or sublet your dental office lease and options to renew.

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

Risk Management Corner

That Patient Just Won't Stop Googling

by Susan Shepard, MSN, MA, RN CPHRM
Director, Patient Safety Education

While health care is not “do-it-yourself,” an informed patient can be an asset. A poorly informed patient, on the other hand, clearly complicates treatment. Assume the responsibility of being the primary information source and educator for your patient. To help deal with a self-diagnosing patient, consider the following:

Encourage your patient to always check with you about the accuracy of information obtained from external sources. Use the intake time to find out what Internet information the patient has found.

Directly discuss what the patient has read, even if the patient’s external source is a good one in your professional opinion. The exchange enhances your relationship with the patient and can increase treatment compliance. Welcome questions, and help put the patient’s information in the appropriate context.

Provide your patient with a list of Web sites that provide accurate information, such as the Centers for Disease Control and Prevention (www.cdc.gov). Make sure the patient understands the limitations of the Internet.

Document in the patient’s chart your diagnosis, your treatment management plan, and medication prescribed, as well as the reasons behind your decisions.

Contributed by The Doctors Company. For more tips, articles, and information, please visit <http://thedoctors.com/knowledgecenter>.



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:

- | | | |
|-----------------------------------|---------------------------------|---------------------------|
| <i>Alexander Antipov, DDS</i> | <i>Brian Harris, DDS, MD</i> | <i>Dieu Pham, DDS, MD</i> |
| <i>Peter Bui, DDS, MD</i> | <i>Armond Kotikian, DDS, MD</i> | <i>David Smith, DDS</i> |
| <i>Jeffrey Caputo, DDS</i> | <i>Donald Liberty, DDS</i> | <i>Eli Tabariai, DMD</i> |
| <i>Dikran Deragopian, DMD, MD</i> | <i>Juan Luque, DDS</i> | <i>Tyler Wilson, DDS</i> |
| <i>Wen Fan, DMD, MD</i> | <i>Daniel Martin, DDS</i> | <i>Brian Woo, DDS, MD</i> |
| <i>Parvaz Farnad, DDS</i> | <i>Nima Massoomi, DMD, MD</i> | |

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

RISK TIP: CYBERCHONDRIA - MANAGING SELF-DIAGNOSED PATIENTS

Search engines and the Internet are impacting patient behavior—eight out of 10 people use the Internet to look for health information, but only 25 percent of those people verify the credibility of their information source before self-diagnosing. It gets even more complicated when patients order drugs directly over the Web.

The debate among physicians about the credibility of online information is as old as the Internet itself. As a caregiver, it’s safe to assume that patients will come into the office already attached to a perceived diagnosis and possibly using medications improperly, based on their own online research.

Consider the following example: A 25 year-old patient experiences a sore throat and slight fever that persists for several days. The patient decides to visit a common Web site known for its medical information. The patient self-diagnoses himself with a bacterial infection and attempts to self-treat by taking expired medication left over from a previous staph infection.



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Upcoming 2011-12 CE Events

For Doctors

Residents' Night September 21, 2011	Pasadena CA
ACLS - Fall Course October 8, 2011	Solano CA
Medical Emergencies* November 9, 2011	Foster City CA
January Anesthesia Mtg. January 14-15, 2012	San Francisco CA
12th Annual Meeting April 28-29, 2012	Westlake Village CA

For Staff

OMSA Summer August 27-28, 2011	Sacramento CA <i>Weekend Seminar</i>
OMSA Fall October 22-23, 2011	Los Angeles CA <i>Weekend Seminar</i>
ACLS - Fall Course October 8, 2011	Solano CA
Medical Emergencies November 9, 2011	Foster City CA

* From this year forward, Medical Emergencies course will be alternating between Northern and Southern California Locations in the Fall. This year it is held in Northern California, and next year (2012) it will be held in Southern California.

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