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The Compass

Staying the Course Through Service and Education

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Volume XV, Issue 2, Summer 2013

CALAOMS & RAM CA - A Winning Team

Providing Access to Health Care in California Communities

The dental floor is a beehive of activity at the RAM California clinic held in Indio, April 2013. The size of the clinic floor was smaller than average, with a meager 70 dental stations divided among extractions, restorations, and hygiene. Photo Courtesy of Mike Whaley

The RAM CA Clinic Event 2013, held at the Riverside County Fairgrounds in Indio on April 4-7, 2013 was a huge success. Since the dental section is the most requested service, CALAOMS' participation is vital to the success of these clinics. And with CALAOMS sponsoring these clinics, we put our Association out front as leaders in healthcare and access to care.

The CALAOMS Board of Directors would like to thank the following members and staff for volunteering for the clinic in Coachella this past April:

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The COMPASS

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California Association of Oral and Maxillofacial Surgeons

Your CALAOMS Central Office Staff

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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CALAOMS also does business as:

* Southern California Association of Oral and Maxillofacial Surgeons
* Southern California Society of Oral and Maxillofacial Surgeons
* Northern California Association of Oral and Maxillofacial Surgeons
* Northern California Society of Maxillofacial Surgeons
* California Society of Oral and Maxillofacial Surgeons
* Southern California Oral and Maxillofacial Surgeons

Compass Direction

RAM & CALAOMS Continued from page 1

Chad Allen, DDS
Moris Aynechi, DMD, MD
Nick Breig, DDS, MD
Shaun Daneshgar, DMD
Jeffrey Elo, DDS, MS
Ryan Falke, DDS
Loretta Gilmore, DDS
Stephen Goei, DDS, MS
Trevor Griffits, DDS
Alan Kaye, DDS
Roger Kingston, DDS
Steve Leighty, DDS
Lester Machado, DDS, MD
George Maranon, DDS
Nima Nassoomi, DMD, MD
Larry Moore, DDS
Ned Nix, DDS
Richard Ogle, DDS, MD - AAOMS retired fellow
Lee Pham, DDS, MD
Peter Scheer, DDS, MS
Charles Syers, DDS
Louis Tieu, DDS, MD
Lonnie Tiner, DDS
Julia Townsend, DDS
Russell Webb, DDS

Dr. Shaun Daneshgar, DMD ***(center), with his son Alex (left) and a dental volunteer (right).***

Pamela Congdon, CALAOMS Exec Dir.
Steve Krantzman, CALAOMS Assoc. Dir.

Here are some interesting statistics from the four day Coachella RAM clinic:

Total Number of Volunteers	**894**
Total Number of Patients Seen	**2,770**
Total Number of Volunteer Hours	**12,841**
Total Number of Services Provided	**12,210**
Total Clinic Cost	**$132,000**
Total Value of Services Provided	**$1,056,176**

All of this is made possible by the dedicated volunteers who donate their time and resources to these clinics, and to whom we are extremely grateful!

Many volunteers, and patients alike, were disappointed that we did not hold a clinic in either Sacramento or Oakland this year. We would like nothing more than to hold clinics in northern California every year. We depend on our parent organization, Remote Area Medical Foundation in Tennessee, for the much needed equipment to hold these clinics. RAM USA puts on numerous clinics throughout the U.S. and abroad each year, and can only be in California for a short period of time. Being RAM California, it is our duty to cover the entire state and not just a specific region such as Sacramento and the Bay Area.

Although we have held clinics for the last three years, RAM CA officially will only be two years old in September. Nonetheless, we have achieved quite a bit in helping our California communities over the past years we've been in operation. Until RAM CA obtains our own equipment to hold clinics, we will only be able to hold one to two clinics a year. That is a very small number for such a large state.

Left Photo - CALAOMS Director, and RAM Ca Liaison Steve Leighty, DDS (center) performing an extraction on a patient, with the assistance of other dental volunteers.

Center Photo - RAM CA Director Daniel Nam, DDS (left) with CALAOMS member Nima Nassoomi, DMD, MD (right).

Right Photo - CALAOMS member Dr. Larry Moore, DDS with his assistant Margie Barraza (left) and another dental volunteer (right).

To be able to hold the same size of clinics that we put on with the help of RAM USA, we require $1.2 million in startup funds. We currently have approximately $350,000 toward that amount. As soon as we reach our goal we will be equipped to hold multiple weekend clinics throughout the state each year without members needing to take time out of their offices during the week. If you would like to help RAM CA raise money for equipment, as an example a fully equipped dental station is $4,500, you might consider making a financial contribution. If so, please go to http://www.ram-ca.org/Donate to make an online donation. Contributions of any size, small or large, would be greatly appreciated. Every dollar will help us obtain our goal of having equipment for RAM CA.

Please Mark your Calendars for CALAOMS and RAM CA's next expedition!

RAM CA Coachella Expedition 2014
Clinic Partner: California Association of Oral and Maxillofacial Surgeons

April 3-6, 2014
Riverside County Fairgrounds
Set-up: April 1 & 2, 2014
Take-down: April 7, 2014

RAM California

Editor's Corner

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

WHY CHARACTER MATTERS

Why does character matter?

I remember reading somewhere when I was a boy about character. In the main hallway in my school was a menacingly large plaque which held words that didn't mean much at the time. Or so I thought. They must have been there so that with repeated passing by, the words would become ingrained in our little minds. The engraving read:

Be careful of your thoughts,
for your thoughts become your words.
Be careful of your words,
for your words become your deeds.
Be careful of your deeds.
for your deeds become your habits.
Be careful of your habits,
for your habits become your character.
Be careful of your character,
for your character becomes your destiny.

The Greek philosopher Heraclitus said it simply: "Character is destiny." Character shapes the destiny of an individual person. It shapes the destiny of a whole society. "Within the character of the citizen," Cicero said, "lies the welfare of the nation."

Transmitting values, in the words of the essayist Lance Morrow, is the work of civilization. A glance at history reminds us that civilizations do not flourish forever. They rise, and they fall. They fall when the moral core deteriorates – when a society fails to pass on its core virtues, its strengths of character, to the next generation. The historian Arnold Toynbee observed: "Out of 21 notable civilizations, 19 perished not by conquest from without but by moral decay from within."

More than a century ago in a lecture at Harvard University, Ralph Waldo Emerson asserted, "Character is higher than intellect." Writes the psychiatrist Frank Pittman: "The stability of our lives depends on our character. It is character, not passion, that keeps marriages together long enough to do their work of raising children into mature, responsible, productive citizens. In this imperfect world, it is character that enables people to survive, to endure, and to transcend their misfortunes." "To do well," Stephen Covey says, "you must do good. And to do good, you must first be good."

All of us who are parents naturally want our children to be successful. But we know in our bones that it's their character – their honesty, sense of responsibility, kindness, perseverance in the face of difficulty, courage in the face of danger or social pressure – that makes them human. If they lack these, brains and success don't count for much. The novelist Walker Percy once said, "Some people get all A's but flunk life." In living a life well, as a proverb puts it, "An ounce of character is worth a pound of intelligence."

Character is having "the right stuff." As parents, surgeons, and educators, we labor to teach kids this – that it's what's inside that counts.

CONGRATULATIONS, FELLOWS!

American College of Surgeons

Four California oral and maxillofacial surgeons will be inducted as Fellows into the American College of Surgeons this coming October in Washington, D.C. They are:

Michael Cadra, DMD, MD
Tony Chu, DDS, MD
Leonard Tyko, DDS, MD
Stephen Connelly, DDS, MD

Congratulations on jobs well done and thank you all for proudly representing CALAOMS and California!

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:

Nam Cho, DDS, MD
Shama Currimbhoy, DDS
Abraham J. Estess, DDS
Narbeh Gharakhanian, DDS, MD
Wes L. Hill, DDS, MD
Jeong D. Kim, DDS, MD
Gennady Landa, DDS, MD
Abhishek A. Mogre, DMD
Chan Park, DDS, MD
Clement Qaqish, DDS, MD
David E. Webb, DDS
William Bradford Williams, DMD, MD

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

President's Message

Alan S. Herford, DDS, MD, FACS
President, CALAOMS

State of the state

The summer's in full swing. Kids and grandkids are on break and going nuts in the house. Operating rooms are at full capacity. We're all working more hours than we'd like to be. It's nearly impossible to find time to stay on top of all that's happening in our state. The dental marketplace is in a constant state of change. Threats are coming from various entities. Allow me to briefly update you all on what's happening.

Over the last few years, the topic of "mid-level providers" in dentistry (and specifically, California) has been a hot one. Proponents and opponents of these providers have made their best arguments. There have been multiple votes and heated discussions by the CDA House of Delegates regarding this issue: Is there a real access to care problem that these alternative providers will help with? Or, is the problem really those not accessing care? This issue is definitely linked to the changing scales of reimbursement in the state.

In 2009, the state eliminated virtually all adult Denti-Cal services for 3 million Californians, resulting in an increasing number of people seeking emergency dental care at emergency rooms. This has not been unique to California. The number of dental emergency room visits in the U.S. increased from 1.1 million in 2000 to 2.1 million in 2010, according to the National Hospital Ambulatory Medical Care Survey. The survey also showed dental ER visits as a percent of total ER visits increasing from 1.06 percent in 2000 to 1.65 percent in 2010. The deterioration in private and public dental benefits coverage for adults has clearly created significant financial barriers to dental care—especially among young adults.

However, because of the advocacy actions of entities such as CALAOMS and the CDA, there has been some recent good news: The governor signed off on a new state budget plan that includes the restoration of adult Denti-Cal benefits slated to begin in May 2014. It still remains to be seen what effect the implementation of the Affordable Care Act (ACA) has on the dental marketplace. The ACA does not mandate dental benefits for adults, nor are dental benefits likely to be included in the essential benefit packages in insurance plans sold through most states' exchanges under provisions of the law.

This new state budget plan will not, however, come cheap. The proposed annual cost is $77 million, and coverage includes preventative care, restorations, and full dentures, along with extractions. This will certainly be an improvement, and CALAOMS, along with our friends at the CDA, is pleased to see lawmakers taking steps to improve what has been a real access to care issue. Lawmakers cited visits to various free dental clinics, such as CALAOMS-sponsored RAM California, as a reason for making the restoration of adult Denti-Cal a priority. Once again, CALAOMS is leading efforts with wide-ranging effects in the state of California.

The safety of oral and maxillofacial surgeons providing anesthesia services has once again come under attack. Various outside entities are more closely

examining what we do and how we do it. AAOMS is working on a nationwide study to help address these concerns with scientific data to answer our critics, but let me please remind you all of two important points: Oral and maxillofacial surgeons are committed to improving safety to decrease the inherent risk of surgery/anesthesia to the lowest level possible, and oral and maxillofacial surgeons have and will continue to lead healthcare in this area and we will train our residents in the safe and effective delivery of high quality care to our patients.

Lastly, recently, Robert Pack—who has aligned himself with Consumer Watchdog and Consumer Attorneys of California—filed a ballot measure for November 2014 to change MICRA. According to CAPP (Californians Allied for Patient Protection), the measure contains a provision to force a cost of living adjustment to MICRA's $250,000 cap on non-economic damages. Filing a ballot measure with the Attorney General is just the beginning of a long and costly process to qualify a measure for the ballot. This is not unexpected news for CALAOMS. We will be monitoring events very closely, and will be joining CAPP and the coalition of other dentists, physicians, hospitals, nurses, community clinics, local governments, labor unions, and business groups to mount a vigorous campaign to defeat the measure. Please join us in the support of such important work. We need the full support of the CALAOMS body presenting a unified voice to the public.

The CALAOMS Board of Directors will be having a strategic planning session on October 26th. You should hae recieved a membership survey a few weeks ago. Please respond to the survey and let us know your answers to the question related to the function of the organization. This will help us prepare for the future and better meet the needs of our members. Your responses are extremely important because they will ensure representative results. Your completed questionnaire will be seen only by Pam Congdon, our Executive Director, who will prepare a report from all responses. No responses will be associated with any particular person or practice. Thank you, in advance, for your cooperation in gathering this very important information.

As always, your CALAOMS Board thanks you for your membership and your support; and if anyone has any questions or comments related to current issues facing CALAOMS, please do not hesitate to contact me.

ATTENTION

CALAOMS MEMBERS!!!

The CALAOMS Board of Directors will be having a strategic planning session on October 26th. In order to help us prepare for the future and better meet the needs of our members, we are surveying our membership on how you feel about the organization and its function.

The survey will be online so that the results can be tallied immediately. Please respond to the survey as soon as you receive it. Your responses are extremely important because they will ensure representative results.

Your completed survey is completely anonymous. No responses will be associated with any particular person or practice. If you prefer to have a paper version of the survey mailed to your office, please contact Pam at the central office (800) 500-1332 and she will be happy to mail one out for you.

Thank you, in advance, for your cooperation in gathering this very important information!

WSOMS

Gerald Gelfand, D.M.D.

The WHATSTERN Society?

(Originally printed in the Compass, Fall 2007. Reprinted here with modification.)

It's time to take another look at the Western since a lot of you seem to have missed this the first time around.

If you're reading this article, you are no doubt a member of CALAOMS and AAOMS, but are you also a member of the Western Society of Oral and Maxillofacial Surgeons (WSOMS) (the Society)? Did you even know there is a WSOMS; and, if so, do you know its mission and purpose, what it does, and why you should be a member? If you answered "yes" to all of the above: Oh, you're the one!

As Immediate Past President of the WSOMS, I thought this might be a good time to answer some of these questions and to tell you why all California oral and maxillofacial surgeons should be members.

AAOMS has a national organizational structure composed of six trustee districts. District VI represents the western states of Hawaii, Alaska, Washington, Oregon, Idaho, Nevada, Utah, Arizona, and, of course, California. Obviously, we in California represent the largest of these member states in District VI. From the AAOMS bylaws: "the purpose of establishing trustee districts is to provide representation on the Board of Trustees for fellows or members of the states, the District of Columbia, the Commonwealth of Puerto Rico, including U.S. territories and counterparts (the five federal dental services)."

The bylaws of the WSOMS include its mission statement which reads:

The Society is a voluntary partnership of dental professionals working together to improve the quality of oral and maxillofacial surgery services in the community. It is the belief of the Society that professional, political, social and economic exchange between states of the Sixth District of the AAOMS will result in a unity of voice which will enhance our effectiveness in our community and at the national level.

The Society exists to improve health in membership communities and to promote the art and science of oral and maxillofacial surgery. The Society will:

- Promote inter- and intra-professional understanding and education.
- Attract new members and address their needs while continuing to address those of existing members.
- Promote participation at every level within the Society
- Encourage members to discharge their civic and professional responsibilities to the communities they serve.
- Provide education to the membership.
- Serve as a focal point for organizational and political issues pertaining to district six and offer assistance to component state societies and Society members in matters pertaining to oral and maxillofacial surgery.

- Provide, among its members, opportunities for social and professional community.

I know that some of you are thinking **BOR-ING**. Maybe, but take a good close look at what this Society stands for and I hope you'll also think **IMPORTANT** and **WORTHWHILE** supporting.

In simple terms, the Western Society provides a venue for an exchange of ideas, concerns, dialogue, and solutions on matters of common interest between the western states—both among our representatives and with our district Trustee who represents all of these states at the AAOMS Board of Trustees. It is a form of decentralization which helps to make our voice that much louder in what is otherwise a very centralized organizational structure and thus provides us with a platform for greater influence regarding our needs and concerns.

The Western sponsors an exceptional annual meeting which has traditionally been a family-oriented affair. These meetings have been held at various outstanding locations within the district, and each one is better than the one before. The locations have all been wonderful and special. Having attended many of these annual meetings, I can tell you from my own experience that they are absolutely great and a lot of fun with continuing education provided by some of the top speakers this specialty has to offer, and all kinds of outstanding and enjoyable functions including the traditional Western barbecue. Though attendance at these meetings has been steadily growing, it still remains unfortunately low. Try it, you'll like it.

The Western Board of Directors meets in person twice a year—once at the annual meeting and again at the end of August at the District VI caucus prior to the AAOMS House of Delegates. The caucus meeting is attended by the AAOMS delegates of the western states as well as our district Trustee and is a venue for exchanging the ideas and concerns of which I wrote previously, reviewing the resolutions and budget to be taken up at the AAOMS HOD, suggesting proposed resolutions from our district, and having an exchange with our Trustee regarding what's happening at AAOMS and what we'd like to see happen. If you didn't know it before, let me assure you that there are some great people representing not only California but our entire district who are committed to protecting your interests at the national level and keeping oral and maxillofacial surgery strong and independent.

If you're not yet convinced of the value of membership in Western so that it will always be there on your behalf, then here's the best news of all: the yearly dues are only $175.00. **That's right, just $175.00**. Now c'mon, nobody can complain about that one. So no more excuses, apathy, or lethargy or any other appropriate description. In the words of that real estate loan commercial that runs on the radio a*d nauseam* (at least in the L.A. area), joining Western is "the biggest no brainer in the history of mankind."

If you have any questions about Western or would just like to discuss it further, please contact me at (818)225-8602 or gelfoms@aol.com or our Executive Director, Linda MacDonald at wsoms@aol.com or (775)626-4478. She'll be happy to send you a membership application.

What Is Required For An Assistant To Work In The Oms Practice?

Most OMS practices employ dental assistants. Under California law, a dental assistant is a person who, without a license, may perform basic supportive duties that are technically elementary, reversible, and with little potential for patient harm. Dental assistants may only function under the supervision of a licensed dentist and are limited to performing only those duties specified by law. In the OMS practice, a dental assistant may place vital signs monitors and read and repeat monitor readings for interpretation by the dentist, remove sutures, and perform chair-side suctioning and retracting.

Continued on page 13

Advocacy Update

Bryce Docherty, CALAOMS Lobbyist

Legislative Update

SB 809: Controlled Substance Utilization Review and Evaluation System (CURES)

This bill, authored by Senator Mark DeSaulnier (D-Concord), will restore the robust and ongoing function of CURES, which is operated by the CA Dept. of Justice (DOJ). Ongoing funding for CURES will come from an annual $6 licensure fee renewal assessment on all controlled substance prescribers (i.e. dentists, physician, etc.) and dispensers (i.e. pharmacists).

CALAOMS was successful in seeking amendments to this bill that removed a mandate that oral and maxillofacial surgeons and other healthcare providers consult CURES prior to prescribing or dispensing any controlled substance.

CALAOMS expressed to DOJ and Senator DeSaulnier that not only was this mandatory requirement impractical, it would have also posed a legal liability in terms of what the oral and maxillofacial surgeon is expected to do with that information. Furthermore, oral and maxillofacial surgeons perform procedures that often result in acute pain and are not particularly treating patients suffering from chronic pain who can often times exhibit signs of drug-seeking behavior. Also noted was that if an oral and maxillofacial surgeon suspects a patient is "doctor shopping" for controlled substances, he or she will seek to protect the public by not only exercising sound clinical judgment but also common sense by consulting CURES. ***CALAOMS POSITION: SUPPORT***

AB 1174: Teledentistry

This bill, authored by Assembly Member Raul Bocanegra (D-Los Angeles), would fully embrace "teledentistry" in order to address increased access to dental care services. Notwithstanding the positive elements of this bill, it would also unfortunately and inappropriately seek to expand the current scope of practice of registered dental assistants and registered dental hygienists.

CALAOMS has expressed to Assembly Member Bocanegra that, at this time, AB 1174 should only focus on establishing "teledentistry" as a billable and reimbursed service in the Medi-Cal program, and also allowing registered dental assistants and registered dental hygienists to determine which radiographs to perform under supervision of a licensed dentist.

CALAOMS also noted to Assembly Health Committee Chair Dr. Richard Pan, M.D., that patients in need of high-quality dental care first deserve rigorous and scientific analysis of these same mid-level dental providers performing "interim therapeutic restorations," which would be authorized under AB 1174 and require the removal or caries using hand instruments and placement of an adhesive restorative material.

Therefore, CALAOMS is seeking an opportunity to unconditionally support AB 1174, but first has respectfully requested that provisions allowing registered dental assistants and registered dental hygienists to perform "interim therapeutic restorations" be deleted.

To that end, CALAOMS was successful in having this bill held in the Assembly Health Committee for the remainder of the year while further negotiations unfold to address these concerns. ***CALAOMS POSITION: SUPPORT IF AMENDED***

***** Micra Ballot Initiative Filed *****

On Wednesday, July 24th, Robert Pack (who has aligned himself with Consumer Watchdog and Consumer Attorneys of California) filed a ballot measure for November 2014 to change MICRA. According to Californians Allied for Patient Protection (CAPP), the measure contains a provision to force a cost of living adjustment to MICRA's $250,000 cap on non-economic damages. This provision will have the effect of increasing the non-economic damages cap to over $1.2 million if passed, with a mandated cost of living adjustment going forward. Filing a ballot measure with the Attorney General is just the first step in a long and expensive process to qualify a measure for the ballot.

The measure filed includes other provisions serving as "window dressing" relating to physician drug testing and prescription drugs. But make no mistake, the main purpose is to change MICRA to make it easier for lawyers to file lawsuits against dentists, doctors, hospitals, community clinics, and other health care providers, and generate big paydays. The measure would increase costs for consumers by billions of dollars per year while reducing patient access to health care providers.

This is not unexpected news for CALAOMS or CAPP. A campaign team has been organized to take the immediate first steps to fight a ballot measure. CALAOMS and CAPP will be monitoring events very closely, and if the trial lawyers proceed to collect signatures and qualify this measure for the ballot, CALAOMS will join CAPP and the coalition of other dentists, physicians, hospitals, nurses, community clinics, local governments, labor unions, public safety, and business groups to mount a vigorous campaign to defeat the measure.

Assistant Requirements ***Continued from page 11***

Although dental assistants are not required to possess a license, the laws changed in 2010 and they now must receive required training if they work continuously for more than 120 days in a dental practice. Training must be completed within one year of hire, and includes a board-approved course in infection control (8 hours), basic CPR, and California law.

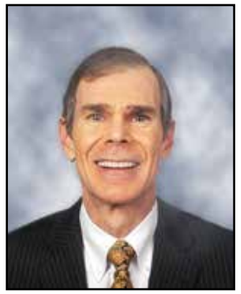
Dental assistants must also complete a board-approved course and receive a certificate in radiation safety prior to taking radiographs. The course of instruction must be, at a minimum, 32 hours and include didactic, laboratory, and clinical components. Cone beam CTs are considered a dental radiographic procedure, and dental assistants may take a cone beam CT, panoramic, cephalometric, periapical, or other dental radiographs.

Radiation safety courses are usually offered within educational programs only for enrolled students. Because of this, it can be difficult to find "stand alone" radiation safety courses for OMS assistants. Although the Dental Board provides a list of approved courses on its web site, it does not distinguish between "stand alone" courses and those offered only to program enrollees. It is, therefore, necessary to do some calling around to locate an appropriate radiation safety course. Some local dental societies offer courses, and these are usually a good bet.

Courses usually cost in the range of $700 plus supplies and require two weekends or more for completion. The assignments require periapical and bite wing radiographs that are not used extensively in the OMS practice making the benefit to the OMS practice somewhat limited. Nevertheless, the radiation safety certificate is a legal requirement that should not be overlooked. Certificates should be posted in the office in a conspicuous location along with other licenses and permits.

The Dental Board of California is in the process of reviewing and updating radiation safety regulations, so please watch for new developments in this area.

Bioethics



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

Critiquing Bioethics Literature – Reader's Perspective

Most bioethics writing is both graceful and lucid; however, there are desert spaces of dreary prose. While authors avow that their text is written for a general audience, there are frequent instances where authors make use of shorthand references and abbreviated arguments that are clearly geared toward the understanding of the coterie of medical ethicists and not toward the understanding of general readership. There are times when authors become somewhat esoteric in their writing, going off into a tangent that is difficult to follow for the general reader. However, for the most part, their presentation is logical, rational, and offers the reader not only a foundation for medical ethics and practice, but also insight into the complexity of the decisions that face healthcare practitioners. Additionally, it is clear that the publications will hopefully provoke rich reflection for any physician seeking new light on the questions duty poses in daily practice.

Authors accurately define the parameters of the ongoing ethical debates that wage over the shifting needs and perceptions of society, the greatest of these being the pull between paternalism in medicine and its recognition of individual autonomy. For centuries the expertise and opinion of the physician has been regarded as sacrosanct, indisputable and unassailable in the ivory tower provided by completely paternalism. This paradigm has been assailed by sociological developments that have put an equal emphasis on individualism and autonomy, that is, the idea that the patient has some say in what should be defined as for the patient's good.

While authors readily acknowledge the principles of patient autonomy and assert that the patient's wishes should be an integral part of the decision making process as to treatment options, authors also seem, at times, extremely reluctant to relinquish all aspects of paternalism. For example, many argue vehemently against the idea that all aspects of clinical decision making should be subjected to negotiation, as some goods are more important than others and cannot be violated without destroying their purposes of medicine itself. This suggests a reluctance to relinquish the paternalistic role; however, many authors make their position clearer and this locates them squarely within the realm that they outline, which is beneficence, to wit, to do what is "good" for the patient.

One of the areas in which this stance is clearly delineated is in regards to the physician's position of "gatekeeper" to healthcare facilities. Many authors posit their interest is not in maintaining social power for physicians, but rather in social justice, that is, in safeguarding the "good" of the patient. The traditional position of "gatekeeper" identifies the physician as being responsible for using only those diagnostic and therapeutic modalities that are beneficial and effective. However, managed medicine, HMOs, PPOs, and the whole alphabet soup of managed care, has introduced various forms of pre-payment systems, which depend on their fiscal viability on physicians limiting the use of health care services, which many authors identify as morally dubious.

A model of gate keeping is to promote the use of healthcare facilities and services for personal and/or corporate profit, which is morally indefensible. As this illustrates, many authors accurately summarize the dilemmas surrounding the problems of health insurance, as well as the ethical dilemmas confronting physicians on such issues as near-death clinical decisions.

Clearly, most authors do an exemplary job of illustrating how complex bio-medical issues are in today's healthcare system. One area of discussion that is particularly intriguing is concerning the case of Nejdl and Barber, two California physicians who were indicted for murder for withdrawing food and water from a patient who had suffered cardiac arrest. In this case, the authors maintain that beneficence dictates that we ascertain, to the best of our abilities, what serves some beneficial purpose in a patient who is in a permanent vegetative state. In this regard, authors concluded that if procedures, such as hydration, make a patient more comfortable and do not impose severe burdens, they ought to be continued. However, in the case of a comatose patient or one in a persistent vegetative state it is impossible to determine whether or not withholding food or hydration causes discomfort. Authors propose that the principle of beneficence dictates that physicians should give the patient the benefit of any doubt. Furthermore, they state that in this case, hydration may be more important than nutrition and, if not burdensome, ought to be continued. This argument brings to mind the controversial case of Terri Schiavo, in which Schiavo's husband battled legally with his in-laws in order to have Terri's feeding tube and hydration discontinued.

The Schiavo case hinged on the medical evaluation that Terri was in a persistent vegetative state. However, her parents were convinced that they saw purposeful activity from Terri when they visited. It took Terri Schiavo 13 days to die from starvation and dehydration, which is a gruesome death if there is any cognition present, even at an infantile level. Regardless of whether or not her parents' evaluation was accurate, the decision in this case seemed to ignore the concept of beneficence-in-trust. However, as this indicates, certainly the presentation of beneficence and the model for its application gives cause for reflection on the circumstances of this and similar cases.

Bioethicists provide a service to society and the medical community by providing this insightful examination of medical ethics and by offering a detailed model for evaluating ethical decision making. However, authors must also be realistic in their position and, therefore, realize that the search for common ethical principles to resolve dilemmas arising in conflicts is sometimes fruitless in a pluralistic society. This conclusion has implications for legislators and the courts, as these policymakers will occasionally attempt to formulate legal doctrine that is designed to delineate medical practice along what are considered by the lawmakers to be moral lines. In particular, this observation seems to negate the possibility of formulating effective legislation that can comprehensively address when abortion is moral or ethical. The circumstances are simply too diverse, which means that such decisions, as many authors indicate, should be left to the parents, and guided by their physicians.

In my opinion, it can be seen that regardless of whether or not the reader agrees fully, partially or rejects the conclusions of the bioethics author, reading carefully is important as it promotes contemplation on some of the most problematic ethical issues of our time.

The Compass - Summer 2013

Technical Articles

Marsupialization as Conservative Treatment of the Keratocystic Odontogenic Tumor: Report of a Case with Discussion of other Treatment Modalities and Histochemical cellular markers

by Stan Hanes, DDS,
Fariborz Farnad, DMD,
Nasser–Said-Al-Naief, DDS, MS

The odontogenic keratocyst (OKC) is a benign odontogenic cyst that was initially described more than half a century ago.[1, 2] OKC is well known for aggressive behavior, high tendency for post-surgical recurrence and extensive expansion and bone resorption.[3] Based on selective, well-defined molecular features, the WHO (World Health Organization) favored re-classifying the cyst in 2005 as an odontogenic tumor, namely KCOT (Keratocystic Odontogenic Tumor).[2] While authorities have uniformly acknowledged the aggressive nature of OKCs and the need for definitive appropriate intervention in its management, preferably at earlier stages, various treatment modalities have been implemented and suggested with a variable incidence of recurrence.[1-4] These include decompression, marsupialization, and enucleation with or without excision of overlying surface mucosa and utilization of adjuvant therapies including mechanical curettage, chemical curettage with Carnoy's solution, cryosurgery, and resection.[4-15] In the present case, we report successful management of a large OKC/KCOT managed with marsupialization with excellent post-operative results. Since several authors and clinicians continue to use both terms interchangeably, the terms OKC and KCOT are being use to describe the same entity interchangeably in the present report.

CASE PRESENTATION

A 21-year old Asian female presented to the OMFS clinic at The University of Southern California in September 2011 for further evaluation of a left mandibular cyst, pericoronal to tooth #17. The periapical radiograph that she presented with was suggestive of a cyst in the area of tooth #17. The patient

was asymptomatic and denied any neurosensory deficit associated with the left inferior alveolar nerve. Past medical history and physical examination were unremarkable with no known genetic conditions, syndromes, systemic and/or cutaneous pathologies; head and neck examination was essentially unremarkable. The teeth on the left mandibular quadrant appeared to be in good status.

A CT scan showed extensive bone resorption that encompassed the left ramus, angle, and body of the mandible extending from the sigmoid notch to the mandibular first molar. A large multilocular cystic lesion in the left angle of the mandible displaced impacted #17 was identified (Fig. 1).

Under local anesthesia of 2% Lidocaine with 1:100,000 epinephrine and Nitrous Oxide/Oxygen inhalation analgesia, the lesion was marsupialized and decompressed via the buccal sulcus, and the roof of the cyst was removed and sent for histological examination. A silastic catheter was sutured to the oral mucosa in order to keep the opening patent and for irrigation.

Histologic examination revealed an odontogenic keratocyst (OKC) (KCOT) (Fig. 2), evidenced by a well-defined cystic cavity lined by a 6-7 cell layer of keratinocytes that were covered by a wavy parakeratinized surface. The basal layer of the cystic epithelium demonstrated a distinct palisaded pattern and the epithelial connective tissue junction was flat and lacked rete ridges. The connective tissue-epithelial interface also exhibited a distinct artifactual separation. Minimal chronic inflammation was identified in the dense fibrocollagenous connective tissue wall. Immunohistochemistry staining with Bcl-2 (Ventana; predilute) demonstrated dense positive staining at the palisaded basal layer of the cystic epithelium (Fig. 3).

In March 2012, the patient appeared in clinic for further evaluation and definitive removal of the cyst, along with removal of impacted tooth #17. The radiograph displayed significant bone regeneration (a ground-glass appearance) and movement of tooth #17 superiorly and mesially (Fig 4).

Figure 1. Note the extent of the large multilocular lesion extending from first molar to the area of the ramus and sigmoid notch. Tooth #17 is displaced inferiorly to the mandibular angle.

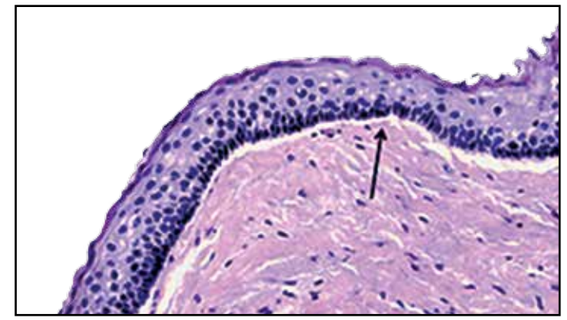


Figure 2. Initial biopsy demonstrated typical diagnostic features of OKC. The cyst demonstrated a uniform 6-8 cell layer thickness with a distinct palisaded pattern of the basal cell layer and a wavy parakeratinized surface. The cyst showed no rete ridges and exhibited clear epithelial connective tissue junctional separation (arrow)

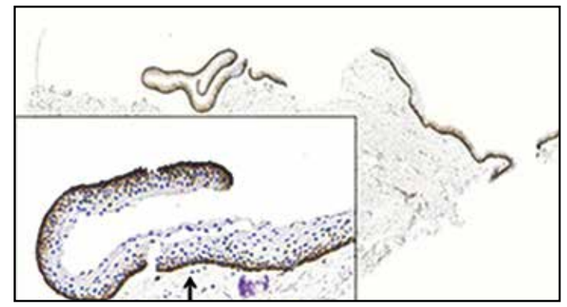


Figure 3. Immunohistochemistry of the original biopsy with Bcl-2. Positive staining was distinctly restricted to the basal layer of the epithelium with focal rare parabasilar staining (insert, arrow)

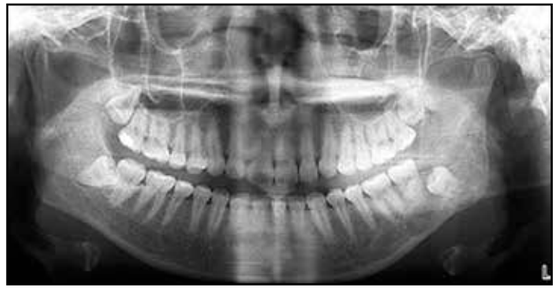


Figure 4. Six months post-marsupialization showing significant bone regeneration in the left mandibular ramus with movement of tooth #17 superiorly and mesially

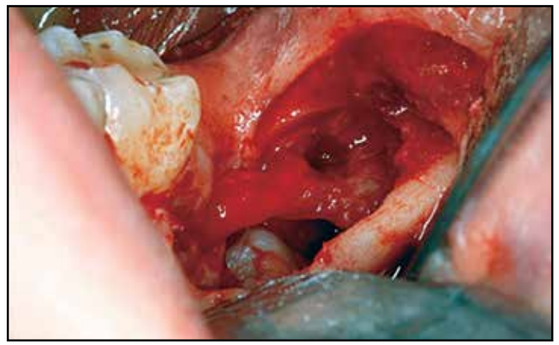
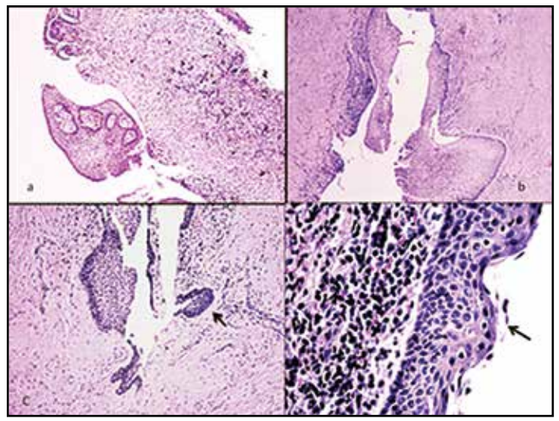


Figure 5. Enucleation of the OKC and impacted tooth #17 (white arrow)



Figures 6a-d: histomorphology of recurrent inflamed OKC. Figures a and b: majority of cystic epithelial lining shows little characteristic features of OKC described in figure 2. Figure c: area of basal layer palisading (small black arrow). Figure d: vaguely palisaded basal cell layer with wavy attenuated surface parakeratin (black arrow)

Under local anesthesia of 2% Lidocaine with 1:100,000 epinephrine and IV sedation of Versed and Fentanyl with N_2O –O_2 supplementation, the cyst was enucleated and #17 was removed (Fig. 5). The histomorphologic features were different from those of the initial biopsy. A major portion of the cystic lining demonstrated hyperplastic stratified squamous epithelium with absence of surface parakeratinization (Figs. 6a and 6b). However, portions of the cystic epithelium demonstrated a palisaded pattern (Fig. 6c) with inconspicuous surface parakeratinization (Fig. 6d). Of significance, the cystic wall supported a generalized mononuclear inflammatory cell infiltrate of moderate density. Immunohistochemistry staining with Bcl-2 (Ventana; predilute) demonstrated dense positive staining identified throughout the hyperplastic thickened epithelial lining (Fig. 7). The diagnosis of odontogenic keratocyst (OKC) (KCOT) was verified.

The patient returned 5 months later and panoramic radiograph reveals complete bony healing without any signs of recurrence (Fig. 8). The patient is scheduled for yearly follow-up visits and will be closely monitored for potential recurrence.

DISCUSSION

OKC is a benign but locally aggressive cyst that has been regarded by the WHO as a benign odontogenic tumor based on its well-documented aggressive behavior and well-characterized molecular features (2). The incidence of keratocystic odontogenic tumors (KCOT) in the general population is reported to be 11% and although they are benign odontogenic tumors, they are locally aggressive and have a tendency to recur after treatment, with recurrence rates that range from 3% to 60%. It is recommended that KCOT be followed for a 5-year period due to the high recurrence rate.[7]

Partsch first described marsupialization in 1892. In recent years, the terms decompression and marsupialization have been used interchangeably. However, technically they have different meanings. Decompression implies any means to reduce

pressure from within a keratocyst. Thus, *marsupialization* is a means of decompressing a cyst, and so is the insertion of a small drainage tube of some kind. Marsupialization in its true sense means the conversion of the cyst into a pouch, and this implies the creation of a stoma or opening capable of maintaining itself.[15]

KCOTs can be treated by either enucleation or marsupialization depending on the size, location, and proximity to vital structures without damage to the vital structures. Marsupialization has been used as a more conservative form of treatment for large KCOTs to minimize the cyst size and limit the extent of surgery.[3] Complete enucleation is performed as a second stage procedure later when sufficient bone has been deposited and vital structures have been saved from damage.

Recent reports have found evidence showing that decompression or marsupialization alters the epithelial lining of KCOT into a lesser aggressive form. Some tumors reportedly completely resolved both clinically and radiographically, and this concept is held to be true for any potential residual tumor island that remains in the cavity while using the open healing technique. The recurrence rate is held to be the same as enucleation combined with adjunctive therapy such as the application of Carnoy's solution.[7]

It has been noted that the cystic lining in OKCs undergoes histologic changes following decompression and marsupialization and eventual replacement by oral type epithelium.[4] Basic histomorphologic and immunohistochemical changes are reported secondary to inflammation in OKCs. The comparison of histochemical markers between inflamed and non-inflamed cysts as well as the favorable relationship between inflammation and keratocysts has been addressed with enthusiasm. It is strongly believed that the presence of inflammation can change the biologic behavior of the keratocyst to a lesser aggressive lesion, in addition to changing the histomorphology of the cystic epithelial lining in an otherwise classic OKC.[4, 7]

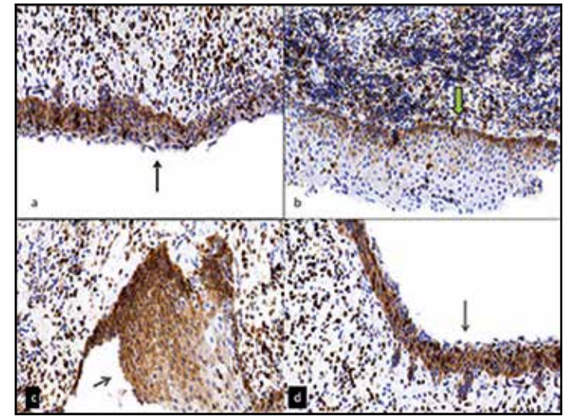


Figure 7. Immunohistochemistry staining from the recurrent inflamed OKC with Bcl-2. Figures a, c, and d: positive staining was distributed throughout the epithelial thickness in the inflamed epithelial lining (black arrows) when compared to a more confined basal/suprabasilar staining with scattered non-specific positive staining in areas where the palisaded pattern was more evident (figure b; green arrow)

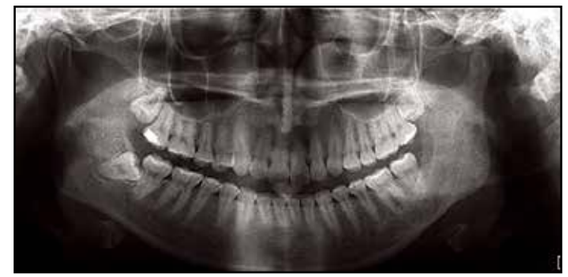


Figure 8. Complete bony healing of left ramus and body without evidence of recurrence

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Fair and Balanced Reporting???

When is the last time you heard this phrase and actually believed it?

News today is all about sensationalism, hype, and trying to get the lead story for the evening news. I say this from both personal observation and personal experience.

Recent mishaps in OMS offices statewide and nationwide have appealed to our news media in their zest for the opening segment. This has heightened CALAOMS' awareness and brought the topic of dealing with the news media to the top of our agenda. CALAOMS is actively pursuing training and obtaining information about getting materials, talking points, position statements and pamphlets about OMS and their training.

I feel it is critical for us to be prepared as a specialty and organization when confronted with the news hungry media. I say this from recent personal experience after having the media hound me—and I mean that literally—to comment on a recent anesthesia mishap in an OMS office. The interview took about 30 minutes, where I expressed heartfelt condolences and explained in depth our training and track record of safety. In the end, after all the selective editing (on their part), the news channel had about a 3 minute clip with fragments of my interview played out to not put OMS in a very good light.

The thing I learned from this experience was to demand final say on the editing of the segment before it is aired! We want our members to know that in the event of an office mishap they can call CALAOMS headquarters immediately for advice, assistance, and support in any manner needed.

by Albert W. Lin, DDS

Risk Management Corner

Lyme Disease: Delayed Diagnosis Is Greatest Risk for Healthcare Providers

By Julie Song, MPH, Patient Safety/Risk Management Account Executive, The Doctors Company

Lyme disease, a bacterial tickborne disease, is one of the fastest-growing infectious diseases in the U.S. Summer is peak season, and most people are bitten by blacklegged ticks, which are small and difficult to see. Lyme disease progresses in phases: early localized disease with skin rash and flu-like symptoms, followed by disseminated disease with heart and nervous system involvement (palsy and meningitis), then late disease with severe fatigue, neurocognitive symptoms, and severe joint and muscle pain leading to physical disability. The challenge is diagnosing this disease in the early phases, when treatment is typically curative.

A claims review found that the main liability risk for Lyme disease is system issues that result in delayed diagnosis. The chief system issue is communication failure in reporting test results to the healthcare provider. In one case, the patient had ongoing headaches, nausea, and vomiting. Although the patient did not recall a recent tick bite, the patient lived in an area with a high incidence of Lyme disease. The provider ordered a Lyme screen, which was positive. A confirmatory test was also positive. The lab faxed the report to the provider and contacted the health department. However, the provider claimed he had not received test results.

The flu-like symptoms of early Lyme disease mimic a viral syndrome, so providers need to consider Lyme disease in their differential diagnosis whenever they see patients with this presentation.

Tips to help make an early diagnosis include:

- Because ***most*** people do not recall a tick bite, ask about recent travel or outdoor activities.
- According to the Centers for Disease Control and Prevention (CDC), in 2011 96 percent of cases came from Connecticut, Delaware, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, New York, Pennsylvania, Vermont, Virginia, and Wisconsin.
- In the early phases, 70 to 80 percent of patients will get a red, spreading rash that can appear anywhere on the body.
- The classic rash has a bulls-eye appearance with a red outer ring surrounding a clear area, but the rash may ***not*** have this appearance.
- Fatigue, chills, fever, swollen lymph nodes, headache, muscle, and joint aches are common early symptoms.
- Early phase blood tests are typically ***negative*** because antibodies have not yet developed. Therefore**,** a negative test does not rule out Lyme disease.
- Those patients who develop a rash ***should be*** treated with antibiotics.
- Remain current on CDC guidelines regarding diagnosis and treatment.
- Oral antibiotics commonly used with adults include doxycycline, amoxicillin, and cefuroxime axetil. For children younger than 8 years old, amoxicillin is recommended.
- Have a system in place for following up on lab test results.
- Advise patients to avoid tick-infested areas, use insecticides containing DEET, and conduct daily exams for ticks on themselves, their children, and their pets.
- If they find a tick, advise patients to gently remove it with tweezers and save it for identification.

THE DOCTORS COMPANY

CALAOMS to Present a SimWars™ Competition at the 2014 January Anesthesia Meeting

What's a SimWar?

SimWars™ is an unscripted, simulated competition in which anesthesia team's work together to save the "patient" from an emergency situation. Following each simulation encounter, a panel reviews the scenario and debriefs the team, and the audience participates via an electronic response system. The result is an exciting, interactive event that engages not only the SimWars™ teams, but also the audience. **We will need 16 members to form four teams to compete.**

The SimWars™ Competition will take place during day two of the CALAOMS 2014 January Anesthesia Meeting, on Sunday, January 19th in San Francisco. **Those first 16 team members that sign up for the competition, register for the two-day meeting and participate in the actual team competition, will receive a $200 refund at the end of the program. That makes your registration fee half price!**

Entry Registration

To register, email your team entry with the subject line "SimWars Entry" to attention Teri Travis, CALAOMS Continuing Education Services coordinator, at teri@calaoms.org. Include the team member's names, and the name, phone number and email address for the team contact. Entries must be received by October 1st. Team contacts will receive final confirmation that their team is competing by November 1st. We will provide you with the scenarios ahead of time.

For more information about the 2014 SimWars™ Competition, contact Teri at teri@calaoms.org or call toll free (800) 500-1332 ext. 13.

Upcoming 2013-14 CALAOMS CE Events

Residents' Night Presentations September 11, 2013	**Southern CA**	**January Meeting** January 17-19, 2014	**San Francisco**
OMSA North 2013 September 28-29, 2013	**Foster City**	**Residents' Night Presentations** January 29, 2014	**Northern CA**
OMSA South 2013 October 19-20, 2013	**Santa Ana**	Risk Management February 5 and 19, 2014	North and South TBD
Medical Emergencies* November 6, 2013	**San Ramon Marriott**	**ACLS** March, 2014	**Solano**
ACLS November 16, 2013	**Solano**	**14th Annual Meeting** May 3-4, 2014	**Newport Beach**

OMSA Online Classes - Status Still Unknown
We will update the membership when we have more information.

** The Medical Emergencies course will be alternating between Northern and Southern California Locations each year.*

Classified Ads

Equipment For Sale

Reduced! iCAT Excellent Condition, used Next Generation Platinum with Extended Field of View. Includes monitors, Codonics medical printer and supplies. Warranty available and selling due to lack of utilization. Asking $95,000. Please contact Frank A. Portale DDS at 209-481-9307.

Practices for Sale

Coastal Orange County OMS office available for immediate sale. 2,100 sq ft +/- office was built in 2010, contains two consult rooms and two operatories. Fully equipped including CO2 monitors, an EMR ready computer network and Kodak digital x-ray. Contact Brady Price & Associates (925) 935-0890) or email Scott Price at scottp_brady@sbcglobal.net. All inquired held strictly confidential.

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Looking to purchase an OMFS office in Southern California (LA and surrounding areas). Please email me at omfsbuyer@gmail.com if interested.

Associate/Partnership Opportunities

California, Full time position with opportunity for buy-in. Position includes two practice locations. Clear Choice Dental is located in San Jose and our private practice is located in beautiful Santa Cruz. Full scope practice specializing in Orthognathic surgery, implants and wisdom teeth. Please e-mail resume to Dr. George M. Yellich at gmyel1@aol.com, or call Dr. Yellich at Clear Choice Dental (408) 556-9587, or Santa Cruz Oral and Maxillofacial Surgery at (831) 475-0221.

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Sacramento Kids Care Dental Group is looking for a talented oral surgeon to join our team 3-4 days a month. With six offices and TONS of maturing kids (LOTS of 3rds) we have way too many referrals for our one doctor to handle. Private patients, an amazing team, and a proven recipe for success. Please email Derek Boyes at dboyes@kidscaredentalgroup.com to discuss the opportunity in more detail.

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