



the **W**esterner

Volume 23, Issue 1
Spring 2010

President's Message



DR. STEVEN BEADNELL

As I sit down to write my President's Message for this spring edition of *The Westerner*, I can't help but be somewhat reflective. A dentist in my community who often referred to my practice passed away this last week and his memorial service was yesterday. It is true that life is short and only the good die young. Mike was an unequalled mentor, friend, colleague, father, coach, grandfather and a great dentist and friend to his patients. In his obituary it mentioned that one of Mike's teachings was that we all must find a balance between family, friends, work and faith. It seems like most of my OMFS colleagues, myself included, have not done too well in this "balance of life" game. To everyone, please take time to tell your family, friends and patients how much you appreciate them and the importance they play in your life. We all need to work daily on keeping things in balance and showing those around us how important and valued they are in our lives.


To that end, we have a great program scheduled for the WSOMS meeting in Sunriver July 2-5, 2010, but there is also much to do to help keep us all in better balance. Dr. Daniel Cullum, one of our members, will present for two days. On the third day we will highlight our district's residents and the residency programs with presentations. But maybe equally as important is the "Fun in the Sun" that is available in and around the Sunriver Resort. Sunriver, a beautiful resort in Central Oregon, is a wonderful spot for a vacation with your family with activities for every



age level: hiking, biking, rafting, sightseeing, fishing, or just lying by the pool. For those of you who want to be pampered, the new Sage



Springs Club & Spa is a wonderful place. Be sure to pack your best blue jeans and cowboy hat for the Western BBQ. We will be having the golf tournament on the Sunriver Meadows course, a beautiful course that can be played by golfers of any skill level. While fireworks are not allowed in Sunriver due to the fire danger they pose, there is a great fireworks display a short drive away in Bend off of Pilot Butte. Hope to see you and your family there, working on the balance of life as we enjoy a great time in Central Oregon.



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Invite a Resident to the Annual Meeting

We are again inviting residents from the programs in District VI to join the Western Society and to attend our annual meeting at Sunriver Resort. Residents may come to the meeting as our guests for the scientific sessions and social events including the Western Barbeque Dinner. In addition, we can offer some financial assistance (up to \$500) to offset other expenses they may incur such as travel, meals and lodging.



If you are friends with one of the program directors ask them to consider having one or more of their residents consider attending this year's meeting. Program directors or residents can receive more information on this by contacting the central office at (775) 626-4478.

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Don't forget to Register for the Meeting



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ORAL & MAXILLOFACIAL SURGEONS
JULY 2-5, 2010**


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**PLAY GOLF ON THE RENOWNED
MEADOWS COURSE
BIKE, HIKE, FISH, SWIM,
AND RELAX WITH US.**


CONT. ON PAGE 5

Are You Reading Your Journal of Oral & Maxillofacial Surgery?

Here are some questions from articles in three recent *OMS Journals*. The editorial board has always attempted to select articles of relevance to one's everyday practice. Hope you find the questions of interest.

-  1. A patient presents in your office with a squamous cell carcinoma in the floor of his mouth. You realize the following to be true regarding this type of pathology.
 - a. The size of the lesion is the most important factor in the prognosis of the case.
 - b. The location of the lesion is the most important prognostic factor.
 - c. The degree of pain experienced by the patient is the most important prognostic factor.
 - d. The presence of neck lymph node metastases is the most important factor in the prognosis of the case.

-  2. A 57-year-old white male presents with a painful swelling in the right submandibular region present for the past two days. You suspect a salivary gland obstruction. You believe the following to be true.
 - a. A pan-o-rax X-ray is of little value in the initial screening of patients with suspected obstruction of a submandibular gland.
 - b. With the refinement of intravenous catheters, sialography has become a painless procedure and easier to perform.
 - c. Magnetic resonance sialography is sufficiently sensitive enough when salivary stones are present to detect their presence.
 - d. The majority of patients undergoing sialography experience moderate discomfort.

-  3. Following the removal of an upper left first molar tooth you note an oral antral communication larger than 5mm in the region of the lingual root socket. You consider as to how best to manage this communication.
 - a. Biodegradable polyurethane foam should be considered to be placed in a socket with a sinus communication.
 - b. The advantage of a surgical procedure such as a buccal flap is far more appropriate than the placement of polyurethane foam in the closure of a sinus communication.
 - c. A disadvantage of polyurethane foam placement to close a sinus communication is the possibility of the displacement of the foam in the socket.
 - d. There is somewhat more discomfort following the placement of polyurethane foam than when a surgical flap is used to close an immediate sinus opening.

Are You Reading? (cont.)

- ? There has been an increase in the number of drugs presently available for office use for sedation purposes for the oral and maxillofacial surgery patient. One such drug is dexmedetomidine. You know the following to be true regarding this drug.
- Should a patient have a low heart rate baseline because of treatment with B blockers, dexmedetomidine is satisfactory for sedation in office procedures.
 - One must realize dexmedetomidine is frequently responsible for an increase in blood pressure of as much as 20%.
 - An advantage of dexmedetomidine is in its minimal respiratory effect.
 - Dexmedetomidine when used alone results in a rapid recovery period.
- ? 5. You are considering a complex orthognathic surgical procedure and, to be on the safe side, you are considering blood replacement. You know the following to be true.
- In most cases the patient's medical insurance will deny blood banking costs when blood is to be used in orthognathic surgical procedures.
 - Allogenic blood transfusion is the collection and then transfusion of a patient's own blood.
 - There is no difference at the present time in the risk of transmitting viruses such as HIV with the transfusion of autogenous blood as compared to allogenic blood.
 - Intraoperative blood collection techniques are considered inappropriate for orthognathic surgery.
- ? 6. You are called in to consult on a patient with a facial fracture resulting in an orbital wall defect. You are aware the following to be true in these types of cases.
- Intractable enophthalmos and diplopia most frequently are detected within a week after trauma.
 - Computer-aided surgical simulation (CASS) may help plan bone graft positions before surgery to recover appropriate orbital volumen.
 - Enophthalmos and eyeball shifting always will lead to diplopia.
 - Titanium mesh is difficult to contour and for that reason is difficult to use in orbital wall reconstruction.

Bonus Question:

7. How many players are there on a soccer team?
- 5
 - 9
 - 11
 - 12

Answers on page 9



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District VI News

Dear Colleagues,

As this ends the first quarter of 2010 the Board of Trustees has met on two occasions and has had several conference calls to discuss matters pertaining to the business of the AAOMS.

I have attended all of the meetings so far and the next face-to-face meeting will be the offsite meeting in Jackson Hole, Wyo. This will be a five-day meeting in which the Board of Trustees will review all items to come before us that have not been reviewed as yet and any new items that we have not discussed so far, as well as meetings with the *JOMS* editor, the *AAOMS Today* editor, ABOMS, OMSNIC and the Foundation.

Of importance to all of us will be the information from the May officers meeting with the AMA officers to discuss the issue of the AMA's data series on the scope of practice for OMFS. This has been an issue that I am sure you are aware of and has significant concerns for all of us in practice or academics. Previous mailings from our president Dr. Cheifetz have kept us all up-to-date on the proceedings as far as the AAOMS is concerned. I believe we will have a positive outcome from the meeting that we will all be aware of after the June BOT meeting.



DR. HENRY WINDELL
DISTRICT VI TRUSTEE

You may access the document on the member's page on the AAOMS website and learn exactly what the AMA has determined, from their prospective, what the education of the OMFS is. Please take the time to review the document, if not only to educate yourselves on the document but also on the direction the AMA is going. This is one of 10 data series on non-medical specialties, but OMFS is the only dental specialty in the group.

The leadership conference was held in Chicago in March and was well attended by representatives from District VI; however, not all states were represented and we would like to see all of our states represented at the 2012 conference.

Day on the Hill was held on April 21st this year and was also well attended with approximately 100 OMFSs across the country as well as several from District VI. I would, of course, like to see more of you attend as we need to have a voice in Washington. Any personal relationship you may have with a Senator or Representative from your state is vitally important to the issues we have to discuss. Most of the issues we passed on to the legislators were not items that appeared in the Health Care Reform Bill recently passed by Congress, so informing the staff and/or the legislators themselves was important.

As always, we are behind in contributions to the Foundation in the Reap Campaign and we need to move forward. The importance of research and technology depend on funding from that source and deserve our attention. My thanks to those of you who have contributed. Following that is the OMSPEC donation to fund our lobbying efforts at the national level, which is vitally necessary for the changes we wish to see in health care as it relates to dentistry and OMFS in particular. I full well realize that giving is at a lower level due to the economic strains placed on all of us and the changes happening around us that we have little or no control over. However, the only

CONTINUED ON PAGE 8

District VI, (cont.)

CONTINUED FROM PAGE 7

way to change these local issues is to have a strong financial response to our association with which to make the changes necessary to strengthen our position and practice as we know it can be. I have so far visited several of the states in the District and have more to do, but the response has been good and I believe we are doing as well as the other Districts are doing with our obligation on the anesthesia evaluations.

I look forward to seeing you either in the state visits or at the Western meeting in July. Until then, the best to all of you in the near future.

Sincerely,

HANK



President's Message

CONTINUED FROM PAGE 1

As this is my final opportunity to try to impart some of my philosophy to the members of this organization, I will ask you all to endear me a few moments to get on a pulpit and preach a little. If you have access to one of the dental schools or residency programs in our district and are not involved in some way, it is time to wake up. Referral patterns and relationships with the specialists within dentistry are well established in the dentists' minds well before they leave their dental school. I firmly believe that OMFS are the best trained and capable "oral surgeons" in the dental field, but establishing a relationship with the general dentists and our other dental specialists starts well before graduation. One of the most rewarding experiences I have had in my professional career is being on the staff at OHSU School of Dentistry, working with the undergraduate students and residents in the OMFS clinic. At the dental school level is where we build the relationship between our specialty and the dentists soon to be in your community. Referral patterns and mindsets of the dentists are based on their experience in their time at school. If you aren't giving back, please consider doing so ... and that means being there. Sure, giving money to the university helps the institution, but being there to establish the relationships with the future dentists in the community will pay dividends to our profession for years to come. I hear many of my colleagues complain that some of the "bread and butter" oral surgery procedures are being referred to other specialists in our field ... maybe that is because they established a stronger relationship between the students and their specialty group during the "formative years" in the dental student's education process. I know many of you are involved in dental school programs at a variety of levels — to you I give great thanks for helping establish the dentist-OMFS relationship and promoting our specialty. To those of you with access to a dental school who aren't involved in promoting the OMFS department in your school ... be there, get involved, make a difference in the future of our specialty!



Life is Short

They say it takes a minute
to find a special person,
an hour to appreciate them,
a day to love them,
but then an entire life
to forget them.

Are You Reading Your Journal? (cont.)

JOURNAL ANSWERS

Answers:

1. d
2. b
3. a
4. c
5. d
6. b
7. c

References:

1. d Capote-Mareno, et al: Prognostic Factors Influencing Contralateral Neck Lymph Node Metastases in Oralpharyngeal carcinoma. JOMS 68.2 pp268-280 Feb. 2010
2. b Hasson O: Modern sialography for screening of salivary gland obstruction. JOMS 68.2 pp 276-280 Feb 2010
3. a Visscher SH, et al: Closure of oral antral communications using biodegradable polyurethane foam: a feasibility study: JOMS 68.2 pp281-286 Feb 2010
4. c Makary L, et al: Prolonged recovery associated with dexmedetomidine when used as a sole sedative agent in office based oral and maxillofacial surgery procedures. JOMS 68.2 pp386-391. Feb 2010
5. d Posnick JC: Blood replacement practices for complex orthognathic surgery: a single surgeon's experience. JOMS 68.1 pp54-59 Jan 2010
6. b Tang W, et al: Individual design and rapid prototyping in reconstruction of orbital wall defects. JOMS 68.3 pp562-570 March 2010
7. c Reference: World Book

HOW DID YOU DO?

Six Correct Board President
Five Correct Professor
Four Correct Assistant Professor
Three Correct Lecturer
Two or Less Let's spend more time on
the Journal!



Resident's Corner

Oregon and the Future Members of our Specialty

Leon A. Assael, DMD

Readers of *The Westerner* would like to know what our residencies are like today. Oregon is a program that could be called a "type 3 residency." Type 1 residencies are the most traditional with a large ambulatory experience and involvement of full- and part-time faculty. In the 1970s and '80s Type 2 residencies emerged that were based upon the new advanced scope of the specialty especially in orthognathic and TMJ surgery and related areas. These were often staffed with full-time hospital based faculty. Today, fellowships and a broad range of new surgical skills have created Type 3 residencies with major emphasis on tumor surgery or craniofacial surgery or similar subspecialty endeavors. For Oregon, this has been most importantly in the arena of tumor surgery and reconstruction with additional endeavors in microsurgery, nerve repair, navigation reconstructive surgery, tissue engineering, and minimally invasive/endoscopic surgery. What is it like to be a resident in the Oregon program? Two senior sixth-year residents, Scott Sklenicka and Tim Osborn, were interviewed for this article.



Describe for our *Westerner* readers what a typical week on OMS service in Oregon is like?

Scott: Every day starts out with early morning rounds at both OHSU and Legacy hospitals. This usually includes a large number of patients, which includes trauma patients, head and neck cancer patients, as well as routine consults and other surgical patients. Upper level residents spend six months at each hospital. When at OHSU the day is split between OR cases and clinic, which is busy five days a week. Many times there are multiple operations being performed at the same time, with IV sedations and consults being performed in clinic as well. The lower level residents are also covering the dental school clinic and performing office surgery as well.

Conferences are held both Monday and Friday mornings. Monday tends to be lecture based on differing subjects, presented mainly by residents. Friday mornings are case-

based discussions on interesting cases throughout the past week.

When at Emanuel, every day of the week is filled with OR cases except Fridays, which is the dedicated trauma follow-up clinic for residents. These cases run the entire spectrum of oral surgery, from OKC marsupialisation, bone grafts and infections to large head and neck reconstructions and malignancy ablations, as well as cosmetics.

Call is extremely busy, as both hospitals are level 1 trauma centers. At Emanuel, every day we are on for full facial trauma call and can expect to receive multiple calls every night. This is an unfiltered experience without Plastic Surgery or ENT services readily available. Call at OHSU is also very busy, and while we share trauma call with other specialties, we often receive more facial fracture consults when not on call from outside hospitals. Days are long, and so are weekends, but this is not a change from residents' experiences in the past. Much time is spent on reading and preparing presentations for the conferences, in addition to upcoming cases.

Resident's Corner

Tim: There is no such thing as a "typical week" in our program. From the time I started to my latter months in the program, every week has been a diverse experience. One can start the week out in the clinic doing consultations for third molars or dental implants or managing patients with significant medical issues, and minutes later be in the trauma bay with a patient with a life-threatening craniomaxillofacial injury who needs your expertise, or resect a malignant tumor and go up to clinic to do a set of thirds while the free flap is being harvested by another member of your team. No, there is nothing that resembles a typical week in our program.

How has your experience in Oregon differed from those of residents you have met around the nation?

Scott: The sheer volume of caseload as well as breadth of experience is different. In my last two years of surgery I will have performed close to 900 OR procedures, in addition to an extensive dentoalveolar component, especially early in training. Many of my friends in other programs are operating cases as primary surgeon for the first time as chiefs only or with minimal cases before being chief. In addition, they do not have any experience with microvascular reconstruction or cosmetics. I've even had friends who will have made less than five neck incisions, other than incision and drainages for abscesses. However, many of these residents will have spent a larger amount of time in clinic with office based procedures than I will throughout my training.

Tim: There are some who have had experiences similar to my own in terms of participating in "major surgery," but none with the diversity that is offered in our program. There are so many opportunities to gain exposure to all aspects of OMFS as well as experience operating with people in different specialties. Our experience on general surgery is also different than most. We spend so much time interacting with people in other specialties that when we rotate on these services, we are allowed more autonomy and they have the opportunity to participate to a greater degree in the operating room, ICU, etc.

What experiences during your residency have really defined the role of the OMS for you?

Scott: One day in particular defined the role for me earlier this year. I performed a resection of a squamous cell carcinoma with neck dissection in the morning, ran to clinic to perform third molar extraction with IV sedation, and then had both a zygoma fracture performed at the same time as dental implants were placed in the dental school. Very busy, but one should be comfortable with all these procedures and able to perform them comfortably.

Tim: The role of OMS in the setting as the specialty to deal with craniomaxillofacial/head and neck diseases is critical. I have observed this from two viewpoints — as one of three specialties dealing with maxillofacial disease, and another as the only service in the hospital to manage these patients. Our background and training in both the medical and dental realm make us the premier specialty to manage patients with maxillofacial surgical needs.

What are your plans for the future in OMS?

Scott: I am weighing my options presently. I would like to join a private practice in my home state of Florida. However, I am also examining a position as a staff OMFS for Trauma at a new Level 1 center in Miami.

Tim: I have taken a job with a group practice in rural Massachusetts/Vermont where I will continue to practice a broad scope of oral and maxillofacial surgery. I will spend about 70% of my time practicing "bread and butter" oral and maxillofacial surgery, which in my mind includes dentoalveolar surgery, dental implants, benign pathology of the jaws, TMJ surgery, trauma surgery, surgical orthodontics, etc. The remaining time I hope to develop a micro neurosurgical practice, treat benign and malignant salivary gland disease, be involved in treatment and reconstruction of head and neck cancers (particularly skin cancer), and perhaps even do some cosmetic surgery.

CONTINUED ON PAGE 12

Resident's Corner

How do you see your practice in OMS being influenced by your training in Oregon?

Scott: I definitely feel more comfortable with larger traumas and facial reconstructions/ablations than the average resident. I thoroughly enjoy trauma, and would like to maintain an active trauma practice in my career. While I will not perform any malignancy surgery or ablations, I do have an appreciation for what will need to be performed and what options are available for patients. Otherwise, I will still have an active office based practice with traditional dentoalveolar, implants, etc.

Tim: Because of our exposure to so many different patient populations, I feel comfortable managing anything from the simplest extraction to the most complex orthognathic problem. The general sense of most of our graduates is that we will have experience dealing with most anything that walks through our doors. Without exposure to such a wide variety of complex problems during training, it would be easy to stay in a narrow comfort zone and never branch out. I am not sure what my practice would be like had I trained elsewhere, but I feel that I am able to manage a wide variety of patients, and then develop a practice doing the things that I enjoy most.

Would you recommend programs like Oregon to prospective OMS?

Scott: Yes and no. It is a special program that is a great fit for some people and a horrible fit for others. No matter where our specialty expands, a large segment will not want to perform full facial and neck trauma 365 days a year, or perform long cancer and reconstruction procedures. For those who want to feel comfortable operating on the entire head and neck and performing lots of OR cases, this is a good program. I can tell when an extern comes through whether this will be a good match for them or not based upon their enthusiasm and interest levels.

Tim: Our program is a great program for the right person. No program is perfect for everyone and ours is no exception. Anyone who wants to have a broad surgical experience would thrive at our program ... but that comes at a price. We work very hard and have a tremendous amount of responsibility, which at times can be daunting. The person who does well at our program is able to think quickly, react decisively and be willing to get in over their head from time to time.

Concluding remarks

Scott: Oral surgery is a fantastic specialty that I take great pride in. I proudly proclaim that I am an oral surgeon, and that I am a resident at OHSU. I appreciate all the time the faculty has taken to educate me along the way.

Tim: I am a firm believer in the saying that "residency is what you make of it." But there are also training programs where the diversity exists that you can have a diverse exposure to "traditional" oral and maxillofacial surgery in addition to the plethora of other surgical experiences within and outside of our specialty. Without these experiences, my confidence, judgment, humility and excitement for surgery would not be the same.



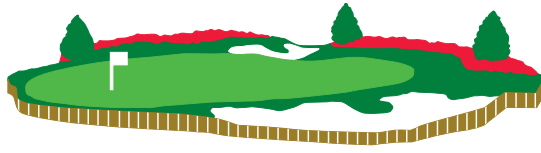
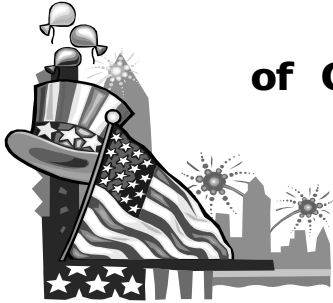
2011 Meeting



SAVE THE DATE!

**Western Society
of Oral and Maxillofacial Surgeons**

Annual Meeting at



The
Coeur d'Alene

July 2-5, 2011

Speakers:

Dr. Robert Bosack and Dr. Robert Hale

For More Information

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e-mail: WesternOMS@aol.com



Annual Meeting 2010

**WESTERN SOCIETY OF ORAL AND MAXILLOFACIAL SURGEONS
ANNUAL MEETING REGISTRATION**
Sunriver Resort, Sunriver, OR • July 2-5,2010

Please print or type the following:

Name: _____ Name (Spouse/Guest): _____

Office Address: _____ Name(s) Children (If attending): _____

City: _____

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REGISTRATION: Please fill in all the blanks (if not attending, put 0)

President's Cocktail Reception, Exhibitors' Cocktail Reception, Daily Continental Breakfasts and Refreshment Breaks.
All other functions/activities are additional and may be registered for below.

WSOMS Member _____ @ \$595 = \$ _____
 OMS (non-member Practice/Resides in District VI) _____ @ \$745 = \$ _____
 OMS (Practice/Resides outside of District VI) _____ @ \$595 = \$ _____
 WSOMS Member, Retired _____ @ \$350 = \$ _____
 OMS Staff _____ @ \$150 = \$ _____
 OMS Resident Member (no charge) _____ @ N.C. = -0-

ACTIVITIES: Please fill in all the blanks (if not attending, put 0)

DATE	EVENT	NUMBER ATTENDING	PRICE PER PERSON	TOTAL DUE
Friday July 2, 2010	President's Reception, 6:30-8:00 p.m. (Spouses/Guests/Family/Staff included)	<input type="checkbox"/>	No Charge	-0-
Saturday July 3, 2010	Golf Outing, Meadows 1:30 Tee Times Golf cart, box lunch and awards included: 1) _____ USGA index or last 4 18-hole scores 2) _____ USGA index or last 4 18-hole scores 3) _____ USGA index or last 4 18-hole scores 4) _____ USGA index or last 4 18-hole scores With whom would you like to be paired?	<input type="checkbox"/>	\$145 per person	\$ _____
Sunday July 4, 2010	Exhibitor's Reception 6:30-7:30 p.m. (Spouses/Guests/Family/Staff included) Western BBQ, Awards and Passing of the Gavel 7:30-9:30 p.m. Registered OMS (Inc. in registration fee) Teens, spouse, friends, staff Children Age 4 - 12 Children Under 4	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	No Charge No Charge \$75 per person \$40 per person No Charge	-0- -0- \$ _____ \$ _____ -0-

You will receive confirmation by e-mail. If you don't, please call the office.

Activities Total \$ _____ Registration Fee \$ _____ Total Enclosed \$ _____

Method of Payment: Check (made payable to WSOMS) VISA MasterCard

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Name on card (please print) _____

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ANNUAL MEETING**

July 2-5, 2010 Sunriver, Oregon

Speaker: Dr. Daniel Cullum on Full Arch Reconstruction and Bone Manipulation in Implant Reconstruction

Meeting Honoree: DR. EUGENE KELLEY

Please attend this year to honor Dr. Kelley (a great asset to the profession and our Society), enjoy the Central Oregon and Sunriver attractions, and attend outstanding scientific sessions with Dr. Dan Cullum. The meeting information has been sent to all your offices, but see the website, www.wsoms.org, for more information. The accommodations will only be held until May 31st, and then the rooms will be returned to the resort, so please get your reservations in soon.

Continuing Education Provider Approval

This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of the American Association of Oral and Maxillofacial Surgeons and the Western Society of Oral and Maxillofacial Surgeons. The American Association of Oral and Maxillofacial Surgeons is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The American Association of Oral and Maxillofacial Surgeons designates the 2010 Western Society of Oral and Maxillofacial Surgeons Annual Meeting for a maximum of 8.0 *AMA PRA Category 1 Credits™*. Physicians should only claim credit commensurate with the extent of their participation in the activity.

The American Association of Oral and Maxillofacial Surgeons is an ADA CERP Recognized Provider.

ADA CERP is a service of the American Dental Association to assist dental professionals in identifying quality providers of continuing dental education. ADA CERP does not approve or endorse individual courses or instructors, nor does it imply acceptance of credit hours by boards of dentistry.

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The American Association of Oral and Maxillofacial Surgeons designates this activity for 8.0 continuing education credits.

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PLEASE HELP!

WE NEED AN EDITOR FOR THE WESTERNER

To the Members of WSOMS:

It is sad to tell you, but Dr. Donald Devlin has decided to retire as Editor of *The Westerner*. He has worked with me for the last eight years, and prior to that, with Beth Bryant, the previous Executive Secretary. Dr. Devlin's editorials have been inspiring, thought-provoking and enjoyable. His column on the *Journal of Oral Surgery* has kept members on their toes with the questions and answers.

Now comes the hard part — we need to replace him at or before the annual meeting in Sunriver. If anyone is inspired to take on this job, please contact me either by phone (775-626-4478), e-mail (WesternOMS@aol.com) or fax (775-626-4479).

The Westerner is published two times each year, one in the spring, prior to the WSOMS Annual Meeting, and one in the fall, after the AAOMS national Annual Meeting. The job description includes the following:

1. Make suggestions to me for content/articles and write an editorial for each issue. (The *Journal* article is very time-consuming and is not crucial in taking the position.)
2. Contact the Resident Training Programs for contributions from the residents or staff.
3. Proof the content of the newsletter prior to publication to check for misspellings, content error, etc.

I do all the design layouts and work with the printer. Without an editor, *The Westerner* would not have the direct leadership of an OMS, which is important to the Society.

LINDA MACDONALD

Thanks for the Memories from Dr. Don Devlin

It was in 1995 I accepted the "Editorship" of *The Westerner*. It has been a wonderful and most rewarding experience. The main benefit I derived from this position was the opportunity to get to know so many outstanding and dedicated individuals. It is now time to move on but I could not do so without a special "thank you" to Linda MacDonald for her tremendous help in the publication of our newsletter.

My best wishes to each of you and to the future of our great Society.

THANK YOU, DR. DEVLIN,
FOR ALL YOU HAVE DONE FOR
THE WESTERNER AND THE SOCIETY



Is Your Checklist Up to Date?

by Don Devlin

The date was October 30, 1935. The place was the Wright Air Force Air Field in Dayton, Ohio. For the past several years the Martin, Douglas and Boeing airplane manufacturers were in competition to build the military's next generation long-range bomber. The Boeing Corporation was far ahead with their aluminum alloy design Model 299, which could fly faster, twice as far and additionally carry five times as many bombs as requested by the Army. One Seattle newspaperman who witnessed a test flight called it a "flying fortress" and the name stuck.

The army was set to order 65 of these beautiful planes with a 103-foot wingspan and four rather than two engines mounted on the wings. The competition was all set with the Boeing Model 299 a shoe-in.

The plane climbed to 300 feet, stalled and plummeted to earth in a fiery explosion. Two of the five crew died, including the pilot, Major Ployer Hill, one of the most accomplished test pilots in the Army service.

There was nothing at all wrong from a mechanical standpoint. The crash was due to "pilot error." Major Hill forget to release a new locking mechanism on the elevator and rudder controls. A newspaper article said the Boeing model was "too much airplane for one man to fly." Douglas's smaller design was the winner while Boeing nearly went bankrupt.

Boeing then did a wise thing. They decided not to send their pilots for additional training, but rather they developed a checklist of all procedures to ensure a safe flight. Flying this new plane was too complex to rely on the memory of one man. With this new checklist the Model 299 went a total of 1.8 million miles without a single accident. The Army bought 13,000 of these great planes and named it the "B17."

Today many of our procedures have entered into the "B-17 phase." Some I'm sure believe these procedures are too complex to be relied upon by a checklist. Yet are not temperature, pulse, blood pressure and respiration rate (vital signs) a form of checklist? In the

1960s it was the nurses, not the physicians, who promoted vital signs concept. Later pain was added as a fifth vital sign, 1-10.

On several occasions I have acted as a defense witness in a malpractice case involving a general dentist whose patient developed a swelling and infection following a dental procedure. Unfortunately the dentist neglected to take and record any post-operative temperature in the follow-up appointments ... and at that point we all know the story.

The patient is placed in the hospital by the physician. Antibiotic IV therapy is started and an extra oral drain placed. Such cases are difficult to defend when the recording of post-operative temperature is overlooked. In all probability the lack of temperature recording had no bearing on the outcome and management of this complication, however, a skillful plaintiff's attorney will cause a jury to think otherwise.

Wouldn't it be a step forward if our specialty would establish a checklist for the management of various procedures? We realize some situations do not lend themselves to checklist help, however, there are many that do.

It was not too many years ago that AAOMS established the "standard of care" for various procedures in our specialty. How many of our residents are familiar with these standards upon completion of their program? How many of us have forgotten details of these standards?

Would it be possible for the Western Society to organize a committee to explore the possibility of developing checklists for various procedures, both pre- and post-operative in order that we may establish a higher standard of baseline performance? Now there's a constructive project!

The thought for this editorial came from a book I was reading by Atul Gawander called *The Checklist Manifesto - How to Get Things Right*. Here's a book every health professional should read!



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Day 3: Resident Presentations