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## *matters*

March 2014





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# MEMBERSHIP *matters*



Official publication of the Oregon Dental Association in support of its core purpose to advance the dental profession and promote the highest standard of oral health and oral health care.



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PO Box 3710, Wilsonville OR 97070  
503.218.2010 • [www.oregondental.org](http://www.oregondental.org)

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- 1) Which cracked teeth are likely to get worse?
- 2) When is intervention needed?
- 3) What is the most appropriate treatment?

**PLUS:** Practice-based Research in Oral Health (PROH) network



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## CONTACT US

### Letters to the Editor

Letters to the editor are welcomed.  
All letters and other submissions  
to this publication become the  
property of the Oregon Dental  
Association. Send submissions to:

Editor, Membership Matters  
Oregon Dental Association  
PO Box 3710  
Wilsonville, OR 97070-3710  
barrytaylor1016@gmail.com

### Articles

Are you interested in contributing  
to Membership Matters?

For more information, please  
contact editor, Dr. Barry Taylor:  
barrytaylor1016@gmail.com.

## Oregon Dental Association

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### Social networks

Look for the Oregon Dental Association group on:

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Dentistry's Professional Social Network

### Twitter

Follow ODA President, Judd R. Larson, DDS: @ODAPrez

**Blog** [www.TheToothOfTheMatter.org](http://www.TheToothOfTheMatter.org)

**APR 3-5**

**Oregon Dental Conference**  
(Oregon Convention Center—Portland)

**APR 6** 9:00 AM

**Board of Trustees meeting**  
(DoubleTree Hotel By Hilton—Portland)

**MAY 31** 7:30 AM

**Board of Trustees meeting** (Salishan)

**JUL 11-12**

**Oregon Mission of Mercy V** (Salem)

**JUL 25** 10:00 AM

**Board of Trustees meeting** (Medford)

**SEP 5-6**

**ODA House of Delegates**  
(Riverhouse—Bend)

**SEP 26** 9:00 AM

**Board of Trustees meeting** (Portland)

**NOV 1** 8:00 AM

**Board of Trustees meeting** (ODA)

## ODA CALENDAR EVENTS & MEETINGS

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on these and other  
upcoming events, visit  
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## COMPONENT CE CALENDAR

compiled by Mehdi Salari, DMD  
Send your component's CE courses  
to [bendsalari@yahoo.com](mailto:bendsalari@yahoo.com).

**TUES, MAR 18** Clackamas County **CE HRS: 1.5**

### Finance

Jake Paltzer

**INFO:** [www.clackamasdental.com](http://www.clackamasdental.com)

**WED, MAR 19** Multnomah **CE HRS: 1**

### Smoking Cessation

Todd Beck, DMD

**LOCATION:** Portland (McMenamin's Kennedy School)

**INFO:** [www.multnomahdental.org](http://www.multnomahdental.org), [lora@multnomahdental.org](mailto:lora@multnomahdental.org)

**SAT, MAR 29** Southern Oregon **CE HRS: 1.5**

### Pharmacology in Dentistry Update

John Smith, PhD

**LOCATION:** Medford (Smullin Center)

**INFO:** [www.sodsonline.org](http://www.sodsonline.org)

**TUES, APR 22** Clackamas County **CE HRS: 1.5**

### Ergonomics

**INFO:** [www.clackamasdental.com](http://www.clackamasdental.com)

**FRI, MAY 13** Lane County **CE HRS: 1.5**

### Dentistry in Social Media and the Web

Nancy Lashley

**LOCATION:** Eugene (Valley River Inn)

**INFO:** [www.lanedentalsociety.org/programs](http://www.lanedentalsociety.org/programs)

**TUES, MAY 13** Marion & Polk **CE HRS: 2**

### Infectious Diseases Risk Management

Pat Preston, MS

**LOCATION:** West Salem (Roth's)

**INFO:** [www.mpdentalce.com](http://www.mpdentalce.com), [mpdentalce@qwestoffice.net](mailto:mpdentalce@qwestoffice.net)

**TUES, MAY 13** Southwestern Oregon **CE HRS: 1.5**

### Prosthodontic Update

Dr. Larry Over

**LOCATION:** Coos Bay (Red Lion Hotel)

**INFO:** Dr. Roger Sims, [roger@rgsims.com](mailto:roger@rgsims.com)

**TUES, MAY 13** Washington County **CE HRS: 1.5**

### Endo Potpourri: What's up 2014?

Dr. Tuong N. Nguyen

**LOCATION:** Beaverton (Stockpot Broiler)

**INFO:** [www.wacountydental.org](http://www.wacountydental.org), [wcdskathy@comcast.net](mailto:wcdskathy@comcast.net)

**WED, MAY 21** Multnomah **CE HRS: 1**

### Table Clinics

**LOCATION:** Portland (Multnomah Athletic Club)

**INFO:** [www.multnomahdental.org](http://www.multnomahdental.org), [lora@multnomahdental.org](mailto:lora@multnomahdental.org)

**TUES, MAY 27** Clackamas County **CE HRS: 1.5**

### Diagnostic Injections

Dr. Kim Wright

**INFO:** [www.clackamasdental.com](http://www.clackamasdental.com)

## “Dear Editor, Your comments are misguided... but I prefer that you not publish my response.”



Barry J. Taylor,  
DMD, CDE

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*Yes, we have changed our governance structure to make our organization more effective. This does not, however, diminish the **NEED FOR INPUT FROM OUR MEMBERSHIP.***

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**B**EING A DENTAL EDITOR is much like being a spouse. At home I can—at times—be a bit opinionated, emotional, and maybe even full of grand schemes. It’s wonderful that my family always agrees with me; they never correct me, nor question what I say. I conclude from their silence that I am always right. My children go to bed each evening thanking me for my sage advice and are left speechless at my parenting skills. My wife, Melissa, likewise, always agrees with me and lives in a state of quiet amazement at some of my ideas. I mean, certainly she would let me know if she disagreed with me or had a different viewpoint? And, if she did, I would certainly love for her to share that with me.

Thank you to **Drs. Jonna Hongo and Mike Shirtcliff.** You have authored two of the handful of “Letters to the Editor” that I can recall publishing since 2007. I think it’s safe to state that there was no backlash against your practices after the letters were published? I have spoken with each of you since publishing your letters; I doubt we even discussed the letters, but likely

talked about the weather instead, or the Timbers’ season.

After *Membership Matters* publishes each month, I actually do receive emails to the editor, to which I reply something to the effect of: “Thank you for the email, I appreciate your comments. Would you allow me to publish your letter in the magazine?” Almost always, the response is, “I would prefer that you don’t.” Our membership is too polite. Most of the letters are articulate, objective, and thought-provoking. I imagine that the views expressed were shared with other members, but we shall never know.

This politeness extends to our House of Delegates, as well. Over the years, there has been a dearth of resolutions that are

even remotely controversial. As a matter of fact, there has been an almost complete absence of any resolution other than those initiated by the Board of Trustees. There was a time when a variety of components would propose resolutions to be voted on, that is just not case these days.

While sometimes the scores of resolutions at ADA’s HOD may seem to bog it down, I believe that a few resolutions of substance at the ODA’s House would spur good debate and give the House of Delegates an essence that is currently missing. There is a balance between the ineffectiveness of discussing every minutia of the organization and having a vast void of member opinion. Yes, we have changed our governance structure to make our organization more effective. This does not, however, diminish the need for input from our membership.

Silver nitrate, mid-level providers, and corporate dentistry are just a few of the issues about which I know there is not 100% consensus among our membership. Without published commentary from members, or resolutions at our House, then our Board of Trustees is navigating without guidance from members.

A healthy organization needs objective debate on the issues it faces. Without member input, the decision-making is left to a handful of people. This is not about a lack of trust in that decision-making body but a plea for greater involvement from our entire membership as part of our ownership of the Oregon Dental Association. ●

After reading this editorial, Melissa sent me a long email correcting some of my inaccurate comments, but she requested I not publish it. I told her that I still loved her despite our disagreements. There were even murmurs that the children were drafting a resolution, that is, until they found out our family’s diarchic government does not have a House of Delegates.

**It probably goes without saying, but I welcome your thoughts, ideas, and comments on this (or any) issue of *Membership Matters*.**

Email me at [barrytaylor1016@gmail.com](mailto:barrytaylor1016@gmail.com).

Barry J. Taylor, DMD, CDE, is editor of *Membership Matters*. He can be reached via email at [barrytaylor1016@gmail.com](mailto:barrytaylor1016@gmail.com).

*The opinions expressed in this editorial are solely the author’s own, and do not reflect the views of the Oregon Dental Association or its affiliated organizations.*



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Salem  
Marion and Polk Dental Society





**Conor P. McNulty, CAE**

## ODA Announces New Executive Director

The Oregon Dental Association is excited to announce that Conor P. McNulty, CAE, has been named the next executive director of the ODA. McNulty began his new duties on February 19, 2014. He previously worked for the California Dental Association in numerous senior association management roles, including director of membership programs.

McNulty achieved his Certified Association Executive (CAE) designation from the American Society of Association Executives in 2013. He is a graduate of the University of San Francisco, earning a BS degree in marketing, where he was also a student athlete in men's division 1 soccer.

McNulty will direct a staff of seven from the ODA offices in Wilsonville. He is stepping in to relieve Dr. Sean Benson who had been acting as interim executive director for the last seven months while the ODA Board of Trustees searched for a permanent executive director.

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# MEMBER BENEFIT OF THE MONTH

## New health insurance resource for members

### Searching for health insurance options? The ADA can help!

The ADA has just launched a new page on [www.ADA.org](http://www.ADA.org) that provides health insurance resources for members. The page lists links and toll-free numbers for members to access health insurance plan options endorsed by their state dental associations.

That information is followed by a link to the new ADA endorsed American Health Insurance Exchange (AHIX), powered by JLBG Health. The AHIX web portal will provide members with access to both state public exchange health insurance plans, the same plans available on [www.healthcare.gov](http://www.healthcare.gov), and private, ACA-compliant plans.

The new ADA endorsed AHIX member-only services include:

- ✓ A dedicated answer line via email or a toll-free number
- ✓ A licensed insurance broker with whom to consult
- ✓ Fast and secure access to rate quotes and plan options
- ✓ The ability to apply for the health plan of your choice—with or without subsidies



Learn more about this new health insurance resource by going to [www.ADA.org/healthinsurance](http://www.ADA.org/healthinsurance).

This column is intended to acquaint you with the benefits that you receive as a member of the Tripartite (ODA, ADA, and your component dental society). More information on member benefits can be found at <http://bit.ly/ODAbenefits>.

## Volunteers NEEDED

The ODA councils and committees listed below currently have volunteer opportunities. **All ODA members are encouraged to participate in the leadership of this organization.**

Interested applicants should submit a letter of interest and a one-page resume to:

**Mail: ODA Leadership Development Committee**  
Jim Smith, DMD, Chair,  
Nominating Sub-Committee  
PO Box 3710  
Wilsonville, OR 97070

**Email:** [leadership@oregondental.org](mailto:leadership@oregondental.org)

### ODA Councils and Committees:

- Annual Meeting Council
- Membership Council
- New Dentist Committee
- Public and Professional Education Council
- Publications Advisory Committee

For more information, please call 503.218.2010.

### ✓ Election held April 6, 2014 Elected by ODA Board of Trustees

#### ADA Alternate Delegate at Large

POSITIONS OPEN Four

TERM 1 Year

DECLARED CANDIDATES Jill M. Price, DMD  
Kimberly R. Wright, DMD

### ✓ Election held Nov. 1, 2014 Elected by ODA Board of Trustees

#### Health Services Group Board of Directors

- If interested, the deadline to submit materials is July 31, 2014. • •

POSITIONS OPEN Two dental directors  
Two non-dental directors

TERM 4 Years

INCUMBENTS Michael L. McKeel, DMD;  
Michael E. Biermann, DMD

DECLARED CANDIDATES

### ✓ Election held Sept. 6, 2014 Elected by ODA Board of Trustees

#### ODA Trustee

POSITIONS OPEN Three

TERM 4 years

INCUMBENTS Fred A. Bremner, DMD  
Richard L. Garfinkle, DDS, MS

DECLARED CANDIDATES

#### ODA Secretary Treasurer

POSITIONS OPEN One

TERM 3 years

INCUMBENTS Sean A. Benson, DDS

DECLARED CANDIDATES

#### ADA Delegate at Large

POSITIONS OPEN Two

TERM one 1-year term; one 3-year term

INCUMBENTS Rickland G. Asai, DMD  
David J. Dowsett, DMD

DECLARED CANDIDATES

#### Leadership Development Committee

POSITIONS OPEN Four

TERM three 3-year terms; one 1-year term

INCUMBENTS Kevin J. Kwiecien, DMD, MS, FAGD  
William F. Warren Jr., DDS  
Renee R. Watts, DDS

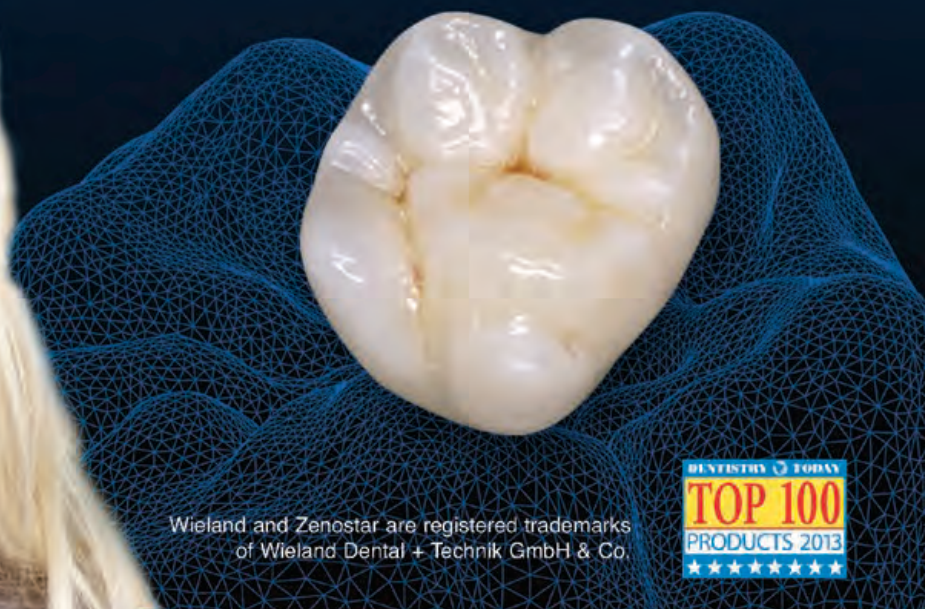
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## Case study: Improper endodontic treatment

**SUMMARY OF COMPLAINT** The complaint alleges that, in 2011, a dentist performed a root canal and then placed a crown on a tooth, but the patient began experiencing pain and swelling again in early 2012. The patient was seen by a subsequent dentist who discovered that only one canal of the root-canalled tooth had been only partially filled.

**FINDINGS** The investigation showed that while attempting to endodontically treat tooth #30, the dentist was unable to access and fill the distal canal and filled the mesial canal short, but before filling the canals, the dentist informed the patient that he wanted to refer her to an endodontist. The patient refused to go, and said that she wanted to “see how it went” before she would pay to see an endodontist; upon the patient’s insistence, the dentist proceeded to fill the canals and prepared the tooth for a crown.

When the patient returned to have the new permanent crown temporarily cemented, she told the dentist that she was fearful of swallowing or aspirating a temporarily cemented crown and insisted on having the crown permanently cemented. When the patient returned for a post-op check he repeated to the patient that if the tooth needed endodontic retreatment, he would retreat the tooth at no charge or refer her to an endodontist and pay for the retreatment, and also remake the crown at no charge; the patient agreed.

The patient then saw a new dentist a year later, and was informed of the now failed endodontic therapy in tooth #30, and was referred to an endodontist. The patient then returned to the original dentist, demanded that he pay for the endodontist’s treatment and a new crown, and denied that she was informed of the short fill, denied she had been referred to an endodontist, and denied that she had insisted on permanent cementation of the crown.

The original dentist then paid the endodontist to retreat tooth #30.

**BOARD ACTION** The Board closed the matter with a STRONGLY worded Letter of Concern addressing the issue of ensuring that the standard of care is followed in reference to permanently seating crowns on teeth with incomplete endodontic therapy.

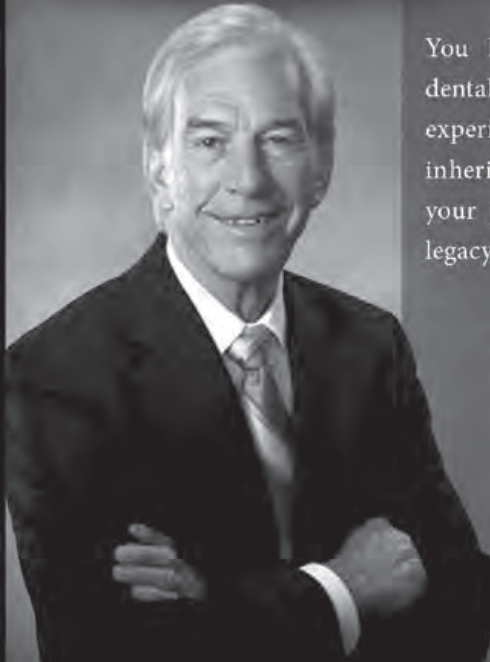
**BOARD’S RATIONALE** Although the dentist’s endodontic treatment of tooth #30 was incomplete, the patient was informed and a referral was offered,

but refused. It is here where the “he said, she said” are in conflict, but because the dentist’s treatment notes documented the conversations with the patient in exquisite detail, the dentist was more credible than the patient; the cautionary letter to the dentist appeared to be appropriate. ●

*As an example of the types of cases they see, and what could have been done to prevent the complaint, the Oregon Board of Dentistry has provided the preceding case summary.*

*As a member dentist, remember to suggest the ODA’s confidential Peer Review process to your patients as the best alternative to filing a complaint with the Board and/or taking legal action.*

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## Generally speaking, we're special



Steven A. Gold, DDS

**W**HEN WE, AS HEALTH CARE PROFESSIONALS, collectively make decisions with only the best interest of the public in mind, it inexorably benefits both the public and the profession. Medical and dental specialties developed out of such a desire to help patients. They allowed for, and required, individuals to seek a higher level of training in a limited area, and to restrict their practices to that area. This served the public best as it afforded patients the highest level of care in areas where technology and complexity were rapidly increasing.

Some have argued that the profession of medicine carried specialization too far, to the detriment of patients. In response to this, the dental profession set its sights on maintaining itself as a generalist oriented profession, and this, again, served the public best. We are

continuously challenged by differences in opinion of how the line between general practitioners and specialists should be drawn. When this challenge is met with only the best interest of the public in mind, both the public and the profession will

benefit, and that line of division will blur and transform into bonds of collaboration and collegiality.

We likely have all witnessed or been aware of conflict between dental specialists and generalists. Perhaps it was an individual practitioner who practiced below the standard of care because they failed to recognize their own limitations and/or failed to refer the patient appropriately. Perhaps it was an inflammatory statement by an individual or professional organization, advocating for the exclusive rights to a particular dental treatment, under the guise of acting in the patient's best interest. Unfortunately these transgressions often arise out of self-interest, and financial gain is often the catalyst.

Providing guidance to overcome challenges, such as this, is truly one of the most important roles of our professional organization. One need only look to American Dental Association policy to see how the relationship between general practitioners and specialist should be.

### The ADA believes that the profession of dentistry should be generalist oriented.

In 1983, following a three-year comprehensive review of dental specialties, Resolution 1H-1983 was passed by the ADA House of Delegates. This, in essence, adopted the document *Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialties*. The introduction to that version of the requirements contained the following statement: "It is the Association's belief that the needs of the public are best served if the profession is oriented primarily to general practice."

In addition to this, one must also consider the ADA's very definition of dentistry. In 1997, the ADA House adopted language stating that dentistry is "provided by a dentist, within the scope of his/her education, training and experience." In doing so, the profession recognized that differences in this education, training, and experience make it all but impossible to outline specifically what procedures general practitioners and specialists should and should not do.

It is important to realize that these policy statements were not developed by a few individuals in an executive office at the ADA. They were hammered out through grass roots representation of all dentists at the ADA House of Delegates. The crafters of these policies were everyday dentists like you and me; specialists and generalists representing all interests of the profession. They have been reviewed and reaffirmed since, and, in the real, everyday world of patient care, they work.

The general practice should be the patient's dental home. The role of the general practitioner is to manage the overall care of the patient and provide treatment to the extent of his or her abilities and desires. It is

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**"It is the [ADA]'s belief that the needs of the public are best served if the profession is oriented primarily to general practice."**

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Dr. Gold formerly maintained a private practice in Santa Monica, Calif. He is currently an assistant professor of restorative dentistry at the OHSU School of Dentistry. He can be reached at [goldst@ohsu.edu](mailto:goldst@ohsu.edu).



the general dentist's exclusive right to determine what that treatment is, and his responsibility to either practice to the same standards a specialist would, or to refer.

The role of the specialist is to provide a subset of a patient's overall care when the patient's needs are beyond the scope of their general dentist. When a specialist accepts a new patient who does not have a general dentist, they are obligated to do one of two things: either provide and manage the patient's overall, comprehensive care to the standard of care, or refer the patient to a general practitioner for this purpose. The exception to this is the provision of urgent care. Any non-urgent treatment, whether rendered by a

general practitioner or a specialist, performed in the absence of a comprehensive oral evaluation, and without proper informed consent, is below the standard of care.

We must be cautious of statements of generality such as, "endodontists should not be placing implants," or "general dentists should not be managing full mouth prosthodontic rehabilitation." These statements fail to consider the differences in training and experience of individuals and fail to recognize the inevitable progression of both specialties and general practice. We must, instead, advocate for and foster relationships like most of us have surely had—ones where a general dentist and specialists collaborate to provide true

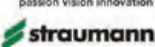
comprehensive and interdisciplinary care. These relationships are grounded in trust and respect, and nurtured through communication. They evolve to the highest levels when all involved professionals hold the patient's well being in highest regard and do not yield it to personal gains.

Among health care professions, dentistry is exemplary in the relationship developed between patient, general practitioner, and specialists. We must take care not to destroy that reputation for selfish gains. Because when it comes to taking care of our patients, generally speaking, we're pretty special. ●

If you are interested in writing a column or opinion piece for a future issue of *Membership Matters*, please contact Editor Barry Taylor, DMD, at [barrytaylor1016@gmail.com](mailto:barrytaylor1016@gmail.com).

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# cracked TEETH

By Thomas J. Hilton, DMD, MS

## Who's Who?

### Northwest PRECEDENT

(Practice-based REsearch  
Collaborative for  
Evidence-based DENTistry)

### PBRN

(Practice-Based Research Network)

### OHSU PROH

(Practice-based Research  
in Oral Health)

**CRACKED TEETH** are a significant problem for dentists and patients alike. The outcomes of a cracked tooth can be serious for a patient, often involving extensive and expensive treatment; in some cases ultimately resulting in the loss of the tooth. For the dentist, it can be a diagnostic conundrum, particularly if the cracked tooth is asymptomatic. When dentists participating in the Northwest PRECEDENT (Practice-based REsearch Collaborative for Evidence-based DENTistry) dental PBRN (Practice-Based Research Network) were surveyed, cracked teeth was the number one topic of concern and interest for research by the network.

While there are certainly a lot of aspects to diagnosing and treating cracked teeth, the vast majority of dentists' concerns regarding cracked teeth can be condensed into one or more of what we term "the big 3." That is, the three major questions that have frustrated the profession for years: 1) Which cracked teeth are likely to get worse? 2) When is intervention needed? 3) Once the decision is made to intervene, what is the most appropriate treatment?

Attempting to find the answers to "the big 3" has been an ongoing endeavor for the OHSU PROH (Practice-based Research in Oral Health) network, the Northwest PRECEDENT network, and now the National Dental Practice-based Research Network.

First, some historical perspective.... Cracked teeth are an old problem; more

accurately, they are an ancient problem. A recent article reported on a Neolithic cracked human tooth (Bernardini et al, 2012). A partial mandible with a cracked canine was found in Slovenia and subjected to multiple sophisticated tests that determined that the individual, and the cracked tooth, were 6500 years old. Interestingly, the researchers were able to determine that the fracture had occurred *ante mortem*, and, even more interestingly, that the tooth had been treated with beeswax. The now familiar term "cracked tooth syndrome" (CTS) was coined in 1964 by Cameron and defined as an incomplete fracture of a vital posterior tooth that may or may not involve the pulp (Cameron et al., 1964). Patients suffering from CTS complain of pain associated with biting and/or thermal stimuli.

However, many patients present with no symptoms even when their dentist visibly identifies an incomplete tooth fracture at a routine exam. A patient register of over 14,000 molars evaluated in the PROH network revealed that a substantial majority of adults have cracks in teeth, with 66% of individuals presenting with at least one cracked molar. *See Diagram 1 on page 14* (Hilton et al., 2007).

A study completed by Northwest PRECEDENT enrolled 630 patients with a cracked posterior tooth from 34 dental practices in five Pacific Northwest states. These patients were followed at routine intervals, for up to two years, to assess

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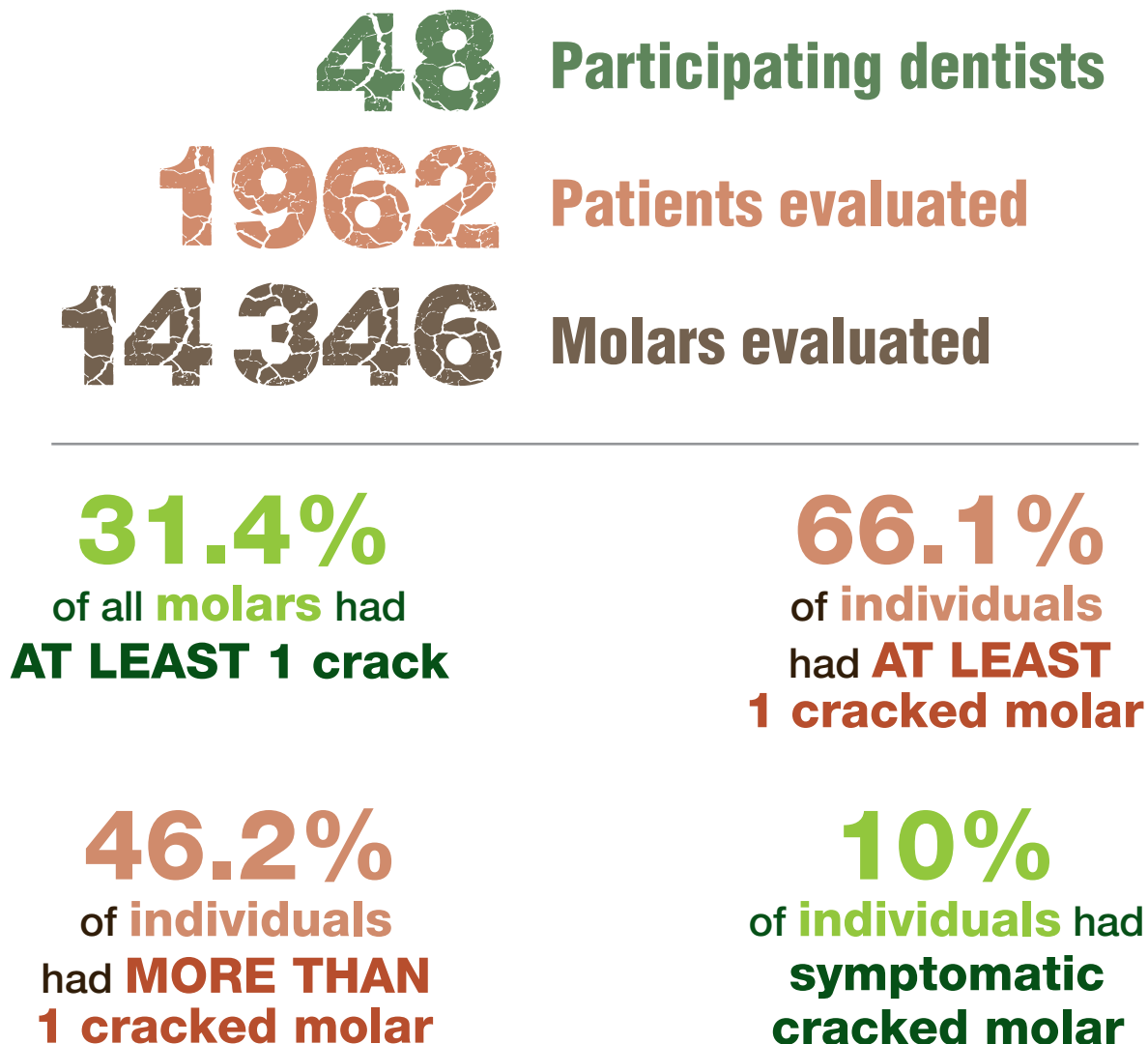
what changes occurred in that time period. The results showed that 71% of the individuals randomly enrolled in the study had at least one cracked posterior tooth, of which 21% were symptomatic (Hilton, et al, 2011). So research confirms what dentists have realized for many years: cracked teeth are ubiquitous in our adult patients.

One of the primary issues that dentists have to contend with when dealing with cracked teeth is the fact that upon visible examination, it is virtually impossible to determine the extent of an incomplete fracture in a tooth. Yet that is precisely the information we need: what cracks extend past the dentinoenamel junction into dentin, or, even more dire for the prognosis of the cracked tooth, to vital structures such as the pulp or down onto the root? A number of clinical tests have been suggested as a means to determine the extent to which a crack traverses into the tooth: examination with magnification, transillumination with a fiber optic light to evaluate for an obvious disruption in

light transmission, tactile examination with an explorer to feel for disruption in the continuity of the tooth surface, and use of stains to highlight a crack are all techniques that have been recommended. While these findings may alert the practitioner to an existing crack, there is little to no research that correlates external cracks to the nature of the crack, and its depth into the dentin is indeterminable without preparing the tooth in some way, and the dentist has little guidance as to how to treat an asymptomatic tooth with an incomplete fracture. Research shows that a large proportion of crowns prescribed are due to incomplete tooth fractures identified by a practitioner, and that dental practitioners have a difficult time reaching consensus as to which teeth containing cracks actually need to have a full coverage restoration (Bader et al, 1996).

However, more research is being done that is defining some of the characteristics of cracked teeth. Cracks are usually associated with non-bonded, intracoronal

#### DIAGRAM 1 Results of PROH study on cracked teeth







restorations, especially amalgam and gold inlays. The larger the restoration, and the more restored surfaces, particularly when the marginal ridges have been compromised due to restoration, the more likely it is that the tooth will have cracks compared to teeth not exhibiting those characteristics. Cracks are also associated with teeth that have wear facets; usually, the greater the wear, the greater the likelihood of the tooth having a crack. Molars more often demonstrate cracks than premolars. Symptomatic cracked teeth are associated with molars, teeth with more extensive crack systems (i.e. more cracks, more surfaces with cracks, cracks that include more than one surface), and teeth with larger restorations, particularly when the facial and/or lingual surface are included as part of the restoration. Crack and/or symptom progression is more likely to occur if the crack is on the mesial or occlusal surface of the tooth; the crack runs in an oblique or vertical direction (vs. horizontal); in teeth with more extensive crack systems; cracked teeth with an isolated periodontal pocket, and if the cracked tooth is also the terminal tooth in the arch.

There are some emerging technologies on the horizon that may enhance the clinician's ability to diagnose cracks in teeth, and in particular the extent of the crack to deeper structures of the cracked tooth. Some of these devices include the use of lasers, cone-beam computed tomography, ultrasound, and quantitative percussion diagnostics. While none of these technologies are yet ready for routine use in dental practice, the profession will undoubtedly have

a significant high-tech aid in diagnosing the severity of cracked teeth in the future.

Another area of uncertainty is the best way to treat cracked teeth. Immediate solutions include occlusal adjustment, cementing an orthodontic band on the tooth, providing a provisional crown or onlay, or placing a bonded composite restoration. More definitive alternatives include bonded intracoronal and extracoronal restorations, or non-bonded extracoronal restorations. Of particular interest is if a bonded intracoronal restoration can provide the same level of tooth integrity as an extracoronal restoration, while being more conservative of remaining tooth structure. There is little clinical evidence to answer that question. One study of 41 symptomatic cracked teeth restored randomly with either an intracoronal direct composite restoration or a cuspal coverage direct composite showed little difference in symptom relief. By six months, ten teeth were still symptomatic: four in the cuspal coverage group, and six in the non-cuspal coverage group. By year seven, only one tooth in the non-cuspal coverage group was still symptomatic. However, the failures due to restorative reasons (defective restoration, restoration fracture, etc.) were significantly higher in the non-cuspal coverage group (Opdam et al, 2008). In general, the literature seems to indicate that cuspal coverage restorations are the best restoration type for cracked teeth. There is no role for unbounded, intracoronal restorations, especially amalgam and cast gold inlays for the treatment of cracked teeth.







Research is now being conducted to further our understanding of cracked teeth. In particular, two PBRN projects are being conducted right now that will hopefully go far to help correlate external crack characteristics with the internal extent of cracks. In the PROH network, 29 dentists recently met at OHSU School of Dentistry to characterize 102 extracted cracked teeth and place each tooth in a cracked tooth risk category. These teeth will then be immersed in dye, sectioned, and digitally imaged in 100  $\mu$ m increments, and computer software will be used to reconstruct the 3D anatomy of the crack system in the teeth. Once this is done, the dentists will be reconvened, the results reviewed, and a cracked-tooth risk assessment system revised to one that is relevant to the practicing dentist.

The other study is a PBRN clinical study, which will be done in the NIDCR (National Institute of Dental and Craniofacial Research) funded National Dental PBRN. This study will include dentists from across the country, each of whom will be asked to recruit 10–20 patients with a cracked posterior tooth, complete a form that describes the characteristics of that tooth, and follow the tooth over four years for any changes. In addition, if that tooth should require treatment during the study period, e.g. a crown needs to be placed, practitioners will be asked to describe the internal cracks found after the tooth is prepared. This should allow the study to help determine patient-, tooth-, and crack-level factors associated with initial tooth

symptom status and what adverse outcomes occur and the association of those outcomes with the aforementioned characteristics.

This is a study for which we are actively recruiting dentist participants. If you would like more information about the national network or about this study, please go to [www.NationalDentalPBRN.org](http://www.NationalDentalPBRN.org), or feel free to contact Dr. Tom Hilton ([hiltont@ohsu.edu](mailto:hiltont@ohsu.edu)) or Dr. Jack Ferracane ([ferracan@ohsu.edu](mailto:ferracan@ohsu.edu)). ●

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# P • R • O • H

## Practice-based Research in Oral Health network

By Barry Finnemore

**LYNN YU, DDS, PHD**, has always been interested in research work. Thanks to her involvement in OHSU's Practice-based Research in Oral Health Network (PROH), she participates in studies that positively impact dental care, even while practicing at the Clackamas County Dental Clinic.

Dr. Yu is far from alone. Dozens of dentists have played, and continue to play, key roles in PROH. Since its launch about a decade ago, PROH has provided infrastructure for more than a half dozen research studies involving private practitioners in Oregon and Southwest Washington.

Dr. Yu said PROH's approach of facilitating evidence-based research conducted in practice settings was one of the factors that led to her participation.

"There aren't too many groups out there doing this kind of work," she said. "It is a very rare opportunity for general dentists to be involved [in research]."

Indeed, OHSU was at the forefront in establishing a practice-based oral health research network. One important advantage to PROH's approach is that the results tend to be more realistic because of the broad base of dentists and patients who are involved, said PROH Program Manager Cindy Barnes, BSDH, MBA, CCRP.

"We standardize some things, but dentists use materials and instruments they are accustomed to using and like using," said Ms. Barnes. "That flexibility leads to more realistic, real-world results."

Dr. Yu echoed that sentiment, noting that the outcome of using certain materials and treatments in a practice setting "is not necessarily what you see in the lab."

"In the lab or Petri dish, the situation is ideal, but that is not the case in the patient's mouth," she said.

Like Dr. Yu, **Brad Marineau, DMD**, and **Rich Knight, DMD**, have volunteered for the network because they find the research interesting, and they want to give back to the profession. All three said their involvement has been rewarding, because they are part of a broad group of colleagues collaborating to advance the field.

"It is very gratifying to see a lot of people with similar interests and backgrounds very enthused to solve a problem as a group," Dr. Yu said.

"I think it's cool to kind of be on the cutting edge," noted Dr. Marineau. "It's interesting to be a part of, and the studies are helpful for me and other dentists."

Dr. Knight said running a practice has the potential to be isolating if a dentist is not involved in a study club or other continuing education. PROH provides an important connection to fellow practitioners. Beyond that, the research tackles the important questions of "how do we know something works, and how do we make good decisions about products, equipment, and treatment modalities."

"You feel like you are doing something on the cutting edge of evidence-based dentistry," Dr. Knight said, noting that the involvement of patient populations from private practices allows the research, and therefore treatment advances, to reach the public much more quickly.

Indeed, Barnes cited a review paper published just a few years before PROH was formed that indicated it takes an average of 17 years for research evidence to reach clinical practice. "Part of the goal of practice-based research is to shorten that time span," she said.

Research projects PROH has facilitated include a 3M temporary crown clinical trial, a clinical evaluation of Premise composite and OptiBond All-in-One adhesive, an OHSU School of Dentistry curriculum survey, and a screening of unmet dental needs in rural Oregon. A steering committee of dentists has input on the research PROH pursues, and the studies are designed so that participating dentists can seamlessly incorporate them into their practice.

Currently, PROH is facilitating a cracked tooth study, focusing on an issue that affects an enormous patient population. Yet uncertainty has long surrounded how to diagnose and treat cracked teeth.

Dr. Marineau said he was drawn to participate in the cracked tooth study, because it's such an ubiquitous problem. "Every dentist in the world deals with this," he said.

Dentists such as Drs. Marineau and Knight also are attracted to PROH because of the respect they have for PROH's leaders, **Jack L. Ferracane, PhD**; **Dr. Thomas J. Hilton, DMD, MS**; and Ms. Barnes.



PROH provides an important connection to fellow practitioners.

Beyond that, the research tackles the important questions... **How do we make good decisions about products, equipment and treatment...?**

PROH's annual conferences also are a big draw. Highly interactive, they are designed around the theme "myths and controversies," with network members surveyed to identify myths, controversies, and clinical questions that arise in daily practice. Survey results are used to line up speakers with expertise in certain topics and who present two views on the myths, controversies, and questions. Conference attendees vote anonymously on multiple choice questions, then the speakers present evidence from the literature. At the end of the presentations, the original questions are asked again of the audience and results are displayed so attendees can see how their opinions were affected by the evidence.


"I found them informative and interesting," Dr. Marineau said.

Dr. Knight, who sold his practice a little more than a year ago, now teaches at OHSU three days a week. Though no longer treating patients in private practice, he still sees himself being involved in PROH in some capacity, in part because it is fun, but also because it sets a good example for dental students and helps inform his teaching.

"If you're gathering information as it's coming down the pike, it gives me more confidence that what I am saying is valid," he said. ●

Barry Finnemore is a freelance writer for ODA and a partner in Precision Communications ([www.precisionwords.com](http://www.precisionwords.com)). He can be reached at [precisionpdx@comcast.net](mailto:precisionpdx@comcast.net).

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## Mentor Dinner

The New Dentist Committee was back at OHSU School of Dentistry on January 30, for the ODA Mentor Dinner. Over 60 dental students spent the evening talking dentistry with nine ODA dentists.



Drs. Brook Noland and Matthew Biermann with a group of dental students.



Dr. Larry Franz speaks with dental students.



Dr. Richard Garfinkle keeps his table interested.



Dr. Fred Bremner speaking about his experiences.

*Thank you to the following ODA members who participated in the Mentor Dinner event:*

**Dr. Andrea Beltzner**  
**Dr. Matthew Biermann**  
**Dr. Sam Bobek**  
**Dr. Fred Bremner**  
**Dr. Nathan Doyle**  
**Dr. Larry Franz**  
**Dr. Richard Garfinkle**  
**Dr. Brook Noland**  
**Dr. Sue Walker**



Over 60 students came to have dinner and speak with nine ODA-member dentists about the profession.





The 2014 ODA Mentor Dinner, held in the second floor lounge at OHSU School of Dentistry, was a great success.



Dr. Andrea Beltzner has a captive student audience.



Dr. Sue Walker talking with the dental students at her table.



Dr. Nathan Doyle talking with dental students.

## NATIONAL SIGNING DAY



### 100% of fourth year dental students join the tripartite!

On January 29th, 56 fourth-year dental students registered to continue their membership in the tripartite following graduation, during an ADA National Signing Day presentation by the ODA's New Dentist Committee.

**Dr. Vanessa Brown**, a second-year ortho resident at OHSU, talked with the students about the importance of participating in organized dentistry. Membership dues are graduated for new graduates; they are free for the first year after graduation and increase 25% each subsequent year.

The ODA offered a challenge to the senior class at the OHSU School of Dentistry, and will contribute \$500 to their class fund because they reached 100% sign-up. Thanks to DS4 **Karley Bedford**, they met this goal within weeks of National Signing Day!

## Oregon's new Early Discussion and Resolution Law



William Pierce, MD

**THE EARLY DISCUSSION AND RESOLUTION LAW, TAKES EFFECT ON** July 1, 2014. The law, while voluntary, applies to most health care providers and facilities, including dentists, dental hygienists, and denturists. If an “adverse health care incident” occurs, defined in statute as an “unanticipated consequence of patient care which is usually preventable, and results in death of, or serious permanent physical injury to the patient,” the program may be activated.

The goals of the program are to allow for free and open discussions of medical/dental errors which have led to serious patient harm or death, and, if appropriate, to allow for fair and just settlements without litigation.

Early Discussion and Resolution programs have been in place for many years at the University of Michigan Health Care System and at the Stanford University Hospital system. Both hospital systems have reported a significant decrease in the number of lawsuits filed, a decrease in liability costs, and improvements in patient safety after initiating early discussion and resolution programs. It is hoped that the Oregon statewide program will experience similar success.

**Participation in the Oregon early discussion and resolution program is entirely voluntary for providers, and neither participation nor lack of participation in the program can be used against the provider if a lawsuit is ultimately filed.** If a serious adverse medical event occurs, and if the practitioner wishes to participate in the Early Discussion and Resolution process, the practitioner files a simple form describing the event with the Patient Safety Commission. It is anticipated that most practitioners will obtain assistance from their liability carriers upon filing with the Early Discussion and Resolution program. Once initiated, all conversations between the provider and patient are protected from discovery. This means that if a lawsuit is ultimately filed, a plaintiff’s lawyer cannot ask you, neither in deposition nor in testimony, about anything that you said to the patient

while engaged in the Early Discussion and Resolution process.

The Early Discussion and Resolution process may—or may not—result in a settlement offer made on your behalf by your liability carrier. If the patient and provider are close to, but cannot achieve settlement, the Patient Safety Commission will provide a list of mediators who can assist in settlement discussions. At closure (and not to exceed 180 days from filing unless agreed to by all involved parties), the provider files a closure notice with the Patient Safety Commission, describing whether or not resolution was achieved and the nature of the resolution.

It is important to note that the Oregon law also allows patients to file a notice asking providers to participate in the Early Discussion and Resolution program. The Patient Safety Commission will notify all involved providers about the filing. Upon receiving the notice, providers may participate or decline participation in the process, with no penalty for non-participation.

The statute of limitations for filing a lawsuit is tolled (put on hold) during the Early Discussion and Resolution process. A financial settlement in Early Discussion and Resolution does not preclude a future lawsuit (unless a lien is obtained as determined by both parties in settlement negotiations). If a future lawsuit results in an additional financial award, the money awarded in the Early Discussion and Resolution settlement is subtracted from the lawsuit award.

To protect the participants of the Early Discussion and Resolution process, information reported to the Patient Safety Commission, as part of the Early Discussion and Resolution process, may not be reported to any entity including the dental board, insurance plans, health care facilities, and government agencies. As dental errors that result in serious patient harm commonly involve errors in care systems, and not deficient care by a “bad” provider, the Patient Safety Commission will alert the dental

William “Bud” Pierce, MD, PhD, is a medical oncologist at Hematology/Oncology of Salem and past president of the Oregon Medical Association. He is co-chair of the Early Discussion and Resolution Implementation Task Force Committee.





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community when system errors are identified, to help prevent future errors. The alerts will be written in a way that protects the anonymity of participants in the early discussion and resolution process.

To summarize, Early Discussion and Resolution programs have a proven track record in closed health care systems, where they have been proven to decrease the number of lawsuits, lower liability costs, and to improve patient safety. Oregon will attempt to replicate these results in our statewide program.

Please consider voluntary participation in the Early Discussion and Resolution program. ●

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Debra Wong watches as **Dr. Patricia Parker** gathers her winnings.

**OVER 80 PEOPLE PARTICIPATED** in the DFO Texas Hold 'em Poker Tournament, sponsored by BnK Construction. The tournament, held February 1 at the Moda Plaza, helped raise over \$21,000 for DFO programs like the Tooth Taxi—a new record!

“All the credit for this event goes to Bill Ludwig and his team from BnK Construction,” said Charlie LaTourette, DFO’s Executive Director. “They worked tirelessly for many months selling sponsorships, gathering prizes, promoting the event and then managing all of the details of the tournament. We can’t possibly thank them enough.”

At 5 p.m., the tournament emcee, Rick Shandy from BnK Construction, thanked sponsors and delivered instructions to the players to “play cards.”

Over the next few hours, eight tables of players worked to eliminate their opponents, and by 11 p.m., we were down to the final table, with Aaron Raasch coming out on top.

Over \$5,000 in prizes were handed out to the top winners, including golf outings, gift cards, a luxury cruise, dinner certificates, Samsung Galaxy Gear, a Kindle Fire, and even a month of free Bikram Yoga instruction.

“We are very grateful to all our sponsors and players for their support,” said Charlie LaTourette. “Special thanks to Moda Health for giving us the space to hold the tournament this year, and to all of the sponsors who donated cash or prizes for the evening.”

For a complete list of sponsors and more photos, visit the DFO website, [www.SmileOnOregon.org](http://www.SmileOnOregon.org), and their Facebook page. ●





DFO Executive Director, Charlie LaTourette with Bill Ludwig, President of BnK Construction.



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Read about the Tooth Taxi at

[www.SmileOnOregon.org](http://www.SmileOnOregon.org)



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## School launches Dean's Seminar Series

By Sydney Clevenger

**T**HE OHSU SCHOOL OF DENTISTRY'S new Dean's Seminar Series—designed to promote oral health research—is stimulating exciting scientific discussions within the school. The Dean's Seminar Series kicked off in late 2013, and three guest speakers have now presented the latest in their research on topics including tissue engineering, inflammatory pain, and oral health quality improvement efforts.

The Dean's Seminar Series is open to the dental community, and information on the regularly-scheduled lectures can be found on the school's Facebook page ([www.facebook.com/ohsuschoolofdentistry](http://www.facebook.com/ohsuschoolofdentistry)).

"Research is a key part of the mission at OHSU, and at the School of Dentistry," said Dean **Phillip Marucha, DMD, PhD**. "We are conducting quality research at the dental school, and we want to share what we're doing with the broader university and dental community in hopes of strengthening collaborations."

Dr. Marucha said the seminar series is designed to promote oral health research and will "provide visioning" for future research at the dental school. Dr. Marucha said he also hopes to further engage dental students in research.

"[The seminar] was an awesome opportunity to see so much of what we've learned, including neurophysiology/patch clamping, histology, and anatomy," said first-year dental student **Alayna Schoblaske**, who attended the first Dean's Seminar Series, which featured the nationally-recognized **Kenneth Hargreaves, DDS, PhD**, professor and chair of endodontics at the University of Texas Health Science Center at San Antonio, presenting "Iron in the Fire: The Role of Endogenous TRPV1 agonists in Inflammatory Pain."

In addition to lecturing on research, Dean's Seminar speakers have made the



Jacques Nör, DDS, PhD, the Donald A. Kerr Professor of Dentistry in the department of cariology, restorative sciences, and endodontics at the Univ. of Michigan, speaks with OHSU School of Dentistry Professor of Restorative Dentistry **David Mahler, PhD**, prior to speaking at the dental school as part of the new Dean's Seminar Series.

most of their visits to Oregon, talking with researchers at other OHSU schools, going on tours of the dental school's new building under construction, connecting with dental students actively involved in research, and meeting with members of the dental community.

Said Professor of Integrative Biosciences and Associate Dean for Research **David Morton, PhD**, "The speakers selected for the series are undisputedly leaders in their respective fields and we are pleased to regularly bring such clinician-scientists to speak at the dental school." ●

*The dental school's annual Research Day is May 9, with Dean Phillip Marucha providing the keynote on his immunology research.*

*(At press time, a speaker was still being determined for April.)*

The OHSU School of Dentistry can be found online at [www.ohsu.edu/sod](http://www.ohsu.edu/sod).

The School is also on Facebook: [www.facebook.com/ohsuschoolofdentistry](http://www.facebook.com/ohsuschoolofdentistry).

Sydney Clevenger is Communications Coordinator for the OHSU School of Dentistry. She can be reached at [clevenger@ohsu.edu](mailto:clevenger@ohsu.edu).





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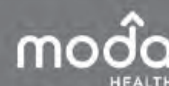
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**GENTLE DENTAL IS CURRENTLY LOOKING** for Orthodontist for Oregon Area. Gentle Dental provides a large network of resources, including an experienced practice management staff, cutting edge technology, and outstanding benefits. You will also have plenty of dental professionals supporting you to confer and collaborate with as you continue to grow in your career. We seek high-caliber professionals possessing degrees or certificates from accredited colleges or technical schools/programs (as well as valid/current state license) with at least 1 year of dental experience and completion of an Orthodontic residency program. We aim to provide our network of affiliated doctors and staff with a competitive benefits package, which include: medical, dental, vision, life insurance, 401K plan, PTO, CE credits, and career opportunities to advance with the company. APPLY: [http://interdent.force.com/careers/apex/ts2\\_\\_\\_JobDetails?jobId=a0xi00000001YVUPAA4](http://interdent.force.com/careers/apex/ts2___JobDetails?jobId=a0xi00000001YVUPAA4).

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*classifieds continue on page 32*

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