Dental Implant Safety Workgroup Meeting
Minutes
May 17, 2018

MEMBERS PRESENT:	Gary Underhill, D.M.D., Co – Chair Julie Ann Smith, D.D.S., M.D., M.C.R., Co – Chair S. Shane Samy, D.M.D. – ODA designee Normund K. Auzins, D.D.S. – ODA designee Cyrus B. Javadi, D.D.S. – Board Appointed Duy Anh Tran, D.M.D. – Board Appointed Russell A. Lieblick, D.M.D. – Board Appointed Donald Nimz, D.M.D. – Board Appointed
STAFF PRESENT:	Stephen Prisby, Executive Director Teresa Haynes, Office Manager Ingrid Nye, Examination & Licensing Manager
ALSO PRESENT:	Lori Lindley, Sr. Assistant Attorney General
VISITORS PRESENT:	Vaughn G. Tidwell, D.M.D., James A. Miller, D.M.D., Jen Lewis-Goff, ODA; Donald Compton, D.M.D., Kaz Rafia, D.D.S., OAGD, Frank Stroud, D.D.S., OAGD, Nathan Tanner, D.M.D., OAGD, Lawrence Ebel, D.M.D., Richard Zeider, D.M.D., Duane Starr, D.M.D., David Carsten, D.D.S., Ian Pham, D.M.D., Tad Hodgert, D.M.D., Keith Collins, D.M.D.

The meeting was called to order by Dr. Underhill at 6:30 p.m. Dr. Underhill welcomed everyone and requested that those present introduce themselves.

Workgroup members reviewed the minutes from the January 25, 2018 Dental Implant Safety Workgroup Meeting. A motion was made by Dr. Auzins, seconded by Dr. Tran, that the Workgroup approve the minutes as amended. Dr. Smith, Dr. Underhill, Dr. Samy, Dr. Javadi, Dr. Auzins, Dr. Tran, Dr. Lieblick, and Dr. Nimz voted aye.

The Workgroup reviewed an email from Dr. Gary Underhill, Co-Chair of the Dental Implant Safety Workgroup and President of the Oregon Board of Dentistry. Dr. Underhill's email constituted a report on the research he had completed into the use of dental implants in the Oregon dental community. Dr. Underhill's report indicates that a "frenzy for revenue" is driving the increasingly widespread use of implants in the dental community. Dr. Underhill's report uncovered what he found to be inadequate training for dentists placing implants, and lax (or nonexistent) treatment planning prior to implant placement. Dr. Underhill referred back to the OBD's Strategic Plan, which was adopted in August of 2016, and the inclusion of Patient Safety as a critical priority. Dr. Underhill emphasized that in order to address the Patient Safety priority in the context of implant placement, the OBD must establish educational requirements for implant placement, as well as a set standard of care.

The Workgroup reviewed a letter from Dr. James Miller that included his suggestions for improving the dental implant education process and implant-related licensing requirements for both specialists

and general dentists.

The Workgroup reviewed an email from Dr. S. Shane Samy. Dr. Samy's email contained his recommendations for appropriate continuing education requirements (including both didactic and live clinical training) that he suggests a dentist should be required to complete prior to that dentist obtaining implant placement privileges from the OBD.

The Workgroup reviewed an email and an opinion article written by Dr. Frank Recker regarding implant dentistry in the context of specialties recognized by the ADA, and CODA's recent decision to add implant dentistry requirements to their accreditation standards for the following ADA-recognized specialties: oral and maxillofacial surgery; periodontics; prosthodontics; and endodontics. Dr. Recker's article compared the standards imposed on accredited post-graduate programs by CODA with the American Board of Oral Implantology/Implant Dentistry's requirements for certification.

The Workgroup reviewed an article from DrBicuspid.com, written by Theresa Pablos, a DrBicuspid.com associate editor. The article delved into the level of public knowledge and awareness (for patients and/or other individuals outside the dental professions) surrounding the use and composition of dental implants for tooth replacement. The article reported gaps in critical knowledge and public awareness; the article suggest that these gaps are possibly due to the relative novelty of dental implant usage and availability.

The Workgroup reviewed a letter from Dr. Kipp Hammon. Dr. Hammon's opinion is that general dentists and specialists placing implants must be "qualified", meaning that they are well trained and prepared to handle complications. Dr. Hammon stressed the importance of good communication amongst all the branches of dentistry. Dr. Hammon also mentioned financial concerns driving implant use in dental practice, and also expressed concern about dentists who utilize "knock-off" implants or mix components in the interests of cutting their own costs and maximizing profit.

The Workgroup reviewed the conditions for ADA CERP recognition, and the AGD PACE program.

The Workgroup reviewed a letter from Dr. Lieblick; the letter expressed Dr. Lieblick's opinion that many of the special skills and training required for successful dental implant use can be compared to the special skills required from oral surgeons. Dr. Lieblick compared the high level of training required in oral surgery programs to the type of training typically received by general practitioners. Dr. Lieblick expressed that oral surgeons do experience complications with implant placement, but are often better suited to fix those problems, resulting in better outcomes on the whole. Dr. Lieblick's letter referred to a July 2014 JADA article (which was provided in full to Workgroup members) entitled "Outcomes of implants and restorations placed in general dental practices". Dr. Lieblick argued against the OBD introducing new implant dentistry regulations to protect the public, as he believes regulation will drive more unqualified dentists to attempt implant dentistry, not less. If the OBD determines that it must regulate the education of dentists wishing to utilize dental implants, Dr. Lieblick stated he believes transparent informed consent is the best way for the OBD to proceed, along with mentored programs for training.

Workgroup members were given the opportunity to express their thoughts about the materials that were being discussed.

Key Discussion Points

- Patients are poorly informed about many issues related to implant dentistry, such as information about the provider placing the implant, potential complications, and the materials or products used.
- Some referring dentists are providing their patients with a great deal of information prior to the procedure, others however are not providing any information. The Workgroup considered whether "spending the time" to foster better verbal communication between the referring dentist, the patient, the lab and/or manufacturer, and the implant provider might resolve some issues.
- Mixing of implant materials and parts, along with the use of inexpensive "knock-off" parts that may be substandard is seen as resulting in a higher risk of failure.
- Although the OBD may be able to introduce new regulations that address issues such as proper training and experience, there are several major factor in bad implant dental outcomes that would be difficult or impossible to address with rule changes of any kind. They include:
    - Poor judgment.
    - A bad "moral compass".
    - A desire for profit that comes at the expense of the patient's health.

  With that said, the overriding opinion seemed to be that most implant dentists are well-intentioned providers who "get in over their heads".
- A debate took place about whether the suggestion that dentists complete a certain number of restorations (100 was the original suggestion) prior to placing implants is a practical and reasonable requirement for the OBD to impose.
- The Workgroup seemed to agree that there should be more than one pathway available if educational or licensing requirements are imposed.
- Some suggestions were made for continuing education that would be required of those dentists who were permitted to place implants (once approved), such as needing to perform a certain number of implants per year, etc.
- Many Workgroup and audience members spoke of the importance of mentoring and supervised training (by other dentists and/or surgeons, rather than by lab technicians or employees of the manufacturers) in effective training programs.
- The Workgroup should consider further defining the scope of practice.
- The Workgroup should consider which party (or parties) is ultimately responsible for implant outcomes.
- A request was made that the Workgroup define what is meant by "weekend courses".

Dr. Vaughn Tidwell presented information pertaining to the proper education of dental professionals in placing dental implants. The Workgroup reviewed Dr. Tidwell's proposal that local county dental societies each implement a dental implant education program or study club; the study club Dr. Tidwell cited as an example was lead by one certified specialist and one general dentist. Dr. Tidwell also provided a letter from Dr. Thomas Alexander, a former member of the dental implant study club. Dr. Alexander's letter was highly complimentary of the dental study club as a venue for implant education.

Dr. Tad Hodgert discussed his own educational background, including courses that decided to complete based on his own perceptions of shortcomings in his training. Dr. Hodgert stated that weekend courses were an important part of this process, and that on the whole, weekend courses "aren't always a bad thing" and that the Workgroup should foster open-mindedness about CE opportunities. Dr. Hodgert stated that he believes that ample continuing education is ideal, and that

in order to be most effective, the course(s) should develop competence through supervised, hands-on training. Additionally, Dr. Hodgert expressed his concern that some dentists may be advertising that they "do implants" when in fact their experience is limited (to an extremely small number of implant placements, and/or to implant restorations only, with no experience placing implants) or entirely non-existent. Dr. Underhill requested a written summary of Dr. Hodgert's comments.

Dr. David Carsten stated that CE hours and the passage of structured clinical examinations cannot necessarily predict competence. Dr. Carsten also stated that the OBD should foster further discussion to better define the scope of practice of dentistry in the context of implant dentistry, as well as consider definitions and parameters for "safe beginners", "competence for a broader scope of practice" and "specialists". Finally, Dr. Carsten stated that mentoring is a vital component of proper training.

Dr. Keith Collins also advocated for mentorship in training courses, particularly in the context of membership in a dental study club, which can foster positive relationships with other providers, an educationally beneficial relationship with a mentor, and valuable exposure to "top lecturers" on the topic of implant dentistry. Dr. Collins noted that oral surgeons sometimes sponsor weekend restorative courses comprising only a few hours are taught by lab technicians and/or employees of the manufacturers with the intent of directing more referrals from restorative dentists to oral surgery, and without any training being provided by the oral surgeon. Dr. Collins unfavorably referred to this type of course as "tinker-toy" course, and stated these "tinker-toy" courses, neither the lab technician nor the dentist taking the course has a comprehensive knowledge base necessary to develop a treatment plan that will result in a positive outcome for a patient. Dr. Collins stated that dentists can learn valuable information at many types of courses, and expressed particular admiration for individuals who complete the multi-year ABOI program. Dr. Collins mentioned CODA's recent review of Loma Linda University School of Dentistry's educational program. Dr. Collins stated that he agreed with Dr. Carsten's suggestion that the OBD's rules provide more than one pathway for individual licensees to meet any requirements the OBD eventually imposes for dentists who wish to include implant dentistry in their practices.

Dr. Underhill thanked Dr. Collins for his input, and reiterated that interested parties should place their comments in writing so that all concerns and opinions could be considered by the Workgroup prior to making a recommendation for action to the OBD.

Dr. Lawrence Ebel discussed his practice as a relatively young general dentist who has been placing and restoring implants for about three years so far. In those three years, Dr. Ebel reports having completed roughly fifty restorations, and commented that requiring a certain volume of implant placements/restorations may not be as expedient for some practitioners as Workgroup Members had suggested during earlier discussions. Dr. Ebel stated that the educational component was of critical importance, and expressed his support for weekend courses, and specifically mentioned the course provided by the ABOI and the ACOI.

Dr. Underhill commented that his concern regarding weekend courses comes from the suspicion that the course providers are motivated by financial concerns, and seek to convince newly licensed dentists to spend money on certain products.

Dr. James Miller introduced himself as a Diplomate of the ABOI. Dr. Miller stated that becoming a Diplomate of the ABOI or obtaining training through AAID will likely take seven years. Dr. Miller stated that by contrast, the Maxicourse is ten months long and includes seven clinical days, during which an instructor scrubs in alongside the enrollee; the instructor provides guidance and ensures

safe pacing, and the course covers every step of the process from treatment planning to the final restoration. Dr. Miller provided an example of one of the problems he sees in his practice, whereby treatment is provided, while technically legal/acceptable, is inappropriately drastic, resulting in a negative experience for the patient. Dr. Miller stated that poor pre-operative treatment planning is the cause of that type of problem. In response to Dr. Miller's comments, Dr. Underhill and Dr. Auzins reiterated the importance of good judgment and ethical treatment of the patient. Dr. Underhill and Dr. Miller engaged in a dialogue about the potentially prohibitive expense of comprehensive implant training courses that include a robust "hands-on" clinical element.

Dr. Ian Pham mentioned the many difficulties dentists experience with the implant materials themselves: design flaws; dentists who choose cut-rate labs or materials that either disappear or fail; dentist who mix different implant components despite fears that mixing components results in a higher rate of failure. Dr. Underhill thanked Dr. Pham for his comments and voiced his agreement that choice of parts and labs was of critical importance. Dr. Underhill also requested that Dr. Pham submit his comments in writing.

Dr. Nathan Tanner spoke to the importance of obtained informed consent from the patient prior to beginning treatment. Dr. Tanner and Dr. Underhill engaged in a dialogue about ultimate responsibility for providing good patient care falling to the dentist providing the implant, despite the pressures of aggressive marketing and patients making specific demands of their dentists that may not represent a good treatment option. Dr. Tanner expressed an opinion that "slowing down" is an important element of providing the best treatment. Dr. Tanner also agreed with other Workgroup members and providers who had suggested a tiered approach to the OBD allowing dentists to place implants, such as requiring a certain number of restorations prior to granting permission.

Dr. Duane Starr commented on the problem of "dental consumerism"; the patients' drive to make specific demands of their dentists can end up rather dangerously coupled with corporate dental offices' desire to "give the patients what they want". Dr. Underhill responded that newer dentists may have a more difficult time than older dentists with long-established practices in turning patients away and/or refusing to provide inappropriate or risky procedures simply because the patient demands that the dentist do so.

Dr. Keith Collins made an additional comment about liability, and which entities ultimately bear responsibility for negative outcomes. Dr. Collins noted that under the current system, labs and manufacturers do not usually end up taking any portion of the blame for negative outcomes.

Dr. Underhill and Dr. Smith summarized the main discussion points of the meeting, as listed above, and the Workgroup's plan to recommend rules to the OBD. Dr. Underhill acknowledged Ms. Lindley's presence and stated that Ms. Lindley would be assisting the Workgroup in navigating existing regulations and laws. Dr. Underhill and Dr. Smith opined that the Workgroup is "close" to finalizing specific recommendations for OBD review. The Workgroup devised a plan for the next steps to be taken by the Workgroup members, the OBD, Board staff, and/or any other interested parties. The Workgroup will make a recommendation to the OBD for action later in 2018.

Workgroup members were encouraged to send any relevant information to the OBD's Executive Director, Stephen Prisby. The Board will correspond with members of the Workgroup via email to set a future meeting date.

The meeting was adjourned at 8:17 p.m.