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EXTRAORDINARY CONTRIBUTIONS OF OUR VOLUNTEERS

Dentists often ask me why the College is so successful. I am always quick to answer that one of the leading reasons is the extraordinary efforts of all our Council members. Time after time I am amazed at their commitment and contribution.

We hear so much about the work of the College Council and committees. But sometimes we might forget that they are composed of real live people who have decided to go out of their way to serve.

Whether an elected member, a public appointee, or a non-Council member, they all make an enormous contribution to the College's critical work. Each one of them clearly understands our mandate of public protection. Dentists and public members work side-by-side, all committed to doing the right thing.

These volunteers spend countless hours on College business. The actual formal meeting days are just the tip of the iceberg. Days of preparation are spent to read the background material for their committee or for Council. Others may take a day and a half or more one way in travel time to get to Toronto for a meeting.

The College does its very best to ensure that all volunteers are treated respectfully and given full support to ensure that their time at the College is both effective and rewarding.

Nothing says it better than the opening welcome statement in the front of the orientation binder that the College gives to each new member of Council:

"As a volunteer Council member, you are to be congratulated for your desire to help others. Many people only wish they could make this a better world – but you have taken action to help turn dreams into reality.

The governing Council is a vital element in the self-regulation of the profession. The College's motto is Ensuring Continued Trust. The responsibility to make that motto a reality is now yours."

CONTINUED ON PAGE 51
Sometimes a good idea takes a little time to grow and take root and blossom. That is certainly the case with the College's continuing education program. Back in early 2003, the College had a dream. As College Registrar Irwin Fefergrad explains: We wanted to capitalize on the use of technology and deliver educational programs right to the dentist’s home or office and we wanted to develop interactive courses where members could work at their own pace and schedule.

To explore the best way to proceed, the Fresh Look at Member Education (FLAME) initiative was launched. FLAME asked members what they would like to see in the future. Through sample groups, questionnaires and face-to-face meetings, we heard your views and opinions.

“The one sure thing was the College’s total commitment to the concept of continuous professional development,” said Fefergrad. “Over the past few years, every Executive Committee, every Quality Assurance Committee and every Council involved in this process has understood the importance of lifelong learning. They all agreed that the ultimate purpose of our continuing education program is to contribute to high-quality patient care.”

The recent amendments to the Regulated Health Professions Act now require each health-care regulatory college to develop, establish and maintain programs to promote continuing competence among its members.

“As usual Council members have demonstrated great wisdom and vision,” explained Fefergrad. “Our College is definitely in good shape when it comes to compliance with these new legislated requirements.

“We have a long history of support to our members for continuing education, from roadshows to the PEAK articles in every issue of Dispatch. This new plan for continuing education is the logical next step forward.”
The College’s Continuing Dental Education program (CDE) is taking on a new look, starting with the 2009 cycle.

The new program will continue to recognize that we all learn in different ways. It also allows great flexibility with a range of continuing professional development options to choose from, depending on your learning preferences, course and time availability, and your geographical location.

Dentists will still have the ability to manage their individualized program of continuous professional development to meet their unique needs.

One of the goals is to decrease some of the paperwork involved in tracking your individualized CDE program.

Like the existing program, members will still be required to obtain 90 CDE points over a three-year cycle.
REPORTING POINTS
Commencing in 2009, members will no longer be required to submit the current reporting form detailing their educational experiences. Members will simply indicate on their annual renewal form whether or not they are in compliance with the College’s CDE program.

RECORDKEEPING REQUIREMENTS
As with the current CDE program, members will be required to keep a file of their educational experiences and provide that file for review if they are randomly selected for a continuing education audit.

ALLOCATION OF POINTS
Members will be required to have a minimum of 60 points from approved course providers, such as dental faculties, dental associations or regulatory bodies, Academy of General Dentistry course providers, or approved study clubs. Of the 60 points, 15 must be collected from programs that the College’s Quality Assurance Committee has approved as core programs.

TRANSITIONAL ASSISTANCE
Each member will receive a continuing education booklet from the College together with their final reporting form in the summer of 2008. The booklet will explain the new program in detail and provide members with a designated helpline to call to clarify any issues. The booklet will list approved course providers and approved core programs. This information will also be online and amended as necessary to keep members up-to-date.

Also, keeping track of your CDE points will be easy with a special section in the booklet for you to record your courses and keep a running total of points obtained in each category.

A storage pocket in the booklet means you can keep all the documentation of attendances and course assessments in one handy location.

FINAL REPORTS FOR CURRENT PROGRAM
Members will make their final report on the current program in the fall of 2008. Members who have only completed a portion of their three-year cycle will be allowed to report for the portion completed.

College staff will be available to assist members who have any difficulties during this transition.
The College’s latest addition to our LifeLong Learning Program, Dental Emergencies – A guide to the treatment of patients requiring urgent dental care, is now released. And it looks like we have another winner!

Feedback from members is extremely positive. Some are impressed with the incredible educational content of the package. Others have noted the $250 fee for submitting the quiz results is a reasonable charge to collect the 15 continuing education points from the College and the additional points from the Academy of General Dentistry.

As one member said: “It’s half the cost of most competitive products out there.” Another member points out, “I just think about the money I have saved by not having to close my office and cover big ticket expenses for travel and accommodation.”

This latest package is the College’s first joint venture with the Faculty of Dentistry at the University of Toronto.

“The College is indebted to the Faculty members who so generously gave of their time and expertise to act as the content experts. That’s why this CD is such a quality learning experience,” explained College Registrar Irwin Fefergrad.

There is an incentive to encourage members to take advantage of this excellent educational opportunity: a $25 discount for members who complete the course and submit their quiz results to the College by May 1, 2008.
LifeLong Learning now has its own special section on the College website. Look for the special LifeLong Learning logo on the right-hand side of the home page at www.rcdso.org.

“This new area on the website is part of our commitment to support dentists in continuous learning throughout their professional practice,” said College Registrar Irwin Fefergrad. “We know that members see our website as an important source of information about the College and its services. Most months we get over 500,000 hits on the site and over 8,000 unique visits.”

The LifeLong Learning section will be the place to go for bonus educational material and updated resource material associated with the College’s learning packages.

Starting with the latest production on dental emergencies, links to additional reading material for each chapter of the CDs will be loaded in this section of the website.

Plus, to ensure that members have the latest available information, in some chapters of this new CD, there is an automatic link to our website. In this way, the information, such as pharmological advice, can be updated as needed to keep it as timely as possible.

“This integration of the learning packages and the College website definitely extends the shelf-life of this valuable educational and reference tool,” said Fefergrad. “We will update members in Dispatch magazine as information is revised or added.”

Members who do not have online services can contact the professional practice staff at the College for a paper copy of the current information.
What effect do the amendments to the Regulated Health Professions Act have in the dental office in an employment context?

What impact, if any, do the amendments have, between an employer and employee in the dental office?

Historically, dental hygienists in Ontario could perform the acts of root planing and scaling only under order of a member of the Royal College of Dental Surgeons of Ontario. Under the new legislation, dental hygienists, who have been approved by the College of Dental Hygienists of Ontario (CDHO), may self-initiate these acts. Those who are not approved, or who choose not to apply, still require an order.

These amendments raise several issues for dental practices. First, do these amendments mean that a dental hygienist, authorized by CDHO to self-initiate, may do so regardless of the wishes and directions of an employer? Second, can the dental hygienist set up a separate practice in competition with the dental practice? Let’s look at these issues.

First, do these amendments mean that a dental hygienist, authorized by CDHO to self-initiate, may do so regardless of the wishes and directions of an employer?

In short, the answer is no. A health-care professional may be qualified and have legal authority by regulation and college authorization to perform a number of procedures. That capacity does not override terms of employment which may limit the exercise of that health-care professional’s skills within a practice or clinical setting.

Since the employment relationship is critical to the question of self-initiation, it is important to identify what distinguishes an employment relationship from more independent forms of practice. While no single factor is determinative,
factors identifying an employment relationship include:

◆ no financial interest in the profits or success of the practice;
◆ no ownership of the business or practice;
◆ an employer directs and controls when and how the work of the employee is to be performed;
◆ individual employee does not own the equipment;
◆ individual employee does not employ assistants;
◆ individual employee receives a calculable income, wage or salary subject to employment deductions.

By definition, an employment relationship means that an employer maintains the right to direct and control when and how work is to be performed.

It must also be understood that not every dental hygienist employed within a dental practice will be legally authorized to self-initiate root planing and scaling.

It should also be noted that not every relationship in a dental office is one of employment. Some relationships may allow for more independent conduct by a health professional in which the professional is by contract engaged as an independent contractor to provide a service rather than be “in the service” of the practice as an employee.

If a dental hygienist has been authorized by CDHO to self-initiate these two controlled acts, such procedures can only be performed under the authority of the Dental Hygiene Act, 1991:

“…if none of the contraindications prescribed in the regulation to performing the procedure are present, and if the member ceases the procedure if any of the prescribed contraindications to continue the procedure are present.”

As the capacity to self-initiate is new, this calls for an employer to make a determination as to whether that capacity, if authorized, will be used in his or her practice. This goes back to the basic premise that a hallmark of an employment relationship is an employer's ability to direct and control. The exercise by an employee of a new capacity or skill at work remains subject to an employer's direction.

Can a dental hygienist set up a separate practice and compete with the dentist?

There is, at common law, an implied duty of good faith and loyalty owed by an employee to their employer. Unless enlarged by express terms in a written employment contract, this duty requires respect for an employer's client lists and developed practice.

Employees, because of this duty, may not use the relationships they develop with patients in the course of employment to advance their own practice to the detriment of their employer while they are employed. This general obligation does not prevent an employee from planning, on her or his own time, to go into business for herself or himself.

The trend today is that our courts are demonstrating an increasing reluctance to enforce written contracts of employment that provide non-competition terms, particularly when it is determined that a non-solicitation provision would protect the economic interests of an employer.

Having said that, written employment contracts are still the best way to ensure there is some certainty as to the terms of an employment relationship. A dentist, as an employer considering an employment relationship with a dental hygienist, should consider these issues with legal counsel when drafting a written contract. Unfortunately, it is often very difficult to introduce a written employment contract into an existing employment relationship. It is possible, but again legal guidance should be secured.

The decision to allow self-initiation in a dental practice by an employed dental hygienist should remain that of the employer.

Every case is different and dentists should seek their own counsel in determining what is permissible in their offices.

This article contains material which is intended to be of general interest and is not intended to be relied upon as legal advice or to replace a consultation with a legal professional on any particular matter.
Spotlight on Self-Initiation

A number of legislative and other changes* have recently taken place that now allow some dental hygienists to self-initiate scaling and root planing under specific circumstances.

This article is directed to dentists to offer assistance and guidance under the new changes. It explains these circumstances and provides dentists with information regarding their responsibilities for their patients, whether the dental hygienists they work with can self-initiate or not.

Q: Can all dental hygienists now self-initiate?

No. Only dental hygienists approved by the College of Dental Hygienists of Ontario (CDHO) will be able to self-initiate scaling and root planing. Dental hygienists not approved to self-initiate will continue to require an order from a dentist for scaling and root planing.

Q: How will I know if a dental hygienist has been approved to self-initiate?

CDHO issues a seal to the members it approves for self-initiation; this seal is intended to be affixed to the dental hygienist’s certificate of registration. The CDHO website (www.cdho.org) lists dental hygienists who have been approved to self-initiate. CDHO can also be contacted by telephone to confirm whether a dental hygienist has been approved to self-initiate.

Q: Can a dental hygienist who has been approved by the CDHO to self-initiate scaling and root planing do so under all circumstances?

No. Dental hygienists approved to self-initiate scaling and root planing can only do so if the patient does not have any of the prescribed contraindications listed in the CDHO’s regulation. (See the highlighted box on page 15 for more details about these contraindications.)

*These changes include:

- proclamation of the Health System Improvements Act, 2007;
- amendment of the Dental Hygiene Act, 1991;
- passage of the College of Dental Hygienists of Ontario’s Regulation on Prescribed Contraindications To Scaling Teeth and Root Planing, Including Curetting Surrounding Tissue, on Member’s Own Initiative (“member” refers to a dental hygienist);
- approval by the College of Dental Hygienists of Ontario of a Standard of Practice for Self-Initiation.
Q: What happens if the patient has any of the prescribed contraindications?

If the patient has any of the prescribed contraindications, the dental hygienist will require clearance from the patient’s dentist or physician. In the case of a cardiac condition for which antibiotic prophylaxis is recommended in the guidelines set by the American Heart Association, clearance can also be provided by a registered nurse in the extended class (the patient’s nurse practitioner).

Q: What is clearance?

Clearance is the authorization to proceed with scaling and root planing for patients with any of the prescribed contraindications.

Q: Can dentists provide clearance for persons who are not their patients?

No. Dentists can only provide clearance for their own patients. Dentists should understand that persons can become patients of a dentist/dental practice for the sole/primary purpose of obtaining clearance from that dentist.

Q: What is necessary to provide clearance?

There is no specific protocol that dentists need to follow to provide clearance. Dentists need to carry out the necessary due diligence in obtaining the information they feel is necessary to be able to determine whether, and under what conditions, the treatment can safely be provided. Depending on the particular circumstances, the required due diligence may include one or more of the following:

- a telephone discussion with the dental hygienist clarifying certain terminology in a patient’s medical history;
- reviewing a copy of the complete medical history;
- consulting with the patient by telephone;
- examining the patient;
- providing a written report or completing a medical clearance form provided by the dental hygienist;
- consulting with the patient’s physician regarding the patient’s medical history if the dentist feels this is necessary.

The information that a dentist may require from the dental hygienist, the patient, and in some cases, the patient’s physician may depend on:

- whether there is a previously existing dentist-patient relationship;
- the specific contraindication;
- the complexity of the patient’s medical history;
- the patient’s oral condition.
Spotlight on Self-Initiation

Q: What information needs to be documented in the patient’s dental record?

The patient record at the dentist's office should detail the process that is used to provide clearance for that patient. Any and all verbal advice and consultations respecting the patient must be recorded in the patient record.

In addition, any and all written reports respecting the provision of clearance, including copies of any medical clearance form provided by the dental hygienist and the medical history form itself (if reviewed) must be kept in the patient record. Examination findings (if an examination is performed) must also be documented in the patient record.

Q: Can dental hygienists perform scaling and root planing without a dentist in the office?

Yes. Dental hygienists can perform scaling and root planing without a dentist in the office regardless of whether they can self-initiate or not.

Q: I do not accept patients for scaling and root planing in my practice who refuse an examination. Must this change with self-initiation?

No. Dentists are able to establish office policies that determine which patients will be accepted for treatment in their practices.

Q: I am willing to accept patients for scaling and root planing in my practice who refuse an examination. The dental hygienists who are employed by me can self-initiate. What happens if the patient requires clearance?

If a patient who has previously refused an examination has any contraindications and requires clearance from a dentist, then the dentist will have to perform the necessary due diligence before providing clearance.

If the contraindication is an oral condition and the dentist determines that an examination must first be performed, the patient should be advised that an examination will be necessary and that there may be a fee associated with it.

NEED FURTHER INFORMATION?

- The Health System Improvements Act, 2007, the Dental Hygiene Act, 1991, and the College of Dental Hygienists of Ontario’s Regulation on Prescribed Contraindications To Scaling Teeth and Root Planing, Including Curetting Surrounding Tissue, on Member’s Own Initiative can all be found on the Government of Ontario website at www.e-laws.gov.on.ca
- The CDHO’s Standard of Practice can be found on the CDHO website at www.cdho.org
- Information about orders can be found in “What is the Status of the Orders Regulation?” which appeared as a supplement to the January/February 2002 issue of Dispatch Magazine and is available on the RCDSO website at www.rcdso.org under Publications and Resources.
Prescribed Contraindications To Scaling Teeth and Root Planing, Including Curetting Surrounding Tissue, On Member’s Own Initiative

(from Ontario Regulation 218/94, as amended, made under the Dental Hygiene Act, 1991)

The following contraindications are prescribed if the patient has not received clearance from a physician or dentist, or both:

1. Any cardiac condition for which antibiotic prophylaxis is recommended in the guidelines set by the American Heart Association (AHA), as those guidelines are amended from time to time, unless the member has consulted with either the patient’s physician, dentist or registered nurse in the extended class (RN(EC)) and determined that it is appropriate to proceed if the patient has taken the prescribed medication per the AHA guidelines.

2. Any other condition for which antibiotic prophylaxis is recommended or required.

3. An unstable medical or oral health condition, where the condition may affect the appropriateness or safety of scaling and root planing, including curetting surrounding tissue.

4. Active chemotherapy or radiation therapy.

5. Significant immunosuppression caused by disease, medications or treatment modalities.

6. Any blood disorders.

7. Active tuberculosis.

8. Drug or alcohol dependency of a type or extent that it may affect the appropriateness or safety of scaling and root planing, including curetting surrounding tissue.


10. A medical or oral health condition with which the member is unfamiliar or that could affect the appropriateness, efficacy or safety of the procedure.

11. A drug or combination of drugs with which the member is unfamiliar or which could affect the appropriateness, efficacy or safety of the procedure.
As regulated health professionals, dentists, dental hygienists and all other self-governing health-care providers are accountable and responsible for the quality and appropriateness of the professional services that they provide.

With regard to oral health care, if a patient expresses concerns about the competence, professionalism, conduct or ethical behaviour of a dentist or a dental hygienist, these matters are dealt with through the complaints and/or investigations processes of the respective regulatory college: the Royal College of Dental Surgeons of Ontario for dentists and the College of Dental Hygienists of Ontario for dental hygienists.

When a patient sues for negligence using the civil courts, at times it is difficult for the patient and/or legal representative to determine whether the responsibility lies with the dentist, dental hygienist, or indeed other health-care providers. Often all who might have had an involvement are named as defendants in the lawsuit.

The courts need to determine the level of liability and who is really responsible for the treatment in each case. The courts will decide the percentage of negligence of the parties named and will apportion the liability of accountability. For dentists, it is our experience that the insurance provided by our professional liability program is more than adequate to cover all circumstances.

The rationale for this shared liability could include:

◆ the services of the dental hygienist or other health-care provider were rendered in the dentist’s office; and/or
◆ the dental hygiene services were rendered by virtue of an order provided by the dentist; and/or
◆ the dentist provided clearance for the self-initiating dental hygienist.

Collaborative discussions are presently underway between the College and the insurance representatives for Ontario’s dental hygienists to explore this issue further.
MANDATORY REPORTS OF
SEXUAL ABUSE OF A
PATIENT BY A REGULATED
HEALTH PROFESSIONAL

The governing legislation of dentists and all other regulated health
professionals in Ontario, the Regulated Health Professions Act, 1991,
requires you to report the sexual abuse of a patient by a health
professional to that professional’s governing body if you acquire this
information in the course of your practice. This article is designed to
assist dentists in understanding their legal obligations with respect to
mandatory reports to the College that must be made in order to further
public interest protection.

Am I obligated to report sexual abuse of a patient by
another regulated health professional?

Yes. Under the governing legislation, the Regulated Health Professions Act, 1991
(RHPA), a regulated health professional must file a report if he or she has reasonable
grounds, obtained in the course of practising the profession, to believe that a
member of the same or different College has sexually abused a patient.
The report should be made to the College to which the regulated health professional
belongs. If you operate a facility, you are obliged to report if you have reasonable
and probable grounds to believe that a regulated health professional operating in
your facility has sexually abused a patient.

How is sexual abuse defined?

Sexual abuse is defined in the RHPA as:

◆ sexual intercourse or other forms of physical sexual relations between the
  member and the patient; or
◆ touching of a sexual nature of the patient by the member; or
◆ behaviour or remarks of a sexual nature by the member towards the patient.

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MANDATORY REPORTS OF SEXUAL ABUSE OF A PATIENT BY A REGULATED HEALTH PROFESSIONAL

What do I include in my report?
The report must be in writing and must include your name, the name of the regulated health professional that you suspect has sexually abused a patient, and an explanation of the alleged sexual abuse. The name of the patient should be included if the concerns relate to a specific patient and you have that patient's permission to reveal his or her name. If the patient declines to give permission for his or her name to be used, you still have an obligation to report the contact, but without the patient's name.

How soon do I have to make the report?
The report must be made immediately to the College to which that regulated health professional belongs and should be made as soon as possible, if you have reasonable grounds to suspect that the health professional will continue to abuse this patient or other patients. If you do not suspect that the abuse is ongoing, you should still make your report as soon as possible, but no later than 30 days after this information has come to your attention.

What are reasonable grounds?
Reasonable grounds to believe that another health professional sexually abused a patient should be based on credible information. This information may be relayed to you directly by the patient, or the patient's parent, guardian or custodian, or some other third party source.

You do not necessarily need to have spoken directly to the patient in order to have reasonable grounds to suspect abuse. Trust your instinct. It is the College's advice that it is better to err on the side of public interest protection when issues of sexual abuse are involved.

Once you make the report, determining the validity of the information is the job of the College to which the regulated health professional belongs.

Which health professions are regulated in Ontario?
In addition to dentists, the following professions are regulated in Ontario:

- Audiology and Speech-Language Pathology
- Chiropody and Podiatry
- Chiropractic
- Dental Hygiene
- Dental Technology
- Denturism
- Dietetics
- Massage Therapy
- Medical Laboratory Technology
- Medical Radiation Technology
- Medicine
- Midwifery
- Nursing
- Occupational Therapy
- Opticianry
- Optometry
- Pharmacy
- Physiotherapy
- Psychology
- Respiratory Therapy

As of June 4, 2009, the following health professions will also be regulated in Ontario:

- Traditional Chinese Medicine
- Kinesiology
- Psychotherapy
- Naturopathy
- Homeopathy

What if I do not know the patient’s name or the health professional’s name?
Even if you do not know the patient's name, if you know the health professional's name who is suspected
of abuse, that is enough to trigger a report. While you do not need the patient’s permission to make the report, you can only identify the patient by name if you have been given permission to do so. You should, however, make your best efforts to notify the patient of your obligation to file a report before doing so. If you do not know the name of the health professional who is suspected of abuse, then you do not have to make a report.

At a social function, someone who is not a patient of mine told me that he had been sexually abused by a colleague. Am I obligated to report this?

The law obligates you to make a mandatory report about information you receive while practising the profession. This does not extend to social situations. However, for public interest protection, you should seriously consider reporting this information to the colleague’s regulatory college. Also, since no patient-doctor privileges attach to you in this situation, you may wish to notify the police.

What if I know of, or suspect child abuse of a patient by a non-health professional, such as a parent or guardian?

If you are aware of or have reasonable grounds to suspect sexual or other abuse of a child patient, another type of mandatory report may be triggered. This is not a mandatory report to the College, as already mentioned. It is a mandatory report to the local Children’s Aid Society, required of professionals by the Child and Family Services Act, 1990. For more information on this topic, consult your local Children’s Aid Society or call the College’s Practice Advisor Dr. Lesia Waschuk at 416-934-5614 or toll-free at 1-800-565-4591.

One of my staff members has told me that my associate sexually harassed her. Do I have to make a mandatory report?

If the staff member also receives or has received dental treatment in the office, then that person qualifies as a patient and you must make a mandatory report to the College about your associate. If the staff person never was a patient, then you are not required to make a report to the College, but you may morally decide to do so in order to ensure that such behaviour does not continue.

Remember that this type of conduct, while not abuse of a patient, may be found to be professional misconduct. Accordingly, if you fired the associate, imposed conditions on his or her employment, or terminated your relationship with him or her for this reason, or if you intended to do so but the associate quit, then a mandatory report to the College is triggered by the RHPA, even if the staff member was never a patient.

What are the consequences of failing to make a mandatory report to the College of sexual abuse of a patient?

The provincial government and indeed the College take the obligation to report sexual abuse of patients very seriously. The RHPA sets out that the failure to make such a report is an offence which is punishable by law by fines of up to $25,000 for a first offence and $50,000 for a second or subsequent offence. The fines are higher if you are the operator of a health facility and fail to file a mandatory report, as required.

Also, if the College becomes aware that a dentist was obliged to report the sexual abuse of a patient to this or another College, but failed to do so, we have the ability to investigate whether the failure to report is an act of professional misconduct and disciplinary action may be taken.
Dentistry is a demanding profession for all members of the dental team. The stresses of daily practice can have a negative impact on the physical and mental well-being of dentists and their office staff. In addition to the constant striving for a perfect result, such factors as perceived busyness, demanding patients, financial worries and workplace discord, when added to the everyday problems of private life, can lead dentists and their staff members to search for ways to cope with their troubles and fears.

Instead of seeking help from their personal physician, health-care provider or support programs available to dental professionals, some dentists and staff members look for ways to deal with their particular issues on their own.

Some may seek solace and comfort from alcohol or prescription/illicit drug use. For some of this group, the drugs and other substances available in the dental office may seem like as a quick-fix solution to their problems.
Office drugs and substances can be misused by dentists and their staff members in various ways, including:

- writing prescriptions for non-dental reasons;
- misdirecting drug samples;
- using office drug supplies for personal use;
- after hours recreational use of nitrous-oxide;
- any combination of the above.

**PREVENTIVE STRATEGIES**

There are a number of strategies and safeguards that can serve to deter, to the extent possible, personal use of in-office drugs and substances by dentists and their staff.

The following are some preventive strategies:

- Institute strict inventory control of all controlled drugs and substances.
- Keep drugs in a locked storage cupboard, along with a drug log that accounts for the dispensing of all narcotic or controlled drugs and substances.
- Keep careful control of blank prescription pads and NEVER pre-sign prescription sheets.
- At the end of the day, either lock nitrous oxide tanks in a safe location or control access to the turn-off key/wrench.
- Use staff training sessions and meetings to discuss the dangers of drug and substance abuse, to remind staff of the safeguards and protocols in the office to prevent misuse of office supplies, and to provide information about resources that are available to dental professionals to assist with wellness issues.

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**WORKPLACE SAFETY AND NITROUS OXIDE USE**

The College's Guidelines on the Use of Sedation and General Anaesthesia in Dental Practice represent the standard of practice relative to the use of the various sedation and anaesthesia modalities used in Ontario.

While the prime purpose of these Guidelines is to ensure, to the extent possible, that patient safety is not compromised in any way by setting out training, staffing, monitoring, equipment, recordkeeping and emergency preparedness requirements, there is a workplace safety dimension to the document as well.

This component relates to the requirement for scavenging systems to be in place whenever inhalant gases (nitrous oxide-oxygen, anaesthetic agents) are utilized. Studies have shown that the health of female dentists/employees can be compromised if the exhaled gases are not properly controlled and are inhaled by staff.

For this reason, we want to remind all Ontario dentists of the requirement for properly installed and maintained scavenger systems in facilities where nitrous oxide-oxygen and anaesthetic gases are utilized.
Recreational/Personal Use of Drugs by Dentists and their Office Staff

>IN CONCLUSION

Health-care professionals, including dentists and their staff, are frequently exposed to periods of high stress. They are prone to perfectionism, and unrealistic expectations about themselves. And, when faced with a disappointing treatment outcome or an unhappy patient or other practice-related stressors, they may have trouble coping and resort to a chemical solution.

Since most dental professionals work in smaller private offices, largely isolated from their peers, this style of practice may facilitate access to drugs of potential abuse and make detection more difficult.

It is important, therefore, that dentists and their staff be vigilant about changing behaviour patterns of their workmates, and endeavour to offer support and assistance as early as possible.

In Ontario, any dentist and his or her staff members can access the Member Assistance Program (MAP) offered by the Ontario Dental Association’s Dentists At Risk (DAR) through the Canadian Dental Service Plans Inc. The College lends its support to this successful ODA program.
Not only is it important to have good communications with patients during treatment plan presentation, as part of the informed consent process and throughout treatment, it is crucial that these discussions be documented in the patients’ records. These two cases illustrate the importance of documenting these discussions.
The Importance of Documenting Discussions with Patients in their Dental Records

Case One

COMPLAINT SUMMARY
The College received a letter of complaint about endodontic treatment stating that following root canal therapy, the general dentist failed to place a temporary filling in the treated tooth.

DENTIST’S PERSPECTIVE
In her response, the dentist advised that, on August 19, 2006, the patient attended her office as an emergency patient. Upon examination, she noted that tooth 25 (upper left 2nd bicuspid) was painful to percussion and had an existing deep amalgam filling that was worn down, chipping, and/or leaking. The dentist recommended root canal therapy, followed by a crown. Given the extent of the leaking that continued underneath the gums on the lingual cervical margin, the dentist stated that she recommended a procedure to expose the decay prior to placing a crown on the tooth.

The patient consented to treatment and a pulpectomy was initiated. The dentist explained that she experienced some difficulty in obturating the entire length of the canal, as it seemed to be clogged about halfway down. She advised the patient about this and also explained that the root canal therapy could not be finished at the time. The dentist recommended that the patient return for a longer appointment, during which treatment could be finalized.

In the meantime, according to the dentist, she left the access to the tooth open and placed a cotton plug rather than a temporary cement filling so “if any buildup of pressure arose or the tooth needed drainage arising from necrotic tissue and bacteria, the cotton plug would allow for the needed escape avoiding unnecessary pain for the patient.”

The patient failed to return for a scheduled appointment on August 23, 2006.

OTHER INVESTIGATION
As part of its investigation, the College obtained records from the patient’s subsequent treating general dentist. The records indicated that, on August 23, 2006, she attended with slight upper facial swelling. Tooth 25 was very sensitive to percussion. It was apparent that the occlusal amalgam filling had been removed by another dentist, that there was a direct pulpal exposure with no temporary filling, and little (if any) enlargement of the root canal of the tooth was noted. An antibiotic was prescribed and root canal therapy was subsequently completed in two appointments.

DECISION OF THE COMPLAINTS PANEL
The panel reviewed all correspondence and records obtained during the course of its investigation, including, but not limited to, documentation submitted by the patient, the dentist in question, and the subsequent treating general dentist.

The panel was concerned about the dentist’s rationale for treatment and endodontic management of the patient’s tooth 25. In their view, the patient did not appear to have been
Case Two

COMPLAINT SUMMARY
A patient complained about her periodontist. The chief concerns were that he:

◆ did not specify the treatment to be provided, other than stating that he could fix her problem;
◆ did not treat the area requested (lower left molar area), but instead, provided treatment to another area of her mouth;
◆ declined to treat the lower left molar area;
◆ failed to provide her with an itemized receipt.

DENTIST’S PERSPECTIVE
In his response to the complaint, the dentist stated that, on March 1, 2006, he reviewed his proposed treatment plan with the patient, using layman terms, and obtained her informed consent to the following treatment:

◆ occlusal narrowing of the maxillary right restorations;
◆ mandibular anterior flap approach with local anaesthesia;
◆ mandibular left sextant procedures to include treatment of the mucogingival problem with free connective tissue graft on mesial abutment and the bifurcation involvement on the distal abutment by osteoplasty and ostectomy.

The dentist noted that, as with other procedures in the past, the patient asked him to speak with her son, which he did. The member advised that both the patient and her son instructed him to proceed with treatment. A predetermination of costs was provided.
The dentist explained that there was a lack of supporting gum over the root of tooth 35 (lower left 2nd bicuspid). This area was treated on March 13, 2006, using a connective tissue graft on tooth 34 (lower left 1st bicuspid) and osteoplasty and ostectomy on teeth 34 and 37 (lower left 2nd molar). Following treatment, the patient alleged that the graft was put in the wrong location. The dentist explained that the treatment was done to preserve the tooth 35 abutment and not for aesthetic reasons. He also noted that the fee of $2,963.29 included, not only the surgical procedures and post-operative care on the mandibular left, but also the periodontal procedure of March 1, 2006 on the mandibular anterior teeth.

The dentist explained that when the patient subsequently came to his office, unannounced, in order to speak with him, he was with patients and therefore unable to speak with her directly.

**OTHER INVESTIGATION**

As part of its investigation, the College obtained copies of records from the patient’s prosthodontist and general dentist. In addition, the College investigator contacted the complainant’s son to find out his recollection of events. He advised that he did not attend the dentist’s office with his mother, but rather, spoke with the dentist on the telephone. As the treatment took place some time ago, he had no recollection of the discussion.

**DECISION OF THE COMPLAINTS PANEL**

Following its review of the records of the dentist, the patient’s prosthodontist and general dentist, the panel agreed that the periodontal surgery was necessary and performed well.

As for the patient’s claims that she was not advised of the area to be treated, the treatment was not completed on the area she requested, and the dentist refused to provide the treatment she wished, the panel noted that from her patient records dated “Mar 13 2006,” there was a handwritten diagram created by the dentist to assist him in his explanation of the planned treatment. In the panel’s view, this diagram clearly demonstrated that the patient was informed of the area of her mouth to be treated and the type of treatment to be performed.

However, other than the handwritten diagram, the panel had concerns about the quality of the member’s records related to informed consent discussions with the patient about post-operative concerns and the recording of financial transactions.

Specifically, the panel did not see any documentation:

- related to the member’s telephone conversation with the patient’s son;
- related to discussions with the patient about treatment options and the associated fees, including a pre-determination that was apparently provided to the complainant, risks and benefits of treatment, and confirmation of the complainant’s informed consent to treatment;
- related to discussions with the patient about her post-operative concerns;
- recording the complainant’s financial transactions with the office.
Accordingly, the panel felt it necessary to caution the dentist, in writing, with respect to his insufficient records. A written caution is a serious outcome for members of the dental profession, as such action arises in circumstances in which the panel is concerned about an aspect of the dentist’s practice, and believes the dentist would benefit from some comment and/or advice and/or direction, as to how to conduct himself or herself in the future.

As for the patient’s allegation that the dentist failed to provide her with an itemized receipt, there was no indication that the patient had ever requested this receipt. The panel was unclear as to what receipts were given to her, as the dentist’s financial records provided on request to the College were sparse.

The panel did note that the fees charged by the dentist were consistent with the procedures and the recommended fees in the specialist fee guide. And, while there did not appear to be any indication that the patient requested an itemized receipt, the panel reminded the dentist of his obligation to provide patients with an itemized receipt on request.

Overall, it would appear that this was a case in which there were problems with communication between the parties. This was acknowledged by the dentist and, in the panel’s view, this was all the more reason for him to ensure that his records were sufficient to support his interactions with patients and/or their designated family member or other representative.

LEARNING POINTS:

• Informed consent discussions and information provided to a patient should be documented, including risk/benefit of treatment, any referrals, as well as any refusal by a patient to proposed treatment, or refusal of a referral to a more experienced practitioner or dental specialist.

• Dental records should include full documentation of all of the procedures and materials, as well as discussions with the patient about follow-up care.

• The records should provide realistic expectations for all parties, so that unexpected outcomes or communications lapses can be avoided. In the event of a dispute process arising from a complaint or lawsuit, your records should be accurate and comprehensive to help you.
Dr. Margaret Benson has been in solo general practice for 20 years in a suburb nearby a large city. She has enjoyed years of good experiences with many of the local residents. Erma Laskins was one of her favourite patients. For the 10 years she was in the practice, Dr. Benson and the staff looked forward to Erma’s visits, her quick wit and gregarious personality. Erma’s daughter, Sandra, also joined the practice along with her family. Six years ago serious illnesses changed Erma’s life from one of independence to a move to a local nursing home.

Sandra kept Dr. Benson appraised of her mother’s health changes during her recall visits. Three years ago the head nurse at the nursing home informed Sandra that her 85-year-old mother had senile dementia and, while she had experienced a few fair days this last year, overall she was deteriorating and occasionally combative. Sandra graciously asked if Dr. Benson would please stop by and see if her mother had a dental problem since she seemed to hold her jaw during her visits.

Dr. Benson decided to visit Erma and found her in bed, holding her right jaw while moaning softly. She did not recognize Dr. Benson. Erma was very co-operative and when asked to, quickly opened
her mouth. Even in the poor room lighting, Dr. Benson observed food packed in the fractured distal of her lower left first bicuspid along with gingival and occlusal caries on the other remaining posterior teeth. It appeared to Dr. Benson that Erma had had no apparent preventive care as she had generalized acute gingivitis. Dr. Benson was concerned that she may have a possible acute or chronic apical periodontitis and left the room to talk to the head nurse.

Dr. Benson found the patient’s daughter, Sandra, at the nurse’s station and informed her that her mother needed a dental examination soon because she had several cavities and was holding her jaw as if she was in pain. The head nurse informed both of them that Erma had been holding her jaw now, off and on, for two months and, “there had been no swelling and the staff was monitoring her daily.” The nurse told Sandra in the presence of Dr. Benson: “We will continue to monitor Erma and call you if there is swelling.” Sandra agreed and said, “We don’t want any unnecessary treatment for Mom at this time – with her dementia she can’t even feel pain.”

Dr. Benson is now facing an ethical dilemma. How should she handle this situation?

◆ Dr. Benson should contact the nursing home administrator and inform her of Erma’s possible pain and infection that may have been allowed to persist for two months.
◆ Dr. Benson should encourage Sandra to contact a dentist who has the equipment to treat patients in a nursing home.
◆ Dr. Benson should stay out of this discussion – she is not Erma’s dentist now.
◆ Dr. Benson was Erma’s dentist for 10 years and should provide the care if possible.
◆ Dr. Benson should again instruct Sandra and the nurse about the potential complications from the decay and oral infection, including pain and the need for a dental examination.

Now turn to page 34 to find the discussion about this ethical dilemma.
Maintaining clear, concise, accurate and current patient records is an important element of providing safe, appropriate and quality patient care. It is also your professional, ethical and legal responsibility.

Bad things can happen to good dentists because of poor records. Good records, on the other hand, can be your best defence against claims of negligence or allegations of professional misconduct.

Here are some helpful hints with respect to keeping thorough patient records.

◆ Medical questionnaires, once completed, should be reviewed, dated and signed by the treating dentist and updated regularly. Follow-up with the patient’s physician, if necessary, should be done only after obtaining the patient’s consent.

◆ Use a consistent style for each entry. Consistency lends credibility to your records and reflects your professionalism in maintaining them.

◆ Check the accuracy of all records typed from dictation.

This feature is prepared to offer guidance to members about the prevention of malpractice claims or complaints and the lessening of the magnitude of an existing claim or a complaint.

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**THIS INFORMATION DOES NOT BELONG IN A PATIENT’S CHART**

◆ Criticism of care provided by others  
◆ Derogatory remarks about patients, staff or other professionals  
◆ Communication with the Professional Liability Program  
◆ Communication with the patient’s lawyer

Remember, the patient and/or his or her lawyer has a right to obtain copies of their records.
Courts usually take the view that if there is nothing in the chart to support a dentist’s contention that a certain action took place, e.g. patient informed of certain risks, then that action is deemed not to have happened. The good news is the reverse is also true. That is, if the records support the dentist, then the action is deemed to have taken place.

For this reason alone, it is vitally important that all interaction with patients, including discussion, information provided, advice/instructions given, treatment recommended or performed etc., be clearly set out in the progress notes, and that all entries be dated and attributable to the treating practitioner.

The other thing to keep in mind is that legal actions typically take three to four years to be heard in court. Because of the frailty of human memories, the record provides reliable details of the patient’s care.

Use large charts. The larger the chart, the more you tend to write.

Many legal actions are nuisance claims. Accurate legible and timely documentation can result in dismissal of these claims.
Write legibly. If someone else were to take over the care of the patient, he or she should be able to review the chart and treatment plan and understand what treatment has been provided, and what treatment, if any, is still outstanding.

- Document clinical and radiographic findings and the diagnosis or the reason for treatment.
- Make sure that the informed consent discussion process and the information provided has been well-documented in the progress notes section of the chart.

*Remember the six key elements of informed consent:*

1. diagnosis
2. nature/purpose of recommended treatment
3. benefits/risks of recommended treatment
4. treatment alternatives, their risks and benefits
5. consequences of no treatment
6. costs

- If a patient refuses treatment or refuses a referral to a specialist, document the refusal.
- Note any concerns about the patient's needs and expectations and how they have been addressed with the patient.
- If mishaps occur (separated endodontic file, untoward result, etc.), immediately inform the patient, provide treatment options to correct the problem, i.e. referral to a specialist, and record this discussion and the patient's reaction to it in the progress notes.
- Make sure that the patient's consent has been obtained for the release of a copy of or information from his or her record. The only exceptions to this rule are cases involving coroner's warrants or court orders and communication with RCDSO, including PLP.
- A patient is entitled to a copy of his or her dental records. Never release original records. The legal entitlement to such copies is not dependent on the account being up-to-date.
- Never make derogatory remarks in the record. Do note any failure or reluctance on the part of the patient to follow treatment advice or report for treatment, but do so in a professional, objective fashion. Remember the patient and/or his or her lawyer has the right to obtain a copy of the chart at any time.

**QUESTIONS ABOUT A PARTICULAR SITUATION?**

If you have questions about how to handle a particular situation with a patient, call the College.

**PLP Claims Examiners** 416-934-5600 • 1-877-817-3757
**Practice Advisory Service** 416-934-5614 • 1-800-565-4591
The practice of dentistry comprises the diagnosis, treatment and prevention of oral diseases, and a major objective in dentistry is the maintenance of tooth vitality. However, pulpal insult due to caries, repeated restorations and/or trauma may ultimately necessitate endodontic treatment to preserve the tooth. Already weakened, the tooth must be further weakened by the procedures required to complete endodontic treatment. As a result, the endodontically treated tooth presents special challenges for the restorative dentist, especially when there has been extensive loss of tooth structure.

The dental literature includes numerous articles regarding the restoration of the endodontically treated tooth. Nevertheless, there remains much confusion and even some controversy regarding the ideal manner in which this should be done.

Presented with a dizzying array of post systems, core materials and luting cements by the dental marketplace, each with its own "new and improved" claims, is it any wonder that the clinician may lose sight of the essential biomechanical principles that must be applied to ensure clinical success and achieve long-term survival of the endodontically treated tooth?

With this issue of Dispatch, PEAK is pleased to offer members the following article on this important subject, "The Restoration of Endodontically Treated Tooth", by Dr. Dorothy McComb, who is Professor and Head of the Department of Restorative Dentistry, and Director of the Comprehensive Care Program at the Faculty of Dentistry, University of Toronto.

The article emphasizes that endodontically treated teeth have a greater risk of fracture and discusses the various reasons for this. It then reviews each of the considerations for the restoration of such teeth, including the need for extra-coronal coverage, the importance of adequate ferrule, post selection and placement, and overall treatment planning.

Key points to consider:

- A major objective in dentistry is the maintenance of tooth vitality.
- Endodontically treated teeth are weaker and have a lower lifetime prognosis. They require restorations that both conserve and protect the remaining tooth structure.
- Abutments, teeth without adjacent teeth and those with reduced bone support are exposed to increased non-axial forces, making them more susceptible to fatigue failure and fracture.
- Adequate ferrule is paramount to resist fracture, and more important than post design, material or luting cement.
- Clinical success depends on the application of sound biomechanical principles for the specific tooth and clinical situation.
The ethical dilemma presented on page 28 raises two key questions:

1. Is Sandra making the best decisions for her mother?
2. What obligations does Dr. Benson have for Erma since she is no longer her patient?

These questions and others lead us to reflect on the ethics of dental needs for the geriatric population, surrogate consent for the incompetent patient, and strategies for managing nursing home issues.
DENTAL NEEDS FOR THE GERIATRIC POPULATION

Statistics Canada’s 2006 National Census Snapshot paints a dramatic national portrait of the new demographic reality in Canada. A record one in seven Canadians is 65 years or older with those aged 55 to 84 as the fastest growing demographic, now accounting for 3.7 million people – a 28 per cent rise from five years ago. The over-80 group is the second-fastest growing group, increasing by more than 25 per cent to 1.2 million over five years.

Clearly this population shift will have an impact on dentistry. Among many concerns is the question of whether dentistry will have the qualified providers to meet these needs, especially for residents in long-term care homes. There may not be enough clinicians who have the skills or interest to treat the geriatric population in settings that may require the use of portable/mobile dental equipment or the skills to deal with the administrative and regulatory requirements for facilities like nursing homes.

There are many other challenges too. In a PricewaterhouseCoopers study for the Ontario Association of Non-Profit Homes and Services for Seniors and the Ontario Long Term Care Association released in 2001, dementia and Alzheimer’s Disease combined were the most prevalent of all diagnoses in the sampled long-term care facilities. Fifty-three per cent of residents in Ontario facilities have one of these disorders.

For Erma Laskins in this case study, Dr. Benson could not treat her in the nursing home, just because she is a dentist.

As a proponent of portable/mobile dental care writes, “It is a specialized area requiring awareness. An unaware provider contracting with an uninformed administration interested in only emergency response and paper compliance can be a prescription for frustration.”

STANDARDS FOR SURROGATE CONSENT FOR THE INCOMPETENT PATIENT

One of the benefits of dentistry is watching our patients age gracefully over time. Of course, aging also can and eventually will create challenges for clinicians. Most general dentists have a favourite patient like Erma, who after years in a practice, has a stroke or an accident. Erma was once a competent person, able to decide for herself what was in her best interest. Now she is incompetent and unable to speak for herself. Who should speak on behalf of Erma and by what standard should that person make decisions about Erma’s care?

This case brings into focus two relevant standards for surrogate decision-making: substituted judgment and best interest.

Under the substituted judgment standard, a surrogate decision-maker makes decisions that respect and are consistent with the patient’s previous autonomous judgments. Essentially, her daughter Sandra would make decisions in accordance with what she believes Erma would have chosen for herself.

Under the best interest standard, the decisions made for the patient reflect what other reasonable people would do under similar circumstances. Thus the values are not those of the patient but of others facing the same situation.
But the fact that society and the courts assume that a surrogate is acting in the best interest of a patient doesn't mean that anything the surrogate chooses will be accepted. While we assume that parents will act in the best interests of their children, we also know that parents may place their children at harm, knowingly or unknowingly, so that the courts feel compelled to intervene to protect the best interest of the child.

The same is true for patients: If a surrogate demonstrates neglect or very poor decisions, medical professionals or the courts may step in and take control.

Not all surrogate decision-making processes are created equal. Medical professionals and the courts tend to put more weight on some over others. For example, it is best if the authorities know what the patient, if competent, would have chosen. Thus, an autonomously executed advanced directive says to caregivers, “This is what I want; please follow my wishes.” Absent such a declaration, substituted judgment is the best approach, especially if a patient has relayed to the surrogate what he or she would want to do if the time should arise.

The other relevant standard for surrogate decision-making is best interests. Under this scenario, those who know the patient best, assuming there was no specific directive or designated surrogate, make a judgment call consistent with what they think the patient would have wanted. But the farther away decision-makers get from specific guidance, the less force the decision has.

In this case, there did not appear to be an advanced directive. The next standard is substituted judgment, and this is where we would expect Sandra, as the surrogate, to make decisions according to Erma’s values and goals.

It is possible, however, that Sandra may have misconceptions about her mother’s goals and values and may not understand the importance of her medical and dental needs. She may believe that poor oral health and chronic dental disease go together with aging and nothing can be done.

While Dr. Benson is not recognized as a surrogate, she does have a 10-year history of providing oral health care for Erma and may understand Erma’s goals and values as well as anyone. Dr. Benson is at the nursing home at the request of Sandra and she is concerned about Erma’s oral health needs but receives no support from the nursing staff or Sandra. What can Dr. Benson do to address Erma’s needs?
STRATEGIES FOR MANAGING NURSING HOME ISSUES
Here are possible ways for managing these issues:

1. **Immediate – Stay involved.**
   The clinician can keep in contact with the staff and the surrogate and remain appraised of the patient’s condition.

2. **Immediate – Advocate for the patient.**
   Contact the nursing home administrator and express your concerns. Make contacts with interest groups and advocacy groups.

3. **Immediate – Educate the nursing home staff and surrogate decision-maker.**
   Help them make the medical and dental connection. Medical authorities say oral diseases and disorders impact health and well-being. Dental authorities too state that the separation between oral health and general health is artificial because the mouth is an integral part of the human body.

4. **Immediate – Consolidate resources.**
   Contact the physician and dentist, if any, for the nursing home and review your concerns. One of the principles for geriatric medical and dental care systems is that overall health care for the older adult is best provided when a dental provider is an integral part of the healthcare team.

5. **Immediate – Contact providers in the area who are trained in geriatric patient care, such as other dentists, dental hygienists, and denturists, and have portable or mobile dental equipment.**
   These patients have special needs and may require special equipment to be treated effectively. Conventional equipment may not be sufficient.

6. **Long term – If there are no providers in the area, additional training should be considered.**

CONCLUSION
While Dr. Benson has not had the opportunity to see Erma on a regular basis for a few years, she is ethically justified in monitoring her condition, advocating for palliative treatment from the nursing home administration, encouraging support from the physician for the nursing home, educating the staff, and even choosing to become competent in the treatment of the nursing home patient through special courses and training.
Medical History Recordkeeping Guide

As you know, the American Heart Association recently issued new guidelines on the use of antibiotic prophylaxis for patients with cardiac conditions. To ensure that the College’s Medical History Recordkeeping Guide, originally published in 2002, was consistent with these new guidelines, a thorough review was undertaken. Council approved the recommended changes in November 2007.

The updated document is now included as an insert with this issue of Dispatch and is also available on the College website at www.rcdso.org under the heading of Publications & Resources.

The College would like to extend our thanks to Dr. Catherine Kilmartin from the Faculty of Dentistry, University of Toronto for her outstanding assistance with this project.

RECORDKEEPING GUIDELINES

The College’s Recordkeeping Guidelines were developed in 1995. Since that time, much has evolved in the area of recordkeeping. The College has been very active in keeping members informed in areas such as patient privacy, informed consent, medical history and electronic recordkeeping. It was timely to revise these guidelines to incorporate the most recent advice in these important areas. Also, there is new information on PLP improvements that would assist members.

A copy of the new Guidelines is provided as an insert with this issue of Dispatch and is now available online on the College website at www.rcdso.org under the heading of Publications & Resources.
Q: Must a dentist examine a patient before prescribing radiographs?

The Healing Arts Radiation Protection (HARP) Act requires that radiographs be prescribed by a person designated in the Act. In the dental office, only the dentist has this authority. To do this the dentist must first determine the clinical rationale for taking the radiograph or radiographs by doing a clinical examination. The dentist may also consider other factors in her or his decision to prescribe radiographs, such as the patient’s expected occurrence of disease and risk for specific dental diseases.

Dentists should keep in mind that specialized investigations, such as sialography, arthrography, computerized tomography and magnetic resonance imaging, are also available through local oral and maxillofacial radiologists.

Q: How often and what kind of radiographs should be prescribed?

In prescribing films, the practitioner must try to strike a balance between keeping the number of films to a minimum and obtaining an adequate number of films for a complete diagnosis. The number, type and frequency of films should be based on each patient’s clinical signs and symptoms and past dental history.

For the initial examination of new patients

An effort should be made to obtain previous films from other practitioners and these should be assessed before prescribing films. A clinical examination must be performed before prescribing films.

It is still reasonable to prescribe a full mouth series, but this should be indicated from the assessment of the previous films and the findings of the clinical examination of the patient, to aid in the initial diagnosis and arrive at a baseline radiographic record of the presence of disease.

When prescribing films for recall patients

A clinical examination must be performed before radiographs are prescribed at recall appointments and they should never be prescribed based on inflexible time periods alone, e.g. bitewing films every six months. Both the number and frequency of radiographs must be prescribed based on the patient’s existing disease and the
Prescribing and Taking Radiographs

The prescription of films on a recall basis may fall between the extremes of a full mouth series for a patient being treated for severe disease and bitewing films every five years for a patient demonstrating no disease.

A dentist can prescribe a radiologic examination to be taken at a specific interval, e.g., at the next recall appointment, based on the findings of the current examination, when the anticipated information may aid in confirming the diagnosis or evaluating the treatment provided. The dentist can document the prescription for future radiographs in writing in the patient's chart.

For emergency patients
In emergency situations, take an adequate number of radiographs as necessary to obtain an accurate diagnosis.

Q: What if a patient refuses radiographs?
Whenever a patient, patient’s guardian or substitute decision-maker refuses recommended radiographs, it is recommended that the dentist explain the reason the radiographs are recommended and the risks of not having these done.

If the patient, guardian or substitute decision-maker still refuses, then note the informed refusal in the patient record. If the refusal compromises the dentist’s ability to make an accurate diagnosis and/or to render the appropriate treatment according to practice standards, the dentist is well within her or his rights to refuse to provide compromised care as dictated by the patient.

Q: Who is qualified to take radiographs in the dental practice setting?
Only those persons meeting the qualifications specified in the HARP Act and Regulations can take radiographs. In the dental office, by virtue of their training, dentists and dental hygienists may take radiographs. Dental assistants who have successfully completed a radiology program approved by the HARP Commission may also take radiographs after they have been prescribed by a dentist. Dentists should ensure that any dental assistant taking radiographs has completed a HARP-approved radiology course.

Q: Can dental staff take radiographs with no dentist in the office?
Dentists are required to comply with the HARP Act and Regulations, which include provisions relating to safety, including:
- approval from the Ministry of Health and Long-term Care for the installation of x-ray machines;
- x-ray machine standards;
- qualification required to take radiographs;
- the designation of a radiation protection officer (In the dental office, this must be a dentist.);
- in-office quality assurance testing both daily and annually as outlined in the HARP legislation;
- the requirements for annual inspections of premises where x-ray machines are installed.
As long as a dentist ensures her or his compliance with the provisions of the HARP Act and Regulations and provides a patient-specific prescription for the radiographs, qualified dental staff may take radiographs that have been prescribed by a dentist without the dentist being present in the office suite.

**Q: Can my dental staff take radiographs on the prescription of another dentist who doesn’t have the same equipment that I have in my dental office?**

Yes. As long as the radiographs have been prescribed by a dentist, qualified dental staff can take them. The dentist, in whose office the radiographs are taken, should retain the prescription and a record documenting the services that were provided by the dentist. The original films should be sent to the prescribing dentist, who is responsible for interpreting the radiographs and retaining these as part of the patient record in his or her office.

**Q: Are thyroid collars and lead aprons always required?**

The HARP Act addresses the issue of patient shielding. The College recommends the use of both gonadal and thyroid shielding devices where possible and practical.

**Q: Is the use of radiation dosimeters mandatory?**

The use of radiation dosimeters, although not required by the HARP Act and Regulations, is strongly advised. The use of radiation dosimeters can be reassuring to dental staff. Radiation dosimeter readings serve as a record of the radiation to which dental staff are exposed and can help dentists to minimize their staff’s occupational exposure to radiation as required by the HARP Act and Regulations, and the Regulations made under the Occupational Health and Safety Act.

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**Need More Information?**


- Information about the approval of dental office facilities and the required forms can be obtained from the Ministry of Health and Long-Term Care’s X-ray Inspection Service at 416-327-7937 or on the Government of Ontario website at www.gov.on.ca.


- Information about radiation dosimeters can be obtained from Health Canada at 1-800-261-6689.
The patient walks into your office, three weeks after his operation, and it doesn’t take long for the appointment to deteriorate into a fencing match. Already frustrated about his condition and upset about the surgery, the patient is now distressed about the slow recuperation time. His resentment rises to the surface, and you suddenly find yourself in a verbal battle. Neither of you is really listening to the other, and the atmosphere is becoming tense. Welcome to a “symptom” exhibited by many patients: anger.

Google “angry patient,” and you’ll get about 2.1 million hits – slightly more than you’ll find if you search for “satisfied patient.” What makes patients angry? Anything from irritation about their care, to being stuck in a waiting room. Whatever the reason, you can’t lose your cool or get baited into butting heads, says Dr. Wendy Levinson, Chair, Department of Medicine, University of Toronto. Instead, you need to look beyond the symptom of anger, to the underlying causes.

“A powerful emotion is like an elephant in the room – you can’t get around it, so you have to deal with it,” says Dr. Levinson.

What makes patients angry? Anything from irritation about their care, to being stuck in a waiting room. Whatever the reason, you can’t lose your cool or get baited into butting heads, says Dr. Wendy Levinson, Chair, Department of Medicine, University of Toronto. Instead, you need to look beyond the symptom of anger, to the underlying causes.

The ability to defuse anger can be one of a doctor’s most important interpersonal skills, says Dr. Levinson.

Dr. Monica Harris-Broome, Director of the Communication Skills Program at the University of Miami’s School of Medicine, doesn’t talk about elephants but another animal: APE, her acronym for the Angry Patient Encounter.

You can tame that beast, she has written, through a strategy that she also calls APE. Here, “A” stands for agree – find something to agree with, to dissipate the anger. “P” stands for pause – back off, to help the patient feel understood. And “E” stands for emotion – acknowledge the patient’s emotions, without using the label “angry.”

“Anger is a stress response,” notes Dr. Harris-Broome. To de-escalate angry feelings, doctors have to understand where that response is coming from.

Consider the range of circumstances that can trigger feelings of hurt, annoyance, fear, despair, and helplessness – and, for some, anger. The diagnosis of a condition. The consequence of that condition. A bad outcome. A medical error. A misdiagnosis. Negative experiences with a previous physician, or the medical community. Unmet expectations. Delays in getting answers or treatment.

Different patients will react in varying ways to all of these situations. Does anger seem like a legitimate response? Or does the patient seem to be way out of line? That’s really beside the point. If the patient is feeling that anger is the appropriate way to express himself or herself, then that’s what you, as the doctor, have to address.

In a way, you can even view the patient’s anger
as a positive. It clearly tells you just how strongly the patient feels, whereas other patients might be just as bothered, but mask their feelings instead, letting a problem gnaw at them and making it tougher for you to help them.

So if anger is a symptom, how do you treat it? Here are 10 strategies to navigate this tricky situation.

1. **Turn the heat down.**
The first step is to calm things down. The pot is boiling on the stove, so you need to reduce the temperature – you can’t just watch it boil over. “Don’t be on the defensive – that just makes people angrier,” says Dr. Levinson. “Listen patiently, so the patient feels heard.” Or as Dr. Harris-Broome says, set an example; don’t ask the patient to calm down, but model calmness yourself.

2. **Validate the emotion.**
“Even if you don’t agree that they’re right, it’s important for patients to feel that you understand what they’re experiencing,” says Dr. Levinson. She suggests using phrases like “I can see you’re really angry” or “I can understand how you might feel angry, because you feel you didn’t get what you needed.” You’re not saying that their anger is warranted, you’re simply validating their feeling. “Naming the emotion goes a long way to reconciling things,” says Dr. Levinson. “You don’t have to say that you would be angry; you have to say that you understand why they would be angry.”

3. **Be empathetic – not apologetic.**
“You shouldn’t say sorry for no reason, but show empathy,” Dr. Levinson says. That doesn’t mean you’re accepting blame. “If someone had surgery and is still in pain, for example, you can say that you feel bad that it didn’t work out, that this clearly isn’t what you both wanted, and that other patients who have been in the same situation feel frustrated too. These are all de-escalating comments.”

4. **Wait a minute.**
When patients are on an angry roll, let them go for at least a minute, with no interruptions, replies or explanations on your part. (The only exception is if they use profane or other language that you find offensive; while patients have a right to be heard, you have the right to be treated with civility.) It’s important for patients to have a chance to vent, and to feel safe to share their feelings, says Dr. Harris-Broome. That alone can be therapeutic.

5. **Turn a rant into a conversation.**
Remember that anger is a secondary emotion. Ask the probing questions, Dr. Harris-Broome says, that reveal the underlying concerns. “You seem adamant about the test – why do you feel it’s so important?” Or, “My decision seems to have upset you, and I regret that – now what can I do to help?”

6. **Disarm the patient.**
Statements like “I see your point” and “I understand” can stop the patient in their tracks. “It’s very hard to stay angry at someone who accepts your anger,” says Dr. Levinson.

7. **Stay curious.**
There is a story behind all of that anger. You may not know, yet, what really caused this response. Encourage the patient to provide the information that you need – “Tell me more about what’s upsetting you,” or “How has this condition affected you?”

8. **Summarize the complaint.**
Once you’ve heard enough, sum up the issue as you see it. “The patient can correct any misperceptions, and experience being heard and understood,” says Dr. Harris-Broome. This gives you the foundation to move on.

9. **Stand your ground.**
Accepting blame needlessly, or giving in to a patient’s bullying or unreasonable request, can actually erode the patient’s trust and respect – and can be unethical. If it’s not appropriate to,
PROFESSIONAL PRACTICE

Turning the Heat Down on Patient Anger

10. Don’t fight back.

Even when patients are hostile, battling back is a trap, says Dr. Levinson. You can only support the patient if you’re dispassionate. A doctor who’s dismissive or acts irritated is a red flag, says Dr. Jerome Groopman, author of How Doctors Think. When he asked numerous doctors to imagine themselves as a patient, dealing with a contentious doctor, every one said that they would find a better doctor.

A 2006 article in the National Review of Medicine said that for a man or woman of science, the worst thing about dealing with out-of-control patients is that they tend not to test your medical skill and knowledge. “Rather,” the article stated, “they try your patience, push your most tender buttons…and can seem like they’re battering rams threatening to take down your professional demeanour.”

Yet you can look at all of that anger as an opportunity, says Dr. Levinson. Just as engaging in a battle with a patient can undermine the relationship, the opposite is true too. Remaining calm and comforting in the face of an angry patient is a clinical skill, and can be a pivotal moment in the relationship.

“If a patient can display negative emotions, and see that the doctor still cares about them, they see the doctor even more as a trustworthy person,” says Dr. Levinson. “Any difficult encounter, when you work it through, is typically trust-building.”

WHEN ANGER ESCALATES

Police truncheons and helmets aren’t the usual medical gear. But in 2007, doctors and nurses at a hospital in eastern China took to arming themselves after a spate of attacks from angry patients – from cursing, to death threats, to serious beatings.

It sounds extreme, but in Canadian health care, too, angry encounters can sometimes turn violent. Most involve nursing staff, though, according to studies, psychiatrists and ER doctors are at the highest risk among physicians.

Verbal aggression may only rarely turn physical, and can typically be dealt with through communications techniques. But if anger escalates, consider these steps:

• Conflicts with patients can spiral out of control, leading to anything from complaints to refusal to accept treatment. Be especially diligent in your record keeping when dealing with unusually angry patients.

• If the patient no longer seems to respect your opinion, and the relationship seems to be damaged beyond the point of repair, it’s prudent to turn care over to another physician.

• If you feel that the encounter is becoming dangerous, take precautions to ensure your safety, e.g., maintain a physical distance, don’t turn your back, and have a safe exit.
Professional Liability Program Update

Arrangements have been finalized for the insurance portion of the errors and omissions (malpractice) coverage that is provided by RCDSO to all Ontario dentists, partnerships of dentists, health profession corporations holding a certificate of authorization from the College, and former members of the College.

The new policy covers the 2008 and 2009 calendar years and it can be reviewed on the Member Resource Centre of the College website at www.rcdso.org.

There have been no substantial changes from the current policy in either the coverage afforded or the individual deductible.

As a reminder, your coverage is as follows:

**LIMIT OF LIABILITY**
$2,000,000.00 per occurrence with no limit to the number of claims in a given year

**INDIVIDUAL DEDUCTIBLE***
$2,000 for the first occurrence, $3,000 for a second occurrence in the previous five years and $5000 for each additional occurrence in the same five year period.

* The individual deductible only applies where PLP has incurred legal and/or related costs and/or a claim payment was made.

For those members who wish to purchase excess coverage, more information can be obtained by contacting the College’s broker Marsh Canada at 416-349-3574 or toll-free at 1-888-711-8399, or you can go to the Marsh Canada website at www.marsh.ca/rcdso.

You are also reminded that if you have questions about how to handle a particular situation with a patient or wish to report a claim or incident, don't hesitate to contact PLP. Our experienced claims examiners can be reached by calling the numbers below.

If you want a paper copy of the policy, simply contact PLP at 416-934-5600, or toll-free at 1-877-817-3757, or by e-mail at plp@rcdso.org.
The scenario goes like this: The caller requests information related to dental claims that were submitted to the carrier for their patients for a particular time period. The caller claims the information is required because of a system failure that prevented the insurance carrier from receiving the claims. The dental office staff are asked to give out claim information over the phone, or fax the copies to a fax number provided by the impostor; or in some instances, the caller has sent a courier to the dental office to pick up copies of the dental claims.

These calls are not legitimate. Insurance companies have informed us that several offices did release this personal and confidential information about their patients and it has resulted in attempts to submit fraudulent dental claims.

The College suggests that members alert all their office staff so that everyone in the office, who might handle this type of call, is forewarned.

If one of these scenarios has already happened in your office, contact the appropriate insurance carrier with a list of the names of those whose information was released. This is important as it will allow the insurance company to flag and monitor claim submissions. If the policy and certificate information has been included on a copied claim form for two carriers to coordinate benefit, then both carriers need to be informed. And finally, any patients who have had their personal information released in one of these fraud scams should be informed.

### Updated Information on Woman Charged with Dental Fraud

The following is an update to the Toronto Police Service news release distributed with the August/September 2007 issue of Dispatch about the arrest of Irina Chernyakhovsky of Richmond Hill on allegations of fraud while working in dental offices.

The police informed insurance investigators that Ms. Chernyakhovsky has been charged with eight offences under the name of “Irina Fooks,” including charges of failing to comply with conditions that she must not work in an environment where she has access to financial transactions. Insurance company officials report that they are aware that Ms. Chernyakhovsky has previously applied for dental office employment under the name of “Irina Rabkin.”

Ms. Chernyakhovsky was scheduled to appear in court on January 15, 2008 in connection with charges of fraud over $5,000 and two counts of breach of recognizance. The OPP charges were in connection with a $90,000 fraud.
Big, Bigger and Biggest on the Web

One of the most significant accessibility issues on a website is font size. Small fonts are more difficult to read. For those of us with good eyesight, it can come as a shock that a significant percentage of the population has trouble reading anything below 14 point type on paper. Screens are less readable than paper because of their lower resolution and fuzziness at the edges.

To address this problem on our website, each text page now has a special feature that allows the reader to adjust the size of the type. The three different sized letters appear on the text only pages of the site. Click on the different sized A and the text size of the page changes. The first A is the default text size of the website.

You also have the option to make the type bigger or smaller in your browser too, depending on your tastes, or your needs. If you are using Internet Explorer 5, look under “View” on the menu bar and choose “text size.”

Different screen contrast options are also available to increase the legibility for some users by heightening screen contrast with alternative colour combinations or by softening the look of the site. On most operating systems, this is available under Accessibility Options.

Largest Dental Research Meeting in the World Comes to Toronto in July 2008

Thousands of dental research scientists, students, and educators from around the world, representing the latest advances in dental research, will attend the 86th general session and exhibition of the International Association for Dental Research (IADR) at the Toronto Convention Centre from July 2-5, 2008.

The meeting will include symposiums, oral and poster presentations on the most up-to-date and influential research in dentistry, as well as a large group of commercial exhibitors of dental products. At the 85th general session in New Orleans last year nearly 3,000 scientific papers were presented.

“This is a rare opportunity for Canadian researchers and Canadian dentists to become involved in a world-class dental research meeting,” said Professor Chris McCulloch, Canadian Research Chair in Matrix Dynamics and Director of the Canadian Institute of Health Research Group in Matrix Dynamics at the University of Toronto.

The meeting is open to registration from non-IADR members. Attendance counts towards RCDSO continuing dental education points: full day, six points; half day, three points.

The International Association for Dental Research (IADR) is a non-profit organization with more than 11,000 individual members worldwide, dedicated to:

1. advancing research and increasing knowledge to improve oral health;
2. supporting the oral health research community;
3. facilitating the communication and application of research findings for the improvement of oral health worldwide.

To learn more about IADR, visit www.dentalresearch.org. Registration is now open.
In an article/advertisement in the October 2007 edition of the Post magazine, I referred to my associate, Dr. Tracy Dole, as a dentist who “specializes in children's oral health.” That is not the case, as Dr. Dole is registered with the College as a general practitioner.

I delegated the submission of this article/advertisement to my staff while I was out of the country. I sincerely apologize for this unfortunate oversight. There was no intent to mislead anyone. Such an error will not reoccur.

The article/advertisement also referenced the dentists in my practice as “keeping abreast of the beneficial changes in treatment and technique through continuing education” and described the benefits of using the “high-tech” ozone approach to the treatment of cavities. I now understand that this may be regarded as misleading and may also be considered as suggestive of superiority or uniqueness over other dentists and practices.

Again, my sincere apologies for in anyway misleading the public or offending my dental colleagues.

Sincerely,

Dr. Nicholas Shabotynsky
Mailbag

We want to hear from you. We welcome your feedback on anything that you read in Dispatch or on any of the College’s policies, programs, and activities.

Sometimes a letter may not be printed with the author’s name either on request or due to its confidential nature. All letters printed in Mailbag are used with the author’s permission.

The College reserves the right to edit letters for length and clarity. Due to space limitations, some letters may not be printed.

COLLEGE CONTACT
Peggi Mace
Communications Director
pmace@rcdso.org

As you know, I was the Ontario Liberal Party candidate in Richmond Hill for the 2007 provincial elections. I am pleased to inform you [College Registrar Irwin Fefergrad] that on October 10, 2007, I won the election in this riding and became the MPP for the riding of Richmond Hill.

As such, I wish to resign from my position as a member of the Council of the Royal College of Dental Surgeons of Ontario, effective October 11, 2007.

It was a great pleasure to work with you, the past and current President of RCDSO and the members of Council. I really enjoyed attending the Council and committee meetings at RCDSO.

RCDSO is providing an excellent service to Ontarians by regulating the dentistry profession across the province. I look forward to working with you and RCDSO in my new capacity as a MPP.

REZA MORIDI

Editor’s Note: Dr. Moridi is now the MPP for Richmond Hill and the Parliamentary Assistant to the Minister of Training, Colleges and Universities.

On behalf of Dr. Donald Stewart and The Academy of Dentistry, I want to say thank you [College Registrar Irwin Fefergrad] for taking the time out of your busy schedule to present your program entitled, “Internationally Trained Professionals” at the Winter Clinic. It was an excellent presentation with a vitally important message. All dentists in the province should have been present to hear you.

DR. JACK DALE
Toronto

Our staff at the University and the office in Hamilton are most grateful for your considerable efforts [College President Dr. Frank Stechey] on behalf of the profession and I am hearing more and more often of the appreciation of dentists in the field of your work as well.

DR. CHRIS McCULLOCH
Hamilton

I would like to personally thank PLP staff for their help. Things were handled very efficiently and expeditiously. The end result was for good for me and my former patient, and I am grateful. Once again, thank you.

NAME WITHHELD

Calendar of Events

RCDSO Council meetings are open to the public, with the exception of any in camera portion dealing with personnel matters or other sensitive or confidential material. Meetings begin at 9:00 a.m. The agenda is available either at the meeting or in advance on request.

COLLEGE CONTACT
Angie Sherban
Senior Executive Assistant
416-934-5627
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asherban@rcdso.org

Mark Your Calendar…

2008 Open Council Meetings
March 6, June 12, November 13
Westin Prince Hotel
900 York Mills Road, Toronto

Seating is limited so if you wish to attend please let us know in advance by contacting the College.
acts are shared, of public expectations for high quality services no matter which health profession is responsible for delivering care or treatment.”

HPRAC’s work is focusing on the legislative, regulatory, policy and organizational issues that facilitate and support interprofessional collaboration between health colleges and their members. It is looking at barriers and opportunities, and yes, even the legislative framework that needs to be in place to ensure interprofessional collaboration.

The possible impacts could be enormous. There is potential for wide ranging implications in a number of policy and practice areas. At a glance, the final recommendations could touch on areas like education, standards of practice, liability coverage, scopes of practice, quality assurance programs, codes of ethics, and maybe even more legislative changes.

Already we have seen the beginning of the change with the inclusion of new objects for health regulatory colleges in the Health System Improvements Act that contained amendments to our governing legislation, the Regulated Health Professions Act.

Those new objects are:
- to promote and enhance relations between the College and its members, other health profession colleges, key stakeholders, and the public;
- to promote interprofessional collaboration with other health colleges;
- to develop, establish and maintain standards and programs to promote the ability of members to respond to changes in practice environments, advances in technology, and other emerging issues.

Regulators have an important role to play in supporting this vision for a better health-care system. Health-care regulatory colleges are the logical place to efficiently and effectively deal with any public safety issues that arise.

The specific details of what lies ahead are not yet clear. What I do know is that there is a new paradigm ahead. Partnerships with government, other regulators, and educators are going to be more and more important. That is the only way to build trust and respect and foster the collaboration that will be essential to move forward.

The College believes in the value of collaboration. We see it as yet another way to fulfill our mandate of public protection. Already we have a number of different initiatives in which we are working with other health-care colleagues.

Here are some of the collaborative projects that we are involved in already with our colleagues in dentistry and medicine and elsewhere:

- A working group made up of representatives of RCDSO, the College of Physicians and Surgeons of Ontario, the College of Nurses of Ontario and the Ontario College of Pharmacists is developing a joint policy on electronic prescriptions with the aim of guiding the respective professions and protecting the public.
- The College and the Ontario Dental Association and the Ontario Dental Hygienists’ Association are jointly hosting a one-day summit on April 9 to push forward workable solutions to the problems of access to oral health care in the long-term care sector.
- We extended a formal invitation to the College of Dental Hygienists of Ontario to meet with our Quality Assurance Committee to explore issues of common interest around employment issues in dental offices.
- We convened a meeting of the Registrars of the College of Denturists of Ontario, the College of Dental Hygienists of Ontario and the College of Dental Technologists of Ontario to develop a planned approach to address products manufactured off-shore and distributed in Canada that may contain contaminants.
- The College of Physicians and Surgeons of Ontario has agreed to work collaboratively with us on trying to address the use of antibiotics before dental procedures to prevent infective endocarditis.
- During our March Council meeting, we are organizing two special educational sessions on sexual abuse and boundary issues and have extended an open invitation to our colleagues at all of the other health-care regulatory colleges to join us.

This new emphasis on collaboration among all the
It is very encouraging to know that the interest from our profession in serving as a volunteer at the College continues to grow. During the last election cycle, we had more people than ever before putting their names forward.

While the government appointment process is different for public members, they too come to the Council totally committed.

Council members are the nucleus of our successful organization. Team up these volunteers together with our incredible and accomplished staff and you have our greatest strength.

Year after year, these volunteers are a pretty extraordinary group of people who most definitely make an essential difference at the College, making it a leader among regulatory bodies.

Le Conseil d’administration joue un rôle déterminant dans la régulation de la profession. L’Ordre a pour devise : « Garantir la confiance du public ». Il vous appartient maintenant de faire vivre cette devise.

Il est très encourageant de voir l’intérêt croissant que manifestent les dentistes à égard du bénévolat au sein de l’Ordre. Lors des dernières élections, nous avons reçu le plus grand nombre de candidatures dans l’histoire de l’Ordre.

Bien que le processus de nomination du gouvernement soit différent pour les membres provenant du public, ceux-ci aussi font preuve d’un dévouement hors pair.

Les membres du conseil forment le noyau de notre organisation. Nos bénévoles et notre personnel chevronné qui les appuie constituent notre plus grand capital.

Année après année, ces bénévoles sont un groupe de personnes formidables dont la présence et le dévouement contribuent largement au succès présent et futur de l’Ordre.

Players in the health-care environment can only led to even more emphasis on patients and addressing their needs. This dovetails very nicely with our mandate to protect the public interest.

Collaboration, communication and partnership are the hallmarks of the province’s blueprint for action on interprofessional collaboration. And we are all for that!
Change is afoot again in Ontario’s health-care system. The Minister has asked the Health Professions Regulatory Advisory Council (HPRAC) for advice and recommendations to address issues associated with interprofessional collaboration.

So interprofessional collaboration is definitely a term we are going to be hearing a lot more about. What does it mean? Our health-care system often separates caregivers rather than uniting them. Each group of caregivers is trained in its own discipline, many belong to a different professional association and many report to a separate regulatory body.

Research has found that better patient outcomes can be achieved by optimizing the expertise of all caregivers involved in the care process. In fact, there is mounting evidence of a host of benefits across the health-care system, including increased access to health care; improved outcomes for people with chronic diseases; less tension and conflict among caregivers; better use of clinical resources; easier recruitment of caregivers; and lower rates of staff turnover.

Interprofessional care is not a new idea. The concept of collaborative, team-based approaches to care has been endorsed by governments throughout Canada and around the world. Here in Canada, in the Health Accords of 2003 and 2004, federal and provincial governments identified interprofessional care as a priority for health-care system renewal.

The Ontario action plan is outlined in a document called “Interprofessional Care: A Blueprint for Action in Ontario” that was submitted to the Ministry of Health in July 2007. (It is posted on the HPRAC website at www.hprac.org.) The Minister of Health is already moving forward. He has asked HPRAC “to recommend mechanisms to facilitate and support interprofessional collaboration between health colleges beginning with the development of standards of practice and professional practice guidelines where regulated health professions share the same or controlled acts, acknowledging that individual colleges independently govern their professions and establish the competencies for their profession.”

The Minister also asked that HPRAC “take into account, when controlled..."