Good dentist/patient communication essential to the informed consent process
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Effective and Close Partnerships Critical in Shaping Our Future

In January, my Council colleagues supported my election as president of the College for another two-year term. I appreciate this vote of confidence and will do my best to reply to that support.

During the past two years, we have done great work, and I am sure there is only more ahead. The credit definitely goes to the great team of dentists and public members around the Council table. While there are some new faces, there is “depth on the bench” as the saying goes, and I know they will get great support from the seasoned veterans.

Over the years that I have been actively involved at the College, I have noticed that time and time again the right people are always there to make good decisions. Thankfully we are not alone. There are the amazing College staff who are genuinely committed to the values of our College and work unstintingly to put them into action.

There are our partnerships with other key players in health care regulation. Whether it is our regulatory counterparts in British Columbia or Quebec, our fellow health care regulators in Ontario, or our colleagues at the Ontario Dental Association, we put great store in the importance of collaborative dialogue and partnerships.

We are equally committed to an open and an effective working relationship with government.

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“The Vulcan mind meld.”
A new technique in dentistry? No, that’s what lawyer Richard Steinecke calls the crucial communications process between dentist and patient during the informed consent process. Star Trek fan or not, you’ll definitely have to view the latest production in the College’s LifeLong Learning program called “Informed Consent Process in the Dental Office” to find out more.

This is slated for distribution by the College to all Ontario dentists in early October.

It is developed and produced by RCDSO in association with the Ontario Dental Association.
The opening sequences of the CD pack a powerful punch: see the in-the-chair informed consent discussions between patient and dentist; when things go wrong, eavesdrop on private discussions the dentist and his patient have with their respective lawyers; follow the dentist as he attends his discipline hearing; and then have a front row seat as real life judge His Honour Mr. Justice J. Patrick Moore of the Superior Court of Justice of Ontario renders the decision.

One of the key chapters in the informed consent CD focuses on specific case studies or scenarios that general dentists and/or specialists deal with on a regular basis in their daily practice. You’ll get to challenge your knowledge about important concepts like implied and express consent, material risks, duty to disclose, handling adults incapable of consenting to treatment and obtaining consent from a minor.

As extra-added learning opportunity, each scenario is followed by a lawyers’ roundtable that gives an easy-to-understand legal perspective on the finer points of each case study. These legal snapshots star well-known Ontario lawyers Brian Gover and Richard Steinecke and the discussions are moderated by College Registrar Irwin Fefergrad.
Bios of the Stars

IRWIN FEFERGRAD
RCDSO Registrar
Irwin Fefergrad has the distinction of being the first lawyer in the history of the Law Society of Upper Canada to achieve a double specialty: one in civil litigation and the other in health law. He is the first Ontario lawyer to receive a specialty in the practice of health law.
In May 2001, he was named Adjunct Professor at the University of Western Ontario, Schulich School of Medicine and Dentistry. In August 2001, he accepted an appointment as Assistant Professor at the University of Toronto, Faculty of Dentistry. He was recently appointed to the Council of the Medical-Legal Society of Toronto.
Irwin is much in demand provincially, nationally and internationally as a guest lecturer in the area of health law and regulation. In addition, Irwin is very active in writing articles for publication in journals and magazines. He is a contributing author to the textbook Dental Law in Canada and this year was the guest editor of the journal Current Practice: Dental Hygiene.

BRIAN GOVER
Stockwoods Barristers
Brian Gover was admitted to the Ontario Bar in 1983 and has practised at Stockwoods since 1994. Prior to joining Stockwoods, he served as counsel in the Crown Law Office – Criminal within the Ontario Ministry of the Attorney-General. As Crown counsel, Brian argued hundreds of appeals before the Ontario Court of Appeal and Supreme Court of Canada. Brian subsequently served as the Executive Legal Officer to Ontario’s Superior Court of Justice from 1991 to 1993. Brian is a Fellow of the American College of Trial Lawyers.
His practice includes competition law, criminal law, discipline proceedings, general civil litigation and administrative law. He acts for private clients who must respond to or defend such proceedings, as well as advising or representing numerous regulators and administrative agencies. In addition, Brian has frequently acted as counsel on federal and provincial Commissions of Inquiry. In that role, he has served in recent years as a Commission counsel on the Walkerton Inquiry, Arar Inquiry, Air India Inquiry and the Cornwall Inquiry.

THE HONOURABLE MR. JUSTICE J. PATRICK MOORE
Superior Court of Justice of Ontario
J. Patrick Moore of Toronto is appointed a judge of the Superior Court of Justice of Ontario. Mr. Justice Moore received a Bachelor of Laws from the University of Toronto in 1972 and was admitted to the Ontario Bar in 1974.
Prior to his appointment to the bench, Mr. Moore was a partner in the law firm of Rogers, Moore. Mr. Moore maintained a defence practice for almost 30 years, encompassing an array of civil litigation cases including matters of products liability, errors and omissions, environmental, personal injury and insurance. He pleaded matters before courts and tribunals in Canada and elsewhere, from the preliminary inquest stage to full trial. He also appeared in Judicial Inquiry and Alternate Dispute Resolution settings.
Mr. Justice Moore is a former director and member of the Advocates Society and member of the Toronto Lawyers’ Association. He is a frequent speaker for the Canadian Bar Association and the Ontario Bar Association and has been an instructor at the Ontario Centre for Advocacy Training.

RICHARD STEINECKE
Steinecke Maciura LeBlanc Barristers & Solicitors
Richard Steinecke is the senior partner in the law firm of Steinecke Maciura LeBlanc. He practises exclusively in the area of professional regulation. He represents about three dozen regulators and associations across many professions. Called to the bar in 1983, Richard’s professional regulation practice has involved many hearings, court applications and appeals. He also regularly advises committees that deal with registration, complaints, discipline, incapacity and quality assurance matters.
Richard has written two books and numerous articles and given scores of presentations on professional regulation and hearing procedures. Canada Law Book has published Mr. Steinecke’s book entitled “A Complete Guide to the Regulated Health Professions Act” and “The Annotated Guide to the Statutory Powers Procedure Act,” (the latter coauthored with Julie Maciura). He is the editor of the widely-distributed Grey Areas newsletter dealing with professional discipline and regulation.
There are significant amendments to the Regulated Health Professions Act, 1991 (RHPA) as of June 4, 2009. The amendments were passed by the provincial government in June 2007 as part of the Health Systems Improvements Act, with a two-year lead time for regulatory colleges to implement the majority of the changes.

“For the overwhelming majority of members, the changes to the legislation will have little impact,” explained College Registrar Irwin Fefergrad. “The underlying reason for these changes is to increase openness, accessibility, accountability and information available to the public as a way to increase public confidence in self-regulation.

“Council and staff have been working diligently for the past two years to develop processes and ensure a smooth transition,” said Fefergrad. “Implementing the new processes and technology required by the amendments has been a big challenge. Late last year we did a massive overhaul of our bylaws to be ready.”

The most obvious changes that impact members are in the areas of mandatory reporting, public access to information and the creation of a new Inquiries, Complaints and Reports Committee.

**Mandatory reporting**

Members continue to be required to file a report if they have reasonable grounds, obtained in the course of practising the profession, to believe that another member of the same or a different regulatory college has sexually abused a patient.

Under the old legislation, facility operators were mandated to file a report with the College if the person had reasonable grounds to believe that a member who practises at the facility had sexually abused a patient.

Now, facility operators (including principal dentists or one who employs one or more dentists) are also required to report if they have reasonable grounds to believe that a health professional practising there is incompetent or incapacitated.

Persons who terminate the employment of, or revoke, suspend or impose restrictions on the privileges of a member, or dissolve a partnership,
associateship or health profession corporation, or would have done so but for the voluntary departure of that member, continue to be obligated to file a report with the Registrar of the College within 30 days.

Also, the legislative amendments require all regulated health professionals to self-report any court findings of professional negligence or malpractice and any findings of guilt for criminal offences as soon as reasonably possible after receiving the notice of the finding.

**Register goes online**

One of the most obvious changes is that the Register – the public information that health regulatory colleges are required to maintain about their members – must be available online.

Up until now people seeking this information had to contact the College by phone or e-mail. As of June 4, 2009, they will be able to access this information themselves on the College's website.

The online Register will contain business information about members and health profession corporations as usual. Home addresses, telephone numbers or personal e-mail addresses will, as before, not be public.

Also, as before, the fact that a complaint has been filed about a member will not be made public nor will cautions to a member resulting from a complaint.

The fact that a Registrar’s investigation has been carried out is not public information either.

Information about terms, conditions and limitations on a member's certificate that are currently in effect, discipline referrals, findings or any reference to publication in Dispatch must now also be on the Register available online.

**New Inquiries, Complaints and Reports (ICR) Committee**

Most of the functions of the Complaints Committee and the Executive B Committee are merged into one screening committee called the Inquiries, Complaints and Reports (ICR) Committee. This Committee reviews investigations conducted as a result of formal complaints and Registrar's investigations.

The new ICR Committee still has the ability to accept member's voluntary undertaking/agreements to upgrade skills by courses and practice monitoring. It now also can require a member to complete a specified continuing education or remedial program.

When investigating a complaint or considering a report, the ICR Committee is now required to consider all previous decisions regarding the member, except where no action was taken because a complaint was frivolous, vexatious, or made in bad faith. The member will receive all the same material as the Committee. In the past, the Complaints or Executive Committee only saw a relevant history of a member by request if they intended to take action on an investigation.
The Register Goes Online: Questions & Answers

Q. What is the Register?
The College has always maintained a register of public information that includes a member’s name, business address and registration status. This is a requirement of our governing legislation, the Regulated Health Professions Act. Historically this information was always available by contacting the College by phone or by e-mail. As of June 4, 2009, this information is accessible at any time on the College’s website.

Q. Why is the Register going on the website?
In 2007, the Regulated Health Professions Act (RHPA) was amended by government to require all Ontario health regulatory colleges to put their Registers on their websites by June 4, 2009.

Q. Are dentists the only health care professionals with an online Register?
All Ontario health regulatory colleges will have their Register on their website starting June 4, 2009. Some colleges already have done this; for example, the College of Physicians and Surgeons of Ontario has had its Register online since 1997.

Q. What personal information appears on the Register?
Your surname and given name(s), including any changes in your name, such as marriage or legal name change, made in the Register since you obtained a degree in dentistry are on the Register, if this information is known to the College. Your home address, phone number and personal e-mail address are not available to the public on the Register.

Q. What information about my dental education is on the Register?
The Register has the name of the university where you obtained your degree in dentistry and the year it was obtained. If you hold a certificate of registration in a specialty class, then the name of the university, the year you completed your specialty training and the name of the specialty also appear.
Q. A complaint has been made against me and the College is currently investigating it. Is this information on the Register?

No. The investigation and the fact of a complaint are confidential.

Q. When a decision is made on a complaint against me, is that decision placed on the Register?

This information is on the Register only if the decision was to refer specified allegations of professional misconduct to the Discipline Committee or to refer to the Fitness to Practise Committee. A summary of the allegations are available to the public and this has been the case since 2000. All other decisions on complaint matters are not available to the public.

Q. As a result of a complaint, I was required to appear before the Inquiries, Complaints and Reports (ICR) Committee for a caution. Is this information on the Register?

No. The fact that there is a caution is not public information.

Q. Does the Register contain a list of all the complaints ever made against me?

No. This information has never been and is not now available to the public.

Q. If the Registrar conducts an investigation of my practice, is that information on the Register?

The investigation itself is not public information. However, if the ICR Committee makes a referral to the Discipline Committee or to the Fitness to Practise Committee as a result of the investigation, the Register contains a notation of that fact and a brief description of the allegation(s). A referral cannot be made without the member receiving the report and having an opportunity to respond and make submissions to the ICR Committee. This information has been on the public Register since 2000.

Q. If a patient sues me, does that information appear on the Register?

No. This information is not made available on the Register.

Q. If there is a settlement, is that on the Register?

No. Only a decision by a judge in the case of a finding of negligence or malpractice is on the Register, and only for findings after June 4, 2009.
Q. If my membership certificate of registration was suspended for non-payment of fees, does this show on the Register?

If your certificate of registration is currently suspended for non-payment of a fee, a notation of this fact and the date that the suspension took effect appears on the Register. This status remains in effect until you either reinstate your certificate of registration or for a period of two years after which a suspension for non-payment is automatically converted to a revocation for non-payment. In both these situations, the legislation states that a notation of the suspension remains.

Q. If my membership certificate of registration was revoked for non-payment of fees, does this information show on the Register?

If your certificate of registration is currently revoked for non-payment of a fee, a notation of that fact and the date on which the revocation took effect appears on the Register. This status remains in effect unless you reinstate your certificate of registration. The legislation states that a notation of a past revocation remains on the Register whether or not reinstatement occurs.

Q. If my certificate of authorization for my health profession corporation is currently revoked, does this information show on the Register?

Yes. The revocation of a certificate of authorization for a health profession corporation and the reason for the revocation appears on the Register. The legislation requires that the notation of the revocation remains.

Q. If I listed my home address and telephone number as the business address of my professional corporation, does this information show on the Register?

Yes. The name, business address and business telephone number of every health profession corporation appear on the Register.

Q. If my family members hold non-voting shares in my professional corporation does this information show up on the Register?

No. Only the names of the dentist shareholders of each health profession corporation who are members of the College appear on the Register.
Q. I have a discipline hearing pending. Is this on the Register?

Since 2000, the fact of a current referral of specified allegations of professional misconduct for a discipline hearing has been public. Now the only change is it will be on the Register on the College’s website, as required by legislation.

Q. If I am found guilty of professional misconduct at my upcoming discipline hearing, is this information on the Register?

According to the legislation, the panel’s finding, the particulars of the grounds for the finding, the order made and a synopsis of the decision must be on the online Register. As required by legislation, with limited exceptions, this information remains on the website.

Q. I pleaded guilty to allegations of professional misconduct prior to March 2000. Does this appear on the Register on the website?

All guilty findings, published with the member’s name, made after March 2000, are noted on the website. This information has already been available to the public since 2000.

Q. Is a voluntary undertaking to take a course and then be monitored made public?

No. Voluntary undertakings entered into either as a result of a patient complaint or a registrar’s investigation that were confidential remain confidential and are not on the Register. This is true of past undertakings, those currently in effect and any new undertakings entered into under the new legislation.

Q. In my undertaking, I agreed to have practice restrictions placed on the public portion of the Register. They are currently in effect. Does this information appear on the Register on the website?

Yes. Since you agreed that the information would be on the Register and the restriction is currently in effect, it is shown on the Register on the College’s website. This information has been available to the public already from the point in time that the undertaking was signed. If the College relieves you of the undertaking in the future, any reference to the restriction will immediately be removed from the website.
Ontario dentists will soon have an opportunity to reduce their deductible under the Professional Liability Program (PLP) with new changes to the program coming into effect in January 2010.

"This is a new and exciting program enhancement," said PLP Director Dr. Don McFarlane. "Dentists now have an opportunity to reduce their deductible by demonstrating that they have either taken steps to improve deficiencies in their practice that led to the settlement of previous claims or are prepared to provide an undertaking to do so.

"The public wins too because PLP now has a proactive way of encouraging dentists to improve the delivery of care to their patients," explained Dr. McFarlane.

Here’s how it all works. Effective January 1, 2010, the basic or minimum individual deductible remains $2,000. The new step-ups in the deductible are as follows:

- $5,000 for the member who has had a prior claim in the previous 84 months;
- $10,000 for the member who has had two previous claims in the previous 84 months;
- $20,000 for the member who has had three previous claims in the previous 84 months.

"Under the new system there is definitely an incentive for dentists with previous claims of a similar nature in the preceding seven-year period to improve their practices to avoid future claims of a similar nature," said Dr. McFarlane.

In a nutshell, these PLP policy changes will see an increase in the amount of the step-ups in the deductible, a new third step added and an extension in the length of time that the step-up is applicable from 60 months to 84 months.

"Of course, PLP staff will continue with their top-notch risk management education program," said the PLP Director. As Dr. McFarlane outlined, over the years PLP has developed a number of resources for Ontario dentists, including the Risk Management Guide, group educational sessions, and individual mentoring – all at no cost to dentists.

More information on the new PLP deductible will appear in future issues of Dispatch before the January 2010 implementation date.
DETAILS ON HOW THE NEW PLP DEDUCTIBLE WILL WORK

1. The PLP Committee has the authority to reduce the deductible to an amount which is not less than the minimum deductible, as set out in the policy, where the Committee is satisfied that is appropriate to do so.

2. Where the PLP Committee determines that there should be a reduction in the insured’s deductible, the PLP Committee has the sole authority to determine the amount of the reduction to the deductible. The reduction could be either all or only a portion of the stepped-up amount.

3. Any member who is called upon to pay a stepped-up deductible will be advised of the opportunity to make submissions in writing to the PLP Committee requesting a reduction in his or her deductible.

4. The factors which the PLP Committee could consider in determining whether to reduce a deductible include but are not limited to the following:
   • There are no similarities between the conduct/circumstances of the current and previous claim(s).
   • The new claim, which gives rise to the stepped-up deductible, is related to conduct which took place prior to the member taking remedial action, plus the PLP Committee is satisfied that the deficiencies which gave rise to the claim(s) have been appropriately addressed by the member.
   • The claim payment(s) is primarily to defence cost and, in the PLP Committee’s view, the member is not likely to have been found to be negligent.
   • The dentist has already proactively addressed any shortcoming identified by the PLP Committee as contributing to the claim.
   • The dentist agrees to enter into an agreement with the College, through the PLP Committee, whereby he or she agrees to successfully complete remedial action, such as a course(s) or additional training, as considered appropriate by the PLP Committee in order to minimize the likelihood of claims of a similar nature occurring in the future.

5. When the PLP Committee determines that a reduction in the deductible is conditional upon the completion of remedial action by the member, the Committee will offer an agreement to the member by which the Committee agrees to reduce the deductible to an amount specified by the Committee (that amount not to be less than the minimum deductible) in consideration of the member successfully completing specified remediation either within a specified time or longer, if permitted by the Committee.
This disease of addiction shows no favourites. Dentists as well as other health professionals are susceptible to this disease just as they are to other diseases that plague mankind.

Evidence gathered from well-designed studies over the past 30 years has shown unequivocally that addiction is a disease, one that comes about from an inheritable predisposition and is expressed through changes in the biochemistry of the brain.

Addicted dentists who are reluctant to seek help, who cast a blind eye to their problems, are hurting themselves, their families and their patients, but also the dental profession as a whole. There is help available.

Since the mid-90s, there has been an increasing awareness of the need for support of the health and well-being of health professionals. This began with the well known Physician Health Program that is now established in every state in the United States and every province in Canada. The American Dental Association is part of this movement towards supporting dentists. Now Ontario is leading the way in Canada to develop a confidential and collegial supportive service for dentists and their families who have addiction issues.
Who’s at risk?

From the perspective of substance use disorder, dentists are no more at risk than the general public. However, they do have a number of risk factors by the very fact that they are dentists.

There is a significant genetic risk. Many dental students come from a home where one or more of parents have been alcohol dependent. The personality characteristics of obsessive compulsive traits, perfectionism, the ability to work extremely hard and not looking after one’s own needs: these are characteristics of dental students at risk of substance abuse.

In addition, many dentists practise in solo practice and use mood altering medications both for anesthesia as well as analgesia.

It is possible that self-administration of these chemicals is a risk and at times does occur; for example, the misuse of nitrous oxide.

It has been the experience of the Homewood Health Centre Health Professional Treatment Program that most dentists entering the residential program use alcohol as their drug of choice, but many have also had experience with nitrous oxide, cocaine, and the opiate class analgesics.

How does it impact a dentist’s life?

Addiction has been described like a target with the addicted dentist in the centre and concentric circles representing the various areas of his or her life that have been affected one by one by the disease process:

- Initially family life: Family fights, separation and divorce, extramarital affairs and absences occur.
- Employment status: This is reflected later in job changes, intervals between positions, and inappropriate references from jobs for which the dentist is apparently over trained.
- The dentist’s health: Often a complicated or vague medical history develops, deterioration of physical appearance occurs, withdrawal and intoxication signs are noted and accidents occur. Professional duties are affected in terms of missed appointments, angry outbursts, sloppy surgical technique and poor dental judgment.
- Office personnel are often the first to notice the changes in the dentist’s conduct; mood swings and slurred speech over the telephone are noted. Day-to-day professional conduct is impacted. By the time the disease manifests itself in the office setting, the dentist is very ill.

What questions should be asked?

Many of us use alcohol and licit drugs in a safe and healthy fashion under the supervision of our own physician or healthy family members. However, a number of us cross the line into dangerous substance use. This is sometimes related to stress at work or just simply the habit of drinking alcohol nightly for relaxation purposes.

In the American Dental Association National Dentist Wellbeing Survey, dentists were asked four questions:

1. Have you ever felt that you should cut down on your drinking or drugging?
2. Have people annoyed you by criticizing your drinking or drugging?
3. Have you ever felt bad or guilty about your drugging or drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?

If, as one answers these questions, the answer is positive to any two questions, there is an 80% correlation with alcohol dependency. If one answers positive to three or more questions, there is virtually a 100% correlation with alcohol dependency.
This simple screening set of questions used by family physicians and emergency room doctors very quickly separates folks who are heavy social drinkers from people who have moved into problematic alcohol or drug use.

Readers of this article can identify themselves within these questions. It is recommended that if you fall into the population who are answering positive to two or more questions, it is advisable that further discussion take place with your family physician.

**Principals of intervention**

The basic principals of success in intervention consist of the following:

- It should be carried out by more than one colleague, particularly those in positions of authority.
- It should occur when the dentist is sober and soon after an incident precipitated by the problem.
- The location should be quiet and non-threatening.
- Documentation of specific incidents of impaired behaviour should be used if available.
- Colleagues should have a non-judgmental attitude – the dentist has an illness.
- Anticipate possible reactions such as denial, anger and threats including legal threats.

The goal is for the dentist to agree voluntarily to an assessment by an independent specialist rather than to accept a stigmatizing diagnosis and mandatory treatment.

**What is treatment?**

Treatment of any addiction must begin with abstinence. Abstinence is the key that allows one to enter the room known as recovery. Abstinence is not a goal, it is a state which sometimes needs to be reached through management withdrawal mechanisms or sometimes can simply be reached by quitting drugs or alcohol oneself.

Basically treatment is simple. It teaches the addicted dentist how to be sober and how to maintain sobriety despite the normal buffeting of daily life events.

The core of being addicted is to be isolated; therefore the treatment is to help the dentist bring healthy people back into his or her life who can support the journey in sobriety.

Once diagnosed and treated, the prognosis for dentists is excellent. A number of studies have demonstrated an excellent prognosis for addicted dentists who have completed treatment and who have continued on a long-term monitoring program. However, duration of the follow-up care is of key importance.

The monitoring program may simply be attendance at Alcoholic Anonymous meetings and a health professional support group, or it may be more intense involving urine monitoring as well as aftercare contracts.

In this age of increased accountability for health professionals, a significant international wellness movement has developed and the Royal College of Dental Surgeons and the Ontario Dental Association have to be congratulated in leading this initiative in the dental profession in Canada.

Afterall the goal is to move dentists from the place of shame of a stigmatizing illness to the dignity of recovery.
Case No.1

COMPLAINT SUMMARY
A patient filed a complaint with the College about treatment rendered to her minor son by a general dentist. The mother complained that the dentist extracted the wrong tooth, one on the upper left side, not the one on the upper right side as planned.

On June 7, 2008, she took her son to the dental office for the extraction procedure. The dentist placed a gel (topical anaesthetic) on a tooth on the upper left side. The mother stated that she showed surprise and commented that she thought it was an upper right tooth that was to be extracted. According to the mother, the dentist laughed and responded that he was old but not stupid and proceeded to extract the upper left tooth, a tooth that had recently been treated. The complainant questioned why the member would treat a tooth one month prior, if his intention was to extract the tooth.

DENTIST’S PERSPECTIVE
The dentist was notified of the formal complaint and provided the College with his response and his patient records for the child. In his response, he stated that he suspected that there had been a communication breakdown which he wished to resolve. The dentist explained that he first saw the child patient on February 3, 2007. Bitewing radiographs taken that day showed large decay on two teeth, namely 54 (upper right 1st primary molar) and 64 (upper left 1st primary molar). And on March 3, 2007, tooth 54 was restored.

Four months later, the child attended for an emergency appointment with pain on the upper left (tooth 64). The patient’s father was informed that the previously identified caries had not yet been treated. The dentist proceeded to restore the tooth, with a note in the chart that a pulpectomy might be required in the future.

On July 25, 2007, the child returned with an abscess on the right side. A prescription for an antibiotic was provided. The dentist performed a pulpectomy on tooth 54, in order to maintain the tooth while the upper four front teeth emerged.

On April 1, 2008 and the next recall appointment, a draining fistula on the upper left side (tooth 64) was observed. The treatment plan in the chart indicated that an appointment would be required to extract tooth 64. The mother also noted a “pimple” that came and went which the dentist now believed to be on the upper right side.

The dentist believed that both he and the child’s mother had agreed that treatment was required; however, there was some confusion between the parties as to which side of the mouth required treatment. There was no
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> notation made in the chart of a draining fistula on the right side.

On June 7, 2008, the child returned for the extraction procedure. The fistula was still present on tooth 64. The member stated that he had no recollection of stating “I am old but not stupid” and apologized if he did make such a remark. He commented that he should have shown the mother the draining fistula and explained what he was doing prior to the procedure and asked if she had questions about the procedure.

The dentist stated in his response that he was confident in his treatment, as the extraction of tooth 64 was clearly planned. He stated that he did not recall the mother advising him of a fistula on the right side that was present the morning of the extraction procedure.

The member proceeded to extract tooth 64 and provide postoperative instructions. The dentist advised that it was possible that between April 1 and June 7, 2008 tooth 54 could also have started draining. He was unaware of this and suggested that, if this was the case, the tooth likely required extraction as well.

DECISION OF THE COMPLAINTS PANEL

The panel reviewed all correspondence and records obtained during the course of its investigation. They reviewed the member’s records to confirm what diagnosis was made, what treatment was offered and what treatment was chosen by the complainant.

While the appropriate treatment may have been provided, the panel had concerns about the adequacy of the member’s recordkeeping and the adequacy of his informed consent protocol.

The panel was of the opinion that the member’s records lacked:

- notations of the clinical observations of tooth 64 made during the patient’s recall appointment on April 1, 2008;
- notations of the diagnosis and treatment options for tooth 64;
- a pre-operative periapical radiograph that showed the condition of tooth 64 prior to extraction;
- notations of discussions between the member and the child’s mother regarding the diagnosis, treatment plan, treatment alternatives, risks and benefits of treatment, and fees for treatment, in order to obtain the complainant’s consent to treatment rendered to the child.

Overall, the panel was of the opinion that the member’s records did not adequately justify and/or support the treatment provided. The panel did accept that teeth 54 and 64 had questionable prognoses and required restorations, pulpectomies and/or extraction. In addition, the panel accepted that tooth 64 later developed a fistula and required definitive treatment.

Accordingly, the dentist voluntarily signed an undertaking/agreement to take and successfully complete a course in recordkeeping, including informed consent, in order to address the concerns about his recordkeeping and informed consent. Following the successful completion of the course, the member agreed that the College would be permitted to monitor his practice for a period of two years to ensure that the knowledge gained in the course was applied in his practice. The panel felt that by the member agreeing to upgrade his skills in this regard, he would benefit and the public interest would be protected.

Based on the above, the panel decided to take no further action with respect to this complaint.
**Case No. 2**

**COMPLAINT SUMMARY**
A registered dental hygienist filed a complaint with the College regarding her former employer alleging billing fraud, insufficient documentation and/or document alteration, and health and safety violations.

She provided specific patient names and examples relevant to the above noted issues. However, since she was not acting in the capacity of an agent for the patients named in the letter of complaint, the College was unable to release any confidential health information for these patients to her.

As part of its investigation, the Registrar of the College authorized an investigation of the dentist’s practice pursuant to Section 75(c) of the Regulated Health Professions Act, 1991 (Procedural Code). The College’s investigator attended the practice and notified the dentist of the complaint and obtained patient records for the 14 patients whose names were provided by the complainant. In addition, the investigator attempted to obtain the financial information for these patients, but was unsuccessful due to a change in computer software and an inability to locate the disks on which the information was stored.

**DENTIST’S PERSPECTIVE**
The dentist provided a written response to the complaint. He stated that he purchased the practice in September 2003. As part of the sales process, the previous dentist terminated the dental hygienist and then the dentist in question immediately rehired her. However, it became apparent that her methods and standards differed from his own and she found the transition difficult. Her employment with his office was terminated in January 2007.

The dentist asked the panel to consider the complaint filed by his former dental hygienist to be frivolous, vexatious, made in bad faith or otherwise an abuse of process, pursuant to s.26(4) of the Regulated Health Professions Act, 1991 (Code). The panel did not make this determination and instructed that the investigation continue.

A copy of the dentist’s correspondence was sent to the complainant for her information and she and the dentist provided further documentation to the College in support of their respective positions.

**DECISION OF THE COMPLAINTS PANEL**
The panel reviewed all correspondence and records obtained during the course of its investigation and the report of the investigator. Based on the material before it, the panel had the following concerns:

- Patients were charged for new patient examinations yet the necessary documentation appeared incomplete.
- The member’s records contained unsigned and/or undated forms.
- There was inconsistent or no follow-up on medical issues that arose during a patient’s completion of the medical history questionnaire.
- Dental treatment was not billed on the date it was provided.

The panel noted that the dentist himself recognized that there were shortcomings in his recordkeeping practices. Accordingly, he voluntarily signed an undertaking/agreement to take and successfully complete a course in recordkeeping in order to address the concerns about his recordkeeping. Following the course, the College would monitor his practice for a period of two years to ensure that the necessary improvement had taken place.
Complaints Corner

The panel could not find anything to support the allegation of fraudulent billing. When the panel compared the financial records to the treatment records, the panel could see that the billings did reflect the work provided, however, they were not always submitted that same day. The panel reminded the member that treatment should be billed on the day it is provided.

Relative to the concerns about poor sterilization and asepsis routines, the panel members were satisfied that proper protocols were in place in the practice. This information was verified by the current staff members. Based on the above, the panel decided to take no further action with respect to this complaint.

learning points

- Complete and detailed patient records are part of the legal, ethical and professional responsibilities of each dentist.

- Patient records must contain:
  - an accurate picture of the conditions present on initial examination
  - the clinical diagnosis and treatment options
  - the proposed and accepted treatment and a record of the informed consent process and discussion
  - a detailed record of all treatment that is recommended and provided
  - an account of all discussions between the dentist and the patient and/or their authorized representative or guardian

- Failure to adhere to the College’s recordkeeping standards and recommendations may have a negative impact on the outcome of a complaint’s investigation or a dentist’s ability to provide an acceptable defence should a lawsuit be advanced against the practitioner.

ON THE WEB
www.rcdso.org
- Recordkeeping Guidelines
- Medical History Recordkeeping Guide
- Risk Management Guide

PROFESSIONAL PRACTICE/PRACTICE RESOURCES
Overtreatment or Appropriate Treatment

For five years you have been trading dental emergency weekend coverage with Dr. Kurt Knell, another general practitioner in your office complex. The arrangement has worked out well, as you can almost plan the entire year and the weekend coverage that suits both of you.

Felix Major is an emergency patient of Kurt’s who lost a small part of an amalgam on his mandibular second molar. Mr. Major is more worried than in pain as he is scheduled to start crowns on all of his molars next week. You expose a bitewing and periapical radiograph and plan to place a temporary filling (IRM) in the missing mesial box of tooth 3.7. The deficiency is small and there is no evidence of clinical or radiographic caries.

Mr. Major asks you, “Do you think these four teeth need crowns? I only had silver fillings before I started with Dr. Knell. He showed me the big cracks in the teeth with his tiny tooth camera and said I should do crowns before I have nerve problems or the teeth split. My teeth don’t hurt me and crowns are expensive, although my dental insurance helps. What do you think?”

Your examination reveals small, two and three surface amalgam restorations on the four molars, with no evidence of decay or excessive occlusal wear from bruxism. Mr. Major is 30 years old and is in good general and oral health. It appears that the replacement of a few of the molar restorations is all that is needed. You are concerned because you know that Kurt is having financial problems because of major losses in the stock market and cost overruns on his new office.

Is it only a coincidence that several other recent emergency patients also have crowns planned when it appears that a few replacement restorations would suffice? Is Kurt overtreating his patients because of his money woes or is this just a difference of clinical opinion?

You are now faced with an ethical dilemma. What would you do?

- Don’t concern yourself with this situation. Take care of the emergencies and don’t worry about possible overtreatment.
- Explain to the patient that you don’t have all the diagnostic materials to make that judgment and can’t answer his questions.
- Call Kurt and describe your concerns to him.
- Suggest that the patient contact the College.

Now turn to page 28 to find the discussion about this ethical dilemma.
Alan Jones presented to Dr. Wendy Smith with throbbing pain in the lower left. Dr. Smith recommended and performed endodontic treatment on tooth 36 on that date. Then later, she restored tooth 36 with a cast post and core and a PFM crown. The patient did not return after insertion of the crown and did not pay the outstanding balance of $500 on his account.

Dr. Smith’s staff issued monthly statements to Mr. Jones. Then 120 days after the insertion appointment, with the outstanding balance still unpaid, the account went to collections and eventually to small claims court.

Mr. Jones issued a counterclaim against Dr. Smith, alleging negligence resulting in the loss of tooth 36.

PLP PERSPECTIVE
Because a claim was issued, Dr. Smith reported this matter to PLP. PLP reviewed the records and noted the following:

- The records showed tooth 36 was heavily restored; however, there was no information in the records about clinical findings, tests performed or diagnosis.
- As well, the only pretreatment periapical radiograph of the lower left was from two years ago and it showed no evidence of periapical pathology.
- Based on the poor recordkeeping, there was no evidence that endodontic treatment of tooth 36 was necessary.
- There was no evidence of a discussion of treatment options, risks and benefits, or of the fact that a crown would be required following endodontic treatment. There was no evidence that costs were discussed. In other words, there was no evidence that informed consent was obtained.
- There was no final radiograph of tooth 36 taken by the insured. A subsequent dentist took a periapical radiograph which showed the canals of tooth 36 were severely under extended.
- This radiograph also showed a post had been placed in the distal canal of tooth 36 and it had perforated into the furcation area.

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
There were numerous telephone messages in the chart, showing Mr. Jones had called Dr. Smith’s office, claiming to be in pain. From the records it did not appear that Dr. Smith had ever returned the telephone calls.

The dental records of the second dentist showed that tooth 36 was eventually extracted due to severe infection in the furcation area and endodontic failure. Because of these shortcomings, PLP recommended and negotiated settlement of the claim against Dr. Smith in exchange for a Full and Final Release in his favour.

DISCUSSION
What a dentist does after an untoward incident occurs can play as much a part in causing or preventing a problem as the incident itself.

In this case, clearly there were problems with Dr. Smith’s treatment of Mr. Jones. However, Mr. Jones did not take any action against Dr. Smith until she pursued his outstanding account. If Dr. Smith had reviewed Mr. Jones’ records prior to pursuing the account, she may have recalled the problems with treatment and decided to write off the outstanding balance. Or, she may have considered calling the patient to discuss treatment concerns. Had she done so, the claim/counterclaim may well have been avoided.

IN SUMMARY
Dentists are entitled to receive payment for services rendered; however, a significant number of complaints to the College and claims against dentists are motivated by an aggressive approach to collections. Remember, if you decide to eliminate the outstanding debt or offer a refund for a particular patient, you should call PLP to ensure that such action does not compromise your coverage.

PLP POINTERS
You are entitled to receive payment for services you render. However, before pursuing an outstanding account, consider the following:

• Did your treatment meet the standard of care?
• Did your patient express satisfaction or dissatisfaction with treatment? Is this documented?
• Have you addressed and documented any payment problems?
• Are your records complete? Have you and your staff recorded all interactions with the patient?

ON THE WEB
www.rcdso.org
Collection of Delinquent Accounts
DISPATCH FEBRUARY/MARCH 2009 PAGE 30
I

Legal and Human Rights Ramifications of Serology Testing for Dental Professionals

Infection prevention and control is an important part of safe patient care. Concerns about the possible spread of blood-borne diseases require dentists to establish, evaluate, continually update and monitor their infection prevention and control strategies and protocols. The best means of protecting both health care workers and patients from the risk of transmitting blood-borne pathogens is adherence to standard precautions.

Standard precautions are based on the concept that all patients are potentially infective, even when asymptomatic, and that the same safe standards of practice should routinely apply to contact with blood, body fluids and secretions (e.g. saliva), mucous membranes and non-intact skin. Standard precautions include immunization against hepatitis B virus (HBV) and subsequent verification of immunity.

Hepatitis B is the single most important vaccine preventable infectious disease for all health care workers. The risk of being infected is a consequence of the prevalence of virus carriers in the population receiving care (approximately 350 million carriers worldwide), the frequency of exposure to blood and other body fluids, and the contagiousness of HBV. Therefore, immunization against HBV is strongly recommended for all health care workers who may be exposed to blood, body fluids or injury involving sharps.

From the patient’s perspective, however, the seroconversion rate for an unprotected individual after significant exposure to a hepatitis B e-antigen positive health care worker is 19 to 30%.

Dentists have a fiduciary duty to ensure that patients are treated in a safe and healthy office environment – but how far does this duty extend? Do patients have a right to expect that dentists will submit to serological testing for infectious diseases and disclose their status? What about the competing rights of dentists to personal privacy and protection from discrimination? What about the rights of applicants and students to pursue the profession of their choosing?

To examine these questions, PEAK offers members the following
article: “The Legal and Human Rights Ramifications of Serology Testing for Dental Professionals,” by Raj Anand and Carrie Bowker, who researched this important topic for a presentation to the Canadian Dental Regulatory Authorities Federation on October 24, 2008 in Montreal.

The article begins by reviewing the rationale and existing policies for serological testing among regulators and dental schools. It then discusses the applicable human rights principles and legality of such testing. As noted in the article, the College has a confidential and compassionate process for members who may be infected with blood-borne diseases to assist them in their particular practice situation. For more information about this process, please call the College’s Registrar Irwin Fefergrad at 416-934-5625 or toll-free at 1-800-565-4591.

ON THE WEB
www.rcdso.org

- Guidelines for Infection Control in Dental Health-Care Settings from the Centers for Disease Control and Prevention, Atlanta, Georgia
- Best Practices for Cleaning, Disinfection and Sterilization in All Health Care Settings from the Provincial Infectious Diseases Advisory Committee, Ontario Ministry of Health and Long-Term Care

KEY POINTS

- All dentists should conscientiously and rigorously adhere to the principles of standard precautions in their practice.
- All dentists should be immunized against hepatitis B for the protection of themselves and their patients.
- All dentists who perform exposure-prone procedures have an ethical obligation to know their serological status with respect to HBV, HCV and HIV.
- If infected, dentists should seek guidance from the College with respect to the potential for transmission of their infection to their patients.
Ethical Dilemma Discussion

The Dental Ethics 101 Ethical Dilemma Case Study appears on page 23.

Overtreatment or Appropriate Treatment

In this ethical dilemma, the dentist has a concern that his colleague’s treatment planning perhaps may be influenced by his personal financial situation and needs. The patient, seen on an emergency basis, is raising questions about the appropriateness of the recommended treatment. Is this a case of overtreatment or is it a difference of opinion about appropriate alternative treatments? What does the research tell us about this treatment decision?

The ethical issues in this case include:

- uncertainty and the science and art of dentistry
- uncertainty and the emergency patient
- treatment outcomes and practice parameters and guidelines

Uncertainty and the science and art of dentistry

When is the right time to replace amalgams with crowns? Are our treatment decisions based more on the art than the science of dentistry?

Uncertainty is a central feature of this case and related cases of amalgam replacement by crowns. Robertson, Bader and Shugars in a 1993 paper related the uncertainty of our current dental knowledge as:

The overall incidence rate for cusp fracture is unknown; rates for teeth with putative risk factors such as old amalgams and weakened cusps are even more problematic.

Finally, risks for pulpal death and periodontal destruction due to crown-preparation treatment, as well as the expected longevity of the crown, are also undetermined.

The authors described how the appropriateness of medical care decisions is under examined, and, as they say, in dentistry, “the focus on the appropriateness of care is in its infancy.” The term “appropriateness” in this context refers to, “the expected health benefit … exceeded the expected negative consequences … by a sufficiently wide margin that the procedure was worth doing.”

Due to the lack of research in this area, dentists must make decisions based on their clinical training, experience and judgment – so the process is more art than science. A dentist’s philosophy could range from, “crown everything” to “if in doubt, prevent, wait and reassess.”

One of the core values in the College’s Code of Ethics is “Beneficence.” This means maximizing benefits and minimizing harm for the welfare of the patient. One of the ethical principles in the Code states that “the paramount responsibility of a dentist is to the health and well-being of patients.” Another states that it is the ethical responsibility of
dentists to “provide timely and competent care that is consistent with the standards of the profession.”

Uncertainty and the emergency patient
How should the dentist providing the emergency care in this case respond to the patient’s inquiry? Should he discuss the question of economic motive with his colleague?

The uncertainty in this case includes many factors:

• Is the patient honest and accurate as to Dr. Knell’s recommendations?
• Is there sufficient diagnostic information available to the emergency dentist to make a determination of appropriate or overtreatment?
• And the central question – Is this overtreatment or a difference of opinion about a preferred treatment?

Treatment outcomes and practice parameters/guidelines
Practice parameters are intended as educational resources, not as legal requirements. They are not intended to establish standards of dental care, which are rigid and inflexible and represent only what must be done; nor are they guidelines which are less rigid but represent what should be done; nor are they intended to undermine or restrict the dentist’s exercise of professional judgment.

For example, for dental caries or a fractured (cracked) tooth, practice parameters might recommend that the dentist should consider the characteristics and requirements of each case in selecting the material(s) and technique(s) to be utilized.

When emergency patients request definitive treatment recommendations in the absence of adequate diagnostic information, the dentist is justified in treating the emergency and then suggesting that the patient speak to his regular dentist about his concerns.

In conclusion
It bears acknowledgement that uncertainty will always be a part of our clinical practice because our knowledge, materials, techniques and abilities are imperfect, plus the oral cavity is a hostile environment in a constant state of entropy.

With the increased attention to outcomes research, practice parameters and guidelines, more and more information is becoming available that may aid clinicians in making appropriate treatment decisions.

RCDSO Code of Ethics speaks to this issue in Ethical Principle #13 which states:

Only make evaluative remarks about the work of others after making reasonable efforts to understand the prior treatment history of patients.

While a practitioner is obligated to inform his or her patients of the findings of a clinical examination and the treatment that is necessary to correct any deficiencies that have been noted, it is unwise to make any comments about treatment provided by a colleague unless adequate information is available.

And, without the consent of the patient, it would not be appropriate to speak to the patient’s dentist about your findings.
Case No. 1

THE COMPLAINT
The patient attended at the dentist’s office for root canal treatment, paying in advance for the procedure. About six months later, the patient returned complaining about discomfort. The dentist referred the patient to an endodontist. However, since the endodontist wanted additional money for the root canal therapy, the patient called the original dentist and asked for a return of her money. The dentist refused and the patient complained to the College. The nature of the complaint reflected poor work and an allegation that the dentist was rude.

The dentist responded by saying that the work had been completed, but that the patient was non-compliant in keeping appointments. During the interim period, the patient had seen other dentists. The dentist denied being rude to the patient.

DECISION OF THE COMPLAINTS COMMITTEE
The Committee reviewed the x-rays of the records and noted that appropriate materials were used and that overall the treatment provided by the general dentist approximated the standard of care. The Committee also noted that the tooth was a heavily restored tooth and that the canals of heavily restored teeth may be calcified complicating endodontic treatment.

With respect to the alleged rudeness of the dentist, the Committee was unable to determine which version of events, the patient's or the dentist's, was accurate. The Committee therefore decided that no further action was warranted.

HEALTH PROFESSIONS APPEAL AND REVIEW BOARD
The complainant was dissatisfied with the decision and sought a review at the Board. The Board was satisfied that the investigation by the staff was adequate and that the reasons of the Committee were clear.

The Board was impressed that the Complaints Committee reviewed all of the materials available to it, including patient records and the records of the other treating dentists. The Board accepted that the Committee came to reasonable conclusions based on the information before it. It, therefore, dismissed the appeal.

Case No. 2

THE COMPLAINT
The patient complained to the College that the dentist billed improperly for dental services and, since the patient and the dentist had a business relationship, this position of trust was exploited.

The dentist and the patient had a business and social relationship. As a result of the falling out over the business arrangement, lawsuits had begun between the dentist and the patient.

The essential issue for the Complaints Committee was that the patient alleged that the dentist was seeking recovery of outstanding fees not covered under an insurance plan even though the dentist's billing records indicated that outstanding fees had been written off.

DECISION OF THE COMPLAINTS COMMITTEE
The Committee ordered no further action. It stated that the dentist is entitled to pursue outstanding accounts that may not be covered under an insurance plan, even though they were written off.

The Committee reviewed in depth the relationship of the parties and concluded that the business relationship had no effect on the
dentist-patient relationship and therefore the Committee decided to take no further action.

**HEALTH PROFESSIONS APPEAL AND REVIEW BOARD**

The complainant was dissatisfied with the decision of the Committee and appealed to the Health Professions Appeal and Review Board. The Board considered the investigation by the College reasonable. It reviewed numerous correspondences, including tapes and transcripts, billing records, charts and records. The Board concluded that it had no reason to question the College's view that dentists are entitled to seek recovery of outstanding fees that may not be covered under a private insurance plan.

The Board looked carefully at the issue on whether the dentist violated the boundary of the dentist-patient relationship and concluded that, while difficulties developed between the parties, it did not affect the patient-dentist relationship. That said, the Board did comment: "In retrospect, it may have been more appropriate for the respondent dentist to relinquish his patient-dentist relationship with the applicant patient upon entering into a business relationship."

The Board therefore confirmed the decision of the Committee.

**Case No. 3**

**THE COMPLAINT**

The patient was treated by the dentist for root canal surgery in 1998. There were numerous post-operative treatments to address pain that the patient was experiencing. As well, the patient was seen by numerous other specialists.

The patient complained to the College regarding his treatment in 2003. The Complaints Committee rendered a decision in 2004 to take no further action and the patient appealed to the Health Professions Appeal and Review Board which confirmed the decision of the Complaints Committee.

The complainant filed a second letter of complaint in 2007 stating that there were aspects of his treatment which the Complaints Committee did not consider. He asked that there be further investigation.

**DECISION OF THE COMPLAINTS COMMITTEE**

In that there was nothing new in this complaint that had not been addressed by the original Complaints Committee, the Complaints Committee determined that the complaint met the criteria in the legislation as being frivolous, vexatious and an improper use of the process, and therefore ordered no further action.

**HEALTH PROFESSIONS APPEAL AND REVIEW BOARD**

The patient was dissatisfied and requested that the Health Professions Appeal and Review Board review the Committee's decision. The Board reviewed all of the materials before it and stated that "this matter has no reasonable chance of success and no practical purpose to be served by proceeding to review in this matter."

It reviewed several cases discussing what constitutes frivolous and vexatious and pointed out that it includes "the bringing of one or more actions to determine an issue which has already been determined by a court of competent jurisdiction...".

The Board also said it was mindful of the fact that the complainant had sought review of the initial complaint and that the patient's conduct "in persistently taking unsuccessful appeals from judicial decisions can be considered vexatious conduct of legal proceedings."

As all the information about the tooth and the treatment were clearly noted in the first decision of the Complaints Committee, the Board's conclusion was in agreement with the Complaints Committee: "... it would be an improper use of process to subject the respondent dentist to another investigation."
I am greatly sorry for the careless and improper wording used to describe the role of my newest associate, Dr. Peter Rival. When I read his academic and curriculum vitae I wished to convey some appreciation for the extra extensive studies post grad that Dr. Rival has accomplished.

I also realize that my wording was improper in that we used the verb “specialized” in the banner that overlayed our general business card to introduce Dr. Rival who had just begun practice. This was a regretful and sorrowful mistake that I will endeavour not to repeat in the future.

I realize that cosmetic and implant dentistry is not a recognized specialty but I only wished to convey that Dr. Rival has a great interest in this field and that it will constitute his area of involvement in our practice.

I have always been respectful of other dentists in our community and feel terribly regretful that I have offended one of my fellow colleagues.

In the future I will carefully scrutinize all future advertisements and will forward all proofs to your attention for approval if you choose.

Yours sincerely,

DR. RONALD K. TONOGAI
Eastgate Dental Centre
Hamilton
Keys to keeping good dental records

Maintaining clear, concise, accurate and current patient records is an important element of providing quality patient care. Thorough records are the key to risk management/complaints avoidance/practice enhancement.

- Use a consistent style for each entry. Consistency lends credibility to your records and reflects your professionalism in maintaining them.
- Date and explain any corrections.
- Always use ink, as pencil tends to fade and can be altered too easily. Using ink supports the integrity of your records if they are evaluated for complaints or litigation purposes.
- If you need to make a change, use a single-line cross out. Do not try to erase or whiteout information as this may lead to suspicions about the integrity of your records.
- Write legibly and make sure that your records clearly show who performed the various services: the principal dentist, an associate dentist, dental hygienist or Level II dental assistant.
- Note any concerns about the patient’s needs and expectations expressed by the patient and how they were addressed.
- Always record any and all conversations with patients, especially those that relate to advice given.
- Never write derogatory remarks in the record. Do note any failure or reluctance on the part of the patient to follow treatment advice or to report for treatment, but do so in a professional and objective fashion.

The Staying Safe kit, with CD and workbook, distributed to all College members in November 2006 as part of our LifeLong Learning program, contains useful information on this subject.
Where are my dental records?

From time to time, patients call the College to report that they have been unable to locate their dental records due to the retirement or death of their former dentist or the closing of the practice.

Guiding principles
Two important principles apply to the maintenance of dental records:

1. Patients must have the right of access to their complete dental records and are entitled to copies of these records if they request them.
2. Dental records must be kept by the treating dentist for at least 10 years after the last chart entry for all adult patients. For child patients, the records must be retained for at least 10 years after the child reaches the age of majority or 18 years of age.

When a practice is sold, the records must be transferred to the other practitioner and the dentist who has purchased the practice has the responsibility to retain the records for the same period of time.

Recommended protocol
When a dentist retires or dies or when a practice is sold, the College Advisory on Change of Practice Ownership recommends the following protocol:

• The dentist leaving the practice should notify his or her patients in writing of the change in practice ownership, or pending retirement, and inform them where their dental records can be found.
• In circumstances where the dentist of record dies, the incoming dentist and/or the estate should notify the patients in writing of the fact and should advise them where their dental records are being stored or how to access them.
• The letter that is sent to each patient of record should point out that copies of the patient record will be transferred to any dentist of the patient’s choosing if the patient provides that instruction.
Almost five years of operation have seen the Adverse Drug Interactions program on the College's website help countless patients and dentists.

The online service is available at no charge to all College members. Look for the special icon on the top right-hand corner of our website at www.rcdso.org.

The service is very simple to use, even while the patient is in the chair. The service allows you to list each of the drugs your patient is taking and immediately view the possible interactions on the screen. The online search will handle interactions from two up to 12 drugs.

In addition, you can view reference citations pertinent to the interaction. There is also an index of over 3,000 brand names with generic equivalents. The program is updated every six months to keep it current.

The Adverse Drug Interactions program is an online version of The Medical Letter on Drugs and Therapeutics, a peer-reviewed non-profit publication. It is independent of the pharmaceutical industry and accepts no advertising, grants or donations.

ON THE WEB
www.rcdso.org

HOW TO LOG ON TO THE ADVERSE DRUG INTERACTIONS PROGRAM


2. Click on the special heading – ADVERSE DRUG INTERACTIONS – on the right-hand side of the home page. This takes you to a special disclaimer message. Please read the message. Then, click on the ACCEPT button.

3. Now you are on the website of The Medical Letter. Look at the column on the left-hand side of the screen for the heading ONLINE PROGRAM. Click on the GO button, right beside the words ADVERSE DRUG INTERACTIONS.

4. A special box will pop up on your screen asking for your user name and password. If you don’t know your user name and password, please contact Joanne Loy at the College for assistance at 416-961-6555, ext. 4703 or toll-free at 1-800-565-4591 or jloy@rcdso.org.
In December 2007, the Safety of Human Cells, Tissues and Organs for Transplantation Regulations (CTO Regulations) came into force. Developed under the Federal Food and Drugs Act, the purpose of these federal regulations is to minimize the potential health risks to transplant recipients in Canada.

The CTO Regulations focus on product safety and do not regulate the practice of medicine or dentistry. They are based on the National Standard, published by the Canadian Standards Association (CSA) in June 2003. They were developed using a risk management approach as well as information obtained during extensive consultations with provinces, territories and transplantation experts.

The regulated parties under the CTO Regulations are:

- processors, including source establishments (e.g. tissue banks in the United States);
- importers;
- distributor intermediary;
- transplant establishments.

Canadian establishments who process, import or distribute CTOs, who must be registered with Health Canada under the CTO Regulations, will be subject to initial and regular inspections by the Health Products and Food Inspectorate of Health Canada.

Key areas of these inspections include:

- processing (includes packaging, labelling, storage, quarantine, etc.);
- exceptional distribution;
- error, accident and adverse reaction;
- records, personnel, facilities, equipment and supplies;
- quality assurance system including audits.
Q: As a dentist, how do these regulations affect me?

Dentists fall under the “transplant establishments” category. While dental practices will not be required to be registered, the following requirements apply:

• **Prohibition**
  Establishments can only transplant a CTO that is processed by a registered establishment and determined safe for transplant.

• **Exceptional distribution**
  The transplant physician or dentist is responsible for authorizing the distribution of a CTO that has not been determined safe for transplant (unlikely to involve dentistry).

• **Errors, accidents and adverse reaction investigation and reporting**
  Establishments must report errors, accidents that could compromise CTO safety and unexpected adverse reactions to source establishments. Establishments must have copies of all notices sent out and notices received and documentation of actions taken.

• **Applicable records must be retained for 10 years**
  • Description of the transplanted CTO
  • Donor identification code
  • Registration number of the source establishment
  • Exceptional distribution records (if applicable)
  • Information that allows for identification of the donor
  • Errors, accidents and adverse reactions and associated investigations

Q: What types of dental products are covered by the CTO Regulations?

In general, the CTO Regulations apply to human organs and minimally manipulated cells and tissues that are for homologous use, that are for allogeneic use, and that do not have a systemic effect and depend on their metabolic activity for their primary function, such as demineralized bone.

The CTO Regulations DO NOT apply, among other things, to human CTO (dental) products that are:

• for non-homologous use;
• for autologous use (taken from one site to another on the same patient);
• tissues and cells, with some exception, that have a systemic effect and depend on their metabolic activity for their primary function;
• medical devices that contain cells or tissues and that are subject to investigational testing involving human subjects under Part 3 of the Medical Devices Regulations;
• subject to clinical trials under Division 5 of Part C of the Food and Drug Regulations; or
• Class IV medical devices that are regulated under the Medical Devices Regulations.
Impact of New Federal Regulations: Dealing with the safety of cells, tissues and organs for transplantation

Q: How do I know that a particular product that I use in my practice has been obtained from a registered source establishment or importer?

The CTO Regulations require that a registered establishment, including source establishments and importers, ensure that its establishment’s registration number is added to the exterior label and in the package insert in addition to the other labelling and packaging requirements.

Dentists can also contact the establishment(s) that process, distribute, and/or import the particular product to inquire if the establishment is registered. Alternatively, dentists can contact Health Canada to inquire if a specific establishment is registered under the CTO Regulations; however, this is not the preferred option.

Q: If I obtain a CTO for use in my practice and then distribute it to dentists at my other clinic locations, does this change things?

Yes. If a dentist obtains a CTO and does not use the CTO but instead gives the CTO to another dentist for use in transplantation, then this act would be considered distribution under the CTO Regulations. That means that the dentist who distributed the CTO would be required to register with Health Canada.

Q: Where can I get more information about the CTO Regulations?

Information about the CTO Regulations can be found on Health Canada’s website at: www.hc-sc.gc.ca.

- *The Safety of Human Cells, Tissues and Organs for Transplantation Regulations* (Canada Gazette Part II)
- *Fact Sheet - Safety of Cells, Tissues and Organs (CTO) for Transplantation.*
- *Draft Guidance Document: Cells, Tissues and Organs (CTO) for Transplantation.*
Treating the Asthmatic Patient

Asthmatic patients require specific and detailed evaluation as a part of every routine medical history taken in a dental office.

Asthma is a disease that is increasing both in incidence and severity. It can present as sudden and rapid attacks that seriously compromise the airway by constriction of the bronchiolar tree. Management of the resultant emergency situation can be difficult.

Dentists must assess the degree of severity of the disease in their asthmatic patients by determining:

- How often do asthmatic attacks occur?
- What triggers these attacks?
- When did the last attack occur?
- Has an attack ever required urgent hospital care?
- What medications are being taken?
- What doses? How often? How effective?
- When was the last time a physician assessed the asthmatic condition?
- In terms of your asthma, how would you rate your condition today?

Asthmatic patients require this assessment together with physician consultation when indicated. Severe asthmatics may not be suitable candidates for ambulatory office outpatient care particularly when sedation or general anaesthesia is involved.

Asthma must be recognized as a potentially life-threatening illness and asthmatic patients given the care and respect that their condition demands.

need to know

- Members should be aware of the signs and symptoms of an acute asthmatic attack, and be prepared to deal with this emergency situation.
- It is a good idea to ask asthmatic patients to bring the medication they use to manage acute attacks to each appointment.
- The emergency kit in every dental office should include salbutamol inhalation aerosol, epinephrine and oxygen.

ON THE WEB
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Preparing for a Medical Emergency in the Dental Office
DISPATCH NOVEMBER/DECEMBER 2008 PAGES 55-56
Maintaining an Amalgam Separator

The College’s Amalgam Waste Regulation under the Dentistry Act, 1991, and the accompanying Standard of Practice, was created to prevent amalgam waste from being discharged into municipal sewer and private septic systems.

The regulation came into effect on November 15, 2003. It applies to every dental office in the province of Ontario in which dental amalgam is placed, repaired or removed. It requires the dental office to have a properly installed dental amalgam device which meets or exceeds the standard for amalgam separators as determined by the International Organization of Standardization (ISO).

✓ Request operations and maintenance manuals from separator vendors before purchase. Maintenance requirements and schedules vary widely among separators. (See chart on the facing page for general maintenance information for amalgam separators.) Knowing this information up front will ensure the separator you choose will fit within the needs, capacities and constraints of your dental practice. As a general rule, the in-line systems require more frequent attention.

✓ Ask your vendor for contact information of similar dental practices that have installed the same separator. Talking to other practitioners with the same separator will help you to understand the nuts and bolts of how to best maintain the separator.

✓ Disinfect the separator equipment on a regular basis. Biological growth can impair separator performance, leading to an increase in your practice’s mercury discharge. Recommended disinfection procedures will vary, with the amount and frequency of cleaning dependent upon the amount of biological material in the system, length of vacuum lines, and type of separator.

In all cases, NEVER USE BLEACH or other corrosive solutions. Some appropriate non-bleach line cleaners are:

- All-In-OneE-Vac Evacuation Cleaner
- Gobble Plus
- Green and Clean ProE-Vac
- Sani-Treet Plus Turbo Vac Line Flush
- VAC-U-EZ
- EZ-Zyme
- MAXI-EVAC Purevac
- Super-Dent VacuCleanse

✓ Inspect the separator weekly to ensure proper operation. Look for warning signs, such as compromised suction power and noisy operation. A decrease in vacuum power can indicate improper installation or clogs in the line.

✓ Clean and replace amalgam-containing elements. Replacement schedules can vary from every month for multi-dentist practices to every few months for single-dentist practices. Contact your separator vendor for more specific information.

✓ Finally, amalgam separators must be operated at all times.
## Amalgam Separator

<table>
<thead>
<tr>
<th>Model</th>
<th>Suggested Maintenance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Guardian Amalgam Collector models, Air Techniques</strong></td>
<td>Clean daily; replace collection container after one pound of waste collection (usually 6 months).</td>
</tr>
<tr>
<td><strong>Amalgam Collector models, R&amp;D Services</strong></td>
<td>Adjust two external valves weekly; monitor liquid level and decant as needed to keep tubing 3 inches above sediment; add sterilant 2-3 times/week; remove sludge after 2-5 years depending on workload.</td>
</tr>
<tr>
<td><strong>ECO II, Pure Water Development</strong></td>
<td>Apply cleaner daily (recommended); replace separator annually.</td>
</tr>
<tr>
<td><strong>REB models, Rebec Simple Solutions</strong></td>
<td>Annual recycling should be scheduled with the manufacturer.</td>
</tr>
<tr>
<td><strong>Avprox AS-9, American Dental Accessories</strong></td>
<td>Replace filter every 3-8 months depending on workload.</td>
</tr>
<tr>
<td><strong>MSS models, Maximum Separation Systems</strong></td>
<td>Replace settling tank annually; non-foaming cleanser (recommended).</td>
</tr>
<tr>
<td><strong>ARU-10, Hygenitek</strong></td>
<td>Apply cleanser daily; service plan: 6 month cycle; replace media filter canister: 6 months; replace sedimentation tanks: 6-24 months depending on workload.</td>
</tr>
<tr>
<td><strong>Hg 5, SolmeteX</strong></td>
<td>Replace filter resin cartridge every 6 months.</td>
</tr>
<tr>
<td><strong>Merc II, Bio-Sum Medical</strong></td>
<td>Replace unit annually.</td>
</tr>
<tr>
<td><strong>Rasch 890 models, AB Dental Trends</strong></td>
<td>Replace canister every 18 months depending on workload.</td>
</tr>
<tr>
<td><strong>Bullfrog, Dental Recycling North America</strong></td>
<td>Replace separator annually.</td>
</tr>
</tbody>
</table>

The annual renewal of your Certificate of Authorization for your health profession corporation is just around the corner. If you currently hold a Certificate of Authorization for a health profession corporation, your annual renewal form will be forwarded directly to you in June.

Reduction of annual renewal fee if paid on or before July 31
The annual renewal fee of $200 is due August 31. If the completed annual renewal form, Certificate of Status and fee are received on or before July 31 and you have met the annual renewal requirements, the fee will be discounted to $175.

To renew your Certificate of Authorization, you will be required to submit your completed annual renewal form with the following information:

• applicable fee payable to the Royal College of Dental Surgeons of Ontario;
• Statutory Declaration – Form B executed by a Director of the corporation before a commissioner, lawyer or notary public not more than 15 days before the annual renewal form is submitted to the Registrar;
• original, current-dated Certificate of Status of the corporation issued by the Ministry of Consumer and Business Services not more than 30 days before the day it is submitted to the Registrar.

EXPIRY DATE – AUGUST 31
All Certificates of Authorization expire on August 31 of every year regardless of the initial date of issuance. For those dentists who applied for a Certificate of Authorization this year, please note that it is only valid until August 31.
dos and don’ts of the HPC annual renewal process

DO ensure that you are in the physical presence of a commissioner, lawyer or notary public to have your Statutory Declaration executed.

DO NOT sign and date the Statutory Declaration prior to your attendance with the commissioner, lawyer or notary public that will be swearing your Statutory Declaration.

DO ensure that you submit the original current-dated Certificate of Status of the corporation and that you submit the annual renewal form and Statutory Declaration with original signatures.

DO NOT fax your Certificate of Status, completed annual renewal form or Statutory Declaration to the College. Original signatures and documents are required.

Statutory Declaration – Form B
The Statutory Declaration must be sworn in the physical presence of a commissioner, lawyer or notary public. The legislation requires that the Statutory Declaration be executed not more than 15 days before the application for annual renewal is submitted to the Registrar, certifying that the corporation is in compliance with section 3.2 of the Business Corporations Act.

What is a Certificate of Status of the Corporation?
A Certificate of Status is a one-page document issued by the Ministry of Consumer and Business Services which indicates that the corporation is active. The legislation sets out the requirements for the annual renewal of your Certificate of Authorization. One of those requirements is that a current-dated Certificate of Status accompanies your annual renewal form regardless of how new your health profession corporation is.
Facility permits are issued based on a review of the training and qualifications of those administering sedation and/or anaesthesia services, as well as a satisfactory on-site review to ensure that all necessary equipment and monitors are in place, are maintained properly, and all emergency drugs are available and current.

This inspection also assesses the facility design with respect to wheelchair and stretcher access and the availability of properly equipped and staffed recovery rooms/areas. To ensure that your new dental facility meets or continues to meet the eligibility requirements to have a facility permit issued, please review the College’s Guidelines on the Use of Sedation and General Anaesthesia in Dental Practice.

If your current dental practice has a facility permit, it is important to know that facility permits are non-transferable. This means that preplanning is important in order to have a smooth transition and ensure that a new facility permit is in place when the move is completed.

Remember, before you can administer sedation and/or anaesthesia in your new dental facility, you are required to apply for a new facility permit and be subject to an on-site inspection by one of our field inspectors.

need to know

- Parenteral conscious sedation, deep sedation and/or general anaesthesia cannot be administered in a dental practice in Ontario until a facility permit is issued by the College.
- If you are relocating your practice, please ensure that you do not book any sedation/anaesthesia cases until a new facility permit is issued.

ON THE WEB
www.rcdso.org
Use of Sedation and General Anaesthesia in Dental Practice
PROFESSIONAL PRACTICE/GUIDELINES
On February 12 and 13, the Discipline Committee members participated in an intensive two-day orientation at the College offices in Toronto led by College Registrar Irwin Fefergrad. From the welcome by Committee Chair Dr. Stanley Kogon and Vice-Chair Dr. John McComb to the closing item on the agenda, the committee members covered topics such as:

- role of Discipline Committee
- role of independent legal counsel
- conduct and demeanour of committee members
- the pre-hearing conference
- disclosure
- agreed statements of fact
- fairness and compassion
- appropriate penalties
- joint submissions
- reasons for decision
- motions
- expert evidence
- penalty/costs
- reasons
- appeals

The backbone of the orientation was a training video production created by the College that dramatizes a real-life Discipline Committee hearing from the opening call to order, through testimony by the expert witness, to the final decision by the panel. Special guests participating in the orientation session included Madam Justice Katherine Feldman of the Ontario Court of Appeal, Madam Justice Nancy Spies of the Ontario Superior Court and Lee A. Pinelli who is a partner in the advocacy department at the Hamilton office of Gowling’s law firm and often acts as independent legal counsel for the Discipline Committee.
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
surface mail:
RCDSO, 6 Crescent Road,
Toronto, ON M4W 1T1
fax: 416-961-5814

We wish to express my sincere gratitude for your help in writing a letter to the Sheriff that resulted in the successful exemption of my summons to jury duty. Your promptness in replying to the Ministry of the Attorney General has made the process uncomplicated and almost worry free. A special thank you to the College Registrar Irwin Fefergrad and the staff person that I called for such sensitivity and attentiveness to this matter.

DR. GABRIELA ADAMACHE
Timmins

The latest PEAK article – Unspoken Fears – by Gretchen Stein is excellent. Thank you to you and your team for providing this valuable resource to our members.

While this article is written with dentists in mind it applies to everyone. We are all one phone call away from “losing it.” Many of my patients are in leadership positions in their workplace or families. I have shared Ms. Stein’s article with them and they are most appreciative.

DR. DOUGLAS A. JONES
Waterloo

Kudos for this amazing article (PEAK article – Unspoken Fears). Thank you for printing this.

DR. PROMILA MEHAN
Cambridge

I want to thank you for your reply [practice advisory service] and wealth of information. I will get started with contacting the persons you suggested as soon as possible in the morning. I would like you to know how appreciative I am of your taking time to assist me in this matter. I realize that it is not a usual matter of business and I am grateful for your time and expertise.

NAME WITHHELD

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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.

Mark Your Calendar…
2009 OPEN COUNCIL MEETING
November 12, 2009
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.

COLLEGE CONTACT
Angie Sherban
Senior Executive Assistant
416-934-5627
1-800-565-4591
asherban@rcdso.org
Source Guide 2009

This year’s version of the membership listings, a.k.a. the Source Guide, is now in the mail. Every member receives one copy as a benefit of registration with the College. The Guide is mailed separately from Dispatch magazine to take advantage of the best rates offered by Canada Post.

As usual, the Source Guide is also available online on the home page of our website at www.rcdso.org.

Limited additional copies of the paper version of the Source Guide are available on request as a courtesy to members, as long as quantities last.

If you would like an additional copy, please contact Aurore Sutton in Communications at 416-961-6555, ext. 4303, or toll-free at 1-800-565-4591, or by e-mail at asutton@rcdso.org.

Questions/Concerns About Your Personal Listing

If you have any questions or concerns about your personal listing, please contact staff in the registration area of the College:

Talelsa Brown
Administrative Assistant, Registration
416-961-6555, ext. 4329
1-800-565-4591
tbrown@rcdso.org
Guidelines, Practice Advisories, Standards of Practice

These and a host of other resource materials are all available on the College’s website at www.rcdso.org. Look under the heading of Professional Practice located in the navigation bar on the left-hand side of the home page.

GUIDELINES
- Conflict of Interest
- Dental Recordkeeping
- Diagnosis & Management of Temporomandibular Disorders & Related Musculoskeletal Disorders.
- Implant Dentistry
- Infection Control in the Dental Office
- Use of Sedation and General Anaesthesia in Dental Practice

PRACTICE ADVISORIES
- Change of Practice Ownership
- Informed Consent Issues Including Communication with Minors and with Other Patients Who May Be Incapable of Providing Consent
- Latex Allergies and Potent Surface Disinfectants
- Practice Names
- Professional Advertising
- Release and Transfer of Patient Records
- Sexual Impropriety
- Technical Service Corporations

STANDARDS OF PRACTICE
- Amalgam Waste Disposal

www.rcdso.org
Effective and Close Partnerships Critical In Shaping Our Future

CONTINUED FROM PAGE 4

And its agencies, like the Health Professions Regulatory Advisory Council and the Office of the Fairness Commissioner.

While the nature of these partnerships varies, the one constant is our commitment to them. Experience has shown us that it is nearly always better to work collaboratively.

I know that this new Council takes office firmly convinced that self-regulation in partnership with the public is definitely the best way to encourage high standards of dental practice, protect patients and be responsive to the demands of the complex regulatory environment.

And as always, we are determined to continue to deliver what the public, government and the profession have the right to expect – fair, accessible, transparent and responsible regulation.

Les relations de partenariat efficaces sont importantes pour l’élaboration de notre avenir

SUITE DE LA PAGE 4

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Conseil consultatif de réglementation des professions de la santé et le Bureau du commissaire à l’équité.

Bien que la nature de ces partenariats varie, nous attachons beaucoup d’importance à la qualité de nos relations avec chacun de nos partenaires.

D’expérience, nous savons que la collaboration apporte presque toujours de meilleurs résultats.

Je sais que ce nouveau Conseil d’administration entame son mandat avec la ferme conviction que l’autoréglementation de la profession en partenariat avec le public représente la meilleure façon d’encourager des normes élevées en dentisterie, de protéger les patients et de bien réagir au changement.

Et comme toujours, nous sommes résolus à continuer d’offrir au public, au gouvernement et aux dentistes ce à quoi ils sont en droit d’attendre : des règlements justes, transparents, responsables et efficaces.
The College and ODA have joined together to welcome new dental graduates from both the University of Western Ontario and the University of Toronto with the presentation of a classy and useful courier bag.

Embossed with the logo of each organization and the particular university, the bags were presented by the presidents of each organization at the special dinner for graduates sponsored by the Ontario Dental Association.

College President Dr. Frank Stechey and ODA President Dr. Larry Levin presented each student with their bag and shared their warmest best wishes as graduates begin their career in the dental profession.

Every year ODA hosts special graduates dinners: one in Toronto for the graduates of the Faculty of Dentistry at the University of Toronto and one in London for the dental graduates of the Schulich School of Medicine and Dentistry at the University of Western Ontario. The bags will be presented annually.

The idea of recognizing the graduates in this way came from the ODA/RCDSO Idea Forum (ORIF). ORIF was formed in 2007 for both organizations to work collaboratively on issues of common interest.
For example, with both amalgam waste disposal and the use of dental anaesthesia, the College sets educational requirements, requires a facility permit, issues the permit when all educational and facility safety requirements are fulfilled, and does periodic inspections.

Safety for both dentists and their patients is a primary concern. Ontario’s Auditor General raised concerns that certain uses of computed tomography in the hospital setting could expose patients and staff to unsafe levels of radiation in his annual report released in December 2006.

The Health Minister has given instructions that the regulation of this technology should be done through the Healing Arts Radiation Protection Act (HARP), as is already the case with other diagnostic imaging, combined with the Regulated Health Professions Act (RHPA). So the actual inspection and testing of the equipment would still be done by government officials under the HARP Act.

The Quality Assurance Committee, at its March meeting, decided to set up an expert working group to make recommendations about the qualifications, education, training and standards for those who use this technology. The end result will be a guideline and accompanying regulations so that the technology can be used safely.

The working group has broad-based representation, including from inside and outside the profession, general members and representation from the Ontario Dental Association.

The schedule for the working group is very tight. The plans are for the working group to report back to the Quality Assurance Committee by the end of June. The Committee would then make a recommendation to Council.

If accepted by Council in principle, the proposed guideline and regulations would be circulated to membership and stakeholders for input. Our goal would be final approval by Council in November this year at the latest. The ministry is hopeful that it will be able to bring the matter to government soon after that. Then, it will be up to government to bring the regulation to Cabinet for approval.

The objective is to provide increased access to a safe and valuable diagnostic tool.

The College is extremely pleased to be working with the Ministry of Health on this important initiative. It is certainly a resounding vote of confidence from government in the integrity of our processes and an indication of the trust that government has in our college to work with them collaboratively in the protection of the public.
The Ministry of Health and Long-Term Care plans to review its moratorium on the designation of dental facilities to install and operate cone beam computed tomography scanners (CT scanners) with a view to expanding its availability.

The use of CT scanners is becoming the standard for diagnosis and treatment planning of many oral conditions. They are used particularly in the placement of dental implants.

Dentists in many other provinces and American states have already been offering this service to patients for a number of years.

This move by government is in line with its policy directions to remove barriers that limit access to care, maximize scopes of practice and to encourage expanded access to high quality and safe services.

In our discussions with Ministry officials, government was impressed at how the College had developed effective regulation models for the disposal of amalgam waste and for the use of dental anaesthesia so they have asked for our assistance on this issue.

If a similar model was used with cone beam technology, the College could be given the responsibility to:

• set qualifications, education, training and standards for the users of the technology, other than oral radiologists who already have the specific authority to use CT scanners;
• do office inspections to determine compliance;
• issue facility permits to operate the equipment;
• require periodic filing of information to the College;
• link the periodic filing of this information to the professional misconduct regulation.

Following the same model as the existing anaesthesia and amalgam waste regulations and guidelines, the College could put in place a number of mechanisms to ensure patient safety.

CONTINUED ON PAGE 51