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RCDSO COUNCIL MEMBERS

President
Dr. Frank Stechey

Vice-President
Dr. Peter Trainor

Elected Representatives

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Kelly Bolduc-O’Hare  
Little Current

Mohammed Brihmi  
Ottawa

Dr. Harpal Buttar  
Rampart

Parminder Chahal  
Scarborough

Mofazzal Howladar  
Toronto

Kurissummoottil Joseph  
Oakville

Catherine Kerr  
Thurber

Evelyn Laraya  
Scarborough

Dr. Edelgard Mahant  
Woodbridge

Jose Saavedra  
Scarborough

Abdul Wahid  

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Dr. R. John McComb

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ISSUE ENCLOSURES:
Guidelines on Infection Prevention and Control in the Dental Office
Summaries of Discipline Committee hearings
PEAK: Tuberculosis epidemiology, diagnosis and infection control recommendations for dental settings
Six years ago we had a dream. We saw a way to knit together the dental regulators across the country to create an effective collaboration to advance our issues of concern, a way to join together to speak with one strong voice.

On April 22, 2004, representatives from across the country met for the first formal meeting of Canadian Dental Regulatory Authorities Federation (CDRAF). That was a landmark event in the history of the dental profession in Canada.

Up until then, we had met, but usually as an add-on to Canadian Dental Association (CDA) meetings. There was no formal organization...no governance structure...no by-laws.

There was no board of directors, no voting structure. The accountability and weight of any decisions taken were very unclear.

But all that changed with the birth of this national federation of dental regulators. It was a monumental achievement.

Our timing in creating CDRAF could not have been better. The world of regulation has definitely got a lot more complicated. Governments at both the national and provincial levels are demanding a unified approach on issues like labour mobility. One or two provinces going it alone is no longer feasible, or in most cases, even wise.

How successful have we been over these past years? Well, there is no question we have had some “teething” problems like any new organization. But we have a pretty impressive record of achievement. There is no denying the results speak for themselves.

Let me rundown just a few of our major achievements in the past six years:

- creating a governance structure, by-laws, a voting formula and funding model that has served us so well and let us address difficult issues without rancour;
- developing a communications strategy, including a logo and unveiling a bilingual website;
- establishing ongoing formal relationships with other important national organizations such as RCDC, ACFD, NDEB, CDAC, Health Canada and CDA;
- finalizing a Memorandum of Understanding on certification and licensure of internationally-trained dental specialists;

De solides relations ouvertes nous permettent d’accomplir bien davantage

Il y a six ans, nous avons fait un rêve. Nous avons vu un moyen d’unifier les organismes de réglementation en dentisterie à l’échelle du pays, afin de créer une collaboration efficace et de faire progresser les enjeux qui nous préoccupent, un moyen de nous unir pour parler d’une voix ferme.

Le 22 avril 2004, des délégués de tout le pays se sont rencontrés pour la première réunion officielle de la Fédération canadienne des organismes de réglementation dentaire (FCORD). Ce fut un événement marquant dans l’histoire de la profession dentaire au Canada.

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Dr. Frank Stechey

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Ensuring Continued Trust
The term “circle of care” is not a defined term in the Personal Health Information Protection Act, 2004 (PHIPA). It is a term commonly used to describe the ability of certain health information custodians to assume an individual’s implied consent to collect, use or disclose personal health information for the purpose of providing health care, in circumstances defined in PHIPA.

This article will clarify the circumstances in which a health information custodian may assume implied consent and the options available to a health information custodian where consent cannot be assumed to be implied.

It should be noted that the assumed implied consent provisions of PHIPA apply equally to paper-based and electronic records of personal health information.
CIRCUMSTANCES WHEN YOU MAY ASSUME CONSENT TO BE IMPLIED

A health information custodian may only assume an individual’s implied consent to collect, use or disclose personal health information if all of the following six conditions are satisfied:

1. **The health information custodian must fall within a category of health information custodians that are entitled to rely on assumed implied consent.**

Most health information custodians may rely on assumed implied consent to collect, use and disclose personal health information for the purpose of providing health care or assisting in the provision of health care to an individual.

A health information custodian is a person or organization described in PHIPA with custody or control of personal health information as a result of, or in connection with, the performance of its powers, duties or work. For example, health information custodians include:

- health care practitioners
- long-term care homes
- community care access centres
- hospitals, including psychiatric facilities
- specimen collection centres, laboratories, independent health facilities
- pharmacies
- ambulance service
- Ontario Agency for Health Protection and Promotion.

However, it is important to note that some health information custodians are not entitled to rely on assumed implied consent. For example, these include:

- an evaluator within the meaning of the Health Care Consent Act, 1996
- an assessor within the meaning of the Substitute Decisions Act, 1992
- the Minister or Ministry of Health and Long-Term Care
- the Minister or Ministry of Health Promotion
- the Canadian Blood Service.

2. **The personal health information to be collected, used or disclosed by the health information custodian must have been received from the individual, his or her substitute decision-maker or another health information custodian.**

The personal health information to be collected, used or disclosed must have been received from the individual to whom the personal health information relates, from his or her substitute decision-maker or from another health information custodian.

Personal health information is defined in PHIPA as identifying information relating to the physical or mental health of an individual, the provision of health care to an individual, the identification of the substitute decision maker for the individual and the payments or eligibility of an individual for health care or coverage for health care, including the individual’s health number.

A substitute decision-maker is a person authorized under PHIPA to consent on
behalf of an individual to the collection, use or disclosure of personal health information.

If the personal health information to be collected, used or disclosed was received from a third party, other than the substitute decision maker for the individual or another health information custodian, consent cannot be assumed to be implied. For example, a health information custodian may not rely on assumed implied consent if the personal health information was received from an employer, insurer or educational institution.

3. **The health information custodian must have received the personal health information that is being collected, used or disclosed for the purpose of providing or assisting in the provision of health care to the individual.**

The personal health information to be collected, used or disclosed must have been received for the purpose of providing health care or assisting in the provision of health care to the individual to whom it relates.

A health information custodian may not rely on assumed implied consent if the personal health information was received for other purposes, such as research, fundraising, marketing or providing health care or assisting in providing health care to another individual or group of individuals.

4. **The purpose of the collection, use or disclosure of personal health information by the health information custodian must be for the provision of health care or assisting in the provision of health care to the individual.**

The collection, use or disclosure must be for the purposes of providing health care or assisting in the provision of health care to the individual to whom the personal health information relates.

A health information custodian may not rely on assumed implied consent if the collection, use or disclosure is for other purposes, such as research, fundraising, marketing or providing health care or assisting in providing health care to another individual or group of individuals.

5. **In the context of disclosure, the disclosure of personal health information by the health information custodian must be to another health information custodian.**

A health information custodian may not assume an individual’s implied consent in disclosing personal health information to a person or organization that is not a health information custodian, regardless of the purpose of the disclosure.

6. **The health information custodian that receives the personal health information must not be aware that the individual has expressly withheld or withdrawn his or her consent to the collection, use or disclosure.**

PHIPA permits an individual to expressly withhold or withdraw consent to the collection, use or disclosure of his or her personal health information, unless the collection, use or disclosure is permitted or required by PHIPA to be made without consent.

In most circumstances, if an individual decides to withhold or withdraw consent, PHIPA requires the receiving health
information custodians or their agents to be notified if the disclosing health information custodian is prevented from disclosing all of the information that is considered to be reasonably necessary for the provision of health care.

For further information about the ability of an individual to expressly withhold or withdraw consent to the collection, use or disclosure of personal health information for health care purposes, and the obligations on health information custodians in this context, please refer to the Lock-box Fact Sheet produced by the Information and Privacy Commissioner of Ontario at www.ipc.on.ca.

FACTORS TO BE CONSIDERED IN RELYING ON ASSUMED IMPLIED CONSENT

In general, a health information custodian must not collect, use or disclose personal health information if other information will serve the purpose and must not collect, use or disclose more personal health information than is reasonably necessary for that purpose. These general limiting principles apply even where a health information custodian is entitled to rely on an individual’s assumed implied consent.

OPTIONS AVAILABLE WHEN YOU CANNOT ASSUME CONSENT TO BE IMPLIED

When consent cannot be assumed to be implied, health information custodians should consider other options. Depending on the circumstances, a health information custodian may be permitted to collect, use or disclose personal health information without consent, with the implied consent of the individual to whom the personal health information relates or with the express consent of that individual. PHIPA distinguishes between implied consent and assumed implied consent.

In the case of implied consent, health information custodians must ensure that all of the elements of consent are fulfilled; whereas in the case of assumed implied consent, health information custodians may assume that all of the elements of consent are fulfilled, unless it is not reasonable to do so in the circumstances.

Without Consent

Health information custodians may collect, use or disclose personal health information without consent if the collection, use or disclosure is permitted or required by PHIPA to be made without consent.¹

For example, health information custodians are permitted to disclose personal health information without consent to a medical officer of health if the disclosure is made for purposes of the Health Protection and Promotion Act. In addition, in certain circumstances set out in sections 37(1)(a), 38(1)(a), 50(1)(e) of PHIPA, health information custodians may use or disclose personal health information without consent where it is reasonably necessary for the provision of health care and the individual has not expressly instructed otherwise.

¹ Sections 36 and 37 of PHIPA, respectively, set out the circumstances in which personal health information may be collected and used without consent and sections 38-48 and section 50 set out the circumstances in which personal health information is permitted or required to be disclosed without consent.
**Implied Consent**
Health information custodians may imply an individual's consent to collect and use personal health information for most purposes. They may also imply consent to disclose personal health information to another health information custodian for the purpose of providing or assisting in the provision of health care to the individual. However, subject to limited exceptions, health information custodians cannot rely on implied consent when disclosing personal health information to a person or organization that is not a health information custodian. This exception applies regardless of the purpose of the disclosure.

In order to rely on implied consent, health information custodians must be satisfied that all the required elements of consent are fulfilled.

**Express Consent**
In all other circumstances, health information custodians may only collect, use or disclose personal health information with the express consent, (i.e. verbal or written consent) of the individual to whom the personal health information relates or his or her substitute decision-maker.

In order to rely on express consent, health information custodians must be satisfied that all the required elements of consent are fulfilled.

---

**ELEMENTS OF CONSENT**

The consent of an individual for the collection, use or disclosure of personal health information by a health information custodian:

- Must be a consent of the individual or his or her substitute decision-maker.
- Must be knowledgeable.
- Must relate to the information that will be collected, used or disclosed.

AND

- Must not be obtained through deception or coercion.

For consent to be knowledgeable, it must be reasonable to believe that the individual knows the purpose of the collection, use or disclosure and knows that he or she may give or withhold consent.

It is reasonable to believe that an individual knows the purpose of the collection, use or disclosure if the health information custodian posts or makes readily available a notice describing these purposes where it is likely to come to the individual’s attention or provides the individual with such a notice.

Although health information custodians are not required to provide notice in those circumstances where consent may be assumed to be implied, health information custodians are encouraged to do so as a best practice.

*For more information, please visit the Office of the Information and Privacy Commissioner of Ontario website at www.ipc.on.ca*
The Circle of Care Concept in Action in The Dental Office Context

It is important that dentists carefully consider whether an individual requesting a patient’s personal health information falls within the patient’s circle of care such that the dentist can assume the patient’s implied consent to release the personal health information in question.

When confronted with such a situation, it is helpful to be mindful of the following:

◆ If the circumstances of a request do not satisfy the conditions for assuming implied consent, there is nothing preventing you from contacting the patient in question to obtain his or her express consent to release his or her personal health information to the requesting party.

◆ Even where a request satisfies the conditions for assuming implied consent, it is always preferable to secure a patient’s explicit consent to release personal health information to a third party, if time permits and as long as it is practical.

As set out in the circle of care article, a health information custodian may only assume a patient’s implied consent if all of the following six conditions are met:

1. The health information custodian must fall within a category of health information custodians that are entitled to rely on assumed implied consent.

2. The personal health information to be collected, used or disclosed by the health information custodian must have been received from the individual, his or her substitute decision-maker or another health information custodian.

3. The health information custodian must have received the personal health information that is being collected, used or disclosed for the purpose of providing or assisting in the provision of health care to the individual.

4. The purpose of the collection, use or disclosure of personal health information by the health information custodian must be for the provision of health care or assisting in the provision of health care to the individual.

5. In the context of disclosure, the disclosure of personal health information by the health information custodian must be to another health information custodian.

6. The health information custodian that receives the personal health information must not be aware that the individual has expressly withheld or withdrawn his or her consent to the collection, use or disclosure.
CASE STUDY
Disclosure to a Health Information Custodian
You receive two separate requests for copies of the dental records of one of your patients. The first request is from an oral surgeon that recently assessed the patient for a minor surgical procedure. The second request is from a business partner of the patient who is planning on framing the patient’s dental X-rays as a gag gift for his upcoming birthday party.

Health information custodians may assume implied consent to collect, use and disclose an individual’s personal health information to other health information custodians and/or their agents. As a health information custodian, you may assume that you have your patient’s implied consent to release his dental records to the oral surgeon, who is also a health information custodian, as all six conditions required to assume implied consent are satisfied.

However, you cannot assume that you have the patient’s implied consent to release his dental records to his business partner who is not a health information custodian and thus does not meet condition #5.

CASE STUDY
Providing or Assisting in the Provision of an Individual’s Health Care
You receive a phone call from the pedodontic dental office of the five-year old son of one of your patients. The father is your patient but the son is not. The pedodontist’s office explains that to better serve your patient’s young son, they are exploring whether there may be a history of disease in the family and would like specific health information regarding the father.

Implied consent is only available where the collection, use or disclosure of personal health information is for the purposes of providing health care or assisting in the provision of health care to the individual to whom the personal health information relates.

While the pedodontist is clearly a health information custodian, the dental office is not requesting your patient’s health information to provide or assist in his health care. Rather, the office is requesting your patient’s health information to provide or assist in the health care of his son and thus does not meet condition #4.

Therefore, you cannot assume implied consent to disclose your patient’s health information to his son’s dental office. In order to do so, you must obtain your patient’s express consent.

CASE STUDY
Withholding or Withdrawing Consent
At her most recent dental appointment, your patient discovers that her new dental hygienist is a neighbour of hers. Your patient telephones you and says that she doesn’t want her neighbour to “know her secrets” or be involved in her dental care.

Individuals may expressly withhold or withdraw consent to the collection, use or disclosure of their personal health information.

Under normal circumstances, you could assume your patient’s implied consent to share her health information with the dental hygienist in your office. However, since this patient has expressly advised you of her objection, you cannot share her personal health information with the dental hygienist, as condition #6 has not been met.

CASE STUDY
Sharing Information with Other Health Care Professionals
Your patient is scheduled to attend at your office for a complicated extraction. While preparing for the upcoming appointment, you note that this patient recently had heart surgery. You would like to contact his family physician to ask whether you should take any special precautions in treating him.

The family physician falls within the patient’s circle of care as he is a health information custodian involved in providing health care to this patient. In addition, the personal health information that you are seeking from the family physician will assist you in rendering health care to the patient.

Accordingly, you can assume the patient’s implied consent to collect his personal health information from his physician and the physician can assume that he has the patient’s implied consent to disclose this health information to you. In short, all six conditions necessary to assume that you can rely on implied consent have been met.

However, while you may legally be entitled to assume the patient’s implied consent in this circumstance, unless it is a medical emergency, it is always prudent for you to seek to obtain the patient’s express consent to contact the family physician.
All four dental organizations – College of Dental Hygienists of Ontario (CDHO), Ontario Dental Hygienists’ Association (ODHA), Ontario Dental Association (ODA) and Royal College of Dental Surgeons of Ontario (RCDSO) – are often asked for advice and direction from dentists and dental hygienists about how to end an existing work relationship and what the dentists’ and dental hygienists’ obligations are when the relationship ends.

As health care professionals, the overriding principle is always to ensure compliance with regulatory requirements, provincial legislation and safe patient/client care. Within that framework, there are sometimes practical questions that arise when a dental hygienist leaves a working relationship within a dental practice.

Guiding Principles
In making business decisions both dentists and dental hygienists are governed by the following principles:

1. **Professional obligations take priority.**
   The primary professional obligation is to the welfare of the patient/client. In addition, both dentists and dental hygienists must comply with the rules and regulations of their own regulatory College.

2. **One must comply with the law.**
   For example, the Personal Health Information Protection Act, 2004 (PHIPA) provides detailed rules about maintaining the privacy and security of patient/client records and of the patient’s/client’s right to control, within limits, the collection, use and disclosure of personal health information about themselves.

3. **One must comply with one’s contractual obligations.**
   Courts require dentists and dental hygienists to comply with valid contractual agreements. Contracts can be verbal, written or in some cases established by the conduct of the parties. The court, however, will not enforce a contractual term if it considers it in violation of another (overriding) law (e.g. PHIPA) or in violation of public policy.

Dentists and dental hygienists need to keep these guiding principles in mind when ending their working relationship.

**Nature of the Work Relationship**
The contractual obligations will vary depending on whether a dental hygienist is an employee of the dentist, or an independent contractor (self-employed). To determine what the relationship is, one needs to review the written documentation outlining the relationship. If there is no written documentation, then one needs to review any oral agreement that has been entered into as well as the nature of the actual relationship.

Whatever the nature of the work relationship, every office should have a privacy policy that describes who has responsibility for ensuring the privacy, security and retention of the records under PHIPA.

Generally speaking, the owner of the practice will be the person who owns the assets of the practice including its patient/client records and goodwill. Goodwill includes the list of the patients/clients of the practice. This does not, however, preclude a dental hygienist from owning a dental hygiene practice which is operated in the same location where a dentist owns a dental practice. Again, a
determination of the nature of the work relationship would have to be made, namely, whether the dental hygienist is an employee of the dentist or an independent contractor (self-employed). The nature of the work relationship is of critical importance to determine fundamental rights and obligations and, therefore, should be properly reflected in the contractual relationship between the dentist and dental hygienist.

Legal advice should be sought by the parties if there is no written agreement in place and there is a dispute between the parties as to the nature of the relationship.

Scenario 1 – Change of Contract
A dental hygienist has worked in a dental practice on a full-time basis for several years. There have never been any issues with her employer and all of her performance reviews have been positive. Without notice, the employer demands that the dental hygienist sign a contract changing her status from employed to that of an independent contractor which contract removes the benefits which she had previously while employed. The dental hygienist recognizes that this may cause problems with the tax authorities. The employer is adamant about the change.

Contracts are the subject of negotiation; however, generally speaking, one party to a contract cannot unilaterally and without notice change the terms of that contract. Both parties should obtain legal advice and attempt to resolve this matter in order to maintain the relationship and to avoid unnecessary and expensive litigation which would likely include a claim for damages for wrongful (constructive) dismissal. As with any negotiation, the dental hygienist can make a counter-proposal or pursue negotiating tactics (e.g. mediation, seeking common ground, threatening to sue for wrongful dismissal). In addition, the tax laws have to be complied with by both parties. The dental hygienist can suggest that the lawyers for both parties talk about the tax implications.

Removal of Patient/Clients’ Records and Lists
Unless permitted by the contractual relationship, the office privacy policy and PHIPA, a departing dental hygienist, who is employed by a dentist, cannot unilaterally remove patient/client records, or patient/client lists. The original records remain with the office.

Similarly copies cannot be removed unless this is permitted by the contractual relationship, the office privacy policy and PHIPA. In this situation the removal of copies should be addressed not only in the contractual documents, but also in the privacy policy so that patients/clients consent to the possibility that copies of their records could be made and removed.

Scenario 2 – Patient/Client Lists
A receptionist in a dental office informs the dentist that a dental hygienist, also employed by the dentist, has been taking a list of the office patients/clients for several months. In this instance, the receptionist reports that the dental hygienist also confided that she was going to be establishing her own dental hygiene clinic in the neighbourhood and was using the list to directly advertise to the patients/clients of the dental office regarding opening her office and informing them that they have the right to have copies of their patient/client records transferred to the dental hygienist in her new dental hygiene practice. The office owner has invested in the establishment of a practice, hiring staff and providing infrastructure to build a patient/client base. The dentist understands that patients/clients have the right to choose their practitioner; but also wonders about the duty of employees in such circumstances.

This scenario assumes that the dentist owner is the custodian of the records, including patient/client lists. The dental hygienist has no right to remove the patient/client list. The dentist is correct in believing the patients/clients have a right to choose who their healthcare practitioners will be and, therefore, the dentist has a professional obligation to give patients/clients who requested it the contact information for the departing dental hygienist. If a patient/client list(s) was removed, it should be immediately returned and all copies destroyed. The unlawful removal of patient/client list(s) or anything else belonging to the dental practice could result in both civil litigation and disciplinary action. This is avoided where both the dentist and dental hygienist act professionally and ethically to ensure that the welfare of the patient/client is dealt with as the overriding priority.

Notification of Patients/ Clients
Sometimes there are competing interests about the notification of patients/clients of the departure of a dental hygienist. The dental office may wish to preserve the goodwill associated with the office and want as many patients/clients as possible to remain with the office. On the other hand, patients/clients are entitled to continuity of care and have the right to choose who they go to for care. There are also courtesy considerations where a patient/client has developed a rapport with a departing dental hygienist and might be offended by not being notified of a departure.

The following considerations apply in balancing these interests:
Ensuring Continued Trust

A departing dental hygienist, particularly one who will be continuing in practise elsewhere, must not solicit patients/clients.

If there are continuity of care concerns (e.g. the office is closing or there will be no one to take over the ongoing care of patients/clients) both the dentist and the dental hygienist have a professional responsibility to ensure that patients/clients receive adequate notification to permit appropriate continuity of care.

Patients/clients have the right to choose their care providers. Contractual obligations cannot create barriers to patients/clients who wish to continue care with the departing dental hygienist. Therefore, patients/clients should be advised of the departure of a dental hygienist with whom they have developed a professional relationship in a constructive, timely and appropriate manner and, if requested by a patient/client, contact information for the departing dental hygienist should be provided.

There are many effective ways in which these principles can be achieved. To ensure a smooth transition for patients/clients, it would be wise for the dentist and dental hygienist to work out a protocol dealing with notification issues. If agreement cannot be reached, legal advice should be sought. Under no circumstances should the dentist or dental hygienist utilize patients/clients to influence the other party’s actions. To do so would be considered unprofessional or unethical.

Scenario 3 – Refusal to Notify Clients

A dental hygienist leaves a dental practice. The practice denies to enquiring patients/clients any information on the whereabouts of the dental hygienist and makes suggestions or implies that a dental hygienist is no longer available to provide ongoing care.

As previously indicated, patients/clients are entitled to be informed, if they ask, of where a departing dental hygienist has gone. If the practice does not have that information, it can direct the patient/client to the CDHO website which contains information on the business address of all dental hygienists. It is unprofessional and unethical for a dentist to refuse to provide information of this type to a patient/client who requests it or to attempt to mislead patients/clients in an effort to make them believe that they do not have the right to obtain ongoing care from the departed dental hygienist.

Scenario 4 – Request for Notification of Patients/Clients

A dental hygienist has been a long-standing employee in a dental practice. In anticipation of leaving that practice to open her own dental hygiene practice, she has recommended that all patients/clients be informed that she is leaving the practice to establish a dental hygiene practice in the community. Traditionally, the dental hygiene care has been provided to patients/clients on a rotational basis by one of the three dental hygienists in the office. When there is a change in the dental hygiene staff, there has not been a practice of proactively informing patients/clients. Instead, the new dental hygienist would be introduced to patients/clients in an efficient manner and, in the limited circumstances where a patient/client asks about a former employee, that information has been provided to the patient/client.

There is no absolute duty to notify patients/clients of the departure of a staff person or to provide detailed reasons that might invade the privacy of the departing staff person. What is appropriate depends on the circumstances including the reasonable expectations of the patients/clients of the practice. In the case of the dental hygienist leaving to set up her own dental hygiene practice, the dental office does not have to agree to become an advertising vehicle for her. On the other hand, the dental office should not refuse to provide any information at all. At a minimum, the dental office would provide information that the dental hygienist had decided to leave the practice and contact information for the dental hygienist if requested by a patient/client.

Transfer of Patient/Client Records

As noted already, the original records remain with the owner of the practice. PHIPA provides specific guidance for transferring all original records when an office ceases operations.

Issues sometimes arise, however, about the transfer of a copy of a specific patient/client record to a subsequent treating practitioner, whether that be a departing dental hygienist or another dentist previously associated with the practice. The general principles are as follows:

1. With rare exceptions, the original record stays with the owner.
2. Patient/client consent is generally required for such a transfer. An exception exists where the transfer is needed for ongoing treatment of the patient/client and consent is impractical (i.e. the “circle of care” concept).
With rare exceptions (e.g. threats of serious physical harm) the wishes of the patient/client about transferring a copy of the record are to be honoured.

The transferring office can ask for reasonable documentary confirmation of the patient’s/client’s wishes. However, the transferring office should not impose artificial documentary requirements that create a barrier to such a transfer (e.g. requiring a special form to be used) where the wishes of the patient/client are not in doubt.

The transferring office can charge a reasonable fee for this service. However, such fees should not be used to create barriers to ongoing care and as with any fees, must be reasonable.

Scenario 5 – Make a Choice
A patient/client requests that a copy of his dental chart be sent to an independent dental hygiene practice. The dental hygienist previously practised in that dentist’s office. The office indicates that they will no longer see the patient/client for restorative work if the patient/client decides to have his preventive services performed elsewhere.

The patient/client has the choice of providers. The patient/client also has the right to have a copy of his/her file transferred. It is unethical and unprofessional for a dental office to attempt to coerce patients/clients to remain in the dental office for all services. Neither a dentist nor a dental hygienist is entitled to terminate services for a patient/client because she or he is not happy with the patient/client’s choice of (other) healthcare providers.

Ongoing Access to the Record by the Dental Hygienist
Dentists have a duty to ensure that dental hygienists have access to patient/client records where the dental hygienist needs access to meet a professional obligation. That obligation cannot be defeated by a dental hygienist agreeing to the dental office retaining records upon the dental hygienist’s departure from the office. The dental office should provide reasonable access to the records to a dental hygienist who requires it in order to fulfill his or her professional obligations. Often such disclosure can be made on the basis of implied patient/client consent or without consent because some overriding legislative provision applies. However, if one is in doubt about the issue or the patient/client asks that the information not be disclosed, the dentist or dental hygienist should seek legal advice. Some examples of such a professional obligation include where the dental hygienist has to do one or more of the following:

1. respond to a complaint;
2. prepare for a quality assurance assessment;
3. prepare a medico-legal report of his or her care at the request of a patient/client; or
4. prepare to defend himself or herself from a civil claim.

If the dentist has a legitimate concern about whether there is sufficient consent from the patient/client to release the record, the dentist should contact the RCDSO or the dentist’s lawyer.

Scenario 6 – Complaint After Departure
After a dental hygienist leaves, a patient/client sends a complaint to both the RCDSO and the CDHO about the TMJ pain suffered by the patient/client. The dental hygienist asks for a copy of the chart in order to respond to the complaint. The dental office is reluctant to do so for fear of a further complaint about breaching the patient’s/client’s confidentiality.

Ideally the dental office’s privacy policy already permits this disclosure to the dental hygienist to be made. The information cannot be considered to be confidential from the dental hygienist to the extent it was information that the dental hygienist had access to prior to her departure from the office. Furthermore, the Personal Health Information Protection Act, 2004 permits the disclosure for the purpose of legal proceedings. In the alternative, the dental office can provide the chart to the CDHO (another explicit exception under PHIPA) so that the CDHO can assist the dental hygienist in responding to the complaint.
It is not uncommon to see dentists and physicians who come for treatment with bodies that are wrenched with pain from years of bodily contortions in an effort to do their craft. Many of the dentists who come to our treatment center are suffering from back pain, neck pain, migraines, shoulder pain, hand pain and other physical ailments due to the daily challenges of the dental profession.

At some point in time they became dependant on the medications that were supposed to ease their physical pain. Some thought they were taking the medications as prescribed, only to realize that they were using more and more medications with little pain relief. But most of all, these men and women have lost faith in themselves and their ability to cope with daily life, as well as their physical pain symptoms.

At the Farley Center, we are not merely treating the addiction and chemical dependency of our patients. There is a focus on addressing the emotional, physical and spiritual dimensions of patients’ health in order for their wellness to become a reality.

Our pain management group started over nearly 10 years ago to teach chronic pain patients strategies to increase their ability to cope with pain without addictive substances.
Initially, when joining the group, health care professionals are skeptical and anxious about giving up their “drug of choice” for the treatment of their pain. Offering mindfulness meditation often creates a paradigm clash for many traditionally trained health care professionals.

The major focus is to teach mindfulness meditation: a practice of focusing the mind on breathing and the present moment while allowing the body to release tension. Stress, anxiety and fear often exacerbate existing physical pain symptoms, and the meditation practice is a great tool for retraining the mind.

The activity of cognitive restructuring is introduced to bring to mind the negative self-talk and to create healthier self-statements. Identifying and accepting emotions of all kinds are encouraged. Through meditation, the patients often learn to allow their emotions to flow without judgment, while learning to release judgment and hatred for themselves and their bodies.

The treatment program also encourages incorporating acupuncture, yoga, neurofeedback, healthy exercise, healing touch, and chiropractic care into a pain management plan. These activities are in addition to medical treatment by the physician, psychiatrist, nurse practitioners and other licensed clinical staff.

The primary treatment goal is to help patients regain self-respect and learn the tools for addiction-free, healthy living. This approach is an opportunity for our patients, through practising meditation, to open themselves up to a new way of treating their pain and to gain a healthy new attitude toward themselves and their recovery.

WHERE TO CALL FOR ASSISTANCE
The College and ODA are joint partners in the creation of a wellness support service for Ontario dentists in crisis with addiction issues. The College and ODA have signed a special Memorandum of Understanding with each of these three facilities so that they will receive Ontario dentists for evaluation and treatment. Each of these centres specialize in treating health professionals in crisis who are dealing with substance addiction diseases.

THE FARLEY CENTER
Williamsburg, Virginia
1-800-582-6066
www.farleycenter.com

HOMEWOOD HEALTH CENTRE
Guelph, Ontario
1-519-824-1010
www.homewood.org

TALBOTT RECOVERY CAMPUS
Atlanta, Georgia
1-800-445-4232
www.talbottcampus.com

Pamela Cappetta, EdD
Pamela Cappetta is a Licensed Professional Counsellor, a Licensed Marriage and Family Therapist and Consultant for the Farley Center at Williamsburg Place. Dr. Cappetta can be reached at drpamm@cox.net.

The Farley Center at Williamsburg Place, located in Historic Colonial Williamsburg, Virginia, is nationally recognized for helping impaired professionals from dentistry and other health disciplines put their personal and professional lives back together after becoming addicted to alcohol, prescription drugs or other substances. The Farley Center at Williamsburg Place has specialized in integrating pain management and addiction treatment for nearly 10 years.
Do You Know the Answers to these Questions on Informed Consent?

Is it enough to give a patient a pamphlet and disclose rare risks with serious consequences?

When do you need to seek consent to a proposed dental treatment?

When presenting treatment options to a patient, do you need to present only those options you perform in the office?

Not sure of the answers? Then check out the College's latest CD-based learning package on informed consent in the dental office. Mailed to every dentist in Ontario in mid-November, it explains how to put the informed consent process into action in your dental office.

The CD has clear and precise information that explains the consent process, the differences between express and implied consent and deals with how to obtain consent in specific situations, such as with children and adults incapable of giving consent.

In addition, the final chapter of the CD contains three downloadable checklists designed to help you in implementing the informed consent process in your office. The lists are: informed consent checklist, incapable adult checklist and children under 16 check list.

The College produced this latest addition to our LifeLong Learning program in association with the Ontario Dental Association.

Includes a self-test quiz for 15 CE points. There is a $250 administrative fee to do this. All the information about how to take the quiz and collect the College CE credit points is on the CD. If you have any questions, contact Joanne Loy at 416-961-6555, ext. 4703, toll-free at 1-800-565-4591 or by e-mail at jloy@rcdso.org

Members who take the self-test quiz have until December 31, 2011 to claim the 15 CE points towards their three year cycle.
Dr. John H. is one of six generalists who occupy a group practice in the suburbs of a university community. The practice started with two dentists, one of whom was John, and has grown and thrived over the past 16 years. John is fortunate that there is a manageable balance of specialists to generalists except for one area: the number of that one particular specialty has tripled in size over the last three years. It seems that John and other general practitioners are invited almost weekly to attend some type of social event by the new specialists.

The events themselves are not the problem. John enjoys meeting the new practitioners and they appreciate his encouragement. What seems to be a problem is that a few of them have been offering John some type of incentive to refer patients. After referral, besides receiving a report of the treatment outcome, a few of them have sent movie and theatre tickets, restaurant gift certificates and even bottles of expensive wine.

John has already told them that he appreciates these gifts but they are unnecessary, since his real reward is the professional attention they give to his patients. It seems that there is a progressive pattern to these gifts depending on the number of referrals each quarter. There is almost a competition among a few of these specialists for upping the expensiveness of these gifts. Other members of John’s group practice have recently commented on this trend as well.

John is now faced with an ethical dilemma. Choose the course of action you would follow.

- John should just ignore this situation for now and enjoy these gifts.
- John should discuss these concerns with the specialists again and insist they stop sending gifts.
- John should offer to assist these new specialists in their networking efforts.
- John should ask other general practitioners if they have had the same experience and plan an effort to address this.
- John should contact his regulatory body for advice.

Now turn to page 32 to find the discussion about this ethical dilemma.
Accurate Diagnosis and Adequate Treatment Plan are Keys to Addressing Patient’s Dental Health Needs

Case No. 1

COMPLAINT SUMMARY
A patient complained about the adequacy of the radiographs taken by her family dentist on which he based his diagnosis and recommended treatment.

DENTIST’S PERSPECTIVE
The dentist was notified of the formal complaint and provided the College with a response and his patient records. In his response, he said he first saw the patient on May 14, 1998 and after that she was seen on a number of other occasions on an emergency basis.

On the appointment in question, April 9, 2008, the patient attended for an emergency examination at which time two periapical radiographs were taken. Because the patient moved, the films were “not perfectly sharp;” however, in conjunction with his clinical examination, he believed that they were of diagnostic value. He did not feel that it would be in the best interest of the patient to retake them.

He observed that tooth 23 (upper left cuspid) had fractured and discussed his findings with the patient. He believed that the tooth was compromised. He explained to the patient what was involved in restoring the tooth, the risks and costs of treatment, including endodontic treatment, post, core and crown or extraction followed by placement of an implant or denture.

According to the dentist, the patient decided to have the tooth extracted and a partial denture fabricated. An appointment was scheduled with an oral and maxillofacial surgeon for the extraction procedure. The patient was given the original radiographs to take to the appointment with the specialist. Copies of these radiographs were not retained.

At the April 9th appointment, the dentist stated that he also spoke to the patient about her reported sensitivity between teeth 26 (upper left 1st permanent molar) and 27 (upper left 2nd permanent molar). He recommended restoration of tooth 27 to close the contact, in order to resolve a food impaction problem. An appointment was scheduled.
In his reply, the dentist noted that the patient later cancelled her appointment with the specialist for the extraction of tooth 23 and contacted his office to cancel her appointment for the restoration of tooth 27.

Concerned about these cancellations, the dentist said he personally contacted the patient on April 23, 2008 to discuss the required treatment. At that time, he discussed the proposed repair for tooth 23 and the option of having a denturist fabricate a partial denture. According to the dentist, the patient stated that she was not feeling well, and, since the tooth did not hurt, she wanted to postpone treatment.

The dentist denied that he was told by the patient that she had changed her mind about the treatment or that she was dissatisfied with the previous consultation.

FURTHER INFORMATION
A copy of the member’s response was sent to the complainant for her information. She provided further comments in which she stated that the tooth in question was not tooth 23, as reported by the dentist, but tooth 24 (upper left 1st bicuspid). When provided with a copy of the patient’s letter, the dentist acknowledged that the tooth in question was tooth 24.

REASONS FOR DECISION
The panel believed that, in conjunction with the member’s clinical observations, the radiographs taken by him were minimally adequate to make a referral to an oral and maxillofacial surgeon for a consultation regarding the extraction of tooth 24.

Based on its review, the panel decided to take no further action with respect to the complaint.

Case No.2

COMPLAINT SUMMARY
The parents of a minor patient complained about their family’s general dentist alleging that he had incorrectly diagnosed decay in their son’s mouth and had told them that flossing was unnecessary.

THE DENTIST’S PERSPECTIVE
The dentist provided the College with a response to the formal notification of the complaint and provided his patient records. He stated that the child attended his office in August 2007. At that time, he noted that the child’s permanent molars were erupting with fissures that made his explorer “stick.” The parents were advised and a restorative appointment was scheduled for December 6, 2007.

At that appointment, 36 (lower left 1st permanent molar) and 46 (lower right 1st permanent molar) were restored using a shallow preparation and composite resin. At the same time, the dentist observed general decalcification on two other recently erupted molars and three primary teeth.

He informed the child’s parents and advised them of the need to restore the other permanent molars more aggressively.
A restorative appointment was scheduled for June 19, 2008. It was also agreed that other changes in the decalcification would also be evaluated during the June restorative appointment.

The dentist stated that, in his experience, waiting six months to complete restorative treatment allows for increased psychological maturation of the patient which results in better co-operation. He added that he has found that waiting this amount of time does not appreciably change the status of the teeth to be treated.

In this particular case, the dentist said he believed that the child was at risk of caries to not only the three primary teeth, but also the immediate adjacent teeth. He said it would be preferable to restore all of the teeth at the same time should that become necessary.

The dentist denied telling the parents in August or December 2007 that everything was “great.” He said that he informed the parents of the decalcification and the need for restorative treatment. He also denied telling the parents that flossing of the child’s teeth was unnecessary. He explained that the dental hygienists on his staff stress the importance of flossing and this was confirmed in the patient’s chart.

The dentist said that, when the child returned to his office in May 2008, he was surprised and disappointed that there was such a significant change in such a short time. That was why he felt it in the patient’s best interests to refer him to a pediatric dentist in order that treatment could be carried out expeditiously.

FURTHER INFORMATION
A copy of the dentist’s response was sent to the child’s parents for their information. They disputed his version of events. The dentist provided further comments confirming that he recognized the problem and referred the patient accordingly.

As part of its investigation, the College obtained records from the patient’s subsequent treating pediatric dentist. The records showed that the child attended the pediatric dentist on May 26, 2008 for a specific examination, as a referral from the family dentist. The pediatric dentist noted the need for pulpotomies and stainless steel crowns for teeth 74, 54, 84 and two surface amalgam restorations on teeth 75, 55 and 85.

REASONS FOR DECISION
The panel reviewed the member’s radiographs and records and noted decay on numerous teeth. There was no real change in the radiographs taken by the member and those taken six months later by the treating pediatric dentist.

The panel was concerned that these multiple areas of decay were not noted on the original odontogram and were not treated by the member. In their view, he failed to diagnose and treat large rampant decay, failed to inform the patient’s parents that he was in need of treatment and failed to offer a timely referral to a pediatric dentist, if he did not intend to treat the child himself.

In order to address the panel’s concerns about his diagnosis and treatment planning, the dentist voluntarily signed an undertaking/agreement to restrict his practice such that he would not perform an examination, render a diagnosis nor provide treatment for pediatric patients 12 years of age and under.
The restriction on his certificate of registration was to remain in place until such time as the College was satisfied that he had taken and successfully completed a comprehensive course or courses in pediatric dentistry, specifically including diagnosis, treatment planning and referral protocols.

The dentist also agreed that, following his successful completion of the course(s), the College would monitor his practice for a period of two years to ensure that the knowledge gained had been applied in his practice.

The panel felt that, with this skill upgrading, the dentist would benefit and the public interest would be protected.

The panel was unable to determine exactly what was said by the dentist or his staff to the parents about the flossing of the child's teeth. However, the panel agreed that oral hygiene instruction at an early age is beneficial to a young patient's dental well-being and certainly it is a good idea to instill oral practices, such as flossing, in patients at an early age.

**learning points**

Dentistry is one of only a handful of health professions, regulated under the Regulated Health Professions Act, that has been assigned the controlled act of communicating a diagnosis to a patient. So it is imperative that this important aspect of patient care is thoroughly and thoughtfully carried out and patient records document the factors considered in formulating the diagnosis and treatment plan.

Failure to carry out a comprehensive examination and to document the findings, diagnosis and related treatment options and to communicate all of this information to patients may call into question that the informed consent process was used.

Miscommunication and misunderstandings with patients and/or their parents or substitute decision-makers can result when there is a lack of attention to the examination, diagnosis and treatment planning details and the communication of such information to patients and/or parents or substitute decision-makers.
In 1990 and again in 1994, the Centers for Disease Control and Prevention (CDC) published guidelines for preventing the transmission of tuberculosis (TB). The guidelines focused primarily on hospital-based health care settings to address an increased number of TB outbreaks, most of which involved multidrug-resistant strains. As a result of the widespread implementation of these recommendations and reductions in community rates, reports of TB transmission among health care practitioners and patients decreased over the next decade.

In 2005, CDC updated the guidelines to include inpatient, outpatient, home health care and correctional settings, as well as TB clinics.

The risk of TB transmission in dental settings is low. Nevertheless, it is important that oral health care workers are knowledgeable about the signs and symptoms suggestive of active TB and appropriate office protocols are in place to prevent its transmission.

With this issue of Dispatch, PEAK is pleased to offer members the

The article first reviews the transmission, pathogenesis, epidemiology and diagnosis of TB. It then presents the chief recommendations from the 2005 CDC guidelines applicable to dental settings. These recommendations emphasize the importance of maintaining appropriate infection prevention and control measures to combat another resurgence of TB and reduce the risk of transmission from patients with unsuspected or undiagnosed infectious TB to health care practitioners.

**KEY POINTS TO CONSIDER**

TB continues to be a leading cause of death around the world. It has been estimated that 2 billion persons are infected with Mycobacterium tuberculosis, and that 1.78 million persons died from TB in 2007. In addition, the prevalence of multidrug resistant TB is increasing and some forms are almost untreatable.

Only persons with active TB are infectious. The disease is spread through airborne particles that may be generated when persons with pulmonary or laryngeal TB sneeze, cough, speak or sing.

Signs and symptoms suggestive of active TB include a productive and persistent cough, bloody sputum, night sweats, weight loss, fever and anorexia.

Patients who present with signs and symptoms suggestive of TB should be offered a mask and removed from the reception/waiting area and seated in a secluded operatory as soon as possible.

Patients with suspected TB should be referred for medical evaluation and possible treatment.

Patients with suspected or confirmed TB should have all non-urgent dental treatment postponed until it has been determined that the patient either does not have the disease or is noninfectious.

All dental settings should conduct an annual risk assessment for TB transmission. In addition, oral health care workers should consult with their family physician about the need for baseline and annual TB skin testing.
Letters of Apology

At its meeting on October 22, 2009, the Executive Committee reviewed my advertisement in the Summer 2009 edition of the City Living magazine. Although I briefly reviewed the article in the magazine, I failed to notice the words and phrases that are not considered appropriate in advertisements by dentists. Only after receiving the College's letter in which it highlighted the specific concerns, did I realize that several references were made in the article that are not in compliance with the regulations. It was never my intention to make comparisons or suggest uniqueness or superiority. I know that “family dentistry” is not a specialty and, therefore, the references to “specializing in family dentistry” should not have been used. As well, the term “specializes” should never be used in reference to me since I am a general dentist. I also realize now that describing the post-graduate training referenced in this article may be regarded as making comparisons or suggesting uniqueness or superiority over my colleagues and is therefore considered inappropriate in advertisements by dentists.

I ask the College and my colleagues to accept my sincere apologies and my assurance that such errors will not occur in my future advertisements. I will have the College review my advertisements prior to their publication and distribution.

Dr. Asraa Ali

In the August 20, 2009 issue of the Windsor Star, I described the benefits of digital impressions over the “traditional and commonly accepted” technique of impression taking for crowns and bridges.

In this article, under the heading of “Goo no more” and “digital impressions eliminate messy experience,” I described this technique as being “state-of-the-art technology,” and that it has “revolutionized the way you do crowns.” The photo used in my story shows my dental assistant using this technology with a photo cutline that states she can “clearly see the surface of the tooth in the 3-D image of the affected area.” In addition, the article states that “unlike with the traditional method, the chances of producing a distorted impression are slim” and although “this technology is not widely used, I am one of the rare dentists doing digital impressions in the region.”

The College does encourage the publication and distribution of information to the public about new technology and advancements in dentistry; however, I accept the College’s view that the article went beyond providing information by implying that the traditional method of taking impressions for crowns more often results in poorly fitting crowns. Having reviewed the College’s concerns with the published article, I understand that some of the references made may be regarded as comparisons with the other practices or members and that it may have implied uniqueness or superiority over other practices or members. This was not my intention.

I sincerely apologize to the College and to the profession for not recognizing that this article is not in compliance with the regulations. I will ensure that this will not reoccur and will have my promotional material reviewed by the College prior to publication and distribution.

Dr. Michael H. Malowitz
Loss Prevention Tips, Advice and Practical Solutions from Your Professional Liability Program

PLP staff appreciate the anxiety you feel when a patient threatens a lawsuit. Remember PLP staff can help you and are only a phone call away. Timely reporting preserves your right to coverage and also can result in matters being resolved on a mutually satisfactory basis for both you and your patient.

When should I call PLP?
If you are ever in doubt about whether the facts of a particular situation may give rise to a claim, please contact us as soon as possible. It would be wise to call PLP in these types of situations:

- You receive a call or letter from a patient or patient’s representative seeking compensation.
- You are served with a legal action.
- You rendered treatment to a patient where the result is adverse and not consistent with the anticipated outcome; for example, extraction of a wrong tooth, soft tissue trauma, etc.
- Your patient is unhappy with treatment rendered and is complaining.
- Something happens and you are just not sure whether or not to call. It is always better to call.

What can PLP do for me?
PLP staff will review demands made against you for compensation and provide you with advice both on how to proceed with the current claim and on how to reduce your chances of being sued in the future. PLP will help you resolve monetary issues as efficiently as possible so that you can get on with your life.

Will I have to pay any money if I call PLP for advice?
Our advice and help is free. You will only be asked to pay a deductible if we have incurred expenses to retain a solicitor, obtain an expert opinion or pay a claim on your behalf.
Loss Prevention Tips, Advice and Practical Solutions from Your Professional Liability Program

If I call PLP, who will find out about my call?
All matters reported and inquiries made to PLP are kept in strict confidence. No information is divulged to other areas of the College or to anyone outside of PLP without your consent.

Do I need to notify PLP if a patient files a complaint with the College?
A complaint filed with the College might also contain a demand for compensation or lead to a demand at a later date. That is why you should consider notifying PLP if you think the complaint to the College could lead to a demand for money. We cannot give you legal advice regarding the nature of your response to the College on the complaint, but we can open a PLP file and discuss with you how to deal with any monetary issues.

My patient is unhappy with the treatment I provided and wants her money back. What should I do?
Call PLP. Patients can become dissatisfied regardless of the quality of the treatment provided. However, if your patient is expressing dissatisfaction or making negative comments, this could be an indicator of trouble ahead. An early call to PLP allows us to provide advice and direction and ensure that your right to coverage is protected.

I have started a small claims court action to collect an outstanding amount and have received a counterclaim order (demand for compensation from the patient). What should I do?
Call PLP immediately if you receive a counterclaim and definitely before you take any further steps. PLP staff will provide you with advice and assistance and with legal counsel, if necessary.

QUESTIONS ABOUT A PARTICULAR SITUATION?
If you have questions about how to handle a particular situation with a patient, do not hesitate to call the College.

PLP Claims Examiners
416-934-5600 • 1-877-817-3757

Practice Advisory Service
416-934-5614 • 1-800-565-4591
I have a few patients who refuse to pay their account. Should I send the accounts to collections? What should I do?

Just because patients refuse to pay their accounts does not necessarily mean that there is a problem with the treatment provided. Some patients can’t or just won’t pay the bill. However, before sending any account to collection you should review your records. Don’t assume the patient is just being difficult. There may be legitimate reasons for non-payment.

Don’t rely solely on the information gleaned from your staff about their discussions with the patient. Speak to the patient directly yourself. Find out if there are concerns on the patient’s part with the treatment provided. What are the patient’s reasons for non-payment? Can you resolve these concerns? If in doubt, call PLP.

need to know

1. The General Conditions of your malpractice insurance policy state that:
   - Upon becoming aware of any occurrence, which might reasonably be the basis of a claim, you must notify PLP.
   - Your assistance and cooperation with PLP in the investigation and defence of any claim is required.
   - You shall not voluntarily assume any liability or settle any claim.

2. In order to protect your right to coverage, notify PLP immediately if your patient wants or might want money. Do not take any steps that may jeopardize your right to coverage.

3. Do Not:
   - Speak to anyone other than PLP about the incident.
   - Contact a patient who has sued you or retained a lawyer or representative.
   - Talk to the patient’s lawyer.
   - Treat the patient after you are informed he or she wants compensation.
   - Record your discussions with PLP in the patient’s chart.
   - Amend, add to or destroy your records.
The patient contacted the dentist’s office for an emergency appointment because of severe tooth pain. The front desk person was unable to provide an immediate appointment, but said that, if the patient came late in the afternoon, the dentist would be pleased to examine the patient. An appointment was made for 5:00 pm.

However, later in the same day, the patient cancelled the appointment and then went to another dentist. That dentist prescribed penicillin, pain medication and referred the patient to an oral surgeon. The oral surgeon advised that the pain was coming from the wisdom teeth.

The patient then saw yet another dentist who advised that the pain was not caused by the wisdom teeth, but by another tooth requiring root canal therapy.

The patient called the first dentist demanding to be seen immediately. The first dentist advised that he was fully booked, but could see him either the next day or suggested that the patient attend at an emergency dental service. The patient attended the emergency dental service and tooth 38 was extracted.

The patient complained to the College stating he was a Patient of Record for that first dentist and the dentist had refused to provide emergency treatment.

DECISION OF THE COMMITTEE
The Committee reviewed the peripheral records and the charts and records of the dentist. The Committee noted that dentists are not required to schedule all patients for emergency appointments at the convenience of the patient, but rather to try to accommodate the patient within the day’s booking or to provide reasonable other emergency treatment. The dentist did do that. The Committee, therefore, ordered no further action.

HEALTH PROFESSIONS APPEAL AND REVIEW BOARD
The patient was dissatisfied with the decision and asked the Board to review the decision of the Committee. The Board reviewed the record of investigation and was satisfied with its thoroughness. At the review, the patient stated that the decision of the College was unreasonable because it failed to take into account the great pain and suffering that he had to endure and the fact that he was a Patient of Record.

The Board noted the accommodation the dentist tried to make. While the Board acknowledged the patient had been under significant pain, the Board recognized that the dentist satisfied the obligation to ensure that the patient received necessary emergency care. HPARB’s decisions stated: “The Board finds no reason to question either the Committee’s reasoning or its conclusions that this obligation was reasonable and appropriately met by the dentist in this situation.” The Board, therefore, confirmed the decision of the Committee.
Complaint No.2

The patient complained of several issues around standards, a lack of informed consent on treatment costs and poor recordkeeping. The College’s process following the investigation encouraged the member to sign an undertaking agreement with the College to address all of these concerns. The dentist voluntarily signed the agreement. This undertaking included requirements for taking courses and monitoring.

DECISION OF THE COMMITTEE

The Committee reviewed the treatment planning, charts and records of the dentist and concluded that the amount and nature of the billings issued and collected were acceptable. The Committee was also satisfied that the undertaking agreement signed by the member addressed all the issues with respect to its mandate of regulating in the public interest and public protection, while at the same time following the College’s policy of trying to be rehabilitative when appropriate.

HEALTH PROFESSIONS APPEAL AND REVIEW BOARD

The complainant was dissatisfied with the decision and appealed to the Board. The Board reviewed the materials which included the College’s investigation. The Board noted “that the Committee had before it a significant and substantial amount of information” and therefore had what it needed “to render a reasonable decision with respect to the issues.”

The Board was satisfied that the Committee gave detailed consideration to all of the charts and records and billings and financial information to come to the conclusion that the billings were fair and reasonable. In its decision, HPARB stated: “The Board can find no compelling reason to disagree with the reasoning applied by the Committee in finding both the billing arrangement as well as the amount charged appropriate.”

The Board was also satisfied that the Committee addressed some of the practice concerns in the undertaking agreement and felt that the Committee had adequately addressed issues around public safety and public protection. The Board, therefore, confirmed the decision of the Committee.
Ethical Dilemma Discussion

The Dental Ethics 101 Ethical Dilemma Case Study appears on page 19.

The Specialist’s Gift

Businesses know that customer satisfaction is essential for success. That often means taking one step more than the competition so that the customer, recognizing the additional effort, will feel inclined to return. As consumers, we come to look for and even expect those thoughtful extras that leave a positive impression.

For example, stay in even a modestly priced motel chain and you will receive individual soaps and shampoos, hair dryers, coffee makers, and maybe even candy on the pillow at night and a newspaper at the door in the morning. Of course, we realize that we all pay for these extras, but they do add to the aura of the experience. These small niceties may even cause us to want to return to the same motel chain in the future.

Are they bribes? No. They are inducements intended to lure us back. But they are no substitute for quality service. A chocolate mint will not make up for a dirty room or rude employees. In the competitive motel service industry, a chain’s market share will depend on its reputation for quality service and whether customers are satisfied.

The relationship between dental specialists and referring generalists could be viewed in a similar light. Specialists depend on referring generalists seeking their expertise in promoting the patient’s overall oral health.

What makes one specialist’s practice better than another? And if there are many particular specialists in a locality, as in this case study, what can they do to secure a fair market share, or maybe even gain a competitive edge?

A small gift can be that little extra that is not obtrusive but expresses appreciation – and provides an edge over other practices. Does this then create a conflict of interest or a feeling of obligation? That is where the role of personal motives comes in.

WHO BENEFITS FROM A REFERRAL?

Patients trust their clinicians to make referrals to specialists and have confidence that the end result will be quality care. In the jargon of the health professions, specialists exceed mere competency and are indeed proficient, even performing, in some cases, at a mastery level. The specialist complements the generalist’s practice by providing special skills.

Two of the principles contained in the RCDSO Code of Ethics speak to the well-being of patients and referral to other practitioners, as follows:

♦ the paramount responsibility of a dentist is to the health and well-being of patients
♦ make the well-being of patients the primary consideration when making referrals to other health-care workers.

While patients may not know the credentials of the specialist, the referring clinician usually does from experience, reputation or reports by other trusted colleagues. The referring clinician will probably know if the person is a recent graduate from a recognized specialty program and registered as a specialist in the jurisdiction. The clinician may also know that the last 10 referrals sent to this specialist were of similar complexity and all were managed well and the patients were pleased. Of course, dentists also often know when just the opposite is the case.
Patients expect that referrals to specialists are made for the patients’ best interest. When a specialist gives a referring dentist a gift, does this action constitute a breach of this expectation, or at least create a reasonable doubt? Is this just a case about simple etiquette or is it really a breach of ethics?

A GIFT BY ANY OTHER NAME...
RCDSO’s conflict of interest regulations state that making or accepting payments, rebates or other benefits from a clinician for the referral of a patient is a conflict of interest and may, in fact, be considered as professional misconduct. It may also be in conflict with the spirit of the College’s Code of Ethics.

Two questions are at the heart of the case:
- Is the referring dentist influenced to change his or her referral patterns based on gifts? If so, then it is clear that the dentist is no longer promoting the patients’ best interest.
- Is the specialist who receives referrals trying to influence those generalists?

Both questions are subjective and depend on the motive of the dentists involved. Even self-evaluation might not provide an accurate answer. One test might be for the dentist to ask whether informing a patient about the nature and cost of the gift would raise concerns in the patient’s mind. Most patients recognize a thank-you gift as part of our culture and also know that there is a difference between a thank-you gift and an inappropriate inducement. One gesture expresses appreciation and the other expectation.

Establishing or changing specialty referral patterns should be based on the cold, hard knowledge that we have made the best match between the needs of the patient and the skills of the specialist. Maybe part of the conflicting views in this case study is the fine line between ethics and etiquette. For example, is there a difference between two tickets to a movie or to the Grey Cup?

Along these lines, Rinchuse et al in their ethical checklist for dental practice that was published in 1995 in the Journal of the American College of Dentists stated, “If a small gift from the dental specialist is an expression of gratitude for referrals – a way of saying thank you – and the quality of patient care is excellent, then it should not be an ethical dilemma. On the other hand, extravagant gifts are inappropriate. In these cases, it is only proper and ethical for the referring dentist to refuse these elaborate material rewards for patient referrals.”

IN CONCLUSION
Clinicians are obligated to act in the best interest of their patients. Each clinician must decide if gifts from specialists have any influence over their referral patterns or create a tension to reciprocate. Whatever the motives are for the gift, the dentist is ethically justified in refusing any gift no matter the value with the simple statement that the office refers to specialists based on their quality of care and, while the thought behind gifts is appreciated, they are not accepted.
College Website Offers Gateway to Immediate Information on Drug Interactions

Almost six years of operation has seen the Adverse Drug Interactions program on the College’s website help countless patients and dentists.

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

It is very simple to use, even while the patient is in the chair. List each of the drugs your patient is taking and then view the possible interactions on the screen.

In addition, you can view reference citations pertinent to the interaction. The online search will handle interactions from two up to 12 drugs. 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.

DISCLAIMER
Access to the online services provided by The Medical Letter, Inc. is provided by the College as a service to its members. The College is neither involved in the preparation of the materials contained at The Medical Letter, Inc. site, nor does the College verify the accuracy or completeness of the information contained therein. Users of The Medical Letter, Inc. site agree not to hold the College responsible for any consequences occasioned to them as a result of their use of the site, or as a result of their reliance upon the information contained therein.
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 by e-mail at jloy@rcdso.org.
At its November 12, 2009 meeting, Council approved new Guidelines on Infection Prevention and Control in the Dental Office. The final document incorporates changes made in response to comments and suggestions submitted by members and stakeholders following circulation of the draft document in June 2009.

The new Guidelines are significantly broader than previous documents and are intended to provide all oral health care workers with the most up-to-date information to implement effective infection prevention and control measures in dental practice. The document consolidates published recommendations from government and other agencies, regulatory bodies and professional associations, and reflects the best evidence and expert opinion available at the time of writing. The document is not a standard or a clinical practice guideline, but rather a best practice advisory.

The new Guidelines present best practices to interrupt the transmission of micro-organisms among patients and oral health care workers, and from dental instruments, handpieces, devices and equipment.

The document is divided into sections that address:

- principles of infection prevention and control;
- patient safety;
- oral health care workers’ responsibilities and safety;
- cleaning, disinfection and sterilization of patient care items;
- office cleaning, housekeeping and management of waste;
- equipment and area specific practice guidelines;
- general and surgical aseptic technique.

As noted in the introduction to the document, infection prevention and control is an important part of safe patient care. Over time, there has been constant
growth in knowledge and understanding of this subject, which has translated into steady improvement in the ability to prevent and control the transmission of infection in all health care settings, including the dental office. Such progress means that the dental office has become an increasingly safer environment for all concerned – for patients, dentists and their staff.

The document also includes a glossary of infection prevention and control terms, as well as two appendices. The first describes methods for cleaning, disinfection and sterilization of patient care items and environmental surfaces. The second lists additional resources and reference materials that are available on the Internet, including publications by the Provincial Infectious Diseases Advisory Committee (PIDAC), the Public Health Agency of Canada, the Canadian Standards Association and the Centers for Disease Control and Prevention (CDC).

The new Guidelines emphasize the use of routine practices, which refer to basic infection prevention and control practices that are required for safe patient care. Routine practices 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, mucous membranes and non-intact skin.

The four principles that are inherent in routine practices are:

1. **RISK ASSESSMENT** – the first step in the effective use of routine practices. The risk of transmission of micro-organisms will vary, depending on the type of dental procedure to be performed and the likelihood of exposure to blood, body fluids and secretions, mucous membranes and non-intact skin. Therefore, a risk assessment must be done before each interaction with the patient in order to determine the interventions that are required to prevent the transmission of infection.

2. **HAND HYGIENE** – the single most important measure for preventing the transmission of micro-organisms. The new Guidelines provide detailed recommendations regarding when hand hygiene should occur, what types of products should be used and how it should be done. Significantly, there is now sufficient evidence that 70 to 90 per cent alcohol-based hand rubs are superior to washing with soap and water, except in cases where the hands are visibly soiled or contaminated with body fluids.
New Guidelines on Infection Prevention and Control in the Dental Office

3. **USE OF PERSONAL PROTECTIVE EQUIPMENT (PPE)** – to shield the exposed tissues of oral health care workers from exposure to potentially infectious material. PPE serves as a barrier to protect the skin of the hands and arms from exposure to splashing, spraying or spatter of blood, saliva or other body fluids, and from introducing micro-organisms into deeper tissues by traumatic injuries. PPE also protects the conjunctival mucosa of the eyes and the lining mucosa of the respiratory tract. Primary barriers include gloves, protective eyewear, masks and protective clothing.

4. **SAFE HANDLING AND DISPOSAL OF SHARPS** – to avoid occupational exposures to blood. Percutaneous injuries pose the greatest risk of transmission of blood-borne pathogens (e.g. HBV, HCV and HIV) to oral health care workers. The new Guidelines present best practices to prevent such injuries, as well as clear advice to manage a significant exposure.

The new Guidelines provide step-by-step recommendations for the processing of reusable patient care items – from initial receiving, cleaning and decontamination of instruments, to preparation and packaging, sterilization and storage – in order to ensure that they are safe for reuse on patients.

In addition, the document presents best practices for the monitoring of sterilization through a combination of mechanical, chemical and biological means, which are consistent with those of the Provincial Infectious Diseases Advisory Committee and the Canadian Standards Association. This is followed by a recommended action plan in the event of a positive biological indicator or failed spore test.

The new Guidelines also address the cleaning and disinfection of environmental surfaces, including clinical contact and housekeeping surfaces, along with the management of biomedical and general office waste. The document encourages the use of low-level, rather than intermediate-level, disinfectants to decontaminate environmental surfaces and the use of disposable barriers, which are particularly effective in protecting those surfaces that are difficult to clean and disinfect, due to their shape, surface or material characteristics.

Taken together, the various elements in the new Guidelines will assist members in developing a comprehensive infection prevention and control program for their dental office that employs effective strategies to reduce the risk of transmission of micro-organisms, making the dental office a safer environment for both patients and oral health care workers alike.

The new Guidelines are available on the College’s website at www.rcdso.org and a paper copy is enclosed with this current issue of Dispatch.
DENTISTS NOW HAVE THE BEST HOW TO MANUAL ON INFECTION PREVENTION AND CONTROL

These new Guidelines present best practices, like a how-to manual for the dental office. They are also an educational tool for dentists:

◆ raising their awareness about the day-to-day risks of transmission in the operatory;
◆ providing practical, up-to-date information they need to minimize those risks.

“It is important to state the obvious: the draft Guidelines are just that – guidelines. They are not attached to any by-law or professional misconduct regulation or standards,” stated College Registrar Irwin Fefergrad.

As the College Registrar explained: “Professional judgement by individual dentists will always inform how each of the best practices outlined in the Guidelines should be used.

“As dentists read through the Guidelines, we hope that they will reflect on their own infection prevention and control practices and consider what changes might be warranted in their own offices.

“I have spoken to many dentists since the Guidelines were approved by Council in mid-November. Many have made some small adjustments in their own offices that will mean better protection for their patients, their staff and for themselves.

“They haven’t been forced to buy new sterilizers, like some have warned. They are using the ones they have properly and they are conducting their own spore tests in-house quickly, cheaply and easily.

“The dental profession has learned much over the last decade or so about infection prevention and control,” said the College Registrar. “The College sees these new Guidelines as an important achievement in its continuing commitment to public safety and protection.”
A new deductible formula will apply to claims reported to PLP on and after January 1, 2010. The new formula will not apply to or affect any matter reported to PLP prior to January 1, 2010.

These changes were part of a number of risk management/practice improvement strategies that were approved by the RCDSO Council in November 2008. They are designed to encourage dentists with a previous claims history to improve their practice by taking courses that will address any shortcomings that were identified during the PLP process which led to the need to settle a claim. And, by doing so, dentists may be able to have their deductible greatly reduced by the PLP Committee.

It is expected that dentists requiring such upgrading will be referred to the College’s Quality Assurance department for assistance in finding courses that meet their individual practice improvement needs.

Here’s how the new formula works.

While the basic or minimum individual deductible remains unchanged at $2,000, the new step-up deductibles are as follows:

- $5,000 for the dentist who has had one prior claim in the previous 84 months;
- $10,000 for the dentist who has had two previous claims in the previous 84 months;
- $20,000 for the dentist who has had more than two previous claims in the previous 84 months.

For pre-2010 claims, the deductible formula in place in the year the file was opened will apply.

“The public wins too because PLP now has a proactive way to encourage dentists to improve the delivery of care to their patients,” said Dr. Don McFarlane, Director of the Professional Liability Program.

“And the PLP staff will continue with their top-notch risk management education program. Over the years, we have developed a number of resources for dentists, including the Risk Management Guide, group educational sessions and individual mentoring – all at no cost to the dentist.”
Why have these changes been introduced?

Under the new formula, there is now an incentive for dentists with previous claims of a similar nature in the preceding 84 month period to improve their practices to avoid future similar claims and, at the same time, to request the PLP Committee to reduce the applicable deductible to a lower amount.

How will I know if I have an opportunity to have my stepped-up deductible lowered?

When a dentist is called upon to pay a stepped-up deductible, he or she will be advised by the PLP claims examiner of the opportunity to make submissions in writing to the PLP Committee to request a reduction in the deductible.

Who will decide if my stepped-up deductible is to be lowered?

Only the PLP Committee has the authority to reduce the applicable deductible. This discretion can be used where the Committee is satisfied that it is appropriate to do so.

The current PLP Committee is chaired by Parm Chahal, a public member of the RCDSO Council. The Committee members are: Dr. Stan Kogan, a dentist member of Council, and five practising dentists selected to serve: Dr. Vincent Carere (Waterloo); Dr. Michael Glogauer (Hamilton); Dr. Gurneen Sidhu (Ottawa); Dr. Gordon Sylvester (Stratford); and Dr. Ronald Yarascavitch (St. Catherines).

Is there any set amount by which the stepped-up deductible might be lowered?

The amount of any reduction is within the sole authority of the PLP Committee and could be either all or only a portion of the stepped-up amount, depending on the circumstances. The amount, however, will never be less than the minimum deductible of $2,000, as set out in the PLP insurance policy.

What factors might the PLP Committee consider in determining whether to reduce a deductible?

The factors that the PLP Committee may consider can include, but are not limited to the following:

- There are no similarities between the conduct or 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 and the PLP Committee is satisfied that the deficiencies which gave rise to the claim(s) have been appropriately addressed by the dentist.
- The claim payment(s) was primarily to defence cost and, in the PLP Committee’s view, the dentist was not likely to have been found to be negligent had the matter proceeded to trial.
- The dentist has already proactively addressed any shortcoming identified by the PLP Committee as contributing to the claim.
- The dentist is prepared to agree 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 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.

Where can I get more information on the stepped-up deductible reduction process?

For more information, contact the PLP Director, Dr. Don McFarlane, at 416-934-5609 or toll-free at 1-877-817-3757 or by e-mail at dmcfarlane@rcdso.org.
1. No Change in Premium for 2010

The Professional Liability Program is pleased to report that ENCON Insurance Group Inc. has maintained the rates for excess malpractice coverage the same in 2010 as in the previous year.

These rates are as follows:

<table>
<thead>
<tr>
<th>Basic Coverage</th>
<th>Excess Amount</th>
<th>Total Coverage</th>
<th>Premium</th>
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<tbody>
<tr>
<td>$2M</td>
<td>$1M</td>
<td>$3M</td>
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<tr>
<td>$2M</td>
<td>$8M</td>
<td>$10M</td>
<td>$411</td>
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</tbody>
</table>

In addition to the $2M per occurrence coverage provided to all Ontario dentists, retired dentists, partnerships of dentists and health profession corporations that hold a certificate of authorization from the College, as part of the annual RCDSO fees, there is excess coverage available through the College’s brokers, Marsh Canada Inc.

In 2009, 1,737 Ontario dentists opted to obtain various amounts of excess malpractice coverage.

Whenever the terms and conditions of the PLP policy of insurance are being negotiated, the continued availability of excess coverage and the premium for it is part of the discussion.

2. Post-Retirement Excess Coverage Packages

Many dentists who regularly purchased excess malpractice coverage while in practice want to extend this excess coverage into their retirement.

In the past, to do this retired dentists were required to make arrangements on a year-by-year basis to purchase excess coverage at the prevailing premium. For some, this was inconvenient and caused problems, e.g. the dentist moved and did not provide a new address to Marsh Canada Inc. or forgot to renew the excess coverage.

Marsh Canada Inc. now offers convenient post-retirement excess coverage packages that have a substantial cost saving over the one year rate:

For those dentists who opt for a three-year package, the premium is equivalent to two times the annual rate (three years for the price of two years).

For those choosing a five year post-retirement coverage package, the rate is equivalent to three times the annual premium rate (five years for the price of three years).

The year-by-year renewal of excess coverage is still available for dentists who want that option.

MORE INFORMATION
Contact Marsh Canada Inc. at 416-349-3574 or toll free at 1-888-711-8399.

ON THE WEB www.rcdso.org
Click on the Professional Liability Program heading in the navigation bar on the left hand side of the College’s home page at www.rcdso.org.
COLLEGE WEBSITE: Your First Stop For Information

Bookmark www.rcdso.org on your favourites and check in regularly for the latest information from the College on important and relevant issues.

Whether it is the latest news from the College under the What’s New section on the home page, or copies of any of the Guidelines, Practice Advisories or Standards available under the Professional Practice heading, it is all available immediately on our website.

You can use the Dentist Search function, found on the top left hand side of the home page, to get the most up-to-date and accurate information about every dentist registered to practise in Ontario. This includes the practice address and telephone number.

Look for the most recent bulletins from the Ministry of Health and Long-Term Care under the heading of Important Health Notices on the right hand side of the home page.

Or maybe you are thinking of creating a Health Profession Corporation. All the necessary forms, regulations and answers to the most frequently asked questions are there under the heading of Health Profession Corporations in the navigation bar on the left hand side of the home page.

All the College’s publications are still available in the usual paper format too. Contact the College at info@rcdso.org with your request and the material will be sent out by surface mail.

www.rcdso.org
The College and the Ontario Dental Association (ODA) joined together to present a highly successful series of four road shows around the province during the first three months of the new year.

Called Practice Advisory: The Business Side of Your Practice, each session focused on issues important in today’s practice environment: employment law, business structures, professional corporations, group practice arrangements and ways to reduce your tax bill.

“The College was delighted to work in collaboration with ODA on this project. It is wonderful when we can create opportunities like this for both our organizations to work together to support dentists across the province,” said the College Registrar Irwin Fefergrad.

“These road shows are following fast on the heels of the release of the amazing CD on informed consent that the College distributed at the end of last year free-of-charge to every dentist in Ontario. It was produced in collaboration with ODA. We can do great things together,” explained Fefergrad.

Dentists attending any one of the roadshows are able to claim three College CE credits.

The presenters at the road shows were Irwin Fefergrad, lawyer and College Registrar; John McMillan, corporate/commercial lawyer; Nancy Shapiro, lawyer in employment law and David Chong Yen, chartered accountant.

The road shows were held in Toronto on January 21, Ottawa on February 11, London on February 18 and Thunder Bay on March 11.
Mailbag

I just saw the new CE CD you folks did on informed consent and it was quite well done and covered all the bases. It addressed escalating degrees of consent as treatment becomes more complex and elective. I think you covered the inability to obtain consent on patients who have been given mood or conscious altering drugs... an area that is often missed.

DR. RICHARD SPEERS
Toronto

Thanks to PLP staff for all of the work you have done to resolve my matter. I wish to thank you for all of your great advice along the way.

NAME WITHHELD

Having received and worked through the Informed Consent CD that the RCDSO has produced and distributed, I feel that the College should be commended for the efforts put into providing us with this most valuable information. The mere fact that they have chosen to provide us with these tools and information is a sign that they have chosen to be proactive and have created reference material for us on this most important subject. A job well done!

DR. LIONEL LENKINSKI
Toronto

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

Mark Your Calendar…
2010 COUNCIL MEETINGS
March 4
June 10
November 18
FOUR SEASONS HOTEL
21 Avenue 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
Strong Open Relationships Allow Us To Accomplish So Much More

Continued from page 4

- discussing the role of regulators in pandemic planning and sharing outcomes and documents;
- addressing concerns around safety standards for dental/medical devices supplied from off-shore, with Health Canada staff speaking to us directly about its regulatory and inspection process;
- co-operating on our submissions to the Competition Bureau in response to its study of the dental profession;
- clarifying our exemption from GST on the provinces’ membership fees to CDRAF;
- exploring a national approach to liability insurance program needs;
- securing significant federal funding for initiatives on certification and licensure for internationally trained dentists;
- developing a standardized Letters of Standing;
- creating and getting agreement on a common national approach on the labour mobility requirements of the Agreement on International Trade;
- making a strong commitment to the development of a national approach to the provide every dentist in the country with access to reliable clinical practice resources for best practice information;
- moving forward to develop a national process for the approval of specialities.

That’s not all. We have organized and delivered a number of top-notch educational sessions. In fact, there’s been an average one major event a year on everything from interprofessional care to serology testing for dentists.

All in all this is a pretty impressive track record for an organization in its infancy.

...the incredible strength and power that emerges when we work together

Now we speak with one strong and united voice on regulatory matters. There is an effective forum for the exchange of information and for collaboration.

We have already demonstrated the incredible strength and power that emerges when we work together. Through hard work, honest commitment, and open and respectful discussion, we have done wonders.

And, perhaps most important of all, we have taken control of our own destiny.

Now I believe is the time we support and encourage CDRAF and CDA to make a similar commitment to the development of a formal relationship between the regulators and the professional associations across the country. To do that, I believe we need to have more trust and a clear understanding of our separate mandates. In today’s environment, no organization can purport to be all things to all dentists.

Here in Ontario, we have created just such a relationship with our colleagues at the Ontario Dental Association (ODA). The lines of communication are open at all times at the level of both senior elected officials and staff.

We have created a small committee with senior staff and elected leadership from each organization that meets regularly to informally and respectfully discuss issues of common concern.

Both organizations have worked collaboratively on a number of key projects to support dentists in the province. Some of the highlights in the last year or so include the CD-based educational package on informed consent, the wellness initiative to assist dentists dealing with addiction issues and now the ODA road shows providing business advice to dentists. That is a pretty impressive track record.

We recognize that each organization has its own individual mandate and we acknowledge that this
Jusqu'alors, nous nous rencontrions, mais seulement sous forme de séance supplémentaire aux réunions de l'Association dentaire canadienne (ADC). Il n'y avait pas d'organisation officielle, ni de structure de gouvernance, ni de règlements administratifs. Il n'y avait pas de conseil d'administration, ni de structure de vote. La responsabilisation et le poids de toute décision étaient très ambigus.

Mais tout cela a changé grâce à la création de cette fédération nationale des organismes de réglementation en dentisterie. Ce fut une réalisation gigantesque.

Le moment de la création de la FCORD n'aurait pu être mieux choisi. Le monde de la réglementation est décidément devenu bien plus complexe. Les gouvernements des ordres provincial et fédéral exigent une approche concertée relative à des enjeux tels la mobilité de la main-d'œuvre. Désormais, une ou deux seules provinces qui collaborent n’est plus réalisable ou, dans la majorité des cas, avisé.

Comment pouvons-nous exprimer notre réussite au cours des dernières années? Il ne fait aucun doute que nous avons eu quelques problèmes aigus comme toute nouvelle organisation, mais nous détenons une feuille de route assez impressionnante de réalisations. Les résultats sont éloquents.

- Permettez-moi d'énumérer quelques-unes de nos principales réussites au cours des six dernières années :
  - La création d’une structure de gouvernance, des règlements administratifs, une structure de vote et un modèle de financement qui nous a si bien servis et qui nous a permis d’aborder des enjeux difficiles sans rancœur.
  - L’élaboration d’une stratégie de communications incluant un logo et la mise en place d’un site Web bilingue.

De solides relations ouvertes nous permettent d’accomplir bien davantage.

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Strong Open Relationships Allow Us To Accomplish So Much More

sometimes means that we may not agree or even take the same position on an issue. But what we definitely do is talk about it. We always understand why a decision is made, why a position is taken and have an opportunity to explain the reason for our differences. The effort that we each have made to make this relationship work has paid off in spades for each organization and for the dentists of this province.

And most importantly, it has meant that each organization can do its job better. In fact, speaking for the College, it has certainly helped us enhance our role and mandate as a regulator.

Development of this type of relationship between the national regulators embodied in CDRAF and professional associations embodied in CDA seems to be a natural next step in the growth and maturity of the dental community in Canada. I believe now is the time to seize the moment and move forward on making it happen.

The effort that we each have made to make this relationship work has paid off in spades for each organization.
De solides relations ouvertes nous permettent d'accomplir bien davantage

...la force et le pouvoir incroyables qui émergent lorsque nous travaillons ensemble

- L’établissement de relations officielles permanentes avec d’autres associations nationales importantes, notamment le Collège royal des chirurgiens dentistes du Canada, l’Association des facultés dentaires du Canada (AFDC), le Bureau national d’examen dentaire du Canada (BNED), la Commission de l’agrément dentaire du Canada, Santé Canada et l’Association dentaire canadienne (ADC).
- La mise au point d’un protocole d’entente ayant trait à la certification et à l’autorisation d’exercer à l’égard des spécialistes en dentisterie formés à l’étranger.
- Le débat au sujet du rôle des organismes de réglementation dans la planification en cas de pandémie et la publication des résultats et des documents.
- Le traitement des préoccupations concernant les normes de sécurité des dispositifs dentaires et médicaux en provenance d’outre-mer, et le personnel de Santé Canada qui s’adresse directement à nous au sujet de ses procédures de réglementation et d’inspection.
- La collaboration relative à nos soumissions auprès du Bureau de la concurrence en réaction à son étude de la profession dentaire.
- La clarification de notre exonération de la TPS concernant les droits d’adhésion de la province à la FCORD.
- La recherche d’une approche nationale quant aux besoins en matière de programme d’assurance de la responsabilité civile.
- L’obtention de fonds fédéraux importants pour les initiatives visant la certification et le droit d’exercer pour les dentistes formés à l’étranger.
- L’élaboration d’une attestation de compétence normalisée.
- La création et la conclusion d’une entente visant une approche nationale commune sur les exigences en matière de mobilité de la main-d’œuvre, conformément à l’Accord sur le commerce extérieur.
- La prise d’un vif engagement concernant l’élaboration d’une approche nationale, afin de fournir à chaque dentiste au pays un accès fiable à des ressources de pratique clinique, pour de l’information sur les pratiques exemplaires.
- Aller de l’avant dans l’élaboration d’un processus national d’approbation de la part des spécialistes.

Ce n’est pas tout. Nous avons organisé et produit un certain nombre de séances éducatives de premier ordre. En fait, il y a eu pour les dentistes, en moyenne chaque année, un événement majeur sur tout allant des soins interprofessionnels aux tests de sérologie.

Somme toute, c’est une feuille de route assez impressionnante pour une association naissante. Dorénavant, nous nous exprimons d’une voix forte et unie sur des questions de réglementation. Il s’agit d’une tribune efficace pour l’échange d’informations et la collaboration.

Nous avons déjà exprimé la force et le pouvoir incroyables qui émergent lorsque nous travaillons ensemble. Grâce à un travail acharné, à un engagement honnête, et à des discussions ouvertes et respectueuses, nous avons accompli des merveilles. Et peut-être le plus important, est que nous avons pris le contrôle de notre propre destinée.
De la part du président

Je crois qu’il est maintenant temps que nous aidions et encourageons la FCORD et l’ADC à prendre un engagement semblable en vue d’élaborer des relations formelles à l’échelle du pays entre les organismes de réglementation et les associations professionnelles. À cet effet, je crois que nous devons faire davantage confiance et avoir une compréhension claire de ce que sont les mandats distincts. Dans l’environnement actuel, aucune organisation ne peut prétendre tout offrir à tous les dentistes.

Ici en Ontario, nous avons justement mis sur pied de pareilles relations avec nos collègues de l’Ontario Dental Association (ODA). Les canaux de communication sont ouverts à tout moment, au niveau des cadres supérieurs élus et du personnel.

Nous avons instauré un petit comité, composé de cadres supérieurs et de leaders élus provenant de chaque association, qui se rencontrent régulièrement pour discuter sans formalité et de manière respectueuse des enjeux de préoccupation commune.


Nous reconnaissons que chaque association a son propre mandat individuel et nous convenons que ceci signifie parfois que nous pouvons être en désaccord ou adopter une position différente sur un enjeu donné. Mais ce que nous faisons en définitive, c’est en parler. Nous comprenons toujours les motifs pour lesquels une décision est prise et une position est adoptée, et nous avons l’occasion d’expliquer les raisons à l’appui de nos divergences.

Les efforts que nous déployons tous afin que ces relations fonctionnent se sont avérés fructueux pour chaque organisation et pour les dentistes de cette province.

Cela a surtout signifié que chaque organisation peut mieux accomplir son travail. En fait, en parlant au nom du Collège, cela nous a certes aidés à rehausser notre rôle et notre mandat en tant qu’organisme de réglementation.

L’établissement de ce genre de relations entre les organismes de réglementation nationaux que regroupe la FCORD, et les associations professionnelles membres de l’ADC semble être la prochaine étape naturelle de la croissance et de la maturité de la collectivité dentaire au Canada. Je crois qu’il est maintenant temps de saisir cette occasion et d’aller de l’avant afin que cela se concrétise.

Les efforts que nous déployons tous afin que ces relations fonctionnent se sont avérés fructueux pour chaque organisation.
COMING SOON!

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This fall the College is launching a Lunch + Learn webinar series with three 60-minutes live professional development sessions. Using the latest in online technologies, participants can interact with leading dental experts in real time. These one hour interactive seminars will feature visuals and a live question and answer session.

BOOK THESE DATES NOW!

September 24
Dr. Charles Shuler, Dean
Faculty of Dentistry
The University of British Columbia, Vancouver
**Topic: osteonecrosis secondary to bisphosphonate therapy**

October 29
Dr. Blake Nicolucci
Implant Editor of Oral Health magazine
Renowned National and International Speaker
**Topic: implant dentistry**

November 26
Dr. Dan Haas, Professor/Associate Dean
Discipline of Anaesthesia, Faculty of Dentistry
University of Toronto, Toronto
**Topic: acute pain control and anxiety management**

ADVANTAGES OF THE 60-MINUTE LUNCH + LEARN!

**FAST**
No wasted time. Get right to the heart of the matter in one hour.

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You will see and hear the speakers and their visuals. You will have a chance to ask questions in real time.

**CE CREDITS**
Participation in each seminar is worth 3 College CE credits.

LOOK FOR REGISTRATION DETAILS IN THE NEXT ISSUE OF DISPATCH AND ONLINE AT WWW.RCDSO.ORG.
January 18, 2010

Mr. Irwin W. Fefergrad
Registrar
Royal College of Dental Surgeons of Ontario
6 Crescent Road
Toronto, ON  M4W 1T1
Sent via fax: 416-961-5814 (1 page only)

Dear Mr. Fefergrad:

Re:  Dental Record Warrants for Ontarians Thought to Have Died in Haiti

The Office of the Chief Coroner for Ontario is assisting with the identification/repatriation phase of Ontario residents who have died in Haiti and whose remains will be brought to Ontario.

I write to ask your assistance in issuing a communiqué to all Ontario dentists. When a Coroner issues a warrant to a dentist, I am asking that all original documents and x-rays be provided expeditiously. Dentists can make copies where possible for their own records, however rapid acquisition of the original records by the Coroner must take precedence. Original documents and x-rays will be returned to the dentist in due course.

Please contact me should you have any questions.

Yours truly,

Andrew L. McCallum, MD, FRCPC
Chief Coroner for Ontario
The Capacity to Care

It has been said that one of the measurements of a civilized community is its ability to respond during a crisis. When the Ontario’s Chief Coroner contacted us recently for assistance with the Haiti earthquakes, we knew with confidence that the dentist community would respond quickly and fully.

Within 24 hours of being contacted by the Coroner, we had his letter posted on our website to ask for dentists’ assistance in the identification of the repatriated remains. A notice was sent out in an e-mail blast to the over 6,000 dentists who have willingly given us their e-mail addresses, and, of course, the Coroner’s letter is reprinted in this issue of Dispatch (page 51).

Immediately upon receiving the e-mail so many of you contacted me personally and the College to say: I am here, I am ready, willing and able to do whatever is needed. Yet again, dentists responded.

I am always so impressed at that capacity to care from members of the dental profession. When I am at local dental society meetings or chatting with Council members, I hear innumerable stories of dentists who, year after year, do incredible volunteer work in their own communities, in the remote north and even in countries abroad.

It is the same compassion and caring that dentists bring to their office every day as they make their patients feel cared for, secure and comfortable.

These values of integrity, decency and compassion are not new to the profession.

As dentistry evolved from the early practitioners who were itinerant barbers to superbly educated professionals, dentists became trusted members of their communities and took on leadership positions in society. Communities in return gave dentists a level of recognition and respect in return for this ethic of service, compassion and care to patients and the public.

The College is making great strides in bolstering that sense of public purpose. This March we are unveiling a new revamped online jurisprudence and ethics course that puts a new increased emphasis on ethics. It is no accident that the title of the course is “Examining the Practice of Dentistry in Ontario Through an Ethical Lens.” This course is still a compulsory requirement for licensure in this province and now will also be available to current dentists as a refresher and completion of the course earns 15 CE points.

I am sure most of you, like me, have found it difficult to find an adequate personal response to the horrific tragedy in Haiti. As I write this column, the estimates are of up to 200,000 deaths, 250,000 injured and around 2 million people homeless. We are left breathless by the scope of these events and their impact. The scale of tragedies like this is almost beyond our imagination.

What is most encouraging is the incredible response from around the world. I don’t mean just governments, but ordinary people. From the transit riders dropping money into the Red Cross pails on the subway platform, to cable customers adding a contribution to their monthly bill by cell phone, we seize these opportunities to show our support even in some small way. That capacity to care is in its own way just as breathtaking as the events in Haiti.

As Pablo Casals, the famous cellist and conductor once said: “I feel the capacity to care is the thing which gives life its deepest significance.”