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RCDSO COUNCIL MEMBERS

President
Dr. Frank Stechey

Vice-President
Dr. Peter Traínor

Elected Representatives

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Appointment by Lieutenant-Governor In Council

Kelly Bolduc-O’Hare  Little Current
Mohammed Brihmi  Ajax
Dr. Harpal Buttar  Ottawa
Parminder Chahal  Brampton
Mofazzal Howladar  Toronto
Kurisummoottil Joseph  Thunder Bay
Catherine Kerr  Scarborough
Evelyn Laraya  Oakville
Dr. Edelgard Mahant  Toronto
Jose Saavedra  Woodbridge
Abdul Wahid  Scarborough

Academic Appointments

University of Toronto
University of Western Ontario

Dr. R. John McComb
Dr. Stanley Kogon
### DEPARTMENTS

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### ISSUE ENCLOSURES:

- Summaries of Discipline Committee hearings
- PEAK: Keys to Clinical Success with Pulp Capping: A Review of the Literature
The College is firmly committed to the value of continuing professional development. We believe that a lifelong commitment to learning is a necessary and essential part of quality dental practice.

The stale-date for professional learning is getting shorter and shorter. It is no longer possible to do all our learning at the start of our career and then spend the rest of our working life using what we learned then. Learning is not something that stops when you walk off the stage with your degree.

Many of us just have to think back over the past two or three decades since we became a DDS to realize how much more we have needed to learn over the years to continue to improve our practice performance and provide the best outcomes for our patients and at the same time allow us to feel personally effective and satisfied.

No matter how much we learn, how much we know, how good we are at what we do and how long we’ve been good at it, we still need to learn and grow – not just because the practice of dentistry is always changing, but because we need to keep growing and learning to stay interested and mentally sharp.

As you probably know, Ontario’s health care regulatory colleges are expected by government to take a proactive role in ensuring the continuing competence of their members. We wanted to do this by moving beyond the traditional Quality Assurance (QA) programs that involved things like office visits.

At the end of January we received formal notification from government that our Quality Assurance Regulation was approved. So over the coming months, we hope to see the rollout of a brand new QA program at the College.

Our QA program is a partnership between you and the College. It is founded on the belief that each member of the College is a competent dentist who is motivated to continuously maintain and improve his or her level of competence.

Of course, we will keep you informed all along the
REGISTRATION NOW OPEN!

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SEPTEMBER 24
Oral Bisphosphonate Use and the Prevalence of Osteonecrosis of the Jaw
REGISTRATION DEADLINE: September 14, 2010

CHARLES F. SHULER, DMD, PHD

is the Dean of the Faculty of Dentistry at the University of British Columbia. Prior to his UBC appointment, he was a faculty member at the University of Southern California (USC) for 18 years. At USC, he served as the Director of the University of Southern California Center for Craniofacial Molecular Biology, holding an endowed chair position as the George and Mary Lou Boone Professor of Craniofacial Molecular Biology. He also served as the Director of the Graduate Program in Craniofacial Biology and the Associate Dean for Student and Academic Affairs at the USC School of Dentistry.

Dr. Shuler received his B.S. in Biochemistry from the University of Wisconsin, his DMD from Harvard School of Dental Medicine, his PhD in Pathology from the University of Chicago and his Oral Pathology specialty education at the University of Minnesota and the Royal Dental College Copenhagen Denmark.

He has served as a member of the Oral Biology and Medicine-2 Study Section of the National Institutes of Health and participated on the editorial boards of several journals including the Journal of Dental Research, Oral Surgery, Oral Medicine, Oral Pathology and the Journal of Periodontology. Dr. Shuler was the principal investigator of the USC-California Science Project that worked with more than 200 teachers in the Los Angeles Unified School District to improve science education in public schools. His current research interests include craniofacial development, oral carcinogenesis and gene therapy. The research continues to be supported by research grant funding from the National Institutes of Health.

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**OCTOBER 29**
Changing the Architecture of Bone
REGISTRATION DEADLINE: October 19, 2010

Dr. Blake Nicolucci is a general dentist who graduated in dentistry from the University of Western Ontario in 1975. His special interest and focus is on implant dentistry. He has placed numerous types of dental implants since 1981.

He is a Clinical Associate Professor of Oral Implantology in the Department of Periodontology at Temple University in Philadelphia, Pennsylvania. He is on the faculty of the Misch International Implant Institute and the Canadian Implant Institute of Quebec; Diplomate of the American Board of Oral Implantology and Diplomate of the International Congress of Oral Implantology where he has held a position as a board member since 1999. He is President of the Canadian Society of Oral Implantology and has also been a member of the editorial board of Oral Health magazine since 1998.

Dr. Nicolucci was honoured with the Alumni of Distinction Award from the University of Western Ontario in 2007. He has written numerous articles, and lectured extensively both nationally and internationally on implant dentistry.

**NOVEMBER 26**
Acute Pain Control: Use of Opioids in Dentistry
REGISTRATION DEADLINE: November 16, 2010

Daniel A. Haas, DDS, PhD, FRCD(C), is professor and Associate Dean at the University of Toronto Faculty of Dentistry, with a cross-appointment to the Department of Pharmacology at the Faculty of Medicine. He holds the Chapman Chair in Clinical Sciences, is Head of the Discipline of Dental Anesthesia and Director for the graduate program in Dental Anesthesia. Dr. Haas is in clinical practice with the Department of Dentistry, Sunnybrook Health Sciences Centre.

He is the 2004 recipient of the International Association for Dental Research Distinguished Scientist Award for Pharmacology/Therapeutics/Toxicology. He received the W.W. Wood Award for Excellence in Dental Education in 2005 and the 2007 Heidbrink Award from the American Dental Society of Anesthesiology for outstanding contributions to anesthesia in dentistry. He has lectured internationally on the subjects of pharmacology, anesthesia, and medical emergencies in dentistry.

**WHAT IT COSTS**
One Webinar: $100 • Value Pack of Three: $200*
(*The registration deadline for the value pack is September 14, 2010.)

**HOW TO REGISTER – It’s Easy!**
- Log on to the College website at www.rcdso.org and look in the What’s New section on the home page for Webinars.
- Read the FAQ backgrounder.
- Complete the fillable form online, print it off and fax it in along with your payment information.
- Once your credit card payment is cleared, you will receive a confirmation notice by e-mail from the College.
- One week before the seminar, you will receive more detailed information by e-mail about how to log onto the webinar.
Development of Alcoholics Anonymous
The development of AA connects back to Swiss psychiatrist Carl J. Jung who, in the later 1920s, stated that his alcoholic patient Roland H. would only recover from his severe alcoholism through a conversion experience. Roland returned to New York, joined a fundamental religious group and had such an experience. Roland conveyed this information to another member of his group, Ebby T. In November 1934, Ebby visited his friend Bill W., a failed stockbroker with advanced alcoholism, who was immediately impressed with Ebby's sobriety. Bill also managed to achieve sobriety after having a spiritual experience that arose from his despair and depression.

Following his discharge from hospital, Bill attempted to help other alcoholics. After many failures, he shared his frustration with his physician, Dr. Silkworth, who responded: “…for God's sake, stop preaching. Tell them about the obsession and the physical sensitivity they are developing – say it's lethal as cancer – a drunk must be led not pushed.” In May 1935, Bill met Dr. Bob Smith, a surgeon in Akron, Ohio and the two became co-founders of Alcoholics Anonymous.

It took several years to develop the Twelve Steps and the Alcoholics Anonymous guide book. Groups of alcoholics who supported each other and used the 12-step program gradually sprung up throughout North America.

During this evolution, AA grew apart from its fundamental religious roots and eventually disconnected from any religious association. The program's spiritual nature is very personal and accepting of any experience so that atheists and agnostics can actively participate.

Over the next 15 to 20 years, the business aspects of AA developed, including the Twelve Traditions, Twelve Concepts and Six Warranties. These are sometimes referred to as the Constitution of AA.
THE PSYCHOLOGY OF THE 12 STEPS

How the 12 Step Program Allows Addicts to Grow up

This process resulted in a program that is still the most effective method for maintaining sobriety. Harvard Medical School psychiatric professor George E Vaillant, in a prospective 30-year follow-up, found that the number of AA visits made by people explained 28 per cent of the clinical outcomes of sobriety. Of interest in this study, medical or psychiatric treatment did not explain any of the clinical outcomes for recovering alcoholics. 3

The development of the Minnesota Model of Treatment, which combined professional treatment with AA, resulted in an improvement in treatment effectiveness. A recent prospective study of employed alcoholics found that treatment plus AA was more effective than AA alone in helping employed alcohol abusers attain and continue abstinence. This study confirms the value of combining professional treatment with AA.4

With roots in medicine, psychoanalysis and religion, AA is compatible with psychiatric treatment. The difference is that AA is not under professional control; it is protected by a set of traditions that have successfully maintained the organization and its program for over 60 years.

We need to understand that AA does not:
• solicit members
• charge user fees
• control or follow-up with members
• provide housing, meals or transportation
• provide medical, psychiatric or nursing care
• join councils or social agencies
• accept money from non-members

How AA Works
Khantzian & Mack provide strong theoretical backing for considering AA as specific treatment. They describe AA as a “sophisticated psychosocial form of treatment that addresses human psychological vulnerabilities that alcoholics and others share related to problems of self-regulation.”5

The therapeutic aspects of AA they emphasize are:
• the installation of hope through contact with others;
• the encouragement of openness and self-disclosure;
• repeated emphasis on shared experiences;
• a focus on abstinence;
• an insistence that one cannot get better on one’s own;
• a spiritual dimension that helps move a person from self-centredness towards a capacity for humility and altruism.

The aspects all contribute to a positive shift in ego defense mechanisms and to a character change.

Elements of AA Recovery Program
The AA Recovery Program has three main elements:

1. Meetings
There are a variety of meetings and, if an individual does not like one type of meeting, they are encouraged to try others until they find a group they are comfortable with. Newcomers are considered the most important people at AA meetings.

Patient resistance to attending 12-step meetings is usually highest when a diagnosis and referral is first made. A useful metaphor for AA meetings is to view them as a medication. To be effective, they need to be taken daily in the first three months of sobriety. Most treatment programs now recommend 90 meetings in 90 days in recognition of the high risk of relapse in the first three months and the need for an intensive experience to break through the defenses of denial, projection and isolation.
2. The Fellowship
Meetings introduce alcoholics to other like folks in various stages of recovery. An important aspect of recovery is obtaining a sponsor who has experience with the program as well as living sober.

This individual can act as a mentor and guide on the journey of recovery. Studies have shown that having a sponsor is associated with a reduced risk of relapse and that acting as a sponsor also improves the program's outcome.

3. Step Work
The Twelve Steps provide the core of the program. Each step presents a specific problem and can be assisted by a family doctor or specialist physician. In return, as the step is worked, it can facilitate psychotherapy.

**Step 1** means becoming comfortable with a new identity as a recovering alcoholic and marks the beginning of sobriety.

**Step 2** requires a belief that someone greater than or different from him or herself can be of help. This is left up to the individual and requires an acknowledgement that “I cannot deal with this problem myself and need help.” This common human experience can help reduce resistance stemming from an unrealistic self-image that requires a person to solve every problem alone.

**Step 3** is a difficult step and requires a conscious surrender of one's will in life to the “power” one has begun to appreciate in the previous step. This step often manifests a struggle between prior religious experience and the entity of spirituality. The alcoholic is encouraged to trust the individuals in the home group and at meetings to help him or her until they begin to experience some healthy inner control.

**Step 4** is also difficult but for different reasons. Working this step usually triggers guilt, shame and grief; it should be done with a sponsor. Support by physicians, without medication, can also be very helpful. The benefits of self-knowledge and self-
awareness that come from working this step are extremely valuable.

From my own experience, recovering alcoholics who have worked Step 4 are more comfortable with and responsive to psychotherapy and it significantly helps in the maturation of ego.

**Step 5** is also a form of preparation for psychotherapy. Individuals are anxious and sometimes anticipate a negative response from the person they share with. In many cases, sharing with another human being is usually a relief. Individuals listening to these admissions never reject or punish. Although this step is therapeutic, it is not true psychotherapy.

**Step 6** is derived from Step 4. Behaviours directly associated with the use of alcohol will usually stop with abstinence, but other character traits will remain. This step demonstrates a willingness to develop behavioural change. Self-awareness without feedback from one’s social support system is much more difficult than self-awareness of ego dystonic behaviour. Psychodynamic psychotherapy and psychoanalysis, both individual and group, interact in a positive way with this step.

**Step 7** is fascinating. It seems to take place internally but it is externally observed. As my wife once put it “it’s in their eyes.”

The humility required for this step reawakens the experience of Step 1. The difference is that it is easier to stop alcohol abuse than to change your personal character behaviours. Change does occur in selfish, blaming or grandiose behaviours. It serves as a great source of hope for others. Alcoholics continue to attend AA meetings years after abstinence has begun not only because they are worried about returning to drinking, but also because they find that working on their own pathological issues is a challenging, positive and rewarding experience.

**Step 8** develops from Step 4 and puts the alcoholic in a state of preparation for relational repair. This step may also help the individual develop the capacity for empathy and it is basic to developing relational skills that can assist the gains made in individual therapy.

**Step 9** puts relational skill into practice and, although usually accompanied by anxiety, it is an extremely positive experience. The recovering person can learn the importance of forgiving oneself, even though working this step does not necessarily result in being forgiven by others.

**Steps 10–12** are said to be maintenance steps. They work by being a continuous stimulus to both personal relationship goals and character change. Spiritual health is improved and working these steps also expresses gratitude.

Working at AA or other recovery programs is usually accompanied by periods of emotional distress. The best results usually come when these symptoms are looked upon from a developmental rather than a pathological point of view. AA members view these symptoms as a motivation for change. They are likely to resent and resist efforts to medicate themselves and many recovering alcoholics now believe that it is important for them to experience and work through these negative feelings in order to change for the better.

**The Goal of Recovery**

Two characteristics of recovering from alcoholism and other addictions are:

1. The ability to manage the stress of living without the support of dependent drugs. This ability is unusual in society where the use of alcohol and prescription medications as stress management is widely accepted.

2. The ability to be around dependence-producing drugs without experiencing craving or engaging in drug-seeking behaviour. This explains why drug dependent health care professionals, given a recovery process has occurred, are able to return to their practice and its associated availability of drugs.

The other aspect of recovery that appears to result from 12-step work is a shift from the immature ego
defense mechanisms of denial, projection, minimizing, grandiosity and acting out to more mature ego defense mechanisms of altruism, humour, suppression, anticipation and sublimation.

The following characteristics occur in individuals working a recovery program over a period of time:

- an honest openness and willingness to learn;
- personal humility with a tolerant acceptance of others;
- compassion and altruistic caring (willing to help others without compensation);
- gratitude for the experience that we have had, for relationships and for the program.

In summary, recovering alcoholics become the kind of people most of us would like to be.

**Conclusion**

In treating the disease of addiction, AA and other 12-step programs provide powerful psychosocial therapies that can enhance psychotherapeutic treatment provided by other care givers including physicians and psychiatrists. When the physician motivates and supports a patient to actively work a 12-step program, a complementary stimulus to growth and development will be added to the psychotherapeutic effect of treatment.

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**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 the Ontario Dental Association 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

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**References**

The College joined with the Ontario Dental Association (ODA) to present Practice Advisory: The Business Side of Your Practice, to dentists in four different regions around the province earlier this year. 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 presentations were especially relevant, for as College Registrar Irwin Fefersgrad said in one of the sessions, “the legal landscape has changed so dramatically in the last several years. The College was delighted to work in collaboration with ODA on this project.”

ODA’s Executive Director Tom Magyarody agreed: “It is wonderful when we can create opportunities like this for both our organizations to work together to support dentists across the province. At ODA, supporting dentists is our focus and when both our organizations have an opportunity to accomplish this together, it is the members who benefit.”

As Fefersgrad pointed out: “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 too was produced in collaboration with ODA and again it shows we can do great things together.”

Dentists attending any one of the roadshows can claim three College CE credits.

The presenters at the road shows were Irwin Fefersgrad, lawyer and College Registrar; John McMillan, corporate/commercial lawyer; Nancy Shapiro and Erin R. Kuzz, lawyers in employment law and David Chong Yen, chartered accountant and tax specialist. Special articles written for Dispatch magazine by Mr. McMillan and Mr. Chong Yen follow on pages 13 to 21.

The road shows were held in Toronto on January 21, Ottawa on February 11, London on February 18 and Thunder Bay on March 11.
Even though Ontario dentists have had the legal right to set up a health profession corporation (HPC) since the fall of 2002, there are still a number of complex questions that dentists need to ask to judge if an HPC is right for them.

“That is why the College continues to urge dentists who are considering an HPC to seek their own legal and accounting advice,” explained College Registrar Irwin Fefergad.

As Tom Magyarody, Executive Director of the Ontario Dental Association noted, “We certainly saw a lot of interest in this topic during the business practice roadshows that we hosted earlier this year.”

To assist dentists in the assessment of their own unique situation, Dispatch magazine is pleased to share two major articles written by key presenters at these roadshows, lawyer John McMillan and accountant David Chong Yen.

Under amendments to the Ontario Business Corporations Act in 2002, a number of professional groups, including lawyers, accountants, dentists, doctors, social workers and veterinarians, were given the right to run their practices through a professional corporation. The legislation lays down the basic conditions for professional corporations and also outlines the responsibilities of the regulatory bodies, such as RCDSO, to establish an administrative process to implement the legislative provisions.
Ensuring a healthy professional corporation requires careful planning, execution and ongoing maintenance.

Planning and Structure
Your first stop should be your accountant. As incorporation is largely a tax-driven decision, an important first step is to determine the most optimal tax strategy for your family.

Yes, family members, including parents, children and spouse of the dentist (to whom you are married or with whom you are living in a conjugal relationship) may own non-voting shares of the professional corporation, but there are more involved questions such as what attributes and values these shares should have. For example, it may be an objective to simply “income split” in which case nominal fixed value discretionary dividend shares would be suitable.

However, other or additional objectives might include the duplication of capital gains exemptions, which would involve an entirely different class of shares. Other objectives might be to have the ability from time-to-time to declare and pay dividends to certain family members to the exclusion of others, which would require a structure with multiple classes of shares.

Documentation
Once you have consulted with your accountant, your solicitor can begin preparation of the Articles of Incorporation for filing. Your solicitor will need to consult with your accountant to be sure that the corporation is properly structured and that appropriate classes of shares are provided.
for in the Articles. Additionally, your solicitor should ensure that the Articles of Incorporation comply with strict statutory requirements, including:

- the name of the corporation complies with the Business Corporations Act;
- the objects and activities of the corporation must be restricted to “the practice of dentistry or activities related or ancillary to the practice of dentistry” and may include “the investment of surplus funds earned by the corporation.”

Your solicitor will also be responsible for the preparation of a myriad of organizing documents including Director and Shareholder Resolutions, Consents and By-Laws, among others. It is critically important that all such documents be prepared and executed prior to the application to the College.

If there will be multiple shareholders, you will also need to consult with your solicitor as to whether a Shareholders Agreement is advisable. One central purpose of a Shareholders Agreement that is relevant to professional corporations is to give you the dentist ultimate control over the shares in the event of certain events including, for example, death, divorce or the sale of the practice (i.e. the sale of the shares of the corporation).

After the Articles have been filed, your solicitor and accountant will also assist you with the preparation and filing of various mandatory forms with both the Ministry of Government Services (Ontario) and the Canada Revenue Agency.

The RCDSO Application

The RCDSO application requires accurate and complete information on the practice location(s), the shareholder(s) and director(s). Additionally, Undertakings and Statutory Declarations must be given and sworn by the dentist shareholders and directors of the corporation.

All materials must then be submitted in a timely fashion to RCDSO, along with notarized copies of the Certificate of Incorporation and Articles of Incorporation, as well as an original and current Certificate of Status from the Ministry of Government Services.

Failing to follow the RCDSO application steps meticulously will likely result in your application being returned for correction or possibly re-execution and refiling. There are a number of trips and traps to watch for, as the smallest error can result in costly and frustrating delays.

Some of the more common errors in applications and renewal applications include:

- stale-dated Statutory Declaration (It must be executed not more than 15 days before the application is submitted to the Registrar.)
- stale-dated Certificate of Status (It must be issued by the Ministry of Consumer and Business Services not more than 30 days before the application is submitted to the College Registrar.)
- Undertaking and Statutory Declaration execution irregularities (e.g. dates, signatures, witnesses and commissioning.)
- photocopied or scanned applications (Original signatures are required.)
- missing notarial seals
- use of the word “Dental” in the corporation name (Schedule 1 of the Regulated Health Professions Act describes the profession as “Dentistry” and College By-law No. 10 expressly requires the use of the term.)
- use of the abbreviated term “Corp”
- adding the word “Inc”
- use of prohibited punctuation
Not on the RCDSO Radar

It is important to know that while following the College’s precise requirements when applying for a Certificate of Incorporation is important, there are many other aspects of professional corporations that require careful consideration and diligence – aspects that fall outside of the College’s scrutiny and that are not subject to its verification.

Your application to the College for a Certificate of Authorization for your professional corporation will contain considerable detail. However, in reviewing the application, the Registrar, understandably, takes everything at face value and is entitled to assume all contents to be accurate and true, as you will have sworn a Statutory Declaration to that effect in support of your application.

Problems can arise when it is later learned that certain requisite steps or underlying elements were missed, which can create all manner of problems, not only with RCDSO, but also with the Canada Revenue Agency.

Shareholders
The application to the College requires all shareholders to be identified. However, it is not just a simple matter of listing voting and non-voting shareholders on the application.

In order for shares to be properly in the hands of the shareholders, certain requirements must be met under the Business Corporations Act:

- The shareholder must subscribe for the shares in writing.
- The director or directors of the corporation must authorize the issuance of the shares, in writing.
- The subscribing shareholder must pay the specified subscription amount to the corporation, using the shareholder’s own funds.

Again, these are requirements that are not subject to the verification of the College in the application process, but remember that you will be swearing a Statutory Declaration to the effect that the application is true, complete and accurate.

Trust Arrangements
In the event that you wish to have shares held in trust for your minor children (as permitted), again, it is not just a simple matter of naming trustees in the application. Setting up a proper trust arrangement is critically important and requires the assistance of a qualified solicitor.

Housekeeping and Ancillary Matters
Often overlooked is the requirement that the professional corporation actually step into the dentist’s shoes in every respect. A few examples of the details that require your attention include:

- banking arrangements for the corporation (including any auto debit arrangements.)
- documentation and Canada Revenue Agency filings in relation to the conveyance of the practice assets from the dentist to the professional corporation on a tax-free basis pursuant to section 85(1) of the Income Tax Act (Speak to your lawyer and accountant.)
- assignment of the rights and obligations of the dentist as tenant under the practice premises lease (if applicable) to the corporation
- assignment of equipment leases, software licenses
- notices to suppliers
- transfer of employees to the corporation (as continuing employer) and obtaining a payroll number for the corporation
- assignment of general liability insurance policies
- addition of corporation as insured party under professional liability coverage
- notification and direction to patients’ insurers
- notification to suppliers
- adding corporate name to letterhead, accounting instruments, business cards, etc.
Going Forward – Caring for your Professional Corporation

Corporations require ongoing care and attention and there are a number of periodic and incidental tasks required to ensure the continued health of your professional corporation:

- Initial Form 1 must be filed with the Ministry of Government Services within 60 days of incorporation, specifying the names and addresses of all directors and officers, failing which the corporation may be subject to penalties under the Corporations Information Act.
- Form 1 Notice of Change must be filed when adding or removing any officers or directors.
- notice to RCDSO of any change in directors, officers or voting shareholders
- notice to RCDSO of any change of dentists practising on behalf of the corporation or any change of or additional practice locations
- annual renewal of Certificate of Authorization with the College by August 31 of each year
- annual provincial/federal filings (Speak to your accountant.)
- corporate minute book maintenance, as required under the Business Corporations Act, including annual director and shareholder resolutions (approving financial statements, appointing accountant, electing directors, etc.), as well as dividend, bonus and other incidental resolutions.

Exit Planning

Just as there are possibly significant tax savings to be had on the sale of shares in your professional corporation, without proper advance planning, there are also significant tax pitfalls.

Throughout your career and particularly as you approach retirement, you should be consulting with your accountant and lawyer to ensure that you maximize your tax savings and that you remain on side for your capital gains exemption eligibility.

Certainly there is much to consider, not only in your decision to incorporate, but also as you move through the incorporation process and beyond. However, as millions of incorporated business owners can attest, it can be one of the wisest decisions of your life. Just be sure to surround yourself with the right advisors.

John McMillan, LL.B
John McMillan, LL.B. is a corporate/commercial lawyer serving dental professionals. He can be reached at 416.364.4771 or johnmcmillan@bellnet.ca.
A health profession corporation (HPC) makes no sense as I need all the profits from my dental practice to repay my personal debt including home/cottage mortgage, children’s tuition fees, etc.

When should I consider a HPC?

Consider a HPC if any or all of the following circumstances exist:

- Your dental practice has a loan.
- You have parents/spouse and/or adult children 18 years and older who live in Canada and don’t make very much income.
- Your income (net of expenses) exceeds the top tax bracket which, in Ontario, is about $127,000.

Even if you need all of the practice’s profits to repay the personal debt, it still could make sense to set up a HPC if you have parents who make no income and live in Canada. The reason is that these parents or adult children who make no income can receive approximately $35,000 of dividends, each from the HPC, and pay approximately $450 in taxes.

These parents and adult children, if they so choose, can subsequently gift the money to anyone, at anytime, including the dentist. The gifts received by the dentist will not be taxable. There is no limit on what amount one can gift. Hence, poor family members can be used as tax savings vehicles and serve as a conduit for extracting money from the HPC at very low tax rates.

When you have a practice loan, it must be repaid with after tax dollars whether a HPC exists or not. When there is no HPC and one is at the top tax bracket ($127,000), the practice loan will be repaid with expensive tax dollars (i.e. dollars taxed at the highest personal marginal tax rate of approximately 46.4%). Hence, where no HPC
exists, approximately $186,000 of pre-tax income must be earned to repay approximately $100,000 of practice loans. Where a HPC exists, approximately $118,000 of pre-tax income must be earned to repay the same $100,000 practice loan. The HPC’s tax rate starting July 1, 2010 is 15.5% on the first $500,000 of taxable income per year.

When adult children are attending university, the amount of dividends they can receive while paying virtually no income tax increases significantly due to the tuition, education, and textbook tax credits arising from attending any local/foreign university. For example, a child who is 18 years old or more living in Ontario and attending university on a full-time basis for nine months of the year and whose tuition is $10,000 will pay about $1,600 taxes on $60,000 of dividend income.

3 Can my parents who live in a foreign country own shares of my HPC?

Shareholders of a HPC should be residents of Canada for tax purposes. Significant complications arise where shareholders of a HPC are non-residents. In fact, the benefits of having a PC could disappear where shareholders of a HPC are non-residents.

4 Can dividends from my HPC be paid at any time? Is there a limit on the amount of dividends which can be paid?

Dividends can be paid from a HPC at anytime from after tax earnings/retained earnings. The practical limitation on dividend payments relates to the amount of cash you have in your HPC. Note that dividends are not a tax deduction to a HPC, but rather are paid from after-tax profits of the HPC. Dividends are taxed at a different rate than salaries. The top personal tax rate on dividends is approximately 32.57%, whereas the top personal tax rate on salaries/wages/interest income is approximately 46.4%.
What happens if I divorce my spouse and he/she is a shareholder of my HPC?

What happens to HPC shares upon divorce depends on the type of shares held and whether you have an enforceable marriage contract. If dividend-only shares are held by the non-dentist spouse, for tax purposes such shares would be virtually worthless. If, on the other hand, equity shares are owned by the non-dentist spouse, these shares certainly would have a value. Upon a divorce, the shares owned by the non-dentist should be redeemed.

What happens if I have a HPC, but no shareholder ever paid money to the HPC for their shares of the HPC?

Where no shareholder has ever paid for their shares, this creates a tax nightmare. Some of the tax benefits of a HPC could disappear. Therefore, extra care should be taken and appropriate record keeping maintained to prove the shareholders purchased the shares with their own funds.

I understand that the HPC pays taxes and anyone who receives a dividend from the HPC pays additional taxes. This means that two levels of taxes are paid if I have a HPC. Doesn’t this mean that the sum of the two levels of taxes (personal and corporate) will be more than if I never had a PC and just paid personal taxes?

The PC is a separate legal entity, files a separate tax return and pays a separate tax from the individual. The individual, if he/she receives dividends and/or salaries, will pay personal taxes on these items. When the taxable income (dental revenues minus expenses) is less than $500,000 per year, the sum of the personal taxes and the corporate taxes paid should be less than if there was no professional corporation. Therefore, a PC should always result in a minimum net tax savings (even when the corporate taxes and the personal taxes are combined) of about 3%. Again, as illustrated in the answer to the first question, where one has adult children attending university or poor parents or spouse, the tax savings from having a HPC increase significantly.

NOTE: This article is intended to present tax saving and planning ideas and is not intended to replace professional advice.
**What tax rate does the HPC pay and is all income earned by the HPC taxed at this rate?**

Up to June 30, 2010, the HPC’s tax rate is 16.5%. Commencing July 1, 2010, it decreases to 15.5%. These rates apply to income generated by the dental practice. However, any investment income earned by the PC will be taxed at approximately 48%. Approximately 27% is refunded to the HPC when and if the PC pays taxable dividends to its shareholders. Hence, the effective tax rate on the investment income will be reduced by this tax refund so long as dividends are paid to shareholders, and especially where the recipients of the dividends are in a lower tax bracket.

**Who is entitled to the lifetime capital gains exemption (LCGE)? Can the LCGE be multiplied?**

Any individual is entitled to a $750,000 lifetime capital gain exemption. This lifetime capital gain exemption can be multiplied by adding shareholders to the HPC provided these shareholders are equity shareholders. Hence, if a HPC has four equity shareholders, then the lifetime capital gain exemption will be $3 million (4 x $750,000). However, the amount actually available to you/other family members may be restricted by several factors. Please consult your financial advisors about this matter.

**I have my dental practice and wish to form a HPC. What’s wrong if all I do is just form a corporation?**

Sadly, sometimes we encounter situations where all that is done is simply creating a corporation. Unless additional steps are taken, you may not have a valid PC. Some steps to consider include:

- Your existing dental practice should be valued. The assets of the practice should be sold to the newly formed corporation and a related agreement of purchase and sale with appropriate price adjustment clauses should be prepared.
- An application to RCDSO should be made and a Certificate of Authorization should be obtained from RCDSO prior to operation via a PC.
- Shares of the HPC should be purchased by each shareholder with money from each shareholder. The assets should be transferred to the newly formed corporation using a section 85 rollover to minimize the risks of future tax problems.
- A fiscal year end of the HPC should be selected taking into account the goal of tax deferral.
- Bank accounts, credit cards, direct debit, lease for your premises, suppliers invoices, your invoices to patients, insurance should all be in the HPC’s name.

**David Chong Yen, CFP, CA**

David Chong Yen, CFP CA of DCY Professional Corporation Chartered Accountants, has completed the CICA In-Depth Tax Courses and has been advising dentists for decades. Additional information can be obtained by phone at 416-510-8888, by fax at 416-510-2699, or by e-mail at david@dcy.ca. The company’s website is www.dcy.ca.
The annual renewal of your Certificate of Authorization for your health profession corporation is just around the corner. If you currently hold a Certificate of Authorization for a health profession corporation, your annual renewal form will be forwarded directly to you in June.

**Reduction of annual renewal fee if paid on or before July 31**

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

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

- applicable fee payable to the Royal College of Dental Surgeons of Ontario;
- Statutory Declaration – Form B executed by a Director of the corporation before a commissioner, lawyer or notary public not more than 15 days before the annual renewal form is submitted to the Registrar;
- original, current-dated Certificate of Status of the corporation issued by the Ministry of Government Services not more than 30 days before the day it is submitted to the Registrar.
Statutory Declaration - Form B
The Statutory Declaration must be sworn in the physical presence of a commissioner, lawyer or notary public. The legislation requires that the Statutory Declaration be executed not more than 15 days before the application for annual renewal is submitted to the Registrar, certifying that the corporation is in compliance with section 3.2 of the Business Corporations Act.

What is a Certificate of Status of the Corporation?
A Certificate of Status is a one-page document issued by the Ministry of Government Services which indicates that the corporation is active. The legislation sets out the requirements for the annual renewal of your Certificate of Authorization. One of those requirements is that a current-dated Certificate of Status accompanies your annual renewal form regardless of how new your health profession corporation is.

DOS AND DON'TS OF THE HPC ANNUAL RENEWAL PROCESS
DO ensure that you are in the physical presence of a commissioner, lawyer or notary public to have your Statutory Declaration executed.

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

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

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

EXPIRY DATE - AUGUST 31
All Certificates of Authorization expire August 31 of every year regardless of the initial date of issuance. For those dentists who applied for a Certificate of Authorization this year, please note that it is only valid until August 31.
Consider Making A Difference...

Submit Your Name for Appointment as a Non-Council Member to College Committees

Every two years, a number of Ontario dentists take the time from their busy dental practices to help the College deliver on its mandate of professional and responsible self-regulation.

It is a challenging job. However, as any of your colleagues who have served as a non-Council member of a College committee will attest, they have found an enormous amount of satisfaction and fulfillment in the experience, and leave with fond memories of the collegiality and goodwill during their term of office.
How do I know if I am eligible to be appointed to a College committee?

You are eligible on the deadline date for receipt of applications, which is Wednesday, November 24, 2010 at 9:00 a.m., if you meet the following criteria:

- You have filed a signed Application & Eligibility Form for Non-Council Committee Appointment with the Registrar of the College.
- You hold a general or specialty Certificate of Registration.
- You are applying for selection in the electoral district in which your designated address on the Register is situated.
- You are not in default of any fees or other monies owing to the College, or in default of returning or completing any prescribed forms.
- You are not currently the subject of any disciplinary or incapacity proceeding.
- Three years have elapsed since you complied with an order from the Discipline Committee or the Fitness to Practise Committee.
- Three years have elapsed since you have been found guilty of an offence under the Criminal Code of Canada, or complied with any penalty.
- You do not have any terms, conditions or limitations placed on your Certificate of Registration, other than ones that are applicable to all members holding that class of certificate.
- Three years have elapsed since you were disqualified from sitting on Council because of a breach of the College’s Code of Conduct for Council members or of the conflict of interest by-law.
- During the previous two years, you have not been a director or other member of the board of directors, governing council, or other governing body, or an officer or appointed official of the Canadian Dental Association, Ontario Dental Association, a national or provincial dental specialty association or similar organization.
- You are not, and have not been, engaged as a dental consultant to a third party dental benefits provider during the previous three years.

What is the time commitment?

It really varies from committee to committee. Some committees like Inquiries, Complaints and Reports meet about once a month, while others, like Fitness to Practise, may only meet three times a year. See the chart on page 27 for more details.

Am I compensated for the time away from my practice?

The 2010 rate is $965 per day, with $1,155 per day for committee and panel chairs. Other reasonable expenses, such as travel, accommodation and meals are reimbursed.

How long is my commitment?

The term is for about two years, the same as for elected Council members.
Consider Making A Difference...

Submit Your Name for Appointment as a Non-Council Member to College Committees

Can I run for elected office and submit my application and resumé for an appointed committee position too?
Yes, you can do both. However, if successful in the election, your name will be removed from the random selection process for appointment to a committee.

How do I go about submitting my name, if I am interested?
It is quite straightforward. The Application & Eligibility Form for Non-Council Committee Appointment is now available online and will be mailed to all members later this year. Fill it out and return it to the attention of the College Registrar Irwin Fefergrad on or before the deadline of Wednesday, November 24, 2010 at 9:00 a.m.

How does the selection process work?
When the application forms are received at the College, they are reviewed to confirm that all the eligibility criteria have been met.

Then a file card is created and sealed in an envelope with the district number as the only identifying information on the front. At the time of selection, the Registrar opens the sealed envelopes, district by district, in front of two scrutineers. The cards for each district are shuffled and one file card is selected at random.

You are only eligible for random selection in the electoral district in which your designated address on the Register is situated on the eligibility date.

Can I choose which committee I sit on?
If your name is selected, the Executive Committee will request your resumé which you must provide within five days. When you forward your resumé to the College, you may include a covering letter listing your committee preferences, if any, and the Executive Committee will then review this information to help place you on the most appropriate committee.

If selected, when do I start?
You start with the first committee meeting in 2011, usually within the first month or so of the beginning of the new year. You may also be asked to attend special education or orientation sessions.

Who do I call if I still have some questions?
The College Registrar Irwin Fefergrad is available to answer any questions that you might have. His direct line is 416-934-5625, toll-free at 1-800-565-4591, or he can be reached by e-mail at ifefergrad@rcdsso.org.
WHAT’S INVOLVED IN COMMITTEE WORK

INQUIRIES, COMPLAINTS AND REPORTS
1 day/month
Reviews public complaints and Registrar’s investigations.

DISCIPLINE
10 days/year
Hears and determines allegations of professional misconduct or incompetence.

FITNESS TO PRACTISE
3 days/year
Determines if a dentist is incapacitated, is suffering from a physical or mental condition or disorder.

QUALITY ASSURANCE
6 days/year
Responsible for the continuing competence of all dentists to ensure maintenance of standards of practice.

PATIENT RELATIONS
3 days/year
Responsible for College’s interaction with the public and dentists on professional conduct issues, especially those of a sexual nature.
PLP Committee Openings...
An invitation to get involved

Interested dentists are invited to apply for the two upcoming vacancies for dentist members on the College’s Professional Liability Program (PLP) Committee. These opportunities might especially appeal to dentists who have experience and/or are interested in the legal process. Also, because of the Committee’s work, its composition benefits from a mix of specialists, as well as some seasoned general practitioners.

What is the mandate of the PLP Committee?

The PLP Committee makes recommendations to Council on the policies and practices of the professional liability program and authorizes some claim settlements and also considers requests from dentists with a previous claims history for a reduction in their applicable deductible payment. This is done with the understanding that the dentist has completed or is willing to complete practice improvement courses and programs approved by the Committee.

How do I know if I am eligible to be appointed to the PLP Committee?

You are eligible if you can say “yes” to each of the following criteria on the deadline date for receipt of nominations.

- You hold a general or specialty certificate of registration and are actively practising dentistry.
- You are not in default of any fee or fine payments to the College or in default of returning or completing any prescribed forms.
- You are not currently the subject of a disciplinary or incapacity proceeding.
Three years have elapsed since you complied with an order from the Discipline Committee or the Fitness to Practise Committee.

Three years have elapsed since you have been found guilty of an offence under the Criminal Code of Canada or complied with any penalty.

You do not have any terms, conditions or limitations placed on your Certificate of Registration, other than ones that are applicable to all members holding that class of certificate.

Three years has elapsed since you were disqualified from sitting on Council because of a breach of the Colleges Code of Conduct for Council members or the conflict of interest by-law.

During the previous two years, you have not been a director or other member of the board of directors, governing council, or other governing body, or an officer or appointed official of the Canadian Dental Association, Ontario Dental Association, a national or provincial dental specialty association or similar organization.

You are not, and have not been, engaged as a dental consultant to a third party dental benefits provider during the previous three years.

What is the time commitment?
The time commitment for the PLP Committee is about four to five days a year.

Am I compensated for my time away from my practice?
Yes, your compensation would be the same as for Council members. The current honorarium is $965 per day, with other reasonable expenses, such as travel, accommodation and meals reimbursed.

How long am I committed?
These positions are for a three-year term, running from 2011 to 2014.

What is the selection process for the PLP Committee?
After the deadline for receipt of applications, the Registrar prepares a list of all eligible candidates. This list and the resumés are given to the Executive Committee which, in turn, prepares a list of recommended appointments, ranked in order of preference. Then, at the first Council meeting after the Executive Committee has made its ranking, Council confirms the selection.

If selected, when do I start?
You would start with the first committee meeting in 2011. You may also be asked to attend a special education or orientation session.

I am interested. How do I submit my name?
It is easy. Just submit a letter of application and a current resumé to the College's Registrar Irwin Fefergrad. Your application must be received on or before Wednesday, November 24, 2010 at 9:00 a.m.
As you know, election time for Council is quickly approaching. It is the College's protocol to provide all candidates with a list of constituents in the candidate's electoral district and with mailing labels. This information may be used by the candidate for election and campaigning purposes.

The member's address provided to the candidate is the designated register address of the member, which is the address in Ontario where the member practises (business address). If the member does not practise, the designated register address is the address in Ontario where the member resides.

If the dentist's home address is the designated register address (in other words, there is no practice address available), that address will be provided to the candidate so that all members entitled to vote in the election will be able to receive election materials.

If you are a member whose designated address is your home address and you do not wish it to be provided to the candidate, you must inform the College in writing before October 1, 2010.

Please send your written notice to:

Julie Wilkin
Supervisor, Registration
6 Crescent Road
Toronto, ON M4W 1T1
jwilkin@rcdso.org
Everyone should be able to work without fear of violence or harassment in a safe and healthy workplace. Violence and harassment in the workplace are not tolerated in Ontario. The Bill 168 amendments to Ontario's Occupational Health and Safety Act (OHSA) will come into force on June 15, 2010. Any employer with more than five workers must implement the provisions.

These amendments are designed to strengthen protection for workers from workplace violence and address harassment at work, and will apply to all workplaces to which the OHSA currently applies.

The OHSA expands the definitions of workplace violence and workplace harassment and requires the employer:

- to prepare policies with respect to workplace violence and workplace harassment;
- to review those policies annually;
- to develop a program to implement workplace violence policies.

Workplace violence includes “a statement of behaviour that is reasonable for a worker to interpret as a threat to exercise physical force against the worker, in the workplace, that could cause physical injury to the worker.”

Workplace harassment means “engaging in a course of vexatious comment or conduct against a worker in a workplace that is known or ought reasonably to be known to be unwelcome.”

The policy that the employer develops must include measures for workers to report incidences of workplace harassment and how the employer will deal with them.

The Act also requires that a committee be struck to assess the risks of the workplace.

If dentists want further information on the provisions of the statute, they should contact their own lawyer or get in touch with the College Registrar.
The College is advising members, on a go forward basis, to reconsider the wisdom of providing dental treatment to romantic partners and spouses, as a result of an Ontario Court of Appeal decision in February. While the College received a letter in 1995 from the Minister of Health permitting treatment of spouses, that landscape appears to have changed.

The appeal court unanimously ruled that even if a regulated health care provider's sexual relationship with a partner predated their professional relationship, that provider has committed sexual abuse and risks losing his or her licence for at least five years, if a complaint is filed and there is a referral of specified allegations of professional misconduct to the Discipline Committee.

The court's decision applies to 26 health professions and the more than 256,000 health care providers in Ontario governed by the Regulated Health Professions Act (RHPA), including dentists.

The zero tolerance rule in the Health Professions Procedural Code,
which is part of the RHPA, stipulates that a health care professional governed by the RHPA who has “sexual intercourse” with a “patient” shall have his/her licence revoked for a minimum of five years, if there is a finding by the Discipline Committee following a complaint or an investigation.

According to the appeal court’s judgement, the Code’s provisions do not exempt the health care practitioner from either liability for sexual abuse or from the mandatory penalty, where the health care professional and the patient are having sexual intercourse in the context of a relationship as spouses or a spousal-type relationship.

There is no room for interpretation. The appeal judges went on to state that “when it comes to sexual relations between a doctor and a patient, there is a black letter, bright line prohibition with a drastic sanction and no exceptions or exemptions. The zero tolerance policy precludes inquiry into any explanation or excuse for the sexual activity. A patient’s consent is irrelevant.”

The appeal court recognized that it “may appear that the strict and significant mandatory penalty that follows from a conviction for professional misconduct by sexual abuse is harsh and arguably unjust in cases where there is a consensual sexual relationship and no exploitation by the health care professional. However, the panel found that the importance of upholding the zero tolerance policy outweighs its pitfalls because the legislation is there to address a growing problem of sexual abuse of patients by some health care professionals.”

The court made a minor exception for what it calls “incidental” care, which covers off situations of emergency care. The court said “it would be unreasonable for a spouse to be denied treatment in such circumstances.”

The court said that if the government wished to provide exceptions it would have done so when it amended the Regulated Health Professions Act in June 2009. The fact that it did not means that it is the law of the land.

This matter arose out of a decision at another College, the College of Chiropractors of Ontario. The issue arises only when there is a formal complaint or formal information leading to an investigation conducted by the College.
Ethical Dilemma Case Study

“‘You’re the Doc, I trust you... just do it!’”

The Ethics of Obtaining Informed Consent

What Would You Do?

John K is a new patient in Dr. M’s practice. John became a patient on the recommendation of his sister Anne, who is also a patient of Dr. M. John works for a large electronics firm and lives less than 15 minutes from the practice. As a sales agent, he travels about 15 days a month. At the age of 32, he has made excellent progress in his company and, other than the pressure cooker environment of sales, he enjoys his work.

John’s medical history reveals a five-year history of borderline hypertension monitored episodically by his physician. Other than this blood pressure concern, his general health is good. However, his oral health reveals the ravages of neglect, with most of his posterior teeth requiring buildups and crowns.

As a child, he disliked his dentist and in general is fearful of dentists. He saw this dentist primarily for emergency care. Both mandibular first molars were extracted ten years ago and he now wants implants to replace these teeth.

After a thorough evaluation, gathering of diagnostic information and careful treatment planning, Dr. M asked John to meet to review his recommendations and concerns. Three-unit bridges are
a reasonable alternative to implants as all of the abutment teeth require crowns. Also, the bone loss in the area makes the placement of implants more complicated.

As Dr. M begins to discuss the complexity of the case and particularly the risks of implants, John raises his hand and says, “Hey, you’re the Doc! You just tell me when to come and I will be here. I don’t need to know what you are planning. Just show me where to sign the consent form. I trust you, and I’ll pay what my dental insurance doesn’t… just do it! I really hate to hear the gory details, and I don’t understand them anyway.”

Dr. M is facing an ethical dilemma. What would you do?

◆ **Have John sign the consent form and proceed with the plan including the implants.**

◆ **Insist that John listen to the treatment alternatives and risks before any treatment is started.**

◆ **Initiate minor care, but not proceed with complex care, included fixed bridges or implants, without further consultation with John.**

◆ **Dismiss this non-compliant patient from your practice.**

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Now turn to page 50 to find the discussion about this ethical dilemma.
Complaints Corner is designed as an educational tool to help Ontario dentists and the public gain a better understanding of the current trends observed by the College’s Inquiries, Complaints and Reports Committee.

These scenarios are an edited version of some of the cases dealt with by the Committee. The law does not allow for either the dentist or the complainant to be identified.

**COMPLAINT SUMMARY**
A parent filed a complaint about the care of his minor daughter by a pediatric dentist. The father complained that the dentist:

- recommended unnecessary restorative treatment to be performed under a general anesthetic;
- took advantage of him due to his dental insurance coverage;
- failed to provide him with treatment options;
- assaulted his young daughter.

**DENTIST’S PERSPECTIVE**
Notified of the formal complaint, the dentist provided the College with a response and his patient records.

He stated that the child’s father brought his daughter to his office for a consultation appointment on April 2, 2009. The primary concern was a cracked tooth 62 (upper left primary lateral incisor) which seemed to be deteriorating. On examination, he noted very poor oral hygiene with moderate to heavy plaque accumulation and carious lesions on the following tooth surfaces:

- tooth 55 (upper right 2nd primary molar) occlusal-lingual
- tooth 54 (upper right 1st primary molar) vestibular
- tooth 51 (upper right primary central incisor) mesial
- tooth 61 (upper left primary central incisor) mesial
- tooth 62 (upper left primary lateral incisor) mesial-incisal-vestibular
- tooth 65 (upper left primary 2nd molar) occlusal-lingual
- tooth 75 (lower left primary 2nd molar) lingual-vestibular
- tooth 83 (lower right primary cuspid) vestibular
- tooth 85 (lower right 2nd primary molar) vestibular-lingual

**Clear Communication with Parents Key to Avoiding Misunderstandings When Treating Minor Patients**

**Case No.1**

Clear Communication with Parents Key to Avoiding Misunderstandings When Treating Minor Patients
The dentist recommended a general anesthetic to properly and safely perform the necessary restorative treatment. This decision was based on the patient’s age, potential behavioural management issues and the type and extent of treatment required.

The dentist explained that radiographs were not taken at this appointment because of the likelihood that the patient would not co-operate and they could be deferred until the general anesthetic appointment.

The member stated that it was customary to inform parents of the possibility of additional treatment at the time of the anesthetic appointment, when the radiographs are reviewed and the treatment plan finalized.

In his response, he denied recommending unnecessary treatment because there was insurance coverage and he took offence at the father’s suggestion in the letter of complaint that he would assault a child.

A copy of the member’s response was sent to the complainant for his information and the child’s father provided further comments disputing the dentist’s version of events.

**Additional Information**

As part of its investigation, the College obtained records from the previous/subsequent treating general dentist.

His clinical chart entry dated April 28, 2009 (after the examination appointment with the pediatric dentist) stated:

*Spec exam Tx 65 OL caries, 75 L – pit. 83V demineralized, 85 LV demineralization, 55 OL caries, 54 V demineralised, 61M caries, 51M caries, 62 caries, crowded accumulates plaque, passive eruptive, class I, pt has high affinity for decay. Specialist recommends fluoride rinses, does not recommend sealants.*

**REASONS FOR DECISION**

The panel reviewed all correspondence and records obtained during the course of its investigation, including documentation submitted by the parent, pediatric dentist and the previous/subsequent treating general dentist.

In his letter to the College, the parent alleged that the pediatric dentist had recommended unnecessary treatment and took advantage of him due to the anticipated insurance coverage. The panel compared the records of the specialist to those of the general dentist who examined the child a few weeks after the specialist’s examination.

The panel could see that the general dentist had essentially made note of the same possible treatment as the pediatric dentist. Therefore, they accepted that the pediatric dentist, as the specialist, had the experience to recognize the likely prognosis of a patient’s primary teeth given the level of oral hygiene.

In this case, the child presented with poor oral hygiene and abundant plaque. The panel accepted that the member appropriately exercised his professional judgment and his treatment plan was reasonable. However, the panel suggested to the member that it would have been helpful to have had a more extensive discussion with the parent about the areas of demineralization that could quickly develop into areas of decay that required treatment.

In the panel’s opinion, there was no unnecessary treatment recommended and the member did not take advantage of the complainant because of his insurance coverage.

As for the parent’s complaint that he was not provided with treatment options, the panel
Complaints Corner

acknowledged that since no radiographs or photographs were taken because of the anticipated lack of co-operation from the young patient, it was reasonable that it was not possible to review and discuss a definitive treatment plan.

With regard to the allegation of assault, the panel did not accept that there was any assault or that performing the recommended and necessary treatment would be considered as assault.

For the reasons stated above, the panel decided that no further action with respect to this complaint was required.

Case No.2

COMPLAINT SUMMARY
A complaint was filed against a general dentist by a mother on behalf of herself and her minor son. With respect to herself, she said that the dentist failed to diagnose and treat the decay present on tooth 18 (upper right 3rd permanent molar). With respect to her minor son, she expressed dissatisfaction with the way that the dentist had spoken with him.

DENTIST’S PERSPECTIVE
The dentist was notified of the formal complaint and provided the College with a response and her patient records for both the mother and the child.

In her response, the dentist stated that the mother attended her office on November 13, 2008, for hygiene treatment performed by a registered dental hygienist. Then, on November 18, 2008, she performed a new patient exam and took a full mouth series of radiographs. The patient did not report any areas of concern at that time. She discussed a treatment plan with her which included distal-occlusal restorations for teeth 16 (upper right 1st permanent molar) and 25 (upper left 2nd bicuspid). This treatment was completed on November 27, 2008.

On the same day, the mother returned to the office with her son for his dental appointment. At that time she asked if there was a hole in the upper left quadrant. While the mother was seated in the dental chair, the dentist told her that the tooth had been cut open to remove the decay and a restoration placed. However, as normal, there was a space between the teeth (the interproximal space). The dentist said that the patient appeared to be satisfied with this explanation.

On January 11, 2009, the mother then saw a colleague of the dentist for a same-day emergency appointment. A periapical radiograph was taken and an antibiotic and pain medication prescribed. Arrangements were made for her to see an oral and maxillofacial surgeon on March 5, 2009, for the extraction of tooth 18. The records show that the patient had declined to see another practitioner at an earlier date.

The dentist explained that, on review of the radiograph dated November 18, 2008, she saw the suggestion of a lesion on tooth 18 which had not been clinically visible. She said her usual practice is to view the radiographs on a view box and call out her observations to her assistant to record in the patient chart. The member said that she can only assume that an error was made in this charting. The member commented that, given the extent of decay, it would be likely that the tooth would have required endodontic treatment or extraction in any event. She regretted that the matter was not dealt with earlier.
With respect to the allegation involving the complainant’s minor son, the dentist responded that the office policy is to have parents remain in the waiting room, as some children behave better when their parents are not present.

The member commented that, despite this policy, the mother did come into the operatory during her son’s appointment. It was obvious, the dentist said, that the child was significantly agitated when he arrived for his appointment as his mother had told him numerous times that he would be getting a needle.

As a result, the dentist decided she would not use a needle and instead try to place the restoration without local anesthetic. A topical anesthetic was applied and cotton roll isolation was used along with new dental burs to minimize patient discomfort. It was the dentist’s opinion that the patient seemed to tolerate the treatment well, but was agitated by the level of noise and chaos in the operatory.

She also noted that the child’s mother was “simultaneously talking to and vigorously jostling a fussing baby in her arms while chastising her son.”

The dentist explained that her usual practice with child patients is to speak in a soothing, warm and compassionate voice, encourage the patient, provide explicit explanation of what is being done and provide instructions to breathe and relax. Children are given an opportunity to look, touch and understand the tools being used. The member reported that she has an excellent reputation with children and parents using these techniques.

In this case, given the noise level in the room and the multiple authority figures present, the patient’s behaviour worsened. So the dentist altered her usual techniques and used a firm but kind voice to advise the child that, if he could not behave, his Mom and baby would have to wait for him in the waiting room and the fillings would still have to get done. This firm statement was followed by a comment made in a softer voice, such as, “so, let’s just get finished quickly and you get to go home, okay sweetheart.” The member denied threatening, punishing or screaming at the child.

In the usual course, if patient compliance is still not attained, the dentist said a referral is made to a pediatric dentist.

The member apologized for not discussing the voice modulation technique with the child’s mother before she used it. She had thought that the complainant would inherently understand what she was doing. The member also said that she was sorry that the mother was not aware that being in the treatment room was a privilege and not the office’s usual protocol. The member commented that her experience with this minor child confirmed for her the benefit of the practice protocol of not allowing parents in the treatment room.

Along with her response, the dentist provided a letter from her colleague and her dental assistant recounting their recollection of the patient and her child.

A copy of the member’s response was sent to the complainant for her information.

**Additional Information**

As part of its investigation, the College obtained correspondence and records from the complainant’s subsequent treating general dentist. In his correspondence, the general dentist stated that the complainant attended
Complaints Corner

the office on January 19, 2009, for a consultation appointment regarding discomfort in the upper right side of her mouth.

An examination and radiograph revealed buccal decay on tooth 18 and a periapical radiolucency around the apex of the tooth. The patient was provided with the treatment options and later another dentist removed tooth 18 under general anesthesia.

REASONS FOR DECISION
The panel reviewed all correspondence and records obtained during the course of its investigation.

As for the patient’s complaint that her general dentist failed to diagnose and treat decay on tooth 18, the panel could see from the records that the patient had gross calculus on her teeth when she first attended the office. Therefore, the panel suspected that the hole she perceived could have been due to calculus removal.

The panel acknowledged that the dentist did agree that she failed to note the caries on the buccal of tooth 18 and/or that the carious lesion was not recorded in the chart. The panel viewed the pre-treatment radiograph dated November 18, 2008, and agreed that the presence of decay was clear on the film and that it should have been noted in the chart and treatment plan.

The panel could also see that the subsequent treating practitioner appropriately addressed the complainant’s pain in tooth 18. Unfortunately, although the oral and maxillofacial surgeon to whom the patient wished to be referred had a long wait list, the complainant declined to be referred elsewhere.

The panel accepted that it was an unfortunate and inadvertent occurrence that the decay on tooth 18 was not documented nor treatment planned. The panel took the opportunity to remind the dentist that she must thoroughly document areas of concern and suggested she might wish to review her treatment plan with patients when they returned for treatment.

The complainant was also dissatisfied with the member’s conduct towards her minor son. The panel reviewed the information related to this allegation, including the corroborating information from the dental assistant. The panel accepted that the member’s conduct was appropriate, noting that the appointment in question was obviously a stressful situation for all involved.

The panel noted that the dentist used known and widely accepted patient management techniques. The panel suggested that it is a matter of choice for an office to determine whether or not parents are allowed in the operatory during treatment of their child. They noted that the mother could choose to seek care for her son at a different office if she was dissatisfied with this office’s child management practice.

Based on its review and deliberation of this matter, the panel decided to take no further action with respect to this complaint.
learning points

• It is important that office policies regarding child management philosophies and practices are communicated to parents of current and future patients so there are no misunderstandings. This might be done with a “Welcome to Our Office” information package. Parents who are not comfortable with these policies would then have an opportunity to seek services elsewhere for their child/children.

• In situations with a very young child with rampant caries when it is impossible to do a clinical examination and radiographs without a full examination, radiographs and treatment under sedation or anesthesia, it is crucial that parents understand the uncertainty of the treatment needs and that a full and final treatment plan will not be possible until the sedation/anesthesia appointment.

• In addition to this explanation, as part of the informed consent process, the parents also need to be informed of the worst case scenario as it may not be possible for the dentist to leave the operatory when the child is sedated/under anesthesia. Extra time and attention needs to be taken to make sure that there are no misunderstandings, financial or otherwise, once the treatment is provided.
Over the years, PEAK has provided members with several articles related to the assessment and management of caries. In 2002, for example, PEAK provided members with an article from Quintessence International, entitled “Minimal Intervention: A New Concept for Operative Dentistry.” This article advocated a shift in philosophy toward minimal intervention in restorative dentistry and, among the key observations, pointed out that affected (lightly demineralized) dentin at the base of a cavity is relatively sterile and can be remineralized. This fact is particularly relevant in proximity to the pulp.

The consequences of pulp exposure from caries, trauma or operative misadventure can be significant, often requiring either root canal therapy or extraction of the tooth. An alternative to these procedures is pulp capping, which involves the placement of a medicament over an exposed pulp (direct pulp cap) or residual caries (indirect pulp cap), with the intention of maintaining pulp vitality.

With the current issue of Dispatch, PEAK is pleased to offer members the following article: “Keys to Clinical Success with Pulp Capping: A Review of the Literature” from the September/October 2009 issue of Operative Dentistry. The article begins by reviewing the basic principles of pulp capping and emphasizes that the key to pulp survival following such procedures is the placement of a well-sealed restoration. It then describes both indirect and direct pulp capping procedures, along with an evaluation of specific direct pulp capping materials.
key points to consider

- Avoid exposing the pulp. The chances for tooth survival are excellent if the tooth is asymptomatic and well sealed, even if residual caries remain.
- If the pulp is exposed, control hemorrhage with water, saline or sodium hypochlorite. Water and saline are the most benign to the pulp, while sodium hypochlorite is the best at controlling hemorrhage and has antibacterial properties.
- Calcium hydroxide remains the “gold standard” for direct pulp capping. It has the longest track record of clinical success and is the most cost-effective of all materials.
- MTA demonstrates comparable results to calcium hydroxide as a direct pulp capping agent in short-term data.
- Zinc oxide and eugenol formulations, glass ionomers, resin-modified glass ionomers and adhesives are poor direct pulp capping agents and should be avoided for this use.
- Provide a well-sealed restoration immediately after pulp capping. This will provide protection against ongoing leakage and bacterial contamination that can compromise the success of the pulp cap.
Letter of Apology

After reviewing the article about my dental practice in the Summer 2009 edition of City Living magazine, I agree with the College’s finding that the statements made in this article violate the College’s advertising policies. We sincerely apologize for this violation and you can rest assured that this will not occur again.

The article was written on our behalf and our intention was to concentrate on the value of going to the dentist and preventing periodontal disease and to highlight the services we provide. We did not intend to state information that would not be in compliance with the College’s regulations.

We failed to thoroughly review the article prior to its publication and we sincerely apologize for this violation. We will be submitting our future promotional material to the College for review prior to their publication and distribution.

Dr. Hammad Afif

Dr. Evangelos Poulos

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

Mark Your Calendar…

2010 COUNCIL MEETINGS
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
Mishaps and patient complaints and then the inevitable stress that follows such incidences are a real and unfortunate aspect of the practice of dentistry. This article deals with strategies that dentists may want to consider and that might turn a mishap or complaint into a positive event for both the patient and the dentist.

1. CONSIDER OFFERING AN APOLOGY

With the 2009 passage of Ontario’s Apology Act, it became possible for health-care practitioners to offer a heartfelt apology in appropriate circumstances without the fear that such an expression of sympathy or regret might be seen as an admission of fault or liability on their part, opening the door to significant court awards.

Scenario

A teenage boy’s family had a longstanding arrangement with the family dentist, Dr. G, to have his wisdom teeth removed. In the meantime, unknown to Dr. G, the boy’s orthodontist had suggested removal of his upper first premolars. However, he sent the referral letter to the boy’s previous dentist, who had made the initial referral to the orthodontist, not to Dr. G.

At the pre-arranged appointment, Dr. G explained to the teenager what he was going to do and proceeded to remove his wisdom teeth. When the family learned that the wisdom teeth not the premolars had been extracted, they wrote a stinging letter to Dr. G accusing him of providing incorrect treatment. They demanded an explanation and hinted at some form of compensation.

After reviewing his records and requesting assistance from PLP, Dr. G decided to telephone the teenager’s parents. He reviewed his chart entries with them and explained the longstanding nature of the wisdom tooth appointment. He also explained that the request for the removal of the premolars had not gone to him.

In addition, Dr. G apologized for the communication lapse that had obviously occurred and offered to see them in person if they wanted a further explanation. Afterwards, the family contacted the office, thanked the dentist for the courtesy that he had shown them and booked an appointment for the removal of the premolars.

2. CONSIDER WAIVING YOUR FEES

While not applicable to every situation, the waiving of fees or the adjustment of fees already charged may be a way to defuse a situation when an unforeseen event arises.

And, from a business perspective, it may prove to be a small investment compared to the personal and practice costs associated with dealing with a formal complaint or lawsuit.

Scenario A

Dr. W was performing endodontic treatment on an upper molar when an instrument separated in the mesiobuccal canal. Her attempts to remove the instrument failed. To make matters worse, she had fallen behind schedule and there were a number of patients waiting to be seen. The stress was mounting so she considered her options.
Dr. W decided to pretend that nothing had happened. She obturated the tooth to the best of her ability but was unable to seal the mesiobuccal canal. She charged the full fee and dismissed the patient without informing him about what had happened.

The tooth later became infected and the patient was seen by another dentist. It was this dentist who informed the patient of the presence of a separated file and the need for referral to a specialist for retreatment and/or surgery.

The patient lodged a complaint with the College and also filed a claim against Dr. W for malpractice.

The resultant legal, disciplinary, financial and emotional ramifications were significant. As well, Dr. W lost the opportunity to provide future treatment to the patient and his family.

It is clear that, while there seemed to be an immediate benefit to this option, the accompanying breach of trust between Dr. W and her patient made this a poor overall business and professional decision.

Scenario B

In another office nearby, Dr. F separated a file while nearing completion of endodontic treatment on a molar. She too was unsuccessful in removing the file, was behind in her schedule, and had to decide how to handle the situation.

Dr. F decided to stop the procedure. She put the chair in an upright position and advised the patient what had happened. She then recommended immediate referral to a specialist for removal of the separated instrument followed by completion of endodontic treatment. She told the patient that, as a goodwill gesture, she would not charge a fee for the treatment she had provided that day.

The patient was seen by an endodontist the following day. The separated file was successfully removed and endodontic treatment was completed uneventfully. The patient returned to Dr. F for restoration of the tooth and soon after referred his wife and children to the practice.

THE DISCUSSION

When mishaps like the ones described occur, the patient may initially have doubts about the dentist’s skills and/or competence and the dentist may have concerns about the loss of chair time and potential loss of the patient to the practice.

The separation of an endodontic instrument in and of itself is not negligence – it happens to specialists too. However, often what a dentist does after such a mishap occurs has more of an impact on what happens next than the mishap itself. Not informing the patient and providing information about the possible

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
outcomes and treatment options, and/or not documenting such discussions, is what makes it difficult to defend a dentist when a claim is advanced against him or her.

Admitting that there has been an unforeseen complication and showing that the patient’s best interests are a priority by suggesting a referral often strengthens the relationship between the dentist and the patient.

With respect to the waiving of fees, the cost of such a decision may appear considerable at the time, but, as stated above, this action could result in any number of positive outcomes such as:

- The patient knows that a difficult situation has been handled competently and compassionately and his/her best interests were the primary concern. The relationship between dentist and patient is strengthened.
- The dental specialist that the patient is referred to is comfortable that the patient has been fully informed of the circumstances of the mishap and the reason for the referral. The relationship between dentist and dental specialist community is strengthened.

The patient may opt to have the original dentist complete the procedure and, in this case, the fee may not be waived. If, however, the procedure eventually fails and the tooth is lost, it may be advisable to consider applying the root canal fee towards the tooth replacement costs, not as an admission of liability but strictly as a goodwill gesture. Or, if referral to a specialist is required, you might want to consider applying the root canal fee towards the specialist’s fees.

CONCLUSION

Studies of patients who have filed malpractice suits show that almost half of those said they might not have filed suits if they had been given an explanation and apology.

Since the Apology Act has come into force, an apology is seen as a sign of compassion, not guilt. Apologies are inadmissible in civil court. The Apology Act gives dentists the freedom to say they are sorry for a mistake or wrongdoing without worrying about surrendering in a lawsuit.

The waiving of fees or the making of an adjustment to fees already charged can be a viable strategy that may help to prevent or at least minimize the results of procedural mishaps or other patient complaints. Some dentists might consider this strategy as internal marketing while others may see it just as a good business decision. Whatever the reason, it can often defuse difficult situations and bring positive results to the practice.

ADVICE FROM PLP

Whenever a waiver/refund/adjustment of dental fees is under consideration as a result of a mishap or patient complaint, it is important that the details of any and all discussion with the patient are documented in his/her chart. The chart entry should clearly note that this is being done for public relations purposes and as a goodwill gesture. In many cases, some sort of written acknowledgement or release form signed by the patient may be justified.

Remember, before refunding money to a patient or paying other practitioners fees on a patient’s behalf, call PLP for advice and assistance to ensure your right to coverage is protected.
On Appeal

Complaint No.1

The complainant attended at the dentist’s office complaining of swelling in the area of the teeth 13 and 14. The dentist explained that he was unable to take a periapical x-ray because the machine was not working. However, he drained the area and provided the patient with an antibiotic prescription, recommended a hot salt water wash and asked the patient to return if the problem persisted.

The patient returned four days later, and since the x-ray machine was repaired, had two periapicals taken, which indicated decay and some endodontic involvement.

The patient declined endodontic therapy. He then returned six days later complaining about persistent swelling and sensitivity. The dentist again recommended endodontic treatment.

The patient attended again without an appointment and inquired why the swelling was still present. According to the complaint, the dentist said that when he could find a break in the schedule he would attend to him properly and asked him to wait in the waiting room.

Complaint No.2

The complainant stated that he attended at the dentist’s office in order to get an opinion on treatment he had received at another dentist’s office. He demanded a full set of radiographs and digital photographs of his teeth.

The dentist suggested that the complainant return to the original treating dentist to address these issues of concern, but the patient insisted on obtaining an opinion from this dentist for other purposes. The dentist suggested that the patient became rude and asked the patient to leave. The patient filed a complaint with the College alleging the dentist refused to provide “a service” to him and acted rudely.
INQUIRIES, COMPLAINTS AND REPORTS COMMITTEE DECISION
The Committee noted that no dentist can be compelled to act as an expert for another matter. It is a dentist’s choice to whether or not he/she wishes to provide either an expert report or opinion or indeed treatment of a non-emergency nature. The Committee ordered no further action.

HEALTH PROFESSIONS APPEAL AND REVIEW BOARD
The patient was dissatisfied and asked the Board to review the decision of the Committee. The Board found the investigation of the College was in compliance with the statutory requirements and then reviewed the reasonableness of the Committee’s decision. The Board found that the Committee’s decision was “reasonable... that a dentist cannot be compelled to act as a patient’s expert for another matter... ” The Board therefore confirmed the decision of the Committee.

Complaint No.3
The complainant filed a complaint with the College about the care provided around fabrication of dentures. The patient stated that, despite repeated visits, the dentures were unusable and that the dentist could not repair the problem, even after several attempts.

INQUIRIES, COMPLAINTS AND REPORTS COMMITTEE DECISION
The Committee reviewed the clinical charts and records, as well as all of the materials, and noted that the patient was “fully informed of the treatment and alternatives, the fee...and the potential difficulties, prior to providing consent to the treatment.” The Committee noted that, while the dentist attempted to have the patient return for numerous appointments for adjustments, the patient missed many of these appointments.

The Committee, as well, reviewed the treatment and determined that the dentist met the standard of care. The Committee ordered no further action.

HEALTH PROFESSIONS APPEAL AND REVIEW BOARD
The complainant was dissatisfied and appealed to the Health Professions Appeal and Review Board. The Board noted that College obtained the patient’s complete record containing all relevant information about the issue raised in the complaint. The Board concluded that the investigation was reasonable. The Board accepted the Committee’s expertise to conclude that the treatment was within standards and therefore confirmed the decision of the Committee.
Ethical Dilemma Discussion

The Dental Ethics 101 Ethical Dilemma Case Study appears on page 34.

“‘You’re the Doc, I trust you... just do it!’”

The Ethics of Obtaining Informed Consent

What should a dentist do when a patient waives his or her right to informed consent?

Should the dentist choose what is in the patient’s best interest?

Should the dentist force the patient to hear the consent information?

Is it legal or ethical to proceed when the patient waives his or her right to consent?

Waiver and (Un)Informed Consent

John waived his right to consent when he interrupted Dr. M and deferred to the doctor’s expertise. The courts have recognized that there may be valid justification for overriding the legal doctrine of informed consent. Those cases include a patient waiver, emergency treatment, a public health emergency, an incompetent patient and therapeutic privilege.

The patient waiver is unique because it is a voluntary act of a competent patient not to receive information or to participate in decision-making. Courts have defined a waiver as a voluntary and intentional relinquishment of a known right.

Compare this to situations where consent may be difficult to obtain, as in emergency situations, or when the patient is incompetent.

Therapeutic privilege is also dissimilar because it is the doctor who makes assumptions about the patient’s competence and deliberately chooses to withhold information to protect the patient’s best interest. Therapeutic
privilege disallows the patient’s participation in decision-making and is often viewed as unjustified paternalism.

Most dental regulators and associations advise that, as part of the informed consent process, dentists should inform the patient of the diagnosis and proposed treatment, any reasonable alternatives, and the material risks and benefits of all treatment options.

In this case, John has waived his right to consent in two ways. First, he waived his right to information when he interrupted Dr. M and said, “I really hate the gory details, and I don't understand them anyway.” He also waived his right to decision-making and delegated this right to Dr. M, when he said, “You're the Doc! I trust you… just do it!” So John had both requested to be uninformed and chose to delegate this decision-making authority to the doctor, thereby freeing the doctor from the disclosure duty.

In essence, John is willing to trust the dentist’s professional judgment. But how important is the trust between the dentist and patient?

**Mutual Trust**
John interrupted Dr. M to tell him that “I trust you – Just show me where to sign the consent form” and waived his right to information and decision-making. What is the basis for his trust in Dr. M? Should Dr. M proceed with treatment, and if so, what treatment? Should John agree to treatment without knowing that there are differences in the risks involved in each treatment and those specific to his situation?

Dr. M has not provided any care except the initial examination for John. So why would John “trust” his dentist? Dr. M may have expected that trust from Anne, John’s sister and source of the referral. Perhaps John has read the public opinion polls that rate dentistry consistently as a highly trusted profession. However, it is unclear if John’s decision is based on trust, fear of dental procedures, economics, or just convenience.

**Overriding the Waiver**
When a patient chooses not to become involved in treatment decisions, has the dentist fulfilled all ethical and legal obligations?

The literature is clear that while the courts recognize the existence of a patient waiver, there are important problems of definition and application. Some would argue that a patient’s waiver of the physician’s or dentist’s obligation to disclose and obtain the patient’s consent should be accepted only after a committed effort has been made to explore the underlying reasons for the patient’s abdication of decision-making responsibility.

There are clear differences in the risks and benefits between implants and the three-unit fixed bridges generically, and the level of risk for implants for John specifically. While it may be legally an option to honour a patient’s waiver, Dr. M would be ethically remiss by not discussing the differences of these risks with John.

**Conclusion**
While John has waived his right to informed consent, Dr. M must still decide how to proceed. Patients who choose to waive their right to informed consent do not release the

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The above discussion is reprinted in part from the Texas Dental Journal of the Baylor College of Dentistry with permission.
dentist from his or her ethical obligation to discuss the patient's right to information and to participate in the decision-making process. When a patient says, “You're the Doc . . . just do it!”, the dentist is ethically justified in overriding the waiver because of the differences in the level of risks involved in each procedure, and those due to specific patient variation.

For these reasons, prudent practitioners should not deviate from the full informed consent process, which includes:

- informing patients of the nature of their oral health problems;
- recommending a preferred treatment plan and the risks and benefits of this treatment;
- discussing all other treatment alternatives and their associated risks and benefits;
- informing the patient about the consequences of not proceeding with treatment;
- giving the patient an opportunity to ask questions and think about the issues previously discussed;
- providing cost estimates for the various treatment options;
- documenting the fact that all of the patient's questions were answered and that his or her consent was obtained.

You’re the Doc, I trust you...just do it!”

The Ethics of Obtaining Informed Consent

INFORMED CONSENT IN THE DENTAL OFFICE

The College's latest learning package called Informed Consent in the Dental Office is full of useful and practical advice. One of the highlights of the CD is how the abstract theoretical concepts are illustrated with real life situations and case studies.

The last chapter on the CD, called Practical Tools, contains three downloadable checklists designed to assist you in implementing the informed consent process in your office. They are:

- Informed Consent Checklist
- Incapable Adult Checklist
- Children Under 16 Checklist

This CD was distributed at no charge to all members of the College in November 2009.

TAKE THE QUIZ

As usual with our LifeLong Learning CD-packages, at the end of the course you have the option of taking the self-test quiz and collecting 15 CE points. This is a significant contribution to the 90 CE points that all members are required to obtain every three years. There is a $250 administrative fee to apply for the points. All the information you need about how to take the quiz and to collect the CE points is on the CD. If you have any questions about CE points, please contact Joanne Loy in our Quality Assurance department at 416-961-6555, ext. 4703, toll-free at 1-800-565-4591 or by e-mail at jloy@rcdos.org.
In December 2009, the Provincial Infectious Diseases Advisory Committee (PIDAC) released a new document entitled Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings. Over 150 pages long and citing more than 200 references, this document provides detailed recommendations for cleaning and disinfecting all environmental surfaces, including clinical contact and housekeeping surfaces.

The Ministry of Health and Long-Term Care established PIDAC in 2004, following Ontario’s SARS outbreak. PIDAC brings together respected experts in infection control, infectious disease, medical microbiology, public health, epidemiology and occupational health and safety. Its purpose is to advise the province’s Chief Medical Officer of Health on prevention, surveillance and control measures necessary to protect the people of Ontario from infectious diseases.

The working group that developed the College’s new Guidelines on Infection Prevention and Control in the Dental Office reviewed the PIDAC document while it was still in draft form. Now that it has been finalized, the Guidelines available on the College’s website have been updated to include a reference to this document in Appendix 2: Additional Resources and Reference Materials Available on the Internet.

To date, PIDAC has published 10 Best Practices documents on various infection prevention and control topics, including:

- Routine Practices and Additional Precautions in All Health Care Settings, 2009
- Best Practices for Hand Hygiene in All Health Care Settings, 2009

For more information about PIDAC and a complete list of its Best Practices documents, please visit www.health.gov.on.ca and search PIDAC.
Best practices for the secure destruction of personal health information

A patient’s dental records can speak to a great deal. By their very nature, the personal health information in dental and medical records is among the most privacy-sensitive when it comes to one’s personal information.

As Ontario’s Information and Privacy Commissioner, Dr. Ann Cavoukian, has said: “A single medical record can reveal a great deal about an individual including recreational and lifestyle habits, or major health issues, all of which can result in potentially devastating consequences if revealed to family, friends or employers.” The information management practices of health care providers have very real and lasting consequences for their patients, explained the Commissioner.

To assist the health care industry to deliver functional services and ensure the security of personal health information, the Privacy Commissioner has released an educational paper called, Get Rid of It Securely to Keep It Private: Best Practices for the Secure Destruction of Personal Health Information. It was written in collaboration with the National Association for Information Destruction.

The publication outlines a number of best practices that can be employed in the secure destruction of personal health information records. These include:

• developing a secure destruction policy that is clear, understandable and leaves no room for interpretation;
• segregating and securely storing records;
• determining the best methods of destruction;
• documenting the destruction process;
• considerations before employing a third-party service provider;
• disposal of securely destroyed materials;
• ensuring compliance.

The publication was created in response to several recent orders issued by the Commissioner. One order was about records containing personal health information found scattered on the streets in Ottawa outside a medical centre housing a medical laboratory. The other order dealt with the discovery of patient health records found blowing around downtown Toronto streets.

This publication can be downloaded free of charge from the IPC/O website at ipc.on.ca.
FOCUS ON DENTAL RECORDS

Dentists are required by the Personal Health Information Protection Act, the regulations made under the Dentistry Act, 1991 and by the College’s Guidelines to maintain patient confidentiality when disposing of records after the required retention period for dental records ends. Dentists who wish to destroy records on-site in dental offices can discard photographs, radiographs and models in the garbage once patient identification/identifying labels have been removed, obliterated or rendered illegible.

Some dentists may have large volumes of records to sort and dispose of at one time and may want to have a shredding or information destruction company destroy and dispose of these records for them.

For dentists who wish to enter into a contract with a shredding company to provide these services, radiographs, photographs, models, radiographic mounts (both rigid plastic and flexible vinyl), small metal objects (paperclips, staples and brads from dental charts) and electronic media can be shredded by various types of commercial shredding machines.

An acceptable alternative to shredding of these materials is incineration.

Dentists should ensure that the shredding service providers can meet the dentists’ confidentiality agreements before entering into any contractual agreements. The Privacy Commissioner suggested that you look for a provider accredited by an industrial trade association or willing to commit to upholding its principles, including undergoing independent audits. Check references and insist on a signed contract spelling out the terms of the relationship.

AS FOR RECYCLING

The Privacy Commissioner has stated in the past that “recycling does not equal secure disposal” and that “the only acceptable method for disposing of records is to destroy them by a method that ensures the information is completely obliterated, for example, by irreversible shredding of the documents.”

Once paper records have been shredded, as required, then the white paper can be recycled. Once patient identifiers, mounts and other materials are removed from radiographs, the silver in the radiographic emulsions on developed radiographs can be recovered and recycled.
Privacy Commissioner expects health sector to encrypt all health information on mobile devices: Nothing short of this is acceptable

Ontario Information and Privacy Commissioner Dr. Ann Cavoukian has directed the province’s health sector not to remove any personal health information on mobile devices from their premises – unless this very sensitive information is encrypted, as required in a health order issued in 2007.

The Commissioner has also made it very clear that she expects all personal health information stored on any type of mobile device in Ontario to be protected with strong encryption.

"While I accept that custodians may not be able to totally eliminate the loss or theft of mobile devices, what I cannot accept is that the information contained therein is not encrypted," the Commissioner stated in an order released in mid-January.

"Unauthorized access to health information stored on these devices that happen to be lost or stolen may clearly be prevented through the use of encryption technology. However, despite strong incentives to avoid privacy breaches and the availability of encryption to prevent such breaches, unencrypted mobile devices continue to be used. This is both distressing and completely unacceptable."

The Commissioner’s health order was issued to address a privacy breach in Durham Region in mid-December 2009 that saw the loss of a USB key containing the health information of almost 84,000 patients who attended H1N1 flu vaccination clinics.

This incident was “very distressing,” said the Commissioner, “especially in light of the fact that I directed all Ontario health information custodians not to
transport personal health information on laptops or other mobile computing devices unless the information was encrypted.” This direction was included in a 2007 order under the Personal Health Information Protection Act (PHIPA).

“Our health orders set a minimum standard for what we expect from all health information custodians, all of whom are required to protect personal health information under PHIPA,” said the Commissioner. Every health information custodian in Ontario is subject to the Personal Health Information Protection Act and is required to protect personal health information.

“I want to make this very clear,” the Commissioner said. “No personal health information should be transported on mobile devices, unless the information is encrypted. This requirement is perfectly clear and encryption technology is readily available.”

The Commissioner’s investigation report on the incident in Durham Region was issued in January 2010. In March 2007, the Commissioner had issued guidance to the Ontario health sector as part of a health order (HO-004) to Toronto’s Hospital for Sick Children after a laptop computer containing the personal health information of 2,900 patients was stolen from a parked vehicle.

The Information and Privacy Commissioner is appointed by and reports to the Ontario Legislative Assembly and is independent of the government of the day.

For more information, visit the website of the IPC/O at www.ipc.on.ca.

The College is currently working on Guidelines for Electronic Records Management that will address emerging issues, such as mobile and wireless computing and the use of laptops, USB keys and e-mail.

ENCRIPTING PERSONAL HEALTH INFORMATION ON MOBILE DEVICES

In May 2007, the Office of the Information and Privacy Commissioner/Ontario released a fact sheet on encrypting personal health information on mobile devices.

This fact sheet explains why it is not acceptable to rely solely on login passwords to protect personal health information on devices that are easily stolen or lost. It also gives helpful information on how to encrypt and secure health information on mobile devices.

Recognizing that encryption software may be unfamiliar to those who have a responsibility for this level of data protection, the fact sheet lists several encryption solutions currently available with website addresses for more information.

This fact sheet is available on the IPC/O website at www.ipc.on.ca.
The Ontario government recently passed changes to the Needle Safety Regulation 474/07, made under the Occupational Health and Safety Act. These changes, which come into effect July 1, 2010, are intended to protect health care workers from needle-stick injuries by making the use of safety-engineered needles (SENs) mandatory where health-related services are provided, including dental offices.

Needle-stick and other percutaneous injuries pose the greatest risk of transmission of blood-borne pathogens (e.g. HBV, HCV and HIV) to health care workers.

The new regulation states that, when a worker is to do work requiring the use of a hollow-bore needle, the employer shall provide the worker with a SEN that is appropriate for the work.

The regulation also states that a SEN is not required if:

- the employer is unable, despite making efforts that are reasonable in the circumstances, to obtain a SEN that is appropriate for the work OR
- there are reasonable grounds to believe that, in the particular circumstances, the use of a SEN would pose a greater risk of harm than the use of a conventional hollow-bore needle.

The College has reviewed this issue and consulted with Dr. Dan Haas, Head of the Discipline of Dental Anaesthesia, Faculty of Dentistry, University of Toronto.

Although there are SENs available for the administration of intraoral local anesthesia, evaluations of these devices have reported concerns with their usability and, in some instances, an increase in needle-stick injuries. Accordingly, it appears that they are no safer and may pose a greater risk of harm than the conventional hollow-bore needles that dentists are currently using.
In contrast, there are reasonable alternatives for the administration of parenteral sedation and anesthesia, including SENs for intravenous and intramuscular procedures, and dentists using these techniques should investigate available options.

Dentists using hollow-bore needles and other sharp devices should consider safer versions as they become available in the dental marketplace. In addition, best practices should be implemented to prevent needle-stick and other percutaneous injuries, including the following:

- Always use extreme caution when passing sharps during four-handed dentistry.
- Needles should remain capped prior to use.
- Needles should not be bent, recapped or otherwise manipulated by using both hands.
- Following use, needles should be recapped as soon as possible by using a one-handed scoop technique or a commercial recapping device.
- When suturing, tissues should be retracted using appropriate instruments (e.g. retractor, dental mirror), rather than fingers.
- Remove burs from handpieces immediately following the procedure.
- Identify and remove all sharps from trays before cleaning instruments.
- Used sharps must be collected in a clearly labelled puncture-resistant container.
- When cleaning contaminated instruments by hand, heavy-duty utility gloves, appropriate clothing and long-handed brushes should be used.

The College will continue to monitor this issue and advise members of new developments as they arise.

For more information about preventing the transmission of blood-borne pathogens and managing significant exposures, please refer to the College’s Guidelines on Infection Prevention and Control in the Dental Office at www.rcdso.org.
Informed Consent CD: Take The Quiz and Collect CE points

Just a reminder that members who take the self-test quiz after completing all four chapters of the CD-based course have until December 31, 2011 to claim the 15 CE points towards their three year cycle.

Since this learning package was just distributed in late November 2009, this extra time will allow many more members to take the quiz and select the option to claim the 15 CE points during this time of transition to our new quality assurance program.

The College was just notified at the end of January that the College’s quality assurance regulation was passed by Cabinet. Check out the Quality Assurance section of the College website at www.rcdso.org for more information and a link to the new regulation.

More details about the College’s new Quality Assurance program will be shared with members as they become available.
The careful selection of employees is an important responsibility. A brief telephone call to a reference or a perfunctory interview is no longer enough. Thorough reference checking needs to be central to the hiring process.

By carefully checking business and professional references, employers can demonstrate that they used reasonable care in the hiring process. Careful reference checks also help ensure that candidates are right for the job and that they are who they claim to be.

If the candidate needs to hold a particular licence to practise, it is wise to check with the relevant regulatory college to ensure that they indeed hold the required certificate of registration and that their licensure is still valid. Since June 4, 2009, this information about regulated health care providers is available online on the website of the respective regulatory college.

Due diligence will pay off, even when under pressure to recruit quickly. The time investment made in thorough reference checking can pay off many times over in the long term because unfortunate situations can arise.

For example, in March 2009 in Toronto a Richmond Hill dental assistant who defrauded dentists, insurance companies and banks out of nearly $200,000 was jailed two years for a series of scams.

Irina Chernyakhovsky worked for six dental offices in and around Toronto between late 2005 and 2007. She submitted fraudulent insurance claim forms for expensive dental procedures under patients’ names and then intercepted their insurance cheques, pocketing the cash. In total, she swindled $193,336 from various banks and insurers, including TD Canada Trust, CIBC, Manulife Financial and Great-West Life, in what court officials called a “well planned, sophisticated piece of work.” She also cheated a dental practice out of $10,000 during four months in late 2005 by stealing credit cards and jewellery.

Chernyakhovsky pleaded guilty to six charges of fraud, along with two charges of failure to comply and recognizance. She was sentenced to serve a maximum of two years jail time in a federal penitentiary followed by three years probation. The judgment also barred her from working in dental clinics or in any job that would provide her access to a company’s finances.
The 2010 version of the membership listings, a.k.a. the Source Guide, is now posted on the College’s website. This electronic version is easy to search to find the specific information you need, like practice addresses and phone numbers for a particular dentist.

As usual, the information is divided into a number of key categories that are all easily searchable to find the information that you and your staff need:

- Dental specialists by specialty
- Dentists in alphabetical order
- Dentists by geographical area
- Health profession corporations

It is easy to print off specific pages or even sections too. You can also search the document to look for exactly what you need; for example, a specific dentist by name.

The information in the Source Guide is as accurate as possible as of March 31, 2010. For the most current information in real time, please use the Dentist Search function available from the home page of the College website at www.rcdso.org.

Questions/Concerns About Your Personal Listing?
If you have any concerns or questions about your personal listing, please contact staff in the registration department of the College:

**Kim Vivash**  
*Administrative Assistant, Registration*  
416-961-6555, ext. 4346  
1-800-565-4591  
kvivash@rcdso.org
MAILBAG

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

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

The College reserves the right to edit letters for length and clarity.

COLLEGE CONTACT
Peggi Mace
Communications Director
pmace@rcdso.org

Thank you to PLP staff for your help and guidance. You made an unpleasant task simpler. I really appreciate all your time.
NAME WITHHELD

As a director of the dental health and training center of the Faculty of Medicine at Addis Ababa University in Ethiopia, I would like to thank the College for providing a variety of educational materials including publications and instructional CDs.
Having the latest educational CDs will allow us to better prepare our students for their own practices when they graduate. We expect them to use them in lectures and as review.
Already one of them has been used by the Canadian Dental Team in one of three clinical operations where 48 students in our graduating class are taking turns observing and working with patients.
Once again, on behalf of Addis Ababa University, I extend my gratitude for your generosity.
DR. SOLOMON MULUGETA
Addis Ababa, Ethiopia

Once again I would like to send my thanks to PLP for all the support and guidance that you provided. You have helped make this process as painless as possible and your advice has definitely contributed in resolving this matter in a very timely manner.
NAME WITHHELD
Getting Better at Getting Better: Our New Vision for Continuing Professional Development

way as our innovative and imaginative QA program rolls out. We will do all we can to help you.

We have already demonstrated our commitment to supporting dentists in continuing professional development. Over the past six or seven years or so, the College has made incredible steps to open doors for dentists beyond the traditional opportunities. From our Staying Safe CD with its 110-page workbook to the latest CD-based learning package on informed consent, the PEAK articles in every issue of Dispatch, and our current pilot project on webinars, the College has made these valuable resources available at no charge to Ontario dentists.

There is no single model or technique of continuing professional development that meets the needs of every dentist. We recognize that each professional’s development is unique and each individual’s needs are specific. It could involve a mixture of courses, web-based or computer aided learning or journal study. In fact, all those different options are currently recognized in our existing continuing education program.

However, building on the current continuing dental education system that has been in place for a number of years, we want to help you identify learning gaps and assist you in seeking the right resources to meet your needs.

All this is nothing new for most dentists. Lifelong learning is a fundamental part of the tradition of the profession here in Ontario. The best examples of this are the study clubs all around the province where dentists relish the regular opportunity to learn new information that will improve their practice. Most local dental societies have active educational programs that support this concept.

Why does the College make such a strong commitment to continuing professional development? The obvious answer is that it is our statutory responsibility. It is all part of the new world of regulation, especially for health care providers, where there is an increasing trend to demonstrate accountability.

But most importantly, it is the College helping the profession to constantly expand its professional capacity and knowledge so our patients reap the benefits.

Astuce d’amélioration constante : notre nouvelle vision en matière de perfectionnement professionnel continu

servant de ce que nous avons appris.

L’apprentissage n’est pas quelque chose qui prend fin quand vous descendez d’une estrade, diplôme en main.

Plusieurs d’entre nous n’ont qu’à se souvenir des deux ou trois dernières décennies depuis que nous sommes devenus des médecins chirurgiens-dentistes (DDS), afin de réaliser tout ce qu’ils nous a fallu apprendre au fil des ans pour continuer à améliorer notre savoir-faire, et à prodiguer à nos patients d’excellents soins, tout en nous permettant de nous sentir personnellement efficaces et satisfaits.

Peu importe tout ce que nous apprenons, tout ce que nous savons, comment nous excellons dans ce que nous accomplissons et depuis combien de temps nous y brillons, nous devons encore apprendre et progresser – non seulement parce que la dentisterie évolue sans cesse, mais également parce que nous devons constamment nous
Astuce d’amélioration constante : notre nouvelle vision en matière de perfectionnement professionnel continu

> Astuce d’amélioration constante : notre nouvelle vision en matière de perfectionnement professionnel continu qui correspond aux besoins de chaque dentiste. Nous admettons que le perfectionnement de chaque professionnel est exclusif et que chaque personne a des besoins particuliers. Cela pourrait comprendre un ensemble de cours variés, un apprentissage assisté par Internet ou ordinateur, ou des études au moyen de revues. En réalité, toutes ces options diverses sont présentement reconnues par notre programme actuel d’éducation permanente.

Cependant, en tirant parti du système actuel d’études dentaires continues en place depuis bon nombre d’années, nous voulons aider les dentistes à identifier les lacunes de cet apprentissage et vous aider à chercher des ressources appropriées qui sauront répondre à vos besoins.

Tout cela n’est rien de nouveau pour la majorité des dentistes. Ici en Ontario, l’apprentissage continu fait partie intégrante de la tradition de la profession. À ce sujet, les meilleurs exemples sont les clubs d’études à l’échelle de la province, où les dentistes saisissent régulièrement l’occasion d’apprendre de nouvelles informations qui amélioreront leur pratique. La plupart des associations dentaires locales ont des programmes d’études en cours qui appuient ce concept.

Pourquoi le Collège s’engage-t-il aussi fermement envers le perfectionnement professionnel permanent? La réponse est évidente : c’est notre responsabilité statutaire. Tout cela fait partie du nouveau monde de la réglementation, surtout en ce qui a trait aux fournisseurs de soins de santé, domaine où il y a une tendance émergente à faire preuve de responsabilisation.

En bout de ligne, le Collège aide la profession à perfectionner sans cesse ses capacités et ses connaissances professionnelles, de sorte que nos patients en récoltent les fruits.
The College's new QA program had to meet all these requirements, plus incorporate the nurturing, non-punitive philosophy of the College.

Our new QA program needed:

- to take into account that the overwhelming majority of dentists in Ontario are competent practitioners who continually upgrade their knowledge and skills;
- to meet the demands of changing practice environments and patient needs;
- to ensure members can and do demonstrate their continued competence.

We wanted to use this window of opportunity to look at new and imaginative ways to support members in their practice. That is why the College contacted the Wilson Centre at the University of Toronto for assistance.

The Wilson Centre is an international leader in health professional education research. Over the last decade or so, the Wilson Centre has grown to be recognized internationally as a leader in health professional education research. Research from its members is published widely in major international journals and has received awards from several international organizations. The scientists and researchers of the Wilson Centre are invited around the world to give talks both on the results of their research and on how to engage in world-class research in the health professional education field. Staff from the Wilson Centre are on board and are supporting the College.

During this process, the QA Committee is also seeking advice from the universities, the Royal College of Dentists of Canada, and is working closely with the National Dental Examining Board.

Now, with the formal proclamation of our new QA regulation, we have reached the first major landmark in the development of the new QA program.

The program is founded on the belief that each member of the College is a competent dentist who is motivated to continuously maintain and improve his or her level of competence.

While the regulation was carefully drafted by legal counsel with expertise in the development of government health-care regulations and reviewed by government lawyers and other experts, it does not contain all the nuts and bolts of the QA program. That is yet to come. It is the next step.
What we do know now are the main features of the new quality assurance program. They include:

- **Practice Enhancement Tool**: This is a computer-based self-assessment program that will allow members to evaluate and assess their practice, knowledge, skill and judgment based on peer-derived standards.

  The self-assessment program (Practice Enhancement Tool) will be designed to address the needs of both general dentists and specialists. It is important to note that the self-assessment program will be designed so that the assessment will only be of the areas of practice that the individual dentist is involved in.

- **Practice Enhancement Consultants**: As part of our nurturing, supportive philosophy towards members, there will be consultants available to assist members at any time to interpret or discuss the results of their self-assessment. The consultant can assist members in identifying appropriate continuing education or professional development activities to help them address any deficiencies or weaknesses.

- **Continuing Education Portfolio**: The College will provide each member with a specially designed portfolio case to assist in logging your CE credits and keeping paper records about attendance and participation in CE activities. The portfolio will make it as easy as possible to keep all your CE records in one convenient location for the five years from the end of each three-year cycle, as required in the regulation.

- **Annual Declaration**: Each year members are entrusted with the responsibility of completing a section on their registration renewal form to self-declare whether or not they are in compliance with the QA program requirements.

You may want to review the new QA regulation that is now posted on our website. Check it out under the Quality Assurance heading in the navigation bar on the left hand side of the home page at www.rcdso.org.

Here at the College, we are incredibly excited about this new venture. We are already hard at work developing the actual details of how the program will be implemented.

What wouldn't change as we move forward is our strong belief that QA is all about sustaining, improving and assuring the professional standards of our members, without creating any undue burdens for individual dentists.
Our New Quality Assurance Regulation: Where We’ve Come From and Where We’re Going

It was an incredibly fine day on January 31 this year when I received an e-mail from health ministry staff to inform the College that our new quality assurance regulation had received final approval from the Ontario Cabinet. It was a go!

In June 2007, new requirements for quality assurance were created with the amendments to the Regulated Health Professions Act (RHPA) passed as part of the Health System Improvements Act. Under these RHPA amendments, Quality Assurance (QA) programs must include continuing education or professional development designed to promote continuing competence and practice improvement. Also, any QA program must include the following components: self-assessment, peer and practice assessments and monitoring of members’ participation and compliance.

Our challenge was to develop a new QA regulation and program that met the government’s current expectation for health care regulatory colleges to take on a proactive role in monitoring the performance of their members. We wanted to do this by moving beyond the old traditional QA programs that involved things like office visits, while providing members with a way to demonstrate continuing competency.

Our starting point was the comments made by Health Professions Regulatory Advisory Council in its New Directions report that college members “must have confidence that when changes are identified as necessary in their own practice…that there is no link to the discipline process. Rather the link is to enhanced competence, continuing improvement and outcome evaluation.”

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