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Modernizing the RHPA – a work in progress

In the coming days we expect to see more from the Ministry of Health and Long-Term Care on how it plans to amend the Regulated Health Professions Act (RHPA). Since the Ministry released the Report of the Task Force on Sexual Abuse of Patients, the College has taken part in two consultations and many conversations with the MOHLTC.

Most recently, we had a chance to comment on the Ministry's proposed amendments to the RHPA. Many of the proposals reflect work that we and others have done in recent years. We support moves to build more transparency into the system and to make sure that patient safety and reduction of risk are the top priorities. We've had a chance to comment on about a dozen suggested changes; more may be in the pipeline. Here are just a few that stand out:

Expanding the list of acts that fall under mandatory revocation
We strongly support expanding the list of acts that will trigger mandatory revocation. There is no place in our profession for members who engage in sexual impropriety with patients. We think the best approach is to remove all references to body parts and, instead, prohibit all touching of a sexual nature with a penalty of mandatory revocation for five years. Sexual touching of others, such as staff members, should have the same penalty.

Eliminating gender-based restrictions
We do not support the use of gender-based restrictions at any point in the College process. In our view, there is no justification for permitting gender-based restrictions and we do not use them. Under our transparency by-law, we along with all health regulatory colleges, post bail conditions and sentencing in the criminal courts. Some bail conditions ordered by the bail hearing judge impose gender based restrictions. As this College has repeatedly suggested, regulatory colleges need a mechanism to be notified by the Crown when there are criminal charges against health professionals and have the right to make submissions in such cases.

We support moves to build more transparency into the system and to make sure that patient safety and reduction of risk are the top priorities.

Expanding funding for therapy and counselling
Currently there are provisions in the RHPA for colleges to provide funding for therapy after a finding. We join the Ministry in the belief that therapy and counselling for the complainant should be funded from the time a complaint is filed or from the time a registrar orders an investigation under section 75 for matters involving allegations of sexual abuse or impropriety. We believe funding should be expanded to include staff as well as patients.

Increasing information on college registers
We need to continue to evaluate and improve the information we make available to the public on our website. Transparency is our default position and should be the common standard for all colleges.

There is also a need to be transparent about “no finding” discipline decisions. Members of the public who follow a case on a college’s website from referral to hearing will find that the information simply “disappears” from the register if the Discipline Committee does not make a finding of guilt. This change would require a legislative amendment.

There is an opportunity to take big steps forward in public protection by improving the current safeguards against the sexual abuse of patients and health care staff. We look forward to making further contributions and to seeing draft legislation soon. We will keep you posted!
Moderniser la LPSR Loi sur les professions de la santé réglementées – le chantier de l'heure

Nous devrions dans les jours qui viennent en savoir davantage sur la manière dont le ministère de la Santé et des Soins de longue durée compte amender la Loi de 1991 sur les professions de la santé réglementées (LPSR). Depuis qu’il a publié le rapport du groupe d’étude sur la sécurité et le bien-être des patients ontariens, le Collège a pris part à deux consultations et à de nombreuses discussions avec le ministère.

Nous avons plus récemment eu l’occasion de commenter les amendements proposés par le ministère relativement à la LPSR. Plusieurs de ces propositions reflètent le travail que nos collègues et nous avons réalisé récemment. Nous appuyons les efforts de rendre plus transparent le système et d’assurer en priorité la sécurité des patients et la diminution des risques.

Il nous a été possible de commenter une bonne dizaine de changements proposés et quelques autres suivront sans doute. Voici les principaux :

**Étoffer la liste des gestes conduisant obligatoirement à une révocation**

Nous appuyons fermement le renforcement de la liste des gestes qui conduiront obligatoirement à la révocation. Notre profession n’a aucune intention de conserver en son sein des gens qui s’adonnent à des mauvais traitements d’ordre sexuel envers leurs patients. Nous sommes d’avis que la meilleure approche consiste à s’abstenir de parler de telle ou telle partie du corps et plutôt d’interdire tout attouchement inapproprié sous peine de révocation pour une durée de cinq ans. Des attouchements inappropriés sur quiconque, par exemple des membres du personnel, devraient entraîner les mêmes pénalités.

**Éliminer les restrictions fondées sur le sexe**

Nous n’encourageons aucunement les restrictions fondées sur le sexe dans le fonctionnement du Collège. Nous sommes d’avis que ce genre de discrimination n’est jamais justifié. En vertu de nos règlements sur la transparence, tout comme les autres collèges de réglementation en santé, nous affichons les conditions de libération sous caution et les sentences imposées par les tribunaux criminels. Les conditions de libération sous caution émises par certains juges imposent des restrictions fondées sur le sexe. Comme notre Collège l’a suggéré à maintes reprises, les collèges de réglementation ont besoin d’un mécanisme par lequel la couronne devrait les aviser lorsque des poursuites criminelles sont intentées contre des professionnels de la santé et ils devraient avoir le droit de présenter un exposé dans de pareils cas.

**Nous appuyons les efforts de rendre plus transparent le système et d’assurer en priorité la sécurité des patients et la diminution des risques.**

**Améliorer le financement du traitement et du counselling**

La Loi sur les professions de la santé réglementées permet actuellement aux collèges de financer le traitement d’une victime à la suite d’un constat. Tout comme le ministère, nous sommes d’avis que le traitement et le counselling d’un plaignant devrait être financé dès que la plainte est reçue ou que le registraire demande une enquête en vertu de l’article 75 en cas d’allégations d’abus ou de mauvais traitements sexuels. Nous croyons que ce financement devrait être étendu au personnel et non seulement aux patients.

**Améliorer l’information des registres du collège**

Nous devons continuer d’évaluer et d’améliorer les renseignements que nous communiquons au public par le biais de notre site Web. La transparence constitue notre approche par défaut et devrait être la norme pour tous les collèges.


Nous avons aujourd’hui l’occasion de faire un grand bond en avant en matière de protection du public en améliorant les sauvegardes actuelles contre l’exploitation sexuelle des patients et du personnel médical. Il nous tarde de participer davantage et de voir bientôt apparaître un avant-projet de loi. Nous vous tiendrons au courant! 🌟
ARE YOU PREPARED FOR THE END OF YOUR CE CYCLE?

For all members with a general or specialty certificate of registration who were registered with the College between December 15, 2012 and December 14, 2013, your first CE cycle ends this year on December 14, 2016.

Ensure that you have entered your CE activities in your personal online e-Portfolio which is accessible in the Member Resource Centre at www.rcdso.org. Make sure you have obtained at least 90 CE points in the CE cycle and met the minimum requirements in both Category 1 and Category 2.

Your e-Portfolio provides information to help you enter your CE activities. To make things easier, have your course certificates and other proof of attendance documents ready and refer to them as you fill in the required information fields, such as course title, sponsor name and CE points. You may claim CE points for a specific core course in Category 1 only once. If you repeat the same core course in a subsequent three-year cycle, you may claim CE points for it in Category 2, but not again in Category 1.

Remember: Starting on February 15, 2017, you will be subject to random selection to have your e-Portfolio reviewed. Make sure that you have entered all your CE activities for the cycle by this date and you have original supporting CE documentation.

The College reviews a random selection of members every month to ensure that they are meeting their obligations under the Quality Assurance Regulation. Members who have been selected will be notified in writing and given 30 days to submit their original CE documents to the College.

You must keep the original proof of attendance documents as evidence of your successful participation in the CE activities you have claimed. These documents must be retained for five years from the end of each three-year CE cycle and submitted to the College on request.

For more information or assistance regarding continuing education and the e-Portfolio, please contact the Quality Assurance department or visit www.rcdso.org. Simply click on Continuing Education on the homepage.

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Continuity of patient care is a top priority when a dental practice is sold

Make a plan to deal with ongoing patient care and retreatment

As the demographics of our profession change and the business modes of practice evolve, a growing number of dentists are moving toward retirement; many dentists in mid-career are choosing to change their practice environments.

Patients can feel anxious when a new dentist takes over a practice. They may feel abandoned by their previous dentist. This feeling is commonly reported when the sale of a dental practice is a surprise to patients. In some cases, patients are not notified that changes are coming and there is no transition period during which the selling dentist remains with the practice as an associate.

When selling or buying a practice you should consider a number of issues related to the completion of treatment plans and retreatment, if necessary. The continuity of patient care must always be a top priority.

Develop a plan to resolve potential problems that may arise during and after the transfer of practice ownership. This way it is more likely that patients will stay with the practice, and the investment made by the purchaser (in paying the goodwill portion of the purchase price) will be realized. As well, patients are less likely to make a complaint to the College or start a legal action against the dentist as a result of feeling betrayed by the circumstances of the sale. Taking steps early can help prevent problems in the future.

Prior to the sale, review the ongoing treatment needs of individual patients and identify those who are part-way through a treatment plan. Establish a plan of completion for these patients, with financial arrangements that do not cause them unnecessary hardship.

The purchasing dentist may have a more limited scope of practice or different areas of expertise than the selling dentist. If the completion of treatment will require a referral to a general dentist or dental specialist outside the practice, consider who will make the referral, and how the financial arrangements will be affected.

Make a plan for ongoing patient care and retreatment of failed treatment. Include the plan as part of the agreement of purchase and sale. Consider a transition period in which
both dentists work at the practice, and patients have the opportunity to get to know the new dentist. Ideally the selling dentist will complete treatment and take care of retreatment. This will have the added benefit of making patients feel a continuing connection, and increase the chances that they will continue as patients of the practice.

Identify patients who may have made special financial arrangements with the selling dentist, for example a payment plan or assigning dental benefits. The purchasing dentist could either agree to continue those arrangements, or notify patients in advance of any change in office financial policy that will affect them.

Discuss whether the purchasing dentist will want to perform and charge for a comprehensive dental examination. If patients who have been part of a practice for many years are charged a much higher fee than they are accustomed to paying for their first examination with their new dentist, it is important that they understand the difference between this and their usual recall examination.

If retreatment is required for work that was performed relatively recently by the selling dentist or the patient requires remedial treatment for an ongoing issue, inform the patient of the treatment that is required. Present the situation to the patient in a way that does not criticize the dentist who did the treatment. All dentists, regardless of their expertise, will have outcomes from time to time that were not anticipated and the purchasing dentist may not be aware of circumstances that may have contributed to the failure of the patient’s treatment.

Patients may appreciate an attempt by the purchasing dentist to consult with the selling dentist about any concerns that arise (even after the transition period) with respect to the care that the previous treating dentist has provided. If the selling dentist is no longer working in the practice, any release of personal health information will require the patient’s consent.

Consider ways to smoothly introduce any change in dental treatment philosophy; discussing changes in treatment plans with patients will help avoid misunderstandings that could result in complaints to the College. Simply presenting patients with a different treatment philosophy may lead them to an unfavourable conclusion about the new dentist or the previous dentist’s quality of care, even though both dentists’ philosophies may have merit. Both parties may wish to discuss their respective treatment philosophies at an early stage in the negotiations of the sale. This kind of discussion may help determine if a practice is the right dental practice for a prospective dentist to purchase.

Ideally the selling dentist will complete treatment and take care of retreatment. This will have the added benefit of making patients feel a continuing connection, and increase the chances that they will continue as patients of the practice.
Questions about your practice?

We have answers.

The College offers a professional Practice Advisory Service for both dentists and the public. Dedicated staff assist members with practice-related questions involving clinical, regulatory and ethical issues.

416-934-5614 • 1-800-565-4591

practiceadvisory@rcdso.org

Check out our Practice Advisory Service FAQs at:

www.rcdso.org/Members/PracticeAdvisoryService
The perils of making assumptions

A successful dentist-patient relationship is based on trust. Dentists can establish and nurture trust by having open, collaborative communication with their patients. By informing and involving patients, they can make decisions that reflect their individual preferences and circumstances. As illustrated in the following examples, assumptions may lead to patient dissatisfaction and loss of confidence in the practice or practitioner.

**Scenario 1**

An elderly male patient sees an oral and maxillofacial surgeon for the removal of a molar which has a full gold crown. The surgeon assesses the tooth and agrees to extract it on the same day. When the patient returns for his follow-up appointment, he asks the oral surgeon what happened to the crown. The surgeon informs the patient that the crown was donated to charity for its gold value. While the patient is happy that the money went to a worthwhile cause, he is nonetheless upset that the practitioner did not discuss the disposal of his crown.

**Scenario 2**

An adult female patient attends the dentist for an implant consultation. The dentist discusses the procedure and informs the patient that she may require some bone augmentation concurrent with placement of the implant. The patient consents to implant surgery as well as to bone grafting, and both are performed uneventfully. At a subsequent appointment, the patient discovers that the source of the bone graft is bovine. The patient is a strict vegetarian and is extremely upset that a xenograft was used without her knowledge and consent.
SCENARIO 3

An adult female attends for consultation about restoring an implant that had been placed while she was working overseas as a teacher. The patient was not able to have the prosthetic phase completed at that time. The dentist determines that the implant placed is one not currently approved for sale in Canada. The dentist consults with her laboratory technician about possible restorative options and finds compatible prosthetic parts that are licensed for use in Canada. The dentist restores the implant and the patient is pleased with the esthetics. Three months after restoring the implant, the patient returns to the dental office with a loose crown. The dentist examines the patient and discovers that the retaining screw has failed. During the ensuing discussion the patient is informed that the restorative parts used were compatible but manufactured by another implant company. Given the failure, the patient is concerned whether the components were truly compatible and wonders why their selection was not previously discussed.

SCENARIO 4

A dentist is out golfing with a group of long-time friends. A few of these friends are also patients of the dentist. While on the sixth hole, one of the friends, who is a patient of the dentist, casually mentions to no one in particular that he has been having pain in one of his molars over the past week. The dentist, not thinking much of it as they are amongst friends, comments that the friend should not have cancelled his last three appointments, joking that he is avoiding him and this is why he is having a problem. The friend contacts the dentist later that day and complains that his private affairs were discussed in front of others.

In each of these scenarios the dentist has made certain assumptions based on routine practices and/or relationship with the patient. As a result, the dentist did not discuss issues or risks that were of particular importance to the specific patient. In some instances, the dentist essentially decided on the course of treatment for the patient, by not presenting reasonable treatment alternatives for consideration. By not involving the patient in the discussion, the dentist did not learn the patient’s preferences and could not propose appropriate options. If patients are not encouraged to participate during the consultation, it may be difficult for them to make their views known. Dentists must always obtain consent from patients related to treatment or the disclosure of personal health information.

Dentists should never assume that the dentist-patient relationship, no matter how close it is perceived to be, negates the need for good communication regarding treatment, and respect for patient confidentiality. Whether the decision involves the disposal of a gold crown or expensive implant treatment, good communication will help eliminate misunderstandings and dissatisfaction.
The importance of addressing periodontal disease

Despite steady progress in the field of periodontontology, periodontal disease remains the most common cause of adult tooth loss.

Here are some common scenarios:

A patient with poor oral hygiene persistently declines the dentist’s recommendations for an examination and radiographs. The patient maintains that his teeth are just fine and he only needs a regular cleaning once a year. The dentist gives in, but fails to document their discussions.

A patient with no insurance, and obvious signs of a gradually worsening periodontal condition, repeatedly declines the dentist’s referral to a periodontist for evaluation. After several attempts, the dentist admits defeat and never raises the issue again.

A patient has two upper crowns inserted. Soon after, the patient attends a second dentist’s office on an emergency basis, complaining of discomfort with both teeth. The second dentist finds that the periodontal condition of both teeth is hopeless and recommends they are extracted.

A patient presents to a periodontist’s office and complains of a loose tooth. After years of regular attendance at her general dentist’s office for recall and hygiene appointments, she claims that she has “never been told” about her generalized, advanced periodontal disease.

Each of these situations could result in legal action or College complaints with allegations of failure to diagnose, failure to treat, failure to refer and/or supervised neglect.

WHAT ARE THE BARRIERS PREVENTING PATIENTS FROM OBTAINING ADEQUATE PERIODONTAL CARE?

There are a number of reasons that patients may not seek or dentists may not pursue adequate periodontal care.

Patients may not:

• realize they have periodontal disease, because they have few or no symptoms
• understand the effects and consequences of untreated periodontal disease
• know the treatment options and advances in periodontal therapy
• fully appreciate the value of recommended periodontal treatment
• have the financial resources to access such treatment
• understand the importance of good oral hygiene and prevention
Dentists may not:

- have sufficient knowledge or interest in the field of periodontology
- regularly perform a comprehensive periodontal examination and charting, and establish an accurate periodontal diagnosis
- take the time to educate patients about the importance of periodontal disease prevention and treatment
- have the communication skills to clearly convey information in a way that is easy to understand
- invest the energy to motivate their patients
- be comfortable recommending extensive, expensive periodontal treatment plans to patients who present just for a regular cleaning
- treat periodontal disease before performing restorative, endodontic, prosthodontic or orthodontic procedures

ADVICE
Dentists should recognize and address the barriers that prevent patients from accepting and proceeding with treatment.

1. Establishing a periodontal diagnosis
Determining whether periodontal disease is present and identifying its type, distribution and severity are key factors in the establishment of both the periodontal and overall treatment recommendations. For an accurate diagnosis, the dentist must:

- Review the medical history and identify periodontal disease risk factors.
- Perform a comprehensive full-mouth periodontal examination and charting whenever possible. Alternately, a screening tool such as Periodontal Screening and Recording (PSR) may be used, provided an appropriate comprehensive periodontal examination and charting is carried out for those patients whose screening results warrant more in-depth follow-up.
- In addition to probing depths, a comprehensive periodontal examination and charting should include, if applicable, documentation of mucogingival problems, gingival anomalies in colour, texture and/or contour, bleeding points, purulent exudate, furcation involvement and mobility.
- Take appropriate radiographs.

2. Overcoming barriers and managing the periodontal case
To gain acceptance for periodontal services, especially when there may be financial concerns, educate patients on the health benefits of periodontal disease prevention and early intervention. Good communications skills are important.

Provide visual aids, such as information pamphlets, demonstration videos and/or models. These have all been shown to increase patients’ interest and understanding of their periodontal health. Use radiographs to point out calculus and bone loss, and intraoral photographs to show bleeding, staining, calculus and any suppuration.

Describe the purpose of periodontal probing by telling patients:

- what you are looking for, and why
- before probing, what the numbers mean
- while probing, what those numbers are, by calling them out; by hearing the numbers, patients are more likely to become engaged in the diagnostic process.

Explain why nonsurgical and surgical periodontal therapy may be necessary. Describe the consequences of not proceeding with recommended treatment (e.g., bone loss, tooth mobility, tooth loss, halitosis).
Explain why the expense of replacing lost teeth may be far greater than the expenses associated with preventive and corrective measures to achieve and maintain periodontal health. Consider offering a payment plan to patients whose finances are preventing them from accessing care.

Emphasize how the patient can work with the dental team to improve and maintain periodontal health.

If referral to a periodontist is indicated:

- Explain the reason for the referral and what patients can expect at an appointment with the periodontist.
- Maintain the continuity and quality of care amongst all general dentists and specialists involved through effective communication and collaboration among the practitioners and their dental teams.
- Determine who should be the most responsible dentist or coordinator of the patient’s periodontal treatment and have a clear understanding of each provider’s role.
- Following periodontal therapy and during the maintenance phase, monitor patients’ periodontal status regularly for recurrent or refractory periodontal disease and intervene, as appropriate.

Dentists should also:

- Ensure all members of the dental team coordinate their efforts and collaborate on implementing office protocols for periodontal disease prevention and management.
- Pursue continuing education to refresh and increase their knowledge about advancements in periodontology.

3. Documenting informed consent
Dentists should respect their patients’ autonomy. Some patients may refuse treatment after the periodontal diagnosis, treatment plan and consequences of no treatment are presented and discussed; that is their choice. Dentists should consider, however, that the provision of elective treatment may be contraindicated in the presence of active periodontal disease.

Whether patients accept or refuse recommended treatment, the informed consent discussion should be carefully documented.

Dentists should document:

- all periodontal examination findings, including periodontal charts and radiographic reports
- the periodontal diagnosis and prognosis
- all discussions relating to treatment options, including benefits and risks
- the likely consequences of not proceeding with recommended treatment
- any referrals and reports to or from other general dentists and specialists
- the patient’s informed consent or informed refusal

OVERALL
In order to fulfill their professional, legal and ethical obligations, dentists should take the time to perform periodontal examinations on a regular basis. Educate patients about the importance of periodontal disease prevention and management, and ensure all members of the dental team are committed to early detection and treatment of periodontal disease.

When dentists are dedicated and enthusiastic about seeing periodontal health improvement, their patients are more likely to accept treatment recommendations, improve their home care regimens and return for maintenance appointments.

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Early detection is the key to successful prevention and management of periodontal disease, which remains the leading cause of tooth loss in Canada. The Periodontal Screening and Recording (PSR) program can be a valuable tool for dentists, as an integral part of oral examinations. PSR is simple, quick and easy to record, because it does not require extensive charting. Many practitioners use this method to screen patients for periodontal disease. Unfortunately, too often, practitioners use PSR as a replacement for a comprehensive periodontal examination and charting; this is not its intended purpose.

PSR is designed as an efficient screening system to detect periodontal disease, determine if a comprehensive periodontal examination and charting is indicated, and assist communication between practitioners and patients. Each tooth is examined with a periodontal probe. The recommended probe has a 0.5 mm balled end and a coloured band, extending from 3.5 to 5.5 mm. Six areas of each tooth are examined (mesiofacial, midfacial, distofacial and corresponding lingual/palatal areas) and the depth of probe insertion is read against the coloured band and assigned a score from 0 to 4. The mouth is divided into sextants and for each, only the highest score (corresponding to the deepest probing depth) is recorded.

The management of patients according to their sextant scores requires clinical judgment on the part of the dentist; however, there are recommendations with treatment implications for each code, as described in the following table.

For those patients who have recently received treatment for periodontal disease and/or are in a maintenance phase following such therapy, a comprehensive full-mouth periodontal examination and charting should be performed.

PSR is an excellent screening system; however, it is not intended to replace or substitute for a comprehensive periodontal examination, when necessary. It is a valuable tool for
<table>
<thead>
<tr>
<th>Code</th>
<th>Clinical Signs</th>
<th>Recommendations</th>
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| Code 0| • Coloured band completely visible  
• No calculus or defective margins of restorations present  
• Gingival tissues healthy, no bleeding on probing | • Appropriate preventive care only                          |
| Code 1| • Coloured band completely visible  
• No calculus or defective margins present  
• Bleeding is present on probing       | • Appropriate preventive care only                          |
| Code 2| • Coloured band completely visible  
• Supra and/or subgingival calculus and/or defective margins present | • Appropriate preventive care  
• Removal of calculus  
• Correction of plaque retentive margins |
| Code 3| • Coloured band partially visible, indicating probing depth between 3.5 and 5.5 mm | • Comprehensive periodontal examination and charting of affected sextant is necessary  
• Comprehensive full-mouth periodontal examination and charting is indicated if two or more sextants receive a code 3 |
| Code 4| • Coloured band not visible, indicating probing depth greater than 5.5mm       | • Comprehensive full-mouth periodontal examination and charting is necessary  
• It is probable that a complex treatment plan will be required |
| Code *| • Symbol added to code for sextant exhibiting clinical abnormalities, such as furcation involvement, mobility, mucogingival problems, recession |                                                            |
| Code X| • Symbol used if sextant is edentulous                                          |                                                            |

Early detection of periodontal disease and is designed to indicate when a comprehensive periodontal examination should be performed. Unfortunately, some practitioners ignore these recommendations and fail to perform a comprehensive periodontal examination of the affected sextant or full mouth, when it is clearly indicated. When this occurs, and especially if the patient’s periodontal disease progresses, it may lead to allegations of professional misconduct and/or malpractice for which there may be little or no defense.

If PSR is used, it should only be for the intended purpose: as a screening system for early detection of periodontal disease and indication for performing a comprehensive periodontal examination. If PSR is used without appropriate follow-up, when necessary, then the patient’s periodontal condition may be inadequately diagnosed and managed. This has implications for both the patient and the dentist, including dental and legal consequences.

**COLLEGE CONTACT**
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416-934-5614  
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WELLNESS INITIATIVES FOR ONTARIO DENTISTS

The College is committed to continuing its emphasis on the values of remediation, rehabilitation and support for those dentists who struggle to cope with addiction.

For more information on the resource network that the College has created to support Ontario dentists, visit our website at www.rcdso.org/Members/WellnessInitiative.

You will find more information about:
• RCDSO Partnership with Homewood Health Centre
• Dr. Paul Earley’s “Emotional Health of Dentists” article series
• Other wellness support resources

RCDSO WELLNESS CONSULTANT

Dr. Graeme Cunningham is available for addressing assessment and treatment needs of dentists by helping them find suitable assessors, treatment providers and residency programs.

HOW TO REACH DR. CUNNINGHAM
Dedicated Direct Line: 416.722.9997
All calls are private and confidential.
Evidence-based clinical practice guideline on the nonsurgical treatment of chronic periodontitis

Chronic periodontitis is a prevalent condition, affecting nearly half of patients aged 30 years or older. As the condition progresses, tooth-supporting connective tissue and alveolar bone are lost. Left untreated, it is a major cause of adult tooth loss.

Every day, clinicians are challenged with the management of patients whose periodontitis varies widely in terms of extent and severity. In addition, they are expected to exercise reasonable professional judgement when making decisions about the care of their patients.

At the same time, clinicians are faced with a range of treatment options that are available for the management of periodontitis, including non-surgical interventions, such as scaling and root planing with or without adjunctive treatments, and surgical procedures.

This requires clinicians to consider the evidence for and against these treatment options, the expected benefit versus the risk of adverse events, along with the needs and preferences of their patients.

When faced with a range of treatment options and evidence of differing strength, the question becomes: what is the real evidence for any of these treatment options?
on the nonsurgical treatment of chronic periodontitis by means of scaling and root planing with or without adjuncts, from the July 2015 issue of the Journal of the American Dental Association.

The clinical practice guideline was prepared by a multidisciplinary panel of experts, convened by the American Dental Association Council on Scientific Affairs. The guideline is intended to assist general practitioners with decision-making about the use of scaling and root planing, as well as locally delivered and systemic antimicrobials and the nonsurgical use of lasers. The guideline does not address surgical periodontal treatments.

The guideline reviews and summarizes the strength of the evidence for various non-surgical treatments for chronic periodontitis (Table 4), and provides a net benefit rating for each (Table 5).

According to the American Dental Association, the guideline has been scheduled for review and update at five-year intervals from the date of its publication.

PEAK (Practice Enhancement and Knowledge) is a College service for members, whose goal is to regularly provide Ontario dentists with copies of key articles on a wide range of clinical and non-clinical topics from the dental literature around the world.

It is important to note that PEAK articles may contain opinions, views or statements that are not necessarily endorsed by the College. However, PEAK is committed to providing quality material to enhance the knowledge and skills of member dentists.

Colleges Contact
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mgardner@rcdso.org
The management of pain is an important component of dental practice. Dentists frequently consider the use of analgesics and other drugs to manage the patient’s condition, which requires appropriate knowledge, skill and professional judgment to be effective and maintain safety.

Before prescribing any drug, dentists must have current knowledge of the patient’s true health status and clinical condition. This can only be acquired by obtaining a medical history and conducting an appropriate clinical examination of the patient in order to make a diagnosis or differential diagnosis, or otherwise establish a clinical indication for the use of a drug. There must be a logical connection between the drug prescribed and the diagnosis or clinical indication.

When prescribing a drug, dentists must provide:

- name of the patient
- full date (day, month and year)
- name of the drug, drug strength and quantity or duration of therapy
- full instructions for use of the drug
- refill instructions, if any
• printed name of prescriber

• address and telephone number of dental office where the patient’s records are kept

• signature of prescriber or, in the case of electronically produced prescriptions, a clear and unique identifier, which indicates to the dispenser that the prescriber has authorized the individual prescription.

If the prescription is for a monitored drug, as defined in the Narcotics Safety and Awareness Act, 2010, dentists must also provide their registration number, as well as an identifying number for the patient (e.g., health card number) and the type of identifying number it is (e.g., health card).

Written prescriptions must be legible. It is recommended that dentists use the generic name of the drug to ensure prescriptions are clear and consider including more information when appropriate (e.g., include both brand name and generic name, and the reason for prescribing the drug). When writing prescriptions, dentists must pay particular attention to the use of abbreviations, symbols and dose designations. Avoid using abbreviations, symbols, and dose designations, as their use has been associated with serious, even fatal, medication errors.

When issuing written prescriptions for opioids, take the following precautions:

• If using a paper prescription pad:
  - write the prescription in words and numbers
  - draw lines through unused portions of the prescription
  - keep blank prescription pads secure.

• If using desk-top prescription printing:
  - use security features, such as watermarks
  - write a clear and unique signature.

• If faxing a prescription:
  - confirm destination and fax directly to the pharmacy, ensuring confidentiality;
  - destroy paper copy or clearly mark it as a copy.

Written prescriptions must be communicated in a clear manner. The more direct the communication between a prescriber and dispenser, the lower the risk of error. Accordingly, if dentists use verbal prescriptions, it is recommended that they communicate the verbal prescription themselves. If this is not possible, it is recommended that dentists consider asking a staff person who has an understanding of the drug and indication to communicate the prescription information, unless the prescription is a refill.

Drugs stored in a dentist’s office should be kept in a locked cabinet and out of sight. Dentists are advised to avoid storing drugs in any other location, including their homes. Never leave drug bottles unattended or in plain view. A drug register must be maintained that records and accounts for all opioids, as well as other narcotics, controlled drugs, benzodiazepines and targeted substances that are kept on-site. The register should also be kept in a secure area in the office, preferably with the drugs, and reconciled on a regular basis.

Use staff training sessions and meetings to discuss the dangers of drug and substance abuse. Remind staff of the safeguards and protocols in the office to prevent misuse of supplies and provide information about resources that are available to dental professionals to
Emphasize that dentists and their staff must not access in-office supplies of opioids, or other drugs that normally require a prescription, for their own use or use by their family members.

Always take reasonable precautions to prevent the unauthorized use of in-office supplies of opioids or other drugs by staff and others with access to the office.

For more information about additional issues related to the management of pain, please refer to the College’s new Guidelines on The Role of Opioids in the Management of Acute and Chronic Pain in Dental Practice, posted at www.rcdso.org in the RCDSO Library.

Dentists should be aware that pharmacists are responsible for confirming the authenticity of each prescription, which may require direct confirmation with the prescriber before the prescription is filled.

Part One: The management of acute pain – February/March 2016

Part Two: The management of chronic pain – May/June 2016

Part Three: The management of risk for opioid use – August/September 2016

Part Four: The management of pain - some additional issues – November/December 2016
Reimagining the register and rcdso.org

You’ve probably heard about the College’s ongoing efforts to ensure that transparency, openness and accessibility are values that permeate the organization and the work we do. When the public, a new member or government visit our website or interact with our staff, they should immediately recognize our commitment to those values.

First impressions mean a lot, particularly online. It should be quick and easy to access all of the information and content we make available. The hard part, for us, is defining what “easy” means to our audiences. How do we do that?

The only way to understand how our various audiences use our website and register is by doing something revolutionary. Asking them!

We are currently gathering feedback from the public, members and applicants on their interactions and experience with our online assets. Our goal is to increase engagement and to make our sites more user-friendly.

Examples of that include making it easy for the public to search for registered dentists in their neighbourhoods and to make it clear that the vast majority of our members are competent practitioners with no disciplinary concerns with the College.

If there are concerns with a particular member, we hope to provide more context and clarity around those concerns. The public has a right to access information about their dentists, and it is the College’s obligation to provide that information in simple, plain language, so they can make educated and informed decisions about their health care treatment.

As members, you use our site to access Dispatch, review standards and guidelines and for information on our Quality Assurance program. You and your staff also use the register as a tool for referrals. We want to make your experience seamless and ensure our practice advice, member data and educational materials are easy to find.

In gathering your feedback and views from the public, we aim to make improvements to our sites that create a truly engaging and useful online experience. We want your first, second, tenth impression to be a good one! Stay tuned for updates on these website changes sometime in 2017.
August 2, 2016

As part of my marketing of my dental practice, Northern Dental Care (NDC), I included contests/draws for prizes on Facebook that, in addition to other information posted, were not in compliance with the Advertising Regulations and the College’s Practice Advisory with respect to Professional Advertising.

Being heavily engaged in the community, I promoted NDC’s charitable and community oriented initiatives. In order to promote those events, draws were held with prizes that included a barbecue and other items. Although entrants to the contests were not required to be patients, they were required to provide their contact information.

I now understand that dentists’ charitable activities are not appropriate to be included in their promotional material. Dentists’ charitable donations are not to be used as part of any promotional material, including their practice website or any other social media.

Furthermore, I have also been reminded that including the following information on my website was also contrary to the Practice Advisory with respect to dentists’ promotional materials:

- Continuing education courses at the Las Vegas Institute for Advanced Dental Studies and courses on conscious sedation and orthodontics
- Fellowship of the Academy of General Dentistry
- Past president of the local dental society
- Past member of a College committee
- Board member of a local health promotion foundation

It was not my intention to suggest uniqueness or superiority and I sincerely apologize to the public and my colleagues for such inappropriate advertisements. I have taken the appropriate steps to ensure that all my future promotional material will comply with the Advertising Regulations and the College’s Practice Advisory with respect to Professional Advertising.

Sincerely,

Dr. Carlo Biasucci
Improper use of an Unregulated Individual

In our office for quite some time, we have had an unregulated individual who has been referring to herself as a dental technician, and who we have been promoting as our own “Dental Technician” or “Denture Technician” in our in-house laboratory. We now understand that using and/or permitting the use of these titles may have suggested to our patients that this unregulated person was a registered denturist or dental technologist.

The *Regulated Health Professions Act* stipulates that no person shall design, construct, repair or alter a dental prosthetic, restorative or orthodontic device unless the technical aspects of the design, construction, repair or alteration are supervised by a member of the College of Dental Technologists of Ontario or the Royal College of Dental Surgeons of Ontario. We have become aware that this individual, who is not registered with any regulatory body, in some instances has fabricated dentures, performed denture adjustments, including bite adjustments, and delivered dentures to some of our patients without our proper supervision, and on occasion, without seeing a dentist.

In the past, our practice website stated that whereas many dentists commonly send their laboratory work out to a commercial laboratory and the technician never sees the patient, “we are very fortunate” to have this individual as part of our team to “see and assess” the best cosmetic results for our patients. “Our on-site Denture Technician will work directly with you to ensure the best possible fit and appearance.”

We understand that that in permitting this to occur, we have acted contrary to the legislation and the public may have been misled as to this person’s qualifications. We offer our sincere apologies to the Royal College of Dental Surgeons of Ontario, The College of Denturists of Ontario, and the College of Dental Technologists of Ontario, our patients and to the public at large. We have assured our College that this conduct has been rectified in all three of our dental offices. Furthermore, we will ensure that everyone in our offices use proper titles and follows set office policies and protocols in compliance with the legislation in dealing with patients.

SIGNED this 31st day of August, 2016

Dr. Steven Mascarin

SIGNED this 19th day of September, 2016

Dr. Yasmin Monemdjou

SIGNED this 31st day of August, 2016

Dr. Ramez Salti
Sedation/anesthesia renewal reminder

Renewal forms for facility permits and for those members/visiting members holding authorization to administer sedation will be mailed out in early January 2017.

Facility permit renewal
If your dental practice holds a current sedation facility permit, it expires March 31, 2017 and must be renewed on or before that date.

Requirements for annual renewal
1. Complete the annual renewal form.
2. The permit holder signs and dates the annual renewal form.
3. Enclose fee payable to the Royal College of Dental Surgeons of Ontario in the amount of $350.

Member authorization or visiting member authorization

If you hold a current member or visiting member authorization, it expires March 31, 2017 and must be renewed on or before that date.

Requirements for annual renewal
1. Complete the annual renewal form.
2. The person holding the authorization signs and dates the annual renewal form.
3. Enclose proof of current CPR (regardless of whether it was previously submitted) at the health care provider level as a minimum or equivalent. Note that the frequency of recertification is determined by the course provider and ranges from annually to every three years. Online CPR courses will not be recognized or accepted.
4. Enclose fee in the amount of:
   - $150 for member authorization
   - $300 for visiting member authorization

IMPORTANT INFORMATION
If you are the facility permit holder AND you hold a member or visiting member authorization, you will be receiving two renewal forms as described above and must complete and return both forms to the College on or before March 31, 2017.
Calendar of events

COUNCIL MEETINGS 2017:
January 11-12, 2017
May 11, 2017
November 16, 2017

MEETING LOCATION:
Double Tree by Hilton Toronto Hotel
108 Chestnut Street, Toronto

Council meetings are open to the public. The only exception is for any in-camera portion of the meeting dealing with personnel matters or other sensitive or confidential items.

Meetings usually start at 9 am. The agenda and materials will be available either at the meeting, in advance on the website or by request.

PLEASE NOTE: Seating is limited, so if you wish to attend, please contact Angie Sherban in advance.

Continued from page 28 ➔ Putting patients first and acting in the public interest in the face of international trade agreements

of a general dentist in Canada will be accepted for registration.

That includes, but is not limited to, the successful completion of the national examination administered by the National Dental Examining Board of Canada in the case of general dentists and the National Dental Specialty Examination in the case of specialties.

And, it works. Last year 44 per cent of newly registered dentists got their initial training outside of Canada. We are approaching a third of our entire membership not being domestically trained.

Ontario’s Fairness Commissioner keeps a close eye on all our processes and our third providers’ processes to make sure they are fair. Each time it has been audited, our system, designed to protect the public interest, has been found to be valid and we have come in for praise.

In meetings and consultations with the international dental regulatory community, our goal is to harmonize protocols and training curriculums on the international stage to aid credential recognition. That’s part of the task of the International Society of Dental Regulators, sponsored, in part, by us.

Our registration practices also stand up to international scrutiny. You will recall that in 2013, the College invited the Professional Standards Authority (PSA) of the United Kingdom to come in to conduct an objective third-party audit of our work as a health care regulator.

In its review, PSA concluded that this College’s registration process was “fair, efficient, transparent, secure and continuously improving.”

Continuous improvement also applies to the way we do quality assurance. In Europe, mandatory education is the rule.

The central authority tells you which courses you must take and when. Fail and you’re done.

We take a very different approach to revalidation. Our Continuing Education and e-Portfolio system is an innovative way to promote genuine “life-long” learning.

The bottom line is that government gets to make the call. The public policy and legislation that enshrines that policy belongs to our elected representatives. It is our duty to make sure those decisions are well-informed.

Ontario has a fantastic system that works and we are making it better. We are well-positioned for the future and we will continue to take a leadership role in helping to raise the bar, right around the world.

COLLEGE CONTACT
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Putting patients first and acting in the public interest in the face of international trade agreements

The U.S. elections have been and gone, leaving in their wake a certain amount of uncertainty, to say the least! How will international trade agreements be affected by a president-elect who has promised to tear them up? The Trans-Pacific Partnership (TPP) is already dead, we are now told; even our old friend NAFTA seems destined for the scrapheap.

But global trade agreements will not end with a new U.S. president. North America is still a crucial trading region and Canada may benefit in unlooked-for ways. Certainly, the threat to some agreements seems to have pushed the Comprehensive Economic and Trade Agreement (CETA) to the front of the stage. Last month’s opposition to CETA has swung in some areas to acceptance – even support.

Here at home, worldwide economic drivers are shifting the focus of the governments from interprovincial labour mobility to global labour mobility. We are told these initiatives are critical to assuring our place in the competitive world marketplace.

Like it or not, labour mobility is happening. Our job is to understand the challenge and ensure it becomes an opportunity. We need to guard against the notion that the people who provide services like health care, should be able to cross borders much the same way that a bushel of wheat, a tanker of oil or a rack of shirts do now.

In November the Healthcare Professionals Crossing Borders Conference featured speakers from the European Union (EU) and Britain. Most European countries were represented as were many from the Secretariat of the European Union Commission.

The U.K. folks were clear that, with Brexit on the horizon, they are looking for opportunities to negotiate bilateral trade agreements that address labour mobility for health care professionals. Canada will be an important focus for such agreements. Speakers from the European Commission spoke glowingly about the signing of CETA and suggested they will continue to promote unrestricted labour mobility as a result.

We need to be aware of some very different approaches to labour mobility. The EU says, in effect, a dentistry degree is a dentistry degree, no matter where you were trained. This has rattled many interested parties in Britain; there is great concern about “under-trained” or differently trained health professionals arriving from different countries.

A meeting of the Federation of European Dental Competent Authorities and Regulators (FEDCAR) just a few weeks ago in Paris also focused on labour mobility. No one in Europe has all the answers but there is clearly an understanding that the issue must be dealt with.

Canada, I am happy to say, has taken a different approach and we can make a good case for the success of the Canadian model and how Ontario currently manages labour mobility. It starts with the clear mandate of all provincial dental regulatory authorities: public protection.

It does not matter where an applicant was trained or where they practiced. What matters is that a transparent, objective, impartial and fair assessment of the applicant’s competencies and qualifications is available.

In Ontario, every certificate of registration issued by RCDSO is a warrant that the holder was held to a common standard, protocols and validated qualifying conditions allowing for interprovincial portability of credentials and labour mobility.

Only applicants who are able to establish they have the knowledge, skill and competencies required

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