

# DISPATCH

FALL 2005 VOL. 19, NO. 4

## Growing the next generation of professionals

New dental students pledge to support ethical values with new Oath of Commitment



Royal College of  
Dental Surgeons of Ontario

*Ensuring Continued Trust*

SEE PAGE 6  
for Special Feature



Royal College of  
Dental Surgeons of Ontario  
*Ensuring Continued Trust*

**DISPATCH**

**Vol. 19, No. 4**  
**Fall 2005**

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**ISSUE ENCLOSURES**

- PEAK: The Two-Way Relationship Between Diabetes and Periodontal Disease
- Risk Management Guide – A Handbook for Ontario Dentists
- *Dispatch* Reader Survey
- There is no Summaries of Recent Discipline Committee Hearings with this issue.

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- University of Toronto  
Dr. Philip Watson
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Dr. Cam Witmer

# New Challenges Ahead In 2006

It is hard to believe that another year has almost past. That means one more year to go in my presidency, and one more year before election time rolls around again.

It is never too early to give serious consideration to standing for election to Council. One of our biggest strengths continues to be the calibre of people sitting around the Council table. We are extremely fortunate that this incredible group is constantly open to new ideas, and acts decisively and with creativity.

Just look at several highlights of what we have accomplished this year. We launched our CD-ROM based LifeLong Learning program with free distribution of our first interactive continuing education course. Called Medical Emergencies in the Dental Office, it has been an outstanding success. Response from members is very positive; in fact, you are asking for more. Obviously we struck the right chord with members.

We knew that dentists are committed to continuous professional development. We wanted to make it as easy as possible for every dentist in the province to have access to the same high quality educational experience.

I am delighted to say that one of the key items on the Council agenda for next year is to move forward with a second CD-ROM based course in our LifeLong Learning program. We hope to perhaps work in partnership with others in the Canadian dental community on this new project.

Our commitment to members in the realm of education, as a way of enhancing protection of the public, got another big boost this year with

the distribution of the research papers delivered at the one-day symposium, Oral Health: A Window to Systemic Disease. Under the banner of our PEAK service, this focus on current research in the field has taken the message about the importance of periodontal disease to every dentist in the province. This educational outreach is an important win-win situation for both dentists and our patients.

What lies ahead in 2006? Well, as I said in my column at the beginning of this year, more of the same.

There is still much to do. One of our immediate challenges is the preservation and improvement of professionally-led regulation. We believe that this model offers the best way to encourage high standards of dental practice and to ensure public safety.

As you know, the Minister of Health and Long-Term Care has asked the Health Professions Regulatory Advisory Council for advice on legislative ways to make health-care regulation work better. There is no question that improvements are needed. Consistently across all the health professions, the public needs increased and unfettered access to the process, and to information about the process and its results.

This College will continue to make a forceful case that self-regulation can and does work. As we have demonstrated time and time again at this College, it is possible.

Our Dentists Care pilot project is moving forward. It is a humanitarian program to

*Continued on page 38*

# De nouveaux défis à relever en 2006

**I**l est difficile de croire que l'année 2005 va bientôt toucher à sa fin. Je vais donc entamer ma deuxième année de présidence, et dans un peu plus d'un an nous aurons à nouveau des élections au Conseil d'administration.

Il n'est jamais trop tôt pour prendre la décision de poser sa candidature. Le calibre des individus qui siègent au Conseil d'administration est l'un de nos meilleurs atouts. Nous sommes fortunés d'avoir ce groupe d'exception constamment ouvert aux idées nouvelles, et qui agit de manière décisive et créative.

Il suffit de voir le travail qui a été accompli pendant l'année. Nous avons introduit notre premier cours sur CD-ROM dans le cadre de notre programme de formation continue. Chaque dentiste en Ontario a reçu un exemplaire gratuit de notre trousse d'apprentissage interactive sur les urgences médicales dans les cabinets dentaires. Ce premier cours sur CD a remporté un franc succès, et même vous en redemandez.

La profession dentaire reconnaît l'importance du perfectionnement professionnel continu. Notre objectif consiste à offrir à tous les dentistes dans la province la même formation de haute qualité avec flexibilité de temps et lieu.

Je suis ravi de vous informer que le Conseil a l'intention de continuer sur sa lancée avec l'élaboration d'un second cours sur CD. Nous espérons que d'autres membres de la communauté dentaire viendront se joindre à nous dans cette entreprise.

Nous avons également renforcé notre engagement quant à la formation continue avec la publication et distribution aux membres des comptes-rendus de notre symposium intitulé « Oral Health: A Window to Systemic Disease ». Cet engagement traduit notre volonté de remplir adéquatement notre

mandat de protection du public. Sous la bannière de notre service PEAK, nous avons pu vous faire connaître les dernières recherches sur l'importance de la maladie périodontique. Ce type d'activité bénéficie à la fois les dentistes et les patients.

Qu'entrevoions-nous à l'horizon pour l'année 2006 ? Nous allons continuer de nous appliquer aux dossiers en cours.

L'un des principaux défis que nous avons à relever est de préserver et améliorer nos mécanismes d'autogestion et d'autodiscipline. Nous sommes convaincus que ceux-ci offrent la meilleure protection au public et permettent de garantir les plus hautes normes de qualité en matière de soins dentaires.

Comme vous le savez sûrement, le ministre de la Santé et des Soins de longue durée a demandé au Conseil consultatif de réglementation des professions de la santé (CCRPS) de procéder à un examen exhaustif des critères de réglementation des professions de la santé et de formuler des recommandations. Il n'y a pas de doute que des améliorations s'imposent car le public est en droit de s'attendre à des règlements justes, transparents, responsables et efficaces.

Le Collège va continuer de faire part au CCPRS de sa propre expérience qui prouve que les mécanismes de réglementation en place fonctionnent.

Notre projet-pilote Dentists Care avance. Il s'agit d'un programme humanitaire ayant pour objet d'offrir aux groupes vulnérables de notre société un meilleur accès aux soins dentaires. L'Ontario bénéficie de l'un des meilleurs systèmes de santé bucco-dentaire au monde. Et pourtant, nous connaissons probablement tous des personnes dont

*Suite à la page 38*

# Historic Start of Significant New Tradition at Ontario's Dental Schools With White Coat Ceremony and Oath of Commitment



*Dr. David Mock, Dean, Faculty of Dentistry, University of Toronto and Irwin Fefergrad, RCDSO Registrar (centre) celebrate with some of the students from the Class of 2009 at the White Coat Ceremony.*

D

Dental schools at the University of Toronto and the University of Western Ontario started a new tradition this year – a White Coat Ceremony and an Oath of Commitment.

The Class of 2009 created history in late August and early September as they donned new white lab coats and recited, in unison, the Oath of Commitment, led by College Registrar Irwin Fefergrad.

“The College is very proud to participate in these ceremonies. It is a significant rite

of passage for the students as they enter dental school. The White Coat Ceremony establishes a psychological contract with the students that stresses important key values of honesty, integrity, compassion and fairness,” said Fefergrad.

“The short white lab coat signifies the students’ entrance into the profession of healing, and an accompanying oath of responsibility to uphold the ethical standards and professionalism that go along with the art and science of dentistry,” explained Fefergrad.

The College gave a formal copy of the

Oath of Commitment to each student. The wording of the Oath was created and produced by the College. It was designed with the hope that students would keep it in their work areas throughout their time at dental school as a reminder of their ethical responsibilities as a dental student, and later as dentists.

The University of Toronto ceremony was part of the Ontario Dental Association’s Welcome to the Profession luncheon hosted by ODA President Dr. Jocelyn Pearce.

## WHAT DID THE CEREMONY MEAN TO THE U OF T CLASS OF 2009?

### KETAN MISTRY

*Becoming a dentist has been such a dream of mine for many years, today it is now a reality.*

### RONIT WEILBLIT

*The oath has really brought home to me the commitment I am making by entering dental school.*

### FEHMIDA DOSANI

*This is really my inauguration into the profession. It allows me to see beyond just getting an education, I now realize I am part of something much bigger.*

### PATRICK ROSSI

*The ceremony has brought a sense of reality to the importance and commitment I owe to the profession and my future patients.*

### VIPIN GROVER

*This has brought such a sense of happiness to me. I have been waiting all summer for this day. It will make my parents very happy seeing me in this white coat, and it brings home to me a sense of responsibility.*

### RACHEL MILLS

*It is the first time that I really realized that something important is happening and the first time I have a sense of pride.*



### OATH OF COMMITMENT

*As a new dental student, I recognize that the practice of dentistry is a privilege that comes with considerable responsibility.*

*I solemnly acknowledge that my paramount responsibility is to the health and well-being of my patients.*

*I pledge that I will practise my profession with conscience and dignity.*

*I will strive to always act with sympathy and kindness to all patients in alleviating their concerns and pain.*

*I will respect my patients' rights to make informed decisions about their care, based on their personal values and beliefs.*

*I will endeavour to work with the faculty and my colleagues in a spirit of co-operation and respect.*

*I recognize the limits of my knowledge and will seek to maintain and increase my understanding and skills throughout my professional life.*

*I will always uphold the ethical standards of this honourable profession, and behave with honour and decency.*

*In the presence of this gathering, I make this oath of commitment solemnly, freely, and upon my honour.*

Continued on page 8

# Historic Start of Significant New Tradition at Ontario's Dental Schools with White Coat Ceremony and Oath of Commitment

Continued from page 7

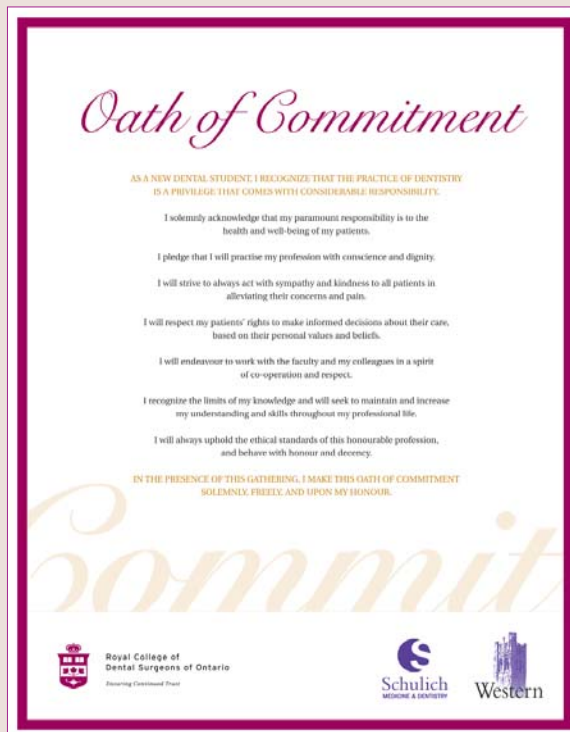
## MOMENTOUS DAY FOR STUDENTS SAYS WESTERN DEAN

*Excerpts from the speech by Dr. Carol Herbert, Dean of the University of Western Ontario's Schulich School of Medicine and Dentistry*

This is an important and exciting day for members of Class 2009, marking the beginning of your careers as dentists. Putting on your white coat symbolizes your agreement to assume the role and responsibilities of a professional. What it means to be a dental professional will be conveyed to you by your faculty over the next months and years. But paramount is your dedication to the welfare of your patients.

The notion of patient-centredness is very important to us at Western. We expect you to see context, to understand your individual patient in order to intervene and to prevent further illness.

Dentists are key members of the health-care team. Health professionals are expected to work in teams responsibly and effectively. As dental professionals, you will work with other associated personnel to deliver oral health care, and increasingly, you will work with nurses and physicians in hospitals and seniors facilities, as well as in the community, to care for patients with complex illness that affects, and is affected, by their oral health.



RCDSO Registrar Irwin Fefergrad leads the dental students from the Schulich School of Medicine and Dentistry at the University of Western Ontario in the recitation of the Oath of Commitment.

# Volume of New Drugs on Market Makes the Drug Interaction Service on the College Web Site More Important Than Ever

In addition to taking a very good medical history that identifies all of the agents a patient may be taking, invest in a good on-line drug interaction program that quickly and effectively provides you with the information you need to prescribe safely for their patients. That's the advice from Dr. Michael Siegel, past Chairman of the American Dental Association's Council on Scientific Affairs, and current President of the American Academy of Oral Medicine, at a symposium on oral medicine at the recent FDI World Dental Federation conference in Montreal.

Dr. Siegel pointed out that new drugs to treat many of the common conditions patients present with, such as hypertension, are being developed and introduced to the health-care community on an increasingly frequent basis. He also noted that more patients are presenting in dental offices with a medical history that indicates that they are taking multiple prescription and/or non-prescription drugs and/or herbal remedies. Most of these drugs and herbal remedies have the possibility of significant interaction with drugs that a dentist may wish to prescribe.

Due to the sheer volume of information, Dr. Siegel concludes that it would be virtually impossible for any practising dentist to be well versed in all of these drugs, and their potential for negative interaction with another agent. That's why he recommends that

dentists have immediate access to an on-line drug interaction program.

In the spring of 2003, Council anticipated the need for this type of program and provided, at no charge to members, immediate on-line access from the College's Web site to the Drug Interactions Program of The Medical Letter, one of the more respected programs of this type.

"Council should be complimented on the proactive approach they took to this important clinical issue," said Registrar Irwin Fefergrad. "This decision has allowed hundreds of dentists to treat their patients in a more efficient and effective manner. This decision also allows members to benefit from such an important service without the significant costs that would be required if they subscribed on an individual basis."

## How to log on to The Medical Letter. FOUR EASY STEPS!

1. Go to [www.rcdso.org](http://www.rcdso.org).
2. Click on the special graphic for The Medical Letter on the front page, top right hand corner. You will first be taken to a disclaimer message. Please read it and click on "Accept."
3. You are now at the Web site of The Medical Letter. To access the Adverse Drug Interactions Program, scroll down to locate the "Online Program" box on the left side of the window and click the "Go" button.
4. You will be asked for your user name and password. Your user name is **rxhelp**. The password is **dentist**.

Questions? Please contact:

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# DISTRIBUTOR'S FEEDBACK ON RCDSO PRACTICE ALERT:

## Paraesthesia Following Local Anaesthetic Injection

### LETTER NO.1 – WEDNESDAY, AUGUST 17, 2005

I'd like to bring to your attention a few points in regards to your article published on page 26 of the *Dispatch* Summer 2005 issue that I strongly feel should have been pondered before writing an article under the heading of "Practice Alert."

Over the years, I've heard many references to Dr. Haas's and Dr Lennon's paper published in 1995 on the subject of dental paraesthesia. As we all know, his conclusions were that there is a higher incidence of that condition with the use of 4% anaesthetics. There are several things to be kept in mind about that study:

- As stated in Dr. Dower's article, which you also quote in yours, "most dentists and patients would define paraesthesia as a prolonged numbness." In reality, what most people think of when they hear the word paraesthesia is permanent numbness; but, as stated in the same article, this condition includes a wide range of symptoms. They range from numbness for a few hours longer than expected, tingling sensation, loss of taste, etc. to the actual permanent paraesthesia. The latter condition is the only one that does not resolve itself with time. All of the other symptoms usually disappear hours, days or, at worst, months after the onset. The article doesn't clarify how long the condition was present in each case.

- Out of the 143 reported paraesthesias that were analyzed in this study, in 47 of the cases the anaesthetic drug used was unknown. Therefore, over 30% of the reported cases could have very well be attributed to, say, Lidocaine, or even Articaine, which would have changed the statistics dramatically. The lack of such an important piece of information in such a large percentage of the cases reported would, at the very least, make questionable the rest of the information provided in these reports.
- Dr. Haas's was not a double-blind study. It was a subjective assessment and not a true scientific study.
- His own conclusions were that there is a possibility for paraesthesia of 2.8 (Prilocaine) to 2.05 (Articaine) paraesthesia cases per million injections. Considering the average practitioner performs 1,800 injections every year, and assuming the incidence is 1:250,000 just in blocks, the average dentist can expect a true anaesthetic-caused paraesthesia case every 100 plus years. And, we are not even talking about permanent cases.
- Therefore, even assuming his conclusions are accurate, it is quite surprising that you would consider this a Practice Alert, even more so, when this study was published 10 years ago or so.

I can envision a lawyer using Dr. Haas's conclusions to question the use of

Articaine on a patient. Nonetheless, any dentist should feel very safe using a drug that has a probability of 1:500,000 or 1:250,000 to cause a paraesthesia. (We are not even talking of a permanent one.) What about the increased risk of trauma to the nerve sheath by having to inject a patient two or three times using, say, Lidocaine to obtain the same results as less than one cartridge of a 4% drug? Damage alone does not prove malpractice.

There are a number of studies like those of Krafft and Hickel (*Journal of Cranio-Maxillo-Facial Surgery*, 22, 294-296, 1994) or Harn and Durham (*Journal of the American Dental Association*, 121, 519-523, 1990) that show an incidence of direct trauma to the nerve during blocks of 7.7% and 3.62% respectively. What about that risk? For a practitioner, taking a calculated risk of one incident every 10, 20 or 100 plus years would not outweigh all the benefits of using these drugs on a patient which can reduce the number of injections required, patient stress, chair time, number of appointments, etc.

B. Hoffmeister published an article (*Dtsch Zahnartzl Z* 46, 828-830, 1991, 12) of a study called "Morphologic changes in peripheral nerves following intraneural injection of local anaesthesia," in which he concluded that, after direct intraneural injection of 4% Articaine, no morphologically detectable toxic lesions were observed. His paper reports that the neurosensory disturbances caused by intraneural local-anesthetic injection are the result of intraneural hematomas with consecutive fibrosis and cicatrization.

The Ontario court system has also ruled accordingly, as you also reference in your article. They have determined that paraesthesia is not a common enough occurrence that would deem obtaining consents from patients necessary before administering an anaesthetic drug. They considered this possibility, based on expert witness testimony "infinitesimal, minimal, extremely small, or in order of magnitude of 1:800,000."

Nonetheless, anecdotal evidence seems to be significant when talking about this issue.

Thousands of dentists across Canada, let alone across the world, swear by 4% anaesthetics and have been using them every single day in their practices for many years, some even for decades. Dentists using them as extensively would have stopped using these drugs years ago, regardless of any publications against or in favour, if their clinical experience showed they were indeed experiencing a high number of paraesthesias that could only be attributed to the anaesthetic drug itself.

All of these drugs would already be history and no one would buy them, if people had really experienced permanent paraesthesias that could only be attributed to the drug, in the numbers some people are claiming they are. Or, actions from the health authorities, such as the ones that banned the use of paraben as preservative in local anaesthetics, would have made these anaesthetics completely unavailable.

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## DISTRIBUTOR'S FEEDBACK ON RCDSO PRACTICE ALERT: Paraesthesia Following Local Anaesthetic Injection

Continued from page 11

Ever since Septocaine started selling in the USA, this discussion reached a different level. This could be explained by the concerns of the dental professionals for all the malpractice lawsuits that are prevalent in that country.

If you read the application submitted to

paraesthesia rate for Articaine in this study, but forgets to mention that Lidocaine had an identical percentage of cases: 1% for both groups after 7 days! Strangely enough this information is missing from your article too. (See below direct-copied images from the application documents available at the FDA site.)

### Section 8.4.1 Paresthesia:

All information on parasthesias was collected by follow-up phone calls. Some of the paresthesias reported resolved before the first phone call and others occurred only after the first call. Paresthesia was not always considered an adverse event. The sponsor felt that when symptoms began after the day of drug administration, it indicated that these symptoms may have been due to the procedure rather than the anesthetic. The sponsor calculated the incidence of paresthesia at 2% for both treatment groups. All cases of paresthesia resolved without sequelae.

[Item 7.2 Vol.1.40, pp.93-94]

The sponsor reported that, overall (drug related and non-drug related), 21/882 (2%) of Septanest<sup>®</sup> patients and 10/443 (2%) of lidocaine patients had numbness or tingling at either or both one and seven days post-op. Of these patients, 8 (1%) of Septanest<sup>®</sup> patients and 5 (1%) of lidocaine patients reported numbness or tingling of the mouth or face at approximately seven days post-procedure. In the Septanest group, one patient had speech impediment, burning and drooling with the numbness or tingling, and concomitant pain was associated in two other cases. In the lidocaine group numbness and tingling was accompanied by pain, speech impediment and drooling in one case and only pain in a second case. The sponsor further reported that there were no differences between treatment groups in the rate or nature of prolonged numbness/tingling following anesthesia and a dental procedure. These patients are listed in the table beginning on the next page:

the US Food and Drug Administration (FDA) for the approval of Septocaine, in the section about the clinical complications in the clinical trials (Part 2 of the Medical Review section of the application), you will be shocked to see they report 21 of 882 (2%) subjects receiving Articaine 1:100 and 10 of 443 (2%) patients receiving Lidocaine 1:100 experienced numbness or tingling 1-7 days after the injection. Then again, among the adverse events reported, there were two patients that experienced diarrhea, one reported constipation, and another one back pain.

It is interesting to note, also, that Dr. Dower's article emphasizes the "high"

Needless to say, the FDA approved the drug based on the findings of this study. Now, this is the only "three identical, single-dosed, randomized, double blind, parallel group, active-control, multicentre" study. The conclusions of this study are that Articaine and Lidocaine were comparable in many ways, even their likelihood of causing a paraesthesia.

If you read the details in this application of the paraesthesias they refer to, you'll find the following details:

"It's always important to hear what a key practitioner responsible for these studies says, more so when he is probably the most respected authority in dental anaesthesia in the world."

These are Dr. Stanley Malamed's thoughts about these issues posted by him personally in the Anesthesiology Forum of Dentaltown.com.

**Posted by Dr. Stanley Malamed in Dentaltown.com: 6/4/2004 7:50:32 AM**

*(1) The published paraesthesia rate of 1%: In the clinical trials we did for the FDA's approval of articaine we used 1400 patients, 2/3rds of whom received a-caine, the remainder lidocaine. Both LAs contained epi in a 1:100k concentration. Dentistry was done... whatever the patient required (the overwhelming majority of patients received non-surgical perio or conservative restorative procedures. The study was double-blinded. The results of the efficacy and safety studies were published in three subsequent papers: two in JADA the third in a pedo journal. As for the 1% paraesthesia rate, we found an equivalent rate with lidocaine and articaine. Now, with a study involving only 1400 patients it is difficult to come up with any truly significant differences between the two drugs... after all lidocaine is one hell of a great anaesthetic. Our findings are similar to what happens in many clinical trials of drugs: the numbers of patients included is adequate to demonstrate the clinical efficacy and safety of the drug... and THAT is what the FDA wants to know about a drug before approving it. It is not until a drug is released for general use and the numbers of patients receiving it soars into the millions that we oftentimes find out that there are, indeed, differences between the new and the old drugs.*

*So, our clinical trial (29 dental schools in the USA and UK) demonstrated conclusively that a-caine is a safe and effective drug.*

Now that it is being used extensively (it is available in more than 132 countries... dating back to 1975) we are 'hearing' about differences. These are anecdotal, non-scientific, 'in-my-opinion' type stories, not evidence-based data.

Does a-caine work better than other LAs? Does it work faster? Is the anaesthesia more profound? Is there an increased risk of paraesthesia with a-caine or any 4% LA?

So far the answers to all of the above questions are PURE CONJECTURE...

Judging by the postings on DentalTown re a-caine I would have to say that in the opinion of the vast majority of you, a-caine appears to be in many and varied ways a superior LA to the other LAs we have available... but again, this is unscientific... but really, except for a few of us who really care about evidence-based medicine or dentistry, all the doctor in practice wants to know is (1) is this drug better than what I have now, and (2) should I use it.

So far the answer appears to be YES, even though in the more than 170 published papers on a-caine not a single one (yet) has demonstrated its superiority to other locals.

As I say in all of my LA lectures: local anaesthetics are the safest and most effective drugs in all of medicine for the management and prevention of pain.

Even if you decide to conclude that every single recent report, from any source, about paraesthesias due to 4% Articaine is reliable and accurate, you have to keep in mind that these reports are mostly originating from the USA and that the formula for Septocaine is not

exactly the same as all the 4% Articaines available in Canada. There are distinct differences that could maybe explain why the experience with Articaine in Canada has been significantly different over the last 20 years or so.

These recent claims are also a handful of reports out of millions of 3 and 4% anaesthetic cartridges administered every year around the world.

But let's go back to Canada.

I have recently reviewed all the Adverse Reaction Reports (1983 to date) in Health Canada's Web site on 4 and 2% anaesthetics, and these are my findings:

#### **Paraesthesias caused by Articaine and reported by dentists**

Definite: 5

Possible\*: 9

(\*possible means the file shows the patient had symptoms that could be associated to a paraesthesia, but the Adverse Reaction Report does not read "paraesthesia.")

#### **How long ago?**

Most recent "definite" one: April 1994 (UC DS)

Most recent "possible": one: May 2000 (Astracaine F)

#### **I also checked Citanest F, Citanest and Prilocaine (the other 4% drug)**

Possible: 1 (July 1987)

Lidocaine (Xylocaine 2%) has only four paraesthesias reported, but the files do not show they were claimed by dentists, and all were resolved. The four say they were reported by "pharmacist," and notifier location was "Hospital."

I choose to believe that Health Canada's figures are accurate and, had the incidence been higher or concerning in any way, they would have issued a

warning themselves. There is no clear indication in those 19 reports on when the paraesthesias were resolved, and if there are still any permanent cases out there. I do not think Canadian dentists would create a "cover-up" to protect 3 and 4% drugs by not reporting the adverse reactions they encounter in their practices to the relevant authorities.

In a country where upwards of 12 million injections are given per year, 19 reports over so many years are negligible, to say the least.

I really feel that the publishing of the article is a disservice to your colleagues and the members of the RCDSO that currently use, or intend to use 3 and 4% anaesthetics in their practices. I believe you had an obligation to publish both sides of this issue and to quote the studies that support every angle allowing the readers to decide for themselves.

Issuing a warning, as you did, in such a prestigious publication and under the heading of "Practice Alert" will undoubtedly cause panic in some instances, and at the very least, will have dental professionals questioning their own good judgement and experience over many years.

Some professionals may feel forced or pressured to stop using these drugs that work so well in their hands, with the thought in mind that an article like yours can be used against them in the court of law.

In the past few days, I have already had

*Continued on page 14*

## DISTRIBUTOR'S FEEDBACK ON RCDSO PRACTICE ALERT: Paraesthesia Following Local Anaesthetic Injection

Continued from page 13

to address these concerns with several of our loyal customers and, fortunately, the vast majority sees things in the same light. Their experience with Ultracaine, the original 4% Articaine, and other 4 and 3% drugs over so many years, is what really counts, and the likelihood of a complication of this nature caused by the drug itself is very remote, as their own personal experience can attest.

HANSAMed will also take whatever measure needed to ensure dentists across Canada and abroad promptly get all the pieces of information that were missing in this article, so they can better decide what to do about their local anaesthetic use.

Our company feels the RCDSO members deserve an immediate clarification on this issue from you, and we also request an opportunity for a rebuttal in the pages of the next issue of the *Dispatch*.



**DR. MAURICIO DIAZ**

Manager, Pain Control Division  
HANSAMed, Mississauga

### COLLEGE REGISTRAR REPLIES

Under the *Regulated Health Professions Act, 1991*, we are the regulator for the dental profession, and pursuant to that statute, we have obligations and objects with respect to human health care. We are also required to develop and establish programs with respect to standards of practice to assure the quality of the practice of the profession. We are required as well, as part of our mandate to develop, establish and maintain standards of knowledge and skill, to promote continuing competence among our members.

Section 3(2) of the legislation states "in carrying out its objects, the College has a duty to serve and protect the public interest."

The purpose of the advisory was to raise an awareness in our members to the research findings and significant experiences from this College's Professional Liability Program respecting the seemingly high risk of temporary or permanent paraesthesia associated with the use of certain local anaesthetic agents for mandibular block injections.

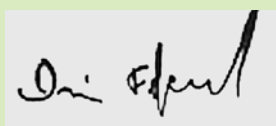
We made it very clear in the notice that, while the incidence of such paraesthesia is low, there appears to be a growing body of statistically significant scientific knowledge supporting the fact that Articaine and Prilocaine are more likely than other local anaesthetics to be associated with paraesthesia, especially lingual paraesthesia.

The research was conducted by the Assistant Dean of the Faculty of Dentistry at the University of Toronto, Dr. Daniel Haas, who is an internationally recognized expert in the field of anaesthesia.

In addition, I am confident that you are aware that the *British Dental Journal* has published an article in the year 2003, noting at the Leeds Dental Institute, "...we too have observed an apparent increase in the incidence of prolonged dysaesthesia following inferior alveolar nerve block injection in the last few years (seven cases), all but one of which has been associated with articaine administration." I am attaching a copy of that article.

This College received legal advice from our general counsel, and from outside counsel, before publishing what we did. It was never our intention to interfere with our members' professional judgement in their selection of an appropriate local anaesthetic agent. However, the advice we received was that it was certainly within our obligation to advise members to be aware of the literature before determining which agent to utilize for mandibular block injections.

We did comment that it would be helpful if there would be further research to clarify this issue. That said, the College believes that the information that was provided to our members is both in their interest, as well as in the interest of the public of this province.



**Irwin W. Fefergrad, BA, BCL, LLB**

Registrar, Royal College of Dental Surgeons of Ontario

**LETTER NO.2 – WEDNESDAY,  
SEPTEMBER 14, 2005**

I read your letter with great interest, and would like to make a few comments.

Among other things, you mention that the RCDSO decided to publish the advisory based on “significant experiences that this College’s Professional Liability Program respecting the seemingly high risk of temporary or permanent paraesthesia associated with the use of certain local anaesthetic agents for mandibular blocks.”

I have no questions about Dr. Haas’s reputation and credentials, but it is also my understanding that he sourced the information for his publication in 1995 from these same reports that the College compiles. As expressed in my previous letter, there are some important bits of information that I understand, based on my conversation with Dr. McFarlane, are still, to this date, not being collected. These include needle size and gauge, pain during injection, duration of the episode, etc. These are very important pieces of information that can further bring light to this issue, and should be pondered, before making any assumptions one way or the other.

On the other hand, is the information on these reports available? Would you be kind enough to share the statistics with us? What specifically does the questionnaire ask?

As direct representatives for the manufacturers of the original Articaine, this information is very valuable.

I also don’t understand why you consider a letter to the editor of a Journal (BDJ 2003; Vol 195, No 3, page 119) an “article.” This lacks even the most basic information. How can anyone put that emphasis on a letter that reports “an apparent” increase in paraesthesia cases “in the last few years?”

Even if these reports were accurate and 100% reliable, millions of cartridges of Articaine are injected worldwide in a year. These reports make up an infinitesimal part of the total injections of Articaine.

Please don’t think that an advisory such as the one in question is not taken VERY seriously by the dentists in our province. They know that you are the governing body that really holds their licences. They also know any lawyer or patient can use this publication, successfully or not, against them. They will have to put their professional judgment in a balance versus the legal implications of not paying attention to your advice.

You titled the article “Paraesthesia Report: Important Member Advisory” on the cover of the *Dispatch*, “Important Practice Alert” in the index, and “Practice Alert” in red letters on page 26.

If your intention was not to sway your College members one way or the other and just present the facts, the titles reflected quite the opposite, to say the least.

The RCDSO put many dentists across the province in the position of having to switch anaesthetics due to legal

concerns, even though their experience with this drug had been completely different, in some cases for over 20 years.

HANSAméd proudly distributes Ultracaine, a product with an impressive safety and performance track record worldwide for almost 30 years, and in Canada for over 20 years. We would like to better understand why the information you have on Articaine is so different from our own, our customers’, and even our health authorities’ experience. Again, I’d like to request that you share the information you have on these incidents, and which name brands are involved in those reports. It is also my understanding that there is a comparative study in progress that I’m sure will provide us with more current data.

I sincerely appreciate the fact you are willing to publish my letter to Dr. McFarlane in the next issue of the *Dispatch*, and look forward to reading it. Should you deem it appropriate, please feel free to publish this letter as well.



**DR. MAURICIO DIAZ**  
*Manager, Pain Control Division*  
HANSAméd, Mississauga

# Deadline for Annual Renewal is December 15, 2005

The annual membership renewal forms will be mailed out the first week of November and that means your membership fee for the year 2006 is due at the College by December 15.

***Is there any incentive for paying on time, or even early?***

The annual fee is unchanged at \$1,560. It pays to be an early bird. There is a discount of \$100 if you pay on or before the due date of December 15. That means if you pay by December 15, your annual fee is only \$1,460.

***Why do I have to fill out the sections with my address and contact information every year?***

That is not necessary, as long as the preprinted information on your form is correct. We only need new information or corrections.

***What happens if my renewal form gets lost in the mail?***

Please remember that, even if you don't receive your renewal form in the mail, it is still your responsibility to pay your annual fee by the due date. Any loss or delay in the mail is not accepted as a reason for late payment, and you'll lose the early bird discount.

***What's the best way to ensure my payment gets to the College by the deadline?***

We strongly advise members to use a courier service or to fax in their payment with a credit card authorization. It is imperative that you retain a fax transmission report. Please do not wait until the final few days to send in your fax. Our system becomes overloaded with last minute faxes and your transmission may be lost.

Any loss or delay in the mail or by fax is not accepted as a reason for late payment, and you'll lose the early bird discount.

***Do I need to fill out that form again asking for information about conduct and about amalgam separators?***

Yes. We would ask for the support of each and every member in filling out these two short questionnaires. It takes just a few seconds.

***What do I do if I am not renewing?***

All you have to do is complete the Resignation Form and return it to the College by the due date of December 15, 2005.

***Who do I call with questions?***

The staff in the College's registration area can help you with any of your questions.

**phone: 416-961-6555**

**toll-free: 1-800-565-4591**

**e-mail: kvivash@rcdso.org**



# The Two-Way Relationship Between Diabetes and Periodontal Disease



In the Spring 2005 issue of *Dispatch*, members were informed about the College's one-day symposium on "Oral Health: A Window to Systemic Disease" held in Toronto on February 4, 2005. The symposium included presentations by respected researchers and academics to illuminate the current state of the evidence for possible associations between periodontal and systemic diseases.

In addition, PEAK announced that it would be providing members with a series of four articles written by the presenters at the symposium. The first article, by Drs. Chris McCulloch and Michael Glogauer, served as an introduction to this important topic and the series. The second article, by Drs. Howard Tenenbaum, Avi Shelemay, Michael Goldberg and Jim Lai, explored the associations between periodontitis and cardiovascular disease.

With this current issue of *Dispatch*, PEAK is pleased to provide members with the third article in the series, "The Two-Way Relationship Between Diabetes and Periodontal Disease," by Dr. Debora Matthews. The article reminds dentists of the signs and symptoms of diabetes, as well as the importance of maintaining periodontal health for diabetics.

Key points to consider:

- One in ten Canadians has diabetes, although the disease may be undiagnosed.
- Periodontitis is often referred to as the sixth complication of diabetes.
- There is strong evidence that diabetics experience a greater prevalence and severity of periodontal disease.
- There is weak evidence that diabetics with periodontal disease require more thorough and aggressive therapy than non-diabetics with periodontal disease.

- The prevention and control of periodontal disease must be considered as an integral part of the control of diabetes.

The fourth article in the series, exploring these issues in women's health, will appear with the Winter 2006 issue of *Dispatch*.

PEAK is also pleased to announce that it will be providing members with a fifth article written by Drs. Sandra Cassolato, Austin Chen, David Chvartzsайд and Melissa Sander, who presented at the symposium. The article will describe the results of the authors' systematic review of the available literature to determine if periodontal disease is a causal risk factor for preterm low birth weight infants.

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, the PEAK advisory board is committed in its desire to provide quality material to enhance the knowledge and skills of member dentists.

If you have any suggestions for subjects to be addressed by PEAK, or questions about this membership service, please contact:

**Dr. Michael Gardner**

*Assistant to the Registrar, Dental*

phone: 416-934-5616

toll free: 1-800-565-4591

e-mail: [mgardner@rcdso.org](mailto:mgardner@rcdso.org)



## LETTERS OF APOLOGY

The RCDSO Executive Committee regularly reviews office newsletters, brochures, newspapers, and other advertising by dentists that have been brought to the College's attention. The Committee has accepted the letters of apology for publication from the following members.

The RCDSO Executive Committee regularly reviews office newsletters, brochures, newspapers, and other advertising by dentists that have been brought to the College's attention. The

If you have any questions about the issues raised in these letters, please contact:

**Dr. Fred Eckhaus**  
*Assistant to the Registrar, Dental*  
phone: 416-934-5624  
toll-free: 1-800-565-4591  
e-mail: feckhaus@rcdso.org

In an article published about my practice, I was described as one of a dozen dentists in Ontario using laser instead of a drill, and as a dentist who tries to put his patients above profit. The same article also noted the advantages of the laser technique and referred to my practice as a "cutting edge practice." I was quoted as saying that most dentists do not follow my lead because they were only trained in the basics at university. It was not my intention to demean other dentists or any dental faculty.

Although this article was not an advertisement, and had not been solicited by me, I realized that these advertorials must comply with the advertising regulations. I had no opportunity to ensure that the statements printed were accurate. However, now I understand that dentists need to be more vigilant when interviewed for articles that describe their dental practices.

In expressing my view, it was not my intention to suggest uniqueness or superiority. I now understand that this may, in fact, have been the case, and I sincerely apologize.

Dr. Arthur Shulman  
Waterford

In my recent advertisement in the telephone directory, I included statements suggestive of uniqueness or superiority over another practice or member that raised concerns with the College's Executive Committee. Specifically, the descriptive information included statements such as "Tomorrow's Dentistry Today," as well as descriptive information about the accuracy of the diagnostic and treatment planning of the intra-oral digital camera examinations provided at my office, and the statement that I am a graduate of the Las Vegas Institute for Advanced Dentistry.

I now realize that, although the goal in marketing a business is to inform the prospective client as to the uniqueness of services or products available, advertisements by dentists, as health-care providers, must comply with existing advertising regulations under the *Regulated Health Professions Act*.

Advertisements by dentists should include relevant dental practice information as listed in the College's Practice Advisory on Professional Advertising. This information includes location, hours of operation, languages spoken, services being offered (general or specialty practice), etc. Therefore, information describing specific techniques or treatments, advantages of specific materials or equipment used, would not be in compliance with the advertising regulations.

Similarly, as all dentists take continuing education courses, and all must maintain the standards of practice, it is inappropriate to include in advertisements the completion of courses taken. Only specialists may make reference to the advanced education that qualifies them as specialists in the recognized specialty.

I did not intend to offend our profession nor to mislead the public. I deeply apologize to those who feel my wording implies superiority. Unfortunately my advertisement cannot be corrected for another year.

I will now utilize the advertising review service provided by the College to ensure that I comply with the advertising regulations.

Dr. Douglas Hanson  
Val Caron



# Enthusiastic Response to Volunteer Call for New One-To-One Program

The new One-To-One Program is now a reality. "Because of the positive response from members who called to volunteer, after reading the article in the summer issue of *Dispatch*, we have already held our first orientation session," explained College Registrar Irwin Fefergrad.

The aim of the program is to support dentists who are involved in the College process as a result of standards of practice issues. These are dentists who could use a guiding hand and support from a colleague to achieve improvements in their practice.

"The response was incredibly heart warming. Dentists really care about their colleagues and want to help them in a very tangible way," said Fefergrad.

The program has already been running on a limited basis with real success. As the College Registrar explains, "The member's practice actually improves. That means public protection is enhanced."

The program volunteers will meet occasionally with the member to support and advise him/her on how to improve some weaknesses in their practice. Or they may be asked to observe dental procedures performed by the member, and to report regularly in writing to the College on the member's progress.

If you are interested in having a mentor, contact:

**Irwin Fefergrad**

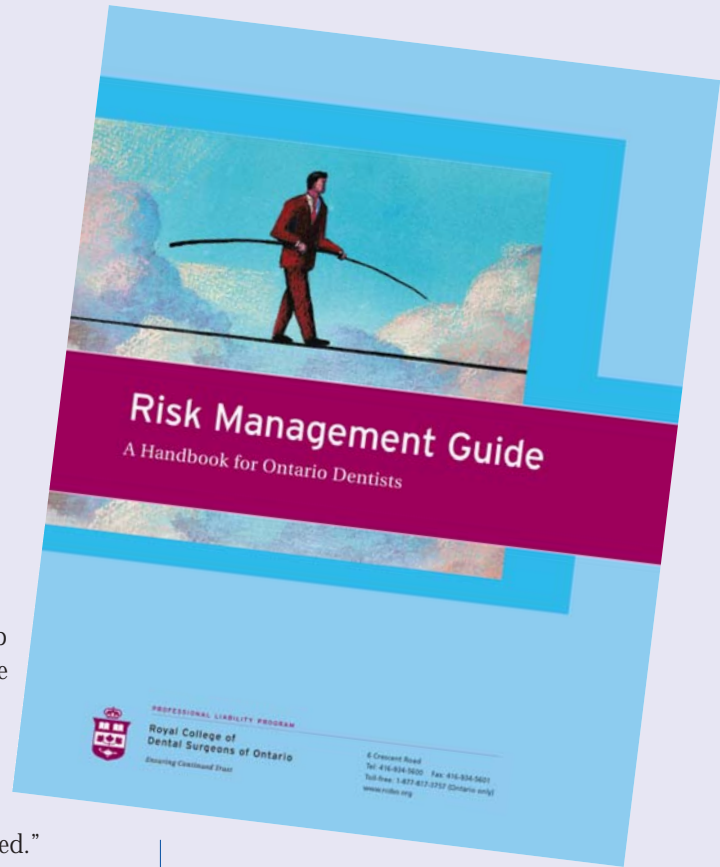
*Registrar*

phone: 416-934-5625

toll-free: 1-800-565-4591

e-mail: [ifefergrad@rcdso.org](mailto:ifefergrad@rcdso.org)

# New Risk Management Guide Distributed To All Ontario Dentists



**R**isk management is not new to the dental profession or any other health-care professional. Physicians in their Hippocratic Oath and incoming Ontario dental students in the new Oath of Commitment, that has just been introduced at both dental schools (see page 6 for the story), entrench the concept of “Do No Harm” in their value systems.

On a practical basis, dentists adopt risk management principles, such as infection control, informed consent and accurate and complete documentation, into their practice everyday.

“The College’s Professional Liability Program (PLP) is delighted to distribute this new Risk Management Guide to every dentist in the province as part of our commitment to an extensive educational program that also includes group sessions and individual mentoring,” explains Dr. Don McFarlane, Director of the Professional Liability Program.

“Risk management has always been an important aspect of PLP. This new Risk

Management Guide will help dentists reduce the incidence of disputes with patients, and help them deal appropriately with issues that may arise. It also ensures the public is protected.”

Since the 1970s, the College has provided errors and omissions insurance to all Ontario dentists under its Professional Liability Program (PLP). The cost of this program is included in the annual registration fee.

The PLP coverage for professional liability or malpractice claims is also extended to former/retired and deceased members, as well as dental partnerships and health professional corporations that hold a valid certificate of authorization from the College.

“Over the years the College has successfully kept the cost of the program in check. The reasons we have been able to do this are directly related to the way the program is funded. Because the College acts as co-insurer, it assumes a considerable level of financial risk on

each claim, up to a yearly maximum. In this way, the per member cost is about half of what dentists outside of Ontario and Quebec are required to pay for similar coverage,” explained Dr. McFarlane.

This new Risk Management Guide is also available on the College Web site at [www.rcdso.org](http://www.rcdso.org). It will also be distributed to each new registrant at the College’s Jurisprudence and Ethics course required for registration in Ontario.

If you have any questions about the new guide, please contact:

**Dr. Don McFarlane**  
Director, Professional Liability Program  
phone: 416-934-5609  
toll-free: 1-877-817-3757  
e-mail: [dmcfarlane@rcdso.org](mailto:dmcfarlane@rcdso.org)

# Ontario moves to Regulate Traditional Chinese Medicine and Acupuncture

The Ontario government plans to introduce legislation by year-end to recognize traditional Chinese medicine practices (TCM) and to ensure that alternative health-care services, such as acupuncture, are delivered safely.

At the end of July, Health Minister George Smitherman unveiled a report that recommends the province create a regulatory college for TCM, allow only qualified health-care professionals to practise acupuncture, and establish different classes of practitioners, depending on education and experience. The classes would differentiate between medical doctors of TCM with advanced education, and practitioners with a general TCM education.

Ontario would join British Columbia as the only provinces to regulate TCM and acupuncture. Two other provinces, Alberta and Quebec, regulate acupuncture.

Currently no standards exist on who may practise TCM or perform acupuncture. There are no statutory public protection mechanisms in place relating to registration qualifications, complaints and discipline processes, and professional standards. There is no governing body to which practitioners are held accountable.

In March 2005, the Minister of Health and Long-Term Care requested four MPPs to undertake, on his behalf, public consultations on the best and safest way to regulate TCM practitioners, prior to the development of legislation. This MPP group heard almost 100 presentations and received over 200 written submissions.

If you have any questions, contact:

**Irwin Fefergrad**

*Registrar*

phone: 416-934-5625

toll-free: 1-800-565-4591

e-mail: [ifefergrad@rcdso.org](mailto:ifefergrad@rcdso.org)



# Handling The Difficult Problem of Dismissing A Patient

One of the least pleasant tasks that a dentist may have to consider is the dismissal of a patient. For a variety of reasons, a dentist-patient relationship may begin to deteriorate. Sometimes this results from a single incident. More often, it is the result of a series of problems that incrementally build one on another. Finally, it may become apparent that the relationship is no longer co-operative and trusting; in fact, it may even be antagonistic. When this occurs, it may be beneficial to both parties that they go their separate ways.

Before coming to the conclusion that it is necessary to dismiss a patient, it may be worthwhile to re-examine the events that led to this juncture, and consider whether or not all reasonable efforts have been made to address the problems.

*Is the problem a result of miscommunication?*

It may be useful to attempt to speak with the patient directly and clarify matters.

*Is there a disagreement regarding treatment options?*

It may be appropriate to refer the patient for a second opinion.

*Is the patient's account in arrears?*

New payment terms may be offered and agreed upon.

*Is the problem related to treatment outcome?*

It may be possible and prudent to resolve the patient's concerns.

In accordance with good recordkeeping practices, your patient records should include details of any relevant problems and issues, as well as notations of all communication with the patient.

If your conclusion is that dismissal is the best decision, the patient should be informed in an appropriate fashion, preferably in writing.

Your letter should be polite, professional, and to the point. It should avoid words or phrases that might inflame the situation. Rather, it should attempt to present the termination of the relationship as being in the patient's best interest. (See the sample provided with this story on the opposite page.)

A well constructed letter should address the following five areas:

1. Provide the patient with the reason for their dismissal. For example, the patient is unwilling to follow through with recommended treatment, or is demonstrating a lack of confidence in your abilities, or is disruptive to office routine and abusive to the staff, or is not complying with agreed upon payment terms, etc.

2. Outline any treatment needs that the patient should have attended to in a timely manner. For example, the patient may still require specified fillings or should have a root canal treated tooth crowned.
3. Provide the patient with the means of obtaining the services of a new dentist. Your letter might provide the telephone number of a local dental society or the Ontario Dental Association so that the patient can obtain a list of dentists in the area.
3. Inform the patient that you will forward copies of any records or radiographs that may be of assistance to the new dentist. The patient must authorize the transfer of records and clearly indicate where they are to be sent. If the patient indicates that the records are to be sent to their home address, you should comply with their request. The College recommends that you retain the original records and provide copies.
4. Inform the patient that, until they have obtained the services of a new dentist, you will agree to attend to any true emergency situation.
5. You might also provide the telephone number of a local dental emergency service. Note that this information may be provided in addition to, but not in place of, your offer to render emergency care.

If you have any questions, please contact:

**Dr. Lesia Waschuk**

*Practice Advisor*

phone: 416-934-5614

toll-free: 1-800-565-4591

e-mail: [lwaschuk@rcdso.org](mailto:lwaschuk@rcdso.org)

## SAMPLE PATIENT DISMISSAL LETTER

Dear Mrs. Smith:

I am writing to you following your last scheduled dental appointment that was on June 13, 2005. On this date, you were to attend my office to have a lost filling replaced. When you failed to show at the appointed time, my receptionist contacted you by telephone. You informed her that you were too busy to leave work. This was the fourth time this year that you did not keep a scheduled appointment.

You will remember that we have had several discussions on the subject of missed appointments. Additionally, I wrote to you and clearly provided my office policies regarding this subject in a letter dated May 30, 2005.

If a dentist-patient relationship is to be successful, co-operation is essential. Obviously, I cannot treat you if you do not attend your scheduled appointments. I can only conclude that either you do not value the appointment time that is set aside for you, or my office is not convenient to your needs. Whatever the reason, it is with regret that I must insist you seek the services of another dentist.

In order to prevent further damage to your lower left tooth, please arrange to have your new dentist replace the lost filling as soon as possible.

If you require assistance in locating a new dentist, you may wish to contact the Ontario Dental Association for a list of dentists in your area. The ODA telephone number is 416-922-3900. I will be pleased to forward copies of your records at your written request.

Should the need arise before you find a new dentist, I am prepared to see you on an emergency basis or, if you prefer, assist you in making arrangements at another suitable dental office.



# Release of Patient Information of Deceased or Missing Patients

**T**he College frequently receives calls from members regarding their legal responsibility to release records of deceased or missing patients. The request for these records is made either by the coroner or police for identification or criminal investigation, or by family members for various reasons. The new provincial privacy legislation, *Personal Health Information Protection Act, 2004* (PHIPA), includes provisions relevant to these types of situations, so the College would like to update dentists on this important issue. Many dentists may not be aware that, according to a regulation of the *Dentistry Act, 1991*, it is professional misconduct for a dentist to give information about a

patient to a person other than the patient, or his/her authorized representative, except with the consent of the patient or unless the dentist is required to do so by law. “By law” means a court order or warrant from a coroner, judge, or justice of the peace.

Of course, dentists want to co-operate with the police or coroner or family members, particularly during stressful times for the family.

Information in this article will help dentists to respond to these types of requests for information while complying with the requirements for consent or legal authority to release that patient’s information.

## **Request From Family Members**

If a dentist is contacted by family members of a deceased patient for copies of the patient’s information, it is important for dentists to determine who is legally authorized to consent to the release of the patient’s health-care information.

Under PHIPA, the authorized person is the deceased’s estate trustee or the person who has assumed responsibility for the administration of the deceased’s estate. It may be helpful for dentists to retain a copy of documentation attesting to that person’s legal authority and that person’s signed consent to the release of information to the patient’s family in the patient’s record.

Requests are often made by family members for a patient who is missing, or for the identification of a body presumed to be their relative. Although the compassionate reasons to provide the records to the relatives is compelling, dentists should not normally do so without the appropriate legal authority that, under most circumstances, can be easily obtained by the police.

In the case of a child who, under normal circumstances, would not be competent to consent to the release of their personal health information, the authorized representative is the child's parent or guardian. Records can, therefore, be released to the parent or guardian.

### **Requests From The Police**

A mechanism exists for the police to legally require dentists to turn dental records over to them during the course of an investigation. For a missing person or in the case of a police investigation of a crime, this legal authority is a search warrant issued by a judge or a justice of the peace. In the case of a deceased person, a Coroner's Warrant for Seizure, as allowed under the *Coroner's Act*, is required.

As mentioned, police should not have difficulty in obtaining such legal

authorization, and family members should not have difficulty in having the police act on their behalf in the circumstance where a patient is presumed deceased.

Under PHIPA, dentists are permitted to release personal health information about a person who is deceased, or is reasonably suspected to be deceased, for the purpose of identifying the individual. However, this legislation is permissive rather than prescriptive. Therefore, the College still advises that, under most circumstances, dentists request that a Coroner's Warrant for Seizure be provided.

### **In Summary**

Summing up, the advice to members is not to release any patient information or records to family members or to the police unless:

- There is a consent from the authorized representative of the patient.
- The police produce one of the warrants listed in this article.
- Because of unusual circumstances, the police are not able to produce a Coroner's Warrant of Seizure and the dental records are required urgently to assist in the identification of a deceased individual.

By following this advice, it is possible for dentists to provide the necessary assistance to the police or family members without compromising the confidentiality sections of the provincial legislation.

### **Additional Information**

The regulations made under the *Dentistry Act, 1991*, and the *Personal Health Information Protection Act, 2004*, can be found on the Ontario government Web site at [www.e-laws.gov.on.ca](http://www.e-laws.gov.on.ca).

### **Need Assistance**

If you require assistance in dealing with the police, or have other inquiries related to the release of patient information, please call:

#### **Dr. Lesia Waschuk**

*Practice Advisor*

phone: 416-934-5614

toll-free: 1-800-565-4591

e-mail at [lwaschuk@rcdso.org](mailto:lwaschuk@rcdso.org)

#### **Irwin Fefergrad**

*Registrar*

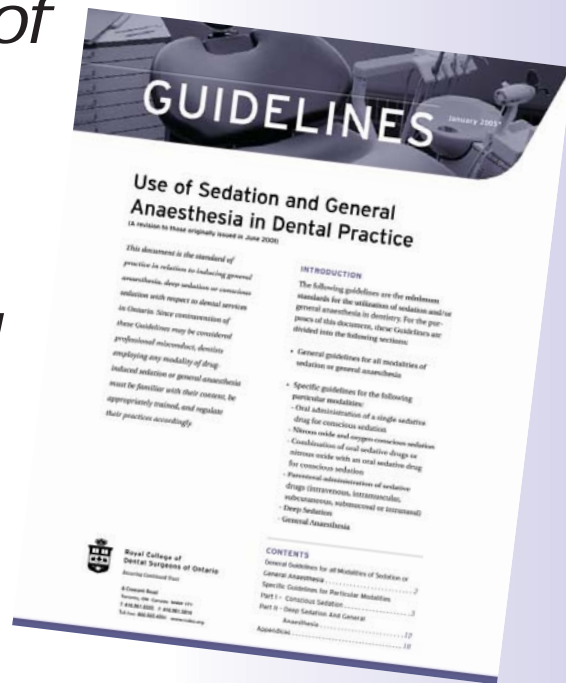
phone: 416-934-5625

toll-free: 1-800-565-4591

e-mail: [ifefergrad@rcdso.org](mailto:ifefergrad@rcdso.org)



# Conscious Sedation: Using A Combination of Oral Sedatives Or Nitrous Oxide-Oxygen With An Oral Sedative Requires Greater Level of Responsibility



The administration of either a combination of oral sedative drugs or nitrous oxide-oxygen inhalational sedation with an oral sedative drug requires a greater level of responsibility than the administration of an oral sedative, or nitrous oxide and oxygen as a single agent.

The College has clearly outlined the dentist's responsibilities in its Guidelines for the Use of Sedation and General Anaesthesia In Dental Practice. These Guidelines are the standard of practice in relation to sedation and general anaesthesia in Ontario. They are enforceable under the professional misconduct regulations.

For easy reference, this article summarizes the requirements for training in sedation, patient assessment and monitoring, recordkeeping, and emergency equipment and training.

## **Training in sedation**

In order to provide conscious sedation using a combination of oral sedative drugs, or nitrous oxide-oxygen inhalational sedation with an oral sedative drug, dentists must have completed training that has incorporated techniques for the administration of more than one sedative agent. The training must include an evaluation of the dentist and attested to his/her competence in these techniques.

Dentists who qualify for the administration of parenteral conscious sedation using a single sedative agent, and dentists who qualify for the administration of deep sedation and general anaesthesia, as outlined in the Guidelines, may also administer conscious sedation using a combination of oral sedative drugs, or nitrous oxide-oxygen inhalational sedation with an oral sedative drug.

Dentists who administer conscious sedation using these modalities are expected to include relevant continuing dental education courses in their personal continuing dental education planning.

## **Patient assessment and monitoring**

The preoperative assessment of patients by the dentist must include a current medical history and an appropriate physical examination. The medical history must include past and present illnesses, hospital admissions, current medications, allergies, and a functional inquiry.

The Guidelines outline the minimal requirements for a core medical history and core physical examination for dentists administering sedation. The College has produced an excellent educational package called Medical History Recordkeeping that is available on-line at [www.rcdso.org](http://www.rcdso.org), or on request from us.

Oral sedative drugs should be administered in the dental office. They should not be taken by the patient prior to presentation at the dental office, except as noted in the Guidelines. If an oral sedative drug has been administered, nitrous oxide-oxygen must be titrated slowly to achieve conscious sedation, and the level of consciousness vigilantly assessed.

During the administration of sedation, the patient must be monitored directly and continuously by the dentist, or by an appropriately trained registered nurse or respiratory therapist acting under the order and supervision of the dentist. The patient must be monitored by means of clinical observation of the level of consciousness and monitoring of vital signs.

When a combination of oral sedative drugs or nitrous-oxide and oxygen with

an oral sedative drug is administered, continuous pulse oximeter monitoring and intermittent monitoring of blood pressure, pulse and respiration must be performed, except as noted in the Guidelines. When a single oral sedative drug or nitrous-oxide and oxygen alone is administered, continuous pulse oximeter monitoring is not required.

When an oral sedative drug, or a combination of oral sedative drugs, or nitrous-oxide and oxygen with an oral sedative drug are administered, the patient must be discharged to the care of a responsible adult once the patient has met the discharge criteria outlined in the Guidelines.

#### **Recordkeeping**

Recordkeeping for sedation must include the patient's vital statistics, a current medical history, physical examination findings, and a sedation record that includes vital signs, details of sedative drugs administered, and information regarding the condition of the patient on discharge, and the other elements listed in the Guidelines. Again, the College's educational package called Medical History Recordkeeping provides an excellent resource for additional information.

#### **Emergency equipment and training**

Gas delivery systems must be equipped and maintained as outlined in the Guidelines, and the alarm setting (including audio) should be used on monitoring equipment. Gas delivery systems must accommodate a full-face mask for resuscitative ventilation. A reserve portable supply of oxygen must be available ("E" size cylinder as a minimum) for emergency situations.

In addition, the College recommends that the dentist have an emergency kit containing the following drugs: epinephrine (injectable), nitroglycerin (sublingual tablets or spray), diphenhydramine or chlorpheniramine (injectable), salbutamol (inhalation aerosol), and acetylsalicylic acid (ASA).

The dentist and staff must be prepared to recognize and to treat adverse reactions using appropriate emergency equipment and drugs, and must be able to perform basic cardiac life support. The dentist and all clinical staff should maintain current cardiopulmonary resuscitation (CPR) training. The dentist should also establish and review protocols for emergency procedures with staff on a regular basis.

The College's CD-ROM learning package on Medical Emergencies in the Dental Office is an ideal resource for the whole dental office to regularly review how to handle common medical emergencies.

If you have any questions, please contact:

#### **Dr. Lesia Waschuk**

*Practice Advisor*

phone: 416-934-5614

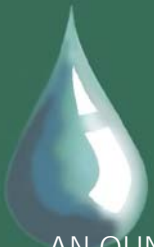
toll-free: 1-800-565-4591

e-mail: [lwaschuk@rcdso.org](mailto:lwaschuk@rcdso.org)

## **FURTHER INFORMATION**

The following information is available on the College's Web site at [www.rcdso.org](http://www.rcdso.org):

- Guidelines for the Use of Sedation and General Anaesthesia In Dental Practice
- Practice Check: Preparing for a Medical Emergency - *Dispatch*, Winter 2000 issue
- Medical History Recordkeeping: A Guide for Ontario Dentists and Their Patients



## AN OUNCE OF PREVENTION

This feature in *Dispatch* has been prepared by the College's Professional Liability Program (PLP) to offer guidance to members regarding the prevention of malpractice claims or the minimization of the magnitude of an existing claim.

RISK MANAGEMENT ADVICE FROM PLP

# Records Records Records

## *The Three Rs of Risk Management*

### WANT ADVICE IN HANDLING A SPECIFIC SITUATION?

*If you have questions about how to handle a particular situation with a patient, call PLP and one of our Claims Examiners will be happy to assist you.*

**phone: 416-934-5600**

**toll-free: 1-877-817-3757**

**M**aintaining clear, concise, accurate and current patient records are an important element of providing safe, appropriate, and quality patient care. They are also the best defence that a dentist might have against claims of negligence or allegations of professional misconduct.

#### THE SCENARIO

Ms. Short presented to Dr. Alpha for new patient examination. Dr. Alpha also took two bitewing and six periapical radiographs. One of the radiographs showed that tooth 44 had been endodontically treated. Dr. Alpha recommended a post/core and crown, and soon after, inserted them.

Eighteen months after the crown was inserted, while Dr. Alpha was on vacation, Ms. Short presented to another dentist, on an emergency basis, with pain in tooth 44. She was referred to an endodontist to discuss possible surgery. However, when Ms. Short learned about the risk of trauma to the mental nerve during surgery, and the possibility of paraesthesia, she opted to have the tooth extracted.

## KEYS TO GOOD RECORDKEEPING

- Use a consistent style for each entry. Consistency lends credibility to your records and reflects your professionalism in maintaining them.
- Check the accuracy of all records typed from dictation.
- Diagrams that locate lesions, growths, and anomalies are helpful in avoiding misinterpretation.
- Take notes while patients give their history. Doing it from memory later is less detailed and less accurate.
- Make sure each entry in the progress notes section of the patient record can be attributed to the treating practitioner.
- Always use ink, as pencil tends to fade and may be too easily altered. Should your records be evaluated for litigation or complaints investigation purposes, use of ink would support their integrity.
- If you need to make a change, use a single-line cross out. Do not try to erase or white out information, as this may lead to suspicions about the records.
- No changes, additions or deletions should be made after notification of a malpractice claim or formal complaint. Subsequent notes should be made separately and accurately dated.
- Write legibly. If another practitioner were to take over the care of the patient, he/she should be able to review the chart and treatment plan and continue with the necessary care.
- Document clinical and radiographic findings and the diagnosis, or the reason for treatment.
- Make sure that the informed consent discussion process and the information provided has been well-documented in the progress notes section of the chart.
- If a patient refuses treatment or refuses a referral to a specialist, document the refusal.
- Make sure that the patient's consent has been obtained for the release of a copy of or information from their record. The only two exceptions to this rule are cases involving court orders and communication with the RCDSO, and that includes PLP.
- Note any concerns about the patient's needs and expectations and how they have been addressed with the patient.
- If mishaps occur, e.g. separated endodontic file, untoward result, immediately inform the patient, provide treatment options to correct the problem, i.e. referral to a specialist. Record this discussion and the patient's reaction to it in the progress notes.
- Never make derogatory remarks in the record. Do note any failure or reluctance on the part of the patient to follow treatment advice or report for treatment, but do so in a professional, objective fashion. Remember the patient and/or the patient's lawyer has the right to obtain a copy of the chart at any time.

### THE FOLLOWING INFORMATION DOES NOT BELONG IN A PATIENT'S CHART:

- **Criticism of care provided by others.**
- **Derogatory remarks about patients, staff or other professionals.**
- **Communication with the Professional Liability Program and/or communication with the patient's lawyer.**

Ms Short subsequently alleged Dr. Alpha was responsible for the loss of tooth 44 and advanced a claim for loss of wages, pain and suffering, and strain on her family.

### THE DISCUSSION

Dr. Alpha claimed that he clearly recollected his discussion with Ms. Short regarding tooth 44. He explained that he remembered showing her the periapical radiograph he had taken in the lower right quadrant. It showed that the endodontic fill of tooth 44 was 5mm short of the apex. There was also a large periapical radiolucency on the mesial aspect of the root.

*Continued on page 30*

# Records, Records, Records

## The Three Rs of Risk Management

*Continued from page 29*

He recalled discussing the need for retreatment of tooth 44 with Ms. Short and advising her that, without retreatment, the tooth might become symptomatic. He had urged Ms. Short to see an endodontist for consultation, and had explained that, if he placed the post, retreatment would probably not be possible, and surgery would be required. He also recollected telling her about the risk of paraesthesia with surgery due to the location of the mental nerve. He said Ms. Short had said she just wanted a crown because the tooth was unsightly, and she did not want to go through another root canal. Her first experience with root canal on that tooth had been very bad. She had said if the tooth flared up she would simply have it extracted and replaced with a bridge.

In reviewing Dr. Alpha's records, PLP had the following concerns:

1. The records were severely deficient.
  - There was no record of clinical or radiographic findings specific to tooth 44.
  - There was no evidence in the records of any discussion about the need for retreatment of tooth 44, prior to placement of the post/core and crown, or that Dr. Alpha had advised Ms. Short of the risks of not accepting his recommendation.
  - Finally, there was no documentation to confirm that Ms. Short refused Dr. Alpha's recommended referral to an endodontist.
2. As well, after reviewing the records on behalf of Ms Short, a pathologist concluded that the 18-month delay in treatment had resulted in the development of an apical cyst, and there was a possibility it might not resolve following the extraction. Because of the tooth's proximity to the mental foramen, removal of the residual cyst, if necessary, could traumatize the mental nerve and cause paraesthesia.

With the records available, PLP would not have been able to hold a good defence in a court of law. PLP, therefore, recommended settlement of the claim, and Dr. Alpha agreed. PLP subsequently

negotiated a settlement amount, and obtained Ms Short's full and final release in favour of Dr. Alpha. This release stated specifically that Dr. Alpha had not admitted liability.

For risk management purposes, it is necessary to keep in mind that the courts have consistently held that matters not recorded in the patient chart at the time each treatment is rendered and/or advice is given, did not happen.

On a positive note, the reverse is also true. Information recorded in a patient record by a health professional at the time of treatment is considered by the courts to accurately reflect the circumstances of the particular appointment, including the treatment rendered and discussions with the patient.

If you have questions or comments about this article, contact:

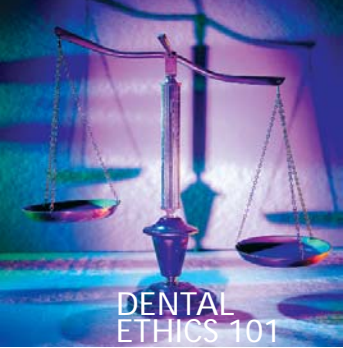
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## Ethical Dilemma Case Study

# I Want the Whitest Teeth!

**H**arold Davies is a patient who has come to your office eager to improve his appearance with a new set of dentures. He is a healthy, 64-year-old male, who believes that these dentures will help him feel “younger and more vigorous.”

After completing your dental history and clinical examination, you conclude that Mr. Davies’s existing dentures are more than seven years old, and not aesthetically pleasing due to interproximal staining. You also believe that the fit could be improved.

Two weeks later, having completed the jaw relationship records, you begin tooth and shade selection. Mr. Davies states “just give me the whitest shade you have!” With his ruddy complexion, you emphatically inform him that this would not look natural. Mr. Davies insists “I want the whitest teeth!”

*Printed with the permission of Dr. Thomas K. Hasegawa, Baylor College of Dentistry, Dallas, Texas.*

### What Would You Do?

You are now faced with an ethical dilemma. Choose the course of action you would follow.

1. Show Mr. Davies the whitest shade.
2. Show Mr. Davies only those shades that you think are appropriate choices.
3. Insist that, if Mr. Davies doesn’t trust your judgement, he should find another dentist.

**Now turn to page 40 to find the case study discussion of this ethical dilemma.**



When the Complaints Committee issues a decision, either the member or the complainant has a right of a review by the Health Professions Appeal and Review Board (HPARB) – as long as it is not a referral of specified allegations to the Discipline Committee.

Under the *Regulated Health Professions Act*, HPARB hears appeals and reviews decisions made by the self-governing regulatory agencies of the 23 regulated health professions.

The following summaries of some HPARB reviews are published in *Dispatch* as an educational resource for both members and the public. Institutional parties may be named, but individual parties will not.

If you would like a full version of any of these decisions, contact the HPARB at 416-327-8515 or RCDSO at:

**Petula Widyaratne**  
*Co-ordinator, Complaints*  
 phone: 416-961-6555, ext. 5311  
 toll-free: 1-800-565-4591  
 e-mail: pwidyaratne@rcdso.org

# On Appeal

## CASE #1

### THE COMPLAINT

The parents attended with their minor child at the dentist's office for a consultation about braces. The dentist examined the child and quoted a fee, but did not charge for the appointment.

Subsequently, the parents complained that the dentist billed their insurance company for x-rays, scaling and polishing. They also said that they were unaware that the dentist was a general dentist, not an orthodontist.

The dentist responded that these procedures had been done and that he had explained this to the parents. Then, the same information was reiterated by the receptionist when the office called to confirm the appointment. All this was properly charted.

### COMPLAINTS COMMITTEE

The Committee ordered no further action. The Committee was satisfied informed consent had taken place. The Committee believed it was appropriate for scaling and polishing to be done, since the minor had not seen the dentist for some two years. In addition, the Committee observed that nothing in the dentist's information stated that he was an orthodontist; quite to the contrary, as the dentist's privacy information sheet stated specifically that he "was not an orthodontist." Finally, the charts and

records indicated the dentist had stated that, if the treatment was beyond his skill, he would refer the patient to an orthodontist.

### HEALTH PROFESSIONS APPEAL AND REVIEW BOARD

The parents were dissatisfied with the decision of the Complaints Committee and appealed to the Board. The Board was impressed with the reasons of the Complaints Committee's decision, and with the records of the dentist. Therefore, HPARB confirmed the decision of the Complaints Committee.

## CASE #2

### THE COMPLAINT

The complainant alleged that the dentist failed to properly treat decay in several teeth, resulting in endodontic treatment and the fracture of a tooth. In addition, the dentist interfered with future treatment by advising the subsequent treating dentist not to treat the patient. Finally, the patient complained that the dentist's conduct was unprofessional, and he was loud and rude.

### COMPLAINTS COMMITTEE

The Committee reviewed the x-rays, charts, and records, and noted that the patient had rampant decay and dentition in poor condition. It also observed that

the dentist attempted to provide treatment within the financial means of the patient. The Committee stated that, given the size of the pre-existing filling, it was not surprising that the patient would experience post-operative pain. In fact, the patient was advised of this beforehand. As there was no apparent nerve exposure during the procedure, the dentist was correct to continue placing the filling. When the patient later complained of pain, the patient was referred to an endodontist.

The treatment appeared to be within the standards of the profession. There was no indication of any interference with the treatment of the patient by the subsequent dentist, nor was there any corroboration of the allegations.

### HEALTH PROFESSIONS APPEAL AND REVIEW BOARD

The complainant was dissatisfied with the decision and appealed to the Board. The Board was satisfied with the College's investigations, as it was clear that there was no compelling information to support the allegations. HPARB confirmed the decision of the Complaints Committee.

### CASE #3

#### **THE COMPLAINT**

A patient complained that when she attended the dentist office for an examination, the dentist commented that her existing bridgework had problems and needed to be redone. The dentist suggested that the patient write to the dentist that originally provided the bridge to ask for a refund to cover the cost of the new bridge, and to complain to the College.

The patient did so, and the dentist proceeded to do work.

The patient made several allegations: certain work, such as laser gum surgery, was done without a consent; the new bridge was poor, did not fit properly and did not look good; and the dentist pressured the patient to have the bridge permanently cemented and her teeth whitened.

#### **COMPLAINTS COMMITTEE**

The Committee ordered a Caution, stating that it is not generally a good practice to advise a patient to complain about another dentist's treatment in order to get payment into the hands of the subsequent treating dentist. The Committee, in reviewing the work of the dentist, felt that, in all other respects, the work was within standards. As for the laser surgery, the notes and records of the dentist indicated the patient had given consent.

#### **HEALTH PROFESSIONS APPEAL AND REVIEW BOARD**

The complainant was dissatisfied and appealed the decision. Based on the records and the reasons of the Committee, HPARB confirmed the decision of the Complaints Committee.

### CASE #4

#### **THE COMPLAINT**

The patient complained to the College with several allegations: her dentist did not inform her of gum disease; he continued to treat, rather than refer her to a periodontist; and there was supervised neglect.

#### **COMPLAINTS COMMITTEE**

The Committee reviewed, in depth, the charts and records of the dentist. The Committee noted that it was obvious that the periodontal condition had been an issue for at least seven years, and the patient was made aware of the periodontal condition. The dentist had made notes such as "told of moderate gum disease, especially mandible-lingual" and "periodontal status explained."

The Committee wrote in its reasons that the condition was made clear to the patient, and that the dentist had decided to monitor the patient to determine her stability and treatability. It was difficult for the Committee to determine what else the dentist could have done, unless the patient had agreed to be referred to a periodontist. The Committee, therefore, ordered no further action.

#### **HEALTH PROFESSIONS APPEAL AND REVIEW BOARD**

The complainant was dissatisfied with the decision and appealed to the Board. The Board was satisfied with the investigation and found the Committee's decision to be reasonable given the notes and records of the dentist. For these reasons, the Board confirmed the decision of the Committee.

## Web Site Spotlight

### **Hotlink to Health Canada's Adverse Drug Reaction Information System**

For the first time, all Canadians now have immediate and direct access to the latest reported adverse reactions to health products as recorded in Health Canada's Canadian Adverse Drug Reaction Information System. This system receives reports of suspected adverse reactions from consumers, health-care professionals and product manufacturers.

The database can be searched by the name of the product or active ingredient, the date a report was received, patient age and gender, and the outcome of the report.

Go to the College Web site at [www.rcdso.org](http://www.rcdso.org) and click on the Important Health Notices box on the lower right-hand side of the screen.



## COMPLAINTS CORNER

of the cases dealt with by the Committee. The law does not allow for either the dentist or the complainant to be identified.

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 Complaints Committee.

These scenarios are an edited version of some

If you have any questions about this column, please contact:

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*Registrar*  
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toll-free: 1-800-565-4591  
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# Complaints Corner

## CASE # 1

### Complaint Summary

A complaint was filed with the College regarding unsuccessful root canal treatment and subsequent loss of the tooth in question. Concern was also expressed about the refusal of her regular dentist to transfer her records to her new dentists even though a release had been signed.

According to the complainant, during the course of having root canal treatment (RCT) performed on one of her molar teeth, the dentist broke off a part of a file and was unable to remove it. A temporary restoration was placed, and the complainant was referred to an endodontist who removed the broken file and placed a temporary restoration. The patient subsequently contacted her regular dentist for an appointment to complete the RCT with a permanent restoration.

The patient stated that she was advised that no appointment could be booked until the office received the endodontist's report and, furthermore, she never received a call back to schedule an appointment. As a result, the temporary filling fell out and the tooth collapsed. According to the patient, when she contacted the office again to schedule an appointment for extraction of the tooth,

she was told to return to the endodontist for the extraction. She went to the endodontist who then referred her to an oral surgeon to have the tooth removed.

### The Dentist's Perspective

According to the dentist, following an examination and review of radiographs, she diagnosed irreversible pulpitis of tooth 46 and scheduled a RCT. While performing the RCT, a file separated in the mesial lingual canal. The treatment was stopped, a temporary restoration was placed and the patient was advised that she would need to see an endodontist. An appointment was booked for the patient with an endodontist.

The dentist was advised by the endodontist that the separated instrument had been removed and RCT had been completed on the tooth in question. The dentist's staff then telephoned the complainant and left a message for her to contact the office to schedule an appointment for a restoration. However, the complainant did not call.

Approximately two months later, the patient contacted the office and said she was in pain. She was referred to the endodontist's office and was seen that same day. The endodontist advised the regular dentist that tooth #46 would need to be extracted. A subsequent

appointment was booked with an oral surgeon for extraction of tooth #46.

The regular dentist later received a telephone call from the complainant's new dentist asking for the complainant's radiographs to be forwarded to his office. The complainant came subsequently to sign a release, and the duplicate radiographs were forwarded to the new dentist.

### Complaints Panel Decision

The Complaints Panel, after reviewing the complainant's patient records, believed that the procedures performed by the dentist were required, were performed with the best interests of the patient in mind, and that they met the standards of practice of the profession.

The panel was of the view that the fact that an endodontic instrument had separated in the mesial lingual canal of tooth #46, while unfortunate, was an unpredictable occurrence, that this can happen on rare occasions. In their view, the actions taken by the dentist following this incident were correct. The patient was advised of what had occurred, and made a referral to a specialist for treatment when she realized that removal of the file was beyond the scope of her practice.

Regarding the issue of the subsequent failure of the root canal therapy, the

panel was satisfied that the complainant was informed that a permanent restoration would be required to protect tooth #46. In the covering letter that accompanied the endodontist's records, he stated that the complainant was advised of the need for a permanent restoration. The panel also noted in the patient records, forwarded by the dentist, that the complainant was advised that a permanent restoration was required, and that tooth #46 needed a crown. The panel was fully satisfied that the complainant was made aware of the requirement for replacement of the temporary restoration.

With respect to the issue of transfer of records to the new dentist, the panel was satisfied that the dentist forwarded the radiographs requested by the new dentist in a timely fashion and that the forwarding of duplicate radiographs was sufficient to meet the requirement of the College's Transfer of Records and Recordkeeping Guidelines.

### **Lessons Learned**

Whenever a mishap occurs in dental practice, the patient must be informed and given the recommended treatment options to correct the problem, including referral to a specialist.

In this case, the dentist's records were helpful to the panel in that they spelled out the various messages given to the patient, and showed that she was well informed of the need for, and the importance of, the placement of a final restoration when the root canal treatment was completed.

The panel was also pleased to see that the dentist followed the recommended protocols for the transfer of patient records to a new dentist and had obtained the patient's written authorization to do so.

## **CASE # 2**

### **Complaint Summary**

According to the patient, her general dentist last saw her approximately 18 months prior to filing her complaint. During the fall of 2003, she went to another dental clinic where she was advised she required seven root canals and four basic fillings for a total cost of approximately \$5,400.

### **The Dentist's Perspective**

According to the dentist, during the 12 years that he treated the complainant, he had never noted a periodontal problem. It was his opinion that the problems outlined in the letter of complaint related to a high decay rate, possibly influenced by diet, genetics, and saliva with an acidic pH. He noted that seven years prior to this complaint, the complainant had several large and deep carious lesions that followed 45-month interval between examinations. The rate of decay continued, and taxed the integrity of the teeth, and the properties of the available restorative materials. The dentist concluded that based on this history, root canal therapy and full coverage crowns was inevitable.

### **Complaints Panel Decision**

After reviewing the pre- and post-treatment radiographs and records, the Complaints Panel had a number of concerns related to:

- the dentist's radiographic technique and interpretation, including diagnosis and treatment planning;
- the dentist's ability to place composite resin restorations and the adequacy of the decay removal;
- the dentist's recordkeeping that demonstrated a lack of detail about oral diagnosis and treatment planning.

In order to address the panel's concerns, the dentist voluntarily signed an

Undertaking Agreement to take and successfully complete, at his expense:

- a hands-on course in restorative dentistry focused on the placement of composite resin restorations and decay removal;
- a course in radiology that emphasizes radiographic technique and interpretation, including diagnosis and treatment planning;
- a course in recordkeeping.

Following successful completion of these courses, the member also agreed to allow his practice to be monitored for a period of two years.

The Committee also required the dentist to attend before a panel of the Committee to be cautioned with respect to the above issues.

### **Lessons Learned**

In addition to attending continuing education courses on modern dental techniques and materials, it is important for dentists to also include courses or other educational programs in their continuing education plans that focus on the basic principles of dental practice. Topics such as review courses on dental materials, principles of cavity preparation, RCDSO Roadshows or other presentations on recordkeeping, informed consent etc. are but a few examples.

It is the College's experience that lapses in some of these practice basics have made it difficult for dentists to defend themselves when their conduct is under the scrutiny of a formal complaints investigation.



## 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 on request or due to its confidential nature. All letters

printed in Mailbag are used with the author's permission.

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

Please send your letters to:

**Peggi Mace**  
*Communications Director*  
Surface mail: RCDSO, 6 Crescent Road, Toronto, ON M4W 1T1  
fax: 416-961-5814  
e-mail: pmace@rcdso.org



I am a dental student at the University of Toronto and have just completed my first year. I am writing to express my deep appreciation and gratefulness for being awarded the RCDSO Scholarship in Basic Sciences. I thoroughly enjoyed first year dental histology and worked with the professor (Dr. Eric Freeman) to make significant improvements to the course curriculum. The enhancements we made are in the process of being formally written and published. Once again, thank you for the generous award.

**Jaffer Yusufali Kermalli, BSc, DDS Candidate**

Thornhill



I just wanted to send a note about how impressed I was with your help during my unusual experience. You [PLP Claims Examiner] were exactly correct in every aspect of your recommendations in dealing with one of my patients. The patient settled very happily with the arrangement we discussed. Another unusual aspect to the situation is that I believe he may want to return to me as a future patient. How can I politely refuse him without getting myself into trouble? It was a pleasure dealing with you, and, although I hope this situation does not happen again, I am comforted that I may have the opportunity of working with you again.

EDITOR'S NOTE

*In a separate e-mail message, the PLP Claims Examiner provided the dentist with*

*the following reference material about dismissing a patient that is available on our Web site at [www.rcdso.org](http://www.rcdso.org):*

- *Dispatch – July/August 2002, pages 24/25*
- *Dispatch – Fall 2000, pages 8/9*

*Also, advice on management of a situation or dismissal of a difficult patient is always available from the College's Practice Advisor Dr. Lesia Waschuk at 416-934-5611, toll-free at 1-800-565-4591 or e-mail at [lwaschuk@rcdso.org](mailto:lwaschuk@rcdso.org).*

*Also, see the article on page 22 of this issue about how to dismiss a patient.*



Thank you very much for writing a letter on behalf of me to the Sheriff to defer my jury duty. I appreciate your efforts to support me and I congratulate all of you at the College for the wonderful things you do for the dental profession in Ontario, particularly, the continuing educational CD on medical emergencies and the privacy kit and support information. Once again, I thank you for your assistance.

**Dr. Mohan Pancharathnam**

Nepean



On behalf of the Ontario Society of Oral and Maxillofacial Surgeons, I would like to thank you [Irwin Fefergrad] and Peggi Mace for meeting with myself and members of our hospital services committee. The threat to hospital services for the provision of dentistry is of great concern to us. We certainly

appreciate your insight and possible suggestions as to how we should go in dealing with this situation.

We will wait until the end of June when the Canadian Association of Oral and Maxillofacial Surgeons meets to see if this issue is of national concern. If not, we will certainly deal with the threat to hospital services on a provincial basis. The idea of developing a retreat involving all of the relevant stakeholders seems to be an appropriate plan of action.

Once again, we are grateful for your support, both in this issue, and as well, with many others that we are currently dealing with. We look forward to a continued and fruitful relationship with you and the RCDSO.

**Eddie I. Reinish, BSc, DDS, FRDC(c)**  
*President, Ontario Society of Oral and Maxillofacial Surgeons*



Just a quick thank you to the College, and especially Irwin Fefergrad, for helping me with my summons for jury duty. Thanks to the letter from Mr. Fefergrad sent to the Sheriff on my behalf, I received a phone call letting me know I would not be required to attend for jury duty. Your help in this matter was greatly appreciated. Thanks again.

**Dr. Zane Zelsman**

Markham

# Insurance Meeting Clarifies Issues

In response to concerns with some correspondence between Manulife insurance company and Ontario dentists, representatives from the College and the Ontario Dental Association (ODA) met on August 23 with Manulife staff in Kitchener.

“At the meeting we clarified that it is inappropriate and unsafe for Manulife, or any insurance company, to have a letter going out to a patient that speaks to diagnosis, and then communicates that diagnosis,” explained RCDSO Registrar Irwin Fefergrad.

“The *Regulated Health Professions Act*

reserves this responsibility, as a controlled act, to the treating dentist. Anyone else performing this controlled act is in breach of the RHPA, and the *Provincial Offences Act*.

“We advised them that any concerns about inappropriate billing practices or the recommendation of unnecessary services should be directed immediately to us here at the College,” explained Fefergrad. “Manulife was very responsive to our points.”

ODA, with its extensive experience and expertise in insurance claims, has offered to assist Manulife in drafting

correspondence to avoid similar issues in the future.

If you have any questions, please contact:

**Irwin Fefergrad**

*Registrar*

phone: 416-934-5625

toll-free: 1-800-565-4591

e-mail: ifefergrad@rcdso.org

**Peter Arison**

*Director, Advisory Services*

*Ontario Dental Association*

phone: 416-355-2254

toll-free: 1-800-387-1393

## HAVE A PROBLEM?

*Call at any time for confidential, compassionate support.*

The College is pleased to lend its support to the Member Assistance Program that the Ontario Dental Association (ODA) offers to the entire dental community through its Dentists At Risk Program.

Services include short-term counselling, consulting and referrals at no cost to dentists, their families and dental office staff. Any dentist in the province registered with the College (whether a member of ODA or not), a dental student or retired dentist can call for help 24 hours a day, seven days a week.

Call the CDSPI Member Assistance Program anytime – 24 hours a day, seven days a week.

- It is absolutely free.
- Absolutely confidential.
- Available when you need it.

## CALL 1-800-268-5211

# New Challenges Ahead In 2006

*Continued from page 4*

provide substantive oral health care to vulnerable adults.

Ontario's standard of dental care is one of the highest in the world, yet we all probably know of people whose lack of dental care prevents them from fully participating in society. While there is no one easy answer to this problem, Council will continue to forge ahead to find long-term viable solutions.

This year the issue of access to the profession by foreign-trained professionals has been high on our priority list. The College has taken a leadership role nationally to find solutions that are tailor-made for the

dental profession. There is incredible political pressure to weaken a system that works so well to protect the public.

As I have stated before, and I will again, Council will not go that route. We are holding firm to maintain our values and principles. We believe strongly in accreditation, competence and licensure. We are not going to do anything to jeopardize these principles. Nor will we to do anything that will threaten our ability to ensure public safety.

Closer to home, Council, with the PLP Committee, is working diligently to ensure that our professional liability program is on even more solid financial

footing for the future. By running our own malpractice program, we are able to offer the dentists of Ontario one of the best financial deals of any regulator in the country. And at the same time, we provide patients with consistent protection right across the province.

So, once again, we have our work cut out for us. No doubt there is another exciting year ahead. I know that Council is up to the challenge. I hope you will consider joining the team here at the College as we meet the future head-on.

---

# De nouveaux défis à relever en 2006

*Suite de la page 5*

le manque d'accès aux soins dentaires les empêche d'intégrer complètement la société. Il n'y a pas de solution simple, le Collège va continuer ses efforts pour trouver une gamme de solutions viables au problème de l'accès aux soins.

Le Collège doit aussi trouver un équilibre délicat sur le sujet brûlant de l'accès des dentistes formés à l'étranger au marché du travail canadien. Le Collège assume déjà le leadership en matière de recherche de solutions adaptées aux besoins de notre profession. Nous subissons une pression

politique incroyable qui pourrait affaiblir notre système, qui protège bien le public.

Le Collège entend maintenir le cap. Comme je vous l'ai déjà affirmé, le Collège est catégorique quant au maintien de ses valeurs et principes. Nous croyons fermement en la reconnaissance professionnelle, la compétence et le droit d'exercer. Nous ne ferons rien qui puisse compromettre ces principes. Et le Collège ne compromettra pas non plus ses responsabilités en matière de sécurité et de protection du public.

Enfin, le Conseil d'administration, en collaboration avec le comité d'assurance responsabilité professionnelle, est en train d'évaluer notre régime d'assurance pour s'assurer de sa stabilité. En gérant

notre propre régime d'assurance contre la faute professionnelle, le Collège est capable de fournir à ses membres le contrat d'assurance le plus concurrentiel parmi tous ceux offerts par les organismes de réglementation canadiens. Et en même temps, le niveau de protection dont bénéficient les patients est maintenu et renforcé.

Une fois de plus, nous avons du pain sur la planche. L'année 2006 promet d'être riche en événements. Notre Conseil d'administration est à la hauteur des défis à relever. Et je vous encourage à venir vous joindre à cette équipe.



## ACROSS THE NATION

from their publications or have been submitted by the regulators themselves.

Across the Nation provides a snapshot of activity highlights of the dental regulators across Canada that may be of interest to dentists in Ontario. They are gleaned

If you have any questions about this column, please contact:  
**Irwin Fefergrad**  
*Registrar*  
phone: 416-934-5625  
toll-free: 1-800-565-4591  
e-mail: ifefergrad@rcdso.org

# Across the Nation

## Alberta

### **New President**

Dr. Jack Sherman is the new president of the Alberta Dental Association and College as of July 1. He is a graduate of the University of Alberta and has practised in Lethbridge since 1967.

### **Amalgam Separators**

The Alberta Dental Association and College is recommending that its members have amalgam waste separators installed by the end of 2005.

### **Help for Dentists in Financial Need**

The Alberta Dental Association and College has set up a Compassionate and Loan Fund to help members gain access to counselling, on an ongoing basis, where they need help with a financial burden. Government and local dental societies have been approached to help with the funding of this benevolent fund.

## Saskatchewan

### **New Registrar**

Dr. Bernie White of Saskatoon is the new full-time Registrar/CEO of the College of Dental Surgeons of Saskatchewan. He replaces the part-time registrar Dr. P. Grassick.

### **Amalgam Separators**

The deadline for the voluntary installation of amalgam separators is December 30, 2005, after which date, the installation may be mandated by the College of Dental Surgeons of Saskatchewan.

### **Advertising**

Bylaw amendments are underway at Saskatchewan's College of Dental Surgeons to deal with the inclusion of unearned or unaccredited degrees that imply a specialty, and the publishing of letters of apology from members who violate these bylaws.

## New Brunswick

### **New President**

Dr. Andrew Rowe of Fredericton, a graduate of the University of Western Ontario, was elected as President of the New Brunswick Dental Society in June 2005.

## Nova Scotia

### **New Registrar**

Dr. Bill MacInnis, former dean of the Faculty of Dentistry at Dalhousie University, is now the new Registrar of the Provincial Dental Board of Nova Scotia. He continues to teach at Dalhousie in the dental clinical sciences department. He recently co-authored a book entitled "Dental Law In Canada."

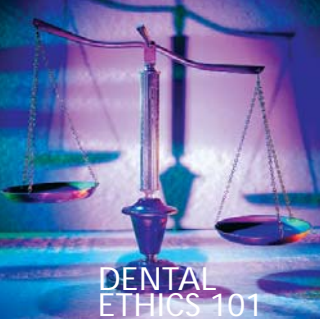
## Manitoba

### **Seniors Oral Health Care**

The Manitoba Dental Association has set up a working group to brainstorm an action plan to, among other things, create a co-ordinating body to facilitate efforts across the province to deliver dental care to home-bound seniors and residents of personal care homes.

### **First International Graduates**

The Faculty of Dentistry at the University of Manitoba graduated its first group of international dentists this past June from its two-year International Dentist Degree Program. The University of Manitoba is one of only three Canadian institutions, including the University of British Columbia and the University of Alberta, to offer a degree program for international students.



## Case Study Discussion What Should You Do?

The Dental Ethics 101 Ethical Dilemma Case Study appears on page 31.

# I Want the Whitest Teeth!



The ethical dilemma, presented on page 31, dealt with a 64-year-old patient, Harold Davies, who demanded the whitest shade of

teeth possible on his new dentures. This request was in conflict with the dentist's view that the aesthetic result would not look natural.

Mr. Davies desire to feel "younger and more vigorous" is part of our culture to improve our health, our bodies, and our overall appearance. Articles in the popular press, makeover reality television programs, and the promotion of cosmetic dentistry by dental materials companies and dentists alike, all accelerate the public's quest for a beautiful smile.

The discussion of this particular case raises the following questions:

- Are dentists simply the agent for patients like Mr. Davies in their quest for an enhance self-image?
- Are dentists responsible to inform patients of their aesthetic flaws, just as they inform them of their periodontal condition?
- How do dentists balance patients' demands for cosmetic dentistry

against questions of function and their own professional judgement about aesthetics?

The ability to restore function and aesthetics is one of the distinctive qualities of dental practice. The interplay of these qualities may be clarified by viewing two standards for aesthetics, and by relating these standards to oral function and patient autonomy.

### **Aesthetics – Two Standards**

Aesthetics has been described as having both an objective and subjective sense: the former concerned with the beauty of the object itself, e.g. proportion and harmony, and the latter with what is beautiful in the eyes of the beholder, e.g. the patient's perspective.

The objective element of aesthetics and complete denture prosthodontics has been described as "an area of prosthodontics where art dominates science, where aesthetics is the major concern, and where knowledge must be applied to create a pleasing appearance while simultaneously maintaining oral function."

Creating objective esthetics requires that the dentist assess Mr. Davies' oral anatomy, facial features, current dentures and photographs of the patient, if possible. The dentist then makes an objective decision about tooth colour, size, and morphology, the arrangement

of the teeth to create optimal lip support, tooth display, anatomic harmony, phonetics, and the gingival colour and tooth material.

Prosthodontists have acknowledged the subjective aesthetic preferences of patients and have, for example, identified three types of pleasing appearances:

1. the natural look selected by the dentist;
2. the ideal look characterized by a youthful appearance;
3. the preferred appearance achieved by the orthodontist or represented by small white teeth.

The interplay of subjective and objective esthetics illustrates one of the subtleties of dental practice. Mr. Davies, who desires to look "younger and more vigorous," is making a subjective judgment about aesthetics when he asserts, "just give me the whitest shade you have." The dentist, however, views this 64-year-old man with the ruddy complexion, and wonders if a dentist's objective assessment of aesthetics could realistically include the white shade demanded by the patient.

The elements of patient autonomy and oral function are also effected by the patient's subjective and the dentist's objective judgments about esthetics.

### **Appropriate Oral Function/Patient Autonomy**

The dentist is permitting Mr. Davies to exercise his autonomy with his selection of the tooth color for his complete dentures. However, is the dentist merely the agent who fulfills patient requests and is, therefore, free of responsible clinical decision-making?

Patients may have a diminished autonomy when they are in pain or have compromised oral function and esthetics. The edentulous patient has suffered a loss, just as patients who suffer the loss of another body part and must adapt to a prosthesis. Some argue no prosthetic restoration, even if mechanically and aesthetically perfect, can restore a person's image of himself as a whole person with no parts missing.

Most patients adapt to complete dentures, and some even welcome the treatment. Even if they do adapt, they may feel, however, as one patient said: "The denture fits, I am not suffering any physical pain, but part of me is gone. These are not mine, they are a deadpan of myself."

The edentulous patient may feel as physically and psychologically vulnerable during a dentist's oral

examination as during a physician's physical examination. One patient expressed the pain of seeing herself without dentures by saying "It just ripped my whole self apart. I felt I was old...it was absolutely ghastly!"

Although Mr. Davies's choice may seem misguided, even foolish, he has not asked for a treatment that is harmful, or will compromise his appropriate oral function.

Philosopher D.T. Ozar has ranked value categories in clinical dental ethics to establish a hierarchy that compares conflicting values in an ethics case. Ozar reasons, for example, that "accepting a trade-off which would leave a patient with significantly impaired oral function, even for the sake of autonomy...would be unethical practice."

For example, if another patient requested full mouth extraction of his healthy, natural, objectively aesthetic dentition so that he would feel "younger and more vigorous," his request would not override the dentist's responsibility to make a clinical judgment, and determine if the treatment would significantly impair the patient's appropriate function.

### **Conclusion**

When patients request aesthetic dentistry, the subtle considerations of objective and subjective esthetics, and the elements of respect for patient autonomy and preserving appropriate function, must be considered in each case.

Although Mr. Davies's subjective request may not be congruent with the dentist's more objective judgment, in cases where appropriate function is not compromised, the dentist should attempt to educate the patient about these differences. However, in the end, the dentist is justified in deferring the final judgment to the patient.

From a risk management perspective, it is wise to record all discussions with the patient in the chart, as well as the fact that the patient had given approval for the shade ultimately selected.

*Printed with the permission of Dr. Thomas K. Hasegawa, Baylor College of Dentistry, Dallas, Texas.*

## **MARK YOUR CALENDAR**



**MARCH 2, 2006  
RCDSO Council**

Westin Prince Hotel  
900 York Mills Road  
Toronto

Seating is limited so if you wish to attend please let us know in advance by contacting:

**Angie Sherban**

Senior Executive Assistant

phone: 416-934-5627

toll-free: 1-800-565-4591

e-mail: asherban@rcdso.org

*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.*

# Have you earned your 6 CE points for completing the medical emergencies CD home study?

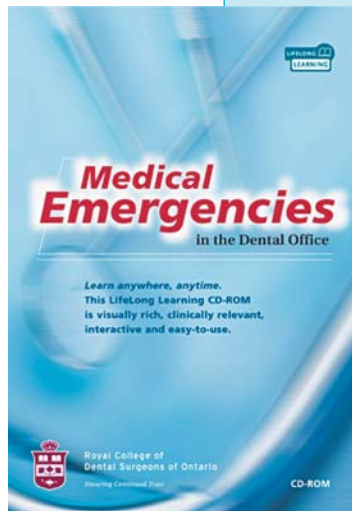
The College's continuing education CD, Medical Emergencies in the Dental Office, continues to receive rave reviews. This program, developed as part of the College's Lifelong Learning Program, was distributed at no cost to members in April this year. Members who have faxed in the completed questionnaire form to the College have already collected six continuing education points.

Members' feedback highlights the convenience of taking the course in the comfort of their office or home at a time that suits them. Many have remarked on how easy it is to enhance their staff's professional development by including them in a review of pertinent areas of the CD program.

Information on how to receive the six CE points is right on the CD and on the instruction sheet enclosed in the distribution package.

If you have any questions, contact:

**Dr. Robert Carroll**  
Manager, Professional Practice  
phone: 416-934-5611  
toll-free: 1-800-565-4591  
e-mail: rcarroll@rcdso.org



## ***One Dentist's Story About the Powerful Impact of Viewing the College's CD-ROM on Medical Emergencies in the Dental Office***

I would like to relay a story about an incident that occurred in my practice earlier this summer. I had just received the CD-ROM Medical Emergencies in the Dental Office and reviewed it in my spare time. It was excellent.

Coincidentally enough, two days later a patient of mine had a full-blown anaphylactic reaction to an anaesthetic, just like the one shown in the introduction to the video. The resemblance to the scenario was unreal! The patient went blotchy and was grasping her throat as the airway was closing. I administered 50 mg of Benadryl by intramuscular injection and waited a minute or so, but the symptoms worsened. I immediately administered 1 mL of 1:1000 epinephrine and within minutes her breathing became better.

This story has a happy ending and I wanted to thank CDA for having the foresight to provide its members with that excellent CD-ROM that all dentists should be familiar with. In 10 years of practice, I had

never seen anything like this before. The timing of the video and the event was uncanny. I thought you might find this realworld story of interest.

**DR. LONNY LEGAULT**  
*Prince George, British Columbia*

### **JCDA EDITOR'S NOTE**

The Royal College of Dental Surgeons of Ontario (RCDSO) developed the CD-ROM Medical Emergencies in the Dental Office for distribution to Ontario dentists. RCDSO graciously approached CDSPI (which administers the Canadian Dentists' Insurance Program's malpractice plan) and invited them to distribute the material across Canada. CDSPI and CDA felt that the CD-ROM was a useful continuing education resource and distributed it to dentists outside of Ontario who were participants of the malpractice plan and whose licensing body agreed to provide CE points for the test.

*Our thanks to the Canadian Dental Association for its permission to reprint this article from the September 2005 issue of the Journal of the Canadian Dental Association.*

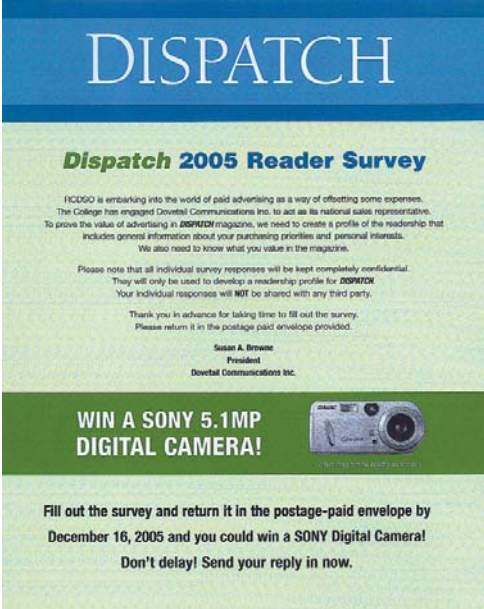
### **DISPATCH EDITOR'S NOTE**

This is an amazing story. It is tangible proof of the importance of the College's new LifeLong Learning Program and of our commitment to the production and distribution of high quality learning packages like the Medical Emergencies in the Dental Office CD-ROM.

# Thanks for Your Help!

A special thanks to our readers who filled out the readership survey that accompanies this issue. It takes just a few minutes. You can return it in the postage-paid envelope provided. Your participation will help our national sales representative, Dovetail Communications Inc., assemble a strong business case for advertising with the College. Thanks again for your support.

**Peggi Mace**  
Communications Director  
Editor, *Dispatch*



**DISPATCH**

**Dispatch 2005 Reader Survey**


RCDGO is embarking into the world of paid advertising as a way of offsetting some expenses. The College has engaged Dovetail Communications Inc. to act as its national sales representative. To prove the value of advertising in *DISPATCH* magazine, we need to create a profile of the readership that includes general information about your purchasing priorities and personal interests. We also need to know what you value in the magazine.

Please note that all individual survey responses will be kept completely confidential. They will only be used to develop a readership profile for *DISPATCH*. Your individual responses will NOT be shared with any third party.

Thank you in advance for taking time to fill out the survey. Please return it in the postage paid envelope provided.

Susan A. Bransie  
President  
Dovetail Communications Inc.

**WIN A SONY 5.1MP DIGITAL CAMERA!**



Fill out the survey and return it in the postage-paid envelope by December 16, 2005 and you could win a SONY Digital Camera! Don't delay! Send your reply in now.

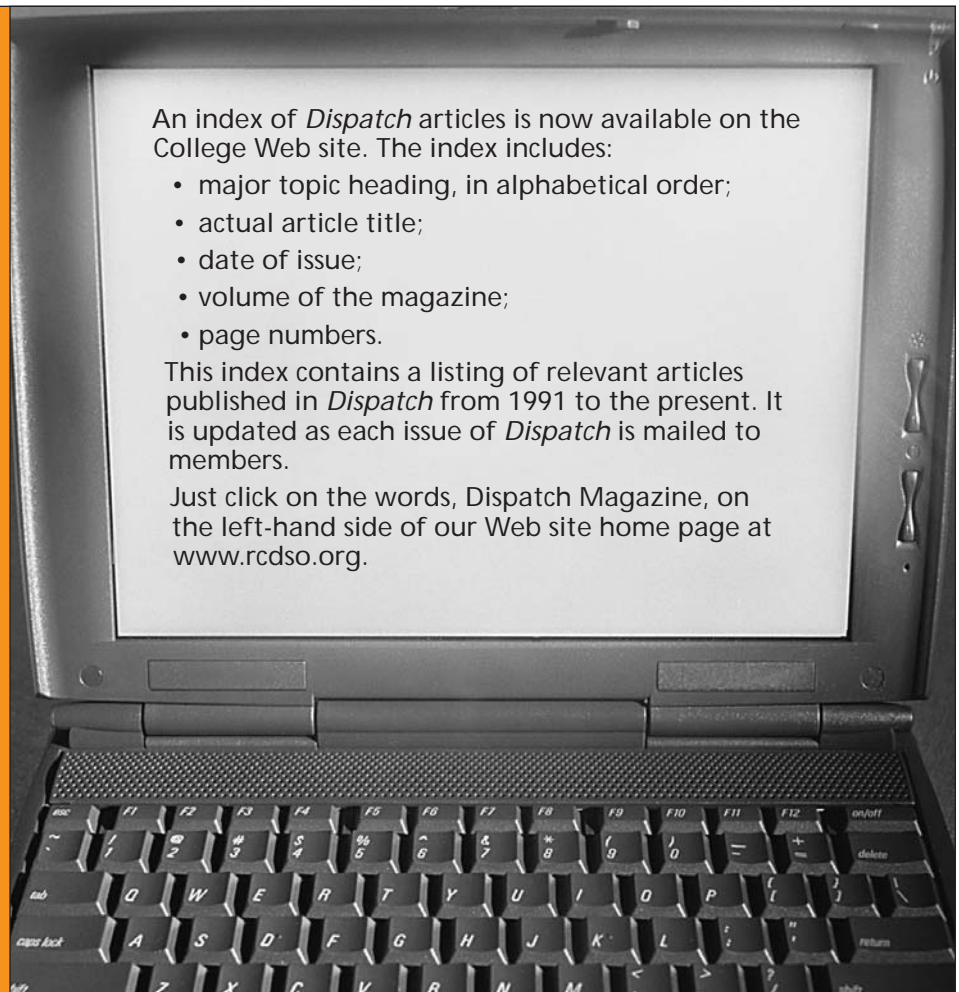
## It's Flu Season

Monitor the College's Web site at [www.rcdso.org](http://www.rcdso.org) for latest bulletins from the Ministry of Health and Long-Term Care.

## INDEX OF DISPATCH ARTICLES NOW AVAILABLE ON-LINE

If you have any questions, please contact:

**Peggi Mace**  
Communications Director  
phone: 416-934-5610  
toll-free: 1-800-565-4591  
e-mail: [pmace@rcdso.org](mailto:pmace@rcdso.org)



**YOUR CHANGE OF ADDRESS IS IMPORTANT INFORMATION**

Each member of the College is required by law to report all addresses where he/she engages in practice. Practice addresses are then available to the public from the College register. A member must report any change within 30 days of the change occurring.

You may choose to designate any address as your preferred mailing address for College communications. Please note that if your home is your preferred mailing address, then that address is not published or available to the public.

In order to ensure accuracy, all changes must be received in writing. Please forward changes by mail or by fax using the form below.

**By Mail:** Registration  
 Royal College of Dental Surgeons of Ontario  
 6 Crescent Road  
 Toronto, ON M4W 1T1

**By Fax:** 416-961-5814

SURNAME	GIVEN NAMES	RCDSO REGISTRATION NO.

Previous Practice Address	New Practice Address
STREET	STREET
CITY	CITY
PROVINCE	PROVINCE
POSTAL CODE	POSTAL CODE
PHONE	PHONE
FAX	FAX
E-MAIL	E-MAIL
EFFECTIVE DATE	SIGNATURE

Previous Home Address	New Home Address
STREET	STREET
CITY	CITY
PROVINCE	PROVINCE
POSTAL CODE	POSTAL CODE
PHONE	PHONE
FAX	FAX
E-MAIL	E-MAIL
EFFECTIVE DATE	SIGNATURE

# New Emphasis on Closing Technology Gap in Public Health Sector

Professionals working in the public health sector now have two new ways to get information faster and more easily. The provincial health ministry recently launched two new specialized Web sites, or portals, that are gateways to a wide variety of useful information.

The sites provide links to important health notices, as well as information on the latest developments in e-Health, public health issues, and advances in health-care delivery.

In a newsletter from the ministry, Dr. Sheela Basrur, Chief Medical Officer of Health and Assistant Deputy Minister, Minister of Health and Long-Term Care, explained there is new recognition that technology in public health may have lagged behind other areas, like hospitals, physicians and laboratories. Concrete work is underway, she said, to develop faster emergency response systems, more effective tracking and controlling of infectious disease, and better ways to share information.

Check out these new Web sites at:

[www.publichealthontario.ca](http://www.publichealthontario.ca)

[www.ehealthontario.ca](http://www.ehealthontario.ca)

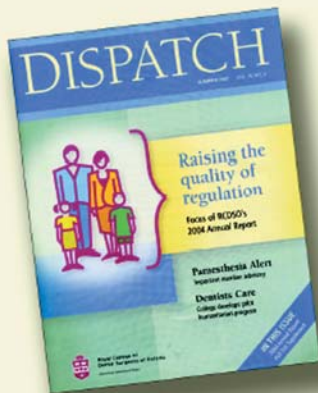
# When It Comes to Self-Regulation, We Believe We've Got It Right

Continued from page 48

2. We place a high value on the support and enhancement of the role of the public members on our governing Council and statutory committees. We hold a special one-day orientation session for the full Council, both professional and public members, at the beginning of each new term. We have intensive on-going orientation for the Complaints and Discipline Committee members that includes written orientation binders and video training packages.
3. We are actively involved in ongoing public outreach to assist a wide range of communities to understand and access the regulatory process. For example, just in the last few months, staff met with a number of women's support agencies in Sudbury, and with representatives of the Tamil community and media in Toronto. College staff also met recently with members of the Muslim community in Greater Toronto. It is important to note that the College covered the costs of the Council members from the Sudbury area, both the elected and public reps, to attend the Sudbury meeting.
4. We support, at our own expense, services such as the drug interaction database, that is available immediately to every dentist in the province right from the College's Web site, as a significant way to enhance public protection.
5. We take immediate legal action through the civil courts to get injunctions to shut down individuals who are practising dentistry without a licence.
6. We formally investigate every complaint that we receive.
7. We are committed to a regulatory process that is open, fair and transparent. At this College, both the complainant and the dentist member are given full access to review and comment on each other's statements during the investigation of a complaint. We report regularly, in writing, to both the complainant and the member about the progress of the complaint through our system. All the information gathered is given to the Complaints Committee panel.

# DISPATCH

*"Professionalism delivered with impeccable standards"*



*DISPATCH* magazine will be accepting advertising starting with the Winter 2006 issue.

It is the *only* dental magazine to reach *every* licensed dentist in Ontario!

For more information about placing your ad contact  
Kathryn Bertsch, Account Manager,  
905.886.6641 ext.317 • [www.dvtail.com](http://www.dvtail.com)

**DOVETAIL**  
COMMUNICATIONS INC.

8. We continue to work on solutions to expand the public's access to oral health care. In 2003, we organized a symposium to explore ways to increase access to dental care in the long-term care sector, with the participation of a wide range of service providers and consumers. At the beginning of this year, the College hosted a one-day event for leaders in both the medical and dental communities to share information about leading research into the relationship between periodontal disease and systemic conditions, such as diabetes and heart disease. And now, we have launched a pilot project for dentists to provide substantive dental care to vulnerable adults, at no charge to the patients.
9. We have made a significant commitment to support lifelong learning for our members. We launched with the very successful CD interactive learning package called Medical Emergencies in the Dental Office, and there is more to come.
10. For several years now, we have promoted research-based practice knowledge with leading peer-reviewed research PEAK articles in each issue of *Dispatch*. We regularly review our Guidelines and Practice Advisories. We make a major investment in the roadshows around the province to encourage improvements in areas like recordkeeping and informed consent. Staff teach at both of the province's dental schools.

11. We are the only health-care regulatory college in the province to run its own errors and omissions program (PLP) to provide compensation for patients in cases of negligence.
12. There is a dedicated staff person to handle sexual abuse complaints.
13. This College has a formal arrangement with the Ontario College of Pharmacists to share information about restrictions on dentists' prescription privileges to all Ontario pharmacists.
14. There is an option, in the appropriate cases, with the agreement of both the patient and the dentist, to resolve concerns through an alternate dispute resolution process that is speedier and less formal than the usual complaints process.

Our discussions, during the HPRAC review process, will continue to emphasize that the RHPA can and does

work. We have demonstrated that time and time again.

The legislation was passed well over ten years ago, so there is no question that changes are long overdue. The legislation must keep up with the changing environment and the increasing consumer demand for a more active role in decisions about their health. However, we maintain that change must occur within the framework of the RHPA.

It is not an exaggeration to say our College has got it right. We have a remarkable record of public protection that each member of this College should be proud of. Of course, there is always room for improvement. Your Council is committed to taking reasonable steps to do just that.

Again, I ask for opinions and views. I welcome every opportunity to hear what you think, and to answer your questions. Please call me directly at 416-934-5625, toll-free at 1-800-565-4591, or contact me by e-mail at ifefergrad@rcdso.org.

## DIALOGUE WITH MEMBERS...

*"Who says there is no such thing as a free lunch? I appreciate that you spent the time listening to my concerns about giving in to government even one inch on the subject of self-regulation. I do now better understand, however, the political implications."*

*"When you said in your column that you were available to meet for coffee, lunch or dinner to discuss self-regulation, I didn't think you really meant it. I appreciate the time we spent over coffee, and while I don't agree with everything the College does, I do feel it is true to its word in being open and accessible."*

# When It Comes to Self-Regulation, We Believe We've Got It Right

As you read in my last column, these are tempestuous times for health-care regulators in Ontario. Self-regulation, as we know it, is under intense scrutiny.

In my last column, I asked to hear from you with suggestions about how we should proceed on a number of key issues. Your response was incredibly gratifying. Many of you took to time to get in touch. Your comments are of great assistance as we move forward in developing the College's approach and position on a number of key questions. It was great to have a chance to discuss the issues with many of you in person over a cup of coffee or lunch, or on the phone and by e-mail. It is always heartening to know that dentists have such an incredible commitment to the College and to the philosophy of self-regulation. I look forward to continuing this dialogue in the months ahead.

Our approach during the current provincial review is to focus on two main

messages. The first one is this College believes in the principles of the *Regulated Health Professions Act* (RHPA). There is no question refinements are needed. However, our experiences are proof that the Act can and does work. All the Council members, both dentists and the public members, are very responsible and are genuinely committed to making self-regulation work in the public interest. The second message is about enhancements to the legislation.

In this column, I want to share with you why we believe that the RHPA can and does work. We believe that there is the flexibility within the existing legislation to make it work. We are proud to tell one and all about what we have done to address the three key issues identified by the Health Professions Regulatory Advisory Council (HPRAC): accessibility, accountability, and transparency.

We have used these examples in our discussions and correspondence with both Health Minister George Smitherman and HPRAC Chair Barbara



IRWIN FEFERGRAD

Sullivan. They also demonstrate that this College continues to work creatively to fulfill its mandate to work in the public interest under the RHPA. We call them our success stories.

1. We are committed to reducing the barriers to registration and licensure for internationally trained professionals. We have actively supported the work of the Ministry of Training, Colleges and Universities. We have participated in national efforts, with other dental regulators, to create a seamless approach right across the country. And, we have done all of this without compromising our commitment to ensuring standards are maintained.

Continued on page 46