

# DISPATCH



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**Information All The Time.  
Information When You Need It.**



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

Fight for fluoridation  
continues across the  
province

# DISPATCH



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

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# Fighting for Fluoridation – All Over Again



**DR. FRANK STECHEY**

**I**t is hard to believe but almost 65 years after the landmark introduction of fluoridation to Canadian drinking water in Brantford, Ontario in 1945, we are fighting that battle once again.

Municipalities across the province are questioning the use of community fluoridation as they grapple with significant expenditures to upgrade their water systems. Some are even holding public referendums on the issue. This makes fluoridation one of the few public health measures decided by the public ballot box.

Many are too young to remember that during the early to mid-1900s tooth decay was one of life's unpleasant certainties. But by the mid-1980s, there was an enormous drop in the incidence of caries and the severity of oral health diseases.

Many are not aware that, with the exception of vaccine-preventable childhood infectious diseases, few other public problems have waned so quickly. Of course, there were many factors for this dramatic improvement. However, there is no question that the wide exposure to fluoride played a crucial role.

Over the decades, the anti-fluoridation forces have fanned public fears by describing fluoridation as a dangerous poison and the cause of a wide range of diseases and ailments – everything from sudden infant death syndrome to AIDS.

Now, once again, fluoridation is on the public agenda. In fact, what history shows us is that the battle for fluoridation is never really won.

As dental professionals, we know that fluoridation of drinking water is still the most economical means of getting the proven protection that it gives teeth. Although other fluoride-containing products are available, water fluoridation remains the most equitable and cost-effective method of

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## Fluoruration de l'eau : le débat est relancé

Il est difficile de croire que plus de 60 ans après l'introduction historique du fluor dans le réseau de distribution d'eau potable de Brantford en Ontario, la fluoruration des eaux est à nouveau remise en question.

Plusieurs autorités municipales en Ontario questionnent aujourd'hui l'ajout de fluorure dans l'eau de consommation alors qu'elles doivent faire face à des dépenses importantes pour améliorer leurs systèmes d'approvisionnement en eau.

Malheureusement la plupart d'entre nous sont trop jeunes pour se souvenir que durant la première moitié du 20e siècle la carie dentaire était l'une des maladies les plus fréquentes et les plus largement distribuées. Mais à partir des années 1980, la prévalence de la carie dentaire a sensiblement diminué ainsi que la sévérité des maladies buccodentaires.

La grande majorité des gens ne réalisent pas qu'à

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# Provincial government working with health-care regulators to create health professions database

**T**he Ontario health care system relies on a range of health professionals, each with unique expertise, to meet the health needs of Ontarians. However, the government knows very little about the 40% of the regulated health workforce in Ontario, such as dentists.

Staff at the Ministry of Health and Long-Term Care are now working with 19 health regulatory colleges of Ontario to address this gap by creating a database that will provide the evidence needed by government for sound health human resources planning and shape research, policy and programs that help make sure Ontarians have access to the right number and mix of health professionals.

Over the summer, the Ministry and these health regulatory colleges have worked diligently to develop a minimum data set for the Health Professions Database. Once populated, the database will provide standardized, consistent and comparable demographic, geographic, educational, and employment information on all of the regulated health professionals in Ontario.

Over the next two years, the colleges will be expanding their registration and renewal forms to collect additional information from their members. The process is supported by a recent amendment to the Regulated Health Professions Act that requires the regulatory colleges to collect information from their members and provide it to the Ministry for health human resources planning.

RCDSO members will see this expanded collection of information in the upcoming registration renewal process.

Colleges began to submit the data they collected in January 2009. Aggregate data and analytical reports from the database will be available on

[www.healthforceontario.ca](http://www.healthforceontario.ca) in 2010. The database is an initiative of the HealthForceOntario health human resources strategy.

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**Better Information.  
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*Health Human Resources Database*

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# WORLD EXPERTS REAFFIRM ROLE OF FLUORIDATION IN FIGHTING TOOTH CARIES

**T**he efficiency, cost-effectiveness, and safety of the daily use of optimal fluoride was reaffirmed by 80 world experts from 30 countries gathered in Geneva for a Global Consultation on Oral Health Through Fluoride, jointly convened by the World Health Organization (WHO), the FDI World Dental Federation and the International Association for Dental Research (IADR) in November 2006.

In their public call for action, the experts stated that the use of fluoride is “the only realistic way” of reducing the worldwide burden of tooth decay affecting children, adults and the elderly and causing considerable pain, suffering and economic hardship.

They also confirmed that universal access to fluoride for dental health is a part of the basic human right to health.

The group expressed their deep concern about growing disparities in dental health and the lack of progress in tackling the worldwide burden of dental caries, particularly in disadvantaged populations.

The experts urged governments and other influential bodies to take the following actions:

- ◆ Develop effective legislation, necessary directives and programs ensuring access to fluoride for dental health in all countries.
- ◆ Include fluoride in health communications, health promotion strategies and programs.
- ◆ Include fluoride for dental health when promoting health through healthy diets. Encourage governments to reduce or remove taxation and tariffs on fluoride products for dental health.
- ◆ Encourage suppliers to improve availability of effective affordable fluoride toothpaste for disadvantaged populations.

Health Canada commissioned an expert panel to review the scientific studies available on fluoride and its possible effects on health. The expert panel made a number of recommendations including:

- ◆ to decrease slightly the amount of fluoride that can be added to municipal drinking water;
- ◆ to encourage the availability and use of low-fluoride toothpaste by children;
- ◆ to suggest to makers of infant formula to reduce levels of fluoride in their products.

This report was submitted to the federal government in January 2007 and made public in June 2008 on Health Canada’s website at [www.hc-sc.ca](http://www.hc-sc.ca)

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## LETTER TO CANADIANS FROM THE CHIEF DENTAL OFFICER FOR CANADA ON FLUORIDATION

July 30, 2008

As the Chief Dental Officer for Canada, I would like to highlight some of the many benefits of water fluoridation.

Water fluoridation is the process of adjusting the level of fluoride in the water to provide dental health benefits. Many governments and health organizations, including Health Canada, the Canadian Public Health Association, the Canadian Dental Association, the Canadian Medical Association and the World Health Organization endorse the fluoridation of drinking water to prevent tooth decay.

Community water fluoridation has been identified by U.S. Centers for Disease Control as one of 10 great public health achievements of the 20th century.

Canada has one of the best systems in the world to ensure water quality. Health Canada supports water fluoridation as a public health measure to prevent dental decay. Dental disease is the number one chronic disease among children and adolescents in North America; fluoridation can therefore be an important public health measure.

An expert panel was formed to provide Health Canada with advice and recommendations on the current state of relevant science with respect to the fluoridation of water. The report from the panel reinforces Health Canada's position that water fluoridation is important from a public health perspective and that our position on water fluoridation is sound. The report's recommendations are based on the latest science.

In undertaking the study, we consulted with a number of experts including scientists from the Universities of British Columbia, Toronto, Iowa; scientists from many areas of Health Canada; and also received input from the Canadian Dental Association, the U.S.

Environmental Protection Agency and public health experts from Canada and the U.S.

The safety and efficacy of water fluoridation has been frequently studied and continues to be supported by current science. Canadian and international studies agree that water that was fluoridated at optimum levels does not cause adverse health effects. For example, an adult male would need to consume at least 15,000 litres of water that is fluoridated at optimum levels continuously in one sitting to get an acute toxic (lethal) dose of fluoride.

There is also no evidence to suggest that children should avoid drinking fluoridated water at the accepted levels in Canadian drinking water supplies.

The big advantage of water fluoridation is that it benefits all residents in a community, regardless of age, socioeconomic status, education, or employment. Health Canada continues to support water fluoridation as a safe, cost effective public health measure, and encourages Canadians to review respected and credible sources of information to reach their own conclusions about water fluoridation.

DR. PETER COONEY, BDS, LDM, DDPH, MSc, FRCD(C)  
*Chief Dental Officer*  
Health Canada

### THANKS FROM THUNDER BAY

*I wanted to express my personal thanks to each of you for the efforts you put forward in preparing and presenting your deputations to Thunder Bay City Council on Monday evening. Dr. Sam Graham, Medical Officer of Health*

*(Acting) was extremely appreciative of your efforts and is viewing Monday night's meeting as an important foundation for future work in the area.*

*I have to say that I personally felt proud and humble at the same time that so many of you took such pains to help our City move forward on this important public health initiative. I look forward to continuing this important work.*

*Thanks so much and I'm sure we'll be in touch.*

CATHY FARRELL, BSW, RSW  
*Manager, Children's Clinical Programs*  
*Thunder Bay District Health Unit*

### ON THE WEB [www.rcdso.org](http://www.rcdso.org)

*Policy Statement on Water Fluoridation*

PROFESSIONAL PRACTICE/PRACTICE RESOURCES/POLICY STATEMENTS

#### EDITOR'S NOTE

On July 21, Thunder Bay City Councillors voted against fluoridation of the municipal drinking water.

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# Addiction

*and the*

# Road to Recovery

PAUL H. EARLEY, MD, FASM

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*It is no longer surprising when a movie star, a politician, or a sports hero reveals to the news media a personal struggle with the perils of addiction. The disease is common; we now know that it afflicts an estimated 10% of the population. In Canada, this would equate to three million individuals who will develop addiction in their lifetime, or 1.2 million in Ontario alone. Alcoholics Anonymous, the oldest and largest self-help group for addiction recovery, reports that more than 500 AA meetings are held each week in the Greater Toronto Area. Addiction specialists use the term “addiction” to refer to alcohol, drug and many behavioural addictions such as gambling. In this article, when I use the word addiction, I will be referring to all of these types of addiction.*

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### **Barriers to Recognition**

While these numbers are remarkable, the most troublesome number is that of the addicts and alcoholics who continue to suffer with their disease. Addiction continues to be misunderstood and the consequences of this misunderstanding are gravest for the addicts themselves.

The most formidable barrier to a rational understanding of the disease is the mental image people have of addicts, based on nothing more substantial than prejudice. When people think “alcoholic” or “addict,” they envision a down-and-out street person cradling his bottle in a torn brown paper bag. Despite the celebrity confessions and the odds that most of us have a family member, colleague, or neighbour with chemical dependence, this image persists in the back of our minds and interferes with awareness of our own addictive behaviour. We struggle instead with the more palatable idea that next time, by handling our drinking or drug use differently, we will prove ourselves immune from this haunting mental image. Family members are blinded to addiction as well. When discussing their spouse’s addiction I commonly hear: “He could not be an addict, he goes to work every day!”

Addiction to alcohol or drugs is a final common pathway illness. That is to say, many factors propel an individual along the road toward becoming an addict; once there, however, research and clinical experience show that the addicted individual cannot go back to the days when alcohol or drug use was casual and voluntary.

One of the most powerful factors leading to addiction is genetics. This does not mean that people inherit addiction, but that they inherit the propensity to become addicted. Whether



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# Addiction and the Road to Recovery

➤ they go on to develop an addiction depends not only on genetics, but on the repeated consumption of addicting substances or addicting behaviours.

In addition to genetics, addiction has other factors that stimulate its appearance. Family structure, personality, other psychiatric disease and environment all play a part in the etiology of addiction. Children who have grown up in an atmosphere of shame experience a high incidence of addiction. People who tend to be anxious and driven or who have other psychological problems seem especially vulnerable to addiction. Childhood trauma – whether intentionally inflicted, like sexual abuse, or unintentionally inflicted, like the death of a parent – can result in an emotional injury that leaves one susceptible to becoming addicted later in life. Stress can also lead a casual substance user along the road to compulsive use of chemicals.

Each of these factors link in various combinations to reach the final common pathway: the disease of addiction. Regardless of the particular combination of contributing factors, once a person has developed an addiction, complex alterations in the brain's chemistry make it impossible to return to an earlier phase of moderation and control. Unfortunately, addicted individuals spend a lot of time and energy trying to return to a relationship with mood altering chemicals that is no longer possible.

Another barrier to recognizing chemical dependence is that people addicted to drugs tend to misinterpret the source of the chaos in their lives. Alcoholics and addicts invariably define their problem as something external to themselves: a nagging spouse, hormones, a stressful job, or the drug itself, which they have come to love, crave, and hate.

Research during the last decade has revealed that many individuals suffer from more than one addiction – 60% of people with bulimia nervosa are also alcoholic, 80% of gambling addicts are addicted to chemical substances. Addiction Medicine physicians

understand addiction as a disorder in the brain that creates a distorted relationship between the brain and the substance or behaviour.

Whatever the addictive substance or behaviour, symptoms of addiction are the same. One of the primary symptoms is denial, which makes it very difficult for the addict to seek help. Denial is the subtle reorganization of reality that occurs in the addict's mind that keeps him or her from seeing their problems as arising from their addictive disease. This is why the alcoholic is often the last to know they have a problem. Other manifestations of chemical dependence include physical dependence and increasing tolerance for the drug. Once the person is under the sway of addiction, what began as apparently harmless and voluntary social drinking or occasional drug use becomes the ruling passion of his life. Nothing is as important, not the entreaties of his wife, tears of his children, loss of a job, or even skirmishes with the law appear to get through to him.

## **What Happens to the Brain in Addiction?**

Understanding how addiction affects the brain helps explain these perplexing symptoms. To appreciate how things go haywire in the addict, it is helpful to visualize the basic structure of the brain. The cortex is the part of our brain in which conscious thought occurs, and the part of the brain that makes us distinctively human. The cortex is also called the “new brain” because from an evolutionary point of view, it appears in more highly evolved species such as lower primates and humans. The cortex houses the superior mental faculties – memory, learning, and judgment – of which we are understandably proud; it is, in fact, the part on which all conscious thought is based.

Despite its amazing properties, however, the human cortex is baffled by addiction. To see why, we must look at another part of the brain, the midbrain. The midbrain is the seat of the five basic drives: hunger, thirst, the fight or flight reaction, sex, and pain regulation. No conscious thought occurs in the



midbrain; instead, pressure from the midbrain is transmitted to the cortex, where it registers as conscious thought (“I’m hungry”). Although the cortex may appear to be running the show, the midbrain wields deceptive power. Several times in life – at puberty, for instance – the midbrain totally rearranges the way we see the world.

From the perspective of addiction, the midbrain is where the action is. In people who develop addiction, the midbrain takes on a sixth activity in addition to the five basic drives. This sixth activity is a primitive push for the addictive substance or behaviour, which

feels to the individual exactly like a basic drive. But there are two fundamental differences between this sixth function and the basic drives. The sixth (addictive) function eventually grows so powerful that it eclipses all the drives. And whereas the drives push the individual toward self-preservation, the sixth drive, the pressure to get drunk or high, leads ultimately to self-annihilation.

The midbrain sends its signals to the cortex through the motor cortex, which controls movement. The pressure from the midbrain drives action, a motor event. For example, the midbrain transmits pressure for alcohol. The alcoholic turns into the liquor store parking lot. Only then does what cortical neurophysiologist Michael Gazzaniga has labelled the “Interpreter” kick in to analyze the action. “You deserve a drink,” it whispers. The interpreter tries, in retrospect, to make sense of the action triggered by the midbrain and carried out by the motor cortex.

Such an assessment mechanism is doomed to fail because of the discrepancy between the raw drive for a drug and the individual’s rational functioning. Errors in interpretation multiply, entrenching the person in denial. These misperceptions and rationalizations are the hallmark of addictive thinking.

#### **Implications for Treatment**

For treatment to be effective, the brain must be educated about the errors in circuitry by which it has been baffled. From our current understanding of the subtle changes in chemistry that occur in the brain during addiction, two important corollaries emerge:

##### *1) You Can’t Think Your Way Out of Addiction:*

Treatment helps the addicted person reconcile the basic conflict between the cortex and the midbrain, or the old brain and the new brain. The critical role of the midbrain in preserving the organism, Homo sapiens, underscores why even the most sophisticated analytical thinking cannot lead a person out of his addiction.



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# Addiction and the Road to Recovery

➤ Professionals, like dentists, often seem to have an especially difficult time in coming to terms with addiction. They may have achieved brilliantly in their careers and highly value their analytic abilities and reasoning powers. The mental capacity that has served them so well and distinguished them from their peers, however, is unreliable as an ally in the struggle to recover. Instead, one needs the retraining and cooperation of the midbrain, which is the common denominator not only of our humanity, but also our relation with the rest of humanity.

A tragic error in addiction treatment early in the 20th century was the mistaken belief that if the addict could develop enough insight into his problems and feel better about himself or herself through psychoanalysis or another form of psychotherapy, he or she could stop the addictive behaviour.

Sadly, the relapse histories of countless patients proved this type of approach to be a critical and often fatal error. To the addict, no amount of insight about underlying causes is enough to overcome the craving for chemical relief that occurs when one is actively using drugs and alcohol. In order to recover, the addict needs to stop the behaviour first.

*2) Recovery Takes Time:* When a drug is introduced to the body of a person who will become addicted, it leads to a surge of euphoria that is quicker and more intense than any “high” the body can produce through natural means. This artificial activation of the brain’s reward system increases the release of chemical substances that mediate the euphoria; however, this surge of euphoria does not last. After the body develops tolerance, larger quantities are needed; the addict begins to need the drug not to feel high but to feel normal. The brain’s chemistry develops tolerance for the artificial surge produced by addiction. When the drugs and behaviours are withdrawn in treatment, it takes the body a while to resume production of substances that make the person feel a sense of calm and well-being. This process of detoxification and normalization of

thought takes time, meaning months or years.

Once detoxified, the individual in recovery must hack through the thicket of excuses and rationalizations by which his brain has attempted to make sense of his bizarre behaviour. This also takes time.

When the addict finally and deeply understands the havoc wrought by drug use in the brain’s natural chemistry, the midbrain essentially gives up. When treatment occurs and the addict or alcoholic engages in a specific set of actions (called working a program of recovery), the individual is set free from the compulsion to drink or use drugs.

## **The Nature of Treatment Today**

Based on our current scientific knowledge about addiction, the treatment process at all recovery centres, including the Talbott Campus, encompasses four distinct phases.

*1. Behavioural Intervention:* The first step in treatment involves behavioural containment, stopping the drug from entering the body. Once the individual feels the tug of addiction as a primitive drive, no further improvement can occur until he or she stops taking the drug. Acute detoxification usually takes several weeks; it may take months before the brain’s chemistry returns to normal. During this early phase, alcoholics and other addicts often feel like they have lost their best friend or lover and experience enormous grief and/or anger, as well as depression.

*2. Cognitive Insight:* The phase of cognitive insight is the “Aha!” phase, during which the recovering person begins to recognize and make sense of his or her formerly perplexing behaviour. This usually occurs in a series of fits and starts over a period of about a week.

*3. Emotional Integration:* During the phase of emotional integration, the recovering person begins to rediscover his feelings. This process takes weeks; feelings may have been buried for a long time, and they are usually covered in shame. Among the most destructive cultural attitudes toward alcoholism and drug addiction is the notion that the addicted person

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is morally weak and lacks self-discipline. When internalized, this attitude interferes with the alcoholic's realization that he or she has a disease and with his or her understanding of the insidious disease process. We sometimes call the phase of emotional integration the "Ugh" phase because it is difficult work – work that requires courage and perseverance. Most people who do not recover from chemical dependence give up or attempt to sidestep this painful phase.

**4. Transformation:** Transformation is the last stage of change – the transition into recovery. Transformation does not mean changing one's mind about using drugs. It means nothing less than seeing the world in a different way. The transformation phase is what recovering addicts often describe as a spiritual experience. Some patients describe the increasingly unfamiliar way they were before, as if they had been looking at life from atop a strange mountain. Others discover a new or rediscover a past spiritual or religious practice. To the individual entering this phase everything and everybody looks different, though it is in fact he or she who has changed. People who make it to the transformation phase generally lock in their recovery and go on to live life free of drugs and filled with an inner peace that often surprises them and those around them.

Effective treatment is based upon the 12 Steps of Alcoholics Anonymous and Narcotics Anonymous. We add individual and group therapy, training in intra and interpersonal skills and family components to produce a good outcome. Treatment is matched with long term monitoring; the marriage of treatment and continuing care produces excellent remission rates for this chronic disease.

### Conclusion

Our society provides us with an increased exposure to addiction though the media. Despite this exposure, many people still do not understand the complex nature of the brain disease called addiction. Addiction affects so many aspects of a person's life and our culture and, as such, is difficult to tease out from the fabric of that culture.

Recent science has clearly established this is a disease of the brain that affects the emotions, heart and soul of the afflicted and his or her family. The recovery process is slow and occurs in phases, each one helping the addict or alcoholic transition into a life of meaning and peace. Despite this, treatment is remarkably effective – as effective as or more so than any other chronic disease.



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#### PAUL H. EARLEY, MD, FASM

*Dr. Earley is an Addiction Medicine Physician who treats all types of addictive diseases. He has 25 years of experience in the treatment of addiction, with a specialty in the assessment and treatment of addiction in health care professionals. Dr. Earley also works with patients already in recovery, providing long term therapy for those who suffer from addiction. His professional expertise extends to advocacy for professionals before agencies and licensing boards. He is an expert witness*

*across the United States in legal matters regarding professionals and addiction.*

*Dr. Earley is a dynamic speaker and educator; he speaks nationally and internationally on topics of addiction, its treatment and impairment in health care professionals. His work was featured in one part of a documentary series on addiction entitled Close to Home by Bill Moyers. Dr. Earley is a Fellow of the American Society of Addiction Medicine (ASAM) and sat on the board of ASAM for*

*over 10 years in several capacities.*

*Dr. Earley is the Medical Director of the Talbott Recovery Campus in Atlanta, Georgia, USA. The Talbott Campus is the largest and oldest health professionals' program in the world. Talbott has treated patients from all walks of life with its legendary treatment model for over 30 years. The website address is [www.talbottcampus.com](http://www.talbottcampus.com).*

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# INFORMED CONSENT

## *Do You Know the Answer to These Questions?*

*What is the connection between documentation and informed consent?*

*How does a dentist deal with the dynamic, even tension sometimes, between the need to be candid with the patient and the duty to your personal colleagues in a case of supervisory neglect?*

*Informed consent is a process and a standardized consent form is inadequate, so what is the best approach for a dentist to use?*

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Are you confident that you know the right answer to these questions? Well, if you have any doubts at all, the latest LifeLong Learning production will definitely help you out. It is called “Informed Consent – A guide to understanding the informed consent process in the dental office.”

Slated for distribution to all Ontario dentists in early October, this CD-based interactive learning package is a comprehensive source of information about this complicated and extremely important concept in the delivery of health care.

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

This CD will be the newest addition to the College’s Lifelong Learning program. Check out the list of all our learning packages on our website [www.rcdso.org](http://www.rcdso.org). Click on Quality Assurance/Lifelong Learning Program heading.

# Poor Communication A Common Thread in Patients' Complaints

## *Case No.1*

### **COMPLAINT SUMMARY**

A patient complained that her former dentist and his staff members misled her by telling her it was illegal for him to directly bill her insurance provider and her insurance provider would not accept direct billing from the dental office.

### **DENTIST'S PERSPECTIVE**

In his response, the dentist stated that the complainant had been a patient of his practice for about three years. During this time, he saw her on three occasions only, as she primarily received treatment from his associate dentist and dental hygienists in the practice.

The dentist stated he and his staff members were unaware of the patient's concerns. He said the complaint was a matter of gross miscommunication and a big misunderstanding and it was common knowledge that there are both assignment and non-assignment dental practices in Ontario. He explained that, except in a few exceptional cases, his office operated on a non-assignment basis as it did not accept direct payment from dental insurance companies: patients paid for treatment on the day it was rendered and then were reimbursed by the insurance provider.

He stated patients were informed of this policy at the initial appointment or when calling to inquire about the office. The dentist denied his staff members had ever told patients that it is against the law to accept the assignment of insurance benefits. He also said that, if the patient had informed either him or the office manager of her financial situation, the office would have made some kind of arrangement for payment for services.

The dentist concluded his response by advising that, although he could not say exactly what occurred between the patient and his staff members, he was certain she must have misunderstood what was communicated to her.

*Complaints Corner is designed as an educational tool to help Ontario dentists and the public gain a better understanding of the current trends observed by the College's Inquiries, Complaints and Reports Committee.*

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

### **COLLEGE CONTACT**

**Irwin Fefergard**  
Registrar  
416-934-5625  
1-800-565-4591  
ifefergard@rcdso.org



## Complaints Corner

➤ He noted that his receptionist was fairly new to the office so he had taken this opportunity to review this situation with her to ensure that no similar situation would arise in the future.

### **DECISION OF THE COMPLAINTS COMMITTEE**

*As of June 4, 2009, now called the Inquiries, Complaints and Reports Committee.*

The panel reviewed all correspondence and records obtained during the investigation. The panel confirmed that it is not illegal for a dental office to directly bill an insurance provider and acknowledged that each dental office is free to make its own decision with respect to the acceptance of the assignment of benefits from insurance companies. If an office chooses to have patients pay for treatment at the time it is rendered, then the patient would receive reimbursement directly from his or her insurance provider. This is acceptable and it was clear that this was agreed upon by the complainant.

The panel's view was there was a complete breakdown in communication and a possible misunderstanding between the office staff and the complainant. Given the differing versions of events, the panel could not determine with a reasonable amount of certainty as to what was said by the staff to the complainant. The panel was pleased to learn that the dentist has taken appropriate steps to ensure that his staff members were correctly informed about the assignment of insurance benefits and now communicating accurately with patients about these issues.

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

## *Case No.2*

### **COMPLAINT SUMMARY**

A patient filed a complaint stating that a denture adjustment was traumatic and caused intense pain. She went on to state that her medical doctor diagnosed this as a post traumatic experience.

### **DENTIST'S PERSPECTIVE**

In his response, the dentist stated the patient had been in his practice for one year. She attended for a routine framework fitting for fabrication of a new partial upper denture. At that time, the patient seemed aggravated by the whole procedure and was upset to have lost her previous denture and unhappy that she did not have insurance coverage for a new one.

The dentist noted that the patient did not like the feel of the metal on the lingual of teeth 22 (upper left lateral incisor) and 23 (upper left cuspid). He explained that it was designed this way to take into consideration the poor prognosis for tooth 23 and the design allowed for easy alteration of the denture in the future when required.

The dentist reported that the patient did not like being tipped back in the dental chair in order to adjust the framework around the free standing tooth 27 (upper left 2nd permanent molar). She was dismissed from the office after the appointment in obvious distress. He stated that nothing out of the ordinary took place while performing the necessary procedures that day.

## learning points

- Poor communication or miscommunication is the common thread to disputes with patients, whether they are minor disagreements and misunderstandings, formal complaints or malpractice claims.
- The deciding factor that determines whether or not a patient files a formal complaint with the College or a malpractice claim is advanced is often the type of trust relationship that exists between the patient and the dentist and the manner in which the problem, mishap or treatment outcome was explained.
- Excellent communication is a key factor for:
  - diagnosis and treatment plan discussions;
  - obtaining informed consent;
  - knowing your patients' wants, needs and expectations;
  - informing patients of mishaps, unexpected results or treatment failure and what needs to be done to get back on track;
  - achieving and maintaining a long lasting and trusting dentist/patient relationship.
- Communication lapses can and do occur so an extra effort is needed to make sure that excellent communications are a priority in the dental office. It pays to have checks in place to minimize problems, such as:
  - written pre-operative and post-operative instructions;
  - information brochures/sheets to explain treatment;
  - post-treatment follow-up calls;
  - willingness and openness to discuss issues with patients.



## Complaints Corner

➤ The dentist went on to state that the patient's daughter had called the office, and after receiving an explanation of the events, had suggested that her mother had exaggerated the situation.

A copy of the member's response was sent to the patient and she provided further comments disputing the dentist's version of events. Subsequently, the patient contacted the College withdrawing her complaint.

As part of its investigation, the College obtained records from the patient's medical doctor. These records showed that she had attended her physician the day after the appointment in question, complained of not sleeping well the previous night and of dizziness since the previous day. The doctor noted a post-traumatic experience and reassured the complainant. A month later, the patient returned to her medical doctor with continued dizziness. The physician advised that this symptom was not necessarily related to her dental experience.

### DECISION OF THE COMPLAINTS COMMITTEE

*As of June 4, 2009, now called the Inquiries, Complaints and Reports Committee.*

The panel reviewed all correspondence and records obtained during the course of the investigation, including documentation submitted by the patient, the member and the patient's physician.

The panel noted the patient's request to withdraw her complaint. However, all parties were advised that the panel must complete its investigation and render a decision because, notwithstanding the withdrawal, the jurisdiction of the College continues.

The panel noted that the patient had complained about a denture adjustment during the try-in stage of a new partial denture. However, there was nothing in the dentist's records that suggested a traumatic experience. The panel noted the dentist spoke with the complainant's daughter, who reported that her mother did not seem to have had any real problems or issues.

In its decision, the panel took the opportunity to advise the patient that the amount of force necessary to insert and adjust a denture could be perceived differently by different patients because the perception of the degree of pain varies from patient to patient. While the panel could not confirm the patient's particular experience during this procedure, they could not find any fault with the actions of the dentist.

# “I’m pregnant. Please don’t tell my mother.”

# K

Kristen S, a 15-year-old girl, came into a dental clinic for a recall appointment. She had been a patient of Dr. Virginia M for many years. While waiting near the clinic’s radiology area, she saw a sign instructing females to inform their dentist if they were pregnant. Kristen became upset and asked Dr. M why the sign was there. Eventually she acknowledged that she was pregnant and asked Dr. M not to tell her mother.

Dr. M felt she had an obligation to inform the mother of Kristen’s condition. Although Kristen was capable of providing her own consent for treatment, her parents were legally responsible for the payment of the account. Because Dr. M knew Kristen’s parents, she was convinced that it would be beneficial to Kristen if her parents knew and could provide care and support during this difficult period in her life.

Dr. M is now faced with an ethical dilemma. What course(s) of action would you recommend for Dr. M?

- ◆ *Try to convince Kristen to discuss her pregnancy with her mother. Dr. M should also tell Kristen that if she doesn’t inform her mother, she will.*
- ◆ *Dr. M should contact Kristen’s mother and inform her that Kristen is pregnant.*
- ◆ *Dr. M should try to convince Kristen to discuss her pregnancy with her mother. Dr. M will not inform Kristen’s mother and will try to delay dental treatment.*
- ◆ *Dr. M should suggest that Kristen contact the local public health unit in her community where she can obtain necessary information, advice and support.*



*Reprinted in part from the Texas Dental Journal of the Baylor College of Dentistry with permission.*

*Now turn to page 26 to find the discussion about this ethical dilemma.*

# THE BENEFITS OF Early Reporting to PLP

*This feature is prepared to offer guidance to members about the prevention of malpractice claims or complaints and the lessening of the magnitude of an existing claim or a complaint.*

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**Dr. Judi Heggie**  
Dental Advisor, PLP  
416-934-5605  
1-877-817-3757  
jheggie@rcdso.org

*PLP staff appreciates the anxiety created for dentists when a patient gives an indication, either orally or in writing, that there is dissatisfaction with treatment provided. If a patient also makes a demand for compensation and/or a refund, the anxiety increases even more. If one of these situations arises, let PLP help you. We are as close as your telephone.*

*Timely reporting not only preserves your right to coverage, but it can also result in having matters resolved on a mutually*

*satisfactory basis for both you and your patient. On the other hand, failure to report a potential claim may, in some circumstances, result in a denial of coverage.*

*Usually PLP is able to convince the insurers that their position has not been prejudiced by a dentist's failure to give notice of a potential claim; however, on rare occasions, coverage has been denied.*

## THE BENEFITS OF CALLING PLP

- Early contact with PLP can ensure that you do not unwittingly admit liability when dealing with dissatisfied patients.
- It preserves your right to coverage.
- There is no cost for you to receive advice and assistance from PLP in dealing with patients who are dissatisfied or are demanding money.
- Potential claims can usually be resolved on a mutually satisfactory basis for you and your patient.
- If you are considering a refund, PLP's knowledgeable claims examiners can coach you on how to approach patients about provision of a refund in exchange for a release.

## Case Study

Dr. J, a general dentist, treated a patient for 14 years. The patient moved and presented to a new dentist who informed her that a crown, recently inserted by Dr. J, was faulty and required replacement. The patient then demanded a refund of fees paid to Dr. J for the crown. Without prior advice from PLP, Dr. J provided the refund.

Six months later, the patient advised Dr. J she had seen a specialist who had prepared a treatment plan for follow-up dental repair work totalling \$25,000. Dr. J refused the patient's demand for more money.

One month later, Dr. J received a letter from the patient's lawyer, notifying him that the patient intended to file a claim for damages. Dr. J then contacted PLP. A Statement of Claim was subsequently served, alleging supervised neglect and demanding compensation for pain and suffering.

The malpractice insurer agreed to investigate and defend this claim subject to a reservation of its rights under the Notice of Claim and Co-operative Provisions in the policy.

Notice of Claim refers to a general condition of the policy, which states that: "If the (member) first becomes aware of any claim or circumstances of an error, omission or negligent act which a reasonable person would expect might subsequently give rise to a claim hereunder, such (member) shall immediately give notice

thereof or cause notice to be given to the Professional Liability Program of the Royal College of Dental Surgeons of Ontario."

Co-operative Provisions refers to a general condition of the policy, which states that: "The (member) shall not voluntarily assume any liability or settle any claim."

Dr. J did not notify PLP at the outset of the claimant's dissatisfaction with treatment and demand for a refund. Further, Dr. J failed to obtain PLP's input, including both assistance in drafting a letter to the claimant and a release for the claimant to sign, before making the refund. In other words, Dr. J had breached each of the above provisions of the policy.

PLP eventually convinced the malpractice insurer that, although Dr. J should have reported the matter when he was first aware of the potential claim, neither his failure to do so, nor his refund with respect to the crown had prejudiced its position. Coverage was afforded and PLP was able to settle the claim.

Since the refund was made without the prior knowledge of PLP, it did not serve to reduce Dr. J's deductible applicable under the policy.

### IN ORDER TO PROTECT YOUR RIGHT TO COVERAGE

Notify PLP immediately if your patient wants or might want money. Do not take any steps that may jeopardize your right to coverage.





## The Benefits of Early Reporting to PLP

### ➤ *Case Study*

Dr. S, a general dentist, treated a patient over a period of five years. During that time she performed extractions, root canal treatment and restorative treatment and placed a bridge. The patient subsequently moved and, soon after, developed dental problems.

He wrote a letter to Dr. S alleging she had performed negligent extractions, improper root canal treatment and had placed an ill-fitting bridge. The patient demanded \$15,000 compensation. Dr. S responded with a letter to the patient, indicating that she had enclosed a cheque in the amount of \$2,000 for costs associated with the new bridge; however, she

was not prepared to pay anything more. Dr. S neither reported the matter to PLP, nor obtained a release from the patient.

Over the next year and a half, the patient wrote four more letters. During that time, all College members received notice that there was to be a change of malpractice insurers. They were informed that it was imperative to give notice to PLP of any instances that could reasonably be expected to give rise to an insurance claim, no matter how insignificant. Members were further advised that failure to do so before a specified date might result in the claim being uninsured. Dr. S still did not report this matter. After receipt of the fifth letter from the patient, Dr. S increased her offer of payment to the patient to \$4,000 and, shortly thereafter, contacted PLP.

PLP informed Dr. S that it was possible the malpractice insurer would deny coverage due to the late reporting.

Following deliberation, the insurer denied coverage because:

1. Dr. S delayed in reporting the claim to PLP.
2. The claim arose before the policy was in force.
3. Her actions were considered to have prejudiced the underwriter's ability to defend the matter.

PLP advised Dr. S that, if she had not already done so, she should retain defence counsel immediately.

We wish we could tell you that everything turned out well for Dr. S, but we simply do not know. This sort of situation is most distressing to PLP as it surely must have been to Dr. S. Unfortunately, in this case, there was no argument to be made. The failure to report was simply irrefutable.

### WHEN TO CALL PLP:

- You receive a call or letter from a patient or patient's representative seeking compensation.
- You are served with a legal action.
- You rendered treatment to a patient where the result is adverse and not consistent with the anticipated outcome.
- Your patient is unhappy with and complaining about the treatment rendered.
- You are unsure whether or not to call – if in doubt, call PLP. There is no downside to doing so.

### QUESTIONS ABOUT A PARTICULAR SITUATION?

If you have questions about how to handle a particular situation with a patient, do not hesitate to call the College.

PLP Claims Examiners

416-934-5600 • 1-877-817-3757

Practice Advisory Service

416-934-5614 • 1-800-565-4591

# Letter 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 this letter of apology for publication.*

## COLLEGE CONTACT

**Dr. Fred Eckhaus**  
Assistant to the Registrar,  
Dental  
416-934-5624  
1-800-565-4591  
feckhaus@rcdso.org

In the February 28, 2009 edition of the London Free Press an advertisement placed by me said that I received a "Fellow designation from LVI" and indicated that my continuing training at LVI in aesthetic and muscular dentistry distinguishes me in the provision of the best care to my patients.

I acknowledge that all designations obtained from completion of courses at LVI are not recognized in Ontario. I am also aware that neuromuscular dentistry is not a recognized specialty. Furthermore, as all dentists are required to take continuous education courses, I know it is considered inappropriate to include such references in my advertisements.

It was not my intention to offend anyone or to suggest uniqueness or superiority over other practices or members of our profession. My sincerest apologies to RCDSO and to my colleagues.

I do accept and I will comply with the existing regulations, and will ensure that all my promotional material, including advertisements and websites, are in compliance with these regulations.

Sincerely,



DR. KAREN LOGAN  
London, Ontario

## Dental Anaesthesia Specialty

Information about how to become registered as a dental anaesthesiologist is available online from our website at [www.rcdso.org](http://www.rcdso.org), under the heading of Sedation/Anaesthesia on the left hand side of the home page.

And for updated information on the 2009 examinations, look for the headline in the What's New section right on the home page.

## COLLEGE CONTACT

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PEAK

# Oral Appliances in the Management of Temporomandibular Disorders



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

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

## COLLEGE CONTACT

**Dr. Michael Gardner**  
Manager, Quality Assurance  
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mgardner@rcdso.org

**F**or decades, dentists have used oral appliances (OA) to treat temporomandibular disorders (TMD). Throughout this time, however, there has been continuous debate regarding how they should be designed and used and what they actually do.

TMDs are a complex of ailments involving the temporomandibular joints (TMJ) and associated structures, whose etiology is poorly understood. Most early concepts focused on mechanistic theories of occlusal disharmonies and/or skeletal malalignments. As a result, OAs of varying designs have been promoted over the years for the treatment of TMDs, some with the simple promise of reducing muscle activity in bruxers by introducing a foreign object between the teeth, whereas others reposition the mandible with the goal of recapturing an anteriorly displaced disk.

More recently, such narrow mechanistic theories have been refuted and gradually replaced with a more encompassing biopsychosocial model. Moreover, several studies have clearly demonstrated favourable responses to placebo treatments, such as nonoccluding OAs and mock equilibration, thus supporting the concept that for many patients, clinical remission occurs without treatment and, perhaps for some, even despite it.

Clearly, OAs have their uses in the treatment of certain groups of TMD patients, but the emphasis should be on conservative management.

With the current issue of Dispatch, PEAK is pleased to offer members the following article: "Oral Appliances in the Management of Temporomandibular Disorders", from the February 2009 issue of Oral Surgery, Oral Medicine, Oral Pathology, Oral Radiology, and Endodontology.

The article reviews the available literature on the use of OAs in the treatment of TMDs. The various designs of OAs are examined, including their proposed mechanisms of action and claimed clinical objectives. The article goes on

**ON THE WEB**  
[www.rcdso.org](http://www.rcdso.org)

*Professional Practice/Guidelines/Diagnosis & Management of Temporomandibular Disorders & Related Musculoskeletal Disorders*

## ORAL APPLIANCES CAN

- Decrease or alter loading on the TMJ by reducing force intensity, frequency and/or duration of oral parafunctional activities.
- Briefly reduce muscle activity by introducing a foreign object between the teeth.
- Reduce headache intensity or frequency, if it is triggered by sleep bruxism (SB).
- Improve internal derangement symptoms of locking or catching upon awakening related to SB.
- Disrupt neuromuscular engrams that determine TMJ-fossa relationships (deprogramming).
- Protect the occlusal surfaces of the teeth and dental restorations from SB forces.

## ORAL APPLIANCES CANNOT

- Unload the TMJ by distracting the condyle or pivoting on molar contacts.
- Retrain muscles to be less active after the OA is removed.
- Relieve headache conditions that are primarily neurovascular or vascular in origin.
- Recapture displaced disks, enhance retrodiskal tissue healing or prevent the progression from anterior disk displacement with reduction to anterior disk displacement without reduction.
- Produce an ideal neuromuscular/occlusal relationship.
- Permanently reduce or eliminate SB activities.
- Establish correct vertical dimension of occlusion.

to describe the role that OAs can or cannot play in the management of TMDs.

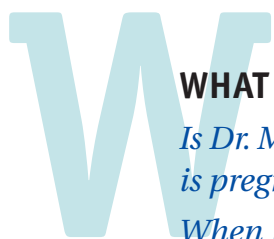
The guiding principle of any treatment must be *primum non nocere* or, freely translated, “above all, do no harm.”

Irreversible procedures should only be considered after attempts at treatment with more conservative measures have failed, and only if the severity and/or persistence of the patient's symptoms warrant it.

In general, most TMDs are actually managed, rather than definitively treated.



# *“I’m pregnant. Please don’t tell my mother.”*



### WHAT IS AT STAKE IN THIS CASE?

*Is Dr. M obligated to tell Kristen’s parents that she is pregnant?*

*When Kristen confides in her dentist, should this confidence be respected?*

*What moral obligations are required of dentists to respect the confidentiality of the dentist-patient relationship?*

*Are there special considerations in this case because Kristen is not legally independent?*

#### **Confidentiality as a Core Value**

Kristen’s case illustrates the fact that dentists, as health professionals, are responsible for managing the personal information revealed by their patients. This moral responsibility is referred to as “confidentiality.” It is a core value in the doctor-patient relationship and is cited in codes of ethics. This relationship of trust may only be broken in certain extraordinary circumstances.

Codes of ethics provide an insight into the central values of a profession. These codes may change and evolve, as society changes and evolves. Keeping the confidences of patients is an integral part of most Canadian dental codes of ethics, including the College’s Code of Ethics.

One of the core values of the RCDSO Code of Ethics is autonomy. It is defined as “understanding and respecting patients’ rights to make informed decisions based on personal values and beliefs.”

In addition, an ethical principle in the Code relates to the protection of the confidentiality of the personal and health information of patients. This value of confidentiality underscores the necessity of trust in the relationship between patients and their doctors.

### **The Importance of Trust**

To understand the role that trust plays in a successful doctor-patient relationship, it must be viewed from the perspective of the dentist and the patient.

From the dentist's view, sound therapeutics begins with the patient's trust because dentists ask patients to share personal and sensitive information necessary to properly assess their health and to determine proper therapeutics.

Dentists are privy to information about serious health conditions, such as cancer and heart disease, or about conditions that may have profound social implications, such as HIV status and substance abuse, and about sensitive personal experiences, such as child abuse and eating disorders.

Without accurate and complete information openly communicated by the patient, the dentist's care could harm rather than benefit the patient.

Dentists also trust the patients to keep appointments, fulfill financial obligations, and take responsibility for the maintenance of his or her own oral health.

From the patient's view, the dentist is trusted to abide by the dental code of ethics. Kristen has asked Dr. M to keep information that has serious social and economic implications confidential. Confidentiality is a central means of assuring patients that their doctors will not misuse facts about their lives pertinent to the understanding of their illnesses.

Unlike the trust that must be earned, as in a friendship, the patient assumes a trusting relationship because of the dentist's training and special role in society.

### **In Conclusion**

To summarize, keeping confidences promotes trust and openness between doctors and patients and allows the patient autonomous control over personal or private information about themselves.

Confidentiality affirms and protects the fundamental value of privacy and the social status of the patient and encourages patients to seek professional help when it is needed.

Breaking confidences, the central question in this case, must be justified considering these, as well as other, factors.



*Reprinted in part from the Texas Dental Journal of the Baylor College of Dentistry with permission.*



## ON APPEAL

# On Appeal

*When the Investigations, Complaints and Reports Committee (before June 4, 2009, known as 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 all the regulated health professions.*

*These 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.*

### COLLEGE CONTACT

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Registrar

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### THE COMPLAINT

The complainant visited the dentist to repair a broken filling. Following administration of local anaesthetic, the patient suffered a minor stroke while in the chair. The patient complained that the dentist's office lacked proper procedures and that the agent used created the problem.

### DECISION OF THE COMPLAINTS COMMITTEE

The Committee was satisfied that the dentist had complied with the College's requirements as set out in the College's educational CD on Medical Emergencies in the Dental Office. In addition, the list of contents in the emergency medical kit, the agent used for local anaesthetic and dosage used were all appropriate. The Committee ordered no further action.

### HEALTH PROFESSIONS APPEAL AND REVIEW BOARD

The Board was satisfied as to the investigation and as to the reasons of the Committee. The Board confirmed the decision of the Complaints Committee, but also noted that the patient's own family physician noted that the exact etiology of the presumed cerebral infarct is not known.

The Board reviewed the medical procedures with respect to emergency in the office and commented that the member had complied with the medical emergency guidelines as set out in the College's educational CD.

## Free Offers For Life

### COLLEGE CONTACT

**Dr. Fred Eckhaus**

Assistant to the Registrar,  
Dental

416-934-5624

1-800-565-4591

feckhaus@rcdso.org

It has come to the College's attention that some dentists are advertising a free offer of "Whitening for Life."

Please note that although dentists are permitted to offer their services at no charge or at a reduced fee, offering free products/gifts to patients on the basis they continue to receive their dental treatment at your practice could be regarded as a violation of the conflict of interest regulation.



# Focus on Occupational Health and Safety: The Use of Inhalant Gases

## COLLEGE CONTACT

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*Practice Advisor*  
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lwaschuk@rcdso.org

The College's Guidelines on the Use of Sedation and General Anaesthesia in Dental Practice are the standard of practice in relation to inducing general anaesthesia, deep sedation or conscious sedation with respect to dental services in Ontario.

The Guidelines contain requirements for training, staffing, monitoring, equipment, recordkeeping and emergency preparedness to help ensure that patient safety is not compromised.

As employers, dentists have responsibilities under occupational health and safety legislation to implement measures to help protect the health of their employees.

Studies have suggested that chronic exposure to nitrous oxide or volatile anaesthetic agents may adversely affect the health of dentists and staff in the operator. Exhaled and excess gases can be contained by properly functioning scavenging systems.

For this reason, the Guidelines also contain a requirement for gas delivery systems used for inhalant gases (nitrous oxide and volatile anaesthetic agents) to be equipped with scavenging systems installed as per manufacturers' specifications; the Guidelines also outline inspection and maintenance requirements for gas delivery systems. Therefore, it is the standard of practice to always use scavenging systems whenever any of these gases are being administered.

**ON THE WEB**  
[www.rcdso.org](http://www.rcdso.org)

*Use of Sedation and General Anaesthesia  
in Dental Practice*

PROFESSIONAL PRACTICE/GUIDELINES



# New Requirement for Oral Moderate Sedation

**E**ffective June 1, 2009, all dentists who wish to treat patients using the oral administration of multiple sedative drugs, with or without nitrous oxide and oxygen, must now register with the College and obtain a facility permit.

In addition, all dentists who intend to achieve moderate sedation using any modality of conscious sedation, including the oral administration of a single sedative drug, with or without nitrous oxide oxygen, must adhere to the Guidelines for moderate sedation. This includes the professional responsibilities of registering with the College and obtaining a facility permit.

The granting of a facility permit is subject to training and conformance with all aspects of the Guidelines, as well as satisfactory on-site inspections and evaluation by the College.

The Guidelines describe the training required to administer oral moderate sedation. The Guidelines also contain a provision whereby dentists whose prior training is not as described, but who have been practising this modality for some time and can demonstrate that they have successfully completed an appropriate course in airway management, may submit their qualifications and experience in writing to the College for consideration.

These new Guidelines were approved by Council earlier this year at its May meeting, and are included with this issue of Dispatch magazine.

## IMPORTANT TIMELINES

All dentists currently administering oral moderate sedation must now register with the College and apply for a facility permit no later than December 31, 2009.

## REGISTRATION FORM

The Registration Form for the administration of Oral Moderate Sedation can be found on the College's website at [www.rcdso.org](http://www.rcdso.org) under the heading of Sedation/Anaesthesia on the left hand side of the home page. Please complete this form and submit it to the College no later than December 31, 2009.

You are required to apply for a facility permit if your dental facility does not currently have one.

## FACILITY PERMIT APPLICATION

If your facility does not currently have a facility permit, please also complete the Facility Permit Application Form and submit it to the College along with your Registration Form. It can be found on the College's website at [www.rcdso.org](http://www.rcdso.org) under the heading of Sedation/Anaesthesia on the left hand side of the home page.

Once the College has received your application form, one of the College's field inspectors will contact you to arrange for an inspection.

It will be helpful if you are prepared for the inspection by ensuring that your facility is properly equipped with the requisite sedation equipment and emergency drugs, as outlined on pages 11 and 12 of the Guidelines.

## COLLEGE CONTACTS

**REGISTRATION FORM/FACILITY PERMIT APPLICATION FORM**  
**Stephanie Bickford**  
*Administrative Assistant, Registration*  
416-961-6555, ext. 4325  
1-800-565-4591  
[sbickford@rcdso.org](mailto:sbickford@rcdso.org)

**TRAINING/QUALIFICATIONS – ORAL MODERATE SEDATION**  
**Dr. Michael Gardner**  
*Manager, Quality Assurance*  
416-934-5616  
1-800-565-4591  
[mgardner@rcdso.org](mailto:mgardner@rcdso.org)



You may also refer to the Oral Moderate Sedation Checklist of Sedation Equipment and Emergency Drugs, which is available on the College's website at [www.rcdso.org](http://www.rcdso.org) under the heading of Sedation/Anaesthesia on the left hand side of the home page.

#### **FACILITY INSPECTION**

Following the inspection of your facility, the inspector will forward a report to the College for review and a facility permit will be issued.

As all facility permits expire on March 31st of every year regardless of the initial date of issuance, your facility permit will remain valid until March 31, 2010.

#### **FACILITY PERMIT ANNUAL RENEWAL**

In early January of 2010, you will be billed for the renewal of your facility permit. The due date for annual renewal is March 31, 2010. Upon receipt of your completed Annual Renewal Form and fee, a new facility permit will be issued for the period April 1, 2010 to March 31, 2011.

It is anticipated that all facilities will be reinspected on a three-year staggered cycle and billed annually for the facility permit renewal.

**ON THE WEB**  
[www.rcdso.org](http://www.rcdso.org)

*Use of Sedation and General  
Anaesthesia in Dental Practice*

PROFESSIONAL PRACTICE/GUIDELINES

## **Gas analyzers are now required for certain general anaesthetic techniques**

For certain general anaesthetic techniques, clinical observation of patients must now be supplemented by the following additional means of monitoring:

- If intubated or a laryngeal mask airway is used, monitoring by oxygen analyzer is now required.
- If a volatile inhalational anaesthetic agent is used to maintain anaesthesia (e.g. isoflurane, sevoflurane, desflurane), an anaesthetic agent analyzer is now required.

All facilities employing the above-noted techniques to administer general anaesthesia must now obtain appropriate gas analyzers no later than December 31, 2009.

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## *Retaining the Services of a New Dentist or Physician to Administer Sedation and/or Anaesthesia in Your Dental Practice?*

# Here Are Some Things You Need to Know

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When a member applies, a facility permit is issued by the College after a review of the training and qualifications of those administering sedation and/or anaesthesia services, as well as a satisfactory on-site review to ensure that:

- all necessary equipment and monitors are in place and are maintained properly;
- all emergency drugs are available and current;
- all other requirements and conditions set out in the College's Guidelines for the Use of Sedation and General Anaesthesia in Dental Practice are met.

If you are thinking of retaining the services of a new physician or dentist to administer sedation and/or anaesthesia in your dental practice, please note:

**It is your responsibility to inform the College of this change prior to booking any sedation/anaesthesia cases with this new dentist or physician. You need to ensure that this new person is, in fact, on file with the College as approved to administer sedation and/or general anaesthesia in a dental practice.**

In addition, if this new physician or dentist brings his or her own sedation equipment, emergency drugs, etc., to your dental facility, please note:

**It is also your responsibility to ensure that the sedation armamentarium has been inspected by the College and is in full compliance with the College's Guidelines.**

Once you have informed the College of any changes about who is administering sedation and/or general anaesthesia in your dental practice, the College will confirm, in writing, that the individual that you are planning to engage is qualified to do so. The College will then also issue a new facility permit reflecting this change.

If this new physician or dentist will be using a sedation/anaesthesia modality that is different from the one currently being administered, you also need to inform the College about this change.

## GENERAL INFORMATION ABOUT THE ANAESTHESIA AND SEDATION FACILITY PERMIT PROCESS

The RCDSO Regulation and RCDSO Guidelines on the Use of Sedation and General Anaesthesia in Dental Practice represent the standard of practice in relation to inducing general anaesthesia, deep sedation or conscious sedation with respect to dental services in Ontario.

Since the contravention of the Regulation and Guidelines may be considered as professional misconduct, dentists employing any modality of drug-induced sedation or general anaesthesia must be familiar with the content, be appropriately trained and regulate their practices accordingly.

The Guidelines require that all dental facilities that provide oral moderate sedation, parenteral conscious sedation, deep sedation or general anaesthesia must be registered with the College and obtain a facility permit. Permits are not required for offices that use nitrous oxide and oxygen conscious sedation and/or oral minimal sedation.

These permits are granted subject to a review of the qualifications and training of the person administering the sedation/ anaesthesia and conformance with all aspects of the Guidelines and subject to a satisfactory on-site inspection and evaluation by RCDSO.

The permits are also subject to annual renewal and a periodic reinspection of the facility.

**ON THE WEB**  
[www.rcdso.org](http://www.rcdso.org)

*Use of Sedation and General Anaesthesia  
in Dental Practice*

PROFESSIONAL PRACTICE/GUIDELINES



## Expert Witness Training Session Unique Learning Opportunity

### COLLEGE CONTACT

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On June 22, the College hosted a special training session for the wide range of experts used, from time-to-time, as witnesses in the College's processes. An invitation to attend was also extended to other health-care regulatory colleges. About 75 people were in attendance.

These experts included forensic accountants, psychologists, document examiners, psychiatrists, substance abuse and addiction counsellor experts, and of course, dentists.

"The goal of the session was to ensure our experts have a clear understanding of what their roles are, how their written reports can be the best they can be, and to perfect the unusual role of witness so that the decisions of the College's committees are beyond reproach or criticism by a review court," explained College Registrar Irwin Fefergrad. "It was a dynamic session and a wonderful opportunity to improve what is already an excellent process."

The session featured presentations by the Honourable Mr. Justice Stephen T. Goudge of the Court of Appeal of Ontario and lawyer Linda R. Rothstein. It was chaired by College Registrar Irwin Fefergrad.

The Ontario Government appointed the Honourable Justice Goudge as Commissioner



*Linda R. Rothstein and the Honourable Mr. Justice Stephen T. Goudge of the Court of Appeal of Ontario*

of the Inquiry into Pediatric Forensic Pathology in Ontario. That inquiry was created because, in April 2007, the Office of the Chief Coroner of Ontario released the results of a review into 45 cases of suspicious child deaths between 1991 and 2002 where forensic pathologist Dr. Charles Smith either performed the autopsy or provided an opinion as a consultant.

In 20 cases, the panel of internationally respected experts in forensic pathology did not agree with the opinions given by Dr. Smith in a written report or court testimony or both. In a number of these cases the reviewers felt that Dr. Smith "had provided an opinion regarding the cause of death that was not reasonably supported by the materials available for



review.” Twelve of those cases had resulted in criminal convictions, and one in a finding of “not criminally responsible.” One of the cases was the subject of an application for ministerial review.

A large part of Honourable Justice Goudge’s report and final recommendations to the Attorney General addressed the use and qualifications of experts and their training. The final report was released on October 1, 2008.

Linda Rothstein was the Commission Counsel for that inquiry. She is the managing partner of the law firm Paliare Roland Rosenberg Rothstein LLP. Her practice includes civil and administrative litigation, and she has particular expertise in public law. Recently, she was the City of Toronto’s lead counsel at the Toronto Computer Leasing Inquiry. She is the co-author of the leading Canadian text on legal malpractice and an author of many articles on substantive and procedural law. In June 2005, Ms. Rothstein was awarded the Law Society Medal for distinguished service to the profession. Ms. Rothstein is also a Bencher to the Law Society of Upper Canada.

**ON THE WEB**  
[www.goudgeinquiry.ca](http://www.goudgeinquiry.ca)

## Calendar of Events

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

### *Mark Your Calendar...*

#### **2009 COUNCIL MEETINGS**

November 12

Westin Prince Hotel  
900 York Mills Road, Toronto

#### **2010 COUNCIL MEETINGS**

March 4

June 10

November 18

*Seating is limited so if you wish to attend please let us know in advance by contacting the College.*

#### **COLLEGE CONTACT**

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# Source Guide 2009 Update

*The 2009 edition of the Source Guide to Dentists and Specialists in Ontario contained incorrect information for some of our members. The corrected information is listed below. We regret any inconvenience this may have caused.*

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# *Information All The Time. Information When You Need It.*

## Go to [rcdso.org](http://rcdso.org)

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The College's website is your source of timely and important information to help you in your dental practice.

Whether it is an Important Health Notice with the latest information from the Ministry of Health on the pandemic, Council Highlights with an update on what happened at the most recent Council meeting or copies of the most up-to-date version of Guidelines and Practice Advisories, it is all there.

The What's New section on the home page profiles the latest information on College activities, government notices, and practice information, etc.

The Member Resource Centre makes it easy to update your personal address information with the College or to open a file with our Professional Liability Program.

Click on Continuing Education and find out all you need to know about collecting your required CE points and extra reporting forms that you can print off.

Under Health Profession Corporations are all the forms you need, plus the background legislation and excellent reference articles to answer your questions.

*Check it out!*



## Need It On Paper?

All publications, including Council Highlights, Guidelines and Practice Advisories, are still available in the traditional paper format. Please contact Aurore Sutton at 416-961-6555, ext. 4303 or 1-800-565-4591 or [asutton@rcdso.org](mailto:asutton@rcdso.org) to have a copy sent to you.

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## Upfront Chronique Du Président Upfront Chronique Du Président Fluoruration de l'eau : le débat est relancé

SUITE DE LA PAGE 4

► L'exception du contrôle des maladies infectieuses grâce à la vaccination pendant l'enfance, peu de problèmes de santé publique ont été enrayerés aussi rapidement. La fluoruration des eaux de consommation est considérée par l'Organisation mondiale de la Santé (OMS) comme l'un des dix plus grands accomplissements du 20<sup>e</sup> siècle dans le domaine de la santé publique.

Depuis plusieurs décennies, le mouvement anti-fluoruration attise les craintes de la population en décrivant le fluor comme un poison dangereux, toxique et associé à toute une gamme variée de troubles et maladies – allant de la mort subite du nourrisson au sida.

Aujourd'hui la fluoruration de l'eau est à nouveau inscrite à l'agenda politique. Dès le début, la fluoruration fut un sujet controversé que l'on réétudie sans cesse.

En tant que professionnels de la santé dentaire, nous savons que la fluoruration de l'eau est le moyen le plus rentable pour prévenir et réduire la carie dentaire.

Bien que d'autres produits fluorés soient disponibles, la fluoruration de l'eau demeure la mesure de santé publique la plus efficace, la plus équitable et la plus rentable pour prévenir et réduire la carie dentaire dans la population.

Dans le cadre de son mandat de protection du public, le Collège juge important de s'impliquer dans ces débats publics.

Suite à la demande de représentants locaux, généralement des dentistes locaux ou le personnel d'un bureau de santé, le Collège n'a pas hésité à participer aux débats municipaux. Par exemple, au cours des derniers huit mois, le Collège s'est déclaré en faveur de la fluoruration de l'eau devant les conseillers municipaux de Halton, Hamilton, New Tecumseth et Thunder Bay.

Nous allons poursuivre nos efforts. En fait, lors de sa dernière réunion en mai, le Conseil a décidé à l'unanimité de joindre force avec l'Association dentaire de l'Ontario pour promouvoir la fluoruration de l'eau potable.

La fluoruration de l'eau potable est l'une des mesures préventives les plus efficaces dans l'histoire des soins de santé. À titre de dentiste en chef du Canada, le Dr Cooney déclare que la maladie buccodentaire étant la maladie chronique la plus répandue chez les enfants et les adolescents en Amérique du Nord, la fluoruration s'avère donc une importante mesure de santé publique. Le Collège continuera d'appuyer l'utilisation des fluorures pour la prévention des caries.

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## Upfront The President's Message Upfront The President's Message Fighting for Fluoridation – All Over Again

CONTINUED FROM PAGE 4

► delivering fluoride to all members of most communities, regardless of age, educational attainment or income level, and generally by a method that is not dependent on an individual's behaviour.

Our College has an important role to play in these public discussions. We believe it is part of our legislated mandate of public protection and safety.

When asked by local community representatives, usually local dentists or the public health unit staff, our College has not hesitated to participate in the formal public discussions. For example, over the last eight months or so, our College has shared the pro-fluoridation message with councillors in Halton

Region, Hamilton, New Tecumseth and Thunder Bay.

We will continue this important work. In fact, at our last Council meeting in May, Council voted unanimously in support of a joint effort with the leadership of our College and the Ontario Dental Association to develop an initiative to promote fluoridation.

Community water fluoridation is an important oral health issue. As the Chief Dental Officer of Canada, Dr. Peter Cooney says, with dental disease as the number one chronic disease among children and adolescents in North America, fluoridation is an important public health measure. Our College will continue to speak out.

## “The Times They Are a-Changin’”

CONTINUED FROM PAGE 40

➤ Let me share another anecdote. Canadian businessman Izzy Sharp has written a book called *The Story of a Business Philosophy*, where he describes how he developed the enormously successful worldwide hotel chain, Four Seasons.

Mr. Sharp saw recessionary times as an opportunity. Going against current thinking, he didn't cut back, in fact, he spent money. He put fresh flowers in the lobby and big new pillows and fluffy towels in the rooms. He created an image of value. Hotel staff were trained to understand how to deliver great customer service.

So what can we glean from these stories? I would like to suggest that there are several points to be learned about how to navigate these turbulent times for success.

We need to:

- reaffirm our core values;
- maintain and strengthen our messaging about the valuable services that we offer to our members and to the public;
- focus on what we do well;
- continue with our creative approach to problem-solving.

Thanks to the wisdom and courage of present and past Councils and committees, this College has embraced incredible changes over the past few years in the world of self-regulation here in Ontario and in Canada. All the while, we have never lost sight of our primary mandate of working in the interest of public protection and safety.

As a regulator, we are under incredible scrutiny from a number of independent watchdogs. There are now the Health Professions Regulatory Advisory Council, the

Office of the Fairness Commissioner of Ontario, the federal Competition Bureau, the Ontario Human Rights Tribunal and the Office of the Privacy Commissioner of Ontario.

And let's not forget the power of the provincial

government to require regulators to implement the federal/provincial Agreement on Internal Trade. We have never shirked from this heightened level of accountability.

I believe that these are not the times to retrench. We have proven time-after-time that we are good with change. We are resilient, nimble and agile.

We have never struggled with our mission. We know why we are here and have always stayed true to our core value of public protection and the values of the Charter of Rights and Freedom.

We willingly accept our defined role as a regulator. We are totally committed to working collaboratively with others in a fair and transparent way.

We believe we are good at what we do and we constantly try to do better. We want to share that good news story with the public, government and our members.

The times are indeed a-changin'. There is much to be said for the truism that changes can be viewed from two very different perspectives – as an opportunity or as a threat. We choose to see these changes as a source of opportunity and will continue to ask ourselves how we can leverage them to create value for our members and for the public of Ontario.

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*Keep your eye on the future and don't let short-term considerations trump long-term potential.*

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# “The Times They Are a-Changin’”



**IRWIN FEFERGRAD**

**T**he Times They Are a-Changin’.

That phrase and sentiment have been with us since biblical times. Today, in 2009, there could still be no better description of the times we are living in.

The challenge for any organization is what is the best way to respond to these uncertain times. Worldwide economies have cratered. Consumers and governments are demanding ever higher standards of accountability and transparency from regulators.

There may be useful lessons to be learned if we turn to the world of business. Let me share with you a short story from a recent issue of *The New Yorker* magazine.

Two companies in the late 1920s – Kellogg and Post – dominated the market for packaged cereal. Packaged cereal was a relatively new market. Consumers had not yet been won over from the traditional oatmeal or cream of wheat. So, when the Depression hit, no one knew what would happen to consumer demand. Post did the predictable thing: it reined in expenses and cut back on advertising. But Kellogg doubled its ad budget, moved aggressively into radio advertising, and heavily pushed its new cereal, Rice Krispies. By 1933, even as the economy hit bottom, Kellogg’s profits had risen almost 30 per cent and it had become what it remains today: the industry’s dominant player.

Of course, we are not in business to make a profit. But what can we learn from this example? Tough times create opportunities. Keep your eye on the future and don’t let short-term considerations trump long-term potential. Accept change and be a part of it. Have confidence and stay true to your real purpose.

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*Accept change and  
be a part of it.  
Have confidence  
and stay true to  
your real purpose.*

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CONTINUED ON PAGE 39