

DISPATCH



Royal College of
Dental Surgeons of Ontario

Ensuring Continued Trust

APRIL/MAY 2004

VOL. 18, NO. 2

It's Election Time – Get Involved!

Privacy Legislation

Update on the Latest Developments

Birth of the CDRAF

An Historic Landmark in Dentistry

College Elections

Important Dates for Election 2004

Specialty in Dental Anaesthesia

Start of a Long Process

Oral and Maxillofacial Surgeons

College Clarifies Scope of Practice



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Dental Surgeons of Ontario
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Vol. 18, No. 2
April/May 2004

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- PEAK: The American Academy of Periodontology Statement Regarding Gingival Curettage

College Juggles Delicate Balance in
The Hot Political Issue of

Access of Foreign-Trained Dentists to Canadian Job Market



DR. CAM WITMER

Access of internationally trained and educated professionals to the Canadian workforce is on the top of the political agenda for both provincial and federal governments.

Major national daily newspapers are publishing stories of doctors and engineers driving taxis, and rocket scientists selling cinnamon buns in a Toronto subway station.

The reality is that we can no longer afford to rest with the status quo on this issue.

Provincially, in the closing days of 2003, Minister of Training, Colleges and Universities Mary Anne Chambers wrote to each of the provincial occupational regulatory bodies.

She stated that her government has set a target of one year in which to make substantial progress.

Federally, the new *Immigration and Refugee Protection Act* has significantly changed the selection system for immigrants that had been in place since the late 1960s. There has been a complete elimination of occupation from the selection criteria. Now the government is looking to choose immigrants with transferable skill sets.

Why so much action on this issue now? A few statistics tell the story.

According to a recent *Globe and Mail* article, within the next seven years, when

half of all baby boomers will be 55 years old and over, new Canadians will account for virtually all of the country's new workers.

A recent Conference Board of Canada study showed that the economy loses up to \$6 billion a year in income as a result of "under-employing highly skilled and educated internationally trained workers."

In a speech last year to the Canadian Bar Association, the then federal Minister of Citizenship and Immigration Denis Coderre talked about foreign credential recognition. Again, let me quote:

Canada can no longer afford not to unlock the vast potential of the new immigrants we already bring here each year. Too many highly-trained immigrants are forced to seek employment in less-skilled occupations – because their skills and credentials are undervalued or go unrecognized.

It is plain to see. The political reality is that if we don't come up with solutions on our own, governments will impose them on us. Far better we take charge in our own house.

As a regulatory college, we have a delicate balancing act to maintain.

We are legally obliged to operate in the public interest. We are legally obliged to

set standards of admission to the profession to ensure that only those qualified to practise are licensed or certified to practise.

At the same time, we do not want to limit access by restricting opportunities to enter the profession for those who are as competent as those already practising.

We have two goals:

1. We want to ensure public interest protection, safety and welfare by setting and maintaining standards that ensure that dentists are qualified to practise competently and ethically.
2. We want to ensure that practitioners who meet those standards, wherever they are trained, have an opportunity to obtain licensure in dentistry in Ontario.

We already have a system in place to do that, and it works. Foreign-trained dentists must prove competency and equivalency.

Their applications must be approved by the university faculties of dentistry, by the National Dental Examining Board (NDEB), and by the Royal College of Dentists of Canada.

Competency is fundamental for gaining

Continued on page 20

Le Collège doit trouver un équilibre délicat sur le sujet brûlant

de l'accès des dentistes formés à l'étranger au marché du travail canadien.

L'accès des professionnels ayant reçu leur formation et leur éducation à l'étranger au marché du travail canadien représente une priorité dans le programme politique des gouvernements provinciaux et fédéral.

Les grands quotidiens nationaux publient des articles sur des médecins et des ingénieurs devenus chauffeurs de taxi et des scientifiques qui vendent des brioches à la cannelle dans les stations de métro de Toronto.

En vérité, nous ne pouvons pas nous permettre de maintenir le statu quo relativement à cette question.

Dans la province, au cours des derniers jours de 2003, la ministre de la Formation, des Collèges et Universités, Mary Anne Chambers, a écrit à chacun des organismes de réglementation professionnelle provinciaux.

Elle affirmait que son gouvernement visait à réaliser des progrès considérables en l'espace d'une année.

À l'échelle fédérale, la Loi sur l'immigration et la protection des réfugiés a grandement changé le système de sélection des immigrants qui était en place depuis la fin des années 60. Les critères de sélection reposant sur l'occupation ont été complètement éliminés. Désormais, le gouvernement recherche les immigrants qui détiennent

des ensembles de compétences transférables.

Alors pourquoi accorde-t-on à présent une si grande attention à cet enjeu ? Quelques statistiques suffisent à raconter toute l'histoire.

Selon un article récent paru dans le *Globe and Mail*, au cours des sept prochaines années, lorsque la moitié des baby-boomers sera âgée de 55 ans et plus, les nouveaux Canadiens constitueront pratiquement la totalité des nouveaux travailleurs au pays.

Une nouvelle étude du Conference Board du Canada révèle que l'économie perd près de 6 milliards de dollars par année en raison du « sous-emploi des travailleurs hautement qualifiés formés à l'étranger ».

Dans un discours à l'Association du barreau du Canada l'année dernière, Denis Coderre, qui était ministre de la Citoyenneté et de l'Immigration à l'époque, traitait de la reconnaissance des titres de compétence étrangers. Permettez-moi de le citer :

Le Canada ne peut plus se permettre de ne pas puiser dans le vaste potentiel des nouveaux immigrants que nous faisons déjà venir ici chaque année. Trop d'immigrants hautement qualifiés sont forcés de prendre des emplois moins spécialisés – parce que leurs

compétences et leurs diplômes sont sous-évalués ou ne sont pas reconnus.

Cela est évident. La réalité politique est que si nous ne trouvons pas nos propres solutions, les gouvernements nous imposeront les leurs. Il serait grandement préférable de prendre nos affaires en main.

En tant que collège de réglementation, nous devons conserver un équilibre fragile.

D'un point de vue juridique, nous sommes tenus de fonctionner dans l'intérêt du public. Nous sommes obligés par la loi d'établir des normes d'entrée dans la profession pour voir à ce que seules les personnes qualifiées obtiennent un permis ou un certificat d'exercice.

D'autre part, nous ne voulons pas limiter l'accès en restreignant les possibilités d'entrée dans la profession des personnes compétentes qui exercent déjà leur profession.

Nous visons deux objectifs :

1. Nous voulons protéger l'intérêt du public, sa santé et son bien-être en établissant et en appliquant des normes qui nous permettent de nous assurer que les dentistes sont qualifiés, compétents et qu'ils respectent la déontologie professionnelle.

Suite à la page 22

More Questions and Answers About The Federal Privacy Legislation

RECENTLY INDUSTRY CANADA, TOGETHER WITH THE OFFICE OF THE PRIVACY COMMISSIONER OF CANADA, RELEASED A THIRD SERIES OF QUESTIONS AND ANSWERS GEARED TOWARD ASSISTING THE HEALTH CARE SECTOR IN APPLYING PIPEDA.

You can access this material directly on the Industry Canada Web site at <http://e-com.ic.gc.ca/epic/internet/inccic-ceac.nsf/vwGeneratedInterE/gv00228e.html>.

While these are not legally binding, they do provide some guidance to the health sector. Most significant in these questions and answers is that through them the government seems to have relaxed some of the consent requirements.

Provincially Ontario has introduced its own health-specific privacy legislation that is now proposed to come into effect January 1, 2005. See page 10 for more information about the possible impact of the proposed provincial legislation. The draft version of this legislation does contain more detailed provisions related to consent.

These developments seem to have created some confusion around issues of informed consent for collection, use and disclosure of personal information. As always, the College will continue to provide assistance to guide you through these issues.

Q Why has advice from the College on some of these privacy issues, like consent, been modified?

This is an excellent question, and the situation is frustrating for College staff too.

The College continues to provide information that is as current and relevant as possible. However, since the application of the federal privacy legislation to the health-care sector is brand new, and the provincial legislation is still in the making, formal

interpretations by both the federal and provincial privacy commissioners, and by government ministries and staff, are extremely fluid.

Our aim is always to try and provide the best insulation for the members to be in compliance with what we are told at the moment by either the Office of the Privacy Commissioner of Canada or Industry Canada whose legislation it is.

We are all in a learning process that, no doubt, will continue for some time. If you are unclear about anything or have

questions at any time, the best advice is to call College staff. Contact names and numbers are listed at the end of this article.

Q Am I required to have my patients sign the consent form in the compliance kit?

The College believes that having patients sign the consent form in the kit is still the best way to clearly explain to your patients how your office collects, uses and discloses personal information about them. Take a few minutes to explain to your patients that there is nothing new in what you are asking for – you are merely explaining to them how your office handles their personal information. Having a detailed and signed consent form should eliminate any confusion down the road.

That being said, you are not required to use the College's form. You should be able to rely on informed consent to communicate between those treating the patient (specialist, general dentist, physician, laboratory, pharmacy, etc.). In all other circumstances (billing,

insurance claims, etc.) you will require express consent under the Ontario legislation, which is best to obtain in writing.

The consent form was drafted at the request of members who asked for help in this area, and the College has received overwhelming positive feedback from both dentists and patients on the form. The choice of whether or not to use the form and obtain signed consent rests with the professional judgement of each dentist.

The consent form will likely be a complete answer to a patient who said he/she did not give consent. The draft provincial privacy law mandates both express and implied consent, and it may well be that the provincial government may wish the express portion to be in writing.

In our submissions to government on the draft provincial privacy legislation, on our own behalf and on behalf of the Federation of the Health Care Regulatory Colleges of Ontario, we have asked that the consents not be onerous. We hope that the posting of the type of consent form in the PIPEDA kit will satisfy both the implied and express consent provisions of the draft provincial bill.

Q *What if a patient refuses to sign the consent form?*

If a patient refuses to sign, find out which aspects of consent they are reluctant to give you permission for. It may be that they are refusing only one or two points on the form, and you may be perfectly agreeable to delete those items. You should know that, for some of the items that you are seeking the patient's consent, you actually have a legal right or even obligation to disclose in certain circumstances. The reason for including these items on the consent form is to explain to the patient all of the ways that you may use and disclose personal information.

Many dentists see this as an opportunity to discuss why you are seeking consent from the patient, and explain the privacy legislation. As long as you are satisfied that you have the patient's consent to collect, use and disclose the information that you do, you can continue to treat the patient.

Q *What is the age of consent for collection, use and disclosure of personal information?*

This is one of the most common questions that we get asked. Age of majority is 18, but that essentially deals with legal contracts which is very different than informed consent. If your patient has the understanding to give you consent to treatment, then that patient can give you consent for privacy purposes.

There is no magic age, but one would suppose that it would mean someone who is at least in their teens. If the dentist thinks in his/her professional judgement that a patient, regardless of age, has the capacity to consent to his/her own collection, use and disclosure of information then consent should be obtained from the patient directly. For example, if a teenaged patient gives you personal information (e.g. on birth control) and asks you not to share it with mom and dad, you are obliged to keep that information private. The Ontario health privacy legislation is expected to provide more guidance on this topic.

Q *Do I need locks on my filing cabinets?*

Your obligation is to ensure that patients' personal information is protected from loss, theft, unauthorized access, copying, modification or destruction. The College recommends that you store records securely in an area that is clearly for staff only, and staff are trained to guard against unauthorized access. How you

carry out this responsibility is left to your sound professional judgement; however, locks on cabinets are not a necessity.

Q *How do I ensure a student working or observing in my office complies with the privacy legislation?*

You can make the student part of your staff and they will be bound by your policies, or you can have the student sign a confidentiality agreement. Staff employed by a dental office are not required to sign a confidentiality agreement. Of course, you should ensure that you fully explain to the student doctor/patient confidentiality, privacy obligations and the possible consequences of any breach.



If you have any questions about compliance with the federal privacy legislation, you can contact any of the following College staff.

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College Takes Proactive Role

Responding To Ontario's Privacy Legislation

The College continues its active role with privacy legislation, on federal and provincial fronts, with both a written submission and verbal presentation in late January to the Standing Committee on General Government on Ontario's *Personal Health Protection Act* (Bill 31).

The College also took an instrumental role in the development of the submission for the Federation of Health Care Regulatory Colleges of Ontario (the Federation), and in the Federation's appearance before the Committee.

In both submissions, the recommendations focused on changes to draft Bill 31 to ensure that there are no unintended limitations on the ability of health-care regulatory colleges to protect public safety.

The key recommendations in the College's submission were as follows:

1. The Royal College of Dental Surgeons of Ontario welcomes the introduction of this legislation that provides one set of rules for the provision and regulation of the health-care sector, distinct from commercial information and activities. This legislation will provide much needed clarity in the application of these important privacy principles, while recognizing the unique pressures for the health-care sector and the regulators of health professionals.
2. Complementary amendments to the *Regulated Health Professions Act* (RHPA) should be made to make it paramount to the *Personal Health*

Information Protection Act (HIPA) in the event of a conflict to ensure that the strong public safety protections built into the RHPA are not jeopardized.

3. The quality assurance programs that regulatory colleges are legislated by the RHPA to provide to its members be afforded the same protections under the *Quality of Care Information Protection Act* (QCIPA) as the quality assurance committees and programs of health facilities.
4. The College and the Federation welcome the clarification around express and implied consent in the legislation, a position the College took with the initial provincial privacy bill.

RCDSO's written submission is available on our Web site at www.rcdso.org. Click on the Advocacy heading on the left side of the home page.

The Committee members congratulated the College for its work on the federal privacy legislation, and asked the College and the Federation for assistance in redrafting sections of the proposed legislation.

As the College pointed out in its submission, RCDSO was one of the few regulatory colleges in Canada to make a significant commitment to ensuring its members were compliance-ready for the introduction of the federal privacy legislation. Copies of our kit were distributed in advance to all of the



College Registrar Irwin Fefergrad (right) and Dayna Simon, Assistant to the Registrar, Legal (centre), take a break during their preparations with Michelle Kennedy, Registrar, College of Denturists of Ontario (left) to appear before the Standing Committee on General Government to present the verbal submission of the Federation of Health Care Regulatory Colleges of Ontario on January 27. The College made its own verbal presentation to the Committee on January 26.

Committee members, to the health critics for the Official Opposition and the NDP, to the Minister of Health and Long-Term Care, and to the Premier of Ontario.

If you have any questions about Bill 31, please contact:

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Media Profile For Dentists' Work On Protecting Patient Privacy

Dentists and the College's privacy kit were featured in a major story in the *Toronto Star* on February 2 about the new federal privacy law. The article quoted extensively the College Registrar Irwin Fefergrad and Toronto dentist Dr. Domenic Belcastro (in the photo above).



Still On The Road With The Privacy Message

College staff, primarily Irwin Fefergrad and Dayna Simon, continue with the College's commitment to meet with dentists around the province to help them understand the privacy legislation. In the past several months, Irwin and Dayna have spoken with dentists in Owen Sound, Sault Ste. Marie, Peterborough, Hamilton, Windsor, Timmins, Woodstock, Stratford, Cornwall and Sarnia. The College also accepted invitations to speak on privacy to groups outside the dental community including psychiatrists at Mt. Sinai Hospital. Pictured here are the public health dentists from the City of Toronto with Dr. Hazel Stewart (centre back row), Director, Community and Neighborhood Services, Dental and Oral Health and College Registrar Irwin Fefergrad (extreme left).

College Reps Meet With Two Key Provincial Cabinet Ministers

The College has quickly got the attention of the new Liberal government.

In the last issue of *Dispatch*, we printed a letter from Premier Dalton McGuinty praising us for our accomplishments in assisting Ontario dentists to become compliance-ready for the federal privacy legislation.

During March, College representatives met with Mary Anne Chambers, Minister of Training, Colleges and Universities. In April we are meeting with Minister of Health and Long-Term Care George Smitherman.

President Cam Witmer explained the background to this significant accomplishment during his President's

Report to Council on March 4:

It is important to note that these two ministers called us to set up a meeting.

How did we do it? It was because of our unbeatable list of achievements.

These cabinet ministers told us they wanted to meet with us because:

- They were impressed with our work on the federal privacy law.
- They were impressed with our work on the draft provincial health care privacy legislation.
- They were impressed with our work on access to oral health care for seniors.
- They were impressed with our work

on medical history recordkeeping.

- They were impressed with our work on the amalgam waste regulation.

They see the dentists of Ontario as caring professionals who are concerned about the safety and protection of their patients, concerned about the environment, and concerned enough to put resources into developing workable solutions.

They recognize that this College has got it right. They recognize that our Council and staff are a great team with a track record of success and achievement. We should all be very proud.

The Registrar Answers The Question:

What is the Impact of The Proposed Provincial Privacy Legislation on My Dental Practice?



As members know, the federal privacy legislation came into force on January 1, 2004. The College was a leader in providing Ontario dentists with a full compliance kit, including materials tailor-made for the dental office.

Members will recall that the College is not involved in any way in the creation or the enforcement of this legislation.

The Privacy Commissioner's office in Ottawa and the Federal Court in Ottawa are the bodies responsible for dealing with complaints and the legislation's enforcement.

On December 17, 2003, the provincial government brought forward Bill 31 as privacy legislation for the health-care sector in Ontario. This College has been actively involved in making submissions

Clarifying Questions Around Implied And Express Consent

One area of concern has been around the notion of consent. Industry Canada in Ottawa, the federal Privacy Commissioner, and indeed the wording of the legislation require that information collected may not be used or disclosed for purposes other than those for which patients have given consent.

Initially these federal groups insisted that written and express consent were what they were looking for. Our kit provides a consent form that dentists might consider using in Ontario.

Over time the federal Privacy Commissioner issued several statements reaffirming that implied consent would likely be acceptable. However, these statements are not legally binding opinions, but are merely suggestions.

Recently, the federal Privacy Commissioner advised the College that if a patient contacts the Privacy Commissioner's office with a complaint, and that complaint revolves around disclosure of information without the patient's consent, the best evidence and the best protection for the dentist is a signed consent form from the patient.

That is why the College suggests to members that, when and where possible, a signed consent provides the best possible protection. Without a signed document from the patient, the issue of consent becomes murkier and does expose the dentist.

Some dentists have said that they have show their patients the consent form or have

to the provincial Information and Privacy Commissioner, to the Ministry of Health and Long-Term Care, and to the Legislature's Standing Committee on General Government that held public consultations on the draft bill. Bill 31 is now intended to take effect on January 1, 2005, and still needs to go through some legislative amendments.

Once the bill is finalized and passed, the province will need to make application to the federal government so that this provincial legislation will have supremacy over the federal privacy legislation.

All that said, members may well ask, "What will be the impact of this legislation on my practice?"

The answer, frankly, is it should be very little. The provincial privacy legislation is substantially similar to the federal legislation. That means our privacy kit should provide a virtual seamless transition for members. There may be

some slight nomenclature changes, however, essentially all of the advice and principles set out in the kit will assist members to be fully compliant as well with the provincial legislation.

Of course, the College will continue to update our members and provide you with any additional information you should need about the provincial privacy legislation.

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posted it in the waiting room, and then asked patients whether they have their consent. If the answer is yes, the dentist has entered this in the patient's chart. This option is also acceptable, even though the patient has not been asked to sign a consent form.

Here in Ontario, the proposed Bill 31 attempted to redress this difficulty. The legislation actually provides for express and implied consent in different circumstances. Express consent almost always needs something in writing. The consent form in the College's privacy kit would be most suitable and useful to meet this requirement.

It is unclear as yet, but the area of implied consent appears to relate to communications among direct health-care providers or as we've been saying, the "circle of care" providers. So, for example, there would be an implied consent through the legislation for the dentist to communicate with other health-care providers such as the family doctor, the specialist, the dental lab technologist, and the dental hygienist. However, for communications outside that circle of care, and these might include disclosure and communications with any other entity beyond the circle of care such as insurance companies, or prospective purchasers of a practice, the legislation appears to require express consent which may have to be in writing.

ORAL BIOPSY

Province Developing New Strategy For Oral Biopsy Services Says Health Minister

The Ontario Minister of Health George Smitherman advised the College by letter in January that senior ministry staff are currently developing a strategy for oral biopsy services that will include a new funding proposal.

As soon as the ministry's review is complete, all the stakeholders will be advised of the outcome said the Minister.

In late 2003, the College wrote again to the Ministry, this time to the Minister, to urge restoration of public funding for oral pathology diagnostic services. Our letter included a powerful presentation made by Council member Dr. Bohdan Kryshchalskyj on the topic to the May 2003 Council meeting, and a copy of the Council motion in support of public funding for these vital services.

Effective March 2003, Cancer Care Ontario ceased funding for oral biopsy interpretation by the oral pathology diagnostic programs at the University of Toronto and the University of Western Ontario. The two universities were then forced to introduce a private fee-for-service model.

With an end to public funding, the dental community had grave concerns that patients might defer or refuse important biopsies because they could not afford them. The implications of this on the prevention and early detection of cancer are critical.

Creation of a Specialty in Dental Anaesthesia Approved in Principle by College Council – The Start of a Long Road Toward Government Approval of Necessary Regulation

College Council approved in principle the creation of a new specialty in dental anaesthesia in Ontario at its meeting on March 4.

As College President Dr. Cam Witmer explained during Council discussions, the approval of the motion is only the first step of a very long, involved and complicated process. It will include extensive membership and stakeholder consultation, several more opportunities for discussion at the Legal and Legislation Committee and at Council.

At the end of the process, if Council approves the creation of the specialty, its introduction is dependent on government approving regulation changes that would be necessary in order to legally create the specialty. Dr. Witmer reminded Council that there are some College regulations that have been awaiting government approval for over 10 years.

This is not the first time that Council has been asked to consider the issue of a specialty in dental anaesthesia. Back in 1996, the College passed a motion to support, in principle, its recognition on a national level. However, a motion to create the dental specialty was defeated by the Board of Governors of the Canadian Dental Association, and not subsequently pursued.

The current efforts to create this dental specialty started with a submission to the Executive Committee by RCDSO Councillor Dr. Hartley Kestenberg, who is specially-trained in dental anaesthesia,

and Dr. Daniel Haas, chair of the Specialty Steering Committee of the Canadian Academy of Dental Anaesthesia.

They explained that there are currently 38 dentists trained in dental anaesthesia in Canada, and 30 of them practise in Ontario. All of these dentists have received advanced training at the dental faculty at the University of Toronto.

With the overwhelming majority of potential specialists in dental anaesthesia practising in Ontario, it was a logical move to come to RCDSO to request recognition of the specialty.

At the Executive Committee, Dr. Haas made a detailed presentation at the March 4 Council meeting. Highlights of this presentation included:

- Dental anaesthesia education prepares the dentist for the clinical application of the knowledge necessary to assess and manage, primarily by pharmacologic means, those dental patients who require advanced techniques in pain and anxiety management. It also trains clinicians to undertake teaching and research in dental anaesthesia.
- The only Canadian graduate program in dental anaesthesia is at the University of Toronto. It was established in 1960, and is currently a three-year course leading to a Masters in Science degree. The U of T program devotes 14 months of its program to general anaesthesia in the hospital

setting and a two-month rotation in medicine. The program admits one student per year.

- Graduates in dental anaesthesia provide treatment in settings such as specially staffed and equipped private offices, hospital dental departments and dental schools offering the full spectrum of dental services.
- Epidemiological data supports the need for an organized specialty to provide the full spectrum of pain and anxiety control for patients with special needs. These patients include those with dental phobias, special needs children, the mentally challenged, elderly patients with dementia, and patients with local anaesthetic problems.

Dr. Haas cited a number of key benefits if the specialty were recognized:

- It will make it easier and clearer for both dental patients and other dentists to identify who is trained in this area.
- It will improve the public's access to a complete spectrum of sedation and anaesthesia care.
- It will encourage research and other scholarly activity in this field.
- It will enhance teaching at the undergraduate, graduate and postgraduate levels.
- It will ultimately raise the standard of care in dental anaesthesia for the direct benefit of patients.

If you have any questions on this issue, please contact:

Dr. Don McFarlane

Director, Professional Liability Program

phone: 416-934-5609

toll free: 1-877-817-3757

e-mail: dmcfarlane@rcdso.org

Irwin Fefergrad, Registrar

phone: 416-934-5625

toll free: 1-800-565-4591

e-mail: ifefergrad@rcdso.org

Birth of Canadian Dental Regulatory Authorities Federation is Landmark in History of Dentistry in this Nation

THE FOLLOWING IS AN EXCERPT FROM THE ADDRESS OF RCDSO PRESIDENT DR. CAM WITMER TO THE MARCH 4, 2004 MEETING OF THE RCDSO COUNCIL WHEN HE REPORTED TO COUNCIL ON THE BIRTH OF THE CANADIAN FEDERATION OF DENTAL REGULATORS IN FEBRUARY 2004, AND THE INSTRUMENTAL ROLE THIS COLLEGE PLAYED IN THE CREATION OF THE FEDERATION.

You know, from time to time, over the past several years, I have wondered why we seem to have all the luck. Why do great opportunities just seem to fall into our lap? What I have learned in the past year or so as President is that luck isn't lucky at all.

What I have learned is that this is what happens when hard work and opportunity meet. This is what happens when our Council has the courage and wisdom to recognize opportunities, to make difficult decisions. What I am talking about is not luck. It is leadership. It takes leadership to create defining moments that change the direction of history forever. Just such a defining moment occurred on February 24 in Ottawa.

It was the birth of a national federation of dental regulators – the Canadian Dental Regulatory Authorities Federation. A hundred years from now, this will be seen as an historic landmark in Canadian dental history.

Let me give you a bit of background. Up until now, the dental regulators have met, usually as an add-on to meetings of

the Canadian Dental Association. Any decisions made by the dental regulatory authorities had no validity or certainty.

There was no formal organization with a governance structure, no by-laws. The group operated under a one province, one vote system. Accountability and the weight of the decisions made by the group were unclear.

Well, that has all changed. It changed because of the leadership of our College.

With Council's endorsement, on your behalf, last spring at a meeting of the dental regulatory authorities, I moved a motion to have a formal governance structure. That motion was passed.

A working group was formed to move that motion into reality. Last summer we hosted a two-day meeting of the working group here at the College.

Now, a year later, life was given to the Federation when incorporation documents were filed in Ottawa just weeks ago under the signatures of three members of the working group, one of whom was our own Registrar Irwin Fefegrad.

The first formal meeting of this new Federation will take place in Ottawa on April 22.

This is a monumental achievement.

It means one strong and united voice for regulatory matters for all 17,500 dentists in Canada.

It means an effective forum for the exchange of information about regulatory trends, policy and legislation.

It means the development and

promotion of harmonized and global perspectives on issues like labour mobility and dental practice regulations.

Let the history books note the critical role that this College has played. And believe me, luck had nothing to do with it!

Have We Got Your E-mail Address?

The College would like to be in a position to send out e-mail messages to alert all members about time-sensitive, critical information, like a SARS outbreak. The problem is that we do not yet have e-mail addresses for a significant enough portion of our membership to make this a reliable way to distribute important information.

We have pledged that e-mail addresses will only be used to send out information from the College. They will not be included in the membership listings.

So, if you haven't yet sent us your e-mail address, please consider forwarding your address to the College at info@rcdso.org. And thanks to all members who have already done so!

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

Peggi Mace, Communications Director

phone: 416-934-5610

toll free: 1-800-565-4591

e-mail: pmace@rcdso.org



It's Election Time!

Have You Considered Making A Commitment?

OUR STABILITY AND SUCCESS DURING THE LAST 130 YEARS AS A REGULATORY COLLEGE IS DUE IN LARGE MEASURE TO THE OFTEN UNSEEN CONTRIBUTION OF HUNDREDS OF DENTISTS WHO TOOK TIME AWAY FROM THEIR BUSY PRACTICES TO GET ACTIVELY INVOLVED. IT IS ONLY WITH THIS LEVEL OF COMMITMENT THAT THE CONCEPT OF SELF-REGULATION IS ABLE TO WORK. ON A PERSONAL LEVEL, SPEAK TO ANY OF YOUR COLLEAGUES WHO HAVE SERVED ON COUNCIL OR A COMMITTEE AT THE COLLEGE. THEY WILL TELL YOU ABOUT THE IMMENSE AMOUNT OF SATISFACTION AND FULFILLMENT THEY GAINED FROM THE EXPERIENCE.

QHow do I know if I am eligible to run for Council?

You are eligible if you can say "yes" to each of the following criteria on the deadline date for receipt of nominations, which is Friday, November 5 at 11:59 p.m.:

- You hold a general or specialty certificate of registration, and are actively practising dentistry in the electoral district for which you are nominated. If you're not practising, then you must be a resident of that district.
- You are not in default of any fee or fine payments to the College, or in returning or completing any prescribed forms.
- You are not currently the subject of a disciplinary or incapacity proceeding.
- Three years have elapsed since you complied with an order from the Discipline Committee or the Fitness to Practice Committee.
- You do not have any terms,

conditions or limitations placed on your certificate of registration, other than ones that are applicable to all members.

- Three years have elapsed since you were disqualified from sitting on Council because of a breach of the College's code of conduct for Council members, or the conflict of interest by-law.
- During the previous three years, you have not been a member of the governing boards, or an appointed official, of the Canadian Dental Association, or the Ontario Dental Association, or similar organizations where you were in a decision-making capacity. Please note that being a committee chair or committee member is not included in this exclusion.
- If you were elected in four consecutive elections to Council, more than five calendar years have passed since you were last elected as a Council member.

QWhat exactly is the Council of the College?

RCDSO's Council is the board of directors of the College. It is composed of 14 dentists in total, and up to 11 public members. Two of the dentists are academic representatives: one from the University of Toronto, and the other from the University of Western Ontario.

The dentists on Council are elected by their peers through regional elections. You bring understanding of the profession, and represent the commitment of all dentists in the province to quality care.

Public members are appointed by the Lieutenant-Governor-In-Council to bring the public perspective to Council discussions.

QWhat is my role as a Council member?

The *Regulated Health Professions Act*, its *Procedural Code* and the *Dentistry Act* provide the legal foundation for RCDSO's governance structure, activities and powers. RCDSO is required to fulfil the role of a regulatory college established in the legislation. Council decisions must be congruent and consistent with the legislation.

It is important to note that at a College the link of accountability is different than, for example, in a membership organization. Once elected, the dentists

are not accountable to the members in their district, but instead to the statutes and the laws governing the College.

While there is a role in bringing regional perspectives to the Council table, and in communicating Council decisions in your regions, elected Council members do not represent the electorate. For example, if you are sitting on a committee such as Complaints, Discipline or Registration, you are bound by statute to confidentiality and cannot report back to the members in your district.

As members of the College's board of directors, Council members have a fiduciary relationship with the College. The root of the word "fiduciary" comes from the Latin meaning "trust." Council members have a legal duty to act in what they believe to be the best interests of the College.

By accepting a position as a Council member or committee member, you occupy a position of trust and confidence. Your personal interest, and the interest of any constituency that you may represent, must at all times be subordinated to the best interest of the College, and to the interest of self-regulation.

All Council members, whether dentists or public members, are equal around the table, and participate equally in discussion and decision-making. Likewise they are equally bound by statutes and the code of conduct.

Q *What are the organizational values of the College?*

It is expected that the behaviour of Council and committee members will reflect the following values to ensure the continuing trust of the public and our members:

- accountability;
- integrity;
- openness, transparency and accessibility;

- fairness and equitable treatment;
- respect for the individual and group differences;
- flexibility and openness to change;
- mutual respect and collaboration;
- quality service.

In addition, all Council members must adhere to the statutory requirements, the code of conduct, and the College's by-laws.

There is another important aspect not to be overlooked. As part of the unwritten contract between the organization and you as a volunteer, we try to never forget that having fun is as important a value as all the others. The organizational culture of the College believes the seriousness of our mandate certainly does not preclude staff, Council and committee members from enjoying working together.

Q *How do Council meetings work?*

The Council holds at least three regular meetings a year in Toronto. These meetings are usually open to the public.

The first meeting is held between January 15 and April 15, the second meeting is held between May 1 and June 30, and the third meeting is between September 15 and November 30. Each meeting is usually two days in length. Sometimes Council holds additional regular meetings, in person or by teleconference.

Q *If I am elected to Council, do I also sit on some committees?*

Council members are also appointed to serve on one or more committees. The Executive Committee makes these appointments. Committees meet anywhere from three days a year to once a month, depending on the committee. Check out the chart on page 16 to get more details.

Q *How long is my commitment?*

The term of office for elected Council members is about two years.

Q *Am I compensated for my time away from my practice?*

The significant commitment of Council members is recognized with an honorarium that primarily will go towards covering your office overhead. The 2004 rate is \$830 per day, with \$995 per day for committee and panel chairs. Travel, accommodation and meal expenses incurred related to your Council activities are covered too. There also is preparation time fees.

Q *I'm interested. How do I go about running for election?*

It is not difficult to enter your name to stand for election. Your nomination forms must reach the College on or before the deadline of Friday, November 5 at 11:59 p.m. You must submit five nomination forms signed by other dentists in your district.

Q *What kind of support can I expect from the College for my election campaign?*

Once your nomination is confirmed, you will receive one set of mailing labels for all the members in your electoral district.

Q *If elected, when do I take office?*

Your first Council meeting following the election is January 19 - 21, 2005, which includes a special orientation session.

Q *I want to know more. Who do I call?*

Just call Irwin Fefergrad, the College's Registrar. He can be reached at 416-934-5625, toll free at 1-800-565-4591, or by e-mail at ifefergrad@rcdso.org

College Committees Offer a Great Opportunity to Get Involved

Openings Available For Members Who Are Not Elected Members of Council

Q How do I know if I am eligible to be appointed to a College committee?

You are eligible if you can say “yes” to each of the following criteria on the deadline date for receipt of nominations, which is Friday, November 5 at 11:59 p.m.

- You have been in active practice in Ontario for a minimum of 500 hours during the previous 12 months.
- You have engaged in clinical practice for a minimum of five years.
- You hold a general or specialty

certificate of registration, and are actively practising dentistry in the electoral district for which you are putting your name forward. If you're not practising, then you must be a resident of that district.

- You are not in default of any fee or fine payments to the College, or in default of returning or completing any prescribed forms.
- You are not currently the subject of a disciplinary or incapacity proceeding.
- Three years have elapsed since you complied with an order from the Discipline Committee or the Fitness to Practice Committee.
- You do not have any terms, conditions or limitations placed on your certificate of registration, other than ones that are applicable to all members.
- Three years have elapsed since you were disqualified from sitting on Council because of a breach of the College's code of conduct for Council members, or the conflict of interest by-law.
- During the previous three years, you have not been a member of the governing boards, or an appointed official, of the Canadian Dental Association, or the Ontario Dental Association, or similar organizations where you were in a decision-making

What's Involved?

COMMITTEE # OF MEETINGS*	RESPONSIBILITIES
COMPLAINTS 1 day/month	Reviews public complaints.
DISCIPLINE 1-3 days/month	Hears and determines allegations of professional misconduct or incompetence.
FITNESS TO PRACTICE 3 days/year	Determines if a dentist is incapacitated: suffering from a physical or mental condition or disorder.
QUALITY ASSURANCE 6 days/year	Responsible for continuing competence of all dentists to ensure maintenance of standards of practice.
PATIENT RELATIONS 4 days/year	Responsible for the College's interaction with public and dentists on professional conduct issues, especially those of a sexual nature.
PROFESSIONAL LIABILITY PROGRAM 4 days/year	Recommends policy related to malpractice policy and claims, and authorizes some claim settlements.

capacity. Please note that being a committee chair or committee member is not included in this exclusion.

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

QWhat is the time commitment?

It really varies from committee to committee. Some committees like Complaints meet about once a month, while others like Fitness to Practice may only meet about three times a year. See the chart for more details.

QAm I compensated for my time away from my practice?

Your compensation is the same as for Council members. The 2004 honorarium is \$830 per day, \$995 for committee and panel chairs which is to basically cover your office overhead. Other reasonable expenses, such as travel, accommodation and meals, are reimbursed.

QHow long am I committed?

The term is about two years, which is the same as for elected members of Council.

QWhat is the selection process?

When your application is received, it is reviewed to confirm that you have met the eligibility criteria. Then a file card is created and sealed in an envelope with the district number as the only identifying information on the front. At the time of selection, in front of two scrutineers, the sealed envelopes are opened, district by district, by the Registrar. The cards shuffled, and a file

card selected at random. You are eligible for random selection in the electoral in which your designated registered address is situated.

QIs this the same process for the PLP Committee?

The process is different for PLP. After the deadline for receipt of applications, the Registrar prepares a list of all eligible candidates. This list, plus the resumes, are given to the Executive Committee. Executive then prepares a list of recommended appointments, ranked in order of preference. Then at the first Council meeting in 2005, Council makes its selection.

QCan I choose which committee I sit on?

It is literally the luck of the draw, as the saying goes. It is a blind selection process to ensure its fairness and integrity. If your name is selected, then the Executive Committee will review your resume to help place you on the most appropriate committee.

QCan I run for elected office, and submit my application and resume for an appointed committee position?

Yes, you can do both. However, if successful in the election, your name will be removed from the random selection process.

QIf selected, when do I start?

You start with the first committee meeting in the new year, usually within the first month or so. You may also be asked to attend special education or orientation sessions.

QI am interested. How do I submit my name?

It is easy. Just submit a letter of application and a current resume to the College's Registrar Irwin Fefergrad. Your application must be received by Friday, November 5 at 11:59 p.m.

QWho do I call if I have questions?

For PLP:

Dr. Don McFarlane
Director, Professional Liability Program
phone: 416-934-5609
toll free: 1-800-565-4591
e-mail: dmcfarlane@rcdso.org

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Dayna Simon
Assistant to the Registrar, Legal
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e-mail: dsimon@rcdso.org

Irwin Fefergrad
Registrar
phone: 416-934-5625
toll free: 1-800-565-4591
e-mail: ifefergrad@rcdso.org

ELECTION DATES

Key Dates For Election 2004

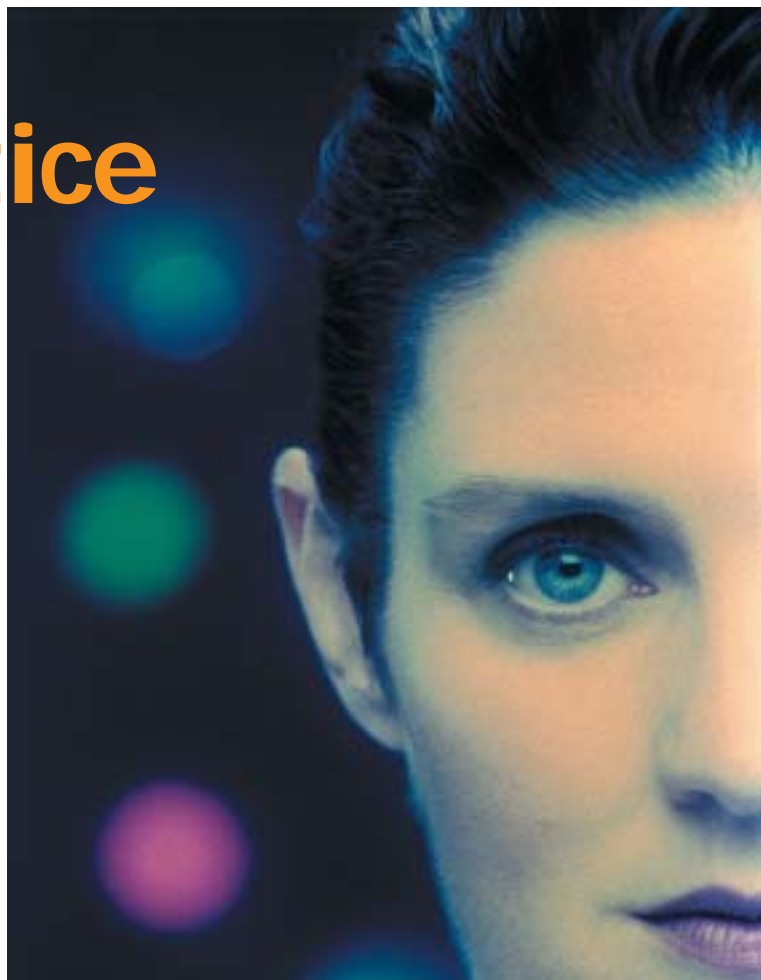
Call for nominations mailed out no later than	Friday, October 22
Deadline for receipt of nominations	Friday, November 5
Last day for candidates to withdraw	Tuesday, November 16
Ballots to be sent out by College no later than	Wednesday, November 24
Election Day	Wednesday, December 8
Deadline for receipt of ballots at the College	Wednesday, December 8 at noon

Scope of Practice

Council Clarifies Key Issues For Oral And Maxillofacial Surgeons On Scope Of Practice And Extent Of Professional Liability Coverage

Five motions from the Ad Hoc Committee on the Scope of Practice of Oral and Maxillofacial Surgeons were passed at the March 4 Council meeting giving the specialty more clarity about its scope of practice and coverage under the College's Professional Liability Program.

"Council has given oral and maxillofacial surgeons in Ontario much-needed recognition of this specialty of dentistry that has exquisite education and experience. And more importantly perhaps, we now have assurance and comfort that the College agrees that our mainstream activities are captured by the current legislative definition of scope of practice for dentistry," said Council member Dr. Bohdan Kryshchalskyj, chair of the Ad Hoc Committee, and an oral and maxillofacial surgeon.



MOTION #1

That Council acknowledges the Canadian Dental Association definition of oral and maxillofacial surgery: Oral and maxillofacial surgery is that branch and specialty of dentistry which is concerned with and includes the diagnosis, surgical and adjunctive treatment of disorders, diseases, injuries and defects involving both the functional and aesthetic aspects of the hard and soft tissues of the oral and maxillofacial regions and related structures.

MOTION #2

That Council accepts that the performance, by appropriately trained practitioners, of the non-elective and emergency dental surgical procedures and the oral and maxillofacial surgical procedures described in OHIP's Schedule of Benefits for Dental Services (Jan. 1, 2004), and of the procedures codified in the Ontario Dental Association's Suggested Fee Guide for Certified Oral and Maxillofacial Surgeons (Jan. 1, 2003), are within the scope of practice of dentistry as defined in Section 3 in the *Dentistry Act, 1991*.

MOTION #3

That Council confirms that, in its opinion, since the performance of the procedures as described in Motion #2 are within the scope of practice of dentistry as defined by the *Dentistry Act, 1991*; and therefore, they also fall within the definition of professional services in the insurance policy provided through the College's Professional Liability Program, and its errors and omissions coverage applies.

MOTION #4

That Council supports an in-depth investigation of the legal, insurance, regulatory and legislative issues that would need to be resolved to expand the scope of practice of oral and maxillofacial surgeons to include other safe procedures which they are trained to perform, but may not currently be within their scope of practice here in Ontario.

MOTION #5

That Council directs the Royal College of Dental Surgeons of Ontario, when in communication with its members about the nature of services of the Professional Liability Program, should remind its members through a Practice Advisory that they should not be undertaking any task within their specialty unless they are competent to do so.

“The Committee recognizes that this report is really only the first phase,” said Dr. Kryshatskyj in his presentation to Council. “With this firm foundation in place, the Committee believes that the next challenge in phase two is to consider many of the procedures under cosmetic maxillofacial surgery used to correct conditions that are elective, and that normally are not considered as falling within the mainstream practice of dentistry and/or maxillofacial surgery in Ontario.”

As was emphasized during discussions at Council, phase two will require significant study and deliberation, and could be quite lengthy. Any recommendations coming out of this phase will need to come before Council for review and discussion, and may even require statutory change, which is usually a very long process with no guarantee of success.

Other Ad Hoc Committee members were Council members Mary Ann Labaj, Dr. Randy Lang, Krystyna Rudko and Elesh Ruparel; and RCDSO President Dr. Cam Witmer. Non-Council members appointed to the Committee were Dr. Joseph Friedlich, Dr. Daniel Omura, Dr. David Psutka and Dr. David Segal.

EXCERPTS FROM THE REPORT OF THE AD HOC COMMITTEE

Historical Context

Dentists have performed extensive surgical treatments about the face for over 100 years. Great experience was gained through each of the great wars, where dental specialists contributed to the salvage of untold numbers of combat-induced maxillofacial traumatic wounds. This experience led to tremendous growth in the written science regarding maxillofacial trauma surgery.

The principles of this surgery are now applied to maxillofacial reconstructive surgery. During the last 20 to 25 years, the growth of these procedures has been exponential.

As the science of oral and maxillofacial surgery has grown, education has evolved to keep in step. The Commission on Dental Accreditation of Canada’s latest revision of its requirements for oral and maxillofacial surgery programs was in November 2003. Including strict admission standards, these programs must now be a minimum of 48 months in duration, and have both didactic and clinical components. Most oral and maxillofacial programs require the completion of a Masters of Science. Training includes residency level rotations in medicine, surgery, intensive care, anaesthesia and otolaryngology.

The Challenge for the Ad Hoc Committee

The immediate challenge for the Ad Hoc Committee was to ensure that the specialty of oral and maxillofacial surgery could continue to evolve with the advances in surgical techniques, it could continue to be true to its dental roots, and at the same time, meet the changing needs of the public of Ontario whom it serves. And all of this, for the time being at least, had to be achieved within the current legislative context of the *Dentistry Act, 1991*.

Philosophical Approach of Committee

During its discussions, the Committee decided that it must take a conservative approach and, during this first stage, look at the broad, substantive, critical areas. The Committee was also always mindful of the responsibility of the College to protect public safety and the public interest.

WORDS OF PRAISE ON SCOPE OF PRACTICE

I am writing to congratulate and thank you and your team for the tremendous accomplishment made by the RCDSO in recognizing the established scope of practice for oral and maxillofacial surgeons in Ontario. This will be of great benefit to all dentists in Ontario and their patients. By allowing the oral and maxillofacial surgeons in our province to provide their services with the support of the recognized scope, we can ensure that patients with surgical needs in the oral and maxillofacial complex will be managed the highest quality of care.

I would also like to take this opportunity to acknowledge the exceptional leadership in this effort provided by Dr. Bohdan Kryshatskyj. As chair of the RCDSO’s ad hoc Scope of Practice Committee for Oral and Maxillofacial Surgery, Bo strategically designed a course of action that led to this tremendous achievement. His thorough evaluation of the issues and careful selection of a committee resulted in a very effective group whose recommendations will allow the oral and maxillofacial surgeons of Ontario to continue to deliver their customary exceptional quality of service with the full support of the College.

Speaking on behalf of the Ontario Society of Oral and Maxillofacial Surgeons and the Graduate Training Program in Oral and Maxillofacial Surgery at the University of Toronto, I would like to reiterate our gratitude for all of your efforts. This achievement is viewed as a significant advance in dentistry’s ability to provide the citizens of the Province of Ontario with the most advanced approaches to oral healthcare. Please keep up the good work. Best wishes.

CAMERON M.L. CLOKIE, DDS, PhD,
FRCDC, FICDC, FADI, DIP. ABOMS

President, Ontario Society of Oral and Maxillofacial Surgeons

Professor and Head, Oral and Maxillofacial Surgery, University of Toronto

College Juggles Delicate Balance in the Hot Political Issue of Access of Foreign-Trained Dentists to Canadian Job Market

Continued from page 4

admittance to the qualifying programs at U of T and at Western.

Applicants are thoroughly assessed before acceptance. Currently there are about 26 students in the program at U of T, and 12 at Western.

I know that all the players in the system are doing their very best to ensure that the public is protected, and only qualified people are allowed to practise.

WHAT THE COLLEGE IS DOING

It is important for every dentist in the province to understand what the College is doing on this issue.

Let me be unequivocal about what we are **not** going to do:

- This College is not going to sacrifice its responsibilities on public safety and protection.
- This College is not going to be a gatekeeper to control the supply of dentists in the profession.
- This College is not going to throw open the doors and let just anyone into the province to practise.

Let me be equally clear about the message we are taking to government:

We are not like doctors, nurses or engineers. There is no shortage of general dentists. There is no shortage of specialists. So do not lump us together. And don't impose the same solutions on us as you may for these other professions.

This College has already taken a leadership role in finding solutions that are tailor-made for the needs of our professional group.

With the assistance of the Ministry of Health and Long-Term Care, we

organized and hosted a two-day negotiation session with regulators from across the country in the summer of 2001.

We played a key role in organizing a national labour mobility agreement so that dentists who have been licensed have transportability.

This means foreign-trained dentists, who satisfy minimum requirements as set out by the provincial government, have transportability. And dentists from outside the province are recognized here too.

The biggest challenge immediately before us is how to deal with foreign-trained dentists from non-accredited special programs who have passed the qualifying program, NDEB, have licensure, but now want a specialty certificate.

MAINTAINING CORE VALUES

We have no process to deal with these dentists. And it is for this lack of process that we may be criticized.

We have been trying to find a solution, while maintaining our core values.

But we should not be naïve. There is incredible political pressure to weaken this system that works so well to protect the public.

This College will not go that route. We will never let NAFTA sell out competency. We will never give money to any organization, whether it is the CDA or CDAC, to do anything that will compromise our standards.

This College is firm about maintaining our values and principles.

We believe strongly in accreditation, competence and licensure.

These are the foundations on which we have built the delivery of the best oral health care in the nation.

We are not going to do anything that will jeopardize these principles. We are not going to do anything that will threaten our ability to protect the public safety.

The College to take a leadership role in finding solutions. For example, there was a national meeting in Ottawa on February 21 on the whole issue of access to professions. The College was represented by myself, the Registrar, and Rob Lees, our Manager of Registration.

EXTENSIVE DISCUSSION

The Registration Committee, chaired by Dr. Larry Parker, is also fully involved. Both the chair and the full committee participated in another meeting here at the College on March 27. Several interested regulators joined us.

This is an important issue too for many of our members. Please be assured that, if and when there are any proposed changes to the registration process, these changes will follow the right process. They will come through the Registration Committee to Council for an extensive public discussion.

This is a tough issue. It is not our first. And I am sure not our last.

Are we ready to meet the challenge? I believe we are.

I am proud to be a member of this Council. We have tackled thorny issues. We have made difficult decisions. We have done that wisely and compassionately. I have no doubt we will do the same again this time too.



The American Academy of Periodontology Statement Regarding

Gingival Curettage

SINCE ITS LAUNCH IN JUNE 2001, PEAK HAS OFFERED 13 ARTICLES ON A WIDE VARIETY OF SUBJECTS. A COMMON THEME HAS BEEN THE PRESENTATION OF NEW TECHNIQUES, NEW RECOMMENDATIONS AND NEW CONCEPTS IN DENTISTRY, TO ASSIST MEMBERS IN THEIR PRACTICES. WITH THIS ISSUE OF *DISPATCH*, HOWEVER, PEAK OFFERS SOMETHING QUITE DIFFERENT.

When the weight of evidence demonstrates that an old technique has outlived its usefulness, the profession must be prepared to abandon it. Such is the case with gingival curettage. As originally conceived, gingival curettage or the removal of the pocket lining and junctional epithelium with a curette was intended to promote new connective tissue attachment to the tooth. Yet, subsequent research has shown that this is an unattainable goal. Gingival curettage offers no additional benefit when compared to scaling and root planing alone.

In light of these findings, the advisory board to PEAK has selected the following article, *The American Academy of Periodontology Statement Regarding Gingival Curettage*, from the *Journal of Periodontology*.

The statement was developed under the direction of the Research, Science and Therapy Committee and approved by the Board of Trustees of the American Academy of Periodontology. The article reviews the evidence against gingival curettage and considers the various means by which it has been performed, including curettes, chemicals, ultrasonic

devices and, more recently, dental lasers.

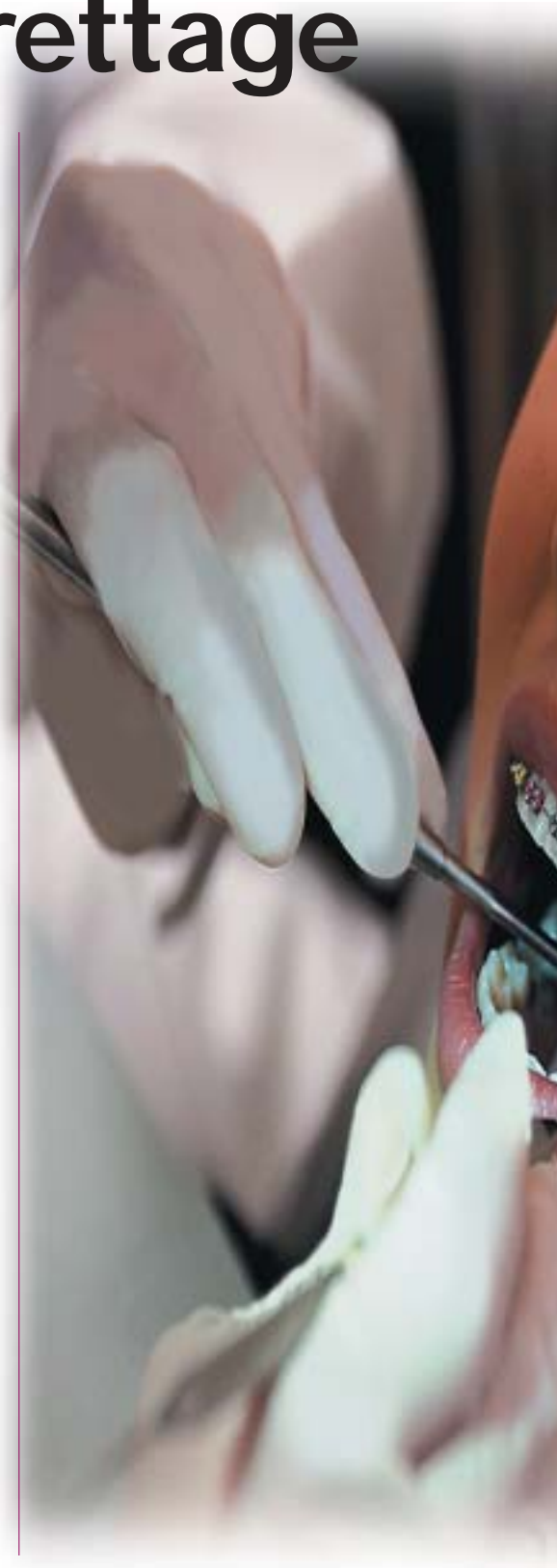
Key points:

- There is convincing evidence that gingival curettage, by whatever method performed, offers no additional benefit to scaling and root planing alone in the treatment of chronic periodontitis.
- While it provides historic interest in the evolution of periodontal therapy, gingival curettage has no current clinical relevance in the treatment of chronic periodontitis.
- The dental community as a whole regards gingival curettage as a procedure with no clinical value.

PEAK (Practice Enhancement and Knowledge) is a College service for members. The 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 at 416-934-5616, toll free at 1-800-565-4591, or by e-mail at mgardner@rcdso.org.



Le Collège doit trouver un équilibre délicat sur
le sujet brûlant

de l'accès des dentistes formés à l'étranger au marché du travail canadien.

Continued from page 5

2. Nous voulons nous assurer que les praticiens qui répondent à ces normes, peu importe où ils ont reçu leur formation, puissent obtenir un permis d'exercice de la médecine dentaire en Ontario.

Nous détenons déjà un système qui nous permet d'effectuer cela et il fonctionne. Les dentistes formés à l'étranger doivent démontrer leurs compétences et leur équivalence d'études.

Leurs demandes doivent être approuvées par les facultés de médecine dentaire universitaires, par le Comité national d'examen dentaire et par le Collège royal des chirurgiens dentistes du Canada.

Les compétences sont essentielles à l'admission aux programmes de qualification à l'Université de Toronto et à l'Université de Western Ontario.

Les candidats doivent subir une évaluation complète avant d'être admis. Présentement, on compte environ 26 étudiants dans le programme de l'Université de Toronto et 12 dans celui de l'Université de Western Ontario.

Je sais que tous les intervenants dans le système font de leur mieux pour protéger le public et pour veiller à ce que seules les personnes qualifiées soient autorisées à exercer.

Il est important que chaque dentiste dans la province comprenne ce que fait le Collège à ce sujet.

Permettez-moi d'être sans équivoque à propos de ce que nous N'ALLONS PAS faire :

- le Collège ne compromettra pas ses responsabilités en matière de sécurité et de protection du public;
- le Collège ne sera pas le garde-barrière qui contrôlera l'offre de dentistes dans la profession;
- le Collège n'ouvrira pas grandes les portes pour laisser n'importe qui exercer leur profession en Ontario.

Laissez-moi être tout aussi clair à propos du message que nous lançons au gouvernement : nous ne sommes pas comme les médecins, les infirmières ou les ingénieurs. Il n'y a pas de pénurie de dentistes généralistes, il n'y a pas de pénurie de spécialistes, alors ne nous mettez pas tous dans la même galère. Et ne nous imposez pas les mêmes solutions que celles qui s'appliquent à ces professions.

Le Collège assume déjà le leadership en matière de recherche de solutions adaptées aux besoins de notre groupe professionnel.

De concert avec le ministère de la Santé et des Soins de longue durée, nous avons organisé et été l'hôte d'une séance de

négociations de deux jours avec les organismes de réglementation de partout au pays à l'été 2001.

Nous avons joué un rôle fondamental dans l'établissement d'un accord de mobilité pour que les dentistes qui détiennent un permis d'exercice puissent être mobiles.

Cela signifie que les dentistes formés à l'étranger, qui répondent aux normes minimales établies par le gouvernement provincial, pourront se déplacer. De même, les dentistes des autres provinces seront également reconnus dans notre province.

Le plus grand défi que nous devons maintenant relever est de déterminer comment traiter les dentistes formés à l'étranger dans des programmes de spécialité non accrédités qui ont réussi le programme d'admission, qui détiennent un permis d'exercice et qui souhaitent désormais obtenir un certificat de spécialisation.

Nous ne détenons aucun processus pour composer avec ces dentistes, et on pourrait nous le reprocher.

Nous tentons de trouver une solution respectueuse de nos valeurs et principes de base.

Nous ne devrions toutefois pas être naïfs,

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New Limitation Period For Commencing Lawsuits Now In Force

Effective January 1, 2004, the limitation period for commencing lawsuits against dentists and other health-care practitioners changed. Previously, the *Regulated Health Professions Act* (RHPA) legislated a one year limitation period from when the patient “knew or ought to have known” of the facts that gave rise to the claim.

The new provincial *Limitations Act, 2002* states that a patient must commence a lawsuit within two years of discovering the act, omission or error that gives rise to their claim.

Unless proven to the contrary, there is a presumption that a patient knows something has occurred on the day of the incident. However, we anticipate that most limitation periods won't start running until a patient has had an opportunity to consult with another dentist and discovers the “error”.

Similar to the former provisions of the RHPA, there is a reasonable person test to protect potential defendants. That is, it's not just when the patient found out about the error, but also whether a reasonable person under the same

circumstances would have made the discovery.

Finally, the new Act provides for a 15-year ultimate limitation period. This means that if a person has failed to discover an act, omission or error within 15 years of the date of the incident, their claim would be out of time.

Will this mean that a prudent dentist would retain dental records for more than the prescribed 10-year requirement now in place? More information on this aspect of the new *Limitations Act, 2002* will be provided in future issues of *Dispatch*.

Confused? Don't be. Just remember that generally the limitation period is now two years, and that PLP will handle that aspect of a defence if you find yourself in need of the program's services.

If you have any questions on this topic, please contact Dr. Don McFarlane, Director, Professional Liability Program, at 416-934-5609, toll free at 1-877-817-3757, or by e-mail at dmcfarlane@rcdso.org

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car nous subissons une pression politique incroyable qui pourrait affaiblir notre système, qui protège bien le public.

Le Collège ne s'aventurera pas dans cette direction. Nous ne laisserons jamais l'ALENA sacrifier nos compétences. Nous n'accorderons aucun financement à un organisme, qu'il s'agisse de l'ADC ou du CDAC, qui risque de compromettre nos normes.

Le Collège est catégorique quant au maintien de ses valeurs et de ses principes.

Nous croyons fermement en la reconnaissance professionnelle, la compétence et l'autorisation d'exercer. Ce sont les fondations sur lesquelles repose le meilleur système de santé bucco-dentaire au pays.

Nous ne ferons rien qui puisse compromettre ces principes. Nous ne ferons rien qui puisse nuire à notre capacité de protéger la sécurité du public.

Le Collège fait preuve de leadership dans la recherche de solutions. Par exemple, le 21 février dernier, une réunion nationale sur l'accès aux professions a eu lieu à Ottawa. Rob Lees, gestionnaire des inscriptions, et moi-même, registraire, représentions le Collège.

Le Comité des inscriptions, présidé par le Dr Larry Parker, fait également preuve d'une participation totale. Le président et tous les membres du Comité ont pris part à une autre réunion au Collège le 27 mars. De nombreux organismes de réglementation intéressés étaient présents.

Cela est un enjeu d'importance pour bon

nombre de nos membres. Soyez assurés que si et quand des changements seront proposés au processus d'inscription, ils devront respecter un processus adéquat. Ils devront passer par le Comité des inscriptions et par le Conseil et faire l'objet de discussions publiques approfondies.

Cela est un enjeu complexe. Ce n'est pas le premier et ce ne sera certainement pas le dernier.

Sommes nous prêts à relever ce défis? Je crois que oui.

Je suis fier d'être membre de ce Conseil. Nous avons déjà composé avec des enjeux épineux et pris des décisions difficiles.

Nous avons fait cela avec intelligence avec compassion. Nous ferons assurément de même cette fois-ci.



Boil Water

The Dental Perspective On Boil Water Advisories Issued By Medical Officer of Health



When a serious problem develops with a community's water supply making it no longer potable, the local Medical Officer of Health is empowered by the *Health Protection and Promotion Act* to issue a boil water advisory.

Once such an order has been issued, residents are notified by the public health unit via media announcements, usually televised press conferences or radio announcements. In some areas, health-care providers are notified by telephone, if the public health unit maintains such contact lists.

Since dental offices routinely use communal water supplies during their day-to-day practice, a number of changes need to be made during a boil water advisory, including:

- Water should not be delivered to patients through the dental unit, ultrasonic scaler, or other dental equipment that uses the public municipal or regional water system.
- Patients should not drink or rinse using tap water from faucets

connected to the public water system.

- Restorative dental treatment that requires water coolant or irrigation should be performed with bottled or distilled water.
- Surgical procedures should be performed with a sterile irrigant.

If these safeguards cannot be implemented, the treatment should be rescheduled until the boil water advisory has been cancelled. Also dentists and staff should not use tap water for hand hygiene unless the water has been brought to a rolling boil for at least one minute, and then allowed to cool before using it.

The Centers for Disease Control and Prevention advises using antimicrobial products that do not require water, such as alcohol-based rubs, for hand hygiene. When hands are visibly contaminated, or contaminated by contact with water from communal water supplies by means of dental equipment such as automatic X-ray processors, dentists and staff may use bottled water and soap or an antiseptic towelette prior to using the alcohol-based rub.

After the boil water advisory has been cancelled, dental unit waterlines and all waterlines from the public water system should be flushed according to instructions issued by the local public health unit or water utility and manufacturers of dental equipment.

Instructions for routine flushing of dental unit waterlines was featured in the *Dispatch* article, "Important Information: The Care of Saliva Ejector Systems and Dental Unit Waterlines" in the February 1996 issue.

The Ministry of Health and Long-Term Care (MOHLTC) is currently developing a protocol for issuing a boil water advisory, which includes measures to be implemented in dental offices. The College will advise members when the final protocol of the MOHLTC is available.

For further information regarding this article, contact Dr. Lesia Waschuk, Practice Advisor, at 416-961-6555, ext. 3348, toll free at 1-800-565-4591, or by e-mail at lwaschuk@rcdso.org



Dental Devices

Dental Devices Must Be Approved For Use In Canada.

Health Canada has asked the College to remind members that all dental devices used for the treatment of patients must comply with Canadian regulations.

There would be very little defence available if a claim is advanced against a dentist involving the use of a non-licensed dental device or an unapproved use of a dental device. Liability would almost certainly be unavoidable.

In addition, aggravated, exemplary or punitive damages might be awarded for knowingly using a device in such circumstances. It is important to note that these damages are not covered under the College's malpractice policy and would become the responsibility of the member.

Health Canada classifies all dental devices into four classes, with Class I representing the lowest risk and Class IV the highest. Class I devices do not transmit energy and make only non-invasive contact with the patient. Class II, III and IV devices expose the patient to increasingly higher risks, determined

by such factors as the degree of invasiveness, energy transmission and potential consequences to the patient in case of device malfunction or failure. Accordingly, Class II, III and IV devices require a licence to be sold in Canada. Examples of Class II, III and IV devices include:

Class II

high-/low-speed drills and burs, temporary cements and filling materials

Class III

dental implants, permanent cements and filling materials, e.g. amalgam, composite resin, casting alloys, porcelains

Class IV

bone substitutes and regenerative materials containing animal or human tissues

WHAT YOU NEED TO KNOW

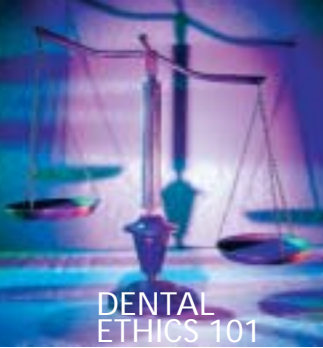
- Only use Class II, III and IV devices that have a valid licence.
- **Do not** import or purchase a non-licensed device.
- Follow the manufacturer's instructions to ensure that the device is used in a safe and effective manner.
- **Do not** use a device for an unapproved purpose.

WANT MORE INFORMATION?

Health Canada's Web site lists all devices with a valid licence. This list may be searched by company or device name using Health Canada's search tool located at the following Web address:

http://cpe002078d58daccm00803785ac.e5.cpe.net.cable.rogers.com/mdall/english/index_e.cfm

For more information about this article, please contact Dr. Michael Gardner, Assistant to the Registrar, Dental at 416-934-5616, toll free at 1-800-565-4591, or by e-mail at mgardner@rcdso.org.



Ethical Dilemma Case Study

Confidentiality and the Patient with Eating Disorders

WHAT WOULD YOU DO?

Ashley Jacobs is a new patient in your general dental practice who has recently moved with her family to your area. You learn that due to her father's occupation, the family has moved six times in the last four years. She is 16 years old and her mother reports that she is in good health. Her vital signs are within normal limits, and she has had the usual childhood diseases.

Your first impression is that Ashley looks very thin at 5'4" and 105 pounds. She has received yearly dental examinations. Ashley's mother notes that she has had a few fillings, although her teeth have been more sensitive to cold these last three years. Ashley stopped eating ice cream and drinking cold drinks about the same time, and her mother notes that her weight is about the same since then.

Ashley has a quiet, pleasant demeanor and answers questions with a "yes" or "no." As you begin your examination, she immediately asks, "Please don't use water or air on my teeth." Her previous dentists, she explained, avoided using cold water or air. The oral examination reveals mild to moderate enamel loss due, you think, to acid erosion on the lingual surfaces of the upper front four teeth.

As you ask if she ever has any problems with a "sour stomach" or vomiting, she becomes very nervous and upset. "How

do you know that?" she asks, and says, "Maybe I have an occasional problem with vomiting." You explain that acid from vomiting causes erosion of the enamel, and that chronic vomiting may be a serious health problem. She and a few friends have the "same problem." She pleads, "Please don't tell my mother, she'll just freak out! I'm better now and my mom doesn't need to know."

You are faced with an ethical dilemma. Which of the following course(s) of action would you take?

1. Follow Ashley's recommendation and avoid telling her mother.
2. Ask Ashley to tell her mother or you will.
3. Inform Ashley that you will inform her mother, as you are concerned for her health.
4. Inform Ashley that she may need professional help and that not telling her parents may contribute to further medical and dental problems.
5. Provide Ashley with community resource contacts through the public health unit where she can obtain confidential counselling and advice.

Now turn to page 36 to find the case study discussion of this ethical dilemma.

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

Facility Permits

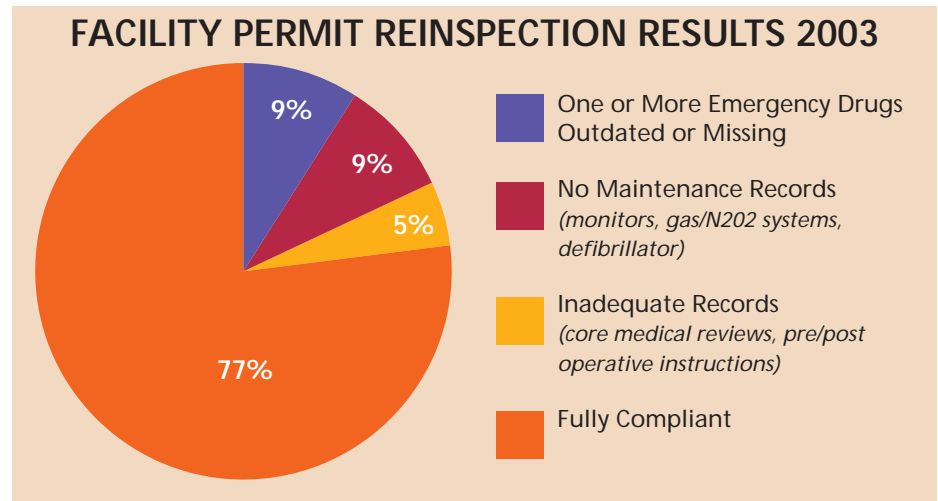
Common Problems With Facility Permits Point To Change In way Reinspections Are Done To Ensure Continuous Compliance

Since the College started issuing anaesthesia/sedation facility permits in 1995, over 650 facility permits have been issued to dental offices utilizing parenteral conscious sedation, deep sedation and/or general anaesthesia.

Each facility undergoes an initial inspection prior to the issuance of the permit, and the College re-inspects an average of 150 dental facilities each year, usually over a staggered three-year cycle.

The attached graph depicts the statistical data gathered from the 2003 reinspection program. It shows that facilities not in full compliance with the College's *Guidelines for the Use of Sedation and/or General Anaesthesia in Dental Practice* are deficient mainly in the following three areas:

1. One or more emergency drugs and/or anaesthetic drugs are outdated.
2. No maintenance records on file for gas delivery systems and/or N2O2 delivery systems.
3. No maintenance records on file for anaesthetic/emergency/monitoring equipment.



To ensure that those dental offices holding facility permits are in continuous compliance with the RCDSO Guidelines, the College will be implementing changes to the annual facility permit reissuance process.

One possible change being considered is an in-depth questionnaire to accompany the permit renewal forms that will require the permit holder to:

- verify that all drugs used for the management of medical emergencies are current;

- prove that the gas delivery systems, N2O2 delivery systems, and anaesthetic/emergency/monitoring equipment have been maintained according to the Guidelines.

If you have any questions about facility permits or this article, please contact:
Julie Wilkin

Coordinator, Professional Corporation

phone: 416-934-5612

toll free: 1-800-565-4591

e-mail: jwilkin@rcdso.org

DENTAL HYGIENIST

Notice About Illegal Practice Of Dental Hygiene

The Honourable Mr. Justice Trafford signed an order late last October directing Hila Sorinov to comply with sections 4 and 9 of the *Dental Hygiene Act, 1991* and section 27 of the *Regulated Health Professions Act, 1991*; to refrain from using the title "dental hygienist" or a variation or abbreviation or equivalent in another language; from holding herself out as a person who was qualified to practise in Ontario as a dental hygienist, or in a speciality of dental hygiene; and from performing any controlled acts including scaling teeth or root planing and orthodontic and restorative procedures. The College of Dental Hygienists of Ontario does remind all its registrants to show their current certificate of registration to their employers each year.



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

Do Your Records Justify Your Treatment?

When poor or unexpected treatment outcomes occur, patients often allege that the treatment was not necessary, or that they were inadequately informed of the risks and possible consequences associated with the treatment provided.

If such matters are reported to PLP, the first questions that we need to address are whether or not the treatment in question is clearly justified by the entries in the patient record, and whether or not the records document adequate communication with the patient respecting the informed consent process. To illustrate these issues, here are two similar practice situations with very different results.

SCENARIO 1

Treatment Not Justified in Records – Case Not Defendable

Ms. Fine presented to Dr. Knot for recall and at that appointment, Dr. Knot replaced a restoration in tooth 17. The following day he replaced restorations in teeth 25 and 26.

Two weeks later Ms. Fine returned with cold sensitivity in tooth 17 and Dr. Knot performed endodontic treatment.

Ms. Fine initiated a small claims court action alleging Dr. Knot had unnecessarily replaced fillings in three teeth, simply due to the fact that her dental insurance was about to be terminated. She claimed the teeth were asymptomatic, and Dr. Knot had told her there were no problems with her teeth. Ms. Fine alleged it was the unnecessary restoration in tooth 17 that caused the need for root canal treatment.

Discussion

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

- The radiographs, clinical notes and treatment records did not support the need for replacement of the restorations in teeth 17, 25 and 26. This made it difficult to determine whether the restorations in question were indeed necessary.
- Similarly, the radiographs and the records did not support the need for endodontic treatment of tooth 17. There was no evidence that Ms. Fine had any symptoms other than cold sensitivity. There was no record of any vitality or other tests being performed. There was no documented diagnosis or discussion of treatment options. In other words, there was no evidence that informed consent for endodontic treatment had been obtained.

PLP recommended settlement of the claim and Dr. Knot agreed. The reason for this recommendation was the fact that the treatment could not be justified by the records, and there was no documented informed consent. PLP subsequently negotiated a settlement amount and obtained Ms. Fine's full and final release in favour of Dr. Knot. This release stated specifically that Dr. Knot had not admitted liability.

SCENARIO 2

Treatment Justified in Records – Case Defendable

Mr. Carie presented to Dr. Kay for new patient examination and Dr. Kay recommended replacement of two amalgam restorations. She replaced a restoration in tooth 45 on that date. One week later she replaced the amalgam in tooth 16.

Two weeks later Mr. Carie returned with pain in tooth 16 and Dr. Kay performed endodontic treatment. One month after that, tooth 45 required endodontic treatment as well.

Mr. Carie subsequently filed a claim against Dr. Kay alleging the restorations in teeth 16 and 45 were unnecessary and the treatment was negligent, resulting in the need for root canals on both teeth. He further alleged the root canal treatment was poorly done and retreatment of both teeth was necessary.

Discussion

PLP was able to defend this case because:

- The records and radiographs clearly showed there was deep recurrent decay in both teeth 16 and 45. Replacement of the restorations was warranted.
- Radiographs taken prior to endodontic treatment showed the restorations were well placed.

- The records showed that, prior to initiating endodontic treatment on both teeth, Dr. Kay performed standard tests, appropriately diagnosed irreversible pulpitis and discussed treatment options, risks and benefits. In other words, the records clearly showed that endodontic treatment of teeth 16 and 45 was necessary and informed consent was obtained.
- Final radiographs of teeth 16 and 45 showed the canals were well filled to the apices.

COMMENT

Often, when a patient presents, his/her dental problem is obvious and the treatment needed is clear, both to the dentist and to the patient. As discussed in this article, it is important to keep in mind that if things go wrong with the treatment, the patient may allege the treatment was not necessary. The records must be able to demonstrate that the treatment was in fact required, and informed consent was obtained.

HAVE ANY QUESTIONS?

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. Our numbers are 416-934-5600 or toll free at 1-877-817-3757.

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

Dr. Judi Purvs

Dental Claims Advisor

phone: 416-934-5600, ext. 3103

toll free: 1-877-817-3757

e-mail: jpurvs@rcdso.org



ON APPEAL

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, you can either contact the HPARB directly at 416-327-8515, or contact the College's Petula Widyaratne, Co-ordinator, Complaints at 416-961-6555, ext. 5311, toll free at 1-800-565-4591, or by e-mail at pwidyaratne@rcdso.org.

On Appeal

CASE 1

The Complaint

The patient was referred to a specialist by her family dentist regarding the removal of tooth 48. Radiographs taken by the general dentist revealed a possible cyst at the base of the tooth.

The oral surgeon removed the tooth under local anaesthetic uneventfully and without complication. Subsequently, the patient complained of numbness in the lip, chin and teeth areas. For approximately four months the numbness did not resolve. The oral surgeon referred the patient to a neurologist as well as to a speech pathologist.

The complainant alleged that the member did not advise her that the wisdom tooth involved some risk.

Complaints Committee

The Committee reviewed the member's chart and noted the completeness of them. The Committee made note that, in particular, the member discussed numbness and paraesthesia associated with disturbance of nerve function. The Committee also noted from the x-rays that the extraction was definitely necessary.

In addition, in looking at the member's detailed account of the procedure, the Committee noted the extra precautions taken in order to remove the tooth as atraumatically as possible. Nerve damage is a known risk of wisdom tooth extraction and unfortunately this is the kind of sequela that is encountered from time to time. The Committee stated that this is not tantamount, in this case, to a failure to maintain standards. The Committee ordered no further action.

Health Professions Appeal and Review Board

The complainant being dissatisfied appealed the decision of the Complaints Committee to the Board. The Board noted that the complainant was given a full opportunity, as was the member, to respond to the various allegations and responses. All relevant records were acquired and the Board was satisfied that the College's investigation was thorough.

The Board was particularly impressed with the records of the member that completely corroborated his position that he had discussed with the patient her paraesthesia and possible nerve damage. As well the member's care and treatment were well within standards,

and the Board was also impressed that the member referred the patient to a neurologist when the numbness did not subside. The Board confirmed the decision of the Committee.

CASE 2

The Complaint

The patient complained about the conduct and actions of a member over a four-month period. The patient presented with dull pain at the upper incisors. The member noted generalized amelogenesis imperfecta, tender percussion, no response to vitality and sensitivity to cold on some teeth, poor oral health and that the patient was a heavy smoker. The patient said he wished the best aesthetic result since he wished to get married soon.

The member prepared a treatment plan that included root canal on various teeth and composite restorations on others.

A payment plan was discussed. The member proceeded at subsequent appointments, but the patient did not attend for six scheduled appointments. The patient filed a letter of complaint to the College. Following the letter of complaint, the patient received a second

opinion which confirmed the treatment plan as outlined by the member, and the patient wished now to have the member continue the dental plan. The patient withdrew the letter of complaint.

The member, at subsequent appointments, began to complete the treatment plan, however, the patient who apparently was satisfied with the work, began to fall into arrears with the payment. The total amount of the work was around \$13,000 but the patient had only paid for some \$3,000. When the member attempted to contact the patient for payment, the patient filed a letter of complaint with the College.

The complaint alleged, among other things:

1. substandard work;
2. pain which the patient had complained of and the member did not resolve;
3. a lack of informed consent;
4. root canals were performed on healthy teeth that were unnecessary;
5. the twelve crowns placed by the member were too big and crowded other teeth.

Complaints Committee

The Complaints Committee felt that the patient was in bad faith. At no time did he allege pain or bring forward issues with respect to the work until the member sought payment. The College's expert confirmed all the work was necessary.

The Panel was particularly troubled by the use of the complaints process in order to receive dental treatment at no cost to the patient.

Further it appeared that the work was within standard and the work was necessary. While the crowns were not ideal in terms of colour, they were certainly acceptable in size and shape. The Panel ordered no further action.

Health Professions Appeal and Review Board

The complainant was dissatisfied and appealed the decision of the Complaints Committee to the Board. As added submissions to the Board, the patient asserted that he had good oral hygiene, the teeth did not require root canal, and that the College was biased.

The Board was satisfied with the investigation of the College.

The Board found that there was no information in the record or otherwise, other than the allegation of the patient, to suggest the Committee erred in its assessment. The Board also took time to comment: "There was no indication bias seen by the Board in its review of this case. The Committee appears to have reasonably assessed the information before it."

The Board noted that the Committee found that the patient's "prime motive in making the complaint may have been to receive significant dental treatment at no cost to himself." The Board found "the Board is also dismayed by the apparent motives of the complainant."

The decision of the Committee was therefore confirmed.

CASE 3

The Complaint

A principal complained about an associate who was dismissed and alleged that the associate failed to maintain standards, submitted false and misleading accounts, and falsified patient records.

As part of the complaint, the principal advised that the Professional Liability Program had opened several files in regards to patients of the associate. The principal provided a list of 44 patients including charts.

The associate responded in detail, and expressed the view that this complaint was really a dispute being fought at the

complaints level when the subject matter was, in fact, a civil law suit.

As part of the College's investigation patients were contacted; and in one case, out of the 44, the member offered to correct a problem by doing work for free.

Complaints Committee

The Committee reviewed the extensive investigation and noted that there were some occasions when the member adjusted a fee structure according to a patient's insurance status. The Committee, however, was of the view that this was not done regularly.

The Committee ordered caution in respect to that conduct.

With respect to all of the other allegations, the Committee noted that there was no evidence to support the principal's allegation.

The Committee stressed to both the complainant and the member that the College should not be used as a bargaining tool in disputes which may develop between practitioners.

Health Professions Appeal and Review Board

The complainant was dissatisfied and appealed the decision of the Complaints Committee.

The Board was satisfied with the investigation of the College. The Board went out of its way to comment that the College's investigation staff was most helpful in obtaining information from several of the patients. The Board also noted there were no patient complaints, and this appeared to be a complaint to bolster a civil action.

The Board was satisfied that there appeared to be no serious substantiated irregularities, and therefore confirmed the decision of the Complaints Committee.



COMPLAINTS CORNER

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

If you have any questions about this column, please contact the College's Registrar Irwin Fefergrad at 416-934-5625, toll free at 1-800-565-4591, or by e-mail at ifefergrad@rcdso.org.

THEME: Supervised Neglect

THE CASE

A mother of a nine-year-old boy complained that she had been taking her son to their family dentist every six months for the past five years. Over the Labour Day holiday weekend her son began experiencing pain in the upper left area. The mother called their regular dentist and found the office closed for the week. The office answering service directed her to the on-call dentist. She contacted the on-call dentist and arranged an emergency appointment.

The emergency dentist examined the child and asked the mother if he had been receiving regular dental care. The emergency dentist was surprised to find that the boy had been seen only five months earlier and was told that everything was fine. The emergency dentist explained that the boy had an abscessed tooth 63 and decay on teeth 55O, 65O, 75MO and 85DO. Further, as teeth 74 and 84 had been previously extracted, there was obvious space loss. Tooth 63 was extracted and the boy was booked to restore the carious lesions. A

referral was also made to an orthodontist who confirmed the space loss and expressed concern that orthodontics would not have been required if space maintainers had been placed after teeth 74 and 84 were extracted. The orthodontist recommended lower arch treatment to open the lost space for teeth 34 and 44.

The dentist responded to the complaint by confirming that the boy had been attending his office on a regular basis for the past five years. At the last

appointment he had placed a deep filling on tooth 63 and had noted incipient lesions on teeth 55 and 85. He also confirmed that he had extracted teeth 74 and 84 the previous year and that he was monitoring the spacing. He stated that regardless of whether space maintainers were placed, in this case the need for orthodontics was inevitable. He also wrote that the decision whether to monitor incipient lesions or treat them is often a “judgement call,” and in this case he chose to monitor the teeth. The dentist further mentioned that the child’s behaviour was often poor and he found treating the child difficult and stressful.

Committee Decision

After examining the records and submitted documentation, the Complaints Committee agreed that, although there is some degree of “judgement” in deciding when to observe or treat a lesion, in this case the lesions were clearly through the enamel and required treatment. The dentist did not adequately diagnose cavities or deal with space loss issues. The Committee

Helpful Suggestions

- Although the decision to monitor or treat carious lesions involves clinical judgement, the dentist must be careful not to let other factors, such as a child’s poor behaviour, cloud that judgement.
- If a dentist is not comfortable treating children, or any other patient, he or she should be prepared to refer the patient to another dentist or specialist.
- Complete and detailed daily records and treatment plans must be maintained for all patients.

noted that the lesions were through the enamel on the bitewing radiographs taken five months before the emergency appointment. These films also showed that teeth 75 and 84 had noticeably drifted forward resulting in a loss of space for teeth 34 and 44. The Committee noted that there was no treatment plan, and that the clinical notations were either missing or lacking in detail.

The Committee also questioned why teeth 74 and 84 were extracted. They agreed that the dentist’s hesitancy to treat caries in children contributed to the loss of teeth 63, 74 and 84. They agreed that this was an unfortunate case of “supervised neglect.” The Committee noted that the dentist may have consciously or unconsciously avoided working on the child due to the child’s behaviour, and the stress it caused him.

To satisfy their concerns and protect the public interest, the Complaints Committee requested that the dentist sign an undertaking with the College to take and pass a course on pedodontics, including diagnosis, managing space problems treatment planning and recordkeeping. The dentist voluntarily signed the undertaking and successfully completed the course, which was followed by office monitoring by the College for two years.

The final decision of the Complaints Committee was to issue an oral caution to ensure that the dentist understood the severity of the issues in this case, and that if he feels uncomfortable treating a child, he should refer the child to another dentist or specialist.

MAILING LABELS

HOW THE COLLEGE HANDLES MAILING LABEL REQUESTS FROM EDUCATIONAL ORGANIZATIONS

From time to time the College gets requests from educational organizations, such as universities or third party providers, for mailing labels or member information in order to advise our members about continuing education courses. As it is part of the College’s legislated mandate to promote the education of Ontario dentists, we have usually fulfilled these requests.

Now, because of the federal privacy legislation, we will do business a bit differently. When the College receives a request like this, we will review the requesting organization’s privacy policy for collection, use and disclosure of personal information. If the policy meets the approval of our College’s privacy officer, who is the Registrar Irwin Fefergard, the information will be released in accordance with our own College’s policy.

Those members who have indicated to us that their home address is their preferred address for information from the College will be contacted to see if they would like to opt in or opt out of these mailings.

If you have any questions contact:

Irwin Fefergard, Registrar

phone: 416-934-5625

toll free: 1-800-565-4591

e-mail: ifefergard@rcdso.org

Dayna Simon

Assistant to the Registrar, Legal

phone: 416-934-5618

toll free: 1-800-565-4591

e-mail: dsimon@rcdso.org

Infection Control

Infection Control Recommendations For Patients With Febrile Respiratory Illness Announced

The spread of SARS that occurred in health-care settings caused the health-care system to re-examine the infection control and surveillance practices now in place to prevent droplet spread respiratory infections – both in outbreak and in non-outbreak conditions.

As part of that review, the Ministry of Health and Long-Term Care established a task force to make recommendations for infection control and surveillance in community health settings, including dental offices, that would guide these health-care facilities in treating patients



who present with symptoms of respiratory illness. The report of the task force was published on March 8, 2004. As a service to members, the College has posted this report on the its Web site www.rcdso.org.

The Quality Assurance Committee will be reviewing the report and will make recommendations to Council in the near future pertaining to specific advice to members in implementing these recommendations.

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

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

Mercury Clean Sweep

College Supports Clean Sweep Project To Collect Stores Of Unused Elemental Mercury From Dental Offices

The College has endorsed the Clean Sweep Project sponsored by the federal and provincial environment ministries and the Ontario Dental Association to facilitate the removal and disposal of all unused stores of elemental mercury from dental offices in Ontario.

According to a 2001 survey conducted by the Ontario Dental Association, there are about 170 kilograms of unused elemental mercury stored by dentists around the province.

Only a handful of dentists still use elemental mercury, while the vast majority have switched to pre-capsulated amalgam. However, about nine per cent

of dental practices continue to store unused elemental mercury which if spilled might pose a significant health risk.

Environment Canada will supply hazardous waste management companies with appropriate containers and labels for the removal of the stores. The cost of the one-time collection by carriers will be passed on to the dentists. However, since other amalgam wastes must already be transported in this way, the additional expense is expected to be minimal.

The College has taken an active role in supporting the development and distribution of practical information to assist members in the management of dental wastes.



Late last year, every dental office in the province received four

flowcharts providing best management practices for dealing with various dental wastes. The flowcharts are posted on our Web site at www.rcdso.org.

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

Dr. Michael Gardner
Assistant to the Registrar, Dental
phone: 416-934-5616
toll free: 1-800-565-459
e-mail: mgardner@rcdso.org

Advertising Concerns

Coming To The College

On The Rise



The number of concerns about advertising issues coming to the College's attention continues to increase. The major areas of concern are in regard to advertising in telephone directories, and advertisements that suggest uniqueness or superiority of one dental practice over another.

Telephone Directories

The problem with advertising in phone directories usually involves the publishing of a general dentist's name, address and phone number under headings designated for dental specialty.

The College would like to remind members that it is the dentist's responsibility to ensure that directions given to the publishers of the telephone directories are accurate and precise, and that the advertisements are only listed under the appropriate headings.

As well, dentists should note that when the advertisement, announcement or

information related to a member's practice makes reference to areas of practice, dental procedures or treatments, it should also disclose whether the member is a specialist or a general practitioner, and if a specialist, in what particular specialty.

Uniqueness or Superiority

As the regulations under the *Dentistry Act, 1991*, state, advertisements cannot use words that may reasonably be regarded as suggesting that you or your dental practice are in some way unique or superior over another practice or another dentist. The easiest way to fulfil these requirements is to just avoid using adjectives when referring to your office or treatment in your advertisements.

More Information

The College's Practice Advisory updated in September 1998 has a series of questions and answers that help clarify the issues involved in advertising. It is

available on our Web site at www.rcdso.org under Publications.

Need Help?

If you are unsure if your advertising is in compliance with the advertising regulations and the College's Practice Advisory, you may have your advertisements reviewed for approval prior to publication. Also staff are as close as the phone to answer your questions about advertising.

Contact:

Dr. Fred Eckhaus

Assistant to the Registrar, Dental

phone: 416-934-5624

toll free: 1-800-565-4591

e-mail: feckhaus@rcdso.org

fax: 416-961-5814

MARK YOUR CALENDAR



JUNE 10 & 11, 2004

RCDSO Council

Westin Prince Hotel
900 York Mills Road
Toronto

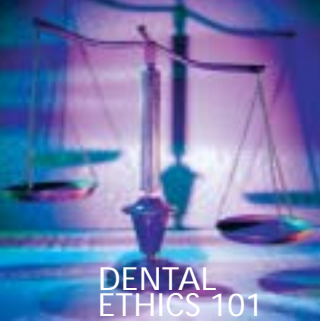
NOVEMBER 18 & 19, 2004

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 calling Angie Sherban, Senior Executive Assistant, at 416-934-5627, toll free at 1-800-565-4591, or by e-mail at 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.



Case Study Discussion What Should You Do?

Confidentiality and the Patient with Eating Disorders

Ashley presents an ethical dilemma because each of the options has consequences that are harmful to her physical or emotional health. If her condition is revealed to her mother, Ashley may suffer psychological harm. She may also lose trust in the dentist who does not respect her request and breaks confidentiality. We will examine three elements of this case:

1. dental/medical aspects of anorexia and bulimia nervosa;
2. keeping and breaking confidences;
3. hierarchy of values: general health, oral health and autonomy.

Anorexia and Bulimia Nervosa

Most dentists reading Ashley's case would not be surprised by her disclosure that she frequently self-induces vomiting. The dental signs associated with eating disorders like anorexia nervosa have been described as early as 1970. In 1980, bulimia nervosa was identified as a separate eating disorder characterized by binge eating followed by purging behaviour, such as self-induced vomiting by the patient.

Ashley presented with two common dental signs of chronic vomiting: demineralization of anterior enamel, and smooth erosion of the lingual surfaces of maxillary anterior teeth with accompanying sensitivity. While patients like Ashley may be silent about their eating disorders, their physical and oral signs may be painfully evident. Dentists and dental hygienists may be the first health professionals to detect an undiagnosed eating disorder.

Ashley seems genuinely surprised when the dentist asks if she has any problem with "sour stomach" or vomiting and explains about enamel erosion and the serious health problems associated with chronic vomiting. Her social history revealed that she has moved

six times in the last four years. That may be a factor in her disorder. Her mother observes that she stopped eating ice cream and drinking cold drinks three years ago, about the same time she failed to make appropriate weight gain. Ashley reports that the sensitivity was present at previous dental visits. From the patient's history, one could speculate that the eating disorder has persisted for at least three years.

Some dental signs in Ashley's case are directly attributable to her self-induced vomiting. However, other oral findings not associated with Ashley's case could include: raised appearance of amalgams in posterior teeth; moth-eaten appearance of the incisal edges of the maxillary teeth; a possible open bite of the anterior teeth; sore throat (from chronic acid reflux); burning tongue; bleeding gingiva; salivary gland enlargement causing a square-looking facial appearance; and dental caries due to the chronic acid exposure and the high intake of simple carbohydrates.

The oral signs and the disclosure by Ashley are sufficient to establish that she probably has an eating disorder.

What is the obligation of the dentist to the patient and her family to inform, educate and refer the patient for proper medical and psychiatric counselling? Not intervening in her disorder is vexing because an acceptable prognosis for dental treatment depends on cessation of binge eating and vomiting habit. When the dentist chooses to treat the patient's symptoms, he or she may be ignoring a life-threatening condition. Is protecting Ashley's general health sufficient reason to override the obligation to keep her disorder confidential?

Keeping and Breaking Confidences

The proper doctor/patient relationship depends on collaboration about symptoms, personal values, histories, and findings in a setting of mutual trust. Mutual trust cannot exist without the assurance of confidentiality.

The philosopher David Ozar describes confidentiality in this way:

The accepted standard is that every fact revealed to the health professional by a patient is, in principle, subject to the requirement of confidentiality, so that nothing may be revealed to anyone else without the patient's permission.

Philosopher Tom Beauchamp refers to confidentiality, telling the truth (veracity) and privacy as principles that are all derived from the principle of autonomy, or respect for persons. Beauchamp explains:

To respect persons is to see them as unconditionally worthy agents, and so to recognize that they should not be treated as conditionally valued things that serve our own purposes.

Confidentiality is a principle of ethics in the RCDSO's Code of Ethics. The Code recommends that dentists should not reveal confidential communications or information without the consent of the patient, unless provided for by the law or by the need to protect the welfare of the individual or the public interest. Protecting Ashley's welfare is central to this case.

The central issue in Ashley's case is whether the dentist should respect the confidentiality for a minor. One could hold the view that Ashley's parents are the responsible parties, pay the bills and should be told what the doctor finds and what he thinks should be done to preserve or recover his patient's health. Another perspective is that since Ashley is a minor, the parents will need to be informed of the dental findings and their probable cause and the dental problems addressed by the dentist through her parents.

There is some agreement in the literature that intervention for the eating disorder patient is appropriate. However, any attempt at intervention may result in the patient who may temporarily or permanently leave the practice. Although the RCDSO Code does not provide guidance in this area, the American Medical Association Code does offer the following:

In cases when the physician believes that without parental involvement and guidance, the minor will face a serious health threat, and there is reason to believe that the parents will be helpful and understanding, disclosing the problem to the parents is ethically justified. When the physician does breach confidentiality to the parents, he or she must discuss the reasons for the breach with the minor prior to the disclosure.

Continued on page 38



Case Study Discussion What Should You Do?

Hierarchy Of Value: General Health, Oral Health, And Patient Autonomy

The doctor must decide if a serious health threat exists before breaching the confidentiality of the minor. The question of the level of harm is a complex matter. The philosopher David Ozar has proposed a hierarchy of central values to better understand these issues.

At the top of the hierarchy is the value of the patient's life and general health, as every treatment recommended or performed by the dentist must consider this value. The dentist would be acting unprofessionally if he or she failed to consider treatment that would place the patient's life and general health at risk.

For example, the decision to do periodontal surgery for the non-compliant patient who refuses to take antibiotics to prevent infective endocarditis places the patient's life and general health at risk.

Ranked second on the hierarchy is the value of the patient's oral health, including appropriate and pain-free oral function. Due to her eating disorder, Ashley's oral health is neither appropriate nor pain-free. If her disorder continues, the prognosis for her oral health will worsen.

Third on the hierarchy is patient autonomy that identifies respecting the unconditional value of patients as an important, but not the only, value for health professionals.

Practising professionally requires not only respecting the patient's autonomy, but also benefiting the patient by providing treatment congruent with promoting the patient's general and oral health.



Conclusion

Confidentiality is a core element in a successful doctor/patient relationship and is the basis for mutual trust. Patients with eating disorders present an ethical

dilemma, since they may deny the existence of this serious health problem.

However, dentists who understand the symptoms of eating disorders may be the first health professionals to identify an undiagnosed case. The dentist has the responsibility to all patients, whether adult or minor, to educate them about the risks and complications to their general and oral health. This will include the need for further medical referral and possible psychiatric counselling.

In cases of minors with eating disorders, the dentist has a more stringent obligation to encourage the patient to discuss the eating disorder with parents or guardians. If after these efforts Ashley continues to resist telling her mother, the dentist may be ethically justified in breaking confidentiality, but before doing so, should discuss the reasons with the patient.

This discussion is reprinted with the permission of Dr. Thomas K. Hasegawa, Baylor College of Dentistry, Dallas, Texas.

CHILD AND FAMILY SERVICES ACT CONSIDERATIONS

Ontario's *Child and Family Services Act* (CFSA) provides for a broad range of services for families and children, including children who are or may be victims of child abuse or neglect.

The CFSA clearly states that professionals who work with children, including dentists, have a legal obligation to report promptly to a Children's Aid Society (CAS) if they suspect that a child or youth under the age of 16 is or may be in need of protection. Such reports include physical, sexual and emotional abuse, neglect and risk of harm.

In the example used, Ashley's plea "Please don't tell my mother, she'll just freak out!" may need further exploration. If Ashley is referring to the fact that she might be grounded by her mother or that her mother would be disappointed in learning of her eating disorder, then a report to CAS would likely not be required. However, if on further questioning, you learn that Ashley may be fearful of physical or emotional harm or abuse, then a report to CAS might be warranted.

Your local Children's Aid Society will be happy to provide guidance on a particular matter, and this can be done initially on a no-name basis. If in doubt, it is always wise to take the time to contact CAS for advice.



LETTERS OF APOLOGY

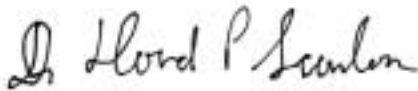
The RCDSO Executive Committee regularly reviews office newsletters, brochures, newspaper and other advertising by dentists that have been brought to the College's attention. The Committee has accepted the following letters of apology for publication from the following members. If you have

any questions about the issues raised in these letters, please contact Dr. Fred Eckhaus, Assistant to the Registrar, Dental by calling 416-934-5624, toll free at 1-800-565-4591, or by e-mail at feckhaus@rcdso.org.

Penetang Dental Dr. David P. Scanlon

I am writing this notice to let my colleagues and the public know that I sincerely regret any misrepresentation and/or misinformation that my advertisement in the 2003 Fall edition of *Body, Mind and Spirit* may have caused. It was not my intention to suggest any uniqueness or superiority over other dentists or practices.

Sincerely,



DR. DAVID P. SCANLON

In an advertisement in the local newspaper, Dr. David Scanlon in Penetanguishine made several references that raised concerns at the College, including:

- 1. the use of the designation "LVI certified graduate of cosmetic dentistry;"*
- 2. the reference to "dentistry for quality conscious;"*
- 3. references to "dentistry for quality conscious, the finest materials – the latest techniques" and "advanced restorative services."*

The advertisement also included the use of the term "gentle" as part of the practice name heading.

Dr. Scanlon explained to the Committee that the advertisement which appeared as an insert in one of the local newspapers by an individual not associated with his practice. Neither his office manager nor he had an opportunity to proof or authorize this particular advertisement, according to Dr. Scanlon.

However, Dr. Scanlon realizes that the final responsibility and consequences fall directly on him. Dr. Scanlon has apologized in another advertisement he placed in that newspaper. He also agreed to remove the word "gentle" from his signage and practice name.

Dr. Jason Goldshlager Web site Advertisement

A Web site developer who, with my input, created my home page for me has created my Web site. I routinely review my Web site to make sure it complies with the RCDSO's guidelines and update any relevant information.

Only after being notified by the College that a reference to me being an orthodontist has appeared on the Web site, did I realize that a Web search for an orthodontist brought up my name with reference to me being an orthodontist.

I do not purport myself to be an orthodontist or any other kind of specialist, and this blatant misrepresentation was absolutely unintentional. I have reviewed this matter with my Internet host, so that such occurrences will not happen again.

I sincerely apologize to my colleagues, especially those in the orthodontic profession, for this misleading mistake.

Sincerely,



DR. JASON GOLDSHLAGER



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

Sometimes a letter may not be printed with the name of the author 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, all 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

QUESTIONS ABOUT PLP

I have some issues with the article on changes to our PLP policy (Jan/Feb 2004 issue of *Dispatch*). In changing the deductible for our professional liability program, the author states that the increased deductible "will serve as a wake-up call to members, with the hope that they will learn from the particular case and make changes in their practice to reduce the risk of claims of a similar nature."

A patient sued me and I was exonerated because there was no basis for the suit. However, the case went all the way to court. I had to pay the deductible. Explain how the deductible was a benefit to me. Furthermore, many years ago RCDSO set fees at a level that allowed for a fund that would eventually allow the dentist of Ontario to self-insure for malpractice. That fund contains millions of dollars, and is used to pay our aggregate deductible. It would be helpful for the dentists of Ontario to know the fiscal reasons for which our deductible is being raised.

DR. PAT DURONIO

Windsor (by e-mail)

**Response from Dr. Don McFarlane,
Director, Professional Liability
Program:**

You are correct in your statement that the costs associated with the PLP program are shared by the program itself and the insurer. PLP is responsible for the first \$75,000 of any claim lodged within a particular year with a maximum

liability of \$2.75 million in any given year. By partially self-insuring the losses, PLP is able to provide comparable protection to that available in the rest of Canada, excepting Quebec, for half the cost.

The PLP reserve fund was established, according to actuarial criteria, for the main purpose of allowing the College to be able to continue to provide members with errors and omissions protection in the event that an insurer could not be found, and the College would have to fully fund the program.

Two events recently confirmed the wisdom of that decision:

- The aftermath of 9/11 had a devastating effect on the liability insurance and reinsurance market.
- Our previous carrier, Reliance Insurance, was forced into liquidation by the courts.

A recent actuarial study by Pricewaterhouse Coopers recommended that the reserve fund would have to be increased if the College wanted to explore the feasibility of taking a much greater risk itself. Because we were able to renew the policy with ENCON Insurance Managers for another two years, we see no need at the present time to change the amount of risk the College assumes.

Relative to your comments regarding the reasoning behind the decision by Council to increase the individual deductible, a number of factors influenced this recommendation by the PLP Committee, and they are

spelled out in the article in *Dispatch*.

Unlike you with only one or two claims in a career, we have many "frequent flyers" on whose behalf claims have been settled due to poor or missing records, and even records that have been supplemented with detail after the lawsuit was filed. The substantial raise to the step-up deductible was made with the hope that these members will institute risk management changes to their practices.

To try and put things in perspective, almost 85 per cent of those matters reported to PLP are closed without any monies being paid, and therefore no deductible being required. Through claims management activities and risk management advice, we are trying to further reduce the number of files requiring a deductible payment.

I hope this explanation helps.

KIND WORDS ABOUT OUR DISCIPLINE PROCESS

I have had two of my Council members tell me that your discipline process is quite amazing, and we at the College of Opticians of Ontario should look at some aspects of your system that would assist us in streamlining our process. Some mention was made of alternate dispute resolution, along with various other steps. Any information you could offer would be appreciated.

CAROLINE MACISAAC-POWER, RO

*Registrar, College of Opticians of Ontario
(by e-mail)*

ROAD SHOWS

On The Road Again!

The College road shows are getting ready to roll again! The road shows are one of the College's most popular membership services. Key College staff are going on the road to specific locations around the province to meet face-to-face with dentists.

In addition to special presentations on topics like recordkeeping, staff will also be available for an open question-and-answer session. Watch the July/August issue of *Dispatch* for all the details.



THANKS TO PLP STAFF

(Editor's Note: Although we have respected the confidentiality of the dentists involved, we wanted to share some of the feedback that PLP gets from dentists who have been involved with PLP staff during difficult moments in their practice.)

Thank you so very much for all your help regarding my recent case of an upset patient. I'm so glad I called you immediately. I then met with the patient, and using your advice I was able to fully communicate with the patient, to the point that not only did he refuse to receive any refund from me, but he asked if I would accept the rest of his family as patients. Thank you for your long phone call which was so prompt and caring. As you know, occurrences such as this can be very stressful, and it's nice to know people like you are out there, so helpful to the profession.

Thank you for your sympathetic approach to my recent problem. Your comments put me at ease and certainly made a difference in being able to continue functioning with an easier mind.

Thank you again for your help, kindness and handholding!

Membership Listings 2004 Coming Soon!

As you will have already noticed, this year's membership directory is not, unlike previous years, included with this issue of *Dispatch*. Due to Canada Post regulation changes, *Listings 2004* can no longer be mailed in the same envelope as *Dispatch*. The separate mailing will mean significant postage savings. Each member can expect to receive his/her copy of this year's membership directory in a separate mailing before the end of April.



College Welcomes Invitations to Speak at Society Meetings Anywhere in the Province – And at No Cost to the Society.

The College is always willing to come out to your dental society – and at absolutely no cost to your society. We welcome these opportunities to meet face-to-face with local dentists to share about what's happening at the College, and answer your questions.

WHO'S AVAILABLE?

The President or the Registrar is available to speak on the latest developments on current issues, and to answer your questions, whatever the topic. You can find out more about the exciting plans for the future in areas like continuing education.

Key staff are also pleased to come to address issues from the provincial privacy legislation, and risk management.

Or maybe your society has a topic of particular interest that you would like the College to address. Just ask us.

HOW TO BOOK A SPEAKER

It is very easy. Just call the College Registrar Irwin Fefergrad at 416-934-5625, toll free at 1-800-565-4591, or by e-mail at ifefergrad@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

Both Ontario Dentists and Their Patients are the Winners when Leaders of Vision and Courage Sit Around the Council Table.

Continued from page 44

We began evaluating our approaches to education and felt that we needed to get out to the communities where dentists live and practise. We created the road shows where our staff visited local societies to teach on a variety of topics. The notion was that we would go out to the members, instead of members coming to us.

We also looked at our publications with a view to using them as a way to provide educational information and materials, as we now use *Dispatch* to circulate the PEAK (Professional Enhancement and Knowledge) articles.

We looked at other avenues too.

We started modestly with our health professions incorporation seminar available on CD-ROM and video. Then we moved to the next generation with the privacy kit complete with workbook and a more sophisticated CD-ROM with learning modules. Now, with the guidance and support of the Quality Assurance Committee, we plan to move to yet another new level.

Sometime late this fall, we hope to distribute a CD-ROM learning package on medical emergencies in the dental office to each and every dentist in the province at no additional cost to members.

It will be completely interactive. Dentists will be able to learn at their own pace, and at a time that suits their hectic schedule.

The College's goal is to enhance and

increase the learning opportunities for every dentist in the province. Geography should not be a barrier.

Our thinking is that it is not logical to assume that core education stops on graduation. We know that materials, techniques, and approaches are forever changing.

It is not our goal, at this point in time, to get into the continuing education business to make a profit. We hope other organizations and institutions will follow our lead, and move in to fill the vacuum.

It is not our intention to do away with the point system either.

Local societies will still be able to provide the very valuable service that they already do, and of course, in the process generate some much needed income.

The theory is that the College will develop criteria for core courses, and then those who wish to deliver these courses will need to get approval from the College – no different than the current system. Our hope is to create another level of educational opportunity for our members that is consistent with our mandate.

And finally, Council is moving forward on another initiative. It is a project that recognizes that we live in a very difficult society today, and that dentists, as frontline health-care providers, face many incredible pressures and stresses.

Unfortunately there are not many options out there for dentists to get the

help they need. This College wants to do everything it can to support the individual dentist who, like any of us might, is facing a troubling time in his/her life.

We are currently investigating ways we can provide the compassionate and understanding support that dentists need, and protect the public at the same time. Maybe we can move out of the regulatory regime associated with Fitness to Practice, and move beyond an adversarial process.

We have asked our colleagues at the Ontario Dental Association (ODA) to join us. We have already met with the Ontario Medical Association to learn about how their assistance program works.

In turn we were invited to a session which ODA held with others, and with their Dentists At Risk committee, with a view to changing the manner in which the organizations of institutional dentistry offer help to dentists in trouble. We were very encouraged at the initiatives being looked at by ODA in this area, as we look to revamp our approaches.

It is early days yet to know exactly how this important initiative will unfold. We will, of course, keep you informed.

The challenges ahead are many. However, with a dedicated Council and committed members, together we will meet them in the weeks and months ahead.

Both Ontario Dentists And Their Patients
Are The Winners When

Leaders of Vision and Courage

Sit Around The Council Table.



IRWIN FEFERGRAD

One of the hallmarks of this Council is its ability to offer leadership by looking ahead, assessing the future, and then not hesitating to take concrete action. There is no better example of that leadership than Council's response to the federal privacy legislation.

When no one else was ready, willing and committed to help the dentists of this province with a tailor-made user-friendly kit, our Council members made the tough decision. They believed that they had a duty and obligation to help our members. It took a lot of guts to take the lead when no one else was. Of course, once it became clearer what was going to happen, and it was safer and more acceptable, others came along.

To use a quote that I like to believe comes from Winston Churchill: "My grandfather once told me that there are two kinds of people: those who do the work, and those who take the credit. He told me to try to be in the first group – much less competition there."

We always look for ways to help others in the greater dental community, as we did with the privacy kit. First there was the medical history recordkeeping project, and then our health professions incorporation kit. There are the PEAK articles, our magazine and now the privacy kit. We have also made staff available to assist others. This College continues to be very generous in sharing our good work for the benefit of both dentists and patients across the nation.

That same reputation carries over in our dealings with government too. Based on our work on the federal privacy legislation, it was natural for us to take a leadership role in the response of the Federation of Health Care Regulatory Colleges of Ontario to draft provincial privacy legislation.

We were highly involved in the development of the submission from the Federation to the committee of the Legislature. College staff were part of the Federation delegation to appear before the committee. Of course, we also made our own submission and presentation too.

Staff member Dayna Simon is now recognized in the province as a leading resource on privacy. She was asked to attend committee hearings at the Legislature to help committee members on the line-by-line redrafting of the bill.

We continue to get requests from organizations outside the dental community to come and share our expertise on privacy.

We recently got a call from a leading financial institution that told us that they would be very comforted to know, when lending money to a dentist who is buying a practice or who is seeking security arrangements, that the dentist has been following our privacy kit.

That's an incredible profile for this College, and for the dentists of this province.

Another creative initiative from this Council is the Fresh Look At Member Education, or FLAME as we call it. As you know, over the last several years we have moved beyond the traditional opportunities for membership education.

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