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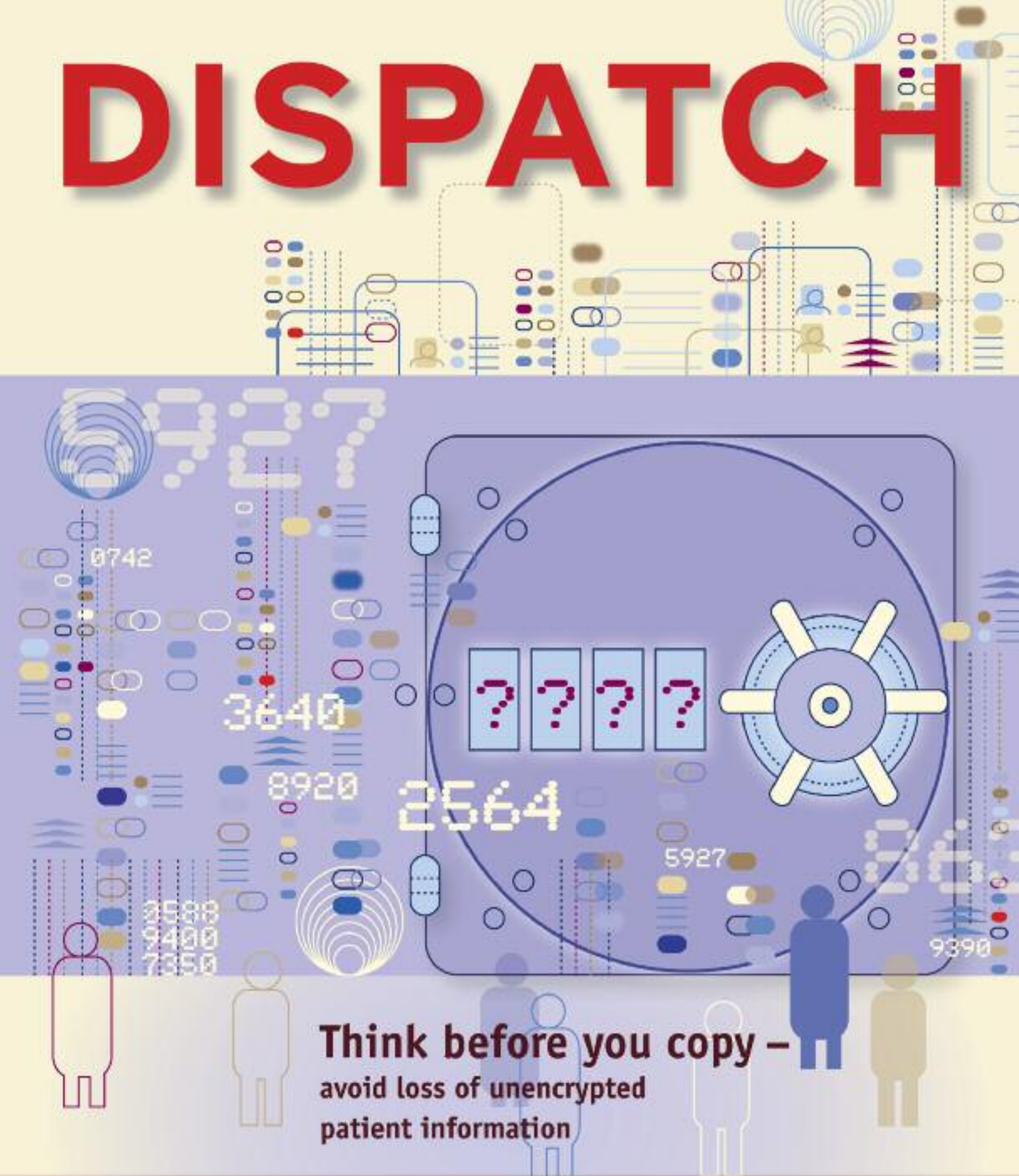

Think before you copy –
avoid loss of unencrypted patient information

Royal College of Dental Surgeons of Ontario
Ensuring Continued Trust

November/December 2010
Vol.24, No.4
www.rcdso.org

DISPATCH

Royal College of
Dental Surgeons of Ontario

Ensuring Continued Trust

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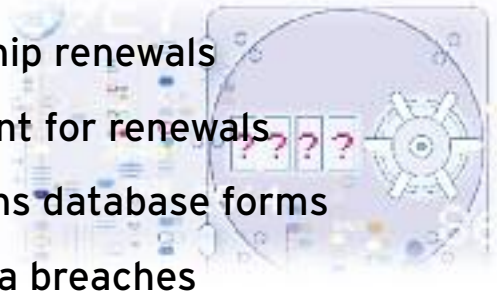

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DEPARTMENTS

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ISSUE ENCLOSURES:

Summaries of Discipline Committee hearings

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All good things must come to an end

DR. FRANK STECHEY

My friends, the time has come. This is my last column as president of this great organization. I have had the privilege of serving as president for two consecutive terms. What an exciting four years it has been.

Best of all, I can still say with total confidence and conviction exactly what I said in my first column in Dispatch magazine: Being president of this regulatory college is truly the pinnacle of my 40 year career as a dentist.

Looking back, I have to say that one of the things that has given me the most satisfaction is that whatever we have achieved, we achieved together.

Council and committees, Registrar and staff, colleagues at the Ontario Dental Association and at the Canadian Dental Regulatory Authorities Federation: What we have accomplished we've done because of the incredible work of a lot of people pulling together in the same direction.

We have achieved great things, such as:

- the wellness program for dentists struggling with addiction issues
- our new quality assurance regulation
- labour mobility for both general dentists and specialists
- recognition of the new dental anesthesia specialty
- new Guidelines on Infection Prevention and Control
- provincial roadshows with our colleagues at ODA
- launch of webinars
- first online educational courses
- sound financial stewardship
- outstanding reviews from the provincial Fairness Commissioner

Believe me, I have only scratched the surface with this list.

CONTINUED ON PAGE 43

Toute bonne chose a une fin

Mes amis, le moment est arrivé. Ceci est ma dernière chronique en tant que président de cette remarquable organisation. J'ai eu le privilège de servir à titre de président pendant deux mandats consécutifs. Quelles quatre années emballantes elles ont été.

Le meilleur, c'est que je peux encore affirmer en toute confiance et conviction exactement ce que j'avais dit dans ma première chronique du Dispatch magazine : « Être président de ce Collège de réglementation est vraiment le summum de mes 40 années de carrière de dentiste.

En me tournant vers le passé, je dois dire que l'une des choses qui m'a procuré la plus grande satisfaction, c'est que ce que nous avons accompli, nous l'avons fait ensemble.

Le conseil et les comités, le registraire et le personnel, les collègues à l'Ontario Dental

SUITE À LA PAGE 42

New Strategic Approach to Action on Fluoridation

Significant progress was made at an important meeting on November 8 when College representatives met with the province's Associate Chief Medical Officer of Health Dr. Francoise Bouchard and officials from three government ministries.

"The results of the meeting are definitely a major proactive move by the provincial government on this issue," said College President Frank Stechey. "It is an exciting development that will see the creation of a broad base of interested parties combining forces to develop and implement a targeted approach to support the use of fluoridation in municipal drinking water in Ontario."

The meeting was organized by the Chief Medical Officer of Health Dr. Arlene King and her staff in response to a letter sent to her by the College on June 24 suggesting a formal meeting to explore how the College could support the government's work on the promotion and enhancement of the use of fluoride.

The College was congratulated and thanked by Dr. Bouchard for our "offer of partnership" and for the important signals of support that we send to government with our request for this meeting and for the Council motion of monetary support for a study to demonstrate the cost benefits of municipal water fluoridation.

A proposed plan would include the following actions:

- Create a broad-based working group to develop a strategic plan to support fluoridation in this province as a recognized public health intervention.
- Pursue the College's idea of an unbiased study to create Ontario evidence-based research to demonstrate the cost benefits of water fluoridation.
- Develop and implement a cohesive communications strategy to raise public awareness of the benefits of fluoridation.

"The College indicated its willingness to commit its staff and Council members to join these working groups," said Stechey. "We have a good track record in working on complicated issues like this and also in creating and implementing effective communications strategies."

Other proposed members of the working groups could include the Ministry of Health and Long-Term Care, the Ministry of Health Promotion and Sports, the Ministry of Environment, the Ontario Agency for Health Protection and Promotion, the Association of Municipalities of Ontario and the Association of Local Public Health Agencies and staff from public health units involved with this issue.

It was suggested that representation from the dental community might be expanded to include the Ontario Dental Association, the Ontario Dental Hygienists' Association, and the Ontario Dental Assistants Association.

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College taking action on growing problem with opioids in Ontario

There are growing problems in Ontario with the use and misuse of opioids; in fact, some have even described it as a public health crisis. Ontarians are among the highest users in the world of prescription drugs containing narcotics. Between 1991 and 2009, the number of prescriptions in Ontario for oxycodone drugs rose by 900 per cent.

Managing patient pain is fundamental to most medical and dental practices. Opioids are effective in managing patients with pain, but their use presents a unique set of challenges to both patients and prescribers.

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"The College, as the regulator with a mandate of public protection, has an important role to play in this public health issue," said College Registrar Irwin Fefergrad. "Canada is one of the world's top users of prescription narcotics and Ontario is at the top of the list for narcotic use on a per capita basis. We have a responsibility to step up to this issue and we intend to do just that."

The College brought together a group of distinguished experts for a one day symposium to initiate discussions on the issue of pain management in the dental context. There will be full coverage in future issues of Dispatch.

The symposium took place on November 17 and focused on the following topics:

- nature and complexity of the full spectrum of pain
- appropriate and inappropriate use of opioids in the management of pain
- use of chronic opioid therapy in dentistry
- management of the high risk patient
- resources for dentistry

The Ontario government has already introduced legislation called Bill 101, an act to provide for monitoring the prescribing and dispensing of certain controlled substances, in the Legislature. As of early November this bill had already passed through the public hearings of the Standing Committee on

THE MANAGEMENT OF PAIN IN DENTAL PRACTICE

NOVEMBER 17, 2010

Social Policy and been amended and was awaiting third reading in the Legislature and then Royal Assent.

This legislation, commonly known as the Narcotics Safety and Awareness Act, is an important part of the provincial government's narcotics strategy to improve the health and safety of Ontarians by permitting the monitoring, analyzing and reporting of information, including personal information, related to the prescribing and monitoring of drugs. The goals of the strategy are to:

- promote appropriate prescribing and dispensing practices for monitored drugs in order to support access to monitored drugs for medically appropriate treatment, including the treatment of pain;
- identify and reduce the abuse, misuse and diversion of monitored drugs;
- reduce the risk of addiction and death resulting from the abuse or misuse of monitored drugs.

"RCDSO fully supports the ministry's efforts to improve health care and educate health care practitioners on how to prescribe opioids safely and effectively. The symposium is the first critical step in assisting the dental profession with this important issue," explained Fefergrad.

QUICK FACTS

- Canada is the leading country in prescribing opioids for non-cancer chronic pain.
- Ontarians are among the highest users in the world of prescription drugs containing narcotics.
- Between 1991 and 2009, the number of prescriptions in Ontario for oxycodone drugs rose by 900 per cent.
- Chronic pain is a significant public health problem afflicting about 30 per cent of Canadians, with the rate rising to almost half for those aged 55 and older.
- The cost of chronic pain in treatment, lost hours and disability benefits is estimated to be about $10 billion.

For more information about the Ontario government's Narcotics Strategy, please visit http://www.health.gov.on.ca/en/public/programs/drugs/ons/

RCDSO Webinar Series provides dentists with a unique, interactive educational experience

The College broadcast its first-ever live webinar to dentists from Ontario and British Columbia on September 24, 2010. Dr. Charles Shuler, Dean of the Faculty of Dentistry at the University of British Columbia, delivered an engaging and informative presentation and fielded questions during the interactive live question and answer session.

"This pilot project highlights the diverse ways the College successfully offers continuing education opportunities to its members," said College Registrar Irwin Fefergrad. "Based on the overwhelmingly positive feedback we've received, online continuing education and e-learning will continue to be a top priority for the College."

The second webinar in the series, featuring Dr. Blake Nicolucci, was broadcast on October 29. The third session with Dr. Dan Haas of the Faculty of Dentistry at the University of Toronto was broadcast on November 26.

"We're hoping to facilitate an exchange of ideas and knowledge by breaking down barriers to communication," explained Fefergrad. "Webinars and the online learning format enable dentists from across the province to come together to discuss important topics without having to leave their homes or offices."

In the photo (from left to right): Dr. Charles Shuler, Dean of the Faculty of Dentistry at the University of British Columbia, with Irwin Fefergrad, RCDSO Registrar.

Participants offered feedback throughout the presentation, submitting comments and questions online. As a courtesy, the College sent out a follow-up document to participants with answers to those questions the presenters did not get to during their presentations.

In order to provide this educational experience to dentists who were unable to attend the live sessions, the College is offering access to an archived version of all three webinars in this series. Those who sign up for the archived version will receive a complete package of handouts, including the presentation and all follow-up material provided by the presenters to participants.

You can sign up on the College website at www.rcdso.org. Look for the webinars icon on the home page.

"What a great way to learn. I hope that the College continues with this mode of continuing education for its members."

"Dr. Shuler put on a great presentation; he's a very good speaker. I hope that this will become a standard way for lectures and courses in the future. Dr. Shuler has armed me with valuable information."

In the photo (from left to right): Dr. Blake Nicolucci with Dr. Frank Stechey, RCDSO President.

"Wow! What a fantastic presentation and methodology to learn from. Dr. Shuler was wonderful. This is great leadership for the profession."

"Excellent presentation and a wonderful way to learn and to stay current with our continuing education requirements. This method is extremely beneficial and economic from a time point-of-view for those of us who live and practise in Northern Ontario."

"Congratulations on a clear and precise presentation."

"Dr. Shuler put on a great presentation. I hope that this will become a standard way for lectures and courses in the future."

"This was a timely topic presented in a unique way by a great speaker and expert. Web learning is easy and flawless."

"This was a great way to take a course. Thank you for a very informative, clear and interesting presentation. I hope to see many more topics covered in the future."

"Thank you for the very informative and excellent presentation and format."

"I very much enjoyed the webinar. It was well presented and having the information sent ahead was very helpful. For a first event, I thought it went very smoothly.

"Congratulations to the College staff for such a resounding success on our first webinar. For my first involvement in a webinar I found it to be both extremely well presented and an effortless and highly efficient way to learn. Yet another new beginning for this College!!"

"Congratulations, that was excellent."

College hosts media conference for CDRAF funding announcement by federal cabinet minister

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On September 15, the College hosted a media conference at which the Honourable Diane Finley, Minister of Human Resources and Skills Development Canada, announced a funding grant of over $790,000 to the Canadian Dental Regulatory Authorities Federation (CDRAF).

The grant is Foreign Credential Recognition Program funding for a project to assess internationally trained general dentists from non-accredited dental programs. The new process will evaluate whether these individuals have the same knowledge, skills and competencies as a graduate from an accredited Canadian dental program. If they successfully complete the assessment process, they then can take the National Dental Examining Board of Canada examination. If they pass the exam, they can register to practise as a dentist anywhere in Canada.

During the media conference, the Minister graciously thanked the College for hosting the event and congratulated CDRAF for achieving "what many said could not be done: labour mobility across the country."

CDRAF President Dr. Cam Witmer acknowledged the support of the Minister and her department for the "tangible indication of support for our efforts" and pledged that CDRAF would continue "to work with her and her government to reduce barriers by registering qualified and competent internationally trained dentists" in this country.

He also made special mention of the debt of gratitude that the CDRAF Board owes to the College of Dental Surgeons of British Columbia (CDSBC) for their support in managing the project, and, in particular, to CDSBC Registrar Heather MacKay who, along with RCDSO Registrar Irwin Fefergrad, took the lead in the negotiations with Human Resources and Skills Development Canada.

This grant will assist CDRAF in meeting its obligations required by the Agreement on Internal Trade

In the photo (from left to right): Dr. David Clark, CDRAF Board member and RCDSO Council member and Executive Committee member; Dr. Cam Witmer, CDRAF President; Mohammed Brihmi, RCDSO Council member and Executive Committee member; Kelly Bolduc-O'Hare, RCDSO Council member and Executive Committee member; Minister Finley; Dr. Frank Stechey, CDRAF Board member and RCDSO President and Executive Committee member; Irwin Fefergrad, RCDSO Registrar; and Dr. Peter Trainor, CDRAF Board member and RCDSO Vice President and Executive Committee member.

(AIT), which came into effect in 1995. Under AIT, federal, provincial and territorial governments agreed to eliminate interprovincial barriers to the free movement of workers, goods, services and investments.

In early 2009, all governments approved amendments to Chapter 7 of the Agreement to achieve full labour mobility for workers in regulated professions and regulated trades. The Chapter now requires that, with very few exceptions, a certified worker in one province or territory who wishes to relocate to another province or territory to work shall, upon application, be certified for that occupation by the destination province or territory.

The federal government, the provinces and territories created a partnership to address barriers to foreign credential recognition in Canada. Called the Pan-Canadian Framework for the Assessment and Recognition of Foreign Qualifications, it articulates guiding principles and desired outcomes for improving the assessment and recognition of newcomers' qualifications in cooperation with the provinces and territories.

Under the Framework, foreign credential and experience recognition is to be streamlined for eight priority occupations: architects, engineers, financial auditors and accountants, medical laboratory technologists, occupational therapists, pharmacists, physiotherapists and registered nurses.

During the next phase of implementation ending December 2012, the Framework will be implemented in the following six occupations: dentists, physicians, medical radiation technologists, engineering technicians, licensed practical nurses and teachers.

This means that foreign trained workers who submit an application to be licensed or registered to work in certain fields will be advised within one year whether their qualifications will be recognized. Otherwise, they will be advised of additional requirements or be directed to alternative occupations that would benefit from their skills and experience.

The Framework is part of the Government of Canada's strategy to have the best educated, most skilled and most flexible workforce in the world.

Want to Renew Online But Forgot Your Password

It's as easy as one, two, three (or possibly four if your e-mail is not on file with the College).

1. Go to the Member Resource Centre at www.rcdso.org and enter your ID number which is the College's 4 or 5 digit registration number. (Do not use the 06 if your ID number begins with 06).

2. If you don't remember your password, simply click on 'FORGOT PASSWORD' and you will automatically be e-mailed a new temporary password to the e-mail address on file with the College.

3. Enter the temporary password. The system will then prompt you to create your own personalized password. Confirm your address information, complete the questionnaire and pay your fees.

4. If we don't have your e-mail address, please e-mail kvivash@rcdso.org with your name and College registration number. Your records will be updated within two business days. You can then request a temporary password as detailed above.

Troubleshooting Tip

Clicked on 'FORGOT PASSWORD' but didn't receive it? Your internet service carrier may be slow. Confirm that the College has your current e-mail address on file. If we do have the right e-mail, check your spam or junk mail folder as well.

Early Bird Discount for Renewals by December 15

Q: Can I complete the conduct disclosure and amalgam waste disposal survey online?

You certainly can. Just click on the Member Resource Centre icon on the top right-hand corner of our website home page at www.rcdso.org. In fact, you will need to answer these questions first before you can access the online payment portion of your renewal. Clear instructions lead you step-by-step through the process.

Q: Is it safe to use my credit card to pay online?

We take the privacy of our members very seriously. Your personal information shared with us online is safe and secure.

Q: Do I have to fill out the sections on the renewal form with my address and contact information again?

This is not necessary as long as you verify that the information that we have on file is accurate. If it is not, please make the necessary changes and/or add any new information.

Q: What happens if my renewal form and payment are late getting to the College because I think they got lost in the mail?

Any loss or delay due to problems like "lost in the mail" is not accepted as a reason for late payment. We strongly advise you to consider using a courier service to avoid this problem or to renew online.

Q: The end of November has passed and I still haven't received my renewal form in the mail. What do I do?

Even if you don't receive your renewal form in the mail, it is still your responsibility to pay your annual fee by the due date of December 15. But don't worry: you can renew your membership directly online. To renew online, you will need your registration number and unique password.

Q: What do I do if I am not renewing?

All you need to do is complete the resignation form and return it to the College by the due date of December 15, 2010. This form is included in your renewal package and is also available online by clicking on the Registration/Licensing heading that you will find on the left-hand side of the home page of the College website at www.rcdso.org.

Q: Who do I call at the College for help?

It would be no surprise to learn that renewal time is very busy for our registration staff.

Between mid-November and the beginning of January, they process over 8,500 renewals. So we ask for your patience and understanding.

If you have a question, call 416-961-6555 or toll-free at 1-800-565-4591 and ask for one of our registration staff members.

HealthForceOntario

What you do counts!

That's why we're asking for your cooperation in an important endeavor – the Health Professions Database.

The Ministry of Health and Long-Term Care is working with 19 health professional regulatory Colleges across the province to learn more about you – Ontario's health workforce.

The goal is to make sure Ontario has the right number and mix of health care professionals. Once we learn more about you, we'll have **better information** to make **better decisions** during planning. That in turn, will mean **better health care** for the people the system serves.

The role you play in this project is vital. The information is coming from the forms you fill out when you register for, or go to renew, your license. Under the *Regulated Health Professions Act, 1991*, you are required to provide the information requested on the forms. So please take the time to answer the questions fully and completely.

Let's all work together to ensure our health care system is the best it can be.

For more information please visit **www.healthforceontario.ca**

what you do counts

Better Information.
Better Decisions.
Better Health.

Ontario

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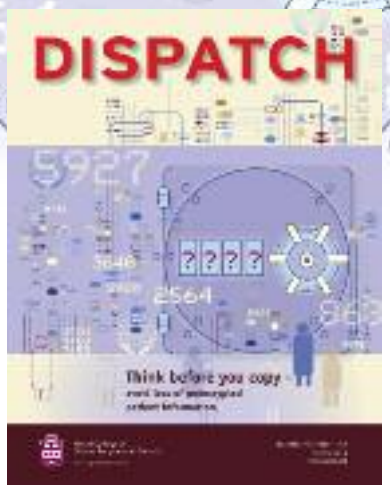
Educational campaign to eliminate avoidable data breaches



The College is pleased to join with Ontario's Information and Privacy Commissioner, Dr. Ann Cavoukian, in a multi-level education campaign aimed at preventing the far-too-frequent disclosure of unencrypted personal health information through the loss or theft of portable electronic devices such as laptops and USB keys.

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Educational campaign to eliminate avoidable data breaches

As College Registrar Irwin Fefergrad notes, the College has already taken a very proactive stance on the security of electronic patient records, even before the campaign was announced. "Earlier this year the College established a special working group to write College Guidelines on Electronic Records Management. Council passed, in principle, the draft version of these new Guidelines in mid-November. The draft document will now go out in circulation to stakeholders and members for comment as part of the consultation process."

The Privacy Commissioner's call for this campaign came on the heels of yet another USB key containing the unencrypted, identifiable personal health information of more than 750 patients being lost through the theft of a purse.

"These privacy breaches, which in recent years have included the loss or theft of the unencrypted personal health information of more than 100,000 patients, can and must be stopped," said the Commissioner. "Portable devices should never be loaded with unencrypted personal information. Either encrypt the information, or remove all personal identifiers from the information before loading it onto a portable device."

While several of the recent breaches have involved hospital staff, many different sections of the health sector have encountered problems, said the Commissioner. "It is essential," she added, "that all health-care practitioners, their staff and other agents ask themselves one key question before copying any

health information to a mobile device. Is it necessary to store personal health information on this device? If the answer is yes, then they must either encrypt the information or effectively de-identify the information by removing all personal identifiers. It's that simple."

The Information and Privacy Commissioner is appointed by and reports to the Ontario Legislative Assembly, and is independent of the government of the day. The Commissioner's mandate includes overseeing the access and privacy provisions of the Freedom of Information and Protection of Privacy Act and the Municipal Freedom of Information and Protection of Privacy Act, as well as the Personal Health Information Protection Act, which applies to both public and private sector health information custodians, in addition to educating the public about access and privacy issues.

Advice from the Information & Privacy Commissioner: strong encryption for health care records

In recent orders, Ontario's Information and Privacy Commissioner (IPC) has required that health information be safeguarded at all times, specifically by ensuring that any personal health information stored on any mobile devices (e.g. laptops, memory sticks, PDAs) be strongly encrypted.[1] Up until now, the Commissioner has not defined what constitutes "strong encryption" in the context of protecting the confidentiality, integrity, and availability of personal health information.

However, in a recent IPC Fact Sheet, there is a working definition of strong encryption and a discussion of the minimum functional and technical requirements of what may be considered to be strong encryption in a health care environment. These, in turn, provide procurement criteria that, if met, will ensure that personal health information stored on encrypted mobile devices or storage media will remain accessible to authorized users, but no one else. Because of the importance of this issue, Dispatch is running the complete text of this IPC Fact Sheet.

The term 'strong encryption' does not refer to a particular technical or design specification, or even to a specific encryption feature that could be inserted into a procurement or audit specification. No particular encryption technology – no matter how 'strong' it may be – can ever, by itself, ensure that information remains secure. Instead, a variety of

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Educational campaign to eliminate avoidable data breaches

circumstances and factors need to be taken into account to ensure that personal information is protected against access by unauthorized parties.

To begin with, a good encryption algorithm must be used – one that has been subjected to rigorous peer review. Next, the algorithm must be properly implemented. This may only be confirmed if the encryption system is tested by an independent security testing lab. Once the encryption system is deployed, the encryption keys must be protected and managed effectively. Users who are authorized to decrypt data must be securely authenticated by means of passwords, biometrics, or security tokens. Systems must not leave unencrypted copies of data in web browser caches or on laptop disk drives where they may later be read by an unauthorized third party. Authorized users should be properly registered, trained and equipped. The encryption system's protections should be operational by default, without busy health care users needing to take special steps to ensure that data remains encrypted. Finally, personal health information must remain available throughout its life cycle, regardless of forgotten passwords or misplaced security tokens.

The above considerations place several requirements on encryption systems that are used to protect the confidentiality of personal health information.

All of the following are technical requirements for strong encryption.

1. Secure implementation

The encryption system should have met a minimum standard for the protection of sensitive information. This, in turn, has two components: encryption systems must be designed to meet a minimum standard; and encryption products should be independently validated against standards to ensure that they are designed and implemented properly. As explained below, the most suitable and widely used standard for encryption systems for mobile devices is FIPS 140-2[2] and this standard specifies only a few acceptable algorithms. Strong encryption requires the use of devices or software programs that are FIPS 140-2 certified for use in the way that they are designed to be operated.

2. Secure and managed encryption keys

Encryption keys must:

- be of a sufficient length (sometimes also called key size and measured in bits) that they effectively resist attempts to break the encryption;
- remain protected so that they cannot be stolen or disclosed to unauthorized individuals.

3. Secure authentication of users

Prior to decrypting, authorized users must be securely authenticated (e.g. by means of robust passwords) to ensure that only authorized users can decrypt and access data.

4. No unintended creation of unencrypted data
No file containing decrypted data should persist as a consequence of a user having accessed encrypted data and viewed or updated it in decrypted form. A copy of the decrypted data must not persist unless an authorized user has intentionally created one.

In addition, the following are functional requirements of encryption systems that protect client privacy while at the same time supporting health care providers in their ongoing provision of quality health care.

5. Identified, authorized and trained users
Health information custodians should be able to determine at any given time which users have access to encrypted information on a given mobile device or on mobile media. This means that users who are authorized to access or update encrypted data need to be individually identified beforehand and given appropriate authentication tokens (e.g. robust passwords), as well as adequate training in how to access and protect the encrypted information.

6. Encryption by default
Once an encryption system has been installed on a mobile device or to protect mobile media, users should be able to rely on the encryption being in place without having to explicitly activate it to protect data.

7. Availability and information life cycle protection
There must be a reasonable assurance that encrypted data will remain available (e.g. despite forgotten passwords, staff who are unavailable due to illness or death, etc.). This, in turn, requires centralized management of passwords and other authentication tokens. It also requires that encrypted files or media be capable of being backed up along with other (unencrypted) files during routine backup operations.

All of the above considerations apply when encryption is used to secure the data stored on mobile devices and media such as laptops, cellphones, portable hard drives and memory sticks. They also apply to encryption used as an integral part of secure communications such as virtual private networks, secure email systems, and secure web access. But there is a final functional consideration when entire IT infrastructures are being designed and built.

8. Threat and risk assessment
IT infrastructures that use security technologies such as encryption should be subjected to a threat and risk assessment prior to live operations (and preferably prior to implementation) to ensure that they work as expected.

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Want more detail on the technical requirements? Here it is...

1. Secure implementation

Encryption technology has evolved rapidly over the last decade, and formerly acceptable encryption algorithms such as the Data Encryption Standard (DES) and Wireless Encryption Privacy (WEP) are now considered much too weak to be relied upon. There are also many examples of proprietary algorithms from vendors that later proved to be flawed. Fortunately, well-respected encryption standards exist that clearly specify which algorithms are acceptable and which vendor products have properly implemented those algorithms.

The most widely used standard for cryptograph models is the (U.S.) Federal Information Processing Standard FIPS 140-2, published by the (U.S.) National Institute for Standards in Technology (NIST). The Cryptographic Module Validation Program (CMVP) validates cryptographic modules to FIPS 140-2 and other cryptography-based standards. The CMVP is a joint effort between NIST and the Communications Security Establishment (CSE) of the Government of Canada. Products that have been validated as conforming to FIPS 140-2 are accepted by the federal agencies of both countries for the protection of sensitive information (United States) or Designated Information (Canada). Vendors of cryptographic modules use independent, accredited testing laboratories to have their modules tested. The CSE accredits such laboratories in Canada.

In addition to accreditation, FIPS 140-2 specifies an essential component of any encryption system: suitable encryption algorithms. FIPS140-2 Annex A lists the approved encryption algorithms that can be used. Of the three that are currently approved, only two are in widespread use in mobile device encryption: the Advanced Encryption Standard (AES), and the Triple-DES encryption algorithm.[3] Either one is acceptable for use in FIPS 140-2 validated encryption solutions.

2. Secure encryption keys

AES supports key lengths of 128 bits, 192 bits, and 256 bits, and all are currently considered secure for routine use. As a practical matter, key lengths (sometimes also referred to as key sizes) for AES of 128 bits may not be sufficiently secure for the long-term storage of sensitive information, especially if the encrypted information is being archived for many years. Triple-DES supports a key length of 112 and 168 bits. Triple-DES keys of 112 bits are also no longer typically used for storage of sensitive information.

Encryption keys are best kept secured inside a hardware device with dedicated cryptographic support, such as a USB stick, smart card, or laptop with a crypto-module installed. In the absence of hardware protection, the keys must be protected by software modules that store the keys in encrypted format and only provide access to an authorized crypto-program that in turn can only be activated by users who are successfully authenticated.

3. Secure authentication of users
A variety of means is provided by commercially available encryption systems for remote media and devices. These include strong passwords (a mixture of alphabetic characters, special characters, and digits of at least eight characters in length), biometric fingerprint readers (in the case of mobile devices and USB memory sticks), and USB fobs (in the case of mobile devices such as laptops). Whatever authentication method is chosen, it must be able to securely defeat attempts by unauthorized users to impersonate authorized users.

4. No unintended creation of unencrypted data
A copy of the decrypted data must not exist unless an authorized user has intentionally created one. Poorly designed encryption systems may leave temporary file copies of encrypted data in unencrypted form on the disks of mobile devices such as laptops. This can happen, for example, where the encryption product vendor has failed to take account of events, such as a power interruption, to a laptop. Poor design can also plague web-based systems that allow browsers to cache unencrypted copies of data that were otherwise securely delivered to the user via SSL (Secure Sockets Layer).

5. Identified, authorized and trained users
It is not usually sufficient in health care to merely authenticate users; e.g. by giving all users the same password. Otherwise, the dismissal of a single staff member would require that dozens, perhaps hundreds, of other users would need new passwords. Moreover, if users shared passwords it would not generally be possible for health information custodians to be able to say with any assurance which users had accessed a given file or database. Users who are authorized to access or update encrypted data need to be individually identified beforehand and given unique user names and appropriate authentication tokens (e.g. robust passwords). Whatever access control system is used to track users and equip them with user IDs, the system must work seamlessly with the chosen encryption system.

Finally, only users who are adequately trained can be relied upon to gain access to encrypted data when it is needed and to protect its confidentiality throughout its use.

6. Encryption by default
Busy health care providers cannot be expected to check an encrypted data file every time they view the data or update it to ensure that the encryption system is still working, and that the data remains encrypted. Once set up, the encryption system must reliably continue to protect encrypted data without ongoing configuration and testing by users who use the system to view or update the data.

7. Availability and life cycle protection
Personal health information used in the provision of health care must be accessible round-the-clock and hence encryption systems must be able to make data available whenever it is needed. If an encryption system renders data permanently unreadable when a user becomes unavailable (e.g. through death, illness, or other calamity), or when a user merely forgets his/her password, then that encryption system is unsuitable for deployment in a health care environment. Fortunately, a variety of products exist from well-known vendors that provide centralized management features that allow master passwords, remote password resets, and other features to facilitate the deployment and management of a large number of mobile devices or media without fearing loss of data.

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THINK BEFORE YOU COPY

Educational campaign to eliminate avoidable data breaches

In a similar vein, encryption systems must either facilitate the backup of encrypted data files, or at least not impede backup systems already in place, so as to ensure that copies of encrypted data files are securely backed up on a regularly scheduled basis.

8. Threat and risk assessment

Encryption must be commensurate with, and responsive to, known threats and risks: loss or theft of a portable device, staff carelessness or lack of training, malice, hackers, and many others. If organizations building IT infrastructures cannot articulate and weigh the threats and risks to their data holdings in a methodical, objective and credible manner, then they will never know whether they have deployed encryption properly. The best method for ensuring that an encryption technology is properly deployed within a larger IT infrastructure is to carry out a threat and risk assessment (TRA). Fortunately, there is a widely used and well-respected methodology for performing TRAs that was jointly created by the Canadian Communications Security Establishment (CSE) and the RCMP and is available at www.rcmp-grc.gc.ca/ts-st/pubs/traemr/tra-emr-1-eng.pdf.

In Ontario, health information network providers are required to perform a Threat and Risk Assessment by provisions of the Personal Health Information Protection Act, (PHIPA) and its regulations.[4]

Footnotes

1 *See www.ipc.on.ca/images/Findings/ho-007.pdf*

2 *See http://csrc.nist.gov/publications/fips/fips140-2/fips1402.pdf*

3 *Triple DES is defined in ISO/IEC 18033-3:2005 Information technology – Security techniques – Encryption algorithms – Part 3: Block ciphers*

4 *PHIPA O. Reg. 329/04 states (section 5) "The [health information network] provider shall perform, and provide to each applicable health information custodian a written copy of the results of an assessment of the services provided to the health information custodians, with respect to: i) threats, vulnerabilities and risks to the security and integrity of the personal health information…" See www.canlii.org/en/on/laws/regu/o-reg-329-04/latest/o-reg-329-04.html*

Additional IPC Guidance

PHIPA Order HO-007: Encrypt Your Mobile Devices: Do It Now (January 2010)

PHIPA Order HO-004 (March 2007)

Fact Sheet #12: Encrypting Personal Health Information on Mobile Devices (May 2007)

Fact Sheet #13: Wireless Communication Technologies: Video Surveillance Systems (June 2007)

Fact Sheet #14: Wireless Communication Technologies: Safeguarding Privacy & Security (August 2007)

Further Reading

FIPS standards: http://csrc.nist.gov/publications/PubsFIPS.html

List of FIPS 140 certified encryption products: http://csrc.nist.gov/groups/STM/cmvp/ documents/140-1/140val-all.htm

ISO/IEC 19790:2006 – Security requirements for cryptographic modules

ISO 27799: Health informatics – Information security management in health using ISO/IEC 27002

The following Government of Ontario guidance document is intended for provincial government Ministries, but contains useful material on how encryption/passwords should be properly addressed. See in particular Appendix A: Approved Algorithms and Protocols: Government of Ontario IT Standard (GO-ITS) 25.12: Security Requirements for the Use of Cryptography Version #: 1.1 (2008) at: www. mgs.gov.on.ca/en/IAndIT/258071.html

"Will You Stand Behind Your Work?"

THE ETHICS OF MAKING THINGS RIGHT

What Would You Do?

Ms. Stacey A, along with her three children, has been in your practice for a decade. Ms. A, who is 45, is in excellent health, exercises regularly, and is conscientious about her yearly medical and dental examinations.

Her chief dental complaint was the space caused by the loss of her mandibular first molar 20 years ago. She has excellent periodontal health, a stable Class I occlusion, no evidence of bruxism, good aesthetics and only a few small anterior and posterior restorations.

Since she did not have dental insurance, she saved her money until she could pay for a three-unit porcelain fused to metal bridge with all porcelain occlusion to replace the missing molar. Both abutments had small occlusal restorations, but overall the tooth size, crown-to-root ratio, alignment, and gingival attachment were favourable. The three-unit bridge was cemented three years ago and she has been satisfied with the overall aesthetics and function.

Last Friday, while Ms. A was eating a sandwich, she felt a hard object and, as she told your receptionist, "it's the tooth-coloured part of my bridge." Your examination found that the buccal cusps of both molars had failed, leaving some bare metal and some porcelain on the buccal surface. Although she wasn't in pain, the aesthetic deficiency was obvious and she was angry. She wants to know if you "stand behind your work" because she cannot pay for another bridge. Although you explain to her that there are no guarantees for dental care, she still wants to know if you will "stand behind your work."

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

Offer to replace the three-unit bridge at no fee.

Offer to replace the bridge with Ms. A paying the laboratory fee only.

Offer to replace the bridge for half of the full replacement fee.

Ms. A should pay the full replacement fee.

Now turn to page 32 to find the discussion about this ethical dilemma.

COMPLAINTS CORNER

Good Records... Poor Records The Difference is in the Details

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

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

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COMPLAINT SUMMARY

A patient complained that the dentist did not give him a pre-treatment estimate, had provided treatment that resulted in ongoing pain, and charged him $4,000 above his dental insurance coverage when he had only agreed to pay up to $1,900 above his insurance coverage.

DENTIST'S PERSPECTIVE

In January 2009, the dentist completed the endodontic therapy and then performed a complete examination and prepared a treatment plan. The goals were to remove all hopeless teeth that could be potential sources of acute pain and infection and to rehabilitate his occlusion.

In March, a bridge retained with a post and core abutment was inserted in the lower right quadrant. The patient was instructed on its maintenance and shown how to use a floss threader. In addition, tooth 38, that had developed a dry socket, was treated.

It was the dentist's understanding that the patient wished to wait until the next 12 month period of insurance coverage before continuing with further major treatment. In the interim, he would only attend for hygiene and emergency treatment.

Later in the month, the patient came back for an emergency examination complaining of cold sensitivity in the anterior mandible. On examination, the dentist determined that the sources of pain were teeth 43 and 42. She informed the patient that the insulation provided by the natural tooth structure was abraded away by the unglazed opposing bridge, resulting in severe deterioration of the natural teeth. She recommended the fabrication of three crowns and provided a fee estimate. In addition, the treatment coordinator provided an estimate of about $2,000 for the three crowns and post and core procedures.

The dentist stated that patients are always provided with written estimates and pre-determinations are sent to insurance companies, when appropriate, in order to calculate the patient's financial obligation for treatment.

The dentist explained that the discrepancy the patient complained about was the 50 per cent unpaid balance from the initial bridge treatment plus the fees for the three additional crowns. The office had tried to contact him on numerous occasions to explain the outstanding balance but he could not be reached. In addition, messages were left with his wife for him to call but he did not do so.

As for ongoing pain, the patient had numerous areas of potential disease that still remained untreated.

REASONS FOR DECISION

In conducting its review, the panel looked to the member's clinical chart entries to assist in understanding the treatment provided. The panel was concerned about the adequacy of the dentist's recordkeeping as there was no documentation of previous dental history nor of discussions regarding treatment options and the risks and benefits of treatment, no comprehensive treatment plan, and no documentation of a follow-up with the complainant about his history of fibromyalgia and a head and neck injury.

In addition, there were no notations of the telephone calls that the dentist said occurred between herself and the complainant.

The dentist had failed to obtain and document the complainant's consent to treatment, including consent to the treatment fees prior to initiating treatment. There was no information documented to confirm that there was a discussion between the parties about the fees or the results of the pre-determination.

There was no pre-operative radiograph of tooth 38 to show the root configuration and the location of roots in relation to the inferior alveolar nerve prior to extraction.

In the panel's decision, the dentist had to complete a course in recordkeeping, including informed consent, plus a course in restorative dentistry, that included case work-up, diagnosis, treatment planning, and the options and risks of comprehensive fixed prosthetic treatment.

Following the member's successful completion of the courses, the panel ordered that the College monitor the dentist's practice for a period of two years to ensure that the knowledge gained in the courses has been applied to her practice.

In addition to the remedial training, the panel also decided to caution the dentist with respect to the care she provided in this case.

learning points

- Patient dental and medical records should be detailed in all respects and fully document the relevant clinical observations and findings. This documentation must be organized in a systematic and logical manner.
- It should be clear from the entries that any and all suggested treatment plans are well considered and consistent with clinical findings and the relevant diagnoses.
- Documentation should include notations that the patient has been given all this information as part of the informed consent process.
- Financial estimates and payment policies should be provided and clearly discussed prior to any treatment being commenced. This is not only a sound business principle, it is also a critical part of the informed consent discussion.

Microbial Biofilms in Osteomyelitis of the Jaw and Osteonecrosis of the Jaw Secondary to Bisphosphonate Therapy

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

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

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As previously reported by PEAK, articles began to appear in the medical and dental literature in 2003, describing a serious and previously unrecognized complication of cancer treatment: the exposure of necrotic maxillary and/or mandibular bone in patients receiving intravenous bisphosphonates (e.g. pamidronate – Aredia, zoledronate – Zometa). Subsequently, similar oral complications were described in patients taking oral bisphosphonates (e.g. alendronate – Fosamax).

Bisphosphonates comprise a class of drugs that act primarily by inhibiting osteoclastic activity, thereby reducing bone remodeling and turnover. These drugs are administered orally or intravenously, vary in potency, and are commonly prescribed for the treatment of osteoporosis (e.g. post-menopausal women), certain cancers that give rise to metastatic skeletal lesions and resorptive defects (e.g. breast, lung, prostate and multiple myeloma) and Paget's disease of bone.

With the May/June 2006 issue of Dispatch, PEAK provided members with a position paper from the American Academy of Oral Medicine entitled: Managing the Care of Patients with Bisphosphonate-Associated Osteonecrosis. The article emphasized that all existing treatment modalities had failed to yield consistent resolution and healing of bisphosphonate-related osteonecrosis of the jaw (BRONJ), and that prevention of this complication was of paramount importance.

Until recently, little had changed regarding our understanding of why BRONJ occurred and how to prevent or manage this complication.

On September 24, 2010, the College launched its webinar series with a 60-minute live presentation by Dr. Charles Shuler on "Oral Bisphosphonate Use and the Prevalence of Osteonecrosis of the Jaw." Dr. Shuler is the Dean of the Faculty of Dentistry at the University of British Columbia. This webinar is available online from the College's website at www.rcdso.org.

In the course of his presentation, Dr. Shuler presented the findings of several studies in which he and other researchers have demonstrated a link between microbial biofilm development and BRONJ. Most importantly, the findings of these studies indicate a potential target for clinical therapy by employing antibiofilm modalities in the prevention and management of BRONJ.

With the current issue of Dispatch, the PEAK insert is the published article of one of these studies: Microbial Biofilms in Osteomyelitis of the Jaw and Osteonecrosis of the Jaw Secondary to Bisphosphonate Therapy, from the October 2009 issue of the Journal of the American Dental Association. In addition to Dr. Shuler, the article represents the collective work of Dr. Parish Sedghizadeh, Dr. Satish K. S. Kumar, Ms. Amita Gorur, Dr. Christoph Schaudinn and Dr. William Costerton.

key points to consider

- Biofilm theory appears to explain the etiology of 65 to 80 per cent of infectious diseases that are treated in the developed world.
- Most cases of osteonecrosis secondary to bisphosphonate therapy occur in the jaws because oral bacteria have easy access to bone, especially after it is exposed following a dental procedure, such as an extraction.
- Microbial biofilms may play an important role in the pathogenesis of BRONJ.
- The prevention and management of BRONJ may depend on the effective use of antibiofilm modalities.

DAILY PROGRESS NOTES... *Details Make the Difference*

Professional, ethical and legal responsibilities require that detailed patient records documenting all aspects of each patient's dental care are maintained. A crucial component of a patient's record is the daily progress notes.

Progress notes describe the treatment rendered for a particular patient. However, in addition to a concise and complete description of all services rendered, the progress notes should also document all recommendations, instructions, advice given to the patient and any discussion with the patient regarding possible complications and/or outcomes.

In general, dental progress notes usually contain adequate information about treatment rendered. However, there is often little or no recorded detail of discussions with the patient regarding his/her treatment. Dentists often comment that it is too time consuming to document details of discussions with patients. Remember that short forms are acceptable provided the dentist is able to provide a "key" to the short forms.

This article presents some examples of good progress notes for a number of dental procedures and a description of the importance of each entry. To assist in the understanding of the chart entries, explanations of the short forms used in the examples are shown on this page.

C/C	Chief complaint
DNS	Did not show
EN	Endodontist
IC	Informed consent
LA	Local anaesthetic
MB	Mandibular block
MHNC	No change in medical history
MHU	Medical history unremarkable
N/A	Next appointment
NALM	No answer, left message to call
NIS	Not in service
NP	New patient
O/E	On examination
PD	Periodontal disease
PE	Periodontist
PT	Patient told
Q	Questions
R/C	Risks/possible complications
RD	Rubber dam
S/N	Short notice
WCU	Will call us

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

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CASE #1: ENDODONTIC FILE SEPARATES IN CANAL

During endodontic treatment, an endodontic file separated in a lower molar. From the progress notes, it was clear that the patient was adequately informed of the separated file and of the recommendations and possible consequences associated with it.

DAILY RECORD ENTRY

Aug. 16/10	1.8 ml Lido (1:100,000 epi) – MB; RD Cont'd RCT tx 46. Filed D to #30 @ 21mm. File sep in MB canal. Unable to bypass. PT file separated, unable to seal canal, should see EN for file removal and finish RCT. PT if EN can't remove file, might need surgery. Pt agreed. Refer to Dr. GP – appt. made for Sep 8, 3pm.

Record entry clearly shows the patient was informed that:

- A file had separated in a canal.
- The endodontic treatment could not be completed.
- Referral to an endodontist was necessary for the removal of the file.
- Additional treatment might also be required.

CASE #2: CONSULTATION FOR WISDOM TEETH EXTRACTION

Below are the details of a consultation appointment where extraction of teeth 18 and 48 is contemplated. The progress notes clearly show that informed consent for the extractions was obtained.

DAILY RECORD ENTRY

June 16/10	MHNC; C/C: pain O/E: 48 partially erupted, pericor. PA – impacted, tipped M against 47. Roots not close to mand. canal. Recom exo 48, 18. Disc'd optn: leave as is but 48 will not erupt due to position. Symptoms will persist, inf'n may develop. If leave 18, will likely overerupt. Disc'd procedure, R/C, as per 8's IC form, provided cost est. No Q. IC obtained. N/A: 4u – exo 48, 18 LA

Record entry clearly shows that:

- The extraction of 48 was necessary.
- The patient was warned of risks and possible complications of surgery.
- Options were discussed, consequences of no treatment were discussed and a consent form was provided.
- The treatment procedure was discussed.
- Costs were discussed.
- Informed consent was obtained.

DAILY PROGRESS NOTES...
Details Make the Difference

CASE #3: NON-COMPLIANT PATIENT WITH PERIODONTAL DISEASE

This is an example of a non-compliant periodontal patient. The progress notes, over an 18 month period, clearly show that the dentist informed the claimant of his poor oral health, warned him of the consequences of periodontal neglect, and tried to convince the patient to schedule appointments for treatment and to see a periodontist for evaluation.

DAILY RECORD ENTRIES

Feb 3/09	MHNC; Perio exam: Mild-mod bone loss in BWs, deep pockets esp post. OH poor. OHI. Discussed PD. PT needs referral to PE. "Will think about it." N/A 4u scale
Feb 24/09	S/N cancel'n. WCU to rebook.
March 25/09	Called pt. Busy at work right now. WCU when not so busy.
Sept. 24/09	MHNC; C/C "want check-up." Reminded did not come back for cleaning. Ging. puffy, red, deep pockets in post. PT must come back ASAP for cleaning and needs to see PE. Expln'd if PD not brought under control bone loss will likely con't. and teeth could be lost! Promises to book hyg appt. today.
Oct. 27/09	No show for hyg. appt. Called – NALM.
April 30/10	Pt. presents on emerg. C/C pain 46. PA.-bone loss to furc'n. Told pt MUST see PE. Pt agreed. Refer to Dr. S for complete eval.
June 4/10	Dr. S office called. Pt. DNS. Called pt. Forgot. WCU to rebook.
Aug. 15/10	TCF Dr. S. Pt. did not rebook appt. Called pt. Home #NIS Called work, no longer works there-moved to BC.

Record entries show that:

- Complete periodontal charting was done.
- The patient was advised of periodontal condition.
- The patient was referred to a periodontist.
- The patient was told of consequences of failure to treat periodontal condition.
- Patient was non-compliant.

Claims often arise when a patient, who has been non-compliant and who has periodontal disease, becomes the patient of a new dentist. When the second dentist advises the patient of his or her poor periodontal condition, the patient looks for someone to blame. Detailed progress notes demonstrate that the patient was aware of his/her condition and is responsible for the periodontal deterioration that occurred over time.

Deep Restoration

DAILY RECORD ENTRIES

Oct. 12/09	NP emerg. MHU. C/C pain to sweet, cold LL (points to 34-35 area). PA-deep recurrent decay 35D, no PA path. PT decay very close to nerve, may need RCT. If RCT, post/core/crown also nec. If no RCT other option is exo. PT RCT not always successful, may need add'l tx and/or surg. Pt understands, wants RCT if nec. Discussed costs of all. 1.8 ml lido (1:100,000epi) MB; RD, Deep DOV decay but no exposure. "X" liner and "Y" comp. PT decay very deep, RCT may still be req. Call if symptoms.
Nov. 2/09	Emerg. C/C spont. pain 35, up all night last night. O/E 35 P+++, C+++. Dx: irrev. pulpitis PT needs RCT as disc. last appt. PT can start today. 1.8 ml lido (1:100,000 epi) MB; RD, pulpectomy. File to #20K @22m. 1PA NAOCl, dried. Closed with cotton, cavit. N/A 3-u complete RCT 35

Record entries show that:

- The initial treatment was required.
- The patient was told decay was deep and RCT might be required.
- The tooth subsequently became symptomatic and RCT was necessary.
- The option of extraction was discussed.
- The patient was told post/core/crown would be required following RCT.
- The patient accepted revised treatment plan.

IN CONCLUSION

Courts usually take the view that if there is nothing in the chart to support a dentist's contention that a certain action took place, e.g. patient informed of certain risks, then that action is deemed not to have taken place.

For this reason alone, it is vitally important that all interaction with patients – discussion, information provided, advice/instructions given, treatment recommended or performed, etc. – be clearly set out in the progress notes and that all entries be dated and attributable to the treating practitioner.

The examples given in this article demonstrate that it is relatively easy to record detailed, accurate and timely progress notes that will serve you in good stead if or when a complaint is lodged or a lawsuit commenced.

QUESTIONS ABOUT A PARTICULAR SITUATION?

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

PLP Claims Examiners
416-934-5600
1-877-817-3757

Practice Advisory Service
416-934-5614
1-800-565-4591

Ethical Dilemma Discussion

The Ethical Dilemma Case Study appears on page 23.

"Will You Stand Behind Your Work?"

THE ETHICS OF MAKING THINGS RIGHT

Are dentists obliged to redo treatment that fails at no charge?
What do our professional codes say about this?
Should dentists guarantee their work and, if so, for how long?

To help answer these questions, let's look at this case study from three different perspectives.

Appropriate Function/ Technical Considerations

One of the predicaments dentists face is satisfying both the functional and esthetic demands of the patient. Some patients have extremely high esthetic expectations without an appreciation for the limitation of the materials and technique.

Whether the failure of the bridge was related to a dental technology error, poor choice of material or just an unfortunate accident, both the dentist and the dental laboratory technician are restricted by the clinical parameters of the patient and the physical requirements/limitations of the dental materials and techniques.

This case highlights the importance of communication and teamwork between the dentist and dental technologist as they both strive to accomplish the rehabilitation of form, function, and aesthetics in complex clinical situations.

Guarantee or Informed Consent

It is unwise for dentists to guarantee treatment. Instead, a wise course of action is to involve patients in treatment decisions as part of the informed consent process.

Guarantees infer that dentists provide a product or commodity, as in a commercial business, rather than a valued professional service. The dental educator Dr. David A. Nash, who is the William R. Willard Professor of Dental Education at the University of Kentucky College of Dentistry, where he served as dean from 1987 to 1997, in a 1994 article describes the difference between the business focus of "selling cures" and the professional culture of "curing" in an article in the Journal of Dental Education.

In medicine, making claims that a health professional can "guarantee" a successful treatment does not acknowledge the inseparable role of the patient's attitude and aptitude in the successful maintenance of his or her own health.

Education may help to explain why dentists often focus on the procedures rather than the person. Traditionally, the clinical training of dentists is technically-oriented, with success or failure measured more by the fit of the margin in microns and the completion of required numbers of clinical procedures than restoration of health itself. If the crown doesn't fit, the dental student will redo the crown until it is acceptable.

If dentistry is perceived as simply the selling of services and procedures, rather than the restoration of oral health, we could move dentistry into a marketplace where guarantees and warranties are expected by the patient.

By contrast, informed consent establishes a professional relationship which acknowledges both the patient's awareness of his or her own goals or values and the dentist's expert knowledge of the risks and benefits of dental treatment. The dentist seeks to involve the patient in treatment decisions by making the patient aware of the risks and benefits of the recommended treatment, reasonable alternatives, and the risk of no treatment.

In Ms. A's case, we do not know if she insisted on porcelain occlusion over the dentist's objection, if she was informed that the risk of failure due to fracture was higher for porcelain over metal occlusion, or if she was informed about any replacement policy in the office before treatment was started.

These three factors define some of the risks of treatment and may have prevented Ms. A's angry response. As for the longevity of restorations, patients should be informed that there is no absolute.

Promise-Keeping/Fidelity

Two of the core values in the RCDSO Code of Ethics are compassion and fairness. Compassion is defined as "acting with sympathy and kindness to all patients in alleviating their concerns and pain" and fairness is defined as "treating all individuals, patients, colleagues and third parties in a just and equitable manner."

The moral obligation to keep promises is an important part of the dentist-patient relationship, just as it is in any other interpersonal relationship. Ms. A's question, "Do you stand behind your work?" focuses on whether the dentist is working in her best interest and questions the very trust that is essential for a healthy dentist-patient relationship. Patients trust their dentist to do the right thing and expect that their dentists would consider the patient's perspective.

CONCLUSION

Ms. A's dilemma asks us to consider our obligations to patients when treatment fails and to reflect on and acknowledge the reality that there is no absolute standard for longevity in our treatment. Preparing the patient for this possibility includes educating the patient about these risks as part of the informed consent process.

Finally, it is important to also consider Ms. A's loyalty to the practice over the past 10 years as a factor in replacing the prosthesis at a reduced rate or at no cost. This kind of consideration would be evidence that the dentist was "caring and fair" in dealing with her problem.

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Letter of Apology

In an article published in the July 2010 edition of the Thornhill Post, several statements and references were made that might be regarded as suggestive of uniqueness or superiority over other dental practices or dentists, contrary to existing regulations.

I recognize that some of the contents of the article violated our regulations.

I apologize to the profession and to the public for any misleading information provided. It was not my intention to denigrate our professional image in the eyes of the public, nor to imply superiority of my clinical skills over any of my colleagues.

I will ensure that this will not reoccur and will have my promotional material reviewed by the College prior to their publication and distribution.

Sincerely,

Dr. Jose Olavo Queiroz

CALENDAR OF EVENTS

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

Mark Your Calendar…

2011 Council Meetings

January 20 • May 5 • November 17

Sutton Place Hotel
955 Bay Street, Toronto

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

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New login instructions for drug interaction information on College website

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DISCLAIMER

Access to the online services provided by The Medical Letter, Inc. is provided by the College as a service to its members. The College is neither involved in the preparation of the materials contained at The Medical Letter, Inc. site, nor does the College verify the accuracy or completeness of the information contained therein. Users of The Medical Letter, Inc. site agree not to hold the College responsible for any consequences occasioned to them as a result of their use of the site, or as a result of their reliance upon the information contained therein.

Almost seven years of operation have seen the Adverse Drug Interactions program on the College's website help countless patients and dentists. The online service is available at no charge to all College members. Look for the special icon on the top right-hand corner of our website at www.rcdso.org.

It is important to note that the login instructions to use this service have been changed slightly by the service provider. It remains extremely easy and quick to use, but please note the new instructions about how to log on. The username and password for all RCDSO members remain exactly the same as before.

The drug interaction service allows you to list each of the drugs your patient is taking and immediately view the possible interactions on the screen. The online search will handle interactions from two up to 12 drugs.

In addition, you can view reference citations pertinent to the interaction. There is also an index of over 3,000 brand names with generic equivalents. The program is updated every six months to keep it current.

The Adverse Drug Interactions program is an online version of The Medical Letter on Drugs and Therapeutics, a peer-reviewed non-profit publication. It is independent of the pharmaceutical industry and accepts no advertising, grants or donations.

ON THE WEB
www.rcdso.org

New Login Instructions for the Adverse Drug Interaction Program

1. Go to the home page of the College's website at www.rcdso.org.

2. Click on the special heading – ADVERSE DRUG INTERACTIONS – on the right hand side of the home page. This takes you to a special disclaimer message. Please read the message. Then, click on the ACCEPT button.

3. Now you are on the website of the Medical Letter. Close the pop-up window that scrolls across the home page by clicking the "X" in the top-right corner.

4. Scroll to the top-right corner of the Medical Letter homepage, locate the "Login" button and click on it.

5. You will be asked for an EMAIL and a PASSWORD. Please enter your USERNAME in the email field. All RCDSO members have the same username and password. If you do not remember the USERNAME and PASSWORD, please contact Joanne Loy for assistance at 416-961-6555, ext. 4703 or toll-free at 1-800-565-4591 or jloy@rcdso.org.

Advice About Treating Patients Who Are Not Ontario Residents

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It is not unusual for dentists to provide professional services for people who do not ordinarily reside within the province. Visitors, tourists and athletes may suffer from a dental condition that requires immediate treatment. Some patients, normally residents in the United States, may come to Canada for elective treatment, such as implants, because of the reputation of certain dentists or a favourable currency exchange rate.

As a general principle, your malpractice insurance covers you for professional services provided in Ontario while you were a member of the College. PLP coverage does not cover situations where you provide treatment outside the geographical boundaries of Ontario.

There are significant incentives for a US resident to commence action in his or her own jurisdiction, rather than instruct Ontario counsel to commence on action.

- It may be more convenient for a US resident who is dissatisfied with the dental services provided to bring a lawsuit in his or her own state rather than travel to Canada to instruct Canadian legal counsel to commence an action in this jurisdiction.
- Damage awards in the United States are usually much more generous.

If you are sued by a US resident in American courts for professional services provided in Ontario, you will still be afforded coverage under your policy in the absence of any other policy violations.

However, an action against a dentist in a United States court raises significant concerns that are not found in defending an action in Ontario courts.

- Your policy limit is $2 million, subject to additional elective excess coverage for up to a total of $10 million, while damage awards in the United States are much higher than awards here in Ontario.
- Your policy limit is expressed in Canadian dollars, so your coverage might be reduced by the exchange rate.
- Damage awards in the United States more frequently include punitive and exemplary damages for which no coverage is afforded under the policy.
- You will need to attend for depositions and for trial in whatever jurisdiction the plaintiff has chosen and that means you will incur loss of income, travel costs and increased time away from your practice.

If an action is commenced against an Ontario dentist in the United States, PLP would most likely protest the jurisdiction of the American court over the subject matter of the litigation.

It is traditional to use the expression "conflict of laws" or "private international law" to describe the body of principles and rules applicable to transnational cases involving private relationships containing legally relevant foreign elements.

The questions that arise in conflict of law disputes are: Does the court have the jurisdiction to hear the dispute? If yes, what system of law should apply?

Although there are many facts that the court should consider when resolving conflict of law issues, the domicile of the plaintiff is an important one.

It is important to note that if the American resident was enticed to Canada for elective procedures through advertising in US media, there would be a greater likelihood that the US court will conclude that it should accept jurisdiction.

RISK MANAGEMENT ADVICE

You need to be aware that if you treat patients who reside outside of Ontario, there are certain risks. If you treat non-Ontario residents, you may want to incorporate the wording suggested below into your current consent form or patient agreement to assist in keeping any disputes in Ontario courts. This wording is a suggestion only and your own legal advisor can draft the actual wording to be used in your practice. Also, it is a good idea to personalize the document by inserting the actual name of the patient and the actual name of the dentist.

Although the consent should be signed in the normal course of events, you should have the patient initial beside both of the sections in this additional wording.

GOVERNING LAW

The patient agrees that the relationship between himself or herself and the dentist shall be governed and construed in accordance with the laws of the province of Ontario.

JURISDICTION

The patient acknowledges that the treatment/service is to be performed in the province of Ontario, and agrees that the courts of the province of Ontario shall have exclusive jurisdiction to adjudicate any complaint, demand, claim or cause of action, whether based on alleged breach of contract or alleged negligence arising out of the treatment.

The patient hereby agrees that he or she will commence any such legal proceedings in the province of Ontario and only in the province of Ontario and hereby submits to the jurisdiction of that province.

Patient Signature:

Patient Name (printed):

Date:

Place (name of town/city):

Witness Signature:

Witness Name (printed):

New position paper from the American Academy of Oral Medicine on the dental treatment of patients with joint replacements

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In February 2009, the American Academy of Orthopaedic Surgeons issued an information statement[1] in which it recommends that clinicians consider antibiotic prophylaxis for all patients with prosthetic joint replacement prior to any invasive procedures that may cause bacteraemia, including dental procedures, because of the potential adverse outcomes and cost of treating an infected joint replacement. This information statement is available on the website of the American Academy of Orthopaedic Surgeons at www.aaos.org.

In June 2010, the American Academy of Oral Medicine published a position paper, "The dental treatment of patients with joint replacements"[2] which is available on the website of the American Dental Association at www.ada.org.

Drs. James Little, Jed Jacobson, and Peter Lockhart reviewed the literature on this subject as it relates to the 2009 information statement from the American Academy of Orthopaedic Surgeons for the American Academy of Oral Medicine (AAOM). They state "given that the 2009 information statement is more an opinion than an official guideline, the AAOM believes that it should not replace the 2003 joint consensus statement prepared by the relevant organizations: [the American Dental Association, the American Academy of Orthopaedic Surgeons and the Infectious Diseases Society of America]."

The 2003 joint advisory statement from the American Dental Association and American Academy of Orthopaedic Surgeons[3] was

distributed to Ontario dentists as part the College's PEAK series as an insert with the January/February 2004 issue of Dispatch. Highlights of the 2003 joint advisory statement were first published in the October/November 2003 issue of Dispatch and are available on the College's website at www.rcdso.org.

The American Dental Association reports, in a news item that appeared in ADA News on April 5, 2010, that they are working with the American Academy of Orthopaedic Surgeons to develop evidence guidelines for prophylactic antibiotics for dental patients with total joint replacements, which they expect will be completed by 2011. The ADA states that the new guidelines "will undergo a rigorous evidence-based approach by the AAOS, ADA and others who participate in the work group put together by the AAOS Guidelines and Technology Oversight Committee."

The College will advise its members when further information becomes available about the work of the ADA and AAOS on the guidelines. In the meantime, members may consider following any of the recommendations set out in the American Academy of Oral Medicine's position paper. The authors suggest that a dentist could:

- Discuss the limited scientific evidence for the use of prophylactic antibiotics and their risks with the patient, and to let the patient make his or her own informed decision.
- Base his or her clinical decisions on the 2003 joint advisory statement from the American Dental Association and American Academy of Orthopaedic Surgeons.
- Discuss the issue with the patient's orthopaedic surgeon and suggest to the orthopaedic surgeon that they both follow the 2003 joint advisory statement until a new joint consensus statement/guideline is approved.

1 Available at www.aaos.org/about/papers/advistmt/1033.asp, accessed September 22, 2010

2 J Am Dent Assoc 2010;141(6);667-671

3 J Am Dent Assoc 2003;134(7);895-899

Important News About Excess Malpractice Coverage

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The PLP policy of insurance for 2010 and 2011 is available through the Member Resource Centre on the RCDSO website at www.rcdso.org. To view the document, simply log on and click on the Document Downloads heading. If you wish to have a hard copy of the policy, feel free to print one or contact PLP at 416-934-5600 or toll-free at 1-877-817-3757 or by e-mail at plp@rcdso.org and a copy will be sent to you.

1. No Change in Premium for 2011

The Professional Liability Program is pleased to report that ENCON Insurance Group Inc. has maintained the rates for excess malpractice coverage the same in 2011 as in the previous year.

These rates are as follows:

Basic Coverage	Excess Amount	Total Coverage	Premium
$2M	$1M	$3M	$70
$2M	$2M	$4M	$125
$2M	$3M	$5M	$173
$2M	$8M	$10M	$411

In addition to the $2M per occurrence coverage provided to all Ontario dentists, retired dentists, partnerships of dentists and health profession corporations that hold a certificate of authorization from the College as part of the annual RCDSO fees, excess coverage is available through the College's brokers, Marsh Canada Inc.

Whenever the terms and conditions of the PLP policy of insurance are being negotiated, the continued availability of excess coverage and the premium for it is part of the discussion.

Q: Should I consider purchasing excess malpractice coverage?

The basic $2M per occurrence coverage that has been in place for many years for Ontario dentists has served the Professional Liability Program and College members well. In the past 10 years, any and all claims that have been settled have been well within this amount. In other words, the excess coverage insurer has yet to payout any money with respect to any claim.

Q: Does that mean that I don't need to consider purchasing such protection?

No, not at all. Each practitioner needs to assess his or her own particular situation (general practitioner or specialist carrying out high-risk procedures or cosmetic services that may attract dissatisfied patients) and make an individual decision as to whether or not excess coverage would be in their personal best interests so that there will never be a time that his or her own assets would be at risk to a large claim settlement over and above the basic policy limits.

Q: I work in a large group specialty practice and many of my colleagues see the same patient for surgical, endodontic, periodontic and prosthodontic care during the course of following a complex treatment program and plan. Would extra coverage be required to protect my colleagues and me?

Not necessarily. If each of the specialists listed in your question provided discrete dental

services separate and apart from each other and all of the members were the subject of a lawsuit from a disgruntled or unsatisfied patient, each dentist would bring $2M to the table since any claim would be considered as a separate occurrence. Dentists practising in a group setting often mutually agree to purchase extra coverage to insulate themselves and the group should a serious unexpected or catastrophic matter arise that leads to a lawsuit being filed against one or more of them.

Q: If I decide to purchase excess coverage, how much is enough?

As stated earlier, PLP claims experience has shown that the basic $2M coverage has been sufficient. Even with a more litigious society and a growing number of aggressive lawyers who are able to bill on a contingency basis and the rising costs of repairative services, claims experience has not had an erosive effect on the available coverage. Having said that, every dentist has to determine what (if any) level of additional comfort they would like. Based on the rates above, the fact that an extra $8M coverage per occurrence can be obtained for less than $425.00 seems to make it fairly easy to arrive at the decision.

ON THE WEB www.rcdso.org

Click on the Professional Liability Program heading in the navigation bar on the left hand side of the College's home page at www.rcdso.org.

2. Post-Retirement Excess Coverage Packages

Many dentists who regularly purchased excess malpractice coverage while in practice want to extend this excess coverage into their retirement.

In the past, to do this retired dentists were required to make arrangements on a year-by-year basis to purchase excess coverage at the prevailing premium. For some, this was inconvenient and caused problems e.g. the dentist moved and did not provide a new address to Marsh Canada Inc. or forgot to renew the excess coverage.

Marsh Canada Inc. now offers convenient post-retirement excess coverage packages that have a substantial cost saving over the one year rate:

For those dentists who opt for a 3-year package, the premium is equivalent to two times the annual rate (3 years for the price of 2 years).

For those choosing a 5-year post-retirement coverage package, the rate is equivalent to three times the annual premium rate (5 years for the price of 3 years).

The year-by-year renewal of excess coverage is still available for dentists who want that option.

MORE INFORMATION

Contact Marsh Canada Inc. at 416-349-4387 or toll free at 1-888-711-8399.

Toute bonne chose a une fin

SUITE DE LA PAGE 4

Association et la Fédération canadienne des organismes de réglementation dentaire (FCORD) : Ce que nous avons accompli, nous l'avons fait en raison de l'incroyable travail de nombreuses personnes qui ont mis ensemble la main à la pâte dans une orientation commune.

Nous avons réalisé de grandes choses, notamment ce qui suit :

- le programme de bien-être pour les dentistes aux prises avec des problèmes de toxicomanie,
- notre nouvelle réglementation en matière d'assurance de la qualité,
- la mobilité de la main-d'œuvre pour les dentistes généralistes et spécialistes,
- la reconnaissance d'une nouvelle spécialité en anesthésie dentaire,
- les nouvelles lignes directrices sur la prévention de l'infection et la surveillance (Guidelines on Infection Prevention and Control (lignes directrices),
- les tournées provinciales avec nos collègues de l'ODA,
- le lancement de webinars,
- les premiers cours éducatifs en ligne,
- l'intendance financière saine,
- les excellents résultats d'examen du commissaire provincial à l'équité.

Croyez-moi, avec cette liste, je n'ai fait qu'effleurer la surface.

Ensemble, avec le concours de votre appui et de votre encouragement, nous continuons à atteindre succès après succès. Le travail que nous accomplissons est grandement admiré. Notre nom est reconnu par les gouvernements provincial et fédéral.

C'est parce que nous travaillons fort à établir et à entretenir des relations ouvertes et de collaboration. Nous croyons que la réglementation professionnelle consiste aussi bien à soutenir et à améliorer les normes professionnelles qu'à identifier et à aborder la négligence professionnelle.

Nous sommes vraiment engagés à continuer à tirer parti des principes de la protection du public et à améliorer sa confiance en nous en tant qu'organisme de réglementation.

Lorsque nous parlons d'ouverture, de transparence, d'accessibilité et d'équité, ce sont là bien plus que des mots. Nous avons intégré ces valeurs dans tout ce que nous accomplissons, tant à l'intérieur qu'à l'extérieur de notre organisation.

En fin de compte, ce sont les gens qui font fonctionner tout cela et le rendent si utile.

Au cours des quatre dernières années, j'ai apprécié les occasions que j'ai eues de rencontrer individuellement plusieurs d'entre vous d'un bout à l'autre de la province. Peu importe où je vais, je suis toujours frappé par la fierté que chacun d'entre vous manifestez envers cette grande profession, et par votre engagement à servir la profession et la collectivité où vous vivez. C'est ce même niveau d'engagement qui dessert si bien le Collège à la table du conseil et au sein des comités.

J'ai l'immense honneur d'avoir occupé le poste de président au cours des quatre dernières années. J'espère que j'ai pu bien vous servir. Je tiens à vous remercier de votre soutien continu et de votre appui. Cela m'a été fort précieux.

FROM THE REGISTRAR

Putting A Dent In The Universe

CONTINUED FROM PAGE 44

The College has already made "a dent in the universe" with our LifeLong Learning Program with its CD and online based educational packages and now our webinars. Our new and innovative Quality Assurance program to be rolled out next year will make a significant impact.

But we cannot rest in our drive to safeguard and improve the quality of patient care. As a regulator, that is our core business. It is what we are all about.

Co-operation and collaboration is key. Nowadays fewer and fewer problems can be solved by one individual or organization alone. The drive for change in health care and society are beyond the control or influence of any one organization. Nor can challenges be dealt with simply or reactively. Good solutions will require all of us to work in tandem.

Over the last decade or so, The Great Group here at the College has pursued a very ambitious agenda. But we have never forgotten that it is the quality of oral health care that really matters.

Dentists in Ontario make an immeasurable difference in people's lives every day. Your pride and commitment to your patients are the human bricks and mortar on which the oral health care system in Ontario is built. We want to continue to ensure that we do our part to take practical action to support your efforts.

FROM THE PRESIDENT

All good things must come to an end

CONTINUED FROM PAGE 4

Together, with your support and encouragement, we continue to achieve one success after another. The work we do is admired far and wide. Our name has currency with both provincial and federal governments.

That is because we work hard at creating and nurturing open and collaborative relationships. We believe that professional regulation is as much about sustaining and improving professional standards, as it is about identifying and addressing poor practice.

We are truly committed to continuing to build on the principles of public protection and to enhance the public's trust in us as a regulator.

When we talk about openness, transparency, accessibility and fairness, these are more than mere words. We have incorporated these values into everything we do inside and outside the organization.

The bottom line is that it is people that make it all work and make it all so worthwhile.

Over the past four years, I have treasured the opportunities I have had to meet personally with many of you from one end of the province to the other. Regardless of where I go, I am always struck at the pride each of you – general dentists and specialists alike – have in this great profession and your commitment to serve the profession and the community in which you live, work and play. It is this same level of commitment that serves our College so very well around the Council table and at committees.

It is my greatest honour and privilege to have served as your president over these past four years. I hope that I have served you well. Thank you for your ongoing support and encouragement. It has meant a lot to me.

IRWIN FEFERGRAD

Putting A Dent In The Universe

I recently read something that really stuck with me and I would like to share with you: There are groups and then there are Great Groups; Great Groups hope to put a dent in the universe. That is how I like to think of the College, as a Great Group. It is a place where everyone – Council, committees and staff – is doing their very best. That is definitely what we are going to need to deal with the technological and political complexities that confront us at an ever accelerating rate.

The challenges are many. Just a few examples include rising consumer expectations, rapidly changing advances in treatments, increasing demands by patients to have a greater degree of control and influence over their health, more and more government intervention into the regulatory world, and the ever shrinking world boundaries. They all have an impact on our core business of health care regulation.

The College is a place where everyone is doing their very best.

The Great Group here at the College made "a dent in the universe" when it played a leadership role in the national effort by dental regulators to address the issue of labour mobility. Now there is more work to be done as Canada finalizes a free trade agreement with the European Union (EU). The agreement will mean permit-to-permit recognition between Canada and all of the 27 EU member countries to allow the free movement of skilled workers. Obviously this is a situation that will have enormous implications for us here in Ontario, the province that welcomes over half of the new immigrants to Canada each year.

Another challenge facing us is how to continue to keep improving the quality of care delivered and increasing patient safety. It means getting better at teaching, better at giving patients more control over their care, better at measuring outcomes, better at regulation. We need to bring greater clarity to what high quality oral health care looks like. Often the knowledge and information needed to deliver excellent care can be hard to find. This is a national issue that crosses professional boundaries and will require active involvement of professional groups, educators, regulators and government.

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