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Little Current
Sudbury
Thunder Bay
Stevensville
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Academic Appointments

Dr. David Mock
Dr. Richard Bohay
University of Toronto
Western University
Sometimes there are things in life that are just worth fighting for. For me, one of those things is the College’s commitment to support our fellow dentists and their families struggling with addiction disease.

Almost a decade ago, the leadership of this College asked the tough questions: Were we doing the best we could to help our colleagues in distress? Were we doing our best to assist dentists in a progressive and compassionate manner that supported their recovery?

It was clear that we could do better. So back in 2005 the College started to deal with the challenges of answering those questions. We started small with a PEAK article inserted with Dispatch magazine on dentists’ use, misuse, abuse or dependence on mood-altering substances. Over the passing years, our commitment to this important issue has grown and grown.

In November 2008, Council unanimously passed a motion to authorize staff to take all necessary steps to move forward on the implementation of a wellness program.
One of our goals was to bring addiction disease out from behind closed doors. We learned that drug and alcohol addiction is a disease. There are effective treatments that can help people recover and go on to lead productive lives.

We kept the issue in the forefront of dentists across the province. In 2009 alone there were three major feature articles on addiction disease in Dispatch magazine, written by leading specialists in addiction medicine from Canada and the United States.

We tried to eliminate many of the barriers to appropriate treatment. That is why in the middle of 2010 the College announced the creation of a wellness support service for Ontario dentists in crisis with addiction issues.

The College signed a special agreement with three different treatment facilities to give Ontario dentists immediate access to evaluation and treatment. Each of these centres specializes in treating health professionals in crisis who are dealing with addiction diseases. The centres are The Farley Center in Williamsburg, Virginia; Talbott Recovery Campus in Atlanta, Georgia and Homewood Health Centre in Guelph, Ontario.

Then, in early 2011, the College brought on board Dr. Graeme Cunningham as a special wellness consultant to assist College members in dealing with addiction or substance abuse issues.

Dr. Cunningham is uniquely suited to this role. He had a key part in starting the Ontario Medical Association’s Physician Health Program. As a former president of the College of Physicians and Surgeons of Ontario, he understands the unique role of a regulator in balancing protection of the public and supporting an ill health care provider to get better. He is also the former Director of the Addiction Division at the Homewood Health Centre in Guelph.

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Une aide contre la toxicomanie spécialement conçue pour les dentistes est désormais offerte partout au Canada

Dans la vie, certaines causes valent la peine qu’on se batte pour elles. Pour moi, l’une d’elles est l’engagement du Collège à soutenir nos collègues dentistes et leur famille aux prises avec la maladie de la toxicomanie.

Il y a près d’une décennie, la direction de ce Collège s’est posé cette question difficile : faisons-nous tout ce que nous pouvons pour aider nos collègues en détresse? Faisons-nous de notre mieux pour venir en aide aux dentistes avec compassion et des méthodes modernes pour favoriser leur rétablissement?

Il était évident que nous pouvions faire mieux. C’est ainsi qu’en 2005 le Collège a entrepris de relever le défi de répondre à ces questions. Nous avons commencé à petite échelle en publiant dans la revue Dispatch un article du programme PEAK sur l’utilisation, le mauvais usage et l’abus des substances psychotropes et la dépendance de certains dentistes à ces substances. Au fil des ans, notre engagement envers ce problème capital n’a cessé de croître.

En novembre 2008, le conseil a adopté à l’unanimité une motion autorisant le personnel à prendre toutes les mesures nécessaires pour mettre en œuvre un programme de bien-être.

L’un de nos objectifs était d’étaler au grand jour la maladie qu’est la toxicomanie. Nous nous sommes rendu compte que la dépendance à l’alcool et aux drogues est une maladie et qu’il existe des traitements efficaces qui peuvent permettre de récupérer et de retrouver une vie productive.

Nous avons fait de cet enjeu une priorité pour tous les dentistes de la province. Pour la seule année 2009, la revue Dispatch a publié trois articles de fond sur la toxicomanie rédigés par des toxicologues réputés du Canada et des États-Unis.
When it comes to addiction in health care professionals – including dentists – it is often the very skills they have acquired that get in the way of recovery.

“They (health care professionals) are successful people, so when they are faced with an uncontrollable disease like addiction, it baffles them,” says Dr. Harry Vedelago, director of the addiction division at Homewood Health Centre.

Homewood, a mental health and addiction facility in Guelph, Ontario, treats approximately 100 health care workers each year, and has done so for the past 20 years. Having treated addicted health professionals for years, including a number of dentists, Dr. Vedelago is recognized for his expertise in this field, and has presented at an international conference on the topic.

According to Dr. Vedelago, health professionals believe that their success should have prepared them to avoid the risk of addiction, and prevented them from becoming mired in this insidious disease.

Add to this the fact that most health care professionals, while experts in their chosen disciplines, often lack an understanding of the disease because they receive little training in addiction.

This results in a punishing cycle of repeated attempts to control the addiction, followed by repeated failure to do so.

Paradoxically, health care professionals believe that if they work harder, put in longer hours, they can manage the disease. But this only serves to exacerbate the situation. They spiral into a circuitous process of overwork, relapse, and renewed effort to control their substance use.

When an addicted health care professional finally comes to treatment, these barriers must be addressed in order to achieve a successful recovery.

Dr. Vedelago says that health care professionals arrive at treatment feeling that they should have known better. They are immersed in shame, and they struggle with the concept that their addiction is indeed a disease.

They use the same approach to treatment that served them so well in their career. They are task-oriented, intellectual, and they see treatment as a continuing education course.

“They think that by learning a few rules they can get better,” says Dr. Vedelago. “But they miss an important step in the recovery process, and that is to shed the health
professional persona and understand that they are human beings like everybody else.

“When the health professional finally acknowledges and accepts their addiction as a disease, and that it strikes democratically – that is, it can affect anyone – then the health professional does well in recovery.”

In addition, the addicted health worker can begin to deal with the overwhelming sense of shame, which is a doubly significant issue to confront for these individuals.

“Their sense of shame is compounded because they believe that they have violated a public trust by succumbing to an addiction and putting their patients at risk,” says Dr. Vedelago. “They experience their addiction as a moral dilemma.”

Once they recognize the addiction as a disease, then they can address the shame, according to Dr. Vedelago. The patient begins to work through the process, recognizing that they are not personally defective, and that this violation of public trust was not done on purpose.

Still, this does not absolve the health care professional of personal responsibility for seeking help in the first place. The addicted person must seek the appropriate care and treatment.

“Once they recognize this, they start getting better,” says Dr. Vedelago.

Help is just a phone call away for any RCDSO member.

If you have an addiction and need treatment, call the number below and a Homewood representative will assist you.

Realizing you have an addiction and need help is the first step; making that call to Homewood can put you on track to coping with an addiction.

The number to call is: 1.866.478.4230
At the end of the one-day meeting, there was unanimous agreement to institutionalize this dental regulators conference as an annual event. A working group was struck to organize the 2014 meeting. Members include RCDSO President Dr. Peter Trainor and Registrar Irwin Fefergrad from Canada and representatives from Australia, Dubai, France, Ireland and New Zealand.

The inaugural meeting featured Harry Cayton, Chief Executive of the Professional Standards Authority, as the keynote guest speaker. Conference delegates came from around the world: Australia, Canada, Croatia, Dubai, France, Ireland, Malaysia, New Zealand, Poland, Singapore, and the United Kingdom.

For the first time, dental regulators from around the world came together to discuss critical issues of common concern at the 1st International Conference of Dental Regulators on Saturday, October 12 in Edinburgh, Scotland. Conference co-chairs were RCDSO President Dr. Peter Trainor and Marie Warner, Chief Executive of the New Zealand Dental Council. College Registrar Irwin Fefergrad acted as the conference organizer.
The conference addressed such pressing issues as labour mobility, international accreditation, development of standards and guidelines and the role of continuing education to ensure continued competency.

The dental regulators conference was followed the next day by the annual conference of The International Society for Quality in Health Care. ISQua is a non-profit, independent organization with members in over 70 countries. Annually it organizes the leading scientific international conference in health care quality and safety. This year ISQua’s conference hosted over 1,000 delegates. The scientific content had a record 1250 abstracts from 50 countries, over 250 speakers presenting and 370 posters on display.

RCDSO President Dr. Peter Trainor made a presentation on challenges and systems around mutual recognition and labour mobility.

RCDSO Registrar Irwin Fefergrad participated in a panel discussion called “Do we need all the regulators” looking at opportunities to promote safety and quality for patients more effectively by bringing together learning from institutional and professional regulation.
Proposed RHPA changes would impact our operations and members

Bill 117, the Enhancing Patient Care and Pharmacy Safety (Statute Law Amendment) Act, 2013 received first reading in the provincial legislature on October 10, 2013, and continued with second reading on October 22, 2013.

While largely focused on amendments to the Drug and Pharmacies Regulation Act that relate to the regulation of hospital pharmacies, Bill 117 also proposes several amendments to the Regulated Health Professions Act, 1991 that would impact the operations of all health colleges and their members.

The proposed amendments fall into four broad categories:

- appointing a College supervisor by the Minister of Health;
- mandatory reporting requirements for employers and others;
- confidentiality and information sharing rules for colleges;
- changes to the process for dealing with certain complaints against members.
Appointing a College Supervisor
The proposed amendments expand the ability of the Minister of Health to appoint a supervisor to take over the operations of a health college. Under the current legislation, in order for a supervisor to be appointed, the Minister must hold the opinion that the council of the health college failed to comply with a requirement the Minister previously issued to the college.

The proposed amendments remove this requirement and permit the Minister to appoint a supervisor where she considers it to be appropriate or necessary to do so.

To date, the Minister of Health has appointed a supervisor on one occasion, when in March 2012 she appointed a supervisor to take over the operations of the College of Denturists of Ontario and its Council.

Mandatory Reporting Requirements for Employers and Others
Under the current legislation, an employer or other person must file a report with the Registrar when she terminates the employment of or revokes, suspends, or imposes restrictions on the privileges of a member due to reasons of professional misconduct, incompetence or incapacity. The report must be filed within 30 days and set out the reasons for the termination or suspension.

This reporting requirement continues even if the member in question resigned or voluntarily relinquished his or her privileges before they could be terminated or suspended.

Bill 117 expands this reporting obligation such that an employer or other person must submit a report to the Registrar whenever a member resigns or voluntarily restricts his or her privileges or practice, and the employer or other person reasonably believes that these actions were related to the member’s professional misconduct, incompetence or incapacity.

For example, if a member’s associate resigns from practice and the member has a reasonable basis to believe that this resignation was due to a substance abuse issue, the member would be required to report that fact to the College.

This proposed requirement applies to any person who employs a member, who offers privileges to a member, or who associates with a member for the purpose of offering health services, whether in a partnership or otherwise.

In particular, this reporting requirement applies to all members in respect of their partners, associates, and employees who are also members of a regulated health profession.
Confidentiality and Information Sharing

The RHPA imposes a strict duty of confidentiality on all persons employed, retained or appointed by a College and on all members of a College Council and its committees.

This duty of confidentiality is balanced by various exceptions that permit a College to disclose information during the administration of the College’s duties. For example, while complaint and other investigations into a member’s professional conduct are normally confidential, the RHPA permits information regarding these investigations to be shared with the police and other regulatory bodies.

Bill 117 would grant the Minister of Health the authority to create regulations setting out additional circumstances in which a college can share information regarding a complaint against a member, or obtained during an investigation into a member’s possible professional misconduct, incompetence, or incapacity. This information could be shared with a public hospital that employs or grants privileges to that member, or with any other person or class of persons specified in the regulations.

Bill 117 does not set out the purposes for which this type of information could be disclosed or outline the limitations on such disclosure. The details and any limitations would be provided for in the regulations made by the Minister of Health, if any. Unless and until such regulations are passed by the Minister of Health, no changes to the rules regarding information sharing under the RHPA are in effect.

Changes to the Complaints Process

Bill 117 also proposes changes to the process for handling complaints filed with the College against members. The amendments would allow the Registrar to evaluate a complaint when filed and to make a preliminary determination as to whether it is reasonable to believe that the allegations in the complaint, even if established, could constitute professional misconduct, incompetence, or incapacity on the part of the member.

If the Registrar determines that it is not reasonable to believe that the allegations, even if proven, could constitute professional misconduct, incompetence, or incapacity, the Registrar must notify the parties within thirty (30) days and no investigation of the complaint would take place.

In other words, this process would permit the Registrar to perform a screening function with respect to complaints over which the College has no jurisdiction.

It is important to note that this process would apply in only very limited circumstances, as the Registrar must be satisfied that even if all the allegations in
the complaint were true, they could still not result in a negative finding against the member. As an example, a complaint made against a dentist for publicly supporting the fluoridation of municipal drinking water could be handled through this process, since such actions by a dentist could not be considered an act of professional misconduct.

Importantly, this process would not cover complaints about subjects within the College’s jurisdiction, even if such complaints are eventually proven to be without merit or frivolous. For example, a complaint made against a dentist regarding treatment he provided would not be caught by this process, as the College has jurisdiction over such conduct and the Registrar must assume that all the allegations have been established.

These complaints would be dealt with according to the normal procedures and would be reviewed by a panel of the Inquiries, Complaints, and Reports Committee (ICR Committee) following an investigation.

Even if the Registrar determines to exercise these proposed new powers, a complainant can request a review of the Registrar’s decision in writing within 30 days.

Any request would be reviewed by a panel of the ICR Committee, which would determine whether to confirm the Registrar’s decision or to direct that the complaint be investigated according to normal protocols. If the panel confirms the Registrar’s decision, there is no further appeal and the complaint is closed.

Although considerably limited, this new process would provide the College with greater flexibility to better handle complaints made against members that are clearly outside of its jurisdiction and that therefore could not reasonably be expected to result in a finding of professional misconduct, incompetence or incapacity.

Bill 117 will be returning to the legislature for continuation of second reading in the coming weeks. Until the Bill is passed and proclaimed into law, the current law remains in force.
Dental Firsts: A Visual History

To help members and the public understand the evolution of the College and the many achievements and milestones reached by the profession, we created an online microsite that takes visitors through a remarkable visual history of dental firsts.

From information on the first dental act adopted anywhere in the world to the launch of the quality assurance program, the site spans decades of Ontario dental history. An interactive slideshow reveals significant dental artifacts, including one of the first dental chairs, practice photos and unique advertisements.

The site also provides details on several important figures that helped take the profession from two small rooms at the corner of Church and Court Streets in Toronto to where it is today.

You can access the microsite by going to history.rcdso.org, or by visiting our website, www.rcdso.org. The site design is optimized for smartphones and tablets, so you can surf using any device.

Remember that we also have a microsite that provides information about College programs, including Quality Assurance and PLP. You can access this orienteering microsite by going to orienteering.rcdso.org.
Several dental firsts are explored throughout the microsite, including the first dental faculty, dental school, military clinic and first female practitioner.

http://history.rcdso.org/Home

This interactive slideshow takes you through significant dental artifacts, including one of the first dental chairs, practice photos and unique advertisements.

http://orienteering.rcdso.org/Home
Membership renewals online are the fast and easy way to go!

How do I get started?
Go to the College website at www.rcdso.org and click on the Member Resource Centre. Now enter the members-only section of the website by clicking on the Log In button. Fill in your ID number. This is the four or five digit registration number assigned to you by the College. If your ID number starts with 06, do not use those two digits.

Do you need to have my e-mail address on file for me to register online?
Yes, we do. Nearly 95% of the College membership has already shared their e-mail address with us. Once we have your e-mail address, you are automatically signed up to receive any news bulletins sent out by the College and can make changes to your basic address information anytime on your own, and access your e-Portfolio and the annual health human resources survey.

How do I formally give my e-mail address to the College?
Just send us an e-mail message with your name, your e-mail address and your College registration number. Within two business days of receiving your e-mail, your records will be updated. Then you can easily renew your membership online. Send that e-mail to registration@rcdso.org.
I had a password but I have forgotten it. Can I still renew online?
Yes you can. Go to the Member Resource Centre accessible right from the home page of the website at www.rcdso.org. Now enter the members only section by clicking Log In. Click on ‘Forgot Password.’ Fill in your ID number. Automatically a new temporary password is sent to the e-mail address you have on file with the College.

I used ‘Forgot Password’ but did not get a new temporary password back. What happened?
This happens from time-to-time. Usually it is because the speed of your internet service is too slow. Check your spam or junk mail folder too. As a last resort, e-mail us at registration@rcdso.org to ensure we have your e-mail address on file.

Are all the other documents that I need to fill in like the annual declaration for the quality assurance program and the conduct disclosure online too?
All these can quickly be completed online. In fact, you need to answer all these questions first before you can access the online payment portion of the renewal process. There are clear instructions to lead you through the process step-by-step.

Can I complete the Health Human Resources Survey online?
Yes, in fact, this year, the Health Human Resources Survey is available exclusively online.

I still haven’t received my renewal package from the College. What do I do?
The packages were mailed during the first week of November. However, even if you don’t receive your package by post, it is still your responsibility to pay your annual fee by the due date. The easiest solution is to renew online.

What happens if I mail in my renewal and it gets lost?
Any loss or delays due to problems like “lost in the mail” are not accepted as reasons for late payment. The easiest way around this scenario is to renew online or to send your completed renewal to the College by courier service.

What if I opt to fax in my renewal?
This is not the safest option. There is no guarantee that we have received it. At renewal time, our fax machine often gets overloaded. That is why it is your responsibility to maintain a fax confirmation slip to verify the date and time your paperwork was sent.

I have decided not to renew my licence. Do I have to do anything special?
You need to complete the resignation form. It is available online and in your mailed renewal package. It too must reach the College by the due date.

I need some help. What do I do?
Staff in the registration department are here to help you. However, it will be no surprise to learn that renewal time is very busy. Between mid-November and the beginning of January, staff process over 9,500 renewals. So we ask for your patience and understanding.
E-mail registration@rcdso.org or phone at 416-961-6555 or 1-800-565-4591.
Whether looking for information to share with patients or searching for the most up-to-date clinical information, several effective tools are readily available that make the internet a valuable resource. There are a wide variety of options to source online scientific literature, but you may find what you need by using one or more of these options.

Many databases contain information of interest to dentists. One is Medline, compiled by the U.S. National Library of Medicine. It is the largest and most widely available free health sciences and medicine database in North America. Another is the Cochrane Database of Systematic Reviews, which represents one of several databases in the Cochrane Library. The Cochrane Collaboration consists of a large group of volunteers, who review the effects of health care interventions and prepare the reviews. These and other databases are searchable in many different ways, including PubMed, Google Scholar and TRIP. These sites do not require institutional access and are freely available.
A PubMed search can also be done using the MeSH (Medical Subject Headings) feature. This is the Medline indexing system. It is available in a drop-down menu next to the search bar. It requires more steps, but it produces more specific and contextual results. It is analogous to looking up a term in the index of a textbook. Once your topic of interest is found, MeSH permits an even more detailed and selective search.

For those who wish to use more advanced search strategies, you can view the online PubMed tutorial, available on the PubMed website.

Also you can find information on how to do searches on the University of Toronto Dentistry library website. Select “Research Guides” and then choose “Evidence-based dental practice: searching the literature and writing a report.”

In addition, the UofT dentistry library staff are available to answer questions about search techniques and other available resources. The contact information is: http://dentistry.library.utoronto.ca or 416-979-4916, press 1 and then extension 4560.

Grey literature is a term used in library and information science. This category of information includes material not published commercially or not widely accessible. It may nonetheless be an important source of information for researchers. Examples of grey literature include conference proceedings, excerpts from textbooks, theses, association newsletters and information for patients, technical reports from government agencies or scientific research groups, working papers from research groups or committees, white papers, and preprints.

TRIP also provides images, videos and educational material.

Many of the resources produced will be the same as those provided by PubMed, but the search results will be more generalized and voluminous.
Acting as an expert: Another way of giving back

Many dentists generously offer their time, money, and clinical services as a way of giving back to their community and profession. However, perhaps because compensation is involved, they may not view acting as an expert in the same light.

This article describes the role of an expert in a dental-legal dispute and encourages members to consider providing expert assistance to patients and colleagues.

What does it mean to be an expert?
Experts play an important function in the legal process by helping the parties and the ultimate decision-maker understand issues in the dispute beyond a layperson’s knowledge. They must have special skills, education, and/or training to be accepted by the court as qualified to comment on a particular topic. Beyond that basic requirement, there are many qualities that make an expert witness more or less effective. The following are examples of what a good expert is not.

An expert should not be a hired gun
Litigants and lawyers should be wary of professional experts who abandon active practice in favour of writing opinions and appearing as witnesses at trials all over the country, continent, or abroad. Judges tend to view such hired guns with skepticism, especially if they always act for one side.
On-going engagement in the profession can be critical to the strength of an expert’s opinion. For example, in actions for dental malpractice, expert evidence is often required to determine whether the defendant met the standards of the profession and whether the treatment provided caused harm to the patient. Since the standard of care is evaluated by measuring the dentist’s actions against those of his peers, the best standards experts are not professional witnesses with little or no recent clinical experience, but rather competent, well-regarded colleagues who practise in the same or a similar environment as the defendant. And while it is not uncommon to look to other jurisdictions for expert input on causation, opinions from foreigners on standards of practice carry less weight than those of local practitioners.

An expert is not an advocate

Experts are expected to remain objective. Unfortunately, though, some experts feel a duty to help their clients by straying beyond their expertise or offering opinions that do not withstand close scrutiny. Ironically, this often prolongs proceedings rather than resolving them, resulting in increased cost, anxiety, and inconvenience to everyone involved, including the client.

Courts are becoming increasingly intolerant of such witnesses. In Ontario, judges are more and more willing to disallow or restrict expert testimony on the basis of inadequate qualifications, which can be devastating to the client’s case. An expert who exaggerates, is argumentative, or appears biased risks having her evidence rejected and causing irreparable damage to her professional reputation.

An expert is not the judge or jury

At the other end of the spectrum, some experts believe they are not bound by, and may even be morally or legally obliged to ignore, the instructions of the person retaining them. For example, an expert may exceed the scope of her mandate out of fear that omitting information from her report is misleading and could contribute to an injustice. It is not up to the expert to decide what the outcome of the case should be or what the judge or jury needs to know. The issues in litigation are framed by the parties, and some of the facts an expert may discover may not be relevant to the proceedings. It is neither unethical nor unprofessional for an expert to accede to a request to limit her review and written comments, though legal counsel will usually want to know if the expert’s opinion on extraneous matters would be unhelpful to the client’s position. The lawyer will determine whether the expert’s concerns make her vulnerable as a witness at trial.
Acting as an expert: Another way of giving back

An expert is not a treating practitioner

Similarly, in the course of reviewing a matter, an expert may come across something she feels should be disclosed to another party. A dental or medical expert for the defence might, for example, conclude that the patient/plaintiff is suffering from a previously undiagnosed condition requiring treatment. In such circumstances, the expert has no legal duty to advise the patient of her findings; she does, however, have obligations to her client, and she must be careful not to breach client confidentiality. An expert who believes she has uncovered something about which the other side should be made aware should therefore advise the instructing lawyer, who will decide what to do with the information. If the problem is potentially serious, the lawyer will likely convey the expert’s concerns to opposing counsel.

Giving Back

Patients and PLP sometimes have difficulty finding dentists to comment on a case. Some practitioners may feel they are not qualified to hold themselves out as experts or are uncomfortable reviewing another dentist’s care. Many say they are too busy, and others are likely put off by the relatively low hourly rates some patients and PLP can afford to pay. A lawyer approaching a clinician to request a dental-legal opinion has likely already done enough homework to determine that she has the right qualifications and qualities to comment on the matter. And although writing reports does not always come naturally, the instructing lawyer will outline the questions requiring the expert’s attention and provide guidance on approach and format. Importantly, dental experts perform a valuable public service. Since PLP only compensates those injured as a result of dental negligence, patients require expert input to advance their cases and PLP often needs expert commentary to determine if a matter should be settled or defended. Experts help ensure that worthy patients receive early, reasonable compensation for their injuries or provide support to colleagues who have done nothing wrong.

So the next time someone asks you to provide an expert opinion in a PLP matter, give it some serious thought.
Like most health professionals, dentists will inevitably have patients who are dissatisfied with their clinical care or treatment results. Such situations are usually stressful, and the dentist’s anxiety will be compounded if a patient’s complaints are accompanied or followed by a demand for compensation or a threat of legal action.

The following are important guidelines and strategies for dealing with unhappy or threatening patients.

**RISK MANAGEMENT DOS AND DON’TS**

**Remain calm and professional**

The manner in which a health care provider deals with an unhappy patient or an adverse event may play as much a part in what happens next as the incident itself. No matter how upset or difficult the patient may be, you must try to remain professional. Rather than engaging in an argument, hear the patient out. Allowing the patient a chance to vent may defuse the situation and enhance the prospects of having a productive discussion.

**Be empathetic**

Studies have shown that apologizing to a patient for a less than ideal treatment outcome does not increase the risk of litigation against the health professional, but failing to offer sympathy in such circumstances may. And since such an apology is not admissible in legal proceedings, there’s no reason not to say “I’m sorry.”
RISK MANAGEMENT

Dealing with unhappy patients and the threat of litigation

It may be in your and the patient’s best interests to refer the patient to a colleague for further or remedial treatment.

Notify PLP
You must contact PLP immediately if you become aware of circumstances relating to dental services provided by you that could give rise to a claim (a demand for compensation). Not only is timely reporting a requirement under the terms of your liability protection, but getting PLP involved early also increases the chances of resolving a dispute quickly and favourably. Failure to report a potential claim may impair PLP’s ability to assist you with that matter, so when in doubt, call. Never assume the problem will go away if you just ignore it.

Keep notes about legal matters separate from the clinical record
Information about legal proceedings threatened or commenced by a patient and any conversations you may have with PLP staff do not form part of the patient’s chart and should be recorded in a separate, confidential document.

Maintain confidentiality
In order to protect yourself and the patient’s privacy, only discuss specifics of a reportable patient situation with PLP staff or the lawyer assigned to assist you. If you are having trouble coping and need to speak to a friend or confidante about the matter, be sure not to disclose the patient’s name or personal health information.

Consider referring the patient to another dentist
You should consider whether a request for compensation by a patient suggests a breakdown in the therapeutic relationship. Continuing to treat a dissatisfied patient or trying to fix your own mistakes is risky business, and it may be in your and the patient’s best interests to refer the patient to a colleague for further or remedial treatment. Obviously, except in an emergency, you should not treat a patient who has threatened or commenced proceedings against you or whose legal representative has contacted you regarding alleged deficiencies in your care.

Don’t alter records
It is dangerous for a health care provider to alter or add to a chart after a patient has expressed dissatisfaction with treatment. At best, any such changes will be seen as self-serving; at worst, they will be considered fraudulent. Either way, they seriously undermine that practitioner’s defence in a legal action. If you learn of a patient’s concerns and feel that the record is inaccurate or incomplete, any information a subsequent health practitioner would need to know may be recorded in the chart as a clearly identified late entry. Information that is irrelevant to the patient’s ongoing care, however, such as the content of a previous informed consent discussion, should not be added to the chart and should rather be noted in a separate document.

Don’t offer compensation or admit liability
Admitting liability or offering any sort of compensation to a patient, including a refund of fees or paying for the costs of retreatment, prior to contacting PLP could jeopardize your liability protection.

COLLEGE CONTACT
René Brewer – Director, Professional Liability Program
416-934-5609 1-877-817-3757 rbrewer@rcdso.org

If you learn of a patient’s concerns and feel that the record is inaccurate or incomplete, any information a subsequent health practitioner would need to know may be recorded in the chart as a clearly identified late entry.
Clarification of the advice on advertising of dental fees and services

The College’s Practice Advisory on Professional Advertising, last updated in November 2012, was created to help members comply with the professional misconduct regulations made under the provincial Dentistry Act.

The Advisory highlights advice on how to ensure compliance with the regulations. Part of that advice states: “incentive programs, including giveaways, contests, draws or free products or services” should not be included in any professional advertisement.

It is important to understand what is meant by the word “services.” It does not include dental services. In this context, it refers to marketing incentives of non-dental services.

When it comes to fees, the fees charged by dentists are not regulated by the College. You may reduce your fees or charge no fee for services you provide. However, it would be considered inappropriate to do that solely on the basis of whether or not the patient had dental insurance. If fees are advertised specifically, those fees must apply to all patients, regardless of insurance coverage.

In addition, a patient should not have to bring in a coupon or something similar to have the benefit of the lower fee.

This Advisory is posted in the RCDSO Library found in the Knowledge Centre on the College website at www.rcdso.org.

REMINDER ABOUT TESTIMONIALS

As outlined in the Practice Advisory on Professional Advertising, the College considers promotional materials that include testimonials a violation of the advertising regulation.

The recent Ontario Divisional Court Decision of Yazdanfar v. College of Physicians and Surgeons of Ontario found that the regulator’s prohibition of advertising that contains patient testimonials or superlatives is consistent with the Canadian Charter of Rights and Freedoms. Such advertising restrictions are necessary to ensure “a high degree of professionalism and the protection of the public from irresponsible and misleading advertising.” Testimonials, in particular, are of concern because “the public is left with an unbalanced and biased assessment, as only favourable descriptions are included in such testimonials. The public does not know the circumstances of the reliability of this information.”
In this scenario, dental laboratory services are provided exclusively for the patients of the office. The treating dentist oversees the dental laboratory operation and assumes responsibility for the quality of the finished products.

It is natural that questions arise about the supervision of an in-office dental laboratory like this by a dentist and about the operation of a commercial dental laboratory offering services to the professional community at large.

The College draws a clear distinction between an in-office dental laboratory and a commercial operation.

In Ontario, only a registered dental technologist or a dentist may supervise a commercial dental laboratory. It is the College’s position that any dentist who proposes to supervise a commercial dental laboratory must be able to fulfill the same role as the RDT.

WHAT THE LEGISLATION SAYS:
Section 32(1) (a) of the Regulated Health Professions Act, 1991 stipulates that no person shall design, construct, repair or alter a dental prosthetic, restorative or orthodontic device unless the technical aspects of the design, construction, repair or alteration are supervised by a member of the College of Dental Technologists of Ontario or the Royal College of Dental Surgeons of Ontario.
The College of Dental Technologists of Ontario has published standards about dental laboratory supervision for its members that stipulate that the supervising RDT must:

- Assume full responsibility and accountability at all times for the technical aspects of dental technology practice, as well as for the administration of the laboratory.
- Be responsible for overseeing the design, construction, repair and alteration of each dental prosthetic, restorative or orthodontic device that is processed in the laboratory.
- Ensure that no case can be released, other than on an interim basis, without his or her authorization.
- Only supervise a single laboratory on a given day and be available within the suite of offices housing the laboratory when prescriptions are processed.

Such authorization means that the supervisor has:

1. Examined all records supplied by the prescribing dentist and any other records, such as impressions, intraoral records, models, diagrams, and written and verbal instructions that are necessary to the design, fabrication, repair or alteration in question.
2. Certified that the records reviewed are adequate to design, construct, repair or alter the case.
3. Examined the case for conformity to the prescription.
4. Certified that the case was designed, constructed, repaired or altered in accordance with the CDTO’s standards.
5. Confirmed that the invoice accurately reflects the processes, materials and charges for the case.

RCDSO will use this same CDTO document to determine whether a member of this College has performed according to acceptable standards and is maintaining their responsibilities as a health-care professional.

The complete CDTO document is available online at www.cdto.ca under the label “Standards of Practice.”

In addition, all invoices, design consultations and any document authorizing the release of the case must clearly identify the supervising RDT or dentist.

If the invoice or document does not properly identify the supervising RDT or dentist, members should take precautionary measures to determine if a qualified practitioner was onsite during the design and/or fabrication of the dental appliance. If in doubt, members should call the CDTO at 416-438-5003 or toll-free at 1-877-391-2386 or get in touch with the College.

Dentists are reminded to look for the official verification stamp of the supervising RDT that signifies the case conforms to acceptable standards and the RDT accepts responsibility for its release. If a dentist supervises the commercial laboratory, then look for the signature or Ontario Dental Association verification stamp of the supervising dentist.

**LOOK FOR THE STAMP**

**NEED TO KNOW**

Dr. Lesia Waschuk – Practice Advisor
416-934-5614  1-800-565-4591
practiceadvisory@rcdso.org
Elaborate Health Canada safeguards protect against illegal or counterfeit dental materials

In the United States, the Food and Drug Administration is responsible for overseeing the safety and effectiveness of many of these products. This includes drugs and medical devices that are marketed in the United States, whether they are manufactured in domestic or foreign establishments. The FDA regulates the material used in the construction of crowns, bridges, and other devices commonly fabricated by dental laboratories.

Here in Canada, the Medical Devices Bureau of Health Canada has the same role as the US Food and Drug Administration. Health Canada has authority in medical device regulation through the Medical Devices Regulations of Canada’s Food and Drugs Act. Almost everything a dentist uses in daily practice is regulated under some aspect of the Medical Devices Regulations. This includes dental tools, such as dental instruments and equipment, and dental restorative and prosthodontic materials that are regulated as medical devices. Under the regulations, medical devices, including dental materials and devices, are classified in one of four classes of risk, with Class IV as the highest.

Periodically media stories, especially from the United States, report on findings of lead in dental prostheses produced in a dental laboratory.
For example, here are some of the devices or products that fall into these classes:

- Class II: hand instruments, dental units, orthodontic materials
- Class III: endosseous dental implants, dental restorative materials, dental sealants, dental casting alloys
- Class IV: bone void fillers containing human or animal tissue

The key point is that Health Canada regulates the manufacture, importation and sale of medical devices, but not the use of the products.

In nearly all cases, a manufacturer must apply for a Medical Device Licence for a device to be authorized for sale in Canada. For example, in the application process for a Class III device licence, the manufacturer provides Health Canada with a premarket review document. It includes appropriate objective documentation proving that the new material is effective and safe in accordance with Canadian medical devices regulations.

This pre-market review document contains background information about the product, including a description of the device, its chemical composition, physical and mechanical properties, the design philosophy and marketing history of the product, and reports of any adverse events or recalls associated with the sale of the device in any jurisdiction.

It also contains a summary of safety and effectiveness clinical and preclinical studies performed on the product, as well as any appropriate labelling information that includes warnings, precautions, any purposes and uses for which the device is manufactured, instructions for use, expiry date, etc.

Health Canada relies on independent auditors accredited by the Standards Council of Canada and trained by Health Canada to audit manufacturers’ quality systems to ensure that they comply with ISO 13485, an international consensus standard for medical device quality systems.

**REQUIREMENTS FOR DENTAL RESTORATIONS AND PROSTHESES MANUFACTURED IN AND OUTSIDE CANADA**

**Canadian Dental Laboratories**
- Fixed dental restorations or prostheses (crowns, bridges, inlays, onlays, veneers, and implant fixtures) are Class III medical devices and their importation or sale in Canada is subject to the Medical Devices Regulations.
- Fabricators of fixed dental restorations or prostheses must have a Class III device licence for the restorations or prostheses they fabricate, unless the fabrication of the device is conducted or supervised by a dental technologist who is a member of a self-regulating profession.
- Fabricators are required to use licensed materials in the fabrication of dental restorations and prostheses.

**Fixed Dental Restorations or Prostheses Fabricated Outside Canada**
- Manufacturers of fixed dental restorations or prostheses from outside Canada must have a Class III device licence for that restoration or prosthesis.
- The device is required to be fabricated of materials licensed under Canada’s Medical Devices Regulations.
- Dentists who import crowns and bridges directly from an offshore lab do not need an Establishment Licence, but the offshore laboratory or manufacturer that fabricated the fixed dental restorations or prostheses must have a Class III licence to fabricate crowns or bridges, etc.
Elaborate Health Canada Safeguards Protect Against Illegal or Counterfeit Dental Materials

DENTISTS NEED TO ENSURE DENTAL MATERIALS ARE SAFE AND EFFECTIVE

The bottom line for dentists is that medical devices that are not licensed for sale in Canada should not be purchased.

Health Canada strongly advises dentists not to enter into any contractual agreements with manufacturers to purchase medical devices until they have confirmed that the manufacturer has obtained a device licence. This is because some manufacturers have advertised devices for sale prior to obtaining a medical device licence.

How do you do that? Information on licensed devices is available online on the Health Canada website. Go to www.mdall.ca and you will find a searchable list of all licensed medical devices. There is also an archive of devices that were previously licensed for sale but no longer have a valid medical device licence.

Dentists who are contemplating the purchase of a Class II, III or IV device should use this list to verify that the manufacturer has a valid licence.

It is important to conduct this verification each time you are considering the purchase of a medical device, as these licences can be suspended by Health Canada, cancelled during the annual renewal of licences by Health Canada, or discontinued by the manufacturer.

Information on licensing requirements of the Medical Devices Regulations is available from:

Manager, Device Licensing Services Division
Medical Devices Bureau
Health Canada
phone: 1-613-957-7285
fax: 1-613-957-6345
e-mail: mdb_enquiries@hc-sc.gc.ca

Consumer and trade complaints may be submitted to Health Canada at:

Health Products and Food Branch Inspectorate
Ontario Operational Centre
phone: 416-973-1600
fax: 416-973-1954
e-mail: insp_onoc-coon@hc-sc.gc.ca

Health Canada depends on dentists and other health care professionals to report adverse incidents related to medical devices. Any serious or unexpected adverse incident related to medical devices should be reported to Health Canada.

Health Products and Food Branch Inspectorate
Health Canada
Address Locator: 2003D
Ottawa, Ontario K1A 0K9
HOTLINE: 1-800-267-9675

Dr. Lesia Waschuk – Practice Advisor
416-934-5614 1-800-565-4591
practiceadvisory@rcdso.org
Educational requirements for the use of botulinum toxin and dermal fillers by Ontario dentists

As reported in the last issue of Dispatch, Council has approved a new College position on the use of botulinum toxin and dermal fillers by Ontario dentists:

Members who wish to use botulinum toxin and dermal fillers may do so, but only for procedures that are within the scope of practice of dentistry.

Members may inject botulinum toxin and/or dermal fillers intra-orally for either therapeutic or cosmetic purposes, or botulinum toxin extra-orally for therapeutic purposes, but in either case only if they are appropriately trained and competent to perform the procedures.

It is not within the scope of practice of dentistry and members are not authorized in Ontario to inject botulinum toxin or dermal fillers extra-orally for cosmetic purposes.

Members who wish to use these substances as described are expected to successfully complete a course of instruction that adheres closely to the following criteria. The course should:

- include a didactic component with formal evaluation that addresses:
  - pharmacology of these substances;
  - physiological activity of these substances;
  - diagnosis of relevant conditions;
  - indications for the use of these substances, as well as other first-line treatment modalities;
  - contraindications for the use of these substances;
  - related head and neck anatomy;
  - adverse reactions and their management;
- include a hands-on clinical or clinical simulation component with formal evaluation;
- promote the critical evaluation of research and literature on related topics.

Due to the potential for serious and even life-threatening adverse reactions to this neurotoxin, members who wish to use botulinum toxin extra-orally for therapeutic purposes, such as for the management of certain temporomandibular disorders and other oral-facial conditions, and especially where this involves deep injections and/or injections below the inferior border of the mandible, are expected to pursue more extensive training.
New Guidelines on Educational Requirements and Professional Responsibilities for Implant Dentistry

WHAT YOU NEED TO KNOW.

The College first issued Guidelines on Educational Requirements and Professional Responsibilities for Implant Dentistry in June 1995. Since then, there have been considerable advancements in the knowledge and technology related to both surgical and prosthetic phases of implant dentistry. Dental implants are increasingly an important treatment option for dentists and their patients.

In May 2015, following circulation of a revised draft document to all members and other stakeholders to obtain their input, Council approved new Guidelines on this subject. The Guidelines were distributed to College members with the August/September issue of Dispatch and are posted at www.rcdso.org in the RCDSO Library found in the Knowledge Centre.
HERE ARE THE 10 THINGS YOU NEED TO KNOW ABOUT THE COLLEGE’S NEW GUIDELINES.

- Guide dentists in the use of “best practices” for providing implant dentistry.
- Broadly divide clinical cases into two levels of complexity: straightforward cases and complex cases. Using this framework, dentists are advised that the level of complexity of the cases they elect to undertake should reflect the commensurate level of training and courses they have successfully completed, and the competency and experience they have acquired.
- Describe initial education requirements that dentists must successfully complete in order to undertake straightforward cases. Of particular note is the increase in the minimum initial education requirements for dentists wishing to provide both phases (surgical and prosthetic) of dental implant treatment from four days to seventy hours of combined instruction.
- Describe additional education requirements that dentists must successfully complete in order to undertake complex cases.
- Describe ongoing educational requirements for dentists involved in implant dentistry in order to maintain their knowledge and clinical skills.
- Emphasize the necessity for careful patient evaluation and treatment planning, followed by meticulous execution of treatment steps, to achieve the desired outcome.
- Deal with each of the successive treatment steps in detail under separate headings.
- Provide guidance regarding the management of complications.
- Describe recordkeeping requirements.
- Include several checklists to help dentists assess their preparedness to undertake the different levels of complexity of clinical cases and improve their situational awareness.

DENTAL IMPLANTS HAVE BECOME AN INCREASINGLY IMPORTANT TREATMENT OPTION FOR DENTISTS AND THEIR PATIENTS.
The patient complained that he had a significant amount of dental work performed by his dentist, but that nearly all of the work had to be redone. Specifically, two bridges placed by the dentist, both less than five years old, had to be removed. In addition, the abutment teeth for the bridges were cracked and had to be extracted, and other teeth that the dentist had crowned also needed to be extracted because they became loose.

The dentist explained that when the patient first attended her office, he admitted that he had not visited a dentist for over three years. The patient, a heavy smoker, had poor oral hygiene, and was also suffering from bone loss and numerous areas of decay. The dentist explained that extensive treatment was required and the patient agreed. However, the patient explained that he was on a rather limited budget, and that he could not afford all of the required treatment. The dentist agreed to provide the treatment at a significant discount.

Allowing a patient to dictate treatment

Treating patients with financial limitations can present a number of challenges. The dentist shares her expertise and recommendations, while the patient expresses his desire for treatment within the patient's budget. The following case illustrates that it is not always possible to provide appropriate treatment within the boundaries set by the patient.
The dentist advised that the treatment consisted of:

- A crown on tooth 11: This crown was later fractured due to an accident and was repaired with a post, core and new crown at no charge.
- A crown on tooth 21: This crown later showed decay around the buccal margin and eventually fractured as well. The dentist again placed a post, core and a new crown at a greatly reduced cost to the patient.
- Treatment of tooth 12 in an effort to save the tooth: The tooth had a questionable prognosis. The patient had been referred to an oral and maxillofacial surgeon to discuss the option of an implant. The dentist said that she did what she could to save the tooth and advised the patient that the tooth would not last.
- A bridge spanning teeth 44-47
- A bridge spanning teeth 13-17

In evaluating the treatment provided, the Inquiries, Complaints and Reports Committee panel noted that:

- Although extensive treatment was provided, there were insufficient discussions about the risks, benefits, options and costs of the treatment.
- It was not clear that the dentist fully informed the patient of the condition and prognosis for his teeth.
- The tooth preparations for the bridge spanning teeth 44-47 were inadequate. In addition, both the 44 and the 47 were poor choices for abutment teeth. Tooth 44 was thin with overextended root canal treatment and insufficient fill, and tooth 47 was angulated.
- For the bridge spanning tooth 13-17, again both abutment teeth were poor choices. Tooth 13 was over prepared, while tooth 17 had been endodontically treated and had insufficient tooth structure left to be a suitable anchor for the bridge.

In light of its finding, the panel recommended that the dentist take a course in informed consent, as well as a comprehensive hands-on course in fixed prosthodontics. The prosthodontics course would include diagnosis, treatment planning, discussion of options and the restorability of teeth. The panel also advised the dentist that she should not allow a patient to dictate treatment, for financial reasons or otherwise, when in her professional judgement the treatment is likely to be unsuccessful.
In early October, College President Dr. Peter Trainor and College Registrar Irwin Fefergrad appeared before the Standing Committee on the Legislative Assembly to make the College’s presentation regarding Bill 70, An Act to amend the Regulated Health Professions Act (Spousal Exception), 2013.

RCDSO was in full support of this Bill and went on record that it was pleased that the proposed legislation gives each regulator the discretion to deal with this matter in a way that is appropriate for them.

In his presentation, Dr. Trainor emphasized that the College understands its role to protect the public and the Standing Committee and the public of Ontario should have full confidence in our ability to deal with sexual abuse matters with all integrity and vigour as intended in the original RHPA legislation.

He went on to assure the Standing Committee that spousal abuse is not a problem within the dental profession. As he explained, for decades, starting way before the decision of the Court of Appeal in 2009, thousands and thousands of dentists have treated their spouses. And they have done so safely and without any cause for concern, said Dr. Trainor. “Since 1993, at our College there has only been one complaint about a dentist treating a spouse – and that complaint was filed by someone other than the spouse,” stated Dr. Trainor.

In closing, he reiterated the College’s support for Bill 70 as proposed. However, he added one caveat. He asked that, once the Bill receives Royal Assent, the accompanying regulations get fast tracked.

On October 23, Bill 70 was carried on third reading in the Ontario Legislature.
On November 14, 2013, RCDSO Council passed, in principle, a regulation change that once passed into law would allow dentists to treat their spouses. As you know, the College has been actively involved in advocating to the Ministry to allow this exemption for spouses.

This proposed regulation change is now in circulation for a period of 60 days to members and stakeholders to allow an opportunity for feedback and comment. This is a requirement of the Regulated Health Professions Act. The consultation information is now posted on the College website.

Following the 60-day circulation period, Council will meet in a special session to consider all the submissions and, if warranted, give final approval to the regulation.

Once the regulation is approved by Council, it will be immediately delivered to the Minister of Health and Long-Term Care. She is then required to have the regulation sealed before being brought forward for approval by Cabinet. Only at that point, once the regulation is approved by Cabinet, will dentists be legally allowed to treat their spouses.

Typically this is not a fast process but the College will continue to urge government to expedite the approval of the regulation.

PLEASE SEND YOUR COMMENTS AND FEEDBACK ON THE PROPOSED REGULATION CHANGE TO:
Irwin Fefergrad, Registrar
Royal College of Dental Surgeons of Ontario
6 Crescent Road, Toronto, ON M4W 1T1
Email: ifefergrad@rcdsso.org.

ALL RESPONSES MUST BE RECEIVED BY THE COLLEGE ON OR BEFORE MONDAY, JANUARY 20, 2014.
Going to the dentist can be a highly stressful event for any patient. This anxiety can be further heightened in those suffering from a particular mental illness and be manifested by the unmasking of emotional or cognitive deficits.

It is also important to realize that, when a patient admits to having a mental illness, it not the same as admitting to any other serious health issue. That is because usually the admission incurs more suspicion than support from those around them.

Because of this stigma, many patients with mental illness may not willingly discuss their problem. Also, there may be hesitation because of self-denial or even the patient’s lack of information about their illness.
Problems may only manifest later as they encounter stress during treatment. Or patients may become more willing to be open as they become more comfortable, sensing empathy and genuine understanding from the dentist and all other members of the team.

To be effective, a patient/dentist interview must focus both on the content, the verbal dialogue, and on the process, non-verbal communication like behavioural clues.

A successful patient/dentist interview needs to acknowledge the potential severity of a particular psychiatric disorder as discovered in the initial history taking or medication review. This is particularly important as patients with chronic mental illness, especially dementia, may be poor historians.

As with any medical condition that appears poorly controlled or perhaps not yet diagnosed, like high blood pressure or the signs and symptoms of diabetes, we need to communicate to the patient our inability to proceed

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**AT THE CHAIRSIDE**

*Open-ended questions one might ask of your patient to enhance the understanding of a particular psychiatric diagnosis*

- When was your mental illness diagnosed?
- What are/were your original symptoms?
- What psychiatric medications are you taking?
- How long have you been taking the medication(s); changes in dosages?
- Who is the GP/psychiatrist treating this condition?
- Can you tell me about your previous dental experiences?
- Have you experienced any oral side effects to your prescribed medications, such as dry mouth, burning tongue, excessive saliva or swollen gums?

*Approaches to a successful consultation or referral*

- Incorporate any referral as one part of the patient’s evaluation for dental care.
- Ensure staff also supports both the referral and the patient.
- Treat the referral in a matter-of-fact fashion as with any outside specialty referral.
- Provide as much detail as possible to the family physician or psychiatrist in order to assist you in your provision of comprehensive dental care for your patient.

*Communicating with a patient who may be suffering from a psychiatric illness*

- Respect the patient and the reality that they might be living with.
- Be direct, straightforward and yet, maintain a strong sense of empathy.
- Maintain consistency, predictability and employ positive reinforcement in order that the patient knows what to expect.
- Exercise patience and flexibility at all times. Understand and appreciate the episodic nature of mental illness.
- Maintain both a non-judgemental attitude and heightened sensitivity to a patient’s potential sense of shame or embarrassment surrounding his/her current dental situation.
with safe dental care until further information can be obtained through the patient’s physician or psychiatrist to ensure that a suitable level of control or stability has been achieved. As always, any outside consultation is dependent on the explicit consent of the patient or substitute decision maker.

Unlike other medical problems, there are no specific blood tests or other diagnostic tools, such as a blood pressure monitor or x-ray assessment, that can be used to gain further information on the current status of the patient’s mental health problems.

In addition, the dentist must facilitate the patient’s understanding of their current dental needs in a way that the patient will understand. This might require a subsequent follow-up appointment to again review clinical findings and treatment options if the patient is unable to assimilate properly all of the information gathered during the initial appointment. Without such an understanding, the patient would be unable to offer true informed consent.

Of course, in instances of true cognitive impairment (e.g., dementia) it is important to have a caregiver or substitute decision-maker in attendance at the appointment.

The degree of control or stability of a particular psychiatric illness may vary continuously, depending largely on compliance with prescribed medications, as well as the patient’s potential vulnerability to outside stressors as a consequence of other social, emotional or medical circumstances. This would also include potential issues of ongoing substance abuse.

A key difference in treatment approach for patients with a mental illness is that long-term oral health goals may need to be reduced to a series of short-term goals.

The dental professional should strive to be aware and empathetic and understanding of the potential signs and symptoms of mental illness in order to begin to establish a trusting and viable rapport with the patient.

The provision of safe and effective dental care remains a key component in any quality of life improvement for those suffering from chronic mental illness.
Recently I completed the online test called the Practice Enhancement Tool sent from the RCDSO.
Having practised for over 40 years my initial reaction was defensive and I was somewhat intimidated. A whole month to complete 200 questions in an "open book" format seemed reasonable though. The process turned out to be fair, educational and actually fun.
Over the years I have chosen restorative, surgery and practice management over other fields in my continuing education courses. The PET soon demonstrated to me my shortcomings in pathology and especially in pharmacology. By investigating the answers I learned easily and I’ve decided to pursue more CE in those areas. Discovering educational resources was a big part of the process.
The test is well named and the principals involved in its development should be applauded by the membership. We are self-governed and this quality assurance vehicle is comfortable. The online help mechanism is terrific and the computer software is very user friendly. There is plenty of time to complete the questions and to review one’s answers. The final result feedback is immediate upon completion with a big congratulations.

Dr. Derek MJ Turner
Toronto

Just a note on PET. At first I thought this to be very degrading to my degree and ability to practise dentistry. Having done it I have changed my position.
It was actually fun, challenging and rewarding as it confirms what I thought. I knew that I did know this stuff.
Looking forward to the next one.

Dr. Robert Perkins
London
The dental profession holds a special place of trust within society. As a result, society extends opportunities and privileges to the profession that are not available to the public at large. In return, the profession makes a commitment that its members will adhere to high standards of clinical expertise and ethical conduct. The ethical behaviour of dentists is one of the most important factors in the promotion of quality dental care and recognition of dentists as professionals. Continued public trust in the dental profession and in the principle of profession-led self-regulation is dependent on the commitment of individual dentists to high standards of ethical conduct. Ethical behaviour is the foundation of the public’s continuing trust in the effectiveness of self-regulation.

PEAK (Practice Enhancement and Knowledge) is a College service for members. The goal is to regularly provide Ontario dentists with copies of key articles on a wide range of clinical and non-clinical topics from the dental literature around the world. It is important to note that PEAK articles may contain opinions, views or statements that are not necessarily endorsed by the College. However, PEAK is committed to providing quality material to enhance the knowledge and skills of member dentists.
To provide our members with a unique perspective on this issue, PEAK is pleased to offer the following article along with the current issue of Dispatch: “Dentists Versus Auto Mechanics – Are There Ethical Differences”, from the Summer 2013 issue of the Journal of the American College of Dentists. The article was written by Dr. Crystal Riley in 2008, while she was an undergraduate dental student at the Schulich School of Medicine and Dentistry, Western University.

The article compares and contrasts the ethical perspectives of dentists with another occupational group, auto mechanics, in relation to several issues, including:

- the primary concern of both groups
- billing procedures
- advertising
- emergency care
- the level of autonomy provided to patients/clients
- the amount of disclosure given to patients/clients
- the ability to judge the work of others
- the freedom to pursue romantic relationships with patients/clients.

In analyzing the differences between dentists and auto mechanics, the author determines that dentists have much greater ethical obligations to the public, which are captured in a Code of Ethics and enforced by a self-regulatory body through regulations. She concludes that it is the responsibility of all dentists to consider the effects of their actions on the individual patient, society, the dental profession and, finally, themselves.

The College’s Code of Ethics sets out principles of ethical conduct, which are based on the core ethical values of integrity, fairness, beneficence, compassion and respect for patient autonomy. The College’s Code of Ethics is available from our website at www.rcdso.org.
RCDSO President Dr. Peter Trainor has been appointed to the Ethics Committee on Clinical Research at the University of Waterloo for a three-year term. The appointment began on October 1.

It is very special that a dentist from the regulatory environment has been appointed to this important committee.

The University of Waterloo has two Research Ethics Boards: the Clinical Research Ethics Committee and the Human Research Ethics Committee. As constituted sub-committees of the University of Waterloo’s Senate Graduate and Research Council, both of these committees are established and empowered under the authority of the University of Waterloo Senate. The Clinical Research Ethics Committee (CREC) has jurisdiction over clinical trials research (i.e., involving a drug or natural health product or its medical device testing) conducted under the auspices of the University of Waterloo and any research involving a controlled act as defined under the Regulated Health Professionals Act of Ontario, 1991.

The university, located at the heart of Canada’s technology hub, has become one of Canada’s leading comprehensive universities with 34,000 full- and part-time students in undergraduate and graduate programs. It is home to the world’s largest post-secondary co-operative education program.

In 2012 Maclean’s magazine again recognized the University of Waterloo as the most innovative university in Canada.

Waterloo is consistently one of the top universities in the Reputation Survey of the Maclean’s annual rankings of Canadian universities. Waterloo is among the top three in Canada in the categories of Best Overall, Highest Quality and Leaders of Tomorrow. This is the 21st consecutive time that Waterloo has been ranked Canada’s top university for innovation.
Addiction help tailor-made for dentists now open to all of Canada

Continued from page 5

Dr. Cunningham continues to be available to address assessment and treatment needs of dentists by helping them to find suitable assessors, treatment providers, and residency programs. All calls to Dr. Cunningham are private and confidential. His phone number is a direct line to a dedicated phone used only for this purpose.

In November 2012, the College, as a member of the Canadian Dental Regulatory Authorities Federation, organized a two-day national conference here in Toronto on dealing with addiction in dentistry. This conference was jointly sponsored by CDRAF and the Canadian Dental Association.

The conference helped the leaders from the dental community across the country to learn more about addiction disease, explore the appropriate roles of professional associations and regulators, and discuss how to formally support dentists and their families.

Now, this year, we achieved another significant milestone. The College has entered into a special relationship with Homewood Health Centre. Homewood has set up the Dental Professional Addiction Program. This program is tailor-made for dental professionals to ensure those who are addicted have quick access to effective treatment.

With 130 years of experience in the field of addiction medicine, Homewood is a centre of excellence for addiction care in Canada.

In the last issue of Dispatch magazine, the College was pleased to distribute a brochure called “Overcome Your Addiction” jointly produced by us and Homewood.

The latest development is that our unstinting efforts to support Ontario dentists struggling with addictions is paying off now for dentists right across the country. Homewood Health Centre has agreed to accept dentists from other provinces and territories into its Dental Professional Addiction Program.

This is wonderful news for the profession.

My fervent personal wish is that the College will continue with its determined commitment to this issue. We need to do everything we reasonably can to create a culture in dentistry where no dentist is confronted by a prevailing sense of helplessness in the face of addiction.

With a recovery rate of around 90% for health care professionals in treatment, this is a cause worthy of our efforts. Dentists struggling with this disease are our friends, classmates and colleagues. They deserve the dignity of recovery.

RCD SO WELLNESS CONSULTANT

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

HOW TO REACH DR. CUNNINGHAM

Dedicated Direct Line: 647-867-6025
All calls are private and confidential.
Une aide contre la toxicomanie spécialement conçue pour les dentistes est désormais offerte partout au Canada

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Nous avons tenté d’aplanir plusieurs des obstacles à un traitement approprié. C’est pourquoi vers le milieu de 2010, le Collège a annoncé la création d’un service de bien-être en vue de soutenir les dentistes de l’Ontario aux prises avec des problèmes de toxicomanie.

Le Collège a signé avec trois centres de traitement une entente spéciale procurant aux dentistes de l’Ontario un accès immédiat à l’évaluation et au traitement. Chacun de ces centres se spécialise dans le traitement des professionnels de la santé en crise aux prises avec des troubles de toxicomanie. Ces centres sont le Farley Center de Williamsburg, en Virginie, le Talbott Recovery Campus d’Atlanta, en Géorgie, et le Homewood Health Centre de Guelph, en Ontario.

Dès le début de 2011, le Collège a eu recours aux services du Dr Graeme Cunningham à titre de consultant spécial en bien-être pour permettre aux membres du Collège de venir à bout de leurs problèmes de dépendance ou de toxicomanie.

Le Dr Cunningham est l’homme tout indiqué pour occuper cette fonction. Il a joué un rôle de premier plan dans la mise sur pied du programme sur la santé des médecins de l’Ontario Medical Association. À titre d’ancien président de l’Ordre des médecins et chirurgiens de l’Ontario, il comprend la tâche particulière d’un organisme de réglementation, à qui il revient d’assurer la protection du public tout en offrant à un fournisseur de soins de santé malade tout le soutien nécessaire à son rétablissement. Il a également dirigé le service de toxicomanie du Homewood Health Centre de Guelph.

Le Dr Cunningham demeure disponible pour prendre en mains le besoin d’évaluation et de traitement des dentistes en leur permettant de trouver les évaluateurs, les fournisseurs de traitement et les programmes résidentiels qu’il leur faut. Tous les appels au Dr Cunningham sont privés et confidentiels. Son numéro de téléphone correspond à une ligne directe utilisée uniquement à cette fin.

En novembre 2012, à titre de membre de la Fédération canadienne des organismes de réglementation dentaire (FCORD), le Collège a tenu ici même à Toronto un congrès national de deux jours sur la manière de combattre la toxicomanie en dentisterie. Ce congrès était commandité conjointement par la FCORD et l’Association dentaire canadienne.

Ce congrès a permis aux chefs de file canadiens de la dentisterie d’en apprendre davantage sur la toxicomanie, d’examiner le rôle approprié des associations professionnelles et des organismes de réglementation et de discuter des moyens officiels de venir en aide aux dentistes et à leur famille.

Nous avons atteint cette année un autre jalon important. Le Collège entretient désormais des relations privilégiées avec le Homewood Health Centre. Ce centre a mis sur pied à l’intention des professionnels de la dentisterie un programme de traitement de la toxicomanie. Ce programme bien structuré permet d’offrir rapidement accès à un traitement efficace à ceux qui manifestent une dépendance. Grâce à ses 130 années d’expérience dans le domaine de la toxicomanie, Homewood est un centre d’excellence pour ce genre de soins au Canada.

Dans le dernier numéro de la revue Dispatch, le Collège a eu le plaisir d’insérer une brochure intitulée « Overcome Your Addiction », élaborée conjointement par nous et Homewood. Nos efforts incessants pour appuyer les dentistes de l’Ontario aux prises avec une dépendance connaissent un nouveau rebondissement et portent désormais fruits pour les dentistes de tout le pays. Le Homewood Health Centre a résolu d’ouvrir aux dentistes des autres provinces et territoires son programme de traitement de la toxicomanie destiné aux professionnels de la dentisterie. Ce sont là d’excellentes nouvelles pour notre profession.

Je souhaite avec ferveur que le Collège poursuive avec détermination son engagement envers ce problème. Nous devons tout faire pour créer en dentisterie une culture dans laquelle aucun dentiste n’éprouve un sentiment d’impuissance face à la toxicomanie.

Avec un taux de succès d’environ 90 % chez les professionnels de la santé, ce traitement est digne de nos efforts. Les dentistes qui sont aux prises avec cette maladie sont nos amis, nos compagnons de classe et nos collègues. Ils méritent la dignité d’une entière guérison.
It is common practice now to involve representatives from other regulatory colleges and topic experts as members of working groups, looking at everything from serology status to the use of drugs in pain management. We have begun adding members of the public who have been involved in our process to our stakeholder distribution list for consultations.

This is good practice and progress. It means better and more informed decision-making.

More changes are now underway. At its November meeting, Council unanimously adopted a set of eight transparency principles. They can be found on our website under Who We Are/Mission and Values.

Several other major health care regulators, including medicine, nursing, pharmacy, optometry and physiotherapy, have adopted these same principles. In fact, we worked on their development together. It is all part of a major collaborative project as we reply to the question from government about how we might be more transparent in the regulatory work we do and make more information available to the public.

The purpose of these principles is to guide future decisions about making more information available to the public.

This is not a new challenge for this College. We were a leader in making reprimands open to the public. At its meeting last month, Council passed in principle a bylaw change that would allow posting information on our website when deficiencies are found during office inspections for facility permits for the use of dental anesthesia and for the operation of dental CT scanners. This is an area of significant impact on the safety of the public, as we now issue close to 1,500 facility permits.

The College understands that a commitment to transparency is yet another important way to fulfill our mission to work always in the interests of public safety and protection. In fact, transparency is one of our core values, along with trust, accountability, equality, accessibility, fairness and responsiveness.

We have made it very easy for members and the public to get information too. We have a vibrant and remarkable website where information is easy to access. As you will recall, our approach to making information public on our website garnered great praise during the external review by regulatory expert Harry Cayton of The Professional Standards Authority in London, England.

Of course, the overriding imperative is to strike a balance between openness and fairness to our members. For example, is it reasonable and responsible to make public the fact that a complaint has been laid? I believe it would be unacceptable to leave our members open to complaints filed for nefarious motives. Accusations that are unfounded and untested will damage a reputation and a career.

As we move forward, I am sure there will be many more challenges. But I don’t think we can go far astray if we are guided by the profound statement made by one of the former Supreme Court of Canada justices originally from Ontario, the Honourable Mr. Justice Peter Cory, when he said: “Everything that prevents light being shed only leads to darkness and suspicion.”
It is hard to believe but there was a time, and not too long ago in the annals of time in the last century, when what went on at the College was behind closed doors. Council meetings were not open to the public. In the complaints process and the discipline process, there was no disclosure of allegations, of evidence or of the results of our investigations. Discipline hearings were held in secret. Reprimands were done in secret. There was even a time when there were no public representatives sitting at the policy decision-making table of Council.

Those days are long gone now. The doors and windows are open. Disclosure is now full and complete – within the confines of what is legally permissible, of course. Hearings are open and the decisions published. Our website hosts the College Register containing information about dentists. Council meetings are open to the public. Minutes of Council meetings, once approved, are posted on our website.

All these changes are markers of how far our commendable commitment to transparency has travelled over the past few decades.

For some time now transparent policymaking has been the norm at the College. In fact, it is a requirement of our governing legislation, the Regulated Health Professions Act. The 60-day consultation period for bylaw and regulation changes involves an open process with the opportunity for input from our members and relevant stakeholder communities.

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