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What are the greatest threats to health in our society today? It is tobacco and alcohol abuse and chronic conditions like diabetes, cancer and heart diseases. No wonder that Ontario’s Chief Medical Officer of Health, Dr. Arlene King, is calling for a new conversation, a conversation about health, not health care.

As the year wound down, Dr. King released her annual report to the legislative assembly at the beginning of last December. Unfortunately it didn’t make it on the radar of big media in the province. It should have. We need this kind of public dialogue.

Dr. King states that good health starts in childhood, in our homes, our schools, our workplaces and our communities. It involves a multitude of factors, the vast majority of which do not relate to the health care delivery system. Recent research says that the health care system only accounts for 25 per cent of the population’s health outcomes.

Dr. King calls for a comprehensive plan that is geared towards health promotion and chronic disease and injury prevention. She recommends:

- Applying a health lens to every program and policy.
- Setting clear health goals and targets.
- Settling on a finite set of health indicators.
- Tearing down the impediments to collaboration between the municipal, health, education, social services and environment sectors.
- Greater collaboration among the public health, primary care and acute care sectors.
- Recognizing and rewarding the health achievements of both the health and non-health sectors.

That is a message dentists can certainly support. I am sure every dentist in the province would agree that we need more emphasis on preventing poor health.
That’s because dentists have been working on the frontlines of health prevention and promotion in our communities for years.

For example, dentists are already active around the province in supporting their patients with tobacco reduction programs. Thirteen thousand smokers in Ontario die every year – that is a death every 40 minutes. Most of these deaths are preventable. Dentists play an important role in changing these terrible statistics.

Dentists are also in an ideal position to sensitively and effectively support patients who are struggling with addictions. The College will be addressing this issue head-on over the coming year as the working group looking at implementation of the recommendations from our symposium on the management of pain in dental practice reports to Council.

It is well-established that periodontal disease poses risk of morbidity and significant societal costs. There is ever increasing evidence-based research that demonstrates the links between periodontal disease and systemic diseases, such as diabetes mellitus and cardiovascular disease, and the effects of periodontal disease in pregnant women on birth outcomes, such as preterm low birth weight infants. The College was in the forefront of shining a spotlight on this area for Ontario dentists with its one-day symposium, Oral Health: A Window to Systemic Disease in February 2005 and the subsequent educational PEAK articles distributed through Dispatch magazine.

Dr. King has called on the three levels of government, community leaders, the private sector and all Ontarians to actively engage in this conversation. This is a perfect opportunity for dentists, as leaders in our communities, to take an active role in this dialogue. I know that dentists will be brimming with fresh ideas and vision about how to work collaboratively to accomplish great things.

If you would like to read a copy of the 2010 annual report of the Chief Medical Officer of Health of Ontario to the Legislative Assembly of Ontario, please send an email to info@rcdsdso.org and we will send you a link to the report on the Ministry of Health website.

Changer notre discours pour parler davantage de santé que de soins de santé

Dans la société d’aujourd’hui, qu’est-ce qui menace le plus notre santé? Ce sont incontestablement le tabac et l’abus d’alcool, de même que des maladies chroniques telles le diabète, le cancer et les maladies coronariennes. Rien d’étonnant que la Dre Arlene King, médecin hygiéniste en chef de l’Ontario, nous recommande désormais de parler davantage de santé que de soins de santé.

Alors que l’année se terminait, la Dre King a déposé au début de décembre son rapport annuel devant l’Assemblée législative. Les grands médias de la province n’en ont pas fait leur une et c’est bien dommage, car un dialogue public de ce genre est une nécessité.

La Dre King affirme que de bonnes habitudes de santé doivent commencer dès l’enfance, à la maison, à l’école au travail et dans la collectivité. Elles regroupent une multitude de facteurs, dont la plupart n’ont rien à voir avec le système des soins de santé. De récents travaux de recherche affirment que les soins de santé ne peuvent améliorer que dans 25 pour cent des cas les problèmes de santé publique.

La Dre King recommande un programme exhaustif de promotion de la santé et de prévention des blessures et des maladies chroniques. Elle recommande en particulier :

- d’appliquer l’optique santé à tout programme et à toute politique.
- d’établir des objectifs clairs en matière de santé.
- d’élaborer un ensemble déterminé d’indicateurs de santé.
- d’aplanir les obstacles à la collaboration entre le secteurs municipal et ceux de la santé, de l’éducation, des services sociaux et de l’environnement.
- d’établir une collaboration accrue entre les secteurs de la santé publique, des soins primaires et des soins actifs.
- de reconnaître et de récompenser les réalisations en matière de santé des secteurs de la santé et de ceux autres que de la santé.

Suite à la page 42
Since the introduction of the Ministry of Health and Long-Term Care’s Narcotics Strategy on November 1, 2011, both the Ontario Dental Association and the College have received many calls from Ontario dentists either requesting clarification of some issues or asking dentistry-specific questions that may not have been addressed in Ministry publications and FAQs.

For this reason, the College and the ODA have collaborated on this article to address the concerns that our members have expressed, with the hope that it will help our members to have a better understanding of their new practice requirements.
What was the rationale for the Narcotics Strategy?

The Ontario Narcotics Strategy aims to make the prescribing and dispensing of narcotics and other controlled substance medications safer and more secure by:

- providing education and raising public awareness about the safe use of these drugs;
- educating the health care sector on appropriate prescribing and dispensing practices;
- monitoring the prescribing and dispensing of narcotics and controlled substances through a provincial narcotics monitoring system;
- providing options for treatment and support for those addicted to prescription narcotics and controlled substances.

What are monitored drugs and controlled substances?

The Narcotics Safety and Awareness Act, 2010 and its requirements apply to a list of prescription medications called monitored drugs. Monitored drugs are defined as any controlled substance under the federal Controlled Drugs and Substances Act, such as narcotic analgesics (e.g. Tylenol 3®, Oxycontin®).

Also included are non-narcotic controlled drugs such as methylphenidate (e.g. Ritalin®), benzodiazepines (e.g. Valium®), and barbiturates (e.g. phenobarbital) as well as other opioid medications not listed in the Controlled Drugs and Substances Act, such as tramadol-containing products (Ralivia®, Tramacet®, Apo-tramadol/acetaminophen®, Tridual®, Ultram®, Zytrin XL®) and tapentadol (Nucynta®).

A list of monitored drugs can be found at: www.health.gov.on.ca/en/pro/programs/drugs/ons/monitored_drugs.aspx

Controlled substances included in the list of monitored drugs are subject to change if the Controlled Drugs and Substances Act is modified.

A complete list of controlled substances under the Act can be found at: http://laws.justice.gc.ca/eng/C-38.8/index.html

In addition to the information that I have always included on all prescriptions that I have written for my patients in the past, what are the additional legislative requirements?

The new legislated requirements for prescriptions for monitored drugs are:

- The identification number of the patient and the type of identification used.
- The registration number on the certificate of registration issued to the prescriber by the College of which he or she is a member (prescriber ID).

What is the prescriber ID number for dentists?

Your prescriber ID number is your College registration number and it can be found on your annual renewal wallet card. This is the number that you use to submit dental insurance claims with the digits “06” preceding it, which designate that your dental practice is in Ontario. For prescriptions of monitored drugs the digits “06” are not required.

Won’t the public availability of my prescriber ID number compromise its use elsewhere, such as on the RCDSO Member Resource Centre and the members-only section of the ODA website?

Your College registration number is already available to the public through the public register on the RCDSO website and the Source Guide publication which is also available online. Access to member-only websites require passwords that are only known to you so unauthorized access will not be possible.
Can I preprint my prescriber ID number on the prescription pad that I use for all prescriptions that I write?

Your prescriber ID number is only required to be written by prescribers on prescriptions for monitored drugs and not for other drugs, such as antibiotics, anti-inflammatory drugs, and other analgesics. Nevertheless, it might be a good idea to preprint your ID number on your prescription pads to ensure that it is not omitted on those prescriptions that do require your prescriber ID number.

If you practise in a multi-practitioner office, a preprinted line under the signature space stating “Prescriber ID” would allow each practitioner to handwrite his or her own prescriber ID number on their prescriptions for monitored drugs.

Dentists should be aware that the prescriber’s registration number is required for dispensers to fill prescriptions for patients who are covered by the Ontario Drug Benefit program, and third party payers will want this information for adjudication of claims for prescriptions. Pharmacy software will usually require the prescriber registration number field to be completed by the dispenser.

What are acceptable forms of patient ID?

The legislation requires patients to provide identification to you whenever you prescribe a monitored drug. Approved forms of patient identification include:

- Ontario Health Card or other health card issued by a Province or Territory in Canada
- Valid Driver’s Licence or Temporary Driver’s Licence (issued by Ontario or other jurisdiction)
- Ontario Photo Card
- Birth Certificate from a Canadian province or territory
- Government-issued Employee Identification Card
- Ontario Outdoors Card
- BYID (age of majority card)
- Certificate of Indian Status
- Valid Passport – Canadian or other country
- Certificate of Canadian Citizenship
- Canadian Immigration Identification Card
- Permanent Resident Card
- Old Age Security (OAS) Identification Card
- Canadian Armed Forces Identification Card
- Royal Canadian Mounted Police/Provincial/ Municipal Police Identification
- Firearms Possession and Acquisition Licence (PAL)
- Official letter from Immigration Canada addressed to the patient (if the patient is a refugee who does not have any of the above-noted forms of identification)

Should we automatically be obtaining patient ID numbers for all of our patients?

While it is not mandatory that the patient ID number be obtained for all patients (it is only required for prescriptions for monitored drugs), from an administrative standpoint a dentist may choose to collect such information as part of a new patient record.

It is important, however, to confirm if the ID is still valid at the time of writing a prescription for a monitored substance.

One approach to collecting this information would be to include a line on the patient information form that states: “Since Ontario legislation requires that a patient ID number be included on prescriptions for certain drugs (i.e. narcotics), please provide a type of ID you wish to use (from the attached list) and the expiry date (if applicable) and your number.”

Do we need to keep the patient ID numbers in our patients’ clinical dental records?

Yes. This can be accomplished either by noting the details of the prescription, including patient ID used and its number, in the progress notes section of the patient record or by keeping a copy of the prescription itself.

Where do I note the patient ID number and form of ID on the prescription? Where should I note the prescriber ID number?

The patient ID number should be on the front of the prescription because pharmacies typically paste a sticker which is a hard copy of their electronic record of
prescriptions dispensed on the back of written prescriptions (and their notes of verbally received prescriptions/directions from prescribers). Also, it makes sense for it to appear with the patient’s personal information because dispensers (pharmacists) have to keep records of the patient’s identification number for prescriptions of monitored drugs.

Likewise for the dentist’s registration number, it makes sense for this to appear with the dentist’s practice (business contact) information or under the dentist’s signature.

**What if the patient presents without an approved form of ID or doesn’t have one?**

In situations where a patient is unable to present any of the approved forms of identification, an exemption is permitted if all of the following conditions are met:

- The prescribing dentist notes on the prescription the reason the patient needs to receive the monitored drug before he or she can obtain the appropriate identification from the approved list.
- The dispenser keeps a record of the above (i.e. the reason the patient needs to receive the monitored drug before he or she can obtain the appropriate identification from the approved list).
- The patient receives the monitored drugs directly from the dispenser (i.e. the patient cannot use a third-party to pick up the drug or does not use a mail or courier service to receive the monitored drug).

**How do the new requirements work for prescriptions for monitored drugs called in to the pharmacy?**

The requirements for patient ID and prescriber ID still apply for verbal prescription narcotics and controlled drugs, such as benzodiazepines, that can be prescribed by verbal direction. When a dentist is calling in a prescription for such drugs, these ID numbers should be provided to the dispenser (pharmacist) for his/her records. Because your patient’s clinical dental record will likely be your only record of the prescription that you have called in to the pharmacy, you should record the patient ID number and form of identification in your patient’s clinical dental record so that you can provide it to the dispenser (pharmacist).

**What information needs to be included in the records that I keep for such patients?**

Before prescribing any drugs, dentists should review the patient’s medical history and document the patient’s complaint and history of present condition. If the patient presents with, or reports, postoperative pain or an infection, the patient’s clinical dental record should include information about recent dental treatment provided and the name of the regular/treating dentist. If a prescription is required, the patient’s clinical dental record should include the name of the drug prescribed, strength, quantity and instructions for use, and, if the prescription is for a monitored drug, the patient ID number.

**How does this work for children for whom I am prescribing monitored drugs?**

Prescriptions for monitored drugs for children require the patient identification number. When the parents obtain the patient’s prescription from a dispenser (pharmacist) they may need to provide identification. If the parents have questions about what form of identification will be required, they should contact the pharmacist at the pharmacy where the monitored drug will be dispensed.
Q My practice provides anesthesia and sedation services and I order monitored drugs for that purpose from my local pharmacy and write “for office use” on the prescription. Is any form of ID (prescriber/patient) required?

No. A prescriber ID and patient ID are not required for monitored drugs administered in the office of a prescriber.

Q We sometimes provide patients with analgesics to administer at home for postoperative pain from an office supply. How do we document this?

Dentists are required to retain a log of narcotic and controlled drugs administered in the dental office from an office supply. This log should include the names of the patients to whom the drugs are administered and the quantities provided to them and the patients’ clinical records should include the drug, strength, quantity provided and the instructions for use.

When dispensing monitored drugs for home use by patients, dentists are also required to note the patient ID number and form of identification in the drug log, as well as in the progress notes section of the patient’s record.

COLLEGE WEBINARS ABOUT PAIN MANAGEMENT

There are two excellent webinars now available online as part of the College’s LifeLong Learning Program for members. The first is called “Acute Pain Control: Use of Opioids in Dentistry” presented by Dr. Daniel Haas, Faculty of Dentistry, University of Toronto.

The second is called “The Nature, Complexity and Mechanisms of Acute and Chronic Craniofacial Pain” presented by Dr. Barry Sessle, Faculty of Dentistry, University of Toronto.

You can register for archive access to these webinars from the College website at www.rcdso.org in the Member Resource Centre on the home page.

ONTARIO MINISTRY OF HEALTH AND LONG-TERM CARE

Information about Ontario’s Narcotics Strategy

Additional frequently asked questions for prescribers and dispensers

Information about the Narcotics Safety and Awareness Act, 2010 and its Regulation
Symposium on The Management of Pain in Dental Practice

In November 2010, 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. Called The Management of Pain in Dental Practice, the purpose of the symposium was to kick-start the dialogue on how:

- The dental community could best work with government to remedy the significant societal problems associated with opioid abuse.
- The College could support the profession in gaining a better understanding of pain management in the dental practice.

The recommendations that came out of the roundtable discussions at the symposium focused on the following five key areas that provide a broad and comprehensive framework for action by the regulator, dental educators and the dental community:

- education of undergraduate students
- continuous education of dentists in practice
- improvements in the education of patients
- use of technology to support patient care
- College support of interprofessional collaboration

Working Group for the Management of Pain in Dental Practice

As the next step, this working group has already begun work on how to address the recommendations that came out of the roundtable discussion groups at the November 2010 symposium.

The working group is chaired by Dr. David Mock, Dean of the Faculty of Dentistry and Dentist-in-Chief, Staff Pathologist and Associate Director of the Wasser Pain Management Centre at Mount Sinai Hospital in Toronto. The working group will be reporting back to Council in 2012.

Members of that working group are:

- Dr. David Clark, Chair, Quality Assurance Committee
- two public members from Council, including one public member from the Executive – Dr. Harpal Buttar and Catherine Kerr
- one dentist member from the Executive – Dr. Natalie Archer
- one dentist member from Council who is an oral and maxillofacial surgeon – Dr. David Segal
- Dr. David Mock, Dean of the Faculty of Dentistry at the University of Toronto
- Dr. Harinder Sandhu, Director of the Dental Department, Schulich School of Medicine and Dentistry at the University of Western Ontario
- a representative from the College of Physicians and Surgeons of Ontario
- a representative from the Ontario College of Pharmacists

We are out of the starting block now with the College’s Quality Assurance Program with the start of the CE cycle on December 15, 2011.

In many ways, it is business as usual. There is still the usual three-year cycle to collect the required 90 CE points. December 15 was the first day of the new three-year cycle.

You still need to keep all the documentation that demonstrates that you attended the CE activities. In fact, you need to retain all the information for each three-year cycle for five years from the date that the three-year cycle ends. So, for example, if your CE ends on December 15, 2014, you must keep your information until December 15, 2019.

The last three issues of Dispatch magazine in 2011 featured very detailed write-ups on the new program. You can also checkout the special section on our website at www.rcdso.org devoted to the Quality Assurance Program.
FOUR COMPONENTS OF QA PROGRAM

1. Practice Enhancement Tool Assessment
This is a computer-based self-assessment program, also known as PET, that allows members to evaluate and assess their practice, knowledge, skill and judgement based on peer-derived standards.

The online program is easily accessible right from the College’s website. It is easy to use and is designed to the same high standards as the educational packages in our LifeLong Learning program.

The College has been working closely with the National Dental Examining Board in the development of this tool to ensure its validity and integrity.

Each year a certain percentage of the membership will be selected at random to take this peer-derived assessment. This process starts in the spring of this year.

2. Practice Enhancement Consultant
There is now a dentist consultant on staff, Dr. Greg Anderson, to assist members all along the way. He can help out at any time in identifying appropriate continuing education or professional development activities. Once you get notification that you are being asked to take the self-assessment, Greg is available to answer your questions about the self-assessment. He is also there afterwards to assist you in coming up with a continuing education plan to address any weaknesses.

3. e-Portfolio
Later this year, every dentist will have secure access to his/her own individualized online e-Portfolio right from the College’s website. You will be able to track your own CE points and see in an instant how many points you need to collect in each category to meet the requirements for the three-year cycle. That means no more forms.

At the end of each three-year cycle, a certain percentage of the membership will be selected at random to have their e-Portfolio reviewed to ensure they are meeting their obligations under the Quality Assurance regulation.

4. Annual Declaration
Starting with the registration renewals in 2012, on a special section of the registration form, each year you will be entrusted to self-declare whether or not you are in compliance with the QA Program requirements.

WHO TO CALL IF YOU HAVE QUESTIONS

<table>
<thead>
<tr>
<th>CE Points/Courses Categories/Approved Sponsors</th>
<th>PET Assessment</th>
<th>The QA Program</th>
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<tbody>
<tr>
<td>Joanne Loy – QA and CE Assistant 416-961-6555, ext. 4703 1-800-565-4591 <a href="mailto:jjoy@rcdso.org">jjoy@rcdso.org</a></td>
<td>Dr. Greg Anderson – Practice Enhancement Consultant 416-934-5620 1-800-565-4591 <a href="mailto:ganderson@rcdso.org">ganderson@rcdso.org</a></td>
<td>Dr. Michael Gardner – Manager, Quality Assurance 416-934-5611 1-800-565-4591 <a href="mailto:mgardner@rcdso.org">mgardner@rcdso.org</a></td>
</tr>
</tbody>
</table>
What is the Practice Enhancement Tool?
The Practice Enhancement Tool is a computer-based self-assessment program that allows you to review your practice, knowledge, skill and judgement based on peer-derived standards. It is easily accessible from any computer with an internet connection.

The College has been working very closely with the National Dental Examining Board in the development of this tool to ensure its validity and integrity.

Why do I need to take this self-assessment?
Our governing legislation, the Regulated Health Professions Act, requires the College to have a QA Program that includes self, peer and practice assessment. The College wanted to build a program that would benefit both the profession and the public. That’s why we designed an easy-to-use self-assessment and worked in collaboration with the NDEB to ensure a positive and fruitful experience.

This self-assessment provides a vehicle to demonstrate your continued competency and knowledge without having to go through office visits and other traditional ways of assessing performance.

Who is required to take the self-assessment?
In accordance with our Quality Assurance Regulation, every member with a general or specialty certificate of registration is to complete a self-assessment once every five years.

Starting in late spring of this year, the College will begin the random selection of 150 members each month to complete their self-assessment. The random selection is taken from a computer-generated list of current members.

How are randomly-selected members notified?
You will be notified in writing 30 days in advance of your start date and provided with login instructions and a temporary password to access your online self-assessment. You will also receive a detailed user guide to help you navigate the assessment.

Once you reach the start date, you will have 30 days to complete your self-assessment.

How does the self-assessment work?
The assessment consists of 200 multiple choice and case study questions that are based on a foundation of knowledge that is required of all dentists. Initially, the questions will cover six different areas of practice, including:

- pharmacology
- oral medicine and pathology
- radiology
- diagnosis and management of caries
- diagnosis and management of endodontics
- diagnosis and management of periodontics

The self-assessment is essentially open-book. You can refer to

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- pharmacology
- oral medicine and pathology
- radiology
- diagnosis and management of caries
- diagnosis and management of endodontics
- diagnosis and management of periodontics

The self-assessment is essentially open-book. You can refer to
textbooks, journals and other resources to help you answer any and all questions. This is all part of the learning process. You can pause during a session, log out and research a particular subject area before proceeding or use a built-in feature that allows you to flag questions that you would like to review before asking the program to provide you with your results, that only you will know about. You can log out and log back in repeatedly during the 30-day period, completing as many of the assessment questions as you wish during any given session.

**What happens after I finish my self-assessment?**

Once you’ve asked the program for your results, they will pop up on the screen immediately. We expect that the overwhelming majority of members will find out that, relative to their peers, they are competent in all areas of practice covered by the self-assessment. Others may find that, relative to their peers, their results indicate that they may benefit from continuing education activities in one or more areas of practice that they may pursue on their own initiative.

All you need to do is print off your results to keep them with your other CE documentation.

As part of the supportive philosophy of the new QA Program, Dr. Greg Anderson, the College’s Practice Enhancement Consultant, is here to assist you at any time in identifying appropriate continuing education or professional development activities.

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**WHO TO CALL IF YOU HAVE QUESTIONS**

**PET Assessment**  
Dr. Greg Anderson – Practice Enhancement Consultant  
416-934-5620  
1-800-565-4591  
ganderson@rcdso.org

**The QA Program**  
Dr. Michael Gardner – Manager, Quality Assurance  
416-934-5611  
1-800-565-4591  
mgardner@rcdso.org

You will be provided with a link to the login page, seen here. You will then type in your Member ID and password to proceed to the self-assessment.

Every time you log in you are taken to this welcome screen which provides information on the assessment and also provides contact information if you encounter any difficulties.
The vast majority of dentists reading this article will ask “what’s his point?” These are social drinkers who take three or four ounces of alcohol on a social occasion, forget where their glass is and never think about their drinking.

These social healthy drinkers don’t realize that about 10% of us have a disease called alcoholism. When we drink, we develop the phenomenon of craving. This is often a desire for more alcohol at almost any cost and is excessive, because, by definition, we have lost control of our drinking.

This silent minority harbour shame, guilt and frustration. At some level they are aware that their amounts are taken with significant consequences. Drinking is dangerous and inappropriate, but they feel helpless and hopeless to do anything about it.

Similarly, the families feel helpless and hopeless as well. They are hoping that tomorrow dad or mom won’t drink as much or the child won’t use as much drugs as he/she did the previous day.

How do we tell if we are in difficulties with drinking? There are a number of simple questions.

I caution readers. Some of you may find information in this that is disturbing for you and may give you a reason for sober second-thinking.

If you find the answer is ‘yes’ to even 2 or 3 of these questions, you should seriously consider the possibility your alcohol or drug use is a problem. If there are more than a few ‘yes’ answers, you should seek help now.
Have you ever felt you should cut down or control your drinking or drug use?
Have you ever felt bad or guilty about your drinking or drug use?
Did you ever take a morning eye opener to steady your nerves or get rid of a hangover?
Are alcohol or drugs sometimes more important than other things in your life – your family, your job, your values?
Do you find yourself lying to your spouse, your kids, your friends, your employer to cover up your drinking or drug use – though you really don’t like lying?
Have you ever switched from one brand of drink to another in the hope that would keep you from getting drunk?
Have you had a problem connected with drinking or drug use during the past year such as an impaired driving charge, lost work, missed appointments or financial problems?
Has your substance use caused trouble at home or work? Are those around you annoyed by or concerned about it? Are you annoyed about their concern and do you become defensive?
Have you been drunk or high more than four times in the past year?
Do you need to resort to chemical assistance in order to do something such as work, have sex, socialize, or to change how you feel or to banish shyness and boost your confidence?
Do you crave situations where you can drink such as inviting friends over for a drink or arranging a meeting at a bar?
Do you panic when your bottle of pills gets low?
Have you ever felt your life might be better if you didn’t drink or take drugs or life as it is just isn’t worth living?

We now know that addiction is a brain disorder. It may be inherited or it may occur innocently in an individual. It is important to remind ourselves that the alcoholic/addict has no trouble stopping. They may be arrested, they may pass out or they may have severe withdrawal. The problem for the alcoholic/addict is not stopping, it is starting again.

This means that the addict can’t stop starting and this presents a very different picture to someone who might say ‘I quit for a month so I can’t be an alcoholic.’ I remind my patients that social drinkers never have to quit.

If you answered “yes” to several of the above questions I strongly recommend that you speak privately with your family doctor. They can arrange a confidential OHIP-covered assessment by an addiction-trained physician.
College Webinar Series Delivers Dynamic Educational Experience

On October 14, 2011, the College kicked-off its second webinar series featuring leading-edge content and a line-up of dynamic speakers who are experts in their respective fields.

“College webinars provide Ontario dentists with a unique opportunity to interact with experts no matter where they practise,” said College Registrar Irwin Fefergrad. “The feedback from these sessions continues to be extremely positive and points to the educational value they provide to dentists across the province.”

Presenters for the webinar series included Drs. Richard Bohay, Dorothy McComb and Barry Sessle. The webinars began with a 45-minute presentation followed by a 15-minute question and answer session. The presenters focused on offering educational tools to help deal with possible practice challenges. The sessions, delivered during the lunch hour, were designed to fit members’ busy practice schedules. The convenient format meant you could watch from your office or home and learn about topics that are relevant and impactful.

The 2011 webinars form part of the College’s continuing education program’s core courses and are worth one core course credit. Please visit the College website at rcdso.org and read the August/September 2011 issue of Dispatch for information on the presenters and their topics.

In order to provide this educational experience to dentists who were unable to attend the live sessions, the College offers access to archived versions of all RCDSO webinars. Those who sign-up for the archived versions will receive a complete package of handouts, including the presentation and all follow-up material provided by the presenters. Remember, if you missed the 2010 series, you can still sign up for those sessions as well.

To register for access to an archived version of a College webinar, please visit the College website, www.rcdso.org, and click on the webinars icon located on the homepage.
RCDSO webinars feature both a live visual of the presenter in the top-left corner of the screen along with his/her PowerPoint presentation to the right. Archived webinars include index points that take you to specific topic areas.

Presenter Dr. Dorothy McComb
Minimally Invasive Dentistry - Current principles of caries diagnosis and management

“It was a challenging experience being live and on camera – but a tremendous opportunity to provide a synthesis of current evidence and critical thinking with regards to early caries management. The College showed great insight with regard to the chosen topics – and this mode of delivery, directly to the dental office in short, focused, topical presentations, should be very convenient for clinicians and their staff. Thank you for providing the podium!

“I am hoping that my presentation will provide greater understanding of caries as a ‘disease’ process and increased recognition of the limitations of operative treatment for the early lesion. I have already had some positive feedback in this regard.”
On January 10, College President Dr. Peter Trainor, accompanied by
College Registrar Irwin Fefergrad, made a forceful presentation before
the Health Profession Regulatory Advisory Council at the open public
consultation held in Toronto urging the Health Professions
Regulatory Advisory Council to recommend the lifting of the
requirement for mandatory revocation for spousal treatment.

The College believes that sexual abuse of patients by a dentist or any
health care professional is abhorrent and involves a breach of the
trust that is the bedrock of the patient/professional relationship. As a
health regulatory college, it is our fundamental responsibility to deal
with reported cases of sexual abuse in a sensitive, respectful, but yet
effective manner and we take that responsibility very seriously.

However, treatment of a spouse is not automatically the same or even
the equivalent of predatory, sexual abuse. In fact, as Dr. Trainor
pointed out, it is extremely offensive to both the dentist and the
spouse or co-habiting partner to equate their normal relationship
with one of abuse.

Dr. Trainor clearly outlined the College’s proposal: “Instead, when
specified allegations of professional misconduct are referred to the
Discipline Committee, let this Committee, composed of both
professional members and public representatives, appointed by the

Robust role for College in HPRAC referral on spousal treatment
Minister, have the discretion to do what it does so well in other situations. The Discipline Committee is the committee that already deals with many serious matters of professional misconduct and uses its judgement to consider any aggravating or mitigating factors.

“We strongly believe that lifting the automatic five year revocation for spousal treatment in no way weakens or jeopardizes our ability as a regulator to fulfill our mandate of public protection. The integrity and vigour of the original intention of the legislation is maintained without compromising our obligations to protect the public.”

Dr. Trainor explained that spousal abuse is not a problem within the dental profession: “For decades, starting way before the decision of the Court of Appeal in 2009, thousands and thousands of dentists have been treating their spouses – and have done so safely and without any cause for concern. 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.”

Dr. Trainor ended his presentation strongly by stating that our College is a responsible regulator and that we have demonstrated year after year that we take our legislated mandate of public protection extremely seriously. As he said, we continue to excel at fulfilling the full intention and the spirit of the Regulated Health Professions Act and only ask to be able to continue to shoulder that same responsibility and accountability in this particular situation.

The College’s written submission made by the January 18th deadline in response to the questions posed by HPRAC followed this same spirit.

HPRAC is scheduled to make its recommendations to the Minister by the end of April. Then the Minister sets her own timeframe. During her decision-making process, she can accept, reject or modify the advice from HPRAC.

Then We Heard From You!

Following the oral presentation to HPRAC, the College sent out an e-mail to let the entire membership know about our involvement. Our position definitely resonated with members.

We received very positive feedback. Comments ranged from “I have never been more proud to be a member of the RCDSO” to “Bravo, well done and appreciated.”

HPRAC is posting its synopsis of the oral presentations plus copies of the written submissions on its website at www.hprac.org/end/projects/spousaltreatment.asp

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With a Common Voice

Quality Assurance Programs

THE LEGISLATION

The Regulated Health Professions Act (1991) (RHPA): Chapter 18, Sections 80 – 83 outlines that all colleges must have a quality assurance program. The regulations regarding that program must be approved by the government and the program must include a professional development component, a practice assessment and a method for the college to monitor compliance. Among the RHPA colleges there are a variety of programs but all must be approved by the Ministry of Health and Long-Term Care.

Program designs are based on the founding philosophy that the overwhelming majority of health care practitioners are competent and continually upgrade their skills and knowledge.
COLLEGE OF DENTAL HYGIENISTS OF ONTARIO

CDHO’s Quality Assurance Program (QAP) is based on the registrant’s self-evaluation against the CDHO’s published standards of practice and a peer review of the registrant’s portfolios. Dental hygienists:

1. develop goals related to their specific area of practice,
2. determine learning strategies to meet those goals,
3. implement those strategies, and
4. describe how the implementation affected their dental hygiene practice.

The Quality Assurance Committee (QAC) sets the criteria for selection and may randomly request that a specific number of registrants submit their professional portfolios in any given year.

Peer assessors review the portfolios and contact the registrant by telephone for clarification if necessary. If further clarification is required, an on-site practice review may occur.

CDHO suggests that the registrant notify the employer, if any, that the on-site review is to occur. The assessor tries to arrange a convenient time when s/he will randomly select charts of clients treated by the registrant. Copies, if possible, will be made. If copy facilities are unavailable, the assessor will provide a receipt for the originals, have them copied and return the originals to the office within a reasonable time. The registrant is responsible for the cost incurred in copying the records. In addition, the registrant’s work environment is assessed as noted in the Practice Assessment Tool available in the QA section at www.cdho.org.

The registrant is provided with the assessor’s report and may choose to make a submission to the QAC who review both the assessor’s report and the registrant’s submission. The registrant is informed of the results and any follow up that is required. The outcome of the quality assurance assessment is between the QAC and the registrant, respecting the confidentiality afforded in the RHPA.

CDHO has conducted surveys of registrants with respect to the QA process, the total quality improvement process and has conducted two major surveys of registrants to determine practice commonalities in Ontario. There may be additional surveys in the future.

ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO

RCDSO’s Quality Assurance Program was designed to meet four key goals:

1. It is meaningful to dentists.
2. It is nurturing and non-punitive.
3. It does not involve office visits.
4. It encourages continuous learning and practice improvement.

The two major elements of the program are:

- Continuing Education – Each dentist is required to collect a total of 90 CE points over a three-year period. These 90 points are to come from three categories: core courses (15 pts), approved sponsored courses (45 pts), and other courses (30 pts).

- Self-Assessment – Every five years, each dentist will self-assess to evaluate and assess their practice, knowledge, skills and judgement in specific competency areas.

The Practice Enhancement Tool (PET) is a computer-based self-assessment program that gives dentists an opportunity to evaluate and assess their practice, knowledge, skills and judgement based on peer-derived standards. Outside resources may be used to answer the questions based on core competencies. PET is accessible to all RCDSO members on the RCDSO website at www.rcdsso.org. Over a five-year period, all RCDSO members will complete the assessment.

The multiple choice and case studies were developed in conjunction with the National Dental Examining Board (NDEB).

A Practice Enhancement Consultant, a dentist at RCDSO, is available to support dentists through this process. The consultant may assist members in interpreting the results of the self-assessment tool and locating professional development courses/activities.

Each RCDSO member will have secure access to his/her own e-Portfolio through the RCDSO website. This allows for personal tracking of educational activities and the monitoring of the 90-point requirement.

Members are to complete a section on the registration renewal form self-declaring compliance with the QA Program requirements.
Does the College of Dental Hygienists of Ontario (CDHO) have the authority to perform an in-office audit in a dental office?

The Regulated Health Professions Act (RHPA) 1991: Chapter 18, Sections 82(2)(3) gives the authority to the Quality Assurance Assessors to enter and inspect the premise(s) where the dental hygienist works and inspect the records relating to the dental hygienist’s care of patients/clients. Both RCDSO and ODA confirm the obligation for the employer to cooperate with assessors.

How do you know that the assessor has been authorized by the CDHO to undertake an in-office audit?

Assessors are provided with a letter indicating that they have been appointed to conduct an on-site practice assessment of the dental hygienist under section 20 of Ontario Regulation 167/11 with the purpose being to gather sufficient information so that the Quality Assurance Committee can evaluate the dental hygienist’s knowledge, skills, judgement and attitudes. This letter may be viewed by the practice owner upon request.

Generally, how much time does it take to complete a CDHO in-office audit?

On average, the audit of the work environment takes approximately an hour. The assessor will select approximately 20 charts of patients/clients for whom the registrant has provided treatment. As per the RHPA, the complete chart is required. The copying of client records takes 3 to 4 hours depending on the equipment available. Electronic records greatly reduce this time. Not having an in-house copier for use by the assessor prolongs the time required for the audit.

Will the CDHO assessor ask or need to speak to the owner or other staff in the practice?

There is generally no need for the assessor to speak with the owner or other staff in the practice. An assessor will let the dental hygienist know if an interview with a colleague will be needed and will make arrangements with them in advance of the visit.

Are there limits on what the CDHO assessor is authorized to examine with respect to the office practice, equipment, policies and/or practices?

Regulated Health Professions Act (RHPA) 1991: Chapter 18, Sections 82(1) gives the authority to the Quality Assurance Assessors to inspect any records relating to the dental hygienist’s care of patients/clients.

What happens to any records or reports that are duplicated/obtained during the in-office audit?

The records and reports are retained, stored and destroyed by the regulatory college according to privacy legislation. The college is responsible for the security of the records when the assessor takes possession.

The CDHO’s Quality Assurance Program has been in effect for many years. However, the RCDSO’s formal program has just begun. Therefore, updates may be provided in future publications. Questions regarding the Quality Assurance Programs may be directed to either College at the links below.

www.rcdso.org/quality_assurance/overview.html
www.rcdso.org/contact_us.html
www.cdho.org/quality+assurance.asp
www.cdho.org/contact.asp
Province’s new accessibility standards now in effect

Starting on January 1, the Accessibility Standard for Customer Service came into effect for all businesses and organizations in the province with one or more employees. You can visit www.ontario.ca/AccessON to learn more about how the changes apply to your office and find free tools and guides to help out.

Does this impact dental offices?
Yes it does, as long as you have at least one employee.

Why is the government doing this?
In the next 20 years, an aging population and people with disabilities will represent 40 percent of total income in Ontario. That’s $536 billion. So, as the Ministry of Community and Social Services say, accessible customer service is not only the right thing to do, it makes good business sense too.

What is the impact of this to me in practical terms?
Accessible customer service is not about ramps or automatic door openers. It’s about understanding that people with disabilities may have different needs.

There is detailed information about what compliance means on the government website www.ontario.ca/AccessON. However, it could be as simple as looking around your office and thinking about what the experience of visiting your office would be for someone living with a disability. Think about the barriers that might exist and how you could take steps to reduce or eliminate them.

Sometimes providing accessible service is as simple as asking, “How can I help?”

Do I have to fill out forms or report to the government?
Businesses with more than 20 employees need to file regular compliance reports. This can be done quickly online. If you have fewer than 20 employees, you are exempt from filing reports but still must meet the requirement of the standard.
How long do I have to keep dental records?

The required retention period depends on the age of the patient. For adult patients, dental records must be retained for at least 10 years after the date of the last entry in the record. For a child, dental records need to be kept for 10 years after the child reaches or would have reached the age of 18.

I don’t have room in my office to store all of my archived records. Can they be stored off-site?

Yes. The only proviso is that privacy legislation requires that dental records of patients must be stored in secure premises to prevent unauthorized access. You must also take reasonable steps to protect the records from theft and damage from fire or flood. This might mean, for example, storage in waterproof plastic bins with lids.

It is also recommended that stored records be kept in a systematic fashion so they can be easily retrieved if the patient returns to the practice or if they are needed for another purpose.
If I decide to store my archived records off-site, do I need to notify my patients or former patients?

It is not necessary to notify patients if the records are archived in the basement of the dental office or in some other area controlled by the dentist. However, if the records are moved to premises that are not under the control of the dentist, such as a private record storage facility, provincial privacy legislation requires that patient consent be obtained before the records can be stored in such a facility.

There was a flood/fire in my dental office and my dental records were destroyed. What do I have to do?

The first step is to see which records can be retrieved or salvaged. There are companies that specialize in recovery/reconstruction of paper records and data recovery for electronic records. Your general liability or office overhead insurance policy may cover some of these costs.

As for electronic records, the College does recommend that they be backed up on a routine daily basis and stored in a physically secure environment off-site. In addition, your recovery procedures should be periodically tested to ensure that all patient records and critical data can be retrieved and reliably restored from the backup copy.

If the system cannot be restored from a backup copy, it may be possible to recover data from a damaged hard drive.

Do I need to notify patients that their records were damaged or destroyed?

The College advises dentists to notify patients currently in treatment and other active patients about what has occurred and what records may need to be recreated. For example, this might include examinations or radiographs or other diagnostic records and medical histories required to provide sufficient information to deliver safe and appropriate dental care. Patients can be notified verbally, by posting a notice in the office, or in writing.

Should I notify the College of this mishap?

If your records have been destroyed by fire or flood, you can notify the College that this has occurred. This information could be helpful if later on there is an investigation of a complaint or a lawsuit (claim) filed against you.

In any report that you might make, you should describe the steps that you have taken to salvage or reconstruct the dental records and what records are remaining; for example, electronic records of treatment provided in the patients’ financial records.

Your notification should be in writing and you can request that it be placed in your permanent file. These files are retained indefinitely at the College, even after you are no longer registered or are deceased.
When a dentist dies, what is the responsibility of his/her estate to retain patients’ dental records?

Under privacy legislation and the regulations made under the Dentistry Act, 1991, the dentist who is the owner of a dental practice is deemed to be the custodian of his/her patients’ dental records.

When a dentist passes away, the estate trustee or the person who has assumed responsibility for the administration of the deceased dentist’s estate assumes responsibility for retaining the dental records until the records can be transferred to another dentist.

If my estate is able to find another dentist to transfer the records to, how should patients be notified of the change of ownership of the records?

The College’s Practice Advisory on Change of Practice Ownership and the guidelines and checklist from the Information and Privacy Commissioner/Ontario provide guidance on how to deal with this situation.

The notification of the change of ownership of the dental records can either be done by the estate trustee or by the dentist who has assumed ownership of the dental records.

Under the Personal Health Information Protection Act, a patient’s health records can be transferred to a successor if the health information custodian makes reasonable efforts to give notice to the patient before transferring the records or, if that is not reasonably possible, as soon as possible after transferring the records.

If the estate trustee finds a dentist to assume custody and control of your dental records, that dentist will retain the records and provide copies of the records to the patients at their direction or request.

Estate trustees also have obligations as health information custodians to provide access to and copies of dental records to patients as directed or requested.

What sort of agreement needs to be in place with the dentist who assumes ownership of the records?

The College recommends that when the ownership of a deceased dentist’s records is transferred to another dentist, there be an agreement or understanding that:

• The records will be retained for the retention period described in the College’s Guidelines for Dental Recordkeeping.

• The records will be available to the previous dentist’s estate should they be required in the case of a complaint or claim.
If the estate trustee is not able to find another dentist to transfer the records to, is there anyone else the records can be transferred to?

The only regulated health professional who can be a successor health information custodian for dental records is another dentist.

On the death of the dentist, it is the responsibility of the estate trustee, or the person who has assumed responsibility for the administration of the deceased dentist’s estate, to arrange to transfer the custody and control of the dental records to another dentist.

If this is not possible, they need to be transferred to a person whose functions include the collection and preservation of records of historical or archival importance, provided that the person who assumes responsibility for the records fulfills the requirements set out in the Personal Health Information Protection Act.

If, in the meantime, a patient requests in writing that his/her records be transferred to their new dental practitioner, it is permissible for the estate trustee to transfer the original dental records to that dentist.

The College advises that there be an agreement as above regarding the retention of records and access in the case of a complaint or a claim.

I am preparing my will and want to know whether I can leave my private dental practice, including my patient records, to my spouse.

No. While non-dentists can own dental office premises, supplies and equipment, non-dentists cannot own dental records or profit from the practice of dentistry.

The conflict of interest sections of the professional misconduct regulations made under the Dentistry Act, 1991, which dentists must abide by, prevent non-dentists from employing dentists, having dentists as associates, or being partners with dentists.

For these reasons, the non-dentist members of the family or the estate of a deceased dentist cannot own and operate the dental practice of a deceased dentist or employ dentists to provide care to patients for the long term.

The College does allow the estate trustee limited time (no more than one year) to sell a deceased dentist’s practice following the death of the dentist and to enlist a locum to provide urgent and ongoing dental care to patients until the dental practice is sold and dental records transferred to another dentist.

The College advises that it is usually best to arrange for another dentist’s assistance in operating the practice and to have the practice valued as soon as possible.

MORE INFORMATION

Practice Advisory on Change of Practice Ownership – College website at www.rcdso.org
Guidelines on Dental Recordkeeping – College website at www.rcdso.org
How to Avoid Abandoned Records: Guidelines on the Treatment of Personal Health Information, in the Event of a Change in Practice – Information and Privacy Commissioner/Ontario website at www.ipc.on.ca
Checklist for Health Information Custodians in the Event of a Planned or Unforeseen Change in Practice – Information and Privacy Commissioner/Ontario website at www.ipc.on.ca

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Treating a Medically Compromised Patient

In the course of your professional career, you will regularly encounter medically compromised patients. These patients have special medical and/or dental needs that could directly impact their medical condition. The following case from the Inquiries, Complaints and Reports Committee (ICRC) illustrates how difficult treatment decisions become when a patient is medically compromised.

An elderly patient, 82 years old, presented with a significant medical history, including coronary artery disease and the use of many medications. She wanted extensive treatment involving her upper crowns and made clear her choice was replacement, not repairs, as the treatment was largely for esthetic reasons. During the treatment discussion, she seemed knowledgeable about dental matters. She was asymptomatic and appeared to be medically under control.

The treatment plan was discussed, including at least two appointments for work-up and consultation, as well as the cost of over $13,000. The patient was provided with a written estimate and a treatment information form. Since the patient needed help to get to the appointments, she asked the dentist to perform the treatment over a shortened period of time. The dentist agreed.

Her initial treatment appointment lasted five hours, during which eleven crowns were prepared. This long appointment included at least one hour for lunch and several brief breaks. The dentist used five carpules of local anesthetic, administered in intervals as he worked on individual teeth. The treatment
appeared to go smoothly and the patient did not report any post-treatment discomfort.

About three weeks later, the patient returned for another appointment that was about two hours long. This time the member used two carpules of anesthetic. Again the patient took a number of short breaks during the treatment. After the appointment, the dentist was not contacted about any complications or concerns.

Unfortunately, only one week after the second treatment appointment, the patient died of a stroke.

A complaint from the patient’s representative followed, in which it was alleged that the dentist:

- did not properly advise the patient of the high stress associated with the treatment she wanted;
- did not inform the patient that the treatment was potentially fatal;
- did not offer to perform the treatment during a number of shorter appointments;
- administered too much local anesthetic, given the patient’s age and medical history;
- provided unnecessary treatment.

During its review of the complaint, the ICRC panel sought the opinion of an expert in dental anesthesia. The expert’s opinion was that the two hour appointment was acceptable, but the five hour appointment was inappropriate for a patient with cardiac illness. In addition, during this appointment, the dentist had not monitored the patient’s blood pressure and heart rate properly.

However, the expert said that, although much of the treatment could be considered unnecessary, ultimately the dental treatment could not be linked to the stroke suffered by the patient one week after the treatment was completed.

Despite the expert’s conclusion, the panel was concerned about the dentist’s management of this patient as there was a failure to record some of his discussions with the patient and it was not clear that she had received sufficient information about the treatment. Also, the records did not provide clear justification for the treatment.

The panel concluded that, when a medically compromised patient is being treated, particularly if that treatment is extensive, the dentist must take great care to obtain and document the patient’s informed consent to treatment.

The panel also noted that the dentist allowed the patient to dictate treatment, instead of using his professional judgement to determine the timing and duration of the appointments.

The complaint was resolved when the member agreed to refresh his knowledge of proper recordkeeping practices and to take a course in the treatment and management of medically compromised patients.

...when a medically compromised patient is being treated, particularly if that treatment is extensive, the dentist must take great care to obtain and document the patient’s informed consent to treatment.
The Importance of a Complete Medical History

Every year, PLP receives reports of claims or potential claims in which inadequate medical history-taking and/or failure to update a patient’s medical history have been pivotal factors in the treatment outcome. The following scenarios involving inadequate history-taking that lead to serious consequences illustrate the importance of medical histories to providing safe and appropriate dental care.
SCENARIO 1

Mr. H presented to his dentist, Dr. B, regularly for 12 years. He required very little dental treatment, other than routine cleanings.

After scaling had been completed at a recall appointment, Mr. H mentioned to Dr. B that he’d had a diseased heart valve replaced with a prosthetic one four months earlier. Dr. B explained the importance of premedication to Mr. H and prescribed antibiotics to be taken prior to his next appointment.

Eight months later, Mrs. H called to say her husband had passed away. An autopsy confirmed that her husband had developed prosthetic valve endocarditis (PVE), reportedly caused by the dental cleaning.

DISCUSSION

In reviewing Dr. B’s records, PLP staff had the following concerns:

- While there was a medical history form in the record, completed on Mr. H’s initial appointment with Dr. B, there was no evidence that the claimant’s medical information had ever been discussed or updated after that.
- It was clear from the records that the discussion about Mr. H’s prosthetic heart valve occurred after the scaling appointment, not before.
- Having discovered that the patient had a prosthetic heart valve and had just undergone dental cleaning, Dr. B took no immediate action, such as consulting with Mr. H’s cardiologist, referring him back to his physician, or immediately prescribing a post-exposure regimen of appropriate antibiotics.

SCENARIO 2

Ms. S presented to Dr. A on an emergency basis for extraction of an infected tooth. Dr. A extracted the tooth under local anesthetic and he told Ms. S she should make an appointment for a new patient examination. She said she would do so.

A week later, Ms. S’s son called to report that his mother had developed a serious infection and was in hospital on IV antibiotics.

DISCUSSION

In reviewing Dr. A’s records, PLP staff had the following concerns:

- The medical history questionnaire form used by Dr. A did not include important questions that would elicit critical information in assessing a patient’s true medical status.
- There was no evidence that Dr. A had reviewed the scant medical history with Ms. S or that he had investigated her positive responses to “Do you have any illnesses or medical conditions?” and “Do you take any medications?”
- There was no evidence that the tooth needed to be extracted. Dr. A hadn’t taken an x-ray. There was no information in the records about why the tooth required extraction, although Dr. A said the tooth was severely broken down and non-restorable. Unfortunately, this was not documented.
- There was no evidence of any discussion about the risks and benefits of extraction or the alternatives.
- There was no informed consent for treatment.
- There was no evidence that Ms. S was provided with any post-operative instructions, verbal or written, or that she was told to call the office if she experienced any complications.
- Review of Ms. S’s full medical records demonstrated that she was severely medically compromised. She was a very poorly controlled Type II diabetic and was suffering from many complications of the disease.
- Because he failed to investigate the positives on the medical history form, Dr. A was not aware that Ms. S was a poorly controlled Type II diabetic on insulin. Further, he did not know that she needed specific instructions post-operatively or that she probably required prophylactic antibiotics.
Understanding the relationship between oral and general health is an essential component in providing safe dental care. Treating the medically compromised patient requires that the dentist be knowledgeable about medical diseases and conditions and familiar with the implications of medications used to treat these diseases. It also requires the ability to assess the significance of these diseases before, during and after dental procedures.

On our website at www.rcdso.org, the College provides members with a “Medical History Recordkeeping Guide” comprised of four parts:

- the Medical History Questionnaire Companion;
- a sample of a Medical History Questionnaire;
- a patient information pamphlet entitled “When it Comes to Your Medical History, Tell Your Dentist Everything”;
- a sample Recall History Questionnaire.

The Companion section of the guide points out that a medical history questionnaire can be worthless if the dentist cannot interpret the answers and, when necessary, seek out and obtain additional information.

The questionnaire provides a starting point to elicit information from the patient. It assists the clinician in identifying a patient whose medical history is uncomplicated, and whose treatment may be conducted safely with a minimum of treatment modifications.

The questionnaire can also assist in identifying a patient whose medical history is complex or clouded, and when further information is needed to clarify any positive or unclear responses before initiating care.

Additional information may be acquired through a dialogue with the patient and by conducting an appropriate physical examination (head, neck and intra-oral examination, and taking and recording vital signs) and/or consultation with the patient’s physician.

In Scenario 2, had Dr. A discovered that Ms. S had diabetes, there were a number of follow-up questions he should have asked.

The Medical History Questionnaire Companion explains that, when it is determined that a patient suffers from diabetes, the dentist needs to establish the type and severity of the disease and the presence of complications, which are often related to the duration of the disease. For example, diabetic patients are more likely to suffer from atherosclerotic heart disease, kidney disease, blindness, xerostomia, periodontal disease, burning mouth syndrome, and to have problems related to impaired healing and infection.

As important as it is to be able to appropriately interpret the medical history questionnaire and to investigate the positive responses, it is equally important that the medical information is updated and followed-up on a regular basis.

Two methods can be helpful to ensure the medical history is updated and the information is accurate. One is to have the patient review the information previously obtained and advise the dentist of any changes. The other is to ask specific questions of the patient. On page 11 of the Medical History Questionnaire Companion there is a list of appropriate questions to be asked at recall appointments and also a sample abbreviated Recall History Questionnaire.

LEARNING POINTS

Understanding the relationship between oral and general health is an essential component in providing safe dental care. Treating the medically compromised patient requires that the dentist be knowledgeable about medical diseases and conditions and familiar with the implications of medications used to treat these diseases. It also requires the ability to assess the significance of these diseases before, during and after dental procedures.

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- a patient information pamphlet entitled “When it Comes to Your Medical History, Tell Your Dentist Everything”;
- a sample Recall History Questionnaire.

The Companion section of the guide points out that a medical history questionnaire can be worthless if the dentist cannot interpret the answers and, when necessary, seek out and obtain additional information.

The questionnaire provides a starting point to elicit information from the patient. It assists the clinician in identifying a patient whose medical history is uncomplicated, and whose treatment may be conducted safely with a minimum of treatment modifications.

The questionnaire can also assist in identifying a patient whose medical history is complex or clouded, and when further information is needed to clarify any positive or unclear responses before initiating care.
Latest Round of Support for Fluoridation

The College continues to take a high profile role in speaking out for fluoridation.

On January 25, College Vice President Dr. Natalie Archer participated in an open consultation meeting held by the Civic Works Committee of the Council of the City of London. London, with a population of over 350,000, has had fluoridated water since 1967.

On January 31, College President Dr. Peter Trainor appeared as a formal delegation in support of fluoridation before the Halton Regional Council. The population of Halton Region is more than 500,000 and includes the municipalities of Burlington, Halton Hills, Milton and Oakville.

In London, the Civic Waste Committee asked staff for a further report; while in Halton, the Council voted to retain fluoridation.

Over the past years, the College has responded to a number of requests from public health units to make public representations in support of fluoridation to city and town councils around the province. To add more weight to our argument, at the request of the College, the heads of the two dental schools in Ontario have released public letters in support of the use of fluoride in municipal drinking water.

In addition, at its November 2009 meeting, Council passed a motion indicating the College’s willingness to work with government, if there was interest, on a province-wide evidence-based study to determine reliable and meaningful information on the long-term financial implications for municipalities of maintaining or instituting water fluoridation.

The College has only two formal policy statements, and one of them is in support of fluoridation. It is posted online at www.rcdso.org/Professional Practice.
Management of Dental Patients Taking Anticoagulant Medications

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.

Millions of patients worldwide take medications that alter hemostasis in order to reduce the risk for thromboembolic events, such as strokes. These patients, however, present the most common potential bleeding problem that dentists encounter.

Dental care for such patients requires an assessment of the opposing risks of significant hemorrhage from procedures against the potential for thromboembolism resulting from reducing or withdrawing anticoagulant therapy.

In addition to the use of the International Normalized Ratio (INR) system for monitoring anticoagulation status, it is also important to
consider the use of adjunctive bleeding management strategies to further reduce the risk of an untoward medical event.

Appropriate measures may include minimizing trauma, primary closure of surgical wounds and pressure application, combined with the use of absorbable gelatin sponges to encourage hemostasis by promoting occlusion at the site of the surgical injury and providing a mechanical aid to clot formation.

With the current issue of Dispatch, PEAK is pleased to offer members the following article on this important subject: “Management of dental patients taking common hemostasis-altering medications,” from the March 2007 issue of Oral Surgery, Oral Medicine, Oral Pathology, Oral Radiology, and Endodontology.

The article begins with a description of the aim of oral anticoagulant therapy and presents the results of an extensive literature review. While the primary focus of the article is related to the anticoagulant medication warfarin (Coumadin), issues specifically related to heparin and aspirin are also discussed.

Of particular interest is the article’s inclusion of an algorithm for the treatment of patients taking warfarin.

Based on their research findings, the authors present several evidence-based recommendations:

- For most patients taking oral anticoagulant medications, the benefit of preventing a thromboembolic event clearly outweighs the risk of a significant bleeding episode.
- For patients within the therapeutic range of INR of 3.5 or below, warfarin therapy need not be modified or discontinued for simple dental extractions. However, the clinical judgement, experience and training of the clinician, as well as access to appropriate bleeding management strategies, are important considerations.
- A two-day regimen of post-operative 4.8% tranexamic acid mouthwash (an antifibrinolytic agent) is beneficial to achieve adequate hemostasis after simple oral surgical procedures. Other effective hemostatic agents include gelatin sponges, fibrin glue or fibrin adhesive dressing, oxidized cellulose and epsilon-amino caproic acid (EACA) mouthwash.
- It is not necessary to interrupt low-dose aspirin therapy (100 mg/day or less) for simple dental extractions.
A 79-year old woman comes to your dental office. She says her health is good and amazingly is on no medications. You check her blood pressure and heart rate and they are normal for a person of her age.

Your clinical examination shows multiple teeth missing. The remaining teeth show moderate periodontal involvement with generalized pockets of mild bone loss. She has one necrotic tooth that needs extraction. Her periodontal problems are not severe, but overall the patient does not exhibit good oral hygiene.

She says she lost a set of partial plates a couple of years ago. So now she wants you to make permanent bridges so she won’t have to worry about losing another set. You have a thorough discussion with her about your treatment recommendations and she gives consent. But she asks you to speak with her son.

The conversation with her son does not go as well. He bluntly states that his mom is “losing it.” He doesn’t want any money spent on what he calls “expensive” treatments. He says she is old and he wants you to take out all her teeth and make her a set of dentures.

This scenario might soon be commonplace for most dentists.

In Ontario, the number of seniors aged 65 and over is projected to more than double from 1.8 million, or 13.9 per cent of population, in 2010 to 4.1 million, or 23.4 per cent, by 2036. This acceleration in the share and number of seniors is projected to increase over the 2011–2031 period as baby boomers begin to turn age 65.
What is at stake here is the ethical principle called autonomy. Autonomy is one of the core values in the College’s Code of Ethics. It is the moral basis for the informed consent process. Competent people have the right to make decisions about what they want to have done to their bodies. If we believe that our patient is capable of making decisions, then we need to respect her/his wishes.

As a professional health care practitioner, our obligation is to always act in the best interests of our patients. To do that means that our professional decisions must respect patients’ values and personal preferences.

Patients must be informed of possible complications, alternative treatments, advantages and disadvantages of each, costs of each, and expected outcomes. Together, the risks, benefits, and burdens can be balanced. It is only after such consideration that the best interests of our patients can be assured.

Health care practitioners need to be alert to the influence of our assumptions or misconceptions about our patients’ capacity to participate in informed decision-making about their treatment. Most elderly patients are extremely capable and motivated. Despite contrary stereotypes, most elderly patients are competent.

Of course, advanced age does not negate the legal and ethical necessity of obtaining informed consent from competent patients. To facilitate communication, family members or other third parties may take part in the decision-making process. But the patient, if capable, must make the actual decision. Even if there is a power of attorney document in place for health care decisions, if the patient still has capacity, then the patient can consent on his or her own behalf.

It is important to document all informed consent discussions and decisions thoroughly. If the patient makes what you consider an unwise choice, document your attempts to persuade the patient otherwise. And, if the patient asks you to practise below the standard of care, you should refuse.

The fundamentals of dentistry remain the same no matter the age of the patient. As the principles of the Code of Ethics state: “The paramount responsibility of a dentist is to the health and well-being of patients.”

But dealing with older patients may call for an extra measure of awareness, sensitivity and commitment to clear communication. By making these adjustments, you can provide the safe, high-quality care that this large and growing group of patients needs.

... if our patient is capable of making decisions, then we need to respect his/her wishes.
Continuing education resources on rcdso.org

Website Spotlight is a regular feature that highlights important content found on the College’s website, www.rcdso.org. Adventurous types who eagerly await the next spotlight can visit our site and tour the many e-resources available online, such as the online register, standards of practice and information on the College’s webinar series.

The College officially launched its new Quality Assurance program on December 15, 2011. One of the key components of the QA program is continuing education and the need to obtain 90 CE points during your three-year cycle.

The May/June 2011 issue of Dispatch, available on the College website under Publications/Dispatch, outlined the College’s philosophy on continuing education and the requirements for members to obtain points in three categories: core courses, approved sponsor courses and other courses.

If you visit the College website and click on Quality Assurance Program in the main menu, you will find information on our Lifelong Learning programs, which form part of the continuing education program.

All Lifelong Learning programs are classified as core courses, including the College’s first online course called Jurisprudence & Ethics: Examining Practice of Dentistry in Ontario Through an Ethical Lens, which was profiled in a previous website spotlight in the February/March 2011 issue of Dispatch. You can download an application form for the course, along with our other LifeLong Learning programs, right off of our website.

Also included in the core course category are the College webinars, profiled on page 18. You can sign up for the archived versions of the 2010 and 2011 College webinars through the online member resource centre.

During the transition period to the new online e-Portfolio, where you will be able to track your own CE points throughout your three-year cycle, you can make use of the log sheets available for download off of the website to track your CE activities. You can also find information on the credit point system and download a list of approved and non-approved study clubs.

Please be sure to visit the website regularly as we will continue to post the most up-to-date information on the QA Program.
If you visit the Quality Assurance Program section of the website, you will find a list of core courses, approved sponsor courses and other courses first highlighted in the August/September 2011 issue of Dispatch.
C'est là un message que les dentistes peuvent certainement appuyer. Je suis certain qu'aucun dentiste de la province ne serait en désaccord avec le fait que nous devons accorder une plus grande importance à la prévention d'une santé médiocre.

Cela est attribuable au fait que les dentistes travaillent en première ligne depuis des années pour ce qui est de la prévention et de la promotion de la santé au sein de nos collectivités.

Ainsi, aux quatre coins de la province, les dentistes incitent déjà leurs patients à cesser de fumer. Treize mille personnes meurent chaque année en Ontario des suites du tabagisme, soit un décès aux 40 minutes. La majorité de ces décès peuvent être évités. Les dentistes jouent un rôle important dans le changement de ces horribles statistiques.

Les dentistes sont également très bien placés pour appuyer de manière sensible et efficace leurs patients qui sont aux prises avec les drogues. Le Collège abordera de front cette question au cours de la prochaine année, alors que le groupe de travail chargé de mettre en œuvre les recommandations de notre symposium sur la gestion de la douleur dans le cadre des soins dentaires fera rapport au conseil.

Il est bien établi que la parodontopathie représente un risque de morbidité et entraîne des coûts sociétaux considérables. Un nombre sans cesse croissant de travaux de recherche clinique démontrent les liens qui existent entre la parodontopathie et les maladies systémiques tels le diabète sucré et les maladies cardiovasculaire, ainsi que les effets de la parodontopathie sur l’issue de la grossesse, notamment les naissances prématurées et le faible poids à la naissance. Le Collège a été parmi les premiers à signaler cet enjeu aux dentistes ontariens en février 2005 à l’occasion de son symposium d’une journée sur la santé buccale et les maladies systémiques et, par la suite par le biais d’articles éducatifs PEAK parus dans la revue Dispatch.

La Dre King a fait appel aux trois ordre de gouvernement, aux leaders des collectivités, au secteur privé et à tous les Ontariens afin d’engager activement le dialogue à ce sujet. Voilà pour les dentistes, à titre de chefs de file de leur collectivité, une occasion de jouer un rôle actif. Je crois fermement que les dentistes sauront faire jaillir des idées et une approche novatrices sur la manière de collaborer en vue de susciter de grandes réalisations.

Si vous désirez lire un exemplaire du rapport annuel de 2010 du médecin hygiéniste en chef de l’Ontario à l’assemblée législative de l’Ontario, veuillez envoyer un courriel à info@rcdso.org, et nous vous ferons parvenir le lien de ce rapport sur le site Web du ministère de la Santé.
Supporting Dentists in their Personal Journey of Continuous Learning

Then, in April 2010, we launched our first online learning course. Focusing on jurisprudence and ethics, it examines the practice of dentistry in Ontario through an ethical lens. It is available from the College website.

Later that year, we broadcast our first webinar series. With three different sessions, we brought dental experts to your computer with an opportunity to ask questions. We followed that up with another three-part series in the fall of 2011.

By investing in a delivery system based in the latest technology, we have thrown open the doors of the classroom and the conference hall to welcome all members of the profession.

All these programs now form the backbone of the core courses section of the continuing education credits portion of the Quality Assurance Program.

Above and beyond that, individual dentists have significant freedom to choose courses or other development opportunities to meet their needs. This leaves dentists to develop their own learning plans, with the opportunity for help from Dr. Greg Anderson, the College’s new Practice Enhancement Consultant, to identify programs and opportunities.

There is no single, linear pathway or professional development plan that fits everyone. Each dentist’s professional journey is complex and individualistic. We trust that dentists will make the right choices that will ultimately benefit their patients.

Our goal is to make the College’s LifeLong Learning program an important part of the professional life of Ontario dentists. We want to work in collaboration with the profession to support rich learning experiences.

One of our important partners in the development of the LifeLong Learning Program has been the Faculty of Dentistry at the University of Toronto. Dean David Mock and his faculty colleagues have never hesitated to commit significant time and energy to support the content development and delivery of many of these core courses. They have brought a currency and credibility to the content that is irreplaceable.

It is just one of innumerable ways that David has been such a friend to this College.

As many of you may know, David is retiring later this year as faculty dean. David already tried to retire once, but continued on for an additional five-year term at the request of the university. And no wonder.

Under David’s leadership, the faculty has solidified and immeasurably enhanced its reputation as the foremost dental research centre in Canada with an international reputation for scholarly activity, in both the clinical and biological sciences.

Personally, I have had the pleasure and honour to work with David on a number of projects that had national implications for the profession. For example, there is no doubt that without David’s involvement it would have been very difficult to achieve a national program for specialty recognition.

I know that you join me in wishing David the very best of luck as he moves on to new excitements and adventures in his life.
Now, with our new Quality Assurance Program underway, the value of continuing professional development has never been more important.

Dentists need opportunities for learning, opportunities that are appropriate to your daily challenges and the stage of your career. The College has recognized that need and over the past few years has made a significant commitment to education.

One of our first major projects was the Medical History Recordkeeping Guide sent to all members in the fall of 2002 with Dispatch magazine. We also held roadshows around the province on topics like privacy legislation and health profession corporations. We saw time and time again the appetite for quality and relevant educational experiences.

It seemed then that the creation of our LifeLong Learning Program was a logical next step. In 2004, we launched our first interactive CD-based educational program, Medical Emergencies in the Dental Office. It was a big success with members. This positive reception proved that dentists were ready for innovative approaches to professional development.

Then, in the spring of 2006, we launched our second LifeLong learning package. Called Staying Safe, it contained a DVD and 102-page workbook.

We haven’t looked back since. Over the past several years, we produced and distributed at no charge two more CD-based interactive learning packages: one on dental emergencies and the other on informed consent.

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