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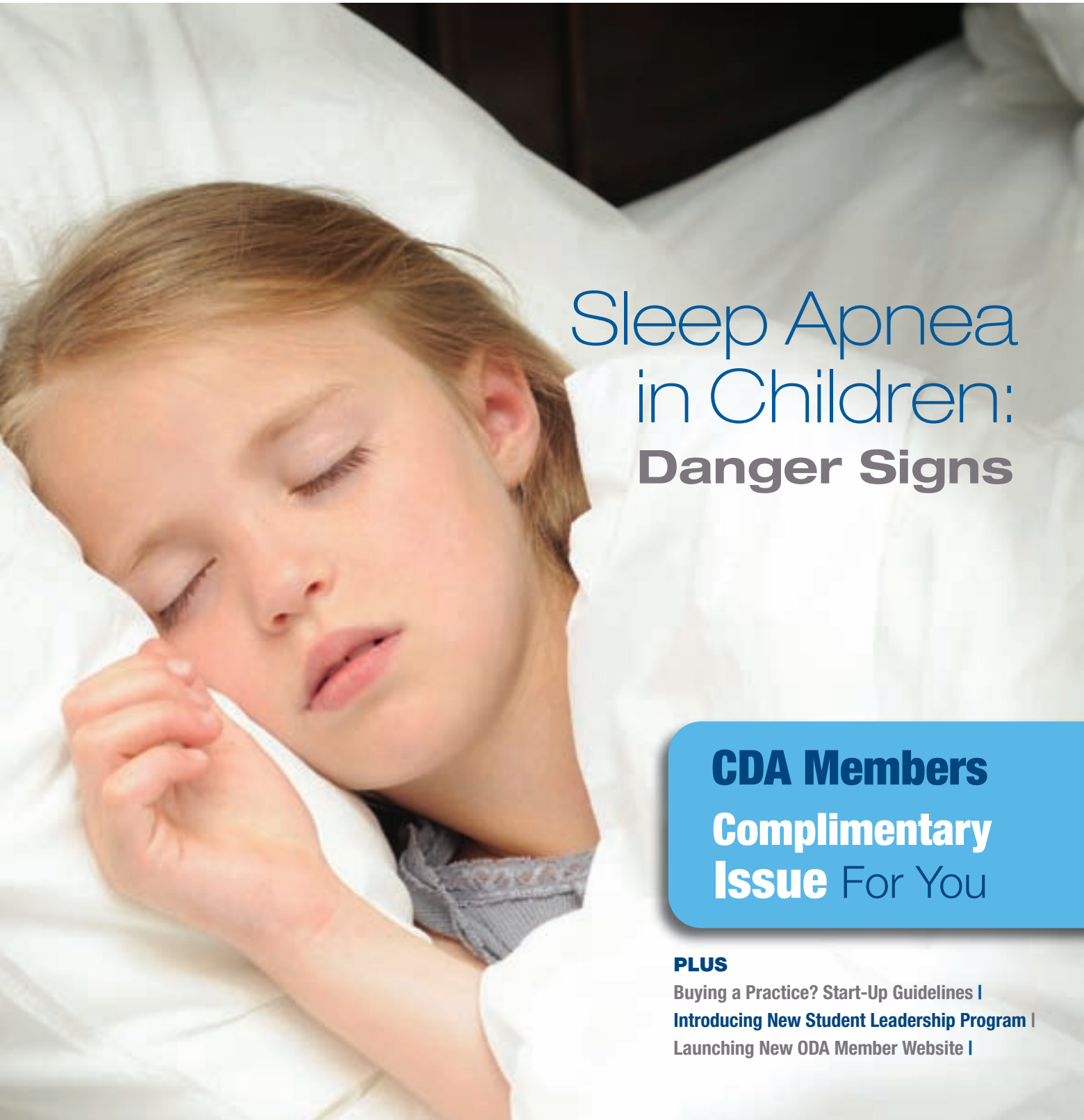
THE JOURNAL OF THE ONTARIO DENTAL ASSOCIATION

OCTOBER 2010



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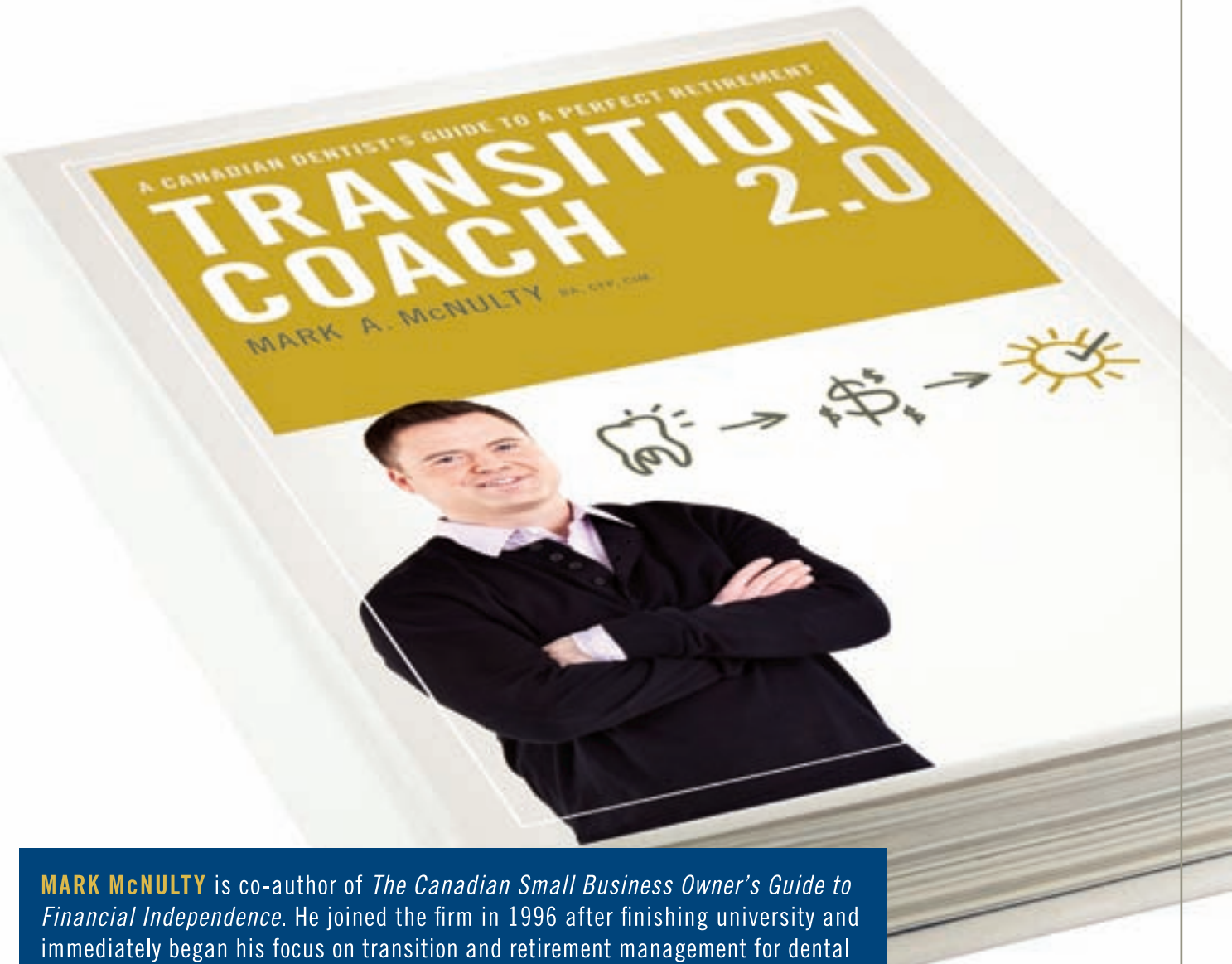
MARK A. McNULTY BA, CFP, CIM



MARK McNULTY is co-author of *The Canadian Small Business Owner's Guide to Financial Independence*. He joined the firm in 1996 after finishing university and immediately began his focus on transition and retirement management for dental professionals. Mark is the co-creator of *The Transition Coaching Program and The Retirement Paycheque*. For more information on the author and their services, visit **www.yournumber.ca**

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clinical

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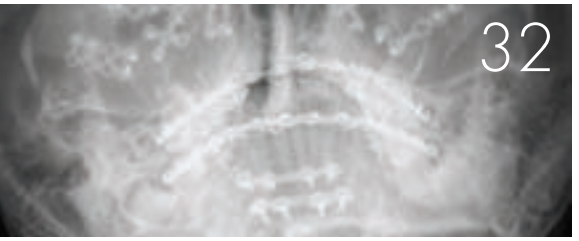
members



ODA Mission Statement
The Ontario Dental Association is the voluntary professional organization which represents the dentists of Ontario, supports its members, is dedicated to the provision of exemplary oral health care and promotes the attainment of optimal health for the people of Ontario.

Ontario Dental ASSOCIATION
Your Partner in Practice

Proof Positive

Dr. Brian N. Feldman's excellent editorial, "Where's the Proof?" (June 2010), confuses some issues, which most people believe are based on "proof," regarding the wearing of gloves.

There is significant evidence that wearing gloves contributes to needle-stick injuries, not reduces them. This is due to the gloves blocking of proprioceptive sensations. What's more interesting is that there is not a single documented case worldwide of a dentist occupationally transferring the AIDS virus bare-handed to a patient, or from a patient to himself. There is only one case, the infamous Dr. Acer Florida case, in which AIDS was transferred from a dentist to a patient, and this was when the dentist was wearing gloves and observing Universal Precautions.

Considering the incredible amount of resources (gloves, masks, etc.) being used for standard precautions, prompted by the FAIDS (fear of aids) epidemic, the "proof" for these measures is essentially non-existent.

Dr. E. J. Neiburger, Director
Center for Dental AIDS Research
Waukegan, IL

Privacy Tips

Regarding the first of the series of articles on privacy in the July/August 2010 issue of *Ontario Dentist* ("Privacy Practices for the Dental Office: Tips for PHIPA Compliance," by Jasmine Ghosn), I would like to say thank you to the author for the useful and novel way she has categorized her article. The tips are friendly and simple to understand. It is a pleasure to read. I wish to read more of your ideas.

Dr. Nabil Tabbara
Adjunct Clinical Professor
Schulich School of Medicine & Dentistry
University of Western Ontario

CORRECTIONS

Gremlins were definitely at work in two past issues of *Ontario Dentist*.

In our July/August issue, on page 23, we mistakenly identified the ODHA President as Ms. Shelley Newton. The ODHA President, shown in the photograph of the opening ceremonies of the ASM, is Ms. Kim Ivan.

In the same issue, in the article, "The Female Perspective," Dr. Yasaman Garakani was mistakenly identified as a member of the ODA Board of Directors.

In our September issue, on page 42, the date of the convocation at U of T should have been June 4, 2010.

Ontario Dentist apologizes for the errors.

Pearls of Wisdom

I was one of Dr. Feldman's students at the University of Toronto a few years ago. I just wanted to say that I really enjoy his editorials in *Ontario Dentist*. I especially liked the one in the May 2010 issue, in which he shared several tips and words of wisdom based on his experience ("Wisdom from Experience"). I would love to see more of this type of content, since new dentists need to be informed of, and reminded of, as many of those pearls as possible.

Keep up the good work!

Dr. Ryan Lindo
Toronto, Ont.

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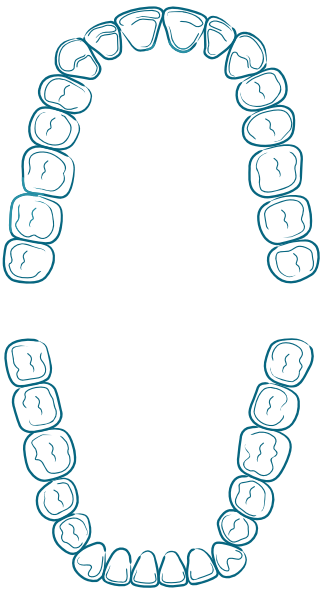

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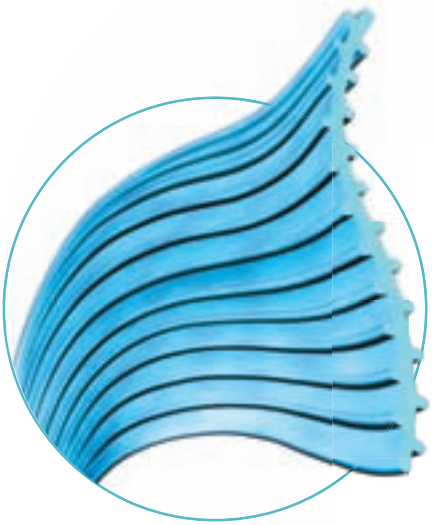

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References: 1. Data on file, Johnson & Johnson Inc. 2. Morris A, Santos S, Sinatra K,et al. Plaque removal of a revolutionary monofilament Floss with Flexible Micro-Grooves™. J Dent Res. 2009;88 (Spec Issue A); Abstract 1574.

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Brian N. Feldman
DDS BA

Adjusting our Focus

One way to get quick snapshots of the dental profession's priorities in any given year is to analyze the scientific programs of Canada's three major dental conventions. Attendees at the 2010 Pacific Dental Conference (PDC), the ODA's Annual Spring Meeting (ASM) and the Journées dentaires internationales du Québec (JDIQ) could choose from a combined total of 235 lectures, seminars and hands-on workshops. These sessions traditionally reflect current topics and key issues, showcasing what the profession feels is important for its members to know. Here's the breakdown.

What's Hot?

Restorative Dentistry

Thirty-four percent (80 of 235) of the presentations dealt with restorative dentistry, including esthetics, endodontics and implants. This is probably as it should be — clinicians have a life-long duty to update their knowledge and refine their skills to adequately prepare for and respond to an increasingly demanding public.

Practice Management

This topic appears to remain of great interest, occupying 13 percent of the presentations (31 of 235). Financial strategies, personnel issues and government and regulatory concerns were included in this category, reflecting the importance of incorporating effective business principles into everyday office routines.

Oral Medicine, Oral Pathology and Emergencies

In a strong third place at 11 percent (25 of 235), these topics suggest the continued expansion of dentistry into its rightful position as a medical specialty, and perhaps also reflect the increasingly evidence-based connection between oral health and systemic health. Entirely appropriate, in my view.

What's Not?

Pediatric Dentistry, Orthodontics and Health and Wellness

These topics tied for third-last, a position that may be explained away by the separate conferences available to specialists (pedodontists and orthodontists) in these disciplines, and by a general fatigue with the entire subject of health and wellness. Still, considering the recent attention to the problem of early childhood caries, I would have expected a greater number of speakers on this topic.

Geriatric Dentistry

Geriatric dentistry stands alone in second-last spot, a finding that both surprises and concerns me. Despite the massive recent emphasis on an impending "seniors' crisis", as well as dentistry's frequent calls for increased access to dental care for the aged and institutionalized, the issue of geriatrics occupied a mere two percent of the scientific programs (four of 235). Because the statistics and circumstances certainly have not changed recently, except maybe to worsen, I suggest this issue deserves far more attention when planning future programs. Ignoring it may mean being unprepared when the long-predicted crisis of inadequate oral health care for our aging population becomes a reality.

Ethics

Coming in absolutely dead last, ethics was the topic of just one of the 235 presentations, registering a barely noticeable 0.4 percent of the programs. It is a glaring omission that I find deeply troubling, and here's the reason: **a profession that does not understand, debate or even make its members aware of the importance and role of ethics in everyday practice risks losing first its integrity, and then its independence.** OD

Dr. Brian N. Feldman is the Editor of Ontario Dentist. *A 1971 graduate of the Faculty of Dentistry, University of Toronto, he teaches part-time in the Departments of Histology and Pathology. Dr. Feldman may be reached at 416-319-6585 or at downsviewboy@rogers.com.*

Lynn Tomkins
BSc DDS

A Strong Profession – A United Community

I would like to take this opportunity to welcome the members of the Canadian Dental Association who may be reading *Ontario Dentist* and this President's Page for the first time in this special edition of our journal.

Welcome, welcome to the Ontario Dental Association and all the wonderful benefits it has to offer all dentists in Ontario. Whether you are an academic dentist, an associate dentist, a hospital dentist, a public health dentist, a consultant dentist, a general practitioner or a specialist, the Ontario Dental Association has the knowledge, the experience, the resources and the services to be your essential partner in practice. I am very proud to be a member of this community, and I hope that you will feel the same.

My husband and practice partner, Dr. Daniel Kmiecik, and I have been members of both the Ontario and Canadian Dental Associations every year since we started dental school more than 30 years ago. That's over 120 years of individual association memberships, and why? Because we feel that as Canadian dentists living and working in Ontario it is our responsibility and privilege to support the associations that help make dentistry a strong, respected and independent profession.

When we started dental school one of the first lectures we received told us that going through dental school would be a conforming experience and that when we graduated we would be much more alike than when we had started. I thought it was a rather odd and obvious thing to say; we were a pretty homogenous group to start with; but over the years as the demographics of our province and profession have changed I appreciate more and more what was intended by that statement. The day to day experience of being in the same profession transcends boundaries of gender, culture and religion. Our concerns unite us, our diversity strengthens us.

The Ontario Dental Association already represents more than 80 percent of the dentists in this province. Our membership is voluntary and the significance of this cannot be overstated. Our mandate crosses all cohorts and special interest groups and for over 140 years the ODA has been the authoritative voice of dentistry and oral health in this province to all stakeholders. We are the largest and strongest provincial dental association in this country.

The oral health practice environment is changing. Increasing government regulation at the provincial level, the clamouring of other professional groups who wish to encroach on our scope of practice, the increasing interference of third-party providers in the dentist-patient relationship, the challenges of treating an aging population in an era of diminishing resources, and the funding of dental education and scientific research are just some of the issues that will affect your ability to practise dentistry as you would like. The Ontario Dental Association knows and understands this environment and is here to help you get ready for the future, whatever dental career path you choose.

As a dentist practising in Ontario you have benefitted already from the strength and advocacy of the Ontario Dental Association. I invite you to add your voice to ours, so that together we can continue to make the profession of dentistry in this province the best that it can be.

Dr. Tomkins maintains a private practice in Toronto and is on staff at the University of Toronto's Faculty of Dentistry. She may be contacted at president@oda.ca.

Ronald G. Smith
DDS

The CDA and ODA: Working in Harmony

It is an honour to have this opportunity to address my Ontario colleagues in the pages of *Ontario Dentist*. I believe this is symbolic of the renewed spirit of co-operation that exists between your national and provincial dental associations.

As you know, beginning in 2011, the Canadian Dental Association (CDA) will officially implement a new membership and governance model. Along with our corporate members (all provincial and territorial dental associations, except Quebec) we are adopting a federation-type model that will shift the CDA's focus to serving the profession and dentists almost exclusively through your provincial dental association.

The origins of this new membership model date back to 2007, when the CDA and ODA created a joint working group to explore ways to help integrate all ODA members into the CDA. At the same time, the CDA worked closely with the corporate members on formalizing a process that would clarify the exact roles and responsibilities of each organization.

After some productive discussions, the membership and governance model is now ready to provide dentistry with a more efficient structure to address the many issues and challenges that face our profession. Our scanning of the professional environment has identified numerous challenges that lie ahead, including:

- an uneven distribution of dentists across Canada
- human resource shortages
- evolving scopes of practice
- increasing government intervention
- an aging, more medically compromised patient population
- increased costs of running a dental practice

For dentistry to adequately address these and other challenges, your professional organizations must be working in harmony. Under the new model, the CDA and ODA will act as true partners, increasing our ability to work in a collaborative fashion to improve service quality, reduce duplication of programs or services, and gain from economies of scale.

To prepare for this new model, the CDA has streamlined its operations and is now focused on three results-oriented strategic priorities. The CDA's overall objective is to continue to build a **strong profession**, nurture a **united community** and support initiatives for a **healthy public**. We will implement these strategic priorities by concentrating our activities on two areas of focus: knowledge and advocacy. The role of the new CDA is to be a trusted knowledge broker for dentists and to be an effective and articulate advocate for the profession.

To fully realize the knowledge-broker function, the CDA is currently refining its internal and external communication vehicles in order to capture, organize and disseminate information that will be useful to the dental leadership in Canada and to chair-side dentists. The CDA's role in advocacy is to protect the dental profession, and to promote and advance it with the federal government and other key organizations and decision makers.

Projects that the CDA and ODA are currently working on together include:

- a national branding initiative that is analyzing the attitudes and opinions of dentists and the public;
- formalizing a process for developing national policies;
- building a network of media relations experts, to ensure the profession speaks with a united voice on key issues.

In 2011, a new era for the CDA and ODA will officially begin. We will continue to explore ways to share our resources, integrate our programs and services, and allow local projects to benefit all dentists across Canada. I am proud to say that we are already enjoying such collaboration, with the CDA and ODA working side-by-side to serve dentistry.

Dr. Smith is President of the CDA and may be reached at president@cda-adc.ca.

Message from the Chair of ODA Membership and Programs Core Committee

Robert Tracogna
DDS BSc

Welcome to the ODA!

I would like to join Dr. Tomkins and the rest of the ODA in welcoming our CDA colleagues.

I know you have all received several letters from our Membership and Communications Department outlining the many benefits of ODA membership. But membership in the ODA allows you to do far more than just access our benefits. I think one of our greatest strengths as an association is that we listen to you, our members, and try to give you what you want.

For example, you told us you wanted a new ODA website that your patients could access, to get information on any number of topics — and www.youroralhealth.ca was born.

We value the ideas and concerns of all of our members — including our young student members. Thanks to our innovative programs, tailored specifically to these future members, the student membership of ODA was at an all-time high of 96 percent as of June graduation.

Of the many seminars organized by ODA, one in particular has elicited a great response: **The Female Perspective** is a brand-new initiative in which our more senior and seasoned dentists give presentations to and discuss issues with our female students. Our first University of Toronto student seminar attracted 24 students and our University of Western Ontario seminar had 40. As well, our office tours — Spend an Evening with a (Practising) Dentist — have recorded enthusiastic attendance.

We are also exploring an interesting new program, aimed at students as well, called the **Student Leadership Initiative**. Students will emerge from these workshops armed with the tools to engage with media, manage public relations crises and more. Linda Samek, Director of our Professional Affairs Department, tells us that the successful launch of the resource manual for personal-care workers (PCWs) looking after oral health-care in long-term care (LTC) homes, resulted in more than 25 percent of LTC homes in the province requesting copies of this important resource.

I feel that our ODA component societies are a rich resource for every member — both personally and professionally. Where else will you make lifelong friends, enjoy social activities, network with your colleagues, and earn continuing-education points?

Don't forget about your continued use of ITRANS and CDAnet; once January 1, 2011, rolls around, and if you are not an ODA member, you will no longer have access to these resources to transmit your dental claims.

And finally, I must mention one of our most-valued member benefits — admission to one of the premier free-standing dental events in North America, available to you as an ODA member. Held every spring, this three-day convention in Toronto attracts world-renowned speakers, exhibitors, and dentists and their teams from across the province. The ODA's Annual Spring Meeting — April 28-30, 2011 — is open only to ODA members and their staff.

BUT — if you don't join the ODA, you will miss out on all the above — plus our other benefits:

- six ODA Suggested Fee Guides, written for general practitioners and specialists;
- member-only practice-management tools — including economic reports and office-staff wage surveys, dental office-employer resources, and business guidance on owning and running a dental practice;
- interactive member website with valuable practice-management and continuing-education tools, as well as dental information for your patients;
- job opportunities, posted on the member website;
- your name listed on "Find A Dentist" on the ODA public website: www.youroralhealth.ca;
- access to member-benefit programs, including the ODA Wellness & Prevention Program at Cleveland Clinic Canada (CCC);
- the ODA's Extended Health Care (EHC) plan;
- political-contact dentist network helping to expand government relations at the grassroots level.

Dr. Robert Tracogna is the Chair of ODA Membership and Programs Core Committee and may be contacted at robert@eastcreditdental.ca or 905-567-1132.

The ODA warmly welcomes the following CDA members:*

Dr. Sam Adouri, Grimsby
Dr. Ahmad Al-Barazanchi, Ottawa
Dr. Dhia Al-Hakak, Ottawa
Dr. Sylvia Elise Apitz, Toronto
Dr. Jerrold E. Armstrong, London
Dr. Rajiv Arya, Toronto
Dr. Marietta Avetissova, Thornhill
Dr. Vinay Badhwar, Brampton
Dr. Sharon Barr, Happy Valley-Goose Bay
Dr. Balraj Basra, Brampton
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*As of September 8, 2010

Jasmine Ghosn
BSC LLB

Responding to a Privacy Breach in the Dental Office

This third article, of our four-part series on privacy considerations for the dental office, discusses recommendations of Ontario's Information and Privacy Commissioner (IPC) on how to respond to, contain, investigate and notify individuals in the unfortunate circumstances of a privacy breach.

A privacy breach may be intentional or inadvertent and occurs whenever a person has contravened or is about to contravene the *Personal Health Information Protection Act, 2004* (PHIPA) or its regulations. Section 12(1) of PHIPA requires health information custodians (HICs) to take steps that are reasonable in the circumstances to ensure that personal health information (PHI) in their custody or control is protected against theft, loss and unauthorized use or disclosure, and unauthorized copying, modification or disposal.[1] Section 12(2) requires HICs to notify individuals whose privacy has been breached — and to do so at the first reasonable opportunity. Options for the notification requirement depend on the circumstances. Below are case examples of privacy breaches before the IPC, actions taken by the HIC, and a concluding list of steps to follow if a privacy breach occurs in the dental office.

(a) Media Reporter Violates Patient Privacy in a Hospital[2]

A reporter shadowed a physician in the emergency department, compromising patient confidentiality, despite a hospital policy requiring signed consent forms from patients or members of their immediate family, before granting media requests to photograph, videotape or interview patients, staff, volunteers or visitors on hospital property. As a result of this incident:

- Staff were provided with retraining sessions on privacy issues;
- The media policy was reviewed and revised where necessary, and all media outlets were sent a copy of the new policy, requiring reporters to sign in and wear media badges;
- The Privacy Officer would conduct ongoing walkabouts with supervisory staff to evaluate privacy on an ongoing basis and make changes where necessary;
- The hospital's President wrote to the newspaper explaining the hospital's obligation to protect patient privacy and the hospital's expectation that the media personnel would adhere to it;
- The individual who complained was given an apology.

(b) Compact Discs (CDs) Stolen from a Hospital Lab[3]

CDs were stolen from a hospital lab and some images had not been saved on the computer hard drive. It was impossible for the hospital to determine the identity of affected patients. As a result:

- A new policy, to be audited on a regular basis, was implemented, requiring all CDs to be stored in a locked desk;

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- The doors to the laboratory itself were required to be kept closed and locked;
- The hospital would acquire a new computer server to store images, and all accompanying PHI would be stored on the hard drive and backed up by the server, eliminating the use of CDs.

Since it was not possible to identify which patients' PHI was stolen, in order to notify affected patients, the hospital worked with the IPC to produce a notice for posting at the laboratory. The notice provided details of the incident and the contact information for the hospital's Privacy Officer.

(c) Misdirected Faxes Are Received[4]

An individual received misdirected faxes from three Community Care Access Centres (CCACs) at his private fax machine. One centre found inconsistencies in ways in which staff had sent out faxes. A staff member had manually inputted the incorrect number, instead of using the pre-programmed fax system. A new corporate fax policy was implemented and staff were re-educated on privacy issues. In order to fulfill its obligations under the Act, CCAC contacted affected patients by telephone to inform them of the privacy breach.

(d) Break-In At Health Facility[5]

A break-in at a rehabilitation facility resulted in two unencrypted laptops being stolen. Information contained on the laptops included names of approximately 3,000 to 4,000 clients plus dates of birth, addresses, physician information, diagnosis, insurance details and information regarding invoiced services. All of the information was also contained in hard copies of patient records. Some of the addresses of past clients were not up-to-date, and the centre had no way of knowing which addresses on file were current. As a result, the centre worked with the IPC to produce a notice for posting at the clinic and on their website.

In a similar case, a computer, which contained scheduling information for clients seen over a two-year period, was stolen from an audiology clinic. The IPC accepted that the most appropriate method of notification, under the circumstances, was to place a short announcement in two local newspapers and post a notice at the clinic itself, to ensure that the approximately 40 percent of its clients who return for services, were also made aware of the loss.[6]

continued page 16

(e) When Notification May Cause Emotional Harm[7]

A computer was stolen from a psychological-services clinic, and the clinic's main concern was to meet its obligation to notify affected patients without causing any emotional trauma or harm. The clinic considered different ways to reach patients, many of whom were no longer receiving services. Options considered were to:

- Send letters or make phone calls to each former patient using the last available contact information;
- Run a newspaper notice;
- Contact referral sources, if available, to attempt to convey information about the loss.

Each alternative could potentially create further concerns for the client. One worry was about disclosing the fact that the individual was a patient receiving psychological services; another was that the referring source may not have been aware that such services were actually received, for example, where employee-assistance programs were involved. Attempting to make contact with patients at their homes meant that some patients might be placed in the difficult situation of having to explain a registered letter or a call from a psychological-services firm. Notification of the breaches might also cause alarm that the contents of sessions would be revealed; in many cases, this worry appeared not to be justified since, for most patients, very limited information was on the computer.

When all considerations were weighed, it was determined that the most appropriate method of notification was to communicate directly to patients. A notice about the loss was posted in the clinic and all affected clients still receiving services were told directly by their care providers about the incident. For former patients, a system was implemented to keep a record of all patients affected, to ensure they would be notified should they return to the clinic. Information about the loss of the PHI would be documented on each patient's chart and made available if the patient returned to receive services.

Summary of Suggested Steps to Take after a Privacy Breach

The IPC recommends that all HICs establish a privacy-breach protocol. The most important step is in notifying individuals whose PHI has been lost, stolen or accessed by an unauthorized person, as this is a requirement of PHIPA. In the event of a privacy breach in a dental office, the dentist should:

(1) Take immediate steps to contain the privacy breach and commence an investigation.
(2) Conduct a security review.
(3) Notify the police if criminal activity, such as fraud or theft, is suspected.
(4) Determine the best method for notifying patients of the incident, then inform them of the steps taken to contain the damage and to prevent this type of incident from occurring again.
(5) Work with the IPC, if necessary, to draft notices for posting in the office, or to determine the best method of notifying affected individuals in a particular set of circumstances.
(6) Provide individuals with the contact information of the IPC.
(7) Notify patients in a manner that is appropriate to the situation, for instance:
    - By letter;
    - In cases where the information is of a sensitive nature, patients should be informed in person during a clinic appointment or through a personal phone call;
    - In cases where it is not possible to identify the affected patients, a notice may be posted on the wall of the office, or by other means, such as the clinic's website;
    - For inactive patients, a newspaper notice may suffice;
    - A press release may be posted to the custodian's website;
    - In cases where the incident receives fairly broad media coverage, the IPC may be satisfied that it is likely individuals would have become aware of the incident.[8]
(8) If financial information or information from government-issued documents is involved, individuals should be advised to contact the applicable bank, credit card company, insurer, government agency or credit-reporting bureau, in order that they may take precautionary measures to prevent identity theft.
(9) Consider what specific changes need to be implemented in your office to address the privacy practices that led to the privacy breach — and implement the changes required.[9]

For more information on PHIPA, please visit the member section of the ODA website or contact Jasmine Ghosn, the ODA's Health and Legal Policy Advisor. She may be reached at jghosn@oda.ca or 416-355-2277.

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9. For more information on establishing a privacy breach protocol, visit www.ipc.on.ca

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The ODA's Oral Health Strategy for 2010-2011

Catharine Capener

In light of the ODA's and our Oral Health Strategy's focus on seniors' oral health in 2010-2011, the ODA has been raising awareness regarding the need for continuing oral health care for an aging population, not only with members, but with the long-term care sector as well. Says Dr. Deborah Saunders, Chair of the 2010 Oral Health Strategy: "Our goal for the ODA Oral Health Strategy is to provide evidence-based knowledge to the dentists on issues related to the oral and overall health of the population in Ontario."

Some facts and figures about seniors in Canada:

- In 1981, there were 2.4 million seniors in Canada[1]. By 2005 that number had almost doubled to 4.2 million, or 13.1% of Canada's total population[2]. By 2036, it is estimated that there will be 9.8 million seniors — 24.5% of the population![3]
- Newly proclaimed regulations to the *Long-Term Care Homes Act, 2007*, require licensed LTC homes to provide assisted morning and evening oral hygiene (brushing teeth) for all residents, and to offer every resident the opportunity for a dental assessment once a year.

In May 2010, the Oral Health Strategy Committee presented two sessions on seniors' oral health at the 2010 ODA Annual Spring Meeting. In addition, the ODA sent letters to all of the 623 LTC homes in Ontario with five copies of ODA's new *Seniors Oral Care: Providing Oral Hygiene Care to Residents of Long-Term Care Homes — A Guide for Personal Support Workers* with a sample of the poster, *Oral Care for Persons in Residential Care*. As of August 30, more than 30 percent of the LTC homes have requested additional copies of either the Seniors Oral Care Guide (almost 9,000) or the poster (almost 3,400), or both.

In June, the ODA sent a toolkit of information to the presidents of each ODA component society consisting of a list of LTC homes in the component society catchment area, the Seniors Oral Care Guide, a poster and a wealth of other information that the ODA hopes that Component Societies would develop a roster of local dentists who would be willing to provide dental care in LTC homes.

"The oral-systemic link is evident daily when caring for older adults," says Dr. Saunders. "Our OHS feature article, reprinted from JADA, reflects the assessment and measurement of quantity of life (in the elderly) as influenced by their oral health."

The ODA and OHS see this as an opportune time for dentists to make a positive difference in their own communities by becoming actively involved in this fast-growing healthcare sector.

Catharine Capener is the ODA's Professional Affairs Administrative Assistant.

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Quality of Life as an Indicator of Oral Health in Older People

Michael I. MacEntee
LDS(I) Dip Prosth FRCD(C) PhD

ABSTRACT

Background. Quality of life is dynamic, fluctuating and resilent; it has both positive and negative attributes and is influenced by personal and social expectations. However, it is difficult to measure the experience in a way that is clinically relevant and useful.

Methods. The author examined the literature relating to the assessment and measurement of quality of life as influenced by oral health.

Results. It is difficult to interpret the clinical relevance of measurements from questionnaires or structured interviews that use predetermined response options to indicate health-related quality of life. In contrast, open-ended interviews and focus groups have helped to clarify the mouth's effect on the quality of life of older people. They also have helped to construct a new model of oral health that is consistent with current concepts of aging and disability.

Clinical Implications. The new model of oral health offers the possibility of developing interviews and questionnaires using language that has the scope and sensitivity needed to reveal the positive strategies that older people use to manage their oral health and quality of life.

Key Words: Research; aging; oral health; outcome assessment; quality of care

Abbreviations: WHO: World Health Organization

The biomedical model of disease dominates our professional education to direct how we examine, measure and interpret oral health, and it focuses our attention on the physical structures and processes associated with the mouth. However, some clinicians and researchers are uneasy with this narrow focus, partly because it can exaggerate the need for treatment. For example, researchers[1,2] exaggerated by between 30 and 90 percent estimates of the need and time required to treat oral health–related problems among frail elderly people in residential care when they ignored patients' propensity to benefit from treatment.

In addition, the biomedical model provides a limited explanation of what causes or promotes disease. For example, the theory regarding the cause of periodontal disease has moved from germ theory to molecular and genetic biology, and from a nonspecific to a specific plaque hypothesis. However, it is more likely that the cause — in contrast to the pathogenesis of this and many other chronic diseases of the mouth—will surface at the population and societal level within the realms of economics, sociocultural structure and behavior.[1]

The promotion of oral health might benefit more from knowing why people choose to neglect their oral hygiene, or binge on sweet snacks, than it does from an explanation of how DNA polymorphisms influence susceptibility to periodontal disease. Similarly, reconsideration of what constitutes a minimal threshold of physical function — prompted by an increased awareness of the propensity to seek and tolerate treatment, as well as to benefit from it — has led dental professionals to promote the "shortened dental arch" as a healthy alternative to prosthodontic replacement of missing molars, at least among older people.[2–6]

The propensity for treatment is influenced by the physical, psychological and social context in which treatment is

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considered, along with a person's desire for treatment and ability to benefit from it.[7] Several practical observations support this concept. We find, for example, that elderly people maintain, for as long as possible, patterns of oral care established early in life.[8] They seek treatment for problems they believe to be serious and are likely to be treated successfully[9]; moreover, they are more accepting of treatment that they believe will benefit their self-image and social interaction than they are of treatment that enhances their physical function.[10,11] This leads us to consider quality of life as an experience that warrants our attention when assessing treatment needs and outcomes, as well as a motivator of behavioral change to enhance the oral health of older adults.

Experiencing Quality of Life

The terms "quality of life" and "health-related quality of life" defy simple definitions, although they are used widely in various contexts associated loosely with the impact of disease and health on personal experiences. Sometimes they are associated with subjective well-being, happiness, satisfaction, goodness and the like.[12,13] Similarly, dental professionals have used the term "oral health–related quality of life" to describe the impact of oral health on a patient's personal experiences. Gregory and colleagues[14] defined the term as "the cyclical and self-renewing interaction between the relevance and impact of oral health in everyday life." Clearly, this is a complicated psychosocial interaction.

Relationships between oral function, health perceptions and oral health–related quality of life have been portrayed, for the most part, as negative experiences.[15] However, quality of life is a dynamic and subjective blend of biological and psychosocial experiences influenced by our personal and sociocultural environments.[16,17] Quality of life seems to be influenced by the extent to which we feel capable of participating in activities that meet our needs and expectations. These activities, in turn, are influenced by our environment, economic status, responsibilities, biological constitution[12,18] and, of course, time.[14,16] Essentially, when our oral health is good, we feel that we can comfortably meet our expectations, but when it is poor, we feel frustrated and sense that our expectations are being compromised.[19]

Dolan[20] defined oral health broadly as "a comfortable and functional dentition which allows individuals to continue in their desired social role." Similarly, the Canadian Dental Association defines oral health as "a state of the oral and related tissues and structures that contributes positively to physical, mental and social well-being and enjoyment of life's possibilities, by allowing the individual to speak, eat and socialize unhindered by pain, discomfort or embarrassment."[21] Clearly, there is an interaction between how we experience quality of life and how we perceive our oral health. However, central to our understanding and interpretation of this psychosocial intricacy is the question of whether we can measure quality of life and the impact that oral health has on it.

Measuring Quality of Life

About 17 dental questionnaires or structured interviews (sometimes referred to as "sociodental indicators") have been developed. (Details of the instruments are found in Brondani and MacEntee.[22]) These instruments have been developed, directly or indirectly, to measure the impact of oral health on quality-of-life experiences.[22] Clinicians and researchers are pointing to these experiences as possible indicators of how a person's self-assessed quality of life is influenced by different treatments in clinical practice or in a clinical trial, or by different programs in a health care system.[23] However, quality of life is influenced by a complicated array of phenomena with positive and negative attributes that probably defy simple explanations, assessments or measurements. Certainly, the phenomena are much more than experiences of ill health, despite the orientation toward dysfunction and disease that dominates many of the questionnaires that assess oral health-related quality of life.[22,24]

Some researchers have questioned the appropriateness of questionnaires or indicators relating to quality of life when developed only from professional notions of normality without the direct input or advice from healthy people.[12,25,26] Consequently, according to Hunt,12 "a good 'quality of life' automatically becomes equated with optimal functioning defined within narrow confines of doubtful relevance to patients." In addition, Bowling[25] explained that "few indicators attempt to measure patients' perceptions of improvement or satisfaction with level of performance; yet it is this element which is largely responsible for predicting whether individuals seek care, accept treatment and consider themselves to be well and 'recovered.'"

Controversy persists as to whether quality of life, as reflected by the broad and multidimensional experiences of negative and positive health — or illness and wellness — can be measured sensitively, reliably or meaningfully.[12,13,22] In general, the predictive validity of the oral health-related indicators is untested. Good evidence exists that the association is weak between the clinical status of older patients and their responses to oral health-related questionnaires.[27,28] This observation, which casts doubt on the concurrent validity of the questionnaires, is compounded by the discordance between global self-ratings of oral health and the satisfaction or dissatisfaction with oral health that emerges on further questioning of older patients. Moreover, the discordance seems to increase with age.[28]

Some investigators have raised similar concerns about the content and construct validity of many dental indicators, because of the way in which they have been developed and the theory upon which they are based.[15,22] Locker and Gibson[29] questioned the merits of "positive health" as a practical concept in applied oral health research; they

found that it lacks a precise definition and empirical support, and it poses measurement problems. These authors concluded, nevertheless, that "the notion of positive health, irrespective of its merits and public policy implications, provides a context for methodological and theoretical debate that can only serve to enrich theory and practice with respect to measures of health and quality of life and therapeutic interventions at the individual and population level."

Theoretical Foundations and Practical Applications in Dentistry

About 30 years ago, Cohen and Jago[30] called for a "sociodental indicator" or questionnaire that was capable of quantifying the impact of oral disorders from a psychosocial perspective, rather than from a biological perspective. This prompted other investigators to use role theory as a conceptual foundation for developing the questionnaire.[24,31,32] Role theory portrays health, or rather the absence of health, as a negative experience, and illness is portrayed as a social deviance that exempts people from their functional role in society.[33] Locker[34] moved the development of sociodental indicators further by offering a model of oral health derived from the World Health Organization's (WHO) International Classification of Impairments, Disabilities and Handicaps[35] that was rooted firmly in role theory and the language of disablement (such as "impairment" and "handicap").[15] The result was a flurry of activity spawning at least 17 dental questionnaires, each with a specific number and range of questions that address mainly the negative impact of disease and ill health.[22,24]

Nonetheless, no consensus exists regarding how health and ill health interact with quality of life. Moreover, no consensus exists regarding the most suitable questions for measuring the interactions or, indeed, on how to interpret the clinical significance of the scores they produce.[12,13,36,37] Indeed, the number and range of psychosocial measures of oral health currently available suggest difficulty with the theoretical foundation and scope of the measures. However, this might reflect the practical possibility that each questionnaire is designed for a particular purpose, because one questionnaire cannot possibly cover the complete range of psychosocial experiences. Also, researchers are concerned about the fact that so many questionnaires project oral impairment (that is, the physical abnormality) and disability (that is, the physical, psychological or social impact of the impairment) strictly as negative experiences, which clearly is not the case for everyone.[38–40]

The negative concepts and language of the questionnaires contrast with current perspectives on impairment and disability.[39] They also fail to accommodate the positive puzzle of disability, such as the "disability paradox" of the quadriplegic person who reports a remarkably high quality of life41 or of the writer with a severe craniofacial disfigurement who feels fortunate because others are less fortunate.[40]

On the other hand, concerns about the negative focus of the questions are tempered pragmatically by the view "that it is more important to know about the sick than it is to know about the healthy, particularly when health care resources are limited."[27] Several indicators are exceptions to this predominantly negative focus, such as the Geriatric Oral Health Assessment Index,[42] the Dental Impact Profile,[43] the Oral Health Quality of Life Inventory[44] and the Oral Health Quality of Life United Kingdom questionnaire.[45] These indicators offer opportunities for respondents to indicate that oral health has been a positive experience. For example, the Geriatric Oral Health Assessment Index[42] asks, "How often were you pleased with the looks of your teeth and gums, or denture?" Unfortunately, the mix of positive and negative questions in this instrument has raised other unresolved issues regarding scoring and interpreting the scores.[29]

Despite their widespread use in clinical trials and health care evaluations, we do not know whether a structured set of questions can probe with completeness and practical relevance the intricate and dynamic experiences of oral health and related quality of life.

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Interpreting Oral-Health-Related Quality of Life

Researchers have adopted theories and assessment methods other than the ill health role theory and structured questionnaires for exploring and interpreting the impact of oral health on quality of life.[14,46–49] Self-efficacy theory, for example, offers an explanation for pain tolerance[50] and the behavior of patients as it relates to prevention of periodontal disease.[51,52] Davis[53] suggested that compliance theory, social structure theory and labeling theory explain how people address the social stigma of oral disorders. Stolar and colleagues[54] found that Antonovosky's concept of social coherence can help explain how older people make sense of their oral health and quality of life.

Open-ended interviews following the traditions of qualitative research[55] and similar to the informal but systematic interview techniques used by clinicians offer rigorous methods and trustworthy opportunities, when transcribed and analyzed thematically, to elicit and interpret a wide range of detailed and sometimes unexpected information about human experiences and beliefs.[39,56,57] Using this research method, Fiske and colleagues[11] discovered how denture wearers suffered from depression and social isolation as a consequence of tooth loss.

My colleagues and I[19,54] used a similar approach to analyze interviews to explore the significance that oral health had in the lives of relatively healthy dentulous and edentulous elderly people. I combined the information from these interviews with the current concepts on health and disability advocated by the WHO's International Classification of Function[58] to construct a new model of oral health.[15] Brondani and colleagues[59] used additional information gathered from several focus groups of elderly people to develop the model further. The result is a model of oral health composed of four major themes: comfort, general health, hygiene and diet. These themes affect people's lives both socially and personally.

The model draws attention to the interaction between the major themes, as well as the overarching influence of personal and social environments on oral health. It illustrates the potential for a person to adapt to, and cope with, impairment and disability, and the influence that the different constituents (such as diet, hygiene) have on a person's activities. The new model is based directly on the experiences of relatively healthy elderly people, as recommended by Bowling[25] and Hunt.[12] It accommodates current theories of aging and disability, with an emphasis on physical, psychological and social adaptation to maintain a sense of coherence[49] and a positive response to disability and ill health despite their tendency to detract from quality of life in old age.[58,60,61]

The model offers a conceptual framework for studies and possibly for questionnaires to explore how people adapt to, and cope with, oral ill health and impairment to maintain a positive perspective on life. More specifically, the model should help in the development of research methods that will explain the disability paradox of why tooth loss and other oral impairments are severely debilitating for some people and merely an indisposition for others.[53]

Finally, responses to a questionnaire focused essentially on wellness or positive health should add constructively to the information already accumulated about the negative impact of oral ill health. These responses also should help explain the different perspectives of elderly people and dental professionals regarding the need for oral care.[2,28]

Conclusions

Oral impairment and disability are inevitable features of old age, but they do not necessarily have a negative impact on one's quality of life. Aging usually proceeds as an unpredictable series of fluctuating experiences, some for the worse and some for the better. Through them, people adapt to cope with adversity and maintain an overall sense of coherence. Typically, people assimilate what is at hand to compensate for expectations and perceptions of loss, and they modify activities and expectations to achieve an acceptable quality of life.

Numerous questionnaires and structured interviews have been developed to document and measure the negative effect of oral ill health, and some also seek information regarding the positive attributes of oral health. However, it is difficult to interpret the measurements in a practical and clinically useful way. As an alternative to the questionnaires and interviews with predetermined response options, open-ended interviews and focus groups with elderly people have led to practical insights regarding the significance of the mouth in old age, and they have provided an empirical foundation for a new model of oral health that is in keeping with current concepts of aging and disability.

As a complement to the existing questionnaires that assess the impact of oral ill health on quality of life, the new model offers a conceptual foundation derived directly from older people for the design of studies and questionnaires that have the scope and sensitivity of language that will enable us to identify the positive strategies people adopt to manage their oral health and quality of life as they age.

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Full references for this reprint are available online at www.ada.org.

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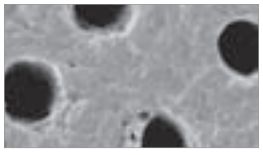

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Scientific works cited: 1. Petrou I et al. *J Clin Dent*. 2009;20(Spec Iss):23-31. **2.** Cummins D et al. *J Clin Dent*. 2009;20(Spec Iss):1-9. **3.** Nathoo S et al. *J Clin Dent*. 2009;20(Spec Iss):123-130.

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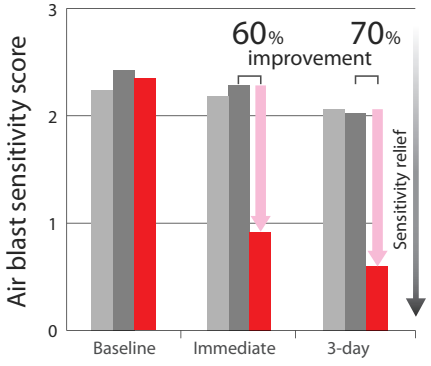

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Irv Feferman
MD

Discipline for Children

Spanking Children – A Risk Factor for Aggressive Behaviour

I thought the days of corporal punishment (spanking) were long gone. Pediatric societies have spoken out against it and some have gone as far as condemning any form of hitting a child as child abuse. In the United States, estimates of parents who use some form corporal punishment vary between 35 to 90 percent. In 2005, 72 percent of parents surveyed stated it was 'OK' to spank their child. A multicenter study in 29 U.S. cities surveyed 4,898 families to determine if corporal punishment had any adverse long-term effects on these children. The mothers were interviewed when the children were three and five years of age, and the results are both surprising and disconcerting:

- Although 46 percent of mothers reported no spanking in the previous month, 28 percent spanked their child one to two times and 26 percent spanked more than twice.
- Increased risk of spanking was more common in families that were younger, black, non-Catholic and with parents who had a high school education or higher.
- At age five, children who were punished more than twice a week exhibited higher levels of aggressive behaviour.
- In addition to spanking, child neglect, intimate partner aggression, maternal stress, depression, substance abuse and consideration of abortion were also factors predisposing a child to aggressive behaviour.

The phrase "spare the rod, spoil the child" was first coined in 1662, and for generations this was an accepted form of child discipline. It is now frowned upon in most families, yet it continues to be practised. This study adds to the large body of data condemning the practice and confirming that children who are punished by spanking are more likely to be aggressive in later years. It would be interesting to follow these children to adulthood. Will their childhood aggressive behaviour persist and will they, as parents, use the same form of punishment on their children?

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Body Checking and the Risk of Injury

Hockey is considered a contact sport and body checking, too often promoted by coaches and parents, remains part of the game. Injury to young players in contact leagues is common and can result in significant morbidity. In a recent prospective study players aged 11 to 12 years (n=2,154) in two leagues (one in Alberta, where body checking is permitted, and one in Quebec where it is prohibited) were followed for one season to compare the rates of injury. Analysis of the findings revealed:

- Players in the contact league were three times more likely to sustain a severe injury.
- Head and face injuries were the most common, followed by knee injuries.
- Players with **previous injuries** and concussions were **more likely to be re-injured**.
- Smaller body size, in both height and weight, were also risk factors for significant injury.

Despite this and numerous other studies, body checking is still permitted in many hockey leagues. Mandatory helmets, faceguards, harsher penalties and rules limiting body contact in the sport have helped. This study focused on a small group of players early in their hockey careers. Further data on older age groups, where contact can be more severe and tolerated, undoubtedly will confirm the potential dangers of allowing body checking in leagues where the players participate primarily to enjoy the sport.

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Ingrid Sevels
DDS BA

Who's on First?

Oral or Systemic Disease

Chronic non-communicable diseases (CNCDs) cause about 60 percent of worldwide mortality. Systemic CNCDs include cardiovascular disorders, diabetes, some cancers and dementia. Oral CNCDs include dental caries, periodontal disease, some oral cancers, and leukoplakia. The relationship between systemic and dental CNCDs has been viewed in different ways and these influence preventive efforts. A recent review article evaluated the two major schools of thought on the associations between oral and systemic disease:

Cleave-Yudkin's Hypothesis

- High dietary intake of **fermentable carbohydrates** is an evolutionary abnormality, which first **causes dental chronic non-communicable diseases** that are viewed as a marker for an unhealthy diet and an alarm bell for future systemic diseases.
- This then causes systemic chronic non-communicable diseases.

Keys' Hypothesis

- High dietary intake of fermentable carbohydrates is nutritious, has no metabolic adverse effects and causes only dental CNCDs that are viewed as a local dietary side effect and a local infection.

Keys sees an ideal diet as one high in fermentable carbohydrates and low in fat to reduce systemic CNCDs. Keys has **not offered reasons** why a diet bad for dental health would good for systemic health, why caries and periodontal disease are not related to changes in civilization, or how the lipid hypothesis is related to evolutionary principles. **Few clinical trials support Keys' view, yet it has been incorporated into recommendations offered by the United Nations and the World Health Organization**.

Because of the dominance of **Keys' theory**, dental professionals have focused on non-dietary preventive approaches in managing CNCDs. **Fluoridation, tooth sealer, oral hygiene devices, rinses and caries treatment with antimicrobials have been the traditional tools of the dentist, rather than dietary modifications**. Most industrialized countries have caries rates among school children and adults in the 60 to 90 percent range.

Keys' hypothesis has suffered a **lack of agreement** among proponents on many dental-systemic issues, giving Cleaves-Yudkin's hypothesis the advantage of offering a more **consistent theory to explain and predict oral-systemic connections**. The authors suggest that rather than a silent side-effect, oral diseases are a loud bell sounding the alarm, for those willing to listen.

J Dent Res 88:490-502, 2009

Eco-Friendly Dentistry

As dental professionals we can learn to reduce our waste and pollution that generates 230 million tons of trash per year. Here are some ways to "pre-cycle" or to choose to avoid creating trash:

- Purchase prophy paste in **bulk containers** rather in individual plastic cups;
- Employ **reusable aids** such as glass cups and metal suction tips;
- Promote reusable **stainless steel water bottles**;
- Switch to **digital imaging systems** to eliminate X-ray fixer and lead foil.

The United Nations has declared a worldwide water crisis generated by population growth, changes in climate and mismanagement of resources. The "Save 90 A Day" campaign encourages everyone to **save an average of 90 glasses of water each day simply by turning off the water while brushing your teeth**. Other energy savers include:

- **Turning off lights** and computers at night;
- Using a **water distiller** in the operatory to avoid chemically disinfecting water lines;
- Using **email instead of paper** brochures to communicate.

As dental professionals we can learn to **rethink, reduce, reuse and recycle** and educate our staff and patients to appreciate and contribute.

Access 23:14, May/June 2009

Motivation for Cosmetic Dentistry

This study investigated concerns of individuals attending a cosmetic dental clinic for esthetically driven dental treatment. The cross-sectional comparative study included 170 persons from six cosmetic clinics; a sample of 878 subjects in the general population served as a control group. The expectation was that dental patients seeking cosmetic procedures would be generally less happy with their appearance and would be more likely to exhibit characteristics of body dysmorphic disorder (BDD). The results showed:

- **Study group members were more likely** to experience **impaired occupational function** than control group members;
- The proportion of **female individuals** in the study group meeting BDD criteria **was higher** than in the control group.

Dental patients seeking cosmetic treatment were distinguished from the general population by psychological characteristics, the number of previous cosmetic treatments and clinical characteristics of BDD. Researchers concluded that if patients seeking cosmetic dental procedures are more likely to exhibit characteristics of BDD than the general population, **clinicians must be cautious of inappropriate motivation**. Further research is needed to assess the long-term effects of cosmetic procedures in dental patients, particularly those showing BDD tendencies or other dysfunctional esthetic perceptions or personality traits.

Community Dent Oral Epidemiol 37:350-356, 2009

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Les Priemer
DDS

Severe Obstructive Sleep Apnea in an 11-Year-Old Patient

Introduction

Obstructive sleep apnea (OSA) is well-documented in adults. This condition involves the collapse of the airway numerous times per hour during sleep, resulting in chronic intermittent hypoxemia. The generally accepted incidence of OSA is approximately four percent of the population,[1] and is associated with excessive daytime sleepiness, morning headaches, depression, memory loss, motor vehicle accidents,[2] marital discord,[3] impotence,[4] acid reflux,[5] gout, diabetes, hypertension,[6] strokes[7] and myocardial infarction. It has been shown that individuals with untreated OSA have a significantly increased morbidity and mortality rate.[8 9]

There are a number of treatment options for OSA: weight loss, altering sleep position, alcohol and smoking avoidance and various surgeries. However the American Academy of Sleep Medicine (AASM) practice parameters suggest that continuous positive airway pressure (CPAP) and oral appliance therapy (OAT) are the treatments of choice for this condition, with CPAP being the gold standard of care for severe (OSA) although OAT can be used if CPAP isn't indicated.[10] CPAP therapy involves a machine which blows air under pressure through the airway and holds it open. CPAP is considered the optimal care because in almost all cases, air pressure can be adjusted (titrated) to an appropriate degree to hold open the airway. OAT works by advancing the mandible and with it the genioglossus muscle which thereby opens the blocked air passage. While OAT is not as predictably effective as CPAP, especially for severe OSA, it is better tolerated by patients.

Juvenile Sleep Apnea

OSA in children is generally considered to be due to enlarged tonsils and adenoids. The recent increased incidence of childhood obesity is considered a secondary cause.[11] Due to poor sleep quality, children with OSA often behave poorly and are misdiagnosed with attention deficit disorder. As well, it has been demonstrated that academic performance suffers and then improves once the OSA is managed. First degree relatives (parents and siblings) have a significantly higher likelihood of OSA.[12 13] Treatment options include tonsillectomy, adenoidectomy, CPAP and orthodontics (jaw expansion and correction of retrognathia).[14] More recently, OAT is being considered as an additional treatment option.[15]

Key Definitions

Apnea: a total blockage of the airway for at least 10 seconds

Hypopnea: a decrease in airflow accompanied by oxygen desaturation

Apnea Hypopnea Index (AHI): The number of apneas and hypopneas per hour of sleep

Mild OSA: AHI between 5 -15

Moderate OSA: AHI between 15-30

Severe OSA: AHI greater than 30

These indices are general. The degree of severity also depends on the number of apneas vs. hypopneas, the degree of oxygen desaturation and symptoms such as excessive daytime sleepiness.

Body Mass Index (BMI): Weight in kilograms divided by height in metres. An index greater than 30 is considered obese.

Case Report

Initial Presentation & Clinical Findings

The patient first presented on Nov. 22, 2007 as an 11-year-old female with a diagnosis of severe OSA, based on the following findings:

- **AHI of 33**
- **AHI of 55, supine. This situation is often called positional obstructive sleep apnea and is generally considered due to the tongue dropping against the back of the airway.**
- **230 obstructive apneas, the longest lasting 86.5 seconds.**

There were no hypopneas and her BMI was 19.13. She was being treated with CPAP, and her mother, father and brother also were utilizing this modality. She was referred by her orthodontist for an opinion as to whether the maxilla and mandible should continue to be advanced to further open her airway. In June 2008, an MRI revealed hyperplastic tonsils and adenoids.

Treatment

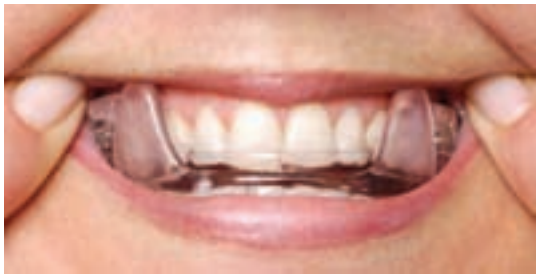
In June 2009, the orthodontist terminated active treatment due to lack of co-operation. It was agreed that the patient would be treated with a mandibular advancing splint (MAS) on the condition that her parents agreed she visit the orthodontist regularly to monitor any occlusal changes.

The patient was seen that month. She had had her tonsils and adenoids removed, but OSA was still present although improved. A post-surgical polysomnogram (sleep study) revealed that she still had moderate OSA with an AHI of 17.5. There were 81 obstructive apneas, the longest lasting 47 seconds. The supine AHI was severely elevated to 79.6. This is significant, because if she had spent a longer amount of time on her back during the second study, her AHI would have been greater.

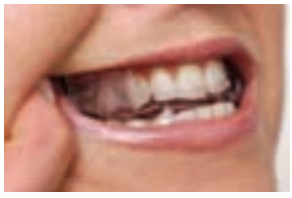
The patient was not using CPAP regularly (three times per week at best). A consultation with the patient and her mother included a discussion of oral appliance therapy, its side effects and complications and the importance of treating this as a serious medical condition.

continued page 30

The mandibular and maxillary components separated.



The Somnodent inserted. Frontal view.



Lateral view. Adustment of the maxillary screws bilaterally advanced the mandible.

The two units lined up as they would be worn intraorally. As they are unattached, the patient can open the mouth at will.

Impressions and registrations were obtained and a Somnodent MAS appliance (figures shown at left) was inserted on June 22, 2009. This particular device was chosen for its long-term comfort and 0.1 mm increments of mandibular advancement. She was reassessed one month later. Her father said that her snoring had stopped. The patient said that she felt more rested but since she appeared somewhat fatigued, her mandible was advanced a further one millimetre. No occlusal changes were noted. She continued to be monitored and by December 2009, her occlusion remained unchanged and she was sleeping well with the oral appliance.

- A polysomnogram was recommended in order to assess the effectiveness of the appliance, and the results revealed:
- The patient's OSA was totally resolved, with only four events for the entire night yielding an AHI of 0.6 per hour.
- The occlusion was unchanged and she will be reassessed on a regular basis.
- When the patient learned that the treatment was successful, she became more co-operative. Her mother noted an increase in her energy level and athletic performance.

Discussion

Treatment of childhood OSA in the past has generally been limited to adenotonsillectomy for most children, followed by CPAP as an option for those who are not surgical candidates or those that do not fully respond to surgery. This case involved an 11-year-old girl with a lower than normal BMI, who had all tonsil and adenoid tissue surgically removed and was not compliant with CPAP. Oral appliance therapy successfully treated her condition. Case studies such as this help validate the role of OAT as an effective treatment modality for obstructive sleep apnea in children.

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The author would like to acknowledge Dr Iris Kivity-Chandler's co-operation and participation in the management of this case.

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Facial Trauma in Northwestern Ontario

Introduction

Facial trauma remains an ongoing concern in Northwestern Ontario (NWO). Despite advances in highway infrastructure safety, improved personal restraints, increased societal awareness of alcohol-related problems, decreased public tolerance of impaired driving and increases in social programs addressing substance abuse, there does not appear to be any significant decrease in the numbers of trauma cases treated in NWO.

Emergency Dental Care

Dentistry continues to play a vital role in managing the wide spectrum of trauma that occurs to patients in NWO. The oral and maxillofacial surgery (OMFS) service provides the first call coverage and the majority of initial and reconstructive care for head, neck, facial and dento-alveolar trauma in the vast area serviced by the Thunder Bay Regional Hospital Sciences Centre (TBRHSC). This area stretches from the Manitoba border to Sault Ste Marie — a catchment zone the size of France (Figure 1) with a population of approximately 232,000, of which the First Nations population comprises 16 percent.

With 100,000 visits per year, the TBRHSC Emergency Department is the busiest in the province. Many of the trauma victims suffer multi-system injuries, and often end up in the Intensive Care Unit, with which the OMFS service works closely. In addition, the OMFS service co-ordinates with colleagues in Otorhinolaryngology, Plastic Surgery, Neurosurgery, Ophthalmology, Orthopedics and Emergency Medicine to provide comprehensive patient care. OMFS also acts as the bridge between initial trauma stabilization and subsequent restorative dentistry, so that trauma victims may regain masticatory function and esthetics utilizing secondary grafting procedures and endosseous implants, as needed.

Types of Trauma

Facial injury patterns most commonly presented were: mandibular and zygomatic fractures as well as dento-alveolar injuries. Trauma statistics gathered by the Oral & Maxillofacial Surgery Service at TBRHSC demonstrate some of the worrisome demographics underlying the majority of trauma cases:

- Trauma continues to be a young male problem. Alcohol and illicit substances play a large role in the etiology of interpersonal violence.
- Patients of First Canadian descent demonstrate a disproportionate percentage (more than 60 percent) of patients involved in serious trauma requiring hospitalization and operative intervention.
- NWO regional influences such as reliance on and the use of off-road vehicles, ATVs, snowmobiles and heavy equipment used in mining and forestry also contribute to the pool of trauma cases. Not surprisingly, a recent paper on maxillofacial trauma from the South Island of New Zealand with a population similar to NWO, shows an identical trauma and fracture experience.[1]

Cases selected for this article (and Facial Trauma In Northwestern Ontario: Part Two – coming in November OD) illustrate the wide scope of OMFS, and show the utilization of peri-orbital incisions, nasal reconstruction, skull fracture repair and complex laceration repairs.

Conclusion

Dentistry continues to play a leading role in managing the unrelenting caseload of traumatic head and facial injuries. Despite advancements in surgical expertise and technology, the emphasis should still be directed towards prevention and education of these costly and sometimes permanently debilitating injuries.

Figure 1
Northwestern Ontario land surface comparison to France.

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1. K.H. Lee. *J Oral Maxillofac Surg.* 67(9) 1878-85, 2009

Beer Bottle Trauma

Thirty-eight-year-old female assaulted with a broken beer bottle. Lacerations were closed in multiple layers — buccal mucosa, deep tissue approximation and finally skin. Procedure required three hours and more than 200 stitches.

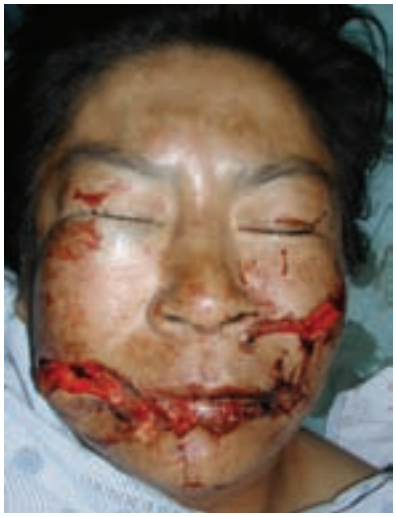

Figure 2a

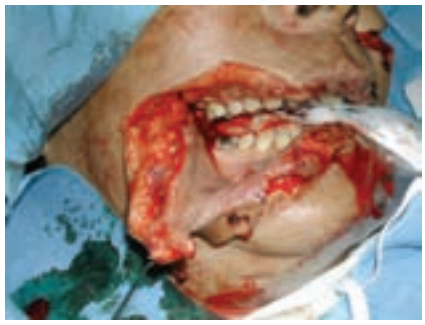

Figure 2b

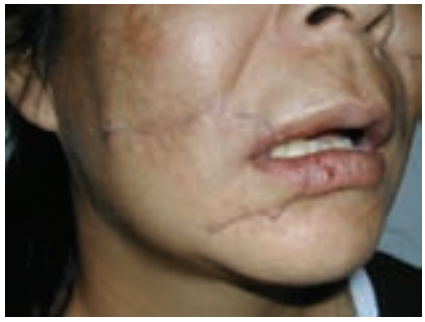

Figure 2c
Appearance at one-year post-surgery.

Fall

Twenty-year-old female fell three storeys from the roof of a school.

Figure 3a
Note red line outlining the path of fall.

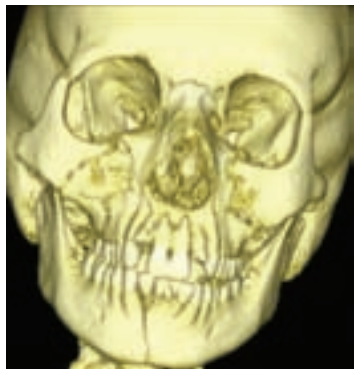

Figure 3b
CT image showing pan-facial trauma involving fractures of mandible, condyles, zygomatic and naso-ethmoid arches, malar complexes and infra-orbital rims.

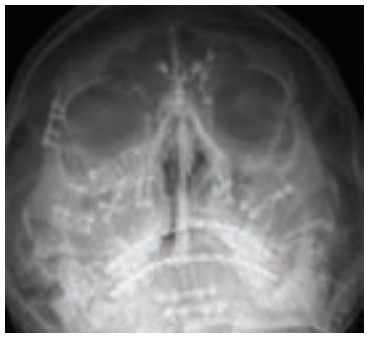

Figure 3c
Radiograph showing Erich arch bars, 12 osseous fixation plates and 43 bone screws. The patient underwent a total of 18 hours of combined orthopedic (eight hours) and oral and maxillofacial (10 hours) surgery in two separate procedures.

The majority of people who smoke want to quit.

Quitting is hard but you can help your patient make it happen.

In less than 3 minutes, you can make a difference in your patient's health.

Follow the 5As:

Ask your patient if he/she smokes.
Advise your patient to quit smoking.
Assess your patient's readiness to quit smoking.
Assist your patient to quit smoking.
Arrange a follow-up.

For more information on helping your patients quit smoking contact your local Public Health Unit or **www.youcanmakeithappen.ca**

Adapted with permission from BCHS Tobacco Cessation Support Program Taskforce

smokers' helpline
CONNECT TO QUIT
smokershelpline.ca
1 877 513-5333

SMOKE FREE ONTARIO

ADVERTORIAL

QUITTING IS HARD

Dentists are in a unique position to help - it just takes 3 minutes!

Dentists and other dental professionals have an important role to play in helping their patients quit using tobacco. Dental professionals are effective cessation counsellors and tend to care for a different population than other medical professionals[i].

As a dentist, you see the impact of tobacco use on your patients. Tobacco use can lead to cancer of the mouth, lips and throat, increased risk of periodontitis, extrinsic tooth staining and halitosis. It is estimated that nearly 75% of gum disease in adults is attributable to smoking[ii]. Further, smoking is related to the initiation of periodontitis, is a determinant of the extent of the disease, and can reduce the effectiveness of proven therapies for the disease[iii].

With so many health effects of tobacco use, why do patients continue to use tobacco industry products? Quitting tobacco is difficult; tobacco is an addictive substance and the tobacco industry designs its products to attract users and keep users addicted. On average, Ontario smokers will make 3.5 quit attempts before they quit for good[iv]. When Ontario smokers were surveyed, over half of smokers intended to quit within six months and one quarter intended to quit within the next 30 days[v].

By screening patients for tobacco use and providing a minimal cessation intervention, you can find out which patients use tobacco products and work with those patients to increase their readiness and confidence to quit using tobacco. The 5A's model is an easy and effective brief intervention that dentists and other health professionals can follow to help patients quit using tobacco industry products.

The 5A's Model:

- **Ask – patients about tobacco use at every visit**
- **Advise – patients about the health risks of tobacco use and to quit**
- **Assess – patients' readiness to quit**
- **Assist – patients that are ready to quit**
- **Arrange – for referral to Smokers' Helpline or follow-up**

Still not convinced?

The World Dental Federation, Canadian Dental Association, Ontario Dental Association, Canadian Dental Hygienists Association, and many other professional organizations all support the role health professionals can play in smoking cessation interventions[vi vii]. The Joint Statement for Smoking Cessation, developed in part by the Canadian Dental Association, asserts that helping smokers stop smoking is one of the most important services a health care provider can offer and that every healthcare provider should ask each patient about their smoking status and document it[viii].

Need help getting started or want more information?

Visit www.youcanmakeithappen.ca where you can quickly access clinical practice guidelines, information on stop smoking medications, find out about learning opportunities and link to other evidence-based resources that you can use within your clinical practice. In less than 3 minutes, you can help your patient make it happen.

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Sarah Bull


Philip Lieberman

Buying a Dental Practice: Start-Up Guidelines for Young Dentists

Why you might want to work as an associate — even if your goal is buying a practice.

If you are a recent graduate, you've left the challenges of dental school behind and are ready to face your next new challenge — which often means buying your own practice. The following tips, created for new dentists, can help guide you through this all-important purchase. Success can be yours if the practice matches your values, delivers a healthy profit and has good growth potential.

Timing Matters

Dentists today need to have more than clinical knowledge. Running a practice requires skills in human-resources, marketing and financial management. One of the best ways to gain these skills prior to purchasing a practice is to work collaboratively as an associate under the guidance of a senior dentist who is planning to retire in a few years. Three of our dental clients suggested you do this for at least two years. The value of working as an associate for a few years:

- This will give you time to repay student loans;
- You will gain confidence in clinical procedures;
- You will learn how the practice operates before you consider making an offer to purchase;
- You will develop a greater understanding of the aspects of owning and operating a business.

Understand the Vision, Values and Culture

Most successful organizations have a set of key core values. In dental practices, these values can be defined by the services offered, the level of care given to patients and the overall patient experience. Here are some issues to consider.

- Problems arise in practice transitions when the values of the buyer and seller are not aligned. Take time to understand your own values and strengths before purchasing a practice. For example, determine what matters to you in a practice: For instance, is your greatest concern client services (the way clients are treated from the moment they walk in until they leave)? What sort of atmosphere, including the staff attitudes, do you want in the office? Are you concerned about having specific kinds of equipment?
- Understand the practice's mission, history, goals and management philosophy. One of the key success factors of a dental practice is how the team interrelates. Employee culture relates to the core values of the practice — the attitudes, beliefs and behaviours of the team influence the atmosphere in your practice. A strong employee culture creates a team that is in tune with the overall goals and is motivated to achieve them. Remember: every interaction and transaction with patients is included in their overall evaluation of the practice.
- If you have worked as an associate *outside* of the practice you are considering buying, it's important to spend time in that office observing and studying the doctor-patient-staff interactions. Try to spend at least six to eight weeks in that practice to make sure it's the right fit.
- Questions you should ask yourself include: Can I walk into the practice and replicate what the senior doctor is doing? Are staff members likeable and easy to work with?

Due Diligence

The main advantage to buying an existing practice is acquiring an immediate patient base and having the accompanying revenue potential. Financial due diligence is important, but you cannot neglect an analysis of the patient base. There are a number of steps you can take to determine if your acquisition will be successful:

- Understand the demographic makeup of the patients. Depending on the services being offered, a roster comprised mainly of older patients may be more of a problem than one with patients of various ages;
- Consider where patients live, their proximity to the dental office and the average household income of the surrounding community;
- Determine the size of the patient base. Most new business will come from word- of-mouth marketing. Having a large patient roster will contribute to the success of the business.
- Analyze the new-patient flow; determine if current patients are active (regularly visit for annual appointments), or inactive
- Perform a chart audit on at least 10 percent of a practice you are intending to purchase. This will give you a good sense of the services and procedures being provided, the scheduling and work flow and the volume of emergency work. For instance, a high volume of emergency work will generate higher revenues.

Location, Location, Location

Many new dentists work in urban areas, since they prefer to practise close to where they live. Consider a more rural location; in smaller communities, profit margins can be higher since overheads, such as rent, are often lower.

Get Professional Help

Once you are considering buying a practice, contact a dental broker or other advisor who has expertise in the dental profession. You will also need the services of an accountant and lawyer who understand the complexities of dental practice acquisitions, as you work through the terms of the agreement and sale.

Learn Your Financing Options

Brokers, accountants and lawyers may be able to recommend lenders. Many lenders specializing in dental-practice acquisition typically do not consider the debt obligations of the buyer, but focus almost entirely on the strength and quality of the seller's practice. Lender policies — for length of the approval process, interest rate, terms of the loan and penalties for early repayments — can vary widely. You will require life and disability insurance as collateral (typically life insurance must equal the full value of the loan, and disability insurance can equal up to 80 percent.)

Liabilities Associated with Purchasing Shares of a Professional Corporation

Dentists in Ontario can incorporate their dental practices. Many sell their practices as share sales, rather than the asset sales. Buying the shares of a corporation means buying the assets and the liabilities. Liabilities can include: outstanding debts, rental arrears, employer liability (any employees who are not terminated will be deemed to be continuously employed by the corporation), taxes payable and lawsuits (unhappy patients may name the corporation in a lawsuit).

The due diligence stage is a good time to identify risks. Professional advisors can often negotiate a "price holdback" for a period of time to cover any of these contingencies. Following wise guidelines and getting good advice from professionals can help minimize mistakes and create the groundwork for success.

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Dale Willerton

Rent Check

Measure twice – pay once

Many dentists are detail people. But they may not always be careful when it comes to leasing their clinic spaces. Dentists, like other tenants, may frequently trust the reported square footage of their leased premises. Whether this figure is reported by the landlord, or by a distant property owner, the amount of recorded square footage can easily be wrong. The discrepancies are often due to negligence, not fraud, but that's small solace. The end result is that you may needlessly be overpaying for your space.

Space Cases

The Chief Operating Officer (COO) of a large chain-store organization told me that her company had recently moved into a new 4,400 square-foot office. She described how spacious and comfortable the office was. When I asked if she had ever verified the square footage, she wondered why it would be necessary. After all, the total area was stated on her Lease Agreement.

Eventually she agreed to let me measure the premises; they were 800 square feet smaller than she'd thought – and 800 less than she was paying for. In the real estate industry, this is called "phantom space."

Dentists must consider two ways in which phantom space increases their costs. Every dental tenant pays two rents — the base rent, which is negotiable, and Common Area Maintenance (CAM) charges. CAM costs cover property upkeep (for example, trash removal, property taxes and building maintenance), which benefits all tenants; the costs are charged proportionately. Therefore, if a dentist occupies 1,800 square feet, he or she is responsible for the CAM charges on that area as well. Every dentist paying for phantom space is also overpaying on his or her CAM charges.

In the case of the COO, her company would have paid $50,000 for space she didn't have over the course of her five-year lease term. When informed of the situation, we negotiated with the landlord who reimbursed the tenant for her overpayments and adjusted the rent.

Even a small amount of phantom space can become a big loss. Another client had a size discrepancy of only 27 square feet — but this unit was located in a prime downtown shopping mall with high rent. When the size difference came to our attention, the tenant was seven years into his lease, and the landlord had collected $20,000 more — in combined rent and CAM charges — than was rightfully due. Again, this case came to a satisfactory conclusion, with the tenant being reimbursed.

With both of these examples (and typically many other cases as well), phantom space was caused accidentally, when the commercial space was initially measured improperly. Regardless of the reason for the error, it is the dental tenant who is left to pay the price, so question the measurement of your space — even if you are presented with a "measurement certification." A location may be "verified" as correct, yet still be incorrect, since the certification simply reports on the initial measurement made. Typically an architecture firm (small or large) will have someone on staff or someone they can refer to who can come out and do a space measurement. Architects who design buildings are accustomed to doing measurements. Usually a firm will send a junior architect to do a simple space measurement.

No one can ascertain the exact size of a space by naked eye alone. Nor should a dentist always trust what is stated on a Lease Agreement. Double-checking the measurement of your premises will give you peace of mind — and might save you thousands of dollars.

Dale Willerton is The Lease Coach, a Senior Commercial Lease Consultant.. He may be contacted at 1-800-738-9202, or DaleWillerton@TheLeaseCoach.com.

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Provide the expiry date(s) of your current home and/or auto policy, or get a quote, and your name will be automatically entered into the **Choose Your Own Adventure Contest****. You could win one of two $5,000 travel vouchers for a destination of your choice. With a draw in June and another in December, enter soon for a chance to win! Call **1-877-293-9455, ext. 5002** or go to **www.cdspi.com/contest**.

** CDSPI Home & Auto Insurance is underwritten by The Personal Insurance Company and distributed by CDSPI Advisory Services Inc.*

*** Contest is sponsored by CDSPI. Contest closes on November 30, 2010. Entry and participation is at all times subject to the complete contest rules. Eligibility requirements, terms and conditions do apply. No purchase is necessary. Residents of Quebec are not eligible. Visit www.cdspi.com/more-info for complete contest rules.*

CDSPI DENTISTS FIRST

10-178-2 01/10

Mark McNulty

Transitions That Work

How to succeed at selling – and buying – a dental practice

Buying and selling a dental practice are two of the most critical decisions in a dentist's career. For most practice owners, the proceeds from the sale of their practice represent a lifetime of work and form the cornerstone of their retirement plan. For purchasers, buying a practice is like buying a professional home; it's not only a source of job fulfillment, it is also an economic engine that will form the foundation of their family's future.

Three groups of shareholders win in a successful transition — the seller, the buyer and the practice participants (that is, patients and staff). The chances of a win-win-win are much greater when the buyer and seller have a shared mindset for what a successful transition is all about. So how do you get to that shared mindset? Following this model will help create a win-win-win transition:

- Find a like-minded practitioner — one who shares your clinical and practice philosophies, from treatment-delivery regimes to team-management concepts
- If you are the seller, create a retirement plan
- If you are the buyer, create a financial plan
- Work with experts (such as a practice broker and/or financial advisor) to help you through the transition.

Find a like-minded practitioner

This is the first area that must match, if the buyer and seller want to create an ideal practice transition. Most good transitions start with several meetings between the dentists so they can find out more about one another.

If you're the buyer, don't be afraid to ask tough questions about the seller's anticipated timeline for leaving the practice, plans for dealing with existing staff, the financial policies of the practice, and openness to introducing new dental techniques and materials.

Points for the seller

- All dentists should retire secure in the knowledge that their legacy endures in the practice they built. Don't compromise.
- Look for a buyer who is keen to be introduced to your patients and team, and appears comfortable and at ease communicating with people.
- Consider the changes in dentistry since you graduated — from advances in clinical techniques and materials, to the integration of technology into all facets of the practice. The new generation of dentists is comfortable with technology throughout the office; during training, they were likely

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introduced to new concepts, which may result in them taking less time with certain procedures than was previously required.

Points for the buyer

- Look for a practice that mirrors your personal philosophy; for instance, is it community-family based or urban-transient? Is it solo or multi-doctor? Is it high-end tech or not? Take time to find the right practice, because any compromises you make here are compromises you will be dealing with for years to come.
- Don't overlook the importance of the team's role in preserving patient retention. The familiarity and acquired interpersonal relationships the team has built over time will play a significant role in helping to bridge the transition gap between you and the seller.

Create a retirement plan if you are the seller

A successful retirement plan will take all your investment assets, including the practice sale, and translate them into an optimal after-tax cash flow you can sustain for the rest of your life. You must have your retirement plan in place before you begin investigating potential buyers.

In my experience, buyers have not been interested in associating for more than a year or two without buying in. If you are not ready to sell within the next couple of years, you may not be ready to bring on an associate.

One 62-year-old dentist who recently sold his practice for $1.3 million could not afford to sell two years ago. He simply did not have the asset base to sustain his lifestyle if he sold the practice. While most people think $1.3 million is a lot of money, it only translates into $43,000 per year (assuming three percent growth and a 30 percent tax rate, with mortality at age 95). Most dentists I know spend more than $120,000 per year in lifestyle costs, as was true with our 62-year-old dentist and his wife.

This dentist first reached his retirement goal and got personally into a position to sell, before he looked into potential buyers.

Create a financial plan if you are the buyer

There are not many businesses you can invest in that provide the immediate return of a successful dental practice. The dentist who bought the above-mentioned practice for $1.3 million will earn $420,000 this year (pre-tax). If he had invested the $1.3 million in a bond, at a three percent growth rate, he would have earned only $45,500.

However, because your practice income is high doesn't mean you will achieve financial success. Here's what to look for:

- Find out if the practice profit will provide you with enough after-tax money to pay down the loan you've taken out to buy the practice.
- Understand what production targets you must meet in order to maintain ideal overhead ratios; you cannot radically reduce costs in dentistry without compromising the practice.
- Be sure you will have enough income to fund all your debts and lifestyle costs.
- Hold off on renovating or buying new equipment if these purchases will make it difficult to pay your existing loans.

Create a healthy practice transition

Both seller and buyer must have total clarity on the financial aspects of ownership transfer. From a tax, valuation, legal, and accounting perspective, concluding these transactions is not cheap.

Draft and sign agreements: To ensure that both parties are protected during the phase-in time, it is essential to have agreement around compensation, hours, expectations of performance, and patient care.

Set a time-frame: While it's important for all parties to become comfortable with the concept of a change in ownership, the seller and buyer must come back to the table to

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declare their final intentions by a set date — otherwise, the seller becomes vulnerable and the buyer is frustrated in his or her goal to assume ownership.

For the seller: You need to take a well-planned, carefully executed approach to transferring ownership. You don't want just any buyer, you want to find someone who really wants to be in your particular practice and who you know will be successful in it. This is especially true, of course, in cases where you intend to work with that new dentist during a transition period.

Given the high stakes on both sides of the transaction, creating the right match between your practice and a new owner will bring you peace of mind, ensuring continuity and ongoing quality care for your patients, and job security for your team.

For the buyer: This is your opportunity to hone and refine the tenets of leadership — honesty, fairness and, above all, patience. Until the ownership transfers completely, take advantage of this transition period to increase your clinical speed and competence as you grow under the guidance and mentorship of the established dentist.

Ideally, once both staff and patients become familiar and comfortable with a slightly different pattern of behaviour, everyone will settle into the day-to-day practice life as though nothing has changed. When the time comes for the final transfer of ownership, you and the practice will be ready for each other and the transition will be smooth and practically guaranteed to succeed.

Mark McNulty, BA, CFP, CIM, is a financial advisor with Raymond James Ltd., Independent Financial Services - Member CIPF. This article is for information only. Its opinions are those of the author, not necessarily those of Raymond James Ltd. Mark may be contacted at 1-866-261-4768 ext. 209 or at mark.mcnulty@raymondjames.ca.

Susan Roberts
BA

Have You Left the Door Open to Potential Problems?

Make your practice safe and secure

Are you aware of potential risks to your dental practice? If so, it's important you identify problems that could threaten your practice, and devise ways to prevent or cope with them. Take these steps to safeguard your business, your employees and your patients from physical or financial perils.

Identify Potential Problems

Take a walk around your office and ask yourself, "What can go wrong, and if it does, how will I prevent harm to people or the business?" Here are some things to look for:

- Check for hazards, such as uneven walkways, inadequate lighting and loose railings that could lead to "slip and fall" injuries;
- Make sure your dental office is protected against potential after-hours break-ins: install a centrally monitored alarm system and deadbolt locks, and keep valuables secured or out of sight during business hours;
- Inspect all your equipment and maintain it regularly to ensure safety and avoid breakdown (and loss of productivity);
- Guard against employee theft; perform background and reference checks on new employees and do annual audits;
- Back up your clinic records regularly, and keep copies stored at a secure off-site location.

Make detailed notes of all the deficiencies you find, and correct the problems.

Do You Have Adequate Insurance

If a fire destroyed your clinic, would you have enough insurance to replace everything, including the building, if you own it? Find out if you are covered for office contents, practice interruption, commercial general liability and building insurance.

- Office-contents insurance covers the cost of repairing or replacing office equipment and supplies that are lost or damaged in an insured incident.
- Practice-interruption insurance pays for necessary ongoing office expenses and income loss, when the practice is interrupted by covered events such as fire, theft or vandalism.
- Commercial general-liability insurance insures against third-party legal actions arising from the practice, such as a patient slipping and falling on the premises.
- Building insurance covers the building's structure, including the walls, roofing and attached fixtures.

Regular Check-ups

Perform regular office inspections and use maintenance checklists to help ensure your office remains accident-free. If there is an accident that results in an injury, or if damage to property

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or equipment occurs, record the details in an accident-and-incident report, and keep the report on file. These reports will help you identify areas in the practice that need improvement and allow you to provide detailed information to your insurer for insurance claims purposes.

You can obtain sample business risk-management policies, maintenance checklists and accident-and-incident report forms at the Insurance Bureau of Canada's website (www.ibc.ca). For personalized advice about the amount of insurance that is appropriate for your dental practice, contact a licensed insurance advisor at CDSPI Advisory Services Inc. at 1-877-293-9455, ext. 5002.

Savings on Office Coverage

The **TripleGuard™ Insurance** plan — which includes office contents, practice interruption and commercial general-liability coverage — provides a five percent premium reduction on your office coverage when you purchase both office contents and building insurance. Reductions of up to 15 percent are also available when you insure multiple office locations. (The reduced rates for multiple office locations apply to coverage billed under the same account.) Visit www.cdspi.com/tripleguard-insurance to learn more.

Susan Roberts, a licensed life and health insurance agent and a licensed general insurance broker, is the Service Supervisor of the Insurance Services department at CDSPI Advisory Services Inc.

Adam Butler
CFA

Risky Business

In a volatile market, timing may be everything.

My wife and I recently woke up to a flooded basement. We debated about making an insurance claim but decided in the end to do so. The insurance company was very responsive; it sent over a contractor and an adjuster later the same day. It turns out our downstairs walk-in wasn't draining properly, so the water collected and flowed in under the door. After a short consultation, the adjuster advised us that our situation was unlikely to "activate" the policy. This is insurance-speak for, "You're out of luck."

It turns out that this type of flood qualifies as an "Act of God," so the insurance company isn't held responsible. That's life. Unfortunately, the wealth-management industry has many small investors fooled into believing that poor market returns are like "Acts of God." That is, advisors and firms can't be held accountable if the market performs poorly. Unfortunately, this doesn't help investors, who are diligently saving for future goals, such as retirement.

Traditional methods for protecting investors' wealth involve scattering chunks of their savings among dozens of mutual funds, stocks and bonds. This is called "diversification," and it is the only nod to risk management most investors are likely to get. During good times, this diversification does tend to smooth the daily "wiggles" in portfolios. However, during those periods when markets are dangerous and investors actually need risk management, diversification stops working. In fact, diversification strategies are a lot like driving a car with seat belts and air bags that work when the driving is smooth, and then fail when you get into an accident.

In my experience the best risk management strategy is an exit strategy. Let me propose a simple one with a long history of success.

A dominant truism among small investors is that it is not possible to time the market. This belief makes some sense: no strategy can accurately predict every significant turn in the market. However, most small investors are not aware that there are proven methods of identifying potentially risky periods in markets which, if properly applied, can add very significant value over time. These methods sometimes deliver false signals; that is, they sometimes signal a market turn that doesn't materialize. However, some investment systems, such as the one described below, have a superb record of protecting investors from major bear markets that threaten long-term investor goals — for instance, those of 2000 to 2003, and 2008 to 2009.

The payoff to a good timing strategy is similar to the value patients receive from regular dental visits to prevent periodontal disease. It is well established that regular hygiene treatments and check-ups, combined with brushing and flossing, may guarantee healthy gums for life.

In the same way, a timing system may sometimes trigger a move to the sidelines (a temporary exit from the market) when a major drop doesn't materialize. This is the cost of "insuring" against the threat of major long-term losses. That said, the small opportunities that may be lost from moving out of markets on false signals, may pale in comparison to the money saved by avoiding those major drops.

I prefer to use a simple "moving average" timing system, which signals when markets may be risky. A monthly moving average is just the average closing price of any index (the S&P/TSX Composite Index for example) over a defined time period, such as 10 months. Investors can use inexpensive Exchange Traded Funds (ETFs) (generic funds traded on major stock exchanges), to gain exposure to five broad asset classes: domestic stocks, foreign stocks, commodities, Real Estate Investment Trusts, and bonds.

To apply the strategy, simply track the 10-month moving average for each of the five asset classes above. If the index for an asset class closes below its 10-month moving average at the end of any month, simply sell the ETF for that asset class and hold cash. When the index closes above the moving average at the end of any month, it's time to repurchase the ETF. History tells us it is nearly impossible to pick bottoms or tops and

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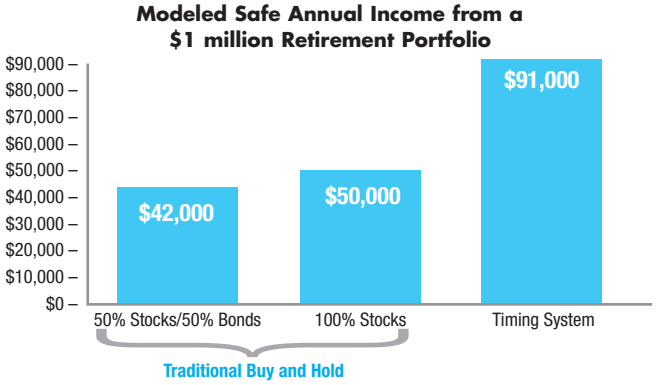
that people often make poor decisions around these peaks and troughs. Instead, it makes sense to use a system that identifies and captures the 'belly' of a trend.

When we discuss timing strategies with investors, they tend to focus on the strong long-term returns these strategies have delivered. For example, the simple system described above has delivered 11 percent annualized returns from 1973 through 2008, compared with nine percent for stocks. Note that this period includes five major bear markets, as well as the longest, most intense bull market in history from 1982 through 2000.

While simple timing systems may deliver stronger returns, many investors, especially those near or in retirement, should take greater interest in the considerable drop in risk that these systems can provide. The above system reduces portfolio risk by between 58 and 75 percent, depending on the measure one uses. For example, the largest cumulative loss to U.S. stocks since 1973, using end-of-month values, is almost 40 percent, while the biggest cumulative loss to the timing system is less than 10 percent over the same period.

The biggest threat to retirement success is poor or negative market returns, especially in the five years immediately before, and the years immediately after retirement. This is due to the impact of withdrawing funds from portfolios when portfolios have dropped substantially in value. By harbouring assets during periods of high market risk, timing systems can deliver much higher levels of income for retirees.



Source: Shiller (2010), Faber (2009), Milevsky (2005), Butler J Philbrick & Associates (2010)
Chart is pro forma and for illustrative purposes only.

The chart above demonstrates the impact a simple timing system can have on retirement income, using unadjusted historical data. The chart compares the theoretical income a retiree can safely draw from a $1-million portfolio that follows the timing system, with the same income available to a retiree invested in an all-stock portfolio, or a balanced 50 percent stock/50 percent bond buy-and-hold portfolio. Learn to manage your risks wisely; doing so could provide you with good insurance against volatile markets.

Adam Butler, CFA, is a Director, Wealth Management and Portfolio Manager at Richardson GMP in Toronto. Adam can be reached at: 416-941-6719 and by email at adam.butler@richardsongmp.com. For related articles and research visit: www.ButlerPhilbrick.com.

Kari Cuss

THE ODA INTRODUCES A *NEW PROGRAM*

Student **Leadership** Initiative

Being a student is tough. Classes, study groups, exams — there's a lot going on.

We know that you have invested a lot of time and money in your dental education. And we are excited for you to enter the world of dentistry. It's a great profession, full of new and different opportunities every single day.

One of those opportunities is to become a leader — not just in your class, but in your school, in your office, and in your community.

As an oral health-care professional, you are seen as an expert by the public, and people want your opinion on issues that come up. It's part of being a DDS. It's part of your life. The Ontario Dental Association wants to help you with this.

For the first time ever, the ODA and CDSPI are teaming up to offer the **STUDENT LEADERSHIP INITIATIVE**.

This November, we will be offering two workshops — Saturday, November 13 in London (UWO students) and Saturday, November 20 in Toronto (U of T students) — focused on leadership skills you might not learn anywhere else. The session, run by seasoned experts, will include (but are not limited to):

- media training,
- how to run a meeting,
- grassroots organizing,
- how to lobby an MPP,
- how to tell your story in 30 seconds,
- how to handle a crisis in your office.

And, the **STUDENT LEADERSHIP INITIATIVE** is free to all four years of students and to graduate students who are interested. Breakfast, lunch and early evening hors d'oeuvres are included. Admission is on a first-come, first-served basis, and space is limited, so enroll today.

We hope to see you there.

For more information, or to enroll, please contact Rose Zisko, ODA Student Services Associate, at rzisko@oda.ca or at 416-922-3900 or toll free at 1-800-387-1393, ext. 3318. ■

Kari Cuss is the ODA Director of Membership, Marketing and Communications.

Treatment Time: Scaling and Root Planing

The ODA's Practice Advisory Services Department has received a number of calls from members about the definition of time, particularly as it relates to scaling and root planing. *The ODA Suggested Fee Guide for General Practitioners* defines a unit of time as 15 minutes. The Economics Core Committee has discussed the issue of when time begins, and its position is and always has been that time is not simply instrument-on-tooth time; it is in fact treatment time. One should view scaling and root planing as one would view any other dental procedure. No one would argue that treatment time begins [only] when the bur, forceps or elevator touch the tooth and, likewise, there is no justification for the argument that scaling and root planing time begins when the instrument touches the tooth.

Treatment time includes the time spent reviewing the chart to prepare oneself for the procedure. If the dentist administers a local anesthetic prior to performing a surgical or operative procedure, this time is considered part of the procedure. Thus if a practitioner reviews the patient chart in preparation for scaling and root planing and administers a local anesthetic, all of these activities would be considered part of the treatment time.

> *"One should view scaling and root planing as one would view any other dental procedure."*

Examples of time spent that would *not* be included in treatment time would be the breakdown, disinfection and set up of the operatory, as well as administrative functions such as billing and reappointing the patient, since the costs associated with all of these procedures are captured in the "cost" factor, which is part of the formula used to derive the suggested fees for every dental procedure. A further example of time that should not be included in the scaling and root planing time would be time spent measuring probing depths. That time would be considered part of the dentist's examination and diagnosis time, whether the examination and diagnosis is performed at that appointment or at a subsequent appointment.

If a dental hygienist has advised you that she is obligated to record instrument-on-tooth time, she will not be capturing the treatment time, and since it is the treatment time that determines the procedure code to be used, dentists may want to direct the dental hygienist to also record the start time for the procedure as described above, as well as the time when the procedure is completed (for instance, when post-treatment instructions are given to the patient and the patient is discharged from the operatory, or when another procedure begins). When completing a claim form for a patient, the dentist will select the procedure code that reflects the procedure performed, and the number of units within the code will reflect the actual treatment time. When using a "per unit of time" procedure code such as scaling, time is always measured in 15-minute units.

The ODA is the ultimate authority on the use of the ODA Guide and it provides support for members in understanding the guide and how it is to be used. Members are cautioned against following the advice of anyone other than the ODA on the use of the ODA Guide or the coding of dental services. Inaccurate advice can place the dentist at risk of a complaint. Members who have questions about the use of the guide should contact the Practice Advisory Services Department at 922-3900. ■

ODA Website

Catherine Perdue

New ODA Member Website Launched

We've listened to you and created an easy-to-navigate website with new features.

"We've worked hard over the past year to make this website a substantial benefit for our members," says Dr. Lynn Tomkins, ODA President.

Go to ODA.ca and click on the Member Login tab, or to reach the page directly go to **ODA.ca/member**. Let us know what you think by clicking the feedback button on the home page. We look forward to hearing from you. ■

Horizontal navigation bar allows quick access to your ODA Profile, a searchable event calendar, the current issue of *Ontario Dentist* and archives, the Media Room and Frequently Asked Questions (FAQ.)

Vertical navigation bar is divided into categories with information for your business and your patients.

We welcome **your feedback**.

Photos of members will rotate in the top banner. Send us your photo!

Did you know topics will change twice a week. Send us your suggestions!

Main banner will change twice a week to highlight ODA services and benefits for members.

Latest Updates highlight topical issues and information.

Category Main Page
Here you'll find an index of all the category's subsections and links to specific areas.

A **component society section** with 39 individually tailored component society pages, highlighting events.

Update Your ODA Profile
Click on the headings to change or add new information in Your ODA Profile. It's simple and quick. You can also change your login password here and find your fee guide password and your Component Society. In May you'll also be able to access ODA online membership renewal.

Attend the TAD's Annual Winter Clinic

Michelle Holden

Mark **November 12, 2010**, in your calendars for the 73rd Annual Winter Clinic, being held in the South Building at the Metro Toronto Convention Centre.

One of the largest one-day comprehensive dental meetings in North America, the Winter Clinic promises to deliver a world-class clinical program and trade show. Organized by the Toronto Academy of Dentistry, along with the support of the four Toronto Component Societies, the Winter Clinic welcomes attendees from across Canada, and is sure to have something of interest for every member of the dental team.

Speakers who are experts in their respective fields, more than 100 exhibitors, an exhibit show floor showcasing dental products and innovations, a silent auction and a photography contest are the highlights of this year's Winter Clinic.

The Winter Clinic is more than a network of knowledgeable professionals willing to offer their experience and advice to newer members. All those involved in Winter Clinic take an interest in shaping the future of their profession.

Once registered, you will have access to all general lectures, the exhibit floor, a box lunch and entry to the cocktail reception.

For complete program details, and to register online, please visit www.tordent.com. ■

Michelle Holden is the Executive Director of the Toronto Academy of Dentistry.

DENTAL Calendar

EVENT: AACP CANADIAN CHAPTER 4TH ANNUAL INTERNATIONAL SYMPOSIUM
Location: Hyatt Regency Toronto,Ontario, Canada
Date: October 15 and October 16

Sleep, Pain, TMD — What's the Connection?

Explore how sleep, pain, and TMD can be treated through professional services such as physiotherapy, chiropractic therapy, cranial sacral treatments and more.

Speakers include:
Dr. Steven Olmos, DDS
Dr. Jeffery Mersky, Chiropractor
Dr. German Ramirez, DDS
Dr. Brian Rotenberg, ENT Sleep Surgeon
Dr. James Carlson, DDS

For more information on the conference program, speakers and registration, please visit: www.aacpcanada.ca

ODA GENERAL COUNCIL INTERIM MEETING
November 26-27, 2010
Marriott Toronto Eaton Centre Hotel
Agenda items must be submitted no later than October 20, 2010. The call for credentials has been distributed to component society secretaries on September 27 with credentials due no later than October 27.

Questions regarding this meeting can be directed to ODA staff member Sharon De Furia at sdefuria@oda.ca
or 416-355-2280/1-866-739-8099, Ext. 2280.

April 28 – 30, 2011
FOR CLASS REUNIONS AND ALUMNI EVENTS BEING HELD AROUND THE 2011 ODA ANNUAL SPRING MEETING
Listings will be featured in the
Ontario Dentist/ODA Website/On-Site Program
To receive a listing form - please contact:
Diana Thorneycroft, Ontario Dental Association
Telephone – 416-355-2266 / 1-800-387-1393 ext. 2266
Fax - 416-922-9571 Email – dthorneycroft@oda.ca

In Memoriam

The ODA regrets to announce the passing of:

Dr. Anthony Peter Barzan, on July 13, at the age of 55. He graduated from the University of Toronto's Faculty of Dentistry in 1980 and maintained a general dentistry practice in Sault Ste Marie. A member of the Sault Ste. Marie Component Society, Dr. Barzan is survived by his wife Louise and family.

Dr. Vernon Charles Evered, in July 2010, at the age of 85. He and one other pilot (who is still living) were the last of the WWII RAF pilots. Dr. Evered graduated from Guy Hospital in London in 1954 and registered in Ontario as a general practitioner in 1974. He maintained a practice in Toronto. Dr. Evered is survived by his daughter Margaret Ann.

Dr. Howard Allen Ferguson, on August 2, at the age of 86. He graduated from the University of Toronto's Faculty of Dentistry in 1949 and maintained his general dentistry practice in Markham, until his retirement in 1996. A member of the North Toronto Component Society, Dr. Ferguson received the ODA's Award of Merit in 1987 and his 50-year pin in 1999. Dr. Ferguson is survived by his family.

TRIBUTE
Dr. Leonard (Len) Shapira

Dr. Len Shapira was born in Saskatchewan in 1923. He graduated from the University of Toronto's Faculty of Dentistry in 1945 and entered the Canadian Dental Corps before buying his practice in Toronto.

A 65-year member of the ODA, Dr. Shapira served as President of the North Toronto Dental Society and Toronto Alumni Chapter of the Alpha Omega Fraternity. He volunteered at the Mt Sinai Hospital in the Restorative Dept. for several years. Dr. Shapira also served in all capacities of the Toronto Academy of Dentistry, including Chairman of the annual Winter Clinic before being appointed President for 1980-81.

Dr. Shapira practised dentistry for 46 years and passed away on April 8, 2010. He survived by his daughters and grandchildren.

ASSOCIATES

Vaughan
Our practice is in the heart of Vaughan. We are looking for an enthusiastic and energetic associate to join our dental team for Saturdays and evenings, with an opportunity to grow into a full-time position. 3-4 years experience required. Send resumé to vaughandental@rogers.com.

Dentist needed one day per week to provide treatment in a community-based clinic. Income guarantees, plus incentives. Please send resumé to DrLeon@YongeEglintonDental.com.

Seeking pediatric dentist. Unique opportunity awaits you at this large, general dental practice located in Ottawa. This up-to-date practice has an outstanding reputation and dedicated staff. Newly remodeled office with great location and every convenience for a motivated individual. Guaranteed daily minimum compensation of $1,350. Please email your resumé to Lida Tohidi, clinical manager, at l.tohidi@gmail.com.

PT/FT associate opportunity available for a motivated and energetic DDS in a state-of-the-art, friendly and growing family practice in Bolton, Ontario (Hwy. 50/Healey Rd.). New grads welcome. Please email your resumé to healeydental@gmail.com.

LONDON, Ontario. Full-time dental associate required for a busy family practice. Our energetic and highly motivated team requires a dentist to provide services in all facets of dentistry including orthodontics, pediatric dentistry, surgery, endodontics and restorative dentistry. Our commitment is to provide the finest dental service to our patients in an environment conducive to personal and professional growth. For further information about our practice, please visit our website at www.cosmodentalcentre.com or our ad in www.ypg.ca. Should you wish to explore this opportunity, please reply indicating your interest along with your resumé by email to anwar.dean@sympatico.ca, fax to 519-659-6339 or by mail to Cosmo Dental Centre, 373 Clarke Road, London, Ontario, N5W 5G4.

Associate needed for established Mississauga practice. Successful candidate will be caring, team-oriented and dedicated to outstanding patient care. Experience with paedo, endo and surgery preferred. Tuesday 8-5, Wednesday 1-8 and Friday 8-1, with opportunity for growth. Please forward CV, with cover letter telling us about yourself and your practice philosophy, to rhondaleeservices@gmail.com.

Markham, Ontario – Associate Required
Part-time associate needed for comprehensive family practice. Excellent learning opportunity. Previous partner has retired. Email to schari157@rogers.com.

Don't miss this opportunity!
Associate position leading to ownership, if desired. The office features eight beautifully appointed operatories newly equipped with the best of everything! Other features include a motivated long-term team, non-assignment and chartless, completely digital records. Excellent location in a young, vibrant, high-growth area, minutes outside of Sudbury. Live the cottage lifestyle every day! Here you can own a beautiful lakefront home for a fraction of southern Ontario prices!
Current owner can't accommodate client demand and welcomes the opportunity to discuss your future. Send your CV to drdouglashanson@eastlink.ca.

Established dental practice in Ridgetown, Ontario (between London and Windsor) looking for part-time associate (2-3 days and possibly more). Three operatories recently renovated, digital radiography. Practice has grown 20% from 2009 to 2010 with many new patients monthly. Committed to providing excellent general dentistry to all ages.
Contact Dr. Jeffree Dempster at dempsterfamilydentistry@hotmail.com.

Lloydminster, AB
We are a busy, non-assignment clinic looking for a full-time associate. We perform a full range of general dentistry, including implants and Invisalign. Our office hours are weekdays only – no evenings or weekends. This modern clinic is fully computerized, including charts and radiographs. The associate will have sole use of two operatories and a third, if required, as well as a large personal office. This position is available immediately. Please email resumés to lloyddentist@hotmail.com.

Toronto – FT/PT Associate required for a busy dental office. Experience is preferred but new grads are welcome. Please contact Dr. N.C. Sharma by fax, 416-222-9777, or email rscharma@hotmail.com.

Large Six-Figure Dental Opportunity
Large, modern dental facility is looking for a Dentist to join an expanding practice. This 13-chair practice is the most modern in the area. Signing bonus, large six-figure starting income, regular hours, no evenings or weekends and huge career growth potential. Situated in a modern community of 40,000+ in northeastern Ontario. If you are interested in an excellent income potential in a modern facility with limitless dental career possibilities, send resumé to dental@toppenn.com.

Associate Wanted – Ottawa
Do you want to be an associate with the opportunity of becoming a partner?
If yes, we are looking for people-oriented dentists seeking to associate with the opportunity of becoming a partner.
Please phone 613-526-3535 or fax resumé to 613-526-1515.

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Very busy, successful, large ten-op practice, whose focus is on comprehensive family dentistry, is looking for an exceptional general dentist to join us. We are looking for a quality team member with proficient skills who has a positive personality. Our office offers a full range of services including endo, ortho, prostho, implants and surgical dentistry. Located in the heart of Sunset Country, our surroundings are more than a tease for those outdoor enthusiasts. If you are looking for a great work/life balance in a beautiful part of Ontario, you are welcomed. Inquiries and resumés, please forward to sherryffdc@bellnet.ca.

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FORT FRANCES
Opportunité financiére inégalée. Bell pratique avec 4 dentists, 10 salles opératoires, récement renovée recherché un(e) dentist motive(e) pour accomoder une clientele grandissante. Si vous désirez être occupé(e), notre carnet de rendez vous se rempli plus de 3 mois à l'avance. Des services d'endodontie, ortho, prostho, implants, chirurgie, etc. sont offerts. Située au Coeur de Sunset Country, les environs sauront combler les amateurs de plein air ainsi que de shasses et pêche. La vie prés du lac ainsi que la libertié des soirs et des weekends vous laissera d'avoir une vie familial de qualité. Pour plus d'information, contactez ou envoyez votre c.v. à sherryffdc@bellnet.ca

DENTAL CONFERENCES

Announcement: Unique Inter-professional course — Holistic and Integrated Approaches to Dental Health. November 11, 2010 at the elegant University Club of Toronto. 4:30 p.m. sharp (dinner served).
This is what you get: New patients though inter-professional referrals and online search; free one-year membership to HAPA; free product samples; clinical pearls and protocols; four CE credits. Please call/email (limited space available). $185/person. 416-483-9600; summerhillgardensdental@rogers.com; www.HAPA-id.org.

EQUIPMENT

Four nitrous oxide flowmeters, scavenging systems, masks, tank and unit valves, hoses, etc. Price $4,000. Contact Dr. Robert Sare – robinsare@gmail.com.

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Locum Dentist: Experienced and proficient in all areas of dentistry. Caring and gentle manner. Short- or long-term. References and resumé available. Please call Hugh Kinkartz at 416-917-3289.

Locum dentist with more than 30 years in general practice, including 15 years' locum experience, will provide locum services during illness, maternity leave or other leaves of absence, vacation, etc. Will accept part-time or full-time locum position. Willing to travel to anywhere in Ontario. Available immediately. Please contact Dr. Peter Rockman at 905-889-7474, cell phone at 416-564-8303 or email mprockman@rogers.com.

LOCUM DENTIST AVAILABLE
Experienced and proficient in all aspects of dentistry. Caring and gentle. Short- or long-term. Will to provide service anywhere in Ontario. Please call Dr. Philip Lovick at 705-740-9749.

MISCELLANEOUS

Seats available for Intra-Oral Level 2 Dental Assistant Program
Everest College Kitchener has six seats available for the Intra-Oral Level 2 Dental Assistant Program that starts on Tuesday, October 12. The program lasts 12 weeks and it is a morning class. All qualified applicants can contact an Admissions Representative at Everest College Kitchener at 519-745-1140.

OFFICE SPACE

Luxurious Finish – Dental Office for Lease
Approx. 900 sq. ft. Call: Days – 416-421-6830; evenings – 416-445-2576.

Tired of Renting?
An enterprising group of select professionals seeks a dentist from each area of specialization to join them in developing and retaining ownership of professional centres in a number of strategic locations in Toronto and surrounding areas of southern Ontario. 416-417-7052 or doncarroll@statimdiagnostics.com.

PRACTICE OPPORTUNITIES

Practice for sale – Dryden, Ontario. Approximately 1,500 patients, one full-time hygienist and one part-time hygienist. $100,000. Contact Dr. Peter V. Cortens at 807-223-7444. Available June 30, 2011.

NIAGARA PENINSULA
Active orthodontic practice for sale. Services a large, urban, populated area, centrally located, great opportunities for expansion. Call 289-821-1139 between 6 and 7:30 p.m.

Upper Ottawa Valley – Practice for Sale. Well-established in Whitewater region, 50-minute drive from the west end of Ottawa. Please contact gmdthompson@hotmail.com for further details.

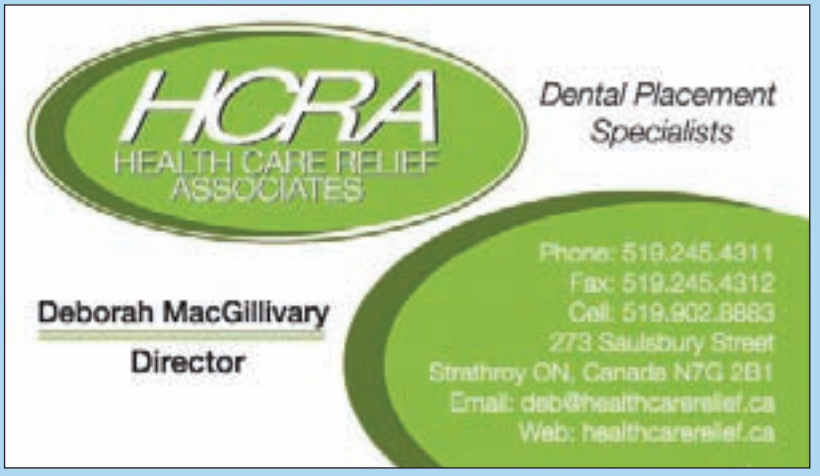
Family general dentistry practice at Lawrence and Bathurst. Freestanding house with parking. Looking for cost-share or associate with own patient base. Please email dentistryonlawrence@yahoo.ca.

Practice Wanted – Ottawa and Area
Thinking of retiring?
Interested in selling your practice?
Save the brokerage fees and sell your practice privately.
Contact Andy: 613-298-9919.

ADVERTISER INDEX

ONTARIO DENTIST MARKETPLACE

ONTARIO DENTIST MARKETPLACE



VACANCIES AT THE ONTARIO DENTAL ASSOCIATION

The Ontario Dental Association is the voluntary professional organization of the dentists of Ontario, promoting optimal oral health and the highest standards of practice to the people of Ontario. The ODA mandate is to create an environment for delivering quality, accessible, oral health care and to assist its membership in meeting professional and economic responsibilities.

The ODA has an immediate need for an:
Assistant Dental Information Officer

The Assistant Dental Information Officer in the Practice Advisory Services department is a member/customer service position that provides technical support and services to member dentists, public and third parties related to the Ontario Dental Association Suggested Fee Guides and policies for the Practice Advisory Services Department.

Major Responsibilities include:

- Respond to telephone, email and written inquiries from member dentists, public, and insurance carriers primarily related to the ODA Suggested Fee Guides and ODA Policies
- Respond to telephone, email and written inquiries concerning electronic dental claims submission tools such as CDAnet and ITRANS
- Lead or provide support in the development of current and future department resources that assist members in dealing with the business of running a dental practice
- Update the ODA Intranet and Member website with department specific content
- Provide back-up minute taking and related support duties to the Economics Core Committee and its Subcommittees and Task Forces
- Provide back-up support for the administration of the ODA Member Extended Health Care Plan

Required skills and experience:

- Secondary school diploma plus additional specific training, via college, or other recognized institution (one year)
- Minimum four years dental office experience, front desk and chair-side assisting
- Knowledge of dental procedures
- Familiarity with dental terminology
- Minimum three years working with Suggested Fee Guides
- Ability to communicate effectively with profession, public, and insurance industry
- Dental Claim Adjudicator with Insurance Carrier an asset
- Word, Excel, PowerPoint, Access
- Minute taking skills
- Excellent interpersonal skills and presentation skills

Please send resumes with salary expectations to:
Ingrid McDonald, Senior Manager, Human Resources
Email: recruit@oda.ca

Only those candidates selected for an interview will be contacted.

The Ontario Dental Association is the voluntary professional organization of the dentists of Ontario, promoting optimal oral health and the highest standards of practice to the people of Ontario. The ODA mandate is to create an environment for delivering quality, accessible, oral health care and to assist its membership in meeting professional and economic responsibilities.

The ODA has an immediate need for an:
Education and Meetings Manager

The Education and Meetings Manager works collaboratively with staff and volunteer committees to promote the highest professional standards for ODA members through the development and delivery of continuing dental education offerings and /or related programs and services. This position also provides oversight in securing appropriate internal and external sites for ODA approved meetings within identified parameters.

Major Responsibilities include:

- Provide advice and support to the Education Core Committee
- Work with identified committee(s) to develop, promote and deliver ODA education programs for ODA members and, as appropriate, other members of the dental community
- Provide logistical planning, organization and oversight support for ODA Board, Council and other ODA off site meetings and events
- Prepare draft budgets and financial considerations for the approval of the Department Director
- Finalize contracting of education presenters/speakers in accordance with approved budgets, committee direction, ODA policies and practices
- Prepare draft contracts with service suppliers for education/ODA meeting functions for approval by the Director
- Draft education and exhibit promotion materials and oversee the review/approval process within identified time lines
- Supervise staff within the education and meetings section of the department

Required skills and experience:

- College or University degree in a related discipline or equivalent experience
- Minimum of five (5) years experience at a supervisory/management level
- Minimum five (5) years experience in planning, managing and executing meetings/events
- Minimum five (5) years experience in project management related to the delivery of education programs and events, including exhibits
- Experience in budget planning and management
- Good written and verbal communication skills, including report writing
- Good interpersonal skills
- Problem solving and critical thinking
- Ability to work under pressure, to meet tight deadlines, multi-task, prioritize work and to work both independently and within a team
- Pays attention to detail
- Strong computer skills: MS Word, Excel, Access and database management
- Experience in the field of Adult Education an asset
- Either a member of MPI or willing to become a member of MPI or equivalent organization

Please send resumes with salary expectations to:
Ingrid McDonald, Senior Manager, Human Resources
Email: recruit@oda.ca

Only those candidates selected for an interview will be contacted.

Catherine Morana

Under One Roof

In 1951, 234 St. George St. in Toronto, was the "Dental Centre Home" for dentists in Canada. Its offices would house the CDA, ODA and RCDS.

Photo by Julia Fraser

In November 2009, the ODA General Council unanimously approved the ODA Board of Directors' strategic direction for the approval and implementation of a new proposed CDA Corporate Membership Model. With bylaw amendments recently approved at our May 2010 General Council, we are now set to implement a new governance structure that will finally resolve the ongoing competition for members between the ODA and CDA, that has existed for almost 35 years.

Prior to that, operations between the ODA and CDA were so closely entwined, they even shared the same roof.

In 1950, the CDA purchased 234 St. George St. in Toronto as their national headquarters. The ODA, having outgrown its offices at 86 Bloor St. West in Toronto, would move in as a tenant, along with the Royal College of Dental Surgeons (RCDS.)

Formerly the home of Robert Watson (ironically a candy-factory owner), the building was designed by E. J. Lennox. The main floor housed the ODA office, a library and a boardroom. The CDA and RCDS offices were on the second floor. All records were housed in the basement.

Centralization made sense: it allowed all the dental organizations to share resources, utilities and knowledge, and it enhanced communications. In 1953, the ODA would find itself operating at a deficit. The RCDS worked out an arrangement that allowed the Association to continue to function: all dentists would automatically become ODA members upon payment of their license dues, and RCDS would fund the ODA with grants. (Such an arrangement would not be allowed today).

By 1958, the CDA needed the entire space at 234. The RCDS would purchase 230 St. George Street, and in 1959, the ODA, CDSPI and the Toronto Academy of Dentistry (TAD) became tenants there. ODA and TAD staff would walk next door to borrow the CDA's Gestetner and Addressograph machines when needed.

However, this arrangement didn't last. On June 29, 1966, the Robarts' provincial government announced his appointment of the *Ontario Committee on the Healing Arts*: "The committee with powers of a royal commission, will investigate 'healing arts," standards and discipline and will advise the government on all training, education, licensing, and punishments for doctors, dentists, chiropractors and nurses." [1]

When the committee's final report was tabled in the Ontario Legislature on April 28, 1970, one of its first recommendations was that all licensing bodies, being responsible for "the pursuit of the public interest", must now operate distinctly from professional associations.

The Health Disciplines Act was finally proclaimed on January 1, 1975. That year, the ODA and CDA would begin collecting voluntary dues for the first time.

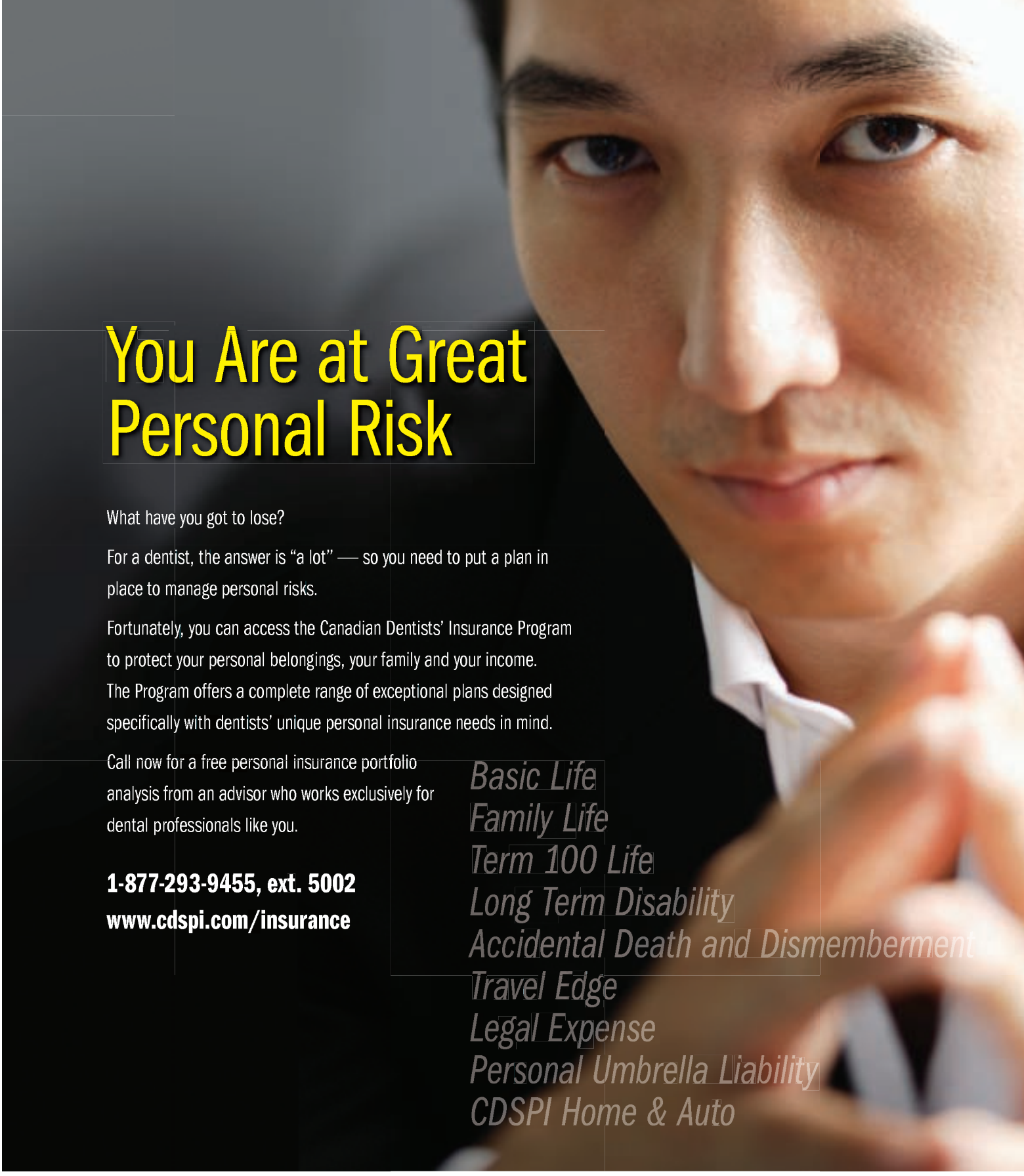
The CDA and ODA initially began collecting joint dues. However, the CDA would eventually move to Ottawa to be more reflective of its national role, selling 234 St. George to the ODA. The two organizations would eventually start collecting their own dues.

Though several attempts have been made to create a membership model that both associations could agree to, a final resolution has been elusive, until just recently. With both associations now free to operate without competition, this new structure will mean less duplication of services and an enhanced ability of both the ODA and CDA to represent dentistry. ■

Catherine Morana is the ODA's Research Librarian and may be contacted at cmorana@oda.ca.

References

1. *The Toronto Star*, All Star Night Edition, Front Page, June 29, 1966



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