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# CDA *essentials*

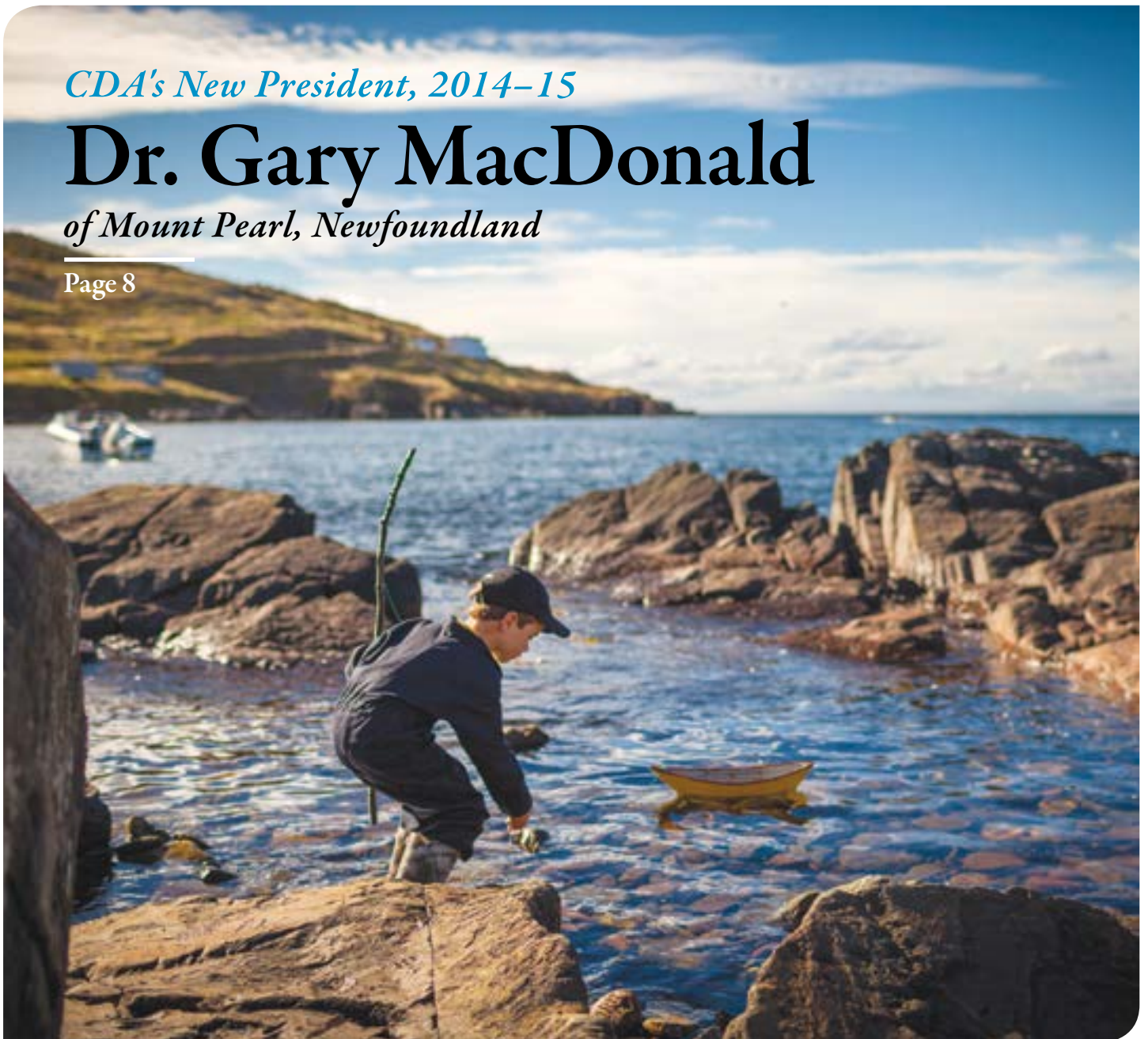
The Canadian Dental Association Magazine

*CDA's New President, 2014–15*

## Dr. Gary MacDonald

*of Mount Pearl, Newfoundland*

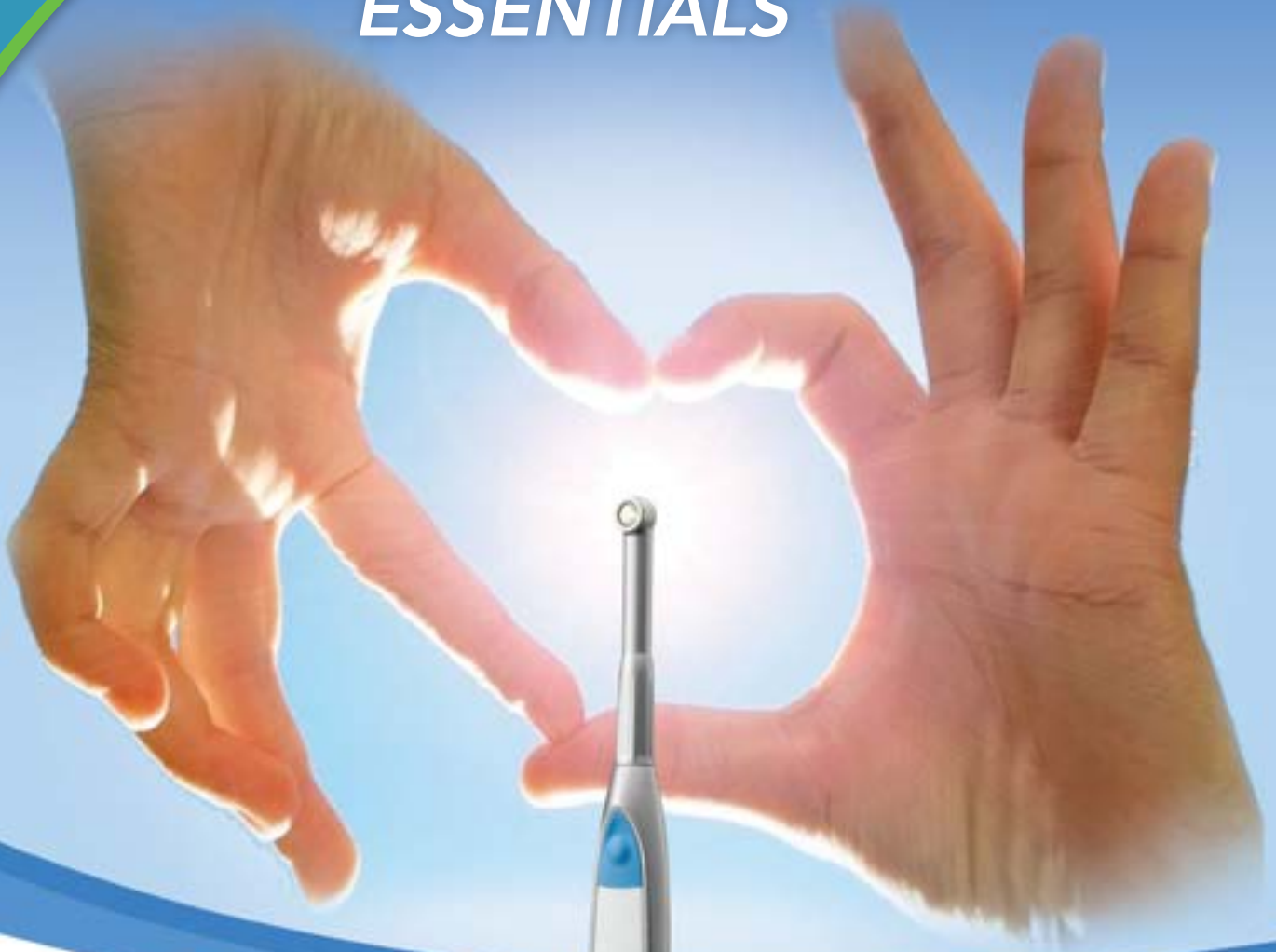
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# CDA *essentials*

2014 • Volume 1 • Issue 2

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The Canadian Dental Association (CDA) is the national voice for dentistry, dedicated to the advancement and leadership of a unified profession and to the promotion of optimal oral health, an essential component of general health.

*CDA essentials* is the official print publication of CDA, providing dialogue between the national association and the dental community. It is dedicated to keeping dentists informed about news, issues and clinically relevant information.

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*Dr. Gary MacDonald, of Mount Pearl, NL  
CDA's new president, 2014-15*

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*"Financial barriers  
appear to contribute  
substantially to  
inequity in oral care  
for older adults..."*

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Launching a Toy Punt in Winterton, Eastern, 2012  
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# The Value of YOUR CDA



For my first President's Column, I considered the importance of CDA's programs and services to the life of a practising dentist. Although the details could fill many pages of our magazine, for now I want to focus on two general areas: shaping the future of the profession and supporting a dentist's day-to-day practice.

CDA focuses on professional issues that must be dealt with on a national basis, such as federal government affairs, international relations, national and international standards, public policy issues and other matters beyond the influence of an individual dentist or provincial association. By providing a unified Canadian voice to discussions about emerging issues in dentistry, CDA helps shape our professional future. These efforts are greatly supported by CDA's annual environmental scan, which analyzes the political, economic and social environments as they relate to health care and dentistry.

Serving as a hub for facilitating discussion and consensus-building on oral health issues, CDA provides dentists with evidence-based clarifications on many issues, some of them contentious. This is accomplished through the development of position statements that draw on the knowledge of a range of experts: academics, clinicians, provincial association leaders and dental regulators.

Connecting to organizations within the oral health care family and the broader health care community allows CDA to gain new perspectives—an important part of identifying best practices for


dentists and patients. Of particular note are CDA's strengthened connections with the Canadian Medical Association and Canadian Pharmacists Association, given the growing body of evidence supporting a link between oral health and overall health.

At a more tangible level, CDA supports dentists in running their practices. Leaving aside clinical support (more on that in future columns), CDA programs and services help dentists in daily office management. Without them, our usual routines might be difficult to conduct. Consider, for example, the task of electronically submitting a dental claim. This process relies on procedure codes derived from the CDA's Uniform System of Coding and List of Services (USC&LS), the services of CDAnet and then, for the majority of offices, ITRANS. It's estimated that the CDA services related to electronic claims submission result in an annual savings for a Canadian dentist of anywhere between \$1500–\$2000 (calculated based on an average of roughly 1900 claims sent per Canadian dentist in 2013 and compared to claims transmission costs for our American colleagues).

In addition, CDA's new eReferral service allows patient records, radiographs and documentation to be securely transmitted from office to office over the Internet. On the financial side, CDA and our corporate members offer dentists valuable investment advice and insurance services through CDSPI. This includes essential products like disability and malpractice insurance and travel, home and car insurance, to name just a few.

There's no doubt that CDA works hard for Canadian dentists. Ultimately, the value of CDA's efforts lies in the progress we make towards our profession's goal of helping Canadians achieve optimal oral health. ♦

GARY MACDONALD, DDS

 [president@cda-adc.ca](mailto:president@cda-adc.ca)



# DOCTOR GARY MACDONALD

*Dedicated to Community Leadership*

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**Tricia Abe**

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**BSc, MSc**

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*Ms. Abe is  
CDA writer/  
editor.*

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Dr. Gary MacDonald, CDA's new president for 2014–15, vividly recalls June 10, 1975, as a day of great consequence.

Having recently graduated from dental school at Dalhousie University, Dr. MacDonald and his wife Marie packed up her Ford Pinto with everything they owned and started out from Halifax, headed for the ferry to Newfoundland. Marie had encouraged him “persuaded, actually” to move to her home province of Newfoundland to start his dental practice. After an uneventful crossing, they made it as far as Gander, where they were forced to wait out a snow storm in a hotel.

“

*Dr. MacDonald  
credits his mentors with  
instilling a sense of caring in  
him that still drives his work....*

Raised in the lush agricultural landscape of Nova Scotia's Annapolis Valley, a June snow storm gave Dr. MacDonald pause to consider his move to The Rock. “I said to Marie, we have a decision to make: we can either turn around and go back—which was sort of what I was leaning towards—or head on to St. John's,” recalls Dr. MacDonald. Still undecided, by morning they awoke to find the sun was shining and the snow had melted. The decision was made: they were going to St. John's.

## The path to dentistry

He met Marie while both were studying at Acadia University, Dr. MacDonald in sciences and Marie in home economics. At the end of his third year at Acadia, he was accepted into medical school. “I broke my mother's heart because she was so excited about me going to medical school and I made the decision that I wasn't going to go,” he says.

Instead, he followed the advice of a good friend who encouraged Dr. MacDonald to join him in dental school. “I just felt that dentistry was something perhaps I'd be more interested in doing—no real rhyme or reason why,” he admits.

For a dentist fresh out of school, the decision to push on towards Mount Pearl, a city on the outskirts of St. John's, would prove to be a fruitful one. “I always say that day determined my future, really,” he reminisces. Only one other dentist was practising in Mount Pearl at the time, so “I pretty well had an instant practice in one of the fastest growing communities in the province,” says Dr. MacDonald. After buying a house and renovating it for a dental practice, he put a notice in the paper and was fully booked 6 weeks prior to opening. Today, the practice has been running for 39 years and counting, now operating from a professional building in the centre of Mount Pearl.

Scenic photograph: Newfoundland & Labrador Tourism



## Giving back to his community

In Newfoundland, Dr. MacDonald also found an opportunity to become involved with the Newfoundland Dental Association and he seized the chance to take part. “They needed some young blood, someone who wasn’t shy about speaking their mind.” The summer of 1975, CDA held its first convention in Newfoundland, where he met the leaders of the profession and had his first taste of organized dentistry at the national level.

When asked about his mentors from the early days of his career, Dr. MacDonald replies without hesitation “Drs. Charlie Daly, John King, Dave Peters, Mike Maguire, Bruce Bowden—the leaders in dental politics in Newfoundland at the time who took me under their wing and encouraged me.” He continues, “These were people who not only cared about their patients, but also cared about their profession. They felt it wasn’t enough to just practise dentistry—they had a lot of other things to offer to the profession.” He credits his mentors with instilling a sense of caring in him that still drives his work and for inspiring him to achieve as much as he has.

Dr. MacDonald has served organized dentistry in many capacities. Between 1981–83, he served as president of his provincial association. In 1987, he became NLDA executive director, a position he would hold for 18 years. He served as both a Board member and clinical examiner with the National Dental Examination Board of Canada (NDEB). Dr. MacDonald acknowledges one of his most fascinating and challenging tasks was serving on the National Health Care Advisory Committee to Correctional Services Canada, chairing the committee for 3 of the 12 years he served. This federal government committee was tasked with advising Corrections Canada on all aspects of health care within Canada’s federal institutions. In 2002, he started his involvement with CDA, where he has served on a variety of committees and working groups, joining the Board of Directors in 2005.

His motivation to make a difference in his community reaches beyond dentistry, into other parts of his life too.



## Professional Milestones

- 1975: Dental degree from Dalhousie University
- 1981–83: President of the Newfoundland Dental Association
- 1985–97: Member of the National Health Care Advisory Committee to Correctional Services Canada (CSC)
- 1987–93: Board member of the National Dental Examination Board of Canada (NDEB)
- 1987–2004: Executive director of the Newfoundland and Labrador Dental Association (NLDA)
- 1994–97: Chair of the Health Care Advisory Committee to CSC
- 1995–2000: Clinical examiner for NDEB
- 1998: Award of Merit – CDA
- 2002: Outstanding Alumnus Award – Dalhousie University
- 2003: Distinguished Service Award – NLDA
- 2005: Elected to the CDA Board of Directors
- 2011: Life Membership – NLDA



## Capturing the Moments...

- ① Dr. Gary MacDonald and his wife Marie at the CDA President's Installation Dinner in Ottawa.
- ② Gary and Dr. James Tennant (CDA Board member) enjoy team building during the FDI Congress in Istanbul, Turkey.
- ③ Gary's family all celebrated his induction as CDA president: (L. to r.) Stephanie, Lindsay, Gary, Marie, Jodi and Danica.
- ④ Gary relaxing with Dr. Peter Doig (CDA past-president) and Dr. Tennant.
- ⑤ Gary and Marie share a smile with a local merchant in Istanbul.

He's served on 3 different high school councils, the Board of Directors for the Canadian Red Cross Society (Newfoundland Division), and the Recreation Commission for Mount Pearl.

One of the biggest challenges facing dentistry today, in his opinion, is access to care. "There's no question—there are people out there who, for

**“**Take time to be involved, not only with your family and your community, but with your dental family as well—your dental association.

one reason or another, cannot access dental care. And they're suffering," he says. "I think CDA has made a great step forward with the National Oral Health Action Plan." Continuing the momentum started by the National Oral

Health Action Plan Symposium, a meeting that focused its discussions on improving access to care for those most in need, is one of his priorities.

Upholding professionalism and ethics in dentistry is another prime concern. He believes that dentists are here to serve the public by providing patients with the treatments they need. He says, "I feel that the notion of dentistry as an essential health service to the public can sometimes get lost."

## All in the family

His passion for dentistry is shared with his daughter, Jodi, one of his four children. "I've been very fortunate to have Jodi as an associate in my practice," he says. "We work very well together. I'm there if she needs me, if she wants any help, and I learn from her too because she's up to speed on the latest technology. Lots of times I go to her looking for advice."

Gary and Marie are proud of their daughters. Danica, is a PhD student in linguistics and phonetics at the University of Calgary, Lindsay is an occupational therapist in St. John's and mother to their 2 grandchildren, and Stephanie is an aerospace engineer with a Calgary company.

For someone who understands the importance of giving back through community leadership, the advice he offers to dentists just starting out is not surprising. "Take time to be involved, not only with your family and your community, but with your dental family as well—your dental association. It provides an opportunity to meet colleagues and talk dentistry. It keeps you connected." ♦

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# DENTSPLY AND CDA CONTINUE TO SUPPORT STUDENT RESEARCH IN CANADA

*The 2014 CDA/DENTSPLY Student Clinician Research Program took place in March during the Pacific Dental Conference in Vancouver. The national competition invites dental students from the 10 accredited Canadian dental schools to present research table clinics in front of qualified judges.*

"The commitment to research shown by CDA and DENTSPLY is really incredible and vital to the future of our profession," says Mrs. Quattrini. On behalf of her study collaborators, she adds, "We were very excited to represent our university, and to have the invaluable opportunity to learn from other student clinicians and industry leaders."

First prize is one expense-paid trip to the American Dental Association (ADA) Annual Session, where the winning table clinic will be presented as part of the ADA's scientific program. First prize was awarded to a study from the University of Saskatchewan that developed and tested a novel mercury-free metal restorative material. The table clinic was presented by Mrs. Kellyana Quattrini, along with her research collaborators Mrs. Anapaula Campos and Ms. Jenna Schmitt.

Second prize went to Mr. Tobias Meiszingger of McGill University. Mr. Meiszingger and his research partner, Ms. Gabrielle Lemay, examined special care dentistry training in a Canadian dental school. As runner-up, Mr. Meiszingger received a \$1000 cash award. "What I enjoyed most was the opportunity to use my research findings as a platform to advocate for those with special needs. It was a humbling experience to meet dental professionals who were lifelong advocates for people with special needs, and who recognized the importance of increasing didactic and clinical exposure of dental students to these patients," he says.

DENTSPLY has sponsored the student clinician research program in Canada since 1971. The program's purpose is "to stimulate ideas, to improve communication and most of all, to increase student involvement in the advancement of the dental profession."

The student clinicians participating in the event were also honoured by the Canadian section of the Pierre Fauchard Academy (PFA). The students were presented with a PFA scholarship recognizing their special efforts in the advancement of dental education over and above their academic careers. ♦

Jenna Schmitt



Anapaula Campos



Kellyana Quattrini

## 1st Place

### A Novel Mercury-Free Restorative Material

By: Anapaula Campos, Kellyana Quattrini and Jenna Schmitt  
University of Saskatchewan

Advisor: Dr. Azita Zerehgar

## 2nd Place

### The Place of Special Care Dentistry Training in Undergraduate Dental Studies

By: Tobias Meiszingger and Gabrielle Lemay  
McGill University

Advisor: Dr. Zovinar der Khatchadourian



Photographs: Teckles Photo Inc.

Visit [cda-adc.ca/news](http://cda-adc.ca/news) to read all 10 abstracts submitted for the 2014 Program.

# Detection and Prevention of Oral Cancer: ARE SCREENING METHODS EFFECTIVE?

In dentistry, screening for oral cancer by visual inspection and palpation is an essential part of a clinician's routine practise. Yet achieving the goals of screening—identification of precancerous lesions or cancers so that interventions can reduce malignant transformations or improve chances of survival—can be a major challenge.



**Catherine Poh**

“Despite inconclusive evidence, dentists should remain vigilant for signs of precancerous or cancerous lesions in all patients while performing routine follow-up and new patient oral examinations.”

Diagnostic delays mean that more than half of all people with oral and pharyngeal cancer have regional or distant metastases at the time of diagnosis.<sup>1</sup>

Three reviews examined the latest evidence on the effectiveness of screening programs for oral cancer and arrived at generally similar conclusions: there isn't enough evidence to definitively say whether oral cancer screening is effective or not. The take-home advice for dentists? Despite inconclusive evidence, dentists should remain vigilant for signs of precancerous or cancerous lesions in all patients while performing routine follow-up and new patient oral examinations.

“Dentists should use the opportunity of a routine oral examination to screen for oral cancer,” says Dr. Catherine Poh, associate professor in the UBC faculty of dentistry and researcher in the areas of community screening and management of high risk oral precancerous lesions. “Soft

tissue screening is our responsibility as dentists—it has the potential to detect a variety of irregularities, including early signs of mouth or throat cancer. Three minutes could save a life!”

### Cochrane Collaboration

A Cochrane review<sup>2</sup> assessed current screening methods—visual examination and adjunctive technologies like toluidine blue, fluorescence visualization or brush biopsy—

and found no evidence of their effectiveness in reducing mortality from oral cancer. The authors found some evidence that a visual examination reduces the death rate for oral cancer in high-risk individuals—those who used tobacco or alcohol or both—although the evidence came from only one study.

Another Cochrane review<sup>3</sup> attempted to evaluate the diagnostic accuracy of an oral cancer screening examination and other adjunctive technologies, but the substantial variability in the included studies made it difficult to compare studies or conduct a pooled analysis of the data.

### U.S. Preventive Services Task Force

A review by the U.S. Preventive Services Task Force (USPSTF)<sup>4</sup> found there was inadequate evidence that the oral screening examination—visual examination and palpation—performed by primary care providers accurately detects oral cancer or results in improved morbidity or mortality through treatment. However, the USPSTF statement clearly notes that its recommendation on oral cancer screening does not pertain to dentists or otolaryngologists.

Although tobacco and alcohol use are considered the major risk factors for oral cancer, risk also increases with age. An increasingly important risk factor for oropharyngeal cancer is sexually transmitted oral HPV infection (HPV-16). Yet all adults—not only high risk individuals—should be screened for oral cancer, according to Dr. Poh, who says there has been an increase in the number of younger-age oral cancer patients and patients without obvious known risk factors. “It's time to consider and conduct a large-scale, multi-centre study with a standardized protocol to investigate this potentially life-saving measure. What's needed is more solid research-based evidence to answer the questions ‘Should we screen or not screen for oral cancer? Are adjunctive techniques useful, and what is their value in screening?’”

### REFERENCES

Complete list of references available at: [jcda.ca/article/e27](http://jcda.ca/article/e27)

Dr. Poh was a co-author of a JCDA article that includes step-by-step advice on performing a head and neck evaluation to screen for oral cancer.

[www.cda-adc.ca/jcda/vol-72/issue-5/413.pdf](http://www.cda-adc.ca/jcda/vol-72/issue-5/413.pdf)

# Royal Canadian Dental Corps: 100 YEARS OF HISTORY

Canada's military dental services have looked after the oral health needs of Canada's troops in both World Wars, Korea, Afghanistan and many other peacemaking, peacekeeping, humanitarian and forensic operations. In the lead-up to the 100th anniversary of the Royal Canadian Dental Corps (RCDC) in 2015, this article is the first in a series that will bring to light the history of the RCDC over the last century, celebrating the heritage, accomplishments and dedication of the dental services personnel of the Canadian Armed Forces.



**CDAessentials** is honoured to publish a regular series of articles, leading up to the celebration of RCDC's 100th anniversary.



RCDC's roots can be traced back to South Africa during the Boer War from 1899 to 1902. It was here where two Canadian dental surgeons operated in a theatre of war for the first time. Dr. David Henry Baird of Ottawa served with the No. 10 Canadian Field Hospital and Dr. Eugene Lemieux of Montreal served with the 2nd Battalion Royal Canadian Regiment; both accompanied Canadian troops in operations in the Transvaal, the Orange River Colony and the Cape Colony. The great number of soldiers who presented with dental emergencies established the fact that dental services in the field were indispensable. CDA responded to this need while the Boer War was ongoing by pressing the government of Canada to form a Regular Army Dental Staff as a distinct branch of the service. CDA's efforts were successful: an establishment of 18 dental

surgeons was authorized by General Order No. 98 on July 2, 1904.

A decade later, when World War I began, many recruits were rejected for dental reasons. The 26 serving military dentists could not cope with the demand for service to make the recruits ready to deploy; therefore, civilian dentists were asked to volunteer to help with the treatment of recruits. On May 13, 1915, General Order No. 63 authorized the creation of the Canadian Army Dental Corps (CADC) as a distinct corps.

The CADC began operations overseas in July 1915 with 30 dental officers and 74 other ranks—a ratio of 1 dentist for every 1400 personnel. Canadian dental officers were attached to the field ambulances and did wonders in the forward area, treating patients close to the battle in order for them to return to combat quickly.

From July 1915, when the CADC began operations in the theatre of war, until December 1918, over 2.2 million dental treatments were performed. This included 97000 treatments for British troops and 50000 treatments for trench mouth. Another 1.4 million treatments were provided



*From July 1915, when the CADC began operations in the theatre of war, until December 1918, over 2.2 million dental treatments were performed.*



Allied soldiers line up in a "dental sick parade" during World War I. (c.1915).

Pictured below, the Badge of the Canadian Army Dental Corps, 1915–28.



in Canada. Considering the relatively small number of oral health care providers, this represented an immense effort.

When the war ended on November 11, 1918, the CADC had increased to 223 officers and 459 other ranks serving in stationary hospitals, field hospitals and field ambulances in Great Britain, France and Belgium. Among CADC personnel, 7 officers and 10 other ranks had died in action. In addition, 4 medals for Meritorious Service and 10 Orders of the British Empire were awarded to CADC personnel.

The demobilization of 60000 soldiers within a month following the war presented the Corps with the challenge of returning these soldiers to the state of dental fitness they had prior to embarkation. The result was a short-lived increase in the strength of the Corps. Once demobilization was completed, the CADC was disbanded.

However, it wouldn't be long before the CADC would be reformed as a corps in the Non-permanent Active Militia, authorized by Special Army Order No. 4 on January 11, 1921. In reality, from the end of the war until 1939, the Dental Corps became little more than a number of individual dental officers scattered thinly throughout the units of the Medical Corps. It was not until the start of World War II that the Dental Corps would have an opportunity to again provide support to operations. ♦

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**CDA is playing a central role in commemorating the 100th anniversary of the RCDC in May 2015, reflecting CDA's role in establishing a military dental service in Canada and the close partnership between CDA and RCDC since that time.**



**Front row** (L. to r.):  
 Dr. David Sweet, Dr. Garry Lunn, ICD Master Fellow, Dr. Jack McLister, ICD president, Dr. Tim Milligan (ground), Dr. Bob Baker, ICD registrar, Dr. Donna Brode.  
**Middle row** (L. to r.):  
 Dr. Amarjit Rihal, Dr. John Kalbfleisch, Dr. Dan Haas, Dr. Tim Dumore, Dr. Arnie Weingarten, Dr. Leandra Best, Dr. Richard McCowan, Dr. Bruce Yaholnitsky, Dr. Gloria Tyler, Dr. Bill Tyler, Dr. Louie Kriel, Dr. Brian Barrett, Dr. Rick Hallett, Dr. Noriko Boorberg.  
**Back row** (L. to r.):  
 Dr. Roger Armstrong, Dr. Karin Van Ryswyck, Dr. Edwin Yen, Dr. Izchak Barzilay, Dr. Ken Wright, Dr. Samira Jaffer, Dr. Eric Selnes, Dr. LouAnn Visconti.

## International College of Dentists Convocation

The Canadian Section of the International College of Dentists (ICD) held its annual convocation ceremony on March 7, 2014, in Vancouver. Twenty-three new Fellows were inducted into the ICD, recognized for their contributions to dentistry and humanitarian service. ♦

 Visit [icd-canada.com](http://icd-canada.com) for more details.


## OSAP Symposium: Infection Prevention in Oral Health Care

The Organization for Safety, Asepsis and Prevention (OSAP) is holding its 30th anniversary symposium from **June 5-8 in Minneapolis, Minnesota.**

The symposium's theme is "Moving Forward to a Safer Tomorrow in Dentistry." Participants will learn about current and emerging issues related to infection prevention and safety challenges in oral health care. The program addresses topics such as infection control in dentistry then and now; emerging diseases and antibiotic resistance threat; and how to conduct medical screenings in dental practices. Up to 18 hours of continuing education credit are available.



Register **before May 23** to save on registration fees.

 For more information, visit [osap.org](http://osap.org)





# Saint John, New Brunswick DISCONTINUES FLUORIDATION

On March 10, Saint John, New Brunswick, city council voted to stop fluoridating the city's water supply. Dr. Jeff Clark, president of the New Brunswick Dental Society (NBDS), and Dr. Kelly Manning, president-elect of NBDS, were both invited to present to Saint John council in advance of the debate. Drs. Clark and Manning spoke with CDA about their experience and what they learned in the process.



**Jeff Clark**

## How do you feel about what happened on March 10?

**JC:** We were very disappointed with the results. After the councillors voted, it came down to a 5-5 tie, and the mayor broke the tie with his vote. Unfortunately, he voted against fluoridation. It was actually a surprise to us because we were led to believe that the meeting was for information gathering purposes—so needless to say we were quite disappointed.

## What were the main arguments used against fluoridation?

**JC:** Certainly the main decision that came from council was that it was an economic decision: they felt that the distribution of fluoride was inefficient and a waste of money. The water manager for the city of Saint John recommended that council get rid of fluoride due to inefficiencies.

**KM:** I'd have to agree that the main thrust of the debate was from an engineering perspective. They didn't think it would harm anyone to take fluoride out. As a municipality, they didn't want to have to pay for a health program.

## Can you comment on the tactics that were used leading up to the vote, particularly by the anti-fluoridation groups?

**JC:** We were aware that city councillors were receiving emails from various sources on the issue of fluoride toxicity that we would consider to be not credible. Unfortunately they may have been influenced by what I consider to be bad science. As I said, the vote came by surprise. We were prepared for a round table discussion on the issue and then we were blindsided by the vote.

## What are the biggest lessons that you've learned from this campaign?

**KM:** Be prepared that the vocal minority can have a bigger influence than we may expect. We need to do a better job explaining the benefits of water fluoridation and if you're in an area that has water fluoridation, don't wait until city council brings up the issue. As dentists, we take it for granted that water fluoridation is a good thing, but maybe we don't explain this in an ongoing conversation with the public—how important, effective and cost-effective water fluoridation can be.

**JC:** Councillors told us that they were hearing only from people against fluoridation. Although we suspect most people are in favour of fluoridation, they're not calling their councillors to express their support—so the vocal minority can have greater influence.

## What is your advice to colleagues across the country—individuals or associations—about how to prepare for similar debates on water fluoridation?

**JC:** Be organized and expect the unexpected. Assume elected officials are uneducated on fluoride. It's our responsibility to try and educate them. But sometimes it's difficult to make them see the benefits.

**KM:** I would add, educate other staff in the city—the engineers and the people who are not necessarily sitting around the council table but who are making recommendations to council. If they better understood why fluoride is added to the water, they might be more likely to make recommendations in favour of water fluoridation. ♦

*This interview has been condensed and edited.*



**Kelly Manning**



To listen to the full interview, visit [oasisdiscussions.ca](http://oasisdiscussions.ca) 2014/03/27/wf-2



*Unfortunately they may have been influenced by what I consider to be bad science.* – Jeff Clark

The logo for ADA 2014 features a stylized 'A' composed of three curved segments in red, green, and blue, followed by the text 'ADA.2014' in a bold, sans-serif font.

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# University of Manitoba Holds ORAL-SYSTEMIC HEALTH DAY

*Innovative oral health curriculum provides the backdrop for interprofessional learning*

## Renée Barclay

Ms. Barclay is a medical writer-editor, division of continuing professional development, University of Manitoba, faculties of dentistry & medicine.

*This article was supported in part through an unrestricted educational grant from Johnson & Johnson Inc.*

An innovative interprofessional education day at the University of Manitoba recently brought together more than 200 Manitoba-based dentists, dental hygienists, physicians, nurses and other non-dental health care providers (HCPs), driving home the message that oral health is part of overall health.


Non-dental HCPs learned how to detect rampant caries in children and oral and oropharyngeal cancer in adults at the inaugural Oral-Systemic Health Day.

The full-day event was hosted by the faculties of medicine and dentistry on February 7, 2014, as part of an innovative curriculum entitled *Oral-Systemic Health Education for Non-dental Healthcare Providers*. In addition to the onsite participants, a significant number of people also participated via Manitoba Telehealth.

The morning of Oral-Systemic Health Day featured presentations by dental experts, Dr. Susan Müller of Emory University and Dr. Travis Nelson from the University of Washington. Course participants later engaged in facilitated round-table discussions where they considered simulated case studies and discussed how health and human services professionals can better work together to improve patient outcomes.

An optional hands-on session in the afternoon taught non-dental HCPs how to build simple screening techniques into routine doctor-patient visits. Participants learned how to distinguish between oral leukoplakia and oral lichen planus, including distinct signs and symptoms of oropharyngeal cancer that non-dental HCPs may not be familiar with. "We are at the beginning of an epidemic," Dr. Müller said of oropharyngeal cancer. "The goal for you as a health care provider is to identify cancer at a very early stage."

Meanwhile, Dr. Nelson explained that preventive maintenance of dental caries in young children hinges on routine visits with pediatricians and primary care physicians. "Patients come to see dentists at three years of age, which may be too late," he said. "Who is seeing the kids? You guys are. Doctors see kids 10 times before age three." During his portion of the workshop, Dr. Nelson showed participants how to look for white spot lesions near the gum line, and offered practical positioning techniques to facilitate screening young children.

"Making the connections between the mouth and the rest of the body is to recognize that they are truly extensively integrated," said Dr. Bruce Martin, associate dean, students, faculty of medicine, who was also a speaker at the event. "Oral-Systemic Health Day gave us an opportunity to learn, to meet each other, to build connections with each other, and to improve the health of our patients. It is about the integration of our health systems and the health of our communities." 

Oral-Systemic Health Day participants put their new knowledge into practice during the optional hands-on workshop.

"The fact that the medical and non-dental health community has embraced this Oral-Systemic Health Day shows how far the concept of patient co-management has come," said Dr. Anthony Iacopino, dean of the faculty of dentistry.

"We are finally reconnecting the mouth to the rest of the body and recognizing their bi-directional influence," Dr. Iacopino said. "An accumulating body of evidence infers that individuals who receive health care within a coordinated and comprehensive approach across multiple disciplines do better, especially older persons, children and those within high-risk categories. A prime example of this revolves around the relationship between oral and general health."



 [Read more at oasisdiscussions.ca/2014/05/12/osh](http://oasisdiscussions.ca/2014/05/12/osh)

# DENTAL CLINICS *in Rural Newfoundland*

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The Challenges and Opportunities



*For many residents of Newfoundland and Labrador finding a dentist can be a challenge. According to Dr. Jason Noel, president of the Newfoundland and Labrador Dental Association (NLDA), the shortage of dentists affects mainly central Newfoundland and smaller towns. “Patients in those areas just don’t have access to care,” says Dr. Noel. “They’re waiting until they have a major problem before going to the dentist because they can’t see one on a regular basis.”*

CDA statistics from 2013 put the ratio of dentists to patients in Newfoundland and Labrador at about 2800 people per dentist. According to Dr. Noel, this ratio increases to about 4000 people per dentist once you get off the Avalon Peninsula. Compared to the national average of about 1700:1, these numbers highlight the difficulties facing many people living in this province when it comes to getting dental treatment.

Without a local dentist, some patients with major dental problems turn up in hospital emergency rooms—which aren’t equipped to deal with dental emergencies—or travel long distances to get the care they need. Dr. Noel says that by the time a patient finds their way to a dentist, “The situation is: ‘Doc, make the pain stop.’ In my own clinic, we have patients that come from a 2 or 3 hour drive away because they can’t get in anywhere else. I’m in Bay Roberts, which is about 45 minutes from St. John’s.”



Residents of Bonavista, a town of 4300, have first-hand experience with the hardships that come with not having a local dental practice—it's been 12 years since a dentist last practised there. "Patients up there have been travelling really far for treatment, so as a result their treatments have been delayed or not done at all. Or patients will choose an extraction over a root canal and a crown just because it's less visits," says Dr. Pat Redmond, a dentist with a private practice in Gander.

Recently, Bonavista residents received some good news. Through the efforts of Dr. Redmond and 2 dental colleagues, along with help from the NLDA, the province, and Bonavista town council, the town finally has its own dental clinic, which opened in April. Bonavista residents are "quite excited and really pleased that they won't have to travel as far anymore," says Dr. Redmond.



Jason Noel

*“It's not only difficult to attract associates, but it's also difficult to retain them. There are clinics that get a new person every year—somebody leaves, somebody comes.”*

The shortage of dentists in rural parts of the province has also put a strain on dentists. "The dentists that are here now are overworked," says Dr. Noel. "It's not only difficult to attract associates, but it's also difficult to retain them. There

are clinics that get a new person every year—somebody leaves, somebody comes."

Another challenge, according to Dr. Noel, is that about half of the dentists in the province within the next 10 years are within retirement age. "The problem isn't going to get better any time soon, unless we do something."

To encourage dentists to practise in rural Newfoundland, the provincial Rural Dental Bursary Program and Specialist Bursary Program provide financial support for dentistry students while they're in school in exchange for one year of service in rural or in-need areas of the province.



However, the bursary program was initiated in 2008 and its impact, in terms of addressing dentist shortages in rural communities, is not yet clear.

Dr. Noel believes that probably the biggest incentive to work in rural Newfoundland and Labrador is the opportunity to have a busy practice right from the start. "You could come out of school and right from day one you hit the ground running," says Dr. Noel. Practising in rural communities also allows you to do perform a wide variety of procedures, according to Dr. Redmond. "It's more than you'd get in larger urban centres. It makes your work more enjoyable because you're doing everything you were taught to do."

There is also the appeal of living and working in a small, close knit dental community. "The issue of not getting along is not one what you'll experience in Newfoundland. Life has treated me very well here in Newfoundland," says Dr. Noel. "I don't regret for a second coming back home." ❖

## In Conversation with Pat Redmond: The Bonavista Clinic

*Dr. Pat Redmond, a dentist with a private practice in Gander, was involved in opening a dental clinic in Bonavista, a town that hasn't had a dentist since 2002. Dr. Redmond spoke with CDA about the new clinic and how it finally came to be.*

### What has been the biggest challenge in setting up a practice in Bonavista?

Finding suitable space. We eventually ended up in the space that was used by the last dentist to practice there over a decade ago. The clinic used by the previous dentist was located in a commercial building, and the cost of rent meant that a practise wasn't going to be financially viable. Normally, what happens in these small towns is that their dental clinics are located in a provincial building, like a hospital, so there is very little or no rent. But in Bonavista, there was no available space in any provincial building. Eventually, the town came in and offered us financial incentives to basically offset most of the costs of our rent.

### Why did it take so long to open the clinic?

Bonavista kept going to the provincial government looking for dentists, and the government's response was, "Well we have this bursary program in place to attract new graduates." But Bonavista needed a dentist to set up the office and no one was willing to do it. We couldn't get a dentist to go there without a clinic being built that they could see first. And we weren't willing to go and invest money in a clinic and commit to paying commercial rent, without knowing if we're going to have a dentist or not.

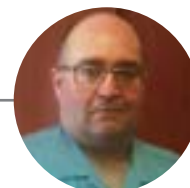
So Drs. Wade Abbott, Jon Ballard and myself decided to get together so that even if we don't have a dentist, we can go there 2 days a month each, and we can hire a hygienist to be there 2 days a week. So we found a way to make it work without an associate dentist, and the town stepped in to resolve the issue of rent.

### Is the clinic open for patients?

Everything's gone a little bit quicker than we anticipated. We've been successful in getting an associate to come and she wanted to start right away. As soon as the clinic was operational, we were fully booked! The town provided us with a big list of patients to call. ✦

*This interview has been condensed and edited.*

“Recently, Bonavista residents received some good news. Through the efforts of Dr. Redmond and 2 dental colleagues, along with help from the NLDA, the province, and Bonavista town council, the town finally has its own dental clinic.



**Pat Redmond**

*Inequity in Oral Health Care for Elderly Canadians:*

PART 2

# CAUSES and ETHICS





**Chao Shu Yao****BDS, MDS Prosthodontics**

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**Michael I. MacEntee****LDS(I), FRDC(C), Dip Prosth. (MUSC), PhD**

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*The authors have no declared financial interests.*

*This article has been peer reviewed.*

The Canadian Health Measures Survey, conducted between March 2007 and February 2009, revealed unmet dental needs among older adults in Canada. This article, the second of a 3-part series, explains that the inequity in oral care faced by elderly Canadians is due largely to the current fee-for-service dental service system. However, the inequity has arisen because of financial, behavioural and physical barriers, and both the community at large and the dental profession have a social responsibility to reduce this unfairness and provide equitable access to oral care for older people.

Aging of the population, through increasing longevity and decreasing fertility, affects many developed countries. Canada is experiencing this phenomenon, despite having one of the highest per capita immigration rates in the world.<sup>1</sup> About 15% of the Canadian population is older than 65 years, a proportion that is anticipated to increase to 25% by 2036,<sup>2</sup> when the last of the baby boom generation reaches age 65.

The first article<sup>3</sup> of this 3-part series considered data from the Canadian Health Measures Survey (CHMS),<sup>4</sup> which reported that among Canadians 60–79 years of age, nearly all (90%) had at least 1 decayed, missing or filled tooth (excluding wisdom teeth), about one-third (31%) had periodontal pockets of at least 4 mm, and about one-fifth (22%) had no natural teeth. Not only did older participants in the survey report many unmet dental treatment needs, but it is likely that these needs will increase as more people get older and more frail. This second article in the series examines the barriers that prevent elderly people from obtaining professional oral health care and discusses the ethical implications of this inequity.

## Equity in Oral Health Care

To begin, we would like to clarify that equality is the state of being equal, whereas *equity* is the quality of being fair and impartial. Equity in health care may be achievable if Canadians can agree on what constitutes a fair distribution of health-related resources, such that no one is deprived of care because of their age, sex, geographic location or socio-economic status.<sup>5</sup> We acknowledge that comorbidities occurring in old age create inequality in health status throughout a population; however, we believe it is desirable to have equity in access to oral health care for the elderly population. In this regard, we refer to the principle of equity, which is based on *proportionality* and *distributive* justice (as explained by Aristotle<sup>6</sup>) and on people's autonomy to select the care they need.<sup>7,8</sup>



Accordingly, in a country like Canada, where everyone should have equal access to health care, an elderly person who is frail, should be entitled to more care than an abled person, if there is a reasonable prospect that the care will be beneficial.

## Oral Health Care System in Canada

Canada's health care system (Medicare) has evolved through decades of discourse on whether health care is a social good or an individual responsibility. The Medical Care Act passed in 1966 was based on defined criteria of comprehensiveness and universality. However, additional criteria on accessibility, public administration and portability were adopted as part of the Canada Health Act in 1984, such that "insured persons must have reasonable and uniform access to insured health services, free of financial or other barriers. No one may be discriminated against on the basis of such factors as income, age, and health status."<sup>9</sup>

The Canada Health Act supports equity and solidarity in Canadian health care policy. However, apart from specific oral surgical procedures performed in hospitals, dentistry has been largely excluded from medicare because of budgetary constraints. Some provinces and territories provide a limited array of dental services to children, members of the Armed Forces and recipients of social assistance.<sup>10-12</sup> Only Alberta and the Yukon Territory provide some financial assistance for dental services to residents over age 65.<sup>13,14</sup>

A personal dental care plan can be purchased from a private provider—either directly by a Canadian resident or indirectly by an employer on behalf of an employee—in the form of a tax-free, nonwage benefit. Many employees of small businesses and the "working poor" do not qualify for public assistance, nor do they work the number of hours required to be eligible for nonwage benefits. Furthermore, people who retire lose their employer-sponsored dental benefits and must pay for

dental services with after-tax money. Thus, there appears to be inequity in oral health care, whereby insured people receive subsidized dental services and people with relatively low income and limited public benefits must pay for dental care out of their own pockets.<sup>15</sup>

## Barriers to Oral Care

Inequity in oral care is influenced by several interrelated factors, broadly categorized here as financial, behavioural and physical barriers.

### Financial Barriers

Data from 2 surveys conducted nearly 20 years apart, examining the income and expenditures of older adults in all 10 Canadian provinces, showed that spending on health care tended to follow income levels closely.<sup>16</sup> Possession of dental insurance was also a strong predictor of dental service utilization. Elderly people have progressively lower income as they age and are less likely to have dental insurance or to visit a dentist.<sup>17</sup> The CHMS found that currently, about two-thirds (63%) of the Canadian population aged 6–79 years have private insurance, 5% have publicly funded insurance, and about one-third (32%) have no dental insurance and pay directly from their own pockets.<sup>4</sup> It is particularly significant that about half (53%) of those age 60–79 years do not have dental benefits. The CHMS also confirms that uninsured and low- to middle-income people, including older adults, tend to avoid dental visits because of the financial cost despite many unresolved oral problems.<sup>4</sup> Others have documented that people with low incomes typically seek only emergency care.<sup>18,19</sup>

The scenario of an imbalance between dental demand and dental need contrasts with the utilization of medical services in Canada, where resources

are redistributed across different age and income groups so that people usually receive the medical care they need.<sup>20</sup> Hence, the dental care system in Canada is an example of an "inverse care law," whereby those with the most needs receive the least care.<sup>21-23</sup> Furthermore, treatment decisions may be influenced more by the limited coverage offered by a dental insurance plan or allowed by the patient's finances than by a determination of optimal treatment.<sup>24,25</sup>

### Behavioural Barriers

A 1995 study from Sweden showed that even when financial barriers are removed, visits to dentists do not increase proportionately.<sup>26</sup> In fact, the relationship between patient and dental care provider is also influenced by the behaviour of both parties. People generally are prompted to seek dental care by oral problems that cause pain or discomfort,<sup>27,28</sup> and there are some who believe that tooth loss is an inevitable consequence of aging and postpone treatment until they are ready to replace all of their remaining natural teeth with complete dentures.<sup>24,29-32</sup> In any event, poor rapport with dental professionals typically leads to a disregard for professional advice and missed dental appointments.<sup>19,32</sup>

Anxiety or phobias about dentistry, which affect 12% of the older population,<sup>33,34</sup> can seriously impede the search for treatment. This neglect of oral care is compounded by ageism and other stereotyping of the behaviour of elderly people on the part of dental professionals.<sup>32,35</sup> Indications of ageism were apparent in the responses of about 80% of Vancouver area dentists, who reported that they had never treated a patient in a long-term care facility; furthermore, about two-thirds of respondents expressed no interest



*We believe that reducing inequity in oral care is a form of social responsibility, the obligation to act for the benefit of society as a whole.*

in offering services to elderly patients.<sup>36</sup> Much more empathy for frail and dependent elderly patients was evident from the 88% of dentists in Scotland who attended to residents in care facilities,<sup>37</sup> presumably because dentists received support from the public health system to provide services to patients in domiciliary care.

The impacts of poor oral health on the quality of life of elderly people is not always recognized by dental professionals,<sup>38,39</sup> who may focus more on “quick fixes” for acute dental problems than on effective management of the chronic conditions that so often lead to deterioration of the dentition in old age.<sup>40,41</sup> Management of frail elderly patients with multiple comorbidities typically requires collaboration with other health care professionals (e.g., physicians, nurses, care aides, speech language pathologists, dieticians, facility managers and social workers). Yet formal interprofessional educational programs are missing from the curricula of most health care professions because of constraints of time, logistics and resources, as well as a low perception of the significance of this aspect of career development.<sup>42</sup> Consequently, other professional groups often overlook the role of dentistry in integrated care for older people.<sup>43</sup>

Access to dental care for elderly residents in long-term care facilities depends strongly on the culture and values of each facility.<sup>41</sup> Even in the United States, where federal regulations dictate that long-term care facilities provide oral care and supplies, documentation of a standardized protocol is uncommon, and nursing assistants provide oral care inconsistently.<sup>44</sup>

Discrepancies have been even more apparent in similar facilities in Canada, despite legislation in some jurisdictions mandating access to and assistance with oral care for the residents.<sup>45</sup> Nurses, as front-line personnel in the facilities, are typically given the responsibility for oral care, with dental hygienists playing a supplementary role when necessary.<sup>46</sup> Unfortunately, nurses receive little practical education on oral care, and what little information they have is impeded by busy schedules, more pressing priorities,<sup>47</sup> and in some situations by a fear of dislodging oral bacteria that can cause aspiration pneumonia.<sup>46</sup> Therefore, health care providers often struggle with unclear procedural guidelines, division of responsibilities and ethical conflicts in delivering oral care to frail elderly patients, especially when patients exhibit uncooperative or aggressive behaviour.<sup>40,41</sup>

### *Physical Barriers*

In 2010, Canada had about 19 000 dentists, 21 000 hygienists, 2 200 denturists and 300 dental therapists<sup>48</sup> for a population with 4.8 million people aged 65 years and older,<sup>49</sup> which translates loosely to 1 oral care provider for every 100 older residents of the country. However, dental professionals tend to prefer urban settings, and only 10% of them practise in rural areas,<sup>50</sup> where one-third of senior Canadians live.<sup>51</sup> Hence, there is an obvious inequity in access to dental care between urban and rural areas.

In addition, 1 in 4 Canadian senior citizens reported restrictions in their activities of daily living, 15% required home care services, and 7% lived in a residential care facility.<sup>52</sup> Consequently, many elderly people, whether living at home or in a long-term care facility, have physical challenges that may affect their ability to visit a dental office and would prefer to have a visit from a dental professional in their own environment.<sup>37,53-55</sup> However, dental professionals are generally uncomfortable offering services outside the clinical setting.<sup>56</sup> Furthermore, many residential care facilities lack space for a dental unit, and not all private dental clinics can accommodate a wheelchair or the demands of providing oral care to patients with dementia, severe dyskinesia or incontinence.<sup>36</sup>

## Social Responsibility and Distributive Justice

We believe that reducing inequity in oral care is a form of social responsibility, the obligation to act for the benefit of society as a whole. Health care is a common good, and the principles of common good and distributive justice posit that society should promote and





distribute its social advances, including health and welfare, justly and for the benefit of all, without regard to age, socioeconomic status or the nature of individual needs. The baby boomers have contributed significantly to the nation's achievements, and many of them continue to do so after reaching age 65, either as members of the paid labour force or as providers of social support and care to their families and the community.<sup>52</sup> A healthy society is an economically productive society. Consequently, giving elderly people equitable access to oral health care contributes to society's economic stability. A just public dental health program must be flexible enough to accommodate diversity with a fair allocation and distribution of resources, whereby those in better socio-economic positions bear a social responsibility to assist others in less favourable positions for the welfare of all.

In addition to the social responsibility of society as a whole, dental professionals have a social responsibility to offer services, beyond

their duty as health care providers in alleviating oral pain, to everyone in need, including elderly patients who are burdened with chronic disabilities. Some dentists are willing to continue providing care when their aging patients enter long-term care facilities, although others feel that this responsibility belongs to the public-based dental sector.<sup>37,57</sup> For example, in the 1980s dentists in the Vancouver area reported providing dental services to elderly patients in care facilities with little concern for financial gain,<sup>36</sup> but data from 2011 suggest that financial loss alone is used by some dentists to justify withholding services from residents of the facilities.<sup>56</sup>

Services to members of underprivileged populations are usually offered by institutions or not-for-profit organizations with a sense of social responsibility to deliver care to those in need,<sup>58,59</sup> filling gaps where governments and for-profit organizations have failed.<sup>60</sup> Although some social advocates contend that there will be less incentive for individuals to develop personal responsibility and that non-profit organizations will fade out if and when government adopts the principles of social justice,<sup>61</sup> others argue that a partnership between public and non-profit sectors may develop.<sup>60</sup> However, we believe that government involvement in delivering oral care should not be a deterrent to contributions from non-profit organizations.

The American College of Dentists, in its *Ethics Handbook for Dentists*,<sup>62</sup> states that dentistry is both a business and a profession, and that "every dentist is called upon to participate in service – the chief motive being to benefit mankind, with the dentist's financial rewards secondary."<sup>62</sup> Similarly, in the context of managed care, the College states that "the standard of care should be the same for all patients regardless of the means of reimbursement." Dentists in Canada have generally been nervous about changes to the dominant

fee-for-service mode of delivering care. In the past, they opposed public funding of dentistry through taxation, and succeeded in keeping dentistry as a self-regulating profession.<sup>63</sup> More recently, they have been encouraging governments to offer tax incentives to dentists who work in disadvantaged communities, and to subsidize services for underprivileged groups, including elderly people who are frail.<sup>57</sup> It seems to us that this cannot be achieved without a general decrease in the income expectations of dentists and a substantial increase in support from governments for the more vulnerable people in our society, without compromising standards of care or balanced budgets.

## Conclusion

Dental care in Canada is mostly excluded from the public health care plan and is instead paid for on a fee-for-service basis. Hence, financial barriers appear to contribute substantially to inequity in oral care for older adults, especially among retirees and frail elderly people. Behavioural barriers impede older people who have limited knowledge about oral care and those with serious dental phobias. Behavioural barriers also prevent care providers from offering services because of ageism and conflicting priorities. Physical barriers hinder access to dental care for elderly patients in remote communities and for those who are frail, confined to the home or living in institutions and therefore dependent on others for transportation and routine daily care. A growing awareness of these barriers and a renewed sense of the social responsibility incumbent upon dental professionals should help to reduce the barriers in the foreseeable future. The third and final part of this series will describe ways in which the current inequity in oral care for the elderly population might be reduced. ♦

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## REFERENCES

Complete list of references available at:  
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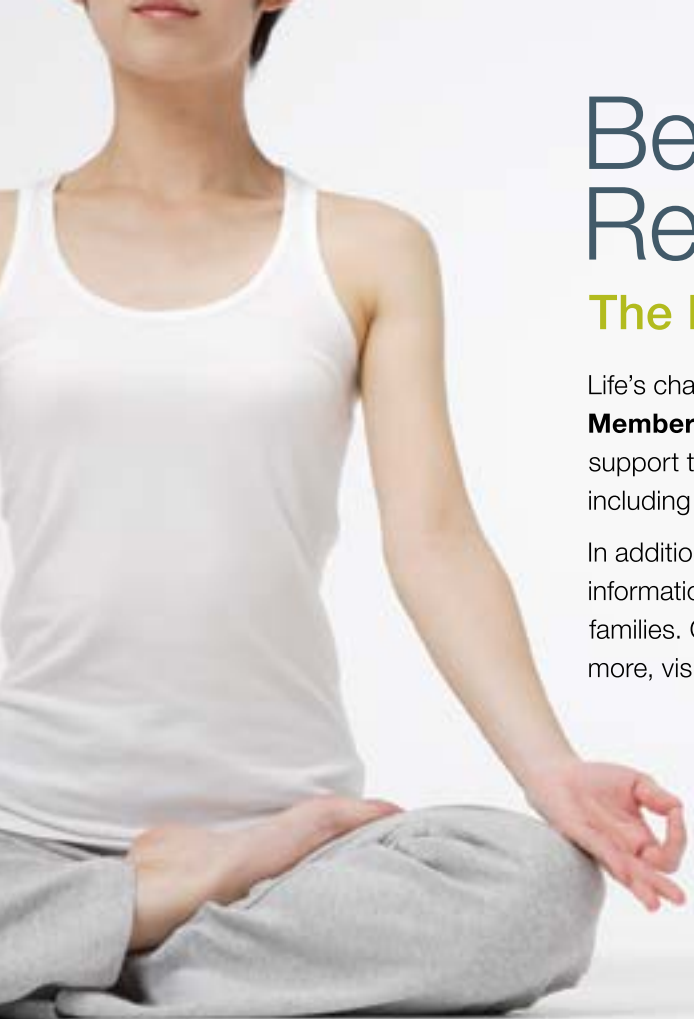


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## CDA Conversations:

# DR. RICHARD PRICE



**Richard Price**

*Dalhousie University professor Dr. Richard Price is a world expert in light curing. He received his doctorate in dental materials from the University of Malmö, Sweden, in 2001; his doctoral thesis focused on factors affecting resin–dentin bonds. It is during the course of his graduate studies that he recognized the importance of dental curing lights, and he has been working on improving light curing outcomes ever since. To that end, he designed the MARC® Patient Simulator, the MARC® Resin Calibrator and initiated the development of check MARC™ device, now marketed by BlueLight Analytics, a Halifax-based company.*

*Dr. Price is also the driving force behind a 2-day international symposium on light sources in dentistry, which will be hosted at Dalhousie University on May 29 and 30, 2014. CDA met with Dr. Price to discuss life as a clinician-scientist.*



**CDA:** What is your ultimate goal as a researcher?

**RP:** My primary focus is to improve the oral health of all Canadians.

**CDA:** What is the focus of your research work?

**RP:** I work on improving the design of dental curing lights. I noticed important discrepancies in curing success rates both in the literature and when talking to other dentists.

One of the reasons I decided to focus on light curing and dental curing lights is that it's something we can measure. And when you can measure something, you can at least manage that particular aspect of the problem. There is actually not a single publication that says curing lights are working as well as they could and should.

**CDA:** What are the challenges in getting public funding for dental and material research?

**RP:** It's very challenging! My experience has been that granting agencies believe that material research has either already been done or is being done by manufacturers. It's almost impossible to receive funding to do pure material science research.

**CDA:** What is your scientific approach?

**RP:** I like to relate my research to clinical practice. I always go back to the same questions: "How is it going to improve the life of the clinician and the patient?" and "How will it improve the restoration's longevity?"

I looked at how people measure curing lights and realized it doesn't relate to what actually happens in the mouth. I therefore worked on developing the MARC® Patient Simulator to closely simulate what might be happening in dental offices and measure the outcome. My conclusion? We need to improve the performance of both the curing lights and how the operators use the lights.





**CDA:** How has the world of light curing evolve this past decade?

**RP:** Dental curing lights have changed dramatically these past 10 years. Yet there hasn't been much information provided on the impacts of these changes on restoration longevity and on how to use curing lights. I'm more specifically referring to the introduction of LED lights, poly-wave LED lights and short curing times. Traditional halogen and tungsten lights emit a broad spectrum of blue light and can therefore cure all composites. However, LED lights only emit a very narrow spectrum and don't cure all composites as well as they could. All curing lights will cure the top of the restoration, but you need a good light used properly to cure the bottom of the restoration. We can easily assess whether the top is cured, but what about the bottom? There is no way for the dentist to know.

**CDA:** Who do you collaborate with?

**RP:** I have a research laboratory at the Dalhousie University dental school. Within the university, I collaborate very closely with the departments of physics and chemistry. One of the great things about Dalhousie is that I can just walk up the street and go to those departments to receive expert help and advice. I also collaborate with experts from the United States and United Kingdom.

**CDA:** Tell us about the 2012 light curing symposium.

**RP:** Thanks to a Canadian Institutes of Health Research (CIHR) knowledge translation grant, we were able to bring key opinion leaders to Halifax in October 2012 to discuss the important role of light curing in everyday dental practices. Following the event, we disseminated some of that knowledge using YouTube, multimedia presentations and articles featured in peer-reviewed and non-peer-reviewed publications.

These world leaders agreed that the profession and dental literature does not fully recognize the importance of the curing light and how it is used in dental offices. Yet small differences in technique and curing light brands can have a huge impact on the amount of energy received by the restoration and, depending on the light chosen, on the wavelengths of light received by the restoration. It's like the curing step is an afterthought, with many lecturers and textbooks just saying, "...and then you light cure."

**CDA:** What will be focus of this year's symposium?

**RP:** We'll work on identifying solutions to the problems highlighted at our last symposium in 2012. We'll discuss how manufacturers can design better curing lights, how we can better teach light curing, and how we can improve instructions to dentists. This year's symposium will be sponsored by the industry (Benco, Bisco, BlueLight Analytics, Henry Schein, Patterson, DENTSPLY, 3M ESPE, Kerr, Heraeus-Kulzer, Ivoclar-Vivadent, and Ultradent). ♦

*This interview has been condensed and edited.*



## ON THE SPOT

with Dr. Richard Price

### Why did you choose to practice dentistry?

Quite honestly, I picked dentistry, and prosthodontics because I enjoy making things, like jewellery, and I enjoyed the idea of improving people's health. I've always had an inquisitive mind, so I naturally gravitated toward research.

### What brings a prosthodontist to do light curing research?

A desire to improve human health outcomes. My research and publications have actually been very diverse, but all had that same outcome in mind.

### If you weren't a dentist, what would you be?

A ski instructor! I'm actually a level-2 ski instructor. I share this passion with my son; we did our level 1 and 2 courses together.

### Looking back at your life and career, what are you the most proud of?

My children. My son is a student at the University of Waterloo. He was accepted in The Next 36 program, whose goal is to nurture the entrepreneurial promise of 36 undergraduates in Canada. My daughter is a student at Acadia University. She is currently on an international exchange program and is spending 6 months at the University of Dundee, in Scotland.

### Where do you see yourself in 5 or 10 years?

Realistically, I hope to be retired in 10 years time! That said, I want to keep conducting research. I enjoy a good challenge, and I enjoy trying to understand how to improve the design of curing lights. I strongly believe that research and working with students keeps the mind young.

### If you could talk to your 20-year-old self, what advice would you give him?

Tough question. I think the best advice is to always have an open mind and question what people tell you. Don't get discouraged from your setbacks. Instead, learn from them and try to do it better next time. Question what the manufacturer says, ask for proof. Question your own research—does it make sense? Replication of your own and others' results is key!



# Canada's Anti-Spam Legislation: WHAT DOES IT MEANS FOR DENTAL PRACTICES?

Minister of Industry James Moore announced last December that Bill C-28, Canada's Anti-Spam Legislation (CASL), will come into force on July 1, 2014. With CASL, the federal government will prohibit the sending of unsolicited commercial electronic messages (CEMs), in the hope of putting an end to the use of misleading and deceptive spam. In anticipation of the enforcement of Bill C-28, CDA tried to simplify the CASL document to understand what will be required of dental practices when communicating with patients electronically.

## ***What types of electronic communications will fall under CASL?***

Bill C-28 will apply to electronic communications of commercial nature, including client recuperation messages, promotional offers, and potentially newsletters. It will encompass all CEMs sent by text, sound, voice or image messages to an electronic address, which includes an email account, instant messaging account, telephone account or similar account (e.g., Facebook, Twitter, LinkedIn).

Dental offices should obtain consent before sending CEMs to patients or other parties in order to avoid the potential penalties applicable under CASL where no exceptions apply.

## ***What types of electronic communications will not fall under CASL?***

Exclusions will include, among others:

- Estimates for the supply of a product or service, given that the patient requested to receive them electronically
- Messages that facilitate, complete, or confirm a commercial transaction that has been agreed to by the patient
- Warranty-related communications
- Recall or safety information about a product or service the patient has used or purchased

From a dental office standpoint, it means that appointment reminders, post-treatment follow-up instructions and order notifications should be excluded from consent requirements under CASL. However, it is important to note that such electronic messages will still need to include the prescribed information discussed in this article.

## ***How can dental offices obtain patient consent?***

Bill C-28 is built around a consumer opt-in approach where dental practices will need to obtain consent, whether express or implied, from recipients to receive CEMs before such messages are sent to them. It is important to verify and confirm this consent *before July 1, 2014*.



**Express consent** means that the patient specifically agreed to receive CEMs either orally or in writing. When seeking patient consent, dental offices will need to clearly explain what the patient would be consenting to and identify the person or organization requesting consent.

Dental offices can assume **implied consent** if they have a pre-existing business relationship with a patient, which includes situations where they sold a product or service to that individual within 2 years before sending the CEM or that they received an inquiry related to their services within 6 months before sending the CEM.

In case of an allegation of non-compliance with CASL, it will be the dental office's responsibility to prove consent was obtained before CEMs were sent.

**What should CEMs include to comply with CASL?**

All CEMs will need to include the following:

- Information that identifies the sender or the person on whose behalf the CEM is sent
- Contact information enabling the recipient to readily contact the sender or the person on whose behalf the CEM is sent (that contact information will need to be valid for a minimum of 60 days after sending)
- An unsubscribe mechanism

**What will be the requirements for the unsubscribe mechanism?**

- All CEMs will need to include a functioning unsubscribe mechanism.
- The mechanism will need to allow recipients to unsubscribe easily and at no cost. It will also need to be conspicuous and simple.

- Unsubscribe requests will need to be put into effect within 10 business days without any further action required from the recipient.

**Will dental practices have a grace period?**

Yes, they will. CASL provides a 36-month transition period to comply with the new legislation, considering that small businesses might not have the technology required to automate their distribution lists. Existing implied consents will remain in effect during those 36 months unless recipients specifically withdraw consent.

**Are there tools available to help dental offices comply with CASL?**

Different companies offer tools and practice management systems that can facilitate compliance with Bill C-28. Dentists are encouraged to discuss this matter with their computer and software vendors. They may also wish to speak with their insurance broker to discuss whether or not their existing policies can be expanded to cover liability for their practices under CASL. ♦

*Disclaimer: The information in this article is an interpretation of the legal implications of Bill C-28 for dental offices. CDA assumes no legal liability for the accuracy of this information. When in doubt, dentists are encouraged to consult with a legal advisor.*

**Learn more about Bill C-28**

[fightspam.gc.ca](http://fightspam.gc.ca)

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The following article originally appeared on the Oasis Discussions (oasisdiscussions.ca) website in the "View from the Chairside" section. This site answers your clinical questions, discusses issues related to the profession, voices dentists' experiences, touches on the business of dentistry and showcases innovations in the dental industry.

# I USE MOTIVATIONAL INTERVIEWING, DO YOU?



## Richard K. Anderson

*Dr. Anderson is a practising general dentist in Ottawa. He graduated from The Schulich School of Medicine and Dentistry at Western University in 2008. He is involved with the Ottawa Dental Society and volunteers with the Ottawa Mission Dental Clinic.*

**Picture this:** *A patient walks into to your dental office, and before you even pick up the drill or carry out an injection, a conversation takes place that leads your patient to a lifetime of optimal oral health. What just happened? How could a simple conversation change your patient's life so positively? I would like to introduce you to Motivational Interviewing (MI), its purpose, its techniques, and how you can elicit a positive behavioural change in your patients.*

As a dentist, I want the best oral health for my patients. In other words, I want to prevent and eliminate oral disease. If I can encourage my patients to adopt positive behaviours, I can then consider myself successful in preventing and eliminating oral disease. As you are well aware, it is not that simple to motivate patients to change their habitual behaviours, even when they learn about the damage it causes to their health. Ambivalence to change is common. On the one hand, the patient knows that they need to change, but on the other hand, they are comfortable and set in their ways. Traditionally, this has led the counsellor or clinician to give direct advice as the authoritative expert in their field. And, most often, this type of advice lead to patient's resistance and lack of

change, because the patient would defend their ambivalence.

The stubbornness, evasiveness and anger that ensued was the opposite of the desired result. This has led clinicians into an area of research within psychology which has been shown to increase the likelihood of eliciting positive behavioural change. Motivational Interviewing addresses the common problem of ambivalence about behaviour change and honours people's autonomy and self-determination to make their own choices. MI is a person-centered, goal-oriented, collaborative conversation intended to strengthen a person's own motivation and commitment to change. This is the intent of MI: the clinician does not impose change, but supports change congruent with the patient's own values and concerns.

## Motivational Interviewing (MI) in Action: *The New Year's Resolution*

Edward is a 50-year-old male patient with a history of smoking a pack a day for the past 30 years. He does not have a family physician. The poor conditions of his gum and his teeth mean that Edward will be frequently returning for appointments. He presented for a new patient examination where the following conversation unfolded:

- \* Would you mind telling me about your tobacco use?
- \* People often smoke because there is a something that has benefited them in some way. How has smoking benefited you?
- \* What are some aspects of smoking you are not happy about?
- \* I'd like to let you know about some of the risks in smoking that you might not already be aware of, but I want to emphasize that it is your choice alone to decide to make a change.
- \* Could you rate, on a scale of 0-10, the importance of making this change relative to other priorities in your life?
- \* What would it take for you to go from a '5' to a '7'?
- \* If things worked out in the best possible way for you, what would you be doing in a year from now?
- \* After this discussion, are you clearer about what you would like to do? What will be your next step?
- \* What else do you think you will need to support you in this plan for change?

Edward proceeded to set an intention to live a smoke-free life as his New Year's resolution. Supplemental information and helpful resources were supplied. Nicotine replacement therapy and smoking cessation medications were prescribed.

I arranged for follow-up appointments (either in-person or in the form of a phone call) beginning with the first week after the quit/change date.

This initial conversation, grounded in MI techniques, may dramatically change Edward's life and give him a lifetime of optimal oral health.

### The MI Approach

There is more to the practice of MI than simply understanding its intention. I personally like to use MI techniques in a particular way:

- I use non-judgmental, open-ended questions which allow for further conversation, rather than a brief 'yes or no' answer.
- I affirm the patient's skills and strengths which builds rapport and helps the patient see themselves in a new and positive light.
- I listen carefully and give reflective responses which demonstrate empathy and guide the patient towards talk of change.
- I summarize the key points of the conversation which allow for structured, organized thinking, and summaries that promote some ideas and minimize other ideas.

I hope that I have demonstrated how MI can be an effective approach to bring about positive lifestyle changes in patients. MI is a collaborative person-centered form of guidance, which elicits and strengthens one's motivation to change.

Do you think that you could use the MI approach in your practice? Why or why not? Have you tried it before? I look forward to hearing about your experiences using the MI technique or any another successful approach you have been using. ❖

Visit [oasisdiscussions.ca/2014/02/13/mi-3](http://oasisdiscussions.ca/2014/02/13/mi-3) to comment on the article.





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# MANAGING BLEEDING

## *under, or adjacent to, a dental prosthesis*



**Cheryl Cable,**

**BSc, DDS, MBA,  
FRCD(C)**

*Dr. Cable is a prosthodontist and associate professor in restorative dentistry, University of Alberta, Edmonton. She also practices prosthodontics and maxillofacial prosthodontics at Empire Dental Associates in Edmonton.*



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*The author has no declared financial interests.*

*This article has been peer reviewed.*



### Dental Emergency Scenario

This article was originally created for the JCDA Oasis searchable database.

Visit Oasis Help at [jcdaoasis.ca](http://jcdaoasis.ca) to access this and other point of care clinical consults.



*Acute or chronic bleeding of the oral tissues directly under, or adjacent to, a fixed or removable dental prosthesis.*

## Presentation

### Population

- Elders
- People with xerostomia
- People with thin tissues
- People with compromised manual dexterity or who receive inappropriate dental care from a caregiver
- People with special needs

### Risk Factors

- Long-term prosthesis wear
- Nutritional deficiencies
- Hormonal discrepancies

### Signs

- Bleeding upon examination or in response to probing or movement of the prosthesis
- Erythema and/or edema
- Localized pain
- Taste of blood
- Swelling
- Altered prosthesis fit

### Symptoms

- May or may not be symptomatic
- Sore to palpation and prosthesis pressure; avoidance to wearing the prosthesis

## Investigation

1. Question the patient about their medical and dental history.
  - How long have you noticed bleeding and/or discomfort?
  - Where is the bleeding coming from? Please show me with your finger.
  - Is there a time when the bleeding is worse (e.g., when eating or waking up in the morning)?
  - Do you wear the prosthesis at night?
  - Do you grind your teeth?
  - How old is the prosthesis?
  - How do you clean the prosthesis? How do you clean your teeth?



- When was the last time you had a dental professional check the prosthesis? Did you have a dentist or someone else adjust it for you? Did you adjust it yourself?
  - Has your medication changed? Has your medical history changed?
  - When you cut yourself, does it take a long time for the bleeding to stop? Do you bruise easily?
  - Is there any numbness in your mouth or face?
  - Describe your diet.
  - Is your mouth dry?
  - Have you noticed any white or red spots in your mouth? Any areas of roughness that do not go away?
  - Do you smoke?
2. Evaluate the patient's mouth and prosthesis. *Before removing the prosthesis, look for, or ask the patient to point out, the bleeding area. With permission, manually move the prosthesis to attempt to stimulate bleeding and/or elicit discomfort.*
  3. Evaluate the occlusion. Look for balanced pressure with freedom in centric. Ensure that there is appropriate interocclusal space.
  4. Remove the prosthesis and look for indents in the tissues (assess for overseating).
  5. Use a pressure indicator paste (PIP) to identify areas of heavy contact when passive and active.
  6. Mark the areas of soreness with a marker and relieve the prosthesis.
  7. Look for sites of thin mucosa over non-yielding areas such as tori or sharp bony ridges where a denture base may have traumatized tissues. Assess path of insertion and see if insertion/removal by the patient or caregiver may have damaged tissues.
  8. Clinically assess if the prosthesis is clean and assess the condition of the reline material, if any.
  9. Take radiographs of the area and compare with the contralateral side to assess anatomical changes.

- Inadequate relief on non-yielding areas
- Sharp ridges or projections in the resin
- Clenching or bruxism
- Inadequate diet
- Health profile (e.g., diabetes, menopause, medication)
- Oral pathologies (e.g., erosive lichen planus, carcinoma)
- Xerostomia

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## Treatment

### Common Initial Treatments

- Localized relief of overextensions and heavy contact as indicated by PIP and assessment
- Reline of prosthesis
- Education: care and maintenance (for both the patient and caregiver)
- Prescription of chlorhexidine rinse
- Referral for further assessment

### Referral to Specialist

If problem does not resolve or worsen despite cooperation from the patient, refer to an oral pathologist or surgeon for further evaluation.

- Oral pathologist: further assessment of chronic area. Biopsy and specific diagnosis of unknown etiology. If further intervention is needed, the oral pathologist will refer to either an oral surgeon or head and neck surgeon.
- Oral surgeon: further assessment of chronic area. Biopsy and specific diagnosis of unknown etiology. If further intervention is needed, the oral surgeon may refer to a head and neck surgeon.

### Advice to Patient

- Document symptoms (e.g., time of day and medications taken).
- Discontinue prosthesis wear at night.
- Avoid sharp foods such as pretzels, chips, popcorn, or nuts that may worsen the symptoms. Keep a diet record until the next appointment.
- If medication has been prescribed, take it as instructed.
- If the situation worsens before the follow-up appointment, contact your dentist. ✦

---

## Diagnosis

Based on localized erythema and/or edema within a relatively short period directly associated with prosthesis wear, a diagnosis of ill-fitting prosthesis can be established.

### Differential Diagnosis

- Overextended prosthesis
- Occlusal interference (vertical and horizontal dimensions)



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**ALBERTA - Stony Plain:** Group practice in Stony Plain, Alberta requires full-time associate. We work in a fantastic, community-oriented town with great staff. Successful candidate likes "small town by big city" living, enjoys learning, loves working with children, and focuses on patients' well-being. If you look after your patients, they will reward you well. Please email: turnerhm@yahoo.com or fax: (780) 963-2904. D9946

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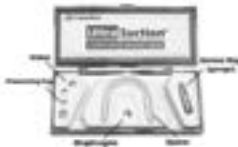
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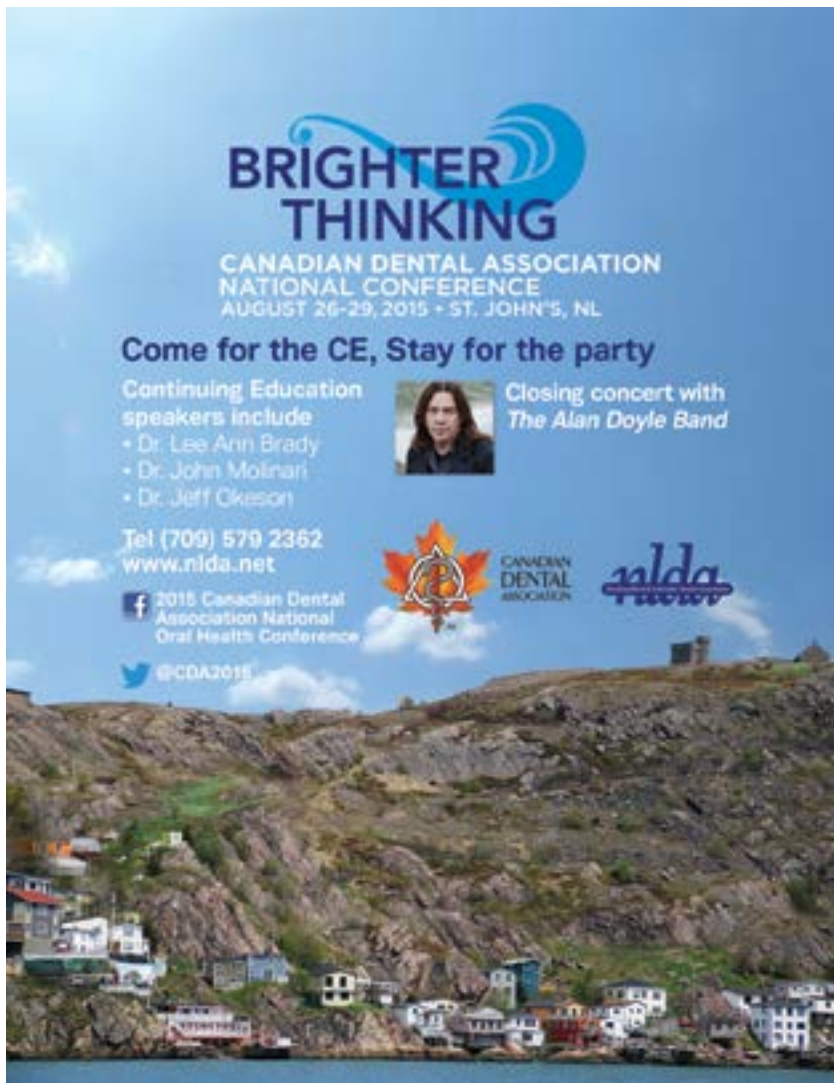
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# CANADA CELEBRATES NATIONAL ORAL HEALTH MONTH

## Trust and Value Working Group

*a unique collaboration of provincial and national dental leaders that develops communications strategies to promote the benefits of good oral health for all Canadians.*

In April, dental organizations across Canada celebrated National Oral Health Month by spreading the word to the public about the importance of maintaining good oral health. Below are just a few of the highlights from across the country.



The 4 provinces from Atlantic Canada joined together to collaborate with CTV Morning News to feature weekly interviews with dentists. The segments promoted good oral health habits, including booking visits to the dentist by age one.

The award-winning "We Be Brushin'" music video, originally created by the Manitoba Dental Association, was rebranded by the Nova Scotia Dental Association for use on TV, and by the Ontario Dental Association (ODA) for use on its website ([youroralhealth.ca](http://youroralhealth.ca)) and YouTube channel ([OntarioDentalAssoc.com](http://OntarioDentalAssoc.com)).

The College of Dental Surgeons of Saskatchewan (CDSS) created online videos and radio ads about oral health, including a weekly "Ask the Experts" radio segment. The CDSS also produced brochures for dentists to promote the benefits of community water fluoridation with their patients.

The ODA's new online initiatives included a "Dr. Oz Health Minute" and a cobranded *Chatelaine*/ODA ad on CTV and Rogers Media. The ODA also continued with its radio and online advertising campaign titled, **Not everyone can see it but your dentist can.**

The British Columbia Dental Association (BCDA) launched a new advertising campaign to promote the importance of investing in regular dental care. It combined print, TV and radio ads with online media channels, and features a new public education website ([yourdentalhealth.ca](http://yourdentalhealth.ca)).

CDA produced a 4-page supplement on oral health promotion for the April 2014 edition of *Reader's Digest*, *Best Health* and *Sélection* magazines.

BCDA also published its first issue of *Your Dental Health*, a new consumer dental health magazine available to its members.



This is only a small sample of the initiatives that your dental organizations undertook in April to coincide with National Oral Health Month. If any special events or activities took place in your local area, please send us more details at [publications@cda-adc.ca](mailto:publications@cda-adc.ca)



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