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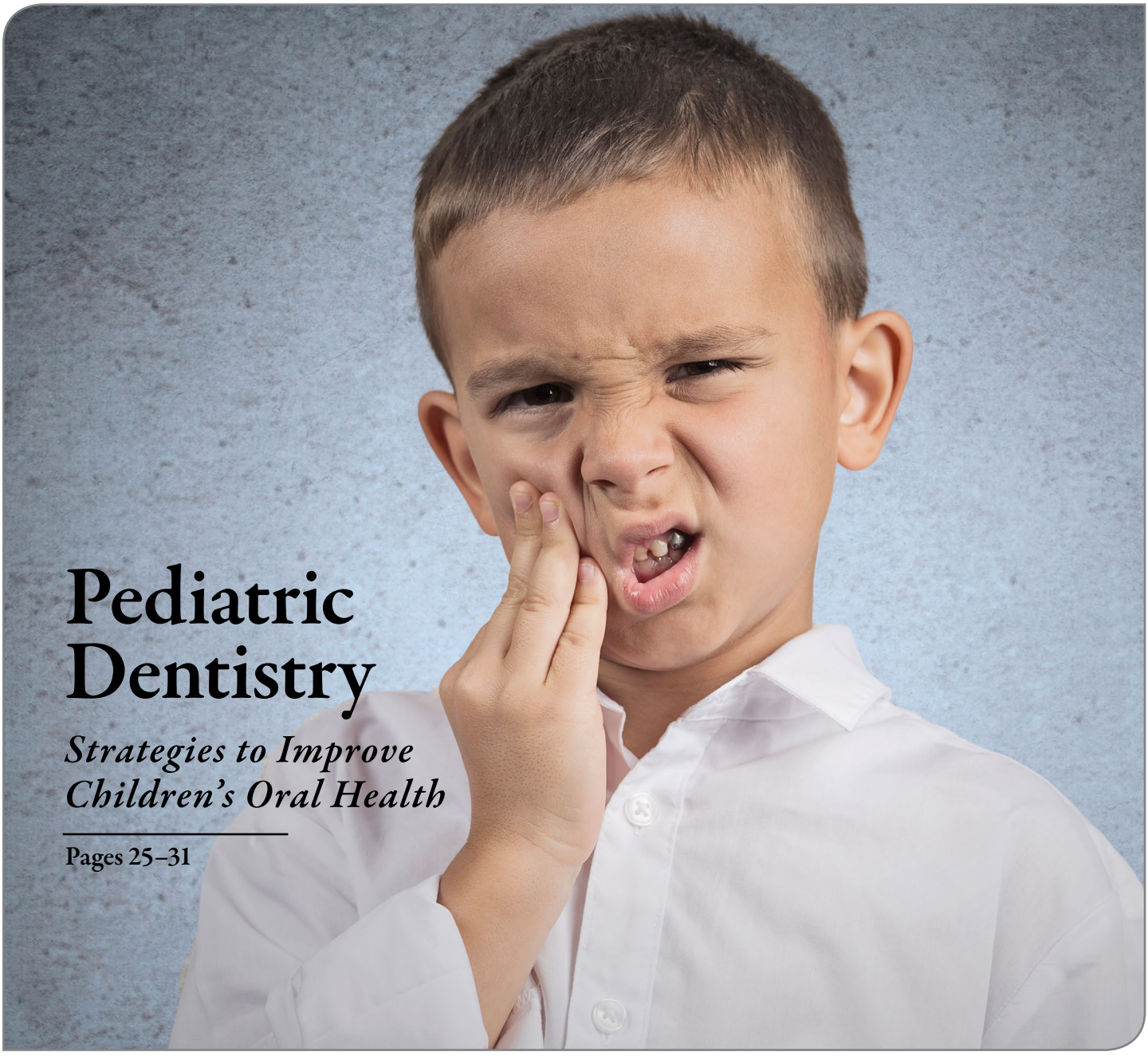
The Canadian Dental Association Magazine



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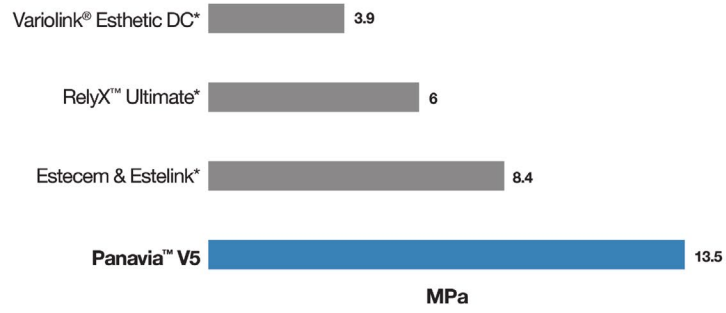

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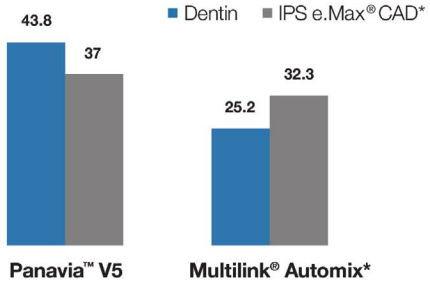

The Dental Advisor, Research Report,
R. Yapp, M. Cowen, J.M. Powers PhD, The Dental Advisor Biomaterials Research Center, Ann Arbor MI. Number 67, February 2015

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CDA essentials

2017 • Volume 4 • Issue 2

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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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Looking ahead to the next decade in dentistry

CANADIAN DENTAL ASSOCIATION

Health care professions are experiencing a transformational change and dentistry will be redefined in significant ways over the next decade. Patients are more informed and engaged, health care delivery models are evolving, and innovative health technologies promise new ways to diagnose and treat patients. Whether we like it or not, external factors beyond our control are influencing our professional paths. It's a crucial time for our profession to identify the important trends in health care and dentistry and determine how these might affect us.

In January, CDA began the first of a series of vital conversations about our professional future. A national task force, comprising 25 members with a wide range of expertise, met over two days to discuss how we can enhance the dental practice of the future (p.11).

How is the overall health care landscape changing? A range of experts, including André Picard, health reporter at the *Globe and Mail*, and Dr. Marko Vujicic, chief economist at the ADA Health Policy Institute, shared their insights on this topic in a series of interviews produced for this initial meeting. They identified just a few of the factors that are contributing to the shifting grounds on which dentistry now finds itself: new challenges in the business climate, decreasing numbers of dental visits by working-age adults in the U.S., evolving views of professional self-regulation and the public interest, a move towards preventive care and collaborative health care.

More insights on trends and challenges in Canadian oral health care can be found in the recently published CDA report, *The State of Oral Health in Canada* (p.13). The report notes that "for most Canadians, choice and availability of dentists is a non-issue." In terms of access to care, Canada ranks among the best the world; the number of Canadians who reported visiting their dentist at least once a year is increasing, from roughly 60% in 2001 to over 75% in 2012, and the supply of dentists is increasing, as shown in declining population/dentist ratios. Yet the report notes that people in vulnerable segments of the population do not receive the dental care they need; improving access to care for these groups remains a significant challenge.

Conversations about value are an essential part of planning for the future. Value to patients, in terms of meeting their demand for information about the cost and quality of services. Value to society, in terms of meeting our professional obligations to provide care for vulnerable groups. Value in health, in terms of bringing attention to the benefits of a healthy mouth for the entire body and in preventing further illness later in life. And finally, value to dentists, in terms of how our organizations can support practising dentists in this evolving environment.

Although these conversations are just beginning, it's clear that adopting a business-as-usual approach simply isn't an option. Task force members have pledged to develop a set of recommendations for the profession by 2018. Dentistry's vision of optimizing the oral health of Canadians and maintaining the integrity of our profession remains unchanged. Although the path to realizing this vision may be uncharted, it promises to present dentistry with new opportunities if we are ready to recognize and act upon them.

RANDALL CROUTZE, BSC, DDS

president@cda-adc.ca

Conservative Party of Canada Health and Finance Critics as well as Rona Ambrose, Interim Leader of the Official Opposition, met with representatives of the health care coalition on this issue.

Successful Campaign Keeps Employer-Provided *Health and Dental Benefits Tax Free*

Canadians will retain their employer-provided health and dental benefits and avoid potentially thousands of dollars added to their federal tax bill, thanks in part to the 80,000 Canadians who voiced their concerns about a proposed tax.

On February 1, 2017, Prime Minister Justin Trudeau stated in the House of Commons that there would be no new taxes on health and dental benefits for Canadians. It's a decision welcomed by the coalition of health care groups, including CDA, that campaigned against a proposed tax.

Through the **DON'T TAX MY HEALTH BENEFITS!** website (donttaxmyhealthbenefits.ca), this coalition urged Canadians to write to their MPs with their concerns. The campaign was widely supported by health care providers and was backed by other professional sectors, such as the insurance industry, chambers of commerce, and labour unions, as the campaign gained steam.

"Collaboration was the key to this advocacy campaign, and this coalition grew quickly and organically," says Kevin Desjardins, CDA director of public affairs. "In particular, the provincial dental associations were instrumental in getting the word out to their members, their provincial health care colleagues, and the local media about this important issue."

> *Collaboration was the key to this advocacy campaign, and this coalition grew quickly and organically.*
>
> Kevin Desjardins
> *CDA Director, Public Affairs*

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The Future of the Dental Profession: On the Cusp of Change

In January, a national task force examining the future of the dental profession held its first meeting in Toronto.

CDA created a 25-member task force to explore trends in the dental care environment, assess their potential impact on the profession, and determine concrete steps for addressing key issues. Task force members, representing various segments of the dental profession, were selected for the diversity of perspectives they would bring to the discussions.

The conclusion reached by those who have studied and researched trends in health and dental care is that change in the dental profession is inevitable. Over the course of its initial meeting, task force members considered a wide range of issues, including shifting demand patterns for dental services by age and income group, a focus on interprofessional collaboration, innovation in health care delivery models, and a trend towards preventive—as opposed to restorative—care.

"This is the time for thoughtful leaders in our profession to explore new ways of doing things and recognize the opportunities for our profession," says Dr. Alastair Nicoll, task force chair and a CDA past-president. "We want all Canadians to enjoy good oral health and value it as an integral part of their overall health. The leadership provided by this task force can help dentistry reach this goal in the decades ahead."

The task force report, containing recommendations for the profession, will be completed in 2018.

We want all Canadians to enjoy good oral health and value it as an integral part of their overall health. The leadership provided by this task force can help dentistry reach this goal in the decades ahead.

Dr. Alastair Nicoll

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Current State of Oral Health *in Canada*

"The only adequate preparation for tomorrow is the right use of today," said American author John C. Maxwell. To better understand where we currently stand in term of oral health and to help guide future actions, CDA published a report that examines the oral health landscape in Canada.

Titled *The State of Oral Health in Canada*, the report provides an overview of:

- the state of oral health around the world
- how Canada compares against other countries
- information on the financing of oral health care
- statistics on dental usage and access to oral health care
- key trends in oral health
- priority areas for improving oral health
- national initiatives, such as the Canadian Oral Health Roundtable
- programs being spearheaded by provincial dental associations
- volunteerism by Canadian dentists

Read the full report at **cda-adc.ca/stateoforalhealth**

The report shows that the oral health of Canadians is very good, with a significant decrease in levels of tooth decay over the past 40 years. "Three out of every four Canadians visit a dental professional at least once per year, and 84% of Canadians believe they have good or excellent oral health," the report says. "In Canada, wait times to see a dentist and receive treatment are among the shortest in the world. And for most Canadians, choice and availability of dentists is a non-issue."

Although Canada is among the world leaders regarding overall oral health, the report mentions that specific groups of the population still experience challenges in accessing care. "In particular, Canadian families and individuals with lower incomes and of lower socio-economic status, those without dental insurance, older Canadians and Aboriginal Canadians experience worse overall oral health outcomes than the general population." The report also recognizes provincial and national initiatives that are bearing fruit—with the goals of inspiring other key players and lifting obstacles to care for those vulnerable members of society.

The report also recognizes provincial and national initiatives that are bearing fruit—with the goals of inspiring other key players and lifting obstacles to care for those vulnerable members of society.

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Value is demonstrated. Trust is earned.

Explaining the benefits of treatment to our patients adds value. Patients appreciate the time we spend with them on their care. The following has been reprinted from a previous article in Ontario Dentist, the Journal of the Ontario Dental Association. It discusses communication skills and ways to talk to your patients about their oral health care needs. Financial discussions can be difficult. While our approaches might be different, this article highlights some of the important points to address when discussing the cost of care.

– Dr. Linda Blakey, CDA Board Member and Chair, Trust and Value Working Group

MONEY MATTERS: *Why Talking to Your Patients Makes Sense*

Harry Höediono
DDS, BSc

Dr. Höediono of Kitchener, Ontario, served as president of the Ontario Dental Association in 2011-12.

When I reflect on the many issues explored during my time as President of the Ontario Dental Association, one theme comes to mind: the importance of respect and trust.

This is true not only with colleagues or in our personal lives, but in our practices. The way we treat patients can have lasting effects; when we show them we care about them as individuals, share information with them and give them an opportunity to ask questions, we are creating an atmosphere of trust that can result in a healthy, long-term, dentist-patient relationship.

The payback for good communication is priceless.

Too often patients view dentists as business people who make decisions based on financial concerns rather than on a patient's health care needs. Here's some food for thought:

- Very few patients know what a clinical dental examination entails, or that the dentist is a medical practitioner and the only member of the dental team who can diagnose and communicate the condition of the oral cavity. (Most patients believe that the dentist performs a "checkup" that focuses on teeth, gums or is simply checking the work of the dental hygienist.)
- Patients feel that dentists don't spend enough time with them, which would explain why patients often don't understand the value of preventive care or the importance of the dentist's recommended treatment plan. We need to spend more chairside time with our patients.

Your patients need to know that the procedures you recommend will benefit their health and that you are their trusted advisor.

Given these perceptions, it's not surprising that many patients interpret a dentist's diagnosis as more of a suggestion than a requirement, and defer to their insurance plans or their own judgment when it comes to treatment.

In my own practice, when new patients come into the office, I make it a point to spend as much time listening to their primary concern as is necessary. In many cases patients come to our office with a specific problem, and to not address that problem would leave them feeling as though they were not being respected.

On recall or re-care appointments, I always have my dental hygienists inform the patient that I will be coming in to do an examination and then discuss the diagnosis. My hygienists also inform patients that if they have any questions regarding their treatment plan, "the doctor will be happy to review it with you and provide any treatment options that will best suit your particular dental situation."

When you spend time with patients discussing their oral health and treatment options — the what, why, how long and how much — they'll be more likely to trust you as a medical professional and accept your recommendations. Patients may be unaware of their dentists' goals and skeptical of their motivations, and have the perception that dentists base treatment recommendations on their own financial objectives, rather than the patient's well-being. The result: patients are not always willing to pursue dentist-recommended plans, regardless of the importance of those treatments.

Your patients need to know that the procedures you recommend will benefit their health and that you are their trusted advisor. Above all, ensure that you include *choices* or *options* in all your recommended treatment plans. Patients want to know that it is they themselves who make the final decision about a treatment that will affect their dental and overall health care.

The cost of dental care can be surprising, so even when patients trust their dentists, they may hesitate to follow dentists' advice. Discussing fees is never easy, but it's important that you pursue the conversation. Here are some suggestions I hope will help ease that discussion, and build on the relationship of trust you have with established your patients.

Connect

- Take time at the beginning of a visit to ask about your patients' general well-being and explain procedures as you go along. If you have an intraoral camera, take photos before treatment as well as after so the patient can see what you are planning to do and what you have done. A picture is certainly worth a thousand words. Many patients believe the hygienist cares more about them than the dentist, because the hygienist spends more time with them. Exchange information; ask your patients if they have any questions or concerns. No one wants to feel they're being rushed out the door or dismissed. Time spent with a patient is an investment in trust.

  I once spent nearly 40 minutes discussing a patient's concern over a failed root canal treatment. When he came back several weeks later to have his treatment needs addressed, he also booked his entire family for new patient examinations! He later explained that he had never had someone spend so much time answering all his questions and giving him treatment options. He appreciated that I took the time to do this and in response gave our office the privilege of treating his entire family. Trust is something you cannot buy — it has to be earned one patient at a time.

Discuss

- Talk about dental plans carefully. The question, "Do you have a dental plan?" implies that patients will be treated differently if they are covered, and suggests that dentists are driven by profit. In our office our new patient chart, which patients fill in when they arrive, has a section asking whether they have dental insurance or if they are the person responsible for the account. If it is insurance, we ask them to write down the insurance name, group, and policy or certificate number. At the end of their first appointment I always let patients know (if I'm aware they are on a plan) that our patient coordinators are "always available to help them with their insurance forms or if they have any questions regarding their plans." This way patients will understand that asking about plans is part of our office service to help them and save them time.

Explain

Present the health benefits of having treatments and dental exams. It's important that patients understand that regular dental exams can prevent small problems from becoming larger more complicated ones. Regular visits to the dental office not only help maintain dental health but can provide valuable clues about overall health. Dentists check for oral cancer, often monitor blood pressure and can detect throat infections by observing enlarged or swollen glands. A dentist does so much more than just teeth.

Describe

Walk your patients through what you are doing. During an oral exam, for instance, after a cleaning, tell patients that you will do an examination and let them know his/her diagnosis and about any possible treatment. Many patients may not even be aware that the procedure is occurring unless you point it out. Use the words "examination," and "diagnosis." These words distinguish us as doctors and also set us apart as the only person on the dental team who can communicate our findings through a diagnosis.

Be Clear

Discuss the diagnosis and recommended treatment plan and elaborate on alternatives and their costs, if several options exist. Don't forget to explain why costs may vary. Remember to keep the language simple; talking about the "superior belly of the lateral pterygoid" won't mean anything to a non-dentist.

Be Open

Talk about costs before you book a procedure. No one likes surprises, and patients want to understand upcoming treatments and know the fees. If it's difficult to provide an exact cost, give high and low estimates, backed up with details. Record these options in the chart. If the bill comes in at the lower range, your patients will be pleased; if it's in the higher range, at least they will have been advised.

If a predetermination is required before you can commence a specific treatment plan, then send one, complete with all X-rays properly labelled and any intraoral photos that may clarify, and include a clear diagnosis. I always send a note of thanks to the dental consultant for taking the time to review my treatment plan for my patient.

Show Respect

Recommend necessary procedures, but practice a "watchful waiting" attitude, and avoid "pushing" cosmetic procedures. Research shows us that when we speak to patients about cosmetic procedures their level of trust drops.

Care

Do not rush through the treatment and fee discussion. Have it in a private area and try to avoid sounding defensive. You can be empathetic, but it's important to explain the health benefit of the procedure. Like all of us, our patients want value for their money from someone they trust. They need to understand that the dentist treats them — not their health benefits plan. Those who have confidence in you as their thorough and understanding oral health doctor, will know that a visit to your office is a critical part of maintaining good health.

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Trust and Value Working Group *is a unique collaboration of provincial and national dental leaders that focuses on developing communications strategies to promote the benefits of good oral health for all Canadians.*

GIVING BACK

Nova Scotia dentists run pilot program for working poor

For more information on the Fundy Dental Community Project, visit **fundydental.com/community**

Project

The Fundy Dental Community Project (FDCP), a pilot program in Coldbrook, Nova Scotia. The program provides low-income residents in the Annapolis Valley with basic dental services: restorative treatment, hygiene, extractions and dentures.

Team

Dr. Scott Schofield leads a team of 8 dentists, 2 hygienists and 1 dental assistant. Each dentist works roughly 3–4 hours, every second week. Dalhousie University also supplies dentists in the General Practice Residency program and fourth-year students in the public health elective on one-week rotations.

Patients

The program is targeting the working poor; those who don't qualify for income assistance and don't have enough disposable income to get the preventative services they would like to have. "We are looking for patients with significant dental need and financial constraints who are motivated to get back to a state of good oral health. There is no recall system in the FDCP; our aim is to help patients deal with any acute dental problems and then get them back to a general dental practice for ongoing care," Dr. Schofield explains.

Fundy Dental Community Project

1. Wife and husband, Dr. Elizabeth Jackson and Dr. Scott Schofield, spearhead the Fundy Dental Community Project (FDCP).
2. The FDCP launched in 2016 with dentists and team members from the Annapolis Valley region.
3. The FDCP team of dentists: (l. to r. - standing) Dr. Gráinne O'Malley, Dr. Schofield, Dr. Jackson, Dr. Leanne Easson and Dr. Ryan LumTai. (l. to r. - seated) Dr. Alison Nette and Dr. April Nason.

How it came together

"Dentists know that access to care is an issue. A lot of dentists do pro bono work. This program lets us target a patient group that can fall through the cracks in the dental world," says Dr. Schofield. Doing something to help underserved populations was always an interest of Dr. Schofield and Dr. Elizabeth Jackson, his wife and a fellow dentist. The motivating force to develop a program for an underserved population came in 2013 when Dr. Schofield's brother, critically injured in a scooter accident while working overseas, required significant rehabilitation and had to navigate the province's disability support program.

How it works

Motivated patients apply for the program and are evaluated on their dental need and financial constraints. They pay a nominal fee of $100 per hour for basic dental services and $50 per hour for hygiene services. The clinic keeps its overhead costs low by operating in space donated to the program within an emergency dental clinic.

Challenges

Connecting with the target patient group was an initial challenge for the clinic. "We don't have money for promoting the program and many people don't know how the community project works or how to access it. Literacy can often be a barrier too," says Dr. Schofield. "We're trying to build relationships with community partners like local food banks, churches, Lions and Rotary Clubs—groups where people can recommend our program to prospective patients or help with the application."

Another challenge is offsetting dental laboratory fees for patients. The not-for-profit Fundy Dental Community Association was established as the fundraising arm of the program, with a primary mandate to fund patients' lab fees.

Memorable moment

One of the clinic's first cases involved a person who needed 14 teeth extracted and immediate dentures. The patient was not in a situation to be able to pay for this treatment in a fee-for-service model. Dr. Schofield uses this case study to illustrate that the program works: "The patient paid $350 for a $4000 treatment plan, the community association paid the lab fees, overhead costs were relatively low and dentists did the work for a lower rate than they'd earn in private practice—and in the end, everyone felt really good about it."

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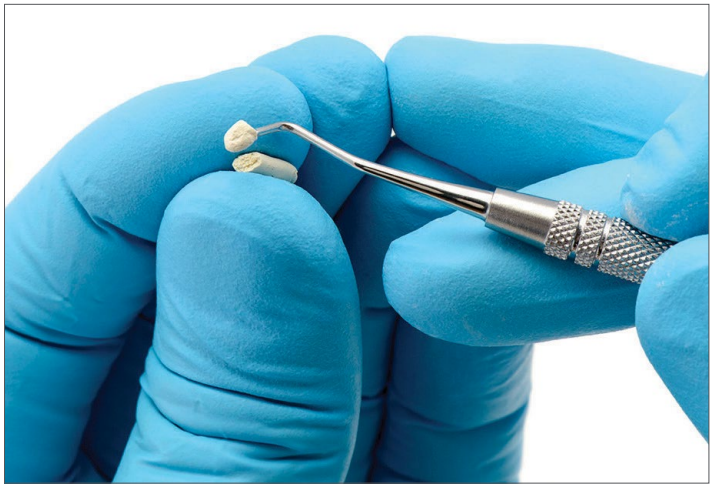

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The future of dental pharmacology

*Exciting developments in research and technology are making it possible to re-imagine how dentistry will be practised in the future. In a series of interviews on Oasis Discussions (**oasisdiscussions.ca**) CDA reached out to leaders in various dental specialties to ask them how their particular fields might be transformed in the next 10 years.*

Dr. Peter L. Jacobsen

pgjacobs@pacbell.net

Peter L. Jacobsen, PhD, DDS, is an adjunct professor at the Arthur A. Dugoni School of Dentistry in California, where he served as director of the Oral Medicine Clinic for 30 years, and currently practises general dentistry part-time in San Francisco. He lectures extensively on dental pharmacology and over-the-counter dental drugs. He authored *The Little Dental Drug Booklet*, a quick reference guide for drugs commonly used in dental practice and has been named one of the leaders in continuing education by *Dentistry Today* magazine for ten years in a row. He is also a part-time farmer, supplying produce to some of the finest restaurants in San Francisco and Napa Valley. Here, he shares his thoughts on the future of dental pharmacology.

Prescribing practices for pain medications will be more regulated.

In the United States, we're seeing new government-directed guidelines for prescribing pain medications and these guidelines are impacting dentistry in terms of the types of drugs we can prescribe and the duration for prescribing those drugs. There is an increased awareness of dentistry's responsibility to address a national epidemic of narcotics abuse and how our prescribing patterns may be contributing to this problem.

There will be more regulation related to antibiotic stewardship.

I think the concept of responsible prescribing of antibiotics will lead to more regulation related to antibiotic stewardship—meaning we need to address which antibiotics to use, when to use them, at what dosage and for what duration. Of course we should be responsibly prescribing all medications, but antibiotics are at the forefront because of the worldwide problem of antibiotic resistance. As prescribers, we have a responsibility to deal with that problem. In the U.S., dentists prescribe 10% of all antibiotics, so our prescribing responsibly can have a meaningful effect.

> *There is an increased awareness of dentistry's responsibility to address a national epidemic of narcotics abuse and how our prescribing patterns may be contributing to this problem.*

To hear the full interview with Dr. Jacobsen, see:
oasisdiscussions.ca/2016/05/13/fpd

This interview has been condensed and edited.

The views expressed are those of the author and do not necessarily reflect the opinions or official policies of the Canadian Dental Association.

Dental decay will be viewed as a medical, rather than a surgical, problem.

In the past, dental decay was a surgical problem; we found it, drilled it out, put in a filling. Today, dental decay is managed as a microbial problem, as some kind of infection in the oral cavity. We still need to drill and fill and we've made some advances in eliminating the specific organisms that cause the disease, but in reality we haven't effectively eliminated the disease. We sometimes blame the patient for not following our directions properly but maybe one of the reasons they're having such a hard time getting rid of the disease is that the tools we currently have available are not directed at the underlying cause of the disease. Why are those specific organisms there? It probably has to do with the acid/base balance, the foods they're eating, the components in their saliva. We need to step back and look at all of those factors beyond the specific organisms.

There will be a new paradigm of periodontal disease.

I think we're making advances in understanding that we're not focusing on the right problem in periodontal disease. We've all seen patients with all kinds of plaque and calculus, yet their bone is as solid as stone and holding those teeth in place. Other people do a great job of brushing and flossing, and rinsing with the rinses we have for them, and they're still losing bone. We call it all one thing: periodontal disease. But I suspect there are multiple periodontal diseases. What we're not capturing in our understanding of periodontal disease is the host inflammation response; the inflammatory mediators destroy bone, not the organism. Advances in understanding the human inflammatory response will lead to an understanding of periodontal disease that goes way beyond brushing and flossing.

There will be a growth in host inflammatory mediator medications.

Because we're still doing basic science in trying to understand host mediators in periodontal disease, we're pretty far away from developing drugs that are going to make a difference. But we already have one host inflammatory mediator medication for treating periodontal disease: doxycylcine. You might think it's just an antibiotic but doxycycline used in periodontal disease is not prescribed at a dosage that affects organisms. The dosage that's commonly used affects collagenase, the host enzymes that break down collagen. This category of medication will only grow as we better understand periodontal disease.

Could professional self-regulation become a thing of the past?

What does it mean to be a self-regulating profession? According Dr. Tracey Adams, professor and chair of sociology at Western University and an expert on professional regulation, our understanding of professional regulation has changed with time.

In particular, the idea that it upholds the public interest has been debated in countries around the world, resulting in changes to how some professions are regulated. Canada, according to a paper Dr. Adams recently published in the journal *Professions and Professionalism*[1], is considered by some to be the "last bastion of unfettered self-regulation" in the world. She spoke with CDA about the changing views of professional self-regulation and the implications for Canadian dentistry.

Dr. Tracey Adams

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This interview has been condensed and edited.

The views expressed are those of the author and do not necessarily reflect the opinions or official policies of the Canadian Dental Association.

What are the key points you make about professional self-regulation in your article?

I focus on the changing nature of professional self-regulation in Canada and argue that how we define the public interest has changed. It's long been said that professional self-regulation is in the public interest but it isn't clear what people mean when they say this. For my paper, I looked at how public interest has been historically defined, especially in government reports and legislative records.

How has our understanding of the public interest changed?

Historically, it was defined in terms of raising practitioner quality and establishing high entry standards. In that way, public interest and professional interest went hand-in-hand because everybody benefitted when services were of higher quality.

Around the 1960s there was an upswell in the belief that professions couldn't be trusted to uphold the public interest and perhaps professions were more interested in pursuing their own interests. This sentiment found its way into public and government discourse and shifted the definition slightly to reflect this feeling that professionals needed more oversight from government in order to uphold the public interest, with a new emphasis on fairness, efficiency, accountability and cost.

How is the public interest currently defined?

Most recently, I'm seeing changes again in some of the government discourse. The public interest is increasingly being defined

> *It's also important to recognize that some people, including politicians, are increasingly skeptical about professions and their claims to serve the public interest.*

not in terms of setting higher standards or higher quality services, but rather it's being viewed in terms of supporting a competitive market and more consumer choice. There's a growing sense that professionals are obstructing market practices that would benefit the public more broadly.

To hear the full interview with Dr. Adams, see **oasisdiscussions.ca/2017/01/17/pi-2**

Why do you think views about the nature of public interest have shifted again?

The understanding of public interest varies across provinces and I think political culture is very much a part of it. I think there is also a new public sense of what is right and what is wrong; these things change over time. To some extent, I think people are taking high quality services for granted so the conversation has shifted to focus on other issues and barriers.

Is the concept of self-regulation different in Canada compared to other parts of the world?

In the past, there were some differences in terms of how self-regulation was structured although the concepts were pretty similar. But there is a growing change in that some people consider Canada the sole country that maintains professional self-regulation. In Australia and the UK they've been revising self-regulation to minimize the voice of professionals and increase government oversight and the voice of members of the public.

What could changing views of professional self-regulation mean for the Canadian dental profession?

Professional regulation and self-regulation in Canada could shift to be more like it is developing in the UK and Australia, where professions sometimes have more accountability and less autonomy. It could have an impact on scopes of practice, in that more professionals could be granted the right to do some tasks that dentists currently perform. There's a sense that maybe professionals have lost some value with the public and may have less influence with politicians.

How can the Canadian dental profession position itself in this new climate so that the public and the profession are best served?

It's important to recognize that our world is changing rapidly so we can't assume that just because things have been a certain way that they're going to stay that way. It's also important to recognize that some people, including politicians, are increasingly skeptical about professions and their claims to serve the public interest. I think there's a big role for professions like dentistry to participate in public discourse on what it means to uphold the public interest. To talk about the importance of quality education and the dangers to the public in opening up scopes of practice. It's important for dentists to engage and even shape these kinds of conversations moving forward.

Reference

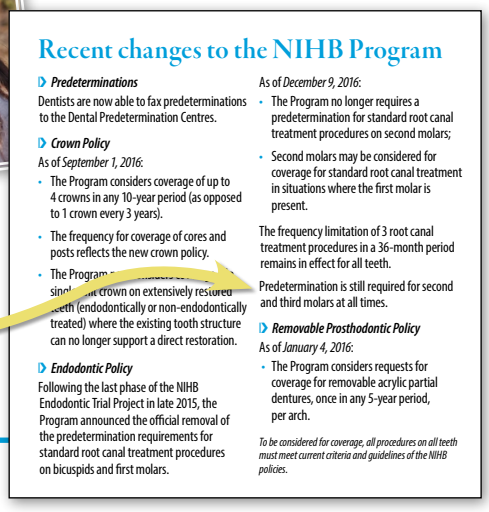
1. Adams T. Professional self-regulation and the public interest in Canada. *Professions & Professionalism.* 2016;6(3):1-15.

Erratum

Conflicting information regarding molar predetermination requirements was published in the article **Navigating the NIHB Program: Dental Care for First Nations** (*CDA Essentials,* Volume 3, Issue 8, 2016. p. 12-13). The correct sentence in the "Endodontic Policy" section should read:

Predetermination is still required **for third molars** at all times.

CDA Essentials apologizes for this error.



Recent changes to the NIHB Program

Predeterminations

Dentists are now able to fax predeterminations to the Dental Predetermination Centres.

Crown Policy

As of *September 1, 2016:*

- The Program considers coverage of up to 4 crowns in any 10-year period (as opposed to 1 crown every 3 years).
- The frequency for coverage of cores and posts reflects the new crown policy.
- The Program [illegible] single crown on extensively restored teeth (endodontically or non-endodontically treated) where the existing tooth structure can no longer support a direct restoration.

Endodontic Policy

Following the last phase of the NIHB Endodontic Trial Project in late 2015, the Program announced the official removal of the predetermination requirements for standard root canal treatment procedures on bicuspids and first molars.

As of *December 9, 2016:*

- The Program no longer requires a predetermination for standard root canal treatment procedures on second molars;
- Second molars may be considered for coverage for standard root canal treatment in situations where the first molar is present.

The frequency limitation of 3 root canal treatment procedures in a 36-month period remains in effect for all teeth.

Predetermination is still required for second and third molars at all times.

Removable Prosthodontic Policy

As of *January 4, 2016:*

- The Program considers requests for coverage for removable acrylic partial dentures, once in any 5-year period, per arch.

To be considered for coverage, all procedures on all teeth must meet current criteria and guidelines of the NIHB policies.

CDA Conversations: DR. ROBERT SCHROTH

Robert Schroth

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This interview has been condensed and edited.

The views expressed are those of the author and do not necessarily reflect the opinions or official policies of the Canadian Dental Association.

Dr. Robert Schroth dedicates his career to reducing oral health inequalities and improving children's oral health. His main focuses are lifting barriers to access to care, advocating on behalf of the most vulnerable groups, and shaping future generations of clinicians to ensure their practice is guided by a sense of social responsibility and compassion.

Tell us a little about your background.

I graduated from the University of Manitoba in 1996 and immediately started working in community dental clinics in Winnipeg. I later completed a Master's Degree in community health sciences with a focus on early childhood caries (ECC), and a PhD also in community health sciences, looking at the relationship between vitamin D levels during pregnancy and ECC prevalence in children. I am currently an associate professor in the Colleges of Dentistry and Medicine at the University of Manitoba.

You recently received funding from the Canadian Institutes of Health Research (CIHR). What projects will you be working on?

I'm fortunate to have received a CIHR Embedded Clinician Researcher Salary Award for the next 4 years. One of our projects relates to the Manitoba Dental Association (MDA) Free First Visit (FFV) program (p. 29). We want to work with the MDA and other stakeholders to make headways in rural and remote regions. The uptake in the city of Winnipeg and larger urban centres is great, but we're aware of the challenges in rural and First Nations communities. By looking at the rates of dental surgery, we hope to identify some hotspots and, in collaboration with the MDA and local dentists, work on enhancing the program. The other project we proposed focuses on the timely delivery of dental surgery under anesthesia. We hope that through good networking we can learn about, and adopt, measures to streamline the process.

Who do you collaborate with?

I collaborate a lot with my pediatric colleagues (pediatricians, pediatric endocrinologists, pediatric dentists, etc.) here in Winnipeg on nutrition studies. On other studies, I work closely with the MDA, the Winnipeg Regional Health Authority, and Manitoba Health. When it comes to community partners, the First Nation Health and Social Secretariat of Manitoba is one of our allies. And I'm happy to report that we'll soon be working for the first time with the Manitoba Metis Federation on an ECC prevention project.

I'm part of a team that is evaluating the Children's Oral Health Initiative (COHI), which was launched by Health Canada to address the oral health disparities between First Nations and Inuit communities and that of the general population. Our team includes collaborators from my university and key researchers like Dr. Alyssa Hayes from the University of Saskatchewan and Dr. Mary McNally from Dalhousie University.

This edition of *CDA Essentials* also includes a summary of Dr. Schroth's research on dentists' views of the Manitoba Dental Association *Free First Visit* program. See p. 29

Can you tell us about the Healthy Smile Happy Child initiative?

It started in 2000, partly in response to the increasing demand for operating room time and the growing wait list for dental surgery. One of our members stressed that we should be working more upstream, that we couldn't just be reactive. In other words, we had to be able to anticipate needs and raise community awareness, and by doing so hopefully lead to improved oral health.

We started by working with four communities. We assessed the oral health knowledge of parents and the oral health status of preschoolers. We then shared our findings with the communities and we provided capacities for them—including a project coordinator—to move forward with ideas. Some communities opted for posters showing the quantity of sugar in drinks often put in bottles and sippy cups, others went for games and fact sheets. Five years later, we reassessed the communities to get a sense of the changes that had since happened. Attitudes and knowledge have improved. There wasn't a huge impact on the dental findings, but we saw a modest—yet statistically significant—improvement in the prevalence of severe ECC. It was encouraging evidence that listening to communities and following through can help. We're now hoping to scale up the program to include Metis and First Nations communities.

How do you get buy-in from stakeholders?

Some recognize the value proposition right away and are committed from day one, others need to reflect on the role they can play. A challenge when working with a new community group is building trust. Some of our partners facilitate that brokering of relationship for us; our allies help us network and develop relationships with new communities. If I didn't have this network to rely on, I think I'd be struggling to find communities interested in working and applying to a grant related to oral health.

When you work with communities, sometimes it's about giving up control and listening to what they want and value. You don't have to abandon all of your principles and ideas, but you must incorporate their ideas and wishes into the project. For example, one of our long-time team members from a rural community suggested that creating short YouTube videos might be a good way to make sure new employees know about the Healthy Smile Happy Child program. They might not come to an orientation session, but they might have 5 minutes to watch a video. We followed through and had summer students work on that last year.

Dental benefits aside, what are some of the access to care barriers?

One barrier often faced by low-income and working-poor families is that their work schedules often conflict with clinic hours. Taking a child in for care often means taking time off from work, and that can translate into a loss of much-needed income. We cannot expect all patients to be able to come to our practices during regular business hours. For 15 years now, I've been doing an evening clinic twice a week—it's our only community-based program in the province with an after-hour service. Transportation and childcare are other issues that add to the "cost" of visiting the dentist.

I know it's an uncomfortable topic, but there's also stigmatization. Sometimes people perceive that they're not being treated fairly. They may think that we're shaming them when we ask that they bring along their income tax information. But I know that we need that information to see if they qualify for the program, yet if it's not done discreetly, it can cause embarrassment.

Also, having dental insurance doesn't mean you're financially off the hook. When a specialist tells a parent they need to prepay for their child's surgery, it can become a real struggle financially. Not many families can easily write that cheque and just wait for reimbursement.

When it comes to refugees and new immigrants, there can also be a language barrier. We've been blessed that the Winnipeg Regional Oral Health Authority employs

When you work with communities, sometimes it's about giving up control and listening to what they want and value. You don't have to abandon all of your principles and ideas, but you must incorporate their ideas and wishes into the project.

interpreters. They interpret for medical and dental visits, so we can have a proper conversation with the patient or parent. That's been a huge help for our community-based clinics. Another barrier may be that newcomers have never had preventive care before, so they might not understand the value of dental care. We also see this in some Indigenous families: they've typically relied on emergency dental care, perhaps not realizing that preventive visits from early on can keep kids on a healthy path.

What service delivery model could help close the access to care gap?

I think there's a balance to be found. Many private practices are providing great care to low-income families, sometimes even doing pro bono work. They're seeing so many people; without them we couldn't keep afloat with the demand. Yet community clinics also serve a need as private offices are not always the best option for the most vulnerable: those without dental insurance, those with a history of not showing up for appointments, etc. I also think we need to start looking for affordable options apart from private practice for rural communities. I know some dentists are doing an amazing job and are stepping up to the plate. But I also think some families fall between the cracks because there are no dentists in the area or they can't afford care and have no alternatives.

What do you want to instill in your students and trainees?

One thing I hope to teach them is to try to always take a nonjudgmental approach. We sometimes make parents feel bad that their kids have cavities. We should be helping them understand the importance of dental health and good oral hygiene routines—not shaming them. Similarly, I hope that they'll have a real appreciation of the different groups who haven't been typically so fortunate in terms of accessing dental care; that they'll be aware of the barriers to care that exist and the oral health conditions of people living in our own backyard. We sometimes take for granted that everybody should have good oral health in cities like Winnipeg.

I also want them to be aware of the role they can play in making improvements for families, and especially young kids. I try to teach them that while they might not feel comfortable seeing young kids when they graduate, they have a moral obligation to connect families with dental colleagues who will be able to provide that service. ◆

ON THE SPOT

with Dr. Robert Schroth

What would you be if you weren't a dentist?

I would probably be a pediatrician… or an art broker! That being said, I think I've been able to tailor my career to what I enjoy doing most. I do research, but I'm not solely a researcher. I'm a clinician scientist, where I still do clinics with the populations I like giving back to, and I also do advocacy and administrative work. I think I truly found what I was meant to do with my life.

Looking back at your career so far, what are you the most grateful for?

I think I've been blessed. I've had great training opportunities, great mentors. I'm grateful for the networks and relationships I've been able to develop, and for the work that collectively we've been able to accomplish. Those are the things that make me smile when I look back.

What do you hope your legacy to be?

That maybe I've been able to train others—dentists, hygienists, medical residents, whoever it may be—to continue to advocate for the oral health of our younger citizens. And maybe that much of my research and work clinically and administratively has led to improvements to policies or service delivery.

What advice would you give to a new graduate?

Find the things that make you happy. I hope no one finishes off their career with regrets. Some of us are gifted in different ways, some can last their whole career in a private practice, others have to do other things. And if you're given opportunities to learn, seize them!

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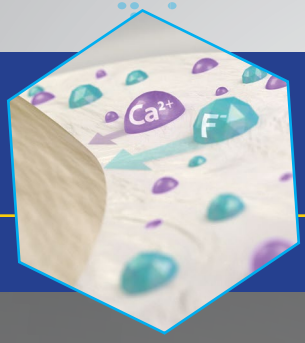

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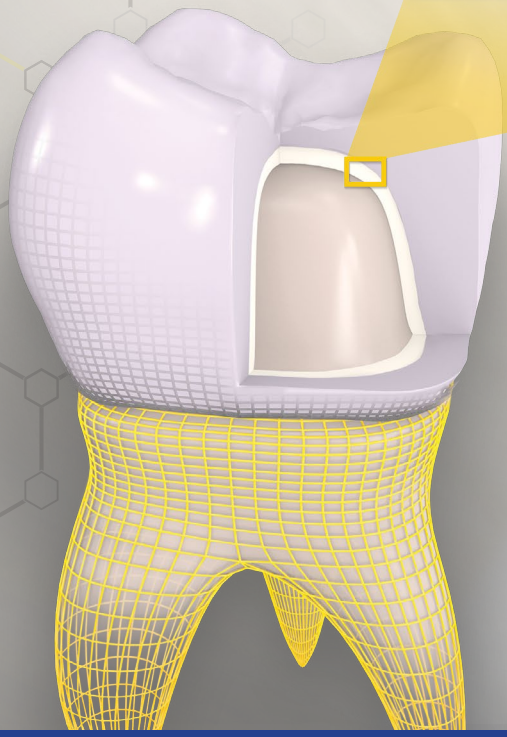

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Manitoba Dental Association's Free First Visit Program
Dentists' Perspectives

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In 2010, the Manitoba Dental Association (MDA) implemented the Free First Visit (FFV) program to provide access to dental screenings for children under 3 years of age and promote the concept of the age 1 dental visit. Today, several professional organizations, including the Canadian Dental Association, recommend an early dental visit within 6 months of first tooth eruption or by 12 months of age.[4,5] In this article, we report on dentists' views of the program.

The establishment of a dental home in infancy is important to set the foundation for good oral health during childhood. Early assessment, preventive care and anticipatory guidance can protect primary teeth by decreasing exposure to cariogenic factors and instill good oral health habits. Furthermore, children whose first dental visit occurs by the recommended 1 year of age have lower rates of restorative and emergency treatment over childhood compared with children do not visit a dentist until 2–3 years of age.[6,7] Evidence suggests that early preventive dental visits can reduce the need for restorative and emergency care, therefore reducing dental-related costs among high-risk children.[7]

Unfortunately, early dental visits are still uncommon for children in Canada.[9] A past survey of Manitoba dentists showed that only 58% were aware of the first visit by age 1 recommendation. In addition, fewer than half of respondents saw children younger than 12 months.[10]

In April 2010, the Manitoba Dental Association (MDA) implemented the Free First Visit (FFV) program as a 3-year pilot project.[11,12] This program provides access to free dental screening for children under 3 years of age. During an FFV, children are given the opportunity to become comfortable with the dentist and have their teeth checked. Parents may receive information on caring for their children's teeth and discuss future dental treatments if needed. Approximately 235 general and pediatric dentists reported that they participated in the program.[11]

The purpose of this study was to determine dentists' views of the FFV program.

Methods

We relied on qualitative methods, namely focus groups, to elicit the views of dentists on the FFV program. Participating and non-participating Manitoba dentists were invited to take part.

Results

Three focus groups and 1 pilot interview were conducted with 30 dentists. Of the focus group participants, half practised in urban areas, one-third in rural areas and 15% in northern

Manitoba, with some dentists practising in more than one location. Analysis of the focus group transcripts revealed common themes, which are presented in this article.

Reasons for Participation (or Not)

Most focus group members (24/30) participated in the FFV program. Both participants and non-participants were extremely supportive of the program.

The most common reason for participating in the FFV program was because it promoted early dental visits. Dentists said the program helped them educate parents about the appropriate age for a first visit and how to care for their child's teeth. The first visit also accustomed the child to the dental office in a non-threatening situation. Several dentists referred to the importance of establishing a "dental home."

> "I participate because I find it's a good idea to get the kids in early so that we can teach the parents about prevention."

Although not a universal view, many agreed that it only took a few minutes to perform an examination.

Of the 6 dentists not formally registered in the program, several said that they offer free visits. Several mentioned filling out FFV tracking forms as an issue: "As silly as it sounds, the reason that we don't do the program is because we don't want to have to track the forms, because we already offer those visits for free."

One dentist said that many pediatric dental practices include a majority of patients whose bills are covered by a third party, including First Nations patients, patients on social assistance and those with insurance. Foregoing payment in these cases could create financial problems for the practice without providing any benefit for patients. He wanted to be able to publicize the FFV to private clients, but continue to charge government and insurance companies for patients with coverage. Other dentists recognized this issue as a legitimate concern.

Uptake and Follow Up

Many focus group participants believed that public demand for the FFV is low. Three said that they had not yet had any preschool patients; nearly half (13) said they saw 5 or fewer in an average week.

Several dentists thought that the program might have attracted a few new patients to their office and brought in some children earlier than otherwise. They also cited the program for helping them to promote early visits.

With respect to follow-up visits, dentists said that parents with insurance returned, but those without insurance often did not come back.

Access to Care

Both general and pediatric dentists said that most (75–90%) of their patients had some form of coverage: private or government-based insurance. However, patients without coverage present challenges. Dentists described how parents of these patients come in for the first visit because it is free, learn of extensive treatment needs and then do not return because they cannot afford the treatment. The overall experience is frustrating to dentists as well as to the parents.

There was overall agreement that the program did not improve access to care for patients in disadvantaged circumstances.

> "I don't think it increases access to care…what we're doing to the kids is we're giving them a free visit with nothing beyond that."

Public Awareness

It was clear that participants viewed the goals of the program as increasing public awareness, educating parents to prevent early childhood caries and allowing early diagnoses to prevent major problems.

> "More prevention, to me it's all about prevention, to put more money in prevention because we have under 3s that come with mouths already destroyed, extractions, crowns. So why don't we start from the beginning when parents are pregnant — teach them what to do to prevent all these."

It was clear that participants viewed the goals of the program as increasing public awareness, educating parents to prevent early childhood caries and allowing early diagnoses to prevent major problems.

First Visit by Age 1 and Free Under 3

There was consensus that the message about the need for a first visit to the dentist by 1 year of age had been lost in the FFV program's advertising. The "free under 3" message had eclipsed that more important message. Dentists were consistent that the key message should be visit your dentist before the age of 1 or 6 months after eruption of the first tooth.

> "A lot of parents see "free first visit under 3," and even though in the fine print we recommend at 1 year, they think, "Oh we have until age 3 to come in."... Parents are surprised that it's recommended at 1 year..."

Impact of FFV on Dentists

Most dentists said that the MDA's promotion of the FFV program had not altered their awareness or practice. There was a suggestion that the age for seeing children had changed relatively recently. As one dentist put it, "We used to always say years ago, that 3 years of age was the time to come, and I think that was ingrained in people's minds."

It was pointed out that most FFVs are performed by pediatric dentists. Many pediatric dentists commented that they wanted to see more general practice dentists do more screening of young children.

Several specialists wondered if general dentists were comfortable examining very young children, and general practice dentists raised this point too. When one dentist commented on "the general challenge of just getting into the mouth of a 15-month-old," heads nodded all around the table, and someone added, "That's why there are specialists."

Discussion

Overall, dentists were enthusiastic about the FFV program and there was general support for its continuation. Focus group participants also said the program helped to raise public awareness about the recommended timing for a child's first dental visit. A survey of Manitoba dentists conducted after the program's first year showed increased awareness of age recommendations for first dental visits: 86.3%, up from 58% in past surveys.[10,11] Further, the average age for a first visit recommended in their practices has decreased significantly over time (18.9 vs. 24.8 months) and is only 6.9 months later than the age 1 recommendation.[11]

Unfortunately, despite growing awareness in the broader oral health community about the age 1 visit, many Canadian children are likely not benefiting from early examinations.[9] However, evidence from the first 3 years of the FFV program indicates that more Manitoba toddlers are benefiting from early examinations.[12]

Visit **oasisdiscussions.ca/2016/02/04/ffv** to view a Panel Discussion about the Manitoba Free First Visit program with Drs. Joel Antel, Carla Cohn and Cory Sul

Dentists viewed the program as a good public health measure and a way to bring in greater numbers of young children for early dental visits. They felt that the FFV program helps educate parents and promote caries prevention while also developing the child's comfort in the dental chair. Barriers to taking part in the FFV program included the expense associated with the program and not being comfortable performing infant dental exams.

Although both general practice and pediatric dentists participated in the FFV program and the program was intended to increase the participation of general dentists, pediatric dentists account for most of these visits. Whereas general practice dentists reported seeing an average of 7 children a week, pediatric dentists saw 16.5 preschool children a week on average.

Participants in this focus group study suggested that increasing general practice dentists' comfort with performing infant examinations might lead to their greater involvement in providing FFV visits in their offices and increased access to care.[17]

Final recommendations that were presented to and discussed with the MDA included the need to continue with this initiative, to tailor messaging to the public and profession so that emphasis is placed on the importance of the first visit no later than 12 months of age and to continue to increase general dentists' ability to work with young children.

Erratum

Please note: An incorrect dosage was included in the article "Antibiotic Prophylaxis: Timing is Everything" (*CDA Essentials*, Issue 1, 2017. p. 25). The correct dosage should read: "**2 g dose of amoxicillin.**"
CDA Essentials apologizes for this error.

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- **Facial Intelligence™:** Drop by the Facial Intelligence™ at booth 147 and learn about the science of reading faces, particularly features and markings to understand others on a more profound level. Each aspect of the face tells a story of a person's innate personality traits, their habitual behaviour patterns and their current emotional state. Facial Intelligence ™ is a valuable tool that can help build rapport, connection and relationships between professionals, their staff and patients.
- **Wellness Lounge:** Drop by the Wellness Lounge at booth 2212 on the exhibits floor and leave with a total feeling of well-being by taking home some tools that will enable you to shift from overwhelmed and sore to feeling balanced. Spend some time at the Oxygen Bar and feel rejuvenated. Let go and relax with a foot massage and learn a technique or two to take care of your feet.

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The Final Guide will be available online in April.

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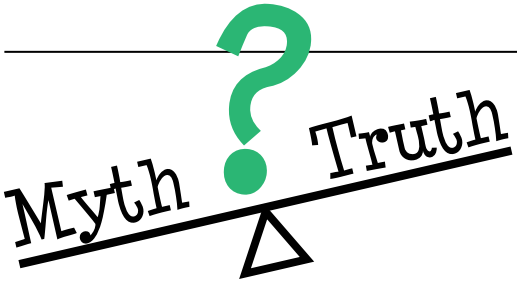

Should cancer patients avoid flossing?

Drs. Deborah Saunders (DS) and Joel Epstein (JE) are dentists who have dedicated their careers to treating cancer patients and others who are medically compromised. They are both active members of the International Society of Oral Oncology, a global group of researchers and clinicians striving for better outcomes in cancer therapy through optimal management of oral complications. The two dentists spoke with CDA about whether flossing presents a risk to patients during cancer treatment.

Dr. Deborah Saunders

DSaunders@hsnsudbury.ca

Dr. Joel Epstein

jepstein@coh.org

Are there risks to flossing during cancer therapy?

JE: In many hospitals, cancer patients may be instructed to stop flossing because of concerns about bleeding and bacteremia, but in most cases flossing should be part of their daily oral care.

DS: We need to dispel the myth that flossing is not safe for patients with a compromised bone marrow function and immune dysfunction and in those with clotting issues related to their cancer therapy. The truth is that flossing during chemotherapy is safe and important for maintaining tissue health and reducing the potential burden of bacteremias from a gingival source. As dentists we appreciate the impact of gingivitis on the development of periodontal disease, and the potential impact this could have on a patient with bone marrow dysfunction resulting in neutropenia and/or thrombocytopenia.

Is there evidence to support the safety and need for flossing during cancer therapy?

JE: A limited number of studies have looked at whether there is a higher risk of bacteremia in cancer therapy with flossing versus without. Flossing is preventive. Studies show that there is no increase in bacteremia probably due to a reduction in gingivitis.

DS: Studies have looked histologically at the periodontal pockets of patients undergoing cancer treatments. These studies describe oral mucositis, an ulceration breakdown in tissues secondary to chemotherapy agents, associated with periodontal pockets. This provides a potential portal for the pathogens in periodontal pockets to enter the bloodstream.

> *Flossing is preventive. Studies show that there is no increase in bacteremia probably due to a reduction in gingivitis.*
>
> Dr. Joel Epstein

To watch the full discussion, visit: **oasisdiscussions.ca/2016/10/25/floss-2**

This interview has been edited and condensed.

The views expressed are those of the authors and do not necessarily reflect the opinions or official policies of the Canadian Dental Association.

What are the best practices for oral health care during cancer treatment?

DS: Cancer Care Ontario has developed a tool box for health care professionals on proper techniques for oral care. In a basic oral care program, flossing is recommended once a day. If there is bleeding after the patient starts flossing and it continues for two minutes, it could indicate that the patient is suffering from thrombocytopenia or other bleeding disorders. In this situation, the patient should inform the dental oncology clinic in their region—which are few and far between in Canada—or their oncologist.

Are other forms of interdental cleaning, such as a rubber tip stimulator or a Proxabrush®, contraindicated during cancer treatment?

DS: Some well-designed studies in Europe compared the benefits of flossing to other approaches for interdental cleaning and showed no difference. I think the dentist is best at guiding their patient on what approach to take for interdental cleaning.

JE: I agree. The most important thing is that the patient use some form of interdental cleaning with a method that is atraumatic. That means patients should continue using the tool that is most familiar to them. In North America, that's typically dental floss.

What should a patient do if the medical team contradicts the advice of the dental team on the issue of flossing?

JE: Patients do hear conflicting opinions from the medical team and could be told to stop flossing because of a concern about bleeding. But dentists know that gingivitis and bleeding is a result of inadequate brushing and flossing leading to gingivitis.

DS: Patients might like to know that the International Society of Oral Oncology and the U.S. National Cancer Institute endorse flossing while patients are on active treatment. The International Society of Oral Oncology has a patient fact sheet on how to care for your mouth during cancer treatments, and these are available on their website. Cancer Care Ontario has a patient guide to mouth care as well.

Resources for Dentists and Patients

Cancer Care Ontario Symptom Tool Box for Healthcare Professionals
› cancercare.on.ca/toolbox/symptools
Resources for download include a symptom management guide and oral care plans.

Cancer Care Ontario Patient Guide for Mouth Problems
› cancercare.on.ca/common/pages/UserFile.aspx?fileId=357469

International Society of Oral Oncology Patient Fact Sheet
› mascc.org/oral-care-education

Your Oral Health.ca, fall/winter 2016-17
› youroralhealth.ca/images/YOH/YOH_FW_2016-LR.pdf
A special issue of this ODA patient magazine, dedicated entirely to flossing

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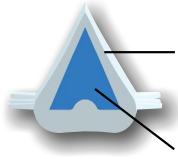

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UNIVERSITY OF SASKATCHEWAN: Faculty Position - College of Dentistry. The College of Dentistry invites applications from qualified individuals for a full time tenure-track position in Endodontics. The College is seeking a dynamic teacher scholar who possesses a DMD/DDS or equivalent, specialty training in Endodontics and a PhD. The primary focus of this position is research and teaching. The ideal candidate will possess a strong research portfolio that includes a proven track record of scholarly output and successful grant funding. The successful candidate will deliver and continue to develop undergraduate dental core courses in Endodontics (didactic and pre-clinical) as well as help develop and participate in the College's undergraduate student research program. Effective classroom teaching skills and mentorship; clinical experience in endodontics, and effective interpersonal and communication skills are required. As this is a research intensive position, there will be no opportunity to engage in clinical practice. Salary bands for this position are as follows: Assistant Professor - $93,293 - $112,109; Associate Professor - $112,109 - $130,925 and Professor $130,925 - $152,877 This position includes a comprehensive benefits package which includes a dental, health and extended vision care plan; pension plan, life insurance (compulsory and voluntary), academic long term disability, sick leave, travel insurance, death benefits, an employee assistance program, a professional expense allowance and a flexible health and wellness spending program. Interested candidates should submit a detailed curriculum vitae, a statement of teaching and research interests, a plan for future research, three letters of reference, and any supporting documents, copies of up to five selected recent publications, and proof of education including notarized, translated (English) copies of undergraduate and graduate degrees to: Dr. Gerry Uswak, Dean, College of Dentistry, 105 Wiggins Road, University of Saskatchewan, Saskatoon, Saskatchewan S7N 5E4, Telephone: (306) 966-5121 Fax: (306) 966-5132 email: dentfacultysearch@usask.ca. Applications will be accepted and evaluated until the position is filled. Anticipated start date is July 1, 2017. Electronic submissions by email are preferred. The University of Saskatchewan thanks all applicants for their interest; however, only applicants selected for interviews will be contacted. The University of Saskatchewan is strongly committed to a diverse and inclusive workplace that empowers all employees to reach their full potential. All members of the university community share a responsibility for developing and maintaining an environment in which differences are valued and inclusiveness is practiced. The university welcomes applications from those who will contribute to the diversity of our community. All qualified candidates are encouraged to apply; however, Canadian citizens and permanent residents will be given priority. D11935

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One Story at a Time

Dr. Charles G. Baer: Kindness and Resiliency

Husband. Father. Holocaust survivor. Dentist. Dr. Charles G. Baer of Montreal passed away on November 26, 2016, at the age of 94.

One of Dr. Baer's patients remarked that she was reluctant to call him about a toothache: "He felt so badly for me," she said. Long before the concept of holistic care was popular, Dr. Baer practised that way. It was just as important to understand the context of patients' lives as to provide skilled dental care. Healthcare was a family tradition when Charles was born to Arthur (an ophthalmologist) and Emily, in Essen, Germany.

In 1938, he and his father were deported to the Dachau concentration camp, but freedom was available to those with the resources. Charles's grandmother put up the funds so he could escape Germany through the Kindertransport project. Charles was one of 10,000 unaccompanied children sent to Britain in an effort supported by the Central British Fund for German Jewry. But it was to be a short stay. Faced with a threatened German invasion, Britain sent "enemy aliens" to the colonies. Arriving safely in Canada in 1940, Charles was sent to an internment camp in New Brunswick, and then to Île aux Noix (Quebec). Henry Oelberg, who befriended him there, recalled that "Charles was constantly studying. He was already planning to become a dentist."

Dr. Charles Baer and his wife, Eva.

Upon graduation in 1949, he accepted a position in the small town of Baie-Comeau (Quebec). This was an opportunity, he was told, to "learn a lot because you'll have to do everything." The words were prophetic. Called to see a lumberjack whose horse had kicked him in the face, Charles single-handedly wired the broken jaw. Decades later, he said, "In the ER [in Montreal], there were four dentists to do a procedure like that." Three months after arriving, he married Eva Marcuse, whom he had met in 1948. They worked side by side, often putting in 13-hour days.

Preventive and restorative dentistry was new to a population for whom extractions were the norm. Charles was all for saving teeth. Dentures, not available locally, had to be ordered from Quebec City. One order went through the ice on the river, along with the snowmobile! Undeterred, Charles remade the dentures himself, setting them to cure in the couple's room in the Manoir Baie-Comeau. In 1952, Charles and Eva moved to Montreal, where he practised for almost six decades. He served as president of the Mount Royal Dental Society and as an examiner for the Order of Dentists of Quebec. He was honoured with a fellowship and emeritus status in the Académie dentaire du Québec.

What mattered most, however, were the patients. They, in turn, revered him. One recalls Charles remaining at the hospital with her overnight following an accident. "He would have done that for anyone," she said.

Charles was most proud of his children, Philip, Carolyn and Daniel. He doted on his six grandchildren as well, comforted in the knowledge that his family, nearly wiped out in the Holocaust, had been preserved and was flourishing with each new generation.

Charles, survived by Eva, died peacefully in Montreal.

Submitted by Janet Chandler Allingham, a patient of Dr. Baer for over 50 years. Originally published in the Globe & Mail *"Lives Lived" section, February 1, 2017.*

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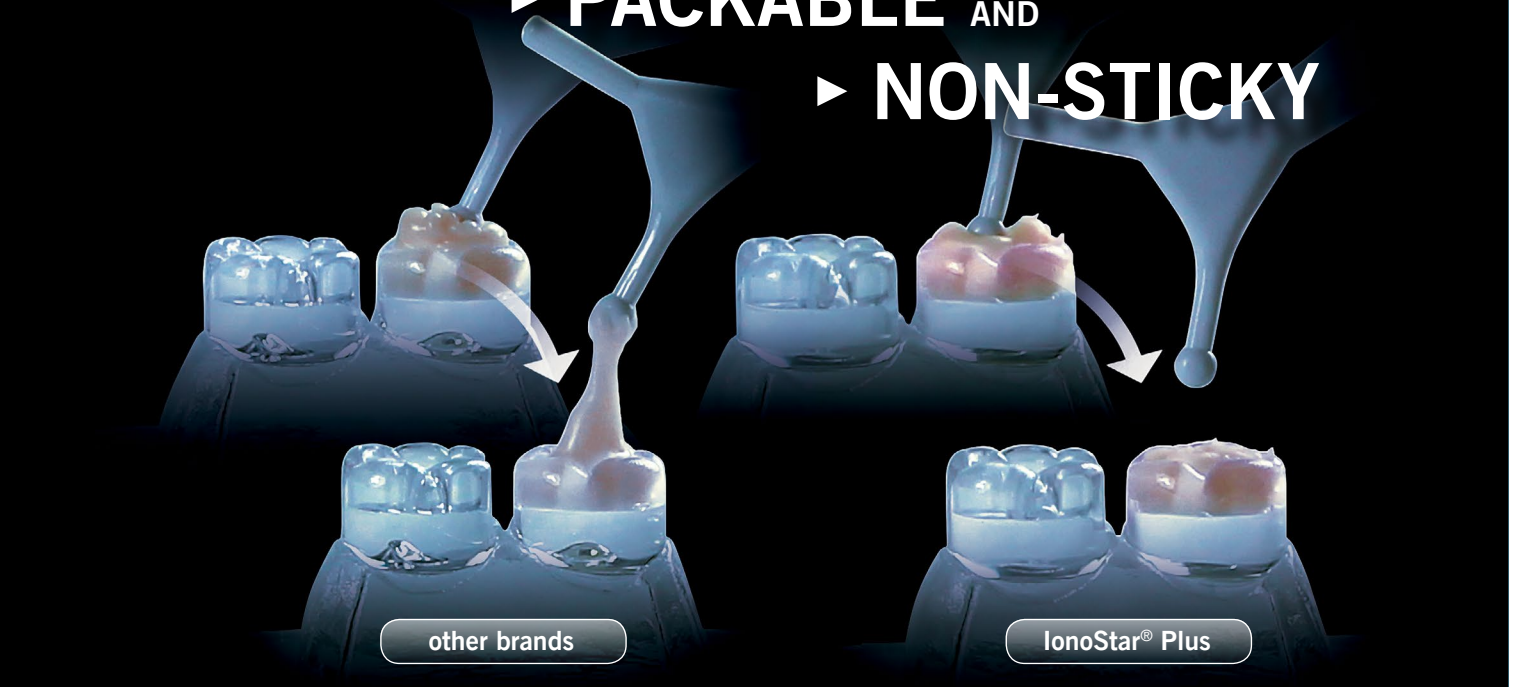

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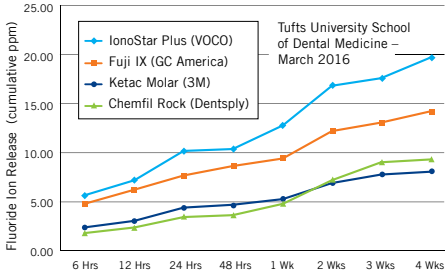

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