Access to Dental Care
Policy Leaders Weigh in on a New National Report

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- Fostering a collaborative workplace environment which promotes creativity and personal growth while celebrating achievements; and
- Advocating with a unified voice for accessible and sustainable optimal oral health for all Ontarians.
What We Can Learn About Access to Care

I read with interest “Access to Care: Research Findings Brief” in the September issue of Ontario Dentist. To me, it seems that premature conclusions are being made about independent dental hygiene practice and access to care in Ontario. Ontario has not had enough time for a proper evaluation to be done. However, one can certainly look at the U.S. where some states have had independent dental hygiene practices for many years. For some reason, the ODA is not looking south of the border. Has anyone studied the U.S. models already in place?

If anyone wishes to examine a thoughtful evaluation of independent dental hygiene practice in California, simply look at “Alternative Practice Dental Hygiene in California: Past, Present, and Future,” E. Mertz and P. Glassman, J Calif Dent Assoc., Jan 2011; 39(1): 37-46. Evaluations of the California model, which began in 1986, have shown that access to care was improved for those most in need, particularly patients in nursing homes. In fact, demand for dental care increased due to the work of these “independent” dental hygienists.

However, if one looks at the history of jurisdictions with alternative structures to provide dental health care for the most neglected in their respective states, provinces or countries — from independent dental hygienists to dental nurses — there is a common theme. The biggest obstacle, so far, to providing care to those least able to afford it is dentists and their political organizations. In California, against the opposition of the California Dental Association and the American Dental Association, the legislature had to step in with legislation to allow pilot projects for independent dental hygiene practice. Neither organization presented credible solutions to the problem of access to care, they simply opposed a possible solution. Anyone who believes that the private practice, fee-for-service model will ever solve the problem of access to care is not facing reality. Governments will not pay the huge sums of money required to make it lucrative to treat the poor, the working poor, those living in nursing homes and the increasing number of seniors living only on the Canadian Pension Plan and Old Age Security. Either we eventually have a cohort of dentists who work for a fixed salary to service the neediest of our population or we will have to have alternative practitioners who will. I fear that eventually the government will make an ill-conceived attempt at a solution.

Dr. Pat Duronio
Lion’s Head, Ont.
Losing Sight of Original Female Perspective

It was interesting for me to read the article in the September issue of *Ontario Dentist* (“The Changing Face of Dentistry”) and the one entitled, “The Work-Life Balance” in the October issue. Since you asked for feedback, I thought I would take the time and give you my two cents.

I was a speaker at an ODA Female Perspective Seminar for students a few years back and, with this experience, would like to make a constructive criticism. The “female perspective” idea started out with a certain goal, but it may have been lost over the years. I think we need to get more specific: we need articles, seminars and talks about how to keep organized and how to feel empowered, and we need solid advice about how to balance it all. We all know we need to have balance and we all know some do it better than others (given their very specific family and support circumstances).

To attain that balance, we need help. We need speakers who give us tools on how to keep stress levels down, and many of us would probably love to hear speakers (such as child psychologists) who can help us deal with the overwhelming guilt we may feel about being away from our children all day and having nannies raise them, or how we compare ourselves constantly to stay-at-home moms. We need professional information and guidance about the power of meditation and being present, and how this can help us attain the work-life balance.

On my journey as a working mother and periodontist, I have spent a great deal of time and energy investigating these avenues for myself and would love a section in the journal dedicated to the female perspective that addresses these issues.

*Dr. Sally Safa*

*Toronto, Ont.*

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Why Focus on Gender?

I am writing in response to the articles on the Female Perspective Series (“The Changing Face of Dentistry” and “The Work-Life Balance”) that appeared in the September and October issues of *Ontario Dentist*. The seminar in February (held at Western) with Drs. Susan and Jennifer Rumble was full of conventional wisdom, quirky anecdotes and helpful insight into the dental profession. Dentistry certainly offers the opportunity to set one’s own hours and be fairly independent, a quality that many family-minded people find appealing. I do wonder, however, if we really need a “female” dental seminar. Many of the topics that were covered could be applicable to either gender; for example, I am sure plenty of men want to raise a family, while not all women necessarily want children. Lectures and articles such as, “The Changing Face of Dentistry” and “The Work-Life Balance” are interesting topics on their own; adding the female perspective qualifier is unnecessary and may alienate potential audience members. Moreover, I think that such a seminar is actually counter-productive to the fight for gender equality. If we are truly interested in being treated — and treating others — equally, we should not be focusing on gender at all.

*Nicole Johnson*

DDS Candidate Class of 2015
Schulich School of Medicine and Dentistry
Western University
London, Ont.
Ebola — Just the Beginning

This Ebola outbreak is different from all the 12 previous outbreaks since the virus was identified in 1976, and we should expect unpredictable changes from other infectious diseases as we move forward, especially from RNA viruses.

The most important difference is the infection of a large number of front-line health-care workers in the “hot zone” in West Africa, with mortality rates between 50 and 60 percent, as well as the infection of health-care workers in hospitals in North America and Europe. This represents a significant change in the virus, of which genetics studies have shown at least 300 new mutations since the start of the epidemic. We should not expect anything different from encapsulated group V viruses (including influenza), which use negative-sense, single-stranded RNA as their genetic material. This group is notorious for its very high mutation rate and constant change, making it a moving target even during the course of an epidemic.

The incidence of health-care personnel in North America and Europe having been infected is attributed to the fact that they were not provided with proper training, protocols and equipment — and were simply caught unprepared. Dentists and staff have to be trained and prepared for all types of infectious diseases and know how to identify their patient demographics. The proper questions and protocols need to be in mind in the potential case of an infected patient, ideally before the patient is in the office or, worse yet, in the dental chair. The threat from each infectious disease may be different, and each outbreak brings its own challenges. But the solution can and should be one uniform approach to universal protection. The time to prepare is now.

Dr. Joseph Zeisler
Infection Prevention Training for Dentistry
Richmond Hill, Ont.

Ebola Virus Update From the ODA

Ebola virus disease is a severe illness that causes hemorrhagic fever in humans and animals. Diseases that cause viral hemorrhagic fevers are often fatal, as they affect the body’s vascular system and can lead to significant internal bleeding and organ failure.

The Ebola virus does not spread easily from person to person. It is spread through direct contact with infected bodily fluids, not through casual contact. Severely ill patients require intensive supportive care.

The ODA has been closely monitoring the Ebola virus situation since August 2014 and is committed to keeping members up to date on the latest directives, resources and publications by the relevant health authorities. To view this information, visit: http://www.oda.ca/member/healthadvisories.

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A new book by Mark McNulty
On Tour With the ODA

“Ohh we’re halfway there. Oh-oh, living on a prayer.” I just heard Living on a Prayer, on the radio. One of Bon Jovi’s greatest and arguably most familiar songs. I thought about how much those words remind me of my presidential year.

It’s December and I’m six months into my presidency or “halfway there.” I can tell you that there are indeed times when I feel like I’m living on a prayer and most certainly living out of a suitcase. I’m part dentist, ODA spokesperson, chair of the board, travel agent, husband and father. I have long days, short nights and not a particularly healthy lifestyle on the road (although I do try to watch what I put in my mouth and make it to the gym occasionally). It’s no surprise that I often feel like I’m on tour, minus the roadies!

Since June 1, I’ve been away from my practice and family for about 50 days — travelling on planes, trains and automobiles around the province. I’ve met with ODA members, politicians, new grads, new dental students, academics, other professionals, ODA staff and more. I’ve participated in media interviews and media training. I’ve chaired ODA board meetings and been to General Council. I’ve been on conference calls and talked to concerned members. I’ve been to the CDA meeting, talked with the ACDQ and met with the RCDSO. I’ve given ODA presentations to component societies in restaurants, private clubs, banquet halls and, one time, in a member’s living room! I survived three days at the Northern Ontario Dental Association meeting in Timmins (Too much fun! You’d be hard pressed to find a more enthusiastic and engaged group anywhere.) Oh, and I’ve written several “President’s Page” columns.

I’m often asked, “Why would you want to be the President of the ODA?” Initially my answer was, “To give back to the profession and association that have given me so much.” I mentioned this in my introductory interview in the June issue of Ontario Dentist. Indeed, that remains true, however, I must tell you that now my answer is more complex, and it is all because of YOU! The ODA has wonderful members and that has made all the difference in the world. It has made being President extremely rewarding and certainly a lot of fun. I have received a very warm welcome and been made to feel at home everywhere I’ve been. It is a great feeling to be thanked for your efforts by loyal members.

I cannot say enough about the extraordinary members we have and the joy I get from attending component society meetings and talking with members one-on-one, listening to your comments and concerns, and socializing. I’ve met great people who have a sincere interest in the betterment of the profession, and in their patients, their community and the ODA.

I’ve had the pleasure of presenting membership awards at many component society meetings. I was fortunate to dine with 60-year ODA members such as Drs. Jack Glenny and Phil Scott. What a treat that was, and what wonderful memories they shared with me. And how about Dr. Gil Chapnick, ODA Service Award recipient, who has been practising dentistry for 71 years and is still working. Gil is in great physical shape as well as being sharp, witty and willing to share some incredible memories. Certainly an inspiration to us all!

As well as meeting members, I’ve enjoyed meeting with politicians from all three parties. Yes, that really is the truth! I’ve also been able to get to know our ODA staff better and work together with many of them. We are fortunate to have such knowledgeable and dedicated staff, who work every day for the benefit of you, our members. I have found their guidance, education, encouragement and support indispensable. The best backup anywhere!

We have an outstanding, hard-working and diligent Board of Directors that take their responsibilities very seriously and make my life so much easier. They are all great friends.
I must not forget that I am home occasionally and get to see my loyal patients, who’ve been understanding regarding my absences. As for the saying, absence makes the heart grow fonder, that is certainly the case with my wife and daughter. Without their love and support I would not have been able to have had such a remarkable experience with you, the members of the ODA.

Thank you, the members of our association, for the kindness, support and hospitality you’ve shown me. Thanks for being a member and giving me the opportunity to serve you. As both Frank and Elvis sang, “Regrets, I’ve had a few, but then again too few to mention.” That is my experience as President of your association. I’m looking forward to the next six months!

Volunteering with the ODA has been so rewarding for me, I encourage you to also get involved in our association, or in your local component society. I guarantee you’ll find it rewarding, too!

Dr. Gerald Smith maintains a general dentistry practice in Thunder Bay, Ont. He may be reached at ODAPresident@oda.ca.

If you would like to volunteer for an ODA Committee or serve on the Board of Directors, you will find more information about the vacancies available, on page 50. And, for a first-hand response on how volunteering for the ODA has been meaningful and educational, please read “Dentistry Beyond the Office” on page 48.

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Access to Dental Care: Old Story, New Risks

The issue of access to dental care is an old one. As someone who studies the history of dentistry, I can tell you that, in Canada, the issue was identified by professional leaders as far back as the early 20th century, and likely even earlier. We all know that the lower a person’s income, the greater the difficulty in accessing care. We all know that the further one is from an urban or regional centre, the harder it is to receive care. We all know that remuneration in public programs has not kept pace with the costs of delivering care, limiting people’s access by creating disincentives among providers. Yet this old story now has new twists, and we need to care about them not only because of our moral and professional obligations to meet the public’s need, but also from a risk-management perspective.

Let’s start this new part of the story with a recent report released by the Canadian Academy of Health Sciences (CAHS). The report, Improving Access to Oral Health Care for Vulnerable People Living in Canada, found substantial inequalities in access to care, and outlined a vision for achieving equity in oral health care in Canada — again, an old story. But who CAHS is, is important. CAHS is made up of leaders “with outstanding performance in the academic health sciences, and is an independent, not-for-profit organization that provides timely, informed and unbiased assessments of urgent issues affecting the health of Canadians.” As expected, dentists, including me, were asked to be part of the CAHS panel that produced the report. What we quickly learned was that the issue of access to dental care was no longer a debate occurring only within the halls of dentistry and the government departments we interact with. As we looked around at the CAHS panel, it became clear that there is now a sense of urgency among pediatricians, geriatricians, nurses, lawyers, health economists and former deputy ministers of health. This is new.

From this expanded perspective, the CAHS panel crafted arguments based on previously unidentified risks. For example: the lack of common sense in segregating the health of the mouth from that of the body given new evidence on the oral health/systemic health connection; the significant health, social and economic impacts on individuals and families as a result of poor oral health; and the economic burden that poor access to dental care places on the health care system, due to physician and emergency department visits for dental problems that are best treated in dental offices.

The panel also identified new aspects to this old story, including the observation that financial barriers to dental care are moving up the economic spectrum. Middle-income Canadians now face some of the greatest financial barriers to dental care. Indeed, the CAHS panel found that severity of caries is now the worst in children of middle-income families. As well, some middle-income seniors are at particular risk due to the loss of employment-based insurance upon their retirement. In turn, the CAHS panel identified changes in labour markets and in the quality of dental insurance. As we all know, fewer employers are offering dental benefits to their new hires, more employers are making existing employees choose between benefits, and are reducing annual maximums, increasing service limits, co-insurance, and/or co-pays.

Importantly, the CAHS panel made recommendations that, as a profession, we tend to shy away from. For example, they suggest: a review of the tax legislation concerning employment-based insurance to address the lack of tax benefits for those without insurance; the use of alternative service providers and service settings; creating national oral health care standards to ensure reasonable access to an agreed-upon basket of oral health care services for all people, regardless of their situation. They also identified an aggressive communications strategy to promote these issues with governments and policy leaders, one that is now being implemented by public health and advocacy groups across Canada.

I think it is worthwhile to note that the public appears to care as well. Dr. Paul Allison, Chair of the CAHS panel, and Dean at McGill’s Faculty of Dentistry, wrote an op-ed in the Globe...
and Mail on why some level of dental care needs to be included in Medicare. This op-ed has now been shared more than 10,000 times on social media, putting it in the top five ever published in the newspaper's history.

So why should we care here in Ontario? Well, Ontario has Canada’s largest dental care system, and the issues identified in the CAHS report are our issues. From a risk-management perspective, we need to be proactive, not reactive, and steward these debates — and not simply try to stop balls that are already rolling. We need to seek out partners and ideas that might make us uncomfortable at first, but that expand our horizons and better position us for the future. To be sure, one only needs to look at the United States to see what we could risk by acting too late. In the U.S., a lack of access to dental care has, sadly, resulted in deaths. While the professional response in that country has generally been to dig in and resist change, the resultant government response has been to enact federal and state legislation that paves the way for new, robust alternative systems to finance, organize and deliver dental care. In this context, it should be worrisome to us that the U.S. now funds more public dental care on a per capita basis than Canada. In fact, Canada ranks second-last among OECD nations in the public financing of dental care, and Ontario, if ranked, would be last. Finally, given that this is no longer just a public dental care issue, but is one that is reaching into private financing and delivery, it is arguable that we cannot ignore this old story and react in traditional ways.

To steward this conversation, Ontario Dentist has gathered a group of Ontario and Canadian leaders to review and reflect on the findings of the CAHS report. Dr. Paul Allison will review the major findings of the report, the panel’s process, and what the report means for Ontario dentists and the dental profession. Dr. Stephen Abrams will give his insights as a general practitioner and will speak to what is happening in the province and internationally from a policy and programmatic perspective. And Dr. Ian McConnachie will provide his insights as a pediatric dentist and active policy advocate. We also detail important findings from the report and other relevant research in our latest infographic (see page 22). As always, we would love to hear your perspective, so write us and give us your thoughts!

Dr. Carlos Quiñonez is the Editor of Ontario Dentist. He may be reached at 416-979-4908 ext. 4491 or at cquinonez@oda.ca.
Q. What is the Canadian Academy of Health Sciences (CAHS), and how did it arrive at exploring the issue of access to dental care in Canada?

A. To quote the CAHS website (www.cahs-acss.ca), the CAHS provides timely, informed and unbiased assessments of urgent issues affecting the health of Canadians. These assessments, which are based on evidence reviews and leading expert opinion, provide conclusions and recommendations in the name of CAHS.

The CAHS decided to initiate an assessment on access to oral health care for vulnerable groups living in Canada, following suggestions from a number of its fellows, and given that oral health and oral health care were the main themes of one of its annual scientific meetings several years ago. At this meeting, it was clear that inequalities in oral health and oral health care in Canada are an issue. Furthermore, the Canadian Health Measures Survey had recently been conducted and for the first time included oral health and oral health-care data, thereby providing an excellent opportunity to study the issue further with up-to-date information. Dr. Jim Lund, the former dean of the Faculty of Dentistry at McGill University, initially spearheaded this project, and following his untimely and sudden death, I took over the leadership of the project.

Q. Who was on the CAHS panel that conducted the assessment?

A. On the panel were scientists with a broad range of relevant expertise in fields such as public and population health, health economics, health law, health policy and health service delivery, plus members of the dental professions (dentistry, dental hygiene and dental therapy) and members of the medical and nursing professions with expertise in geriatrics and pediatrics, among other fields. Furthermore, there were two international members who were dentists and deans of dental schools in the United States and the United Kingdom.

Q. What did the panel perceive to be the major challenges regarding access to dental care in Canada?

A. The report documents significant inequalities in many indicators of dental health and access to dental care, establishing that those people with the least financial, educational and other socioeconomic means have the greatest level of dental disease and the greatest difficulty accessing dental care. It shows inequalities in oral health are greater than those in general health. It also shows that these inequalities in oral health and dental care are greater in Canadian women than men.

While not the only barrier to care, the cost of dental care, combined with the lack of dental insurance coverage for approximately 40 percent of the Canadian population, means that many people pay out-of-pocket and cannot afford to consult a dentist except in emergency situations, and only then can afford minimal, basic care. Also, while the private system of dental care delivery in Canada serves the majority of Canadians well, dental care that is delivered in combination with government programs cannot meet the often-overwhelming needs of those who require the most care, but lack the financial resources to access it.

Other factors also contribute to these problems of access to dental care, such as the lack of integration of dental care with the medical care system; the lack of flexibility in dental care delivery systems (e.g. a lack of domiciliary and institutional care) and lack of flexibility in personnel who can deliver dental care; the geographic distribution of dental professionals; and the misunderstanding that occurs between dental professionals and members of vulnerable groups in the population. Some of these issues are common to other domains of health care, but some are particular to dentistry.
Q. What potential solutions did the panel propose?
A. The panel recognizes that the problems are complex, covering several vulnerable groups and requiring various strategies to address different barriers, across multiple jurisdictions. The panel described a vision it had of equity in access to oral health care for all people living in Canada. By equity, it meant reasonable access, based on need for care, to agreed-upon standards of preventive and restorative oral health care. To attain this vision the panel made recommendations to 1) make all stakeholders aware of the problem; 2) identify minimum standards of preventive and restorative care; 3) identify the systems and personnel necessary to deliver these standards of care; 4) identify the means to finance the care; and 5) evaluate changes put in place to ensure they are addressing the problem.

Q. What are the next steps for this report?
A. It’s important to publicize the report and its findings and recommendations to all stakeholders to ensure the issue is acknowledged. This is a necessary step before we can begin to agree on how to address the problem. Once the issue is acknowledged, the dental professions can lead the development of solutions.

Q. As a dean of a dental faculty, what do you think Canadian dental and other health professional faculties can do to help?
A. Dental schools have a very big part to play as part of the solution. We need to sensitize students and residents to the problem, make them aware of different forms of dental care delivery that can address some barriers and give them experiences working with different groups in a variety of settings and using varied delivery systems (e.g. mobile dental care for people living in institutions or at home with reduced mobility, or working in community health centres with other health and social service professionals). In addition, dental schools can perform research to investigate the barriers and develop and pilot systems to address them. We can work with the dental profession and governments to develop residency programs that place trainees in a wide variety of settings to help provide care to those unable to access private offices. And we can take leadership in the debate on the issue to persuade all stakeholders to participate in helping find solutions. While I cannot speak for all dental schools, I do know that all Canadian schools see themselves as having an important part to play in this access debate.

Q. What can the dental profession do?
A. The dental profession should take the leadership role in addressing this issue. Private dental insurance is being eroded due to the costs of coverage and to more jobs being part-time or casual and with reduced benefits. The result is that even middle-income Canadians are now facing problems with accessing dental care. Now is the time for the dental profession to act.

Q. What does this mean for dentists practising in the community? What can they do?
A. While it’s important for dentists to be sensitive to the issue and help individual patients whenever possible, the most important thing is to have a more systematic approach to this issue. So the most important thing to do is to become involved with the local dental association and join lobby efforts for action. The exact nature of the action will inevitably differ from province to province, but there are plenty of groups that need help (e.g. young children, the elderly, the working poor, people living in rural areas), and individual dentists can become part of an organized plan to address issues for one of these groups.

Q. What risk does the dental profession face if it does not act on this issue?
A. The risk is that the issue will be taken out of the hands of the dental profession. Actions are already being taken by some governments, and as the problem gets worse more action will be taken by governments — and those actions may be taken with little consultation if there appears to be no professional partner. The result will be that the profession will lose control of its destiny.
Did the CAHS Report, *Improving Access to Oral Health Care for Vulnerable People Living in Canada, Really Address the Underlying Issues?*

I was very pleased to see that the Canadian Academy of Health Sciences (CAHS) chose to investigate this important issue and released its report in September 2014. It is most important that we continue to message government and the public on the linkages between oral health and general health and the importance of providing access to oral health care for Canadians, especially vulnerable Canadians.

Over the last 25 years I have worked on this issue, representing the ODA and the profession, with provincial and municipal levels of government. Our profession, in my opinion, has been very proactive in helping vulnerable Ontarians gain access to oral health care. The genesis of the government programs was with our profession. More than 50 years ago, we gathered funds and dispersed them to member dentists who were providing care to vulnerable Ontarians. This then became the basis for the Family Benefits Allowance (FBA) and General Welfare Assistance (GWA) Dental Programs, which were designed and administered by the ODA up until 1998. As a matter of fact, in return for administering these programs, the ODA was mandated to ensure that “no child went to bed in pain.” We, as providers of oral health care, understand the needs of vulnerable populations and took the first steps to start to solve this problem.

One of the critical questions in designing any oral health program is how does one engage the target population? How do we get parents to bring in their children for “free dental care”? How do we get recipients of the Ontario Disability Support Program (ODSP) to access oral health care? This is one of the areas that the CAHS report does not explore in great detail. Traditionally, under the FBA and GWA, less than 40 percent of the eligible population accessed basic dental care, despite the fact that it was free. This figure has remained stable over the last number of years. Up until 1998 when the FBA and GWA were replaced, access remained low, but provider participation in the program was high. So the low usage was not due to a lack of dentists or the hours available for accessing care. It was and still is the issue of how valuable is good oral health to the target population. Patient surveys tell us that this is critical, but utilization tells a very different story.

With the implementation of Healthy Smiles Ontario, I have heard that participation is now below 25 percent of the eligible population. So we now have a new program that has a clearly defined population (defined by income), some advertising directed at the population and the patient access is even worse. We have new dental clinics built in a number of health units and funding provided to community clinics, yet we are not able to engage the population. This substantial investment in infrastructure did not engage the population or improve their oral health care but wasted valuable and scarce resources.

How do we engage the target population? This is a question that a number of international programs have been studying and addressing. Unfortunately none of this work is being done here in Ontario, nor is it on the “radar screen” of government or public health. Programs in Europe and the United States that are targeted at pregnant mothers or young teenagers have gotten the populations engaged and actually lowered the in-
 incidence of disease. The papers cited here are just a few of the studies published over the last few years. We may have some local programs in some municipalities that are working, but they are not widely reported to the profession and I am not sure of the metrics used to measure outcomes and disease reduction.

Metrics and oral health data are also critical to designing and evaluating dental programs. The CAHS report does include data from the Canadian Health Measures Survey, but this data is only valid nationally and is difficult to adapt to what happens here in Ontario. There are some questions about how robust this data is, especially in the area of caries and periodontal disease rates. Even barring these concerns, this is the first time in many years that there has been any national survey.

In Ontario, this data should have been gathered through regular school screening visits provided by dental public health staff of the local public health unit. However, there have been problems both with data collection and with the screening process. Ontario’s former Chief Medical Officer of Health, Dr. Arlene King, was concerned about the lack of data and states in her recent report on oral health:

“While public health units undertake a range of activities to identify the oral health needs of the children that they serve, I am concerned about the comprehensiveness, quality, comparability and availability of the data that are collected. […] Good data is also required to measure short-term, intermediate and long-term client and program outcomes, as well as to inform program planning, design, delivery and evaluation. Monitoring and evaluation must be built in to any publicly funded oral health program for Ontarians.”

In addition, screening does not identify or track any of the early areas of tooth decay — information that is critical for designing and monitoring any preventive program. There are numerous examples in other jurisdictions worldwide that gather this data and use it for ongoing program analysis.

With good data and an innovative program design that uses methods and ideas that have worked in similar populations worldwide, we can begin to engage vulnerable Ontarians, reduce their disease burden and create better oral health. One prime example is the Childsmile Programme created and implemented in Scotland. This program has resulted in substantial improvement in the oral health of five-year-olds and a return on investment.

The CAHS report does bring to the attention of government and the public the linkages between oral health and overall health and the need to improve access for vulnerable Canadians. The report does offer some solutions that have been around for many years, but it does not address the underlying issues. There is need for better data, need to engage the target population and need to look beyond our borders to see what others have done to solve this problem.

Building more clinics that are only open during the day, contemplating using dental therapists to deliver care, or even looking at taxation of dental benefits are not solutions to this problem. The solutions are there, but we need to engage the provider community and the international experts in solving this problem.

References


The report from the Canadian Academy of Health Sciences (CAHS) is an important addition to the continuing discussion on access to oral health care in Canada. The CAHS joins the dental profession and other stakeholders in recognizing that there exists in Canada a segment of the population not able to access oral health care or achieve levels of oral health that a reasonable person would consider to be a basic right. The report relies on interpretation of the data from the Canadian Health Measures Survey (CHMSS), published in 2010. The data in this survey finally updated, at a high level, the oral health status of Canadians (last surveyed in 1972). Even here, the data of the current survey was silent on disease rates for the age group of zero to five years, and it was not designed to give us detailed data on specific high-risk populations within Canada or Ontario. That data, regrettably, still does not exist at a level that is of sufficient quality to meet the rigours of statistical scrutiny.

We do have the additional report of the Canadian Institute for Health Information (CIHI) from September 2013, Treatment of Preventable Dental Cavities in Preschoolers: A Focus on Day Surgery under General Anesthesia. It states that 31 percent of all preschooler day-surgeries in Canada are for treatment of dental caries. This statistic actually under-reports the extreme need for advanced pediatric dental care, in that it does not include sites such as private surgery centres, which provide care for large numbers of pediatric dental cases. The numbers show that the profession has succeeded in accessing and providing operating room care for our child patients, however, the point is that disease in these preschoolers has reached such a level that the determined best treatment is under general anesthesia. This is a testament to our profession having failed to eradicate a disease that is largely preventable. Further, these results are from a population that actually did have some access to care. Beyond this population, we have no statistics on the segment of the pediatric population that is unwilling or unable to access quality oral health care and instead relies only on episodic emergency care in the presence of pain or infection.

To further underscore the severity of this problem, let’s for a moment look at some data from the city of Ottawa. At Ottawa’s children’s hospital, dentistry has five full days of access to operating rooms as well as a full-time outpatient and inpatient dental clinic. Ottawa also has a reasonable number of pediatric dentists. In spite of this, waiting time for dental surgery for otherwise healthy children is currently 10 months once the children have been assessed at the children’s hospital. Assessment waiting time is at least several additional months. Furthermore, children over five years of age cannot access care; they have been determined to be ineligible for care by the hospital.
largely as a result of the overwhelming waiting times. We all know that these waiting times increase the morbidity of the disease in these children as well as the cost of providing care.

The dental profession can be reassured by the numbers found in the CHMS survey of 2010 that it has succeeded in significantly lowering disease rates for children who are under regular dental care. But based on data such as that from Ottawa and duplicated elsewhere in the province, the profession definitely cannot be satisfied that all children needing care are being assessed and treated in a timely fashion, nor are they achieving the levels of oral health expected from an advanced society such as Canada.

So, where do the problems lie and what recommendations are suggested for improving access? Regrettably, here the CAHS report relies largely on analysis of income disparity as the primary cause of access inequality and oral health inequity and draws conclusions and recommendations from this too-narrow analysis. While the identification of specific problems and recommendations to address the core problems are too numerous to address in detail, a few general observations and caveats are necessary.

"The report gives very small acknowledgement to the whole area of social determinants of health and their impact on decisions that parents and caregivers make in accessing available care."

Where the report identifies affordability of oral health care as a prime driver for numerous recommendations for changes, affordability for children’s care is a barrier only for a very small number of children, given the broad eligibility of provincial children’s dental programs. Even so, parents and caregivers are not accessing care. The report gives very small acknowledgement to the whole area of social determinants of health and their impact on decisions that parents and caregivers make in accessing available care.

The report also calls for widespread reforms of delivery systems and the introduction of new levels of care-providers or new roles for existing providers, without even considering the potential for improved access from existing provider systems, were governments to fund adequately and fairly the care provided. With the complexity of the populations most at risk, and the identified need to elevate the priority of their oral health status, it is indeed likely that a number of substantial changes in public education and delivery systems, based on successful models in place in other jurisdictions, will be needed for identified high-risk populations. Given government finances and absence from the table currently, it will be important as we move forward to take deliberate but careful steps to get it right.

These criticisms are not meant to dismiss the value of this CAHS report. There is much in it to applaud and endorse. Its call to action and dialogue is a welcome addition. It is to be hoped that governments are paying attention and are willing to open both their minds and their wallets for collaboration in the creation of evidence-based reforms, and that other stakeholder groups are equally committed to embracing the evidence of best practices for care so as to close these access gaps that we should all view as unacceptable."
Income is a strong predictor of oral health status and treatment needs. The lower one’s income, the more decayed and missing teeth. Financial barriers to dental care are also a strong predictor of a person’s need for treatment. The more one avoids the dentist or declines a dentist’s recommended treatment, due to costs, the worse one’s oral health gets and the more treatment will be needed.

Income

Mean number of decayed and missing teeth among six- to 79-year-olds, by income, Canada, 2009

<table>
<thead>
<tr>
<th>Decayed Teeth</th>
<th>Missing Teeth</th>
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</thead>
<tbody>
<tr>
<td>Lowest Income</td>
<td>Highest Income</td>
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<tr>
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<td>1.5</td>
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<tr>
<td>1.8</td>
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</tr>
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</table>

Treatment needs and cost barriers to dental care, Canada, 2009

- HIGHEST TREATMENT NEEDS
  - Avoided Dentist: 55%
  - Declined Treatment: 34%

- LOWEST TREATMENT NEEDS
  - Did Not Avoid Dentist: 28%
  - Did Not Decline Treatment: 13%

Ranking International

Dental care spending and the public share, select OECD nations, 2009

- Japan: $170.60, 77%
- Sweden: $275.80, 41%
- Australia: $241.10, 25%
- USA: $333.30, 9%
- Canada: $300.50, 5%
- Spain: $152.40, 1%

Dental expenditures in Canada and Ontario (in constant dollars)

- 2000: $7.2, $12.2
- 2010: $11.2, $14.8

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Expenditures ($Billion)</th>
<th>$ per capita</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>$7.2</td>
<td>$234</td>
</tr>
<tr>
<td>2010</td>
<td>$11.2</td>
<td>$365</td>
</tr>
</tbody>
</table>

Total private dental care expenditures, by source of finance, Canada, 2011 ($Billions)

- Insurance: $6.6, 59%
- Out-of-pocket: $4.6, 41%

Total dental and health-care expenditures, by source of finance, Canada, 2013 ($Billions)

- Dental Care: $11.8, 94%
- Health Care: $148.2, 70%

Ranking Provincial

Private dental care expenditures in Canada, per capita, by province, 1960-2010 ($ constant)

Public dental care expenditures in Canada, per capita, by province, 1960-2010 ($ constant)

Canada ranks very low among OECD countries in terms of government spending on dental care. Many in the international community are surprised by this, as they think that dental care is like health care in Canada, where most investments are public. In Canada, the vast majority of dental care is paid for privately, largely through dental insurance and/or out-of-pocket payments.

Among all provinces, on a per capita basis, Ontario ranks last in public spending on dental care. Yet in terms of private spending, Ontario is second from the top.
Having dental insurance is closely related to age, employment and income. By the time Canadians retire, they report having substantially less insurance than working-age adults. Insurance and income are also the strongest predictors of access to dental care. The lower one’s income, the lesser the likelihood of having job-related dental benefits, and the greater the difficulty in accessing dental care.

Due to changes in the economy and in labour markets, employers have been reducing the robustness of dental benefit packages. As a result, on a per capita basis, insurance is covering less and less of the dental bill. This has impacted low- and middle-income households the most, and over time, they have increasingly reported greater cost barriers to dental care.

The Concentration Index (CI) is a state-of-the-art way to measure inequalities in health outcomes. The CI can range from +1 to -1, where a negative value indicates the outcome concentrates in the poor (and a positive in the rich). The CI can be decomposed, letting us observe what contributes to inequality. Here, for decayed teeth, socioeconomic status (income and education) explains 30 percent of the inequality, access to care close to 60 percent, and oral health behaviours only 11 percent. This has implications for what policies we promote to improve oral health among socially disadvantaged groups. The CI suggests that we focus on access to care and improving living conditions, and not necessarily on oral health education.
Access to Dental Care in Canada

Infographic Sources


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PROTECT

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Sample $1,000,000 Term Life Insurance Guaranteed annual premium for non-smoker male*

<table>
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*All policies are medically underwritten. Final premiums and coverage availability varies depending upon age, gender, smoking history, hazardous activities, and medical history.

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May 7 – 9, 2015 | Metro Toronto Convention Centre | South Building

Keynote speakers who are not only entertaining but provide humour and inspiration

The Opening Ceremonies on Thursday, May 7 feature Canada’s number one comedian, Ron James who consistently packs theatres across the country. The star of his own CBC TV program, The Ron James Show, he cuts a wide swath through contemporary culture with his razor sharp wit and machine-gun delivery, making him a standout among stand-up performers. With Ron’s vast repertoire he is sure to keep any audience howling with laughter. Ron has been recognized for his acting with a nomination for a Genie Award for Best Supporting Actor; he shared in the Genie Award with the writing team on This Hour Has 22 Minutes; and he was voted “Canadian Comedian of the Year”.

Craig Kielburger, activist, co-founder of Free The Children. Craig Kielburger is a social entrepreneur, New York Times bestselling author, and syndicated columnist around the world. He co-founded Free The Children in 1995, when he was 12 years old. Today, more than 1.7 million young people are involved in its programs. Internationally, the organization works in eight developing countries providing a holistic and sustainable development model, including education, health care, food security, clean water, and alternative income programs. Its programs have brought clean water, health care and sanitation to more than one million people. Craig is author of 12 books, holds 15 doctorates and degrees and his work has been featured with multiple appearances on the Oprah Winfrey Show and 60 Minutes, as well as National Geographic, TIME, and the Economist.

For more information, please email rzisko@oda.ca or visit www.oda.ca/member.
When talking to Dr. Christine Hibberd, the word “lucky” comes up a lot. She feels lucky to be part of a large, close-knit family (she has eight siblings). Lucky to have chosen a profession in orthodontics that allows her a good work-life balance. Lucky to have had so many mentors along the way — including her father, Dr. Graeme Hibberd, a well-respected and successful orthodontist in Toronto’s west end, whose busy practice she now shares.

There’s no doubt the odds have been in her favour, but hard work and a “can do” attitude have played a major role in her success. “You just have to be organized, know your priorities and go for it,” says the 32-year-old mother of Jack, 2, and Henry, 1.

It’s a philosophy Christine has always embraced. While she was exposed to the dental profession at a young age (“I have a picture of her on one of my dental chairs holding a toothbrush when she was one and a half,” says Graeme) the one-time competitive dancer, singer and actor had a passion for performing. “I watched her in a high school performance of My Fair Lady and she was magnificent,” says her admittedly biased father. “So I thought, ‘That’s where she’s going.’ When she decided to go into dentistry, especially orthodontics, I felt like I’d won the lottery!”

“It was a total switch,” says Christine. “I loved being on stage, but I wasn’t prepared to give up family. In order to pursue a career in performing, I would really have to go for it and my hours would have been crazy. I knew very early that I wanted to have a family and I wanted time to be around my family.”

Christine took general sciences at the University of Western Ontario before switching to psychology. It wasn’t until her final year at Western that she decided on dentistry and took an additional half semester at the University of Toronto (U of T) to get the prerequisites she needed. Her first acceptance letter came from the University of British Columbia (UBC) and she decided to go for it. “I think it’s probably one of the best decisions I made.” As luck would have it, Christine met her husband, Dr. Andrei Ionescu, at UBC — he was a year ahead of her in the dentistry program and is now finishing a specialty in endodontics at U of T.

After graduating from UBC, Christine applied to the residency program at Toronto’s Hospital for Sick Children. “There were a lot of aspects of dentistry that I really liked and I wasn’t 100 percent sure that I was going to specialize. I thought this would give me a further year of mentorship.” She considered pediatric dentistry, like her aunt, but found that she really enjoyed working in the orthodontic department at the hospital. “There’s a more artistic aspect to orthodontics and it really appealed to that side of me,” she says. “It seemed the one that fit my background and my training. I see the positive change in kids who come in and they’re really self-conscious and not showing their teeth. By the time they leave, they have beaming smiles. I feel very fortunate to have trained at U of T for orthodontics.” She is the third generation of orthodontic specialists in her family.

Graeme attributes his daughter’s people skills to the time she spent at Sick Kids. “It’s a neat thing when I watch her in action. She just knows how to talk to people and make them feel good.” Christine also gets along well with the staff of 16, some of whom have been with Hibberd Orthodontics for 24 years. “A number of them have known me since I was eight, and that has had its challenges.” They’ve seen me go from the little kid who played with the chairs to one of the people who has the final say.”

Working with her dad, however, has always been easy. “We seem to think very similarly,” she says. “I’m sure that’s partly our training — both being at U of T — but it’s also that we’re both very similar. He has such a way of looking at things and just being able to see it. He has all those years of expertise that he’s slowly showing me.” In return, Christine is helping to modernize the office. “He’s been very good about it, but there’s been some, ‘Are you sure we have to
do that?” she says, laughing. “Trying to get somebody to change, now that’s challenging.”

Graeme was born in Australia, the son of two dental professionals and one of eight children. His father, a specialist in orthodontics, prosthodontics and oral surgery, came to Canada in 1967 as chairman of the Department of Restorative Dentistry at U of T. He died suddenly when Graeme was only 16, and Graeme’s mother, who had her BDF from the University of Melbourne, had to write her Canadian accreditation exam after only three months of study in order to provide for the family. She then went on to get her PhD in periodontics after completing her Canadian boards. “I asked her later, ‘How did you do it?’” says Graeme. “And she said, ‘What choice did I have? When you have to, it’s amazing what you can do.’”

While having strong female role models like her grandmother, mother and aunt have had a major influence on Christine, she says it never felt like “I’m a girl and I can do this. It was more like ‘Anyone can do anything they put their minds to.’” She currently works three to four days a week and is grateful for the family-friendly workplace that orthodontics affords. “It’s very important to me that I’m involved with my kids in the same way that my parents were. I’m thankful that I’m able to have everything I want as both a professional and as a mom, which is not always easy or doable for women in a lot of other professions.”

Still, wearing two hats can be a hard juggle some days. “Arranging childcare, kids’ doctor’s appointments and much of the organizing and cleaning of the house are things that I typically take on,” she says. But being the eldest of nine kids helped Christine develop good coping skills. “I had crazy-busy parents and I always had to be aware of time management because there were so many of us.” Her mother, Elizabeth, was a nurse, studied for her masters of social work at night, worked for an adoption agency and became a private adoption practitioner — all while raising nine children.

Christine’s advice to young female dentists: “You don’t have to choose between family or dentistry. You may have to make some sacrifices somewhere, but everyone makes sacrifices.” In many cases, women practitioners more so than men, she acknowledges. “While we may say everything is equal among the genders, the truth is that women need to contend with the physical realities of pregnancy, birth and raising new-borns. Planning when to have babies based on school schedules and major examination dates, arranging all my prenatal appointments and, later, times to pump around my patient schedules — these are things that my male colleagues who were parents or thinking of becoming parents never had to consider.” You have to know when to ask for help, she says. “I don’t think I would have been able to finish school without my sister Jen and my mom looking after Jack.”

Her husband has also been hugely supportive. “When I was thinking about doing the Sick Kids residency, he said, ‘Absolutely, do it.’ And he was in New York taking his residency and considering staying there at the time.” While she says they do talk shop around the dinner table, their No. 1 topic of conversation is their kids. And future plans. “Andrei is finishing school this year, we’re trying to figure out what he’s going to do, is he going to open a practice himself, associate, where are we going to do this? We’re into that new, exciting, let’s get onto the next stage of life-planning mode.”

This month, the entire Hibberd clan will gather on Christmas Eve as they’ve always done. On Christmas Day, upwards of 44, including extended family, will celebrate together. “I absolutely love having a lot of brothers and sisters,” says Christine. “My sisters are my best friends. I hope Jack and Henry have that with their cousins and future siblings.” She remembers having a conversation with her husband when she was thinking about specializing. “I said, ‘What are we going to do? We want to have a big family. Are we going to be able to do that if I go and specialize?’ And then we said, ‘Yeah, you know what, we’ll figure it out. If you want it enough, there’s a way to make it happen.’”

Cheryl Embrett is a Toronto-based writer and editor.
Ingrid Sevels
DDS BA

Pain Control, Infection Control and Oral Pathology

Oral Leukoplakia
This article discusses clinical diagnosis, management and outcomes for patients with oral leukoplakia. Oral leukoplakia is classified as homogeneous or non-homogeneous. Homogeneous plaques are mainly white and uniformly flat and thin with shallow cracks on the surface keratin. The surface can be smooth, wrinkled or corrugated. Non-homogeneous plaques are mainly white and red.

Histopathologically, oral leukoplakia can be dysplastic or non-dysplastic, with dysplasia being associated with malignant transformation. The diagnosis of oral leukoplakia is based on having ruled out other possible etiological factors. After a two- to four-week observation period, a biopsy can determine whether cells are pre-cancerous or cancerous. The management can involve surgery, electro-cauterization, laser ablation or cryosurgery. Non-surgical treatments include the use of carotenoids, vitamins A, C, and K, fenretinide, bleomycin, and photodynamic therapy. However, none of these approaches prevent malignant transformation and recurrence.

Recurrence occurs in 10 to 35 percent of lesions after surgery and malignancy develops in three to nine percent of cases. After laser surgery, 2.6 percent to nine percent of patients develop malignancies. No consensus has been reached concerning the best management of oral leukoplakia.

The possibility of malignant transformation dictates that follow-up will be part of the patient’s life from that point on.


Needle Stick and Infection Exposures
Injury from needles can be avoided most effectively by not recapping. Instead, a rigid puncture-proof container should be kept close at hand to dispose of needles. Dental staff should wear protective clothing, goggles, masks and gloves.

The accidental exposure to blood carries risk of infection by such viruses as hepatitis B (HBV), hepatitis C virus (HCV), human immunodeficiency virus (HIV), cytomegalovirus (CMV), Epstein-Barr virus (EBV), paroviruses, and bacteria (Treponema pallidum, Yersinia, parasites, and plasmodium).

After exposure, steps are as follows:
• Skin wounds should bleed and then be cleaned with soap and water, then 70 percent alcohol. Do not suck wound or use antiseptics.
• Exposed mucous membrane should be rinsed immediately with water or saline solution.
• Record exposures to blood and saliva in accident report.
• If source of blood is known, the source patient should be asked to give permission for a blood sample to be tested for HCV and HIV. If the patient refuses, the patient is assumed to be a carrier. If the blood source is unknown, any blood present on the needle can be tested serologically.
• Further blood samples for HBV, HCV, and HIV are collected one, three, six and 12 months after the injury.

The post-exposure prophylaxis (PEP) treatment for HIV exposure includes three antiviral agents. PEP against HIV reduces risk of transmission by 75 percent when given within an hour of exposure. PEP for HBV is a course of vaccination with immunoglobulins. No PEP is currently available for HCV exposures. Exposed persons should have follow-up examinations after two weeks, one, three, and six months. Trained clinicians should give counselling about the need to avoid transmission to sexual partners.

Ibuprofen and Acetaminophen

This study evaluated the administration of ibuprofen, a non-steroidal anti-inflammatory (NSAID) and N-acetyl-p-aminophenol (APAP) combined to manage pain after third molar extraction. The mechanisms for why combining analgesic drugs provides better pain relief than single agents are:

• The additive effects of two analgesics agents with different mechanisms.
• The increase in plasma concentrations and efficacy.
• The alteration of the nociceptive sensitivity of the other agent.
• The genetic differences in patients may enhance the combination efficacy over single agent administration.

Mild pain can be managed using 200 to 400 mg of ibuprofen as needed every four to six hours. Moderate to severe pain requires 400 mg of ibuprofen plus 500 mg of APAP every six hours. Some medical histories contraindicate their use. Patients taking warfarin or other anticoagulants should not receive ibuprofen or other NSAIDS. Patients taking low dose aspirin regularly should delay taking NSAID for 30 to 60 minutes after aspirin because the NSAID may interfere with the cardioprotective effect of the aspirin. The risk of adverse gastrointestinal and cardiovascular reactions increases with prolonged administration of APAP and ibuprofen. Maximum dosage of APAP is 3000 mg per day with higher doses increasing a risk of liver damage.

The ibuprofen APAP combination provides analgesia that is at least equal to that provided by commonly prescribed opioid combinations and causes fewer side- effects and less chance of misuse or abuse.

*J Am Dent Assoc 144:898-908*

Dr. Ingrid Sevels is a member of the Ontario Dentist Editorial Board and a 1971 graduate of the Faculty of Dentistry, University of Toronto. She received a BA in English and Professional and Creative Writing in 2002. Dr. Sevels currently maintains a part-time clinical practice in Oakville, Ont. She may be reached at Ingrid.sg08@cogeco.ca or at www.oakvilledentalcare.com.
Implant Placement for Soft Tissue Matrix Expansion (Tent Pole Procedure) Grafts in a Severely Resorbed Mandible Utilizing a Modified Model Based NobelGuide™

Introduction

Placement of dental implants requires precise planning that accounts for anatomic limitations and restorative goals. Preoperative planning is a highly desirable prerequisite in surgery, but is not always present. In the diagnosis and treatment planning of severe mandibular ridge atrophy, computed tomography (CT) scanning is a precise and noninvasive technique that has allowed three-dimensional (3-D) evaluation of the mandible. With the use of the 3-D implant planning software Mimics® (Materialise Group, Leuven, Belgium), an acrylic resin model (stereolithographic model) can be fabricated from CT image data which allows the surgeon and the prosthodontist to establish appropriate implant number, implant width, length, diameter and establish positioning on this model. Subsequently, from this stereolithographic model a surgical guide (modified model based NobelGuide™) that fit intimately with the osseous surface of the patient’s mandible is then fabricated. Most importantly, from the initial CT scan the prosthodontic phase and the surgical phase can be completely planned and aligned with the functional and esthetic expectations of the patient. In this case, we describe a novel method for implant placement in a severely resorbed mandible with the Modified Model Based NobelGuide™ surgical template.

CASE STUDY

A severely resorbed mandible with six mm or less of bone height presents a significant treatment challenge for both the oral and maxillofacial surgeon and restorative dentist. A widely accepted method of reconstruction in this clinical situation is autogenous onlay bone grafting followed by implant placement. However, these bone grafts undergo physiological resorption and rarely maintain bone height.1,2,3 As an alternative the “soft tissue matrix expansion procedure” has been shown to allow long-term surgical and prosthetic reconstruction of the severely resorbed mandible.4 One perceived shortcoming of the soft tissue matrix expansion procedure is the difficulty of accurate implant placement in the mandible via a submental approach. With the use of the Modified Model Based NobelGuide™ surgical template, accurate implant placement with simultaneous bone grafting can be easily accomplished via the tent pole procedure.
CT Data Collection and Development of Stereolithographic Model

CT scans of the mandible and the maxilla were performed using a medical CT with 0.5 mm slice thickness under a voltage of 130 Kvp and a tube current of 595 mA. The time for acquisition was 0.2 seconds/slice and the gantry tilt was 0 degrees. The study was done in an 18 x 18 cm field of view and images were mapped on a 512 x 512 pixels matrix; the images were then reconstructed using a bone algorithm.

The study was presented for viewing and processing as a series of 139 contiguous axial slices of 0.5 mm thickness, covering the area from the hyoid bone through the maxillary sinuses. A radiographic guide was made of radiopaque material with implant guiding holes and was placed in the patient’s mouth during the scan acquisition. Resulting in a composite image of bone and a proposed prosthesis/occlusal scheme (Figure 1).

The study data was processed and edited with Mimics® (Materialise Group, Leuven, Belgium). This image was cropped at the level of the mandible to allow for easy manipulation. After filtering the data from scatter and noise sources, a mask that could be edited was given to the bone density structures. Subsequently, a 3-D rendering of the mandible and the radiographic guide was generated (Figure 2). Using the implant guide, holes in the suggested sites were prepared in the mandible by deleting the bone in the shape of a cylinder following the same direction and position of the predetermined implants (Figures 3 and 4). An STL (standard tessellation language) or stereolithography file was generated from the edited data. The STL file was used for rapid prototyping and a 3-D model was created on a Systems® printer (3-D Systems Corporation CircleRock...
Case Report

Hill, SC 29730). The stereolithographic model of the anterior mandible was created (Figure 5) and ideal implant position transferred from the radiographic guide is visible. Replace® tapered dummy fixtures from NobelBiocare are positioned ideally in the predetermined implant positions extrapolated from the radiographic guide (Figure 6). The depth was determined by the operators according to the goals that were clinically achievable. Reversing the process of laboratory model fabrication from a NobelGuide™ surgical template, as outlined in the NobelGuide™ procedure and products manual from NobelBiocare®, a Modified Model Based NobelGuide™ surgical template was then fabricated (Figure 7A). Alterations were made to the anchor pin sleeve in order to house a 1.5 mm bone screw instead of the anchor pin (Figure 7B). In addition, windows were placed for visibility during surgery, for irrigation and to guarantee a stable adaptation of the stent to the mandible throughout.

Surgical Procedure

The patient is placed supine and general anesthesia is induced. A nasoendotracheal tube is placed and secured. Posterior iliac crest bone is harvested by standard technique. The patient is repositioned to a supine position and the face and neck are prepped and draped appropriate for a submental approach to the mandible. The mandible is degloved to the mental foramen bilaterally. The subperiosteal dissection is carried posterior to the ascending ramus on each side. The Nobel Bioguide stent is then screwed with 1.5 mm bone screws onto the mandible. The accuracy of the stent fabrication allows for precise fit of the stent to the desired position on the mandible (Figure 8). Using the NobelGuide™ surgical protocol the implants are placed in the desired position and at the desired depth (Figure 9). There is no intraoperative interpretation of bone contour and implant placement as this element of the surgery is carried out in the office using milled mandibular
reproductions and CT software. The implants are precisely placed based on presurgical calculation (Figure 10). The cancellous autogenous graft is then placed from ramus to ramus as described by Marx et al.4

**Conclusion**

A technique to improve the precision of implant placement has been developed for the “soft tissue matrix expansion procedure”. It utilizes CT and milling technology to manufacture a precise model of the patient’s anterior mandible. Presurgical implant orientation and position are determined. A modified model based NobelGuide™ surgical template is fabricated. The surgical template fabricated is an exact fit to the patient’s mandible and is stabilized in situ with bone screws. The splint then guides the implant placement to the desired position and depth in a predictable and timely fashion.

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**References**


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Two Common Tax Issues for Dentists

RRSP or TFSA? To incorporate or not to incorporate?
Here’s how to decide what will work best for you and your practice.

There are various tax planning options we can choose from, but some can be more advantageous than others. The “right” choices are not always obvious, since they depend on personal considerations such as your age and lifestyle, as well as financial factors such as how you run your practice. This article will look at two common tax planning options. (The dentists in the examples are not actual people, but their situations are real.)

Which is Best? An RRSP or a TFSA?
Dr. Mary Smith established her practice, which is unincorporated, four years ago. She finally has some surplus cash and this year she plans to put away $4,000. She hopes to continue saving every year with an annual increase of 10 percent (i.e. next year, she will save $4,400), without withdrawing the funds until her retirement. She is trying to decide between an RRSP and a TFSA, but she prefers the RRSP because of the immediate tax savings. For an unincorporated dentist, an RRSP is the most important tax break offered by the government.

Dr. Smith had a taxable income (taxable income = revenue minus tax deductible expenses) of $40,000 last year, allowing her to contribute up to $7,200 to her RRSP this year. As well, as a Canadian resident over the age of 17, she can contribute up to $5,500 to her TFSA. The marginal tax rate in Ontario at her income level is currently 20.05 percent.

Dr. Smith will purchase the same investment product whether she decides to contribute to an RRSP or to a TFSA. We will look at the difference between the RRSP and TFSA using a five-year time frame and various rates of return.

RRSP Option
Dr. Smith can contribute $4,802 to her RRSP after a tax refund of $802 ($4,000 X 20.05 percent) in the first year. Five years later, the five contributions will grow tax free to $37,965.

TFSA Option
Dr. Smith can only afford to contribute $4,000 to her TFSA in the first year (as opposed to $4,802 in the RRSP) because she will not be entitled to a tax refund. Five years later, the five contributions will grow tax free to $31,625.

The three charts below compare savings between an RRSP and a TFSA, using a rate of return assumption of 10 percent (Figure 1), eight percent (Figure 2) and six percent (Figure 3).
When is a TFSA better than an RRSP?

If Dr. Smith is planning to leave the funds in her RRSP, she is right in choosing an RRSP over a TFSA. She will be better off by $6,341 in five years because of the RRSP tax refunds. However, the scenario will be different if Dr. Smith plans to withdraw funds from her RRSP while she is still working. In that situation, we need to analyze her tax rates to determine if she will be better off contributing to her RRSP or her TFSA.

If, instead of saving for retirement, Dr. Smith wants to save for a one-year maternity leave (which she is planning for five years from now) and expects her effective tax rate to be 10 percent during that year due to lower income, the financial advantage of an RRSP would be significantly reduced, due to the income tax she would have to pay when withdrawing funds from her RRSP. (See figures 4 to 6). The financial advantage could become a financial disadvantage if the income tax rate on her RRSP withdrawal is higher than 16.7 percent. Therefore, an RRSP is not always better than a TFSA. The factors to consider when making such a decision include, but are not limited to, time frame, income tax rates, rate of return and reason to save.

continued page 38
To Incorporate or Not to Incorporate

Dr. David Jones has practised as an unincorporated dentist for 22 years. His current taxable income is approximately $150,000. He believes the difference between practising as an unincorporated dentist and an incorporated dentist is not that significant in terms of short-term and long-term tax savings, after paying the legal and accounting fees needed to maintain a dental professional corporation. The reality, however, is that the difference can be significant, especially in the long run. (See Figures 7 and 8.)

Dr. Jones is unincorporated and he contributes $20,000 every year to his RRSP. His annual tax bill is $39,468. Dr. Jones can contribute to a non-registered investment account as well, to reduce his taxable income. (He could contribute to a TFSA for up to $5,500 annually, but his tax bill would not be reduced as a result.)

By incorporating, Dr. Jones’ annual tax bill is $26,818. Although Dr. Jones pays $4,000 in legal and accounting fees to maintain the dental professional corporation, he saves $12,650 on taxes. The net savings is $8,650 ($12,650 – $4,000) by incorporating. However, the savings do not end there.

- Net savings can be increased by reducing the amount of dividends paid to the dentist. This can be done because the dentist, in some situations, can access the funds inside the dental professional corporation tax free. For example, the dental professional corporation can generally lend to the dentist, to assist with the purchase of a home, if certain conditions are met.

- A spouse can be a shareholder of a dental professional corporation. Then, the taxable income of the dentist can be reduced by diverting some of the dividends to the spouse. Therefore, net savings can be potentially increased to $12,838 ($8,650 + $4,188).

- The funds accumulated and invested inside the corporation could be subject to a tax rate significantly lower than the personal tax rate (30.36 percent in our example) that a non-registered investment account is subject to. The difference can be very significant over time. (See Figure 9)

- The unincorporated option relies on contributions to an RRSP to minimize tax liability. However, RRSPs are unfriendly to retirees. At age 71, an RRSP must be converted to an RRIF which requires minimum annual withdrawals. The withdrawals are fully taxable. The end result is that the taxable income of a retiree with an RRSP can be significantly higher resulting in higher tax liability. As well, if the taxable income is high enough (around $70,000 for 2014), Old Age Security payments could be reduced at a rate of 15 percent above the threshold.

Conclusion

The benefits and costs of incorporating should be analyzed systematically and with the help of a professional. With a taxable income of $150,000, there are certainly significant benefits to incorporating, especially in the long run.

Victor Lee is a tax partner at BGD LLP and can assist dentists with all tax-related matters and business financing. Victor has been in public practice for seven years. He is also involved in exam development for CPA Canada and has delivered a large number of tax seminars. Prior to his career in public practice, he has spent 15 years at major Canadian financial institutions. Victor is a Chartered Professional Accountant, a Certified General Accountant and holds an MBA from the Schulich School of Business. He can be reached at 416-268-1892 or victor.lee@bgdgroup.com.
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When someone dies in Ontario, the person named in the will who is tasked with administering the estate is called the “estate trustee.” The estate trustee identifies and realizes the deceased’s assets (called the “estate”) and uses the money in the estate to pay for the deceased’s debts, taxes and testamentary expenses. Thereafter, in accordance with the will, the estate trustee transfers specific gifts (e.g. of property, cash, etc.) to beneficiaries and then distributes any remaining assets (called the “residue”) to the residuary beneficiaries.1

Estate trustees are given considerable authority and power to deal with the estate; but they also face significant legal obligations and must account for their actions. Their job is complex, time-consuming and emotionally draining. To help guide estate trustees through these new and murky waters, this article will briefly discuss the six steps they must take to properly administer the estate of a deceased who had a will.2

Step 1: Locating the Will(s)
The estate trustee’s initial task is to locate the deceased’s last fully executed (i.e. signed and witnessed) will. The will needs to be original: whenever someone makes a new will, it generally and in most cases revokes any previous wills. Photocopies or notarized copies (i.e. copies of originals authenticated by a lawyer) of a will are not acceptable. Sometimes, as is the case with a deceased dentist who owned shares in a private corporation, there may be two wills: a corporate and a non-corporate will.

Locating a will is not always easy, as the deceased may not have left instructions on where it is located. Is it with his or her personal papers at home or with the estate trustee? Did the deceased tell the surviving spouse or children where the will is? Ideally, it is sitting in a fireproof box or in a law firm’s safety deposit box.

Step 2: Probating the Will
Once the will has been located, the estate trustee has to determine if the court needs to legally verify the estate trustee’s authority under the will. This process, formerly called “probate,” is now called obtaining a certificate of appointment of estate trustee with a will (the “certificate”) from the court. Although the estate trustee has authority under the will to deal with the deceased’s assets immediately upon death, the certificate is typically required by financial institutions, land title and other government offices, and transfer agents (of public company shares) before they will allow the estate trustee to deal with the deceased’s property.

To apply for the certificate, the estate trustee will need to submit (among other things): a completed application, the original will and any codicils, affidavits from the individuals who witnessed the will being executed, an affidavit from the estate trustee stating that the beneficiaries have been notified of the application, and a completed certificate ready for the court to endorse.

As part of getting a certificate, an estate administration tax4 must be paid to the minister of finance. This tax is payable on the gross value of estate assets but does not include the value of certain assets that can be transferred outside of the will (discussed briefly below).5

Worth mentioning is that obtaining a certificate is not always required. The estate trustee can transfer certain assets outside of probate — thereby avoiding the extra paperwork, costs and delays. This is the case, for example, with jointly held property (such as certain real estate), where the surviving tenants automatically inherit the deceased’s interest in the property. This is also the case with registered funds (e.g. RRSPs, RRIFs) and life insurance policies that designate a beneficiary. Finally, if the deceased had a corporate will dealing with his or her shares in a private corporation, a certificate would generally not be required for the estate trustee to transfer those shares.
Step 3: Locating and Dealing With Assets
The estate trustee has a duty to locate and protect the deceased’s assets. In a perfect world, the deceased would have left behind a memo or checklist, outlining all of his or her tangible assets (e.g. cash in bank accounts, real estate, jewelry, investments, life insurance, etc.), as well as all online accounts and assets (e.g. email, personal or business websites, social media, etc.). Usually family members, financial advisors and accountants are able to assist in locating important assets and documents. Financial statements and previous income tax returns should also be reviewed.

To protect the deceased’s assets, the estate trustee should consider changing locks, paying existing insurance premiums or obtaining new insurance, maintaining vehicles and even renovating a home to be sold (so that the estate receives fair market value for the property).

Step 4: Locating and Dealing With Liabilities
The estate trustee will need to determine the estate’s liabilities — such as mortgage and credit card payments. A notice to creditors should be published in the local newspaper where the deceased resided; once the time specified in the notice has expired, the estate trustee will be able to distribute assets without being personally liable for creditors who did not raise a claim within the specified time.

Step 5: Realizing and Distributing the Estate
The estate trustee will transfer the estate in accordance with the will. This involves following through on making specific gifts of property (e.g. shares of a private corporation, real estate, jewelry, etc.) and then liquidating and distributing the remaining assets to the “residual beneficiaries” named in the will). Sometimes, particularly with beneficiaries who are minors, the estate trustee will invest a beneficiary’s inheritance and make payments from time to time to the beneficiary or those responsible for their well-being.

The estate trustee typically has about one year from the deceased’s death to finish administering the estate. In *Pilo Estate (Re)*, [1998] O.J. No. 4521 and [1999] O.J. No. 1907, it took the estate trustee (a lawyer unfamiliar with estate administration law) more than 10 years to distribute the estate; the court awarded just over $22,000 in costs against him, in part because he failed to administer the estate in a timely fashion.

Shortly after the deceased’s death, the estate trustee should close bank and investment accounts and open “estate accounts.” An estate account is an account that is opened and managed by the estate trustee specifically to administer the deceased’s estate. Estate trustees must not co-mingle their own money with the estate’s money.

The estate trustee will also need to prepare “accounts.” Accounts are detailed statements of all the money collected and paid out during the estate administration; they act as a complete record of the estate trustee’s activities and help prove that the trustee handled the job prudently and honestly. Estate trustees must keep complete and accurate accounts and be ready and give full information whenever required. Each beneficiary will be asked to approve the accounts before money is distributed. In *Zimmerman v. McMichael Estate*, [2010] O.J. No. 2162, the trustee was personally ordered to repay the estate nearly $500,000, which he had taken in compensation without “keeping any proper records...and without the consent of the beneficiaries.” And in *Zimmerman v. McMichael Estate*, [2010] O.J. No. 3022, the trustee was ordered to pay the beneficiaries more than $284,000 in costs for presenting accounts that were “manifestly inaccurate, incomplete and false.”

Before making distributions, the estate trustee should consider holding back a certain amount for contingencies (e.g. tax or estate litigation). Interim and final distribution schedules should be provided to the beneficiaries for their approval. And releases from the beneficiaries should be obtained prior to final distribution to discharge the estate trustee from any liability.
Estate trustees face significant liabilities when it comes to erroneously distributing or managing the estate: paying the wrong amounts to the wrong people, showing preferential treatment to one or more beneficiaries, failing to observe investment restrictions, and charging for unreasonable expenses or agent fees are all grounds for legal action against the estate trustee personally.

Where the estate trustee acted honestly and reasonably, they may be excused from liability. For example, in 
\textbf{Henderson v. Henderson}, [1922] O.J. No. 160, despite expert legal advice and against his own interest, the estate trustee paid out a portion of the estate to the wrong party; the court held, however, that the trustee “acted honestly and reasonably and ought fairly to be excused for the breach of trust and for omitting to obtain the direction of the court in the matter in question.”

\textbf{Step 6: Dealing with Income Taxes}

The estate trustee is responsible for preparing and filing the deceased’s tax returns (including a final or terminal tax return from January 1 to the date of the deceased’s death). The estate trustee must also pay out from the estate any taxes owing. The amount of taxes can be quite high when compared to previous years. That’s because, when people die in Canada, they’re generally deemed to have sold all their assets at fair market value at the time of death, which may trigger large capital gains taxes. If the deceased owned rental properties or businesses, the estate may still be earning income after the death, which may require income taxes to be paid.

To offset capital gains and income taxes, the estate trustee should make sure that full tax advantages are taken in connection with charitable gifts made after the deceased died, transferring property to a spouse or dependent child/grandchild, using the lifetime capital gains exemption (e.g. for the sale of shares of a dentistry professional corporation), or using the principal residence exemption if the deceased owned a house or recreational property. It is also critical for the estate trustee to obtain a “clearance certificate” from the Canada Revenue Agency prior to finalizing the estate, as the estate trustee is personally liable for any taxes owing. A clearance certificate certifies that all amounts for which the deceased is liable have been paid.

\textbf{Compensating the Estate Trustee}

In Ontario, the person making a will can specify in the will if he or she wants the estate trustee to be compensated. This can be in accordance with prescribed amounts set by legislation, a fixed amount based on a memo attached to the will, or simply reimbursement for out-of-pocket expenses. If there is nothing specified in the will, the estate trustee is entitled to the prescribed amounts set by legislation and can apply to the court for compensation. It’s up to the person making the will to determine how they want to compensate the estate trustee. We suggest that estate trustees be given a gift of cash (which is tax-free since it is not taxable income) and which is conditional upon them completing their duties as an estate trustee.

\textbf{Conclusion}

Being an estate trustee is a long and arduous journey. Dealing with courts, beneficiaries, creditors and the tax man (among others) is no walk in the park. Estate trustees must manage everyone’s expectations throughout the process. Thankfully they can (and should) turn to a wills and estates lawyer for professional help along the way.

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Laura Fava is special counsel to DMC Law with a focus on wills and estate administration.

\textbf{Tips for Picking an Estate Lawyer}

\textbf{Look for a lawyer who is:}

\begin{itemize}
  \item knowledgeable and experienced in preparing wills and administering estates
  \item experienced at selling a dental practice and real estate
  \item responsive about getting back to you
  \item able to educate you along the way
  \item able to provide cost-certainty (to the extent that he or she can)
\end{itemize}

\textbf{References}

1. An “executor” is someone who completes the administration of the estate so that debts, taxes and testamentary expenses can be paid, and remaining assets can be handed over to the Trustee. A “trustee” is someone who takes control of trust assets and administers them for the benefit of beneficiaries. Nowadays, the same person is named in the will as the executor and trustee. For the purpose of this article, we will refer to that person as the “estate trustee.”

2. This differs from administering the estate of someone who died without a (valid) will, which will not be discussed.

3. Codicils are legal documents that amend and form part of a will and which are signed and witnessed in the same way as a will.

4. Commonly referred to as a “probate tax.”

5. Presently, the estate administration tax is calculated as follows: $5 for each $1,000, or part thereof, of the first $50,000 of the value of the estate, and $15 for each $1,000, or part thereof, of the value of the estate exceeding $50,000. For a $1-million dollar estate, for example, the estate administration taxes would be $14,500.
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As we enter the final month of the year, I want to wish each of you a wonderful holiday season and a happy new year. Enclosed with this issue of Ontario Dentist you’ll find your 2014/2015 edition of Your Member Directory. In January you will be able to access the pdf version on the ODA member website at www.oda.ca/member under Your Resource Centre.

The Directory, now in its fourth year, is your resource for networking and for patient referrals. Whether you are trying to find an old colleague or need to refer a patient to a specialist — this is your source.

The ODA is constantly working to bring you the benefits and services you, our members, want — and need — to enhance your practice and personal life. For more information on these and other member benefits, visit www.oda.ca/member.

If your information changes throughout the year, I would encourage you to update your member profile by notifying the ODA. Simply call 416-922-3900 or 1-800-387-1393 (within Ontario) or visit www.oda.ca/member and click on Your ODA Profile.

The ODA extends a warm welcome to the following new members:

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Dr. Tasha Marie Chrber, Ottawa
Dr. Ron Ho, Milton
Dr. Joanna Huang, Richmond Hill
Dr. Ayesha Jabeen, North York
Dr. Gurpreet Kapoor, York
Dr. Amarnath Kuruganti, Nepean
Dr. Anuradha Mukhopadhyay, Toronto
Dr. Sei Joa Park, North York
Dr. Mee-Jeong (Kate) Park, Toronto
Dr. Faiza Naz Siddiqi, Toronto

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<td>Adults</td>
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Presented by Dr. H. Tenenbaum

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January 30, 2015 | 1 CE Category 2
Presented by Dr. G. Glassman

LIVE ONLINE WEBINAR: Innovations in Endodontic Obturation and The Restoration of the Endodontically Treated Tooth
February 6, 2015 | 1 CE Category 2
Presented by Dr. G. Glassman

Registration for webinars is not yet available, regularly check http://www.oda.ca/member/CE for details.

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At a Glance ODA 2014/2015 CE Calendar

The ODA CE program has expanded beyond the ASM to include practice management seminars, category 1 (core) and category 2 webinars – both live and recorded – online tools and podcasts. Visit www.oda.ca/member/CE for further details. Questions: Contact skarim@oda.ca

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- Purifying Your Professional Corporation, Dr. David Chong Yen
- Multiplying Your Capital Gains Exemption, Dr. David Chong Yen
- Planning for Financial Independence, Mark McNulty
- Determine Your Readiness to Sell, Mark McNulty

Statement of Acceptance by ADEA CERP Provider

Ontario Dental Association is an ADA CERP Recognized Provider. ADA CERP is a service of the American Dental Association to assist dental professionals in identifying quality providers of continuing dental education. ADA CERP does not approve or endorse individual courses or instructors, nor does it imply acceptance of credit hours by boards of dentistry. Concerns or questions about a CE provider may be directed to the provider or to ADA CERP at www.adacerp.org

Ontario Dental Association • December 2014
Our clinical and business responsibilities demand a great deal of our attention, yet we still take time to recall that ours is a helping profession. The work that dentists do contributes to an improved quality of life for residents of our communities — serving patients you see regularly and, as well, extending a helping hand to people in time of need.

While we are not always compensated for our efforts, the treatment we provide is of immeasurable relief and value to our patients. This represents our contribution to the proper oral care and health of the people of our province. Time and again our member dentists provide above-and-beyond assistance that confirms the positive impact we have on peoples’ lives.

This past September marked the seventh consecutive year that an Ontario dental team fitted young athletes with free custom mouthguards. Earlier in the year, at the Peterborough Examiner Women in Business Awards, a dentist earned a finalist standing. She was recognized for providing dental care to patients, regardless of their ability to pay.

Your community efforts extend beyond the dental chair. An Ottawa Citizen article, “Cancer Care Includes Oral Care,” featured two dentists addressing the importance of dentistry in fighting the disease. And thanks to support from a number of you, a Sarnia woman wrote a book that helps children overcome their fears when visiting us in our offices. Chico’s First Trip to the Dentist, by Jen Dafoe, came to fruition as a result of the time and consultation you generously provided to the author.

While we willingly give to others, we in the dental profession may also need to turn to others for guidance and advice from time to time. Whether the concerns are pressures at home, business challenges or questions related to personal development, there are available resources within the dental community. CDSP! is an important resource that works with ODA dentists in their capacities as family members, practitioners and community leaders. Along with insurance and investment services, CDSP! offers the Members’ Assistance Program, or MAP, to all members of the dental community and their families. Operated by Shepell, MAP boasts a breadth of services — from short-term counselling to professional referrals for managing your health, finances and relationships.

CDSP! also provides professional development initiatives through student programs. From advising on financial strategies for managing student debt to supporting leadership initiatives, CDSP! helps dentistry students at the University of Toronto and Western University learn skills that will benefit them in their professional lives.

The ODA looks forward to continuing to partner with CDSP! to celebrate your accomplishments in the coming year. To learn more about CDSP! and its Members’ Assistance Program, as well as other available products and services, visit www.cdspi.com.
n my position as an Administrative Assistant at the ODA, I help to co-ordinate the volunteer process. From that vantage point I’ve discovered that many new volunteers, who may have tentatively made an initial volunteer commitment, become more interested in volunteering for the ODA and wish to continue serving the association and the profession. While “joining a committee” may not sound intriguing, the ODA member dentists who volunteer at the ODA are a dedicated and passionate group.

I wanted to know what captures the interest of member dentists as they become involved in ODA committees, and it seemed that the best way to find out was to ask them directly.

The following are insightful answers from three ODA volunteers, each with unique experiences on ODA committees.

**Dr. Christine Ng** has volunteered with the Ottawa Dental Society and was Chair of the ODA Education Committee, which organizes the annual ASM. **Dr. Lynn Tomkins** served on the Toronto Central Dental Society Executive, several ODA committees and the ODA’s Board of Directors, eventually becoming ODA President (2010-2011). **Dr. Ronald Yim** has served on the Burlington Dental Academy Executive and several ODA committees, was Chair of the Zero Tolerance Task Force and was as a member of the ODA Board of Directors.

**OD: What elements of volunteering for the ODA captured your interest and kept you engaged as an active volunteer?**

**Dr. Christine Ng:** My initial reason for volunteering with the ODA was curiosity — I wanted to know what the ODA was really all about. Once I began to understand the purpose of the ODA, I then became more curious about the people, the process and the cause.

**Dr. Lynn Tomkins:** Volunteering introduced me to organized dentistry and to the world that exists outside of the dental school or the dental office. It has given me an incredible perspective on larger issues. When I was accepted to dental school, one of the first things I did was call the ODA to find out how I could get involved. To me, being a professional meant being an active member of the professional association.

My parents set a great example for me, they have been and continue to be active volunteers. Early on I was involved with service and community organizations and in high school served with Interact, a youth group of Rotary International. At the CDA National Dental Student’s Conference I was elected to represent dental students across Canada on the CDA’s Board of Directors. I have served as ODA President and continue to volunteer as Chair of the ODA’s 150th Anniversary Committee as well as on the CDA’s Advocacy Committee.
Dr. Ronald Yim: I like to describe my involvement as an evolutionary process, which occurred over time. As I completed each “step” and became more involved, my appreciation for the incredible work done by the volunteer dentists and ODA staff, in addition to the great friendships that naturally develop over time, enhanced my passion to stay engaged and involved.

I began my volunteer experience at the component society level after being invited to sit on the executive by a fellow society member. The mentorship and encouragement I received there led me to get involved at the ODA committee level. I then served on General Council and finally joined the Board of Directors.

OD: Has your volunteer involvement with the ODA been fulfilling to you as an individual or as a practising dentist in Ontario?

Dr. Christine Ng: My volunteer involvement with the ODA has been fulfilling both professionally and personally. It has given me a greater appreciation of our profession’s role within society. But more so, volunteering at the ODA has benefitted me as an individual. I have grown through greater self-awareness, by broadening my knowledge, learning new skills and connecting with more people.

Dr. Lynn Tomkins: In both ways it has been fulfilling. Personally I’ve found it intellectually stimulating to be part of discussions around public policy, the future of dentistry and access to care. As a dentist, my volunteering has helped me develop some very useful management and analytical skills, such as conducting effective meetings, developing risk assessments and managing some major projects. My understanding of financial management has grown through involvement with the ODA’s building renovation, the review of the ODA’s pension plan and recommending Accerta’s Public Focus, as well as my experiences as ODA Treasurer and Chair of the Audit Committee.

Developing all of these skills has improved my knowledge of financial and risk management and has been useful to me in my practice. Dentists are business people as well as clinical practitioners. Strong business skills enable a dentist to be a better practitioner because you can focus your discussions with patients on the clinical aspect of their treatment if you know that the business side of your practice is under control.

Dr. Ronald Yim: I strongly believe that I have gained much more in both my professional and personal life as a result of my involvement with the ODA. Being involved and having an understanding of the ever-changing regulatory landscape, government regulations and trends in the profession, allowed me to ensure my practice stayed as current and up to date as possible.

OD: If you had to choose a word to describe the experience overall, which would you choose and in a few sentences, why does that best describe the experience for you? For example:

Rewarding — I was able to …

Educational – I learned …

Challenging – It tested …

Social – I enjoyed …

Dr. Ronald Yim: Rewarding — broadening my understanding of the trends and challenges facing the profession, making decisions and being able to have a direct impact on resolving issues have made volunteering extremely satisfying. The Zero Tolerance issue and attaining a defensible, pragmatic solution comes to mind as one of the most challenging, sometimes frustrating, yet most satisfying results we have been able to obtain for our membership and the profession as a whole.

The network of friendships I developed over the years has expanded the often-confining nature of the dental office and opened opportunities for both personal and professional growth. Personally, the life-long friendships I developed through the ODA can never be replaced. I have never regretted taking those initial steps and becoming involved in the association. ■

Kimberly Figueira is an Administrative Assistant in the ODA’s Executive Office and Professional, Government and Component Society Affair. She may be reached at kfigueira@oda.ca
Get Involved
Volunteering at the ODA

To me, being a professional meant being an active member of the professional association.
– Dr. Lynn Tomkins

Volunteering with the ODA has been an essential part of making me a better dentist.
– Dr. Christine Ng

I have never regretted taking those initial steps and becoming involved in the association.
– Dr. Ronald Yim

The ODA member dentists who volunteer at the ODA exemplify commitment to the dental profession. They are actively involved in working on behalf of their colleagues and the profession and provide input and guidance on matters that directly impact the profession. ODA volunteers expand their understanding of dentistry by working alongside colleagues with different levels of experience from around the province.

Please take a moment to read the first-hand responses of how volunteering for the ODA has been meaningful and educational for three ODA dentist members in the article “Dentistry Beyond the Office”, on page 48.

The election for Vice-President and Committees for the 2015-16 membership year will be held at the March 26-27, 2015 Board of Directors’ Meeting. The election for the Board of Directors will take place at the General Council Meeting on May 1-2, 2015.

The ODA is a member-driven, member-supported volunteer organization. Your input is always welcome and encouraged. The ODA values the diversity of its membership and encourages applications from everyone.

HOW TO GET INVOLVED
To apply, please submit a Nomination Form, a Volunteer Information Form and a copy of your curriculum vitae. These forms are available on the ODA member website and can be found under Get Involved – Volunteering and the ODA – How to Apply. Electronic copies of the forms will be sent through ODA Advantage throughout the election period.

The deadline for the submission of nominations for the Committee and Vice-President positions is January 26, 2015. The deadline for the submission of nominations for the Board of Directors is March 1, 2015.

FOR MORE INFORMATION
If you are interested in a position or if you would like more information about the committees or the time commitments involved, please contact Kimberly Figueira at kfigueira@oda.ca or by:

Phone: 1-866-739-8099 or 416-922-4162 ext. 3326
or Fax: 416-922-9005
#### Call for Nominations!

**Notice of Vacancies on ODA Committees**

**Spring Elections 2015-2016**

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### Positions open for election in 2015 are:

<table>
<thead>
<tr>
<th>Positions</th>
<th>Number of Openings</th>
</tr>
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<tbody>
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<td>Board of Directors (Recommended nominees have a minimum of two years’ experience at the Component Society level.)</td>
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</tr>
<tr>
<td>Vice-President (Nominees must be current Board Members with at least two years of Board service completed.)</td>
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</tr>
<tr>
<td>Articles and By-laws Sub-Committee</td>
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</tr>
<tr>
<td>Nominations Sub-Committee</td>
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<td>Health Policy and Government Relations Committee</td>
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<td>Membership Services and Programs Committee</td>
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</tr>
<tr>
<td>Mentored Committee Member Positions (one on each of these committees)</td>
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<td>Benevolence Committee</td>
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<td>Insurance Committee</td>
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<td>Political Action Committee</td>
<td>3</td>
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<tr>
<td>Student Services Committee – (U of T and UWO Campus Representatives)</td>
<td>2</td>
</tr>
</tbody>
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**Vice-President**

- Chosen from among the members of the Board of Directors, the Vice-President provides support to the President and serves as Chair of the Articles and Bylaws Sub-Committee.
- The Vice-President moves through the ranks of President-Elect, President and Past-President in subsequent membership years.

**Board of Directors**

- The Board of Directors is responsible for implementing the ODA’s mission, goals and policies.
- The Board oversees the Committee structure (including electing Committee members and the Vice-President), approves the budget and manages the Association’s finances, conducts annual strategic planning and monitors all activities of the Association at a strategic level.
- The Board meets approximately seven times during the membership year, including a three-day planning session each June.
- It is strongly recommended, although not required, that candidates seeking election to the Board have at a minimum experience at the Component Society level.
Board Committees

**Articles and By-laws Committee**
- To prepare on behalf of the Governance and Nominating Committee any amendments of the articles and bylaws as requested by the Board of Directors, and as otherwise outlined in the Charter of the Board of Directors.
- Advises on alterations and reviews the articles of the CBL so they are kept consistent with the Association’s goals.
- *The Committee usually meets once each year.*
- Please note the committee terms will be staggered in 2015-2016 with two committee members serving a one-year term, and two committee members serving a two-year term initially.

**Nominating Sub-Committee**
- To identify, evaluate and recommend to the GNC all qualified candidates for election or appointment (i) as Directors to the Board of the ODA; (ii) as members of the ODA’s Board Task Forces, and Advisory Committees, and (iii) as members of the ODA’s Board Sub-Committees.
- Identify and encourage those available individuals who are best suited for making a contribution to the strategy and future direction of ODA to stand for election or appointment to positions.
- *The NSC shall meet at least once annually, or more frequently as needed.*
- Please note the committee terms will be staggered in 2015-2016 with three committee members serving a one-year term, and three committee members serving a two-year term initially.

**Advisory Committees**

**Economics Committee**
- Helps the ODA to achieve the Strategic Plan Goal of “assisting members in meeting their professional economic responsibilities.”
- Produces the Suggested Fee Guides,
- Advises the profession on matters that may affect practice economics, insurance industry relations and social services programs.
- *This Committee meets twice each membership year in June and September.*

**Education Committee**
- Identifies the Association’s professional development needs and then markets and delivers the programs that meet those needs. Two primary examples of these programs are the Annual Spring Meeting and the nitrous oxide courses.
- *The Committee traditionally meets four times each year.*

**Health Policy and Government Relations Committee**
- Addresses issues such as scope of practice, clinical standards, public dental health and monitoring, advising and lobbying all levels of government on their oral health policies.
- *This Committee meets three or four times during the membership year.*

**Membership Services and Programs Committee**
- A mandate of the Membership Services and Programs Committee is to understand the needs and requirements of the membership and potential members, to identify ways of continually increasing the value of ODA membership and to effectively market membership to achieve and maintain the highest number of members possible.
- The Committee creates and promotes the ODA’s Oral Health Strategy, oversees Oral Health Month activities and other initiatives related to public awareness.
- *This Committee usually meets four or five times each year.*
**Mentored Committee Members (MCM)**
- These positions are one year, non-renewable terms on each of the following committees: Economics Committee, Education Committee, Health Policy and Government Relations Committee and Membership Services and Programs Committee.
- The MCM positions have full voting rights and privileges on these committees.
- These positions are intended to provide members with enough experience on an ODA Committee so they may make informed decisions about whether to become actively involved as ODA volunteers in future.
- The requirement for candidates is experience gained at the component society level; however candidates should not have worked on an ODA Advisory Committee or Task Force previously.
- When applying to one or more of the four committees mentioned, please indicate which committees are of interest to you.

**Benevolence Committee**
- Responsible for approving grants or loans to dentists, dental students or dependents of dentists who, because of sickness or other misfortune, are in need of assistance.
- Ensures that the Benevolence Fund continues to grow so that it continues to provide assistance in future years.
- *The committee is rarely required to meet, but rather deals with emergencies via telephone, as the need arises.*

**Component Society Committee**
- Reviews and considers all aspects of component society activity including an ongoing review of increasing participation levels and volunteer activity.
- Committee members should have either current or past experience serving on the Executive of an ODA Component Society.
- *The committee meets approximately four times each year and organizes the annual Component Society Leadership Summit in the fall.*
- Each member of the committee will represent one of eight ODA regional areas within the province. When applying, please indicate which regional position is of interest to you.
- The three positions open for election in 2015 are for representatives for the following regional areas:
  - **Regions 2 and 5:** Durham, Peterborough, Bay of Quinte, Headwaters, Muskoka-Simcoe, Owen Sound and Wingham;
  - **Region 3:** North Bay, Kenora Rainy-River, Thunder Bay, Timmins, Sudbury, Temiskaming and Sault Ste. Marie;
  - **Region 8:** Halton-Peel, Hamilton, Burlington and Niagara.

**Dental Benefits Committee**
- The Dental Benefits Committee liaises with government regarding publicly funded dental programs representing the ODA and its members, and is involved with analyzing, planning and designing improvements to programs as required.
- The committee also works with community advocacy groups representing patients covered by publicly funded dental care programs.
- *The committee generally meets by email or by teleconference as required.*
Remote Areas Program

Are you a Certified Dental Assistant?

Join the Remote Areas Program!

ODA’s RAP delivers care in 26 communities spread throughout northwestern Ontario, from the Sioux Lookout area all the way up to the James’ Bay coast.

Oral health needs of First Nations people are extensive and the program provides an opportunity to help improve their oral health status.

Program pays a daily rate and covers costs such as travel, food and accommodation.

Gain a fabulous working and learning experience.

For more information, or to request an application form, please email Janice Sawyer, Remote Areas Program Assistant at jsawyer@oda.ca.
Honours and Awards Committee
- The Honours and Awards Committee manages the honours and awards system of the Association, ensuring that appropriate awards exist, recommending to the Board of Directors the granting of awards to individuals and managing the appropriate presentation of approved awards.
- The Committee usually meets twice each year.
- The appointed ex-officio member’s primary role is research and the preparation of citations for awardees.

Insurance Committee
- This Committee addresses ODA member needs in relation to access to insurance coverage.
- They review the ODA’s participation in the provision of group insurance and make recommendations to facilitate the development and maintenance of programs that are most advantageous to the profession.
- They also liaise with external stakeholders in the insurance industry and advocate for members in dealing with insurance matters.
- The committee schedules one meeting each year. Additional meetings are conducted by teleconference as they are needed.

Political Action Committee
- The purpose of the Political Action Committee is to oversee the work of a network of dedicated, well trained and well motivated volunteers who represent the interests of patients and the dental profession by liaising with legislators.
- The committee does not meet regularly but rather as needed throughout the year.
- The three positions open for election in 2015 are for representatives of the following regional areas:
  - **Central Region**: Scarborough-Pickering, Durham, Peterborough, Haliburton, Markham, Newmarket, Parry Sound, Muskoka-Simcoe areas;
  - **Golden Horseshoe Region**: Dundas-Ancaster-Hamilton, Brampton, Halton-Peel, Mississauga, Niagara areas;

Student Services Committee
- The Student Services Committee’s mandate is to provide support and resources to dental students in Ontario that will inspire them toward lifelong membership in the ODA.
- Committee members serve as mentors and campus representatives at the two faculties of dentistry in Ontario and work directly with representatives from all classes of the dental faculties to achieve their mandate.
- When applying, please indicate which position is of interest to you.
- The committee schedules one meeting each year.
- The two positions open for election in 2015 are for the University of Toronto and University of Western Campus Representatives.

Need help? Wondering where to start?
call 1-800-268-5211 toll free – any time

The Members’ Assistance Program (MAP) is a confidential counselling service that helps dental professionals manage issues that could affect their physical, emotional or financial well-being. It’s also a referral and information service — including information on parenting and eldercare issues.
ODA President-Elect Dr. Victor Kutcher Inducted Into American College of Dentists

The American College of Dentists (ACD) held its Annual Meeting and Convocation on October 8-9, 2014, in San Antonio, Texas, in conjunction with the ADA. The ACD is an honourary dental organization whose members exemplify excellence through leadership and contributions to dentistry and society. The following eight exceptional candidates from Ontario were inducted as Fellows of the American College of Dentists (FACD) at the convocation: Drs. Brian Clark, Stanley Kogon, Victor Kutcher, Peter Nkansah, Paul Romanson, Deborah Saunders, Barry Schwartz and Roderick Stewart.

Dr. Drew Smith
ACD Ontario Editor

Elgin Dental Society Presents Cheque to St. Thomas Elgin General Hospital Foundation

Dr. Derek Haruta, President of the Elgin Dental Society (left), presents a cheque of $5,000 for the Great Expansion to Paul Jenkins, the foundation executive director of St. Thomas Elgin General Hospital.

Awards Presented at Owen Sound and District Dental Society Meeting

ODA President Dr. Jerry Smith attended a meeting of the Owen Sound and District Dental Society on October 21, 2014. ODA Awards were presented to Dr. Rynaldo Fedorenko (left) for 40 years of membership and to Drs. Alex Klym (centre) and Jane Lukasik (right) for 30 years of membership.
Halton-Peel Dental Association Celebrates Gala

On September 11, 2014, the Halton-Peel Dental Association (HPDA) hosted its 9th annual Gala, at Credit Valley Golf Club in Mississauga. The theme was *Around the World*, to celebrate the multicultural nature of the dental community in Halton-Peel. The enthusiastic crowd was entertained by dancers performing waltzes, tango, belly dancing, Bollywood dancing and hip hop. Delicacies from India, Italy, Mexico, Argentina and Asia tempted the more than 200 local dentists and members of the dental industry. The group was honoured to have special guests in attendance: Dr. Jerry Smith (ODA President); Dr. John Kalbfleisch (RCDSO); ODA representatives Frank Bevilacqua and Tom Magyarody; Sylvia Jones MPP, Dufferin-Caledon; Minister of Labour Hon. Kevin Flynn (MPP Oakville); Bob Delaney, MPP Mississauga-Streetsville; and Amrit Mangat, MPP Mississauga-Brampton South.

Since 2011, the HPDA has been actively supporting Heart House Hospice (HHH). The Hospice is an amazing group of people who provide end-of-life care and services to individuals who terminally ill and to their families. HHH is getting closer to realizing the dream of a residential hospice. The land and building design are now in hand, but the support of the community is needed. The generosity and commitment of the dentists of Halton-Peel to this worthy cause was celebrated with the presentation of a cheque for $56,700, representing HPDA donations to HHH over the past three years. Lisa Hoekstra, manager of special events and annual giving for Heart House Hospice, received the donation from the HPDA on behalf of HHH. The generosity continued with the recipient of the 50/50 draw for HHH graciously donating his considerable winnings back to HHH.

After a night of great food, entertainment and conversations, the HPDA dental-industry sponsors were introduced and thanked for their loyal support to the dental community. The Gala ended with HPDA donating a gift card to a lucky dentist to fly to any destination to truly celebrate *Around the World* with HPDA. As luck would have it, the recipient is a local dentist who volunteers twice yearly to provide free dental care in the Third World.

The Gala Committee included Drs. Lisa Bentley, chair; Vikas Soota, president HPDA; Sanjukta Mohanta, Keith Da Silva, Sonia Slawuta, Sunita Joshi and Brenda Thomson, chair of charitable donations.

Dr. Brenda Thomson

**War Child Canada Honoured**

Minister of Health Dr. Eric Hoskins and his wife Dr. Samantha Nutt were awarded the Rotary Peace Award in October, for their work with War Child Canada. Rotarian Jennifer Boyd, Co-Chair of Brush-a-mania, is shown here, with Dr. Hoskins (centre) and Dr. Rafy Choulijian, Founder of Brush-a-mania.
The *Fort Erie Times* published a feature on Dr. Carlos Quiñonez, associate professor and director of the Dental Health Specialty Training program at the University of Toronto, who spoke about the oral health-care income gap, at a dental health forum hosted by Bridges Community Health Centre in Fort Erie. (“Dental Health Forum Explains Link Between Income and Oral Health,” October 8). Dr. Quiñonez, who also serves as Editor of *Ontario Dentist*, states there is a direct link between a person’s income and his or her oral health, and that politicians need to assist in finding funding for public oral health care, so more people can have access to it.

Dr. Maria Van Harten, president of the Ontario Association for Public Health Dentistry, urged the province to move carefully on proposed changes to the Oral Health Programs for Children and Youth. (“Huron Hears Concerns About Merging Provincial Dental Programs,” *Blackburn-News.com*, September 24). According to the article, Dr. Van Harten says the danger in moving too quickly is that it could inadvertently exclude some children who are currently eligible.

Dr. Patrick Roy volunteered to make a new lower denture at no charge for Margaret Lanouette, a woman on social assistance who accidentally lost her dentures and would only qualify for new dentures in 2016. (“Dentist to Provide New Denture for Woman Free of Charge,” *Ottawa Citizen*, September 20).

*Mississauga News* reported on the appointment of Dr. Gagan Bhalla as Ontario Director of the Great Lakes Association of Orthodontists. (“Mississauga Dentist Appointed Director of Great Lakes Association of Orthodontists,” October 15) In his new role, representing more than 350 orthodontists in Ontario, Dr. Bhalla “will promote the highest standards of excellence in orthodontist practice and educate the public about dental health and orthodontic treatment.”

For these and past media clips, visit the Members in the Media section of the ODA member website.

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**ODA Signature Select**

ODA Signature Select offers you discounts on a variety of products and services including travel, office and wireless communications, moving services, sports and leisure, car leasing and purchasing.

Learn more about the offers and how to take advantage of them at www.oda.ca/member/signature-select

Visit today – visit often!
In Memoriam

The ODA regrets to announce the passing of:

Dr. Bob C. Weegar, on August 5, 2014, at age 91. Prior to becoming a dentist, Dr. Weegar served in World War II with the Canadian Air Force as a bombardier, or bomb aimer. Following the war, Dr. Weegar attended the University of Toronto’s Faculty of Dentistry, graduating in 1951. Shortly after, he registered with the RCDSO and opened his practice in North Bay, where he would remain practising for 37 years. Dr. Weegar was the President of the North Bay and District Dental Association in 1972 and 1973 and also was President of the Northern Ontario Dental Association in 1974. Dr. Weegar is survived by his children Karen, Carl, Laurie, Tim and Scott, his grandchildren and great-grandchildren.

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Dr. Ralph Ian Brooke died on September 30, 2014, at St. Joseph’s Hospice in London, Ont., at age 80. He was born on April 25, 1934, in Leeds, England, and studied at the University of Leeds School of Dentistry, graduating in 1957. He sat as house surgeon at the University of Leeds after graduation and in 1968 become head of the Department of Oral Medicine and Pathology. He was a visiting professor in the Department of Oral Diagnosis at New York State University in Buffalo, N.Y., in 1970, and in 1972 he registered with the RCDSO and became a professor at the Department of Oral Medicine at Western University in London, Ont.

Dr. Brooke worked for more than 40 years at the University of Western Ontario as a professor and lecturer, chair of oral medicine, vice-provost of health sciences and chief of dentistry at University Hospital. From 1982 until 1997, Dr. Brooke was dean of Western’s School of Dentistry and under his leadership the school grew and thrived, becoming one of the top dental programs in Canada. Dr. Brooke published many papers and articles in his field of oral pathology and contributed to numerous medical and dental textbooks and professional journals.

For his many outstanding contributions to dentistry in Canada and abroad, Dr. Brooke was recognized as a Fellow of the International College of Dentists, was awarded Honorary Membership in the Canadian Dental Association (1994), and Honorary Fellowship in the Academy of Dentistry International (1995), as well as being named an Honorary Alumnus of Distinction by the Schulich Faculty of Medicine and Dentistry (2006). Dr. Brooke was active with the ODA throughout his career, sitting on the Education Core Committee and the Health Policy and Government Relations Committee, which he chaired from 1998 to 2004. He also served on the OHIP Fee Schedule Working Group in 2000, on the RCDSO Relationship Working Group in 2006, on the eHealth Records Task Force 2010-2013, and on the 150th Anniversary Task Force 2013-2014. Dr. Brooke sat on the ODA Board of Directors from 2004 until 2010. He was the recipient of numerous ODA awards, including the ODA Service Award in 2002, and the Barnabas Day Award for outstanding sustained service to the profession in 2010.

Said Dr. Jack McLister, ODA Vice-President, “The profession has lost a great leader, educator and humanitarian. Dr. Brooke was a tireless supporter, advocate and past member of the Board of Directors of the ODA, who was honoured with the prestigious Barnabas Day Award for his impressive contributions to dentistry. Ralph will be missed, as he was loved, greatly.”

Dr. Brooke is survived by his wife of 51 years, Lorna, his children Michael and Andrew and his grandchildren.
In order to provide support to our members regarding the correct use of the ODA Suggested Fee Guide and dental benefit plans, Practice Advisory Staff at ODA publish a regular column in Ontario Dentist. In this column, they provide answers to questions our members have asked about procedure code use, fee development and dental plans. As always, we welcome your phone calls and emails and ask that you continue to contact us with any questions you may have.

Post-Surgical Care

Q. I have a question about the use of code 01204. I performed an extraction for a patient and three weeks following the surgery, the patient came to the office for a scheduled cleaning. At the hygiene appointment the patient indicated there was something sharp in the extraction site. I smoothed some of the bone in the extraction site. Can I use code 01204 for a specific exam as it has been three weeks since the extraction?

A. The use of code 01204 to describe the smoothing of the bone would be an inappropriate use of the exam code. The note in the Fee Guide states that surgical services include “one post-operative treatment”. The post-operative treatment could be performed at any time after the surgical procedure whether it is one day, one week or three weeks later because it is related to the initial surgical procedure. The patient may not necessarily advise the dentist sooner because he or she knew there was a hygiene appointment in the near future and that the matter could be raised at that appointment rather than at a separate appointment.

Removal of Lesion With Extraction

Q. What procedure code do I use for a simple forceps extraction, then a flap down to osseous margins, curetting out a one-centimetre or greater intra-osseous lesion that may or may not be submitted for biopsy?

A. For the uncomplicated removal of an erupted tooth, the procedure code to use is 71101. The removal of the lesion would be coded separately using codes 74111-74118, depending on the size of the lesion. If tissue is to be sent for oral pathology biopsy services, the procedure code to use is 99222. (See laboratory procedures: Laboratory charges for oral pathology biopsy services when provided in conjunction with surgical services from the 30000, 40000 or 70000 code series)

NOTE: If during the removal of a tooth, soft tissue is removed coincidentally rather than intentionally, it would not be appropriate to use a code describing the soft tissue removal as a separate surgery in addition to the extraction. If the soft tissue is to be sent for oral pathology biopsy testing, code 99222 would be used in addition to the extraction code. If the intent of treatment is to remove a tooth AND to also remove a cyst/lesion as a separate surgical procedure from the extraction, they would be coded separately.
Is your contact information correct?

Are all offices listed on Find A Dentist?

Please help us to ensure that the ODA has all of your office addresses and telephone numbers. You can review your profile online.

Visit www.oda.ca/member – and click on Your ODA Profile. Edit, add or delete your addresses and telephone numbers. You can also email your updates to the ODA at member@oda.ca or call 416-922-3900 or 1-800-387-1393 (within Ontario) to update your information over the phone.

DENTAL Calendar

GENERAL COUNCIL MEETING
The Annual General Council meeting will be held on the following date:

May 1-2, 2015
at the Marriott Toronto Eaton Centre Hotel

MARK YOUR CALENDARS FOR MAY 2015!
The ODA’s 148th Annual Spring Meeting

ASM 15
ANNUAL SPRING MEETING 2015

May 7-9, 2015
Metro Toronto Convention Centre, South Building
For exhibiting opportunities and/or class reunion listings, please contact Vicky Hatzopoulos:
Tel: 416-355-2266
Toll-free: 1-866-739-8099, ext. 2266
Email: vhatzopoulos@oda.ca

BDA
Burlington Dental Academy

Friday, February 20, 2015

A Day with Donovan:
Practical Pearls in Restorative Dentistry

Lecture Topics Include:
1. Clinical Evaluation of Contemporary Ceramic Systems
2. Update on Adhesive Restorative Dentistry
3. Diagnosis and Management of Dental Erosion
4. Controversies in Restorative Dentistry
5. Rigid vs. Flexible posts with ETT
6. Cement versus Screw-retained Implant Supported Restorations
7. Direct Pulp Capping: MTA vs. Calcium Hydroxide
8. Bonding of Zirconia Restorations
9. Cements & Luting Agents

All new lecture with Dr. Terry Donovan
Spend a day with Dr. Terry Donovan, Prosthodontist and Professor from the University of North Carolina at Chapel Hill. Dr. Donovan will help clarify controversies with implant prosthetics, discuss the treatment of dental erosion, as well as reviewing clinical protocols for the use of contemporary ceramic restorations and the management of endodontically treated teeth.

SPEAKER:
Dr. Terry Donovan

Fees include lecture, breakfast and buffet lunch.

Fees:
- Dentists $199 before Jan. 20/15
  $249 after Jan. 20/15
- Staff $135 before Jan. 20/15
  $149 after Jan. 20/15

NOTE: Dentist’s fee must be paid for each group even if no dentist is attending.

Online Registration:
www.adaywithdonovan.eventbrite.ca

Contact Dr. Herman Thang for offline registration and payment: 289-337-1571

Category 2
6 CE Credits

LOCATION:
Burlington Convention Centre
1120 Burloak Drive, Burlington

Attendance is limited. Register early!

Burlington Dental Academy
Dr. Richard Speers is a high-flyer — literally. When the Toronto general practitioner graduated from the University of Toronto’s Faculty of Dentistry in 1975, he headed to Goderich, Ont., to practise. That’s because he also had a pilot’s licence and Goderich had an active community airport. He lived in Goderich until 1981 and, during that time, co-produced two air shows, performed aerobatics and flew as much as possible. He set his sights even higher in Toronto: he recently flew his first charter — to Dulles airport in Virginia — and for the past two years has been the volunteer director of the three-day Canadian International Air Show (CIAS), held annually at the CNE.

**OD: How did you get interested in aviation?**

**Dr. Speers:** There’s something about aviation that gets into some people’s blood, and I am one of those people. When I was 15, I started taking flying lessons. It was my first act of defiance since I was not allowed to drive. We lived in Oakville and, with the money from a part-time job, I came to Toronto on the GO train two evenings a week for ground school. That lasted about 15 weeks. I told my parents I was going out, but didn’t tell them where. One night my father followed me and demanded to know what I was up to. Eventually the whole story came out, and they were pretty good with it. Once I got my pilot’s licence, at age 17 (the minimum age), my father followed suit and obtained his licence as well.
Do you have a story to tell about your passion? Email the details (and a photo or two) to Julia at jkuipers@oda.ca. We may publish it in an upcoming issue.

OD: How did you get involved in volunteering for air shows?
Dr. Speers: In Goderich almost all the dentists were involved in community work and I volunteered for the airport committee. In 1977 the air show was starting to evolve, and I jumped into the middle of it. We organized publicity stunts, with airplanes flying all over Huron County. For instance, I was the “navigator” of sorts for sending four Harvard aircraft down the main street of Grand Bend at very low altitude with the sunrise. Two of us produced the second show in 1980. We booked the acts, raised money, installed 1.5 miles of fencing and moved porta-potties. It was totally hands-on. And people in the community generously offered their help and services. My present job as director of the CIAS is entirely different.

OD: How much flying did you do back then?
Dr. Speers: My flying was mostly seat-of-the-pants visual flying out of fields and grass runways, and then I got into aerobatics, but after two of my instructors were killed, aerobatics seemed to be a bad idea. Subsequently, I went on to get commercial, multi-engine and instrument ratings.

OD: Is the CIAS mainly about the Canadian air force?
Dr. Speers: It’s an air demonstration event, and a huge recruitment vehicle for the RCAF. But we have had both military and civilian performers from the USA, Britain and Italy to name a few. It attracts several hundreds of thousands of spectators annually, and the audience leaves with a lot of smiles.

OD: What are your responsibilities as director?
Dr. Speers: The board of directors has to be sure that budgetary and insurance issues are addressed as well as finding innovative funding sources. We also have to look after policy and HR issues — and with 200 to 300 people involved in the show, it’s hard not to have the occasional misunderstanding or problem. Once the show begins we don’t have much to do. Our work starts the day after the show. Our main responsibility is at budget time. I spend about 100 hours a year working for the CIAS, plus the four days on site (one practice day and three show days).

I’m surrounded by very capable volunteers who are experts in their fields. We have people from the navy handling water recovery; we have experts in hospitality (there are 400 hotel-room nights to manage as well as catering); and an expert in charge of safety and rescue protocols. Some of the volunteers are civilians, some are active military or reserve. All with very specific expertise. Any pretense is left at the door, and you just get on with it.

OD: You wrote a paper for JCDA called, “Optimizing Patient Safety: Can We Learn From the Airline Industry.” Why?
Dr. Speers: In aviation we must learn from our mistakes; in health care, we are too quick to assign blame. We can learn a lot from aviation to make dentistry safer. For instance, in aviation you’re forced to work with a team, you double-check on each other, staff is encouraged to speak up. In the flight deck, hierarchy is minimized and this can improve safety by creating an atmosphere in which all crew (or staff) members feel comfortable speaking up when they suspect a problem. Support staff can be seen as a huge resource.

This interview was written and edited by Gilda Swartz.
PROFITABLE PRACTICE

THE BUSINESS OF DENTISTRY!

This is a great time to start planning for 2015. This seminar will be a joint presentation from noted industry leaders to discuss:

- The best tax strategies for you; deductible expenses to save money for investment
- How practice values are determined in today’s market
- Freedom from ownership! Exiting with dignity and profitability
- Learning the most effective way to sell your practice
- Financing and best practices from both a purchaser and vendor perspective
- Macro view of financial markets with a focus on succession planning
- Sale structure (asset vs. share vs. hybrid)
- Employee severance obligations
- A strong recare system positions you to maximize the value and appeal of your practice at the time of sale

CITIES/DATES/TIMES

Vancouver
Friday, January 23rd, 2015  8:45am - 3:15pm

GTA/Mississauga
Friday, February 6th, 2015  8:45am - 3:15pm

Dartmouth
Friday, April 10th, 2015  8:45am - 3:15pm

Edmonton
Friday, May 1st, 2015  8:45am - 3:15pm

Calgary
Saturday, May 2nd, 2015  8:45am - 3:15pm

Seminar fee is $299 +tax for doctor; non-doctor spouses/partners are highly encouraged to attend at no charge. Continental breakfast and lunch will be served.

Presenters:

ROI Corporation, Canada’s dental practice appraisal and sales leader, specializes in dental practice appraisals, transitions, brokerage, buyer education and business management. Many dentists are planning for the increasing volume of practices coming to market in 2015 and beyond.

BMO Bank of Montreal provides customized financing and banking solutions to dentists across Canada. Our dedicated healthcare banking specialists can deliver a comprehensive offering to meet all your financial needs.

MNP is one of the largest accounting and business consulting firms in Canada, providing client focused accounting, taxation and consulting advice. Succession planning and thinking about retirement needs to start as early as possible in the lifecycle of your practice. By developing an effective succession strategy now, you can save on tax, invest smartly and decide on the best plan according to your circumstances and personal goals heading into the future.

Exclusive to Patterson Dental, Recall System Pro is assisting hundreds of practices to achieve their business goals with the dental industry’s first complete and comprehensive recall solution.

To register please visit: profitable-practice.com/news-events

Or for more information please contact: 1-888-764-4145 or info@profitable-practice.com
ASSOCIATES WANTED

Associate Wanted – Markham, Ont.
Dentist required for long-established family practice three days per week (Thursday, Friday and Saturday), beginning in January 2015. Applicant must be experienced in all aspects of restorative dentistry and enjoy endodontics and surgery. Strong leadership skills are essential and the ability to speak Mandarin and/or Cantonese is important. There will be an opportunity to purchase the practice. Please send resumé.

Email: toothydoc@rogers.com

Associate Needed
Busy east Scarborough office in need of dentist for extractions, wisdom teeth and implants.
Email: dentaloffice74@gmail.com

Associate Position Available
Progressive dental office in St. Catharines is looking for an experienced general dentist. Part-time leading to full-time.
Email: dentaldmd1@gmail.com

Full-time associate needed for busy practice in Guelph. Progressive dental office with a great team. Good communication skills a must. Current associate is fully booked and patients are on a waiting list.
Email: doctors2014@hotmail.com

Great Opportunity!
Phone: 647-294-3310

Kenora, Ont.
Full-time associate required for enjoyable three-dentist practice. No evenings or weekends. Accommodation available. Earn 40% to 45% with buy-in potential. Kenora is cottage country, two hours from Winnipeg.
Email: kenoradent@hotmail.com
Associate Opportunity
“We are committed to the health and appearance of each patient. We aspire to excellence in treatment and personalized service to each and every person.” The team is dedicated and experienced. The practice is a family-oriented modern facility with an outstanding on-site periodontal program. The clientele are loyal and expect exceptional service. Your skills and talents in dentistry could be an asset to our team. We require an associate to cover a maternity leave starting January 2015, for an approximate duration of three to four months. Please submit your resume to:
Dr. Wayne M. Grose
Dr. Lori L. Prior
Dr. Meghan L. Reid
974 Dearness Drive
London, Ontario, N6E 2R8
Phone: 519-681-1905
Fax: 519-681-3697
Email: bookkeeper@dearnessfamilydentistry.com
Website: www.dearnessfamilydentistry.com

Endodontist and Oral Surgeon Wanted
St. Thomas, Ont.
A busy, modern family practice in the heart of St. Thomas (only 30 min. from London) is seeking to add an oral surgeon to its team to perform all aspects of oral surgery and implants on a monthly basis. We are also seeking an endodontist to join on a monthly basis. We offer highly competitive compensation and a schedule that is fully booked with quality cases.
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Are you practising dentistry in fertile soil and at the level you desire? Fantastic career and lifestyle opportunity! Don’t hope any longer. Come share your passion and enthusiasm for dentistry with a connected, like-minded, highly trained team! We are looking for an associate who enjoys people and loves dentistry. Our thriving modern high-tech family practice requires a GP who is confident with a strong clinical skill set. We are in beautiful Muskoka, Ontario’s playground, where you can exceed your professional goals while enjoying a lifestyle desired by many. If you are growth-minded, come and interview us and help us move to the next level. Future buy-in opportunity. Please leave a detailed message about yourself, your experience and your desires.
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Dentist – Toronto
Dentist needed two days per week to provide general dentistry in a well-established, modern union clinic in downtown Toronto. Associate remuneration plus income guarantees. Please send resume.
Email: DrRandy@YongeEglintonDental.com

Toronto, Ont.
Looking for a dental associate, full-time/part-time leading to permanent position. We are looking for an experienced dentist who is proficient in all aspects of dentistry and is friendly and caring with great communication skills. We have well-trained staff and a highly organized modern office. Please email your resume.
Email: dr.sharma.dental@gmail.com

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Email: cambridge.dds@hotmail.com

Toronto Associate Wanted
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Email: drpulec@1888implant.com
Pediatric Dentist Needed
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An exceptional opportunity for a pediatric dentist to join a busy, modern family dental practice located in the heart of St. Thomas, only 30 min. from London. This is an excellent opportunity to work part-time with friendly staff and have the efficiency of a paperless office and digital radiography. We offer highly competitive compensation and a fully booked schedule.
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Website: www.sunsetdental.ca

Part-time Associate
Part-time dental associate needed for busy modern practice located in Brooklin (North Whitby). Must be available for evenings and Saturdays.
Email: tallen.ydg@gmail.com
Website: www.brooklindentalcare.com

Northern Ontario Associate Opportunity
Looking for a lifestyle that is both financially and professionally rewarding? Would you like to take home between $250 and $350 K/year with the potential to earn substantially more? If so, join our state-of-the-art practice, which has more than 10,000 active patients and a skilled support team dedicated to your success. If you are interested in one of the best dental opportunities in Ontario:
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Phone: 613-297-4565

Associate Dentist Opportunity
Cobourg, Ont.
Busy family dental practice in Cobourg is looking for a friendly dentist with excellent communication skills to join our team.
Fax: 905-372-9439
Email: cobourgdentist@gmail.com

Associate needed in a well-established Peterborough office. Looking for a caring and quality-focused dentist to provide exceptional care to long-standing patients. Experience preferred. No evenings or weekends. Part-time leading to full-time.
Email: dentistryinpeterborough@gmail.com

Norton Dental Centres – Part-time Associates
Our offices in Vaughan, Toronto, Hamilton and Ancaster are looking for part-time associate dentists. The right candidates should be confident and team players. Hours and days vary by location. Be part of a growing team.
Please email your resume.
Email: nortondent@gmail.com
Phone: 905-832-8181

Southwestern Ontario
Part-time associate required for two to three days/week in a family-oriented and established, yet growing practice, located outside Windsor. Looking for a confident dentist with experience in molar endo, extractions and peri surgery. No weekends.
Email: careers@dentalcorp.ca
Website: www.dentalcorp.ca
Classifieds

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Full-time and part-time dental associates are needed for a busy, modern dental office located in a prime location only 30 minutes from London. We are looking for enthusiastic, career-oriented, self-motivated dentists to join our team and provide exceptional, comprehensive patient care. Opportunity for extremely high earnings. Recent graduates and experienced dentists are welcome to apply.
Email: info@sunsetdental.ca
Website: www.sunsetdental.ca/apply

**Ottawa, Ont.**
Part-time associate wanted for a well-established family practice, located in Ottawa. Two days a week, with the potential to grow to four days a week. This is a great opportunity to practice in a relaxed, fun environment. If interested, please email your C.V.
Email: carlingdental@gmail.com

**Cornwall and/or Hawkesbury (Alfred), Ont.**
Periodontics ONLY or general dentistry. Looking for a part-/full-time associate (at percentage) to join busy family practice(s).
Email: lucleboef291@hotmail.com
Phone Carole at: 450-370-7131

**Ottawa, Ont.**
Full-time associate needed. Outstanding opportunity for a dynamic, dedicated team-oriented individual to join a large, well-established busy group practice in Kanata, (Ottawa) Ontario. Please submit your C.V.
Email: hazeldeandental@gmail.com
www.laurierdentalclinic.ca
20 minutes east of Ottawa. Very busy, recently expanded dental clinics seeking dentist for long-term, full-time position. Multidisciplinary practice with the latest high tech equipment (2D and 3D X-ray). Mentoring available. Above average remuneration. Phone: 613-446-3368 Fax: 613-446-5006 Email: laurierdental@videotron.ca

**Waterloo, Ont.**
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Experienced part-time associate required for one day/week in a Waterloo family dental practice. Hours are flexible and negotiable. Looking for a pleasant, caring, friendly practitioner who is a good communicator and proficient in all aspects of dentistry. Great staff and a well-organized office!
Email: smilesinwaterlooodental@gmail.com

**Orthodontist Needed**
Orthodontist required for Thornhill general practice. Cases ready to start.
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**Full-time Associate**
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Email: vivadental@hotmail.com

**Associate Required**
**Peterborough, Ont.**
Truly unique opportunity to join a well-established office with a caring team in a busy family practice. Positive attitude, sense of humour and flexibility in scheduling and location will lead to a successful and rewarding position for the right individual. Please contact us by email.
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Scott Family Dentist seeks a full-time associate for its busy general practice, open since 1980. Our clinic includes five computerized operatories, digital intraoral and pan radiography, and an enthusiastic and efficient staff. An option to purchase the practice and building may be available to an interested individual. Resumés may be faxed or emailed, and any questions will be answered by calling Dr. Brian Scott.  
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Fax: 807-345-8581  
Email: bookkeeper.gbscott@gmail.com

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Associate required for 1.5-2 days a week to babysit the practice and perform simple procedures. Flat fee per day and 40% of major restorative work should you decide to do it. Mid-town Toronto, subway-accessible.  
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Website: www.summerhillgardensdental.com

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Full-time associate required for a large group practice in well-established office in new building. Modern, digital, paperless office in growing part of beautiful Kingston.  
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Email: lisawong@on.aibn.com

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Experienced dental associate required for a well-established and prestigious family practice. We offer the latest technology and all aspects of dentistry. This position is for Saturdays, 9 to 5. Seeking a positive, energetic individual with two to three years of experience, excellent clinical and communication skills who is eager to join our progressively growing team.  
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416-922-3900 ext. 3305 or csolmes@oda.ca.
Northern Ontario Associate Opportunity
Very busy, state-of-the-art practice four to five hours north of the GTA needs a full-time associate dentist immediately. Expand your professional skills while taking home $250,000, or much more, in the first year. You will be busy from day one. Our friendly and professional team will support your success. The ideal candidate will be hard-working and dedicated to high quality work as well as excellent patient care and communication. Please send résumé. Email: dental3professional@yahoo.com

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This interactive two-day intensive workshop is designed to provide health professionals with practice, evidence-based and client-centered motivational interviewing tools and skills in order to facilitate patient behavior changes that are both easier for the practitioner and more powerful for the patient. For more information and registration, please see: Website: www.monarchsystem.com/our-events

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Complete Implant Solutions that Add Value and Distinction
**Experienced Family Dentist**
Skilled in all aspects of general dentistry, available for locums in the GTA and anywhere else in Ontario. Great demeanor with adults, children and staff. Excellent references available.
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Email: stan@okorofsky.com

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Dr. Ken Lawlor
Phone: 416-568-4476
Email: drkenlawlor@gmail.com

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**Bowmanville, Ont.**
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Email: dralbertwong@yahoo.com

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Approximately 1,300 sq. ft., 2nd floor space available immediately in professional office building. Ideal for a dental specialist. Please contact Louie.
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Email: portlandconstruction@hotmail.com

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[www.norasupholstery.com](http://www.norasupholstery.com)

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CASE STUDY 6

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