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PUBLISHER (On leave)
Kari Cuss

ACTING PUBLISHER
Catherine Perdue

EDITOR
Dr. Brian N. Feldman

ART DIRECTOR
Kimberly Strange

MANAGING EDITOR
Julia Kuipers

ASSOCIATE EDITOR
Gilda Swartz

CLASSIFIEDS CO-ORDINATOR
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Tel: 905-886-6640  Fax: 905-886-6615
Jennifer DiIorio Sarah Vassos
905-886-6641  905-886-6641
ext. 309  ext. 310
diiorio@dvtail.com svassos@dvtail.com

CONTACT US
4 New Street, Toronto, Ont. M5R 1P6
Tel: 416-922-3900
Fax: 416-922-9005
Email: jkuipers@oda.ca
www.oda.ca

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Visit the ODA member website to view all of our Dentist-Patient Communication tools, resources and downloads at www.oda.ca/member under Your Resource Centre. We will be updating this site frequently, so visit often!

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

X-ray machines were, and most still are, mounted on the walls of dental operatories. The equipment is generally a bit bulky, needs reinforced backing plates and separate electrical wiring, and the technique of exposing radiographs has traditionally been somewhat slow:

• Place a lead shield over the patient’s neck and torso area.
• Place X-ray film or a digital sensor into the patient’s mouth.
• Position the X-ray head correctly.
• Walk out of the room.
• Expose the film or sensor.
• Walk back into the room.
• Remove and prepare another film or sensor.
• Repeat all of the above steps 12 to 16 times, for a full-mouth series of radiographs. (Panoramic films of course reduce this considerably — provided your office is appropriately equipped.)

Those of you who have constructed new dental offices or renovated existing ones may have been forced, as I was, to mount separate X-ray units, as well as separate control boxes, on the walls of each operating room in a multi-operative office.

Now along comes a new generation of machines — NOMAD Pro2 (Aribex), BIOX (Digimed), iRayD3 (Dexcowin) — that have finally offered our profession the option of a truly portable X-ray system. These units feature cordless rechargeable handsets, which promise to change the logistics and costs associated with traditional X-ray systems. Included among the benefits are:

• Safety and Protection. The devices have been tested and proven to deliver, depending on the film speed or digital sensor, an exposure range of 0.12 to 0.30mSv. Exposure for dental personnel from conventional X-rays is 0.20 to 0.70mSv. Improved shielding, both internal and external, has effectively reduced the backscatter radiation.

• Practicality. The operator remains in the room with the patient, ensuring there is no errant movement of the mouth or drifting of the X-ray arm. This is particularly helpful when taking radiographs of children or sedated or special-needs patients. Industry tests have indicated that a full-mouth series of films may be completed within five to eight minutes. A single portable unit does the work of multiple conventional X-ray machines, at a substantial savings in capital cost and ongoing maintenance.

The system works with standard X-ray film or digital sensors, automatically sets exposures for various quadrants, uses a very short exposure time and appears to produce sharp, clear images.

Wilhelm Roentgen’s accidental discovery of X-rays in 1895 brought a new, non-invasive tool to help diagnose disease in the human body. For the next 100 years, X-ray equipment gradually became smaller and safer, and the relatively recent introduction of digital technology delivered diagnosis-enhancing images with superior quality. Still, almost all dental X-ray units remained fixed in position, thus mandating the need for multiple machines in the majority of offices.

The good news for dentistry is that a number of global manufacturing companies had the vision a few years ago to develop both the equipment and the technology to unshackle conventional X-ray equipment and deliver a new level of benefit for patients and practitioners alike. The bad news is that not all of the units described above, at this writing, have been approved for use in Canada.

Dr. Brian N. Feldman is the Editor of Ontario Dentist. A 1971 graduate of the Faculty of Dentistry, University of Toronto, he teaches part-time in the Departments of Histology and Pathology. Dr. Feldman may be reached at 416-319-6585 or at downsviewboy@rogers.com.
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The Ontario Dental Association is the voluntary association for the dentists of this great province. With a voluntary membership greater than 91 percent of all practitioners, we are a unique organization — in more ways than one.

One significant feature of our association is our large dependence on volunteers. As dentists, we voluntarily pay handsomely to be members, and then many of us volunteer to work for the association so we can make Ontario a better place to live and practise. How many organizations can make such a claim?

Our volunteers serve in any number of positions with varying time commitments. Everything from component society executive positions to corporate committee members to serving as a Director on our Board. All these roles require the time and expertise of volunteer members, and all are equally important. But the individuals who form your Board of Directors are among the most dedicated volunteers anyone could have the privilege to work with. These 15 practitioners meet eight times per year, all for multi-day meetings, to work for ODA members while giving up time from their practices and families.

So what is it that the Board actually does for the association? The Board has a number of specific duties, the first of which is to “govern” the association. What this means is that the Board must provide oversight in all areas of ODA business. It is responsible for fiscal resources and ensuring that funds are used appropriately. This is relatively easy to do with our system of checks and balances and fantastic staff who work to ensure the financial health of the organization. What it doesn’t mean is the micromanagement of staff and committee responsibilities and decisions. Knowing where the line is between governing and micromanaging is the difficult part. Board members are engaged in regular education sessions with the Directors’ College — DeGroote School of Business — to continually upgrade their association management skills in order to better understand all their responsibilities.

Oversight must also be provided around the services offered to members. Surveys are conducted and analyzed, specific ideas are discussed such that the Board fulfills its fiduciary responsibility, and then the design and execution of projects are tasked to committees and staff. There are checks and balances along the path — from the idea stage to the completion of each project or delivery of the service to members — to ensure maintenance of intent, not to dictate how things are done. Governance, not micromanagement!

But the biggest thing that the Board must try to do is “influence” the future of our profession. We are always scanning the environment, looking for both threats and opportunities for organized dentistry. By staying attuned to the world around us, we are able to work toward the preferred future for our practitioners, taking advantage of the opportunities and working to mitigate or block the threats.

As members, you can rest assured that the volunteers serving as your Board of Directors work very hard on your behalf to keep Ontario a great place to practise dentistry.

Dr. Rick Caldwell maintains a general dentistry practice in New Liskeard, Ont., and may be reached at ODAPresident@oda.ca.
Dry mouth is an oral health concern that patients are often unaware of. Patients who are on multiple medications are most at risk. So when you recognize the signs, have the conversation about dry mouth and how Biotène® toothpaste can help maintain good oral hygiene. Biotène® also offers a range of products for mouth moisturization.
there are many heartwarming stories about dedicated dental professionals who volunteer their skills to help people and communities in need. They tell of the smiles that appear on patients’ faces, the pain diminished, the fractured teeth repaired, the infections cured. These are wonderful accounts, but there’s a behind-the-scenes story that goes beyond the dedication and caring of the volunteers. There’s the story about how to get funding and supplies, how to select a good team, the real risks volunteers face, the logistics of getting people and equipment to isolated villages, the communication problems. And, of course, there’s the difficulty of performing dentistry in a place with few, if any amenities.

It’s not easy volunteering in far-away places, but it’s even more demanding organizing the projects. Dr. Timothy Lee, who has a practice in Mississauga, has helped improve the lives of thousands of people in South and Central America through an organization he founded called Health Outreach. Dr. Lee says, with some embarrassment, that he’s not good at telling human-interest stories. It’s clear that he does, however, know how to make things happen.

Ontario Dentist asked Dr. Lee to share his advice and information about the often-tough realities associated with setting up temporary dental clinics in so-called “exotic locales”.

The Inspiration
In 1996, Dr. Lee travelled with Foster Parents Plan to Ecuador, where he first witnessed the dental and medical deprivation of poor South American children. Since he was the only dentist, all he could do was offer toothbrushes and toothpaste and show people how to care for their teeth. “I couldn’t do more and I was frustrated,” he says. From that visit on, he vowed to commit part of his life to charitable work. “I looked at the end point, which was how do you get all those kids treated. Back in Canada I worked really hard to gather what was needed, including funding, equipment, fresh supplies and staff. The good thing was, I had some time to prepare.”
Five years and many trips later, Dr. Lee founded Health Outreach, an organization that is actively involved in dental projects in Central America. By the end of January 2002, Dr. Lee had assembled a team to travel to Monterrico, a remote community on the west coast of Guatemala. Since then Health Outreach has conducted one or two projects a year, mainly in Guatemala, but also in Honduras and Mexico. Dr. Lee now develops projects as well as being the President of Health Outreach. The objectives of the project are to offer a wide range of services in remote areas and serve as many patients as possible, while maintaining high standards. “I’ve learned that good judgment in deciding who is treated is important. It’s with great sadness that we sometimes have to walk away from cases that are complicated.”

The First Hurdles
“Getting funding in place is the first obstacle,” says Dr. Lee, who adds, “I can tell you it’s not easy to ask people for money. After that, you’re ready to face the next daunting obstacles. We had to determine how to get equipment to Central America, how to find trustworthy staff down there, and of course, how to get volunteers from here (who also have to pay their own expenses) interested in going down to help.”

Have Everything Organized Before You Leave
Since the work trips last just one or two weeks, it’s important to get as much in place as possible before arriving at a destination. If there are any problems once you’re down there, you’re wasting precious days. The following procedures require time and should be organized in advance:

• Clinic set-up. It’s important to plan with partners and/or a country director in the recipient country to arrange a clinic and convince people to attend.

• Be familiar with customs restrictions and learn how to bring things in legally. “In the early days some things were confiscated and taxed. Now we store a lot of our equipment in Guatemala; we’ve received approval from the Guatemalan government through the consulate, so that has resolved most problems in customs.”

• Find local transportation. Since many remote areas are only accessible by 4x4s, you have to arrange to rent or borrow vehicles.

• Translators. Most rural people in Central and South America don’t speak English well, so sometimes the organization has to look in Canada for translators. “If you’re struggling to communicate when you’re at a clinic, a lot of time is wasted and mistakes can be made. Printing out dental information in Spanish helps,” says Dr. Lee, “although many people read poorly or can’t read at all. Since there’s such poverty, people’s priorities are work, not literacy, so you have to make your literature appropriate.”

• Establish trust. “You can’t just walk into a place and say, ‘I’m here to help.’ You have to build a relationship with a community, and that takes time. Establishing a bond with leaders in specific communities means that acquiring equipment, setting up clinics and spreading the word to patients can be done more effectively than if you set up a program in a new community every time.” It’s one of the reasons that Health Outreach revisits the same places.

• Make safety a priority. It happens that volunteers can, and sometimes do, get ill or injured. Danger can come from disease or violence or civil unrest. There can be natural disasters (such as earthquakes or mudslides), or accidents, or theft aimed at tourists. “We can never guarantee safety but we do everything we can beforehand to learn what the risks are in each country and each specific area,” says Dr. Lee, “and that lowers the risks.”

What Makes a Good Volunteer?
“The people who volunteer are commendable,” says Dr. Lee. “Not everyone will subject themselves to the potential risks.” Dr. Lee and other members of Health Outreach first

continued page 14
assemble an ideal team on paper: dentists, hygienists, translators who speak Spanish. Then they have to assess people’s experience and skills. Furthermore, would-be volunteers may have to provide medical histories, since the projects can be demanding.

Health Outreach will disclose as much as it can about potential risks, so that candidates can self-assess their risk tolerance. They are interviewed as well, so there is an understanding of the working environment. Good volunteers are qualified to do the job that’s necessary and can accept and tolerate the adverse conditions.

**Health and Safety Concerns**

Health Outreach mentions potential problems to prospective volunteers in the form of an information booklet entitled, *Information Session Notes*. “We really want our volunteers to make an educated decision, notes Dr. Lee. Things can change fast, so the *Information Session Notes* are revised annually. What doesn’t change:

- **Follow the rules.** “We’re strict on things like always travel together and only eat in certain restaurants, and we travel with people we trust in the countries we go to. We used to suffer more with gastro-intestinal problems, but we’re now taking more precautions so volunteers stay much healthier.” Travel alerts are posted by the World Health Organization and by the Canadian government, and Health Outreach follows those carefully.

- **Heed travel medical advice.** It’s not that uncommon to develop hepatitis B or malaria or to get insect bites, so it’s important for volunteers to take all precautions. Before leaving Canada, each volunteer should consult a physician and get all the necessary vaccinations and medicines.

- **Possible emotional stresses.** While most of us feel good about helping others, it’s not uncommon for volunteers to feel sorry for the kids. “That’s not the approach I encourage,” says Dr. Lee. “Often the patients don’t feel poor; it’s all they know. Still, we have to forewarn the volunteers about the poverty.”

- **Working conditions.** A lot of dental volunteers are used to working in an ideal environment: clean surroundings, having the best equipment or even having a chair that suits a dentist, but these are things that are lacking in poor communities. Conditions can be frustrating to work in, but volunteers need to adapt to these realities.

- **Be adaptable.** On volunteer missions you have a group of people who have never worked together and who are in a stressful environment with certain expectations placed on them. “There are going to be personality differences and philosophical differences,” says Dr. Lee. “And there are going to be clashes. You have to be able to tolerate other people.”

**Logistical Issues**

No matter how committed and talented your volunteers are, you can’t perform dentistry without functional equipment — and that means getting funding. “With financial support over the years we bought portable chairs, overhead lights, headlamps, drills that already have lights in them, hand-pieces with LED lights, and small equipment such as curing lights. You also need a source of electricity, so we bought generators (with and without compressors). We learned that things can break while we’re down there, so we now have backup equipment, and better quality stuff.”

Health Outreach fundraises and applies for grants. The organization accepts donations from other dentists or suppliers (for supplies/disposables) and it purchases medicines or receives them as donations from pharmaceuticals. “You need money. And you have to be cost-efficient. It’s important that volunteers have a good experience,” says Dr. Lee, “but above all else, a trip must be productive.”
**Why Volunteer Clinics Don’t Always Succeed**

When there’s a natural disaster, relief volunteers are quick to go over to help, but sometimes the effort fails, due to several factors: there are often few contact people to organize and set up clinics, equipment and medications are stolen, much time is wasted due to logistical problems, and often communities are not ready or able to receive volunteers. Another problem may be a lack of compliance from the communities themselves. As well, there are financial considerations for the patients. Many have to take a bus to reach a clinic, and poor people may not be able to afford that.

**Who and Where to Help?**

Health Outreach has worked for several years in the remote Guatemalan communities of El Rosario and Quesada. The catchment area for Quesada is about 30,000 people. For many reasons it does make sense to go back to the same place. “You are not going to run out of kids to take care of when where you’re working in areas that continue to have needs. We try to see the worst of the worst because we don’t have enough volunteers to treat everyone. There are many kids with severe problems — especially pain and infection — and they’re our first priority. Second priority is those children with badly damaged teeth. We identify these as ‘urgent’ cases, where there will be a likelihood of pain or infection in the near future. Mostly we try to see children under 18.”

Why kids? “Unfortunately we can’t see everyone,” says Dr. Lee. “Kids don’t have control over dental disease. Parents have more control over how they eat and take care of themselves, and we feel that if kids can learn good techniques and be motivated at an early age, they will carry this knowledge through to the future.”

**Our Plans for 2014**

Health Outreach is currently preparing for “Guatemala 2014”, a two-week project including two dental teams, in January 2014. We will travel to Quesada, in one of the poorest regions of Guatemala, and to the Rio Dulce in Eastern Guatemala, where we will be treating indigenous Mayan children. The teams will be led by ODA members Dr. Daniel Lee and Dr. Ramzi Haddad.

Gilda Swartz is the Associate Editor of Ontario Dentist. She may be reached at gswartz@oda.ca.
A Patient’s Worst Nightmare

Surgical Events That Should Never Happen

Every surgical procedure has complications despite how routine the operation. However, there are certain events that should never happen. The most common of these “never events” include retained foreign bodies, wrong site, wrong procedure and wrong patient. Despite meticulous checks both pre- and post-surgery these events still occur.

Researchers reviewed all malpractice payments filed with the National Practitioner Data Bank in the United States. They identified 9,744 malpractice reports from 1990 to 2010 involving surgical “never events.” Here is a brief summary of the key findings:

- Almost half (4,857 or 49.8 percent) of the reports involved retained surgical foreign bodies. The wrong procedure occurred in 25.1 percent of patients followed by the wrong site (24.8 percent) and surgery on the wrong patient surgery (0.3 percent).
- Annually there were between 410 and 708 events amounting to malpractice payments of $1.3 billion. The highest payments were awarded to patients who underwent the wrong procedure (median payment $133,055) and the lowest median payment was for retained surgical foreign bodies ($33,953).
- There were 9,562 physicians named in the malpractice reports. Sixty-two percent were involved in separate malpractice suits and, surprisingly, 12.4 percent were named in other “never event” suits.
- Permanent injury occurred in 33 percent of the cases, temporary injury in 59 percent and death occurred in 6.6 percent of the cases.

The above data probably underestimates the frequency of these events. New guidelines require that the surgeon be present before the patient is anesthetized. A recorded checklist is followed in which the patient is identified, the procedure is confirmed and, where applicable, the extremity is marked. During surgery the scrub nurse keeps track of all the instruments and a final count is conducted before closure. In rare cases, if the count is not correct, an X-ray is taken in the operating room.

These strict pre-, intra- and post-op procedures have reduced the number of “never events” and if followed consistently should reduce the incidence to zero.

J Surgery 10:005, 2012

Global Report on Children with Disabilities

One section in UNICEF’s The State of the World’s Children 2013 focuses on children with disabilities. The report details the enormity of the problem, the many barriers to aid and some of the efforts being made by countries and communities to alleviate the suffering. Among the highlights:

- In many low-income countries technology essential to integrate disabled children into schools, recreational and social activities are available to only five to 15 percent of those in need.
- Diet, inadequate nutrition and insufficient medical care can lead to physical, sensory or intellectual disabilities. Globally, between 250,000 to 500,000 children are at risk of blindness from vitamin A deficiency, a syndrome easily prevented by vitamin A supplementation costing only a few cents per child. Anemia from inadequate nutrition affects 42 percent of pregnant women in low and mid-income countries. In developing countries more than half of children are anemic.
- Disabled children are less likely to complete primary school. A WHO survey of 51 countries found the rate to be 61 percent for males without disability but 51 percent for children with disability. For girls the numbers were worse — 52 versus 42 percent.
- Children with disabilities are three to four times more likely to be victims of violence. In particular, children with intellectual disabilities were 4.6 times more likely to be a victim of sexual violence. Unfortunately, many of these children have impaired communication, a condition subjecting them to unreported abuse.
- In countries with active armed conflicts, disabled children are often abandoned by fleeing families and residences are destroyed or left unstaffed, leaving children without care.
• Approximately 1,000 children are injured every year by land mines left behind in war-torn countries and contribute significantly to childhood disability.

Children with disabilities are a global concern. What varies significantly is the causes of these disabilities, the inability to address children at risk and to institute effective prevention. The lack of resources and the finances to assist these children further exacerbates the problem and the suffering. War and poverty continue to be major risk factors. The State of The World’s Children 2013; UNICEF.

Dr. Irv Feferman is a member of the Ontario Dentist Editorial Board, and may be reached at irvfef@hotmail.com or at 416-931-8678.

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Managing Xerostomia

Alleviating Dry Mouth
Patient preference plays a huge role in determining how to manage xerostomia. The products and the procedures must fit well with the patient’s daily home care to encourage compliance and relief from dry mouth syndrome. The authors of this review suggest patients consider some or all of the following routine:

- Use remineralization paste and chewing gum containing casein phosphopeptide-amorphous calcium phosphate (CPP-ACP).
- Have high fluoride varnish applied once every three months to reduce the risk of caries.
- Brush with high fluoride toothpaste at least twice daily.
- Use dental floss and a high fluoride mouthwash daily.
- Chew xylitol gum up to five times daily for five minutes at a time.
- Take medication that stimulates salivary flow and increases comfort.
- Change the diet to low sugar and low acidic drinks.
- Use chlorhexidine-containing mouthwash periodically.
- Dentists can help patients with dry mouth by careful monitoring for evidence of caries and by recommending specific products to address the often troublesome symptoms.

*J Can Dent Assoc* 77:b85, 2011

Rubbing It In
This randomized controlled study occurred over a 24-month period to assess the effect of vigorous surface rubbing action on a two-step adhesive in non-carious cervical lesions. Forty participants had 120 restorations placed. Prime and Bond NT was placed with no rubbing action, slight rubbing action, or vigorous rubbing action. Restorations were placed incrementally using Esthet-X, then evaluated at baseline and six, 12, and 24 months. The results were as follows:

- The retention rates did not show any difference until the 24-month period.
- At 24 months, the vigorous rubbing group had a retention rate of 92.5 percent, compared with 82.5 percent for the no rubbing and slight rubbing groups.

Successful bonding depends on the impregnation of the dentin substrate by blends of resin monomers, so the stability of the bonded interface is linked to the creation of a compact, homogenous hybrid layer. Improved monomer infiltration appears to be achieved by applying mechanical pressure, which compresses the collagen network like a sponge. As pressure is relieved, the compressed collagen expands, and the adhesive solution is drawn into the collagen mesh.

*Clin Invest* 15:589-596, 2011

Resin-Bonded Bridges
This recent article described the role of resin-bonded bridges (RBB) in fixed prosthodontics and offered guidelines with respect to case selection and bridge design. In addition, the following factors and clinical techniques were suggested as contributing to success of these restorations:

Case Selection
- Is the patient motivated to accept this type of restoration?
- Are teeth adjacent to the space periodontally healthy and favourably aligned?
- Is there sufficient enamel surface for bonding and how translucent is the enamel?
- Can the abutments support the proposed width of the pontic span and is there adequate occlusal space for the pontic?
- Are there any habits like bruxism that need to be eliminated?

Bridge Design
- Retainer should have a minimum thickness of 0.7 mm and the maximum extension permitted by esthetics.
- There should be careful management of excursive contacts to avoid undue occlusal forces on pontic.
- An ovate pontic is recommended where esthetics are important.

Clinical Techniques
- Replace existing restorations with composite resin.
Clinical Abstracts

- Ensure adequate clinical crown length to increase bonding surface area.
- Create enough space for the new restoration by adjusting opposing teeth and adequately preparing abutment teeth.
- Extend preparations on restored teeth into the restorations to increase resistance form.
- Carefully assess shade of the cement and consider the possibility of grey shine through of the retainer wings.
- Protect the RBB by asking patients to wear an occlusal nightguard.

Resin-bonded bridges can be effective for replacing missing teeth, restoring oral function and esthetics and for achieving patient satisfaction. They are minimally invasive, cost-effective and have good longevity. For the right patient, RBBs are a good choice, particularly for short spans. 

*Br Dent J* 211:113-118, 2011

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.
Clinical Feature

Teaching Caries Management to Dental Students

Introduction

Despite significant advances made in caries control in North America, caries in the primary dentition, and specifically early childhood caries (ECC) remains the most common chronic childhood disease and a major financial burden on society.\(^1\)\(^2\) This is important because cumulative evidence has linked ECC with caries in the permanent dentition.\(^3\) Therefore, early and accurate identification of children who are at high risk should be followed by risk management and implementation of strategies to convert these children to low risk individuals in future.

It is well documented that caries is a transmissible infectious disease in which pathogenic risk factors prevail over protective factors, producing demineralization of tooth structure.\(^4\)\(^5\) However, much of dentistry is focused on restoring the symptoms of this disease rather than treating the etiology.\(^6\) This approach may lead to multiple replacement or more extensive dental procedures over the patient’s lifetime, resulting in an increased restoration size and additional costs to the patient.\(^7\) Application of caries risk assessment, early diagnosis of disease and development of non-invasive measures to arrest non-cavitated lesions can lead to a cost-effective strategy for caries management in pediatric patients.\(^8\)\(^9\)

Risk Assessment

Dental caries is a multifactorial disease and, although many of the risk factors are well known, it is still not possible to identify fully the extent to which each factor operates either alone or in combination in an individual. Therefore assessment of each patient for individual risk and protective factors to determine current and future dental caries disease is important.\(^10\)\(^11\) Caries risk assessment (CRA) is the estimation of the probability of developing a new carious lesion within a specific timeframe. CRA is typically conducted with the use of a standardized data collection form at the time of routine dental examination. Upon completion of the assessment, the clinician should be able to formulate a caries diagnosis, treatment plan and assess prognosis. Most CRA forms are divided into three major categories: disease indicators, risk factors and protective factors.\(^12\)\(^13\) Numerous CRA forms have been published but their predictive value at baseline examination for future caries development is still questionable.\(^14\)\(^15\) Therefore, it is essential that caries risk assessment be conducted at regular intervals and not simply at one point in time.\(^16\)
Early Diagnosis and Identification

According to the National Institute of Health (NIH) the use of sharp explorers adds little diagnostic information to detect occlusal caries and offers no superiority over the visual or visual/tactile method of diagnosing dental caries (Figures 1 to 3). Caries has usually been diagnosed according to the WHO standard which is based on degree of cavitation. While clinical decision-making at the extremes of the caries continuum may be relatively straightforward, the most challenging decisions involve the early carious lesion. The failure to detect early caries, leaving those detectable only at the cavitated stage has resulted in poor results and outcomes for remineralization. For these lesions, more subtle indices and methods are required focusing on the early stages of the disease. These methods should offer objective information about the presence and severity of a lesion and complement clinician’s subjective interpretation.

The International Caries Detection and Assessment System (ICDAS) is an evidence-based and preventively oriented approach in dental education, clinical practice, research and public health. ICDAS provides a common caries language enabling standardized data collection in different settings and improved long-term caries outcomes. The ICDAS criteria (Table 1) refer to six clinical presentations, three of which relate to increasingly progressive stages of the enamel lesion (coded 1 to 3) and three to the increasingly progressive stages of the dentin lesion (coded 4 to 6).

### Table 1
ICDAS II Criteria

<table>
<thead>
<tr>
<th>Score</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No or slight change in enamel translucency after prolonged air drying (five seconds)</td>
</tr>
<tr>
<td>1</td>
<td>First visual change in enamel (seen only after prolonged air drying or restricted to within the confines of a pit or fissure)</td>
</tr>
<tr>
<td>2</td>
<td>Distinct visual changes in enamel</td>
</tr>
<tr>
<td>3</td>
<td>Localized enamel breakdown in opaque or discoloured enamel (without visual signs of dentinal involvement)</td>
</tr>
<tr>
<td>4</td>
<td>Underlying dark shadow from dentin</td>
</tr>
<tr>
<td>5</td>
<td>Distinct cavity with visible dentin</td>
</tr>
<tr>
<td>6</td>
<td>Extensive distinct cavity with visible dentin (involving more than half of the surface)</td>
</tr>
</tbody>
</table>

Figures 1 & 2
White spot lesions on smooth surfaces.

Figure 3
Untreated white spot lesion on tooth #63.

continued page 22
Clinical Feature

Radiographic Interpretation

Carious lesions are usually diagnosed by visual inspection in combination with radiography. Although radiography is considered the superior method of clinical caries detection, research has shown that there is a large variation among dentists in their interpretation of bite-wing radiographs.\textsuperscript{28-30} Moreover, radiography is not able to distinguish between cavitated and non-cavitated surfaces.\textsuperscript{31} Often proximal lesions, which involve dentin, as seen in bite-wing radiographs, are not cavitated and therefore do not need restorative care (Figure 4).\textsuperscript{32} The five-category system proposed by Mejare is an approach that complements the ICDAS system in caries management. This system gives emphasis to the management of lesions that are disclosed through the bitewing radiographic survey and aid in monitoring non-invasive management of early non-restored occlusal and proximal lesions from baseline through periodic recall examinations (Figures 5 & 6 and Table 2).\textsuperscript{33}

Patient Management

An equally important step in caries management is patient motivation. This can be especially challenging with those patients and/or parents who are reluctant to change; and dentists must be trained and equipped to foster this shift in caries management. Therefore, increased emphasis on non-surgical approaches to caries management within undergraduate dental curricula must be adopted by dental schools. However, education alone has not been shown to result in actual behaviour change in patients.\textsuperscript{34} Successful caries management requires an understanding of all of the options available for maintaining oral health along with patient participation and cooperation.\textsuperscript{35} Promising results have been reported using a brief, patient-centered, personalized counseling approach called “motivational interviewing”. This method focuses on the patients becoming knowledgeable and ultimately taking direct responsibility in the decisions affecting their health. This approach allows exploration of a problem in a supportive environment that expresses acceptance and provides affirmations of the person’s strengths.\textsuperscript{36}

![Figure 4](image1)

Early proximal carious lesions on teeth #'s 74 and 75.

![Figures 5 & 6](image2)

ICDAS Code 2 lesion — clinical view; ICDAS Code 2 lesion — histological view.

<table>
<thead>
<tr>
<th>Criteria for Bitewing Radiolucency Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>C1</strong></td>
</tr>
<tr>
<td><strong>C2</strong></td>
</tr>
<tr>
<td><strong>C3</strong></td>
</tr>
<tr>
<td><strong>C4</strong></td>
</tr>
<tr>
<td><strong>C5</strong></td>
</tr>
</tbody>
</table>
**Clinical Feature**

**Treatment Planning**

Performing caries risk assessment makes little sense if the treatment plan is not individually based. Patient treatment plans should reflect both caries management strategies as well as restorative plans for the destruction created by the disease. The decision to manage an existing carious lesion may be influenced by the location, the depth and the activity of the lesion (active or arrested). A combination of risk assessment, ICDAS and radiographic interpretation can be used to guide treatment decisions in managing early lesions. Treatment plan decisions can be made only if behaviour and motivation is taken into consideration in conjunction with the clinical evidence collected above. These treatment approaches should always be in concert with the patient’s understanding and value systems.

**Benefits of Fluoride Varnish**

Topical fluoride application is one of the most commonly conducted procedures in pediatric dentistry. A Cochrane systematic review on the effectiveness of fluoride varnish for preventing caries reported a pooled prevented fraction of 46 percent for permanent teeth and 33 percent for primary teeth. In comparison with fluoride gel, the advantages of varnish include:

- adherence to the tooth surface
- decreased likelihood of ingestion
- increased contact time between the fluoride and tooth surface, allowing for slow release of fluoride over time.

Furthermore, fluoride varnish creates less patient discomfort and achieves greater patient acceptability than does fluoride gel, especially in children.

If a surgical treatment is needed for cavitated lesions (ICDAS codes greater than 3), the principles of minimally invasive dentistry should apply. The FDI (World Dental Federation) has advocated minimal intervention for over a decade with the intention to preserve as much tooth tissue as possible. Pits and fissures classified as ICDAS code 3 should have “caries biopsy” (conservative fissure widening) to determine whether a sealant and, quite possibly, a restoration is to be placed. If a restoration is to be placed then it should be an ultra-conservative sealed restoration.

Early proximal lesions are most effectively managed with remineralization techniques because topical fluoride works well on smooth surfaces. The recommended management options for proximal surfaces with bite-wing radiolucencies of C1 and C2 in all risk groups is to delay restoration, monitor with bitewing radiographs and provide fluoride therapy and oral hygiene instruction. Restorative treatment is not recommended for two reasons:

- it is more likely that the proximal surface is not cavitated; and
- it is possible that the lesion has already been arrested.

**Change at Schulich Children’s Dentistry Clinic**

Dental schools are in unique position to facilitate this paradigm shift from a predominantly surgical model to the more encompassing model of risk management and minimum intervention dentistry. Schulich Dentistry at Western University is committed to providing comprehensive, patient-centered care in its clinics. Since starting in 2009, the undergraduate curriculum has been re-organized into a modular design with interdisciplinary units. Case-based and problem-based instructions with integrated clinical diagnosis and treatment planning begins in the first year of the curriculum and continues with an increasing complexity, time and emphasis over the entire four years.

Caries is now taught by various instructors in various disciplines either in Oral Diseases I (first year) or within Operative Dentistry. This framework offers an opportunity to bridge disciplines, provide a more organized and unified education and eliminates unplanned redundancy and contradictory curricular content. Through second and third year courses in Diagnosis and Treatment Planning students are required to retrieve and apply knowledge and concepts to multidisciplinary cases through active group activity and large classroom seminar formats.

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These changes in curriculum at Schulich Dentistry attempt to address the issues identified by ADEA’s Commission on Change and Innovation in Dental Education which has stated that “passive learning environments, filled with memorization and repetition of isolated facts, not only fail to develop students’ ability to become critical thinkers and lifelong learners, but also fail to prepare them to address the future needs of their communities and practices”.

Over the past year, the Children’s Clinic has implemented a caries detection and management protocol as a pilot project within Schulich Dentistry with the ultimate goal of implementing the system throughout all of the teaching clinics. The faculty and staff adapted standardized assessment and management forms and focused on more patient-centered, minimally invasive protocols. We adopted the caries risk assessment form that has been previously tested and implemented in teaching environments. The ICDAS codes and images were placed on cubicle walls for easy reference. The protocol included a preliminary inspection of wet tooth surfaces, followed by an examination of dried smooth surfaces and fissures with magnification. The ICDAS codes are entered into an enlarged odontogram (Figure 7) that allows for surface specific recording and may therefore, enable ready reference for caries risk assessment and treatment planning.

All bitewing radiographs were interpreted using the five point grading scheme presented in Table 2 and recorded on a standardized form (Figure 8). This form provides for easy monitoring of non-invasive management of early occlusal and proximal lesions from baseline examination through recalls.

Currently, our students have limited experience in motivational interviewing, but our ultimate goal is to see this approach be adopted universally within Schulich Dentistry and that our students become familiar and confident in its application in caries management. In the future we intend to conduct an outcomes based analysis of the program as well as provide enhanced training in motivational interviewing, investigate other minimally invasive techniques in caries management and new technologies in caries detection.

Conclusion
There is growing evidence for the implementation of caries risk assessment and non-surgical management of dental caries. Successful and accelerated adoption of these techniques is more likely if dental students are exposed to them and learn to apply them while in dental school. We believe teaching students how to detect early carious lesions, identify risk groups, and how to implement appropriate management strategies should be a part of all undergraduate dental programs.

Figure 8
Bite-wing Form.
Dr. Timucin Ari is Assistant Professor, Orthodontics and Pediatric Dentistry Division, Schulich School of Medicine and Dentistry, Western University in London, Ont. Dr. Ari may be reached at 519-661 2111 Ext: 87443 or at tari@uw o.ca

Dr. Sahza Hatibovic Kofman is Associate Professor, Orthodontics and Pediatric Dentistry Division, Schulich School of Medicine and Dentistry, Western University in London, Ont.

ACKNOWLEDGEMENT
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References


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Clinical Submissions for Case Reports

Introduction
Data from the 2010 Ontario Dentist Readership Survey clearly show ODA members want more clinical articles in each issue of Ontario Dentist. Case Reports in particular are very popular. In order to continue to fulfil this need, we are asking for your help. The template attached to this message will make it very easy for you to prepare and submit a Case Report for publication in the journal.

Directions
(1) Select an interesting or unusual completed case from your patient files. Choose one involving a unique presentation, a challenging diagnosis, a difficult operative procedure or a particularly satisfying result. Focus on a case containing information or findings from which you believe the profession would benefit.

(2) Complete the Case Report Template, using the headings as a guide. Feel free to add additional relevant facts.

(3) Include pictures and/or radiographs to illustrate the key elements of the case.

(4) Be sure your name and contact information are on the template form.

(5) Submit the Case Report either as a Word document by email, or as hard copy by fax. Submit the images as separate files – not embedded in the Word document.

(6) You will receive an edited version of the Case Report, prior to publication, for your review and comments.

The Case Report Template is also available in the Ontario Dentist section of the member website. Log on at www.oda.ca/member.

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History & Initial Presentation

Patient: ☐ M  ☐ F  Age _______  Relevant Factors: ______________________________________________

Chief Complaint: __________________________________________________________________________________

Clinical Findings: __________________________________________________________________________________

Soft tissue: ________________________________________________________________________________________

Hard tissue: _______________________________________________________________________________________

Radiographic Findings: _____________________________________________________________________________

Diagnosis: _________________________________________________________________________________________

Treatment Plan: ____________________________________________________________________________________

___________________________________________________________________________________________________

Complications: _____________________________________________________________________________________

What made this case unique? What were the key learnings? ___________________________________________

___________________________________________________________________________________________________

___________________________________________________________________________________________________

Please include captions for all Figures submitted:

Figure 1 ____________________________________________________________________________________________

Figure 2 ___________________________________________________________________________________________

Figure 3 ___________________________________________________________________________________________

Figure 4 ___________________________________________________________________________________________

Figure 5 ___________________________________________________________________________________________

Please include literature/source references, if applicable.

Name: ______________________________________  Address __________________________________________________

Email: ______________________________________  School & Year of Graduation: ________________________________

Phone: ______________________________________  Degrees: ________________________________________________

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FAX: 416-421-2120  *  Email: downsviewboy@rogers.com
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Conflict Management Skills for Female Dentists

Tips to improve your professional image and become a better team leader

Have you ever been impressed by someone who always seems to know what to say and how to say it, in any situation? Such people know how to communicate tactfully, articulately and with confidence.

This article will suggest useful tools and tips to use in a difficult situation. Rather than letting unresolved anger or frustration get the best of you, or letting people take advantage of you, you’ll know how to keep your cool, stand your ground and positively resolve conflict.

The Look
I’ll never forget the day. It was May 10, 2000. My team and I were at our semi-annual retreat when a delicate situation came up on the agenda. The staff informed me that during clinical treatment, if I was tense or frustrated, I had a high tendency to give them what they called, “The Look.” I was surprised and asked, “What does The Look look like?” They replied, “We can’t do The Look!”

Confused, I said, “Really! Well, how do I know what The Look looks like if you can’t show me what The Look looks like?” We all laughed and I said, “Seriously, if I’m giving you The Look, it must mean I’m tense — and the tension will come across to the patient. It may have nothing to do with you. If there’s anything you need to change that day, you’ll never go home wondering about it because we’ll talk.”

I told my team, “I may be giving you The Look because I need you to set up your operatory more thoroughly, or pass me an instrument in a different manner. Or, perhaps, you said something that wasn’t appropriate at the chair. I believe in daily coaching, so you know, that day, if

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Don’t Miss Our ODA Continuing Education Seminars

In September, Dr. Savage and Dr. Sheri Doniger presented “How to Effectively Lead Your Team While Achieving a Work-Life Balance”, one of the ODA’s informative Women in Dentistry Seminars. This seminar focused on the unique challenges and perspectives that come into play when a female dentist leads and manages a dental team.

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there’s something you need to change. You should never wonder where you stand with me or your position in the practice. My goal is to help you be successful in your dental career. That means that I need to be clear about my expectations and the needs of the practice. If I’m giving you The Look rather than communicating needs, I’ve not done my job as a leader.

Continuing, I said, “I’d like to give you permission to hold up the patient mirror behind the patient, and that will be my signal that I need to relax. I need your help in changing this behavior, because it’s obviously not a good habit!” My staff was comfortable coaching myself, as I knew that sometimes I was the problem. The following tips will help you keep your cool and open the lines of communication with your staff.

Tip #1: Have a culture of daily coaching. Agree that if something needs to be said or if someone needs to change what he or she’s doing, it will begin that same day. The tone between both parties needs to be respectful, with good intentions at heart.

Tip #2: Look for and commend the good. It’s so easy to spot the negative. Like all of us, your staff appreciates praise and recognition for a job well done. It’s number one on their wish list.

Tip #3: Hold each person to the same level of accountability. Your staff is looking for fair, firm, consistent leadership.

Tip #4: Hold regular, organized, motivational team meetings. If someone is behaving outside the expected boundaries, speak to this person privately. Don’t hold the entire team accountable for one individual’s actions. A successful practice is one in which staff communicate more, not less. For an outline of how to hold an energetic, productive team meeting, email me at Rhonda@MilesGlobal.net.

Tip #5: Hold performance reviews at least once a year. A performance review, done well, is motivational and forward thinking. This is not a time to confront an employee with a concern about past bad behavior. If you’ve practised daily coaching, employees shouldn’t experience any surprises regarding a problem.

Tip #6: Conflict hits when we least expect it. Female dentists seem to have a higher tendency to back down on issues. Unresolved anger and resentment can build and arise in your tone of voice, a look or in your body language. Daily coaching is crucial.

To approach a person in order talk about a situation and decrease the defensiveness, consider the “Feel-Felt-Found” method. For example:

“Tina, let’s talk for a minute. I feel uncomfortable bringing this up, as I should’ve talked about my concerns months ago. It’s hard for me to talk about changes I’d like, but I’ve felt if we can sit and talk, we can have an even better working relationship. I’ve found that relationships often struggle, and it’s usually due to unclear expectations or unmet expectations. This is the concern I have....”

Tip #7: The calm person is truly the one who is in charge.

Tip #8: If you’ve coached someone multiple times, draw a line in the sand. Sit down for a more serious conversation or for a formal corrective review.

Tip #9: Have zero tolerance for gossip and negativity, as well as personal use of the cell phone/Internet during the business day. Work at being productive and fast paced. Happy people are productive people.

Tip #10: Keep change as a constant element in your practice — enough change so that no one gets complacent. As an example, coach your clinical team on how to speak to the patient from an intra-oral photograph. Their job, I believe, is to set the stage for case acceptance. The more the team talk about dentistry, the higher the case acceptance. Once your team is comfortable with this process, teach them how to have a smoother pass off of the patient to the front desk, which begins with creating value for the next appointment. Whether you’re coaching the front desk or your clinical team, there is always more to learn. Teams that focus on growth are more excited and enthusiastic about dentistry. Be on fire about dentistry! Remember, no one will care about your practice as much as you do.

If you’re not on fire, it’s time to ask yourself why. I find many female dentists burn out by trying to do too much personally and professionally. Delegate as much as possible, within the scope of the law, training and capability.

Tip #11: Finally, learn to say No. Female dentists tend to perform clinical dentistry and purchase supplies/equipment similar to the way men do. Where we struggle is often with personal relationships with team members, who are also typically female. Boundaries of behaviour and expectation can become murky. Female dentists can also respond more emotionally than male dentists.

These tips may help you improve your professional image and perhaps refine your leadership skills, something we’re not taught in dental school.
Good leaders ask the question, “Is whatever happening in the best interest of the patient, or the practice as a healthy practice?” As a dentist, consultant and coach, my hierarchy of importance is this:

1. The patient is of top importance.
2. Second is the practice “as a healthy practice.”
3. My staff, because without them, I couldn’t get where I was going.
4. The doctor.

If your practice isn’t healthy — financially or emotionally — you cannot provide well for your patients. And if your patients aren’t happy, your practice will not thrive and may not survive. Focusing on these two parameters (the patient and the practice) makes “making the hard decision” easier.

An example: If two people aren’t getting along in your practice, and the behaviour is allowed to continue, morale will drop. Gossip will go up, production will go down. Negativity spreads like a virus in a dental practice. “When negative behaviour exists, it creates a tense uncomfortable atmosphere. Ask yourself:

- Is this in the best interest of your patients? Patients often intuitively know when the atmosphere is bad — which means that negative behaviour actually anti-markets the practice.

- Is this behaviour in the best interest of the fellow team members, if they feel “like they’re walking on eggshells?” Whether the answer is “no” for one question or for both, whatever is happening needs to change. Good leaders make the hard decision and move forward. What hard decision do you need to make?

Dr. Rhonda Savage graduated with a BSc in biology from Seattle University in 1985; she attended the University of Washington School of Dentistry, graduating in 1989 with her DDS. Dr. Savage is active in organized dentistry, is a Past President of the Washington State Dental Association and is currently an affiliate faculty member of the University of Washington School of Dentistry. Dr. Savage is a highly regarded speaker, consultant and author. She is the CEO of Miles Global, an internationally known dental practice management consulting company. She may be reached at Rhonda@MilesGlobal.net.
Children and Money

Give your kids the gift that keeps on giving: the know-how to deal responsibly with money

Money makes the world go round. We all need a good understanding of how the financial system — bank accounts, loans, credit cards, RRSPs, taxes and more — works. Often children learn more about finances from their parents than they do at school. As parents, we have about 20 years to impart financial knowledge to our kids before they head into the workforce, get mortgages, do their own tax returns and prepare wills. If you’re a dentist, it’s likely your children are growing up in an affluent household — and it’s possible they could inherit large sums of money. Unless you always want to be supporting your kids financially, it is important to teach them smart money skills.

Pre-Teens and Younger

These formative years are a good time to introduce the concept of money and the role it plays in society. Until you do, kids may think that everything is free or that money just appears, but there are several steps you can take to start teaching youngsters about our financial system:

- The traditional allowance. Avoid handing your children money every week or month. Trade the money for completion of a task such as making a bed, picking up clothes or setting a table. Explain that this aspect of barter (work for money) is the fundamental element of our society.
- Give your children piggy banks. Have them count the contents on a regular basis and explain what happens when they use money to buy something — including that there is a limited amount of money. If the piggy bank is empty, explain that they cannot afford to buy anything. Tell them how our financial institutions serve the same purpose for adults’ money.
- Let children stand in front of you at the ATM machine at your bank. Let them push the buttons, pull out the cash and get the receipt; at the same time you can discuss what is happening. (Look at the ATM as an electronic piggy bank.)

- When your child was born, you may have opened a Registered Educational Savings Plan (RESP), the government-sponsored savings program where you get a 20 percent free grant for every dollar you deposit, up to defined limits. As children approach age 10, they are old enough for a discussion about what an RESP is, what post-secondary education is, how the money can grow and why you make more contributions. At this age they are at the very early stages of learning that there can be school after high school, and that some schools have a cost, for which the family must save.

Teenagers

Children this age may be earning money from babysitting or another part-time job. They likely want to buy music, clothes, games, etc., and since they are active consumers, their financial education should take on a greater level of sophistication:

- Set up a young teen’s savings account at a local financial institution, obtain a debit card for the child, if possible, and set it up to receive a paper statement (at least at first). Take your child to deposit earnings and make withdrawals, using the opportunity to explain how the debit and credit system works.
- If you want your child to be aware of social causes and the importance of charity, an increasingly popular method to teach this is to hold birthday parties where guests are asked to donate money or toys to various causes in lieu of gifts — causes that can be championed by your child including delivering the toys to the charity after the party.
- If teens earn income from a job, you can file a tax return for them. They won’t pay any tax unless they earn more than approximately $10,000 a year, but filing a return starts them earning RRSP-contribution room. An RRSP can be opened and a lump-sum contribution made each year. There are lots of good lessons here: The filing of a
The tax return lets you discuss the concept of taxes and explain how a return is a once-a-year summary of how a portion of your earnings are sent away to provide a variety of services for society (I’m sure you will find your own personal way to say this!).

The RRSP can be used to introduce the concept of saving for retirement and how starting to save at a young age can use the time-value of money (compound interest) to produce large savings amounts.

Often children in affluent households get anything they want and may have little appreciation for the challenges facing those who have limited funds. To help your teenagers appreciate the value and privileges of money, incorporate some financial life lessons. For instance, don’t buy your kids everything they want every day; rethink lavish and endless gifts. Do your children really need $600 phones and designer clothes? If they lose their iPod don’t just buy them another one — consider having them work and earn enough money to buy a new one themselves. Encourage your teens to get a part-time job and remove or limit allowances at this age. Giving them this balanced experience will set them up well for their 20s and 30s, when they will be on their own.

Absolutely no credit cards for kids up to this point. There is no value in teaching children to use other people’s money and spend beyond their means. If you feel the need to give them a card, start with a debit card from a bank account funded by their earnings or gift money.

When your kids are older teens, explain that sometimes adults seek advice from professionals, such as an accountant or financial advisor. You could even bring them to a meeting with an advisor.

For older teens with some money, you can open an intrust-for investment account that can teach them about stocks and bonds. They can buy a share or two in a company they can relate to. They should also be encouraged to buy a bond, a GIC, a mutual fund and other security to learn about different products and how they interact with the market place. They will get a paper statement and should be encouraged to interact with your advisors by email or other means to ask questions about their account, the products and how it all works. Often, because the financial advisor is not mom and dad, the child develops a healthy sense of independence, empowerment and confidence in making financial decisions.

**Young Adults**

Children in their late teens have typically gone in one of two directions: post-secondary education (university, community college, trade school or other) or directly into the workforce after high school. While some children at this age may still look to dad or mom for advice on money matters, they may also rebel against parental guidance. At this stage, more than most, as children gain their independence, having their own financial advisor can be helpful to defray family pressure while keeping them within a financial plan. For the parent, losing this control can be uncomfortable, but a good advisor will treat a young adult as an individual (not as the son or daughter of a client) and can continue the teaching of proper financial management well into the child’s 20s.

Many older teens or young adults will be offered credit cards. Parents or financial advisors can build on the debit-credit discussion from the early teen years by introducing cash-flow budgeting and explaining how a credit card works, interest charges and the importance of not carrying balances month to month. Getting involved early with kids’ credit habits allows you to teach funda-
mentals that can prevent bad credit habits later on: bankruptcy can ruin people’s finances for the rest of their lives.

• For the 20-year-old, whether a student or employed, the discussion can shift to financial goals later in life: will you want to own a car or a home, have a family, travel and so on. It helps to attach prices to goals.

• If children are from a wealthy family or will inherit a large sum someday, a skilled advisor can teach them what it means to have money, the perils of wealth, the complexity of various wealth strategies, and general money management skills.

• After a child reaches 18 it’s possible that a parent’s name will come off any in-trust-for accounts, which means children can take full control of their savings. Whether via a parent or an independent financial advisor, education could now move into asset allocation, investment return, different product types, fees and investment goals.

• For working children in their 20s, goal planning is different from that of the student child: perhaps they will buy a vehicle or home or both in the next five years, and they may be spending their own money for the first time in their life. They are also expected to know how to manage their earnings and, perhaps, a pension plan at their new job, an RRSP or debts from schooling. For people at this young age, long-term goals are often far from their minds. Try to instill balanced thinking with their pay cheque.

Circumstances may force these young people to spend every dollar they earn, but if their level of income permits, encourage them to open several savings accounts and set up automatic transfers from their pay cheque account to these accounts for various amounts. One account may be savings for a car. Another account may be for a home purchase deposit. Another account as an emergency fund. And so on. Get them thinking about how to compartmentalize their money, even if the regular contributions are small in the beginning. Without this coaching, a child may end up getting it backwards—spending most of his or her pay cheque (even when it’s more significant) on lifestyle and then struggling to find money for an RRSP, disability insurance and other important financial goals.

• Similarly, if young working adults have a little money left over for savings, encourage them to open two investment accounts: a Tax Free Savings Account (TFSA), to accrue $5,000 over a few years for emergencies, and a basic RRSP. Hold the TFSA money in a high-interest savings product for easy access. And if possible encourage them to make automated monthly contributions from their chequing account to an RRSP. If their investments have 40 years of compounding time inside an RRSP portfolio, they have a greater likelihood of achieving their retirement goals.

• Finally, it is time for parents to let mid-20s children take control over more of their financial planning. Preparing their own tax return each year is an effective way to teach them about taxes, tax deductions and tax credits. Getting a power of attorney prepared is an introduction to death and estate planning. Having a permanent job introduces the concepts of pension plans, health and dental insurance and even company stock and stock options. At this age your children may still turn to you for advice. Or they may head out on their own to find the answers, armed with the confidence and strong foundation of financial wisdom you have given them over the last 20 years.

Kurt Rosentreter, CA, CFP, CLU is a Senior Financial Advisor with Manulife Securities Incorporated in Toronto. Kurt is an author of seven books on personal finance and a past course instructor with the Toronto Institute of Dental Excellence. Kurt may be reached at 416-628-5761 Ext 230 or at Kurt.Rosentreter@ManulifeSecurities.ca.
HAVE YOU EVER HAD A...

- College Complaint?
- College Investigation?
- Discipline Proceeding?
- Fitness to Practice Hearing?
- HPARB Review?
- Insurance Enquiry?
- Office Employment Issue?
- Hygienist College Inspection?
- Enquiry from Boards of Health?
- Issue with Access to Facilities & Hospital Privileges?
- HARP Inspection?
- Upset Patient?

How would you handle such a situation?

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Choose the Investment Solution That’s Right for You

Smart long-term planning will help you reach your financial goals.

Your financial goals will change as you enter the different stages of your life and career. At each stage, having a financial plan and the right investment solutions will improve your chances of achieving your specified goals.

Investing for Post-Secondary Education

In the early years of raising your family, a registered education savings plan (RESP) can be an excellent choice for post-secondary education savings, since it can offer tax deferrals and government grants. In an RESP you can contribute up to $50,000 per beneficiary and receive up to $7,200 extra for each eligible beneficiary’s education through the Canada Education Savings Grant. (Visit www.canlearn.ca/eng/savings/cesg.shtml for information on how to receive the grant.)

As you become more established in your career, you may decide to explore post-secondary education solutions without any caps on contribution amounts — given the trend toward higher post-secondary tuition costs for programs, including medicine and dentistry. For instance, if you have incorporated your dental practice, you may decide to invest money for your child’s post-secondary education savings through a corporate investment account. If so, at age 18, your child could be paid a dividend, which would be taxable to him or her, at (presumably) a lower marginal tax rate than your own.

With the corporate account strategy, you won’t use your after-tax income (the salary or dividends you receive from the corporation) for education savings. Nevertheless, you may choose to receive a slightly reduced annual salary or dividend (e.g. a reduction equivalent to the annual education plan contribution). Including corporate class funds in the non-registered investment portfolio can provide the tax efficiency of capital gains, irrespective of how the income is earned.

Saving for Retirement

During the early years of your career, a registered retirement savings plan (RRSP) can provide an ideal environment for building your retirement nest egg because tax won’t be payable until you withdraw money from the plan. Plus, your RRSP contribution can also reduce your taxable income each year you contribute.

As your income grows you may require additional investment solutions, since RRSPs have an annual contribution limit (18 percent of the previous year’s earned income to a maximum of $23,820 for the 2013 tax year).

If you operate your dental practice through a professional corporation, the corporation may be able to set up a defined benefit pension plan on your behalf. Depending on your age and other factors, an IPP (individual pension plan) could allow for higher retirement contributions and greater tax savings compared to an RRSP. The corporation would make the contributions to the IPP and receive the tax deductions.

Investing for Short-, Medium- and Long-Term Goals

Two investment vehicles that can allow you to invest for a variety of goals, such as a winter vacation in the near term or retirement many years from now, are a tax-free savings account (TFSA) and a non-registered investment account.

With a TFSA you can invest up to $5,500 annually to help build your retirement nest egg. In 2013, you have contribution room up to $25,500 if you have never contributed to a TFSA previously. The money you contribute to a TFSA...
is not tax deductible, but you won’t pay tax on your investment growth inside a TFSA or your withdrawals. Over a 20-year period of investing $5,000 annually in a TFSA, you could accumulate over $170,000, assuming an average annual rate of return of five percent.

A non-registered investment account does not have any restrictions on how much money you can contribute. However, your investment income could be subject to tax on an annual basis. For tax efficiency, consider including corporate class funds in your non-registered investment portfolio. As mentioned previously, these funds can provide the tax efficiency of capital gains, irrespective of how the income is earned, effectively lowering the taxation rate.

Investing in segregated funds within your personal investment plans can also offer extra security by protecting your investments from claims of creditors when you meet certain conditions. Segregated funds are investment funds provided through insurance companies. They have advantages, including creditor protection, that are not available with mutual funds.

To obtain tax advice specific to your situation, consult your tax advisors. For personalized assistance with your investment goals, contact a certified financial planner at CDSPI Advisory Services Inc. at 1-877-293-9455, ext. 5023.

As your Chair of the Membership Services and Programs Core Committee, I want to update you on some of the current programs available to you.

For student members and those of you in your first five years of practice (licensed with the RCDSO in 2008 or later), it is not too late to consider attending the ODA’s Leadership Initiative. There are two sessions being held — one in Toronto and one in London. For more information, visit the ODA member website.

Over the past year, the ODA has been developing the Health and Safety Highlights to help you better understand your statutory obligations towards workers on a variety of topics. On page 42, in this issue of Ontario Dentist, you’ll find the current Highlight on musculoskeletal disorders. Take time to review it and ensure you are well informed. Additional Highlights, and health and safety resources, can be found in the Health and Safety section of the ODA member website at www.oda.ca/member/healthandsafety. Visit often to ensure you have the most current information available to you.

Our Continuing Education Program continues to build. Visit the Continuing Education section of the ODA member website to learn about the current programs being offered or to take advantage of the recorded ODA Category 1 (Core) Webinars now available to you.

Did you know the ODA offers a special membership rate for dental students attending school outside of Ontario? At only $69, this membership program provides out-of-province students with full access to the ODA member website, free attendance at the ASM, a subscription to Ontario Dentist, and more. Spread the word — ensure that all students have access to the Ontario Dental Association. For more information, please email rzisko@oda.ca or visit the ODA member website.
The ODA extends a warm welcome to the following new members:

Dr. Maxwell Abraham, Leamington
Dr. Eman Ahmed-Muhisn, Ottawa
Dr. Rand Saaf Al-Hufidh, Mississauga
Dr. Mohamed Al-Janabi, Hamilton
Dr. Mina Al-Mosawi, Mississauga
Dr. Tarig T. R. Absalou, Pickering
Dr. Nyresa C. Alves, Toronto
Dr. Gurvinder Kaur Aulakh, Brampton
Dr. Santino Roberto Bambara, Niagara Falls
Dr. Neeraj Bansal, Ottawa
Dr. Sabrina Bedi, Whitby
Dr. Marianne Bourji, Ottawa
Dr. Patricia Joyce Brooks, London
Dr. Rita Calotti, Richmond Hill
Dr. Antoine Chammas, Rosemere
Dr. Henna Chowdhry, Brampton
Dr. Matthew Chuk, Markham
Dr. Sandeep Dab, Toronto
Dr. Joel M. Davis, Toronto
Dr. Kerry Mark D’Costa, Mississauga
Dr. Lovneen K. Dhaliwal, Ancaster
Dr. Amandeep Dosanjh, Markham
Dr. Tommy Chi-On Fok, Pickering
Dr. Yoo Ge, London
Dr. Nivine Ghobrial, Mississauga
Dr. Katarzyna Grella, Toronto
Dr. Shawn Mitchell Grayeski, Thornhill
Dr. Noelle Lundby Hansen, Ottawa
Dr. Omar Hassani, Fenwick
Dr. Halyra Hrynasch, Toronto
Dr. Lawrence Hung, Toronto
Dr. Munazzah Hussain, Toronto
Dr. Tsz Wai Gavin Ip, Markham
Dr. Richard Jackson, Toronto
Dr. Sunita Kadam, Langley
Dr. Deepika Khanna, Mississauga
Dr. Alysson Marie Kohlmeier, Sarnia
Dr. Michael Le, Toronto
Dr. Jacqueylyn Elizabeth Levangie, London
Dr. Justin Joseph Lyn, Willowdale
Dr. Ahmed Marei, London
Dr. Sherri Mathew, London
Dr. Robert Paul Masayuki Matsu, Thornhill
Dr. Mahsa Mehrabzadeh, North York
Dr. Nazek Mohammed, Milton
Dr. Paul Nuevo John Mohan, Toronto
Dr. Ellie Moore, Mississauga
Dr. Maria Valentina Morales Rollinson, Toronto
Dr. Sivashash Nosh, Toronto
Dr. Neda Najad Kazem, Burlington
Dr. Halston A. Nepinak, Oakville
Dr. Ritika Nigam, Toronto
Dr. Stephanie Marie Nigro, Thunder Bay
Dr. Hedyeh Norsen, Toronto
Dr. Ouliana Ogulienko, Toronto
Dr. Sailesh Ram Pershad, Ottawa
Dr. Daniya Pervaiz, Mississauga
Dr. Amanpreet Ranu, Brampton
Dr. Koja Rezania, Toronto
Dr. Sahar Rodfar, Richmond Hill
Dr. Radovan Rudik, Brampton
Dr. Navneet Kaur Saini, Etobicoke
Dr. Niloufar Sajadian, Toronto
Dr. Raminder Sandhu, Mississauga
Dr. Rasha Shaiyk, Toronto
Dr. Shaun K. Sharma, Richmond Hill
Dr. Han Jen Shih, Mississauga
Dr. Sukhraaj Kaur Shinger, Kitchener
Dr. Mohamed Ovais Sultan, Markham
Dr. Muhammad Muzammil Khan Tareen, Windsor
Dr. Tsz Wai Gavin Ip, Oakville
Dr. Kelvin Tay, Toronto
Dr. Deanna Kathleen Vertesi, London
Dr. Jeremy Tyler Wageman, Oshawa
Dr. Gregory Burgess Walsh, Toronto
Dr. David J. Wilson, Thunder Bay
Dr. Michael Yang, Richmond Hill
Dr. William C. W. Yue, Toronto

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nspection blitzes are periodically undertaken by the Ministry of Labour to raise awareness and increase compliance with Ontario’s Occupational Health and Safety Act and the associated regulations. To ensure that members have full understanding of the Ministry’s expectations during inspections, the ODA has introduced Highlights, documents that outline your statutory obligations as an employer towards workers in key areas.

In 2013-14, the Ministry of Labour will be visiting health-care workplaces with respect to:
- Musculoskeletal Disorders (September to October, 2013)
- Recycling and Waste Management (November to December, 2013)

The ODA Highlights are released the month before each inspection blitz. They are posted on the ODA member website and reprinted in select issues of Ontario Dentist. Highlights on the following topics have already been released:
- Infection Prevention & Control
- Workplace Violence & Harassment
- New & Young Workers

This issue, we are pleased to present the Highlight on Musculoskeletal Disorders. For more information, please contact David Gentili, ODA Health Policy Specialist, at 416-922-3900 ext. 2600 or dgentili@oda.ca or visit www.oda.ca/member/healthandsafety.

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attention all ODA members

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.
In September and October 2013, the Ministry of Labour (the Ministry) will be visiting health-care workplaces with respect to Musculoskeletal Disorders (MSDs).

Employers should have measures and procedures in place for the protection of workers from MSDs.

This HIGHLIGHT has been prepared to help dentists better understand their statutory obligations towards their workers with respect to MSDs.

An MSD is an injury, illness or other disorder of the musculoskeletal system — which includes muscles, tendons, nerves and spinal discs — caused by chronic or sudden exposure to work activities that exceed the capacity of musculoskeletal structures. MSD is not a clinical diagnosis; it is an “umbrella” term used to categorize numerous conditions that share similar risk factors. Dealing with a MSD after an injury is difficult. Proactive measures that avoid injury are the best course of action.

Across all workplaces, Ministry inspectors will be checking for:
• employer consultation with the Health and Safety Representative or Joint Health and Safety Committee with respect to MSD measures and procedures
• training and instruction of workers on MSD risks and prevention practices

In health-care workplaces, Ministry inspectors will also be specifically looking for measures and procedures with respect to:
• patient lifting, repositioning and transferring
• item lifting, lowering, pushing, pulling and carrying

Through this blitz, the Ministry aims to:
• raise awareness of MSD hazards
• promote safe handling of workplace items and equipment (e.g. oral evacuators)
• encourage employers to identify and control MSD hazards
• deter non-compliant employers
• enhance health and safety partnerships
• address and remedy non-compliance with the OHSA and its regulations

Did you know ...?
• MSDs are the most prevalent injury among health-care workers, accounting for nearly half of Lost Time Claims in 2011.
• Dentists and other members of the dental team are at risk for developing MSDs.
• During the 2012 MSD blitz, inspectors visited 1,718 workplaces and issued 4,869 orders — including 303 stop-work orders — in health-care workplaces.

Ministry Inspections
MINISTRY INSPECTORS have the authority to enter any workplace without warrant or notice. Inspectors may issue orders that employers are required to comply with.

INSPECTION BLITZES are periodically undertaken by the Ministry to raise awareness and increase compliance with the Occupational Health and Safety Act (OHSA).

RANDOM INSPECTIONS of workplaces — including dental offices — may take place at any time.

For information regarding the Ministry of Labour’s Enforcement Strategy, visit: www.labour.gov.on.ca/english/hs/sawo/.

Additional Resources

ODA MSD Awareness & Prevention: A Guide for Dental Practices
This manual provides information about MSD signs, symptoms and risk factors, tips on MSD controls that can be implemented in the dental office, and tools to help implement a MSD-prevention program in the dental office.

Download a copy of this valuable resource from the member website at www.oda.ca/member/healthandsafety or order a hard copy through the ODA Call Centre at 416-922-3900 (1-800-387-1393).

Ministry of Labour Client Handling & Musculoskeletal Disorders in the Health Care Sector
www.labour.gov.on.ca/english/hs/pubs/clienthandling.php

Ministry of Labour MSD Prevention Series
www.labour.gov.on.ca/english/hs/topics/pains.php

Sources:
• Ministry of Labour (2013). Musculoskeletal Disorders (MSD) Blitz.
• Ministry of Labour (2012). Blitz Results: Musculoskeletal Disorders.

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QUESTIONS? Contact the ODA at 416-922-3900 or member@oda.ca or visit www.oda.ca/member/healthandsafety
The ODA and CDSPI are excited to bring back the successful Leadership Initiative. Since 2010, more than 200 dental students, who are also ODA members, have gained valuable training and insight on an array of topics. With their membership in the ODA, students can also build their leadership skills through one of the many ODA volunteer opportunities.

This year, we are expanding the ODA Leadership Initiative to include members who are in their first five years in practice and dental students in years one to four. The Initiative is designed to identify and cultivate a new generation of dentists to become leaders in their practice and communities. The day will focus on topics such as:

- Public Speaking and Media Training
- Understanding Community Newspapers
- Meeting Do’s and Don’ts
- Etiquette for Professionals
- Presenting Your Public Self

The full-day workshop(s) will be held in the fall on Saturday, October 26, 2013, in London, Ont., and on Saturday, November 30, 2013, in Toronto on a first-come, first-served basis with limited spots available.

For more information on how to register, please visit the member website at www.youroralhealth.ca/member.
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Mention Code Ad Ontario 13
On June 24, 2013, Dr. Rick Caldwell, ODA President (2013-14), along with ODA staff members, enjoyed a day on the links in the company of Tim Hudak, MPP for Niagara West-Glanbrook and Leader of the Progressive Conservative Party of Ontario, and Steve Clark, MPP for Leeds-Grenville.

Events such as golf days with MPPs help to get the ODA’s message out to important decision-makers in an informal setting. Mr. Steve Clark’s Bill 70, Regulated Health Professions Amendment Act (Spousal Exception) is currently in the second reading committee stage and we hope all three parties of the Ontario Legislature can work together for timely passage of this important piece of legislation.

If you have an event that you would like featured in Ontario Dentist, please email Julia at jkuipers@oda.ca.
On July 14, the heat and humidity was oppressive, the sunlight blinding (or was that our yellow shirts?) and the lake had swells that reached almost half a foot. Despite the inherent dangers of water dark and deep (about three feet) the brave band of dental professionals did not hesitate to venture forth. While competitors capsized and rammed us, we paddled to victory – well, only to third place in Division B of the International Dragon Boats for a Cure, but we still got shiny medals! The Essex County Dental Society “Wisdom Teats” bonded together as any team would under great adversity.

We raised almost $7,000 towards the treatment of breast cancer in the Windsor-Essex County area. Now that is a true victory!

Our paddlers included Dr. Domenic Paonessa, Dr. Beata Pecko, Dr. Lara Soulliere, Dr. Christine Brady, Dr. Gary Mannarino, Dr. Angelo Sorge, Dr. Huy Nguyen, Dr. Katherine Berthiaume, John Sementilli, Fran Sementilli, Anthony DiPonio, Sharon Andersen, Joelle Carroccia, Ashley Doe, Renne Chicro, David Heeney, Lee Laliberte, Dunya Bati, Christina Papasodaro, Christine Kawaclare, Diane Zakaria and Dr. Jennifer Valente.

Special thanks to Carl Bernat from Henry Schein, and Shane Sebestyen from Quantum Dental Laboratories for our team shirts and hats.

**NHI is an accredited Agency that provides temporary and permanent 24/7 staffing for the following categories:**

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Throughout the membership year, the ODA publishes videos featuring the President delivering important messages on issues that are valuable to ODA members. In the latest video, Dr. Rick Caldwell discusses the newest benefit offered to members — ODA Signature Select.

The videos are posted on the member website. To access these videos, visit the President’s Message page on the site.

To play a video, simply click in the middle of the video. You can also easily pause and resume the videos.

Videos from the Past President are also available on the Immediate Past President’s Page.

Send your questions and suggestions regarding the member website to webmaster@oda.ca. We look forward to answering any questions you may have in the next issue of Ontario Dentist.
Dentists are Delighted!

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Dentists who switch to CDSPi Home & Auto Insurance are very happy with their choice! In fact, 99 per cent1 of them decide to renew their coverage.

As well, about half2 of all dentists who obtain a quote for this coverage purchase it. That’s because CDSPi Home & Auto Insurance offers preferred group rates — exclusively for dentists and others in the Canadian dental community.

Thanks to these great rates, you too may enjoy significant savings3, just like these dentists:

• Dr. Richard Thain of Embrun, Ontario pocketed $262 in auto insurance savings!
• Dr. Randy Ryan of Springhill, Nova Scotia is paying approximately $400 less annually to insure his home!
• Dr. Greg Austin of St. Albert, Alberta saved over $1,000 by switching his home and auto coverage!

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Go to www.cdspi.com/savings or call 1-877-293-9455, ext. 5002 to arrange for a quote for CDSPi Home & Auto Insurance, or provide the expiry date(s) of your current home and/or auto policy. You’ll be automatically entered into the prize draws for a chance to win4 a $1,000 cash prize! With three draws during 2013, enter soon for a chance to win 1 of 3 cash prizes.

1 Source: Retention Report, September, 2012.
3 The amount of savings, if any, will depend on individual circumstances.
4 Contest is sponsored by CDSPi. Contest closes on November 15, 2013. Entry and participation is at all times subject to the complete contest rules. Eligibility requirements, terms and conditions do apply. No purchase is necessary. Residents of Quebec are not eligible. Visit www.cdspi.com/more-info for complete contest rules.
CDSPi Home & Auto Insurance is underwritten by The Personal Insurance Company and distributed by CDSPi Advisory Services Inc. This auto insurance is not available to residents of Manitoba, Saskatchewan and British Columbia and this home and auto insurance is not available to residents of Quebec.
ODA CONTINUING EDUCATION SEMINAR

Transitioning Out of Your Practice Seminar (Ottawa)
Friday, November 1, 2013 8:15 a.m.-4:00 p.m.

Registration: Open as of September 2
Novotel Ottawa, 33 Nicholas Street, Ottawa, Ont.

This seminar has been designed for those who are looking to transition out of their dental practice in preparation for a successful retirement. Whether you are two years or 15 years away from selling your practice, this seminar is for you. Learn from and interact with a panel of recognized experts offering advice on how to prepare for financial independence. Our experts will guide you through the process of successfully transitioning out of your practice.

By the end of this seminar you will be able to:
• Confidently prepare for financial independence
• Determine your readiness to sell your practice
• Analyze current market conditions and identify future predictors
• Identify key practice value drivers
• Identify strategies to maximize your after-tax gain
• Understand how to avoid legal pitfalls and costly traps
• Assess your options for transitioning out of your practice
• Learn how to develop and execute a transition plan

Speakers
Mark McNulty, Certified Financial Planner (CFP), Canadian Investment Manager (CIM)
David Rosenthal, Business, Corporate and Health-care Lawyer
David Chong Yen, Chartered Accountant and Tax Specialist
Bill Henderson and Dr. Bernie Dolansky, Practice Valuation and Transition Specialists

For more information, please contact Shaila Karim,
ODA Education Program Specialist, at skarim@oda.ca.

Support for the ODA Practice Management Seminar Series is provided by www.scotiabank.com

Get Expert Advice to Navigate the Early Years of Practice

There are many important things to learn when you’re starting out in your career. If you live or work in the Greater Toronto Area, you have a unique opportunity to obtain answers to your top-of-mind questions and earn CE credits.*

A panel of experts in dentistry, employment law, business law, tax, practice management, financial planning, insurance and health and wellness will outline the key things that can help in your early years of practice and provide answers to questions, such as the following:
• How do I choose an associateship that gives me the right clinical experience for my career goals?
• What should I look for when evaluating a dental practice for purchase?
• How do I manage human resources issues in the dental office proactively?
• Can I pay down my debts and invest at the same time?
• What are the tax advantages of incorporating?
• How can I protect my income?
• What are some helpful strategies for achieving work-life balance?

Speakers at the event will include Dr. Lisa Bentley, Chair of the Economic Core Committee for the ODA and Executive Director of the Halton/Peel Dental Association, Mariana Bracic of MBC Legal, Andrea Chan of MNP LLP, David Rosenthal of Spiegel Rosenthal Professional Corporation and David Seagrave of Shepell•fgi.

There’s no cost to you for this exclusive evening which includes cocktails and hors d’oeuvre. Register today at www.cdspi.com/whatsnext or call 1-877-293-9455 or 416-296-9455, ext. 6792. Space is limited.

*The program is eligible for two credits in Category 3 for Ontario dentists who attend.

MOTIVATIONAL INTERVIEWING WORKSHOP

Applied Motivational Interviewing for Health Practitioners, Level 2, November 22, 2013
Pantages Hotel, Toronto, Ont.

Visit www.monarchsystem.com for more specific workshop information about The Monarch System Inc.

Dr. Jen Irwin and Dr. Don Morrow have facilitated Motivational Interviewing (MI) workshops and done MI presentations to local dental groups, clinics across Canada, and internationally to oral health conferences and societies in Athens, Dublin, Cork, and Melbourne, Australia.

They may be contacted at info@monarchsystem.com.

Who Should Attend:
Dental and oral health professionals and their staff, and any allied health-care professionals.

For Details and Registration:
http://monarchlevel2nov2013.eventbrite.com (Level 2)
Members in the Media

ODA Members Are Reaching Out

Would you know what to do if the media called you?

Bonnie Dean

ODA Past President Dr. Lynn Tomkins was featured in a report on Global’s News Hour Toronto about “bedroom dentists,” in reaction to the case of David Wu, accused of practising dentistry illegally in Burnaby, B.C. In the piece, which aired on August 20, Dr. Tomkins urged patients to have a conversation with their dentist if costs are an issue. “There are always options,” she said. “There are treatment options and there are payment options. Dentists are sensitive to the needs of patients.”

Dr. Shahrooz Yazdani offered a day of free dental work at her Yazdani Family Dentistry practice in Kemptville, in September (“Free Dental Clinic Planned for Kemptville”, Ottawa Citizen, August 24).


The Londoner reported on the actions of a group of dentists known as London Dental Community Cares, which provided resources to help restore a 137-year-old building in London, Ont., owned by the Unity Project for the Relief of Homelessness and used as a shelter. (“A Decade of Unity to Fight Homelessness,” August 22).

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

What to do if the media calls you?

Although it is our policy to have the President, Vice-President or Past President act as the spokesperson for the ODA on all issues, there are times when the press would like a local perspective and may give you a call. If you receive a media request, we’d like to help. We can provide insight and guidance to help you prepare.

When the media calls you, just call us! Contact Courtney Sorger, Manager, Public Affairs and Communications, at 416-355-2275, or toll-free at 1-866-739-8099, ext. 2275. You may also reach her at csorger@oda.ca.
The ODA regrets to announce the passing of:

Dr. Gordon Stanley Bowles, on July 8, 2013, at age 84. Dr. Bowles graduated from University of Toronto’s Faculty of Dentistry in 1955 and shortly afterwards opened his general practice in Thunder Bay, where he practised until his retirement in 2001. He belonged to the Thunder Bay Dental Association and became a 50-Year Member of the ODA in 2005. Dr. Bowles is survived by his wife, Iris, and children Jane and Donald.

Dr. Robert (Bob) James Nicol, on July 30, 2013, at age 69. After graduating from the University of Toronto in 1968, Dr. Nicol opened his Niagara Falls practice and served the community as a general practitioner for 42 years. He was a member of the Niagara Peninsula Dental Association and earned his ODA 35-Year Member pin in 2003. Dr. Nicol is survived by his wife, Licia, and children Bobby, Richard and Sara.

Dr. Edward John Iwasiw, on August 7, 2013, at age 69. Dr. Iwasiw graduated from McGill University’s Faculty of Dentistry in 1969 and, that same year, opened a general practice in Windsor, where he practised until his death. He was an ODA member for 24 years and belonged to the Essex County Dental Society. Dr. Iwasiw is survived by his wife, Jessie, and children Greg and Amanda.

Dr. Grant Charles Lee passed away suddenly but peacefully in his sleep on July 9, 2013, at age 64. He was in Budapest, Hungary, with his wife to attend their daughter’s graduation. Grant was a graduate of the University of Western Ontario (DDS ‘74) and operated the Clinton Dental Clinic for nearly 30 years. Grant’s first venture into dentistry, however, saw him swinging a hammer to build an office in Zurich, Ont. He later sold the Zurich practice after acquiring the Clinton office from the late Dr. Don Palmer.

Grant was known throughout the local community as a kind and gentle dentist. He volunteered his time and resources towards programs such as the Child Identification Program and the Huron Healthy Smiles Program (for people unable to afford dental care), and he created sports guards for local athletes. He was known more widely as an active member of the UWO Dental Alumni Society and consistently encouraged new alumni to consider practising rural dentistry. He truly valued the relationships he built with patients and co-workers.

Grant’s enthusiasm for dentistry inspired his daughters, Dr. Veronica Lee (UWO ‘07) and Dr. Melinda Lee (Semmelweis ‘13), to follow the same profession, and they will continue his legacy at the family practice.

He lived and died in the bosom of his family. He leaves behind his loving wife and best friend, Nancy Lee, (nee Haldenby). He is survived by his daughter Veronica and son-in-law Jay McFarlan; his daughter Melinda and her partner Selam Kaddory, and his son Ethan and daughter-in-law Rita Jaroka. Papa of Dashel, Sullivan and Beckett. He is remembered by his twin sister, Lynda Lee, of Guelph; brother Dale Lee (and Ellie) of Brantford, and sister Karen Smith (and Paul) of Caledonia, IL. A celebration of his life was held on August 1, 2013, in Clinton where patients and friends came to share their stories and memories.

The family has created a memorial fund in Grant’s name that will be used to assist local minor sports — something Grant was passionate about. For more information about the fund or how to donate, visit www.GrantLeeMemorialFund.com.

— Dr. Veronica Lee
Dr. Donald Woodside died on July 19 at his family cottage in Nova Scotia, surrounded by his family. Dr. Woodside received his DDS from Dalhousie University, where he was awarded the Gold Medal in Dentistry, and he received his MSc in Orthodontics from University of Toronto. From 1962 to 1993, he was professor and head of the discipline of orthodontics, Faculty of Dentistry, University of Toronto.

His published work ranged through the areas of both human and experimental mandibular growth and the clinical use of functional appliances. He was the 1987 co-recipient of the S.I.D.O. Award for the most outstanding article in international orthodontic literature during the previous two years.

Dr. Woodside received many international awards in orthodontics and was invited to lecture throughout the world. He was the Mershon and Salzmann honorary lecturer for the American Association of Orthodontics. In 1989, he received an honorary doctorate from the Karolinska Institute in Sweden, and in 1990, he received the Ketcham Award from the American Association of Orthodontists. In 1991, he was the Sheldon Friel Memorial Lecturer for the European Orthodontic Congress. In 1994, he received a Fellowship in Dental Surgery-by-Election from the Faculty of Dental Surgery, Royal College of Surgeons of England. He also received the Canadian Dental Association Distinguished Service Award.

In 2005, Dr. Woodside was awarded a Fellowship in Dental Surgery ad hominem of the Royal College of Surgeons of Edinburgh, as part of the 500th Anniversary Celebrations of the founding of the College. Dr. Woodside was also elected to Honorary Membership in the World Federation of Orthodontists during its meeting in Paris in September 2005.

Dr. Woodside was a Fellow in the Royal College of Dentists of Canada, a Diplomate of the American Board of Orthodontics and a Fellow in the American College of Dentists. He was also an honorary member of the Italian Orthodontic Society, the British Society for the Study of Orthodontics, the South African Society of Orthodontists, the Taiwan Association of Orthodontists and the Ontario Association of Orthodontists. In 1996 he was named a Member of the Order of Canada, which is the highest civilian honour awarded by the Government of Canada. In 2003 he was awarded the Queen’s Jubilee Medal.

In addition to his research and teaching Dr. Woodside maintained a private orthodontic practice in Toronto until recently.

— Dr. Daniel Haas,
Dean, University of Toronto’s Faculty of Dentistry
The wing of his plane was damaged when 19-year-old Tony Parnell made an emergency landing on the shores of Nazi-occupied France. Captured, he would spend the next three years as a prisoner of war. But he survived, making himself indispensable as the assistant to the camp dentist.

The ordeal proved the unlikely beginning of a life dedicated to dentistry — a life that ended on July 7, in Lucan, Ont., when Dr. Tony Parnell died at the age of 90.

Born in London, England, he moved with his family to Croydon. It was there that he discovered his love of flight. There was an airport there and he became interested in planes. When the Second World War started, Tony enlisted — but was turned away because he was only 17. Undeterred, he came back and was accepted into the Royal Air Force.

He flew reconnaissance and espionage missions during the early part of the war. But in March of 1942, he was captured by the Nazis and taken to a war camp. The camp dentist needed an assistant. Tony volunteered even though he had no dental training or background whatsoever.

He was freed at the end of the war and subsequently enrolled at the Royal College of Dentistry, where he finished at the top of his class.

In 1962 he immigrated to Canada and worked at the University of Manitoba. At this time Western was opening its own dental school. In 1967, the Dean recruited Dr. Parnell to be the founding chair of the department of oral surgery. “He did an absolutely superlative job as what I would call one of the builders of our school,” recalled former Dean Wes Dunn.

He also took on work at St Joseph’s Hospital, where he was the chief of the dental department until he retired.

Dr. Parnell is survived by his wife of 26 years, Kate, three children, two step-children and several grandchildren.

— Reprinted from the London Free Press.
ASSOCIATES WANTED

Associate dentist wanted with own patient base for North York practice. Please send resume. Email: shtepadental@gmail.com

Burlington, Ont. Part-time Associate Needed
Energetic, personable, excellent communication skills required. Extended hours. Well-known, progressive, newer, bright office with latest equipment. Please send resume and cover letter. Email: emergis.consulting@gmail.com

Dentist position available, part-time leading to full-time, in well-established East Ottawa practice. All aspects of dentistry, including orthodontics. Bilingualism in English and French is an asset. This is an excellent opportunity for a skilled and experienced dentist to join our progressive team. Serious inquiries only. Email: serenitydental7@gmail.com

Associate Opportunity
A progressive office in south Etobicoke is looking for an associate dentist with his or her own patient base. New, fully equipped office, experienced staff, centrally located modern facility with extra space available to accommodate a specialist. Serious inquiries only. Email: info@sherwaydentalcentre.com

Northern Ontario Associate Opportunity
Looking for a lifestyle that is both financially and professionally rewarding? Would you like to take home between $250-$350K/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, Email: dental@toppenn.com or Phone: 613-291-4565
Aurora, Ont.
Part-time associate needed for busy family practice. Looking for motivated, caring individual who is a team player with good communication skills and a comprehensive-dentistry approach. Please email your resumé to: dentalhealthaurora@gmail.com

Finch and Warden, Toronto
Dental associate required to take over for previous associate of five years. Well-established, busy practice. Chinese-speaking preferred. Please send resumé. Email: crystal@crystal28@gmail.com

Tillsonburg, Ont.
Associate opportunity available in a well-established dental practice. Looking for motivated, well-established dental practice. No evenings or weekends. We offer a full range of dentistry. Long-term commitment and some experience required. Please email or fax resumé. Email: rashigrover@yahoo.com Fax: 905-768-1515 Website: www.dental-arts.ca

Oakville, Ont.
Experienced dental associate required for a well-established and prestigious family practice. We offer the latest technology and all aspects of dentistry. Flexible schedule including some evening and Saturday hours. Seeking a positive, energetic individual with excellent clinical and communication skills who is eager to join our progressively growing team. Email: oakvillesmiles@hotmail.com

Dental Associate Needed
We are a multidisciplinary medical practice located in Richmond Hill looking for a dentist-physician partnership to offer medical and dental services to our communities. Please inquire with Dr. Vukiet Tran. Phone: 647-688-2907 Email: vukiet.tran@rogers.com

Ottawa, Ont.
Do you want to be an associate with the opportunity to become a partner? If yes, we are looking for people-oriented dentists seeking to associate, with the opportunity to become a partner. Phone: 613-526-3535 Fax resumé to: 613-526-1515

Calgary, Alta.
Part-time associate needed for busy dental practice in Calgary. Please send C.V. Email: ppb@platinum.ca

Russian-Speaking Dental Associate Needed
Three to four days a week in our modern dental office in Vaughan. Excellent opportunity with chance of full-time position. Please fax or email resumé. Fax: 905-832-8183 Email: nortondent@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: luceboeuf291@hotmail.com Phone Carole at: 450-370-7131

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Busy, growing Toronto dental office is looking for the following providers to join its team:
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Please contact Janice. Phone: 416-248-0045 Email: kiplingdixondental@gmail.com

Ottawa, Ont.
Part-time associate wanted for highly established, busy practice. Advancement to full-time. This is an excellent opportunity to work with a great team that provides exceptional, comprehensive patient care. Please email cover letter, resumé and references. Email: smiledr@magma.ca

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Protect your practice and take more time off with confidence. Professional, productive, caring, skillful, excellent communicator. Very experienced in both private practice and locum services. Excellent references with excellent patient feedback. Please contact Dr. Jonathan Palter. Phone: 416-602-2434 Email: jpalter@rogers.com

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Zeiss Opmi Pico with mobile pedestal base. Excellent condition. Infrequently used. $10,000. Eastern Ontario. Email: jgordon51@gmail.com

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**Additional words:** ______________________

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- ODA Member (basic word count): . . . . $35/50 words
- Non-member (basic word count): . . . . $75/25 words
- Additional words: . . . . . . . . . . . . . . . . . . . . . . . . . $8/10 words
- Shading . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . $20
- Marketplace: . . . . . . . . . . . . . . . . . . . . . . . . . . . $250

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**Ad Text:** __________________________________________________________________

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**Phone:** __________________________________________________________________

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**(FOR ADMINISTRATIVE PURPOSES ONLY)**

- **ODA Member**
- **Non-member**

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**Name:** ______________________

**Phone Number:** ______________________

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### COST:

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**Sub-total:** $ ______________________

**HST (13%):** $ ______________________

**TOTAL:** $ ______________________

**HST # R108090945**

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- **cheque enclosed or sent**
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**Name on Card:** ______________________

**Credit Card #:** ______________________

**Expiry Date:** ______________________

**Signature:** ______________________

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**To submit a classified ad or for any questions, please contact:**

Catherine Solmes  
416-922-3900 ext. 3305 | Toll Free 1-800-387-1393 ext. 3305  
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For information regarding ads with graphics, please contact Catherine.

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**Note:** The ODA is not responsible for spelling mistakes. Classified ads may be edited & condensed to conform to Ontario Dentist Style.

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Thursday, November 14th

Thompson Landry Gallery, Distillery District, Toronto, ON

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6:00 Speakers

8:30 Networking Reception

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