CDA essentials
The Canadian Dental Association Magazine

National Oral Health Action Plan
Harnessing Diversity in Thinking
Page 10
CASE STUDY 2

Helping patients take ownership.

ISSUE
Poor patient self-management of oral hygiene jeopardizes a quality end result.

SOLUTION
Through the Crest Oral-B program, every patient is graded on their hygiene at every appointment as soon as an operator does their initial intra-oral survey. Young patients are especially interested in their scores and are encouraged to grade themselves at home on a daily basis. We quantify developing hygiene problems and alert parents and dentists when attention is needed. Patients finish with beautiful tissues at the end of the treatment. Parents are assured that we are focused on oral health and not just simply straight teeth.

RESULTS
Fewer patients have decalcified markings and those who do, are detected and informed sooner. The bonus is that my practice also has better compliance with risk management protocol.

Find out how our programs are paying off for other practices at www.HealthyPracticeNow.ca
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125% increase in case acceptance.

**ISSUE**
Many of my patients with unhealthy gum tissue required additional appointments which were often painful and stressful.

**SOLUTION**
The Crest Oral-B system helped personalize care and let patients visualize and understand the risks associated with their poor oral health. The tools helped me motivate my patients to book the appointments they need, keep the appointments they book and maintain proper care at home.

**RESULTS**
Our case acceptance has increased from 40% to 90%, doubling the size of the perio program.

Dr. Anna Lubanski  
BSc, DDS  
Dr. Anna Lubanski has not been compensated to appear in this ad.

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CASE STUDY
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BEGINNINGS

In this launch edition of *CDA Essentials*, it is a pleasure to be writing about two exciting CDA initiatives. On February 27, CDA hosted the first National Oral Health Action Plan Symposium, focusing on the issue of disparities in oral health care in Canada (see page 10). The second initiative is *CDA Essentials* magazine, conceived as a new way to provide dialogue between CDA and the national dental community.

To briefly recap the National Oral Health Action Plan Symposium, the day began with three presentations: Dr. Peter Cooney, Canada’s Chief Dental Officer, examined the need for a collaborative approach to delivering oral health care to vulnerable groups; Dr. Louise Desjardins presented her discussion document providing an overview of oral health care in Canada; and Mr. Bill Tholl, a senior health policy consultant, reported the findings of his consultations with stakeholders, which solicited opinions on oral health care through a questionnaire and face-to-face interviews. The presentations were followed by a series of discussions on the oral health status of Canadians, facilitated by Mr. Sean Moore, a public policy and advocacy advisor. After identifying groups with an increased risk for oral disease, participants explored possible areas of collaboration.

The ultimate aim of the symposium was to initiate the discussions that would lead to the development of concrete actions to promote oral health, prevent oral disease and improve access to care for Canadians most in need. On many levels, the symposium was a success. It represented the culmination of a year of planning and the beginning of a much longer process to sustain the conversations started at the symposium. It was an opportunity for CDA to engage stakeholders outside the oral health care family in a discussion about inequities in oral health care and identified priority areas for future collaboration.

Yet, in my opinion, the symposium’s most remarkable achievement is the diversity of voices it brought to the discussions. Organizations that participated at the symposium represented oral health care providers and other health professionals, academia, regulators, government and special interest groups—each with their own unique perspective on the challenges in Canadian oral health care. And it’s this diversity in thinking that will be crucial to any future progress on this issue. Now that my term as president is coming to an end, I am pleased that CDA remains committed to its role in facilitating the development of a national oral health care strategy.

Another first—the inaugural issue of *CDA Essentials*—is a milestone in CDA’s new communication strategy. As the new official print publication of CDA, *CDA Essentials* is dedicated to keeping dentists informed about news, issues and clinically relevant information. The print *JCDA* rightfully earned its place as a respected, peer-reviewed journal that focused on the science and practise of dentistry for almost 80 years. *JCDA* will continue to fulfill this role but will now be solely available online at jcda.ca.

I hope your first read of *CDA Essentials* is informative and engaging, and that you find it to be an essential connection to this wonderful profession.

Peter Doig, dmd

president@cda-adc.ca
About 16% of Canadians—more than 5 million people—reported in the 2007–09 Canadian Health Measure Survey that they have poor oral health. While the issue of having a significant underserved segment of the population may not be new, it remains a glaring omission. With the historic February 27th event, CDA opened the door to teaming up with all parties for a truly patient-focused conversation on the access to care issue.

The symposium brought together representatives from a wide variety of organizations: oral health care providers, academia, government, other health professions and special interest groups. It allowed for an overview of both the nature and extent of the country’s oral health challenges, and for discussing the work that lies ahead to ensure appropriate care for all Canadians.

“Attendees agreed that we need to develop a scientifically supported strategic plan to address challenges in oral health promotion and delivery,” explains Dr. Peter Doig, CDA president. “While the development of such an action plan is too big a mouthful to chew at once, we can set the wheel in motion by taking a bite-size approach using collaborative solutions.”

Collaboration is the cornerstone of this CDA initiative—the oral health action plan must be a comprehensive framework that highlights the different roles relevant stakeholders can play. As such, the symposium provided participants with an opportunity to discuss their current priority programs, and ultimately to explore avenues for future collaborations and further actions.

Dr. Peter Cooney, Canada’s Chief Dental Officer, underscored the crucial role of collaboration during his presentation on projects implemented in the past—some very successful, others not so much. “If we work together, we can achieve a lot. And if we don’t work together, things don’t happen at all,” summarized Dr. Cooney.

Working Together to IMPROVE CANADA’S ORAL HEALTH

On February 27, 2014, CDA hosted the National Oral Health Action Plan Symposium in Ottawa, a significant first step in opening a dialogue about oral health care inequities in Canada.
Willingness to work together

Participants on February 27 agreed that a realistic and reasonable approach to tackling the access to care issue would be to develop targeted, step-by-step initiatives and programs. The vulnerable and underserviced groups and subgroups of the Canadian population often face unique, ongoing challenges—hence the importance of implementing patient-focused measures. As some attendees mentioned, a one-size-fits-all solution does not exist, and a quick fix would only work temporarily. Stakeholders must commit to participate in a sustained, concerted strategy for this initiative to be successful.

Many also stressed the importance of being proactive rather than reactive, highlighting the need for oral health promotion initiatives and preventive programs, and the necessity to “put the mouth back in the body” in the health care dialogue.

Participants agreed that the symposium was a success and an important milestone on the path toward optimal oral health for all Canadians. This bridge-building exercise allowed for an open, fruitful dialogue between organizations that had not had the opportunity to collaborate before.

“We refused to believe it was impossible to bring together such a diverse group to have a thoughtful discussion and join forces,” Dr. Doig told the group to conclude the meeting. “The fact that you’re here today proves that we have people from diverse backgrounds and multiple professions who are willing to come together and discuss the importance of addressing the access to dental care issue.”

Speaking in Unison

Representatives from the following organizations were invited to meet on February 27 to discuss access to oral health care:

- Provincial and territorial dental associations
- Canadian Dental Hygienists Association
- Canadian Dental Assistants Association
- Denturist Association of Canada
- Canadian Medical Association
- Canadian Pharmacists Association
- Canadian Nurses Association
- Canadian Association of Retired Persons
- Canadian Dental Regulatory Authorities Federation
- Canadian Dental Specialties Association
- Association of Canadian Faculties of Dentistry
- Royal Canadian Dental Corps
- Canadian Dental Therapists Association
- Canadian Association of Public Health Dentistry
- Canadian Public Health Association
- Canadian Teachers’ Federation
- Canadian Association of Social Workers
- Patients for Patient Safety Canada
- Patients Canada
- Canadian Institutes of Health Research
- Canadian Paediatric Society
- Association of Dental Technologists of Ontario
- Inuit Tapiriit Kanatami
- Assembly of First Nations
- Royal College of Dental Surgeons of Ontario
- Health Canada
- First Nations Health Authority of British Columbia
- Royal College of Dental Surgeons of Ontario
- Order of Dentists of Quebec
- Provincial Dental Board of Nova Scotia
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In January, dentists from across Canada came to Winnipeg to attend the 2014 national convention, co-hosted by CDA and the Manitoba Dental Association (MDA). As CDA president Dr. Peter Doig noted in his welcome letter to convention delegates, “A national convention is the best way to bridge the gap of our country’s geography.” It was a fitting message for a meeting that drew participants from across the country, brought together by a common interest in learning more about the latest developments from the world of dentistry.

Convention delegates enjoyed 3 days of outstanding programming. Invited speakers presented on a host of topics, touching on the clinical, business and personal aspects of practising dentistry. A string of social events—including an ice fishing outing—ensured that convention delegates had an opportunity to renew old acquaintances and make new connections.

“I have always said that the MDA convention is the unknown jewel of dental meetings in Canada,” says Dr. Doig. “To hold a warm, invigorating and exciting convention at the coldest time of the year in Canada is something unique to Manitoba and a truly Canadian experience.”

Manitoba dentists—including Dr. Doig of Dauphin—share a history of giving back to their profession. The long-standing relationship between CDA and MDA was recognized on the convention floor where a roster of Manitoba dentists involved in CDA activities (past and present) were displayed on a large screen at the CDA booth.

“To participate in this event as CDA president in my home province was special,” continues Dr. Doig. “I have received unwavering support from the MDA and the dentists of Manitoba throughout my time at CDA and I was excited to be able to express my thanks at the convention.” The list of names, along with a description of
their involvement with CDA, was a reminder of the importance of individual contributions in collectively advancing the profession.

Recently, the spotlight shone on Manitoba dentistry for a different reason: an award-winning MDA hip-hop music video with a message for children about the importance of taking care of their teeth. The “We Be Brushin” video was recognized by an international advertising company, Summit International Awards, with a 2013 Visionary Award and a Leader Award.

To watch the video, visit www.youtube.com/watch?v=0KRuyePp2AI.

CDA will co-host the national convention with the Newfoundland and Labrador Dental Association (NLDA) from August 26-29, 2015, in St. John’s, Newfoundland. Representatives from the NLDA were on hand in Winnipeg to help promote next year’s event.

A few words from
Dr. Amarjit Rihal,
MDA President

Personal highlights of the convention?
The highlight for me was the President’s Gala dinner on the last night. Having my CDA friends, colleagues, and members I am close with at the gala while I delivered my farewell thank you speech was truly memorable.

On co-hosting the convention with CDA?
For us, it was like having our best friends over for dinner. We are proud of the priority one projects of CDA and our Manitoba members have good representation on CDA boards and committees.

Why hold the meeting in January?
This is kind of a hot potato! Historically, the MDA meeting has always been the second last weekend in January—not sure why. Next year, the convention will be in Brandon in April. We’ll see how that goes.

Any advice for the NLDA, next year’s convention co-host?
I think they’ve done their homework. It will be an exciting experience, and they’re doing an excellent job promoting their convention. I am scheduled to lecture there and a large group of members from here are planning to attend.

Thank you to Dr. Hermann Lee, an orthodontist based in Winnipeg, who graciously volunteered to take photos at the convention.

Dr. Amarjit Rihal and Dr. Peter Doig.
FIRST VISIT, FIRST TOOTH:
Celebrating the First Visit to the Dentist

Dr. Mitch Taillon  
Chair of the CDA Access to Care Working Group

Children’s oral health has improved significantly over the past few decades, reflecting the success of prevention and early intervention programs. Despite these gains, caries remains prevalent and, in some cases, can lead to hospitalization. According to a recent report from the Canadian Institute for Health Information, dental surgery to treat early childhood caries accounts for about one-third of all day surgery for preschoolers.

That’s why CDA supports a first visit to the dentist by age 1 (or within 6 months of the first tooth eruption) as a best practice to help reduce early childhood caries.

A child’s first visit to the dentist is an important milestone and should be celebrated. It’s an opportunity for parents to integrate oral health care routines into overall health practices and have a personalized caries risk assessment performed for their child. After all, oral health begins at birth and an investment in a child’s oral health is an investment in lifelong health. Ideally, children should see a dentist before their first birthday and regularly thereafter—just like regular checkups with their pediatrician or family doctor.

As dentists, we see the ravaging effects of early childhood caries first-hand. We have a responsibility to help educate parents about preventive measures. Parents should be reminded that their child’s oral health is linked to overall health and that dental visits should begin during an infant’s first year. They may need tips to effectively brush their child’s teeth and gums; information on appropriate nutrition, snacks and drinks for their toddler; or a reminder to refrain from sending their child to bed with a bottle. As you know, instituting good oral health care habits as early as the first year can dramatically improve a child’s oral health and create a solid foundation for a healthy mouth for years to come.

Through the CDA Access to Care Working Group, CDA and provincial dental associations have developed a strategy to focus on reducing early childhood caries. Using a combination of tactics, including traditional media, social media, public education programs, and continuing education opportunities, the working group aims to launch collaborative and coordinated efforts as early as mid-2014 to promote and encourage a first visit by age one.

REFERENCE


CDA BEST PRACTICE

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Public Opinion Survey Reveals

CANADIANS’ THOUGHTS ON DENTISTRY

Canadians are clear about importance of oral health; unclear of role and credentials of their dentist.

What do Canadians think about going to the dentist and their oral health in general? To better understand expectations about dental care from a patient’s perspective, CDA partnered with provincial dental associations to conduct public opinion research in 2013, following up on similar research conducted in 2010.

Given the decline in public trust toward all professionals, the research evaluated patient trust in their dentist and their perception of the value of the care they receive. For example, what do patients expect at a dental visit? What do they understand about the role of the dentist in relation to the other members of the dental team? How important is their oral health compared to their overall health? How do they determine the value of the dental care they receive? The goal of the research is to assist dentists in developing effective communication skills for the benefit of their patients.

A secondary goal of the research was to help provincial dental associations identify where to focus their public education promotion efforts. Through a series of 12 in-person focus groups across Canada and a quantitative survey of over 3400 Canadians, the results reveal:

- 95% of Canadians say that oral health is important.
- 69% of Canadians agree oral health is an important component of overall health.
- 60% of Canadians continue to have a positive or very positive view of dentists.
- 71% of Canadians believe dental care is a worthwhile investment.
- 62% of Canadians say that when the dentist explains clearly what they have found during their dental exam, they are more likely to agree to the dentist’s advice.
- 46% say that they receive this explanation from their dentist.
- 15% say that they would eliminate a dental visit to save money.
- Even among those without dental coverage, only 15% of Canadians would eliminate a dental visit to save money.

More findings from the public opinion research will be shared with dentists through their provincial dental association. The Trust and Value Working Group will also be surveying dentists and dental specialists in 2014 to get their perspectives on the dentist—patient relationship. Look for future articles in CDA Essentials on this research.
Does Dentistry Contribute to Prescription Drug Abuse?

On January 24, 2014, Minister of Health Rona Ambrose and the Canadian Centre on Substance Abuse (CCSA) co-hosted a symposium to help identify measures to fight the growing problem of prescription drug abuse in Canada.

Dr. Benoit Soucy, CDA director of clinical and scientific affairs, attended the symposium along with other representatives from the health care sector, government, First Nations and law enforcement.

CDA asked Dr. Soucy for more details about the event.

CDA: Can you explain the background and context for the symposium?

Dr. Benoit Soucy: About a year ago, the federal government presented a report titled First Do No Harm: Responding to Canada’s Prescription Drug Crisis to explore the issues surrounding the use of prescription drugs in Canada.

Despite the frightening magnitude of prescription drug consumption in Canada—we have the world’s second-highest level of prescription opioid use—there is a general lack of public awareness on the matter. Minister Ambrose and all provincial health ministers agree prescription drug abuse is a major issue in Canada.

Who attended the symposium?

Health-related organizations like the Canadian Medical Association and Canadian Pharmacists Association, government agencies with expertise in the area as well as not-for-profit groups promoting the fight against prescription drug abuse. Aside from CDA, two other dental organizations attended the event: the Canadian Dental Regulatory Authorities Federation (CDRAF) and Association of Canadian Faculties of Dentistry (ACFD).

What were the main points discussed that day and how do they relate to dentistry?

The day was organized around four round tables, two of which related to dentistry.

The first round table focused on prevention. Both CDA and ACFD took part in that discussion, which revolved around ways to limit the supply of prescription drugs, to ultimately avoid inappropriate use. From a dentistry standpoint, the obvious observation is that we do prescribe painkillers to our patients. And since it can be difficult to predict needs, we tend to prescribe more for each event than the patient ultimately uses. Here lies part of the problem: medication that has been dispensed to patients, but not used by patients, becomes unaccounted for.

Another round table of interest to dentists focused on education. We obviously had a lot to say with regard to education at the school level and as a component of continuing education. All parties involved agreed that education needs to be provided in a non-threatening environment. Practitioners must feel comfortable registering to courses, and know that their participation will not negatively affect their licensure.

The other two round tables covered the topics of treatment and enforcement.

Is there a perception that the dental profession needs to be doing more to address the issue?

The role dentistry must play has been clearly identified in the First Do No Harm report. There is no doubt that we contribute to the issue, and that is why we have to be part of the solution.

What concrete actions can the profession take?

We need to make sure we provide dentists with continuing education opportunities on the appropriate dispensation and use of prescription drugs. We also need to work closely with other important stakeholders to address the issue.

Any advice for the individual dentist?

Without a doubt, the most obvious action dentists can take is to change their prescription practices. They should also take the time to discuss pain management with their patients. Dentists need to educate their patients.

We probably all have had patients showing up for an emergency appointment, complaining about excruciating pain. We can often identify those asking for prescription drugs to satisfy their addiction more than to manage pain. Dealing with those patients is something we must do in a very compassionate fashion.

This interview has been condensed and edited.
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A DENTIST RECOGNIZES ECTODERMAL DYSPLASIA 
and Brings Welcome Relief to Family

Like many who suffer from ectodermal dysplasia (ED), 14-month-old Jacob was initially diagnosed by his dentist. As the first health care provider to link together the various symptoms described by the child’s parents—delayed teething, severe facial eczema, sparse eyelashes and missing eyebrows, red rimmed eyes, unwillingness to drink warm beverages—Jacob’s dentist suspected an ED disorder.

“We were incredibly lucky that our dentist knew how to recognize ED,” explains Jacob’s mother Meghan Howard. “Many families go through years of dental treatments without hearing about ED as a possible diagnosis, or enamel and decay issues being blamed on poor diet and dental hygiene.”

Photograph: Rhonda McMaster
Diagnosis

“One of the challenges in diagnosing ED is that it is not always a simple, consistent, predictable clinical presentation,” explains Dr. Kevin Butterfield, division chief of dentistry and oral and maxillofacial surgery at the Ottawa Hospital.

ED refers to more than 170 rare genetic disorders that cause abnormal ectoderm development. The main ED defects can be divided into 4 types of dysplasia—dental, hair, nail and sweat glands. Dentists can be instrumental in diagnosing ED as they can observe first-hand dental defects caused by the various disorders, including:

- Anodontia or hypodontia
- Taurodontism of deciduous molars
- Permanent dentition often limited to: central incisors, first molars and canines (maxilla); canines, first premolars and first molars (mandible)
- Deficient alveolar ridges (associated with hypodontia)
- Underdeveloped jaws
- Malformed teeth
- Cleft lip or palate
- Absence of lingual frenulum

When Jacob’s dentist believed that the toddler likely had ED, he referred him to a pediatric dentist who practises at the Children’s Hospital of Eastern Ontario (CHEO). “We were so relieved and grateful to meet with a specialist experienced in treating patients with ED,” remembers Ms. Howard.

Treatment

Patients with ED are usually good candidates for implant therapy, and the procedure success rate compares to that of normal patients. However, they often have to undergo bone augmentation in preparation for implant placement. In October 2013, Dr. Butterfield performed dental implant placement on Jacob, who is now 5 years old.

“While the varying clinical presentations can cause difficulties in the diagnostic process, the prosthetic management has dramatically improved as we are now able to provide patients with a predictable functional result,” says Dr. Butterfield.

Unlike many patients who struggle to find specialists in any needed area of treatment, Jacob is followed by a multidisciplinary team of health professionals. “Our team of experts includes Dr. Butterfield, a prosthodontist, a pediatric dentist, a geneticist and a pediatrician,” explains Ms. Howard. “We have however been unsuccessful in finding a dermatologist with experience in treating patients with ED, so Jacob’s eczema is not under control at this point.”

Outlook

Prognosis for people with ED is generally very good. They have a normal life expectancy, and most disorders do not lead to developmental delays.

Jacob’s resilience to his condition never ceases to impress his mother. “He absolutely refuses to let ED slow him down. He could teach many of us what courage really means,” says Ms. Howard.

CEDSA

The Canadian Ectodermal Dysplasia Syndromes Association (CEDSA)

When Jacob was first diagnosed, there was no Canadian organization dedicated to helping patients with ED. To help fill that gap in service, Meghan Howard founded the Canadian Ectodermal Dysplasia Syndromes Association (CEDSA) in 2010.

CEDSA supports families through teleseminars with maxillofacial surgeons, a comprehensive website, regular newsletters, a support fund to help cover the important dental and medical costs associated with treatment, and the creation of a secure medical and dental expert database.

To learn more about CEDSA activities and services, visit ectodermaldysplasia.ca.

Sources

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The impact of removing fluoridation from municipal water supplies in Canada:

A TALE OF TWO CITIES

Questions about the effectiveness of municipal water fluoridation in preventing tooth decay have polarized scores of communities across Canada. Dr. Lindsay McLaren, a researcher from the University of Calgary, along with a team of experts in public health and dentistry, is aiming to enrich the debate by examining whether Calgary’s city council decision to stop fluoridating its water in 2011 has affected the oral health of children living in that city. She talked to CDA about her research project that will compare levels of tooth decay in young Calgarians to children living in Edmonton—a city where the drinking water supply is fluoridated.

Why do you think it’s important to conduct this study? Research on drinking water fluoridation as a public health intervention, on balance, supports the benefits of fluoridation for the prevention of tooth decay in populations. But things can change over time. So it’s important that we keep the literature up to date.

Drinking water fluoridation, because it affects the whole population, is potentially a very powerful intervention and that’s a big part of its appeal, or lack of appeal, depending on what side of the debate you’re on. If there’s a benefit that we’re now losing, we need to know this to inform future decision making. I’m not saying we’re necessarily going to see a benefit, but if it’s there we want to document it.

Why does the evidence on drinking water fluoridation need an update? Arguably, most of the research is from cases of fluoridation initiation—when communities start fluoridating their water—and its impact on oral health. There are far fewer studies on the discontinuation of fluoridation. Also, it’s important to consider the time and place of the studies. Unlike in the 1960s and 70s, we now have a greater number of sources of fluoride that we’re exposed to. And finally, the oral health profile of the population has changed. When fluoridation was first implemented back in the 1940s and 1950s tooth decay was almost universal among the child population and that’s not the case anymore. Tooth decay is still common, but not nearly as common as it was back when fluoridation started.

Who will your study be looking at? Our target population is children in grade 2. We picked this age group—around 7 years old—because, on average, children of that age have started to develop some of their adult teeth so it will allow us to examine both baby teeth and adult teeth in one age group. We’re doing oral health assessments, a visual-tactile exam conducted by registered dental hygienists that will take about 10 minutes per child. There is also a questionnaire for the parents to complete. The questionnaire is really designed to tap into other determinants of oral health—aside from drinking water fluoridation—that we’ll take into account in our analyses.

What factors are being evaluated in the questionnaire for parents? Diet, oral health behaviours like brushing and flossing, visits to the dentist, whether they have dental insurance and what type, the primary source of drinking water, how long they’ve lived in their current home. And if a family has moved during the child’s life, what other communities have they lived in? We will also ask about sociodemographic information, like household education level, whether the home is owned or rented, median income of the census area where this child’s school is located, and ethnocultural background of the family.

How many children will be examined? For each city, we hope to examine several thousand from about 150 schools, so it’s quite a big sample size. We’re in Calgary and Edmonton schools for this entire academic year.

What do you expect your study will find? I honestly don’t know. I’m of course very, very curious. On one hand, I feel that the existing research literature, on balance, supports a beneficial effect of drinking water fluoridation on oral health. And so from that point of view, we might expect to see a decline in oral health in Calgary, reflecting the removal of fluoride from the water. But on the other hand, times have changed, and we can’t assume that findings from previous studies will show up in this time and place.

Do you think your work will influence the debates over fluoridating drinking water? Evidence is only one piece of why some people support or don’t support drinking water fluoridation. Our study is only speaking to the evidence aspect. That said, I don’t think it’s out of the question that the Calgary city council will look carefully at our results. I’m not sure what they would do with it, but I do think it would be an important piece of the discussion.

Tooth decay is still common, but not nearly as common as it was back when fluoridation started.
MANY MIDDLE-INCOME EARNERS can’t afford dental care in Canada

An increasing number of middle-income earners in Canada have difficulties affording dental care, according to a study\(^1\) by a team of University of Toronto researchers.

The study examined trends in the affordability of dental care for middle-income Canadians, defined according to total household income and the number of people in the family (e.g., a household of one or two people earning a combined annual income of $15,000–$29,999 would be considered middle-income earners). The study reviewed data on self-reported dental insurance coverage, cost-barriers to dental care, and out-of-pocket expenditures for dental care, based on data from a series of Statistics Canada surveys conducted between 1978–2009.

According to the study’s results, by 2009 middle-income Canadians experienced the greatest decrease in affordability of dental care compared to all other income groups. Middle-income earners had the lowest levels of dental insurance coverage (48.7%) and had equivalent levels of dental insurance for full- and part-time jobs. In contrast, national averages for all incomes show that more full-time workers have dental benefits (72.6%) compared to part-time workers (64.7%).

But insured or not, financial barriers were an issue for middle-income Canadians—almost 20% of insured workers and half of uninsured workers reported cost-barriers to dental care. Overall, about one-third of middle-income earners reported cost barriers to dental care by 2009. And by 2008 middle-income earners experienced the greatest rise in out-of-pocket dental expenditures since 1978.

Dr. Carlos Quiñonez, the study’s senior author, says changes in the labour market have been detrimental to middle-income earners: “In order to stay competitive globally, large firms have begun to offer more part-time and temporary work arrangements, which allows them to not offer dental benefits at all, or they have reduced the amount or robustness of dental benefits for existing employees or new full-time hires.”

The finding that middle-income Canadians find it difficult to afford dental care—even if they have insurance—can be explained by two factors, according to Dr. Quiñonez. “Incomes among the low and middle income segments of our society have stagnated since the 1980s. In real dollars, people simply can’t afford what they used to.” This decrease in purchasing power is compounded by “dental care prices that have risen well above inflation over the same time period.”

For dentists, the conclusion that an increasing number of middle-income earners aren’t getting the dental care they need because they can’t afford it raises questions about the oral health status of many Canadians. Dr. Quiñonez says: “Access to preventive and curative dental care can play an important role in improving people’s oral health. Without it, Canadians don’t have the opportunity to maximize their health.”

As for what the profession can do to remove or reduce cost-barriers to dental care, Dr. Quiñonez offers: “I believe the dental profession can play the most important and productive role in shaping how we finance and deliver dental care in Canada. We should be advocating for mandatory dental insurance in all work arrangements, and more progressive approaches to public dental care programs, so that they reach beyond the traditional groups we view as most in need.”

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Reference

I read Dr. Ernest Lam’s JCDA Guest Editorial¹ on diversity in dental leadership and the responses to it with great interest. Dr. Lam raised a number of questions about why leadership in organized dentistry lacks diversity, particularly in terms of gender. The answers to these questions are complex. Thousands of books have been written and papers published in the business and psychology literature on this topic and we still do not have solutions to the diversity challenge. For those interested, I highly recommend reading the September 2013 issue of the Harvard Business Review, which—once again—devotes a significant amount of space to the vital role of diversity in the success of organizations. Another compelling read is the 2013 bestseller by Sheryl Sandberg, COO of Facebook, called Lean In: Women, Work, and the Will to Lead. The insights offered are enlightening to men and women alike.

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Why is diversity in leadership important? The answer to this question is fairly straightforward. The behaviours, values and decision-making strategies of organizations need to reflect those of the people they represent. The only efficient way to achieve that is to have an inclusive mix of diverse individuals who bring an added critical dimension to the skill set required for an organization to succeed in serving its members. More importantly, for problem-solving teams and organizations, diverse perspectives are imperative. Members of homogeneous groups often share the same culture, background and points of view and may not challenge the status quo. Problems are investigated and analyzed in the same way over and over again, such that deep inquiry into issues is absent and creative solutions become elusive.

The Challenge of Achieving Diversity

Why is diversity in dental leadership lacking? The answer to this is not so straightforward. Although I can only speak from the female perspective, I have had discussions with men from minority groups who have attained high-level leadership positions in dentistry. The barriers and challenges are similar, but different.

In terms of under-representation of women in leadership roles, the most obvious fact is that men and women are different and, of course, have different leadership styles. As Dr. Lam pointed out, the vast majority of leadership roles in organized dentistry (and academia, with only 1 female dean of dentistry in the history of all Canadian dental schools) are filled by men. It is therefore understandable that these roles have been defined by men and that the metrics for assessing our dental leaders is from the male perspective.

There is a significant body of research that describes the qualities that people, in general, most often associate with good leaders: these qualities strongly reflect cultural norms of masculinity, such as decisiveness, confidence, ambition, competitiveness and being action-oriented. The same research tells us that our society considers women to possess traits such as kindness, warmth and friendliness, and to be collaborative and nurturing. While these latter attributes are considered by progressive business leaders to be the hallmarks of emotional intelligence and essential for transformational leadership by either gender, they are more often seen as prerequisites for more subordinate roles for women.

When women approach their leadership roles demonstrating the same qualities deemed to be positive in their peer male leaders, there is often a disconnect in how their behaviour is perceived and what people expect of them, which can cause them to be judged harshly. On the other hand, if their leadership style reflects their feminine nature, they are often thought of as weak. In Lean In, Sheryl Sandberg describes many studies that show that success and likability are negatively correlated for women leaders and positively correlated for men. Women who achieve results in the leadership realm are considered to be aggressive, difficult and abrasive, while men are admired both for their success and for the very same behaviours.

Hidden Gender Bias

Much has been written about “second generation gender bias.” It is now rare (and illegal) for women to be excluded from leadership opportunities in a deliberate manner, as occurred in previous generations. Second generation bias is insidious and involves practices that appear neutral on the surface; for that reason, it has been called the “invisible barrier.” It is subtle, usually unintentional, and often unrecognized by women as well as men. Deeply entrenched cultural norms and gender-based dynamics can create a context that prevents women from seeking and thriving in leadership roles. An obvious example is the social camaraderie and networking that is important for highly functioning teams, such as a board of directors. These activities often reflect the masculine perspective, which can make potential female leaders feel uncomfortable or even excluded. However, invisible gender bias is usually embedded in stereotypes and organizational practices, such as giving women assignments with lower profile or “invisible work” that neither develops nor recognizes leadership skills.

Although a bias may not be overt, many women have experienced meetings in which suggestions from men are acknowledged while the same ideas have been ignored when put forward by women. Women may also have noted the preferential mentoring of men in academia, work settings and volunteerism. One of the most interesting findings of the research in this area is that attitudes can be changed simply through an understanding of this bias by both genders and that male leaders with seniority, because of their established authority and influence, are the most effective change agents for enhancing leadership opportunities for women in their organizations.

Do we need affirmative action (sometimes called positive discrimination)? No, we do not. But there is a natural human tendency for people to be drawn to, advocate for, support and mentor others like themselves. Unless succession planning in our professional associations actively considers the diversity gaps that currently exist, our organizations will not function as effectively as possible and will become increasingly irrelevant to the dentists of Canada.

References

Introducing the first retractionless Tissue Managing Impression System.

Aquasil Ultra Cordless is the first and only Tissue Managing Impression System that eliminates the need to retract tissue. No need for cord. No need for paste. Just an easy, one-step system that places high tear strength wash material precisely in the sulcus within seconds for a stress-free experience that creates incredibly accurate marginal detail. It’s the first true breakthrough in impression making in decades.
Inequity in Oral Health Care for Elderly Canadians:

**PART 1**

**ORAL HEALTH STATUS**
Oral health is a contributory factor to general well-being and quality of life. The Canadian Health Measures Survey between March 2007 and February 2009, documented the oral problems that elderly people experience. This age group faces inequity in oral health care (especially in a fee-for-service system) and the aging of the Canadian population will exacerbate the problem of inequity. This article, the first of a 3-part series, discusses the impact of poor oral health on elderly people. The second article will consider inequity in terms of the financial, behavioural and physical barriers within the Canadian health care system, as well as ethical considerations related to this inequity, and the third will provide suggestions to overcome the barriers.

The mouth is the gateway to the body; hence, good oral health is an integral part of general well-being and a contributory factor to quality of life.1 According to Statistics Canada, the life expectancy for Canadian men and women is 79 years and 84 years, respectively.2 Although there is no universal definition of old age, an adult 65 years or older is considered a senior citizen or elderly person in Canada.2 More than 80% of elderly people have chronic health conditions, including arthritis, cataracts, back pain, cardiovascular disorders and diabetes mellitus.3 These conditions typically worsen with advancing age, eventually restricting daily activities, including oral hygiene activities and regular access to dental care.4 As a result, even though utilization of medical services rises with increasing age, the opposite occurs with dental services.5 In particular, elderly people face inequity in oral health care, especially within a fee-for-service system.6,7 Although all permanent residents in Canada have prepaid access to a general health care plan administered by a provincial or territorial government,9 the legislation for these plans does not cover dental services.10

This 3-part series of articles addresses the inequities faced by elderly patients in a fee-for-service environment for dental services. This first article of the series describes the oral health status of older Canadians, on the basis of findings from a recent health survey, and notes the implications of oral health for general well-being. The second article will briefly discuss the public and private oral health care plans available in Canada and will explore the inequity in care experienced by elderly people and related ethical considerations. The third article will offer suggestions for reducing this form of inequity and improving access to dental care among elderly people.
Canadian Health Measures Survey

Oral problems commonly observed in elderly people include caries, periodontal diseases, tooth loss, xerostomia, candidiasis and cancer. The Canadian Health Measures Survey (CHMS), conducted from March 2007 to February 2009 sampled 5,600 Canadians from approximately 97% of the population, excluding people living on Aboriginal reserves or Crown lands, members of the Canadian Forces, residents of institutions and residents in some remote regions. Dwellings of known household composition were stratified into 5 age groups: 6–11, 12–19, 20–39, 40–59 and 60–79 years. Very young (< 6 years) and very old (> 80 years) people were excluded. Each participant was interviewed and underwent a physical (including oral) examination. During the interviews, questions about oral health were related to the comfort and appearance of the mouth and teeth, the effects of oral disabilities, oral care habits, visits to dental professionals and dental insurance coverage. The oral examinations were performed by dentists whose examination skills were calibrated to achieve high agreement (Cohen’s kappa coefficient ≥ 0.6) with clinical criteria recommended by the World Health Organization. During the examination, the dentist gathered data on occlusion, mucosal lesions, accumulation of debris and calculus, gingivitis, edentulism, prostheses and trauma to the incisors. The prevalence and severity of caries were estimated from the average numbers of decayed (D), missing (M) and filled (F) teeth (DMFT). Periodontal status was represented by the deepest probing depth on 1 of 10 indicator teeth and mean loss of attachment on 6 sites of indicator teeth. The data collected are suitable for developing policies about oral health needs in Canada but are inadequate for clinical research.

Oral Health Status of Elderly Canadians

The CMHS revealed that almost everyone in the oldest age group (60–79 years) had at least 1 DMFT (excluding wisdom teeth). This age group had the highest mean DMFT (15.7, consisting of D = 0.4, M = 5.6 and F = 9.7) and the highest rate of edentulism (22%). Nonetheless, earlier studies in various countries have identified a trend toward the retention of more natural teeth in older age, and this trend is supported by evidence from Statistics Canada that the rate of edentulism among those older than 65 years declined in Canada from 43% in 1990 to 30% in 2003. More recently, the CHMS found that over half (58%) of those 60–79 years of age retained more than 21 natural teeth (mean = 19). Older adults participating in the survey claimed to brush and floss as frequently as the younger participants, yet more than a tenth (11%) had untreated root caries, and nearly one-third (31%) had at least one periodontal pocket of at least 4 mm. Although oral problems were distributed similarly in both the oldest age group and in the 40- to 59-year age group, there was a greater need for professionally administered preventive and restorative therapies, particularly to prevent and control caries. This can be explained by accelerating factors such as loss of gingival attachment, dry mouth and reduced dexterity, and possibly because the pathogenesis of dental diseases follows a different pattern with advancing age.

Among those 60 to 79 years of age, more than a tenth (13%) avoided dentists, and even more (16%) declined treatment because of the cost. Thirteen per cent of this age group, and nearly a quarter (23%) of those without natural teeth reported that they avoided certain foods because of oral problems, while about one-tenth (7%) of the participants reported persistent pain. Although such complaints were not highly prevalent, these responses could be an underestimation of the true prevalence, as older people tend not to report oral pain, possibly because of increased tolerance of noxious stimuli or misattribution of pain to old age. Denture stomatitis was observed in 20% of edentulous mouths. Contrary to the common belief that loss of teeth ends the need for dental visits, a substantial proportion of the edentulous participants (41%) needed treatment for soft-tissue abnormalities.

Consequences of Poor Oral Health

Poor oral health can adversely affect quality of life by imposing a physiological burden, particularly among elderly people. For example, hyposalivation, which is common in old age, arises from hypofunction of the salivary glands, the manifestations of systemic diseases such as diabetes and the adverse effects of medications or radiotherapy for cancer. Polypharmacy is common in older adults, and multiple medications can interact to induce dry mouth. Nearly one-third (29%) of adults 65 years or older living independently in Ontario reported xerostomia. Loss of the natural cleansing effect of saliva increases the oral bacterial load, which predisposes a frail person to dental problems and other systemic conditions, such as aspiration pneumonia, coronary artery disease and cerebral infarction. Moreover, people with subjective xerostomia and tooth loss may have reduced masticatory ability, food avoidance from fibre, protein, vitamins and minerals, and impairment of speech. Malnutrition may reduce immunity against infection and has been associated with cardiovascular disease, poor cognitive performance and periodontal disease in older adults. In turn, periodontal disease increases the risk of root caries and further tooth loss. Indeed, this vicious cycle of poor dentition, malnutrition and
increased comorbidities (including dental comorbidities) can escalate to inflate medical expenses across the population, with far-reaching consequences for society in general.

Mandatory retirement has been abolished in many provinces in Canada and may be removed at the federal level. As such, a large proportion of those over 65 years of age may wish to remain in the workforce. However, poor oral health can create psychological and social constraints, by undermining general appearance and limiting a person’s confidence in social interactions and his or her ability to secure or retain a job. Furthermore, older adults with poor oral health tend to lead an inactive lifestyle. More specifically, the CHMS showed that approximately 40% of those 60–79 years of age reported an average of 3.5 hours lost from work or normal activities per year because of dental sick days. Unexpected absence from work due to acute oral discomfort or pain could create financial and socioeconomic strains at the individual, corporate and social levels.

Furthermore, many systemic diseases exhibit oral manifestations, and oral cancer is among the top 10 most common cancers worldwide. About 3,400 new cases of oral cancer were diagnosed in 2009 in Canada alone, and the incidence increases after age 40. Thus, oral care should remain an important part of health screening for the older population.

Looking Forward

The CHMS provides an incomplete picture of oral health in older Canadians. It did not survey people 80 years of age or older, although this age group now makes up about 4% of the Canadian population. It also excluded institutional residents, who are generally more frail, are unable to execute an optimal standard of oral hygiene, receive less dental care, and have poor oral health and greater treatment needs. In one study, 58% of elderly Canadian nursing home residents were in need of dental treatment; and two-thirds (67%) of the need was attributed to caries and periodontal problems. Although dental services were made available to residents of the facilities, the incidence of tooth loss and edentulism increased over the subsequent 5-year period.

Utilization of dental services in Canada has risen modestly, from 44% to 68%, since 1970. Over the same period, dental expenditures per capita have increased approximately fourfold, which indicates that either dental services have become more costly or individual patients are utilizing more services. Data from the CHMS indicate that income is a strong determinant of health status and access to care.

The inequitable situation is even more palpable for elderly people, especially if they have lost insurance coverage after retirement and have become more frail. The next article in this 3-part series will discuss the barriers to oral health care faced by the elderly population in Canada and the ethical considerations associated with inequities in oral care.

References

Complete list of references available at: jcda.ca/article/d114
### CDSPI Funds

CDSPI Funds can be used in your Canadian Dentists' Investment Program RSP, TFSA, RIF, Investment Account, RESP and IPP.

**CDSPI Fund Performance (for period ending February 28, 2014)**

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<td>7.5%</td>
<td>13.3%</td>
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<td>Income/Equity Fund Portfolios</td>
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<td>Income Portfolio (CI)'</td>
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Figures indicate annual compound rate of return. All fees have been deducted. As a result, performance results may differ from those published by the fund managers. Figures are historical rates based on past performance and are not necessarily indicative of future performance.

MERs are subject to applicable taxes. BlackRock is a registered trade-mark of BlackRock, Inc.

* Returns shown are for the underlying funds in which CDSPI funds invest.
** Returns shown are the total returns for the indices tracked by these funds.
To speak with a representative, call CDSPI toll-free at 1-800-561-9401.
For online fund data or more recent performance figures, visit www.cdspi.com/invest.
Can You Handle the Truth?
...about risks you’re taking with office disasters

The truth is, without adequate insurance, you could end up paying many thousands of dollars out of your own pocket if disaster strikes at your dental office.

If you’ve recently added or upgraded equipment or furnishings in your practice — or renovated your office — there’s a good chance you’re taking that risk.

Fortunately, a licensed insurance advisor at CDSPi can assist you in enhancing your office contents protection, with Canada’s best-selling dental office coverage — TripleGuard™ Insurance. TripleGuard™ Insurance provides three types of superior office coverage (office contents, practice interruption and commercial general liability) in one economical package. Your CDSPi advisor can also help you select options appropriate for your office needs — such as equipment breakdown coverage and protection if you own your practice building.

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TripleGuard™ Insurance is underwritten by Aviva Insurance Company of Canada. The plan is a part of the Canadian Dentists’ Insurance Program — which is a member benefit of the CDA and participating provincial and territorial dental associations. Insurance planning advice is provided by licensed advisors at CDSPi Advisory Services Inc. Restrictions may apply to advisory services in certain jurisdictions.
How Would You Recover
AFTER SEVERE WEATHER
AT YOUR OFFICE OR HOME?

From flooding to ice storms, during
2013 dentists across the country ex-
perienced a number of catastrophic
events which disrupted the normal
routines at their offices or homes. As
vice-president of Insurance Advisory
Services and CDSPI’s Claim Support
Centre, I lead a team of profession-
als who are usually the first point of
contact for dentists with insurance
through the CDSPI programs.

Last year, about one in 15 dentists’
contacted CDSPI about their office
insurance due to flooding, fire and
other incidents—including Dr. Terry
Smorang an endodontist in Calgary,
Alberta. He recalls what it was like dur-
ing the severe flooding that devastat-
ed areas of the province in June 2013.

“As we looked down from our ninth-
floor dental office in the Mission dis-
trict of Calgary, we could see that they
were setting up dykes on the streets
below,” said Dr. Smorang. “Meanwhile,
on the news, city officials were order-
ing the evacuation of the downtown
area. It all unfolded very quickly. My
practice partner, Dr. Dean Staniloff,
and I sent everyone home and locked
up the office.”

“We were lucky,” said Dr. Smorang. “Our
homes were not affected, so we had
safe locations from where we could
get organized and contact CDSPI
about our TripleGuard™ Insurance
coverage.”

“I called CDSPI and told them we
were flooded out of our office,” said
Dr. Smorang. “There was no water
damage to the endodontic dental
practice because it is situated on
a high floor. However, access to
the building was restricted by the
city and the power was shut off
due to the hazardous conditions
created by flooding in the building’s
underground parking garage and
surrounding areas.

“Right away CDSPI reassured us,” he
said. “That was important because we
had been hearing so many negative
stories about insurance coverage and
insurance providers at the time. I have
had insurance with CDSPI for almost
40 years and I have spoken with my
insurance advisor regularly over the
years, but I never had a claim before.”

“When I called, CDSPI immediately
gave me the name and phone num-
ber for the insurance adjuster serv-
ing the area,” said Dr. Smorang. “The
paperwork was fairly simple and the
claim process was very efficient.”

“Our experience was very good. . . just
everything we could expect—quick,
simple, easy...done,” he said. “We were
fully reimbursed for our income loss—
no deductible—for the 3 weeks we
didn’t have access to the office.

“CDSPI was there for us,” said
Dr. Smorang. “They stepped up to
the plate for us and did a really good
job.”

[Image of Dr. Terry Smorang]
According to the Insurance Bureau of Canada, “Canadian communities are seeing more severe weather, especially more intense rainfall.”

Before an emergency happens, it’s wise to confirm with your insurance advisor the amount and type of coverage you have in place, and to update your coverage if necessary to protect your practice as best as possible. With TripleGuard™ Insurance, dentists can reduce the financial impact on the dental practice if catastrophic events occur. Twenty percent of TripleGuard™ Insurance claims in 2013 were due to the intense rainstorms in the summer months and the ice storms in December.1

- To determine the amount of office contents coverage that is appropriate for your practice, consider how much it would cost to replace everything between the four walls of the practice.

- If you own the building, obtain enough building insurance to cover costs to repair or rebuild structures, such as walls, roofing and attached fixtures in the event of a claim situation.

- When an insured event at the practice causes the office to close, the TripleGuard™ insurance plan’s practice interruption coverage reimburses your income loss while the practice is closed.

- The plan’s commercial general liability coverage helps cover the costs of third-party legal actions against you arising from the dental practice, for instance, if a fire originating in the practice damages neighbouring premises.

- Contact an insurance advisor at CDSPI for help reviewing your coverage. To report a TripleGuard™ insurance claim, call CDSPI’s Claim Support Centre at 1-800-561-9401 (outside business hours, call 1-866-556-2821).

This insurance is underwritten by The Personal Insurance Company (“The Personal”) and covers risks to your home, including fire, theft, vandalism and water damage. About 25% of CDSPI Home Insurance claims in 2013 resulted from the summer rainstorms and the December ice storms.3

- CDSPI Home Insurance has some of the most comprehensive water damage protection on the market to protect your home against damage caused by leaks from appliances, sinks, toilets, pipes etc. This home insurance also offers optional coverage for sewer back-up, and for water seepage through your home’s roof, windows and doors.

- The experienced insurance agents at The Personal can assist you with determining the appropriate amount of insurance required to protect your home and its contents, including any additional coverage for special items, such as works of art, jewellery and collectibles.

- CDSPI Home Insurance provides 24/7 claims assistance, so policyholders can contact a claims advisor at any time to report a claim. Call The Personal at 1-888-785-5502 and a claims advisor will guide you through the claim reporting process, quickly and efficiently, and keep you informed throughout the claim process until your claim is resolved.
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Context: Sugar-sweetened beverages (SSBs) are the largest source of added sugar in the U.S. diet. In adolescents aged 12–19, these drinks account for 13% to 28% of total daily calories. Compared with other adolescents, those residing in Appalachia have the highest consumption rates of SSBs.

Methods: Using a Teen Advisory Council (TAC), a student-designed and student-led intervention was conducted at 2 high schools in a rural Appalachian county. Using repeated-measures models design with Bonferroni correction, data were collected on daily and weekly consumption of SSBs and of water at baseline, immediately post-intervention, and 30 days post-intervention. Vending machine surveys were completed.

Results: The 186 participants reported purchasing SSBs from school vending machines (41.4%), cafeteria (36.5%), and school stores (7.7%). Daily SSB servings decreased from an average of 2.32 (SD = 2.14) to 1.32 (SD = 1.29) ($p < 0.001$). Weekly consumption decreased from an average of 4.30 (SD = 2.40) days/week to 2.64 (SD = 1.91) ($p < 0.001$). Water consumption increased 19% from baseline to immediately post-intervention.

Conclusions: Student-directed efforts to support behavioural change are feasible and effective at affecting individual lifestyle behaviors. Small and manageable changes may lead to net improvements in lifestyle behaviours.

“With its student-designed and student-led intervention, this pilot project already had the most important element for success—peer pressure. Earlier this month, JAMA Internal Medicine published the results of a large epidemiological study linking added sugar intake to cardiovascular mortality in adults even in the absence of obesity. Sugar appears to be a bigger threat to health than fat. What could we, as dentists, do to stand up against sugar in such an effective way as ‘sodabriety?’”

“We can add ‘sodabriety’ into our vernacular…and during our interactions with patients they expect us to vilify sugar. We shouldn’t let them down.”
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Disparities in the Availability of Dental Care IN METROPOLITAN TORONTO

Abstract

Objectives: The availability of dentists as a barrier to access to care has not been thoroughly explored, particularly in large cities. In this study, we aimed to identify disparities in the availability of dentists in Canada’s largest urban centre, Toronto, and explore whether distributional disparities are associated with underlying factors, such as affordability as measured by average household income.

Methods: Geocoded data on number of dentists and population estimates for metropolitan Toronto’s forward sortation areas (FSA) were used to calculate dentists per 100,000 population. Dentist density and average annual household income by FSA were then mapped using geographic information system techniques. Pearson testing was used to identify associations of various factors with dentist density. Significance testing was performed to compare average dentist to population ratios in high (> $100,000) and low ($40,000–$60,000) income FSAs.

Results: Communities with high household incomes and high dentist density were clustered in central Toronto. Income-based disparities in dentist distribution were also observed. Compared with low-income FSAs, dentist density increased by a factor of 2.47 in the highest income FSAs. Dentist density also increased with income and education but decreased with immigrant level.

Conclusions: Dentist availability may be linked to demographic factors, including affordability. The income-based disparity in availability in Toronto was as high as that observed elsewhere between rural and urban communities.

Distribution of dentists (no. per 100,000 population) across forward sortation areas in metropolitan Toronto. Areas with high average annual household income are clustered (— — —) as are those with low average income (+ + +).
Managing a Patient with an EXTENSIVE ODONTOGENIC INFECTION

Extensive Odontogenic Infection

Patients will be lethargic, in severe pain, have difficulty speaking or swallowing. Trismus is present most of the time.

Presentation

Population

- Patients with poor oral hygiene
- Patients who do not receive regular dental care
- Immunocompromised patients (e.g., diabetes, HIV/AIDS, connective tissue disease)
- Patients with restorations

Signs

- Fever and lethargy
- Trismus
- Large swelling
- Difficulty to speak and swallow
- Inability to manage secretions (acute onset of drooling is a worrisome sign)
- Inability to recline due to shortness of breath (worrisome sign)
- Extensive caries
- Tooth fracture
- Tooth mobility

Symptoms

- Moderate to severe pain
- Swelling, often associated with surface redness
- Limited mouth opening
- Fever and malaise
- Floor-of-the-mouth edema and decreased tongue mobility
- Rapid and weak pulse
Investigation

Rule Out Local Pathologies

- Obtain a thorough medical history and record vital signs.
- Inquire whether the patient is immunocompromised.
- Obtain a thorough dental history and inquire about the history of pain (onset, location, duration, progression over time, type of pain).
- Take intraoral and extraoral radiographs, pending on the patient’s cooperation and comfort level.
- Investigate the degree of anatomical site involvement, ensuring that the spaces other than the oral cavity are intact.

Diagnosis

Based on the clinical observations and investigation, a diagnosis of extensive odontogenic infection is determined.

Differential Diagnosis

Non-odontogenic infections (major salivary gland infections, peritonsillar abscesses, viral infections, cystic lesion infections)

Treatment

Common Initial Treatments

1. Eliminate the source of infection (e.g., the infected teeth).
2. If the infection is fluctuant, aspirate to get samples and send for Gram staining and aerobic and anaerobic cultures.
3. Incise and drain.
4. Prescribe antibiotics:
   - IV antibiotics if the patient is in an urgent care facility
   - if the infection is mild to moderate, prescribe penicillin V 300–600 mg orally q.i.d. for at least 7 days (if the patient is allergic to penicillin, prescribe clindamycin 300–600 mg orally q.i.d. for 7 days), plus anaerobic coverage:
     - metronidazole (e.g., Flagyl®) 500 mg orally t.i.d. for 7 days; or
     - amoxicillin 500 mg orally t.i.d. for 7 days; or
     - amoxicillin with clavulanate potassium (e.g., Augmentin®) 500 mg orally t.i.d. for 7 days
5. To successfully manage the pain, a combination of narcotics and anti-inflammatory drugs is recommended.

Advice

- First line of referral should be to an oral surgeon to expedite patient’s treatment, as they have access to hospitals and have the option of performing in-office sedation (if patient’s safety is not compromised).
- If an oral surgeon is not available, refer the patient to the hospital E.R. Contact the emergency doctor directly to convey your findings and ask whether you should prescribe antibiotics before referral.
- Ensure the patient understands the severity of the condition and that it could lead to death if untreated or if seeing the specialist is delayed.
- Emphasize the importance of completing the full dose of antibiotics.

Suggested Resources


Dental Emergency Scenario

This article was originally created for the JCDA Oasis searchable database. Visit Oasis Help at www.jcdaoasis.ca to access this and other point of care clinical consults.
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BRITISH COLUMBIA - Kootenays: Busy general practice. Well-established patient base, new patients daily, 2 hygienists, long term staff, 6 operators. Excellent gross. Stable economic base and low cost of living. We enjoy all the seasons have to offer. Ski hills and lakes right outside your door. Enquire to: donellis@shaw.ca D9725

ONTARIO - Downtown Ottawa: Solo practice with brand-new equipment with or without a clientele. Financing available. Contact: (819) 661-7086. D9852

ONTARIO - Greater Toronto Area: Practice wanted! Altima Dental Canada seeks to purchase practices within 1 hour of the Greater Toronto Area. Thinking about selling? Contact us about our exciting purchase incentives. For more information visit our website at www.altima.ca or email us at dentist@altima.ca. D9501

SASKATCHEWAN: Dentist retiring. Very successful practice grossing close to $850K. Over 4500 active files. Modern and computerized. Low overhead. Dedicated staff. Work 4 days a week 8 to 5 / 46 weeks a year. Town offers relocation bonus. Professionally appraised and priced to sell. For more information email: saskdentaloffice@gmail.com. D108270

Positions Available

ALBERTA - Calgary: Looking for an exceptional dentist to join our progressive practice established for 20 years. You should be willing to work one or two Saturdays a month and one or two evenings a week. Knowledge of Arabic language would be a definite asset. Flexible start date. Open to offer future buy-in. Email: associatecalgary@gmail.com. D10810

ALBERTA - Calgary: Associate required for modern central Calgary dental practice. State-of-the-art equipment provided including a Cerec Omni-cam and seven new chairs. Established practice, over 23 years. Practice focus is on cosmetic, restorative, orthodontics, implants and sedation. Looking for a long-term fit with the possibility of an eventual purchase or buy in depending on the individual. Please send resumes to: calgarycosmeticdentist@gmail.com. D10858

FULL-TIME FACULTY POSITION IN PEDIATRIC DENTISTRY
Division of Pediatric Dentistry, Department of Oral Health Sciences, University of British Columbia & Department of Dentistry, BC Children’s Hospital, Vancouver, BC, Canada D10285

The Faculty of Dentistry and BC Children’s Hospital (BCCCH) invite applications for a full-time faculty position at the rank of Assistant Professor, with consideration of a higher rank depending on qualifications. In the Department of Dentistry at BCCCH and the Division of Pediatric Dentistry at UBC, Applicants must have postgraduate training in pediatric dentistry and be eligible to be a licensed specialist in pediatric dentistry in Canada. The successful candidate will be required to demonstrate potential for teaching excellence and service to the University and the community. Preference will be given to individuals whose program of research will contribute to improved oral health of the children of British Columbia and will enhance existing research at UBC and BCCCH. Individuals with promising research, academic and pediatric hospital experience are encouraged to apply. Experience in treating patients and educating trainees using both pharmacological and non-pharmacological behaviour management techniques is essential.

The successful candidate will be expected to contribute extensively to undergraduate and graduate teaching in the JMD and the Pediatric Dentistry graduate programs at the UBC and BCCCH sites, to develop a robust research program and to effectively supervise graduate student research activities. The successful candidate will hold an Active Staff position at BCCCH and a full-time faculty appointment at UBC with salary, remuneration and appointment status commensurate with qualifications and experience. UBC hires on the basis of merit and is committed to employment equity; however, Canadian citizens and permanent residents of Canada will be given priority. Review of applications will begin June 1, 2014 and will continue until the position is filled. Send applications with a curriculum vitae, evidence of teaching effectiveness and contact information for three references to:
Dr. Roseann Hartstein
Head, Department of Oral Health Sciences
Faculty of Dentistry, UBC
2199 Wesbrook Mall, Vancouver, BC V6T 2Z3
rosea@dentistry.ubc.ca

For more information about the Faculty of Dentistry and BCCCH, see our Website at www.dentistry.ubc.ca; www.bccch.ca
ALBERTA - Camrose: Full-time associate for busy practice in Camrose, 50 minutes SE of Edmonton, Alberta. No late evenings or weekends. Progressive dental practice with a great dental team. Good communication skills a must. Current associate is leaving so chosen dentist will be busy from day one! Call: (780) 781-1348 or fax: (780) 672-4700 or email: smellsbyus@hotmail.com.

ALBERTA - Edmonton: We are seeking a full-time dental associate to join our expanding practice located in Northeast Edmonton. Opportunity to assume an existing practice of a retiring partner exists for the right conscientious and motivated individual. Our recently renovated office is equipped with 10 operatories and the latest diagnostic and treatment technologies. We are located in a major mall in an expanding residential area. Possible partnership opportunities available. Please email CV to: drdch@compservice.com.

ALBERTA - Fort McMurray: Fort McMurray dental office is looking for a part-time associate to join our full-time practice, must have at least 2 years experience. Please send resume to: #3 - 101 Signal Road, Fort McMurray, AB, T9H 4N6 or by email to: auroradentaltw@gmail.com.

ALBERTA - Grande Prairie: Busy, well-established practice in need of a full-time general dentist. Must be comfortable with general practice procedures, have an excellent chairside manner and an ability to empathize and communicate with patients. Pay will be based upon agreed percentage of monthly collections. Moving expenses may be covered for well-suited applicant. Exceptional staff and pleasant working environment make any transitions you may encounter trouble-free. Please apply to: Renee Golemba, Bear Creek Dental, Suite 201, 10015 - 102nd Ave., Grande Prairie, AB, T8V 0Z8, (780) 539-0404 phone, (780) 539-1403 fax, renee@bearcreekdental.ca.

ALBERTA - Grande Prairie: Three full-time associates needed for our well-established family practices, with travel to our satellite clinic in High Prairie, AB. Present associates will be leaving end of July, 2014. Very busy practice with above-average remuneration. Please email: drroy04@telus.net if interested.

ALBERTA - Red Deer: The patients of a very busy practice in Red Deer requires a full time energetic and caring dentist to start immediately. The right associate will be the primary caregiver to a large patient base and will have the potential for above average earnings. The entrepreneurial dentist will have the opportunity to buy in after 6 months. The practice enjoys modern equipment, good parking and a friendly environment. Please email carol@rddc.ca.

ALBERTA - Red Deer: Associate wanted. Part-time position with strong growth potential for full-time. Red Deer has continued to grow even in the economy of the past few years. Must have strong confidence/skill level for endodontics and surgical extractions. Please call: (403) 358-6255.

ALBERTA - Spruce Grove: Long-established solo practice in Spruce Grove, AB is seeking associate dentist to join in. To apply please email CV to: dentposition@shaw.ca.

The Department of Pathology at the Schulich School of Medicine & Dentistry at Western University is seeking a faculty member with training and experience in oral pathology. Qualified applicants must hold a DDS or DMD and specialty qualification in Oral Pathology or equivalent. An MSc or PhD is desirable. The successful candidate will participate in undergraduate and graduate teaching in oral pathology, develop an active research program with potential for external funding, and will have the opportunity to participate in the Oral Pathology Biopsy Service. We invite applications from outstanding candidates to fill a tenure-track position at the level of Assistant or Associate Professor, effective July 1, 2015 or as soon as possible thereafter.

The successful candidate will be expected to participate in the Oral Maxillofacial Surgery residency program. This program requires ongoing research in the Oral Pathology field to provide research training for up to 6 master’s degree students per year. The candidate’s research interests should complement or support existing areas of research strength in the Department of Pathology (www.uwo.ca/pathol) at Western University. It is expected that the successful candidate will develop an independent and innovative research program and obtain external funding. The position will entail active collaboration with colleagues in both basic and clinical sciences. The candidate will also have a commitment to and demonstrated aptitude for teaching, and will be expected to teach and supervise both at the undergraduate and graduate levels.

The Department of Pathology has 40 full time faculty members, more than 40 full and part time graduate students, and 10 staff. It is one of 21 departments in the Schulich School of Medicine & Dentistry (www.schulich.uwo.ca). The Department of Pathology at Western University is affiliated with London Health Sciences Centre, one of Canada’s largest acute care teaching hospitals. The Department of Pathology & Laboratory Medicine at London Health Sciences Centre provides a comprehensive range of specialized laboratory testing and clinical consultation to support diagnosis and monitor treatment of patients within London, Southwestern Ontario, nationally and internationally.

Western is one of Canada’s leading research-intensive universities, and Schulich Medicine & Dentistry has a long history of excellence in basic biomedical, applied and clinical research. Western has a full range of academic and professional programs for over 37,000 undergraduate and graduate students. The university campus is in London, a thriving city of over 412,000 people, located midway between Toronto and Detroit. London boasts an international airport, galleries, theatre, music and sporting events and is located close to several lakes and facilities for outdoor activities (www.goodmovelondon.ca). Western’s Recruitment and Retention Office is available to assist in the transition of successful applicants and their families to the university and city.

Consideration of applicants will include an assessment of previous performance and qualifications, including those which go beyond the requirements for the position, and experience. Applications are sought until the position is filled. Please send detailed curriculum vitae, a statement of research interests and the names and contact information of three references to:

Dr. Subrata Chakrabarti, Professor and Chair, Department of Pathology
Schulich School of Medicine & Dentistry, Western University
Dental Science Building, Room DSB 4045
London, Ontario, Canada N6A 5C1
(admin.pathology@schulich.uwo.ca)

Positions are subject to budget approval. Applicants should have fluent written and oral communication skills in English. All qualified candidates are encouraged to apply; however, Canadians and permanent residents will be given priority. Western University is committed to employment equity and welcomes applications from all qualified women and men, including visible minorities, Aboriginal people and persons with disabilities.
ALBERTA - Stony Plain: Group practice in Stony Plain, Alberta requires full-time associate. We work in a fantastic, community-oriented town with great staff. Successful candidate likes “small town by big city” living, enjoys learning, loves working with children, and focuses on patients’ well-being. If you look after your patients, they will reward you well. Please email: turnerhm@yahoo.com or fax: (780) 963-2904.

ALBERTA - Whitecourt: Looking for a full-time or part-time associate for busy practice in Whitecourt, an outdoors-oriented town located about 2 hours NW of Edmonton. New grads welcome; orthodontic experience an asset. Please contact at: (780) 778-3808, fax: (780) 778-4201, or: mkyw@whitecourtdental.com.

SOUTHERN ALBERTA: Opportunity with immense growth potential offered for exceptional dentist two hours south of Calgary. Principal dentist retiring in the next couple of years, leaving huge patient base to be served. Excellent work-life balance, low cost of living and top-notch earning potential. Future opportunity to buy-in for the right candidate. Email: dentistsouthAB@gmail.com.

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Dr. Dennis C. Smith

Dr. Dennis C. Smith, a world pioneer in biomaterials research, passed away on February 21, 2014, at the age of 86.

A chemist, Dr. Smith was recruited to the University of Toronto in 1969 to become professor and head of biomaterials in the faculty of dentistry. “He built a leading-edge research laboratory, and established a graduate program in biomaterials,” explains Dr. Daniel Haas, dean of the U of T faculty. “He then went on to develop one of the few truly international research programs in biomaterials in the world.”

Dr. Smith was also a founding member of the university’s Institute of Biomaterials & Biomedical Engineering. His research achievements include the invention of polycarboxylate cements to chemically bond materials to tooth structure and the development of acrylic cements for the fixation of hip prostheses.

Dr. Smith chaired the ISO committee on dental standards (ISO/TC 106) from 2000 to 2005. “As chair of TC 106, Dennis was compassionate, understanding and knowledgeable in dealing with consensus discussions,” remembers Dr. Derek W. Jones, current committee chair. “We have lost a great man—a wonderful colleague and friend who will be deeply missed.”

Several organizations recognized Dr. Smith’s tremendous contributions to the profession and biomaterials sciences. He received honorary doctorate degrees from four different universities—Toronto, McGill, Dalhousie and Manchester—and was granted CDA’s Honorary Membership in 2006 and Distinguished Service Award in 1995. In 2007, Dr. Smith was appointed to the Order of Canada.

Dr. Smith is survived by his wife of 59 years, Eileen, and their six children, Christopher, Frances, Hilary, Gregory, Helen and Dominic.

On February 22, 2014, CDA’s first and only chair emeritus Dr. Nicholas (Nick) Mancini of Hamilton, Ontario, passed away at the age of 92.

Dr. Mancini chaired CDA’s Board of Governors for 26 years, from 1977 to 2003. In recognition of his many years of service, CDA’s Board of Directors bestowed upon him the title of chair emeritus—an unprecedented honour. Dr. Mancini also served as chair of the Board of Directors of the Ontario Dental Association (1969–96) and CDSPI (1983–95).

“Nick may have been small in stature, but he was a giant in dentistry.”

“Nick was a true gentleman and a diplomat and he always had the best interest of the profession in mind,” recalls Dr. Kevin Roach, CDA president in 1989–90. “I consider Nick to be the epitome of a dental leader as well as a mentor.”

Dr. Roach recalls that Dr. Mancini’s outgoing personality and political relationships greatly helped Canadian dentistry during times when several key issues were at play. But it was the personal touch that made Dr. Mancini so successful, “He could relate to all sorts of people; listen to them, make them feel comfortable. When Nick would chair a meeting, he always found a way of bringing it into line and getting things accomplished,” says Dr. Roach. “Nick may have been small in stature, but he was a giant in dentistry.”

Dr. Mancini earned his dental degree from the University of Buffalo in 1948 and was an accomplished dentist for 63 years. He received several awards for his contributions to the profession, including CDA Honorary Membership, Academy of Dentistry International’s Honorary Fellowship, Ontario Dental Association’s Barnabus Day Award and Pierre Fauchard Academy’s Elmer S. Best Memorial Award.

Dr. Mancini is survived by his three children, Michael, Nicholas and John Patrick.
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