2014 • Volume 1 • Issue 7

CDA *essentials*

The Canadian Dental Association Magazine

Innovation Through Research

Different paths to discovery

Pages 23–30

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CASE STUDY 4

Help reduce no-shows and cancellations.

ISSUE

The biggest issue we face is patient compliance. We're always looking for ways to educate and inspire our patients to comply with their oral hygiene appointments and home care.

SOLUTION

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RESULTS

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Dr. Carmen Sicoly,
Bay Dental Group

DENTAL CORPORATION

CDA essentials

2014 • Volume 1 • Issue 7

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

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

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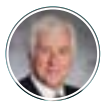

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Coming Soon

Future of Dentistry Survey

The Dental Industry Association of Canada's (DIAC) 19th Annual Future of Dentistry survey will be included with the first edition of *CDA Essentials* in 2015.

Your input is appreciated and will help DIAC's member companies develop products and services that meet the needs of Canadian dentists.

DIAC

From all of us at CDA,
WE WISH YOU AND YOUR FAMILY
every happiness this
HOLIDAY SEASON
AND THROUGHOUT
THE NEW YEAR.

Gary MacDonald, DDS
President

Claude Paul Boivin, CAE, CEC
Executive Director

Access to care: The Affordability Gap

CANADIAN DENTAL ASSOCIATION

The recent report by the Canadian Academy of Health Sciences, *Improving access to oral health care for vulnerable people living in Canada*, reveals that Canada ranks near the bottom among Organisation for Economic Co-operation and Development (OECD) nations in terms of public funding of oral health care. Canada's changing population demographics also mean that fewer Canadians have employment-based dental benefits. The result—a widening gap between those who can pay for dental care and those who can't—is something that should concern us all.

According to the Canadian Health Measures Survey, 2007–09, about 75% of people living in Canada visit the dentist annually, but 17% of our population reported avoiding the dentist due to cost—that's roughly 6 million people. Not surprisingly, more people living in the lowest-income families reported cost as a problem, but the range of people who struggle to afford dental care is broadening.

Canadian statistics show that the number of self-employed, temporary and part-time workers—people with jobs that typically lack employment-based dental benefits—is on the rise. Another segment of Canadians with limited dental benefits is seniors, a demographic with low rates of insurance and high levels of dental disease. For people without employment based-dental benefits, the issue of affordability can often determine their choice to either seek or avoid dental care.

Many of those with dental insurance don't necessarily find it financially easier because dental benefits have become less generous (e.g., limited annual maximums or services, expanded deductibles and co-payments) or are more flexible (e.g., plans that don't earmark specific amounts for dental services). In my own practice in Newfoundland, a province with one of the lowest employment rates in the country and its fair share of temporary employment, I've presented treatment plans to my patients only to have them decide against it once they discover their benefit plan has a sizeable deductible. For some of these patients, I've seen how ignoring a relatively small dental problem can escalate into much costlier treatment.

Cost is just one of many factors preventing people from seeking care. Nevertheless, some groups are questioning if the funding and delivery of oral health care in Canada can be improved—and if so, how? The CAHS report lays out a number of recommendations for achieving a vision of "equity in access to oral health care for all people living in Canada," and notes it "cannot simply depend on the good actions of dental professionals." Rather, the answers will come through engagement with all levels of government, other health care professions, organizations representing vulnerable groups in Canada, and health insurance companies.

CDA is committed to be an important player in the conversation and is working to address some of the core problems mentioned in the CAHS report, such as identifying targeted dental programs for vulnerable groups—which aligns with one of the report's key recommendations. CDA will facilitate these discussions through the Canadian Oral Health Roundtable (formerly the National Oral Health Action Plan Symposium) planned for February 26, 2015. It's a major challenge to make dental care accessible for those who stuggle to afford care. Yet like an aching tooth, it's an issue that can't be ignored.

GARY MACDONALD, DDS

president@cda-adc.ca

CASE STUDY 6

Changing the value clients place on visits.

ISSUE

One of the biggest challenges dental hygienists face is that clients don't always comply with oral hygiene recommendations. Case presentation skills need to be strong because many clients don't want to hear they have a disease.

SOLUTION

The Crest® + Oral-B® system helps standardize and support the case presentation system in the office. Clients get healthier because they begin taking an active role in managing their oral health.

RESULTS

In my experience, when ownership shifts to the patient, over 80% come on their recommended interval.

Beth Ryerse
RDH, Professional Educator
Beth Ryerse has not been compensated to appear in this ad.

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Crest + Oral-B®
We mean business.

What do Dental Practices Need to Know About GST, HST and QST?

To better understand how the Goods and Services Tax (GST), the Harmonized Sales Tax (HST) and Quebec Sales Tax (QST) affects Canadian dentists, Dr. Suham Alexander, CDA clinical editor, spoke with Rob Allwright, Associate Partner at KPMG. This is a summary of their discussion, which includes an update on the Canada Revenue Agency (CRA) policy relating to dentists' and orthodontists' eligibility to recover a portion of their taxes on eligible expenses.

How are dental practices affected by the GST/HST and QST?

The GST/HST and QST are "value-added taxes," which means they are generally charged and collected by suppliers at each stage in the production and distribution of goods and services.

Registered businesses charge and collect the tax on their "taxable supplies" (e.g., sales of goods and services) and claim credits for the GST/HST and QST they pay on expenses related to their taxable activities. The credits are referred to as "input tax credits" (ITCs) in the case of the GST/HST or "input tax refunds" (ITRs) in the case of the QST. The difference between the tax collected from customers and the tax payable to suppliers is either remitted to the government or is refunded by the government, depending on which amount is greater. (*See graphic below*)

Most diagnostic and treatment services provided by a typical general dental practice* are exempt from GST/HST and QST. For tax exempt services, a dental practice is not entitled to ITCs and ITRs.

However, some dental services are taxable. For example, services performed for cosmetic purposes, like teeth whitening, are taxable. For taxable services, registering for the GST/HST or QST facilitates the reporting of tax collected and allows the dentist to claim ITCs and ITRs for the GST/HST and QST paid on costs related to these services.

When should a dental practice register for the GST/HST or QST?

A dental practice is required to register for a GST/HST account if its total annual revenues from taxable sales exceed $30,000. Taxable sales are those subject to GST/HST at the standard rates of tax as well as sales that are zero-rated (i.e., subject to tax at the rate of 0%).

Below the $30,000 taxable sales threshold, registration is optional. In deciding whether to register, dentists should consider both the pros (e.g., recovery of GST/HST or QST on costs) and cons (e.g., compliance costs related to filing returns and potential audits by tax authorities, including a potential audit if your practice de-registers). (*See Table 1*)

Note that if the practice's taxable activities are less than 10% of its total activities, then the practice may choose not to register because ITCs and ITRs are not available on indirect costs.

Registration for the QST in Quebec is separate from GST/HST registration, but the rules are generally harmonized with the GST/HST.

What is the difference between goods and services that are tax-exempt versus zero-rated?

An exempt good or service is not subject to GST/HST or QST but a zero-rated good or service is taxable at 0%. Diagnostic and treatment services (other than cosmetic services) are generally tax-exempt, whereas artificial teeth and orthodontic appliances are taxable at 0%.

In both tax-exempt and zero-rated goods and services, the provider does not collect or report any tax. However, the distinction is important because a practice cannot claim ITCs or ITRs to recover taxes paid by the dentist to provide tax-exempt goods or services. On the other hand, a dental practice providing taxable (including zero-rated) goods or services may claim ITCs or ITRs to recover the GST/HST or QST paid on related costs. (*See Box 2*)

What is the status of the CRA policy relating to dentists' and orthodontists' eligibility to claim ITCs?

The CRA policy relating to dentists' and orthodontists' eligibility to claim ITCs was set out in a letter to the CDA in May 2004. The policy originated with the Orthodontics Supplies Agreement, an administrative agreement from 1998 between the CRA, CDA and the Canadian Association of Orthodontists.

The 2004 CRA interpretation still applies. It explains that ITCs may be claimed for the GST/HST on direct costs (e.g., taxable laboratory fees) and eligible indirect or overhead costs (e.g., lease of the office and cost of utilities) to the extent the costs were incurred for consumption or use in the making of taxable sales, and provided the indirect costs are incurred for at least 10% in taxable activities. As a result, indirect costs must be allocated to exempt and taxable activities for ITC and ITR purposes.

CRA's administrative policy on ITC eligibility requires that the dentist or orthodontist patient fees identify separately charges for taxable sales (e.g., an artificial tooth or orthodontic appliance), as distinct from dental services that are tax-exempt (e.g., diagnostic service).

Are there anticipated changes to the policies on GST/HST and QST for dentists?

CRA is currently reviewing the arrangement and CDA is aware of this situation. CDA provided a submission to the CRA and will be involved in discussions with the CRA in regards to the status of their review. In the interim, the Orthodontics Supplies Agreement and the broader CRA administrative policy relating to dentists' eligibility to claim a portion of the GST/HST and QST they pay on costs continues to apply. If any changes are introduced, the CRA has indicated that they will be introduced on a go-forward basis, not retroactively.

Note: Dentists and orthodontists should seek the advice of their tax professional to determine how these rules apply to their particular circumstances.

** The terms "dental practice" or the "dentist" are used to generally refer to the person responsible for GST/HST registration, which is on a legal person basis – i.e., a sole proprietorship, partnership or corporation.*

2

Examples of taxable and exempt dental services

Tax Exempt

- goods or services covered under a provincial health care plan
- consultative, diagnostic and treatment services (excluding services for cosmetic purposes)
- dental hygienist services (excluding services made for cosmetic purposes)

Taxable

Standard tax rates

- cosmetic services not for medical or reconstructive purposes
- the provision of medico-legal reports to insurance companies or lawyers
- rental of office space or provision of parking

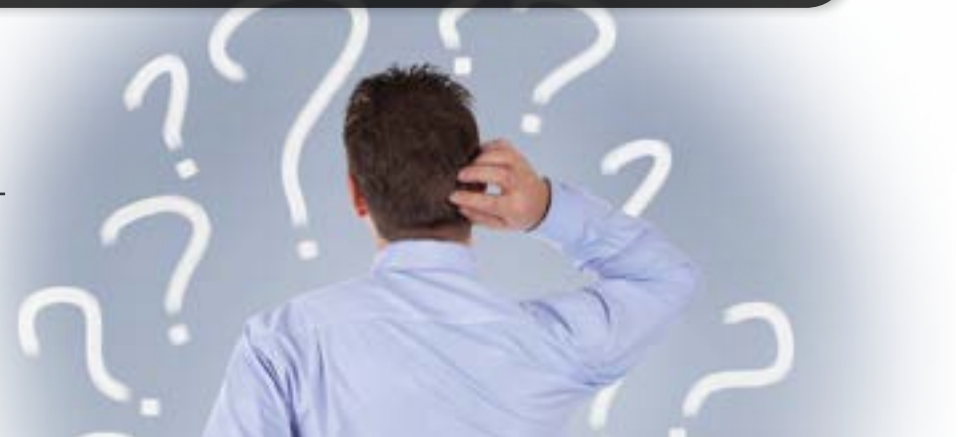
Zero-rated

- orthodontic appliances, artificial teeth
- parts, accessories or attachments specially designed for artificial teeth or orthodontic appliances

1

To Register or Not To Register?

Total taxable supplies > ***$30,000***	**Registration Mandatory**
Total taxable supplies < ***$30,000***	
i) significant ITCs available?	**Register Voluntarily**
ii) minimal or no ITCs available?	**Do Not Register**
Total taxable supplies = ***$0***	**Cannot Register**



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15-103 11/14

Value is demonstrated. Trust is earned.

Earn Trust, Demonstrate Value

SIMPLE STEPS TO IMPROVE PATIENT COMMUNICATION

Dr. Larry Levin

Dr. Levin practises in Hamilton, Ontario, serves on the CDA Board of Directors and chairs CDA's Trust and Value Working Group.

Recent research conducted by CDA revealed that 92% of dentists identify effective communication as the most important factor in building positive relationships with patients.

Clear chairside communication is vitally important and isn't difficult to perfect. Refining and updating this skill is something every dentist should take seriously. A few simple adjustments to patient communication can go a long way to enhance trust and reinforce value in the care you provide.

1. **Help set the tone with new patients.** It's a good idea for the dentist to be available at the start of an appointment to welcome new patients–even if just briefly. This welcoming gesture conveys that you are the leader in the practice, and tells your patient that you value them as a new patient.

2. **Listen and focus on your patient.** Listen attentively to your patient's concerns and oral health goals. Pay attention to body language and clarify if you sense any unspoken concerns. Make sure you have the information you need to make informed recommendations.

92%
of dentists identify effective communication as the most important factor in building positive relationships with patients.

3. **Ask questions.** Patients are more likely to offer valuable information when asked the right questions. To help earn their trust, ask patients how they feel, if they want more details, or if they understand the options you have presented. A little probing can provide insights and help avoid misunderstandings.

4. **Use lay language.** Few patients understand dental anatomy terms or the clinical names of dental procedures. At the same time, some patients may be uncomfortable admitting that they don't understand what you're saying. Clear chairside communication will help patients understand your diagnosis and the recommended treatment options while encouraging open, trusting dialogue.

5. **Explain the 'what' and 'why.'** The dental examination is the basis for your treatment recommendations. Explaining what you're doing during the exam, and why, helps patients understand and value your recommendations. Good communication during their appointment reinforces that you are focused on their care and helps patients understand why recommended procedures are necessary.

6. **Get comfortable discussing fees.** According to our research, 49% of dentists think it's not important to personally explain costs to their patients—in fact, it was rated as one

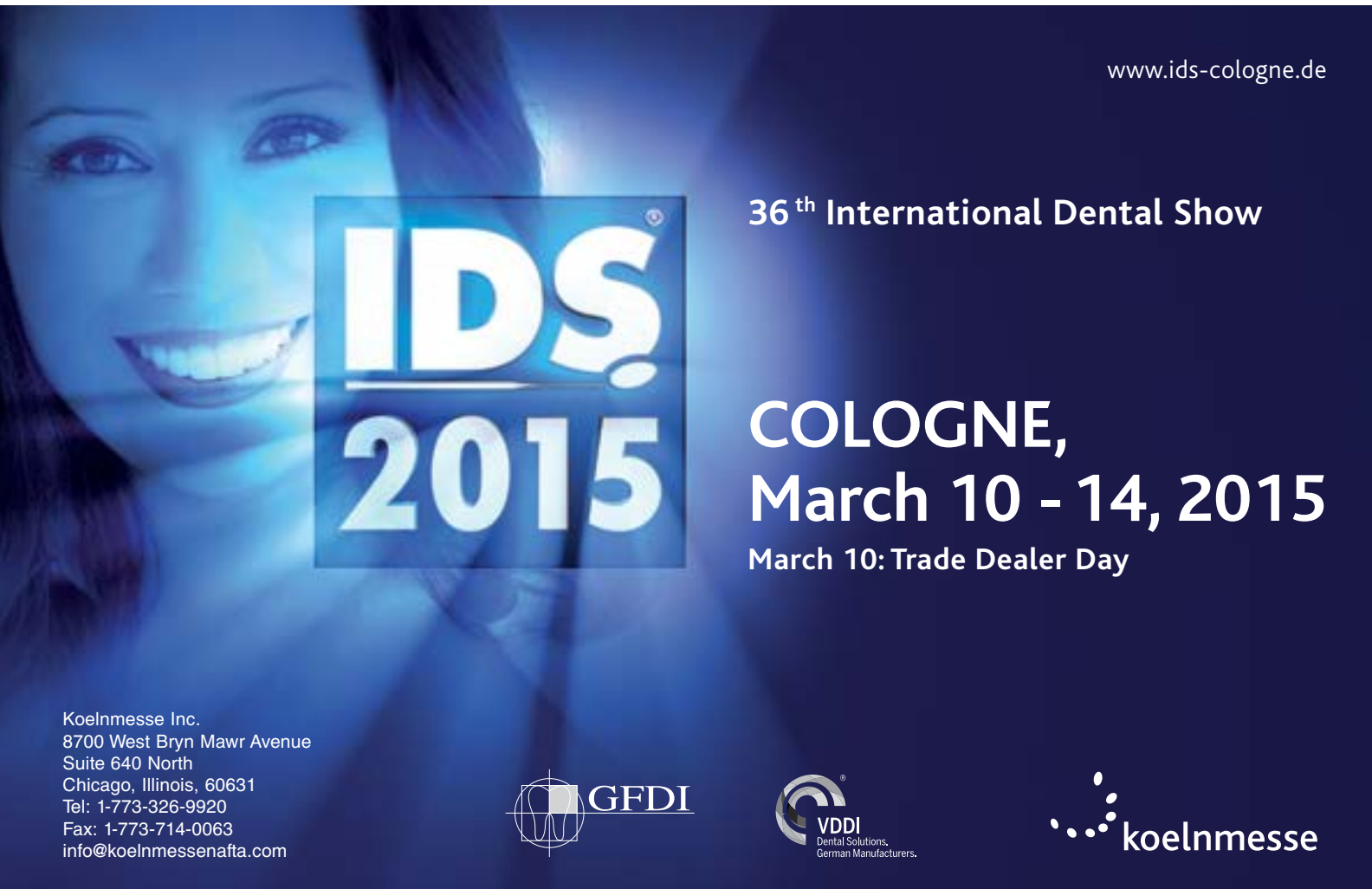
...empower both your staff and your patient to work with you to make the best decisions.

of the least important factors in maintaining a good patient relationship. However, more than half of Canadians think of the cost first when receiving recommendations from their dentist. It's helpful to include a general cost range as part of your discussion. The details of fees, financing and insurance can be provided later by staff.

7. **Work as a team.** The dental team has many players—dentist, dental hygienist, dental assistant, and front office staff—all focussing on the patient. By including the patient's oral health goals, knowledge and understanding into your treatment recommendations, you empower both your staff and your patient to work with you to make the best decisions.

8. **Offer one last opportunity to ask questions.** Real communication is a two-way street, not a lecture. It's difficult for a patient to properly communicate with you while they are lying down. Build in a few moments at the end of the appointment to ask your patient if they have any questions. Have the conversation when both you and the patient are able to give it full attention: when the patient is sitting upright in the chair and your mask down. By creating a respectful environment, your commitment to good patient communication will shine through.

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



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Trois-Rivières *to reintroduce community water fluoridation*

In February 2014, the city councillors of Trois-Rivières, Quebec, voted by a margin of 9 to 7 in favour of reintroducing community water fluoridation (CWF).

The city stopped adding fluoride to its water supply in 2008 because of the cost associated with the needed restoration of its drinking water treatment plants. However, a province-wide program for the fluoridation of drinking water allowed Trois-Rivières to reintroduce CWF, as the program will cover all fluoridation-related expenses. It could take up to 5 years for citizens of Trois-Rivières to start drinking fluoridated water again—the reintroduction of CWF being a multistep process that starts with the construction of new infrastructure.

"This was an important vote," explained Dr. Barry Dolman, president of the Order of Dentists of Quebec. "We needed a major city to take the first step, to cause a domino effect. Such a vote in favour of CWF encourages us to keep advocating in other major cities."

While Trois-Rivières Mayor Yves Lévesque is pleased with the turn of events, many city councillors felt that such public health decisions should be made by the provincial government. "We had to settle a very divisive debate, both within the population and council," said Councillor Jean-François Aubin. "I heard what both sides had to say and, as I am not an expert in CWF, I decided to follow the recommendations made by the province's department of public health."

Listen to a CBC interview with Mayor Yves Lévesque: cbc.ca/quebecam/mauricie/2014/02/06/fluoride-will-be-back-in-trois-rivieres-water-supply/

The Quebec government launched its program for the fluoridation of drinking water in 2005 to improve the oral health of its population. "Water fluoridation is the cornerstone of any public preventive oral health program, and all municipalities concerned should institute it," says the province's director of public health in a position document.

Quebec Dentists Mobilize *for those in need*

In September, the Foundation of the Order of Dentists of Quebec (FODQ) launched the ***Bouche B*** *[Open Mouth] project to offer free care to Quebecers with urgent dental needs. More than 200 dentists have volunteered to take part in this pro bono initiative.*

"This initiative is consistent with the mission of the FODQ, which is to promote access to dental health care for the most vulnerable members of society," explains Dr. Pierre Tessier, FODQ president.

The **Bouche B** initiative relies on its community partners to identify eligible candidates. Regional youth centres in Montreal and the province, Fondation du Dr Julien (a social pediatrics organization) and Fondation PAS dans la rue (an organization helping homeless and near-homeless adults) will be referring patients in need of urgent dental treatment who otherwise could not access care. These individuals will receive free dental services from local dentists volunteering in the project.

"Healthy teeth are an essential part of good overall health. It is therefore important that those in need have access to dental health care despite their financial difficulties—to avert more serious problems that would result in high costs for our health care system," adds Dr. Tessier. "We are proud of the participation of our dentists in this project and we hope it will expand to many regions of Quebec."

Quebec dentists who want to participate in the **Bouche B** initiative can register at **projetboucheb.ca/services**

RCDC Domestic Operations:

HELPING GOVERNMENT AND CANADIANS AT HOME

In the lead-up to the 100th anniversary of the Royal Canadian Dental Corps (RCDC) in 2015, this article is the sixth in a series commemorating the history and accomplishments of the RCDC over the last century. In addition to looking after the oral health needs of Canada's troops during combat, peacemaking and peacekeeping operations overseas, and serving on humanitarian and forensic missions, the RCDC supports our troops by providing assistance at home during natural disasters and other crises. RCDC also played a key role in Health Canada's Canadian Health Measures Survey.

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

The Oka Crisis (Op SALON), 1990

The Canadian Armed Forces (CAF) deployed 4,500 personnel during the crisis in Oka, Quebec, in 1990. In August, the 5 Brigade Field Ambulance Dental Platoon, commanded by Major James Taylor, was deployed to the Montreal area to provide dental treatment services to the brigade troops involved in Operation SALON. Four treatment sections were deployed in support of CAF field units. The original focus was to provide emergency dental care in the field. However, as the operational timeframe expanded, annual examinations and routine treatments were also provided.

Red River Flood (Op ASSISTANCE), 1997

In the spring of 1997, a major flood occurred along the Red River of the North in North Dakota, Minnesota, and Southern Manitoba. It was the river's most severe flood since 1826 and caused over $500 million in damages in Manitoba alone.

The province of Manitoba called in the CAF, the RCMP and the provincial department of natural resources for assistance in supporting approximately 17,000 civilians. Within 2 weeks, the initial request for 100 soldiers to fill sandbags quickly escalated to a joint force operation encompassing approximately 8,500 CAF personnel. The RCDC deployed the dental team of Captain Dan Stuart and Corporal Annie Martin to provide emergency care to the military personnel deployed on Operation ASSISTANCE.

Ice Storm (Op RECUPERATION), 1998

The ice storm of January 1998 caused a massive power failure that affected more than 1 million households in east-central Canada. Emergency efforts were hampered by fallen trees, broken power lines and rivers of ice blocking the roads. New Brunswick, Ontario, and Quebec requested aid from the CAF and Operation RECUPERATION began on January 8.

The operation involved over 15,000 Army, Navy and Air Force personnel—the largest deployment of troops to serve in response to a Canadian natural disaster and the largest operational deployment of Canadian military personnel since the Korean War. All three field dental platoons were deployed to provide oral health care to the numerous military personnel working to restore services. In all, 13 RCDC personnel were deployed.

Okanagan Forest Fires (Op PEREGRINE), 2003

At the request of the B.C. government in August 2003, the military responded to forest fires in the Okanagan Valley. At the height of the crisis, about 800 fires were burning and tens of thousands of people had been ordered out of their homes. Operation PEREGRINE involved more than 2,200 Canadian Forces personnel, who fought 5 of the worst fires over a 45-day period.

A section from 1 Field Ambulance Dental Platoon from Edmonton—Major Costa Batsos, Sergeant Sylvie Marcoux, Master Corporal Andrea Plante, and Corporal Nathalie Sauvageau—provided emergency dental services to deployed CAF personnel. To facilitate access to treatment, the mobile dental clinic was centrally located to many of the fires. When not providing emergency dental care, the dental team transported medical patients to the Field Ambulance location.

Canadian Health Measures Survey, 2007-09

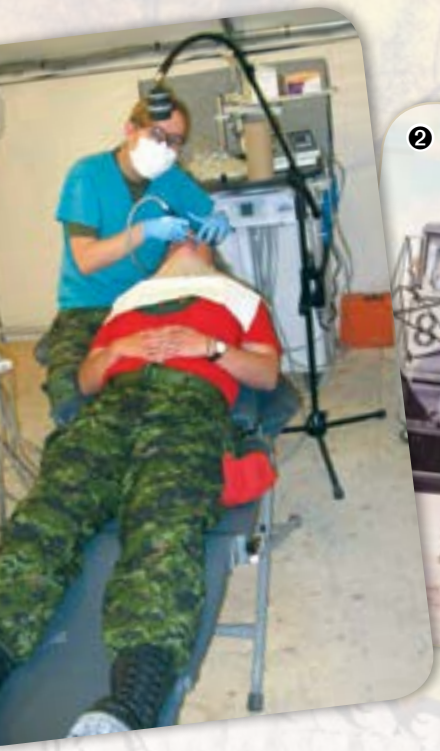
In 2007, Health Canada's Canadian Health Measures Survey (CHMS) included clinical indicators of oral health in a national survey for the first time in over 30 years. 1 Dental Unit provided 14 dental officers to serve as calibrated examiners, carrying out oral examinations for the CHMS' oral health component. In total, dental officers gathered valuable clinical data on over 6,000 Canadians at 15 sites. In 2009, the RCDC received CDA's Oral Health Promotion Award in recognition of their contribution.

Op NANOOK, DVI Resolute Bay, 2011

The dental section of Operation NANOOK was tasked with a double mandate: provide dental support to the over 500 personnel on exercise and provide dental treatment to eligible Resolute Bay residents. It marked the first time an RCDC dental team was deployed to provide dental care to CF members in the High Arctic, and the first dental outreach initiative between Health Canada and the Government of Nunavut that involved RCDC personnel. The dental team of Corporal Kelly Zseder from dental detachment Edmonton and Major Rachel Jetté from 1 Field Ambulance Edmonton deployed to Resolute Bay in July 2011.

Operation NANOOK also involved training exercises based on a scenario of a major air disaster. These activities were suddenly suspended in August when the inbound First Air Flight 6560 crashed just 2 km from camp. During the rescue efforts, the dental section helped care for 3 injured passengers and contributed to the victim identification process. ◆

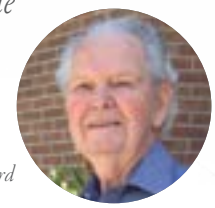
CDA is playing a central role in commemorating the 100th anniversary of the RCDC in May 2015, reflecting CDA's role in establishing a military dental service in Canada and the close partnership between CDA and RCDC since that time.



❶ Corporal Kelly Zseder providing oral hygiene care to a CF Ranger as part of Operation NANOOK in Resolute Bay.

❷ Operation SALON dental personnel in Oka, Quebec, in 1990.
Front row (L. to r.) Cpl JA Montgomery, Cpl JF Bélanger, Pte MM Binette, Cpl JLB Aubin, Cpl BP Hanlon,
Back row (L. to r.): Capt JRD Gagnon, Capt JM Maltais, Maj JC Taylor, Capt JAA Rioux, Capt TW Hogan.

> *We're only where we are today because past dentists made amazing contributions to the profession...*
>
> —Dr. Ralph Crawford



A TASTE OF HISTORY

When Dr. Ralph Crawford and his wife Olga started collecting dental artifacts some 50 years ago to decorate his Winnipeg office, they never imagined their finds would eventually reside at the Museum of Health Care in Kingston, Ontario.

Dr. Crawford and his wife have always shared a passion for collecting memorabilia. After he started dentistry school, the couple added dental items to their treasure hunting at various antique shows and auction sales. And as the local dental community became aware of this interest, colleagues started donating dental relics. "Pack Rat Crawford," as his confreres liked to call him, accumulated more than 4000 items over the years.

Upholstered dental chair from the 1890s.

Photos: From the Collection of the Museum of Health Care at Kingston. Used with permission.

Upper denture created by hunter Francis Wharton in 1968 using deer teeth, plastic wood, and household cement.

When Dr. Crawford became *JCDA* editor in 1987, the family moved to Ottawa, and so did the dental collection. The assortment found a home at the Dentistry Canada Fund office, where the executive director had suggested opening a dental museum. Upon the museum's closure in Ottawa, the collection moved to the Museum of Health Care in Kingston in 2010. "When the opportunity came to house a dental collection, the people at the Museum were quite interested, acquiring every piece that was in storage," says Dr. Crawford.

The Museum named its new acquisition the *Crawford Dental Collection*, to honour the couple's impressive contribution to the history of dentistry. As the Museum explains, it is "the most comprehensive cross-section of dental technology and practice in Canada over the past 200 years."

It includes dental chairs, sterilizers, cabinets, anesthesia units, drills, X-ray units, manufacturer pamphlets, and much more. Visitors may be surprised to even find plaster casts of 1957–63 Prime Minister John Diefenbaker!

"We're particularly proud of our collection of ivory dentures," says Dr. Crawford. "They're about 200 years old and carved out of solid walrus and elephant tusks. How they were created and how people wore them is still a mystery." Ivory dentures could be one of the first attempts in cosmetic dentistry. "For the anterior front teeth, instead of having ivory, human teeth were embedded and riveted for cosmetic reasons," Dr. Crawford explains.

Probably the most unusual dentures in the collection are homemade. As reported by the Kamloops Sentinel in 1968, hunter Francis Wharton of Little Fort, British Columbia, used deer teeth to create dentures for himself. For the palate, he molded plastic wood around the roof of his mouth, and he fitted the teeth he previously filled and grinded using household cement.

Another favourite of Dr. Crawford is a "finger-powered drill" from 1846 that had to be turned by hand. "I figured it did about 75 revolutions per minute."

With his collection and the *Teeth in Time* exhibition, Dr. Crawford hopes his peers can acquire the same kind of pride he feels about being a dentist. "I'm very proud of the progress of dentistry and of its contribution to people's health," he says. The collection mirrors the evolution of our profession. "We were here. We struggled. We innovated. We're only where we are today because past dentists made amazing contributions to the profession, with a mind to bringing optimal oral health to the patients to whom they were dedicated."

Museum of Health Care at Kingston

Support the museum

To help keep our dental history alive, the Museum of Health Care needs your support. Dr. David Tessier is a Kingston dentist who serves on the Museum's Board. He says the Museum always welcomes potential donations to its collection and is currently searching for articles from the mobile dental units used in World War I, to commemorate the upcoming 100th anniversary of the Royal Canadian Dental Corps in May 2015.

Donations can also take the form of commemorative gifts, endowment funds, bequests, annuities or recurring contributions. See **museumofhealthcare.ca/get-involved/donors.html** for details.

Upper denture from the early 1800s. The anterior teeth are human, and posterior teeth, ivory.

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Revealing the SECRETS OF SALIVA

Dr. Walter Siqueira is associate professor in dentistry and biochemistry at the Schulich School of Medicine & Dentistry. He is also the principal investigator at the only Canadian research laboratory dedicated solely to saliva research. CDA discussed the importance of saliva as both a diagnostic and therapeutic fluid with Dr. Siqueira.

Walter Siqueira
DDS, PhD

CDA: What is the focus of your research?

Dr. Walter Siqueira: I'm trying to identify biomarkers in saliva to determine one's vulnerability to several oral and systemic diseases, and I'm trying to prevent oral disease using modified salivary proteins.

CDA: What made you leave Boston University to join Western University?

WS: The support researchers receive in Canada. This country has a unique program, the Canadian Foundation for Innovation (CFI), which helps setting up research laboratories. Thanks to CFI, we have a mass spectrometer dedicated solely to our research purposes. Only in Canada did I have this opportunity.

When I first visited London, I was amazed by the university's infrastructure and people's collegiality. I knew it was a good place to settle down. I've never regretted moving.

CDA: Why is saliva research so promising?

WS: Everything we can detect in serum, we can detect in saliva. Technology used to be our limiting factor but now, with mass spectrometers being so sensitive, we're able to identify salivary biomarkers. On top of being time and cost efficient, saliva collection isn't an invasive prodecure and doesn't need to be performed by highly trained professionals—you only need to spit in a tube.

CDA: How do you think the use of saliva as a diagnostic fluid will change dentistry?

WS: I think dentists will work more closely with physicians to help diagnose systemic conditions. A saliva profile is like a fingerprint of one's health status: it shows their vulnerability not only to dental disease but also many other conditions, such as lung cancer, renal disease and Dengue Fever. Thanks to a 5-minute procedure, dentists could be involved in the early detection of several diseases. That would put dentists where we need to be— key players in our patients' overall health.

CDA: How close are we to using saliva as a diagnostic fluid?

WS: We're not close enough, because each disease needs to be studied separately. That said, we can now buy saliva-based HIV test kits in drugstores in the United States.

My laboratory is working with researchers from the Boston Medical Center on pulmonary disease detection, including asthma. So far, 10 salivary biomarkers have been identified to predict the exacerbation of asthma over a 24–48 hour period.

> *Thanks to a 5-minute procedure, dentists could be involved in the early detection of several diseases. That would put dentists where we need to be— key players in our patients' overall health.*

Two biomarkers have also been identified for renal disease. This could lead to patients collecting saliva samples and, with a test strip, verifying whether they need dialysis immediately or if it can wait. This would greatly improve their quality of life and save the health care system money.

CDA: Could saliva help prevent disease?

WS: Yes, and this is an exciting new area for dentistry! My laboratory is working on predicting how salivary proteins will evolve over time, and on making that evolution happen today. We modify key amino acids in proteins and combine proteins based on genes and proteins to create super proteins that are resistant to—and can kill—bacteria, and that can attach to the enamel surface strongly and prevent tooth decay, periodontal disease and dental erosion.

We're creating "intelligent proteins"—proteins that are only active when required. Basically, we incorporate on/off components in these super proteins. For example, when *S. mutants* or a lactobacillus starts producing acid, the protein will get activated and start killing the bacteria. The protein will remain inactive when there is no production of acid.

CDA: How close are we to using saliva for therapeutic purposes?

WS: It's hard to say, but I think we might be 4 or 5 years away from having our first product in the market.

We're currently exploring easy and inexpensive ways to deliver super proteins. Mouth rinses are an option, just like gels and toothpastes. It could also be interesting to offer them in the form of lollipops or candy.

CDA: Is there potential harm associated with super proteins?

WS: Not at all—we're only modifying proteins that already exist in saliva. To be authorized to do human testing, we had to prove that super proteins are not able to cause damage to the oral mucosa or any cells in the oral cavity.

CDA: What will human testing consist of?

WS: We're planning to start human testing in 2015–16. We'll conduct two studies. In one we'll mimic the environment for tooth decay using an orthodontic apparatus with enamel, to which we'll add both sugar and super proteins. In the other, individuals with a significant incidence of tooth decay will receive super proteins as a preventive measure.

CDA: Do you work on conditions other than tooth decay?

WS: Absolutely! We're in the early stages of creating a super protein to prevent the formation of dental calculus. With regard to periodontal disease, we're working on a protein to add directly in the gingival sulcus after scaling and planning, to help with healing and to keep the pocket clean.

This interview has been condensed and edited.

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

Help advance saliva research

Dr. Siqueira is hoping to create a bank of 15,000 to 20,000 saliva donors—healthy and diseased, young and old—who will be monitored on a yearly basis.

Dentists who want to participate will be asked to collect 2 mL of saliva from patients every year and update their medical and dental history in a shared database. When a donor develops a disease, their "healthy" and "diseased" saliva will be compared to determine the changes. Contact Dr. Siqueria at: **walter.siqueira@uwo.ca**

1-day workshop

In early 2015, Dr. Siqueira will hold a live workshop to discuss the project and how dentists can get involved. The workshop will cover everything from patient consent to sample collection and shipping, and database updates.

Following the event, the workshop will be available on the Network for Canadian Oral Health Research website, divided into modules.

Visit: **ncohr-rcrsb.ca**

Is it time to change our approach to CARIES MANAGEMENT?

Dr. Stephen Abrams is a man of many talents: a clinician with over 34 years of practice experience, chair of the Ontario Dental Association's Dental Benefits Committee for the past 16 years, and a prolific author who has published over 100 articles in international journals and publications.

But his contribution to dentistry does not end there. An innovator and entrepreneur, Dr. Abrams has also been redefining caries management. His company, Quantum Dental Technologies, developed the Canary System used for the early detection and monitoring of carious lesions. CDA met with Dr. Abrams to discuss developments in caries management.

Stephen Abrams
DDS

Listen to the interview at **oasisdiscussions.ca/2014/08/05/mcm**

What is the current state of the science with regard to the management of early carious lesions?

The science is evolving as we speak, and it's evolving on two different fronts: (1) how we detect and measure lesions; and (2) how we treat them.

In your practice, do you manage caries differently than you did 5 or 10 years ago?

Yes, I do. That said, changing our way of managing caries is very difficult because of time constraints and shifts in thinking. We have to consider risk factors, home care and different products, on top of thinking about how we measure lesion progression and when, if and how we replace restorations.

As practitioners, we need to stop and ask ourselves "If I find a lesion, do I immediately pick up my handpiece as I was trained to do as a clinician, or do I begin to look at preventive measures and products that may help stabilize the lesion?"

Are you also engaging with your patients in a different way?

Definitely! I want to educate my patients about what they need to do, so they stay engaged and involved in the treatment plan.

Our patients don't approach their oral health the way they used to. There's a lot more discussion now, and there's a sea of information patients read online—be it accurate or not—on various disease processes, including caries. Our job as clinicians must include patient education.

Do you believe that the North American approach is in tune with the evolution of the science underpinning caries management?

I don't believe so; there's a need for a bigger shift. We're still very much focused on what caries causes—holes, destruction of restoration margins, etc. We need to move our focus to questions such as "How did it get there and why?" and "Why are some of my patients able to resist this disease process?" We also need to go back to the basics and refer to caries as a disease.

> *Our patients don't approach their oral health the way they used to. There's a lot more discussion now and our job as clinicians must include patient education.*

What do you think is the key factor in managing dental caries successfully?

Patient engagement. If your patients aren't engaged in managing any disease process, there's going to be no success. Patients need to understand what the disease is, and we as clinicians need to provide them with quantifiable information so they understand whether things are improving or worsening. For caries management, it's about lesion progression or regression. If it's growing, we need to engage the patient in behavioural changes.

Are there new tools to help us engage our patients better?

Yes, there are. What I would advise dentists to look for in a tool is one that's linked to the disease process—in caries it's measuring change in crystalline structure—that is backed by good science and solid evidence with results that are quantifiable, and that patients can understand.

For example, my patients don't understand what that little interproximal spot is when I show them radiographs. But when I give them a number with a scale, they begin to understand. So looking at devices that have repeatable, numerical results is key. Moreover, patients have to understand what the device is measuring.

Would you say "caries medicine" is the future of caries management?

It has to be. We need to look at the fees for the various services. Because when you think about it, what's considered prevention isn't actually disease prevention—it's disease treatment. We need enough support for practices to run a robust preventive program, as well as a program that covers the cause of the lesion. Prevention is in my opinion undervalued at times. Yet that's the one thing that's going to make the biggest difference down the road.

How can organized dentistry support the evolution of caries management?

Organizations can provide the profession with access to literature and speakers, and knowledge on how to critically evaluate the literature. They can also advocate for a fee or reimbursement system that provides support so we can treat disease early in its process.

Finally, organized dentistry can message the fact that it's important that dental diseases be treated in what I call a "dental home," an environment where the dentist becomes the person who supervises, and is actively involved in, the management of the caries disease process across its spectrum.

This interview has been condensed and edited.

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

The Canary System

The Canary System, developed by Dr. Abrams and his team at Quantum Dental Technologies, uses a laser to measure both release of heat and reflected light from the tooth surface. The device provides information on the presence and extent of carious lesions up to 5 mm beneath tooth surface, including in the interproximal areas, cracks, beneath sealants and around the intact margins of restorations. It uses a numbering system to help patients understand if lesions are improving or worsening.

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Clinician-Scientist in the Making: DR. ZEESHAN SHEIKH

Educated in Karachi, Pakistan, and London, England, Dr. Zeeshan Sheikh worked for two years as a clinician before deciding to pursue his interests in dental research (on the fabrication and characterization of bone grafts) in Canada. He recently completed his PhD at McGill University's faculty of dentistry and is poised to begin a postdoctoral fellowship at the University of Toronto. CDA spoke with Dr. Sheikh about his decision to follow a career in research.

Zeeshan Sheikh
BDS, PhD

Hear the full audio interview at **oasisdiscussions.ca /2014/09/17/res-3**

CDA: Why did you choose research over private practice?

Dr. Zeeshan Sheikh: When I was working as a full-time clinician, it didn't take me long to realize that I was not entirely satisfied with my job. Being in research and academia provides me with the intellectual stimulation that I was missing in a purely clinical setting. I've been an inquisitive soul since childhood. Nothing makes me more excited than the prospect of a question that needs pondering. My aim is to become a researcher/academic/clinician and promote dental health research and education across Canada.

What do you think are the key factors determining success in a research career?

Hard work and perseverance always pay off. But, in our competitive times, success cannot be ensured by merely putting in hours. Every candidate applying for a professorship has degrees and publications; you should bring other attributes to the table to give you and edge over the other candidates. I feel that the Network for Canadian Oral Health Research (NCOHR) plays an important role in this, as it provides a great platform for students and young researchers to build their network and start collaborations.

Why aren't more young dentists pursuing careers in research?

Financial security is the primary reason, in my opinion. After graduation, the opportunity to work in a clinic and make money to pay off student loans is probably one of the main reasons that young dentists don't follow a career in research.

Secondly, not everyone is cut out to be in research. It requires hours of dedication and hard work, and sometimes there are no results to show for it.

And thirdly, there is a lack of awareness and knowledge among young dentists about careers in full- or part-time research. The annual NCOHR workshops provide dental undergraduate students with an opportunity to meet and be inspired by clinicians who are in research.

Who have been your most important career mentors?

I have been blessed with having great mentors who have always guided me in the right direction: my MSc supervisor, Dr. Ihtesham ur Rehman; my PhD supervisor, Dr. Jake Barralet; Dr. Faleh Tamimi; and Dr. Walter Siqueira have all played a critical role in my professional development.

> *The annual NCOHR workshops provide dental undergraduate students with an opportunity to meet and be inspired by clinicians who are in research.*

Has NCOHR played a role in helping you develop your career?

During the first NCOHR workshops held at the Schulich School of Medicine and Dentistry in 2013, I met with Dr. Michael Glogauer from the University of Toronto, who is a periodontal specialist. I stayed in touch with him and he recently offered me a postdoctoral fellowship position. Through the two NCOHR workshops I've attended, I expanded my network and had the opportunity to be part of the organizing committee for the NCOHR workshop that took place at the University of Alberta this summer.

What's next for you?

I will be starting my postdoctoral fellowship at the University of Toronto with Dr. Glogauer. In the future, I hope to work as a clinician-scientist and play a role in academia. I also want to stay affiliated with NCOHR in whatever capacity possible—it has played an important role in developing my career—and one day be part of the steering committee.

Any advice for colleagues considering a career in research?

Only that a career in academia is extremely challenging and competitive. Do it with all your heart and believe in your abilities. There is a need for young dentists to pursue research in Canada.

This interview has been condensed and edited.

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13-187 11/14

Getting Your Practice in Top Condition FOR A SMOOTH AND PROFITABLE SALE

CDSPI is committed to supporting dentists in all phases of their careers. As part of this commitment, CDSPI recently convened a panel of experts to provide advice to dentists in transition. The Navigating Change forum, held in Toronto, included discussions on how to make your practice as attractive as possible to potential buyers, and how to invest your proceeds wisely for retirement.

Buyers are becoming increasingly sophisticated in evaluating practices, according to the experts. They discussed a number of potential obstacles that could lead to decreased value in buyers' minds, and recommended that you start getting your practice in top shape well in advance of your intended sale date.

The Necessity of Employee Contracts

Mariana Bracic (❶), a specialist in employment law for the health care sector, said that, "employment issues have one of the most significant impacts on the value of your business." She explained that a buyer could potentially spend tens of thousands of dollars, or more, to address a vendor's issues related to employment law.

The reason, Ms. Bracic said, is that a number of different laws in Canada cover employment issues and they are often contradictory. According to diverse provincial standards legislation, the maximum settlement that an employee is entitled to can be as low as 8 weeks, while with common law, the rule of thumb for termination pay is one month for every year of employment, up to a maximum of 24 months. For example, to terminate an employee with over 20 years of experience could be extremely costly if there is no proper employment contract in place.

Ms. Bracic emphasized that the remedy is to have contracts that reflect the provisions of the minimum employment standards as legislated by your province. She suggested that you start this process at least 3 years before your anticipated sale date to give employees sufficient notice, and then ask them to sign contracts. She maintained that the vast majority are pleased to do so in order to retain their jobs.

Getting Your Lease in Shape

David Rosenthal (❷), a senior lawyer who advises dentists on purchases and sales of dental practices, focused on potential pitfalls in your building lease that could make a practice unattractive to prospective buyers. These include:

A Demolition Clause – If a landlord decides to demolish the plaza or building, they can terminate your lease and evict you with several months' notice.

A Relocation Clause – The landlord can require you to relocate your practice to another (and potentially less desirable) location within the plaza or building.

> *The main thing I want you to come away with is that you need to surround yourself with experts.*

A Termination Clause – When you request consent to transfer your lease to a purchaser, the landlord has the option to reject your request and terminate the lease instead, which seriously restricts your ability to sell the practice.

A Renewal Clause – At the time of renewal, this option simply states that the rent amount will be "as mutually agreed by landlord and tenant," without a mechanism to resolve the rental amount if the parties cannot agree.

Mr. Rosenthal said your goal is to have these clauses deleted from the lease when you renew. "Remember you have some leverage with your landlord," he explained. "Dentists are AAA tenants, so they won't want to lose you. If your landlord rejects your initial requests, it may be worth offering to pay a higher monthly rent in exchange for an agreement to delete these various problem clauses."

Investing Your Proceeds

After you sell your practice, how do you invest the cash so that you can enjoy the fruits of your labour? According to Ron Haik (❸), Vice-President, Investment Advisory Services at CDSPI, you need a sound plan that doesn't take unnecessary risks.

He cited an example of a dentist who, in 2008, was quite well off at the age of 69. He decided to stay almost completely invested in equities and lost a substantial amount that he didn't really need to put at risk given his net worth. He told of another prosperous dentist who invested in an ill-advised scheme that cost him everything he had worked for his entire life.

"At this stage of your life, capital preservation should be the primary goal, and modest growth a secondary goal," said Mr. Haik. Another challenge is multiple competing priorities. "You can't have it all now *and* in the future," he said. "You have to make choices and for a lot of people that's pretty tough."

Speakers at the forum were clear that if you are planning to sell your business, you need to think well ahead to prepare properly. Mr. Rosenthal provided this sound advice for dentists in transition: "The main thing I want you to come away with is that you need to surround yourself with experts. Selling your practice is a critical life event and professionals will serve you well."

Article by Sandy Kovack

Mr. Kovack is a staff writer with CDSPI.

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Dalhousie University is located in Halifax, Nova Scotia, Canada. Halifax is a vibrant, capital city and is the business, academic and medical center for Canada's east coast.

Review of applications will begin January 1, 2015 and will continue until the position is filled.

All qualified candidates are encouraged to apply. Canadians and permanent residents will be given priority. Dalhousie University is an Employment Equity/ Affirmative Action employer. The University encourages applications from qualified Aboriginal people, persons with a disability, racially visible persons and women. Applicants should submit a letter of application (that includes a statement of the applicant's teaching philosophy and research interests), a Curriculum Vitae, reprints of up to three (if available) research publications and arrange for three letters of reference to be sent by the referees directly to:

Dr. Ronald Bannerman, Chair
Search Committee (General Practice Dentist)
Faculty of Dentistry
Dalhousie University
P.O. Box 15000
Halifax, Nova Scotia, Canada B3H 4R2

D10563

DALHOUSIE UNIVERSITY
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Periodontist

The Faculty of Dentistry, Dalhousie University is seeking applications from a qualified Periodontist to fill a full-time, tenure stream faculty position at the rank of Assistant, Associate or Full Professor. For the appropriate candidate, there may be potential for advancement to the position of Head of the Division of Periodontics or Director of Graduate Periodontics in the Department of Dental Clinical Sciences.

Responsibilities will include didactic, pre-clinical and clinical teaching in all aspects of Periodontics including undergraduate and postgraduate Periodontics courses as well as participation in collaborative research, continuing education, Faculty committees and administrative duties.

Candidates must have completed an accredited, specialty program in Periodontics, hold a Master's degree and are expected to have didactic and clinical teaching experience. Preference will be given to candidates with a demonstrable record of teaching Periodontics at both the undergraduate and graduate levels, and a background in administration. Salary and academic rank will be commensurate with the successful candidate's qualifications, experience and achievements.

The successful applicant must be eligible for licensure in Nova Scotia as a specialist in Periodontics. Priority will be given to those who hold an FRCD(C) fellowship in Periodontics from the Royal College of Dentists of Canada. Opportunity for private practice privilege is available within the Faculty's intra-mural practice.

Dalhousie University is one of Canada's leading teaching and research universities with four professional faculties, a Faculty of Graduate Studies and a diverse complement of graduate programs. Inter-faculty collaborative and interactive research is encouraged, as is cooperation in teaching. Dalhousie University inspires students, faculty, staff and alumni to make significant contributions regionally, nationally and to the world.

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Faculty of Dentistry
Dalhousie University
P.O. Box 15000
Halifax, Nova Scotia, Canada B3H 4R2

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UBC DENTISTRY | THE UNIVERSITY OF BRITISH COLUMBIA

FULL-TIME POSITIONS
in
PROSTHODONTICS and RESTORATIVE DENTISTRY
Department of Oral Health Sciences
Faculty of Dentistry
The University of British Columbia

The UBC Faculty of Dentistry invites applications for two full-time faculty positions in the discipline of prosthodontics, with an emphasis on restorative dentistry. The appointments will be at the rank of Assistant Professor, with consideration of a higher rank depending on qualifications. Applicants must have postgraduate training in prosthodontics and be, or be eligible to be, licensed specialists in prosthodontics in Canada.

The successful candidates will be required to have potential for teaching excellence in restorative dentistry and prosthodontics. Preference will be given to individuals whose program of research will contribute to improved oral health of British Columbians, especially the elderly, and will enhance existing research at UBC. Individuals with promising research and academic experience are encouraged to apply. Service to the University and the community is an expectation.

The successful candidates will contribute extensively to teaching in the DMD and the combined Diploma in Prosthodontics/MSc in Craniofacial Science graduate program at UBC; will develop a robust research program; and will effectively supervise graduate student research.

The successful candidates will hold full-time faculty appointments at UBC with salary, rank and appointment status commensurate with qualifications and experience. UBC hires on the basis of merit and is strongly committed to equity and diversity within its community. We especially welcome applications from visible minority group members, women, Aboriginal persons, persons with disabilities, persons of minority sexual orientations and gender identities, and others with the skills and knowledge to productively engage with diverse communities. However, Canadian citizens and permanent residents of Canada are given priority. Review of applications will begin February 1, 2015 and will continue until the positions are filled. Applicants must send a curriculum vitae that includes research interests, evidence of teaching effectiveness and contact information for three referees to:

Dr. Rosamund Harrison
Head, Department of Oral Health Sciences
Faculty of Dentistry, UBC
2199 Wesbrook Mall, Vancouver, BC V6T 1Z3
rosha@dentistry.ubc.ca

For more information about the Faculty of Dentistry see www.dentistry.ubc.ca

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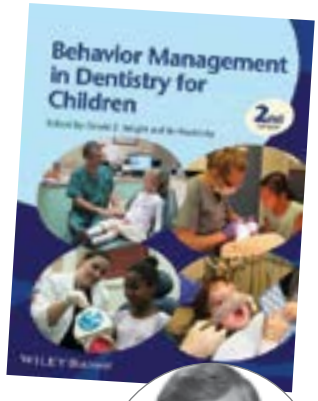
Behavior Management in Dentistry for Children, 2nd Edition



In a guest editorial in Pediatric Dentistry,[1] *Dr. Dennis McTigue, professor of pediatric dentistry at The Ohio State University college of dentistry, reflects on his career of over four decades and notes "there is nothing in pediatric dentistry that has changed more during our practice careers than behavior guidance." How fitting that the second edition of the textbook,* Behavior Management in Dentistry for Children,[2] *has been released almost 40 years after its initial publication in 1975.*

Gerald Wright

The book's original author, Dr. Gerald Wright of London, Ontario, is joined in the second edition by coeditor Dr. Ari Kupietzky and a strong cast of new contributors to update this classic work. Chapters are expertly edited and filled with practical advice for daily practice.

The book editors believe that pediatric dental treatment involves a dynamic relationship between the child, the family and the dentist, and cover all aspects of that relationship. This position concurs with American Academy of Pediatric Dentistry guidelines[3] that state: "The goals of behavior guidance are to establish communication, alleviate fear and anxiety, deliver quality dental care, build a trusting relationship between dentist, child, and parent, and promote the child's positive attitude toward oral/dental health and oral health care."

Dr. Wright established his career at the Schulich School of Medicine and Dentistry (then called the University of Western Ontario) where he is now professor emeritus. I had the great fortune of working in his department and dental practice from 1984–86. In 2011, I approached Dr. Wright about the possibility of speaking at the 2012 Canadian Academy of Pediatric Dentistry Annual Meeting. He agreed and gave a lecture at the meeting on the history of pediatric dental sedation. This lecture served as the inspiration for chapter 9 of the second edition, "Introduction to Pharmacological Techniques: A Historical Perspective."

Many dentists will be interested in the chapters "Sedation for the Pediatric Patient" and "Minimal and Moderate Sedation Agents" by Dr. Stephen Wilson, a leader in sedation of pediatric dental patients at the Cincinnati Children's Hospital Medical Center. Dr. Wilson states that there are no recipes for sedation cocktails, instead emphasizing the importance of being competently trained and having in-depth knowledge.

The new and relevant chapters, "Working with a Dentist Anesthesiologist" and "The Use of General Anesthesia in Behavior Management," discuss the importance of the growing trend in use of anesthesia for the care of pediatric dental patients. Early childhood caries (ECC) is now the most common reason for day surgery, almost always performed under general anesthesia, among young Canadian children. Roughly 19,000 ECC-related day surgeries are performed annually in Canada, not including those conducted in private facilities.[4]

Behavior Management in Dentistry for Children, is a perfect book for pediatric dental residents, dental students and practising dentists who treat children, including pediatric dental specialists. It is a thorough, practical and approachable read and an invaluable addition to any dentist's library.

Book Review by Dr. Lawrence Yanover

> *The book editors believe that pediatric dental treatment involves a dynamic relationship between the child, the family and the dentist, and cover all aspects of that relationship.*

References

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3. American Academy of Pediatric Dentistry. Guideline on Behavior Guidance for the Pediatric Dental Patient [revised 2011; accessed 2014 July 24]. Available: www.aapd.org/policies/

4. Canadian Institute for Health Information. *Treatment of Preventable Dental Cavities in Preschoolers: A Focus on Day Surgery Under General Anesthesia* [accessed 2014 Jul 24]. Available: www.cihi.ca

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