MANITOBA DENTAL ASSOCIATION

Bulletin

ISSN 070-1717 Volume 25, Number 3, Fall, 2006

INSIDE THIS ISSUE

Message from Dr. Johann de Vries, Dean, Faculty of Dentistry

After eight years at the University of Manitoba Faculty of Dentistry, it with mixed emotions that my family and I made the decision to relocate to Australia. We have had an amazing time in Winnipeg, and we are grateful for the support and encouragement we received from the University of Manitoba, the Manitoba Dental Association and our many friends and colleagues.

We came to Winnipeg as a family, and as a family we became part of Winnipeg and its people – part of the University, the Faculty, the profession and the many friends that we made. It is difficult to share our appreciation in words. From the bottom of our hearts we want to thank you for the unforgettable opportunities.

Every day of our time in Canada and at the University of Manitoba was exciting, rewarding, and meaningful. We made friends in Winnipeg, Canada and the U.S. who not only taught us more about ourselves and inspired us in purposeful ways, but also supported us to develop both personally and professionally. We will always cherish the experiences and the people of Canada. We are leaving Winnipeg and the University of Manitoba with very positive feelings, memories and experiences, which will remain with us forever.

I personally appreciate the co-operation and guidance I received both from the MDA and the University of Manitoba. I want to thank Mike Lasko, Ross McIntyre, Rafi Mohammed, Lori Stephen-James, the presidents that I served with, and the MDA Board, for allowing me to be part of the Board, all the support, and cooperation. Without the MDA Board's understanding and support, we would not have been able to create all the successes for the Faculty. I also thank President Emőke Szathmáry and the two Provosts I served under, Dr. Robert Kerr and Dr. James Gardner, for their mentorship, guidance and inspiration. Their wisdom and willingness to be involved have contributed greatly to the level of excellence that the Faculty of Dentistry has achieved.

Please join me in welcoming Dr. Randy Mazurat as the Acting Dean of the Faculty of Dentistry. His leadership, experience and aptitude will guide you to a new chapter that builds on the strengths of the Faculty of Dentistry and the profession overall.

My very best wishes to you all.

Johann de Vries
Dean, Faculty of Dentistry
University of Manitoba

"OPEN WIDE"

The Manitoba Dental Association in partnership with the University of Manitoba-Faculty of Dentistry is once again hosting an "Open Wide" day.

"Open Wide" is a free day of dentistry where licensed dentists and oral health team members provide dental treatment at no cost to the public.

"Open Wide" 2006 will be held **Saturday, October 21st, 2006 @ the Faculty of Dentistry Community Clinic, 790 Bannatyne Avenue, Winnipeg.**

Why get involved, again? We believe that personally, it was such a rewarding experience and professionally, it showed dentists as been socially responsive to the citizens of Manitoba.

The five-hour commitment that we are asking for will be of tremendous value to the dental profession as we again demonstrate to Manitobans the strong social conscience of dentists.

We are also encouraging dental hygienists and dental assistants to volunteer their time as they played an important role in the delivery of care.

Volunteer shifts are 8:00am-1:00 p.m. and 12:30 p.m. - 5:00 p.m.

"**Show Manitobans we care: Volunteer"**

President's Message

Dr. Lori Stephen-James

Even after years away from school, fall brings a sense of "getting back to work". Of course the MDA office has continued to work on our behalf during the summer months and with Ross returning to work in June; there was a collective sigh of relief to see him on the mend. We are all very appreciative of the extra time, work and effort that Rafi, Mike and Diane have done over the past six months; feel free to pass on thanks.

There have been a number of issues that are in the forefront. The Dental Assistants Scaling Module Pilot Project has been completed. As of mid July, these graduates of CDI College were able to perform limited scaling under the supervision of a dentist. Hopefully we will be able to offer the next program later this fall. If anyone is interested in more information, please contact the MDA office,

The registration of Dental Assistants remains in the formative stage. Thank you to all the offices that returned the information sheet. However, there has been a request by the membership to discuss the by-law, and this will occur on September 28, 2006 at the Victoria Inn, Winnipeg.

The self-regulation of Dental Hygienists is also in the formation stages. Dr. Michael Lasko is our representative on the Transitional Council, which was formed by the government. In this role, he will be keeping our interests and those of the public, in mind. It isn't likely to be completed by January of 2007, so we will keep you informed. The CDA has initiated a national dental hygiene task force to address concerns across the country. Dr. Pat Kmet is participating on the committee which will be meeting this fall.

The Workers Compensation Board tried again to include health professionals within its domain. As a result of successful argument against inclusion, enrollment remains optional for the Dental Profession. However, we should bear in mind that by keeping a safe work environment, the WCB won't have reason to insure us.

On the National Front, there have been a few new initiatives and updates on other programs. The CDA-Access Day is a proposal that would provide free dental service on a pre-determined day of the year. As Manitoba currently offers the "Open Wide" Clinic as well as "Tooth Fairy Saturday", we felt that we were already fulfilling this mandate. Within the concept of volunteerism, the CDA will be distributing a survey requesting information about the amount of time and monetary value that we contribute on a "pro bono" basis. The intent is to have concrete stats to show what we already know - we contribute our time and resources.

As well, the CDA is promoting an alliance with the Canadian Federation of Independent Business. The intent is to use their knowledge base, advocacy and resources to improve the business of dentistry. Individual dentists may also become members by registering with the Manitoba branch and, to encourage participation, they are offering a reduced fee.

ITrans continues to take on momentum. This project is up and running and is now a member service. At the outset many of us were restricted by our software. However, most companies have either made the update or are working towards it. The program has the potential for more than just claims submission. The future of electronic transmission includes the Electronic Health Record which would mean that health professionals would be able to access pertinent information at a moments notice. As well, digital images would be transmittable, reducing the need to mail x-rays. Currently, the CDA is ensuring the needs of dentists are included in the development of the EHR. Ultimately this would give access to a patient's health record. As well, prescriptions could be completed on line. Unfortunately the Manitoba government is behind other provinces in this endeavor and we do not know when it will become available.

There hasn't been any change to the FNIHB negotiations. FNIHB is standing firm regarding auditing providers. On the other hand, we are pleased that SAHS has agreed to pay 90% of the 2006 MDA Fee Guide. Thanks again to all the people that negotiate on our behalf.

When reviewing all the business that is ongoing, I realize what a great profession we belong to - but it can't be all work and no play. The Annual Convention will be held in Brandon, February 1-3, 2007. This is a chance to get away for a weekend, collect a few CE hours, and socialize. Just a reminder to book your hotel now - hope to see you there.

Having read this update, if you would like to express any concerns, feel free to contact myself or any other board member. We would like to think that we are representing our profession, but we cannot do it without hearing from you.

Lori Stephen-James, D.M.D.
President, Manitoba Dental Association

Registrar's Column

Dr. Michael Lasko

Dental Assisting Update

The registration process for Level II Dental Assistants is proceeding – but not at the pace that was originally anticipated.

A speed bump has been encountered – probably as a result of mis-information in the dental community. The MDA has been co-operatively working with dental assistant representatives over the last number of years to develop a formal recognition category and an annual renewal process for all dental assistants who are working intra-orally. Numerous articles have appeared in the Bulletin regarding this issue, including a piece in the Bulletin explaining the process prior to sending the by-law to our members for review and approval.

The members were expected to take and read that information and provide a list of Level II Dental Assistants to the MDA office to allow us to continue the development of the Registration Protocol. As a result of receiving in excess of 10 letters from MDA members a Special Meeting was necessary to allow for further discussion of this process. Hopefully, by the time you read this, the meeting result will allow us to proceed with registration of dental assistants.

Dental Hygiene Transition Council

The Transitional Council of Dental Hygienists has been meeting over the last few months to develop registration protocol as well as draft regulations. Additional attention is also being devoted to by-law development by a sub-committee.

It is expected that the Council will continue to meet throughout the fall and, once the drafts are finalized, further information will be provided.

Michael A. Lasko, D.M.D.
Registrar,
Manitoba Dental Association

Because We Live Here.

Every kid deserves a childhood.

However, a lot of kids in our city have no choice but to grow up pretty fast … think of the nine-year-old helping his mom carry groceries home from the food bank, because by the time the end of the month draws near, there's just not enough money left to feed him and his family.

Or imagine the child who can't have a ball game or play street hockey because it's unsafe in the neighbourhood for kids to play out on the street.

Put yourself in the place of the child who is moving one more time, because the rent has gone up again, and her family can no longer afford to stay in the place where they're living. She's going to be "the new kid" all over again, trying to try to fit in with new classmates and teachers, trying to keep up with the new things she's supposed to be learning.

More than 1 in 4 children in Winnipeg have to cope with issues like these on an ongoing basis, because they live in poverty. Moreover, the average household income of those living in poverty is only $14,397. Clearly, not every child in our city is born with the same opportunities.

In total in 2005, United Way invested $2 million in strategies that address the root causes of poverty, including skill development and job preparedness workshops designed to help people re-enter the workforce, money management programs, and adult literacy programs. As well, United Way is working with policy-makers to remove systemic barriers that make it difficult for people to transition out of poverty.

And because kids who live in poverty have precious few places to go where they can just be kids, United Way also invests in organizations that run drop-in centres, and after-school and mentoring programs – places where kids can play and make friends; where they can get help with their school work; where they are safe from the streets. "*Building Belonging*" , Boys & Girls Clubs of Winnipeg and Rossbrook House provide some of the many United Way-funded initiatives designed to provide an environment where kids who would otherwise have little choice but to be out on the streets, can come and be safe, and have fun just as kids everywhere ought to have the chance to do.

Poverty, of course, also has a huge effect on the general and dental health of those who are burdened by it. United Way is proud of the partnership we share with the dental profession through Mount Carmel Clinic. United Way funds the clinic's Dental Program, which allows families with modest income access to quality dental care which they could otherwise not afford.

Continued on page 5

Because we live here:
continued from page 4

As well, with support from United Way, a special twice-monthly dental clinic is conducted for refugees.

Your commitment to our community makes the difference for children in poverty and their families**.**

United Way is most appreciative of the support we have received from the dental profession in past years. Your continued support will mean that children can find a haven from the streets; that they will have the chance to connect with their community in a healthy and positive way; that their families will have the opportunity to get the training and tools they need to work their way out of poverty and give their children a better life.

Please continue to support United Way's work in our community in the 2006 campaign.

We'll all benefit, *because we live here.*

Patient Dental Records

Under the Personal Health Information Act of Manitoba and the Personal Information Protection Electronic Documents Act of Canada patients can obtain a copy of their dental health record upon written request to the provider.

The provider is required to provide to the patient a copy of his/her patient chart, including x-rays, if requested.

The Manitoba Dental Association recommends that the provider retain the original patient chart and x-rays. The provider may charge a nominal fee for the copying of the charts and x-rays. The MDA Fee Guide provides a recommended fee for the copying of x-rays (see code 02911).

If the patient requests in writing that a copy of his/her patient chart and x-rays be forwarded to another provider, you are obligated to do so. In this case, please ensure that the provider does receive the information. Otherwise, the patient should pick up the requested information in person and sign off that he/she has received it.

Dental providers shall respond to this request as promptly as required in the circumstances but no later than 30 days after receiving it.

The dental provider should make every reasonable effort to assist an individual making such a request and to respond without delay, openly, accurately and completely.

Rafi Mohammed, CAE
Membership Services Director
Manitoba Dental Association

Manitoba Dental Association Directory Amendments

For changes to the MDA Directory please contact:
Diane Troubridge at the MDA office - (204) 988-5300

District 1

Dr. Diala Chaaban
&
Dr. Roland Debrouwere
&
Dr. Donald Dziewit
&
Dr. Mark E. Johnston
&
Dr. Michael Lasko
&
Dr. Herman Lee
&
Dr. Linda Simpson

have relocated to:

211-2305 McPhillips Street
Winnipeg, MB R2V 3E1
Phone: (204) 334-4341

Dr. Indira Kalia
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Winnipeg MB R2R 1K5
Phone: (204) 633-4457

Dr. Mariajose Ruiz
28-845 Dakota Street
Winnipeg, MB R2M 5M3
Phone: (204) 257-1891

Oral & Maxillofacial Surgeon
Dr. Jiayan Guan
62 Laurel Ridge Drive
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(204) 775-3009

Orthodontist
Dr. Dr. Amani Morra
2-1190 Taylor Avenue
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Phone: (204) 947-1825

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Paediatric Dentist
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Dr. Natalie Sanche
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Phone: (204) 956-2060

Periodontist
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Phone: (204) 990-5932

Dr. Mohammad Ghiabi
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Prosthodontist
(Academic Affiliate)
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Phone: (204) 822-5506

Dr. Edwin Moran
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Phone: (204) 452-2239

Dr. Sherri Stoski
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Phone: (204) 728-1914

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District 4

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Petawawa, ON K8H 3N2
Phone: (613) 687-9096

Manitoba Dentists on Third Party Payers

The Economics Committee of the MDA commissioned questions about dentists' relationships with third-party payers in this year's economic survey. The five questions, which appear at the end of this article, deal with insurer promptness in paying claims, their administrative burdens on dental offices, their administrative impediments to patient care, and dentists' assignment practices.

Great West Life (GWL) and Blue Cross were the promptest payers of GP claims by a wide margin in 2006, normally paying 94.0% and 91.3%, respectively, within 30 days and 100% within 60 days (Table 1). Both companies were also leaders in alacrity of GP payments in the 2004 survey.

The slowest payers of GP claims for the second successive survey were Employment & Income Assistance (EIA) and First Nations and Inuit Health Branch (FNIHB) with payment rates of 4.5% and 12.6%, respectively, at 30 days and 34.4% and 47.1% respectively at 60 days. By contrast, the listed private insurers usually pay 96.6% to 100.0% of claims within 60 days.

Table 1: Normal # Days to Pay Claims – GPs

Payer	< 31	31-60	61-90	91-120	120 <
Blue Cross	91.3%	8.7%			
FNIHB	12.6%	34.5%	23.6%	12.6%	16.7%
GWL	94.0%	6.0%			
Manulife	68.9%	30.1%	0.5%	0.5%	
MFCW	61.9%	34.7%	2.8%	0.6%	
EIA	4.5%	29.9%	37.9%	15.3%	12.4%
Sun/Clarica	72.0%	24.7%	2.7%	0.5%	
Other	20.0%	40.0%	20.0%	10.0%	10.0%

Great West Life, Manitoba Food and Commercial Workers (MFCW) and Manulife were the insurers with the best standard turnaround times for specialist claims (Table 2). Blue Cross had been the promptest payer of specialists in 2004, settling 100% within 30 days, but its performance has slipped to a ranking of 4th in 2006 (Table 3). Despite some improvement since 2004, FNIHB still ranks last in the speed of payment of specialist claims, and EIA continues to be the second slowest payer.

Table 2: Normal # Days to Pay Claims – SPs

Payer	< 31	31-60	61-90	91-120	120 <
Blue Cross	47.4%	47.4%	5.3%		
FNIHB	9.5%	38.1%	23.8%	9.5%	19.0%
GWL	70.6%	29.4%			
Manulife	64.7%	29.4%		5.9%	
MFCW	58.8%	35.3%	5.9%		
EIA	5.6%	33.3%	50.0%	5.6%	5.6%
Sun/Clarica	47.1%	47.1%	5.9%		

The indices in the following table show that EIA's normal payment times exceeded the all-listed insurer averages for GPs and specialists by 65.2% and 46.4%, and FNIHB's turnaround times exceeded these averages by 57.0% and 55.8%. Conversely, GP leader, Blue Cross, beat the GP average by 40.4% and specialist leader, Great West Life, beat the average by 30.5%.

Table 3: Normal Claims Turnaround Times - Indices and Rankings

Payer	GP Index	Rank	SP Index	Rank
Blue Cross	59.6	2	84.9	4
FNIHB	157.0	7	155.8	7
GWL	58.1	1	69.5	1
Manulife	72.7	4	79.0	2.5
MFCW	77.9	5	79.0	2.5
EIA	165.2	8	146.4	6
Sun/Clarica	72.1	3	85.4	5
Other	137.1	6	-	-

GP and specialist levels of satisfaction with the administrative requirements of insurers were sought using a scale ranging from extremely unsatisfied (numerical value 1) to satisfied (numerical value 4). Average scores were calculated for each insurer. An insurer would receive the highest average score of 4.0 if 100% of responding dentists were satisfied with its administrative requirements and their resulting burdens on dental offices, whereas the lowest possible average score of 1.0 would apply only if all respondents were extremely dissatisfied.

GPs find the administrative requirements of Blue Cross (3.8) and Great West Life (3.6) to be the least burdensome in terms of time spent on paperwork, approvals and getting information (Table 4). These companies were 31.0% and 24.1%, respectively, above the average score of 2.9, whereas the lowest ranked insurers, FNHIB (1.8) and EIA (2.3), were 37.9% and 20.7%, respectively, below average performance.

Table 4: GP Satisfaction with Insurer Admin Requirements

Payer	Extr Unsat	Very Unsat	Some-what Sat	Satis-fied	Avg Score
Blue Cross		4.7%	11.9%	83.4%	3.8
FNIHB	49.7%	26.5%	16.9%	6.9%	1.8
GWL	1.0%	4.7%	26.4%	67.9%	3.6
Manulife	4.7%	16.1%	38.5%	40.6%	3.2
MFCW	0.6%	5.6%	39.1%	54.7%	3.5
EIA	31.2%	25.9%	29.1%	13.8%	2.3
Sun/Clarica	7.8%	12.0%	37.5%	42.7%	3.2
Other	31.3%	31.3%	25.0%	12.5%	2.2

Continued on page 8

Manitoba Dentists: continued from page 7

Over 75% of GP respondents were extremely dissatisfied or very dissatisfied with FNHIB's administrative procedures and over 57% were similarly dissatisfied with EIA's red tape. In contrast, the proportions of GPs satisfied or somewhat satisfied were over 95% for Blue Cross and 94% for Great West Life, and no private insurer had more than a 21% minority of dentists very or extremely unsatisfied with its administrative burdens.

Specialists considered MFCW (3.9) to be the top insurer in terms of administrative requirements but all of the remaining private insurers on the list also scored high ratings of 3.7 to 3.8. FNHIB (2.1) and EIA (2.9) received ratings, which were below average by 36.4% and 12.1%, respectively. FNHIB's requirements were deemed to be very or extremely unsatisfactory by 66.6% of specialist respondents.

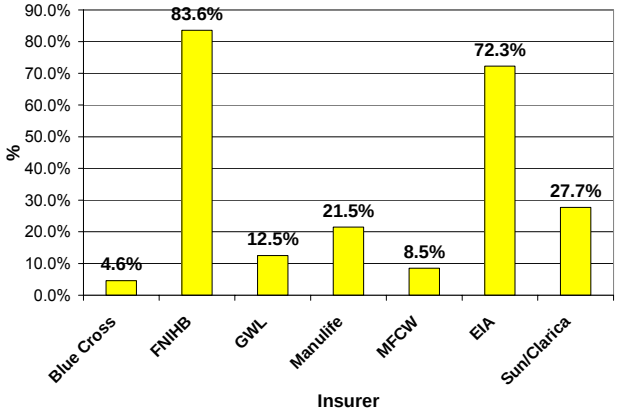
Table 5: SP Satisfaction with Insurer Admin Requirements

Payer	Extr Unsat	Very Unsat	Some-what Sat	Satis-fied	Avg Score
Blue Cross		4.5%	13.6%	81.8%	3.8
FNIHB	45.8%	20.8%	8.3%	25.0%	2.1
GWL	4.5%		9.2%	86.4%	3.8
Manulife			21.1%	78.9%	3.8
MFCW			5.3%	94.7%	3.9
EIA	9.5%	14.3%	57.1%	19.0%	2.9
Sun/Clarica			26.3%	73.7%	3.7
Other		50.0%	50.0%		2.5

Dentists also rated insurers in 2006 by the degree of administrative interference with the provision of required patient care. The four point scale ranged from extremely interfering (1) to not interfering (4).

Large majorities of GPs considered the administrative requirements of FNIHB (83.6%) and EIA (72.3%) to be extremely or very interfering with patient care (Figure 1). The Sun/Clarica (27.7%) and Manulife (21.5%) proportions were also high.

Figure 1: GP % Opining that Insurer Requirements are Extremely or Very Interfering with Patient Care



The least interfering insurers were Blue Cross (3.6), MFCW (3.4) and Great West Life (3.3) with ratings which were 22.2% to 33.3% above the average score of 2.7, according to GPs' subjective opinions (Table 6). GPs opined that the administrative procedures of FNIHB (1.7) and EIA (2.0) interfered the most with good patient care and these insurers' ratings were 37.0% and 25.9%, respectively, below average.

Table 6: Degree of Interference with GP Patient Care

Payer	Extr Interf	Very Interf	Some-what Interf	Not Interf	Avg Score
Blue Cross	1.5%	3.1%	27.6%	67.9%	3.6
FNIHB	55.6%	28.0%	12.2%	4.2%	1.7
GWL	3.5%	9.0%	39.2%	48.2%	3.3
Manulife	6.0%	15.5%	44.5%	34.0%	3.1
MFCW	3.2%	5.3%	40.4%	51.1%	3.4
EIA	41.4%	30.9%	18.3%	9.4%	2.0
Sun/Clarica	11.1%	16.6%	40.7%	31.7%	2.9
Other	50.0%	21.4%	21.4%	7.1%	1.9

All private insurers scored well with specialists: average scores ranged from 3.5 for Manulife to a high of 3.7 for MFCW (Table 7). On the other hand, the scores of FNIHB and EIA were 37.5% and 28.1%, respectively, below average.

Table 7: Degree of Interference with Specialist Patient Care

Payer	Extre mely	Very	Some-what	Not	Avg Score
Blue Cross	4.3%		26.1%	69.6%	3.6
FNIHB	50.0%	11.5%	30.8%	7.7%	2.0
GWL	4.3%		26.1%	69.6%	3.6
Manulife	4.8%		38.1%	57.1%	3.5
MFCW	5.3%		15.8%	78.9%	3.7
EIA	28.0%	20.0%	44.0%	8.0%	2.3
Sun/Clarica	5.0%		45.0%	50.0%	3.4

Over two thirds of GPs (69.9%) accept assignment of payment to all insurers, compared to slightly less than one third of specialists (32.1%) (Table 8). Specialists are much

more likely than GPs to have policies of no assignment (32.1% versus 7.7%) or selective assignment (39.3% and 22.5%).

Table 8: Assignment Policies of GPs and SPs

Policy	*GP*	*SP*
No Assignment	7.7%	32.1%
All Assignment	69.9%	28.6%
Selective Assignment	22.5%	39.3%

GPs who selectively accept assignment were most likely to exclude from assignment the patients of FNIHB (63.6%) and EIA (37.2%). The percentages of all GPs who do not accept assignment range by insurer from a high of 21.7% for FNIHB claimants to a low of 9.7% for Blue Cross claimants.

Conversely, specialists were most likely to exclude patients of Blue Cross, MFCW, Manulife and Sun/Clarica (all 62.5%). The absolute number of specialist survey respondents who selectively accept assignments is low, and this may affect the reliability of specialist data in Table 9.

Table 9: Selective Assignment Dentists – % Not Accepting Assignment by Insurer

Payer	*GP*	*SP*
Blue Cross	9.1%	62.5%
FNIHB	63.6%	20.0%
GWL	9.3%	50.0%
Manulife	13.6%	62.5%
MFCW	20.9%	62.5%
EIA	37.2%	33.3%
Sun/Clarica	20.9%	62.5%
Other	66.7%	

The two Government insurers currently pay dental fees less than those listed in current MDA fee guides. EIA pays 90% of the 2006 MDA fee guides, whereas FNIHB pays 90% of the 2003 guides, which is equivalent to 81.4% of the 2006 guides.

The Third Party Committee will review these findings and may make recommendations to the Board on ways of dealing with insurer issues that adversely affect patient care and impose administrative and economic burdens on dentists.

Wordings of Questions

- How long does it normally take insurers to pay claims after you submit them?
- How satisfied, from a dentist's perspective, are you with the following insurers' administrative requirements when you treat one of their insured patients? In answering, consider your and your staff's time spent on paperwork, approvals, getting information over the telephone and other issues.
- To what extent (if any) do you think that the following insurers' administrative requirements (such as pre-determinations and prior approvals) interfere with your patients' receiving required and appropriate treatments from you?
- What is your current policy on acceptance of assignment on claims payments to a patient's insurer?
- If you accept assignment only from patients of some insurers, please indicate the insurers from whose patients you will and will not accept assignment?

Any questions or comments about this article can be made to Michael Loyd, Michael Loyd & Assoc Ltd. at 489-1386.

The Manitoba Institute of Sculptors and Artistes
62 Albert Street
Winnipeg, MB

The MISA has two openings for stone sculpting and two for clay sculpting.

This is a natural hobby and outlet for dentists.

If assistance or training is required it will be available, gratis.

For information phone the studio at (204) 775-5565 or Jean at (204) 888-6839.

Dental Practice Advertising and Promotional Activities

The Manitoba Dental Association receives numerous requests to review advertisements for dental practices. Based on the content of a particular advertisement, practice owners may be asked to alter or delete some parts of their advertisement because it contravenes the Ethics By-law Advertising guidelines.

The following is a synopsis of the Ethics By-law which deals with advertising and promotional activities of dentists:

Dentists shall not engage in advertising, or any form of promotional activity which:

1. is false, misleading, or deceptive;
2. may create unreasonable expectations in patients or potential patients about the results dentists can achieve; or
3. is incapable of objective verification.

In addition, dentists should not engage in promotional activities that may harm the dignity and honour of the profession.

1. False, Misleading or Deceptive

Statements must be avoided which:

1. contain misrepresentations of fact;
2. omit facts which, if included, would contradict the statement.

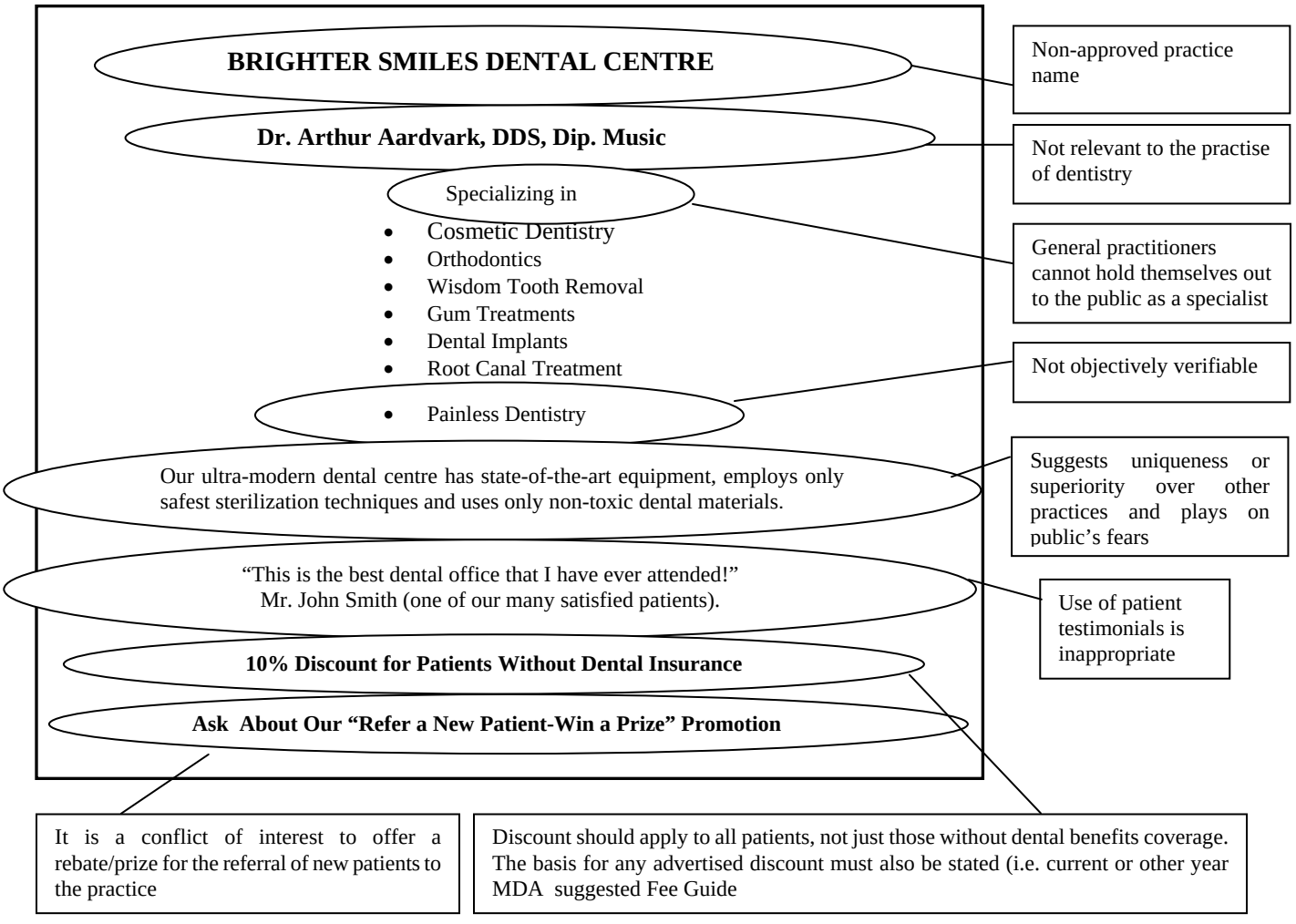
Examples: “Advance sterilization procedures”

2. May create unreasonable expectations in patients or potential patients

Statements must be avoided which is not relevant to the person ability to make an informed choice.
Examples: “Painless Dentistry”, “High quality restorations”, “Gentle Dental Care”, “Life-long Solutions”

3. Objective Verification

Statements must be avoided which are not verifiable by facts or can only be verified by a person’s personal feelings, beliefs, opinions or interpretations



Examples: "Highly-trained professionals"; "Complete Waterline Disinfection and Instrument Sterilization"; "Whiter, Brighter Smile"; "Dental Implants – Regain the security, appearance, and strength of natural teeth"

4. Use of Titles and Announcement of Specialization. All members of the MDA may use the titles of Doctor, Dr. or Dentist. Dentists must not do anything which would lead the public to believe that specialty services are being rendered by qualified specialists in general practice offices when such is not the case.

Examples of advertising that express or imply a specialty which is are not a formal specialty program recognized by the profession:

- Laser Dentistry
- Implants or Implantology
- Cosmetic Dentistry
- Homeopathic, Holistic, Naturopathic Dentistry
- Pain Anxiety Management
- TMJ Management

General dentists who wish to announce the services available in their practices are permitted to announce the availability of those services so long as they avoid any communications that express or imply specialization. The following is an example of how a general practitioner can advertise to the general public services offered:

- Dr. T Smith General Practice Dentist
- Dr. T Smith General Practice Dentist – Limiting Practice to Pain Anxiety Management
- Dr. T Smith General Practice Dentist – Limiting Practice to Cosmetic Dentistry

Other than fellowships in specialties listed in the Ethics By-law, dentists using the attainment of non-accredited fellowships in direct advertisements to the public may be making representations which are misleading or deceptive. Examples of this include:

- Las Vegas Institute of Cosmetic Dentistry Masters Graduate
- Pankey Institute Graduate

If you are unsure whether your present or future advertisements are consistent with the advertising guidelines of the MDA Ethics By-law or have questions about developing your advertisements, the Manitoba Dental Association Ethics Committee will review the advertisements for you.

Thank you to the College of Dental Surgeons of Saskatchewan and the Royal College of Dental Surgeons of Ontario for sharing resource materials to assist in the development of this article.

Rafi Mohammed
Membership Services Director

Health Science Centre Adult Dentistry Update

There have been some changes at the HSC Adult Dental Clinic (well known to most of the University of Manitoba graduates as "C-3") of which the profession should become aware.

Long-time Head of Dentistry, Dr. Ron Boyar, has retired from both his hospital and University positions. Due to his departure and consequential lessening of general dental coverage, no dentists have accepted the two positions available for this year. This has led to a serious manpower shortage.

Presently, Dr. Chris Cottick has taken the position of Acting Head of Dentistry. Unfortunately, due to his other commitments, he is only able to serve one half day per week regularly. There is some occasional coverage from two other dentists but, combined, this is no where near the previous level. Thus the clinic has to be very careful in selecting the patients it treats and the referrals it accepts. Some patients have to be refused and some are being returned to the community to ensure more prompt treatment.

The dental clinic wants the dental community to keep several points in mind:

a) The C-3 Adult Dental Clinic is not a free clinic – regular MDA Fee Guide fees are charged to patients. Please don't refer patients with the expectation of free treatment.
b) There are several dentists in the province willing and able to perform different conscious sedation techniques – including IV sedation. A list is available from the MDA office. Patients who are healthy (i.e. ASA I or II) should not be referred to C-3 for sedation treatment.
c) C-3 Adult Dentistry does maintain a "special needs" operating room general anaesthesia slate. This option is reserved for patients who can not be treated in any other manner due to severe physical or behavioral difficulties. Presently, the waiting time for non-urgent treatment is 9-12 months. If referring patients for OR treatment please be aware of the wait and, if possible, seek treatment in the community through other means of sedation.
d) Due to the difficulty to obtain, and length of time needed to wait for available appointments, any patient who can be treated in the community should be treated there. Complete, detailed, referrals are requested for any patient the community hopes to refer to the C-3 Adult Dental Clinic. A final decision about accepting any patients will be made by the dental staff at C-3.
e) Any dentist who is experienced with medically compromised and mentally challenged patients can apply to Dr. C. J. Cottick to join the rotation of staff dentists.

The C-3 Adult Dental Internship Program is in temporary hiatus, but with appropriate supervisory dentists and oral surgeons, this critical program for the patients of Manitoba can continue its good work of producing dentists capable and interested in treating the under-serviced medically and mentally challenged patients of our province.

C. J. Cottick, D.M.D.
Acting Head, Adult Dentistry
C-3, Health Sciences Centre

faculty of dentistry
The University of Manitoba

FACULTY CORNER

Dr. Lorne Golub Receives award

A University of Manitoba Faculty of Dentistry alumnus has been awarded the 2006 American Dental Association Gold Medal Award for Excellence in dental research. Dr. Lorne M. Golub is the first Canadian to receive the prestigious award – handed out once every three years.

Dr. Golub, DMD (Class of '63), M.Sc. (Class of '65), was notified July 1, 2006 that he would be receiving the award, which includes a $25,000 cash prize, an inscribed gold medal, and a three-year position on the ADA Council on Scientific Affairs.

A Harvard-trained Periodontist and renowned researcher, Dr. Golub and his research team made the discoveries that led to the development of Periostat, the first ever systemic medication approved by the U.S. Food and Drug Administration and by the Canadian Federal Drug Agency, as a collagenase-inhibitor drug. Collagenase is the only enzyme produced by human tissues that can degrade collagen, the major constituent of periodontal tissues and many other tissues in the body. Periostat and newer more potent versions of this drug are now showing evidence of efficacy not only in inflammatory periodontal disease but also in inflammatory skin diseases, arthritis, cardiovascular disease and cancer.

Dr. Golub has received numerous honours over the past 25 years including a MERIT award from the National Institutes of Health, a Distinguished Scientist Award in Oral Biology from the Int. Assoc. Dental Research, an honorary M.D. degree from the University of Helsinki Medical School, and the Annual Norton Ross Award for clinical research from the ADA.

In 2003, he was promoted to the rank of Distinguished Professor at the State University of New York at Stony Brook on Long Island. In 2002, he was given the Distinguished Alumnus Award from the University of Manitoba Faculty of Dentistry.

Graduate Orthodonitcs Shines Ruby Red

Graduate Orthodontics celebrated its 40th anniversary in Winnipeg on the weekend of June 2, 2006 with a gathering that attracted alumni from across Canada and U.S. Visitors enjoyed tours of the Faculty, including a demonstration of the new ViewPoint biometrics software and computer in the Graduate Orthodontics Clinic.

The homecoming event included lectures, a dinner a Tavern in the Park, and planned social activities. Donor recognition plaques were unveiled during the occasion, along with photographs of pioneer orthodontists, Dr. Ernie Cohen and Dr. Lou Melosky, for their dedication and service to the program over many years. After hearing many speeches, faculty, staff, alumni and friends enjoyed a relaxing and informal evening at Assiniboia Downs. The weather was perfect for the event.

At Tavern in the Park, Dr. Conny Athanasopoulos, President, Manitoba Society of Orthodontists, Dr. Billy Wiltshire, Head, Department of Preventive Dental Science, Dr. Emőke Szathmáry, President, University of Manitoba, Dr. Ernie Cohen, Honoree, Dr. Lou Melosky, Honoree, Dr. Johann de Vries, Dean, Faculty of Dentistry, and Dr. Gerry Solomon, President, Canadian Association of Orthodontists.

At the Clarion Hotel, Dr. Billy Wiltshire, Head, Department of Preventive Dental Science, Dr. Anoop Sondhi, Keynote Speaker (sponsored by 3M Unitek), and Dr. Conny Athanasopoulos, President, Manitoba Society of Orthodontists.

Hmm… Who should we bet on? Dr. Billy Wiltshire, Head, Department of Preventive Dental Science and Dr. Gerry Solomon, President, Canadian Association of Orthodontics.

Faculty of Dentistry Researcher Honoured with Spittoon

Over the past 42 years, many staff and students at the Faculty of Dentistry have been called upon to spit for the sake of research.

Dr. Colin Dawes, Professor Emeritus, Oral Biology, has studied the role of saliva in oral and general health since 1959, and he's approached many people over the years to obtain samples for his work. Now in the height of his career, Dr.

career, Dr. Dawes has earned a

Continued on page 14

Faculty of Dentistry Researcher Honoured: continued from page 13

shiny, brass spittoon in recognition of his contribution to salivary research.

The Salivary Research Group of the International Association for Dental Research (IADR) presented Dr. Dawes with the 2005 Salivary Researcher of the Year Award in June, recognizing his many years of dedication and expertise in the field. The IADR, comprised of approximately 12,000 members worldwide, presented Dr. Dawes with the prestigious award at the IADR meeting in Brisbane, Australia.
The award is an engraved spittoon, which is circulated annually from one award recipient to the next. Dr. Dawes is the second Canadian to receive the Salivary Researcher Award since it was first presented in 1982.

"It is a great honour to receive this award, given the very high quality of the previous recipients," Dr. Dawes said.

Dr. Dawes' renowned research projects have included studies of the physiological factors that affect salivary flow rate and composition, the role of saliva in oral sugar clearance, the relation between the volume of saliva in the mouth and the sensation of oral dryness, and the influence of salivary film velocity on the metabolism and pH of dental plaque. His work has been presented in a variety of forums including oral presentations and articles. In 2003, the Wm. Wrigley Jr. Company featured an article by Dr. Dawes in a special publication on *The Benefits of Chewing* and another article in 2006 in *The Benefits of Chewing II*.

Dr. Dawes is currently researching tooth erosion caused by the consumption of acidic beverages, such as soft drinks and juices, and the role saliva plays in the potential remineralization of teeth.

Getting Insurance That's Right for You

With so many types of insurance being offered in the marketplace, and new, specialized choices appearing lately (for example, critical illness coverage), how do you determine which types of coverage are right for you, your practice and your family?

First, keep in mind that each type of insurance guards against distinctive risks. There are no multi-purpose plans offering protection against all potential threats to your financial well-being. So, on the personal insurance side, you'll need **long term disability insurance** to help cover your living expenses such as home mortgage payments and groceries when sickness or injury prevents you from working. However, to pay for the ongoing expenses of your practice such as rent, utilities and employees' salaries during a disability, you'll need another plan called **office overhead expense insurance**. Without both plans you likely won't have sufficient funds to meet your two very different needs during disability.

Your practice could also be at risk if you don't have **practice interruption coverage** to pay for the necessary continuing office expenses as well as income lost when your business is interrupted by office disasters such as fire, theft or vandalism. It's crucial that you also have **office contents coverage** for your practice to cover the cost of repairing or replacing damaged office equipment and supplies in case of fire and other insured perils.

In terms of liability coverage, **malpractice insurance** protects you and your practice against claims arising from the professional services performed by you or your staff. However, you'll need a different type of protection, **commercial general liability coverage**, to insure against third-party legal actions arising from your practice such as a patient slipping and falling on the premises.

Specialized plans fill in the gaps. To supplement your disability coverage, there is **critical illness insurance**. While monthly disability benefits help you maintain the status quo, with the critical illness benefit you could afford the extras. When you are diagnosed with specific medical conditions including heart attack, cancer and stroke, the plan's timely, lump sum benefit payment could cover larger, significant expenses such as medical treatment abroad, in-home care, or retrofitting your home.

Meanwhile, **personal umbrella liability insurance** offers additional personal liability coverage to protect against large lawsuits that go beyond your existing home, auto and other personal liability policies and **legal expense insurance** eases the burden of high legal costs by covering lawyer fees and other expenses incurred in approved legal proceedings.

To determine which insurance plans you need and what amount of each, consider the level of risk with which you're comfortable, your financial resources and your financial obligations. If you have investments, assets and savings that can be liquidated easily should disaster strike, you may need fewer types of insurance or lower amounts of coverage. By the same token, if you have few obligations (no dependents or outstanding debts, mortgages, etc.), you may not require as much coverage.

Generally, practice owners have more possessions at risk than associates, so owners require more office coverage. Younger dentists typically have fewer assets and greater debt, calling for higher amounts of life insurance, for example, to protect dependents and provide collateral for mortgages and practice loans. As you age, your short-term uses for life insurance may diminish (as children leave home and debts are repaid) and they may be replaced with a desire for permanent life insurance as you acquire more possessions and need coverage for estate planning purposes.

Seeking the assistance of a licensed insurance professional can help ensure that your insurance coverage is appropriate. Look for someone who has experience working with dental professionals, so you'll be confident that the insurance you select is suited for your unique personal and practice requirements. As well, be sure to arrange to review your coverage regularly with your advisor since your needs will change over the years.

*To contact a personal insurance planning advisor at Professional Guide Line Inc., please call **1-877-293-9455, extension 5002**.*

The Dental Specialist

"The Dental Specialist" is written by Manitoba Dental Specialists. Each issue features one of the dental specialty groups (on a rotational basis). In this month's issue, the article is submitted on behalf of the Oral Pathologists.

The Diagnosis and Management of Oral-Herpes Simplex Infection: focus on patient education

Background

Among other human herpesvirus-associated diseases, acute herpetic gingivostomatitis and herpes labialis continue to receive attention, as they represent a lifelong viral infection which is often atypical in presentation and potentially life threatening in course. The principal causative agent of primary gingival herpetic gingivostomatitis is HSV-1, and ubiquitous and highly contagious virus. It is estimated that up to 90 % of the population worldwide is seropositive by the fourth decade of life, and up to 40 % of individuals harboring latent infections are affected by recurrent infections (1). Identical disease may be caused by HSV-2, the serotype most often associated with genital herpes. While genital herpes is recognized as a sexually transmitted disease of public health importance, HSV-1 and HSV-2 genotypes are known to be shared between oral and genital lesions. Both HSV-1 and -2 have been implicated in a significant proportion of erythema multiforme, an often-debilitating mucocutaneous disease. From several epidemiologic and molecular studies, evidence is accumulating that infection with HSV-2, and probably with HSV-1, is a predisposing factor in infection with the human immunodeficiency virus (HIV). Therefore oral herpetic disease should be considered within the spectrum of infectious disease of global significance.

HSV-1, is an enveloped, double-stranded DNA virus whose genome encodes over 80 proteins, several of which have been established as essential in viral replicative functions and latency. Over the past few years considerable advances have been gained in the understanding of HSV pathogenicity, including: 1) the discovery of specific cell surface receptors and their interactions with viral envelope ligands for cell entry, 2) the elucidation of complex host-viral interactions in controlling programmed cell death, and 3) cellular signal transduction mechanisms, ultimately leading to overzealous anti- inflammatory responses. HSV-1 and -2 share the ability to damage epithelial cells, to spread via sensory neurons, to establish latency in terminal ganglia, and to cause life-long recurrent infections.

Epidemiology and transmission of infection

Given the overall high prevalence of HSV of either seroptype in the adult population world wide, but relatively rare incidence of overt disease, it is believed that most oral infections, particularly those with HSV-1 are silent, subclinical or minimally symptomatic in immunocompetent individuals.

Earlier epidemiologic studies have shown that most oral infections with herpes simplex virus are acquired through direct contact with active lesions of other patients, the highest risk of contagion being present during the active viral shedding period. This is normally limited to one to four days in immunocompetent individuals. However, transmission through viral shedding into saliva and self-contamination with genital secretions, even during asymptomatic infections should be also taken into consideration. Furthermore, HSV-1 viremia is not only present in the peripheral blood of immunocompromised adults and in neonates, but also during primary herpetic ginigvostomatitis in immunocompetent children at the relatively high frequency of 34 % (2). These findings draw attention to the potential role of viremia in viral dissemination as an important public health consideration, for example in advocating adherence to strict infection control practices during dental intervention.

Cross-immunity between the type 1 and 2 serotypes may develop in individuals exposed by either the oral or genital rout, but cross-protection is not confirmed in all studies [3]. While HSV-1 is the primary cause of oral infection and HSV-2 remains the primary cause of genital herpes, HSV- 1 is emerging as an increasingly important agent of genital herpes in developed countries, oro-genital contact being the probable mode of transmission, especially in younger age groups (3).

Clinical manifestations; primary herpetic gingivostomatitis and recurrent herpes labialis

Primary infection with HSV-1 is manifest typically as acute herpetic gingivostomatitis in children beyond the neonatal period. It is characterized by multiple crops of vesicular eruptions located on any oral mucosal surface, frequently on the movable oral mucosa such as that of the lip, the part of the gingiva that is attached to the alveolar bone (termed attached gingiva) and the oropharyngeal mucosa. The free, unattached gingiva may show intense erythema rather than vesicular eruption. There is fever, malaise, and regional lymphadenopathy. The symptoms develop after a variable incubation period of one day to three weeks. The patients and susceptible contacts, may show vesicular or pustular dermatitis (primary or recrudescent herpetic Whitlow), but not exclusively localized to the fingers. Dysphagia and drooling in children may lead to dehydration. In adults, primary infection (serologically proven or apparent - without known history of childhood infection) is often seen as pharyngostomatitis, with fever and malaise preceding the development of crops of small vesicles on the tonsils and posterior pharyngeal wall.

It is important to emphasize that recurrent herpetic gingivostomatitis may be indistinguishable in presentation from that typically seen in primary infection, and *de novo* infections similar in course to primary infections are known to develop in seropositive individuals. For this reason, it is appropriate to refer to individual cases of herpetic gingivostomatitis as acute rather than primary.

Neonatal herpes simplex infection (occurring between the first and fourth weeks of age) may manifest as disease localized to any area of the skin, eyes and mouth (SEM disease); or more often as life threatening, disseminated multiorgan disease with or without fulminant encephalitis. Neonatal infection can be transmitted from the mother

antepartum, but acquisition is most likely intrapartum during passage through the birth canal, in mothers with primary genital herpes infection, most often with typeHSV-2 rather than HSV-1.

In the immunocompetent population, the typical manifestation of recurrent HSV-1 infection is herpes labialis (in lay terms cold sores). Herpes labialis is characterized by unilateral, coalescing vesicular eruptions surrounded by erythema, followed by crusting. The lesions are localized on or near the vermilion border of the upper lip or in more severe cases spread more widely periorally on the facial skin, ala of nose or nasal mucosa. The list of known triggers of labial HSV reactivation includes: stress, surgical trauma, menses and other hormonal changes, infectious febrile conditions and hyperthermia, ultraviolet radiation and drugs such as corticosteroids. Dental extractions as well as nontraumatic dental procedures may cause reactivation with oral symptoms of various severities. Reactivation during radiation treatment for head and neck cancer appears to be rare (4). The eruptions may be preceded by a prodromal stage, typically characterized by a tingling sensation. The lesions last for 24 to 48 hours and crusting may be present for 5 – 7 days or more before healing occurs generally without scarring. Recurrent oral mucosal lesions are usually restricted to small clusters of microvesicles that rupture to leave punctate ulcers, typically unilaterally on the palatal gingiva. When present, pain is most often reported by the patient as a burning or stinging sensation. In fact, in the majority of cases presenting for medical treatment, pain is the predominating chief complaint. The psychosocial impact of recurrent herpes labialis is estimated to be significant especially in individuals with frequent episodes, mainly because of its undesirable facial esthetic effect and fear of transmission to others.

The intraoral mucosal lesions are also self limiting, generally resolving within 1 to 4 days. However, even in immunocompetent individuals, atypical features such as large, intensely painful ulcers lasting for over 3 weeks, even months are sometimes seen. In immunosuppressed individuals, the oral manifestations of recurrent infections are often persistent and atypical in appearance - mimicking primary infection or other oral mucosal lesions such as major aphthous ulcers. Early in the course of HIV- disease the lesions tend to heal spontaneously within the first two weeks, but later, as the immunodeficiency progresses, lesions left untreated may last for weeks or months. Most importantly, extensive or persistent HSV1-positve oral lesions should raise the suspicion of immunosuppression. Conversely, in immunosuppressed patients oral lesions suspected of being HSV1-induced require prompt laboratory testing and antiviral treatment.

Unusual manifestations of primary and recurrent HSV infection

Both primary gingivostomatitis and recrudescent orolabial infections may coexist with severe extraoral mucocutaneus manifestations, namely those of herpetic retinitis (often in children by self inoculation), and eczema herpeticum (disseminated herpetic rash, often associated with atopic dermatitis). Herpes encephalitis is a rare but severe, life threatening manifestation of HSV infection, most often with HSV-1, and in the majority of cases as a result of reactivation rather than primary infection.

Erythema multiforme (EM) is an acute, polymorphous mucocutaneous disorder of complex etiology. Oral, mucosal-only lesions of EM usually represent self- limiting inflammatory disease. They are characterized by bullae and vesicles that rupture to form raw, erythematous ulcerations or ragged erosions. On the lips, hemorrhagic crusting of ulcerations on the vermilion zone is typical.

Clinical differential diagnosis and laboratory diagnosis

The differential diagnosis of uncomplicated acute herpetic gingivostomatitis includes recurrent aphthous stomatitis (RAS; in lay terms canker sores), herpangina, herpes zoster, and oral cytomegalovirus infection. The differential diagnosis of mucosal HSV-1 infection also includes RAU, and the oral mucosal vesicles of hand-foot-and mouth disease. Familiarity with the distinguishing clinical features of HSV-1 infection allows for accurate diagnosis in most cases, provided that atypical features are taken into consideration. Unlike primary herpetic gingivo-stomatitis, RAS is not normally associated with fever, and unlike the ulcers of recurrent HSV-1, RAS appears exclusively on the movable mucosa. For the definitive diagnosis of HSV, viral culture from swabs of active lesions has been considered to be the gold standard, but the usefulness of this method is limited by the relatively short time span of viral shedding, and by the low numbers of viral particles present in the samples. Sensitive alternatives to viral culture are immunocytochemistry with anti-HSV-antibodies, and *in-situ* hybridization with HSV-nucleic acid probes applied to biopsy sections of early lesions.

Management of symptoms and treatment options

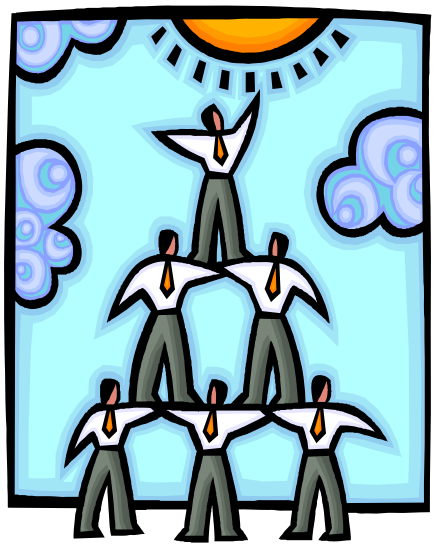
Children with severe symptoms of gingivostomatitis should be considered for antiviral drug treatment in a hospital setting. However, there appears to be consensus that, because primary oral mucosal infections in immunocompetent patients are self-limited, generally they require only supportive measures and symptomatic treatment. Adequate hydration and nutrition are particularly important in children. Topical anesthetics (e.g. oral rinses with over-the-counter viscous lidocaine) should be used with caution before meals, because of reduced gagging reflex and the risk of accidental choking. The use of topical anesthetics is contraindicated in children.

Even uncomplicated oral herpetic infections in immunocompromised patients require prompt systemic treatment with either oral or intravenous antiviral drugs (depending on the severity of symptoms and the immunosuppressed status), at each episode.

Management of recurrent oro-labial symptoms of HSV infection

Several recent, systematic reviews have addressed the management of recurrent herpes labialis, in light of advances made regarding clinical applicability, and evidence for safety and efficacy of antiviral drugs, based on the best evidence available or as obtained from clinical trials. For further reading

reading and concise management guidelines see references
Continued on page 22



123rd MDA Annual Meeting and Convention

February 1 - 3, 2007

Victoria Inn
Brandon, Manitoba

Theme: Teamwork

Thursday Program, February 1, 2007

Evening: MDA Business Meeting

Friday Program, February 2, 2007

Exhibit Program

Dental Program

"Orthodontics for the General Practice Dentist" – Dr. Marcel Korn, Orthodontist

Oral Health Team Program

"Handling Negative Attitudes & Difficult People" – Beverly Beuermann-King, Stress and Wellness Specialist

Friday Night Social – Teamwork with "The Wonderland Band"

Saturday Program, February 3, 2007

Exhibit Program

Dental Program

Canadian Dental Institute

"Lessons On Little People: New Directions For New People" – Dr. Jay Biber, Paediatric Dentist

"Periodontal Systemic Considerations – What Should You Be Aware Of" & "Bone Grafting – Review Of The Available Materials – How They Work And Indications For Use"– Dr. Anastasia Cholakis, Periodontist

"Viral Disease In The Immunocompetent Child – Herpes Simplex Virus Type 1 & Varicella Zoster Virus" & "Clinical Presentations Of Oral Squamous Cell Carcinoma" – Dr. John Perry, Oral Pathologist

Malpractice Suit?
A Lot is in Your Tone of Voice!

As the administrator of the Canadian Dentists' Insurance Program Malpractice Plan, CDSPI tries to keep abreast on articles relating to the interesting area of professional malpractice suits.

It is with this in mind that we provide you with the following comments from the book Blink – written by Malcolm Gladwell, a staff writer for The New Yorker. Kingsley Butler CDSPI President/CEO

Imagine you work for an insurance company that sells medical malpractice protection. Your boss asks you to figure out for accounting reasons who among all the physicians covered by the company is most likely to be sued. You're given two choices. The first is to examine the insureds' training credentials and then analyze their records to see how many errors they have made over the past few years. The other option is to listen in on very brief snippets of conversation between each dentist and his or her patients.

The second option is the best one and here's why. Believe it or not, the risk of being sued for malpractice has very little to do with how many mistakes you make. Analysis of malpractice lawsuits show that there are highly skilled practitioners who get sued a lot and some who make lots of mistakes and never get sued. At the same time the overwhelming numbers of people who suffer an injury due to the negligence of a practitioner never file a malpractice suit at all. In other words, patients don't file lawsuits because they've been harmed by shoddy care. Patients file lawsuits because they've been harmed by shoddy care and something else happens to them.

What is that something else? It's how they were treated on a personal level by their dentist. What comes up again and again in malpractice cases is that patients say they were rushed or ignored or treated poorly. People just don't sue people they like. People come in and say they want to sue some specialist and we'll say we don't think that doctor was negligent – we think it's your general practitioner who was at fault and the client will say, I don't care what she did – I love her and I'm not suing her.

A patient who sued a dentist said she hated this guy because he never took the time to talk to her and never asked her about other symptoms. When the patient has a bad treatment result, the dentist has to take the time to explain what happened and to answer the patient's questions, to treat him like a human being. The ones who don't are the ones who get sued. It isn't necessary then to know much about how a doctor operates in order to know his likelihood of being sued. What you need to understand is the relationship between that doctor and his patients.

Example

Recently the medical researcher Wendy Levinson recorded hundreds of conversations between a group of physicians and their patients. Roughly half of the doctors had never been sued. The other half had been sued at least twice and Levinson found that just on the basis of those conversations, she could define clear differences between the two groups. The surgeons who had never been sued spend time – more than three minutes longer with each patient than those who had been sued – 18.3 minutes versus 15 minutes. They were more likely to make orienting comments such as "First I'll examine you, and then we will talk the problem over", or "I will leave time for your questions", which helps patients get a sense of what the meeting is suppose to accomplish and when they should ask questions. They were more likely to engage in active listening saying such things as "Go on, tell me more about that", and they were far more likely to laugh and be funny during the visits.

Interestingly there was no difference in the amount or quality of information that they gave their patients. They didn't provide more details about medication or the patient's condition. The difference was entirely in how they talked to their patients. Possibly the same relates to dentists and their patients, as poor communications is the number one cause of malpractice claims under the Canadian Dentists' Insurance Program.

Take 10 second clips of tapes of conversations between patients and their dentist. People judged knowing nothing about the skill level of the dentists. They didn't know how experienced they were, what kind of training they had, or what kind of procedures they did. They didn't even know what they were saying to their patients. All they were using for their prediction was daily analysis of the surgeon's tone of voice. In fact, it was even more basic then that. If the dentist's voice was judged to sound dominant, he tended to be in the sued group. If the voice sounded less dominant and more concerned, he tended to be in the non-sued group.

Malpractice sounds like one of those complicated and multi-dimensional problems but in the end, it comes down to a matter of respect and the simplest way that respect is communicated is through tone of voice.

So using best professional tone and treating a patient with more respect and time could keep one away from a malpractice suit; or if you already have this professional style and never been sued, this may be why.

Excerpt from "Blink – The Power of Thinking Without Thinking" – by Malcolm Gladwell – www.gladwell.com – with out thanks for his permission to provide it to Canadian dentists.

CDA Working on Your Behalf

Canadian Dental Association Board Member Report

The Board of the Canadian Dental Association met at the combined Newfoundland and Labrador Dental Association, Canadian Dental Association meeting in St. John's Newfoundland on August 25th.

The Board of the CDA dealt with a number of issues of interest to the general membership. A number of adjustments to codes in the Unified System of Codes and Lists of Services (USCLS) requested by two corporate members were approved. The USCLS is the standardized system of codes dentists in Canada use for claims processing and computer dental office management. The BOD also noted the need to begin a consultation towards revising the process for amending the current USCLS in parallel to ongoing redevelopment.

The BOD approved numerous motions affecting plan renewals. The BOD also undertook a review of the feedback and actions taken on the subject of the "repeater formula" in the malpractice insurance plan. The BOD reaffirmed its position that it would have been imprudent to forge ahead with changes to the plan without the full understanding of stakeholders and there is a need to hold a session on malpractice, likely following the CDSPI AGM in May 2007. The BOD agreed that the CDA officers should discuss the matter with CDSPI officers at the next opportunity.

THE BOD received an update on the status of CSI and ITRANS in all areas of its operations. Overall CSI is operating within the parameters that were set out at the April 2006 AGM.

The ITRANS/E-business working group held its first meeting where the same information provided to the BOD was shared. The WG is a committee of the Board of the CDA and as such is made up of the President of the CDA as chairman, one CDA Board member and 4 dentist members appointed by the corporate members. It functions as an oversight committee to review all facets of the operation of CSI and to report to the PDAs and the AGM.

The Corporate Member Relations Task Force held its first meeting, during which it considered feedback to the proposed questions and methodology for a survey, which will gather information from the provincial associations and the CDA. The survey, when completed, will be conducted via e-mail and telephone. The results will be compiled to give direction regarding improving relations.

There have recently been many new member services initiated by the CDA including Lexicomp, eTOC (electronic table of contents) and Venngo. Additionally a new product called WebAlive has been announced. All these new member services were showcased at the convention in St. John's.

The BOD learned that the Canadian Health Measures Survey (CHMS) launch has been delayed until February 2007 as a result of a delay in the signing of contracts due to the timing of the recent federal election. Memorandums of understanding have been signed between Health Canada and Statistics Canada and also between Health Canada and the Dept. of National Defense and the questionnaires have been finalized.

As the representative for Manitoba on the Board of Directors I have attended all meetings of the BOD since joining the Board. The learning curve has been very steep, but I am fortunate to work on the Board with many bright and competent dentists and CDA support staff. I have recently been appointed to two committees, the ITRANS E-Business Working Group and the CDA-ODA Working Group. The commitment these positions require is considerable but these committees like many others undertaken by the CDA are vital to fulfilling the mission of the CDA.

The CDA-NLDA Convention this August was a rousing success. In 2007 the CDA will again be partnering with a provincial association to provide a joint convention. The Alberta Dental Association and College will be partnering with the CDA to present a joint convention in Jasper in May 2007. I hope you will mark this on your calendars and plan to attend.

Peter Doig, D.M.D.
CDA Board Member

WINNIPEG DENTAL SOCIETY

WINE TASTING EVENING

NOVEMBER 17, 2006

Details and registration forms to follow

Specialist's Article: Continued from page 17

guidelines see references (5-9). Notably, for painful recurrent herpes labialis, acyclovir 5% ointment, (Zovirax) applied five times daily at the onset of symptoms is recommended, as this regimen has been shown to significantly reduce the extent of viral shedding and pain, with minimal and infrequent adverse reactions reported. One of the newer therapies for the topical treatment of cold sores, Docosanol (Abreva), is available as an over-the-counter preparation. The active ingredient is contains N-docosanol, a saturated-alcohol based substance which has been shown to have antiviral properties. Compared to topical agents, oral antivirals offer the advantage of less frequent dosing and better absorption. While not specifically approved by the Food and Drug Administration (FDA) for the treatment of herpes labialis, oral acyclovir at the dose of 400 mg five times daily has been shown to reduce the duration of pain and time to loss of crust]. Valacyclovir, the prodrug of acyclovir, known to have an enhanced bioavailability, has been approved by the FDA for one-day oral treatment of oral HSV infection. The recommended dose for the treatment of herpes labialis is 2 g twice daily for one day.

Individuals with a history of recurrent mucocutaneus HSV1 infections on dental treatment as well as those scheduled for cosmetic laser skin resurfacing or dermabrasion may require prophylactic therapy (9).

The management of recurrent HSV infections should include patient education regarding the importance of good personal hygiene for the prevention of dissemination during the active phase of the disease, protection from or avoidance of know triggering factors, and awareness of prodromal signs for prompt initiation of treatment. For example, the use of sunscreens, the avoidance of kissing during recrudescence of infection, and the use of gloves for topical applications of creams or ointments, should be discussed with all patients presenting with herpes labialis. The patients should be made aware that the drugs prescribed for the treatment of their symptoms are not curative.

The antiviral drugs currently available for the management of HSV disease are generally safe and well tolerated. However, reports of most common side effects and adverse events (e.g. headache nausea, rash, paresthesia for orally administered drugs; contact dermatitis, and other reactions at the site of application of topical antivirals) should be taken into consideration and explained to the patient [for a concise summary see reference (5)]. Concise patient education guidelines are reproduced in the table below.

Table
Patient education, recommendations for patient information

- For avoidance of transmission: persons with active lesion should avoid all oro-oral, oro-genital and skin-skin contact (abstain from kissing and oral sex) *
- For avoidance of transmission and self-inoculation: use finger cot or rubber gloves when applying cream or ointment*
- For reduction of likelihood of recurrence of herpes labialis: avoid known trigger factors
- Protect lips from UV exposure (use sunscreen)*
- Currently available drugs are not curative

After: *Malkin J.E. and Stanberry L. editors, The Management of HSV-1 and Ocular HSV Diseases, posted by The International Herpes Management Forum http://www.ihmf.org

Summary and future perspectives

Evidence is accumulating for the existence of reasonably safe and clinically beneficial systemic, as well as topical treatments for mucocutaneous HSV. However, short of firm, unequivocal standards of practice with respect to antiviral drug treatment, for each case the management strategy and choice of antiviral drug treatment should be tailored individually, based on a thorough assessment of symptom severity (including effect on quality of life), immunocompetent status and risk of dissemination.

The dentist, the oral pathologist or oral medicine specialist is often the first to be contacted and approached for treatment by the patient presenting with localized oral symptoms of infection. In cases of combined oral and extraoral (ocular, dermal, esophageal, or CNS) involvement, a multidisciplinary approach is essential in prompt recognition of symptoms, accurate diagnosis and early initiation of treatment.

Nucleoside antiviral drugs that are available currently for the treatment of herpesvirus disease are not curative, because their action is limited to inhibition of viral DNA replication in the cellular phase, and they do not eradicate the non-replicative, latent form of the virus. However, new drugs designed to inhibit HSV- helicase-primase (essential for replication), are very promising, as they have been shown to be active in animal models.

The goals of putative vaccination against HSV-1 disease would be prophylactic- in reducing acquisition and transmission rates, as well as immunotherapeutic – in the diminution of symptoms. Although such comprehensive vaccines do not yet exist, recent reports of clinical trials indicate that effective protection against genital herpes is achievable with new adjuvant vaccine strategies. It is hoped that concomitant protective effects with respect to both HSV-2, and oral HSV-1 infection will be possible in the near future, as such ongoing trials suggest.

References and Recommended reading:

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Harel L, Smetana Z, Prais D, *et al.* **Presence of viremia in patients with primary herpetic gingivostomatitis.** Clin Infect Dis. 2004, 39:636-640.

Continued on page 24

Preventive Dentistry Scaling Module Pilot Program a Success!

The Preventive Dentistry Scaling Module (PDSM) was completed on June 30, 2006. There were fifteen Level II Dental Assistants who were successful in achieving a passing grade.

This journey started about 3 years about when the Alberta Dental Association and College first introduced the concept of a scaling module for Level II Dental Assistants. During that period the dental profession in Manitoba was faced with a dental hygiene shortage. The MDA Board, who wanted to know how the members felt about an expanded scope of practice for Dental Assistants before making any decisions, directed the Oral Health Team Committee to seek out membership opinion of this issue.

A key finding of the Oral Health Team Committee Survey on a Scaling Module for Dental Assistants was that an overwhelming majority of the dentists (83.4%) were in favour of a scaling module for Level II Dental Assistants. Additionally, 69.9% indicated that they would be willing to pay for their Level II Dental Assistant to take the module and 83.4% would hire the Level II Dental Assistant with the scaling module.

In terms of human resources, 54.8% indicated that they lack the resources to provide adequate scaling services to their patients - and, when asked if allowing Level II Dental Assistants to perform limited scaling (up to pocket depths of 2mm) would alleviate the shortages they are experiencing, 59.7% responded that it would.

Finally, 79.2% of the respondents felt this would not affect the standard of care to patients.

As a result of the survey findings, the MDA Board created the Preventive Dentistry Scaling Module (PDSM) Task Force whose mandate was to develop a scaling module for Level II Dental Assistants in Manitoba. The PDSM Task Force was comprised of dental educators (dental hygiene, dental assisting, dentistry, and dental specialists) and representatives from the dental profession in Manitoba.

Using the Alberta module as its template, the Task Force developed a scaling module to meet the needs of private practice dentists in Manitoba. The MDA Board approved the Preventive Dentistry Module in June 2005.

The next step in the journey was the development of a PDSM Selection Committee whose mandate was the tendering of the module to an educational institution in Manitoba. The Board selected CDI College to host the pilot program at its January 26, 2006 meeting. The MDA Board then directed the Selection Committee to oversee the delivery of the pilot program and provide to the Board an evaluation of the program once completed.

Of the sixteen students that were accepted into the program, fifteen were given a passing grade. A letter, along with a certificate, was sent out to the fifteen students who passed indicating that their credentials have now been registered with the MDA office and that they can start applying their new skills, in private practice, under direct supervision of a licensed dentist starting on Monday, July 17, 2006.

The Selection Committee, overall, was very pleased with the outcome related to the program. However, as with any pilot program issues arose that were not originally considered. The Selection Committee will present a full evaluation of the PDSM to the MDA Board at its October, 2006 meeting.

Once the evaluation has been accepted by the MDA Board, a letter will be sent to each of the Level II Dental Assistant educational institutions in Manitoba indicating that they can start the implementation and delivery of the PDSM on an ongoing basis as of November 1, 2006.

"Thank-you" to the members of the Selection Committee for their hard work in ensuring the successful delivery of this program.

Selection Committee

Chair: Dr. John Campbell, Chair; Dr. Carmine Scarpino (General Dentist) and Ms. Lorraine Goudie (Manitoba Dental Assistants Association)

Rafi Mohammed
Membership Services Director
Manitoba Dental Association

Specialist's article continued from page 22

2. Malkin JE. **Epidemiology of genital herpes simplex virus infection in developed countries.** Herpes. 2004, Suppl 1:2A-23A.
3. Epstein JB, Gorsky M, Hancock P, *et al.* **The prevalence of herpes simplex virus shedding and infection in the oral cavity of seropositive patients undergoing head and neck radiation therapy.** Oral Surg Oral Med Oral Pathol Oral Radiol Endod. 2002, 94:712-716.
4. Birek C, Ficarra G. **The diagnosis and management of oral herpes simplex infection. Curr Infect Dis Rep**. 2006 8:181-188.
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Professional Classified

The Manitoba Dental Association offers a referral service for: **(I) Dentists with Opportunities**: (practices for sale, space to share and associateship/locums) and **(II) Dentists Seeking Opportunities**: (full or part-time associateships, short-term locums and practice purchases/buy-ins). To list with this service please contact Diane Troubridge at the Manitoba Dental Association Office, Phone: (204) 988 5300.

Practice Opportunities

Winkler, MB

Cornerstone Dental Centre has an immediate opening for a full-time General Practice Dentist. Special consideration will be given to an applicant proficient in children's dentistry. Experience is an asset but not a necessity.

Please contact: Cornerstone Dental Centre
Box 1930, Winkler, MB R6W 4B7
Fax: (204) 325-7625
Email: corock@mts.net
Web Site: www.cornerstone-dental.ca

Winnipeg, MB

Busy practice requires P/T Associate for two days per week. Available immediately for highly motivated, caring, individual. Excellent opportunity to practise all phases of dentistry and attract new patients.

Please contact: Lisa
(204) 269-1144

Winnipeg, MB

Rapidly growing dental office requires a F/T and P/T Associate. New Grads welcome. A perfect working environment with an excellent management awaits the right candidate to join our current team of three Associates and the principal. The practice also features an on-site orthodontist and a dental laboratory. Current six operatory expansion to fully functional ten operatories by end of 2007. An excellent one-of-a-kind opportunity to join a professional team geared towards success.

Please contact: Dr. D. K. Mittal
(204) 297-5344 (cell)
(204) 633-8280 (Res.)

Winnipeg, MB

Part-time Associate required for growing practice. Some evenings and weekends. Possible buy-in/buy-out for the right person.

Please contact: Dr. L. Kulbaba
(204) 633-4488

Winnipeg, MB

Full-time Associate dentist position available in the well-established family practice of Northgate Dental Centre. Buy-in option is available for right candidate.

Please contact: R. J. Mezibroski or Dr. M. Karpa
(204) 339-1738

Grande Prairie, AB

A unique opportunity for a financially rewarding Dental Associateship in Grande Prairie, AB – one of the fastest growing cities. Come be the boss while owners are away in graduate school.

Please contact: (780) 539-6769
Email: christina88park@msn.com

Practices for Sale

Winnipeg, MB

Owner seeking a progressive minded and conscientious dentist to assume ownership of an established dental practice with no capital outlay. Owner will take a limited associateship position in practice.

Please contact: The Manitoba Dental Association
(204) 988-5302

Vancouver Island, BC

Beautiful new practice for sale. 2 operatories, plumbed for 3. Featured design. Very reasonable. Amazing growth potential. Close to Victoria.

Please contact: (250) 642-1427
Email: vanidmd@hotmail.com

Dentists Seeking Opportunities

Winnipeg, MB

Experienced dentist seeking either a locum (i.e. sick leave, vacation, etc.) or a regular 1 or 2 days per week basis.

Please contact: Dr. Julius Wise
(204) 489-2263

Winnipeg, MB

Experienced dentist available for short-term locums (i.e. Sick leave, vacations, etc.). References available upon request.

Please contact: Dr. I. R. Battel
(204) 489-4507

Winnipeg, MB

Experienced dentist available for locums (sick leave, vacations, etc.)

Please contact: Dr. Neil Winestock
(204) 269-4314

Space for Lease

Winnipeg, MB

Dental office space available for immediate lease. Freshly decorated premises with 3 operatories. Located in downtown medical services building.

Please contact: Janice McKeever
Phone: (204) 957-1430

For Sale

Sirona Heliomolar DS X-ray with remote timer. Purchased new in 2004.

Please contact: Dr. J. Cabral
(204) 778-6923
Email: bascab1@mts.net

The Bulletin, Fall - 2006
Published regularly as a service by the Manitoba Dental Association.
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