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Volume 31 No. 4

NSDA
Nova Scotia Dental Association

A first look at the NSDA's New Strategic Plan

Early Reports About E-Cigarettes

Clinical Affairs looks at Acromegaly

and...
Insurance, Corporatization and More

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The Next 5 Years

As winter approaches, and getting out of bed each morning takes a little bit longer than usual, the work of the NSDA hasn't been slowed down by the cold one bit. As always there is no lack of news to share, but for this column, I plan to focus on recapping two meetings in particular which took place over the last several weeks.

First, in mid-November, a one day strategic goals and objectives planning session was held. Attendees included NSDA senior staff (Executive Director, Operations Manager, Clinical Affairs Manager, and Communications Manager), project consultant, and member volunteers from Table Officers, CDA representation, academic representation, member-at-large, senior past-presidents and dental specialists. The "think tank" was tasked with reviewing an environmental scan of the profession, and applying it to the current organizational goals of the NSDA to determine continued relevance.

The last five year strategic plan was developed in 2011. Some of the present goals have been accomplished and others are not as relevant as they once were. Much is changing in dentistry and most of the mega trends are having a negative impact. The number of dentists is increasing, fewer patients are accessing dental care, there are fewer dental plans, and many other trends result in more dentists not being as busy as they would like. This is complicated by an administrative burden on dental practices as insurance carriers download more work on dentistry.

The group retained two goals with small revisions from the 2011 strategic plan and added three new ones. Although the wording hasn't been finalized the 5 strategic goals for 2019 (to be proposed to Governing Council for approval) are as follows:

1. The NSDA is the public policy advocate for dentistry/oral health leader.
2. The NSDA is an indispensable resource for all members.
3. The NSDA will significantly enhance practice support activities.
4. The NSDA will cultivate a dental profession with higher ethical standards and professional conduct.
5. The NSDA will have effected improved access to care for populations at risk.

These are lofty goals, with each having at least three objectives (to achieve each goal). Staff will work on these to develop strategies to achieve the anticipated objectives.

This was a great exercise to keep your association relevant and current. Thanks to all who participated for your time and dedication.

The second event I recently attended was a meeting of the Oral Health Advisory Group organized by government and co-chaired by the NSDA and the Department of Health and Wellness. These meetings

have been held bi-weekly since September. Much has been accomplished in Phase 1, which will make recommendations to the Minister of Health and Wellness by year end. The mandate of the group was to review the Children's Oral Health Program and recommend criteria for children's eligibility to qualify for dental services. It is also tasked with making a list of recommendations of improvements/refinements within the current program. Out of scope for discussion are tariff negotiations with the NSDA, implementation of program changes and addressing of specific patient issues.

Each time the eligibility age has expanded within the COHP (such as including 14 year olds as of April 1) program costs increased at double-digit rates. Under the program's current structure, continued age expansion is not sustainable due to lack of funds. This occurs even though children's utilization rates for dental services remain at less than 50%. Of these children, slightly more than 50% have private insurance.

The COHP currently doesn't have a system to proactively identify eligible individuals/families, and target services to those in the greatest need.

The group is looking at all and any measures to make the program more sustainable, effective for patients and workable for providers.

All of the issues that the NSDA identified with the COHP that needed immediate critical fixes have been addressed either through recent tariff negotiations or OHAG. Any recommendations which are implemented by the Minister will be seen by dentists in April 2016. So let's all be patient and keep our fingers crossed that a COHP that dentists can live with, will soon emerge.

Now that the updates are over, we can move onto the important stuff. Please enjoy a safe and festive holiday season and best wishes to all NSDA members and staff alike. See you all in the new year.

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Steve Jennex, Executive Director

Executive Director's Message

Saying Goodbye to 2014 - and Hello 2015!

Let me begin by wishing a safe and healthy holiday season to everyone. In the midst of our busy lives we often forget how grateful we should be for the things we take for granted – things like continued good health, and living in a safe and free country, just to name a couple.

While the activities of organized dentistry take a breather over the holidays, it's an opportunity to look back on some things accomplished and some of the challenges ahead. Here's a sampling:

3rd Party Insurers

For many dental offices, the heavy-handed tactics of 3rd party dental insurers continue to be an issue – from the downloading of administrative fees onto dental offices to the occasional instance when an insurer is accused by a dentist of attempting to dictate patient treatment. Letters have been written to the insurers and information provided to dental offices, and this magazine is set to start printing a regular feature on helpful advice for dealing with insurers. In the meantime, the Atlantic Provinces Insurance Liaison Committee (APILC) set up by the four Atlantic dental associations/societies is looking for your input and 'war stories' about insurers. We have an e-survey that has been sent to you via our regular e-Dispatch newsletter, and we ask you to complete it if you have not already. The link to the survey is: https://www.surveymonkey.com/r/KFP5QFF

A Regional Dental Practice Management Certification Program?

A common response to the member survey on "corporatization" of dentistry this past summer was the need for added business training and dental practice management skills here in Nova Scotia. We have an opportunity to import a regional program to train people as dental practice managers to build efficiencies and produce better businesses. What we are looking for are your thoughts and opinions on the need and practicality of such a program. Would you attend? Would you send a staff member? Fill out our quick survey and have a say on whether this program is a fit: https://www.surveymonkey.com/r/K3VRB8B

Self-Determination of Dentistry

Elsewhere in this issue of Nova Scotia Dentist you will find a well-written article on the issue of "corporatization" of dentistry, authored by the BCDA and re-printed here. This continues to be an issue on the front burner for the NSDA, and our working group looking at the topic has submitted its report and recommendations. Watch for some new activity on this front in the New Year and some new member resources.

The Sparkle Fund for Children's Dentistry

In 2012, the NSDA provided seed funds from the Dentistry Canada Fund to the Halifax Regional Children's

Aid Foundation to help create the infrastructure around a new provincial charitable fund set up to provide oral care for children in extreme need. The Sparkle Fund was born and the NSDA has a representative that sits as part of the fund's Board. The Halifax Regional Children's Aid Foundation has produced a rack card to promote the fund's existence and solicit contributions. These cards will be available for dental office waiting rooms as we embark upon the 2015 traveling presidential presentations at regional dental societies.

Communications – what are you missing?

Monthly – sometimes more often if a critical issue arises – the NSDA sends an e-Dispatch newsletter to members with helpful advice and resources to solve problems. Case in point: our November e-Dispatch included a story on a computer malware virus that we know has hit at least two different dental offices and rendered their electronic files useless. Our tracking system continues to indicate that for most e-Dispatch emails, only about 50% are opened. If you're not receiving it and opening it – what are you missing that could make your life easier?

Elections

In 2015 we will be conducting a series of elections for NSDA Governing Council voting seats. It's your opportunity to have a say in who represents you – or even if you wish to toss your hat into the election ring. Please keep your eye out for the election notices and participate in the process. The NSDA is your association and your voice.

Best wishes from the staff at the NSDA for a prosperous 2015.

Steve Jennex, CAE
Executive Director

What To Tell Your Patients About E-Cigarettes

The jury is still out on e-cigarettes, also known as electronic nicotine delivery systems (ENDS) - are they safe? Or even an effective aid to assist with tobacco cessation? What about health concerns surrounding secondhand vapour emissions to those around them? Although the research is not currently available to answer all of these questions, we are starting to get some preliminary insight into how ENDS can affect our oral health.

E-cigarettes have been around since the start of the decade – but have only become main-stream in North American culture over the past few years. Comprised of three major components – a battery, cartridge and an atomizer (heating element), e-cigarettes do their best to replicate smoking behavior without the use of many harmful chemicals and tobacco.[1] However, even without the tobacco, ENDS contain varying amounts/concentration of nicotine depending on the brand, which potentially can be equally as harmful to your mouth as traditional cigarettes.

Although the contents of e-cigarettes on their own may be less harmful than traditional cigarettes, the increased opportunity for exposure due to expanded occasions in which someone can use a vapourizer is problematic.

So as a consumer attempting to quit smoking, looking for an alternative in areas where cigarettes are not permitted, or someone interested in starting “vaping” as an alternative to smoking traditional cigarettes – what do you need to know about this highly unregulated nicotine product, targeting smokers and non-smokers alike? What are some of the underlying problems looming in the unknown? And how does it affect your oral health?

E-cigarettes use either disposable or replaceable cartridges, and can provide users between 150-300 puffs in a single cartridge – equivalent to 40 cigarettes worth of drags. A 10 ml bottle of e-liquid used to refill many e-cigarettes is equivalent to 200 cigarettes worth of nicotine.[1] According to Dr. Deepak Saxena, a researcher from New York University College of Dentistry , one of these cartridges can be finished in 2 hours. Although the contents of the vapour may be favourable compared to traditional inhaling from cigarettes, early indications suggest prolonged exposure to nicotine can have troubling effects on gum tissue inside the mouth. Saxena used the example of smokers on a “smoke break” knowing it’s time to get back to work when their smoke break is over, once their traditional cigarette is finished. But, with e-cigarettes, many smokers can puff away for hours inside the office or out without noticing how much nicotine is going into their system.

Oral Issues

According to Dr. Saxena, initial research indicates regular e-cigarette usage puts users at a significantly higher risk of periodontal disease from increased exposure to nicotine. Periodontal disease has been linked to heart disease, respiratory issues and even diabetes. Other known side effects include persistent dry mouth.

Based on initial in-vitro research conducted by his team, Saxena also believes gum tissue and microflora are being affected by e-liquid, as e-vapour from e-cigarettes can create an oral cavity environment conducive to gum tissue mutation and changes in the oral microflora.

Additionally, Dr. Saxena is concerned about Hookah smoking which is a growing trend in New York these days. There appears to be a common misconception that having the nicotine or tobacco smoke pass through water during the inhaling process somehow cleans the vapour. According to Dr. Saxena, Hookah smoking may be the worst smoking means of all, as charcoal is used to burn the tobacco.

Advice For Your Patients

With so little information available on e-cigarettes, it may be difficult to answer all of your patients' questions regarding the safety and validity of vapourizing.

Currently, e-cigarette use as a smoking cessation tool is not supported. A recent study comparing the effectiveness of e-cigarettes vs. nicotine patches over a 6-month period showed no significant results. This suggests e-cigarettes may not be a superior smoking cessation aid compared to more traditional forms of medication like nicotine patches, with e-cigarettes also posing the potential threat of additional oral health risks.[1]

Key Messages:

- The long-term safety of e-cigarettes is not yet established.
- E-cigarettes are likely to be less harmful than tobacco cigarettes, but not without their own risks
- The effectiveness of e-cigarettes as either a smoking cessation tool or a harm reduction tool is not yet established.
- At present no e-cigarettes are licensed as a medicine and patients are recommended to use licensed nicotine replacement therapy products to quit smoking or reduce tobacco consumption.
- Early indications suggest e-cigarettes can have harmful effects on gum tissue and microflora.
- Advise patients that referral to a smoking cessation service is an option to consider. [1]
- E-cigarettes can act like a gateway to cigarette smoking by youth, and can often entice young smokers through the use of flavoured ENDS.

Nova Scotia Regulations on E-Cigarettes

Nova Scotians can expect changes to e-cigarette legislation in 2015, when similar restrictions are placed on e-cigarette sales and usage as traditional cigarettes. Until then, the Smoke Free Places Act, which currently does not permit tobacco to be smoked in public indoor places, does not include non-tobacco nicotine or smoking aids such as e-cigarettes, leaving private businesses, schools and government facilities to enforce their own set of rules.

This article was a collaboration of the Canadian Dental Association and the Nova Scotia Dental Association. Together, we would like to acknowledge the efforts made by Dr. Saxena and his team at New York University College of Dentistry; and thank all those who work behind the scenes toward providing a safer environment for everyone to live.

Eliot Coles
Communications Manager
NSDA

Dr. John O'Keefe
Director, Knowledge Networks
CDA

[1] Patients are asking about e-cigarettes. What do we tell them?
[2] E-cigarettes – aid to smoking cessation or smokescreen?
[3] Canadian Cancer Society news release, 2014
[4] Smoke free Nova Scotia Position statement, 2014

Mentorship 2014/15

NSDA | Dalhousie Faculty of Dentistry | CDSPI

On Tuesday, October 7, Dalhousie's Faculty of Dentistry and the Nova Scotia Dental Association co-hosted Mentorship Night. Both parties sent out calls for prospective mentors early in the fall, with the NSDA making a concerted effort to find prospective mentors to attend the October event to lead small breakout groups. We would like to thank the 12 NSDA members and current practicing dentists for volunteering for this event (attended by 44 students). For those interested in attending our next event in January, you may be eligible for CE credits, further adding to the value and benefit of volunteering.

Although January's event has yet to be finalized, the mentorship program hopes to offer students a different perspective in the form of a panel discussion featuring consultants outside of the clinical experience. We anticipate our panel will feature representation from office management, legal counsel, financial and investment advisors and more. Panel members and topics of discussion will be selected based upon event and program feedback – including such topics as the implications of corporate dentistry, dental fraud, and what to look for in an associate position.

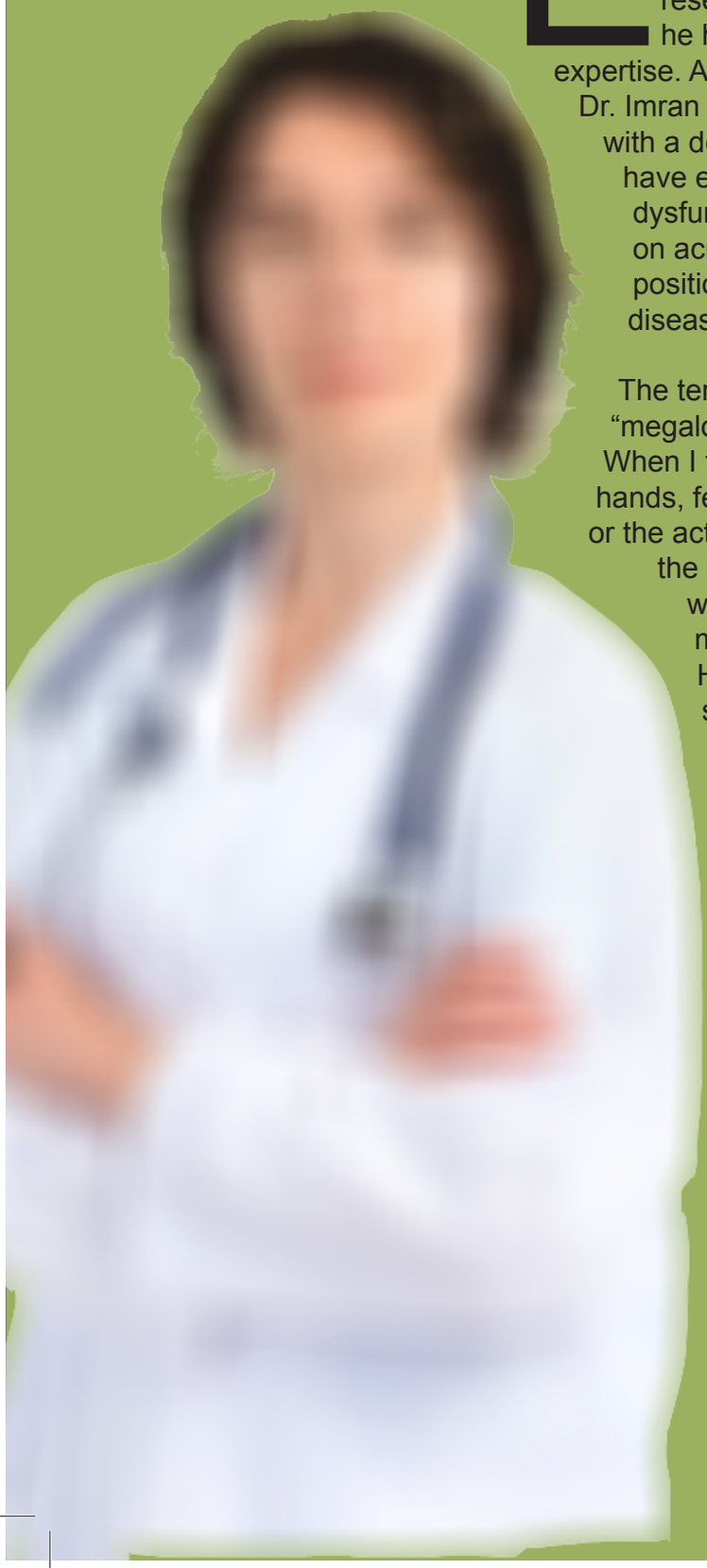
For those who may have missed the sign-up "deadline," it's never too late to volunteer to share your knowledge and experience with the next generation. Pass along your contact information to p.pellerinensda@eastlink.ca

NEW this year. With the generous support of the new program sponsor CDSPI, the mentorship program intends on hosting a yearend wrap & awards program to recognize each of the volunteers for their time, effort and commitment. We hope this event will coincide with the kickoff of the 2015 AGM in Halifax – more details to come.

Special thanks to the NSDA members in attendance: Drs. Simone Abbass, Sarah Foley, Greg Jones, Reena Kapadia, Phil Mintern, April Nason, Andrew Nette, Sandy Pirie, Rick Raftus, Carla Sherman, Mark Sutherland, Jan van der Donk.

Clinical Affairs with Dr. Terry Ackles

The Dentist's Role in Early Detection of Acromegaly



Earlier this year I had the opportunity to speak with Dr. Ali Imran, an Endocrinologist and Professor of Medicine, at Dalhousie University. Dr. Imran's primary clinical and research interests are pituitary and thyroid disorders and he has published several research papers in areas of his expertise. As co-directors of the Halifax Neuropituitary Program both Dr. Imran and his Neurosurgery colleague Dr. David Clarke, along with a dedicated team of nurses (Lisa Tramble and Andrea Hebb) have established a center of excellence for patients with pituitary dysfunction and are nationally recognized for their expertise on acromegaly. It is his opinion that dentists are in a unique position to play a prominent role in the early detection of this disease.

The term "acromegaly" comes from the Greek words "akros" and "megalos" which translate roughly to "extremities" and "large". When I think of acromegaly, I envision a bigger man with enlarged hands, feet and facial features like the wrestler, Andre the Giant, or the actor who portrayed "Jaws" in the James Bond movies. To the best of my knowledge I have not treated any patients with acromegaly; however, I do have an acquaintance of more than 30 years who was diagnosed with the condition. Hindsight is 20/20 or so they say; thinking back, there were subtle changes to the face (I associated them with age), the fingers looked thick and knobby (I thought they had arthritis), their voice was deep and raspy (from smoking, I assumed) and she often commented that her snoring was so bad it kept everyone awake. I was somewhat surprised because "she", a woman of very small stature, did not look at all like the stereotypes I had in mind. My lesson learned – keep an open mind.

The prevalence of acromegaly is estimated to be 50-100 cases per million population and is usually the result of a benign pituitary tumour causing excess production of growth hormone (GH) resulting in an increased liver production of a protein called Insulin-like growth factor-1 (IGF-1). Consequently, if this condition occurs before the normal growth has ceased then the individual can become excessively tall but once the growth plates have fused then the bones and soft tissue would continue to get thicker. Treatments may include surgery, radiation and pharmacology and as with most diseases, the prognosis is more favourable

with earlier detection and therapy, while uncontrolled acromegaly is associated with early mortality. Unfortunately, due to the insidious nature of the disease the diagnosis may be delayed by 10 -15 years in most patients by which time the person may suffer from a number of other associated systemic conditions such as diabetes and hypertension.

The physical changes in appearance develop slowly over many years and often go unnoticed by friends and family who see the person regularly. Recognition of some of the early features of acromegaly may be where the dentist may play a crucial role. Some dental offices take photos of patients as part of their patient record; perhaps for example, for privacy concerns when two patients have the same name or, for “before and after” treatment photos. These records could prove valuable for comparison purposes in the future especially if the dentist finds other indicators of acromegaly. Whether a patient is new or returning to your practice, you probably spend some time reviewing the medical history and asking if they are having any problems. Patients may complain of “bite” problems or chipped teeth, issues with food getting stuck in spaces between their teeth, snoring or sleep apnea, or poorly fitting dentures. Extra-oral and intra-oral examination **may** reveal frontal bossing, a prognathic mandible, thickened lips, an enlarged tongue, a Class III occlusion, an anterior open bite and/or splaying of the lower anterior teeth. Depending on the type of radiographs acquired you **may** see an increased gonial angle, an increase in vertical bone height in the mandible and/or hypercementosis associated with mandibular posterior teeth. A patient visiting an orthodontic office to have their teeth straightened will have a Cephalometric radiograph which **might** reveal an enlarged sella turcica. As with photographs, comparison of current radiographs with previous films could be useful. If a patient is new to your practice then obviously it’s not possible to compare previous findings, however, a medical history that includes diabetes and/or hypertension and/or sleep apnea along with some of the dental findings should cause a red flag to go up.

If you suspect acromegaly then you should discuss this possibility with the patient and their physician. Dr. Imran suggests the best single test to determine the diagnosis of acromegaly is the serum IGF-1 test. Serum IGF-1 levels are elevated in patients with acromegaly and such patient should be referred to endocrinology for further assessment. Once the chronic disease is controlled, any required or requested dental treatments can be coordinated by the medical team with an orthodontist, an oral surgeon and/or the dentist.

Although acromegaly is referred to as a rare or uncommon disease, Raven Glasgow, the Neuropituitary Program Coordinator at the QEII’s VG site, reports they see an average of 3-5 new acromegaly patients per year from the Atlantic Provinces. Neither preventable nor curable, this disease is controllable. With an increased awareness and the ability to recognize early signs and symptoms of acromegaly, dentists can assist in an earlier diagnosis, treatment and hopefully better prognosis for our patients. As health care providers, we have a responsibility to help contribute to a better quality of life for patients with acromegaly.

References available on request.

Professional Support Program - just one phone call away

The Professional Support Program offers confidential help to dentists and their families who are experiencing problems – whether they are personal or professional, financial or psychological, psychiatric or addictive.

The program is not affiliated in any way with the licensing board.

You are not alone; support is just one call away. (902) 468-8215. All calls are confidential and will be returned within 24 hours.

Preventing and Dealing with Insurance Audits: Patient Confidentiality is Key

Over the past several years, insurance companies have increased their focus on auditing dental offices. Most offices are familiar with *next day audits,* where insurers query a billing from the previous day, and program audits, such as through Health Canada's Non-insured Benefit Program.

Insurers have been employing a more formal approach of late; therefore, it is important to bear in mind the following:

1. Audits involve confidential patient records, which the dentist is ethically and legally obligated to protect, consistent with privacy law, including PIPEDA *(Personal Information Protection and Electronic DocumentsAct)*. Patient consent is required prior to the release of their records.

2. For insurers, the focus is to confirm that the treatment provided is consistent with what was billed.

3. Not all audits are the same or employ the same approach.

While the patient owns the information contained in the record, the dentist is the ***keeper*** of the patient information and must ensure that it remains confidential. Hence, the dentist must ensure that proper patient consent is obtained before *any* patient information is released to the insurer.

Insurers should contact patients directly to obtain consent and some patients will even contact the dentist to query the request.

The focus of an audit can vary; for example, an audit may be triggered by a billing pattern where a code or group of codes are considered unusual and/or beyond the provincial average. In the event that the insurer determines there is inconsistency between the treatment provided and what was billed, the insurer may seek financial recovery from the dentist.

In the case of a dispute between the insurer and the dentist, the matter may be resolved through settlement, mediation, or court action. While the insurer's focus is on the recovery of funds and/or correcting billing errors, an audit could also result in a complaint to your regulatory authority.

Some preventive steps:

Bill for the treatment provided: For example, do not bill for services that were pre-determined but not provided, nor the time the patient was booked for, or for a similar procedure to what you did because it was covered. In other words, *bill only for services rendered*.

Accurate patient charting is your best defense: Just like in a patient complaint to your Dental Board, your best defense is an accurate and complete patient chart.

You are responsible for your practice's billings: Even if you delegate this task to your staff, you are still ultimately responsible, so take preventive steps, such as:
• Review billing protocols with staff each year to ensure a common understanding.

• Reconcile your day sheets with your daily billing records to ensure consistency.
• Ensure that your office bills only for the treatment provided.
• If you are unsure which code to use, ask before you bill. Contact your Provincial Dental Association.

The national fee coding system is based on treatment, not on technology. While well intended, advice from a salesperson may not be helpful if you face a financial recovery as a result.

If you are facing an audit:

Patient consent: do not release a patient's record without proper patient consent. Ask the insurer for a copy of the patient's consent *before* releasing the record. Patient consent should include:
• The purpose of the request,
• What information is being sought,
• Who will review the information, and
• The timeframe that consent is given for.

If the patient contacts you: be honest and answer questions to the best of your understanding.

If the patient is concerned about the consent: offer to send them a copy of their records to review and determine if he/she wishes to release the record directly to the insurer.

If you'd like to contact the patient directly: tell the insurer that you will be contacting the patient directly to obtain their consent rather than the insurer. In doing so, you must act with the best of intentions and not use this as a means to disrupt the process.

If you have any other questions regarding the Audit process, contact your local member of the APILC.

Corporatization: The Good, The Bad and the...

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There has been considerable discussion around `corporatization' and the potential impact it will have on the profession. But exactly what are we talking about and is it all bad? This is a worthwhile discussion but requires clarity around the issue to better understand both the pros and cons in order to see the 'forest for the trees.

First, the term corporatization is too broad to be an accurate descriptor as most, if not all, practising dentists are incorporated. Rather the issue lies with ownership and/ or financing arrangements that directly control or influence a dentist's ability to meet their patients' needs. In this case, the dentist's ethical responsibility to the patient is superseded by the interests of the corporation.

Group practices and satellite practices have existed for years. These dentists have benefited from economies of scale through sharing of fixed costs among a larger number of dentists. The most common are clinics where several dentists operate their own practices with their own patients, or alternatively, associates working for a principal within a practice.

The concern arises when a business arrangement places the interest of the business entity over that of the patient. How would this look? The treating dentist's ability to provide care is compromised by restrictions or limits placed by the corporation, such as:

- Treatment options are determined by the corporation and not by the dentist's personal scope of practice;
- Corporate staff are responsible for billing, rather than the dentist;
- Aggressive production/patient quotas are placed on the dentist with financial penalties if they are not met;
- Finance arrangements where a corporate interest takes a share of the practice's net income and has influence over the management of the practice.

Corporate ownership of dental offices is common in the US which provides Canadian dentistry the opportunity to learn what is good or bad.' Many articles cite the positive benefits in terms of releasing the dentist from administrative burdens, decreasing the cost of practice, improving continuing education options, expanding emergency coverage and lowering advertising costs. It is when the agreement strays into the area of treatment that the switch to bad comes into play.

Good Corporatization

Good corporatization exists where the relationship between the dentist and the patient is preserved with no external influences or restrictions linked to treatment. The agreement could be a standard principal/associate arrangement or a loan arrangement. It could also be a management contract in which services are provided based on fees that are not linked to treatment and/or production. In all cases, the clinical dentist providing treatment should always have unfettered decision-making authority.

Bad Corporatization

Bad corporatization has been investigated by no less than the US Senate. Its recent investigation into the impact of "corporate-backed" dentistry on Medicare billings exposed how things can go terribly wrong.2 In its 2013 report on this issue it found that under the guise of a management services contract, dental corporations were eluding state regulations whereby only a dentist can own a dental practice. As well, it outlined the corporate policies that placed profit over patient care including overtreatment of children. The report is a sobering review of what can go wrong when professional ethics are subservient to the best interests of the corporate entity.

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'United States Congress. Senate. Committee on Finance United States Senate & Committee on the Judiciary United States Senate. (2013). *Joint Staff Report on the Corporate Practice of Dentistry in the Medicaid Program.* Retrieved from http://wwwfinance.senate. gov/library/prints/

'College of Dental Surgeons of BC. (2014). *Complaint Summaries 2012/2013.* 2. Retrieved from http://www.cdsbc. org/—ASSETS/DOCUMENT/Complaint-Summaries-2012-13.pdf

Dental Practice Ad Guidelines In Review

It's not uncommon for the NSDA to receive inquiries about advertising rules and regulations for individual practices – sometimes to investigate something they see on television or hear on the radio, while more often it is to ensure they would not be breaking any rules by offering some form of incentive to new patients, or promote a new service.

The Advertising Standards Regulation pursuant to the Dental Act is the regulatory statute that licensed dentists in Nova Scotia must adhere to in their public messaging. The Dental Act and the Advertising Standards Regulations can be accessed on the Provincial Dental Board of Nova Scotia website: www.pdbns.ca

A few key points:

Advertising by a dentist shall

- be accurate and not false, fraudulent, ambiguous, or likely to be confusing, misleading or deceptive;
- be capable of being proven to be true by facts independent of personal feelings, beliefs, opinions or interpretations;
- be of a dignified nature, in good taste, so as to uphold the dignity, honour and ethics of the profession and not bring the dentist or profession into disrepute;
- avoid comparisons with another practice or member, and avoid suggestions of uniqueness or superiority over another practice or member;
- not refer to the quality of service to be provided;
- be directed at the general public and not at an individual member of the public other than current patients of record; and
- be relevant to the public's ability to make an informed choice.

A 2013 Ontario court decision confirmed that regulatory restrictions on advertising do not contravene the *Canadian Charter of Rights and Freedoms*...

The following precedents came from this decision:

1. Advertising is commercial speech, and is not entitled to the same protection as political speech or self-expression.
2. The restrictions arise in the context of a self-governing profession where the ban is not a law

of general application, but only applies to a member of the profession, a "volunteer" who has elected to accept the substantial privileges and significant responsibilities of being a member of a self-governing profession.

3. Patients and potential patients are in a vulnerable position, particularly consumers of elective procedures.
4. The harm that is being addressed is not subject to scientific proof, so logic and common sense can be relied upon to show the harm or potential harm of advertising testimonials and superlatives. Defense should be shown to regulators.

The Ontario Court specifically addressed problems with advertising testimonials and concluded that testimonials are "inherently misleading" and that they are not objectively verifiable.

Restrictions on advertising by a regulatory authority that prohibits misleading statements, claims of superiority, claims that are not objectively verifiable, claims that may lead to unreasonable expectations in patients, claims that are misleading about the professional's registration or specialization, or claims that tent to harm the dignity and honour of the profess, will likely be upheld by the courts as constitutional.

Although the defendant argued the accusation, "everyone else is doing it," it unfortunately did not hold up as a proper defense.

Looking at the Big Picture for Disability Coverage

It may be unpleasant to think about the consequences of a long term injury or illness—it's even less pleasant to think about the consequences of not being prepared for one.

Renata Whiteman
Professional Insurance Advisor
CDSPI Advisory Services Inc.

If you were going on a wilderness trek you would certainly make sure you had everything you needed for a safe adventure. Beyond packing the basics you would take a wide range of items to ensure you could subsist should something go wrong... even terribly wrong. A dental practice may not be as perilous as the wilderness, but it's still important to be fully prepared for an injury or illness that could keep you from treating patients for an extended period of time, especially if you own a practice. That preparation starts with Long Term Disability (LTD) and Office Overhead Expense (OOE) Insurance.

WHAT'S RIGHT FOR YOU?

A good LTD plan will have the flexibility to offer a variety of coverage levels and options, and a provision for pro-rated benefits should a partial disability limit your ability to work full-time.

For basic coverage, the first option to consider is your level of monthly benefits, typically a portion of your maximum allowable coverage, depending on the funds you have available. This level can be increased while saving on premiums in other ways, such as a longer waiting time before benefits begin (usually from 30 to 120 days) which will lower your cost. As you age you may develop medical conditions that can affect your ability to qualify for disability insurance, so it's a good idea to purchase as much coverage as your income will allow while you're young and healthy. A CDSPI Professional Insurance Advisor can provide a no-cost, no-obligation assessment of your needs and recommend the solution that's right for you. In addition to basic coverage, other options that an advisor can help you evaluate include:

Future Insurance Guarantee (FIG) – This is an important option for those who may be concerned about future health problems. It lets you increase your coverage by 25%, without evidence of good health, at specific points in your life, such as an age milestone, marriage or arrival of a child.

Cost of Living Adjustment (COLA) – You never know how long a disability might last. This option increases your LTD benefit each year after you have been disabled for 12 months by the increase in the Consumer Price Index, up to 8% annually (compounding).

Retirement Protection Option – With this option the insurer will establish a trust account and make a monthly contribution for your retirement savings if you are totally disabled and receiving LTD benefits.

The HealthEdge Advantage

If you're in good health—and live a healthy lifestyle—you can take advantage of CDSPI's HealthEdge premium discount when you first apply for LTD or OOE coverage. The discount is available to those who don't smoke, use illicit drugs, drink immoderately, or have not been treated for a major disease such as cancer, coronary artery disease, stroke, diabetes and others. (Other conditions apply.) Even if you do not qualify for HealthEdge, you can receive a premium discount if you're a non-smoker.

PROTECTING YOUR PRACTICE WITH OFFICE OVERHEAD EXPENSE (OOE) INSURANCE

Ownership has its privileges... and its responsibilities. What if you contracted a sports injury that kept you from practising for several months? Your LTD insurance would help cover your personal expenses but what about your business overhead (including the salaries of staff who are depending on you)? As the accompanying table shows, the expenses, even for a modest practice, are considerable.

Office Overhead Expense Insurance offers many options to customize coverage to your specific needs. For example, you can choose the monthly benefit you require, the waiting time before benefits begin, a fixed or reducing schedule of payments, maternity benefits, and more. Again, you can rely on a CDSPI insurance professional to provide the advice you need to determine what's right for you.

Typical Expenses For A Small Dental Practice

Type of Expense	Monthly Costs ($)
Rent	1,650
Equipment Lease	800
Loan Interest	115
Depreciation of Office Equipment	393
Utilities	145
Accounting	172
Membership Dues	120
Bank Charges	494
Telephone and Internet	306
Business Taxes	350
Insurance	180
Repairs and Maintenance	765
Staff Salaries and Benefits	10,280
Total	15,770

Source: Manulife Financial

DON'T GET IT AND FORGET IT

Even if you've made the right decisions about protecting yourself early in your practice—and that's certainly the best time to do it—there are bound to be changes that impact your coverage requirements. As your practice matures you may be living in a bigger house or driving a better car, your family will be getting older, and you'll be ramping up your retirement investments. Similarly, if you own a practice, your overhead will almost certainly increase as your business grows, so your coverage needs to keep pace with those changes.

According to CDSPI claims statistics, approximately 1% of dentists with LTD coverage file a claim in any given year. If you were to practice for 30 or 40 years, it's easy to calculate that you have about a one in three chance of losing income due to an injury or illness at some point in your career. Having insurance in place to protect your family and your practice is important—having the right amount of insurance is equally important.

To learn more about these plans, please visit www.cdspi.com -> Insurance -> Plans -> LTD or Office Overhead Expense.

Renata Whiteman
Professional Insurance Advisor
CDSPI Advisory Services Inc.

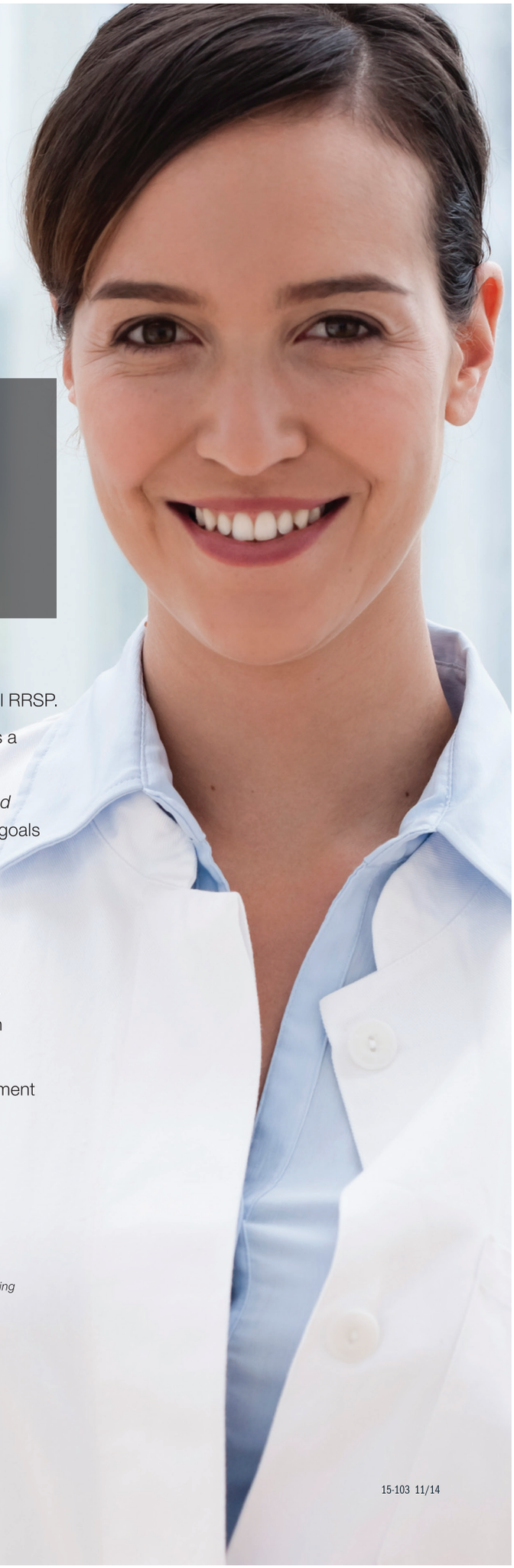
CDSPI Advisory Services Inc. is an organization comprising specialists who can provide no-cost, no-obligation advice at whatever point you may be in your practice. As a licensed insurance advisor at CDSPI Advisory Services Inc., I can offer a combination of expertise and personal knowledge of clients' needs, with an exclusive focus on dental professionals.

For a review of your insurance portfolio, please contact me at 1-800-561-9401 ext. 6806, or send an email to rwhiteman@cdspiadvice.com

The Canadian Dentists' Insurance Program's Long Term Disability and Office Overhead Expense Plans are underwritten by The Manufacturers Life Insurance Company (Manulife Financial).

CDSPI

DENTISTS FIRST



Retire on Your Terms

Canadian Dentists' Investment Program's RSP

Retiring how and when **you** want is a lot easier when you have an exceptional RRSP.

The **RSP** available through the Canadian Dentists' Investment Program offers a range of distinct advantages including:

- Expert assistance from certified financial planners who provide *personalized financial planning advice* based on your individual situation and retirement goals
- Access to a *wide selection of CDSPI investment funds* — managed by world-class investment firms
- Funds without any loads or commissions — just *MERs that are among the lowest available anywhere*

With advantages like these, it's no wonder why dental professionals and their families have more than a quarter of a billion dollars invested* in the Canadian Dentists' Investment Program RSP.

Contact an advisor who understands dentists best to start planning for retirement on your own terms.

1-888-220-1441 (toll-free)

Tim Bugden, CFP, BA, B.Ed.

Investment Planning Advisor, Maritime Provinces Region

** As of August 2014.*

The Canadian Dentists' Investment Program is provided by CDSPI as a member benefit of the CDA and participating provincial and territorial dental associations. Restrictions may apply to advisory services in certain jurisdictions.

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Need a vacation? Take it!

Dr. Carolyn Thomson | Professional Support Program | Coordinator

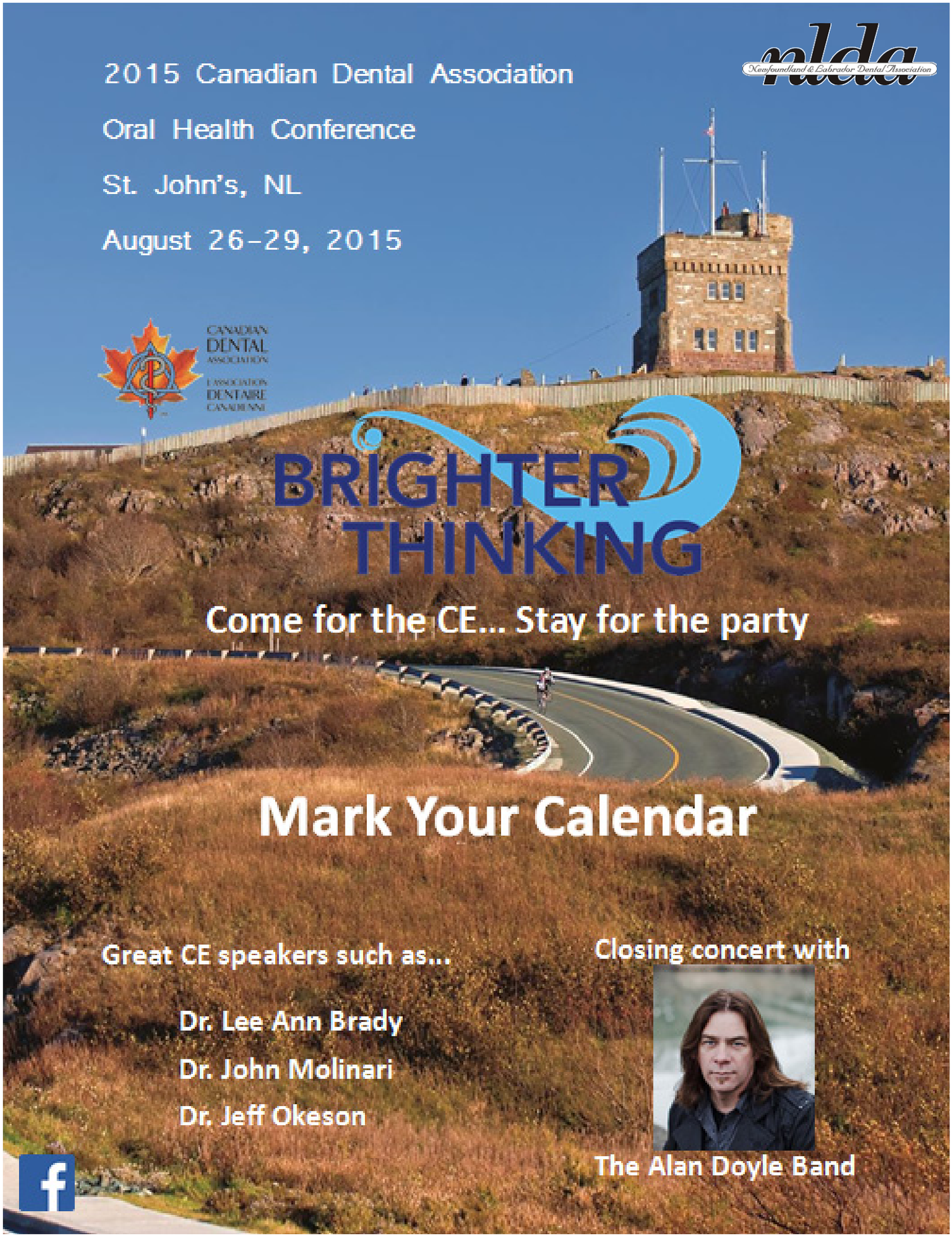
Vacation: Latin “vacatio”: being free from work, being at leisure, having time for.

Research has shown that vacations can be good for you. Vacations are more powerful than evenings or weekends because they are usually spent in a different more relaxing environment which allows you to mentally detach from work and other daily demands and routines. They also allow active engagement in potentially recovering activities such as family time, hobbies and physical activity. A longitudinal study by Gump and Matthews (2000) who followed 12,338 men at risk for coronary heart disease demonstrated that not taking annual vacations is associated with an increased risk of morbidity and even mortality 9 years later.

In 2011, DeBloome et al. looked at a number of variables associated with vacations to determine their impact on health and well being. Those who derived more pleasure from vacation activities experienced increases in their health and wellness. It was the experience of the activity rather than the type of activity that had this positive effect. In other words, skiing down a double black diamond trail or lying on the beach with a good book can both increase health and wellness as long as there is pleasure in doing it. For couples, positive contact and interaction during vacation produced greater detachment from work, increased relaxation and more enjoyment of pleasurable activities. Not surprising is that working vacationers benefitted less from vacation effects with lower levels of work detachment and lower health and wellness scores after vacation. One more reason to leave the journals and Blackberry at home.

In another study by G Strauss-Blasche et. al., health related vacation outcomes were measured by variables such as recuperation, mood, perceived mental and physical fitness and fatigue. Recuperation was facilitated by free time for one’s self, sunnier and warmer vacation locales, exercise during vacation, good sleep, and making new acquaintances, especially among vacationers reporting higher levels of pre-vacation work stress. Vacation duration did not seem to predict these outcomes and benefits could still be seen from shorter vacations (4-5days). This may be explained by the fact that mood peaks at about 7 days but the greatest improvements in mood are seen in the first 3 days of vacation. Post-vacation effects are not long lasting (about 1-3 days) so it may be advantageous to take shorter, more frequent holidays during the year. Vacation-related health problems and time zone differences had a negative impact on outcomes but travel time, which ranged from 1 to 48 hours in this study, did not. How the vacationer planned their time was a strong predictor of recuperation . This is likely due to having the time to look after one’s self in a relaxing environment free of the usual obligations.

Most importantly, vacations are a time to disconnect from work and reconnect with yourself and loved ones. So leave your work behind. Go somewhere you like. Do something you love with someone you adore. Plan your time. Meet new people. Bon Voyage.


2015 Canadian Dental Association
Oral Health Conference
St. John's, NL
August 26-29, 2015
nlda
Newfoundland & Labrador Dental Association
CANADIAN DENTAL ASSOCIATION
ASSOCIATION DENTAIRE CANADIENNE
BRIGHTER THINKING
Come for the CE... Stay for the party
Mark Your Calendar
Great CE speakers such as...
Dr. Lee Ann Brady
Dr. John Molinari
Dr. Jeff Okeson
Closing concert with
The Alan Doyle Band

Community Fund 2014-2015

The 2014-2015 NSDA Community Fund recipients have been announced, amounting to $24,677 awarded to communities across Nova Scotia. This year's recipients are:

$6,000.00 Hillcrest Academy Community Playground Society - Shelburne, NS
(Playground upgrades and repairs)
Dr. Kim Mailman (Sponsor)

$4,000.00 New Players Choral Society - Halifax, NS
(Audio equipment/sound system)
Dr. Patricia Bell (Sponsor)

$6,000.00 Antigonish Boat Club - Antigonish, NS
(Storage shed and equipment storage rack)
Dr. Tim Silver (Sponsor)

$5,000.00 New Minas Sunrise Rotary Club - New Minas, NS
(Shower features for splash park)
Dr. Peter Bagnell (Sponsor)

$2,500.00 Cheema Aquatic Club - Dartmouth, NS
(K2 "Nelo" Kayak for club)
Dr. Joanne Thomas (Sponsor)

$500.00 Halifax Safety Advisory Committee - Dartmouth, NS
(Waverly Road cross walk flags)
Dr. Emmanuel Tawio (Sponsor)

$677.00 Foyer Ecole of Ctr Scholaire de la Rive - Bridgewater, NS
(Bench buddy program)
Dr. Phil Mintern (Sponsor)

Dear Dr Stuart MacDonald,
Chair NSDA Community Fund Committee

I am writing to thank you and your group for selecting and providing $6000 to our school playground project. It is the talk of the Town……really! When my dental staff learned of your contribution they began screaming. I thought something was wrong as the only other time I heard such an outburst was when a transformer blew-up and caught fire across the street from the office.

I know the money will be well spent and managed by frugal, caring members of the school playground committee. I also know that the NSDA has received a huge endorsement from the people of Shelburne area. I am proud of the NSDA and thankful for the NSDA's financial support to this worthwhile project.

A Proud Thank You,

Dr. Kim Mailman

Dalhousie Faculty of Dentistry

Join Dalhousie's Faculty of Dentistry for the 2015 Student Table Clinics and Dental Hygiene Presentations on Friday, January 30 from 5:00-8:00 pm in the Dalhousie Dental Clinic (5981 University Avenue), followed by a reception and award presentations. All oral health care providers and university members are invited to attend this complimentary event, and attendees are eligible for up to two credit hours of continuing dental education credits.

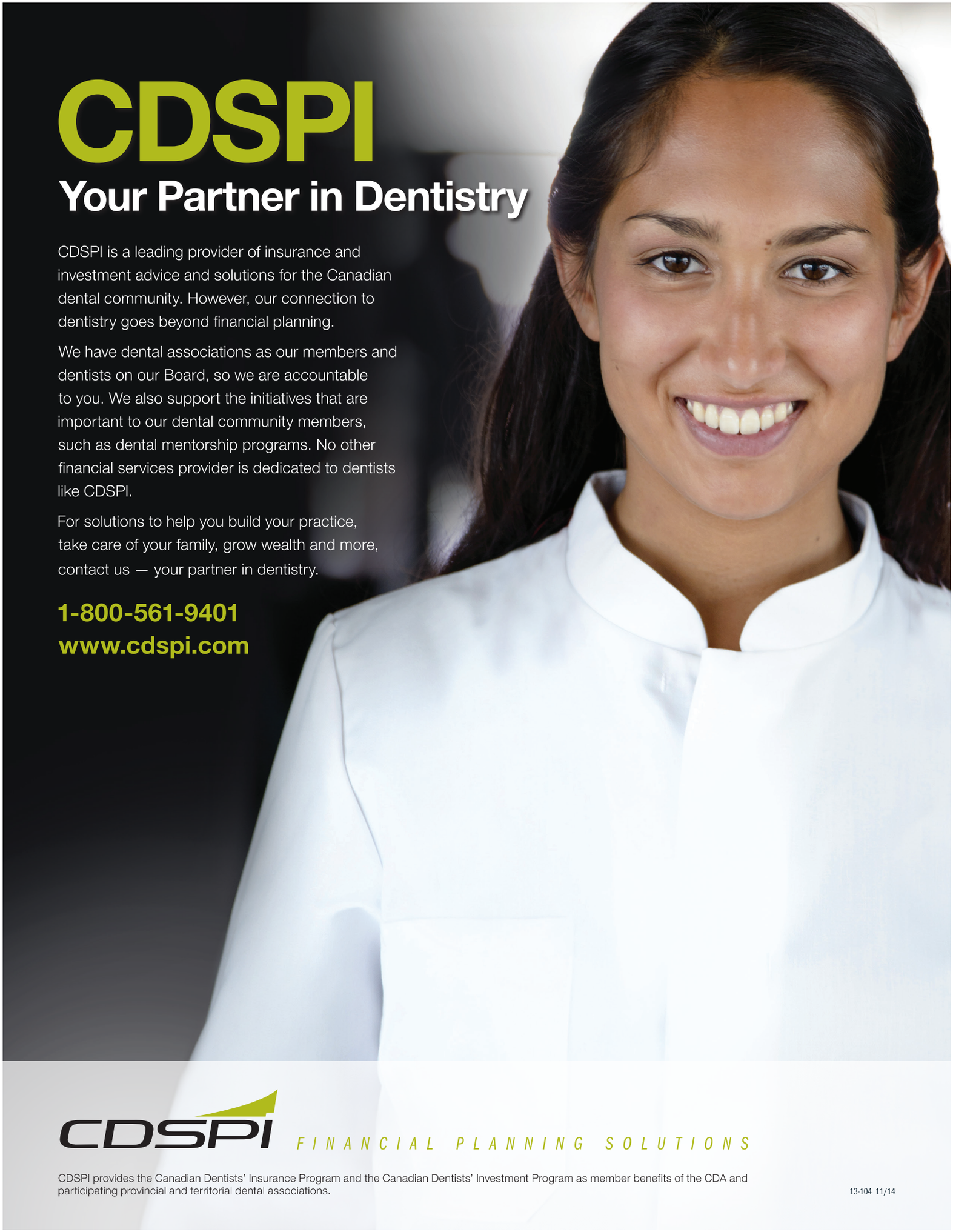
A table clinic is a brief oral presentation in areas of clinical application and techniques, or basic science, research or oral health promotion. The presentation includes display boards, which contain both text and visuals. Clinical and research equipment and materials also may be displayed. Oral presentations are 5-10 minutes in duration. The table clinic exercise is a student-centered learning activity, with the support of a faculty advisor. Students begin by selecting a topic that they wish to present. Students must thoroughly research their topic and provide their own critical analysis, conclusions and recommendations. Alternatively, students may conduct a research project and present their results and conclusions.

In addition, groups of 3-4 second year dental hygiene students will give 10-15 minute evidence-based Power Point presentations on the dental hygiene implications of “Abuse and Addiction.” The presentations will be held in classrooms and scheduled in a way that allows individuals to see all presentations. A fact sheet summarizing key information will be provided to those who attend.

Class of 1984

Thirty years ago this class travelled to the Bahamas to celebrate finishing exams in 4th year. Recently, this group once again travelled to the Bahamas to enjoy their 30th class reunion. The class of 1984 was the first to complete all four years at the new Dental School and was the last of the small classes to graduate.

Pictured from left to right: Drs. Louise Macleod, Ed MacMurdo, Susan Lewis, Kim Mailman, Patti Johnson, Anne MacDonald (holding an I-Pad with Bill Lam “live”), Bill Presse, Marjorie Macdonald, John Conrad


CDSPI
Your Partner in Dentistry
CDSPI is a leading provider of insurance and investment advice and solutions for the Canadian dental community. However, our connection to dentistry goes beyond financial planning.
We have dental associations as our members and dentists on our Board, so we are accountable to you. We also support the initiatives that are important to our dental community members, such as dental mentorship programs. No other financial services provider is dedicated to dentists like CDSPI.
For solutions to help you build your practice, take care of your family, grow wealth and more, contact us — your partner in dentistry.
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FINANCIAL PLANNING SOLUTIONS
CDSPI provides the Canadian Dentists' Insurance Program and the Canadian Dentists' Investment Program as member benefits of the CDA and participating provincial and territorial dental associations.
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