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CDSBC | College of Dental Surgeons of British Columbia

Board Meeting
24 September 2016
Agenda Item 3 b.

BOARD MEETING
Saturday, 24 September 2016

The Hyatt Regency Hotel
655 Burrard St., Vancouver BC
"*English Bay Room", 34th Floor*

MINUTES

The meeting commenced at 8:30 am

In Attendance

Dr. Don Anderson, President
Dr. Susan Chow, Vice-President
Dr. Patricia Hunter, Treasurer
Dr. Chris Callen
Dr. Doug Conn
Mr. Dan de Vita
Dr. Andrea Esteves
Dr. Michael Flunkert
Dr. Dustin Holben
Ms. Julie Johal
Mr. Samson Lim
Ms. Sherry Messenger
Ms. Sabina Reitzik
Dr. Masoud Saidi
Dr. Mark Spitz
Mr. Neal Steinman

Regrets

Mr. Richard Lemon
Mr. David Pusey

Staff in Attendance

Mr. Jerome Marburg, Registrar & CEO
Mr. Greg Cavouras, Legal Counsel
Ms. Nancy Crosby, Manager of CEO's Office
Dr. Chris Hacker, Dental Policy & Practice Advisor
Dr. Cathy McGregor, Health & Directed Education Program Head
Dr. Meredith Moores, Complaint Investigator
Ms. Roisin O'Neill, Director of Registration and HR
Ms. Leslie Riva, Sr. Manager, CDA Certification and QA
Dr. Garry Sutton, Early Resolution & Practice Advice
Ms. Anita Wilks, Director of Communications
Ms. Carmel Wiseman, Deputy Registrar
Mr. Dan Zeng, Director of Finance and Administration

1. Call Meeting to Order and Welcoming Remarks

   The President welcomed Mr. Eli Mina, a Registered Parliamentarian, who assisted with the meeting. Mr. Mina went over the two page handout/guidelines on meeting procedures he prepared to assist the Board.

   The President welcomed incoming Board member Mr. Neal Steinman.

2. Oath of Office – New Member

   Mr. Neal Steinman took the Oath of Office, administered by the Registrar.

3. Consent Agenda *(attachments)*

   a. Approve Agenda for 24 September 2016 *(attachment)*
   b. Reports from Committees *(attachments)*

   ***MOTION*: Holben/Spitz**

   That the items on the Consent Agenda for the 24 September 2016 Board meeting be approved.

   Carried

4. Business Arising from the Consent Agenda

   There was no business arising from the consent agenda.

5. Strategic Plan/Operations Plan *(attachment)*

   In June 2016 the Board, including incoming elected new Board members, held a day –long strategic/operational planning workshop. Board Officers and senior staff met on 18-19 August to analyze and refine the information from the June meeting and to prepare proposed operational planning priorities for Board consideration. The Registrar presented these to the Board, asking Board members to note their top five priorities for the upcoming year. This was done during the break. After reviewing the priorities set by the Board and hearty discussion, an entire survey will be sent to Board members to finalize priorities.

   ***MOTION*: Flunkert/Lim**
   To accept the strategic/operations plan as outlined by the Registrar.

   Carried - Unanimously

6. Prescribing and Dispensing Drugs (*attachment*) – Mr. Marburg, on behalf of the Sedation Committee

   The College has a policy/guideline document on prescribing/dispensing drugs which required revisions to bring it in line with changes to a number of pieces of provincial legislation which have themselves been modified recently. The College document was reviewed by the Sedation and GA Services Committee with input from subject matter experts from the College of Physicians and Surgeons of BC and the College of Pharmacists of BC. No substantive changes have been made to the document. Rather, definitions and references to legislation have been updated to bring them in line with the changes made to the underlying pieces of legislation.

   A Board member asked if this was a standard or guideline and it was agreed that the preamble needs to be inserted, explaining the differences between the two.

   The Registrar asked if the Board was comfortable with the content as policy, with direction to clean up the preamble and bring back to the Board for final approval.

   MOTION: Conn/De Vita

   To Adopt the document with direction to clarify the preamble wording and bring back to the Board for final approval.

   Carried

7. BC Health Regulators (BCHR) Briefing Note – Patient Relations (*attachment*)

   The Board adopted a boundaries document in February of 2016. Also in February the Board passed a revision to Bylaw 13 that has been accepted by Government and which came into effect in August 2016. In 2015 the government asked that the BCHR adopt a common policy on boundaries. The BCHR group has developed that policy for presentation to the Health College Boards. There is a slight gap between CDSBC's document and the BCHR policy. The BCHR has asked that the Board endorse the common policy.

   MOTION: De Vita/Spitz

   That the Board endorse in principle the BCHR Framework for a Model Patient-Practitioner Relationship Program.

That the Board refer this matter to the Ethics Committee to further develop the College's Boundaries Guidelines to <u>consider</u> the elements set out in the BCHR Framework and report back to the Board with recommendations following consultation with stakeholders in accordance with the College's Policy Development Process.

<u>Carried</u>

8. Dental Laboratories (*attachment*) – Carmel Wiseman

Ms. Wiseman provided a brief history/context to this agenda item.

At the Board meeting on 28 November 2015, the Board was informed that the Ethics Committee had concerns that some registrants may be marking up lab bills without any value-added activities attached to that mark-up. Concerns were raised about whether this was ethical and whether registrants should be given guidance on this issue. At the time, the Board agreed that this was a concern and asked that the Ethics Committee consider this issue along with the work being done with the former "Article 5" document.

The issue arose again when the College was contacted by an individual who didn't want to make a complaint but was concerned about a practice observed at a dental office. The dental office in question is one affiliated with a group of dental practices. In the case in question, a particular order had been placed with a lab. When the lab work came back, it came from a different lab (the Lab) accompanied by a bill issued by the Lab in an amount greater than the amount charged for the product by the lab at which the order was placed. The caller believed that the Lab, which was somehow affiliated with the dental office group, was simply repackaging the lab work and issuing an invoice in a greater amount. The caller wondered if this was permitted. The caller was advised the practice raised ethical concerns but was unwilling to make a complaint.

The Inquiry Committee Intake Panel directed that a complaint file be opened and an investigation conducted. The investigation report pointed to a number of ethical concerns. The Inquiry Committee felt that there may be a number of systemic issues which need to be addressed and that the best venue for that would be the Ethics Committee. They felt that the matter warranted urgent attention.

Given that the Board had referred this to the Ethics Committee to be dealt with along with other matters, staff felt that further direction from the Board was needed in light of subsequent events, and the concerns raised by the Inquiry Committee.

***MOTION*: Messenger/Esteves**

That this matter be referred to the Ethics Committee to be dealt with on an expedited basis.

Carried

9. Executive Limitation Reports *(attachments)*

CDSBC Governance policy requires that the CEO report regularly on matters identified by the Board through a series of Executive Limitations policies. This is one of the ways the Board discharges its oversight obligations without delving into operational issues. The CEO routinely submits these reports to the Board.

Dr. Chow asked about EL3, number 9: *The Annual Report includes a detailed graphic breakdown to illustrate how registrant fees are allocated to the various functions*. She would like this detailed in the next EL report, not just in the Annual Report.

***MOTION*: Chow/Saidi**

That the next EL3 report have a detailed breakdown to illustrate how registrant fees are allocated in various functions.

Defeated

A Board member asked that it be recorded that these matters have already been discussed by the Board and whereby the Board expressed there was too much detail already.

The Board recalled that the Governance Committee has been asked to take a look at the EL reports to simplify them and determine the high-level due diligence questions the Board should be asking periodically to exercise their oversight role and refrain from getting bogged down in operational details.

The Registrar asked the Board to provide staff with any thoughts on the types of due diligence questions they would like to see answered

EL2: Treatment of Public
EL3: Registration, Certification and Monitoring
EL5: Financial Planning/Budgeting
EL6: Financial Condition and Activities

MOTION: Lim/Saidi

That the Board receives the following Monitoring Reports:
EL2: Treatment of Public
EL3: Registration, Certification and Monitoring
EL5: Financial Planning/Budgeting
EL6: Financial Condition and Activities

Carried

10. Management Report *(attachment)*

Registrar/CEO Jerome Marburg submitted a written report on behalf of the senior staff and management of the College.

He highlighted the FDI Annual World Dental Conference in Poland. He was impressed by the depth of policy discussions at this conference, attended by representatives from 130 countries. There was a policy-rich agenda with many regulatory issues debated and voted on.

The Registrar will be distributing information to various committees that could benefit from this information.

MOTION: Holben/De Vita

That the Board receive the management report.

Carried

This concludes the open portion of our meeting. Ended at 11:30 am.

The remainder of the meeting will be held in camera, per Section 2.15 (9) of the College Bylaws under the *Health Professions Act*.

There was some clarification of motions, and whether to "receive" reports. Mr. Eli Mina advised that if a report is strictly for information purposes there is no need for a motion before the next item. The discussion would only be for clarification questions, then move to the next item and the document goes to the file.

MOTION: Flunkert
That motions indicating "receipt" of reports strictly for information purposes be disposed of.

Carried

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Board Meeting
24 September 2016
Agenda Item 3.b.

CDSBC Committee Report to Board For Public Agenda

Committee Name Audit Committee and Finance & Audit Committee Working Group

Submitted by Mr. Samson Lim, Chair

Submitted on 20 May 2016

Meeting Frequency
7 May 2015
7 October 2015
4 November 2015
2 February 2016
10 May 2016

Matters Under Consideration

- Each committee/working group member continues to receive and review the monthly financial statements as prepared by management. From a financial perspective, the previous year end results have been properly reported on, and the current year-to-date results continue to appear to be in good order.

- In the event of continuing questions over the independence of the external auditors at this year's AGM, the Audit Committee Chair met with the Smythe engagement Partner to discuss, and agreed there is no issue. However, to address the request we had Smythe introduce a new concurring Audit Partner to review and sign off on the engagement along with the Engagement Partner, as well as utilized a different Audit Manager and different Senior to lead the engagement. Hence, there should be little concern over the appearance of independence for the next few years given this new team composition.

Future Trends

- The Committee/working group is always seeking to improve the communication of financial information to the Board and registrants. Aside from the Management Discussion and Analysis narratives which are now being provided quarterly, we are working with management to develop meaningful key performance indicators (KPI's) that will quickly convey some of the improvements, challenges and trends for the

CDSBC over the current and prior years. These KPI's will need to be objectively developed to adjust for unusual items occurring in each year that will otherwise compromise comparability, but once finalized, should be good metrics for illustrating the underlying trends in key financial areas.

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Board Meeting
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Agenda Item 3.b.

CDSBC Committee Report to Board

For Public Agenda

Committee Name	CDA Advisory Committee
Submitted by	Susanne Feenstra, Chair
Submitted on	23 September 2016
Meeting Frequency	This Committee has not since the last Board Meeting. Next meeting date 11 October 2016
Matters Under Consideration	Educational programs and restricted activities
Future Trends	Module Updates: Orthodontic Module

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Board Meeting
24 September 2016
Agenda Item 3.b.

CDSBC Committee Report to Board

For Public Agenda

Committee Name	CDA Certification Committee
Submitted by	Ms. Bev Davis, Chair
Submitted on	23 September 2016
Meeting Frequency	This Committee has not met since last Board meeting.
Matters Under Consideration	
Future Trends	Further discussion with regard to what are recognized continuous practice hours.

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Board Meeting
24 September 2016
Agenda Item 3.b.

CDSBC Committee Report to Board For Public Agenda

Committee Name Ethics Committee

Submitted by Dr. Kenneth Chow, Chair

Submitted on 11 August 2016

Meeting Frequency The Committee met on the following dates:

- 25 April 2016 (Article 5 Working Group)
- 4 May 2016

Matters Under Consideration

- **Code of Ethics**

The Committee's Article 5 Working Group which first met in April and identified seven provisions of Article 5 under the old *Dentists Act* that are absent from the current Code of Ethics, or other CDSBC policies, standards or guidelines, will be meeting again this Fall. Once the working group has completed its review, it will prepare recommendations for the Ethics Committee's review prior to presentation to the Board.

- **Corporate Structures**

The collection of the necessary data from registrants regarding their health profession corporations and scanning it into the CDSBC's database continues.

Connection to Strategic Plan

- Following the Mission statement – "in the public interest"

- Following the Mandate – "Establishes, monitors, and regulates standards of practice, guidelines for continuing practice and ethical requirements for all dentists and CDAs"

Future Trends

-

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Board Meeting
24 September 2016
Agenda Item 3.b.

CDSBC Committee Report to Board
For Public Agenda

Committee Name	Inquiry Committee
Submitted by	Dr. Greg Card, Chair
Submitted on	07 September 2016
Meeting Frequency	From 31 April 2016, the date of the last report, until 31 August 2016, the Inquiry Committee as a whole met on the following dates:

- 24 May 2016
- 21 June 2016
- 19 July 2016
- 23 August 2016

Inquiry Committee Panels met on the following dates:

- 05 May 2016
- 12 May 2016
- 18 May 2016
- 26 May 2016
- 01 June 2016
- 07 June 2016
- 29 June 2016
- 05 July 2016
- 07 July 2016
- 15 August 2016

In addition, a Panel of the Inquiry Committee meets weekly electronically to review new complaints received and direct how each new file is to be handled (normally through investigation or early resolution).

Matters Under Consideration

Between 01 May 2016 and 31 August 2016, Inquiry Committee Panels had files involving 11 dentists under review; they had been referred to a Panel because the files are complex or because the registrant is a member of a Committee or the Board or because the registrant has asked to meet with a Panel.

Connection to Strategic Plan

The Board's strategic plan requires CDSBC to have a transparent, fair, effective and defensible complaints resolution process and procedures and to take active steps to help registrants enhance the standard of care they provide. The complaints process is designed to collect the information necessary to properly investigate and dispose of complaints. If minor concerns with a registrant's practice are noted they are given practice advice. More serious concerns are addressed by agreement with the registrant whenever possible. Such agreements are tailored to the particular concerns raised. When the complaint files are closed, the complainants receive a comprehensive letter outlining the investigative steps taken, what the investigation revealed and how CDSBC has disposed of the complaint. A complainant has the right to request the HPRB review any Inquiry Committee disposition of a complaint short of a citation.

Statistics/Report

55 files were opened and 71 were closed between 01 May 2016 and 31 August 2016.

CDSBC College of Dental Surgeons of British Columbia

Board Meeting
24 September 2016
Agenda Item 3.b.

CDSBC Committee Report to Board For Public Agenda

Committee Name	Nominations Committee
Submitted by	Dr. David Tobias, Chair
Submitted on	19 August 2016
Meeting Frequency	The Committee has not met since the last Board meeting.
Matters Under Consideration	The Committee is in the process of administering the CDSBC Awards Policy on behalf of the Board and will meet in the Fall as part of the annual Awards cycle.
Future Trends	None.

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Board Meeting
24 September 2016
Agenda Item 3.b.

CDSBC Committee Report to Board For Public Agenda

Committee Name	Quality Assurance Committee
Submitted by	Dr. Ash Varma, Chair
Submitted on	23 September 2016
Meeting Frequency	This Committee has not met since the last Board meeting. The QA Working Group met 16 September 2016
Matters Under Consideration	
Future Trends	1) Competency verification processes 2) Discussion of innovative ways to obtain CE

Quality Assurance Working Group consists of:

Dr. Ben Balevi
Ms. Catherine Baranow
Mr. Paul Durose
Dr. Andrea Esteves
Dr. Ash Varma, Chair
Dr. David Vogt

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Board Meeting
24 September 2016
Agenda Item 3.b.

CDSBC Committee Report to Board For Public Agenda

Committee Name	Quality Assurance CE Subcommittee
Submitted by	Dr. Ash Varma, Chair
Submitted on	23 September 2016
Meeting Frequency	This Committee has not met since the last Board meeting.
Matters Under Consideration	
Connection to Strategic Plan	This Committee continues to improve professionalism and practice standards of dentists, dental therapists and CDAs.
Future Trends	

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Board Meeting
24 September 2016
Agenda Item 3.b.

CDSBC Committee Report to Board
For Public Agenda

Committee Name	Registration Committee
Submitted by	Dr. Alexander Hird (Chair)
Submitted on	1 September 2016
Meeting Frequency	10 June 2016
Matters Under Consideration	
Statistics/Report	One request for full registration from applicant with insufficient continuous practice hours: denied. Required to successfully complete two parts of the NDEB Assessments: Clinical Judgement and Clinical Skills UPDATE: From report of 10 June 2016 One request for full registration from applicant with insufficient continuous practice hours: denied. Required to successfully complete part of the NDEB Assessments: Clinical Judgement *Applicant was successful and is now registered with full registration.
Future Trends	

CDSBC College of Dental Surgeons of British Columbia

CDSBC Committee Report to Board
For Public Agenda

Committee Name	Sedation and General Anaesthetic Services Committee
Submitted by	Dr. Tobin Bellamy, Chair
Submitted on	27 September 2016
Meeting Frequency	15 February 2016 11 April 2016 13 June 2016 19 September 2016

Matters Under Consideration

Revisions to the Minimal and Moderate Sedation Standards and Guidelines were approved at the Board meeting on 11 June 2016. The updates were placed on our website on 22 July 2016.

The framework of the inspection process for parenteral moderate sedation facilities is being developed by a subcommittee and will be reviewed in the next Sedation Committee Meeting in September of 2016.

A subcommittee has been formed to investigate and produce recommendations for sedation of pediatric patients.

Statistics/Report

Since the last Board Meeting, the Committee has approved the initial inspection of one deep sedation facility. Six new deep sedation facilities are in the inspection process. Fifteen deep sedation facilities are in the tri-annual inspection process.

Two new general anaesthesia facilities are in the inspection process. Five general anaesthesia facilities are in the tri-annual inspection process.

Annual self-assessments are now sent to a rota of the Committee for approval. Sixteen self-assessments have been approved since the last Board meeting.

Registration of qualifications applications from three dentists were reviewed and approved.

Future Trends

The process for inspection of moderate parenteral sedation facilities is being developed and finalized. The process and resources required will be determined over the next several months and presented to the Board.

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College of Dental Surgeons of BC

The Year Ahead

September 2016 - September 2017

The Year Ahead 2016/17

- Bylaws
- Boundaries
- Labs
- Article 5
- Quality Assurance
- Governance
  - » Confidentiality Policy Revision
  - » Policy refresh
  - » Board Cohesion
- Sedation
  - » Codes
  - » Parenteral Inspections
  - » Pediatric
- Deep Sedation Guidelines

The Year Ahead 2016/17

- Practitioner Wellness
- Implant Dentistry Guidelines
  - » Any other areas
  - » Resource / Process Issue
- Corporatization
  - » Bylaws Re: Reporting
  - » Bylaws Re: Remedies
- Privacy / Security
- Accreditation / Certification / Trade
  - » RCDC / Fairness / Contract
  - » NDEB
- Engagement
  - » Dentists and public

The Year Ahead 2016/17

- Long Range View on Dentistry – Into the Future
  - » BCDA
  - » Educators
- Facial Aesthetics
  - » Working group
  - » Definition of "dentistry"
    - » Legislation Change
- Specialty and Advanced Practice
  - » Recognition Processes
- Infection Control Breach Protocols (BCHR)

The Year Ahead 2016/17

Ongoing 2016/17

- Policy Development Framework
- Peer Network
- Complaint Process Survey Feedback
- CDRAF October Meeting
- Plus Core Ongoing
- New Registrant Course
  - » phsa.culturalcompetency.ca

The Year Ahead 2016/17

Core Ongoing

- Registration
- Certification
  - » Sedation qualifications
  - » Facilities
- Specialties
- Complaint resolution
- Illegal practice

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CDSBC | College of Dental Surgeons of British Columbia

Board Meeting
24 September 2016
Agenda Item 6.

CDSBC Policy Submission to Board

Submitted by
On behalf of the Sedation and General Anesthesia Committee

Submitted on
9 September 2016, for decision at September 2016 Board Meeting

Issue
Approval to editorial updates to Prescribing and Dispensing Drugs Policy

Authority
CDSBC Bylaws and Governance Manual

16.5. Responsibility for Policy Review

The Committee has responsibility to review, at least every two years, and more frequently as necessary (e.g. based on legislative changes, or a development in regulatory practices), the following Board-approved organizational policies:

- Committee Terms of Reference
- Prescribing and Dispensing of Drugs
- Sedation and Anaesthesia
    - Minimal and Moderate Sedation Services in Dentistry
    - Deep Sedation Services in Dentistry
    - General Anaesthetic Services in Dentistry
- [ntd: insert additional as required]

The Committee also has responsibility to recommend changes to these policies, as required.

Analysis
The Prescribing and Dispensing Drugs Policy was first published in 2005 and updated in 2009. Since that time, there have been a number of changes in Federal and Provincial Legislation and regulation, not reflected in the policy. The changes recommended for approval before you are necessary to bring the Policy in line with the legislation and regulations. In developing this draft, the Committee consulted with our regulatory colleagues and thanks in particular the College of Pharmacists, Physicians and Surgeons, and Nurses for their assistance in reviewing references and definitions for accuracy. And in particular the College of Pharmacists for updating the references to legislation and regulation.

Connection to Strategic Plan
Core mandate of Public Protection and review of CDSBC regulatory documents

Impact on Resources

None

Recommendation

That the Board approve the edits to the Prescribing and Dispensing Drugs Policy for publication

Attachments

Redlined and Final version of Drafts for approval

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The College is updating its documents to reflect the transition to regulation under the Health Professions Act and College Bylaws. The principles and requirements outlined in this document continue to apply to dentists and CDAs.

POLICY STATEMENT

Prescribing and Dispensing Drugs

Preamble:

The College of Dental Surgeons of BC (College) policies and guidelines contain practice parameters and standards which should be considered by dentists and certified dental assistants in the care of their patients. It is important to note that these may be used by the College or other bodies in the province of British Columbia in determining whether appropriate standards of practice and professional responsibilities have been maintained.

I. Regulations

The federal and provincial laws and regulations governing the distribution of drugs by prescription in British Columbia are as follows:

A. *Health Professions Act of British Columbia*

B. *Food and Drugs Act of Canada*

C. *Controlled Drugs and Substances Act*

D. *Food and Drugs Regulations*

E. *Narcotic Control Regulations*

F. *Benzodiazepines and other targeted substances regulations*

G. *Pharmacy Operations and Drug Scheduling Act*

Practitioners who can prescribe drugs under the *Health Professions Act of British Columbia* include dentists with a renewed registration or academic registration. Non-practising, retired or suspended practitioners, or those with a special permit for screening patients in long term care facilities, *cannot* prescribe drugs. Dentists must not prescribe any drugs for family or friends unless they are patients of record. Dentists must only prescribe drugs for patients of record if the drug is required to provide dental treatment for the patient.

II. Definitions

Administration: Provision of medications immediately preceding or during treatment, e.g., local anaesthetic

"Child Resistant" Package: A container that complies with the requirements of the Canadian Standards Association

Controlled Drug: Any drug or substance included in Schedule G to the *Regulations to the Food and Drugs Act of Canada*

Dispense: Means give, sell or provide medications including drugs purchased by the practitioner and/or samples, but does not include administration by or on behalf of the practitioner to a patient in the course of treatment.

Drug Schedules to the *Pharmacy Operations and Drug Scheduling Act of British Columbia*: Alphabetical list of all drugs and their status in British Columbia

Schedule I: Require a prescription for sale and are provided to the public by a pharmacist following the diagnosis and professional intervention of a practitioner. The sale is controlled in a regulated environment as defined by provincial pharmacy legislation.

Schedule IA: Controlled Prescription Program drugs which may be sold by a pharmacist to a practitioner or on the prescription of a practitioner in accordance with *Pharmacy Operations and Drug Scheduling Act*, Bylaw 4(6) and 4(8). The list of drugs covered by the program has been agreed to by all the participating organizations. Unless otherwise specified, both single-entity products and preparations or mixtures of the scheduled drugs require the use of Controlled Prescription forms under the Controlled Prescription Program.

Deleted:

Deleted: .

Inspector: A person designated by the Minister of Health Canada as an inspector for the purposes of the *Regulations to the Food and Drugs Act* and the *Controlled Drugs and Substances Act Regulations*

Minister: Refers to the Minister of Health Canada

Monitored Drug: Any drug that requires a Controlled Prescription Form under Controlled Prescription Program

Deleted:

Narcotic: Any drug or substance included in the *Narcotic Control Regulations*

Controlled Prescription Program (CPP) Narcotic: Any narcotic that requires a Controlled Prescription Form

Non-CPP Narcotic: Preparation containing only one narcotic drug plus two (or more) non-narcotic drugs in a therapeutic dose that does not require Controlled Prescription Form

Practitioner: means a person

Deleted: .

Deleted:

(a) who is authorized to practise medicine, dentistry, podiatry or veterinary medicine, or
(b) who is
(i) in a class of persons prescribed by the minister for the purpose of this definition, and
(ii) authorized under the *Health Professions Act* to prescribe drugs or devices in the course of providing the services of a designated health profession as defined in section 1 of that Act;

Prescription: means an authorization from a practitioner to dispense a specified drug or device for use by a designated individual or animal;

Prescription Drug List (PDL) to the *Food and Drugs Act*: is a list of medicinal ingredients that when found in a drug, require a prescription. It does not include medicinal ingredients that when found in a drug, require a prescription if those ingredients are listed in *Controlled Drugs and Substances Act* Schedules.

Schedule G to the *Food and Drugs Act*: List of controlled drugs

Controlled Prescription Program: Monitoring program to help eliminate abuse and diversion of certain pharmaceutical drugs (DP)

III. Controlled Prescription Program

The Controlled Prescription Program was established to prevent forgeries and reduce inappropriate prescribing of selected drugs. The list of drugs covered by the program has been agreed to by all participating organizations and is provided in Schedule IA to the *Pharmacy Operations and Drug Scheduling Act*, Bylaw 4(6) and 4(8. Unless otherwise specified, both single-entity products and preparations or mixtures of the scheduled drugs require the use of Controlled Prescription forms.

A. Prescribing Requirements: Controlled Prescription Program Drugs

1. A practitioner may **prescribe** a drug under Controlled Prescription Program to a person if that person is a patient under the practitioner's professional care, if the drug is required for the condition for which the patient is receiving treatment, and if the treatment is within the practitioner's scope of practice or training.

2. A practitioner who wishes to prescribe a drug under the Controlled Prescription Program must participate in the Controlled Prescription Program. Prescription forms are personalized and numerically recorded, and the prescription pad must be maintained intact in chronological order.

3. A practitioner who provides a drug under the Controlled Prescription Program shall ensure that it includes the information required in pharmacy legislation. Prescribers are advised that failure to complete the prescription forms may result in rejection of the prescription by the pharmacist with resulting patient and prescriber inconvenience. The following information is required on the Controlled Prescription Program:

    a. Prescriber's name, initials, address and College registration number
    b. Patient's name, initials, address, sex and date of birth
    c. Patient's personal health number (if available)
    d. Name, quantity, strength and form of drug (More than one medication or strength of medication can be included on one Controlled Prescription Program form, provided the orders are legible.)
    e. Dosage instructions for use by the patient which shall include a specific frequency or interval or maximum daily dose

Deleted:

Deleted:

Deleted:

f. Date of prescription
g. Signature of practitioner

4. A practitioner shall record on the patient's chart the following information:

a. Date of prescription
b. Name, strength, quantity, and form of drug
c. Directions for use of the drug
d. Condition being treated and/or dental treatment provided

B. Dispensing Requirements: Controlled Prescription Program Drugs

Registrants of the College of Dental Surgeons of British Columbia must not dispense (give, sell or provide) drugs under Controlled Prescription Program, unless such a registrant is classified as a "provider under the Pharmacare Program" as described in Section C below.

C. Provider Under The Pharmacare Program

In extenuating circumstances, individual practitioners can apply to Council for dispensing privileges for Controlled Prescription Program drugs. If the application is approved, the dentist must register with the College of Pharmacists of British Columbia as a "provider under the Pharmacare Program" and must give written assurance that he/she will comply with the requirements of the *Pharmacy Operations and Drug Scheduling Act* in the dispensing of medications.

D. Administration Requirements

1. A practitioner may administer Controlled Prescription Program drugs to a person if that person is a patient under the practitioner's professional care, if the drug is required to provide treatment for a patient having dental procedures performed, and if the treatment is within the practitioner's scope of practice or training. (Drugs are administered immediately preceding or during treatment.)

2. A practitioner must keep a separate register for each Controlled Prescription Program drug obtained for office use by prescription; such information to be provided upon request to the College or the Bureau of Drug Surveillance. The register should include the following:

General Information

a. Name of drug
b. Name of person who ordered drug
c. Amount purchased
d. Date received
e. Controlled Prescription Form folio number
f. Dates of periodic inventory (physical count of drugs)

Administration Information

a. Date when drug was provided to patient
b. Patient's name, address,
c. Quantity administered
d. Stock remaining

e. Condition being treated and/or dental treatment provided
f. Practitioner's name, initials and College registration number
g. Name of person who supplied drug to patient

The College has developed a "Register of In-Office Controlled Prescription Program Drugs" form which can be used to collect the required information. (See Appendix A)

IV. Other Prescription (PDL) Drugs and Non-CPP Narcotics

A. Prescribing Requirements: PDL Drugs and Non-CPP Narcotics (e.g. Tylenol No. 3, Frosst 292)

1. A practitioner may **prescribe** a drug for a person if that person is a patient under the practitioner's professional care, if the drug is required to provide treatment for a patient having dental procedures performed that are within the practitioner's scope of practice or training.

2. A practitioner shall give a written prescription to the patient or give a verbal prescription to a pharmacist chosen by the patient.

3. A practitioner who provides a written prescription shall ensure that the prescription includes:
   a. Prescriber's name, initials, address, telephone number and College registration number.
   b. Patient's name, initials and address (date of birth optional)
   c. Name, quantity, strength and form of drug
   d. Directions for use of drug
   e. If the prescription can be refilled and how many times (See Prescription Regulations Chart for more information)
   f. Date of prescription
   g. Signature of practitioner

4. A practitioner who provides a verbal prescription must do so personally and shall ensure that the prescription includes:
   a. Prescriber's name, initials, address, telephone number and College registration number
   b. Patient's name, initials and address (date of birth optional)
   c. Name, quantity, strength and form of drug
   d. Directions for use of drug
   e. If the prescription can be refilled and how many times (only Prescription Drug List drugs)

5. A practitioner shall record on the patient's chart the following information:
   a. Date of prescription and method (written or verbal)
   b. Name, quantity, strength and form of drug
   c. Directions for use of drug if copy of written prescription is not kept in the chart

B. Dispensing Requirements: PDL Drugs and Non-CPP Narcotics (e.g. Tylenol No. 3, Frosst 292)

1. A practitioner may dispense a drug to a person if that person is a patient under the practitioner's professional care, if the drug is required to provide treatment

for a patient, having dental procedures performed that are within the practitioner's scope of practice or training.

2. A practitioner who **dispenses** a drug shall comply with all the federal and provincial laws relating to the storage, handling, distribution, labeling, packaging, and recording of information.

3. A practitioner shall **dispense** a prescription in a "child-resistant" package.

4. A practitioner shall **dispense** a prescription with a label containing the following information:

   a. Name, address and telephone number of **dispensing** practitioner (and institution where applicable)
   b. Dispensing date
   c. Name of patient
   d. Directions for use

   e. Identification of contents:
      - Proper, common or brand name of drug
      - Quantity and strength of drug
      - Name of manufacturer or DIN # (unless brand name is used)

5. A practitioner shall have a record of the particulars of the dispensing in the patient's chart including:
   a. Date prescription dispensed
   b. Name, quantity, strength and form of drug
   c. Directions for use of drug

C. Administration Requirements

1. A practitioner may administer PDL Drugs or non-CPP narcotics to a person if that person is a patient under the practitioner's professional care, if the drug is required to provide treatment for a patient, having dental procedures performed that are within the practitioner's scope of practice or training. (Drugs are administered immediately preceding or during treatment.)

2. A practitioner must record the name, strength and dosage of the drug administered on the patient's chart.

D. Register for "In-Office" Non-CPP Narcotics

A practitioner must keep a separate register for each non-CPP narcotic obtained for office use by prescription, such information to be provided upon request to the College or the Bureau of Drug Surveillance. The register should include the following:

1. General Information

   a. Name of drug
   b. Name of person who ordered drug
   c. Amount purchased
   d. Date received
   e. Prescription number (where applicable)
   f. Dates of periodic inventory (physical count of drugs)

2. Dispensing/Administration Information

a. Date when drug was provided to patient
b. Patient's name, address, and date of birth
c. Quantity dispensed/administered
d. Stock remaining
e. Packaging for dispensing (provided in a labeled, child resistant container)
f. Condition being treated and/or dental treatment provided
g. Practitioner's name, initials and College registration number
h. Name of person who supplied drug to patient

The College has developed a "Register of In-Office Non-CPP Narcotics" form which can be used to collect the required information. (See Appendix B)

V. Sedation and General Anaesthetic Drugs

Sedation and general anaesthetic services in dentistry may only be provided by practitioners who have successfully completed a training program designed to produce competency in the specific modality of sedation or general anaesthetic utilized. Practitioners must follow the College's guidelines for sedation and general anaesthetic services, and where applicable, registration and/or accreditation requirements of the College must also be fulfilled. In addition, a practitioner must maintain a Narcotic and Controlled Drug Register as required by the Bureau of Drug Surveillance, Health Canada.

VI. Local Anaesthetic Drugs

The type of local anaesthetic, actual doses and patient response shall be documented in the patient's chart.

APPENDIX A

REGISTER OF "IN-OFFICE" CONTROLLED PRESCRIPTION PROGRAM DRUGS
(For Administration Only)

NAME OF DRUG _____ STRENGTH _____ FORM _____ QUANTITY _____

ORDERED BY _____ PRESCRIPTION # (Where Applicable) _____ DATE RECEIVED _____

PERIODIC INVENTORY

Date _____ Qty in Stock _____ Qty on Record _____ Difference _____ Reason _____ Initials _____
Date _____ Qty in Stock _____ Qty on Record _____ Difference _____ Reason _____ Initials _____
Date _____ Qty in Stock _____ Qty on Record _____ Difference _____ Reason _____ Initials _____
Date _____ Qty in Stock _____ Qty on Record _____ Difference _____ Reason _____ Initials _____

Date	Patient's Name, Address,	Qty Admin	Stock Left	Condition Being Treated and/or Dental Treatment Provided	Dentist's Name, Initials, College Reg. #	Name of Person Who Supplied Drugs to Patient

REGISTER FOR "IN OFFICE" CONTROLLED PRESCRIPTION PROGRAM DRUGS

1. A practitioner must keep a separate register for each narcotic or controlled drug prescription obtained for office use which includes the following:

General Information	Administration Information
a. Name of drug b. Name of person who ordered drug c. Amount purchased d. Date received e. Prescription number (where applicable) f. Dates of periodic inventory (physical count of drugs)	a. Date when drug was provided to patient b. Patient's name, address c. Quantity administered d. Stock remaining e. Condition being treated and/or dental treatment provided f. Practitioner's name, initials and College registration number g. Name of person who administered drugs to patient

The College has developed a "Register of In-Office Controlled Prescription Program Drugs" form which can be used to collect the required information.

2. A practitioner must provide access to records to authorized inspectors as outlined in the *Health Professional Act, Food and drugs Act, Controlled Drugs and Substances Act, Food and Drugs Regulations, Narcotic Control Regulations, Benzodiazepines and Other Targeted Substances Regulations, and Pharmacy Operations and Drug Scheduling Act,* and must:

   a. Furnish on request such information respecting (i) the receipt and use by the practitioner of narcotic and controlled drugs (including the administering and furnishing thereof to a person, i.e. "in-office drugs") and (ii) the prescriptions for narcotic and controlled drugs issued by the practitioner (i.e. all prescriptions written for patients), as the Minister may require:

   b. Produce to an inspector upon request any records that the *Regulations* require the practitioner to keep

   c. Permit an inspector to make copies of such records or to take extracts there from

   d. Permit an inspector to check all stocks of narcotic and controlled drugs on the practitioner's premises

   e. Retain in his possession for at least two years any record that the *Regulations* require him to keep

   f. Take adequate steps to protect controlled drugs in his possession

   g. Report to the Minister (Bureau of Drug Surveillance) any loss (including breakage) or theft of a narcotic or controlled drug **within ten days** of the practitioner's discovery of the loss or theft

Where a practitioner alleges or, in any prosecution for an offense under the laws or regulations, pleads that his possession of a narcotic or controlled drug was for use in his practice or that he prescribed, administered, gave, sold or furnished a narcotic or controlled drug to any person as a patient under his professional treatment and that such narcotic or controlled drug was required for the condition for which the patient received treatment, the burden of proof thereof shall be on such practitioner. The evidence needed to support this would be detailed records.

APPENDIX B

REGISTER OF "IN-OFFICE" NON-CONTROLLED PRESCRIPTION PROGRAM NARCOTICS

NAME OF DRUG _____ STRENGTH _____ FORM _____ QUANTITY _____

ORDERED BY _____ PRESCRIPTION # (Where Applicable) _____ DATE RECEIVED _____

PERIODIC INVENTORY

Date _____ Qty in Stock _____ Qty on Record _____ Difference _____ Reason _____ Initials _____
Date _____ Qty in Stock _____ Qty on Record _____ Difference _____ Reason _____ Initials _____
Date _____ Qty in Stock _____ Qty on Record _____ Difference _____ Reason _____ Initials _____
Date _____ Qty in Stock _____ Qty on Record _____ Difference _____ Reason _____ Initials _____

Date	Patient's Name, Address	Qty Disp.s/ Admin	Stock Left	Disp. in Labeled, Child-proof Container	Condition Being Treated and/or Dental Treatment Provided	Dentist's Name, Initials, College Reg. #	Name of Person Who Supplied Drugs to Patient

REGISTER FOR "IN OFFICE" NON-CONTROLLED PRESCRIPTION PROGRAM NARCOTICS

1. A practitioner must keep a separate register for each narcotic or controlled drug prescription obtained for office use which includes the following:

General Information	Dispensing/Administration Information
a. Name of drug b. Name of person who ordered drug c. Amount purchased d. Date received e. Prescription number (where applicable) f. Dates of periodic inventory (physical count of drugs)	a. Date when drug was provided to patient b. Patient's name, address c. Quantity dispensed/administered d. Stock remaining e. Packaging for dispensing (provided in a labeled, child-proof container) f. Condition being treated and/or dental treatment provided g. Practitioner's name, initials and College registration number h. Name of person who supplied drugs to patient

The College has developed a "Register of In-Office Non-Controlled Prescription Program Narcotics" form which can be used to collect the required information.

2. A practitioner must provide access to records to authorized inspectors as outlined in the *Health Professional Act, Food and drugs Act, Controlled Drugs and Substances Act, Food and Drugs Regulations, Narcotic Control Regulations, Benzodiazepines and Other Targeted Substances Regulations, and Pharmacy Operations and Drug Scheduling Act,* and must:

a. Furnish on request such information respecting (i) the receipt and use by the practitioner of narcotic and controlled drugs (including the administering and furnishing thereof to a person, i.e. "in-office drugs") and (ii) the prescriptions for narcotic and controlled drugs issued by the practitioner (i.e. all prescriptions written for patients), as the Minister may require

b. Produce to an inspector upon request any records that the *Regulations* require the practitioner to keep

c. Permit an inspector to make copies of such records or to take extracts there from

d. Permit an inspector to check all stocks of narcotic and controlled drugs on the practitioner's premises

e. Retain in his possession for at least two years any record that the *Regulations* require him to keep

f. Take adequate steps to protect controlled drugs in his possession

g. Report to the Minister (Bureau of Drug Surveillance) any loss (including breakage) or theft of a narcotic or controlled drug **within ten days** of the practitioner's discovery of the loss or theft

Where a practitioner alleges or, in any prosecution for an offense under the laws or regulations, pleads that his possession of a narcotic or controlled drug was for use in his practice or that he prescribed, administered, gave, sold or furnished a narcotic or controlled drug to any person as a patient under his professional treatment and that such narcotic or controlled drug was required for the condition for which the patient received treatment, the burden of proof thereof shall be on such practitioner. The evidence needed to support this would be detailed records.

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STANDARDS & GUIDELINES

Prescribing and Dispensing Drugs

TABLE OF CONTENTS

Introduction

Preamble

The College of Dental Surgeons of BC (College) policies and guidelines contain practice parameters and standards which should be considered by dentists, dental therapists and certified dental assistants in the care of their patients. It is important to note that these may be used by the College or other bodies in the province of British Columbia in determining whether appropriate standards of practice and professional responsibilities have been maintained.

1. Regulations

The federal and provincial laws and regulations governing the distribution of drugs by prescription in British Columbia are as follows:

a. *Health Professions Act of British Columbia*

b. *Food and Drugs Act of Canada*

c. *Controlled Drugs and Substances Act*

d. *Food and Drugs Regulations*

e. *Narcotic Control Regulations*

f. *Benzodiazepines and other targeted substances regulations*

g. *Pharmacy Operations and Drug Scheduling Act*

Practitioners who can prescribe drugs under the *Health Professions Act of British Columbia* include dentists with a renewed registration or academic registration. Non-practising, retired or suspended practitioners, or those with a special permit for screening patients in long term care facilities, *cannot* prescribe drugs. Dentists must not prescribe any drugs for family or friends unless they are patients of record. Dentists must only prescribe drugs for patients of record if the drug is required to provide dental treatment for the patient.

2. Controlled Prescription Program

The Controlled Prescription Program was established to prevent forgeries and reduce inappropriate prescribing of selected drugs. The list of drugs covered by the program has been agreed to by all participating organizations and is provided in Schedule IA to the *Pharmacy Operations and Drug Scheduling Act*, Bylaw 4(6) and 4(8. Unless otherwise specified, both single-entity products and preparations or mixtures of the scheduled drugs require the use of Controlled Prescription forms.

Prescribing Requirements: Controlled Prescription Program Drugs

1. A practitioner may **prescribe** a drug under Controlled Prescription Program to a person if that person is a patient under the practitioner's professional care, if the drug is required for the condition for which the patient is receiving treatment, and if the treatment is within the practitioner's scope of practice or training.
2. A practitioner who wishes to prescribe a drug under the Controlled Prescription Program must participate in the Controlled Prescription Program. Prescription forms are personalized and numerically recorded, and the prescription pad must be maintained intact in chronological order.
3. A practitioner who provides a drug under the Controlled Prescription Program shall ensure that it includes the information required in pharmacy legislation. Prescribers are advised that failure to complete the prescription forms may result in rejection of the prescription by the pharmacist with resulting patient and prescriber inconvenience. The following information is required on the Controlled Prescription Program:
    a. Prescriber's name, initials, address and College registration number
    b. Patient's name, initials, address, sex and date of birth
    c. Patient's personal health number (if available)
    d. Name, quantity, strength and form of drug (More than one medication or strength of medication can be included on one Controlled Prescription Program form, provided the orders are legible.)
    e. Dosage instructions for use by the patient which shall include a specific frequency or interval or maximum daily dose
    f. Date of prescription
    g. Signature of practitioner
4. A practitioner shall record on the patient's chart the following information:
    a. Date of prescription
    b. Name, strength, quantity, and form of drug
    c. Directions for use of the drug
    d. Condition being treated and/or dental treatment provided
    e. record if the drug is required to provide dental treatment for the patient.

Dispensing Requirements: Controlled Prescription Program Drugs

Registrants of the College of Dental Surgeons of British Columbia must not dispense (give, sell or provide) drugs under Controlled Prescription Program, unless such a registrant is classified as a "provider under the Pharmacare Program" as described in Section C below.

Provider Under The Pharmacare Program

In extenuating circumstances, individual practitioners can apply to Council for dispensing privileges for Controlled Prescription Program drugs. If the application is approved, the dentist must register with the College of Pharmacists of British Columbia as a "provider under the Pharmacare Program" and must give written assurance that he/she will comply with the requirements of the *Pharmacy Operations and Drug Scheduling Act* in the dispensing of medications.

Administration Requirements

1. A practitioner may administer Controlled Prescription Program drugs to a person if that person is a patient under the practitioner's professional care, if the drug is required to provide treatment for a patient having dental procedures performed, and if the treatment is within the practitioner's scope of practice or training. (Drugs are administered immediately preceding or during treatment.)

2. A practitioner must keep a separate register for each Controlled Prescription Program drug obtained for office use by prescription; such information to be provided upon request to the College or the Bureau of Drug Surveillance. The register should include the following:

General Information

a. Name of drug

b. Name of person who ordered drug

c. Amount purchased

d. Date received

e. Controlled Prescription Form folio number

f. Dates of periodic inventory (physical count of drugs)

Administration Information

a. Date when drug was provided to patient

b. Patient's name, address,

c. Quantity administered

d. Stock remaining

e. Condition being treated and/or dental treatment provided

f. Practitioner's name, initials and College registration number

g. Name of person who supplied drug to patient

The College has developed a "Register of In-Office Controlled Prescription Program Drugs" form which can be used to collect the required information. (See Appendix A)

3. Other Prescription (PDL) Drugs and Non-CPP Narcotics

Prescribing Requirements: PDL Drugs and Non-CPP Narcotics (e.g. Tylenol No. 3, Frosst 292)

1. A practitioner may **prescribe** a drug for a person if that person is a patient under the practitioner's professional care, if the drug is required to provide treatment for a patient having dental procedures performed that are within the practitioner's scope of practice or training.
2. A practitioner shall give a written prescription to the patient or give a verbal prescription to a pharmacist chosen by the patient.
3. A practitioner who provides a written prescription shall ensure that the prescription includes:
    a. Prescriber's name, initials, address, telephone number and College registration number.
    b. Patient's name, initials and address (date of birth optional)
    c. Name, quantity, strength and form of drug
    d. Directions for use of drug
    e. If the prescription can be refilled and how many times (See Prescription Regulations Chart for more information)
    f. Date of prescription
    g. Signature of practitioner
4. A practitioner who provides a verbal prescription must do so personally and shall ensure that the prescription includes:
    a. Prescriber's name, initials, address, telephone number and College registration number
    b. Patient's name, initials and address (date of birth optional)
    c. Name, quantity, strength and form of drug
    d. Directions for use of drug
    e. If the prescription can be refilled and how many times (only Prescription Drug List drugs)
5. A practitioner shall record on the patient's chart the following information:
    a. Date of prescription and method (written or verbal)

b. Name, quantity, strength and form of drug

c. Directions for use of drug if copy of written prescription is not kept in the chart

Dispensing Requirements: PDL Drugs and Non-CPP Narcotics (e.g. Tylenol No. 3, Frosst 292)

1. A practitioner may dispense a drug to a person if that person is a patient under the practitioner's professional care, if the drug is required to provide treatment for a patient, having dental procedures performed that are within the practitioner's scope of practice or training.
2. A practitioner who **dispenses** a drug shall comply with all the federal and provincial laws relating to the storage, handling, distribution, labeling, packaging, and recording of information.
3. A practitioner shall **dispense** a prescription in a "child-resistant" package.
4. A practitioner shall **dispense** a prescription with a label containing the following information:
   a. Name, address and telephone number of **dispensing** practitioner (and institution where applicable)
   b. Dispensing date
   c. Name of patient
   d. Directions for use
   e. Identification of contents:
      - Proper, common or brand name of drug
      - Quantity and strength of drug
      - Name of manufacturer or DIN # (unless brand name is used)
5. A practitioner shall have a record of the particulars of the dispensing in the patient's chart including:
   a. Date prescription dispensed
   b. Name, quantity, strength and form of drug
   c. Directions for use of drug

Administration Requirements

1. A practitioner may administer PDL Drugs or non-CPP narcotics to a person if that person is a patient under the practitioner's professional care, if the drug is required to provide treatment for a patient, having dental procedures performed that are within the practitioner's scope of practice or training. (Drugs are administered immediately preceding or during treatment.)
2. A practitioner must record the name, strength and dosage of the drug administered on the patient's chart.

Register for "In-Office" Non-CPP Narcotics

A practitioner must keep a separate register for each non-CPP narcotic obtained for office use by prescription, such information to be provided upon request to the College or the Bureau of Drug Surveillance. The register should include the following:

1. General Information
    a. Name of drug
    b. Name of person who ordered drug
    c. Amount purchased
    d. Date received
    e. Prescription number (where applicable)
    f. Dates of periodic inventory (physical count of drugs)
2. Dispensing/Administration Information
    a. Date when drug was provided to patient
    b. Patient's name, address, and date of birth
    c. Quantity dispensed/administered
    d. Stock remaining
    e. Packaging for dispensing (provided in a labeled, child resistant container)
    f. Condition being treated and/or dental treatment provided
    g. Practitioner's name, initials and College registration number
    h. Name of person who supplied drug to patient

The College has developed a "Register of In-Office Non-CPP Narcotics" form which can be used to collect the required information. (See Appendix B)

4. Sedation and General Anaesthetic Drugs

Sedation and general anaesthetic services in dentistry may only be provided by practitioners who have successfully completed a training program designed to produce competency in the specific modality of sedation or general anaesthetic utilized. Practitioners must follow the College's guidelines for sedation and general anaesthetic services, and where applicable, registration and/or accreditation requirements of the College must also be fulfilled. In addition, a practitioner must maintain a Narcotic and Controlled Drug Register as required by the Bureau of Drug Surveillance, Health Canada.

5. Local Anaesthetic Drugs

The type of local anaesthetic, actual doses and patient response shall be documented in the patient's chart.

Glossary

Administration: Provision of medications immediately preceding or during treatment, e.g., local anaesthetic

"Child Resistant" Package: A container that complies with the requirements of the Canadian Standards Association

Controlled Drug: Any drug or substance included in Schedule G to the *Regulations to the Food and Drugs Act of Canada*

Dispense: Means give, sell or provide medications including drugs purchased by the practitioner and/or samples, but does not include administration by or on behalf of the practitioner to a patient in the course of treatment.

Drug Schedules to the *Pharmacy Operations and Drug Scheduling Act of British Columbia:* Alphabetical list of all drugs and their status in British Columbia

Schedule I: Require a prescription for sale and are provided to the public by a pharmacist following the diagnosis and professional intervention of a practitioner. The sale is controlled in a regulated environment as defined by provincial pharmacy legislation.

Schedule IA: Controlled Prescription Program drugs which may be sold by a pharmacist to a practitioner or on the prescription of a practitioner in accordance with *Pharmacy Operations and Drug Scheduling Act*, Bylaw 4(6) and 4(8). The list of drugs covered by the program has been agreed to by all the participating organizations. Unless otherwise specified, both single-entity products and preparations or mixtures of the scheduled drugs require the use of Controlled Prescription forms under the Controlled Prescription Program.

Inspector: A person designated by the Minister of Health Canada as an inspector for the purposes of the Regulations to the *Food and Drugs Act* and the *Controlled Drugs and Substances Act Regulations*

Minister: Refers to the Minister of Health Canada

Monitored Drug: Any drug that requires a Controlled Prescription Form under Controlled Prescription Program

Narcotic: Any drug or substance included in the Narcotic Control Regulations

Controlled Prescription Program (CPP) Narcotic: Any narcotic that requires a Controlled Prescription Form

Non-CPP Narcotic: Preparation containing only one narcotic drug plus two (or more) non-narcotic drugs in a therapeutic dose that does not require Controlled Prescription Form

Practitioner: means a person

(a) who is authorized to practise medicine, dentistry, podiatry or veterinary medicine, or

(b) who is

(i) in a class of persons prescribed by the minister for the purpose of this definition, and

(ii) authorized under the *Health Professions Act* to prescribe drugs or devices in the course of providing the services of a designated health profession as defined in section 1 of that Act;

Prescription: means an authorization from a practitioner to dispense a specified drug or device for use by a designated individual or animal;

Prescription Drug List (PDL) to the *Food and Drugs Act*: is a list of medicinal ingredients that when found in a drug, require a prescription. It does not include medicinal ingredients that when found in a drug, require a prescription if those ingredients are listed in *Controlled Drugs and Substances Act Schedules*.

Schedule G to the *Food and Drugs Act*: List of controlled drugs

Controlled Prescription Program: Monitoring program to help eliminate abuse and diversion of certain pharmaceutical drugs (DP)

APPENDIX A

REGISTER OF "IN-OFFICE" CONTROLLED PRESCRIPTION PROGRAM DRUGS

(For Administration Only)

NAME OF DRUG _____ STRENGTH _____ FORM _____ QUANTITY _____

ORDERED BY _____ PRESCRIPTION # (Where Applicable) _____ DATE RECEIVED _____

PERIODIC INVENTORY

Date _____ Qty in Stock _____ Qty on Record _____ Difference _____ Reason _____ Initials _____

Date _____ Qty in Stock _____ Qty on Record _____ Difference _____ Reason _____ Initials _____

Date _____ Qty in Stock _____ Qty on Record _____ Difference _____ Reason _____ Initials _____

Date _____ Qty in Stock _____ Qty on Record _____ Difference _____ Reason _____ Initials _____

Date	Patient's Name, Address	Qty Admin	Stock Left	Condition Being Treated and/or Dental Treatment Provided	Dentist's Name, Initials, College Reg. #	Name of Person Who Supplied Drugs to Patient

REGISTER FOR "IN OFFICE" CONTROLLED PRESCRIPTION PROGRAM DRUGS

1. A practitioner must keep a separate register for each narcotic or controlled drug prescription obtained for office use which includes the following:

General Information	Administration Information
a. Name of drug	a. Date when drug was provided to patient
b. Name of person who ordered drug	b. Patient's name, address
c. Amount purchased	c. Quantity administered
d. Date received	d. Stock remaining
e. Prescription number (where applicable)	e. Condition being treated and/or dental treatment provided
f. Dates of periodic inventory (physical count of drugs)	f. Practitioner's name, initials and College registration number
	g. Name of person who administered drugs to patient

The College has developed a "Register of In-Office Controlled Prescription Program Drugs" form which can be used to collect the required information.

2. A practitioner must provide access to records to authorized inspectors as outlined in the Health Professional Act, Food and drugs Act, Controlled Drugs and Substances Act, Food and Drugs Regulations, Narcotic Control Regulations, Benzodiazepines and Other Targeted Substances Regulations, and Pharmacy Operations and Drug Scheduling Act, and must:

   a. Furnish on request such information respecting (i) the receipt and use by the practitioner of narcotic and controlled drugs (including the administering and furnishing thereof to a person, i.e. "in-office drugs") and (ii) the prescriptions for narcotic and controlled drugs issued by the practitioner (i.e. all prescriptions written for patients), as the Minister may require:

   b. Produce to an inspector upon request any records that the Regulations require the practitioner to keep

   c. Permit an inspector to make copies of such records or to take extracts there from

   d. Permit an inspector to check all stocks of narcotic and controlled drugs on the practitioner's premises

   e. Retain in his possession for at least two years any record that the Regulations require him to keep

   f. Take adequate steps to protect controlled drugs in his possession

   g. Report to the Minister (Bureau of Drug Surveillance) any loss (including breakage) or theft of a narcotic or controlled drug within ten days of the practitioner's discovery of the loss or theft

Where a practitioner alleges or, in any prosecution for an offense under the laws or regulations, pleads that his possession of a narcotic or controlled drug was for use in his practice or that he prescribed, administered, gave, sold or furnished a narcotic or controlled drug to any person as a patient under his professional treatment and that such narcotic or controlled drug was required for the condition for which the patient received treatment, the burden of proof thereof shall be on such practitioner. The evidence needed to support this would be detailed records.

APPENDIX B

REGISTER OF "IN-OFFICE" NON-CONTROLLED PRESCRIPTION PROGRAM NARCOTICS

(For Administration Only)

NAME OF DRUG _____ STRENGTH _____ FORM _____ QUANTITY _____

ORDERED BY _____ PRESCRIPTION # (Where Applicable) _____ DATE RECEIVED _____

PERIODIC INVENTORY

Date _____ Qty in Stock _____ Qty on Record _____ Difference _____ Reason _____ Initials _____

Date _____ Qty in Stock _____ Qty on Record _____ Difference _____ Reason _____ Initials _____

Date _____ Qty in Stock _____ Qty on Record _____ Difference _____ Reason _____ Initials _____

Date _____ Qty in Stock _____ Qty on Record _____ Difference _____ Reason _____ Initials _____

Date	Patient's Name, Address	Qty Admin	Stock Left	Disp. in Labeled, Child-proof Container	Condition Being Treated and/or Dental Treatment Provided	Dentist's Name, Initials, College Reg. #	Name of Person Who Supplied Drugs to Patient

REGISTER FOR "IN OFFICE" NON-CONTROLLED PRESCRIPTION PROGRAM NARCOTICS

1. A practitioner must keep a separate register for each narcotic or controlled drug prescription obtained for office use which includes the following:

General Information	Administration Information
a. Name of drug b. Name of person who ordered drug c. Amount purchased d. Date received e. Prescription number (where applicable) f. Dates of periodic inventory (physical count of drugs)	a. Date when drug was provided to patient b. Patient's name, address c. Quantity dispensed/administered d. Stock remaining e. Packaging for dispensing (provided in a labeled, child-proof container) f. Condition being treated and/or dental treatment provided g. Practitioner's name, initials and College registration number h. Name of person who supplied drugs to patient

The College has developed a "Register of In-Office Non-Controlled Prescription Program Narcotics" form which can be used to collect the required information.

2. A practitioner must provide access to records to authorized inspectors as outlined in the Health Professional Act, Food and drugs Act, Controlled Drugs and Substances Act, Food and Drugs Regulations, Narcotic Control Regulations, Benzodiazepines and Other Targeted Substances Regulations, and Pharmacy Operations and Drug Scheduling Act, and must:

   a. Furnish on request such information respecting (i) the receipt and use by the practitioner of narcotic and controlled drugs (including the administering and furnishing thereof to a person, i.e. "in-office drugs") and (ii) the prescriptions for narcotic and controlled drugs issued by the practitioner (i.e. all prescriptions written for patients), as the Minister may require

   b. Produce to an inspector upon request any records that the Regulations require the practitioner to keep

   c. Permit an inspector to make copies of such records or to take extracts there from

   d. Permit an inspector to check all stocks of narcotic and controlled drugs on the practitioner's premises

   e. Retain in his possession for at least two years any record that the Regulations require him to keep

   f. Take adequate steps to protect controlled drugs in his possession

   g. Report to the Minister (Bureau of Drug Surveillance) any loss (including breakage) or theft of a narcotic or controlled drug within ten days of the practitioner's discovery of the loss or theft

Where a practitioner alleges or, in any prosecution for an offense under the laws or regulations, pleads that his possession of a narcotic or controlled drug was for use in his practice or that he prescribed, administered, gave, sold or furnished a narcotic or controlled drug to any person as a patient under his professional treatment and that such narcotic or controlled drug was required for the condition for which the patient received treatment, the burden of proof thereof shall be on such practitioner. The evidence needed to support this would be detailed records.

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CDSBC | College of Dental Surgeons of British Columbia

TO: CDSBC Board

FROM: Carmel Wiseman, Deputy Registrar

DATE: 09 August 2016

SUBJECT: CDSBC Boundaries Guidelines

Background:

The BC Health Regulators (BCHR) formed a working group in 2013 to develop and recommend to the health colleges a common patient relations program.

In June 2015, the Ministry of Health advised it would no longer be stipulating the contents for health colleges' patient relations programs but asked the BCHR to develop a common program to be used by all BCHR members.

In February 2016, the CDSBC Board approved the "Boundaries in the Practitioner-Patient Relationship" Guidelines ("Boundaries Guidelines") (Attachment 1).

Also in February 2016, the Board approved an amendment to Part 13 of the Bylaws by adding a section, 13.03 (5) that specifies that providing dental services to one's spouse does not constitute "professional misconduct of a sexual nature" but is instead a question of professional ethics. The amendment was posted for consultation and, after being deposited with the Ministry, became effective 19 August 2016. The amendment followed extensive consultations with the Ministry of Health which previously had taken the position, despite requests from the College, that it was not willing to amend Bylaw 13.03 to allow for an exception for spouses.

In June 2016, the BCHR approved the "Framework for a Model Patient-Practitioner Relationship Program for BC Health Regulators" (the "Framework") and recommended that the Framework be referred to each college board for endorsement by September 30, 2016 and implementation by March 31, 2017. The recommendations also request an annual report from each college to the BCHR on progress under the Framework. The BCHR's Briefing Note (Attachment 2) and Framework (Attachment 3) are attached.

Analysis:

The Framework is very similar to the theoretical framework set out in the Boundaries Guidelines. It identifies the same three key concepts: informed consent, patient autonomy and objective care.

The Boundaries Guidelines do not, however, address all of the areas identified in the BCHR Framework as necessary elements in a Patient-Practitioner Relationship program. Section 5 of the Framework provides:

> 5. Patient-Practitioner Relationship Program Elements
>
> Each College's patient –practitioner relationship program must address the following areas:
>
> a) romantic or sexual relationship with patients;
> b) treatment of partners, spouses, or other family members;
> c) relationships with former patients;
> d) "bartering" or exchanging health care services for other services with a patient;
> e) monetary gain from patients outside of the cost of the service/care provided;
> f) use of social media;
> g) non-trivial gifts from patients;
> h) care of family members in emergency situations; and
> i) guidance for practitioners working in small, rural or remote areas.

5(a) is partially addressed by the Boundaries Guidelines and College bylaw 13.01(4) which defines "professional misconduct of a sexual nature" to include sexual relationships, sexual touching or sexualized behaviours or remarks.

5(b) is also partially addressed by the Boundaries Guidelines and the Bylaws. College bylaw 13.03(5) provides it is not professional misconduct of a sexual nature to treat one's spouse but rather a matter of "professional ethics involving a) patient autonomy; b) free, full and informed consent by the patient; and c) objectivity of care on the part of the practitioner".

However, the other program elements specified in Section 5 of the Framework are not addressed by the Boundaries Guidelines. The Ministry of Health has indicated its preference that all the colleges have a common patient relations program. The outstanding issues are worthy of consideration and the profession would benefit from guidance in the remaining areas.

Policy Process:

There was recent and extensive consultation with respect to the Boundaries Guidelines. The feedback should be reviewed by the Ethics or another Committee or working group (the "Working Group") to determine if there was any feedback on the items that remain to be covered by the Boundaries Guidelines. In addition, the Working Group should consult with the

profession and other stakeholders on a preliminary basis on the issues that remain to be addressed by the Boundaries Guidelines before referring a revised Boundaries Guidelines to the Board for consideration.

Resources:

Boundaries policies in general have been a hot-button topic for the profession. I expect that the consultation(s) will result in significant feedback that will need to be reviewed and analyzed before the Working Group is able to report back to the Board. It is my view that significant committee and staff resources will be required to move this initiative forward.

Recommendation:

I recommend:

1. the Board endorse the BCHR Framework for a Model Patient-Practitioner Relationship Program; and

2. the Board refer the matter to the Ethics Committee or a Working Group established to deal with this matter with a request to further develop the College's Boundaries Guidelines to include the elements set out in the Framework and report back to the Board with recommendations following consultation with the profession in accordance with the College's Policy Development Process.

Attachments:
1. "Boundaries in the Practitioner-Patient Relationship" Guideline
2. BCHR Briefing Note
3. BCHR Framework

CDSBC

STANDARDS & GUIDELINES

Boundaries in the Practitioner-Patient Relationship

TABLE OF CONTENTS

Standards and guidelines inform practitioners and the public of CDSBC's expectations for registrants. This document primarily contains guidelines that are highly recommended but – while being evidence of a standard – are not, strictly speaking, mandatory. Guidelines contain permissive language such as "should" and "may".

1. Introduction

The issue of dual relationships and professional boundaries is not limited to situations involving sexual conduct with patients. These guidelines consider the broader question of when a dual relationship may create concerns (be problematic) for both the practitioner and the patient. Dual relationships include, for example, family, close personal friendships, commercial relationships, and other forms of non-professional contact with a patient.

This document addresses the issue of when it may or may not be advisable, to enter into, or continue, a dentist-patient relationship, when a dual relationship exists. While this document applies primarily to dentists (and the term "practitioner" is also used) the ethical considerations here apply to all CDSBC registrants.

2. Guideline

There are three elements that must be in place before providing treatment to any patient:

- objectivity of care by the practitioner;
- full, free and informed patient consent; and
- patient autonomy.

These principles are enshrined in CDSBC's Code of Ethics. They may be compromised when treating anyone with whom there is such a close personal relationship as to create a conflict of interest.

GUIDELINE: A practitioner-patient relationship where objective care, full free and informed consent, and/or patient autonomy are compromised is not advisable. A possible exception is where the treatment is minor or urgent. Where additional or ongoing care is necessary, a practitioner should transfer care of the patient to another qualified health care professional as soon as it is practical to do so.

Practitioners should exercise care and judgment in:

1. Recognizing potential conflicts resulting from close personal relationships;
2. Taking appropriate steps to resolve those conflicts when they arise, and;
3. Declining to provide treatment if a conflict cannot be effectively resolved.

3. Context

Fiduciary Relationship

One commonly held view is that the nature of the practice of dentistry (i.e. no sensitive physical examinations) means that boundary violations are unlikely to occur. The issue is not the nature of the physical examination, but the fiduciary relationship and power imbalance inherent in the dentist-patient relationship.

The fiduciary nature of the practitioner-patient relationship is well-established in Canadian law and professional (medical/dental) ethics. The key defining characteristics of a fiduciary relationship are trust, confidence, integrity, fidelity, and power imbalance. These are present in the dentist-patient relationship. The dentist must therefore act with utmost good faith to put their patients' interests above their own. This includes declining to enter into a dentist-patient relationship where a conflict of interest or potential conflict of interest exists (whether personal, business, or otherwise) that cannot be resolved by following the steps below.

The potential for a conflict may vary depending on the nature of the relationship and the nature of the treatment. The likelihood of a conflict will increase relative to the closeness of the relationship between the practitioner and the patient, and the complexity of the treatment being considered.

Steps to Resolve Conflicts

It is possible to take steps to resolve some conflicts by explicitly discussing and documenting the following things:

1. The practitioner is providing treatment in their capacity as a health professional, and not in a personal capacity;
2. The patient must at all times feel comfortable to provide full information, seek a second opinion, or change practitioners without fear of offending the practitioner or harming the personal relationship; and
3. The patient must be comfortable that the practitioner will always hold information provided confidential and for the sole purpose of the practitioner-patient relationship.

While in many cases this process may resolve potential conflicts, in some cases this will not be possible and treatment should be declined.

Anything that does or can compromise or risk the health and well-being of the patient must be considered and avoided wherever possible. This consideration must be viewed objectively from the perspective of the patient and not subjectively from the perspective of the practitioner.

Health professionals must obtain a medical history and be aware of any changes in the patient's health status. The nature of the personal relationship between the practitioner and the patient should not create barriers to obtaining this information. Similarly, no patient should feel constrained from asking questions of their practitioner, or seeking alternative treatments or a second opinion. Nor should the free flow of information central to the ongoing informed consent process be constrained. Dual relationships should therefore be approached with caution to ensure that the patient's autonomy and ability to provide full, free and informed consent is maintained.

The Health Professions Act and CDSBC Bylaws

The CDSBC Bylaws under the Health Professions Act do not allow for sexual relations between health professionals and their patients. The broad language of the legislation equating sexual contact to professional misconduct of a sexual nature, while germane in most cases, is less helpful to the discussion as to whether "spousal treatment" is appropriate. This question is one of professional ethics (involving considerations of objective care, patient autonomy and full, free and informed consent) rather than sexual misconduct.

Patient Choice

There is a widely held misconception that patients have an absolute right to choose their dentist. In fact, there is no absolute "right" to choose a health professional. As professionals, dentists do not have to provide treatment to every patient who demands it. Dentists have the autonomy to decline to take someone on as a patient – or to dismiss them – if they are not comfortable treating that person or if trust and mutual respect no longer exist. This guideline supports that autonomy. The decision to treat or not to treat a patient is subject to the ethical considerations of patient consent and autonomy and the ability of the dentist to provide objective/dispassionate care. It is these considerations that determine whether or not to enter into a dentist-patient relationship.

For all of the reasons noted above, it is imperative that the integrity of the practitioner-patient relationship be maintained. Treatment is not advisable when boundaries cannot be maintained, except in cases of emergency.

4. Related Documents

- CDSBC Code of Ethics
  www.cdsbc.org/CDSBCPublicLibrary/Code-of-Ethics.pdf
- CDSBC Bylaw 13.03
  www.cdsbc.org/Documents/Bylaws-Part13-General.pdf
- CDSBC's Position on Patient Relations and theTreatment of Spouses by Registrants (2012)
  www.cdsbc.org/CDSBCPublicLibrary/Patient-Relations-Statement.pdf
- Donate-Bartfield, Evelyn & D'Angelo, Daniel. "The Ethical Complexities of Dual Relationships in Dentistry." Journal of the American College of Dentists. Volume 67, Number 2 (2000): 42-46.

Board Approved

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Originating Committee

- CDSBC Board

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BC Health Regulators

BRIEFING DOCUMENT: PATIENT RELATIONS WORKING GROUP

Title: Framework for Patient-Practitioner Relationship Program for BC Health Regulators

BACKGROUND

In 2013, the BC Health Regulators established a working group to review programs dealing with patient-practitioner relationships and to make recommendations to the BC Health Regulators on a framework for a model patient-practitioner relationship program. Under s.16(2)(f) of the *Health Professions Act* (HPA), most of the Colleges regulated under the *Act* are required to establish a patient relations program to prevent professional misconduct of a sexual nature.

The working group was comprised of registrars and compliance staff from ten different colleges, serving as members of the group at different times. The working group met 12 times over two years, and reviewed research studies, policy papers, standards of practice, case law and different types of patient relations programs from health regulatory Colleges in BC and across Canada.

DISCUSSION

The BC Health Regulators identified a need for a consistent approach to the requirements for developing a patient relations program. While each College will develop its program in the context of the type of health care provided and the environment in which its registrants work, all Colleges should use consistent principles for developing their programs. As well, each College's program should include several key program elements, identified by the working group.

The working group designed the framework for a model patient-practitioner relationship program with several overarching principles in mind:

- Respect for patient autonomy
- Full, free and informed consent for treatment
- Registrant responsibility for establishing, communicating and maintaining professional boundaries with every patient
- Clear, accessible information for both registrants and the public
- Clear guidance for registrants in remote location and in emergency situations

RECOMMENDATION

That each College regulated under the HPA that is required to establish a patient relations program:

- Endorses the Framework for a Model Patient-Practitioner Relationship Program for BC Health Regulators no later than September 30, 2016
- Agrees to implement the new Framework no later than March 31, 2017
- Provides an annual report to the BC Health Regulators on progress under the Framework.

Framework for a Model Patient-Practitioner Relationship Program for BC Health Regulators

May, 2016

1. Legislative Framework

All Colleges regulated under the *Health Professions Act (HPA)* are required to establish a program to deal with patient-practitioner relationships:

> Section 16 (2) (f)
> ... to establish, for a college designated under section 12 (2) (h), a patient relations program to seek to prevent professional misconduct of a sexual nature.

2. Program Position Statement

Health care practitioners regulated by Colleges of the BC Health Regulators provide health care that is built on a foundation of trust and respect. Patients trust their professional practitioner because they believe the practitioner has special knowledge, skills and abilities and uses these to provide safe, effective and ethical care. Practitioners demonstrate respect for patients by acknowledging their position of power and maintaining professional boundaries.

A Patient-Practitioner Relationship Program helps both patients and practitioners understand the need for boundaries in establishing the context and limits of care. The professional relationship between the professional and the patient exists for the patient's benefit. Setting boundaries requires the practitioner be a professional and to ensure that the autonomy and dignity of patients is maintained.

3. Key Concepts and Definitions

"Professional misconduct" is defined in the HPA (Part 3) to include "sexual misconduct, unethical conduct, infamous conduct and conduct unbecoming a member of the health profession".

"Dual relationships" in the health service context pertains to relationships in which the registered professional has more than one relationship with the service recipient. An example of a dual relationship is providing clinical services to a family member or friend.

"Conflict of Interest" arises where a reasonable person could form the view that a professional's ability and obligation to act in the patient's best interests may be affected or influenced by other competing interests. Such conflicts of interest can be real, potential or perceived. Conflicts of interest occur in a variety of circumstances including financial, non-financial, direct, and indirect transactions with patients and others.

"Informed consent" is defined in S. 7 of this Framework.

4. Principles for the Patient-Practitioner Relationship Program

a) Each program is developed in the context of the type of health care and the health care environment in which it is provided.
b) Each program must establish appropriate professional boundaries between the registrant and the patient, ensuring that:
   (i) the patient is able to provide full, free and informed consent;
   (ii) patient autonomy is maintained at all times; and
   (iii) the practitioner provides objective care to every patient.
c) Each program must have clear, concise and accessible information and materials for both registrants and the public.
d) Each program must provide training for College staff to support their understanding of the program and how it applies in practice.
e) The program is designed to enhance the registrant's capacity to understand and set boundaries and communicate those effectively to every patient.

5. Patient-Practitioner Relationship Program Elements

Each College's patient-practitioner relationship program must address the following areas:

a) romantic or sexual relationship with patients;
b) treatment of partners, spouses, or other family members;
c) relationships with former patients;
d) "bartering" or exchanging health care services for other services with a patient;
e) monetary gain from patients outside of the cost of the service/care provided;
f) use of social media;
g) non-trivial gifts from patients;
h) care of family members in emergency situations; and
i) guidance for practitioners working in small, rural or remote communities.

6. Shared Underlying Principles in the Patient-Practitioner Relationship

1. Avoidance, as much as possible, of any professional relationship with a patient when the professional's objectivity or competence could reasonably be expected to be impaired because of the professional's present or previous familial, social, sexual, emotional, financial, supervisory, political, administrative, or legal relationship with the patient or with another relevant person associated with or related to the patient.

2. If a dual relationship or conflict of interest is unavoidable, the professional should document the specific circumstance, an account of why the duality or conflict is unavoidable and document the informed consent of the patient(s) for all services.

3. Obtaining informed consent at the beginning of professional relationships and understanding that informed consent is an ongoing process, rather than a onetime event.

7. What Constitutes Informed Consent

The BC *Health Care (Consent) and Care Facility (Admission) Act* defines *"Informed Consent"* as follows:

4 Every adult who is capable of giving or refusing consent to health care has

(a) the right to give consent or to refuse consent on any grounds, including moral or religious grounds, even if the refusal will result in death,

(b) the right to select a particular form of available health care on any grounds, including moral or religious grounds,

(c) the right to revoke consent,

(d) the right to expect that a decision to give, refuse or revoke consent will be respected, and

(e) the right to be involved to the greatest degree possible in all case planning and decision making.

5 (1) A health care provider must not provide any health care to an adult without the adult's consent except under sections 11 to 15.

(2) A health care provider must not seek a decision about whether to give or refuse substitute consent to health care under section 11, 14 or 15 unless he or she has made every reasonable effort to obtain a decision from the adult.

6 An adult consents to health care if

(a) the consent relates to the proposed health care,

(b) the consent is given voluntarily,

(c) the consent is not obtained by fraud or misrepresentation,

(d) the adult is capable of making a decision about whether to give or refuse consent to the proposed health care,

(e) the health care provider gives the adult the information a reasonable person would require to understand the proposed health care and to make a decision, including information about

(i) the condition for which the health care is proposed,

(ii) the nature of the proposed health care,

(iii) the risks and benefits of the proposed health care that a reasonable person would expect to be told about, and

(iv) alternative courses of health care, and

(f) the adult has an opportunity to ask questions and receive answers about the proposed health care.

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CDSBC | College of Dental Surgeons of British Columbia

Board Meeting
24 September 2016
Agenda Item 8.

TO: CDSBC Board

FROM: Carmel Wiseman, Deputy Registrar

DATE: 12 August 2016

SUBJECT: Dental laboratories owned or affiliated with dentists: hidden fees

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Background:

At the Board meeting 28 November 2015, Mr. Greg Cavouras advised the Board that the Ethics Committee was concerned that some registrants may be marking up lab bills, that this was unethical and that the Committee was of the view that the College should promptly provide a notice to registrants about this issue.

The Ethics Committee was working on a document to capture a variety of issues Article 5 under the former Dentists Act had covered. When the College transitioned to the HPA, Article 5 lapsed. Many of the provisions of Article 5 provide valuable guidance to registrants, including on the subject of indirect profits. The Committee was of the view that the lab mark-up issue should be dealt with before the general Article 5 re-write. The Board did not agree that the lab issue should be dealt with separately but directed that it be dealt with as part of the Committee's review of Article 5.

The issue arose again when the College was contacted by an individual who didn't want to make a complaint but was concerned about a practice observed at a dental office. The dental office in question is one affiliated with a group of dental practices. In the case in question, a particular order had been placed with a lab. When the lab work came back, it came from a different lab (the Lab) accompanied by a bill issued by the Lab in an amount greater than the amount charged for the product by the lab at which the order was placed. The caller believed that the Lab, which was somehow affiliated with the dental office group, was simply repackaging the lab work and issuing an invoice in a greater amount. The caller wondered if this was permitted. The caller was advised the practice raised ethical concerns but was unwilling to make a complaint.

The Inquiry Committee Intake Panel directed that a complaint file be opened and an investigation conducted.

The Investigation:

The investigation essentially confirmed the report although the investigation also indicated the lab owned a Cerec machine and accordingly, also provided some other lab work.

The dentist affiliated with the Lab (it was owned by family members) advised the Lab also tracks the paperwork associated with lab work ordered by the affiliated dental offices, it acts as intermediary between the affiliated offices and other labs to provide a uniform guarantee of lab work for all patients, and it monitors the quality and cost of lab work. Moreover, the dentist indicates that because it processes the lab work for the affiliated offices, the Lab is able to benefit from economies of scale, which benefit patients.

We asked for the dentist's response to our concern that in situations where the lab work is simply repackaged and shipped on with an increased invoice, patients and insurers are misled about the cost of the lab work. With respect to patients, the dentist denied they were misled. He said he gives quotes for lab work and that is the amount charged the patient, regardless of the actual cost. If the actual cost is higher, the Lab still honours the quote. The patients, however, are not informed about the Lab and its role. The dentist agrees quotes are not given to insurers. The submission to the insurer would include the Lab's fee.

The dentist advised that the practice is widespread and took the position it was outside the College's jurisdiction.

Inquiry Committee:

The Inquiry Committee considered this matter at its meeting July 19, 2016. The Committee agreed that this case raises ethical issues but also considered the issues complex. They were of the view that it would be appropriate to try and determine how widespread the practice is and how dentists may be using in-office or affiliated dental labs. They thought the claim that there was value added by reason of the Lab's role should be explored. The Inquiry Committee thought the profession would benefit from direction and asked that the matter be referred to the Ethics Committee for analysis with a view to developing guidelines for the profession.

Referral to the Board:

Because another Committee has expressed concerns that this is an important but complex issue that requires attention by the College, I am again referring this matter to the Board for direction.

The Board may want to direct the Ethics Committee to deal with this issue on an expedited basis ahead of the rest of the 'Article 5' issues. Alternatively, the Board may prefer it to be dealt with by the Ethics Committee as part of its review of Article 5. However the matter proceeds, the Board may wish to direct consultation with stakeholders on the issues at this early stage to ensure the Committee has a solid understanding of what business models may be in use as well as what stakeholders think of the practice.

Policy Process:

Under the Policy Framework this issue would require a high level of engagement with stakeholders.

Resources:

Given the high level of engagement required by this issue, this issue will require significant Committee and staff resources to properly develop it for consideration by the Board.

POLICY EL 2: TREATMENT OF THE PUBLIC

Due Date: Quarterly - May, June, July, August

With respect to interactions with the public, the Registrar shall not cause or allow conditions, procedures, or decisions which are unfair, unreasonable or disrespectful.

Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:

	Policy	Response/Report
1	**Use forms that elicit information for which there is no clear necessity.**	**Forms collect only the information required.**
2	**Use methods of collecting, reviewing, transmitting, or storing information that fail to protect against improper access to the material elicited.**	**CDSBC has secure document storage facilities for all hard copies. Confidential shredding is used throughout the office for destruction of documents with sensitive information when those documents are slated for destruction. Electronic files are protected by industry standard firewalls and end-point security hardware and software.**
3	**Fail to operate facilities with appropriate accessibility and privacy.**	**CDSBC offices are accessible to any who need/desire access. Premises are alarmed and monitored. Private offices and meeting spaces are available and used when indicated.**

POLICY EL 2: TREATMENT OF THE PUBLIC

Due Date: Quarterly - May, June, July, August

With respect to interactions with the public, the Registrar shall not cause or allow conditions, procedures, or decisions which are unfair, unreasonable or disrespectful.

Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:

	Policy	Response/Report
4	**Fail to establish with members of the public a clear understanding of what may be expected and what may not be expected from the College, including the processes it employs in adjudicating public complaints.**	**Registrar reports compliance. Details are included in complaints and discipline reports tabled at the Board meeting by the Deputy Registrar.** **The new CDSBC website contains more information about complaints, including a designated "news feed" on the homepage, a complaints form, and a detailed description of the complaints process.** **Members of the public who contact the College about how to make a complaint or about the complaint process are provided with information promptly.** **Beginning March 2016, all complainants will be asked to complete an exit survey upon the closure of their complaint. This is a one-year pilot project, the result of which will be useful to improve the complaints process.**
5	**Fail to adjudicate complaints as expeditiously as possible.**	**We have made significant progress in this area. The rate of complaints has slowed and more complaint files have been closed than opened.**
6	**Fail to deal with public inquiries as expeditiously as possible.**	**All inquiries from the public are dealt with as expeditiously as possible. The Director of Communications, in consultation with the Registrar/CEO, responds to media inquiries as quickly as possible.**

POLICY EL 2: TREATMENT OF THE PUBLIC

Due Date: Quarterly - May, June, July, August

With respect to interactions with the public, the Registrar shall not cause or allow conditions, procedures, or decisions which are unfair, unreasonable or disrespectful.

Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:

	Policy	Response/Report
7	**Fail to employ alternate dispute resolution where appropriate.**	**CDSBC resolves approximately 90% of all complaints through alternative dispute resolution. CDSBC has deployed resources to place more emphasis on early resolution through appropriate dispute resolution techniques. With the reduction in the backlog of complaints, staff dentists are trying to resolve complaints quickly after a formal complaint is received if the matter is susceptible to early resolution.**

Respectfully Submitted By:

Jerome M. Marburg
Registrar and CEO

Date: Sep 7/2016

POLICY EL 3: TREATMENT OF REGISTRANTS

With respect to interactions with registrants, the Registrar shall not cause or allow conditions, procedures, or decisions which are unfair, unreasonable or disrespectful.

Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:

	Policy	Response/Report
1	**Use forms that elicit information for which there is no clear necessity.**	**Forms (both paper and electronic) collect only relevant/statutory information needed for registration. Personal assurance of registration staff and review of Registrar/CEO are evidence of compliance. The 2016/17 online renewal process included questions regarding ownership of dental corporations. Moving forward the information already recorded in the previous year will be provided to the registrants to be confirmed during renewal. Questions should be reduced for the 2017/18 year ahead.**
2	**Use methods of collecting, reviewing, transmitting, or storing information that fail to protect against improper access to the material elicited.**	**CDSBC database is secured with password protection and is located on internal servers behind firewall and industry standard end-point protection. Access to said database is restricted to only those persons requiring access for their job functions. Physical files are kept in locked cabinets wherever personal or sensitive information is present. Disposition of paper documents done by confidential shredding. We are now filing all new applications for registration and certification electronically and storing the paper version on-site for one year. We are currently scanning and saving all physical registrant files electronically. Approximately 80% of the files have been completed.**
3	**Fail to register applicants as expeditiously as possible.**	**Application process generally is completed within 2-3 weeks unless extenuating circumstances present. We are working on developing an online registration/application process which will further streamline the application process. This project is expected to be completed before the end of 2016. Note: currently the criminal record checks are taking approximately 4-5 weeks to be processed at the Ministry of Justice. They are experiencing a backlog from high volumes of applications being submitting by various organizations and individuals. This may last for the remainder of the year.**

POLICY EL 3: TREATMENT OF REGISTRANTS

With respect to interactions with registrants, the Registrar shall not cause or allow conditions, procedures, or decisions which are unfair, unreasonable or disrespectful.

Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:

	Policy	Response/Report
4	**Fail to establish with registrants a clear understanding of what may be expected and what may not be expected from the College, including the processes it employs in adjudication of public complaints.**	**The College communicates its expectations for registrants in a variety of ways, such as publications (electronic and print), through courses and presentations. Our newest course, More Tough Topics (about informed consent and other topics that can lead to complaints) will be launched as an online course in fall 2016. Planning is also underway for a joint course with the BCDA for new dentists.**
5	**Fail to adjudicate complaints as expeditiously as possible.**	**The backlog of complaints has been eliminated. The College continues to close more complaint files than it opens with the result that the inventory has been significantly reduced. Beginning March 2016, registrants who are the subject of a complaint are invited to complete an exit survey upon the closure of the complaint. This is a one-year pilot project, the results of which will be used to improve the complaints process.**
6	**Fail to employ alternative dispute resolution where appropriate.**	**The Complaints team seeks to negotiate solutions when possible on files where concerns have been identified.**
7	**Fail to respond to registrants' inquiries as expeditiously as possible.**	**All inquiries, whether from registrants or members of the public, are responded to promptly. When a prompt response is not possible, persons are informed of this fact and when a response may be expected.**

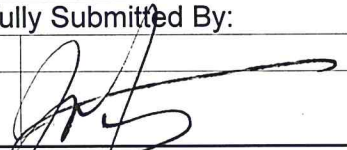
POLICY EL 3: TREATMENT OF REGISTRANTS

With respect to interactions with registrants, the Registrar shall not cause or allow conditions, procedures, or decisions which are unfair, unreasonable or disrespectful.

Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:

Policy		Response/Report
8	**Fail to develop a College communication strategy.**	**Communications materials support the strategic plan and makes use of new communications tools where appropriate. Although most communication with registrants is electronic, the College uses other methods when warranted. We anticipate that communications resources will support of the new brand-new policy development framework, especially on building engagment with registrants in person and online. The College is responsive to trends or issues as they arise.**
9	**Propose registration fees to the Board without a clear rationale.**	**All registration fees are tied to budget and budgeting process over which the Board has oversight and through which the Board and Audit/Finance Committee are consulted. The annual report includes a detailed graphic breakdown to illustrate how registrant fees are allocated to the various functions.**

Respectfully Submitted By:



Jerome M. Marburg
Registrar and CEO

Date: 1 Sept 2016

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CDSBC | College of Dental Surgeons of British Columbia

Board Meeting
24 September 2016
Agenda Item 9.

Quarterly Report

Registration and Certification

1 May 2016 – 31 July 2016

Prepared for the Board

Overview

The Registration/Certification Team, consisting of the Director of Registration & HR, the Manager, Continuing Education and CDA Certification and three support staff, are responsible for all aspects of registration of dentists and certification of certified dental assistants. It is also responsible for the CDA Certification Committee, CDA Advisory Committee, Registration Committee, Quality Assurance Committee and the Quality Assurance CE Subcommittee.

The following represents a statistical breakdown of the activity in these areas for the period 1 May 2016 – 31 July 2016 inclusive.

Where available, the previous year's statistics for the same period (1 May 2015 – 31 July 2015) are provided in brackets.

Continuing Education
Dentists & Certified Dental Assistants

Continuing education credit submissions are received electronically, by mail and fax and applied to each registrant's Transcript of Continuing Education. Of the more than 10,000 registrants, 3447 have their three-year cycle ending 31 December 2016.

In late August or early September, transcripts are mailed to all registrants with unfulfilled cycles ending that year.

DENTIST STATISTICS		
Practising Dentists - 3470		
NEW REGISTRATIONS		
	1 May 2016 – 31 July 2016	1 May 2015 - 31 July 2015
Full Registrations issued (includes Specialists)	54	48
Restricted to Specialty Registrations issued	0	1
Academic Registrations issued	0	0
Limited Registrations issued:		
• Armed services or government	4	3
• Education	1	0
• Post-graduate	4	8
• Research	0	0
• Student practitioner	31	39
• Volunteer	0	0
Temporary Registrations issued	12	11
Non-practising Registrations issued	0	0
GENERAL		
Transfers from Non-practising to Practising	0	8
Transfers from Practising to Non-practising	8	8
Lapsed	0	0
Reinstated	6	5
Resigned/Retired	11	6
Retired (annual $50 fee)	0	0
Deceased	0	4

CDA STATISTICS		
Practising CDAs - 5802		
NEW CERTIFICATIONS		
	1 May 2016 – 31 July 2016	1 May 2015 - 31 July 2015
Practising Certifications issued	23	28
Temporary Certifications issued	111	170
Temporary-Provisional Certifications issued	0	0
Limited Certifications issued	2	1
Non-practising Certifications issued	0	0
GENERAL		
Transfers from Non-practising to Practising	10	15
Transfers from Temporary to Practising	9	6
Transfers from Temporary-Provisional to Practising	3	4
Transfers from Limited to Practising	0	0
Lapsed	7	9
Reinstated	10	16
Resigned/Retired	0	0
Retired (annual $25 fee)	0	0
Deceased	0	0

Module designations granted

Orthodontic Module – * (63)
Prosthodontic Module – * (8)
Dental Radiography Module – 16 (33)

CDA Assessments

Initiated assessments:

- 18 (17)

Certification issued as a result of assessment:

- 11 (7)

POLICY EL 5: FINANCIAL PLANNING/BUDGETING

Due Date: Quarterly - Jun, Sep, Dec, Feb

Financial planning for any fiscal year shall not deviate materially from the Board's Ends priorities, risk fiscal jeopardy, or fail to be derived from a business plan.

Further, without limiting the scope of the foregoing by this enumeration, the Registrar shall not plan in a manner that:

	Policy	Response/Report
1	**Risks the organization incurring those situations or conditions described as unacceptable in the Board's policy Financial Condition and Activities.**	Registrar/CEO reports compliance per EL 6 report.
2	**Fails to include credible projection of revenues and expenses, separation of capital and operational items, cash flow, and disclosure of planning assumptions.**	Monthly financial statements, forecast, and Budget are evidence of compliance.
3	**Fails to maintain a contingency reserve.**	Registrar/CEO reports compliance per EL 6 report.

Respectfully Submitted By:

Jerome M. Marburg
Registrar and CEO

Date: 30 Aug 2016

POLICY EL 6: FINANCIAL CONDITIONS AND ACTIVITIES

Due Date: Quarterly - Jun, Sep, Dec, Feb

With respect to ongoing financial condition and activities, the Registrar shall not cause or allow the development of fiscal jeopardy or a material deviation of actual expenditures from Board priorities established in Ends policies.

Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:

	Policy	Response/Report
1	**Expend more funds than have been received in the fiscal year to date unless the debt guideline (see 2 below) is met.**	**CDSBC does not debt finance. Financial statements reported monthly show that expenditures do not exceed revenues.**
2	**Indebt the organization in an amount greater than 5% of the annual revenue.**	**CDSBC does not debt finance.**
3	**Use any contingency reserves except as authorized by an extraordinary motion of the full Board.**	**No transfers are undertaken without a Board motion. No contingency reserves have been utilized since last report.**
4	**Fail to report to Board at the earliest opportunity the amount by which any item in the approved operating or capital budget is forecasted to exceed the budget for a category.**	**Monthly financial statements are reviewed with the Board Officers and variances are discussed. Monthly financial statements are also shared with the Audit Committee and Finance & Audit Working Group, and the latest financial statements are received at each Audit Committee and Finance & Audit Working Group meeting. Financial statements are tabled at each Board meeting showing performance against budget.**

POLICY EL 6: FINANCIAL CONDITIONS AND ACTIVITIES

Due Date: Quarterly - Jun, Sep, Dec, Feb

With respect to ongoing financial condition and activities, the Registrar shall not cause or allow the development of fiscal jeopardy or a material deviation of actual expenditures from Board priorities established in Ends policies.

Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:

	Policy	Response/Report
5	**Authorize the payment of any item that was included in the approved operating or capital budget in an amount that will exceed the approved budget for that category by more than $50,000.**	**Registrar/CEO reports compliance.**
6	**Fail to obtain authorization from Board before committing the College to any operating or capital expenditure not included in the approved operating or capital budget that exceeds $25,000 or that creates or increases a cash flow deficiency for the current fiscal year.**	**Registrar/CEO reports compliance.**
7	**Fail to settle payroll and debts in a timely manner.**	**Registrar/CEO reports compliance. All payroll obligations are being met.**

POLICY EL 6: FINANCIAL CONDITIONS AND ACTIVITIES

Due Date: Quarterly - Jun, Sep, Dec, Feb

With respect to ongoing financial condition and activities, the Registrar shall not cause or allow the development of fiscal jeopardy or a material deviation of actual expenditures from Board priorities established in Ends policies.

Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:

	Policy	Response/Report
8	**Allow tax payments or other government ordered payments or filings to be overdue or inaccurately filed.**	**Registrar/CEO reports compliance.**
9	**Acquire, further encumber or dispose of real property.**	**Registrar/CEO reports compliance.**
10	**Fail to aggressively pursue receivables after a reasonable grace period.**	**All receivables are recovered in a timely manner.**

Respectfully Submitted By:

Jerome M. Marburg
Registrar and CEO

Date: 30 August 2016

CDSBC College of Dental Surgeons of British Columbia

Board Meeting
24 September 2016
Agenda Item 10.

MANAGEMENT REPORT

Board Meeting - Public

24 September 2016

Strategic Planning and New Board Member Orientation

On 31 May 2016 we held a new board member orientation session, led substantially by Liz Watson. Ms. Watson was retained by the Board in and around 2011 to assist them with the revisions to the Board Governance policies and procedures, predating the hiring of Mr. Marburg as Registrar and CEO. We are pleased to report that the session appeared to be well received, with many questions asked and, hopefully, as many answered. We believe that the session went a long way to bridge gaps in understanding and perspective between all participants.

Building on the success of that exercise, and the strategic planning session attended by old and new Board members, senior staff and Board Officers met in Whistler to continue analysis of inputs into the consultation process and to develop operational plans for consideration of the Board at the September 2016 meeting. We look forward to input and direction from the Board, so that staff can prepare costing and budgets.

Dinner Meeting with BCDA Executive – 13 July 2016

We are happy to report any successful dinner meeting between CDSBC Board Officers and BCDA Executive Officers, along with respective organizational CEOs. The conversations were friendly and collaborative, ranging from details of the upcoming joint strategic planning session on Wellness, Corporate Dentistry, ongoing collaboration where appropriate on issues of mutual concern and respective roles and responsibilities of the two organizations.

Infection Control Protocols

Registrar/CEO Jerome Marburg participated in a preliminary conversation with three other B.C. health colleges (Physicians and Surgeons, Registered Nurses, and Traditional Chinese Medicine Practitioners and Acupuncturists) about developing a common approach along with CDC and Health Boards in the event of a breach of infection control protocols by a regulated health professional or an illegal/unauthorized practitioner raises public health concerns. This would likely involve the creation of a group of experts to develop policy/guidelines on how the health colleges should conduct a risk assessment/lookback, and to advise on when it is appropriate to issue a public health advisory. The College of Physicians and Surgeons of BC will take the lead on this initiative.

UBC Dentistry Events

College representatives led a number of presentations for new and current dentistry students in August and September:

- On 29 August, as part of the orientation for incoming first year students, we provided boxed lunches to the students and discussed what it means to be a regulated health professional and the College's role *(Presenters: Dr. Don Anderson, President, and Dr. Meredith Moores, Complaint Investigator)*

- On 31 August we presented on recordkeeping and professionalism to the graduate dentistry students *(Presenters: Jerome Marburg, Registrar/CEO, and Dr. Garry Sutton, Early Complaint Resolution & Practice Advisor*

- On 2 September, we spoke to first-year dentistry students on the topic of medico-legal recordkeeping *(Presenters: Dr. Garry Sutton, Early Complaint Resolution & Practice Advisor and Greg Cavouras, Legal Counsel)*

- On 8 September we delivered two lectures to third-year dentistry students: "Jurisprudence and Negligence" and "Creating Good Case Notes" *(Presenters: Dr. Chris Hacker, Dental Policy and Practice Advisor and Greg Cavouras, Legal Counsel)*

Joint Board Workshop on Wellness – 23 September

The College and the BC Dental Association have been planning the joint board workshop on practitioner wellness – a hugely important topic to both organizations. This session will increase understanding of various types of impairment, and will identify barriers to reporting. The four speakers are:

- Dr. Paul Sobey, Addiction Medicine Specialist
- Dr. Cathy McGregor, CDSBC's Health and Directed Education Program Head
- Dr. John Palmer of the BCDA's Dental Profession Advisory Program
- Dr. Izabela Schultz and Dr. Darcy Cox from CORTEX Centre for Advanced Assessment

Following the formal presentations there will be facilitated dialogue on possible solutions to address practitioner impairment. (Note: The topic of practitioner wellness will also be addressed as part of the College's presentation at the Pacific Dental Conference in March 2017).

FDI World Dentistry Congress

The Registrar/CEO attended the FDI Word Dental Congress held in Poznan, Poland. This is an annual event bringing together dental Association/Regulators from around the world. The meeting is very well subscribed and attended. I agreed to attend this meeting, with some degree of trepidation, after a number of years of prompting from our friends and colleagues at the CDA. I was scheduled to attend last year but had to defer because of other pressing commitments. Having attended, my perception has changed and overall I would suggest this is an important Congress to attend (periodically) and monitor consistently. The meeting has different phases and streams. There is a massive trade show aspect and a wide range of continuing education opportunities. Of particular interest to me were the general assembly, working group, and governance meetings held daily throughout the session.

Not unlike many organizations, some time was spent on organization/governance matters. There were a series of recommendations around edits to their governance document dealing with definitions of membership and with qualifications to run for executive office and for their board. On that note, the eligibility criteria requires past council experience at the national level and experience on the FDI board before being eligible to run up the ladder to the chair.

Of note, the Congress is wrestling with modifications to the definition of “Oral Health”. This has implications as if adopted as a “world” definition, it affects how oral health is funded and treated in national and provincial health policy and regulation. A think tank was created after the last general assembly meeting – tasked to propose a definition of “Oral Health”. Think tank conducted literature review of how term “oral health” has been used as well as definition used by other National Dental Associations. Think tank identified a stakeholder group to which they proposed a draft definition with instructions to “tear it apart” and tell them what was not good, etc. Stakeholders included patients, NGOs, payers, NDAs etc. After that, a draft was sent to FDI members for comment. 38 responded. General consensus developing.

Proposal:

Oral Health:

- Is a fundamental component of health, and physical and mental wellbeing, which exists along a continuum influenced by the values and attitudes of individuals and communities;
- Reflects the physiological, social and psychosocial attributes that are essential to the quality of life;

- Is multi-faceted and includes, but is not limited to, the ability to speak, smile, smell, taste, touch, chew, swallow and convey emotions through facial expressions with confidence and free of pain or discomfort;
- Is influenced by the individual's changing experience, perceptions, expectations and ability to adapt to circumstances.

Clinical care is just one aspect. Other aspects include:

- Improvement in specific determinants.
- Implementation of programs at community and societal level as well as support for individual actions.
- Investment in health promotion and disease prevention.

Next steps:

- Seek approval of framework and definition
- Start phase II (complicated and time consuming) – define metrics to "measure" oral health
    - measures will need to be developed within each of the three elements: disease and condition status, psychosocial function, physiological function.

Interesting side note: German delegation suggested also adding "kissing" to definitional context. South African representative commented that while kissing could be considered BUT not kissing between the Dentist and the Patient. This comment was greeted with applause. Boundaries are a conversation on the congress floor.

Policy Statements

See pages: 286-312 for set of 11 policy statements being proposed for adoption. Five are revisions. Six are new. Beyond the 11 that are on the list for discussion at this congress, there is a wealth of material on the FDI website relating to policy statements adopted by the group. Many of them are regulatory in nature. See for example their statements on Dental Implants, Dentist/Patient relations, Radiography, etc. etc.

It became evident very quickly that many of the things being debated and discussed in the policy matters are regulatory in nature and would benefit from registrars/regulators turning their minds to these statements. When adopted at the international level, they will influence us provincially and nationally from the regulatory perspective. They may also become de-facto standard we would have to adopt through trade/labour mobility agreements or otherwise through health accords negotiated at the national level. One case in particular is the statement on Amalgam use – about which there is great debate and which can affect practice and practice standards greatly.

See: http://www.fdiworldental.org/publications/policy-statements/draft-policy-statements-to-ga-2016.aspx

Revisions

- Dental Unit Water Systems and Microbial Contamination
- Minimal Intervention Dentistry for Managing Dental Caries [interesting read – contains statement that: Evidence has shown that the long-term survival of repaired defective restorations is as good as that of replaced defective restorations].
- Partnering for Better Health – The Dentist-Patient Relationship [highly recommend reading this. There are parallels to our Dentist/Patient relationship document and some good information for CDSBC registrants to consider]
- Preventing Oral Diseases
- Third-Party Involvement in Dental Practice [highly recommend reading this. This item took a lot of time on the floor. Mostly emotion about perception that insurers are influencing the dental treatment plan. Lots of emphatic statements about inappropriateness of insurers (or others) to influence treatment or interfere with Doctor/patient relationship.]

New

- Evidence Based Dentistry [highly recommend reading this]
- Grey Market and Non-Compliant Dental Products
- Maintaining Lifelong Oral Health
- Oral Health and Dental Care of People with Disabilities [highly recommend reading]
- Sports Dentistry
- Sustainability in Dentistry

See also a range of resources and publications not least of which the Oral Health Atlas: www.fdiworldental.org/media/77552/complete_oh_altas.pdf

See also the section on infection control and a very useful Centre for Disease Control checklist:
http://www.cdc.gov/oralhealth/infectioncontrol/pdf/dentaleditable_tag508.pdf

See the multi-page agenda and reference binder (plus extra materials) which I have retained and which are available to anyone who wishes to visit the office to peruse. It runs over 300 pages and is accompanied by other documents. Of note, reports from numerous other dental organizations and associations with topics ranging from qualifications to continuing education. Also of note, a substantive white paper on Dental Caries Prevention and Management. These resource documents will be shared with the Quality Assurance Committee, Ethics Committee, and Registration Committee among others.

Note also that the FDI, like so many organizations, has a lively discussion on governance review. Pages 21-33 of binder shows deliberations from previous year, and pages 58-61

delineates work done in the current year. This focused on membership criteria and requirements. Of note, the deliberations from the previous year focus on a range of items – Engendering trust, inclusiveness and transparency being one of the loci of focus (resonates with us, no?). See also their aspirations regarding succession planning and recruitment. – to encourage selection of leaders and volunteers based on skill and ability. Also, a recommendation was adopted to establish eligibility criteria for President-elect, Treasurer and Speaker.

Among the materials is an interesting document (Board and Ethics Committee) entitled: International Principles of Ethics for the Dental Profession (See pages 91-95 & earlier version on website at: http://www.fdiworldental.org/media/11263/International-principles-of-ethics-for-the-dental-profession-1997.pdf).

These documents confirm the universality of many of the ethical principles with which we work and about which we debate and discuss. The document can be a useful addition to the reference materials on which the Board and the Ethics Committee, among others, relies in developing and evolving our own policies. The document tabled at the meeting is an update of a document already in use. Work on these principles is a starting point to update the Dental Ethics Manual. Another interesting resource for us to add to the library but which has been noted, is becoming a bit dated. See for example the older wording of duty to enhance the profession is now replaced with stronger wording to the effect of putting oral health care needs as primary consideration (and here I am paraphrasing) See following link for the soon-to-be-updated manual, which still has a lot of instructive content on which to ruminate:

http://fdiworldental.org/media/70462/1-fdi_dental_ethics_manual_1st_edition_2007.pdf

Much of the time during congress meetings was dedicated to receiving a wide range of reports on ongoing projects and adoption of recommendations from committees. These are contained in the reference binder which is worth a read. It provides insight into trends and contemporary topics in dentistry – many of which will have a policy impact on the profession and possible future regulatory directions/forces/trends. See for example the Oral Health for and Ageing Population Partnership Report which, among other things, notes the trend for oral health throughout a person's lifetime to be considered a Human Right. If that status is recognized or conferred, what consequences would that have for us as a regulator. So too the growing policy attention being placed on treatment of persons with [disabilities]. This term is in [ ] because the debate is emerging that the term "disabilities" may no longer be accurate/acceptable. The terms to the effect of "specific or difficult medical conditions" may be emerging as the trending label. In any event, refer to the new policy statement under consideration in this area, noted earlier in

this report on the website at: http://www.fdiworldental.org/publications/policy-statements/draft-policy-statements-to-ga-2016.aspx

In summary analysis, I found that this meeting was a worthwhile one to attend. The congress sessions were, at large, substantive, and dealt with issues of dental practice and regulatory concern. I would recommend attending this Congress again in the future – at a periodic basis to be determined by needs and priorities.