Protection of the Public Interest: A Many-Layered Affair

First Defence in Oral Health: Arthritis

Conflict of Interest Regulation Comes Into Effect
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MILESTONES

President’s Message
Protection of the Public Interest: A Many-Layered Affair

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Michele Carrick District 1 (RDH)
Nicole Chalifoux District 5 (RDH)
Michael "Mike" Connor Barrie (PM)
Eliot Feldman Toronto (PM)
Linda Jamieson District 2 (RDH)
Julia Johnson Orillia (PM)
Shori Katyal Toronto (PM)
Samuel Laldin Kingston (PM)
Pauline Leroux District 4 (RDH)
Derrick McLennon Scarborough (PM)
Inga McNamara District 2 (RDH)
Janet Munn District 6 (RDH)
Laura Myers Academic (RDH)
Jeanine Nighswander District 4 (RDH)
Tote Quzan Scarborough (PM)
Catherine Ranson Academic (RDH)
Salam Rifai Mississauga (PM)
Charles Ross London (PM)
Ilga St. Onge District 8 (RDH)
Kelly Temkin Toronto (PM)
Jennifer Turner District 3 (RDH)
Anne Venton Toronto (PM)

Non-Council
Cathleen Blair (RDH)
Romaine Heskeb (RDH)
Shelli Jeffs (RDH)
Audrey Kenny (RDH)
Gail Marion (RDH)

RDH = Registered Dental Hygienist
PM = Public Member

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The mission of the College of Dental Hygienists of Ontario is to regulate the practice of
dental hygiene in the interest of the overall health and safety of the public of Ontario.
La mission de l’Ordre des hygiénistes dentaires de l’Ontario consiste à réglementer l’exercice de la profession d’hygiène dentaire de sorte à favoriser l’état de santé global et la sécurité du public ontarien.
We are now well into a new year which always brings new challenges and opportunities for not only the College of Dental Hygienists but for all of us. We recently held our first Council meeting of the year in late January with the election of the Executive Committee and the selection of Council Committees. I am honoured to have once again been selected as your President for this year. I would also like to congratulate Heather Blondin for being selected as Vice-President, Linda Jamieson, Anne Venton and Jennifer Turner for their election as members of the Executive Committee, as well as all the Council members who were appointed to the various committees. I also want to welcome Kelly Temkin, Jeanine Nighswander and Pauline Leroux as the new members of Council.

We are very pleased that all committees have been finalized and we can hit the ground running. There is a fairly full agenda this year with the committees dealing with the usual areas that are the mandate of the College along with a number of other issues. Appointment of an ad hoc committee to review the College bylaws, finalization of our strategic priorities for the coming year, the review of our internal registration procedures, the enhancement of technology to improve the registrant database system and the development of a number of public education initiatives by the Patient Relations Committee are some of the projects currently ongoing.

One area which has seen an increase in workload over the last couple of years and will probably continue, is the activities of our Investigations area which includes the Inquiries, Complaints, Reports Committee and the Discipline Committee of Council. It is not surprising that we are getting more issues referred to these committees. We are a college with a large number of registrants of a profession that is still evolving as a stand-alone professional group. We also are providing a service to a public who are for the most part getting more knowledgeable about oral health and the delivery of service by health care professionals in general. Sometimes issues come up that require an enquiry into what transpired by the College to ensure an appropriate level of care was provided and take corrective action if it is found deficient. This is one of the core functions of the College and fulfills the mandate of protection of the public.

One of the issues which the College and the staff in this area are very sensitive to is what information involving ICRC proceedings should become part of the public record. This has become a topic of much discussion lately among professionals, Ministry of Health and Long-Term Care, various colleges and members of the public. In newspaper articles over the recent months, it has been argued that in the public interest, there should be maximum transparency and reporting of all cautions conducted by the ICRC. At the heart of the debate is what is the balance between the public’s right to know and the privacy concerns of the professions involved. The Council, through the ICRC Committee, is monitoring this issue until a clear direction becomes evident and we can proceed in an appropriate manner if deemed necessary.
I f you want to invest a half hour in something valuable, I encourage you to review the Regulated Health Professions Act (RHPA). Not only is it foundation legislation for every regulated health professional in Ontario, it is also replete with references to a concept that is central to every regulatory college that I have ever experienced.

That concept is ‘protection of the public.’ In the November 2010 issue of Milestones, CDHO published an article that helped define Acts, Regulations, Standards, Bylaws and Guidelines. It was a very helpful article. In a recent Milestones article, I highlighted the critical importance of self-regulation. Legal scholars liken self-regulation to a social contract. Society agrees that a profession (in this case dental hygiene) will regulate the activities and behaviours of its members and in exchange for that responsibility/privilege, the profession will act to protect the public interest. In Ontario that social contract to protect the public interest is formally documented in the RHPA.

The RHPA, however, does not stand alone as a piece of legislation. There are supporting players that collectively combine to protect the public interest. Because of this supportive relationship some folks characterize RHPA as umbrella legislation. This implies that other forms of authority, e.g., the Dental Hygiene Act (DHA), Government Regulations associated with the DHA, Standards of Practice, College Bylaws all lay beneath the broad umbrella of the RHPA. While this is a perfectly reasonable way of considering the RHPA and its associated forms of authority, I prefer to characterize it as nesting legislation. The RHPA is foundational and all other forms of authority rest on that foundation. The nest, as it were, is a multi-layered affair. (See Figure 1)

RHPA provides the outer layer of the nest and of course it applies to all regulated health professions in Ontario. RHPA describes in detail the controlled acts that health professionals are authorized to perform. RHPA also goes into great detail on the organizational structure of regulatory colleges and ensures a prominent role for public members. There was a time in the not too distant past when the public had very little voice in health regulatory colleges. Under the RHPA this is certainly not true. In the case of CDHO there are eleven public members who are all appointed by the Lieutenant-Governor through what is called an Order-in-Council. There are also ten elected professional members from across the province and two professional members selected from the province’s dental hygiene educational programs.

Resting on that first layer of RHPA are profession-specific Acts – in this case the Dental Hygiene Act (DHA). While RHPA applies equally to all of Ontario’s regulated health professions, the Dental Hygiene Act applies specifically to registered dental hygienists. The DHA precisely outlines the scope of practice for dental hygienists and the controlled acts that they have the authority to perform.

The next layer in the nest exists in the form of government regulations, i.e., government has the authority to set a regulation within the scope of the Dental Hygiene Act. Dental hygienists in Ontario are subject to a number of regulations as follows:

- Part I – Examinations
- Part II – Advertising
- Part III – Contraindications
- Part III.I – Records
- Part IV – Notice of Meetings and Hearings
- Part IV.I – Conflict of Interest
Part V – Professional Misconduct
Part VI – Quality Assurance – General
Part VII – Registration, and
Funding for Therapy and Counselling

All of the foregoing regulations are available for public viewing on the CDHO website. In January of 2013 Cabinet approved a new regulation re: conflict of interest. In late January of 2013 CDHO Council approved the circulation of a newly proposed Drug Regulation. This regulation has gone to a wide array of stakeholders for commentary and such commentary will be used by CDHO to help improve the final regulation. The final Drug Regulation will be submitted to the government who will follow their own regulation approval process.

Government regulations are often a starting point for CDHO’s Standards of Practice and so, continuing with the nested legislation metaphor, Standards rest on the Regulations noted above. All CDHO registrants are obliged to follow the Standards of Practice since, as noted above, they flow from a Regulation. A standard of practice is a process or a procedure that must be followed. As with the Regulations under the DHA, so the CDHO Standards are also publicly available on the website.

Resting on the CDHO Standards’ layer of the nest is CDHO Guidelines. A guideline is a suggested way of doing something. They are usually written in a more conversational tone of voice and do not carry the same legal weight as standards.

The final layer in the nest is CDHO Advisories. These rest on the Guidelines and they are, simply stated, a way of transferring helpful information to registrants. The information may be helpful in a clinical sense, e.g., in the creation of a treatment plan with a specific medical condition.

Figure 1 is intended as a way of visualizing this extended roster of rules. As you can see in the graphic, moving from the outside layers to the inside layers, they grow more and more specific to the practice of dental hygiene. Stated another way, however, each layer of the nest provides a layer of insulation for the client who rests at the center of it all. Why are there so many layers in the nest? The answer is simple – protection of the public interest. The College has a legal obligation through RHPA, DHA, Government Regulations, CDHO Standards, Guidelines and Advisories to protect the public interest. The College can be very helpful in guiding the profession through all of these steps through direct dialogue with its Practice Advisors, through monthly e-Briefs and of course through the publication Milestones. While the College embraces its role as a guide to the profession, it can never abrogate its fundamental role in protecting the public interest.
Mr. Mike Connor, President of Council, called the meeting to order in Toronto, Ontario and following brief introductory remarks stepped down from the Chair so that Brad Sinclair, Registrar could preside over Council’s election of its President, Vice-President and Executive Committee. Both the President and Vice-President were acclaimed and Mr. Mike Connor and Ms. Heather Blondin were confirmed accordingly. Mr. Sinclair continued to preside over the elections and the following Council members were elected to Council: Ms. Linda Jamieson, Ms. Anne Venton and Ms. Jennifer Turner. Following the elections, Mr. Sinclair stepped down from the Chair and the newly acclaimed President Mike Connor assumed that responsibility for the meeting.

Mr. Connor called for a short recess so that Executive Committee could review and recommend the assignment of Council members to the various Council Sub-Committees. Following the recess, the Committee’s recommended appointments were approved by Council. Council also approved the following motions:

- The National Standardized Clinical Examination Project;
- The ODHA/CDHO Sponsored Educators Forum;
- CDHO’s Most Recent Clinical Competency Evaluation;
- The Federation of Health Regulatory Colleges of Ontario and the Development of the Regulatory Advisory Group;
- E-Health Ontario and Discussions with CDHO re: Their Provider Registry; and
- Status of the College’s Conflict of Interest Regulation.

President Mike Connor also presided over the presentation of a plaque recognizing the contributions of Mr. Ben Shayan and Ms. Heather Murray. Mr. Shayan had served on Council and Ms. Murray had served the College as a Non-Council Member.

2013 Council Meeting Dates

Council meets three times a year to discuss regulatory policy and debate issues that influence the quality of dental hygiene care in Ontario. Council meetings are open to the public.

The next Council Meeting will be held on the following date:

Friday, May 31, 2013

Location: To be determined

Space is limited. Please contact the Office of the Registrar via email at ndalcourt@cdho.org or by telephone at 416-961-6234, ext. 223 on or before Friday May 17, 2013 to reserve a seat.
January 25, 2013

CDHO Registrar and 2013 Executive Committee

Left to right, front:
Mike Connor – President of CDHO
Heather Blondin – Vice-President of CDHO

Left to right, back:
Linda Jamieson
Jennifer Turner
Brad Sinclair – CDHO Registrar
Anne Venton

Mr. Ben Shayan and Ms. Heather Murray receiving plaques recognizing their service and dedication to the College. Mr. Shayan served as a Public Member to Council from 2009–2012. Ms. Murray sat as a Non-Council Member to the Quality Assurance Committee from 2007–2012.

Left to right:
Mike Connor – President of CDHO
Ben Shayan
Heather Murray
Heather Blondin – Vice-President of CDHO

Did you know? Council meetings and Discipline hearings are open to the public and are posted in advance on the College’s website. Interested in attending? Give us a call or send us an e-mail and we’ll be sure to save you a seat!
On January 25, 2013 Council welcomed three new members, two professional representatives from district four and a member of the public appointed by the Lieutenant-Governor.

**Jeanine Nighswander (Professional Member – District 4)**

I will bring my broad knowledge and expertise to CDHO to formulate strategies that will support dental hygienists in our common goal to treat the public while maintaining the best possible standards.

Jeanine has practised dental hygiene for the past three decades in both urban and rural locations and has worked in periodontic, pedodontic, general and public health practices. Jeanine has devoted the last six years building her own practice in the Newmarket area.

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**Pauline Leroux (Professional Member – District 4)**

My passion and motivation includes advocacy for overall health, education and access to oral health care by eliminating barriers for the public and underserved communities.

Pauline has practised dental hygiene in Ontario since 2000 and has been employed for the past seven years as an educator for a Dental Hygiene College in Toronto. Pauline has liaised and promoted community outreach programs, oral screenings and education workshops in the GTA as part of her practice and has travelled to other underserved communities abroad to provide basic dental hygiene care and education to communities where unmet human needs exist.

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**Kelly Temkin (Public Member – Toronto)**

I have a particular interest in health policy and regulation. I have been impressed by the ongoing work of the CDHO and I am delighted to join the Council as a public member.

Kelly is a graduate of Osgoode Hall Law School and has practised law in various legal clinics since being called to the Ontario Bar in 1992. She has experience with alternative dispute resolution and has recently completed a Masters degree in Health Law, focusing on ethics, law and regulation.
Public Education Program Continues for 2013

Robert Farinaccia, RDH, BSc

In 2011, the Patient Relations Committee of the College of Dental Hygienists of Ontario (CDHO) embarked on a new public education campaign to coincide with its committee mandate of:

- helping dental hygienists enhance relations with their clients, and by extension, the public;
- helping the public achieve greater understanding of the range and quality of the professional services offered by members of the College;
- helping clients be fully informed of their rights in dealing with members of the profession and the College, including that they will be treated in an ethical, competent, sensitive and respectful manner;
- helping the public have a greater knowledge of the role of the regulatory College and how to participate in College processes and/or programs.

In 2011, you may recall that the CDHO developed six core messages built around two main positioning statements for its 2011 and 2012 public education campaign. The Mouth Tells Your Health’s Story and the CDHO and its registrants are Your First Defence in Oral Health are the two messages that the public of Ontario have been hearing on radio stations across the province through public service messages and reading in national publications. Six top-of-mind health conditions (oral cancer, diabetes, pneumonia, reflux, stroke, and eating disorders) were chosen to help make the public aware of the possible links between oral health and these conditions and create awareness that dental hygienists have the skills, knowledge and judgment to provide qualified clinical decisions related to the conditions.

Members of the public as well as some provincial and national organizations (Canadian Cancer Society, Canadian Diabetes Association) heard the public service messages and were interested in learning more and possibly partnering to help create public awareness as part of their annual campaigns.

For 2013, public services messages (in print and radio) were created for three new health conditions; arthritis, gum disease, and dry mouth. You can expect members of the public to ask you questions regarding how you can help them address oral issues related to and associated with these conditions. These are the public service messages you can expect to see throughout the year in various magazine issues of Canadian Health and Lifestyle, Canadian Living, and Zoomer. You may also hear the public service announcements on: CFRB 1010 Toronto, JAZZ FM91 Toronto, 1310 News Ottawa, CHAY 93.1 Barrie, CJBK Newstalk London, CKPR 91.5 Thunder Bay, CJMX EZ Rock Sudbury and North Bay, KISS FM Toronto.

For more information, go to www.cdho.org, click on the tab ‘For the Public’, and select ‘Public Education Program’ from the drop-down menu.
On January 25, 2013 Council approved amendments to the Standard of Practice for Self-Initiation that will affect those wishing to apply for authorization to self initiate after July 31, 2013. The new standard will come into effect August 1, 2013, allowing registrants time to familiarize themselves with the amended standard and giving the College time to develop a roster of mentors.

The standard for self-initiation sets out the criteria that must be met in order for dental hygienists to be authorized by the College to self-initiate the controlled acts of scaling teeth, root planing and curetting surrounding tissue. In accordance with legislation passed in 2007, dental hygienists must apply and show evidence that they meet the requisite criteria under one of the three streams in order to receive authorization from the College to self-initiate. This has not changed.

Background

On August 29, 2007 the Standard of Practice for Self-Initiation became effective in preparation for the amendment to the *Dental Hygiene Act* that would empower the College to authorize registered dental hygienists to self-initiate the scaling of teeth, root planing and curettage of surrounding tissue. In accordance with legislation passed in 2007, dental hygienists must apply and show evidence that they meet the requisite criteria under one of the three streams in order to receive authorization from the College to self-initiate. This has not changed.

The Committee found that it was important to differentiate between a decision that it is safe to proceed with controlled acts and the decision about how to treat oral conditions. The review of the standard for self-initiation did not ask if dental hygienists are qualified to plan for and provide dental hygiene therapies. That has already been established through the College’s entry-to-practice requirements. Once a dental hygienist is registered this is not in question. Rather, the Committee looked to see if the current standard provided the adequate balance between the public’s right to access dental hygiene care and risk of harm.

When considering access to dental hygiene care, the Committee considered if the current standard had any requirements that created unnecessary barriers to registrants who were seeking authorization to self-initiate. Stakeholder consultation and staff experience identified barriers that have prevented registrants from meeting the requirements necessary to successfully achieve authorization to self-initiate. Some of these barriers were:

- Inability to get employment in a dental office to meet work experience requirement
- Inability to get an order from a dentist to work in non-traditional practices
- Inability to gain experience in LTC facilities because of difficulty getting an order
- Difficulty finding mentors
- Difficulty finding employers who would allow a mentor or mentee into the office for the clinical observation requirement of mentorship

The Committee felt it was important to consider these registrants in the drafting of amendments to the Standards especially since underemployed registrants may be more inclined to practise in underserviced areas, increasing public access to oral care.

In assessing the risk of harm, the Committee considered if current registrants and future graduates of the new dental hygiene...
The Quality Assurance Committee having completed a review of the Standard of Practice for Self-Initiation recommended to Council that the current standard be amended to include changes brought forward in draft to Council. Council considered the recommended amendments and adopted them unanimously on January 25, 2013.

The amended standard is now on the CDHO website. It should be of interest to registrants who have not yet received authorization to self-initiate. For those who have already received authorization the changes will have no effect.

The most significant change is the addition of a category of authorization that allows approved applicants to self-initiate the controlled acts while participating in a formal mentorship program. This will permit registrants who have not been able to qualify for authorization under the current standard because of difficulty meeting the requisite 3200 hours of practice under a standing order, to obtain a conditional authorization.

Conditional authorization means that as long as the registrant meets the conditions set out by the College, s/he will be allowed to self-initiate her/his controlled act of scaling teeth, root planing and cureetting of surrounding tissue. The significant condition to authorization is a mandatory contract with a CDHO-approved mentor who will support the registrant for a minimum six-month period while s/he gains experience providing direct client care. The College is designing a course that will train mentors and will publish the names of approved mentors on its website. More information about mentorship opportunities will be provided before the August 1, 2013 deadline. Mentorship training and mentoring hours will be acknowledged as CQI goal-related activities for the professional portfolio.

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PROPOSED DRUG REGULATION

Feedback requested by Friday, April 19, 2013

In accordance with Schedule 2 of the Regulated Health Professions Act, 1991, the Council of the College of Dental Hygienists of Ontario (CDHO) is circulating the proposed Drug Regulation to registrants and other stakeholders for comment.

Responses or comments to the proposed Drug Regulation are requested no later than 4:30 p.m. on Friday, April 19, 2013.

All interested stakeholders are invited to visit the College’s website to review the complete regulation and any reference documents associated with the consultation process. Go to www.cdho.org, click on the tab ‘Professional Practice’ and select ‘Legislation and Bylaws’ from the drop-down menu.
The College’s Conflict of Interest regulation has been reviewed by the Minister of Health and Long-Term Care and has met the approval of the Lieutenant-Governor-in-Council. The regulation was filed as O. Reg. 31/13 on January 25, 2013.

Conflict of interest may affect dental hygienists in clinical practice, education, administration, sales or research. The standing of the profession and the welfare of the public is jeopardized when obvious conflicts are allowed to continue. Regulations, such as the Conflict of Interest, contain definitions, practice parameters and standards that should be considered by all registrants in the care of their clients and in the practice of the profession. Above all, dental hygienists must make professional decisions based upon the best interests of the client, and must ensure that their own personal interests do not conflict or appear to conflict with the interests of the client. This new regulation helps dental hygienists understand the scope of that responsibility.

Clients, colleagues and others need to be able to trust their dental hygienists. This trust is breached when a dental hygienist’s personal or private interests interfere with a client’s best interests or with the dental hygienist’s own professional responsibilities. The conflict can be actual, perceived or potential. When a conflict of interest influences, or appears to influence a dental hygienist’s judgment, the trust relationship can be undermined.

While it is always preferable to avoid or prevent a conflict of interest, it is sometimes hard to identify potential sources of conflict. Marketing and market competition should not be allowed to undermine dental hygienists’ commitment to their client’s best interest or to scientific integrity. For example, the regulation does not permit dental hygienists to accept or to offer any payment or benefit to someone for the referral of a client. Offering a client a gift for the referral of a friend or family member is not acceptable practice. Accepting free dental services for yourself or family members based on the referrals you make to a dentist or dental specialist is also unacceptable.

Selecting a product or service or recommending a product based on a supplier’s or employer’s incentive program may also be in conflict. It is always better to provide the client with all the information while not imposing any undue influence on their decision making.

However, there may be times when a dental hygienist will have reason to recommend a product or a service that s/he may benefit from because it is simply the best, more convenient, or the only option even though there may be a conflict present. For example, a dental hygienist who owns shares in a company that has developed a toothbrush specifically for clients with severe arthritis in the hands, that is sold in a local pharmacy. As it is the only product on the market, it would be in her/his arthritic client’s interest to have the dental hygienist promote this toothbrush for home use. In cases like this, the dental hygienist must acknowledge the source of conflict by disclosing her/his interest in the company and by making it clear that the client will not be treated any differently in the future whether s/he chooses to purchase the specialized brush or not.

Another potential source of conflict occurs when dental hygienists offer gifts or loyalty rewards to clients who have insurance coverage. Other than a product of nominal value such as a toothbrush, it is unacceptable to give your client a benefit when services are being paid by a third party and those benefits are not being passed on to that party.

Additionally, it is inappropriate to charge clients different amounts for the same good or service depending on whether the client has insurance or not. And, accepting what the insurer pays if it is less than the invoiced amount and not collecting the balance from the client is in breach of the Conflict of Interest regulation.

The requirements for successfully managing conflicts of interest are quite basic: be aware of your obligations; exercise good judgment; and effectively communicate and document the decisions you make and actions you take when dealing with conflicts of interest. If you are unsure if a conflict of interest exists, please contact a College practice advisor to discuss your situation. Visit www.cdho.org to read the Conflict of Interest regulation.
The College experienced a drop in the number of applications for the clinical competency evaluation in 2012 and this decline is expected to continue in 2013 and onward. Successful completion of the clinical competency evaluation is a registration requirement for graduates of non-accredited dental hygiene programs. In accordance with the CDHO Examination regulation, a clinical competency evaluation must be held a minimum of one time per year. Candidates have at maximum four attempts to successfully complete the clinical competency evaluation. A candidate who fails a fourth attempt of the clinical competency evaluation is not eligible to retake the examinations again until the candidate has obtained another dental hygiene diploma from a dental hygiene program acceptable to the Registration Committee. There were no fourth fails in 2012 or in 2011. There were two fourth-time failures in 2010 and one in 2009. The next clinical competency evaluation will be held on April 27, 2013.

The College of Dental Hygienists of Ontario (CDHO) would like to congratulate Ms. Anthea Chang, RDH on being the first recipient of the Fran Richardson Leadership Development Bursary. This award was created to promote leadership within the profession of dental hygiene in Ontario by encouraging practising dental hygienists to develop leadership abilities through education and/or other activities.

This award comes with a financial grant of $2,500.00 and a keepsake award which will be presented upon completed implementation of various activities and fulfillment of the reporting requirements set out in the award criteria. A formal presentation is scheduled to take place at CDHO’s Council Meeting on October 25, 2013.
2014 Notice of Assessment

In January, letters were mailed or e-mailed to all dental hygienists who have not previously had the opportunity to participate in a portfolio review and who registered with the College prior to July 1, 2011. The due date for submission is January 31, 2014. The College will accept submissions after January 1, 2014.

Letters were sent using the registrants’ preferred method of communication, either mail or e-mail. In response to requests by registrants, you can now check online at www.cdho.org to see if you are required to send in your portfolio. Go to the ‘Registration’ tab and then to the ‘Registrant Login’ link. To access your personal information you will need to log in using your registration ID number and birth date. For added security we encourage you to change your password on a regular basis. Your password must be 8–15 characters in length and may contain a combination of letters and numbers. Once inside your personal page, you will see your last and next portfolio assessment year. If the “Next assessment year” section states “Unknown” you have not been selected to submit your portfolio. You may also confirm our record of your preferred method of communication to receive both Milestones and any other College correspondence.

All registered dental hygienists are required to maintain a portfolio. This includes those who have registered under an inactive status and those who are not working. Names were selected for portfolio submission from those who have held an active or specialty registration at any time in the previous three (3) years as of the time of selection in mid-January. Once selected, you are required to submit your portfolio for assessment. If you are not working at the time of submission, you will not be required to report on your typical day on Form 4A. However, you will need to complete all other sections of the portfolio to demonstrate your continuing competency. The only time a registrant does not have to submit their portfolio is when they have resigned from the College.

RDH Expertise for RDHs

CDHO practice advisors provide confidential consultations to dental hygienists who seek assistance with issues that directly or indirectly affect the delivery of safe, competent, ethical dental hygiene care.

To reach a CDHO practice advisor by phone or e-mail:

416-961-6234 or 1-800-268-2346

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My name is Brigid*. I am a Quality Assurance Assessor for the CDHO and this is the story of how I got here. I do not know any big secrets. There is no special code or handshake. I have been trained to assess portfolios and practices, but I am your peer and I am not special.

My personal experience with the Quality Assurance Program began early in 2004 when I received the dreaded “letter” asking for my portfolio. At the time, the program had been in place for a few years. I had friends who had submitted their portfolios in previous years and who had passed their reviews. I had always participated in continuing education and I was a good dental hygienist who cared for her clients. I worked hard, loved my job and had no worries at all about my ability to pass the portfolio review. My filing system was primitive and more than a little unorganized, but I had kept all of my receipts and certificates together in a bin. My only concern was that I didn’t know where I was going to find the time to organize myself and to fill in the forms as I had recently started a new job and had heard that doing a portfolio was a lot of work. Despite asking for and receiving an extension to submit my portfolio, I managed to put it all together and submit it by the original due date.

You cannot imagine my surprise when I got “the phone call” from a CDHO assessor. She told me she wanted to make an appointment to clarify a few things from my Typical Day. At this point I began to get nervous and perhaps even just a little angry. What didn’t she understand? What was wrong with my portfolio? Couldn’t she see that I knew what I was doing and that my clients were getting good care and everything they needed?

Later during my interview, my assessor asked me questions about my practice and I confidently and without hesitation answered everything she asked. I had always been very proud of the treatment I provided. I knew my clients’ needs and histories and in some families, I was treating the third generation. You cannot imagine how surprised I was when I received the report back on my portfolio review telling me that I needed to have an onsite practice review. My surprise turned to anger and I thought to myself, “Well, she can just come and see for herself how well I treat my clients. She mustn’t have a clue about providing care if she can’t see that from my portfolio.” I had never had strong feelings about the Quality Assurance Program in either direction but at this point I was definitely not a fan.

The day of my onsite review arrived and I met with the assessor on a day that the office was closed. The visit took about 4 hours. During that time we discussed my operatory, infection control, equipment maintenance, emergency protocols and office policies. She also took copies of 20 of my client charts that she indicated she would be auditing following the visit. I felt that the visit went relatively well and was obviously very relieved when it was over. I figured at this point the assessor finally saw how great my practice actually was.

Was I wrong!! The next correspondence I received was a list of the problems that the assessor had identified in my practice. I could not dispute anything she wrote. I was not adhering to the Standards of Practice. I was not following the process of care. I was not following the record keeping regulation. My periodontal charting was not complete. Recession was not measured. CAL’s could not be documented, therefore a dental hygiene diagnosis could not be stated. My documentation was not allowing me to closely monitor their progress. There was no documentation to show exactly what I had instructed for OHI. I began to question how I thought I could make suggestions for improvements when I never bothered to document my previous advice or if something happened to me, how another dental hygienist would know what I wanted to evaluate at the next visit.

As soon as I received the report, I started trying to make changes to my practice. I wrote to the Quality Assurance Committee...cont’d on next page
telling them about the changes but they still requested that I complete a Remediation Program and the remediator was required to report back to them after I was finished. At that time, I was also going to be required to submit client records for their review. I started to work with the remediator on some course work.

I cannot pinpoint exactly when it happened, but at one point, I came to a horrifying conclusion. I was not providing my clients with the quality care that I thought I was and it hit me that I could have actually irreversibly harmed someone. Clients were coming to me and paying me to take care of them. Not only was I not giving them what they were paying me for, they trusted that I was giving them the kind of care they deserved. Instead they were receiving supervised neglect from me for their time and money. I was embarrassed and humiliated when I realized that my clients needed to be protected. This was not the fault of the CDHO or their staff; I owned this problem. That was a turning point for me and I zealously attacked my practice and set about learning what I had to do to bring my practice up to standards. In retrospect, I am so thankful for the support of my employer, my fellow dental hygienist in my practice and my other dental hygienist friends. I know that some in my position are not so fortunate. The support I received was unwavering and we worked together to allow me to make the necessary changes. I think they realized that helping me work towards an improvement in my practice would result in an improvement in theirs as well.

Some time passed and I had completed my Remediation Program. I was ready to send my client records to the CDHO for audit. I had made massive changes to a practice where I had previously erroneously thought I was providing the best care to my clients. I was so proud of what I had accomplished and I was confident that this time I would finally pass my review.

Finally the day came and another letter arrived from the CDHO. They informed me that following the review of my clients’ charts, my portfolio and practice review was complete. I cried with relief when I realized my long journey was finally over. You may find it hard to believe what I did next, but when I got home from the mailbox, I sat down and called the CDHO. I told them that I wanted to become an assessor! I truly believed that I had something to contribute to the program. I had gone through the process and not only had I survived, I had a sense of personal accomplishment and a renewed pride in my practice and in the treatment my clients were now receiving. I had placed blame on my assessor for all I had endured. I now realized she was only reporting on the facts of my practice. I wanted to give back and I felt that I had a view of the program and the feelings that it invoked that few assessors could claim. I knew that I would personally relate to the feelings of fellow dental hygienists who were being assessed.

I am your Quality Assurance Assessor and that is my story. I am your peer and I have been there. CDHO

*Name changed to protect privacy

Photo from CDHO photobank

Did you know?

All QA assessors have had their portfolios reviewed. Currently, eight have participated in an onsite review prior to becoming an assessor.
Investigation and Hearings – Protection of the Public

Evelyn Waters, BA, HDipEd, Deputy Registrar

Concerns respecting registrants’ conduct are investigated by the Inquiries, Complaints and Reports Committee (ICRC). The CDHO’s mandate, protection of the public, has a major influence on the ICRC policies and processes. Although many of the ICRC processes are outlined in the Regulated Health Professions Act, 1991, particularly with respect to procedural fairness and the possible outcomes of an investigation, the overriding principle for consideration by an ICRC Panel, when arriving at a decision, is whether that decision ensures public protection.

If the members of an ICRC Panel, at the conclusion of an investigation, find that the concerns raised about a registrant’s conduct are substantiated, they will deliberate to determine what the appropriate action is. They will consider the nature of the concern, (e.g. recordkeeping, rudeness, fraudulent activity) and consider whether it is appropriate to remediate the registrant or refer the matter for further action. The options available to the Panel are:

- require the registrant to appear before the ICRC to be cautioned
- require the registrant to complete a specified continuing education or remediation program (SCERP)
- refer the matter for incapacity proceedings if there are concerns suggesting that the dental hygienist is suffering from a physical or mental incapacity
- refer the matter to the Discipline Committee
- take no further action
- take other action it considers appropriate and which is not inconsistent with the Regulated Health Professions Act, 1991 (RHPA), part of which outlines the complaint process for all regulated health professionals

When determining what action to take, the members of the Panel will take into consideration the seriousness of the conduct, whether it involved dishonesty or a breach of trust, the potential harm that could result from the conduct and whether the registrant is remorseful and/or recognizes the error and/or impact of her/his conduct. They will also look at a registrant’s past history to determine if there is a pattern of behaviour. If the Panel is satisfied that the concern can be safely addressed through remediation and/or cautions, it will take this approach. If the registrant’s deficiencies can be addressed and the registrant is brought back up to the standard of practice, then both the registrant and the public is well served. However, certain conduct is not tolerated. In most cases, concerns relating to incompetence and fraudulent activity will be referred to the Discipline Committee. The ICRC recognizes the need to protect the public from unqualified, incompetent, unfit or unethical registrants.

The discipline process is entirely separate from the ICRC process. The Discipline Committee deals with allegations of professional misconduct or incompetence through a formal hearing. Unlike ICRC decisions, decisions made by the Discipline Committee are public. Referral to the Discipline Committee demonstrates that certain conduct will not be tolerated by the CDHO and the decision is generally punitive in nature. It further serves to communicate to the profession that such misconduct will not be tolerated.

Unlike concerns relating to professional misconduct, incapacity concerns are treated in a compassionate and non-punitive manner. In many of these cases, if the registrant is willing to enter into an agreement with the CDHO to obtain appropriate treatment and monitoring of the condition, no further action is taken.
Regulatory College and Professional Association. Who Does What?

Robert Farinaccia, RDH, BSc

Hi. I’m a dental hygienist. Can I ask you a quick question? A phrase that is very familiar to the practice advisors as this is how most registrants begin their conversations with us when they call the College for practice advice. Most of the time, as practice advisors we will have an answer, and if not, we will provide one after we have done some research. However, there are times when we simply do not have an answer because the inquiry does not fall under the mandate, mission, and/or role of the College of Dental Hygienists of Ontario (CDHO) and would be better directed to one of the dental hygiene professional associations.

The goal of the College is to serve and protect the public interest by protecting a client’s right to safe, competent and ethical dental hygiene care.

What then are the roles of a College and a professional association? Let us first look at the role of a College. Although the term College at first impression may lead someone to believe that there is an affiliation with an educational establishment, this is not the case. In this instance the term is used to refer to a health profession or group of health professions established or continued under a health profession Act. Simply put, under the Regulated Health Professions Act, 1991, and the Dental Hygiene Act, 1991, the CDHO has the duty to regulate dental hygienists and the practice of dental hygiene in Ontario.1 The goal of the College is to serve and protect the public interest by protecting a client’s right to safe, competent and ethical dental hygiene care. As such, the College is charged with setting regulations, standards of practice, and guidelines. The CDHO and the 25* other health regulated Colleges each have Councils that govern over 256,000 health professionals in Ontario.2 The CDHO Council is made up of twenty-three members that fall into two categories: professional members and public members. Professional members are registered dental hygienists who are elected by their peers for a three-year term. These professional members are elected in their respective districts to represent the public of Ontario. Once elected, they do not represent the dental hygienists in that district, rather, they represent the interest of the public of Ontario as a whole. The public members are appointed by the Lieutenant-Governor-in-Council. Public members are appointed to ensure the public perspective is foremost in Council discussions and decisions.3

The College’s first priority is to the public of Ontario. To help guide its registrants in protecting the public, the College offers a professional practice advisory service. The practice advisors at the CDHO can provide confidential consultation on various issues and dental hygienists are welcome to contact the College regarding:

- ethical questions which involve client care;
- regulations, standards of practice, and guidelines;
- dental hygiene scope of practice.

Now that the role of a College has been clearly defined, what is the role of a professional association? A professional association is usually a nonprofit organization whose primary role is to further a particular profession and look after the interests of the individuals engaged in that profession. In simple terms, a professional association is the collective voice for the members of a specific profession.
and as such, will engage in discussions on behalf of its members to different organizations. The primary role of an association is to look after the interests of its members, which can include lobbying government to make policy decisions that look to expand the scope of dental hygiene practice. Associations are usually governed by a Board of Directors that is made up of professionals. There are two main dental hygiene associations that cater to Ontario dental hygienists; the Canadian Dental Hygienists Association (CDHA) and the Ontario Dental Hygienists’ Association (ODHA). The CDHA exists so that its members are able to provide quality preventive, and therapeutic oral healthcare as well as health promotion for all members of the Canadian public. The ODHA is the professional association that represents the interests and needs of member dental hygienists in Ontario. Its mission is to advance dental hygiene practice and primary health care promotion in the interest of the profession and the public.

The primary role of an association is to look after the interests of its members, which can include lobbying government to make policy decisions that look to expand the scope of dental hygiene practice.

The professional associations usually provide services, support and opportunities to benefit their members. Some examples of the services an association may provide are professional practice liability insurance, membership surveys, professional development opportunities, employment opportunities, discount programs, support on issues of employment, and setting suggested fees and codes for dental hygiene services.

Both Colleges and Professional Associations play vital and distinct roles in a health profession’s governance and development, and constant communication and dialogue between the two ensure that the public’s and the profession’s voice are heard and addressed.

*The following 5 are transitional Councils awaiting proclamation:

Transitional Council of the College of Homeopaths of Ontario
Transitional Council of the College of Kinesiologists of Ontario
Transitional Council of the College of Naturopaths of Ontario
Transitional Council of the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario
Transitional Council of the College of Registered Psychotherapists and Registered Mental Health Therapists of Ontario

Resources
3. Milestones, July 2012
4. www.cdha.ca
5. www.odha.on.ca

Did you know?
Dental hygiene radiography programs are not HARP certified. Only the CDHO has the authority to grant HARP certification to dental hygienists in Ontario. Your current registration with the College is your proof of HARP certification. Showing your 2013 renewal certificate satisfies HARP inspectors.
According to the Canadian Community Health Survey (CCHS) in 2007–08, over 4.2 million Canadians (16%) aged 15 years and older reported having arthritis. With the aging population, this number is expected to increase to approximately 7 million (20%) by 2031.1 Arthritis is classified as a musculoskeletal disorder and refers to over 100 different conditions that can cause physical disability through pain and activity limitation. The main characteristic of arthritis is inflammation of one or more joints. Some forms of arthritis can also cause problems in the organs, such as the eyes or the skin.

Arthritis involves the breakdown of the cartilage that normally protects a joint. Having an adequate amount of cartilage in a joint is crucial as cartilage not only allows the joint to move smoothly but also acts as a shock absorber for the joint when pressure is placed on it, such as during walking or running. Without the normal amount of cartilage present, the bones of that joint will rub together causing inflammation, pain, and stiffness.

**Risk Factors**

Of the over 100 different conditions that are classified as arthritis, the risk factors vary for each specific type. Some of the risk factors common to most types of arthritis include age, gender, hormones and genetics.

**Age:** Although arthritis is most prevalent among seniors it can affect anyone. From babies and children, to people in the prime of their lives, arthritis is not confined to any particular group. Nearly three of every five people with arthritis are of working age (under 65).2

**Gender:** An estimated 64% of all people with arthritis are women.3

**Hormones:** There have been possible hormonal links for certain types of arthritis with evidence of disease changes occurring around menopause and pregnancy.4

**Genetics:** Specific genes are associated with a higher risk of certain types of arthritis, such as rheumatoid arthritis and systemic lupus erythematosus (SLE). Also, it has been found that specific genes influence the severity of rheumatoid arthritis.5

**The Oral Health Connection**

Arthritis can not only affect an individual’s ability to perform proper oral care for themselves due to the limitations in movement, but certain types of arthritis have been shown to have oral manifestations, some of which can be quite painful.

According to the Public Health Agency of Canada, rheumatoid arthritis and systemic lupus erythematosus (SLE) are two of the most common types of arthritis that exist.6 These two types of arthritis will be looked at since they both have oral manifestations and dental hygienists should be alert to the oral signs and symptoms so that they can provide proper care to their clients affected by these conditions.

4. ibid.
5. ibid.
Rheumatoid Arthritis

Rheumatoid arthritis is an autoimmune disease, which means that the immune system attacks healthy parts of the body. It can cause redness, pain, swelling and/or a warm sensation in the lining of an affected joint. The most commonly affected joints are fingers, wrists, feet, ankles, knees, and elbows. The inflammation can also affect internal organs, such as the eyes by causing dryness (Sjögren’s Syndrome) and burning with discharge, itching, or drainage. The inflammation can affect the lungs by causing chest pain when inhaling, and the skin by causing subcutaneous nodules. Also, numbness, tingling, or burning in the hands and feet may be present.

7. College of Dental Hygienists of Ontario, CDHO Advisory Rheumatoid Arthritis, 2012-01-01
http://www.cdho.org/Advisories/CDHO_Advisory_Rheumatoid_Arthritis.pdf
When considering oral manifestations, rheumatoid arthritis has temporomandibular joint (TMJ) involvement in 75% of cases and this can lead to a decreased range of motion in the mandible with pain on opening. The development of an anterior open bite may also occur due to the destruction of the condylar heads of the mandible. Some other common oral manifestations that may be present are xerostomia, oral ulcerations, impaired hemostasis, and increased risk of periodontitis. Some of these may be present as a result of medications that the client is taking.

There is no cure for rheumatoid arthritis. Currently, treatment is aimed at slowing down the progression of the disease and alleviating the symptoms associated with this disease. Clients may be on a number of different medications that could affect the planning of dental hygiene interventions. Anti-inflammatory drugs (NSAIDS), anti-malarials, corticosteroids, and biologic agents may all be used independently or in combination. Also, the client may be on disease-modifying anti-rheumatic drugs (DMARDS) which act by immunosuppression to help inhibit the immune system from attacking the joints. A client’s rheumatoid arthritis may ultimately lead to severe physical limitation, which can make providing dental hygiene treatment very difficult. These clients may have limited opening, and access to the oral cavity may become challenging. Screening and preventive care for associated oral conditions is key to achieving and maintaining optimal oral health.

Systemic lupus erythematosus

Systemic lupus erythematosus (SLE), like rheumatoid arthritis is an autoimmune disease that can affect various parts of the body, including the skin, joints, heart, lungs, blood, brain and especially the kidneys. Typically, the most significant aspect of the disease is eventual kidney failure. SLE affects nearly 50,000 Canadians and its onset usually appears in women aged 10–50. People of African and Asian decent are affected most often and SLE is characterized by flares and periods of remission. Some of the symptoms include chest pain when inhaling, fatigue, fever with no other known cause, a feeling of malaise, hair loss, sensitivity to sunlight, and a skin rash which appears over the cheeks and bridge of the nose and has a butterfly shape. Joint pain is a very common symptom to everyone affected with SLE.

When considering the oral manifestations associated with SLE, oral lesions of the lips and mucous membranes may be present. Lesions may frequently resemble lichen planus or leukoplakia. Other oral manifestations can include xerostomia, glossodynia (burning mouth), and dysgeusia (altered sense of taste).

As with rheumatoid arthritis there is no cure for SLE. The goal of treatment is to relieve the symptoms and protect the organs by decreasing inflammation and slowing down the disease progression. Clients with SLE are advised to avoid sun exposure as this is known to cause a flare up in the disease. Some clients with mild symptoms may require no treatment while others may have some degree of internal organ damage and may require high doses of corticosteroids in combination with immunosuppressants. Anti-inflammatory medications may also be taken to help with muscle and joint pain, while anti-malarials are usually used to help treat skin rashes and mouth ulcers associated with SLE.

   http://www.cdho.org/Advisories/CDHO_Advisory_Rheumatoid_Arthritis.pdf
    http://www.cdho.org/Advisories/CDHO_Advisory_Lupus.pdf
12. ibid.
Your Role

As the oral care professional clients usually see first, dental hygienists are educated to know how to design a treatment plan that properly addresses the oral needs of a client that may be suffering from rheumatoid arthritis or SLE.

Clients with rheumatoid arthritis may have limited ability to open their mouth as well as pain when doing so, and therefore, should not be subjected to long appointment times. Also, the need for prophylactic antibiotics should be explored, especially if the client is taking an immunosuppressant to help slow down the progression of the disease and/or if the client has had a joint replacement. The need for prophylactic antibiotics is best discussed with the healthcare provider that is most familiar with the client’s specific condition (i.e., rheumatologist, orthopaedic surgeon). The use of an appropriate mouthrinse or other agent to help address the client’s oral dryness should also be considered since it is very likely that clients will be taking medications that have xerostomia as a side effect. Clients may have difficulty brushing and flossing and as such, recommending oral hygiene aids such as floss holders, mechanical toothbrushes or modified handled manual toothbrushes can help the client achieve better plaque removal.

Although clients with SLE require no specific treatment planning modifications, the disease does have many potential problems and can affect different organs. Therefore, pretreatment consultation with the primary treating physician is advised. The consultation should include discussion about the use of prophylactic antibiotics before dental hygiene treatment, especially if the client has leukopenia (decreased white blood cell count) and is taking corticosteroids. Dental hygienists can recommend the use of saliva substitutes to help address the client’s xerostomia. As with rheumatoid arthritis, having joint pain is almost certain and dental hygienists should consider that the client may have physical limitations and difficulty using traditional oral aides.

Conclusion

Dental hygienists recognize that dental hygiene care implementation is significantly influenced by a client’s health status and as such, dental hygienists should be prepared to consult with the appropriate healthcare provider to obtain advice on treatment modifications for clients who are affected by rheumatoid arthritis or SLE. By keeping their knowledge base current and using the Knowledge Network as a guiding tool, dental hygienists are a first defence in treating the oral symptoms associated with arthritis.

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14. ibid.
15. ibid.

Did you know?

“itis” is a suffix meaning inflammation. Using the words gingivitis and periodontitis describes an observable condition. Dental hygienists may choose to use these words in their clinical records and discussions with clients. Similarly, if a client describes a reaction to a medication that included red itchy bumps on their body, they might choose to use the term “rash”.
Milestones
March 2013

Across
1. Acronym for a class of medications used to treat inflammatory types of arthritis.
6. An expression of the frequency with which an event occurs in a defined population.
10. Hormone produced naturally by the body’s adrenal glands that regulates routine inflammation from minor injuries.
15. Acronym for a systemic disease characterized by the inflammation of the membranes lining the joint, which causes pain and stiffness.
16. Infections that occur because of a weakened immune system.
18. An anti-microbial agent, available in many forms, such as gels and rinses.
20. The part of the joint that cushions the ends of the bones and allows easy movement of joints.
23. Arthritis and rheumatic conditions currently affect nearly 4.5 _______ Canadians.
24. An umbrella term used to describe the many autoimmune and inflammatory (arthritic) conditions that can develop in children ages 16 and younger.
27. A surgical procedure in which an artificial joint replaces a damaged joint, usually a hip, knee, shoulder or ankle.
28. A form of arthritis that is caused from blunt, penetrating, or repeated trauma or from forced inappropriate motion of a joint or ligament.
29. The name of a disease where the body’s immune system mistakenly attacks healthy tissue.
30. Body part that can be affected by long-term use of NSAIDs.
31. Intentionally suppressing of parts of the immune system.
32. This gender gets rheumatoid arthritis more often than the other gender.
33. Is a type of arthritis caused by too much uric acid in the body that is not adequately flushed out by the kidneys.
34. A prolonged course of arthritis may result in extended periods of pain and suffering, reduced sleep, depression and unemployment, which add up to reduced quality of ________.
35. Increases the incidences of osteoarthritis.

Did you know?
Crossword puzzles benefit your brain four ways.
1. Enhance vocabulary
2. Strengthen word recall and memory
3. Stimulate problem-solving skills
4. Improve focus and attention

Down
2. An arthritis described as a long-term disease that leads to inflammation of the joints and surrounding tissues. It can also affect other organs.
3. Abnormal dryness of the mouth resulting from decreased secretion of saliva.
4. Acronym for drug category that includes ibuprofen.
5. The medical term for inflammation of a synovial membrane which lines those joints which possess cavities.
7. Acronym for an inflammatory arthritis of the spine that causes pain and stiffness in the back and bent posture.
8. Is a measure of the occurrence or disease frequency often used to refer to the proportion of individuals in a population who have a disease or condition.
9. Means scoping or looking into a joint by means of a miniature telescope called an arthroscopic.
11. Still’s disease is most common among children for whom it is commonly referred to as systemic juvenile _______ arthritis.
12. A condition or factor that serves as a reason to withhold invasive dental hygiene treatment.
13. This burden of arthritis in Canada is estimated at $4.4 BILLION annually.
14. This can be impaired as a result of glucocorticoids use and may impact dental hygiene treatment planning.
17. A syndrome named for the combination of dryness of the mouth and eyes.
19. These medications work very well to reduce joint swelling and inflammation. Because of long-term side effects, these drugs should be taken only for a short time and in low doses when possible.
22. Example of a weight-bearing joint where osteoarthritis most commonly occurs.
25. Inflammation of the blood vessels which can lead to skin, nerve, heart, and brain problems that is a complication associated with rheumatoid arthritis.
26. This disease is a form of arthritis characterized by high spiking fevers, salmon-coloured rashes and inflammation of the joints.
32. This gender gets rheumatoid arthritis more often than the other gender.
33. Is a type of arthritis caused by too much uric acid in the body that is not adequately flushed out by the kidneys.
34. A prolonged course of arthritis may result in extended periods of pain and suffering, reduced sleep, depression and unemployment, which add up to reduced quality of ________.
35. Increases the incidences of osteoarthritis.
Crossword Theme: Arthritis

To learn more about arthritis:

- Advisory on Lupus: http://www.cdho.org/Advisories/CDHO_Advisory_Lupus.pdf
- Advisory on Rheumatoid Arthritis: http://www.cdho.org/Advisories/CDHO_Advisory_Rheumatoid_Arthritis.pdf
- Arthritis Foundation: http://www.arthritis.org/
- Arthritis Society: http://www.arthritis.ca/
- Centers for Disease Control and Prevention: http://www.cdc.gov/arthritis/basics.htm
- World Health Organization: http://apps.who.int/iris/simple-search?query=arthrits%2C+lupus
  http://apps.who.int/iris/browse?type=mesh&authority=Arthritis%2C+Rheumatoid

The answers to this Crossword Puzzle will be posted on the last page of our March 2013 online issue of Milestones at www.cdho.org
In a hearing held on January 11, 2013, a Panel of the Discipline Committee found Ms. Piera Passaro guilty of professional misconduct in that she contravened or failed to maintain a standard of practice; falsified a record relating to her practice; signed or issued, in her professional capacity, a document that she knew or ought to have known contained a false or misleading statement; submitted an account or charge for services that she knew or ought to have known was false or misleading; acted disgracefully, dishonourably or unprofessionally, and engaged in conduct that was unbecoming a dental hygienist.

An Agreed Statement of Facts was filed with the Panel which included the facts that Ms. Passaro’s boyfriend had enrolled her as a beneficiary on his insurance benefit plan. It was agreed that Ms. Passaro submitted insurance claim forms for dental services for herself and her boyfriend, when those services were not provided. It was also agreed that the claim forms were not valid. The total amount of the claims submitted by Ms. Passaro was approximately $3,300.00. It was further agreed that Ms. Passaro forged her former boyfriend’s signature on a letter to the insurance provider to change his address to her own.

The parties filed a joint submission with respect to an appropriate penalty and costs order to be made in this case. The Panel carefully considered the Agreed Statement of Facts, the Joint Submission on Penalty and Costs, the case law cited, the oral submissions made and concluded that the proposed Order met the needs of this case and the principles appropriate to setting the penalty. Accordingly, the Panel accepted the joint submission and made the following Order:

1. That Ms. Passaro shall receive a reprimand, the fact of which shall be recorded on the public register of the College.

2. That the Registrar suspend Ms. Passaro’s certificate of registration for a period of twelve (12) weeks.

3. That the Registrar suspend six (6) weeks of the suspension ordered in paragraph 2 herein if Ms. Passaro paid the fine referred to in paragraph 4 herein within thirty (30) days of the date of the Discipline Committee’s Order. The suspension shall commence immediately following the order of the Discipline Committee and will continue until February 11, 2013, inclusively, and for two (2) additional weeks to commence on dates fixed by the Registrar. Ms. Passaro would be required to serve the remaining six (6) weeks of suspension only if she failed to pay the fine referred to in paragraph 4 herein within thirty (30) days of the date of the Order.

4. That Ms. Passaro pay a fine to the Minister of Finance in the amount of $400.00 to be paid within thirty (30) days from the date of the Order.

5. That the Registrar impose a specified term, condition and limitation on Ms. Passaro’s certificate of registration requiring her to successfully complete, in the opinion of the Registrar, the professional/problem-based ethics course “The ProBE Program”, in February 2013 or, if the course does not proceed in February, the next available course, at her own cost.

6. That Ms. Passaro sign an undertaking that she will not engage in any billing activity at her present or future place of employment for twelve (12) months from the date of the Order.

7. That Ms. Passaro pay costs to the College in the amount of $2,000.00 at the rate of $166.67 per month by way of post-dated cheques for eleven
Additionally, the Registrar was directed to impose a specified term, condition and limitation on Ms. Passaro’s certificate of registration requiring her to successfully complete the professional/problem-based ethics course “The ProBE Program”, at her own cost. The Panel is familiar with the program, which is an intervention program addressing ethical and boundary violations. It is the Panel’s expectation that the ProBE Program will serve to rehabilitate Ms. Passaro.

Ms. Passaro was ordered to pay $2000.00 toward the College’s costs of the investigation and hearing process, and to pay a fine of $400.00 to the Ministry of Finance. The Registrant’s certificate of registration would be suspended for a period of six (6) weeks, provided that she pay the fine to the Ministry of Finance within thirty (30) days of this Order. The suspension reflects the serious acts of professional misconduct committed by Ms. Passaro. She will have no income from the practice of dental hygiene during the period of suspension as well as having to pay a fine and costs. Registrants will note that the College will not tolerate acts of professional misconduct. It is the Panel’s belief that the penalty in its totality will act as both a general and specific deterrent.

The Panel considered the following mitigating factors in this case:

- Ms. Passaro had no prior record of professional misconduct
- There was an admission of professional misconduct by Ms. Passaro
- Ms. Passaro expressed remorse for her actions and was cooperative with the College
- Ms. Passaro has committed to reimburse the insurance company in full
- Her guilty plea spared the necessity of calling witnesses

The Panel reviewed penalties given in two (2) cases with aspects similar to those of Ms. Passaro’s case and was satisfied that the penalty was within the range of what is reasonable and appropriate.

At the conclusion of the Hearing, Ms. Passaro waived her right of appeal and the reprimand, as part of the penalty, was administered by the Panel.

RITA MAUREEN O’PHEE – 005513
City: Amherstburg

On October 25, 2012, the Inquiries, Complaints and Reports Committee referred Ms. Rita Maureen O’Phee to the Discipline Committee to hold a hearing relating to allegations that she contravened the Regulated Health Professions Act, 1991, the Dental Hygiene Act, 1991, or the regulations thereunder and engaged in conduct that was unbecoming a dental hygienist, was disgraceful, dishonourable or unprofessional in that she failed to reply appropriately to the College, and/or failed to comply with a direction of a Panel of the College.

A hearing respecting allegations against Ms. O’Phee was scheduled to be heard on March 18, 2013. However, as Ms. O’Phee signed an Undertaking agreeing to resign from the College and never to re-apply for registration as a dental hygienist in Ontario, a Panel of the Discipline Committee agreed to adjourn the disciplinary proceedings against her indefinitely.
## New Registrants


<table>
<thead>
<tr>
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## Authorized for Self-Initiation


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<tr>
<td>Akkbari, Marjan</td>
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<td>Aldeas, Amanda</td>
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**Note:** The text above is a partial listing of new registrants and authorized for self-initiation from November 13, 2012, to February 14, 2013. The full list is available in the PDF document.
Suspected/Revoked/Resigned Registrants

In accordance with section 24 of the Regulated Health Professions Act (Code), the following registrants have been suspected or revoked for non-payment of the annual renewal fee. These registrants were forwarded notice of the intention to suspend and provided with two months in which to pay the fee. If a registrant who has been suspected for non-payment does not reinstate her or his certificate of registration, that certificate is deemed to be revoked two years after the failure to pay the annual fee. Some registrants choose to resign from the College at renewal time.

Suspected for Non-Payment of Fees
February 19, 2013

Adamopoulos, Pety Panagiota 009329
Ahmed, Faizan 016150
Ali, Deeba Khanam 011453
Angeloeus, Alexandra 016094
Angle, Michlle 004642
Antonacc, Allison Margery 013646
Arora, Thiviya 011890
Asselin, Michel 006369
Atanasov, Andrea 011709
Aujla, Kiran 014725
Bahadir, Perihan 015313
Baron, Candace 015381
Baxter, Patti A. 008774
Becchi, Tanya 009831
Benjamin, Meriam 015494
Benincasa, Marisa 004897
Bompa-MacRae, Romana 005426
Breteron, Nancy 010944
Brodar, Sandy 007131

Brown, Katalin 013800
Burke, Nicole 011878
Buttery, Patricia 015370
Caburao, Iris Neenisa 012675
Casiraghi, Crystal Dawn 008983
Chambertin, Chelsea 012903
Chowns, Christine 015712
Cloutier, Stephanie 015325
Cosgrove, Matthew Charles 014888
Cote, Tracey Lee 003609
DaCosta, Karen Rose-Anne 006948
Dai, Shan D. 012726
DaSilva, Denise 015602
Dawson, Victoria Susan 008840
Dhupar, Anita 003621
Diamantini, Marlene Melinda 005871
Dickey, Mimi Teresa 009747
Dietrich, Robin 013476
Dinsmore, Emily 013884
Ducharme, Donnelynn 004223
Elsey, Ellen Marie 002744
Fairbairn, Melissa Susanne 011613
Fasken, Wendy Yvonne M 002908
Flemming, Shannon Erin 013674
Flintoff, Angie 013120
Forie, Natasha 013599
Freah, Julia 012478
Fung, Lisa 014779
Gagnon, Katia Anne 012538
Gauthier, Amanda 010037
Gauthier, Chantal Nathalie 005485
Gillespie, Michele 009315
Green, Christina 009099
Grenier, Simar 016195
Guay, Lucie 002387
Guye, Momar 008786
Ha-Vicky 014756
Halawah, Fatim Kadry 013520
Hedgepeth, Paula Nicole 009659
Hockley, Lindsey Erin 013559
Hussain, Syed Bashalath 014645
Igreda, Ledda 013568
Jacob Farb, Judith 003050
Jenkins, Cassie 010746
Johnson, Margo 007537
Johnston, Aleeya 016199
Jones, Heather 011063
Jung Rappaport, Yvonne Audrey 007090
Kais, Amanda Joy 015971
Khwaja, Rehan 015955
Klenke, Kaitlyn 015752
Klinghoffer, Sharon 001101
Knishko, Joely 001190
Kupila, Stephanie Maria Hazel 014226
Kwon, Jennifer (Hy-Eun) 013018
Laferriere, Louise 008212
Laferriere, Julie 011472
Lafrance, Esther 005236
Lafrance, Josee 011335
Lakhasssi, Amal 011728
Laljee, Natalie 015209
Lam, Sandy 014635
Law, Ginta Ada 002645
Le Dreux, Carolyn 011838
Levas, Camille 010674
Ly,Vu 016139
Marek, Dorothy Elaine 002016
Mares, Roxana 011379
Marleau, Josee Nicole 006899
Masoom, Ruba 014675
Masue, Louise 004683
Matecheskie, Cathy Ann Mae 014711
Maududi, Zarlechtte 014874
Mazanek, Shandel 016135
McAlpine, Alex 013995
March 2013 MILESTONES 29
2013 Revoked

Aminikoo, Reza
Ballantyne, Anne Elise
Bhody, Monica
Buenaustint, Leah Marie
Chung, Dao
Clinton, Lydia Jennie
Colledge, Connine
De Gonzalez, Stacie Anne
De Langy, Suzanne
Doumassis, Christina
Doyle, Sonya Helen
Eid, Antoine
Eskali, Hina
Fornese, Jennifer Ruthe
Flyn, Robyn Resha
Gauthier, Lynn
Grierson, Amanda Leigh
Hasan, Fatma
Hill, Rebecca Susan
Javier, Dexter
Jeyarajah, Geethavani
Jollimore, Alisia Elizabeth
Kadowaki, Karen
Knippel, Manon
Lam, Lisa
Lemieux-Pinsonneau, Penni-Lynn
Lewis, Melissa Susan
Li, Andrea
Madej, Pola
Mahabhi, Rohan
Mardette, Abby
Mark, Olivia
Martin, Sandra Kim
Matson, Kylee
McCruded-Crozier, Isabelle M
Mironescu, Cipriana Adelina
Mistry, Hiral
Ngoy, Tseiba
Pallies, Marisa
Patterson Reid, Krista Pauline
Pineo, Stephanie Nicole
Poulin, Sophie
Qurashi, Farhana
Raymer, Joanna Sandra M
Reis, Nancy
Richard, Tasha
Robitaille, Gilberte Cecile
Sbaraglia, Tresa
Sidhu, Gemma
Stremi, Lindy
Tanner, Shandie Lynn
Taylor, Robert James
Trotter, Allison Dawn
Turk, Lisa Erin
Turner, Tammy Lea
Veizer, Alicja Denise
Walach, Michael
Yasin, Muhammad Zahid
Yu, Sue
Zaid, Ghazala
Zaidel, Romy Gabrielle
Zewudia, Tsedale

Archibald, Terri Lyn
Arora, Neda
Avera, Merja Sultana
Backtash, Soraya
Banzonowski, Joanna Marlena
Barrett, Jane
Beach, Donna Lynn
Beaudry, Brenda Anne
Becher, Lindsay Marie
Benes, Leigh
Big, Barbara
Bova, Jennifer Rebecca
Bolusmjak, Lori
Boose, Celia Marie
Bor, Edith
Botts, Ashley Elizabeth Anne
Bowman, Ana Sofia
Brown, Carmen
Burnham, Sean
Burri, Amanda
Butera, Jessica
Cardier, Lianna Assunciao Oliveira
Chehkhunova, Tetyana
Chereshnevsky, Luba Maria
Chester, Gina Margaret
Chhotker, Josie
Chin, Colin
Chin, Teresa Pui Chun
Chokina, Evva
Cikalo, Veronica
Claus, Christina April
Claypack, Poutoula
Clifton, Katherine Elaine
Coban, Brandy Leah
Cormier, Caroline
Corner, Kathryn Elizabeth
Cruckshank, Sandy
Cuffie, Cathy
Daveiks, Kathleen A
de Jesus, David Theodore
Demaree, Karen Marie
DeMille, Linda Anne
Delor, Julie Ann
Devine, Barbara Jean
DeVries, Randy Joseph
Dias, Sarah Louise
Dietrich, Theressa Lee
Doyle, Amanda
Enns, Theresa Marie
Erdman, Hayley Rochelle
Eshcle, Mandy
Estrabillo, Ronelle
Ewart, Linda Ann
Ewen, Carolyn Anne
Fabjanczyk, Anna
Fahmi, Qalia Ramis
Felbel, Lynda Doris
Ferguson, Tracey Dawn
Floyd, Patricia
Frost, Barbara Joanne
Furtney, Kelly
Futtrup, Charlene
Gabouine, Jenna
Gaffney, Julie
Gailardez-Assunta
Garrett, Kayla Elizabeth
Gerber, Allison Jane
Getzaf, Ashley
Gibbons, Christy
Girard, Lisa
Gindwood, Corissa
Glos, Sol
Gomez Arbelaez, Luz Adriana
Goesein, Vanessa Arlene
Gowan, Marylee Diane
Gowan, Marylee Diane

Resigned


Abbott, Erin Elizabeth
Ahmedeeva, Kateryna
Allen, Ashley
Almeida-Cabera, Aurora
Al-Qubanchi, Saba Aladdin

Archibald, Terri Lyn
Arora, Neda
Avera, Merja Sultana
Backtash, Soraya
Banzonowski, Joanna Marlena
Barrett, Jane
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Gowan, Marylee Diane

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McVeenue, Kelly Maureen
McGee, Rachel Alexandra
McKerrall, Renee Lynn
McManus, Lynn Christine
Melo, Margo Ellen
Milburn, Heather Elizabeth
Mirza, Sumreen
Mohamed, Shabana
Mooney, Rachel Lynn
Nantais, Krisandra Marie
Nelson, Whitney
Nemes, Renata
Nezvorov, Sergei
Newman, Mandi Carolyn
Nguyen, Linda
Niazi, Atia
Nishimura, Kelly Michele
Nobileone, Roselyn
O’Donnell, Heather Anne
Olah, Gal
Oshan, Ru
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Patel, Kajal
Pazdruk, Sophie
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Peluffo, Carla
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Pettryshyn, Rachelle
Pickles, Kyla
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Pluviani, Daniela
Ponce, Celda
Prokopchuk, Joan
Pulendranarajah, Tharani
Pyra, Wioletta
Rappos, Joanne
Rashid, Mehwish Mohammed Abdul
Rezzaza, Habiba
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the College’s promise
to dental hygiene clients

You can expect to receive quality preventive oral hygiene care from health professionals who are registered with the College of Dental Hygienists of Ontario (CDHO).

how we keep this promise

✓ All dental hygienists must be registered with the CDHO to practise in Ontario.
✓ Only persons currently registered with the CDHO may use the title “dental hygienist” or any variety of translation of “dental hygienist” including the initials RDH (Registered Dental Hygienist).
✓ Every dental hygienist in the province must meet the CDHO’s entry-to-practice requirements.
✓ A list of currently registered dental hygienists is available to the public.
✓ The College provides Standards of Care and Practice Guidelines to guide dental hygienists and inform the public.
✓ The continuing competency of your dental hygienist is monitored and supported by the College throughout her/his professional career.
✓ Information about oral health and access to dental hygiene care is promoted to the public.
✓ A fair and transparent complaints process is available to help clients who feel they may not have received the care they had the right to expect.
✓ The College collaborates with the Ontario Government, other health Colleges and consumer groups to promote access to safe and effective oral health care.
Answers to Crossword Puzzle on Page 25

DMARD

XNS

HESY

RATEIRAN

SUCORTISONE

PARIMOSSDV

ETCDATITEHE

VHIOCTIC

ARONOIM

LOPPORTUNISTICSNL

ESARDAICMNN

CHLORHEXIDINE

PINOC

YCDKR

MILLIONT

VCCEI

ARTHROPLASTYEC

SIT

CLAUTOIMMUNES

ULOT

LSIMMUNOSUPPRESSION

IRGR

LOAI

OSTEOARTHRITISSJÖGREN

UFSDTE

TJMFINGERS