Royal College of
Dental Surgeons of Ontario

# 448th Meeting of Council

Vantage Venues, Garden Hall (16th Floor),
150 King Street West, Toronto

*(and via Zoom and Livestream via YouTube)*

## Thursday, March 27, 2025

# RCDSO STRATEGIC PLAN OVERVIEW: 2023-2025

## VISION

Everyone in Ontario has access to safe, high-quality oral health care.

## MISSION

We act in the public interest and are committed to excellence in regulating the dental profession in Ontario.

## VALUES

- ACCOUNTABLE
- COLLABORATIVE
- INNOVATIVE
- INCLUSIVE
- TRANSPARENT

## PILLARS

### PROFESSIONALISM

**STRATEGIC PROJECTS**

- College Standards
- Access to Care

### STAKEHOLDER ENGAGEMENT

**STRATEGIC PROJECTS**

- Service Experience
- Equity, Diversity and Inclusion

### EMERGING ISSUES

**STRATEGIC PROJECTS**

- Governance Review and Modernization
- Practice Models and Corporate Dentistry

## OUR COMMITMENT

- We take an evidence-informed approach to decision making.
- We apply a risk-based perspective in regulating the profession.
- We integrate the principles of Equity, Diversity and Inclusion in all we do.

RCDSO | Royal College of Dental Surgeons of Ontario

05/23_5417

CHECKLIST

# Engaging Council Members for Effective Governance

As a member of Council, I acknowledge my fiduciary duty to the College and the public interest and the statutes and rules that guide me. I am aware of my role and responsibilities, and that of the President and the Registrar. I also acknowledge that an effective governing body requires its members to fulfill behavioural expectations to each other. As a result, I will:

- [ ] Attend at least 75% of Council meetings
- [ ] Arrive so the meeting can start at the scheduled time
- [ ] Be fully prepared for Council meetings by reviewing materials in advance and considering all questions in briefing materials
- [ ] Participate by asking questions to clarify or challenge assumptions, sharing concerns and providing suggestions to meaningfully contribute to discussions and decisions
- [ ] Actively listen and engage in discussions at the Council table to promote transparency in our discussion and decisions
- [ ] Avoid distractions such as cell phones and side conversations during meetings
- [ ] Promote, welcome and value diverse perspectives in all discussions
- [ ] Be critical of issues where warranted, but not of people or their perspectives
- [ ] Be clear and concise in my contributions to topics in order to receive multiple perspectives
- [ ] Commit to Council decisions when the topic is closed and when I speak about decisions publicly
- [ ] Confine all substantive discussions to the meeting

Approved: June 16, 2022

CHECKLIST

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Approved: June 16, 2022

CHECKLIST

# Effective Staff-Council Relationships

As a member of **Council**, I acknowledge my duty to the College and the public interest and the statutes and rules that guide me. I am aware of my role and responsibilities and those of the President and the Registrar. I acknowledge that in order to be an effective governing body, Council and staff members will always interact with transparency and mutual respect. As a result, I will:

- Commit to a culture of community with common purpose which involves both Council knowing staff members(though we have but one employee, the Registrar & CEO) and staff members knowing Council members.
- Encourage a practice of mutual respect.
- Know that there is rigour and analysis in all materials provided to Council and Committees.
- Ask informed questions to deepen individual and broader understanding.
- Provide suggestions for clarity and to clarify assumptions.
- Deliver constructive and substantive comments about content.
- Collaborate effectively and welcome advice and suggestions.

As a member of **staff**, I acknowledge my duty to the College and the public interest and the statutes and rules that guide me. I am aware of my role and responsibilities; those of the President and the Registrar; and the decision-making powers of Council. I acknowledge that in order to be an effective governing body, Council and staff members will always interact with transparency and mutual respect. As a result, I will:

- Commit to a culture of community with common purpose which involves both Council knowing staff members (reporting through their employee, the Registrar & CEO) and staff members knowing Council members.
- Encourage a practice of mutual respect.
- Attend Council and Committee meetings, where appropriate.
- Provide clear, contextualized advice.
- Demonstrate rigour and analysis in all materials for Council and Committees.
- Identify problems early.
- Support principles of Equity, Diversity, and Inclusion through learning, openness, and respect in discussions.
- Be transparent about errors or omissions.
- Explain the wider context of regulation.
- Respond to Council direction, evaluating resources and best practices for implementation.
- Collaborate effectively and welcome advice and suggestions.

## SOURCES


Board-Trust-Toolkit-2021-ENG_2.pdf (icd.ca)
Board-Staff_Interaction-Acceptable-FAQ.pdf (boardsource.org)
How to Effectively Cultivate Board Roles and Responsibilities - NonProfit PRO
The Board - Staff Relationship - Governing Good
How to Connect With Your Board of Directors | The Muse

# LEXICON
## OF COMMONLY USED ACRONYMS

| | |
|---|---|
| **ACFD** | Association of Canadian Faculties of Dentistry |
| **ACLS** | Advanced Cardiac Life Support |
| **ADA** | American Dental Association |
| **ADBA** | American Dental Board of Anesthesiology |
| **ADR** | Alternate Dispute Resolution |
| **AED** | Automated External Defibrillator |
| **AFK** | Assessment of Fundamental Knowledge |
| **AGRE** | Advisory Group for Regulatory Excellence |
| **AI** | Artificial Intelligence |
| **AIT** | Agreement on Internal Trade |
| **AODA** | Accessibility for Ontarians with Disabilities Act |
| **APO** | Association of Prosthodontists of Ontario |
| **BLS** | Basic Life Support |
| **CAG** | Citizen Advisory Group |
| **CDA** | Canadian Dental Association |
| **CDAC** | Commission on Dental Accreditation in Canada |
| **CDCP** | Canadian Dental Care Plan |
| **CDHO** | College of Dental Hygienists of Ontario |
| **CDO** | College of Denturists of Ontario |
| **CDPA** | Canadian Dental Protective Association |
| **CDRAF** | Canadian Dental Regulatory Authorities Federation |
| **CDSPI** | Canadian Dental Service Plans Inc. |
| **CDTO** | College of Dental Technologists of Ontario |
| **CE** | Continuing Education |
| **CERP** | Continuing Education Recognition Program (ADA) |
| **CF** | Craniofacial CT (large field of view) |
| **CINOT** | Children in Need of Treatment |
| **CLEAR** | Council of Licensure, Enforcement and Regulation |
| **CNO** | College of Nurses of Ontario |
| **COA** | Certificate of Authorization |
| **CODE** | Health Professions Procedural Code |
| **COI** | Conflict of Interest |
| **Connect** | Town hall for RCDSO's members |
| **COS** | Certificate of Standing |
| **CPD** | Continuing Professional Development |
| **CPMF** | College Performance Measuring Framework |
| **CPR** | Cardiopulmonary Resuscitation |
| **CPSO** | College of Physicians and Surgeons of Ontario |
| **CQI** | Continuous Quality Improvement |
| **CT** | Computed Tomography |
| **DA/DV** | Dentoalveolar CT (small field of view) |
| **DDS** | Doctor of Dental Surgery |
| **DEI** | Diversity, Equity and Inclusion |
| **DMD** | Doctor of Medicine in Dentistry |
| **DRA** | Dental Regulatory Authority |
| **DG** | Deep Sedation and General Anesthesia |
| **DSA** | Data Sharing Agreement |
| **DSATP** | Dental Specialty Assessment Training Program |
| **DSCKE** | Dental Specialty Core Knowledge Examination |
| **DQ** | Data Quality |
| **EDC** | External Defense Counsel |
| **EDI** | Equity, Diversity and Inclusion |
| **EHR** | Electronic Health Record |
| **EIA** | Equity Impact Assessment |
| **EP** | Equivalency Program |
| **EXEC** | Executive Committee |
| **FARPA** | Fair Access to Regulated Professions Act |
| **FIP** | Facility Inspection Program |
| **FIPPA** | Freedom of Information and Protection of Privacy Act |
| **FNIHB** | First Nations and Inuit Health Branch |
| **FP** | Facility Permit |
| **GA** | General Anesthesia |
| **HARP** | Healing Arts Radiation Protection Act |
| **HC** | Health Canada |
| **HCCA** | Health Care Consent Act |
| **HCP** | Health Care Practitioner |
| **HPARB** | Health Professionals Appeal and Review Board |
| **HPC** | Health Profession Corporation |
| **HPDB** | Health Personnel Database |
| **HPPA** | Health Protection and Promotion Act |
| **HPPC** | Health Professions Procedural Code |
| **HPRA** | Health Professionals Regulations Act |
| **HPRAC** | Health Professions Regulatory Advisory Council |
| **HPRO** | Health Profession Regulators of Ontario |

| | |
|---|---|
| **HSIA** | Health System Improvements Act |
| **ICRC** | Inquiries, Complaints and Reports Committee |
| **ILC** | Independent Legal Counsel |
| **IPAC** | Infection Prevention and Control |
| **IPC** | Information Privacy Commissioner |
| **ITDAOC** | Internationally Trained Dentists Association of Canada |
| **J&E** | Jurisprudence and Ethics |
| **JDIMI** | Jones Deslauriers Insurance Management Inc. |
| **KPI** | Key Performance Indicator |
| **KSA** | Knowledge, Skills and Abilities |
| **L&L** | Legal and Legislation |
| **ML** | Machine Learning |
| **MOH** | Ministry of Health |
| **MOHLTC** | Ministry of Health and Long-Term Care |
| **MOU** | Memorandum of Understanding |
| **NCCPH** | National Collaborating Centres for Public Health |
| **NDAEB** | National Dental Assistant Examining Board |
| **NDEB** | National Dental Examining Board |
| **NIH** | National Institutes of Health |
| **NIHB** | Non-Insured Health Benefits |
| **NLP** | Natural Language Processing |
| **NMS** | Narcotics Monitoring System |
| **OAAG** | Oral Aesthetic Advocacy Group Inc |
| **OADS** | Ontario Association of Dental Specialists |
| **OAO** | Ontario Association of Orthodontists |
| **OAPHD** | Ontario Association of Public Health Dentistry |
| **OCP** | Ontario College of Pharmacists |
| **OCT** | Ontario College of Teachers |
| **ODA** | Ontario Dental Association |
| **ODAA** | Ontario Dental Assistants Association |
| **ODHA** | Ontario Dental Hygienists' Association |
| **ODSP** | Ontario Disability Support Program |
| **OECD** | Organization for Economic Co-operation and Development |
| **OFC** | Office of the Fairness Commissioner |
| **OISE** | Ontario Institute for Studies in Education |
| **OM** | Oral Moderate sedation |
| **OSE** | Ontario Society of Endodontists |
| **OSOMR** | Ontario Society of Oral and Maxillofacial Radiologists |
| **OSOMS** | Ontario Society of Oral and Maxillofacial Surgeons |
| **OSP** | Ontario Society of Periodontists |
| **OSPD** | Ontario Society of Paediatric Dentists |
| **OSPHD** | Ontario Society of Public Health Dentists |
| **OW** | Ontario Works |
| **P1** | Parenteral Conscious Sedation (1 drug) |
| **P2** | Parenteral Conscious Sedation (2 drugs) |
| **PCRA** | Professional Conduct and Regulatory Affairs |
| **PDCA** | Plan-Do-Check-Act |
| **PDSA** | Plan-Do-Study-Act |
| **PEAK** | Practice Enhancement And Knowledge |
| **PEC** | Practice Enhancement Consultant |
| **PET** | Practice Enhancement Tool |
| **PHC** | Pre-Hearing Conference |
| **PHI** | Personal Health Information |
| **PHIPA** | Personal Health Information Protection Act |
| **PHO** | Public Health Ontario |
| **PHU** | Public Health Unit |
| **PIPEDA** | Personal Information Protection and Electronic Documents Act |
| **PLP** | Professional Liability Program |
| **QA** | Quality Assurance |
| **QAC** | Quality Assurance Committee |
| **QI** | Quality Improvement |
| **QP** | Qualifying Program |
| **RCDC** | Royal College of Dentists of Canada |
| **RHPA** | Regulated Health Professions Act |
| **ROI** | Record of Investigation |
| **SA** | Sedation Authorization |
| **SATF** | Sexual Abuse Task Force |
| **SCERP** | Specified Continuing Education or Remediation Program |
| **SDM** | Substitute Decision Maker |
| **SIR** | Self-Insured Retention |
| **SLT** | Senior Leadership Team |
| **SME** | Subject Matter Expert |
| **SOP** | Standard Operating Procedure |
| **SOW** | Statement of Work |
| **SPEC** | Second Pair of Eyes Committee |
| **SPPA** | Statutory Powers Procedure Act |
| **SRBD** | Sleep-Related Breathing Disorders |
| **TCL** | Terms, Conditions and Limitations |
| **TMD** | Temporomandibular Disorders |
| **UWO** | Western University, London Ontario |
| **U of T** | University of Toronto |
| **WHMIS** | Workplace Hazardous Materials Information System |
| **WSIB** | Workplace Safety and Insurance Board of Ontario |

05/24_5587

# Council Member 2025 Annual Conflict of Interest Declaration Form Report - March 2025

In accordance with By-law 13, Council members are required to complete an online Annual Conflict of Interest Declaration Form. Council member forms are appended to Council meeting packages and available to the public. Council and Committee members are required to review all meeting materials in advance to identify conflicts and have an ongoing obligation to declare conflicts as situations arise. At the beginning of each Council meeting, members must declare any updates to their Form responses and any conflict specific to the meeting agenda.

| *Your name* | *Do you or a close family member (e.g., spouse) or close associate (e.g., business partner) stand to be affected financially by your participation in a College decision?* | *For example, please declare the following:- All paid or unpaid employment (e.g., work, consultancies, contracts, paid directorships other than your dental practice (for dentists))- Ownership or other financial interest in any corporation, company, consultancy or other business related to dentistry (see note at top of this page)- Provision of services to dentists (e.g., training, professional development)- Any business arrangements or contracts with the College* | *Do you have any competing interests that you wish to declare?* | *Please declare any membership in other professional bodies or associations (paid or voluntary) as well as other positions which have competing interests with the College.<br><br>Note: There is no issue with belonging to a professional association. We ask that you note it here in the interests of transparency.* | *Do you have any personal or professional relationships that you wish to declare?* | *Please declare the following:- Employment or position at an educational institution dentistry program.* | *Do you have any other conflicts that you wish to declare?* | *If you have further conflicts to declare, please provide details below.* | *I declare that the above information is true and accurate to the best of my knowledge.* | *Date survey completed* |
|---|---|---|---|---|---|---|---|---|---|---|
| Rod Stableforth | No | | No | | No | | No | | Yes | 3/14/2025 |
| Noha Gomaa | No | | No | | Yes | Noha Gomaa is a faculty member at the Schulich School of Medicine & Dentistry, Western University. She is a member of Canadian professional and dental associations including the Canadian Association for Dental Research and the Canadian Association for Public Health Dentistry. Her research at Western University is funded by the Canadian Institutes of Health Research, Colgate, and the Children's Health Foundation. | No | | Yes | 01/22/2025 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Osama Soliman | No | Toronto institute for dental excellence Ontario dental association Ontario dental implant network Nobel biocare Zimvie Straumann Stryker | No | Toronto institute for dental excellence Ontario dental association Ontario dental implant network Nobel biocare Zimvie Straumann Stryker | Yes | Toronto institute for dental excellence Ontario dental association Ontario dental implant network Nobel biocare Zimvie Straumann Stryker | No | | Yes | 01/22/2025 |
| Erin Walker | No | | No | Ontario Dental Association - Member Waterloo Wellington Dental Society - Member Stratford District Dental Society - Member | No | | No | | Yes | 01/22/2025 |
| Peter Delean | No | | Yes | Member of the Canadian Dental Association Member of Ontario Dental Association Member of the North Bay and District Dental Society | No | | No | | Yes | 01/21/2025 |
| Judith Ann Welikovitch | No | | No | Member, Law Society of Ontario President and Board Chair, Geneva Centre for Autism Member, Institute of Corporate Direxors | No | | No | | Yes | 01/21/2025 |
| Antony Liscio | No | | No | | No | | No | | No | 01/21/2025 |
| DANIEL FORTINO | No | | No | Ontario Dental Association Canadian Academy of Periodontology Ontario Society of Periodontists American Academy of Periodontology | No | | No | | Yes | 01/21/2025 |
| Nizar Ladak | No | | No | | No | | No | | Yes | 01/21/2025 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Anthony Mair | No | Shareholder in Corus Orthodontists | Yes | Memberships : Ontario Dental Association. (ODA) ; Ontario, Canadian, and American Associations of Orthodontists (OAO, CAO, AAO) | Yes | Clinical Associate, University of Toronto - Graduate Orthodontics Adjust Professor, Western University - Graduate Orthodontics | No | | Yes | 01/21/2025 |
| Ram Chopra | No | | No | | No | | No | | Yes | 01/21/2025 |
| Jamie Colliver | No | | No | | No | | No | | Yes | 01/21/2025 |
| Vivian Hu | No | | No | | No | | No | | Yes | 01/21/2025 |
| Nalin Bhargava | No | | Yes | Canadian Dental Association, Ontario Dental Association, Ottawa Dental Society | No | | No | | Yes | 01/20/2025 |
| Daniel Haas | No | | Yes | I am a member of several professional bodies, including: Ontario Dental Association, Canadian Dental Association, Royal College of Dentists of Canada, Canadian Academy of Dental Anaesthesia, American Society of Dentist Anesthesiologists, American Dental Society of Anesthesiology, American College of Dentists, International College of Dentists, Pierre Fauchard Academy. | Yes | Professor, University of Toronto | No | | Yes | 01/20/2025 |
| Eleonora Fisher | No | N/A | No | LSO CPD LEGAL | No | N/A | No | | Yes | 01/20/2025 |
| Brian Smith | No | | No | | No | | No | | Yes | 01/20/2025 |
| Robyn Somerville | No | | No | | No | | No | | Yes | 01/20/2025 |
| Eilyad Honarparvar | No | | No | | No | | No | | Yes | 01/20/2025 |
| Cristina Ng Cordeiro | No | | No | | No | | No | | Yes | 01/19/2025 |
| Deborah Wilson | No | | No | | No | | No | | Yes | 01/18/2025 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Neil Gajjar | Yes | I teach CPR to dentists and staff. | Yes | Member of the Academy of General Dentistry Member of the Ontario Dental Association Member of the Canadian Dental Association Member of the International College of Dentists Member of the Academy of Dentistry International Member of the American College of Dentists Member of the Pierre Fauchard Academy. | No | | No | | Yes | 01/16/2025 |
| Harinder Sandhu | No | | No | | Yes | Schulich Dentistry, Adjunct Professor | No | | Yes | 01/15/2025 |
| MARC TRUDELL | No | | No | | Yes | In 2022, the firm Colliers International was retained by the College to assist and provide guidance to the College in matters pertaining to the current and future ownership of the property which the College owns and occupies at 6 Crescent Road, Toronto, Ontario. Colliers continues to assist the College on this matter, on an as required basis. On June 3rd, 2024, it was announced that Colliers had acquired a majority interest in Englobe Corp., being a consulting engineering firm in which I am a shareholder and serve as Vice-President, Corporate Development. Englobe operates as a separate (arms-length) organization distinct from Colliers and the work completed to-date by Colliers for the College has not involved Englobe or myself. | No | | Yes | 01/15/2025 |

| ***All above noted Council members reviewed and confirmed the following statements:*** |
|---|
| I understand the by-laws pertaining to conflict of interest and I understand my fiduciary duty to carry out my responsibilities in a manner that serves and protects the public interest, and to maintain the trust and confidence of the public in the College's decision-making processes. As such, I must not engage in or be perceived to have engaged in any activities or in decision-making concerning any matters where I have a direct or indirect personal, professional or financial interest while performing my College duties and responsibilities, and I will be obliged to avoid and/or manage situations which involve any actual or perceived conflict of interest. |

| |
|---|
| I understand that as a Council and/or Committee member I shall complete an Annual Conflict of Interest Declaration Form, and keep my Conflict of Interest Declaration Form updated by completing and re-submitting to the Registrar if any matter gives rise to a conflict throughout the year. |
| I understand that declaring other conflicts of interest or perceived/actual bias in respect of matters or persons that appear in Council or Committee agendas as matters arise is my ongoing obligation as a Council or Committee member and that the matters and relationships set out in this declaration are not exhaustive. |
| I have familiarized myself with By-law 13 which sets out more full definitions of conflict of interest and related persons and I will declare such conflicts if and when they arise in accordance with the process set by the College. |

Royal College of
Dental Surgeons of Ontario

# AGENDA

## 448th MEETING – RCDSO COUNCIL

Vantage Venues, Garden Hall (16th Floor),150 King Street West, Toronto, ON

**Thursday, March 27, 2025 – 9:00 a.m. – 4:15 p.m.**

| Item | Time | Topic and Objective(s) | Purpose | Page No. |
|---|---|---|---|---|
| 1. | 9:00 a.m. | Call to Order & Land Acknowledgement | Discussion | |
| 2. | | Roll Call | | |
| 3. | 9:05 a.m. | President's Remarks | Discussion | |
| 4. | | Declaration of Conflict of Interest<br>• Conflict of Interest Declaration Forms | | 9-13 |
| 5. | 9:10 a.m. | Consent Agenda:<br>5.1 Approval of Agenda<br>5.2 Approval of RCDSO Council Meeting Minutes, January 23, 2025<br>5.3 Council Evaluation Survey Results, January 23, 2025<br>5.4 Registrar & CEO Report<br>5.5 RCDSO Council Work Plan 2025<br>5.6 Financial Update<br>5.7 RCDSO Strategic Plan 2023-25<br>5.8 Policy Report | Approval (Motion) | 14-16<br>17-46<br>47-49<br>50-69<br>70<br>71-73<br>74-98<br>99-102 |
| 6. | 9:15 a.m. | Registrar and CEO's Remarks | Discussion | |

| | | | | |
|---|---|---|---|---|
| 7. | 9:35 a.m. | **Presentation**:<br>(*Deni Ogunrinde, Policy Analyst*)<br><br>Practice Models & Corporate Dentistry | Discussion | 103-127 |
| 8. | 10:15 a.m. | Registration Regulation | Decision | 128-155 |
| | 10:45 a.m. | **B R E A K** | | |
| 9. | 11:00 a.m. | *In-Camera* Business | | |
| | 12:30 p.m. | **L U N C H** | | |
| 10. | 1:30 p.m. | **Presentation:**<br>Voice of the Patient – Public Polling Results<br>*(Pivotal Research)* | Discussion | 156-185 |
| 11. | 2:05 p.m. | Foundations of Professionalism<br>• Draft document | Decision | 186-201 |
| 12. | 2:35 p.m. | Draft Guidance<br>• Artificial Intelligence in Dentistry | Decision | 202-214 |
| | 3:05 p.m. | **B R E A K** | | |
| 13. | 3:20 p.m. | Professional Liability Program Chair Appointment | Decision | 215-218 |
| 14. | 3:25 p.m. | Draft Standard of Practice<br>• Prevention of Boundary Violations and Sexual Abuse | Decision | 219-236 |
| 15. | 3:45 p.m. | Draft Standard of Practice<br>• Consent to Treatment | Decision | 237-252 |
| 16. | 4:05 p.m. | Other Business | | |

| | | | | |
|---|---|---|---|---|
| 17. | | Date of Next Council Meeting:<br>• Thursday, June 19, 2025<br>*(Virtual)* | | |
| 18. | 4:15 p.m. | Adjournment | | |

# MINUTES OF THE 447th MEETING OF COUNCIL

**January 23, 2025**

**Vantage Venues, 150 King St W., Garden Hall, Toronto, ON and via Zoom and live-streamed via YouTube**

The 447th Meeting of the Council of the Royal College of Dental Surgeons of Ontario was held on Thursday, January 23, 2025.

Attendance:

**Chair**
Daniel Faulkner/Hanno Weinberger

**Council member**

*Elected Representatives:*

| | |
|---|---|
| Nalin Bhargava | District 1 |
| *Robyn Somerville | District 2 |
| *Peter Delean | District 3 |
| Neil Gajjar | District 4 |
| Daniel Fortino | District 5 |
| Harinder Sandhu | District 6 |
| Erin Walker | District 7 |
| Osama Soliman | District 8 |
| Antony Liscio | District 9 |
| Deborah Wilson | District 10 |
| Eilyad Honarparvar | District 11 |
| Anthony Mair | District 12 (left meeting at 2:30 p.m.) |

*University Representatives:*
Daniel Haas, University of Toronto
Noha Gomaa, Western University

*Lieutenant- Governor- in- Council Representatives:*
Ram Chopra
James Colliver
*Cristina Cordeiro
*Eleonora Fisher
Vivian Hu
Brian Smith
Marc Trudell
*Judith Welikovitch

*General Legal Counsel:*
*Alan Bromstein

*Registrar & CEO:*
Daniel Faulkner

*Regrets:*
Roderick Stableforth

*Attended the meeting virtually.

## 1. CALL TO ORDER AND LAND ACKNOWLEDGEMENT

D. Faulkner called the meeting to order at 8:30 a.m. He explained that under the College by-laws, the Registrar is required to act as Interim Presiding Chair to call the meeting to order and oversee the election. He advised that H. Weinberger would chair the remainder of the meeting.

D. Faulkner welcomed Council members, staff and guests to the meeting and all those watching the meeting via YouTube. He offered a Land Acknowledgement by recognizing the traditional lands of Indigenous peoples in Ontario.

He reported that David Bishop, a recently retired public member of Council, passed away recently after a long illness. D. Bishop joined the RCDSO Council in 2019. The College offered condolences to the family.

## 2. REPORT ON 2024 ELECTIONS TO RCDSO COUNCIL

D. Faulkner presented the report and results of the 2024 Council elections, including elected members, public member appointments and university-selected members in accordance with College by-laws. He reported that there were no requests for a recount of votes.

The RCDSO's newly constituted Council for 2025-2027 is comprised of the following elected, public and selected members:

| | |
|---|---|
| Nalin Bhargava | District 1 |
| Robyn Somerville | District 2 |
| Peter Delean | District 3 |
| Neil Gajjar | District 4 |
| Daniel Fortino | District 5 |
| Harinder Sandhu | District 6 |
| Erin Walker | District 7 |
| Osama Soliman | District 8 |
| Antony Liscio | District 9 |
| Deborah Wilson | District 10 |
| Eilyad Honarparvar | District 11 |
| Anthony Mair | District 12 |
| Ram Chopra | Public Member |
| James Colliver | Public Member |
| Cristina Cordeiro | Public Member |
| Eleonora Fisher | Public Member |
| Vivian Hu | Public Member |
| Nizar Ladak | Public Member |
| Brian Smith | Public Member |
| Roderick Stableforth | Public Member |
| Marc Trudell | Public Member |
| Judith Welikovitch | Public Member |
| Noha Gomaa | Western University |
| Daniel Haas | University of Toronto |

D. Faulkner welcomed the three new Council members and presented them each with a Council lapel pin: Daniel Fortino, Neil Gajjar and Eilyad Honarparvar.

## 3. ROLL CALL

D. Faulkner conducted the roll call.

## 4. DECLARATION OF CONFLICT OF INTEREST

There were no conflicts of interest declared on the agenda items for this meeting.

## 5. CONSENT AGENDA

There were two items in the Consent Agenda for approval, the draft minutes of the Council meeting of December 5, 2024 and evaluation survey results of the Council

meeting of December 5, 2024. Council approved the items in the consent agenda, as circulated.

**MOTION 1#:**

**Moved by:** **N. Bhargava**
**Seconded by:** **E. Fisher**

**THAT the following items be approved and/or received for information by Council:**

1. **Approval of RCDSO Council meeting minutes, December 5, 2024**
2. **Council Evaluation Survey Results, December 5, 2024**

**CARRIED**
*(Unanimously)*

## 6. REGISTRAR AND CEO'S REMARKS

D. Faulkner explained that the election and the voting would take place using Zoom and would be the same experience for those in attendance in-person and those attending virtually. He explained the voting procedure for each position.

## 7. APPOINTMENT OF SCRUTINEERS/RETURNING OFFICERS

D. Faulkner recommended Dayna Simon and Jeffrey Gullberg as scrutineers/returning officers for the election of the Executive Committee. He advised that they would supervise the e-voting, receive the vote count and results of the election, and then report to him as Registrar. He would in turn report to Council.

**MOTION #2:**

**Moved by:** **A. Liscio**
**Seconded by:** **R. Somerville**

**THAT the scrutineers/returning officers for the election of the Executive Committee of January 23, 2025 be Dayna Simon and Jeffrey Gullberg.**

**CARRIED**
*(Unanimously)*

## 8. ELECTION OF EXECUTIVE COMMITTEE

D. Faulkner reported that there were five positions for election to the Executive Committee that would be conducted by confidential Zoom poll. The five positions

were President, Vice-President and three other positions. The composition of the Executive Committee should include three dentist members and two public members of Council. He added that there would be five separate elections, one for each position.

(a) President

D. Faulkner reported that he received one self-nomination prior to the meeting from H. Sandhu for the position of President. H. Sandhu confirmed that he wished to let his name stand.

There were no other self-nominations or nominations from the floor for the position and H. Sandhu was elected as President by acclamation. H. Sandhu thanked Council for its support.

(b) Vice-President

D. Faulkner reported that he received three self-nominations prior to the meeting for the position of Vice-President: N. Bhargava, A. Liscio and M. Trudell. There were no other self-nominations or nominations from the floor.

Each candidate, in alphabetical order, was given the opportunity to address Council and the first ballot was cast.

The member with the least number of votes was removed from the ballot (A. Liscio) and a second ballot was cast to vote for N. Bhargava or M. Trudell.

N. Bhargava was elected and congratulated as Vice-President. N. Bhargava thanked Council.

(c) Dentist Member – 3rd position

D. Faulkner reported that he received two self-nominations prior to the meeting for the third dentist member position: A. Liscio and E. Walker. A. Liscio withdrew his name. There were no other self-nominations or nominations from the floor and E. Walker was elected to the third dentist member position by acclamation.

E. Walker thanked Council.

(d) Public Member – 4th Position

D. Faulkner reported that he received three self-nominations prior to the meeting for the first public member position: N. Ladak, B. Smith and M. Trudell. There were no other self-nominations or nominations from the floor.

Each candidate, in alphabetical order, was given the opportunity to give a speech and the first ballot was cast.

M. Trudell was elected and congratulated as the first public member position.

(e) Public Member – 5th Position

N. Ladak and B. Smith confirmed they wished to run for the position of the second public member position and the ballot was cast. B. Smith was elected to the position of second public member.

D. Faulkner congratulated the newly-elected Executive Committee for the 2025-2027 term:

| | |
|---|---|
| President: | H. Sandhu |
| Vice-President: | N. Bhargava |
| Dentist Member: | E. Walker |
| Public Member (1): | B. Smith |
| Public Member (2): | M. Trudell |

## 9. APPOINTMENT OF RCDSO REPRESENTATIVE TO THE NATIONAL DENTAL EXAMINING BOARD OF CANADA (NDEB)

The Chair reported that the NDEB develops and administers examinations to confirm that individuals who apply for registration as dentists have met the national standard. In April 2023, Council appointed Dr. Noha Gomaa as the RCDSO's representative to the NDEB Board. Council was asked to reappoint N. Gomaa to continue as the RCDSO representative on the NDEB Board for the 2025-2027 term of Council.

**MOTION #3:**

**Moved by:** **A. Liscio**
**Seconded by:** **H. Sandhu**

**THAT Council approves the nomination of Noha Gomaa to represent the RCDSO at The National Dental Examining Board of Canada (NDEB).**

**CARRIED**

## 10. COUNCIL STRATEGIC PLANNING MEETING

D. Faulkner reported on planning for the next strategic plan. He advised that Council is updated on each Council meeting on progress on strategic projects.

He added that there are many changes in the regulatory environment and delivery

of oral health care. An in-person Retreat is being planned for Council to understand how oral health care delivery will change in the coming years and develop a foundational vision for our next strategic plan to address those changes. He reported that the Retreat is planned for June, with final dates to be confirmed. Staff are in discussions with facilitators for the event and it is anticipated that all members of Council will be interviewed to gain their perspectives on oral health care delivery in the future.

H. Sandhu emphasized the importance of as many Council members as possible to attend the Retreat. He asked them to make themselves available unless it is impractical to do so.

## 11. ORIENTATION FOR COUNCIL MEMBERS

Following the morning break, there were two orientation closed sessions for Council members. Live-streaming to the public was paused for these sessions.

## 12. BY-LAW AMENDMENT: FINANCE, AUDIT AND RISK COMMITTEE COMPOSITION

Council re-convened at 2:00 PM. A. Coghlan, Chair of the Governance Committee, reported that the Governance Committee met on December 17, 2024 to complete its task of populating committees and committee chairs to prepare a slate of committees for Council's consideration. She added that the Governance Committee bases its recommendation for committee appointments on several factors, including skills and experience to align with the committee's competency requirements, diversity and representation, diversity of practice areas and succession planning.

A. Coghlan reported that the current composition of the Finance, Audit and Risk (FAR) Committee consists of:

- The President;
- two (2) members of Council who are members of the College;
- two (2) public members of Council; and
- one (1) non-Council committee member

The Governance Committee recommended to Council that the composition of the Finance, Audit and Risk (FAR) Committee be amended to include an additional non-Council committee member in order to enable greater diversity of perspective on the committee. To that end, it recommended a proposed amendment to By-Law 4 to effect this change.

A. Coghlan added that if approved, this by-law amendment would take effect immediately to support the committee appointments for the 2025-2027 term of Council.

**MOTION #4:**

**Moved by:** **j. Welikovitch**
**Seconded by:** **C. Cordeiro**

**THAT Council approves an amendment to By-Law 4 (Article 4.11.1) to add one additional non-Council committee member to the composition of the Finance, Audit and Risk Committee, as set out in Appendix A of the Council resources, commencing when the committees are appointed in January 2025, to read:**

**"The Finance Audit and Risk Committee shall be composed of the following members:**

**a. The President**
**b. at least two (2) members of Council who are members of the College;**
**c. at least two (2) public members of Council; and**
**d. two (2) non-Council committee members."**

**CARRIED**
*(Abstention: 1)*

## 13. SLATE OF RCDSO COMMITTEES 2025-2027

A. Coghlan presented the slate of committees on behalf of the Governance Committee. The slate was circulated to Council members in advance of this discussion.

A. Coghlan reported on the process followed by the Governance Committee to appoint the committees and committee chairs. She noted that there was significant interest received for non-Council committee member positions. The Governance Committee finalized the slate of committees following the election of the Executive Committee earlier in the meeting.

The Governance Committee considered many factors in its deliberation to ensure effective working of all College committees. It took into account the Terms of Reference and competencies, together with diversity of perspectives of committees. The Governance Committee also considered staff recommendations and member preferences of committees. She noted that where there were several committee preferences selected, it attempted to satisfy one of them.

There were exceptional circumstances for members of the Executive Committee and Governance Committee who were appointed committee chairs due to their expertise and to enable business continuity. Some public members were appointed to several committees because of legislative requirements and their availability to serve.

A. Coghlan asked Council to approve the slate of committees that would be posted on the College's website.

R. Somerville asked if it was possible for her to remain on the Registration Committee. D. Faulkner reminded Council of the process used and general principles followed by the Governance Committee to appoint committee members, as described by the Chair of the Governance Committee, A. Coghlan.

**MOTION #5:**

**Moved by:** **V. Hu**
**Seconded by:** **C. Cordeiro**

**THAT Council approves the slate of committee members for the 2025-2027 term of Council, as circulated by the Governance Committee.**

**CARRIED**
*(Opposed: 1)*

## 14. REGISTRATION REGULATION: PROFESSIONAL LIABILITY PROTECTION

The Chair reminded Council that a procurement process to transfer the Professional Liability Program (PLP) to a third party is underway.

Hilary Bauer, Manager of Registration, and Margo Orchard, Project Manager supporting the College for the PLP divestment process, gave a presentation (**APPENDIX A**) to review the proposed amendments to the Registration Regulation for approval, in principle, and provide direction to circulate to members and stakeholders for consultation.

M. Orchard reported that in 2013, the Honourable Deb Matthews, Ontario Minister of Health and Long-Term Care, issued a directive to all Councils of health regulators in Ontario to ensure that malpractice insurance was in place. At that time, the RCDSO did not need to take any action as the Professional Liability Program was in place to cover all members.

Once the RCDSO no longer owns and operates PLP, the College will need to identify a way to ensure that all registrants have coverage, that the amount of coverage is adequate, and that the tools are in place to act if registrants do not have coverage. M. Orchard stated that members would continue to have insurance coverage during the transition period.

She advised that there will be regulatory amendments required to ensure that members have adequate insurance coverage by:

(a) making professional liability protection a registration requirement;

(b) establishing an ongoing obligation to maintain professional liability protection; and
(c) providing a mechanism for the College to respond if protection is not maintained by members.

M. Orchard reviewed the proposed amendments to the Registration Regulation with reasons and rationale. She added that these proposed amendments would also be complemented by a set of by-laws that would be brought to Council for approval later in 2025.

A member wishing to register as a dentist will need to show proof of professional liability protection. All members' certificates of registration will be subject to a Term, Condition and Limitation requiring the member to maintain professional liability protection in order to practice.

M. Orchard reported on amendments to the suspension provisions of the regulation that would allow the College to enforce the requirements of professional liability protection. The Registrar would be able to lift the suspension immediately upon being provided with proof that the necessary requirements have been met.

H. Bauer reported that staff have taken the opportunity to propose some additional changes to the registration regulation in order to streamline registration processes that includes:

- Work authorization requirements: introducing a mechanism to ensure that dentists cannot practice without appropriate work authorization once registered.
- Continuous practice requirements: amendments to streamline the process of allowing dentists to work in Ontario after a period of time out of practice.
- Adding additional exclusions to the reinstatement provisions to enhance public protection.

The Chair noted a minor revision in the proposed amendment to the Registration Regulation that was circulated to Council. The revision was that the final three words in "Reinstatement on Application" section 30(3)(i) should be removed:

(i) was charged or found guilty of any criminal offence in any jurisdiction ~~of any offence~~;

He advised that the revised version would be posted on the College website for consultation.

Next Steps

With approval, in principle, from Council, the proposed Registration Regulation amendments would be circulated for a 60-day consultation period. A summary of the feedback received would be provided to Council at its meeting on March 27, 2025 for consideration and final approval then submitted to the Ministry of Health to review and approve.

H. Bauer reported that it is anticipated this Regulation will be in place by the end of 2025. College staff are working with Ministry staff to expedite the regulation amendments as early as possible.

A Council member raised a question regarding the continuous practice provisions under the National Dental Specialty Examination (NDSE) and that it does not capture all dental specialties, specifically dental anaesthesia. H. Bauer confirmed that the intention in the Regulation is that it is NDSE or equivalent, but it was inadvertently omitted from the rationale in the resource materials.

**MOTION #6:**

**Moved by:** **R. Chopra**
**Seconded by:** **B. Smith**

**THAT Council approves the Regulation amendment, attached as Appendix A (as amended) in principle, and directs that it be released for a 60-day public consultation period.**

**CARRIED**
*(Unanimously)*

## 15. NEXT MEETING

The Chair advised that the next meeting of RCDSO Council will be held on Thursday, March 27, 2025 at Vantage Venues, 150 King Street West, Toronto. It will be a hybrid meeting and live-streamed.

An education session for Council members will be held virtually on Friday, February 28, 2025. This session will not be live-streamed.

## 16. ADJOURNMENT

The Chair reported that the public meeting was adjourned and live-streaming ended. Following a short break, Council and staff attended an orientation closed session. The Chair advised that Council only would continue to meet *in-camera* following the orientation session at 4:40 p.m.

**MOTION #7:**

**Moved by:** **A. Liscio**
**Seconded by:** **J. Colliver**

**THAT the public be excluded from the meeting of Council pursuant to clause 7(2)(f) in that financial or personal or other matters may be disclosed of such a nature that the harm created by the disclosure would outweigh the desirability of adhering to the principle that meetings be open to the public.**

**CARRIED**
*(Unanimously)*

## 17. ADJOURNMENT

There being no further business, the meeting was adjourned at 5:30 p.m.

**CARRIED**
*(Unanimously)*

SIGNED: _____
Signature of President

_____
Signature of Recording Officer

_____
Date

Royal College of
Dental Surgeons of Ontario

# ACTION ITEM FOLLOW-UP: RCDSO COUNCIL

Date: January 23, 2025

| ITEM | RESPONSIBILITY | ACTION | STATUS |
|---|---|---|---|
| 1. Council evaluation | Angie Sherban | Send survey to Council | Sent, Jan 23, 2025 |
| 2. Minutes of December 5, 2024 meeting | Angie Sherban/ Communications | Post on website | Completed, Feb 03, 2025 |
| 3. RCDSO Committees 2025-2027 | Communications | Update College website with committee composition | Completed, Jan 24, 2025 |
| 4. Finance, Audit & Risk (FAR) Committee | Mark Edelstein | Amend By-Law 4 (Article 4.11.1) to add an additional NCCM to FAR | Completed, Jan 23, 2025 |
| 5. Registration Regulation | Communications | Post Registration Regulation for 60-day consultation | Completed, Jan 25, 2025 |

# Registration Regulation Amendments
## (Professional liability protection)

January 2025

Royal College of
Dental Surgeons of Ontario

# Purpose of today's discussion

- Discuss the current status of the PLP divestiture and the need for regulatory amendments
- Review proposed regulation changes
- Consider motion for approval to post for public consultation

# Professional liability protection is required of all regulated health professionals

- Professional liability protection provides patients with access to appropriate compensation, if they experience harm or injury related to professional services.
- 2013: Minister’s Directive - All Councils must put requirements in place to ensure professional liability protection is mandatory in all settings for all practicing members.
- While the College oversees the PLP, there is assurance that liability protection requirements are met.

# Current state: Preparing for divestment

- 2023 (Dec): Council directed RCDSO staff to explore the option of divesting the PLP.
- 2025: Divestment to a third party is expected.
- Once the transition is in place, alternative approaches need to be used to ensure all registrants have coverage.

# Ensuring registrants have coverage

- Regulatory amendments are required to:

1. Make professional liability protection a registration requirement
2. Establish an ongoing obligation to maintain professional liability protection
3. Provide a mechanism for the College to respond if protection is not maintained

# Overview of proposed changes

# Amendments related to professional liability protection

- The proposed amendments establish the requirement that:
  - All members have professional liability protection as a basic condition of registration
  - All members' certificates of registration will be subject to a Term, Condition and Limitation (TCL), requiring that the member maintain professional liability protection in order to practice

# Amendments: applying a “right-touch” approach to suspension

- Amendments to the suspension provisions are also being suggested, to allow the College to enforce the requirements.
- "Right-touch" approach allows Registrar to lift the suspension, “over-the-counter,” once requirements are met.
- Public protection maintained at all times, due to the TCL that prohibits member to practice without professional liability protection.

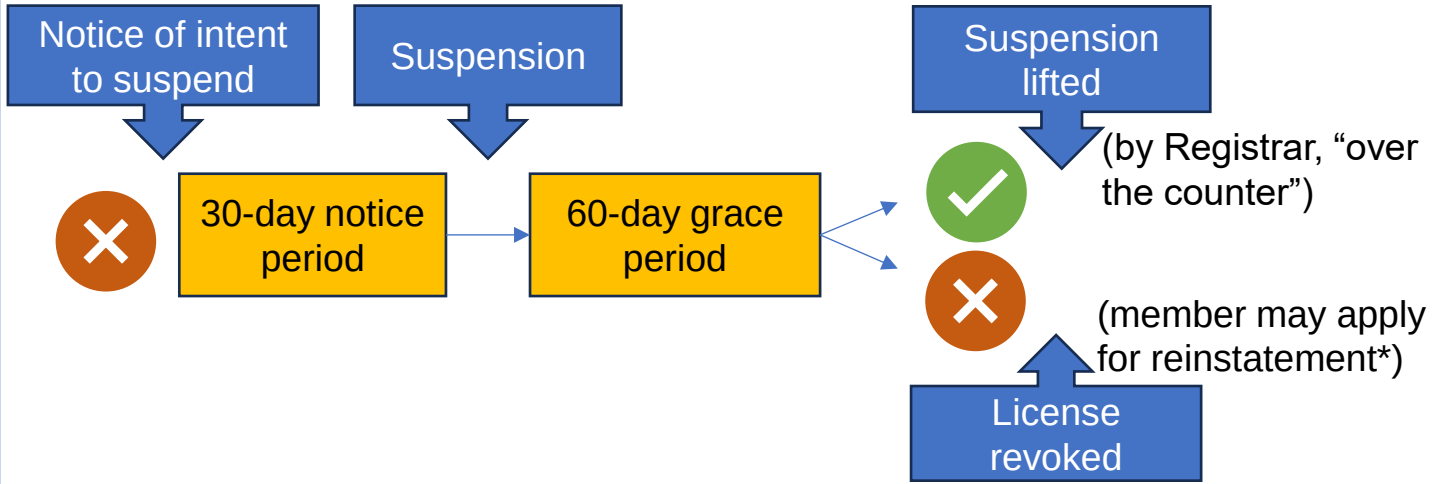
# Changes to the suspension process

Under the current regulation, when members are suspended for non-payment of fees, they must <u>apply</u> to get their license reinstated. The proposed changes allow the suspension to be lifted automatically, eliminating the need to go through the reinstatement process.

= compliant

- Pay annual renewal fees
- Provide the required information about plp
- Provide evidence of plp when requested by the College

<u>If non-compliant:</u>




*Amendments broaden exclusions for reinstatement to enhance public protection

# Additional amendments, beyond PLP

# Additional amendments

1. **Reinstatement provisions**: broaden exclusions to enhance public protection
2. **Work authorization**:  mechanism to ensure that dentists cannot practice without appropriate work authorization once registered.
3. **Continuous practice**: amendments to reduce barriers and streamline the process of allowing dentists to work in Ontario after a period of time out of practice.

# Work authorization

work authorization is an existing registration requirement for all classes

- **Goal**: ensure that dentists cannot practice without appropriate work authorization
- Amendment will achieve this by:
  - Subjecting all certificates of registration to a term, condition and limitation (TCL) requiring registrants to maintain appropriate work authorization while practicing

→ Right-touch approach

→ Consistent with approach taken by other Colleges

# Continuous Practice

- **Goal**: remove unnecessary barriers for dentists who have recently been in practice or recently demonstrated competence through licensing exams
- Amendments will achieve this by:
  - Recognizing continuous practice from jurisdictions where practice is comparable
  - Focusing only on recent gaps in practice (preceding 3 years)
  - Permitting specialty applicants who have recently completed the NDSE to be registered without referral to the registration committee

# Next steps

# Next steps

- Amendments circulated for required 60-day consultation
- Summary of feedback and recommended changes brought to Council for final approval in March
- Staff submit regulation amendment package to Ministry for review and approval

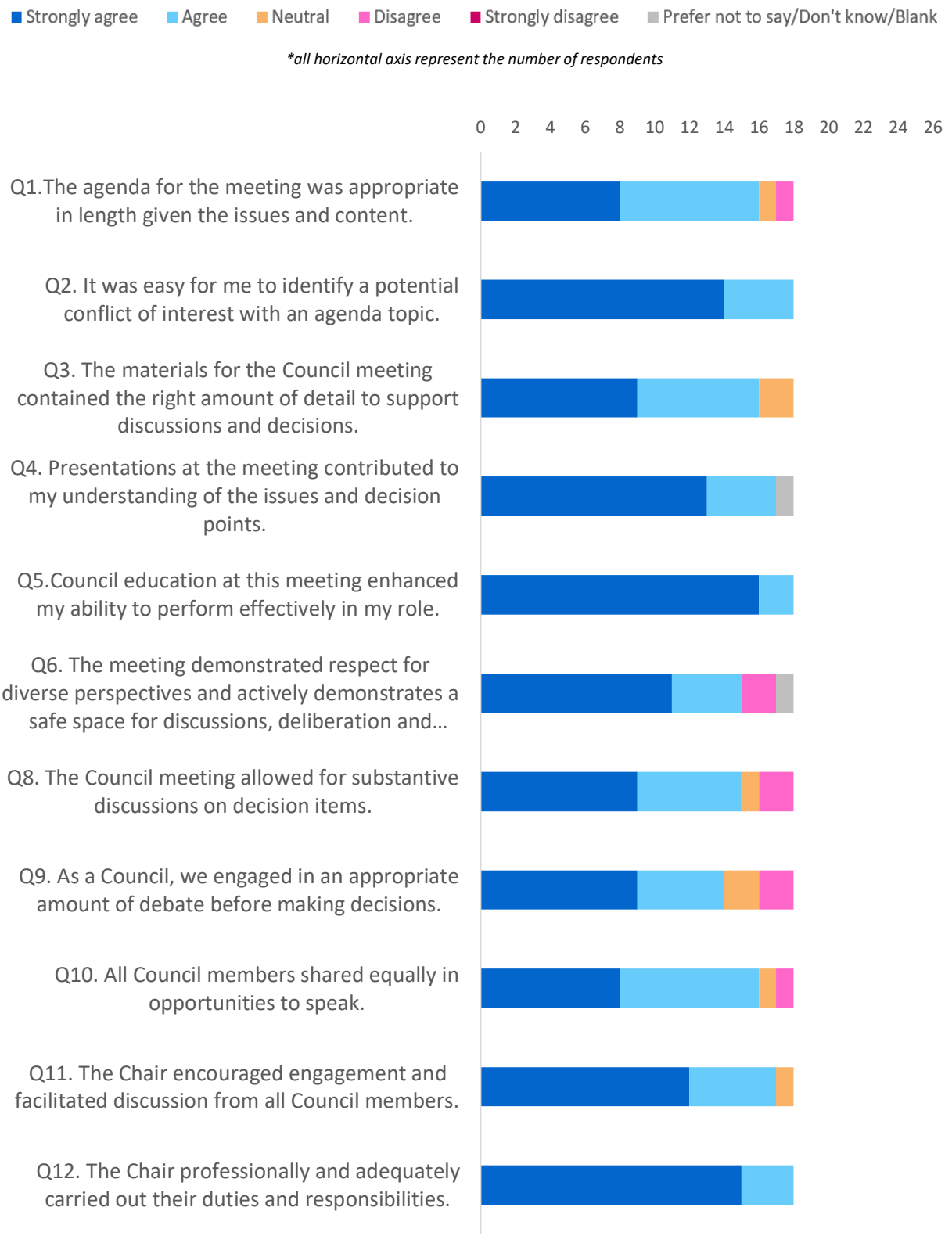
# Proposed Motion for Council

1. THAT Council approves the registration regulation amendment, as amended, attached as Appendix A, in principle, and directs that it be released for a 60-day public consultation period

# Council Meeting Evaluation Survey Report

## Council Meeting #447 January 23, 2025

*Quantitative Results*



# Council Meeting Evaluation Survey Report

## Council Meeting 447 January 23, 2025

*Qualitative Results*

**Q7. Additional Comments to Q6. *The meeting demonstrated respect for diverse perspectives and actively demonstrates a safe space for discussions, deliberation and equitable decision-making.***

- This was one of the best meetings. Presentations were very informative. It makes a difference when educational sessions are in-person. I also appreciated the group activity/rounds. May be we can have a something similar with the committees, so council members are familiarized with the various committees and their work, especially ones they have not served on before. Thanks for a
- Not enough time was allotted for thorough discussion in the in-camera session
- I believe all Council members and staff participated during the meeting, and felt their comments and input was being listened to and considered by everyone involved.
- I enjoyed reacquainting with current council members and staff and meeting new ones. The mentoring concept is good. The idea of meeting staff from different divisions was excellent. I loved the food choices arranged by Angie.
- I did not feel good about how the meeting ended. The last item probably could have used a written briefing note summarizing the EC's discussions and rationale. After being in the room for ten hours, everyone was tired and eager to adjourn, which likely contributed to members' frustration with one another. I wish we could have ended the first meeting of the term feeling the way we felt after the round table session with the staff - ie, highly positive and excited to be working together to achieve great things. Hopefully we can recapture this dynamic ASAP, and make sure that we start off with and maintain constructive team dynamics, because we have some big and difficult tasks to
- ... a place for discussions and deliberation but often does not alter decisions previously made in any way. Discussions are pre made and things are voted through.

# Council Meeting Evaluation Survey Report

## Council Meeting #447 January 23, 2025

*Qualitative Results*

**Q13. What is one thing that will improve the next Council meeting?**

- ◊ End of the day discussion was prolonged unnecessarily.
- ◊ It would have been nice if those of us on Zoom were able to participate in the group discussions.
- ◊ In camera session needed more clarity regarding the topic under consideration. There was debate but confusion as to what form the approval of the motion took with some members confused.
- ◊ Excellent presentations! Both at the dinner event and at the Council Meeting. Very informative, very well communicated.
- ◊ We must be one step ahead of the software updates. I had a difficult time getting hooked up to Zoom app. IT was scrambling at the last second to get people online.
- ◊ Members who disagree with a decision made by council, should be followed up for further clarification to them.
- ◊ I have been a public member of Council for seven years and this was by far the best meeting and orientation we have had agenda content. Congratulations for a very interesting and informative two days. Cheers & thanks!!!!!!!
- ◊ The agenda was very full and I found that there was insufficient time to adequately discuss important issues.
- ◊ Perhaps the 2027 inaugural meeting could be split into 1.5 days, where the first day is a half day consisting of orientation sessions and dinner (and possibly the election), and the second day has the committee appointments and any substantive issues council needs to address or discuss, ending with the roundtable discussions (which were great!) and brief inspirational messages of
- ◊ A comment about the quality of the sound for the first guest speaker, at times it was not clear.
- ◊ Better coffee!
- ◊ The meeting is too long
- ◊ More/longer "break-out" sessions in smaller groups and then come back as a large group to discuss them

# Registrar & CEO Report to Council
# Prepared by Daniel Faulkner
# March 27, 2025

## GOVERNANCE & REGULATORY LANDSCAPE

- On February 25, 2025 the Nova Scotia legislature heard First Reading of the *Free Trade and Mobility within Canada Act*. Bill 36 is a response to remove all barriers to trade in goods, services and investment between the provinces and territories of Canada. In the Bill, it states that "(A)ll service providers and licensees that have met the requisite standards and approvals for licensing or certification in a reciprocating province or territory shall be treated, with regard to the equivalent licence or certification in the Province (Nova Scotia), as if the service provider or licensee was licensed or certified in the Province and shall not be subject to any additional licensing or certification requirements." Health regulators in Nova Scotia are working with their Provincial Government to support mobility and to ensure patient safety when individuals move from one jurisdiction to Nova Scotia. There are some similarities between the Nova Scotia legislation and the As of Right Legislation in Ontario in 2023 (previously discussed). There is also comparable language in many of the jurisdictions already as mobility has been a federal-provincial-territorial priority for many years. RCDSO and the health profession regulators in Ontario will continue to work with our Government to ensure that there are no unnecessary barriers to licensure for individuals re-locating from another province or territory. We will also prioritize patient safety to ensure dentists seeking registration in Ontario are in good standing with other Canadian regulatory bodies. It is likely that renewed political interest in inter-provincial and territorial trade and mobility will lead to similar legislation being introduced in other provinces and territories in the coming weeks.

- In British Columbia in February, there was growing resistance to the *Health Professions & Occupations Act (HPOA)* as it works its way through the legislative approval process. Led by the BC Dental Association, the resistance contends that the legislation could lead to fewer available professionals, longer wait times and higher costs for patients. The Association is concerned the consultation by Government has been insufficient and serious concerns have been ignored. It is not clear how the legislation, similar to the governing statute for the RCDSO, will push dentists away from BC and will undermine access to oral health care. The BCDA has organized a petition and is urging all dentists to sign it. The HPOA received Royal Assent in November 2022.

- Council will be preparing for a strategic visioning session in June. The Regulator's Practice has been retained to support Council in developing its vision based on the anticipated future of oral health care delivery and the changing landscape of regulatory effectiveness. Bradley Chisholm and Kevin McCarthy will be leading the strategic process for The Regulator's Practice. Preparation for the June session will include individual Council member interviews to hear your unique perspective of the College, the environment and the future.

## PARTNERS AND COLLABORATORS

- World Oral Health Day was recognized on March 20, 2025. The day is about uniting the world "to help reduce the burden of oral diseases, which affect individuals, health systems and economies everywhere." This year's spotlight is how good oral health contributes to good mental health. World Oral Health Day is an initiative of FDI World Dental Federation and the website has information about the campaign, partners, resources, and individual stories.

- Last Fall 2024, Council was informed about the Oral Health Care Access Fund, an initiative of the Federal Government to fund oral health education and access to care projects. While the RCDSO was not asked to develop a full proposal following a review of our Expression of Interest, further development work is underway. The intent is to explore a project with partners and the Ontario Ministry of Health. The project purpose is to appropriately utilize internationally trained dentists pursuing full licensure under supervised conditions in dental practices; to address access to care in underserved communities; and to build capacity in dental practices that have difficulty sustaining optimum staffing levels. Now that the Provincial election has been concluded, RCDSO will discuss the project with the MOH and seek support which may include funding.

- A number of changes are being considered by the Board and new CEO of the Commission on Dental Accreditation of Canada (CDAC). Of specific note, CDAC is reviewing its funding formula which relies extensively on grant funding from provincial regulators for dentists, dental hygienists, and dental assistants. RCDSO currently contributes an annual grant of close to $316,000. We have been able to keep this level of funding from increasing for the past three cycles despite attempts to raise all fees, including moving RCDSO's annual fee to almost $400,000. CDAC recently began to meet with Registrars of Dental Regulatory Authorities to discuss principles for a fair and objective fee structure. This is a significant development and Council will be kept informed of progress as details emerge.

- The Association of Canadian Faculties of Dentistry (ACFD) recently launched its Bridge Training to Dental Practice in Canada Program. The program is for graduates of international dental training from unaccredited schools. It was made possible by grant funding under the Foreign Credentials Recognition Program and it provides an alternative pathway to full licensure in a Canadian jurisdiction. In short, the program has established entry criteria and for those candidates accepted into the Bridge Training Program, they will have their competencies assessed and customized education will be delivered in specified areas of knowledge, skills and abilities. The program will prepare candidates for clinical practice and to challenge the NDEB's certification examination, which is a key requirement for licensure. The development of this program has involved a complex process of multiple stakeholders, integration within three faculties of dentistry for the first (2025/26) and second (2026/27) cohorts, and new course development. While many challenges remain in its implementation and evaluation, the program opened in February 2025 to receive applications for the first cohort.

## AROUND THE COLLEGE (REGULATORY, OPERATIONS, COMMUNICATION)

- In the Fall 2024, RCDSO completed its biennial staff engagement survey. The purpose of the survey is to understand staff's experience working at the College across several dimensions including engagement, leadership effectiveness, work environment, innovation and inclusion. I am pleased to report that the survey generated a 91% response rate from staff. This was our first year using Mercer to administer the survey which has generated several benefits including the ability to ask both standardized and customized questions, comparisons with Canadian organizations and not-for-profit/government organizations, and the ability to look at intersections between data points, such as how responses varied with different employment tenure, and how leadership compared to front line staff. Senior leaders and functional area leaders have been reviewing the experience with Mercer and with a focus on appropriately interpreting the results. The survey revealed many things that are working well and some areas for improvement. The full results were shared with all staff on March 12th and much more communication and engagement is planned to address the areas of improvement.

- In January, all College staff completed the annual performance cycle for 2024 and goals were developed for 2025. The performance management cycle is a critical part of our commitment to responsible employee management and ensuring that our daily work stays connected to the College's mandate and strategic plan. Interestingly, the staff engagement survey identified that 80% have a good understanding of the College's goals and strategy and 91% clearly understand how my own job contributes to achieving the goals of the College. However, only 40% agreed that the better my performance, the more I will be rewarded (eg. Salary increases, praise, attending conferences, leading initiatives, etc.). The latter topic will be an area of focus for the leadership team.

- This is the time of year when numerous staff are busy with cyclical activities including the performance review of all staff (mentioned previously), orientation of all new Committees and the completion of our College Performance Management report to the Ministry of Health (due March 31, 2025).

- The College staff is pleased to provide Council with the quarterly Dashboard Report: Operational Highlights, for your information. The report provides quantitative updates on the regulatory programs operated by the College. Council should note that there are positive results in all areas reported (Registration, Facilities Inspection Program, Quality Assurance and Professional Conduct and Regulatory Affairs). I will provide a brief overview at the meeting.

- The annual renewal cycle for dentists was launched in October and closed on January 31st. At the end of the renewal cycle, 37 dentists were suspended for non-payment. This number is comparable with previous years and with last year when 41 dentists were suspended.

- Two RCDSO Connect webinars have been held since the December Council meeting. On February 4th the session discussed a case complexity tool to enhance the dentistry experience for persons with disabilities. Colleagues from the Canadian Society for Disability and Oral Health presented practical ways in which all dentists can build their confidence in treating patients who have unique health needs and support requirements. On March 4th the College was pleased to welcome dentists to learn about the AI Advantage: Transforming Dental Practice in the Digital

Age. Both sessions were very well attended. Not only are we able to provide a question and answer feature for all Connect webinars, the College significantly expanded the webinar seat capacity. There were approximately 900 and 1400 participants respectively, at the two recent sessions. RCDSO Connect has become a recognized event of the College which promotes learning about topical issues and enables the collection of a Category 1 CE point for those dentists watching it as a live event.

- I have attended three Dental Society events since January 2025: Halton-Peel, Headwaters, and York Region. These events have allowed me to share what is topical for the College, to encourage dentists to keep informed about College standards and positions, to provide clear information about the PLP divestment, and to hear from the dentists about what is important to them. Some of the recent topics brought forward from attendees include CDCP and advertising.

Respectfully submitted,
Daniel Faulkner, Registrar & CEO

# Council Dashboard Report

## Operational Highlights

March 2025

Royal College of
Dental Surgeons of Ontario

# Current Metrics

| Program Area | Metrics |
|---|---|
| Quality | Regulatory and Operation Dashboard Summary, 2024<br>PET New Question Development, 2024 |
| Registration | Average Application Processing Timelines, by Month<br>Average Application Decision Timelines, by Month |
| FIP | Open CT Facility Permit Applications by Year of Submission, by Month<br>Average Days to Process Sedation Facility Permit Application and Assign Inspection, by Month<br>Average Days from Completed Inspection to Issuing a Sedation Facility Permit, by Month |
| PCRA | Total Active Cases by Number of Days ***NEW*** |

# Notable Acronyms

| | |
|---|---|
| **CRM** | Customer Relationship Management |
| **CE** | Continuing Education |
| **ERP** | Enterprise Resource Planning |
| **FIP** | Facility Inspection Program |
| **HPC** | Health Profession Corporation |
| **IT** | Information Technology |
| **MRC** | Member Resource Centre |
| **PCRA** | Professional Conduct and Regulatory Affairs |
| **PET** | Practice Enhancement Tool |
| **QA** | Quality Assurance |
| **UX/UI** | User Experience/User Interface |

*For a full list of acronyms, refer to "Lexicon of Commonly Used Acronyms" in the Council Materials*

# Quality | Regulatory Requirements - O. Reg. 27/10 QUALITY ASSURANCE

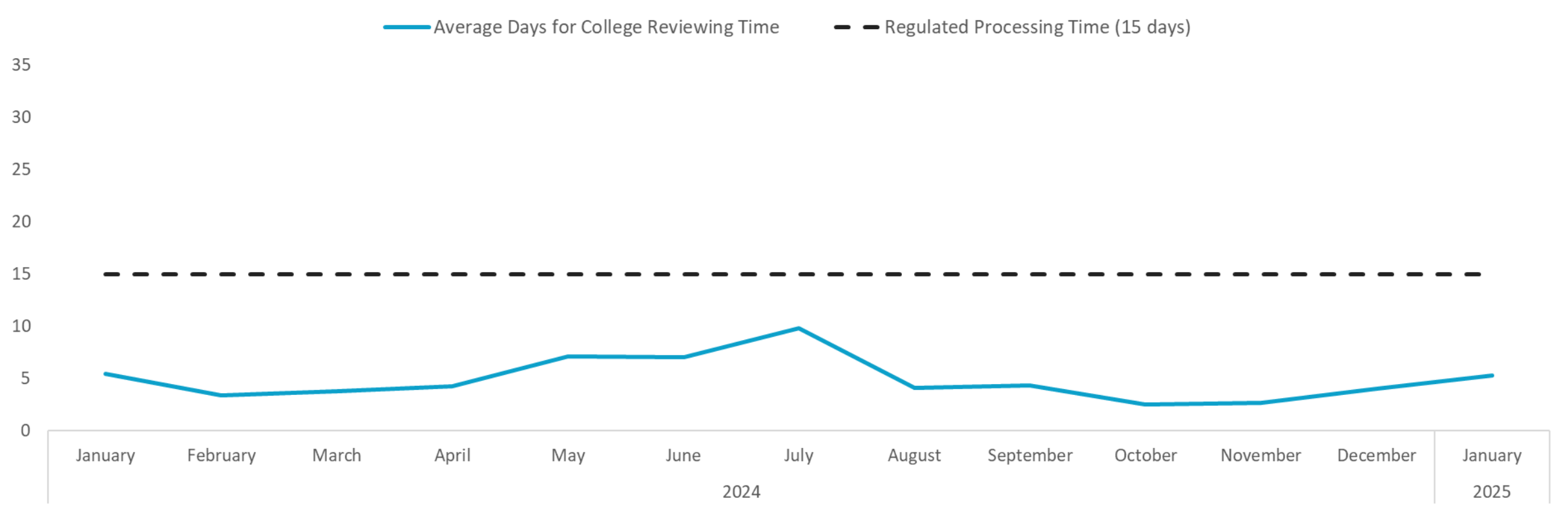
- Upcoming activity
- On track per project plan
- No activity planned
- Minor variation, managed within department
- Course correction required

| Components of QA Program | Jan-Mar | Apr-Jun | Jul-Sep | Oct-Dec |
|---|---|---|---|---|
| Continuing Education audits | n=6737 (100%) | | | |
| CE Category 1 course approval | n=16 (14 new; 2 resubmissions) | | | |
| PET administration (2025-2029) | Pilot complete | | | |
| PET new question development | 2 of 3 in progress | | | |
| Peer and Practice Assessments | As required | | | |
| Annual Declaration of Compliance | | | | |

**Key Points**

- **Audits complete** for 100% registrants who completed their CE cycle in Dec-2024. **93.5% (6302 of 6737)** satisfied the criteria or had a minor shortfall in points based on the thresholds established by the QA Committee.
- **16 new Category 1** courses were approved by the QAC in Q1, bringing the total available to **over 200.**
- **PET pilot testing** was completed, and plans are progressing for broad launch to begin April 2025. The first **1100** registrants have received notice to begin their PET between April 1 – June 30, 2025.
- **PET Writing Groups** for Medical Emergencies and Oral Medicine launched. Decision to combine General Medicine PET competency with Medical Emergencies.

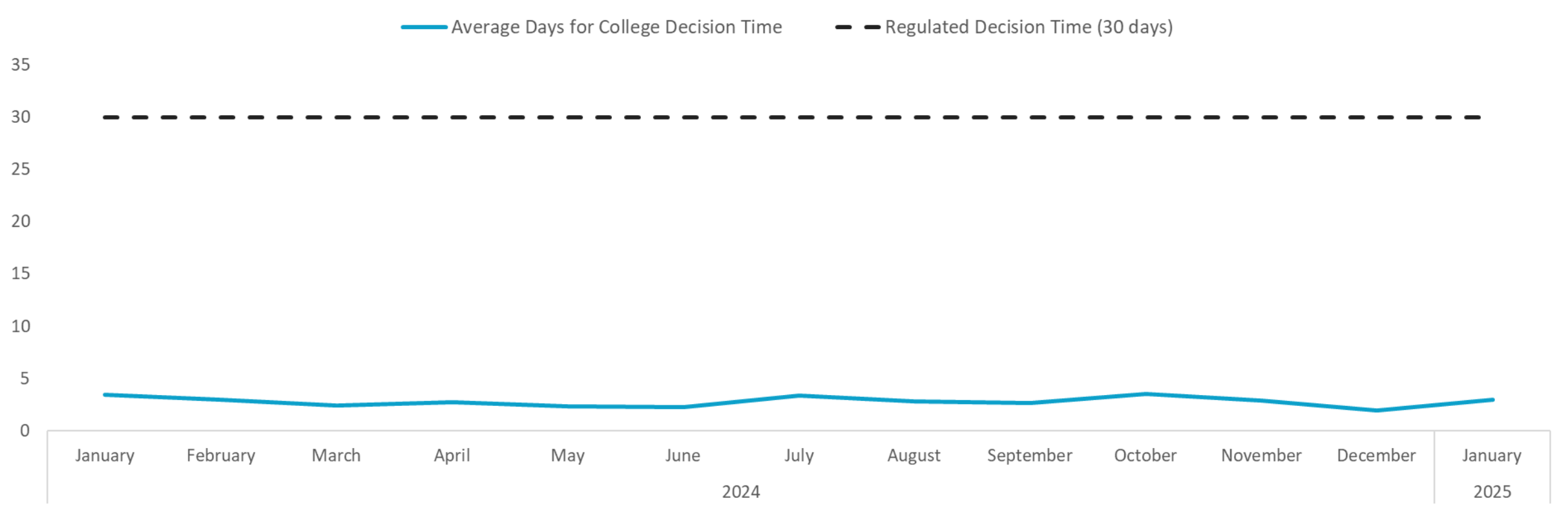
# **Registration** | Average Application Processing Timelines, by Month




**Key Points**

- The Registration Department continues to meet the regulated timelines for application processing in 2025.
- The **blue line** represents the average time (days) it takes to process an application from the time it is initially received by the College to when staff correspond with the dentist to indicate that the application is either complete, or there are outstanding requirements to be met. This timeline must be less than 15 days (dotted black line).

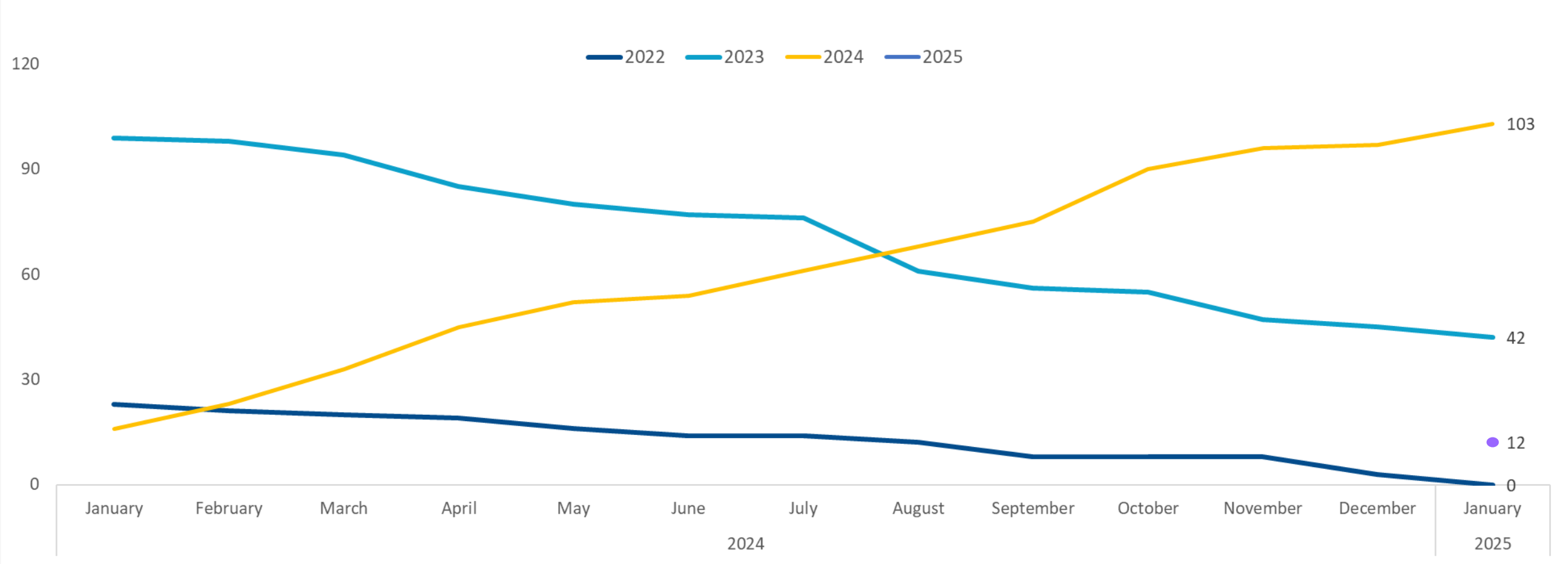
# **Registration** | Average Application Decision Timelines, by Month




**Key Points**

- The Registration Department continues to meet the regulated timelines for application decisions in 2025.
- The **blue line** represents the average time (days) it takes to make a decision on an application once it is complete, which must be less than 30 days (dotted black line).

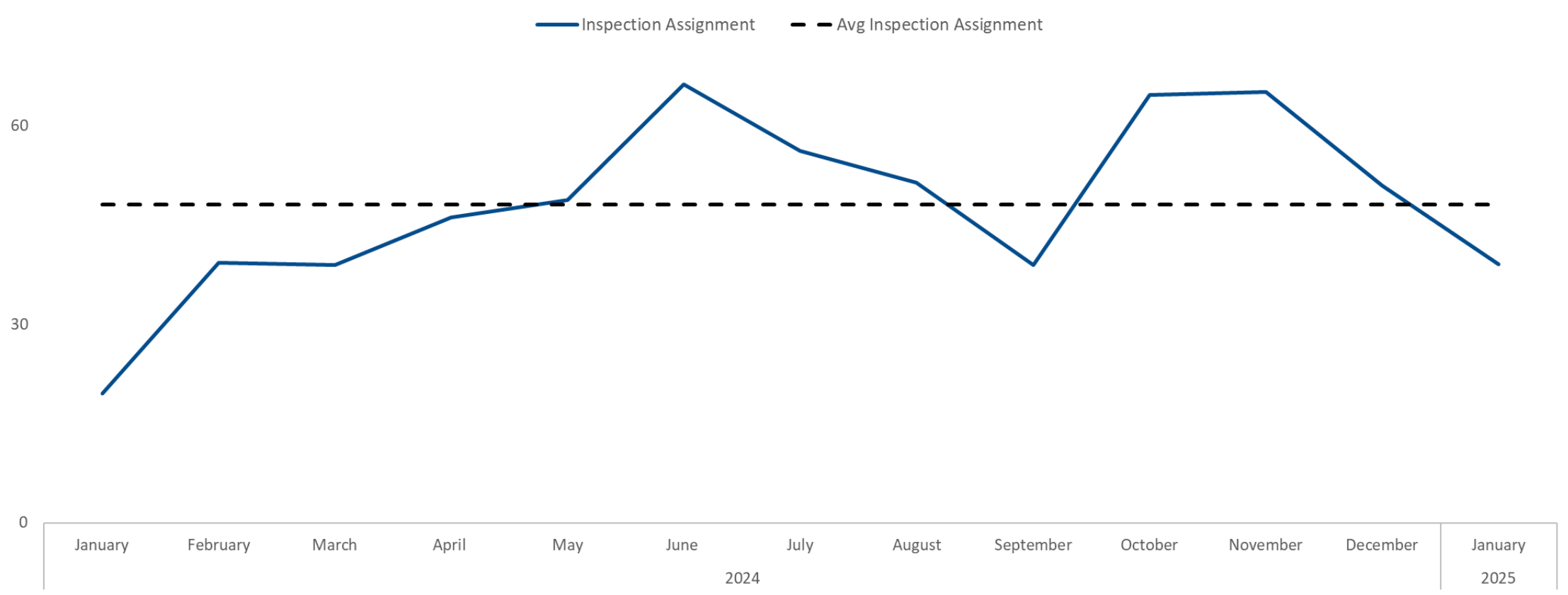
# Facilities Inspection Program (FIP) | Open CT Facility Permit Applications by Year of Submission, by Month




**Key Points**

- The FIP Department closed all 2022 applications in January 2025 and is actively working with applicants to systematically close 2023 applications.

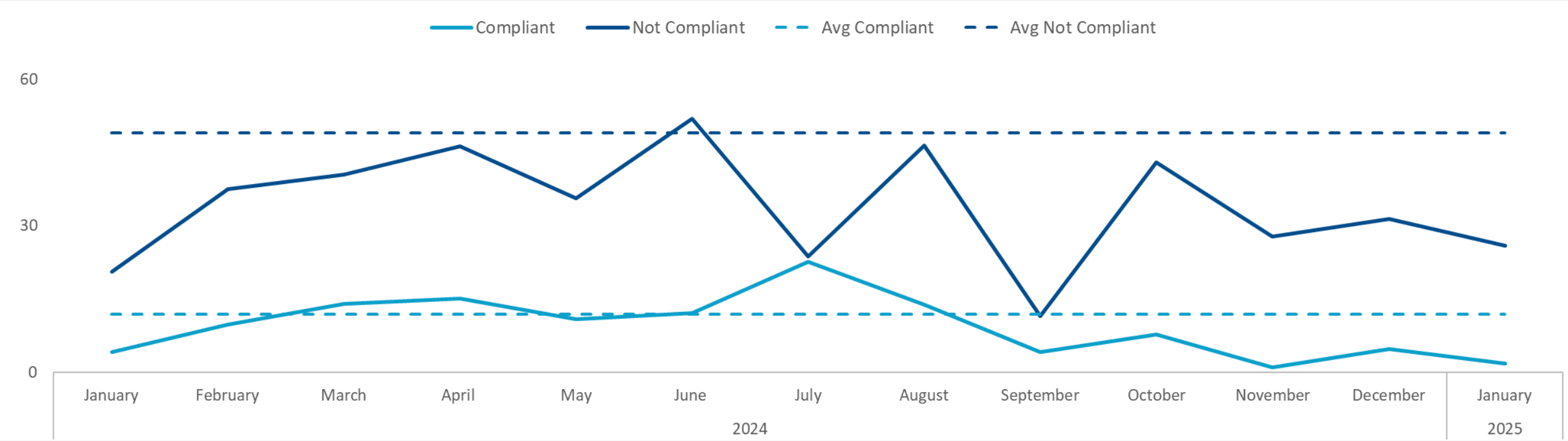
# Facilities Inspection Program (FIP) | Average Days to Process Sedation Facility Permit Application and Assign Inspection, by Month




**Key Points**

- This **dark blue line** represents the average time (days) it takes to process a facility permit application and assign an inspector. The **dashed line** is average time for 2024.
- Processing times in December 2024 and January 2025 were below the 2024 average.

# Facilities Inspection Program (FIP) | Average Days from Completed Inspection to Issuing a Sedation Facility Permit, by Month

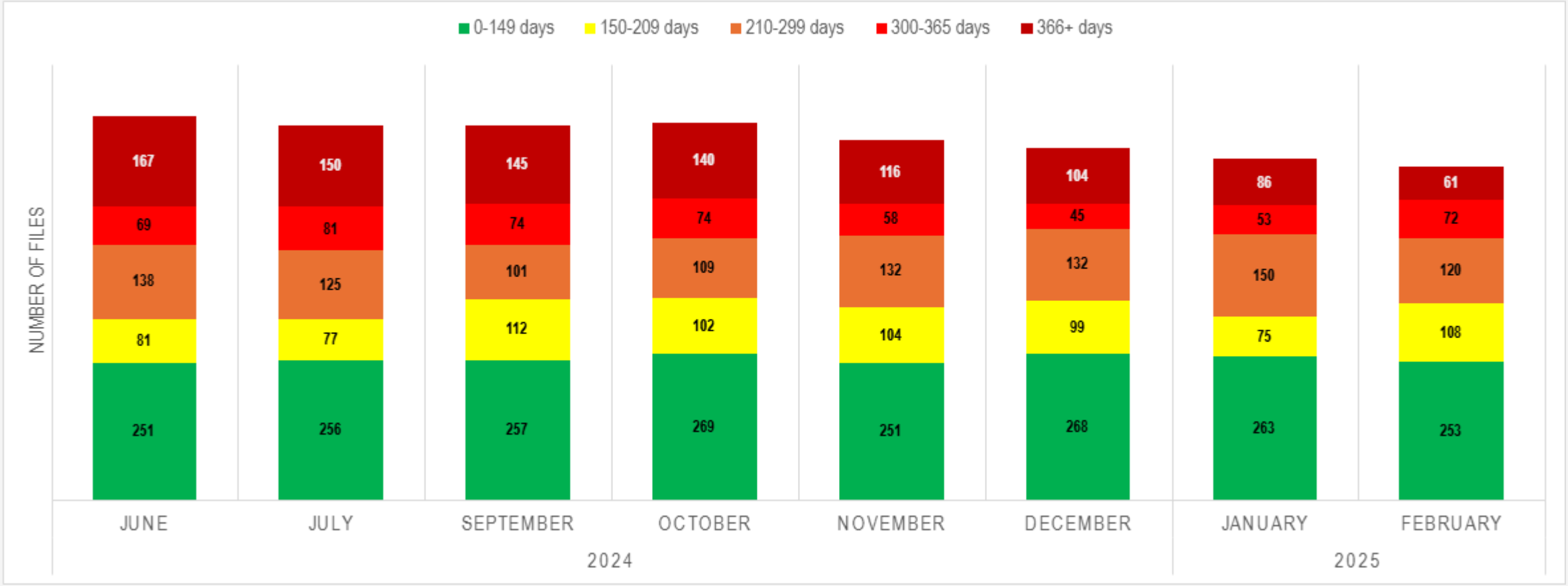



**Key Points**

- The **light blue** line represents the average time (days) it takes to issue permits for facilities that are compliant with the Standard of Practice and the **dark blue** line represents the average time (days) it takes to issue permits for facilities that are not compliant with the Standard of Practice. Average timelines in 2023 are represented with the **dashed lines**.
- The FIP Department takes less than 2 weeks to process an inspection report and issue the sedation facility permit when the Facility is compliant with the Standard of Practice. Processing times are longer for Facilities that are not compliant with the Standard of Practice; the timeline in these cases is not in the control of the College.

# Professional Conduct and Regulatory Affairs (PCRA)

## Total Active Cases By Number of Days




**Key Points**

- PCRA created a new metric for Council showing the timelines for all active investigations. Green indicates the number of cases that are less than 150 days. Yellow and orange show the number of cases under 300 days. And the light and dark red show the number of cases that are 300 days or more. PCRA is focused on reducing the number of cases in the red categories.
- On June 1, 2024, 67% of active investigations were less than 300 days.
- On February 1, 2025, 78% of active investigations were less than 300 days

# Retired Metrics

- Current metrics reported to Council highlight key initiatives departments prioritize to monitor progress and measure success
- Once the departmental objectives are accomplished and reported to Council, the metrics are removed, clearing space for reporting on new initiatives
    - These metrics are often continued to be monitored internally for operational purposes
- For reference, a list of previously reported (retired) metrics along with their duration are found on the following slide
- Following this are a historical account celebrating **Key Accomplishments** stemming from these **Retired Metrics**

# Retired Metrics

| Program Area | Retired Metrics | Duration on Council Dashboard Report |
|---|---|---|
| PCRA | Number of Open Casefiles by Month, 2021-2023* | ● ● ● ● ● ● ● ● ● ● ● |
| | Open Casefiles by Year the Case Commenced, rolling 12-Months* | ● ● ● ● ● ● ● ● ● ● ● |
| IT | The Bridge Journey (2019-2021) *<br>The Bridge Journey (2021-2022)*<br>The Bridge Journey (2023 Q1 & Q2)* | ● ● ● |
| | The Bridge Journey (2023 Q3)* | ● |
| | IT Projects and Initiatives Summary, 2023 | ● |
| FIP | Completed & Remaining Backlog of Provisional CT Facility Permits, by Month* | ● ● ● |
| Quality | Development Milestones for New ePortfolio Platform* | ● ● ● ● |
| | PET – New Question Development 2023 | ● ● ● ● |

2021 | 2022 | 2023 | 2024

Quarters: 1 2 3 4 | 1 2 3 4 | 1 2 3 4 | 1 2 3 4

First Council Dashboard Report (September 2021)

*Retired Metrics associated with Key Accomplishments (see next slides)

# Key Accomplishments of Retired Metrics

## Objectives

With an increasing number of new, open and backlog of casefiles, PCRA undertook dramatic process, information audit and strategic changes with the goal of reducing the number of active casefiles.

## Metrics

1. Number of Open Casefiles by Month, 2021-2023
2. Open Casefiles by Year the Case Commenced, rolling 12-Months

## Accomplishments

Over a 2½ year period, the PCRA team decreased the number of open casefiles by 55%. This can be attributed to a combination of factors including increasing the number of ICRC panel meetings per year, adding additional cases to review during each panel meeting, investigation process changes, data quality cleanup within the CRM (the Bridge) and auditing information of active casefiles.

***PCRA*** *Reducing the number of Open Casefiles and backlog of older Casefiles*

# Key Accomplishments of Retired Metrics

## Objectives

The Bridge metrics were developed to monitor the progress towards technical and program-oriented milestones.

## Metrics

1. The Bridge Journey (2019-2021)
2. The Bridge Journey (2021-2022)
3. The Bridge Journey (2023 Q1 & Q2)
4. The Bridge Journey (2023 Q3)

## Accomplishments

The Bridge was successfully launched in 2020 along with major and minor releases throughout 2021-2023. This key accomplishment was a major financial and operational success for the College that unified access to information across departments and teams.

***Information Technology***

*Developing and Releasing an entirely new CRM platform ("the Bridge") to modernize College Information Systems*

# Key Accomplishments of Retired Metrics

## Objectives

The FIP Department was tasked with converting older Provisional CT Facility Permits to Annual Permits to improve application processing timelines.

## Metrics

1. Completed & Remaining Backlog of Provisional CT Facility Permits, by Month

## Accomplishments

In under a year (9 months), the FIP Department were successful in converting all Provisional CT Facility Permits to Annual Permits. This was well-ahead of the projected timeline of 12 months.

***FIP*** *Eliminating the backlog of older Provisional CT Facility Permits*

# Key Accomplishments of Retired Metrics

## Objectives

Quality partnered with the IT Department to improve Dentists' ability to submit, record and track their CE credits with the overarching goal to help them abide by their Quality Assurance requirements.

## Metrics

1. Development Milestones for New ePortfolio Platform

## Accomplishments

Over the course of 12 months, the Quality and IT Departments developed a revolutionary new system for Dentists to manage their CE credits and transitioning from small sample random audits to automated audits for 100% of current cycle registrants. Additionally, the feedback received from community Dentists was an invaluable source of information the helped refine the development process.

***Quality***

*Modernizing the ePortfolio Platform to improve Dentists' interactions with submitting, recording and tracking their Continuing Education (CE) credits*

# RCDSO COUNCIL WORK PLAN 2025

| Category | Item | Responsibility | Jan | Feb | Mar | Apr | May | June | July | Aug | Sept | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Strategic Plan** | Review progress on strategic objectives | Council | | | C | | | C | | | C | | | C |
| | Discuss and refresh strategic plan | Council w/Registrar | | | | | | C | | | | | | |
| | | | | | | | | | | | | | | |
| **Finance** | Approve annual budget | Council | | | | | | | | | | | | C |
| | Approve audited financial statements | Council | | | | | | C | | | | | | |
| | Review quarterly results | Executive/Council | | | C | E | | C | E | | C | E | | C |
| | Review financial policies and procedures | TBD | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| **Registrar and CEO** | Registrar's Report | Council | | | C | E | | C | E | | C | E | | C |
| | Establish performance goals for Registrar and CEO | Exec/Council/Registrar | | | | | | | | | | E | | C |
| | Performance check-in | Exec/Registrar | | | | | | | E | | | | | |
| | Prepare new CEO evaluation form | Executive | | | | | | | | | | E | | |
| | Performance appraisal | President/VP | | | | | | | | | | | | C |
| | Review succession planning | Exec/Council | | | | | | | | | | E | | C |
| | | | | | | | | | | | | | | |
| **Council Affairs** | Consider/approve governance modernization in line with Ontario MOH proposal and best practices | Governance Committee/Council | | | GC | | GC | C | | GC | C | | GC | C |
| | Council education sessions | Council | C | C | C | | | C | | | C | | | C |
| | Consider/approve bylaw amendments re elections, selections and committee appointments | Governance Committee/Council | | | | | | C | | | C | | | |

Royal College of
Dental Surgeons of Ontario

# COUNCIL BRIEFING NOTE

**TOPIC: Financial Update**

**FOR INFORMATION**

March 27, 2025 Meeting

**ISSUE:** **Draft 2024 Financial Results:** To ensure Council receives regular updates on the College's financial position.

## PUBLIC INTEREST:

- This matter relates to the College financial position and maintaining fiscal responsibility to support the public interest by putting patients first and fulfilling legislative obligations.

## BACKGROUND:

- Staff regularly report to the Finance, Audit & Risk (FAR) Committee with respect to the College's financial performance.
- FAR provides oversight on financial results throughout the year.
- At year-end FAR reviews the audited financial statements with the external auditor and management, which are subsequently brought to Council for approval.

## ANALYSIS:

2024 Fiscal Year

- Attached in Appendix A are the unaudited and draft financial results for 2024.
- These results are unaudited and draft, as the year-end audit has not yet been completed. Further adjustments will be made, as will are still awaiting the PwC actuarial report and those figures will need to be included in the year end financial report. Historically, the PwC report has had a significant impact on year-end results.
- Preliminary year-end results indicate a surplus of $6.2 million for 2024. This is a $4.1 million improvement on the surplus budget of $2.1 million.
- Revenue exceeded budget by $3.7 million, primarily due to large investment gains. The stock market posted strong gains and interest rates were higher than expected. The budget was conservative given the unknown impact of the economy and expectations that the interest rates would drop through 2024. The unexpected change in the market resulted in investment revenue exceeding budget by over $2.6 million. Registration and annual dues have exceeded budget by $878 thousand as new applications and reinstatements were higher than anticipated.
- Expenses were underbudget by $404 thousand, excluding the PLP Loss Provision.

- The Operating Reserve remains underfunded at $3.5 million (50%) of the required amount, $7.03 million based on 2023 audited results. The preliminary 2024 results indicate the Operating Reserve will need to be $7.5 million. This is not compliant with the CPMF nor the College's Reserve Policy. It was anticipated that future surplus will be directed to the Reserve. The goal was to fund this over three years, from 2023 to 2025. FAR will provide a recommendation to Council in June on the movement of funds from Unrestricted to the Operating Reserve. Given the preliminary results the reserve should be fully funded earlier than anticipated.
- Further details will be available when the audited financial statements are presented to Council in June.

## NEXT STEPS:

- The external audit commences March 24, 2025
- The draft audited financial statements will be presented to FAR on April 29, 2025
- The audited statements will be presented to Council in June for approval

## DECISION FOR COUNCIL:

None at this time.

## CONTACT:

Jeffrey Gullberg, jgullberg@rcdso.org

Kelly Tripp, ktripp@rcdso.org

Attachment:

Appendix A – 2024 Financial Results, ***draft and unaudited***

RCDSO | Royal College of Dental Surgeons of Ontario

# Statement of Operations

For the Twelve Months Ending December 31, 2024

***DRAFT and UNAUDITED***

| | Year to Date (YTD) | Annual Budget | % of Budget Used | Prior Year (PY) |
|---|---|---|---|---|
| ***Revenue*** | $ | $ | | $ |
| Registration and annual fees | 39,687,349 | 38,809,150 | 102% | 37,475,204 |
| Investment income | 4,388,378 | 1,741,497 | 252% | 3,553,801 |
| Professional liability program recoveries | 306,018 | 232,500 | 132% | 225,539 |
| Professional conduct recoveries | 297,850 | 285,000 | 105% | 564,855 |
| Other income | 292,849 | 181,250 | 162% | 214,479 |
| **TOTAL REVENUES** | 44,972,445 | 41,249,397 | 109% | 42,033,878 |
| | | | | |
| ***Expenses*** | | | | |
| Staffing costs | 21,123,839 | 20,903,503 | 101% | 19,284,126 |
| Professional liability program provision | 7,000,000 | 7,000,000 | 100% | 7,404,741 |
| Consulting and professional fees | 2,694,458 | 2,765,461 | 97% | 2,413,179 |
| Telecommunications and technology | 2,090,253 | 2,225,755 | 94% | 1,898,607 |
| Amortization | 1,682,914 | 1,846,400 | 91% | 1,702,992 |
| Operations and facilities | 526,687 | 675,455 | 78% | 609,678 |
| Administration | 1,364,377 | 1,389,570 | 98% | 1,496,543 |
| Council and committees | 971,208 | 875,726 | 111% | 1,245,144 |
| Insurance and brokerage | 704,012 | 766,386 | 92% | 675,240 |
| Faculty payments and fees | 567,201 | 681,000 | 83% | 489,778 |
| **TOTAL EXPENSES** | 38,724,951 | 39,129,256 | 99% | 37,220,029 |
| | | | | |
| **Excess (deficiency) of revenue over expenses** | **6,247,494** | **2,120,141** | | **4,813,849** |

Royal College of
Dental Surgeons of Ontario

# Strategic Plan 2023-25
## Report to Council

**FOR INFORMATION**

March 2025

***This Report provides Council with an update on the projects arising from the College's Strategic Plan 2023-25***

## BACKGROUND:

- Council approved the College's 2023-25 Strategic Plan (attached as **Appendix A**) in September 2022.
- The 2023-25 Strategic Plan was deliberately drafted to be a high-level document that describes the strategic direction of the RCDSO over the next three years.
- The key anchor points in the 2023-25 Strategic Plan are three Pillars, together with their corresponding objective. They are as follows:


- These strategic objectives will be advanced through six comprehensive Strategic Projects, each of which is located under one of the strategic pillars.
- Based on the RCDSO's experience under the 2020-23 Strategic Plan, we have focused on a smaller number of strategic projects that will achieve broader, aspirational change and transformation.

- This approach will allow the RCDSO to take a more rigorous approach to each project and strike a better balance between strategic work and the ongoing work of the College that is not captured in the Strategic Plan.

- The Strategic Projects are:

1. College Standards
2. Access to Care
3. Service Experience
4. Equity, Diversity & Inclusion
5. Governance Review & Modernization
6. Practice Models & Corporate Dentistry

- The Strategic Projects are intended to span multiple years. The projects have deliberately been chosen to focus on externally facing issues and developments, not on College operations[1].

- Council will be kept apprised of the College's progress on these projects through two tools:

  1. This Report, which provides Council with a summary of projects and a status report containing highlights of ongoing projects.

  2. A Council Dashboard Report-Strategic Projects, which will chart the impact of specific projects through metrics.

## 2023-25 Strategic Projects: *Status at-a-Glance*

- As this is the first Strategic Plan Report for 2025, included as a special edition to this report is an End of Year Summary 2024 (**Appendix C**). Just as it sounds, this summary provides Council with an overview of the key accomplishments made in each strategic project over 2024.

- Highlights of progress made in each project since the December 2024 Council meeting are included in the charts below.

[1] Updates on key operational projects and initiatives will be provided to Council through a separate report: Council Dashboard Report: Operational Initiatives. This Dashboard Report will supplement the Registrar/CEO's Report to Council, provided at each Council meeting.

## 1. STRATEGIC PROJECT: COLLEGE STANDARDS

| STRATEGIC PILLAR & OBJECTIVE | PROJECT DESCRIPTION | UPDATES SINCE DECEMBER COUNCIL |
|---|---|---|
|  | ***Project Sponsor**: Andréa Foti*<br>***Project Manager**: Cameron Thompson*<br><br>*College Standards will be modernized and updated on a regular basis to ensure currency.* | • The College's Standing Policy Working Group has met to consider the draft "Consent to Treatment" and "Prevention of Sexual Abuse and Boundary Violations" Standards, as well as issues related to ending the dentist-patient relationship.<br>• Both the draft "Consent to Treatment" and "Prevention of Sexual Abuse and Boundary Violations" Standards have been revised following public consultation and referred by the Quality Assurance Committee to Council for final approval by Council.<br>• The draft "Foundations of Professionalism" and "Artificial Intelligence in Dentistry" documents have been completed and were referred by the Quality Assurance Committee to Council for approval to release the drafts for public consultation. |

## 2. STRATEGIC PROJECT: ACCESS TO CARE

| STRATEGIC PILLAR & OBJECTIVE | PROJECT DESCRIPTION | UPDATES SINCE DECEMBER COUNCIL |
|---|---|---|
|  | ***Project Sponsor**: Andréa Foti*<br>***Project Manager**: Michelle Cabrero Gauley*<br><br>*Building on initiatives under the 2020-23 Strategic Plan, this project will focus on professionalism and advancing equitable access to oral health care in Ontario.* | • The Professionalism Working Group met in December 2024 to consider the results of a public poll conducted in Q4 2024 and the feedback Council provided on professionalism at its December 2024 meeting. Council has a dedicated briefing note on the public poll as part of its package.<br>• Early January 2025, the Working Group finalized the draft Foundations of Professionalism document for consideration by the Quality Assurance Committee and ultimately Council. There is a dedicated briefing note on the draft Foundations of Professionalism document in Council's meeting package.<br>• The Working Group has also begun work on the second document they've been tasked to develop: the new Standard of Practice on Accepting New Patients.<br>• At its March 2025 meeting, the Quality Assurance Committee (QAC) recognized the Canadian Society for Disability and Oral Health (CSDH) as an approved sponsor for continuing education (CE) credits in Ontario. The CSDH has been a regular collaborator with the |

| | | |
|---|---|---|
| | | RCDSO, including presenting its Dental Treatment Case Complexity Assessment Tool at the February 4th RCDSO Connect. The CSDH has created new CE courses to help increase oral health professionals' awareness, knowledge, and skill for providing oral health care for people with special needs and these courses have been approved by the QAC as Category 1. |

## 3. STRATEGIC PROJECT: SERVICE EXPERIENCE

| ***STRATEGIC PILLAR & OBJECTIVE*** | ***PROJECT DESCRIPTION*** | ***UPDATES SINCE DECEMBER COUNCIL*** |
|---|---|---|
|  | ***Project Sponsor**: Lesley Byrne*<br>***Project Manager**: Michelle Tremblay*<br><br>*This project focuses on the opportunities that will transform RCDSO processes, systems and corporate culture as it relates to enhancing service experience and user experience.* | • A feedback module for rcdso.org is currently in production with the focus of being able to capture the experience of visitors to rcdso.org. When complete, staff will be able to learn from our visitors how our web content is being used and how we can best support the public and dentists in getting the information they need. This web module will also assist in pointing our web users to our "contact us" area and Practice Advisory Service" area.<br>• Our internal staff team continues to work on a project to refresh the Annual Renewal Survey experience for dentists to have a tool that streamlines and simplifies the experience. |

## 4. STRATEGIC PROJECT: EQUITY, DIVERSITY & INCLUSION

| ***STRATEGIC PILLAR & OBJECTIVE*** | ***PROJECT DESCRIPTION*** | ***UPDATES SINCE DECEMBER COUNCIL*** |
|---|---|---|
|  | ***Project Sponsor**: Lesley Byrne*<br>***Project Manager**: Michelle Tremblay*<br><br>*This project intends to demonstrate the RCDSO's firm commitment towards becoming an equity-focused diverse and inclusive employer and actively leading by example to impact* | • The RCDSO's Internal AODA Committee completed it's 2024 year-end review of our Multi Year Accessibility Plan. (https://www.rcdso.org/about-rcdso/equity-diversity-inclusion/accessibility-policy)<br>• All RCDSO departments completed Equity, Diversity and Inclusion work to help them articulate how principles of EDI apply in their specific areas of work anchoring back to concepts in the HPRO EDI Action Guide. (https://www.regulatedhealthprofessions.on.ca/assets/hpro-edi-organizational-self-assessment-and-action-guide.pdf)<br>• RCDSO hosted an RCDSO Connect Session on Quantifying Disability: The CSDH Case Complexity Tool - A guide to enhancing the dentistry |

| STRATEGIC PILLAR & OBJECTIVE | PROJECT DESCRIPTION | UPDATES SINCE DECEMBER COUNCIL |
|---|---|---|
| | *change in dental regulation.* | experience for persons with disabilities. Dentists heard from Dr. Olaf Plotzke, Dr. Clive Friedman, and Dr. Sharat Pani who provided and in-depth look at the tool. Dr. Daniel Haas joined in the discussion to share with dentists the tool's application in sedation decision making. This session had over 870 live attendees and was available for CE credits.<br>• 21 staff from across the College participated in the CCDI Unconference March 5 & 6 (https://ccdi.ca/unconference/). During two half-days of learning staff heard from speakers on the theme of "Weaving Intersectionality and Belonging into DEIA" |

## 5. STRATEGIC PROJECT: GOVERNANCE REVIEW & MODERNIZATION

| STRATEGIC PILLAR & OBJECTIVE | PROJECT DESCRIPTION | UPDATES SINCE DECEMBER COUNCIL |
|---|---|---|
|  | ***Project Sponsor**: Dan Faulkner*<br>***Project Manager**: Lara Thacker*<br><br>*This project will analyze emerging governance changes in Ontario and beyond, and implement governance proposals for RCDSO, including the implementation of reforms proposed by the Ministry of Health.* | • The Governance Committee met twice to consider applicants for committee appointments and to propose a recommended committee slate for the 2025-2027 term for Council's consideration. Council approved the proposed committee slate in January 2025.<br>• Council has engaged in orientation and education sessions for the 2025-2027 term, including Sir Harry Cayton's presentation on The Publics' Interests, and Facilitative Chair Training to lead productive collaborative meetings, and support the mandate of protecting the public interest. The Governance Committee will consider a proposed 2025 Council Education Plan at the end of March.<br>• Staff has continued research and analysis regarding options for the three integrated governance modernization components Council approved in principle in 2024. The Governance Committee will review and discuss options and analysis at the end of March. |

## 6. STRATEGIC PROJECT: PRACTICE MODELS & CORPORATE DENTISTRY

| *STRATEGIC PILLAR & OBJECTIVE* | *PROJECT DESCRIPTION* | *UPDATES SINCE DECEMBER COUNCIL* |
|---|---|---|
|  | ***Project Sponsors**: Dan Faulkner & Andréa Foti*<br>***Project Manager**: Deni Ogunrinde*<br><br>*This project will analyze various dental practice models, including corporate ownership models, and the implication on quality of care and dental regulation.* | • A briefing note on the Practice Models and Corporate Dentistry strategic project is included in the Council package for the March meeting as a discussion item. This item was postponed from the December 2024 Council meeting.<br>• This briefing note includes a summary of draft options that have been developed for the RCDSO to address issues and harness opportunities related to dental practice models.<br>• Staff will gauge Council's interest in pursuing the draft options and gather feedback. After the Council meeting, staff will conduct a comprehensive analysis of the options that Council is interested in pursuing.<br>• A final report with recommended options will be shared with Council for its approval later in 2025. |

### Metrics

- Project Managers have worked closely with Eric de Sa, the RCDSO's Data Scientist to develop key performance indicators (KPIs) for each strategic project.

- These KPIs are incorporated into the Council Dashboard Report-Strategic Projects, attached as **Appendix B**.

## CONTACT:

Dan Faulkner, Registrar & CEO: dfaulkner@rcdso.org

Andréa Foti, Deputy Registrar & Privacy Officer, afoti@rcsdo.org

**Attachments:**

**Appendix A**: Strategic Plan, 2023-25
**Appendix B**: Council Dashboard Report -Strategic Projects
**Appendix C:** End of Year Summary: 2024

# RCDSO STRATEGIC PLAN: 2023-2025

## VISION

Everyone in Ontario has access to safe, high-quality oral health care.

## MISSION

We act in the public interest and are committed to excellence in regulating the dental profession in Ontario.

## PILLARS

- PROFESSIONALISM
- STAKEHOLDER ENGAGEMENT
- EMERGING ISSUES

## VALUES

- ACCOUNTABLE
- COLLABORATIVE
- INNOVATIVE
- INCLUSIVE
- TRANSPARENT

Royal College of
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# OBJECTIVES

These objectives provide additional focus to the work of the College for the next three years. Objectives are anchored to a strategic pillar and define where we would like to be. The bullet points outline our areas of focus for developing strategies that will help us get there.

## Our Commitment

- We take an evidence-informed approach to decision making.
- We apply a risk-based perspective in regulating the profession.
- We integrate the principles of Equity, Diversity and Inclusion in all we do.

## PROFESSIONALISM

RCDSO promotes a culture of professionalism in dentistry that supports access to quality care, serves the public interest and upholds the public trust.

**Areas of focus include:**

- Access to care
- Practice models & quality of care
- Standards of Practice and Resources
- Continuing Professional Development

## STAKEHOLDER ENGAGEMENT

RCDSO engages with the public, the profession and system partners to advance patient-centered oral health care and regulatory excellence.

**Areas of focus include:**

Enhancing engagement with:

- The public & the profession
- Oral Health Regulatory Colleges in Ontario & partner organizations
- Faculties of Dentistry
- Government
- RCDSO staff

## EMERGING ISSUES

RCDSO anticipates and responds proactively to emerging issues and trends that may impact the public interest.

**Areas of focus include:**

- Emergency preparedness
- Government/political environment
- COVID-19 and post-pandemic recovery
- Technology (e.g., artificial intelligence and teledentistry)
- Governance
- Environment & sustainability

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Appendix B

# Council Dashboard Report

## Strategic Projects

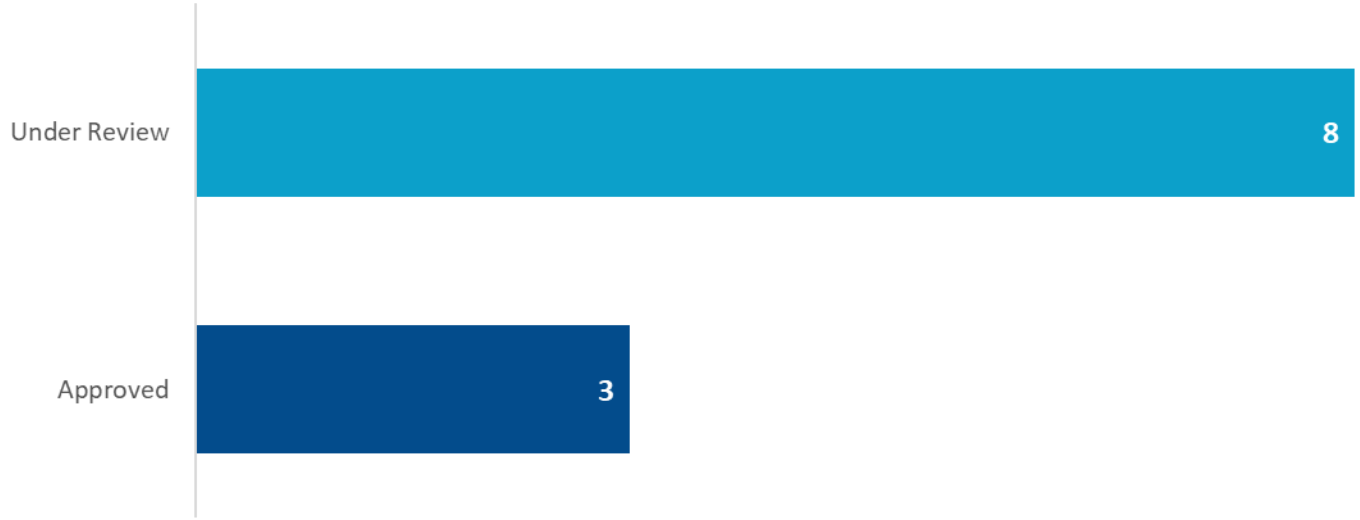
Royal College of
Dental Surgeons of Ontario

March 2025

# Overview

| Strategic Project | Key Performance Indicators (KPIs) |
|---|---|
| College Standards | Number of college standards under review and approved<br>Progress of standards through each phase of the standards review and development process |
| Access to Care | Progress on professional expectations area of focus<br>Progress on information sharing and education area of focus |
| Service Experience | Number of key resources for the public and the profession that support the Active Offer of French language by 2025<br>Number of initiatives/projects underway towards improving service experience |
| Equity, Diversity and Inclusion (EDI) | Progress towards reviewing internal policies with an EDI lens<br>Overall number of participants who have attended EDI learning opportunities from the RCDSO |
| Governance and Modernization | Progress on orientation and training that enhance Council mandate:<br>Number of Council education sessions completed to date<br>Council members who Agreed or Strongly Agreed on post-meeting evaluation survey<br>Progress towards establishing a new Governance Committee |
| Practice Models and Corporate Dentistry | Progress towards developing a Report with options to promote and assure quality of care across dental practice models |

# College Standards | Number of college standards under review and approved



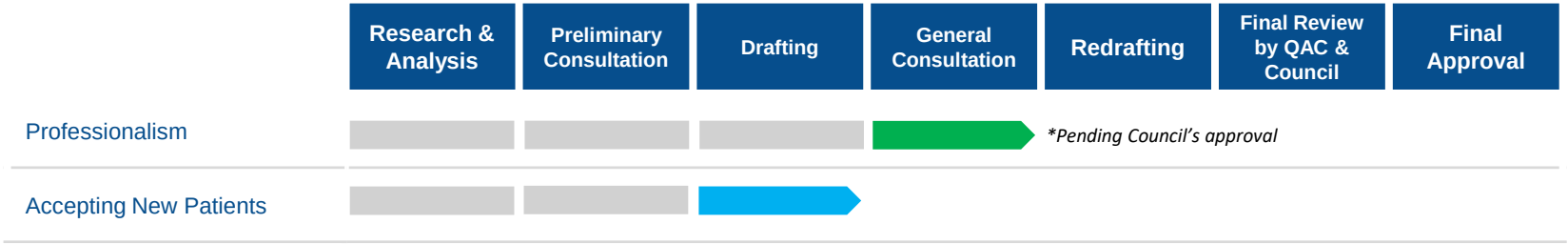
# College Standards | Progress of standards through each phase of the standards review and development Process

New Phase Since Last Reported | Current Active Phase | Completed Phase | Final Approval

| | Research & Analysis | Preliminary Consultation | Drafting | General Consultation | Redrafting | Final Review by QAC & Council | Final Approval |
|---|---|---|---|---|---|---|---|
| Virtual Care | | | | | | | |
| COVID-19: Guidance for In-Person Care | | | | | | | Rescinded |
| Diagnosis & Management of Temporomandibular Disorder | | | | | | | |
| Informed Consent Practice Advisory | | N/A | | | | | |
| Professionalism/Good Practice | | | | | *Pending Council's approval | | |
| Accepting New Patients | | | | | | | |
| Maintaining a Professional Dentist-Patient Relationship | | | | | | | |
| Implant Dentistry | | | | | | | |
| Artificial Intelligence | | | | | *Pending Council's approval | | |
| Prevention of Sexual Abuse and Boundary Violations | | N/A | | | | | |
| Use of Sedation and General Anesthesia in Dental Practice | | | | | | | |

# Access to Care | Progress on professional expectations area of focus

New Phase Since Last Reported | Current Active Phase | Completed Phase | Final Approval



# Access to Care | Progress on information sharing and education area of focus

Active  Retired

## To Be Started

## In Progress

## Review

## Complete

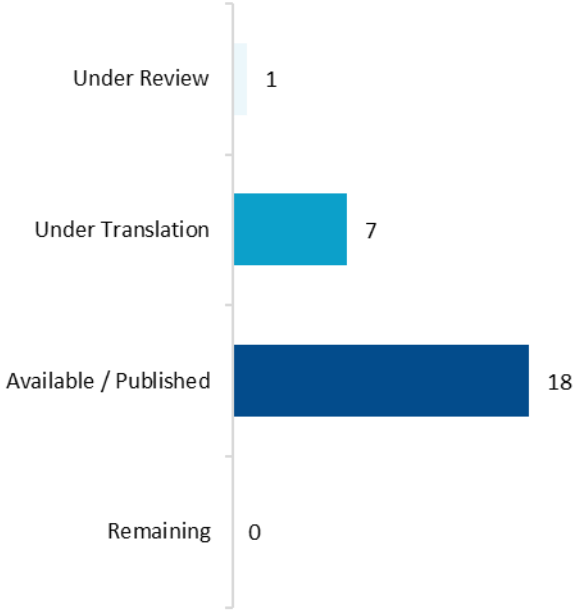
- Update Access to Care on RCDSO Website
- Update Low-Cost and Specialized Dental Clinic Directory for Patients
- Plan RCDSO Connect session on Access to Care (NOV 2023)
- CE: Plan enhancements to CE content and points framework for Access to Care-related activities (PHASE 1)
- Conference Series on Access to Care
- Plan RCDSO Connect session on Access to Care (June 2024)
- CE: Proposal to Expand Approved Sponsors re: Access to Care (PHASE 2)

# Service Experience |

Number of key resources for the public and the profession that support the Active Offer of French language by 2025

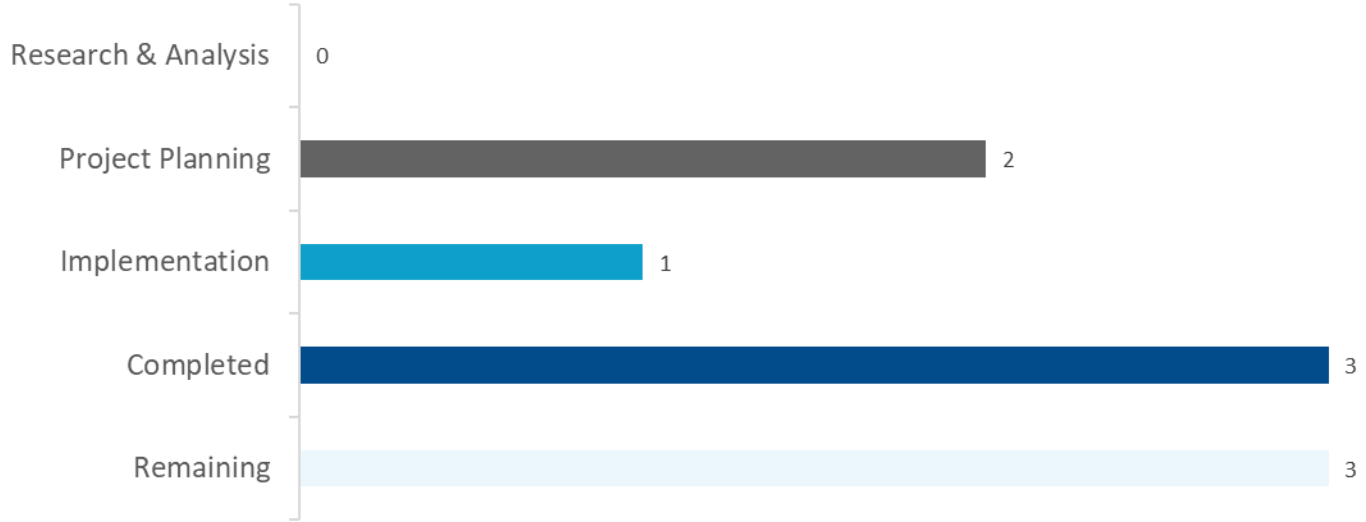
## French Language Translated Material (Published to date):

1. Amalgam Waste Disposal
2. 2022 Annual Report
2. College By-laws (using translation program)
4. Complaints Brochure
5. Complaints Intake Form
6. 2022 CPMF Summary
7. Fair Registration Practices Report
7. French interpretation services on demand
9. French Phone Greetings
10. French Phone Queue
11. Medical History Form
12. PLP Intake Form
13. PLP Website
14. Sexual Abuse Therapy Funding Forms
15. Staff resources in Communications, PRCA (Intake), Practice Advisory Services and PLP
16. Strategic Plan 2020-2023
17. Strategic Plan 2023-2025
18. Medical History Handout



# Service Experience |

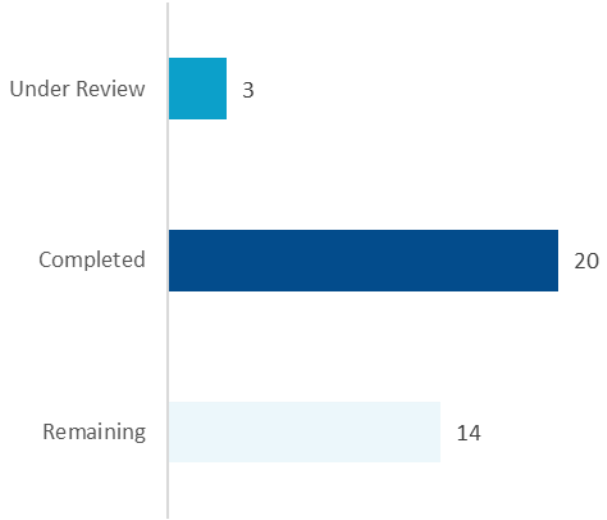
Number of initiatives/projects underway towards improving service experience



# Equity, Diversity and Inclusion (EDI) | Progress towards reviewing internal policies with an EDI lens

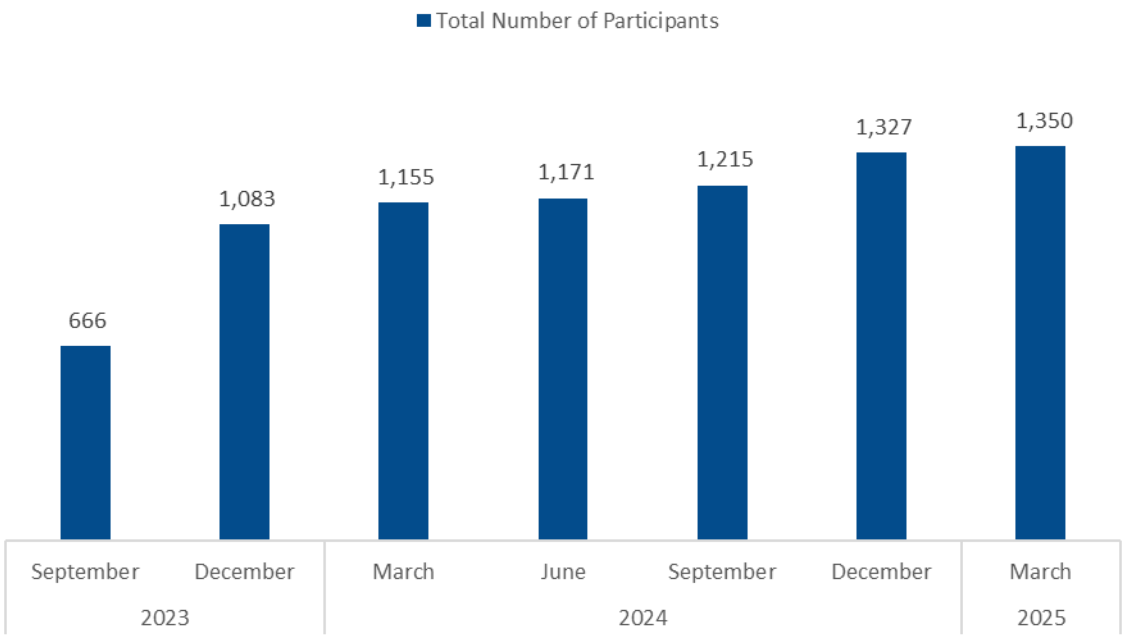
## Internal Policies Completed (to date):

1. Accessibility Policy
2. Alternative Work Arrangements
3. Dressing for a flexible work environment
4. Information Security and Acceptable Use
5. Integrated Standard
6. Language Services
7. Service Standards
8. Individualized Emergency Response Plan
9. Scents and Sensibility
10. Multi-Year Accessibility Plan
11. Compassionate Leave
12. Non-Medical Leave of Absence
13. Disconnecting from work
14. Hours of work
15. Overtime and Time in Lieu
16. Health Related Absences
17. Wellness Days
18. Vacation
19. Staff Social Events
20. Third Party Gifts



# Equity, Diversity and Inclusion (EDI) |

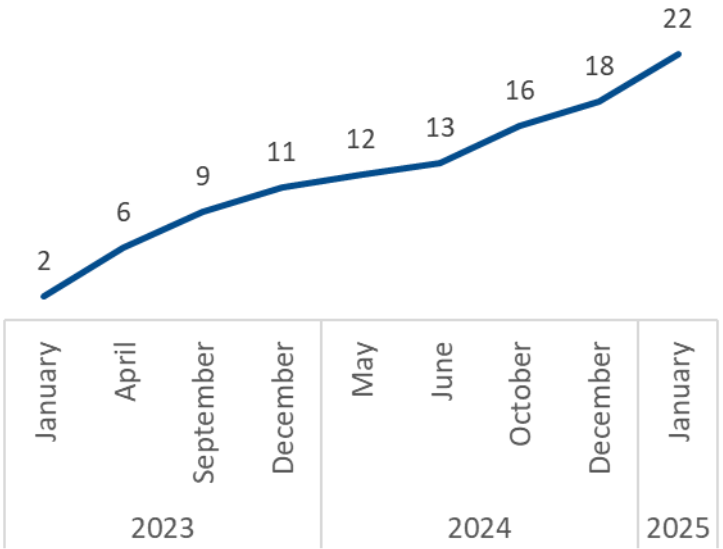
Overall number of participants who have attended EDI learning opportunities from the RCDSO



# Governance Review and Modernization

Progress on orientation and training that enhance Council mandate: Number of Council education sessions completed to date

Cumulative number of Council education sessions completed to date



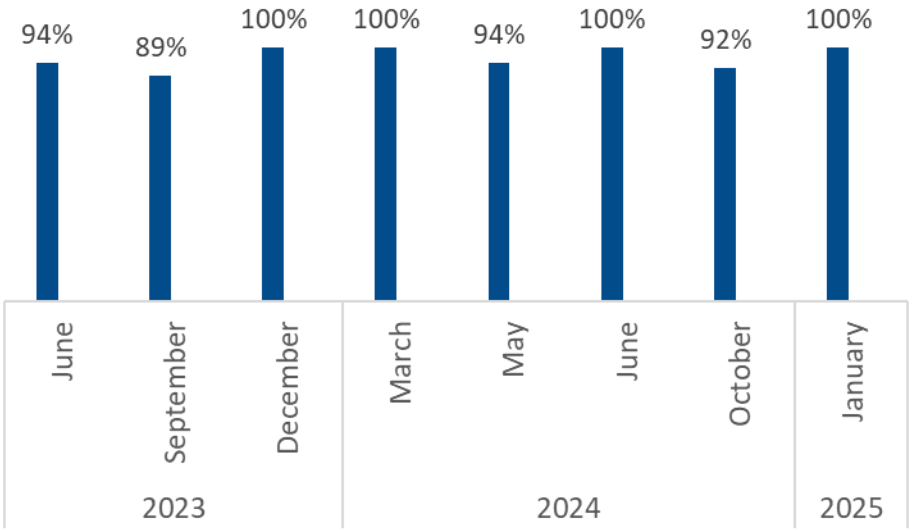

Sessions completed in 2025:

1. Navigator: Issue Management, Crisis Response, and Reputation Recovery
2. Harry Cayton: The Publics' Interests
3. Panel Discussion on Council and Registrar Roles and Responsibilities
4. Rebecca Durcan: Conflict of Interest

# Governance Review and Modernization

Progress on orientation and training that enhance Council mandate: Council members who Agreed or Strongly Agreed on post-meeting evaluation survey

Percent of Council members who **Agreed** or **Strongly Agreed** that "Council education at this meeting enhanced my ability to perform effectively in my role"

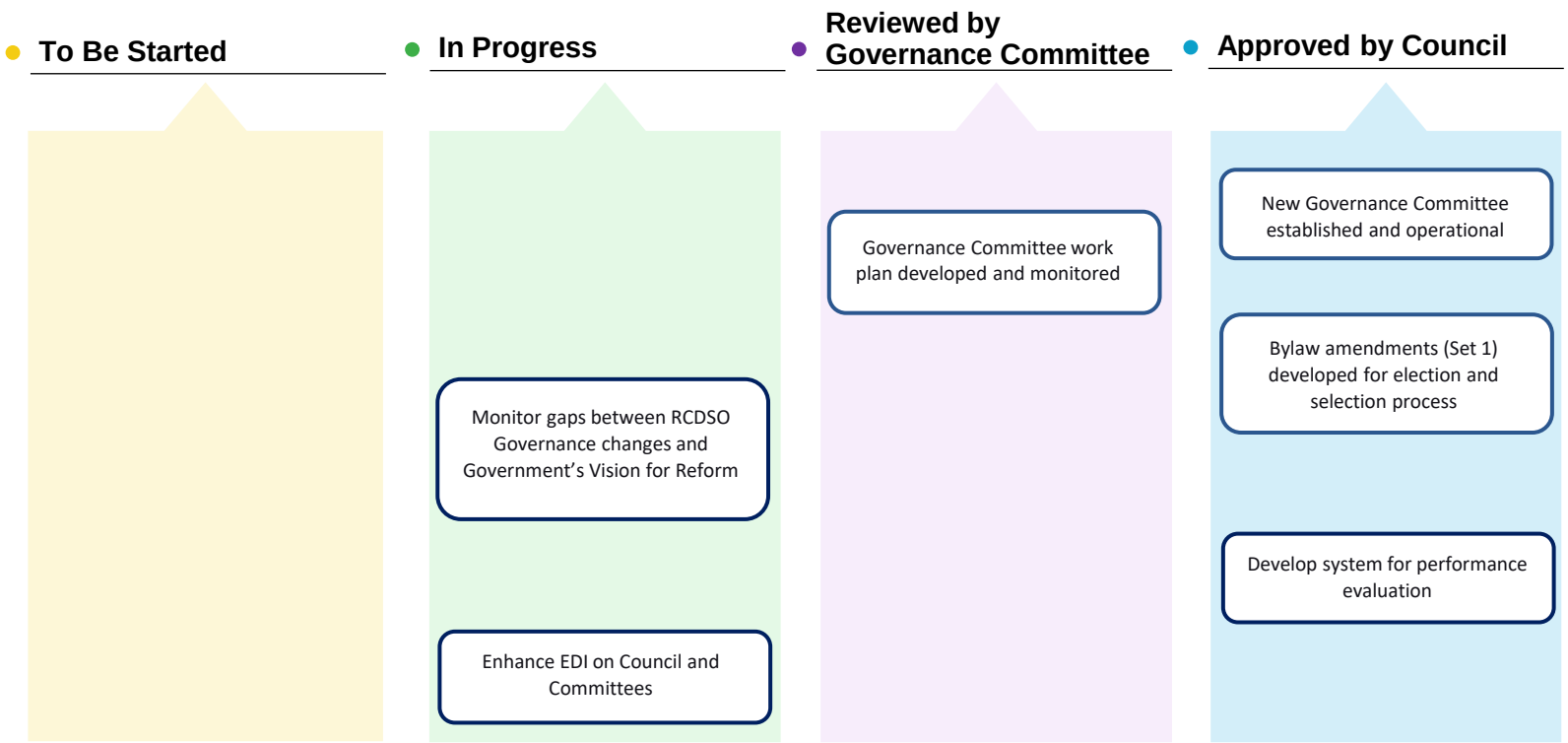



**January 2025 Council meeting education session:**

- Navigator: Issue Management, Crisis Response, and Reputation Recovery
- Harry Cayton: The Publics' Interests
- Panel Discussion on Council and Registrar Roles and Responsibilities
- Rebecca Durcan: Conflict of Interest

# Governance Review and Modernization

Progress towards establishing a new Governance Committee



# Practice Models and Corporate Dentistry

Progress towards developing a Report on dental practice models, including corporate practice models

# Strategic Project Update: End of Year Summary Report (2024)

The following summary provides a high-level overview of key outcomes and successes achieved in relation to the College's Strategic Projects in 2024.

## 1. College Standards

- Progress to review and update RCDSO's critical Standards of Practice continued throughout 2024.
- In January, the Quality Assurance Committee (QAC) approved the policy team's recommendations for the priority review of 8 key College Standards and 1 emerging issue. These recommendations were based on rigorous analysis involving RCDSO's Standards Prioritization Framework and fulfil a key milestone of the Standards Strategic Project.
- In April, a new Standing Policy Working Group was struck to support active policy work. This Working Group met 6 times in 2024.
- In August, updates were made to the RCDSO website to more transparently describe the new Standards review and development process (this includes the introduction of a new Standards infographic).
- In September, two new draft Standards, Consent to Treatment and Preventing Boundary Violations and Sexual Abuse, were reviewed and approved by Council for external consultation.
- Regular updates have been provided to Council via the Policy Report and Council Dashboard Report throughout the year.
- In September, Council also received a dedicated presented on the Standards Strategic Project.

## 2. Access to Care

The Quality Assurance Committee approved several proposals to expand Continuing Education (CE) opportunities for dentists relating to the provision of accessible care. This included recognizing Special Olympics Ontario and Rainbow Health Ontario as approved sponsors for CE credits.

Work on developing two new College documents on professionalism and accepting new patients into dental practices included:

- Launching a broad, external consultation on these topics to solicit preliminary opinions and perspectives;
- Engaging with interested parties at various events and conferences (e.g., Ontario Dental Association Annual Spring Meeting, RCDSO Connect, Alliance for Healthier Communities Conference, Canadian Network of Agencies of Regulation Conference);
- Working with an external research firm to conduct a public poll on access to care, professionalism, and accepting new patients;
- Striking a Working Group that met six times in 2024 to review the foundational research that had been conducted and the feedback that had been obtained via consultation/engagement and outreach, and to provide direction on the contents of the draft professionalism document; and
- Presenting the key positions the Working Group is contemplating for the draft professionalism document to Council for its initial feedback.

## 3. Service Experience

- The RCDSO "Thriving in a Flexible Work Culture" framework was launched in February 2024 to staff. RCDSO staff have worked diligently together to implement operational norms to build a strong flexible work culture that continues to support seamless service, efficient processes, and strengthen information flow across the organization.
- RCDSO complaints information has been published in 11 languages (English, French, Arabic, Chinese, Farsi, Hindi, Punjabi, Russian, Spanish, Tagalog, and Urdu). These languages were selected in consultation with recommendations from MCIS Language Services and internal RCDSO complaints/translation data. These documents help to facilitate greater access to information about the RCDSO processes and support expectation setting.
- A multi-disciplinary group of 58 staff members participated in a customer service training course facilitated by Dr. J Sadavoy via the leadership of our PCRA team. Staff with front-line roles walked through scenarios and shared tips on how to engage with the public in a client-centered and compassionate way. Dr. Sadavoy provided rich information on trauma-informed approaches and mental health considerations in our service work.
- The RCDSO Portal ("the Portal") was updated with a fresh look and feel effective in early September 2024. These changes were in response to service experience questions dentists responded to asking for an improved user experience. The Portal's design focused on the homepage, language, and site navigation.
- The internal college team is now turning its sights to looking at the Annual Renewal Questionnaire and a project is being planned to simplify the technology and improve user experience of the Annual Renewal.

## 4. Equity, Diversity, and Inclusion (EDI)

- We have high engagement from our staff, Council and Committees with over 40 EDI learning hours completed of over the course 2024. This includes AODA customer service training for Council, Committee members, and Inspectors.
- The College leadership team completed work to evaluate RCDSO's efforts with on equity, diversity, and inclusion and how our efforts measured up to the HPRO Action Guide (CPMF-related metrics). Each department reflected on areas of opportunity and developed an EDI statement for their area of responsibility to signal their commitment to reflecting on EDI issues, barriers, and bias in their processes.
- An addressing bias in committee decision making document was published in 2024 to support the public in understanding how the College reflects on and seeks to mitigate bias in our processes.
- An anti-bias vodcast training module was developed and implemented to support the Governance Committee's candidate selection processes. This four-part module included sessions on: 1. Why EDI matters in Governance 2. What is bias? 3. How to address bias when it presents itself; and 4. EDI Considerations when onboarding.
- Council and committee member demographic data was analyzed to reflect on the diversity of our governance and strengthen recruitment communications to welcome registrants whose identities and voices have historically been underrepresented around the Council and Committee tables.
- An Equity, Diversity and Inclusion webpage was developed for our public facing website with resources for the public and the profession including a new AODA form for the public to request the assistance they need in accessing RCDSO services. This new webpage includes RCDSO's EDI

Commitment Statement that was approved by Council in September 2024, publicly signaling RCDSO's commitment to EDI and transparency of actions.

**5. Governance Review and Modernization**

- Council approved in principle the Governance Committee's proposed three integrated modernization concepts (including adopting a province-wide election, and reducing the number of elected Council dentists), and directed the Committee to explore continued development.
- An anti-bias vodcast training module was developed and implemented to support the Governance Committee's candidate selection processes.
- Council and committee member demographic data was analyzed to inform the equity statements for calls for nominations and committee expressions of interest, strengthening recruitment from registrants whose identities and voices have historically been underrepresented.
- Council approved RCDSO's EDI Commitment Statement, publicly signaling RCDSO's commitment to EDI and transparency of actions.
- Council members engaged in several education sessions. On average, 97% of Council members Agreed or Strongly Agreed that education at meetings enhanced their ability to perform effectively in role.
- Council approved a Council Performance Evaluation Framework for 2025, which includes third-party vendor observation of Council meetings.

**6. Practice Models and Corporate Dentistry**

- Foundational research summaries were produced that outline key findings from jurisdictional research, literature review, public consultation, and analysis of College data. Summaries were analyzed to identify key issues and opportunities for patients that may be associated with dental practice models.
- In October, Council was provided with a standalone education session on this project, which included a project update and an overview of key findings from the foundational research.
- In December, Council was provided with a briefing note which summarized draft options to address issues and harness opportunities for patients related dental practice models. A discussion with Council about the options was postponed until 2025.

Royal College of
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# COUNCIL BRIEFING NOTE

**TOPIC: Policy Report**

**FOR INFORMATION**

March 2025

## ISSUE:

- As part of the policy team's regular reporting, Council is provided with an update on recent policy-related activities and upcoming work.
- This report does not represent the entirety of the policy team's portfolio and does not duplicate information presented to Council elsewhere (e.g., as part of the Strategic Dashboard or in a stand-alone briefing note).
- This report is presented for information.

## PUBLIC INTEREST:

- Providing Council with regular updates on policy work ensures that Council is informed of important developments and activities, encourages Council to ask questions and seek additional information, and supports Council in making informed decisions.

### 1. Standards Update

- Since Council's last update, the policy team has continued its work to review and update RCDSO's high-priority Standards of Practice.
- A full update on the status of Standards under review can be found in Council's materials as part of the Strategic Dashboard; however, two updates are highlighted below related to the policy team's broader Standards review and development processes.

*Standing Policy Working Group Update*

- As Council is aware, RCDSO's Standards work is supported by a dedicated Working Group which provides subject matter expertise and advice throughout the lifecycle of each review.

- The membership of the Working Group includes:
    - Dr. Antony Liscio (Chair)
    - Dr. Deborah Wilson (Chair)
    - Dr. Harinder Sandhu
    - Dr. Anthony Mair
    - Dr. Osama Soliman
    - Dr. Nalin Bhargava
    - Dr. Nancy Di Santo
    - Nizar Ladak
    - Eleonora Fisher
    - Patti Latimer (External Public Member)
    - Sharon Rogers (External Public Member)

- Since Council's last meeting, the Working Group has met twice to discuss and provide feedback on key issues and draft guidance. This has included a review of the new draft *Consent to Treatment* and *Prevention of Sexual Abuse and Boundary Violations* Standards of Practice (the Working Group's feedback supported revisions to the draft Standards which are now being presented to Council for final approval), as well as preliminary discussion related to maintaining and ending the patient-dentist relationship.

- As a matter of outstanding business, the policy team continues to solicit interest from prospective *non-dentist* Working Group members. As previously reported to Council, the policy team is working to achieve approximately equal representation of dentist and non-dentist members. To achieve this, the policy team is working to recruit 3 additional public members.

- The Standing Policy Working Group is scheduled to meet again in April 2025, and Council will receive further updates concerning the activity of the Working Group at future meetings.

*Implementation and Knowledge Translation*

- With work advancing quickly to review and update RCDSO's high priority Standards of Practice, the policy team is working with colleagues in Communications, Quality, and other key program areas to ensure that effective implementation and knowledge translation strategies are in place. The overall objective of these strategies is to support registrants in understanding and complying with new and revised College guidance.

- Beginning with the anticipated approval of RCDSO's new *Consent to Treatment* and *Prevention of Sexual Abuse and Boundary Violations* Standards of Practice in March, Council will see a number of new tactics being piloted. These include (as examples):
    - the development of more comprehensive FAQs, developed in collaboration with the College's Practice Advisors, which emphasize "what's new" or changed from the former guidance;
    - more direct communication with registrants about newly approved Standards of Practice (for example, via dedicated presentations at future RCDSO Connect sessions); and
    - the opportunity for registrants to receive CE credits for attending RCDSO Connect sessions which highlight new Standards of Practice, and for reviewing new Standards

- .

- Additionally, staff will ensure that the College's Jurisprudence and Ethics Course is updated to reflect new Standards of Practice.

- The overall objective of these tactics, as noted, is to ensure that registrants are supported in understanding what is expected of them, complying with the College's guidance, and incentivized to stay engaged as new Standards of Practice are developed and approved.

- Council will receive status updates concerning these tactics at future meetings, and staff will continue to explore new and innovate implementation and knowledge translation strategies going forward.

**2. CPMF Update**

- As Council is aware, all of Ontario's health regulatory Colleges are required to submit an annual report to the Ministry of Health outlining performance in key regulatory areas defined by the Ministry's *College Performance Measurement Framework* (CPMF).

- As a brief reminder:

  - The CPMF was first launched in 2021.
  - The intent of the CPMF is to establish common performance indicators among Ontario's health regulatory Colleges, and to require annual public reporting that will drive performance improvement and accountability.
  - The RCDSO has submitted three reports previously, along with brief summaries, which can be found on the College website.

- The Ministry's most recent reporting template was released in December 2024, and includes no substantive changes from past years.

- Project management support for RCDSO's submission continues to be provided by the policy team, led by Policy Analyst Deni Ogurinde, and work is now underway across the College to prepare the final Report.

- The Ministry's deadline is March 31, 2025, and at the time of submitting this briefing note, work is well underway, with most of the College's final report in place.

- As in past years, it is expected that RCDSO will either meet or exceed the Ministry's performance expectations, and Council will receive further updates at a future meeting.

## DECISION FOR COUNCIL:

- This briefing note is for information.

## CONTACT:

- Cameron Thompson, Manager, Standards & Strategy: cthompson@rcdso.org

Attachments:

None

Royal College of
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# COUNCIL BRIEFING NOTE

**TOPIC: Practice Models and Corporate Dentistry Strategic Project: Draft Options**

**FOR DISCUSSION**

March 2025

## ISSUE:

- The key objective of the Practice Models and Corporate Dentistry (PMCD) Strategic Project is the development and implementation of options to assure quality of care regardless of dentists' practice model.
- This briefing note will provide Council with a summary of draft options that have been developed based on research, analysis, and consultation undertaken to date.
- This item is provided for discussion.

## PUBLIC INTEREST:

- The Practice Models and Corporate Dentistry Strategic Project is a three-year strategic project under the Emerging Issues pillar of the 2023-25 Strategic Plan.
- This project will serve the public interest by identifying and supporting decision-making on options to help enable effective regulation of dentists in all practice models, including corporate dentistry.

## BACKGROUND:

- Ontario dentists work in various types of practice models. These include private practices, which are owned and operated by a single dentist or multiple dentists; corporate dental clinics, which are owned and operated by corporations; and other types of clinical and non-clinical settings (for example, hospitals, educational institutions, and governments). [1]
- Corporate dentistry is generally understood to be a dental practice model wherein a corporation, otherwise known as a dental service organization, or 'DSO', owns, aligns, or partners with multiple dental clinics to provide centralized operational support for the business and operational elements of the clinics.

[1] Only dentists can own the business through which dentistry is practiced, however, both dentists and non-dentists can own the premises and physical assets of a dental clinic.

- As Council has heard, there has been an increase in the number of practices owned by dental corporations in Ontario and across Canada,[2] and questions have begun to emerge concerning the risks and benefits of these practice models for patients and the College's expectations of dentists practicing within these models.

- In response, 'Practice Models and Corporate Dentistry' was established as a strategic project in the RCDSO's 2023-25 Strategic Plan, signaling the College's intent to further investigate this topic.

- In line with the RCDSO's mandate to protect the public interest, the objectives of the PMCD Strategic Project are:
  1. to better understand the types of dental practice models operating in Ontario;
  2. to identify issues and opportunities related to various dental practice models, including corporate dentistry, for patients; and
  3. to develop options to promote and assure quality of care and ensure effective regulation of dentists regardless of practice model type.

- This project has three phases. Phase 1 and Phase 2 are complete. Phase 3 is ongoing.

| | |
|---|---|
| Phase 1: Information Gathering<br><br>**COMPLETE** | • This phase involved gathering information through desktop research (e.g., jurisdictional and literature review) and consultation activities (including a consultation survey, and conversations with staff at the RCDSO and other regulatory colleges), to better understand:<br>○ the RCDSO's approach to its work including expectations/guidance related to practice models;<br>○ the types of practice models that exist in Ontario;<br>○ how practice models are regulated in other jurisdictions; and<br>○ issues and opportunities related to practice models for patients. |
| Phase 2: Analysis & Options Development<br><br>**COMPLETE** | • This phase involved reviewing previously gathered information, conducting additional research as needed, and analyzing RCDSO data (e.g., responses to the Annual Renewal Questionnaire) to develop options to address issues and harness opportunities that practice models, including corporate dentistry, present for patients. |
| Phase 3: Decision-making & Implementation<br><br>**IN PROGRESS** | • This phase involves seeking Council's feedback and approval to implement options and establishing an Implementation Plan to guide timelines and next steps for the approved options. |

[2] Group Dentistry Now. (2020, May 27). *Largest Majority Canadian-Owned Network Of Dental Practices Poised For More National Expansion*. https://www.groupdentistrynow.com/dso-group-blog/largest-majority-canadian-owned-network-of-dental-practices-poised-for-more-national-expansion/

Regulatory Tools

This section outlines the core tools available to the College to protect the public interest. These tools have been leveraged to develop the draft options presented in this briefing note.

- **Standards of practice** include requirements for registrants related to a specific issue or area of practice (e.g., boundaries, recordkeeping, virtual care).

- **Other resources** (e.g., FAQs and backgrounders) do not set out new professional requirements, but instead highlight or elaborate on existing responsibilities that may be relevant to a specific issue or area of practice. In many cases, they aim to support registrants in applying the requirements set out in standards, or in exercising their professional judgment in the best interests of patients.

- The College may also introduce **strategic projects or initiatives (e.g., the PMCD and Access to Care Strategic Projects), amend By-laws, or propose legislative and regulatory changes (e.g., to the *Dentistry Act, 1991* or Professional Misconduct Regulation)** to protect the public interest. Note: the College does not have authority to make legislative or regulatory changes independently; government action is required.

- The RCDSO's regulatory authority extends to registrant dentists only. The College does not regulate non-dentists or businesses,[3] however, it can take regulatory action against individual non-registrants who practise dentistry or hold themselves out as a person who is qualified to practise dentistry in Ontario.

## CURRENT STATUS:

- Six draft options have been developed to support Phase 3 of this project: Decision-making & Implementation.

- The draft options were developed to address and respond to key issues and opportunities that were revealed in the research and analysis conducted in the first two phases of this strategic project. For Council's reference, summaries of the key issues and opportunities can be found in **Appendix A** and **Appendix B** to this briefing note.

- The College has taken a **practice model-agnostic approach** to the development of draft options to assure quality of care. This means that draft options have been developed to address specific issues or risks that may manifest across dental practice models for patients, rather than to regulate specific types of practice models.

- While the draft options are presented individually, they are complementary and more than one draft option could be implemented to address issues and harness opportunities related to dental practice models for patients.

[3] Excluding the issuance of Certificates of Authorization for Health Professional Corporations incorporated under the *Business Corporations Act, 1990*.

- The draft options are set out in this briefing note. The intention is to obtain Council's feedback on the draft options and to gauge Council's interest in pursuing them. After the Council meeting, staff will conduct additional analysis on the draft options that Council supports. This will include conducting a more thorough assessment of implementation considerations for the options (e.g., potential impacts on dentists, administrative burden, and legal risks).

- As Council may recall, these options were shared as part of the December 2024 Council materials but they were not discussed as the presentation of the item was postponed. The draft options remain largely the same from the December 2024 briefing note although some draft options have been amended slightly.

- Council is invited to provide feedback on all six draft options:

    - Options 1 to 5 will be presented for Council's discussion in March and will be shared as part of the final report for Council's approval later in 2025.

    - Option 6 will be presented for Council's discussion in March but will not be shared for Council's approval later in 2025 as it is operational in nature (it concerns College processes for information gathering and data analysis).

- All options were shared with the Executive Committee on December 2, 2024, for discussion. The discussion highlighted key themes that should be addressed through this work, namely, the importance of ensuring continuity of care and accountability for patient care. The Committee also provided targeted feedback which has been incorporated into Options 3, 4, and 5.

- Option 3 was shared with the Quality Assurance Committee (QAC) on November 12 for discussion. QAC's feedback has been incorporated into Options 3 and 6.

Draft Options

**Option 1: Update and develop new College requirements and recommendations for registrants to address unique issues for patients related to the business of dentistry.**

- **1a**: It is recommended that the College update and introduce requirements and recommendations for registrants to address issues associated with business interests which can manifest across various dental practice models. This could include, for example, clarifying requirements related to ownership of dental clinics (e.g., of goodwill, records), setting new requirements related to financial conflicts of interest (e.g., regarding maximizing profits, business efficiencies), and making recommendations regarding the maintenance of clinical autonomy (e.g., control over services provided) particularly for dentists practicing as independent contractors/employees.

- **1b**: The College could initiate a legislative or regulatory review, and/or propose new legislative or regulatory requirements to address topics related to practice models where those topics cannot be addressed by the College. For example, regulatory changes may be needed to set new requirements for registrants practicing in arrangements that involve non-registrants.

*Rationale:*

- Findings from the Literature Review and the Consultation concerning practice models and corporate dentistry suggest that policies and procedures implemented by dental practices can have a direct impact on the practice of the profession by dentists. In particular, organizational practices that prioritize business interests, such as maximizing profit or minimizing costs, can create conflicts of interest and/or lead to losses in clinical autonomy which can negatively impact quality of care (e.g., increase the risk of unnecessary treatments, lead to changes in treatment plans that are not made in patients' best interests).[4] These negative impacts can manifest in various practice models.[5]

- Although the current regulatory framework (i.e., legislation, regulation and College guidance) addresses some elements related to practice arrangements in dentistry,[6] it may not be specific enough to address all issues that may arise in emerging practice models. For example, the current regulatory framework does not specifically address earnings- or production-based targets in dentistry,[7] or provisions in employment agreements that could help to ensure a registrant does not engage in the practice of dentistry where they have a conflict of interest.[8]

*Considerations:*

- Information gathering (e.g., as proposed in Options 2 and 6) and legal input would be needed before the College could make a recommendation, and Council could make a decision, on Option 1b. Support from the Provincial Government would also be needed to make any legislative and/or regulatory changes.

- An oversight mechanism may be needed to track and evaluate compliance with new requirements made under Option 1a or 1b. This could take the form of a new authority for the College to ask dentists to provide a copy of their employment agreements, at any time, along

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[4] See pages 142-143 in the September 2024 Council meeting materials and pages 274 in the October 2024 Council meeting materials.

[5] See the top of page 143 in the September 2024 Council meeting materials.

[6] As an example, subsection 5(4) in the Professional Misconduct Regulation considers the following actions related to practice models to be conflicts of interest and acts of professional misconduct:

- an arrangement respecting a lease or use of premises or equipment, under which any amount payable by or to a member or a related person or related corporation is related to the amount of fees charged by the member;
- entering into an agreement or arrangement, or causing another member to enter into an agreement or arrangement, that prevents or would reasonably be regarded as having the effect of preventing the member from properly exercising his or her professional judgment and skill in respect of the treatment or referral of a patient;
- fee or income splitting with non-registrants of the RCDSO or the College of Dental Hygienists of Ontario; &
- engaging in the practice of dentistry in partnership, association, or as an employee of a non-registrant in a privately-owned business or professional practice.

[7] As an example, Bylaws made by the College of Pharmacists of British Columbia requires pharmacy managers to "ensure that meeting quotas, targets or similar measures do not compromise patient safety or compliance with the bylaws, Code of Ethics or standards of practice."

[8] See similar requirements enforced by the College of Optometrists of Ontario outlined here: Independent Contractor: Regulatory Standards Interpreted

with proof that they are acting in accordance with legal conflict of interest requirements including those related to practice arrangements.[9]

- Additional resources may be required to monitor and investigate compliance.

- While the College's standard(s) development and modernization process typically takes 18 to 24 months, working with the Provincial Government to propose legislative and/or regulatory changes, including gathering the necessary evidence, can be a multi-year process.

**Option 2: Develop new requirements to ensure that a registrant holds primary responsibility for each dental clinic, and to ensure that registrant responsibilities for patient care are clear regardless of the practice model.**

- **2a**: It is recommended that the College require a 'lead' registrant in each clinic who has primary responsibility for the clinic, including the oversight and supervision of the clinic for compliance with relevant legislation, regulation, and standards related to practice management (e.g., IPAC, training new staff, ethical billing processes), and responsibility for providing current practice information to the RCDSO (e.g., name and contact information of the lead registrant, the name of any affiliated third-party or dental corporation). These requirements would not absolve registrants who work at a clinic from any existing legal, professional, or ethical obligations, but they would add a layer of oversight to support quality assurance and compliance with RCDSO's requirements or expectations. This may be particularly helpful in assuring quality of care in practice settings where responsibilities for clinic-oversight and practice management are unclear (e.g., if the owner does not practice at the clinic and there is no defined clinic manager). This option would also help the RCDSO to track clinics' affiliation with third-parties/dental corporations for improved oversight.

- **2b**: It is recommended that College requirements (e.g., in the Most Responsible Dentist Practice Advisory) be updated to clarify the dentist responsible for patients in various scenarios, including those where patients of record primarily belong to a practice, and do not have one dentist who is primarily responsible for their care.[10] These changes may be particularly helpful in large group practices where many associates share patients which can make continuity of care more challenging.

*Rationale:*

- Analysis of Annual Renewal Questionnaire (ARQ) responses suggests that as registrants own more clinics, less of those clinic owners practice at all of their clinics.[11] This finding raises the question – in scenarios where the owner of a clinic does not practice dentistry at the clinic, how are the day-to-day clinic operations managed so as to ensure quality of care?

- Further, Consultation feedback from dentists and other oral health care professionals identified the following issues: low practice oversight where owner(s) do not practice in the

[9] See a similar mechanism used by the College of Optometrists of Ontario here: Independent Contractor: Risk & Control under the "Conduct Trumps Contract" heading.
[10] The current Most Responsible Dentist Practice Advisory focuses on expectations for referring general dentists & specialists.
[11] See pages 282-283 in the October 2024 Council meeting materials

clinic; low accountability and continuity of care for patients in 'associate-led' practices; and uncertainty among registrants regarding who holds practice leadership roles (e.g., the health information privacy lead).[12]

*Considerations*:

- Similar requirements to those proposed in Option 2a have been established for registrant dentists in Alberta and Saskatchewan. These requirements have been helpful in assuring quality of care, and in enabling more efficient investigations by providing a clear point of contact for the Colleges to engage with.[13]

- There is potential for increased administrative burden (resources, costs) related to the College's tracking of clinic information, proposed in Option 2a.

**Option 3: Enhance educational offerings for dental students in Ontario and RCDSO registrants that will help reinforce and illustrate their ethical and professional responsibilities regardless of the practice model.**

- **3a**: It is recommended that new scenarios be added to the College's Jurisprudence and Ethics Course, and new resources and questions be added to the College's Practice Enhancement Tool (PET) to make explicit the connection between existing ethical and professional responsibilities and emerging practice models – i.e., corporate dentistry, direct-to-consumer dentistry.

- **3b**: It is recommended that the College engage with dental faculties in Ontario to identify and implement strategies – including course material, presentations, and other options – to reinforce for dental students their responsibility to protect the public interest respecting the practice of dentistry, regardless of their practice model.

- **3c**: It is recommended that the College provide educational resources (e.g., a RCDSO Connect session or ODA New Dentist Symposium session) focused on ethical and professional responsibilities, with scenarios, to illustrate their application across various practice models.

*Rationale:*

- The Literature Review suggests there may be an opportunity to improve practice management courses in dental education programs to help equip dental students with the skills needed to uphold key principles of dental professionalism in all practice models, not just private practice models.[14]

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[12] See pages 275, 279-280, in the October 2024 Council meeting materials.
[13] Staff from the College of Dental Surgeons of Alberta and the College of Dental Surgeons of Saskatchewan (personal communication, 2024).
[14] See page 147 in the September 2024 Council meeting materials

*Considerations:*

- QAC expressed support for this option at its November 12, 2024, meeting. QAC suggested that RCDSO staff engage with dental faculty to develop strategies to engage students on material related to dental practice models and engage with dental corporations to support information sharing (the latter piece of feedback has been incorporated into Option 6).

- Executive Committee expressed direct support for this option at its December 2, 2024, meeting. The Committee suggested, as part of this option, that the RCDSO provide education to support new registrants who may not be comfortable raising ethical concerns about their clinics with clinic owners/management.

**Option 4: Develop a time-limited 'Innovation Advisory Service' pilot program to provide guidance and risk-manage innovative business practices that have the potential to improve quality or delivery of services for patients.**

- This pilot would provide registrants and the public with an opportunity to engage with College staff about Ontario's regulatory framework for dentists. More specifically, registrants and the public could receive **advice** (not approval) regarding how the regulatory framework applies to their new idea or practice model. This would encourage innovators to share new initiatives with the College and support more proactive, risk-based decision-making by the College.

- The pilot would build on guidance and support that the College already provides to dentists and the public through its Practice Advisory Service (PAS), but it would stand as a separate initiative with distinct objectives, guiding principles, roles, and intake/response processes.

- Inquiries related to innovative dental practice models or concepts can be complicated for the College to address. For this reason, a voluntary advisory body – composed of independent subject matter experts in dental practice models and regulation – could be convened to support College staff in providing advice to registrants and the public through the pilot.

- The pilot could be reviewed after an initial period (e.g., 12-18 months) to determine if it is achieving its objectives and if it should be expanded, shut-down, or otherwise changed.

*Rationale:*

- The Jurisdictional Review identified 'regulatory sandboxes' and 'innovation hubs' as useful tools to ensure effective regulation of new technologies and business models. A regulatory sandbox is a program through which a regulator may provide temporary exemptions from its regulatory requirements (e.g., standards of practice) to enable piloting of innovative solutions that have the potential to improve the quality or delivery of services. [15]

- Conversely, an innovation hub does not provide temporary exemptions from requirements set by the regulator, but it provides a point of contact within the regulator for innovators to raise inquiries and seek non-binding guidance on the application of regulatory requirements to their

[15] See page 140 in the September 2024 Council meeting materials

ideas.[16] For this reason, innovation hubs, which are comparable to the proposed Innovation Advisory Service pilot program, generally have lower resource requirements and require less regulatory risk-management.

- Both regulatory sandboxes and innovation hubs can provide an opportunity for proponents to identify if a new concept or model fits within the existing regulatory framework and help the regulator stay up-to-date on new trends.

- Separately, competition has been identified as an important factor in ensuring patients have access to the broadest range of services at the most competitive prices.[17] A better understanding of innovative concepts and practice models may enable regulatory decision-making that limits negative impacts of regulation on competition.

*Considerations:*

- Potential increases in administrative burden (resources, costs) related to the pilot.

- Potential professional expectations of endorsement/approval of innovative ideas would need to be managed.

- Executive Committee expressed an interest in this option at its December 2, 2024, meeting, noting that more discussion concerning risks and opportunities was needed.

**Option 5: Develop resources to help the public make decisions about the dental practice that is right for them, and to provide guidance to dentists who are considering providing direct-to-consumer orthodontic treatment.**

- **5a**: It is recommended that the College develop resources and/or share pre-existing resources to help patients determine if the care provided by a particular dental practice or through a particular model, such as direct-to-consumer (DTC) dentistry, is right for them (e.g., “five questions to ask your dentist about their practice”).

- **5b**: It is recommended that the College publish a resource that provides general guidance (but not new requirements) for registrants who are considering providing DTC orthodontic treatment to support their professional judgement.

- A more prescriptive regulatory approach was considered for registrants related to DTC dentistry (i.e., new requirements for the provision of care through DTC dentistry) but this is not currently recommended for several reasons including its potential to encroach on registrants’ clinical and professional autonomy.

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[16] See page 10 in Scassa, T., Kumru, E.N., & the Office of the Information Privacy Commissioner of Ontario. (December, 2024). Exploring the Potential for a Privacy Regulatory Sandbox for Ontario. https://www.ipc.on.ca/en/media/5116/download?attachment

[17] Competition Bureau. (last updated 2022, January 20). Self-regulated Professions—Balancing Competition and Regulation. Government of Canada. https://competition-bureau.canada.ca/self-regulated-professions-balancing-competition-and-regulation

*Rationale:*

- Feedback from the Consultation concerning practice models and corporate dentistry revealed that sometimes patients' usual dental practice does not always align with their values (e.g., clinic does not have evening/weekend appointments, clinic/dentist does not assign benefits, patient does not see the same dentist at each appointment).

- Additionally, findings from the research suggest that DTC orthodontic treatments can improve access to care but result in poor treatment outcomes for some patients, including damage to patients' oral health, if registrants are not appropriately involved in the provision of care and if the standards of the profession are not met. [18, 19]

- The College has previously provided general guidance for registrants in its March 2024 newsletter regarding how to manage patients of a former DTC orthodontics company, SmileDirectClub, but it has not provided general guidance for those who work in, or are considering working in, other DTC companies/models.[20]

*Considerations:*

- Resources help protect the public by enabling more informed decision-making by patients and by supporting the professional judgement of registrants.

- The Executive Committee expressed direct support for this option at its December 2, 2024, meeting, emphasizing, in particular, the importance of informative resources for patients.

**Option 6: Continue to engage with external parties and explore opportunities to gather information to support improved understanding and oversight of dental practice models.**

- **6a**: Staff will consider opportunities to engage with external parties (e.g., dental faculty, dental corporations, other Colleges) to help assure quality of care across practice models. This engagement could include, as a few examples, seeking feedback on standards and engaging with quality assurance staff at dental corporations to share information about new requirements.

- **6b**: Staff will continue to work across College areas, such as Communications and Professional Conduct and Regulatory Affairs, to determine if there are opportunities to improve existing information gathering and data analysis processes in order to advance our understanding and oversight of practice model-related issues and opportunities.

- Proposed areas for continued or further exploration related to Option 6a and 6b include:

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[18] See page 143-144 in September 2024 Council meeting materials and pages 278 and 286-287 in the October 2024 Council meeting materials.

[19] Wexler, A. Nagappan, A., Beswerchij, A. and Choi, R. (2020) Direct-to-consumer orthodontics: surveying the user experience. *The Journal of the American Dental Association* 151(8), 625-636. https://pmc.ncbi.nlm.nih.gov/articles/PMC7391059/

[20] Royal College of Dental Surgeons of Ontario (2024, March). RCDSO Connect: Winter 2024. p.12. https://az184419.vo.msecnd.net/rcdso/pdf/rcdso-newsletter/2024RCDSO_5517_Connect%20Newsletter.pdf

- ongoing media monitoring and engagement with other Colleges regarding practice model-related topics in dentistry and other health professions (e.g., pharmacy, veterinary medicine);
- new opportunities to centrally track matters related to dental practices or practice models that are brought to the College via formal (e.g., inquiries, complaints) and informal channels;
- new strategies to analyze tracked information to identify insights that can support effective regulation.

*Rationale:*

- There is an opportunity for the College to explore new ways to leverage data to track and identify insights related to dental practice models, for example, where registrants' conduct has had a negative impact on patient care and where the organizational policies and procedures set by a clinic owner or management have played a role.
- This option may generate insights and evidence that can support some of the other options outlined in this briefing note (e.g., Option 1b).

*Considerations:*

- Option 6b requires additional scoping with College departments before feasible opportunities and strategies can be identified and a path forward can be pursued.
- As previously noted, Option 6 is being shared with Council for discussion at its March 2025 meeting but will be put not be put forward for Council's approval in 2025 given it is operational in nature (i.e., it concerns College processes for information gathering and data analysis).

## NEXT STEPS:

- A report with options for Council's approval, including an analysis of implementation considerations for registrants and the College, will be shared with Council later in 2025.
- Once recommended options are approved by Council, an implementation plan that outlines timelines, pace, and other considerations for implementing approved recommendations, will be developed.

## DECISION FOR COUNCIL:

- There are no decisions for Council.
- As noted earlier in the briefing note, the intention is to obtain Council's feedback on the draft options and gauge Council's interest in pursuing the draft options. After the Council meeting, staff will conduct additional analysis on the draft options that Council supports.

- Council is being asked the following:

  1. Does Council have any feedback on the options, including any or questions or concerns?

  2. Which of the draft options does Council support and direct that staff analyze further? Which of the draft options does Council not support?

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Attachments:

**Appendix A: Research Summary Identifying and Analyzing Issues**

**Appendix B: Research Summary Identifying and Analyzing Opportunities**

**Appendix A: Research Summary Identifying and Analyzing Issues**

**Practice Models and Corporate Dentistry Strategic Project – Analysis and Options Development**

## OVERVIEW

- The Practice Models and Corporate Dentistry Strategic Project (PMCD project) is analyzing various dental practice models, including corporate ownership models, their impact on quality of care, and implications for dental regulation.
- This document provides a summary of the research on practice models and corporate dentistry with a focus on the issues affecting patients.
- This summary considers key findings from all deliverables completed to date: the RCDSO Research Summary, List of Practice Models, Jurisdictional Review, Literature Review, Consultation Summary, and Data Analysis Summary.
- This summary is the second deliverable of Phase 2 of the PMCD project:

| | |
|---|---|
| Phase 2: Analysis & Options Development | Deliverable F: Data Analysis Summary |
| | **Deliverable G: Research Summary Identifying & Analyzing Issues** |
| | Deliverable H: Research Summary Identifying & Analyzing Opportunities |
| | Deliverable I: Report on Key Research Findings & Options |

## EXCUTIVE SUMMARY

- Issues related to practice models are complex and most issues, identified through the research, can manifest across various practice models.
- Seven key issues were identified based on a review of all completed research. The key issues are as follows:
  1) Loss of clinical and non-clinical autonomy due to requirements (e.g., contractual) or clinic policies/guidelines;
  2) Financial conflicts of interest that prevent (or could be seen to prevent) registrants from properly exercising their professional judgement;
  3) Organizational inefficiencies in dental practices that can compromise patient care (e.g., low clinic oversight, high turn-over of regulated staff);

4) Lack of accountability and responsibility for patient care (e.g., because patients are treated by a new registrant at each appointment);

5) Direct to consumer orthodontic treatment that lacks necessary clinical oversight (e.g., appropriate evaluation prior to starting treatment, development of a treatment plan, ongoing evaluation of the progression/success of treatment);

6) Direct to consumer orthodontic treatment that includes clinical oversight, but where one or more of the steps in treatment is not carried out in accordance with regulatory requirements and/or does not meet the standard of care;

7) Lack of formal RCDSO positions on key topics, or "informal" positions that are out-of-date (e.g., on some topics related to practice ownership and practice arrangements).

**ANALYSIS**

- Issues related to dental practice models, potential outcomes for patients, and impacted registrants/applicable practice models are outlined below. Descriptions of the options that have been proposed to address these issues can be found in the body of the associated briefing note.
- Each row captures considerations related to the numbered issue in the left-most column.

| Issue related to dental practice models | Potential patient outcomes | Impacted registrants and applicable practice models | Deliverables (Sources) | Proposed options to address the issue |
|---|---|---|---|---|
| 1) Loss of clinical and non-clinical autonomy due to requirements (e.g., contractual) or clinic policies/procedures that are designed with business objectives in mind (e.g., maximize profit, minimize costs) and may not be compatible with professional | Can increase risks for treatment decisions that may not be in patients best interests. For example:<br>• changes in treatment plans based on the availability of | Can impact registrants working in any practice model where they do not work entirely for themselves (i.e., all registrants except for principals who are in complete control of all elements of their practice). | • Literature Review Summary (Deliverable D)<br>• Consultation Summary (Deliverable E) | • Option 1<br>• Option 3 |

| Issue related to dental practice models | Potential patient outcomes | Impacted registrants and applicable practice models | Deliverables (Sources) | Proposed options to address the issue |
|---|---|---|---|---|
| and/or ethical expectations of the profession. | supplies or restrictive referral policies;<br>• delays in treatment. | | | |
| 2) Financial conflicts of interest that prevent (or could be seen to prevent) registrants from properly exercising their professional judgement (e.g., compensation tied to earnings targets, income sharing with non-registrants). | Can increase risks for negative impacts on quality of patient care. For example:<br>• provision of unnecessary or excessive treatments;<br>• billing for unnecessary treatments;<br>• billing and providing treatment based on what insurance will pay for rather than what patients need;<br>• billing for more expensive treatments than what was performed. | Can impact registrants working in any practice model. The extent to which these conflicts of interest materialize may vary based on:<br>1. internal motivations, characteristics, and the ethical reasoning skills of registrants;<br>2. objectives and requirements set by practice owner(s), management. | • Literature Review Summary (Deliverable D)<br>• Data Analysis Summary (Deliverable F)<br>• Consultation Summary (Deliverable E) | • Option 1<br>• Option 3 |

| Issue related to dental practice models | Potential patient outcomes | Impacted registrants and applicable practice models | Deliverables (Sources) | Proposed options to address the issue |
|---|---|---|---|---|
| 3) Organizational inefficiencies in dental practice due to:<br>• low clinic oversight, particularly if clinic owner(s) do not practice at the clinic;<br>• low accountability for patients in 'associate-led' clinics;<br>• non-regulated clinic staff being involved in clinical decision-making;<br>• high-turnover of dentists and dental hygienists;<br>• uncertainty regarding clinic safety policies and whether identifiable practice 'leads' work in the practice (e.g., Radiation Protection Officer). | Can increase risks for:<br>• poor continuity and/or consistency of care;<br>• poor patient-dentist relationships which can lead to a loss of patient trust in their oral health care professionals. | Can impact registrants working in any practice model. The extent to which these risks materialize may vary based on:<br>1. whether dentists in the practice or the practice at large hold the primary responsibility for patients' care;<br>2. the organizational roles and responsibilities of regulated and non-regulated staff in day-to-day clinic operations. | • Literature Review Summary (Deliverable D)<br>• Consultation Summary (Deliverable E)<br>• Data Analysis Summary (Deliverable F) | • Option 2<br>• Option 4 |

| Issue related to dental practice models | Potential patient outcomes | Impacted registrants and applicable practice models | Deliverables (Sources) | Proposed options to address the issue |
|---|---|---|---|---|
| 4) Lack of accountability and responsibility for patient care (e.g., because patients are treated by a new registrant at each appointment). | Can increase risks for:<br>• low consistency in treatment philosophy;<br>• loss of continuity of care;<br>• loss of patients' ability to trust and feel comfortable with their oral healthcare providers. | Can impact registrants working in any practice model where patients regularly receive care from different registrants (e.g., some large group practices or corporate dental clinics). | • Consultation Summary (Deliverable E) | • Option 2 |
| 5) Direct to consumer orthodontic treatment that lacks necessary clinical oversight in one or more of the following steps (list is not exhaustive):<br>• appropriate evaluation of the patient's oral health prior to starting treatment (i.e., diagnostic records and steps);<br>• development of a treatment plan; | Can increase risks for:<br>• ineffective treatment; and/or<br>• damage to patient's oral health (e.g., pain, bite issues, bone loss, tooth loss) which can be permanent. | Not applicable to registrants if they are not involved in providing direct-to-consumer orthodontic treatment.<br>In this scenario, a direct-to-consumer orthodontic company may be practicing dentistry illegally if they are performing a controlled act (e.g., fitting or dispensing a dental prosthesis, or an orthodontic or periodontal appliance or a device used inside the mouth to protect teeth from abnormal functioning). | • Literature Review Summary (Deliverable D)<br>• Consultation Summary (Deliverable E)<br>• Data Analysis Summary (Deliverable F) | • Option 5<br>• Option 6 |

| Issue related to dental practice models | Potential patient outcomes | Impacted registrants and applicable practice models | Deliverables (Sources) | Proposed options to address the issue |
|---|---|---|---|---|
| • obtaining informed consent including discussion of risks of treatment;<br>• recordkeeping in accordance with regulatory requirements;<br>• ongoing evaluation of the progression/success of treatment. | | | | |
| 6) Provision of orthodontic treatment directly to the consumer with the involvement of a dentist, but where one or more of the steps in treatment (bulleted examples in row 5 above) are not carried out in accordance with regulatory requirements and/or do not meet the standard of care. | Can increase risks for:<br>• ineffective treatment; and/or<br>• damage to patient's oral health (e.g., pain, bite issues, bone loss, tooth loss) which can be permanent. | Can impact registrants who provide orthodontic treatment in any model.<br>This issue may be more prevalent in a direct-to-consumer model, especially if the model does not enable or actively prohibits registrants from providing care that meets the standards of the profession. | • Literature Review Summary (Deliverable D)<br>• Consultation Summary (Deliverable E)<br>• Data Analysis Summary (Deliverable F) | • Option 5<br>• Option 6 |

| Issue related to dental practice models | Potential patient outcomes | Impacted registrants and applicable practice models | Deliverables (Sources) | Proposed options to address the issue |
|---|---|---|---|---|
| 7) Lack of formal RCDSO positions on key topics, or “informal” positions that are out-of-date. For example, existing legislation, regulation, and College standards are silent on some topics related to practice ownership and practice arrangements, and some topics are only addressed informally by RCDSO Dispatch articles. | The absence of up-to-date legislation, regulation, or College standards on these topics may inadvertently enable practices in some models that call into question the integrity of patient care, even though they may not violate existing regulatory requirements. | Can impact registrants in models affiliated with non-registrants (e.g., some corporate dental clinics). | • RCDSO Research Summary (Deliverable A) | • Option 1 |

**Appendix B: Research Summary Identifying and Analyzing Opportunities**

**Practice Models and Corporate Dentistry Strategic Project – Analysis and Options Development**

## OVERVIEW

- The Practice Models and Corporate Dentistry Strategic Project (PMCD project) is analyzing various dental practice models, including corporate ownership models, their impact on quality of care, and implications for dental regulation.
- This document provides a summary of the research on practice models and corporate dentistry with a focus on the opportunities affecting patients.
- This summary considers key findings from all deliverables completed to date: the RCDSO Research Summary, List of Practice Models, Jurisdictional Review, Literature Review, Consultation Summary, and Data Analysis Summary.
- This summary is the third deliverable of Phase 2 of the PMCD project:

| | |
|---|---|
| Phase 2: Analysis & Options Development | Deliverable F: Data Analysis Summary |
| | Deliverable G: Research Summary Identifying & Analyzing Issues |
| | **Deliverable H: Research Summary Identifying & Analyzing Opportunities** |
| | Deliverable I: Report on Key Research Findings & Options |

## EXCUTIVE SUMMARY

- Opportunities related to practice models are complex and most opportunities, identified through the research, can manifest across various practice models.
- Seven key opportunities were identified based on a review of all completed research. The first three opportunities are related to practice elements and the last four opportunities relate to regulatory tools and changes that could be implemented to assure quality of care and ensure effective regulation of dentists across various models. The key opportunities are as follows:

  1) Improved focus on the provision of clinical care due to little or no responsibility of registrants for business or administrative elements of the practice;
  2) Elements that may improve the affordability of oral health care for patients (e.g., clinics/dentists who accept patients who receive support from publicly-funded programs, offers of 0% or low interest financing; and no-cost, low-cost, or discounted treatments);

3) Elements that may improve physical access to oral health care for patients (e.g., treatments that are provided directly to consumers, flexible clinic hours and locations);

4) Education concerning practice models can better support registrants to uphold their ethical and professional responsibilities regardless of the practice model;

5) Ensuring that a registrant has responsibility for overseeing and supervising the clinic for compliance with relevant legislation, regulation, and standards related to practice management can help to assure quality of care;

6) Using a regulatory sandbox to pilot innovative concepts or models that have the potential to improve the quality or delivery of services;

7) The College may be able to improve its oversight over dental clinics and, consequently, issues that can arise at the practice-level;

**ANALYSIS**

- Opportunities related to dental practice models, potential outcomes for patients, and impacted registrants/applicable practice models are outlined below. Descriptions of the options that have been proposed to address these opportunities can be found in the body of the associated briefing note.
- Each row captures considerations related to the numbered opportunity in the left-most column.

| Opportunity related to dental practice models | Potential patient outcomes | Impacted registrants and applicable practice models | Deliverables (Sources) | Proposed options that will consider or harness the opportunity |
|---|---|---|---|---|
| 1) Improved focus on the provision of clinical care due to little to no responsibility of registrants for business or | Can, theoretically, make it easier for some registrants to provide comprehensive diagnosis and treatment, though benefits for patients are unclear. | Can impact registrants working in any practice model where the practice/owner assumes responsibility for all business and | • Literature Review (Deliverable D) | • Option 1 |

| Opportunity related to dental practice models | Potential patient outcomes | Impacted registrants and applicable practice models | Deliverables (Sources) | Proposed options that will consider or harness the opportunity |
|---|---|---|---|---|
| administrative elements of the practice. | | administrative activities. This includes corporate dental clinics. | • Consultation Summary (Deliverable E) | |
| 2) Elements that may improve the affordability of oral health care for patients (e.g., clinics/dentists who accept patients who receive support from publicly-funded programs, offers of 0% or low interest financing; and no-cost, low-cost, or discounted treatments). | Can help remove or lower financial barriers to care. | Can impact registrants working in any practice model, but particularly registrants who:<br>1. work in dental clinics with a mandate or commitment to provide low or no-cost care to patients (e.g., community health center, hospital, school-based clinic, not-for-profit dental clinics);<br>2. provide treatments at a lower cost compared to traditional practice models (e.g., direct-to-consumer dentistry);<br>3. generate cost-savings that are passed on to patients (e.g., potentially corporate dental clinics). | • Literature Review (Deliverable D)<br>• Consultation Summary (Deliverable E) | • Option 4<br>• The RCDSO's Access to Care Strategic Project is focused on improving patients' access to oral health care. |

| Opportunity related to dental practice models | Potential patient outcomes | Impacted registrants and applicable practice models | Deliverables (Sources) | Proposed options that will consider or harness the opportunity |
|---|---|---|---|---|
| 3) Elements that may improve physical access to oral health care for patients (e.g., treatments that are provided directly to consumers, multiple providers within a clinic, flexible clinic hours and locations, and accessibility accommodations). | Can improve patients' physical access to care and improve the convenience of care, particularly for patients who live in rural or remote communities, or who have a physical disability or other health condition that may make it more challenging to seek oral health care in a dental clinic. | Can impact registrants working in any practice model, including models where:<br>1. patients can go to any clinic within a network or group of practices rather than only one location (e.g., corporate dental clinic).<br>2. companies provide specialized treatments directly to the consumer (e.g., direct-to-consumer teeth whitening systems, mouthguards, orthodontic treatment). | • Literature Review (Deliverable D)<br>• Consultation Summary (Deliverable E) | • Option 4<br>• The RCDSO's Access to Care Strategic Project is focused on improving patients' access to oral health care. |
| 4) Education concerning practice models can better support registrants to uphold their ethical and professional responsibilities regardless of the practice model. | Can help to assure quality of patient care. | Registrants working in any practice model, but especially emerging models which may be less understood by dental students or new RCDSO registrants (e.g., | • Literature Review (Deliverable D) | • Option 3 |

| Opportunity related to dental practice models | Potential patient outcomes | Impacted registrants and applicable practice models | Deliverables (Sources) | Proposed options that will consider or harness the opportunity |
|---|---|---|---|---|
| | | corporate dental clinic, direct-to-consumer dentistry). | | |
| 5) Ensuring that a registrant has responsibility for overseeing and supervising the clinic for compliance with relevant legislation, regulation, and standards related to practice management can help to assure quality of care. | Can help to assure quality of patient care and improve oversight within clinics. | Registrants working in any clinic-based practice model may benefit from this approach. | • Jurisdictional Review Summary (Deliverable C) | • Option 2 |
| 6) Using a regulatory sandbox to pilot innovative concepts or models that have the potential to improve the quality or delivery of services. | Can enable innovation that improves access to care and provides a safe environment for testing innovations and exploring how to best regulate them. | Registrants working in any practice model could take advantage of a regulatory sandbox. | • Jurisdictional Review Summary (Deliverable C) | • Option 4 |
| 7) The College may be able to improve its understanding and oversight over dental clinics | Greater oversight could help to assure quality care and identify opportunities to more effectively regulate registrants. | Could apply to registrants working in any practice model. | • Consultation Summary (Deliverable E) | • Option 2<br>• Option 6 |

| Opportunity related to dental practice models | Potential patient outcomes | Impacted registrants and applicable practice models | Deliverables (Sources) | Proposed options that will consider or harness the opportunity |
|---|---|---|---|---|
| and, consequently, issues that can arise at the clinic-level. | | | | |

Royal College of
Dental Surgeons of Ontario

# COUNCIL BRIEFING NOTE

**TOPIC:** **Regulation Amendment: Professional Liability Protection**

**FOR DECISION**

March 27, 2025

## ISSUE:

- As directed by Council, a procurement process to transfer the Professional Liability Program (PLP) to a third party is underway. Amendments to the Registration Regulation are required to ensure that all members have adequate professional liability protection once the program is divested.
- In January, Council approved circulation of the draft amendments for the required 60-day consultation period and is now presented with the draft amendment for approval, along with the preliminary consultation results.
- Council is being asked to formally approve the draft regulation and direct the RCDSO to make a submission to the Ministry.

## PUBLIC INTEREST:

- Making professional liability protection a requirement of registration is necessary to ensure that dentists do not practice without professional liability protection once PLP is divested. This is connected to the RCDSO's public interest because it provides assurance that patients experiencing harm or injury through negligence have access to appropriate compensation.

## BACKGROUND:

- In December 2023, Council directed RCDSO staff to explore the option of divesting the RCDSO's direct ownership and operation of the PLP program. The divestment process is underway and is progressing in accordance with milestones presented previously.
- Once the RCDSO no longer owns and operates the program, the College will need to identify a way to ensure that all registrants have professional liability protection, that the amount of coverage is adequate, and that the tools are in place to act if registrants do not have coverage.
- Amendments to the RCDSO's Registration Regulation General Regulation (O. Reg. 205/94) are required to establish professional liability coverage as a registration requirement.[1] Council reviewed the draft regulation amendments on January 23, 2025 and directed staff to launch the mandatory 60-day consultation period.

[1] Subsection 95(1) of the Health Professions Procedural Code of the RHPA provides the authority for Council to make regulations, subject to the approval of the Lieutenant Governor in Council and with prior review of the Minister of Health.

- The RCDSO's consultation period started on January 24 and closes on March 25, 2025. Preliminary consultation results are provided below. Council will be provided with a complete update on final consultation input at the Council meeting on March 27.

## ANALYSIS/RECOMMENDATION:

- Below is a plain language overview of the draft regulation, and a report on the consultation results, together with a proposal for how to address consultation feedback.

### 1. Draft regulation amendment

- With the support of legal counsel, amendments to the registration regulation were drafted to establish a framework that will:
  - Require all members to have professional liability protection to be registered;
  - Establish an ongoing obligation to maintain professional liability protection; and
  - Introduce a mechanism (and accompanying reinstatement provisions) to suspend a member if professional liability protection is not maintained.
- Additional changes to the registration regulation were also circulated for consultation, in order to streamline registration processes. This includes:
  - Work authorization requirements: introducing a mechanism to ensure that dentists cannot practice without appropriate work authorization once registered;
  - Continuous practice requirements: amendments to streamline the process of allowing dentists to work in Ontario after a period of time out of practice; and
  - Adding additional exclusions to the reinstatement provisions to enhance public protection
- The draft regulation amendment is attached as **Appendix A**.

### 2. Consultation feedback and proposal for response

#### *i) Summary of Results*[2]

- As of the time of drafting, a total of **114 online surveys** have been received.
- A small number of additional inquiries have also been submitted directly via RCDSO's dedicated consultation email address; however, these submissions did not address the consultation purpose.
- Of the 114 online survey submissions, 44 respondents did not include any substantive feedback in response to the survey's sole question (see below). In other words, 44 respondents submitted incomplete surveys, leaving a total of **70 "valid" or "complete" submissions**.
- Of the surveys received, the majority of respondents self-identified as dentists (96.5%). One respondent self-identified as a "patient or member of the public", and no submissions have yet been received from an organization at this writing.

#### *ii) Limitations / Caveats*

- Participation in this survey/consultation was voluntary. As a result, this feedback summary is not representative of the opinions of any general demographic group and cannot be generalized.

[2] The analysis in this section is based on consultation input provided up to March 10, 2025. Council will be provided with a complete update on final consultation input at the Council meeting on March 27.

***iii) Summary of feedback:***

- A detailed overview of the consultation feedback the RCDSO received is attached as **Appendix B**.
- 70 respondents provided written feedback in response to the survey question.
- The vast majority of feedback concerns RCDSO's decision to divest the Professional Liability Program (PLP), and very little feedback was received that relates specifically to the proposed regulation amendments.
- In general, key themes arising from the survey feedback include:
    - **Lack of understanding of the reason for divestment and a preference for status-quo:** A considerable number of respondents were not aware of the reason for divestment and expressed a preference for status-quo and the retention of PLP within RCDSO. → *This feedback is not related to the regulation amendment.*
    - **Cost and impact on registration fees:** Many survey respondents expressed concern related to the potential financial impact of divestment on dentists (i.e., increasing costs) and requested that RCDSO's registration fees be reduced to offset any increasing cost to dentists of third party insurance coverage. → *This feedback is not related to the regulation amendment.*
    - **Non-practising dentists:** Several consultation respondents responded to the requirement that professional liability protection will be required of all registrants and requested that specific exemptions be created concerning requirements for liability protection coverage for dentists who are "non-practising" (e.g., those that are retired or semi-retired, and dentists who principally work in an academic or research capacity).

***iv) Proposal for Response & Rationale***

- Staff analyzed participant feedback and have developed a proposal for Council's consideration, along with an accompanying rationale for the proposal.

**PROPOSAL**:

***It is proposed that Council approve the regulation amendment as circulated, with no additional changes.***

**RATIONALE**:

- The majority of participant feedback was related to the decision to divest PLP and/or the costs associated with that decision, not the regulatory amendments (which was the subject of the consultation). These comments are best addressed through other tools, such as protocols, policies and/or communication materials.
- An analysis of the key themes related to the regulatory amendments is as follows:

| FEEDBACK | ANALYSIS/RECOMMEDATION: |
|---|---|
| ***Implications for non-practising dentists***<br><br>Several consultation respondents commented on the requirement for all registrants to have professional liability protection and requested that specific exemptions be created concerning requirements for liability protection coverage for dentists who are "non-practising" (e.g., those that are retired or semi-retired, and dentists who principally work in an academic or research capacity). | The College does not currently have a non-practising class. The proposed regulation amendment maintains the current requirement that all registrants require liability protection. As members of the College, all classes have the authority to perform authorized acts and require professional liability protection. Any registrant can be subject to a professional liability claim, regardless of their class of license, and related to non-clinical activities (e.g. teaching, research).<br><br>→ **Recommendation:** No change to the regulation. |
| ***Continuous practice requirements***<br><br>One respondent raised concerns regarding the implementation of the continuous practice requirements, and how they would be enforced. | Enforcement of regulations is not addressed in the regulation itself; changes to the continuous practice requirement will be implemented through policy tools and clearly communicated to members.<br><br>→ **Recommendation:** No change to the regulation. |
| ***Eligibility for reinstatement***<br><br>One respondent raised concerns regarding the pre-existing criteria that makes a person who is under an ongoing investigation ineligible for reinstatement. | This requirement already exists in regulation and no changes are being proposed. Former members who are ineligible for immediate reinstatement have the option to make an application for a new certificate of registration.<br><br>→ **Recommendation:** No change to the regulation. |

## CONSIDERATIONS:

- The regulatory amendments will also be posted for consultation on Ontario's Regulatory Registry for 45 days (typically, this is done in parallel with the College's consultation process but was delayed due to the provincial election). The Ministry will provide the consultation results to the College. We do not anticipate feedback through the Ministry process that is substantially different than what was received through the RCDSO consultation. Should any substantially different feedback be received through that process, it will be brought back to Council for review and reconsideration.

## NEXT STEPS:

- The consultation closes on March 25, 2025. Any additional feedback will be presented to Council for consideration at the March 27 meeting. Should Council approve the draft regulation amendment as proposed, the RCDSO will prepare a formal submission to the Ministry.

- Following that, the primary responsibility for the remainder of the regulation amendment process shifts to the Ministry. The Ministry is aware of the urgency of these changes, and college staff will support the Ministry in this work to support an efficient process.
- In addition, updates to the College by-laws will be required to establish the requirement for minimum professional liability protection (such as minimum coverage amounts) to ensure that the public is protected.[3] These by-law amendments will be brought forward to Council for approval later this year.

## DECISION FOR COUNCIL:

- Council is asked for its direction on two points:

  1. Absent the receipt of significantly different feedback through the Ministry's Regulatory Registry, does Council approve the amendments to the Registration Regulation as currently worded; and

  2. Does Council direct RCDSO staff to make a formal submission to the Ministry, as required by the Ministry's processes?

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Attachments

Appendix A – Regulation amendment proposal - professional liability protection

Appendix B – Consultation feedback

[3] Subsection 94(1)(y) of the Health Professions Procedural Code of the RHPA states that the College may make bylaws "requiring members to have PLI that satisfies the requirements specified in the bylaws or to belong to a specified association that provides protection against professional liability and requiring members to give proof of the insurance or membership to the Registrar in the manner set out in the bylaws".

**Appendix A: Regulation amendment proposal - professional liability protection**

**Dentistry Act, 1991**
**Loi de 1991 sur les dentistes**

**ONTARIO REGULATION 205/94**

**GENERAL**

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**PART IV**
**REGISTRATION**

INTERPRETATION

**10.** In this Part,

"dental internship program" means a non-specialty residency program;

"dental residency program" means a specialty program in dental anaesthesia, oral and maxillofacial surgery, oral pathology, oral medicine or oral medicine and pathology. O. Reg. 407/04, s. 1; O. Reg. 500/07, s. 1.

**CLASSES OF CERTIFICATES OF REGISTRATION**

**10.1** (1) The following are the classes of certificates of registration:

1. General.
2. Specialty.
3. Academic.
4. Education.
5. Post-Specialty Training.
6. Graduate Student.
7. Academic Visitor.
8. Instructional.
9. Short Duration.
10. Emergency. O. Reg. 75/12, s. 1; O. Reg. 280/23, s. 1.

(2) The holder of a specialty certificate of registration is authorized to practise one of the following specialties as indicated on the certificate and subject to any other terms, conditions or limitations:

1. Dental anaesthesia.
2. Endodontics.
3. Oral and maxillofacial surgery.
4. Oral medicine.
5. Oral pathology.
6. Oral and maxillofacial radiology.
7. Orthodontics and dentofacial orthopaedics.
8. Paediatric dentistry.
9. Periodontics.
10. Prosthodontics.
11. Public health dentistry. O. Reg. 75/12, s. 1.

## GENERAL REQUIREMENTS AND CONDITIONS

**11.** (1) A person may apply for a certificate of registration by submitting a completed application for the class of certificate for which the application is made, in the form provided by the Registrar, together with any supporting documentation requested by the Registrar and the applicable fees required by the by-laws of the College. O. Reg. 75/12, s. 2.

(2) Payment of the fees referred to in subsection (1) is a non-exemptible requirement for the issuance of a certificate of registration of any class. O. Reg. 75/12, s. 2.

**12., 13.** REVOKED: O. Reg. 75/12, s. 3.

**14.** (1) It is a requirement for the issuing of a certificate of registration of any class that in the opinion of the Registrar or of the Registration Committee, as the case may be, the applicant's past and present conduct afford reasonable grounds for the belief that the applicant,

(a) is mentally competent and physically able to safely practise dentistry;

(b) will practise dentistry with decency, integrity and honesty and in accordance with the law;

(c) has sufficient knowledge, skill and judgment to competently engage in the kind of dental practice authorized by the certificate;

(d) can communicate effectively; and

(e) will display an appropriate professional attitude. O. Reg. 407/04, s. 1.

(2) It is a requirement for the issuing of a certificate of registration of any class that the applicant has professional liability protection in accordance with the requirements, if any, set out in the by-laws.

(3) An applicant shall be deemed not to have satisfied the requirements for the issuing of a certificate of registration if the applicant made a false or misleading statement or representation in respect of his or her application. O. Reg. 407/04, s. 1.

**15(1)** It is a term, condition and limitation of a certificate of registration of any class that the member provide the College with details of the following that relate to the member and that occur or arise after the member is registered:

1. A finding of guilt arising in any jurisdiction relating to any offence.
2. If the member is registered or licensed to practise any other profession in Ontario, or any profession in any other jurisdiction, an investigation or proceeding for professional misconduct, incompetence, incapacity or a similar investigation or proceeding.
3. If the member is registered or licensed to practise any other profession in Ontario, or any profession in any other jurisdiction, a finding of professional misconduct, incompetence, incapacity or a similar finding. O. Reg. 407/04, s. 1; O. Reg. 75/12, s. 4.

(2) Where the requirements for the issuance of a certificate of registration include that the applicant is a Canadian citizen or a permanent resident of Canada or has received the appropriate authorization under the *Immigration and Refugee Protection Act* (Canada) to permit the applicant to engage in the practice of dentistry in Canada, then the certificate of registration is subject to the following terms, conditions and limitations:

1. The member **shall not engage in the practice of dentistry** unless the member is a Canadian citizen or permanent resident of Canada or has authorization under the *Immigration and Refugee Protection Act* (Canada) permitting the member to engage in the practice of dentistry in Ontario.
2. The member shall immediately advise the Registrar in writing in the event that the member ceases to be a Canadian citizen or permanent resident of Canada or to have authorization under the *Immigration and Refugee Protection Act* (Canada) permitting the member to engage in the practice of dentistry in Ontario.
3. If a member to whom paragraph 2 applies subsequently obtains Canadian citizenship, becomes a permanent resident of Canada or attains authorization under the *Immigration and Refugee Protection Act* (Canada) permitting the member to engage in the practice of dentistry in Ontario, he or she shall immediately advise the Registrar in writing of that fact.

(3) Every certificate of registration is subject to the following terms, conditions and limitations:

1. The member shall maintain professional liability protection in accordance with the requirements, if any, set out in the by-laws.
2. The member shall, at the request of the Registrar, provide evidence satisfactory to the Registrar that the member meets the requirements in paragraph 1, in the form and manner requested by the Registrar.
3. The member shall immediately advise the Registrar in writing in the event that the member ceases to meet the condition required in paragraph 1, and shall immediately cease to engage in the practice of dentistry until such time as the member meets the requirements in paragraph 1
4. If a member to whom paragraph 3 applies subsequently attains professional liability protection in accordance with the requirements, if any, set out in the by-laws, the members shall immediately advise the Registrar in writing of that fact

**GENERAL CERTIFICATE**

**16.** (1) The additional requirements for the issuing of a general certificate of registration are the following:

1. The applicant has a degree in dentistry evidencing successful completion of a course in dental studies of at least four years duration at a university-based dental school.
2. The applicant,
   i. holds a Certificate of the National Dental Examining Board of Canada issued before January 1, 1994, or
   ii. has successfully completed the National Dental Examining Board of Canada examinations leading to a Certificate of the National Dental Examining Board of Canada at a time when those examinations were approved by the College,
   iii. REVOKED: O. Reg. 75/12, s. 5 (2).
3. ~~Since the applicant satisfied the requirement of paragraph 2, there has been no three-year period during which the applicant has not engaged in the practice of dentistry on a continuous and regular basis in Canada, or the United States of America.~~
3. If the applicant satisfied the requirements of paragraph 2 more than three years ago, the applicant must have engaged in the practice of dentistry on a continuous and regular basis in Canada, or the United States of America or a jurisdiction approved by the Registration Committee for a period of at least three years immediately before the date of the application.
4. The applicant is able to demonstrate the ability to speak and write either English or French with reasonable fluency.
5. The applicant has successfully completed an examination in ethics and jurisprudence set or approved by the College.
6. The applicant is a Canadian citizen or a permanent resident of Canada or has received the appropriate authorization under the *Immigration and Refugee Protection Act* (Canada) to permit the applicant to engage in the practice of dentistry in Canada as authorized by the certificate. O. Reg. 407/04, s. 1; O. Reg. 75/12, s. 5 (1, 2).

(2) Subject to subsection (3), the requirement of paragraph 2 of subsection (1) is non-exemptible. O. Reg. 75/12, s. 5 (3).

(3) The requirements of paragraphs 1 and 2 of subsection (1) do not apply to an applicant if he or she held a general certificate of registration issued by the College at any time before submitting his or her application for a general certificate of registration. O. Reg. 75/12, s. 5 (3).

(4) The requirements of paragraphs 1, 3, 4 and 5 of subsection (1) and the requirement to pay the application fee set out in a College by-law do not apply to an applicant who held an emergency certificate of registration issued by the College within three years before submitting their application for that general certificate of registration. O. Reg. 280/23, s. 2.

**17.** (1) Where section 22.18 of the Health Professions Procedural Code applies to an applicant, the applicant is deemed to have met the requirements of paragraphs 1, 2 and 3 of subsection 16 (1) of this Regulation. O. Reg. 75/12, s. 6.

(2) It is a non-exemptible registration requirement that an applicant referred to in subsection (1) provide a certificate, letter or other evidence satisfactory to the Registrar or a panel of the Registration Committee confirming that the applicant is in good standing as a dentist in every jurisdiction where the applicant holds an out-of-province certificate. O. Reg. 75/12, s. 6.

(3) Without in any way limiting the generality of subsection (2), “good standing” shall include the fact that,

(a) the applicant is not the subject of any discipline or fitness to practise order or of any proceeding or ongoing investigation or of any interim order or agreement as a result of a complaint, investigation or proceeding; and

(b) the applicant has complied with the continuing competency and quality assurance requirements of the regulatory authority that issued the applicant that out-of-province certificate as a dentist. O. Reg. 75/12, s. 6.

(4) An applicant referred to in subsection (1) is deemed to have met the requirements of paragraph 4 of subsection 16 (1) where the requirements for the issuance of the applicant's out-of-province certificate included language proficiency requirements equivalent to those required by that paragraph. O. Reg. 75/12, s. 6.

(5) Despite subsection (1), an applicant is not deemed to have met a requirement if that requirement is described in subsection 22.18 (3) of the Health Professions Procedural Code. O. Reg. 75/12, s. 6.

**SPECIALTY CERTIFICATE**

**18.** (1) In this section,

"approved diploma or degree program" means a program taken in Canada or the United States of America that was, either at the time the applicant commenced the program or at the time the applicant graduated from the program,

(a) approved by the Commission on Dental Accreditation of Canada or recognized by the Commission under the terms of a reciprocal agreement, or

(b) approved by another accreditation body designated by Council;

"National Dental Specialty Examination" means a National Dental Specialty Examination administered by the Royal College of Dentists of Canada that was approved by the College at the time the applicant took it. O. Reg. 407/04, s. 1; O. Reg. 500/07, s. 3 (1); O. Reg. 75/12, s. 7 (1).

(2) Subject to section 19, the additional requirements for the issuing of a specialty certificate of registration are the following:

1. The applicant has a degree in dentistry evidencing successful completion of a course in dental studies of at least four years duration at a university-based dental school.
2. REVOKED: O. Reg. 500/07, s. 3 (2).
3. The applicant has successfully completed a specialty program referred to in subsection (3) for the specialty for which the authorization is sought.
4. The applicant has successfully completed one of the following:
   i. the National Dental Specialty Examination for the specialty for which the applicant is seeking a specialty certificate of registration, or
   ii. another specialty examination set or approved by the College for the specialty for which the applicant is seeking a specialty certificate of registration.
5. ~~Since the applicant satisfied the requirements of paragraph 3, there has been no three year period during which the applicant has not engaged in the specialty practice of dentistry, for which the authorization is sought, on a continuous and regular basis in Canada, or the United States of America.~~

5. If the applicant satisfied the last of the requirements of paragraph 3 and 4 more than three years ago, the applicant has engaged in the specialty practice of dentistry, for which the authorization is sought, on a continuous and regular basis in Canada, or the United States of America or a jurisdiction approved by the Registration Committee for a period of at least three years immediately before the date of the application.

6. The applicant is able to demonstrate the ability to speak and write either English or French with reasonable fluency.
7. The applicant has successfully completed an examination in ethics and jurisprudence set or approved by the College.
8. The applicant is a Canadian citizen or a permanent resident of Canada or has received the appropriate authorization under the *Immigration and Refugee Protection Act* (Canada) to permit the applicant to engage in the practice of dentistry in Canada as authorized by the certificate. O. Reg. 407/04, s. 1; O. Reg. 500/07, s. 3 (2-4); O. Reg. 75/12, s. 7 (2).

(3) The applicant shall have satisfied the requirement in paragraph 3 of subsection (2) if the applicant has completed,

(a) one of the following specialty programs:

(0.i) in the case of dental anaesthesia,

(A) an approved diploma or degree program in dental anaesthesia consisting of a minimum of 22 months of full-time instruction, or

(B) until three years have passed since an approved diploma or degree program in dental anaesthesia is introduced in Ontario, a program described in subsection (3.1), if the applicant also meets the requirements of subsection (3.2),

(i) in the case of endodontics, an approved diploma or degree program in endodontics consisting of a minimum of 22 months of full-time instruction,

(ii) in the case of oral and maxillofacial surgery, an approved diploma or degree program in oral and maxillofacial surgery consisting of a minimum of 48 months of full-time instruction,

(iii) in the case of oral medicine, an approved diploma or degree program in oral medicine consisting of a minimum of 33 months of full-time instruction,

(iv) in the case of oral pathology, an approved diploma or degree program in oral pathology consisting of a minimum of 33 months of full-time instruction,

(v) in the case of oral and maxillofacial radiology, an approved diploma or degree program in oral and maxillofacial radiology consisting of a minimum of 22 months of full-time instruction,

(vi) in the case of orthodontics and dentofacial orthopaedics, an approved diploma or degree program in orthodontics and dentofacial orthopaedics consisting of a minimum of 22 months of full-time instruction,

(vii) in the case of paediatric dentistry, an approved diploma or degree program in paediatric dentistry consisting of a minimum of 22 months of full-time instruction,

(viii) in the case of periodontics, an approved diploma or degree program in periodontics consisting of a minimum of 22 months of full-time instruction,

(ix) in the case of prosthodontics, an approved diploma or degree program in prosthodontics consisting of a minimum of 22 months of full-time instruction,

(x) in the case of public health dentistry, an approved diploma or degree program in public health consisting of a minimum of 22 months of full-time instruction; or

(b) a specialty program that is not an approved diploma or degree program, if the applicant also holds a certificate of completion of a program that was approved by the College at the time the applicant commenced it that evidences the applicant's possession of knowledge, skill and judgment at least equivalent to that expected of a current graduate of an approved diploma or degree program in the specialty for which the application is being made.

(c) REVOKED: O. Reg. 75/12, s. 7 (3).

O. Reg. 407/04, s. 1; O. Reg. 500/07, s. 3 (5, 6); O. Reg. 75/12, s. 7 (3).

(3.1) The program described in sub-subclause (3) (a) (0.i) (B) is a program in dental anaesthesia that included,

(a) a minimum of 12 months of full-time instruction, if the applicant successfully completed it before 1986; or

(b) a minimum of 22 months of full-time instruction, if the applicant successfully completed it in or after 1986. O. Reg. 500/07, s. 3 (7).

(3.2) For the purposes of sub-subclause (3) (a) (0.i) (B), the Registration Committee must be satisfied that the applicant possesses knowledge, skill and judgment at least equivalent to that expected of a current graduate of the specialty program in dental anaesthesia offered by the Faculty of Dentistry of the University of Toronto. O. Reg. 500/07, s. 3 (7).

(4) A specialty certificate of registration is subject to the condition that the member may engage in the practice of dentistry only within the specialty to which the certificate relates unless the member holds,

(a) an academic certificate of registration issued by the College before this section came into force; or

(b) a general certificate of registration. O. Reg. 407/04, s. 1.

(5) Subject to subsection (6), the requirements in paragraphs 3 and 4 of subsection (2) are non-exemptible. O. Reg. 75/12, s. 7 (4).

(6) The requirements of paragraphs 1, 3 and 4 of subsection (2) do not apply to an applicant if he or she held a specialty certificate of registration issued by the College for the specialty in which he or she is applying at any time before submitting his or her application for that specialty certificate of registration. O. Reg. 75/12, s. 7 (4).

(6.1) The requirements of paragraphs 1, 5, 6 and 7 of subsection (2) and the requirement to pay the application fee set out in a College by-law do not apply to an applicant who held an emergency certificate of registration issued by the College within three years before submitting their application for that specialty certificate of registration. O. Reg. 280/23, s. 3.

(7) Nothing in subparagraph 4 ii of subsection (2) requires the College to set or approve a specialty examination. O. Reg. 75/12, s. 7 (4).

**19.** (1) Where section 22.18 of the Health Professions Procedural Code applies to an applicant, the applicant is deemed to have met the requirements of paragraphs 1, 3, 4 and 5 of subsection 18 (2) of this Regulation. O. Reg. 75/12, s. 8.

(2) It is a non-exemptible registration requirement that an applicant referred to in subsection (1) provide a certificate, letter or other evidence satisfactory to the Registrar or a panel of the Registration Committee confirming that the applicant is in good standing as a dentist in every jurisdiction where the applicant holds an out-of-province certificate. O. Reg. 75/12, s. 8.

(3) Without in any way limiting the generality of subsection (2), "good standing" shall include the fact that,

(a) the applicant is not the subject of any discipline or fitness to practise order or of any proceeding or ongoing investigation or of any interim order or agreement as a result of a complaint, investigation or proceeding; and

(b) the applicant has complied with the continuing competency and quality assurance requirements of the regulatory authority that issued the applicant that out-of-province certificate as a dentist. O. Reg. 75/12, s. 8.

(4) An applicant referred to in subsection (1) is deemed to have met the requirements of paragraph 6 of subsection 18 (2) where the requirements for the issuance of the applicant's out-of-province certificate included language proficiency requirements equivalent to those required by that paragraph. O. Reg. 75/12, s. 8.

(5) Despite subsection (1), an applicant is not deemed to have met a requirement if that requirement is described in subsection 22.18 (3) of the Health Professions Procedural Code. O. Reg. 75/12, s. 8.

ACADEMIC CERTIFICATE

**20.** (1) The additional requirements for the issuing of an academic certificate of registration are the following:

1. The applicant has a degree in dentistry evidencing successful completion of a course in dental studies of at least four years duration at a university-based dental school.
2. The applicant holds a full-time appointment of professorial rank to a faculty or school of dentistry at a university in Ontario.
3. The applicant is able to demonstrate the ability to speak and write either English or French with reasonable fluency.
4. The applicant has successfully completed an examination in ethics and jurisprudence set or approved by the College.
5. The applicant is a Canadian citizen or a permanent resident of Canada or has received the appropriate authorization under the *Immigration and Refugee Protection Act* (Canada) to permit the applicant to engage in the practice of dentistry in Canada as authorized by the certificate. O. Reg. 407/04, s. 1.

(2) An academic certificate of registration is subject to the following terms, conditions and limitations:

1. The certificate is automatically revoked when the member ceases to hold an appointment of professorial rank to a faculty or school of dentistry at a university in Ontario.
2. The member may engage in the practice of dentistry only in the faculty or school of dentistry or in a hospital or other facility formally associated with that faculty or school.
3. The member may not charge a fee for the performance of any act within the scope of practice of dentistry. O. Reg. 407/04, s. 1.

(3) Paragraphs 2 and 3 of subsection (2) do not apply to a holder of an academic certificate issued before this section came into force. O. Reg. 407/04, s. 1.

(3.1) The requirements of paragraphs 1, 3 and 4 of subsection (1) and the requirement to pay the application fee set out in a College by-law do not apply to an applicant who held an emergency certificate of

registration issued by the College within three years before submitting their application for that academic certificate of registration. O. Reg. 280/23, s. 4.

(4) Paragraph 3 of subsection (2) shall not be interpreted as in any way affecting the ability of the faculty or school of dentistry or hospital or facility formally associated with that faculty or school to charge fees for services which it has provided. O. Reg. 407/04, s. 1.

**20.1** (1) Where section 22.18 of the Health Professions Procedural Code applies to an applicant, the applicant is deemed to have met the requirements of paragraph 1 of subsection 20 (1) of this Regulation. O. Reg. 75/12, s. 9.

(2) It is a non-exemptible registration requirement that an applicant referred to in subsection (1) provide a certificate, letter or other evidence satisfactory to the Registrar or a panel of the Registration Committee confirming that the applicant is in good standing as a dentist in every jurisdiction where the applicant holds an out-of-province certificate. O. Reg. 75/12, s. 9.

(3) Without in any way limiting the generality of subsection (2), "good standing" shall include the fact that,

(a) the applicant is not the subject of any discipline or fitness to practise order or of any proceeding or ongoing investigation or of any interim order or agreement as a result of a complaint, investigation or proceeding; and

(b) the applicant has complied with the continuing competency and quality assurance requirements of the regulatory authority that issued the applicant that out-of-province certificate as a dentist. O. Reg. 75/12, s. 9.

(4) An applicant referred to in subsection (1) is deemed to have met the requirements of paragraph 3 of subsection 20 (1) where the requirements for the issuance of the applicant's out-of-province certificate included language proficiency requirements equivalent to those required by that paragraph. O. Reg. 75/12, s. 9.

(5) Despite subsection (1), an applicant is not deemed to have met a requirement if that requirement is described in subsection 22.18 (3) of the Health Professions Procedural Code. O. Reg. 75/12, s. 9.

EDUCATION CERTIFICATE

**21.** (1) The additional requirements for the issuing of an education certificate of registration are the following:

1. The applicant has a degree in dentistry evidencing successful completion of a course in dental studies of at least four years duration at a university-based dental school.
2. The applicant is able to demonstrate the ability to speak and write either English or French with reasonable fluency.
3. The applicant,
    i. has a written offer of admission to,
        A. a public hospital-based dental internship program in Ontario that is accredited by the Commission on Dental Accreditation of Canada or by another accreditation body designated by Council, or
        B. a public hospital-based dental residency program in Ontario that is accredited by the Commission on Dental Accreditation of Canada or by another accreditation body designated by Council, or
    ii. has a written offer of admission to a dental educational program approved by a faculty or school of dentistry at a university in Ontario, other than one referred to in subparagraph i, and that program is,
        A. accredited either by the Commission on Dental Accreditation of Canada or by another accreditation body designated by Council, or
        B. approved by the Registration Committee.
4. The applicant is a Canadian citizen or a permanent resident of Canada or has received the appropriate authorization under the *Immigration and Refugee Protection Act* (Canada) to permit the applicant to engage in the practice of dentistry in Canada as authorized by the certificate. O. Reg. 407/04, s. 1; O. Reg. 75/12, s. 10 (1).

(2) An education certificate of registration is subject to the following terms, conditions and limitations:

1. The certificate is automatically revoked when the member ceases to hold the internship, residency or position referred to in subparagraph 3 i or ii of subsection (1) or when the program terminates.

2. The certificate for all members other than those who are enrolled in a dental residency program expires 12 months following its issuance unless extended by the Registration Committee.
3. The member may engage in the practice of dentistry only within the scope of the internship or residency program or the position to which the certificate relates.
4. The member may practise only under the direction of,
   i. a member of the medical or dental staff of the hospital in which the member is an intern or resident, or
   ii. a member who is also a member of the academic staff of the faculty or school of dentistry that approved the position.
5. The member may not charge a fee for the performance of any act within the scope of practice of dentistry. O. Reg. 407/04, s. 1.

(3) The Registration Committee may extend the duration of an education certificate of registration for such period as the Committee considers reasonable in the circumstances and may make the extension subject to any terms or conditions that the Committee considers appropriate. O. Reg. 75/12, s. 10 (2).

(4) The requirement of paragraph 3 of subsection (1) is non-exemptible. O. Reg. 407/04, s. 1.

(5) Paragraph 5 of subsection (2) shall not be interpreted as in any way affecting the ability of the faculty or school of dentistry or hospital or facility formally associated with that faculty or school to charge fees for services which it has provided. O. Reg. 407/04, s. 1.

POST-SPECIALTY TRAINING CERTIFICATE

**22.** (1) In this section, the term "specialty" when used in the word "post-specialty" includes but is not limited to the dental specialties referred to in subsection 13 (2). O. Reg. 407/04, s. 1.

(2) The additional requirements for the issuing of a post-specialty training certificate of registration are the following:

1. The applicant has a degree in dentistry evidencing successful completion of a course in dental studies of at least four years duration at a university-based dental school.
2. The applicant is able to demonstrate the ability to speak and write either English or French with reasonable fluency.
3. The applicant has successfully completed a specialty program in one of the following:
   i. Dental anaesthesia.
   ii. Endodontics.
   iii. Oral and maxillofacial surgery.
   iv. Oral medicine.
   v. Oral pathology.
   vi. Oral and maxillofacial radiology.
   vii. Orthodontics and dentofacial orthopaedics.
   viii. Paediatric dentistry.
   ix. Periodontics.
   x. Prosthodontics.
   xi. Public health dentistry.
4. The applicant has a written offer of an appointment to a program of post-specialty dental education from a faculty or school of dentistry at a university in Ontario, which program has emphasis on additional clinical training or research or both, to gain further education relevant to that applicant's specialty.
5. REVOKED: O. Reg. 75/12, s. 11 (2).
6. The applicant is a Canadian citizen or a permanent resident of Canada or has received the appropriate authorization under the *Immigration and Refugee Protection Act* (Canada) to permit the applicant to engage in the practice of dentistry in Canada as authorized by the certificate. O. Reg. 407/04, s. 1; O. Reg. 75/12, s. 11 (1, 2).

(3) A post-specialty training certificate of registration is subject to the following terms, conditions and limitations:

1. The member may engage in the practice of dentistry only as may be required for the program of studies in which he or she is enrolled and only under the supervision of a member of the College who is either,
   i. a member of the dental staff of the faculty or school of dentistry, or
   ii. a member of the dental staff of a facility formally associated with that faculty or school of dentistry.
2. The member may engage in the practice of dentistry only in the faculty or school of dentistry or in a hospital or other facility formally associated with that faculty or school.
3. The member shall not supervise or direct any person respecting the performance of any act or acts that are authorized to members.
4. The certificate shall have a specified duration equal to the expected length of the program, but not exceeding 12 months, after which the certificate automatically expires unless extended by the Registration Committee.
5. The certificate is automatically revoked if the member ceases to hold the appointment referred to in paragraph 4 of subsection (2) or when the program terminates.
6. The member may not charge a fee for the performance of any act within the scope of practice of dentistry. O. Reg. 407/04, s. 1; O. Reg. 75/12, s. 11 (3, 4).

(4) The Registration Committee may extend the duration of a post-specialty training certificate of registration for such period as the Committee considers reasonable in the circumstances and may make the extension subject to any terms and conditions that the Committee considers appropriate. O. Reg. 75/12, s. 11 (5).

(5) Nothing in paragraph 6 of subsection (3) shall be interpreted as in any way affecting the ability of the faculty or school of dentistry or hospital or other facility formally associated with that faculty or school to charge fees for services which it has provided. O. Reg. 407/04, s. 1.

GRADUATE STUDENT CERTIFICATE

**23.** (1) The additional requirements for the issuing of a graduate student certificate of registration are the following:

1. The applicant has a degree in dentistry evidencing successful completion of a course in dental studies of at least four years duration at a university-based dental school.
2. The applicant is able to demonstrate the ability to speak and write either English or French with reasonable fluency.
3. The applicant,
   i. has been accepted for enrolment as a student in a faculty or school of dentistry at a university in Ontario in a graduate or postgraduate dental program of study accredited by the Commission on Dental Accreditation of Canada or another accreditation body approved by Council, other than a dental internship or dental residency program,
   ii. has been accepted for enrolment as a student in a faculty or school of dentistry at a university in Ontario in a graduate or postgraduate dental program of study approved by Council, other than a dental internship or dental residency program, or
   iii. has been accepted for enrolment as a Masters or PhD student in a faculty or school of dentistry at a university in Ontario in a program, other than a dental internship or dental residency program, that requires the applicant to perform any act or acts authorized to members.
4. The applicant is a Canadian citizen or a permanent resident of Canada or has received the appropriate authorization under the *Immigration and Refugee Protection Act* (Canada) to permit the applicant to engage in the practice of dentistry in Canada as authorized by the certificate.
5. REVOKED: O. Reg. 75/12, s. 12 (2).

O. Reg. 407/04, s. 1; O. Reg. 75/12, s. 12 (1, 2).

(2) A graduate student certificate of registration is subject to the following terms, conditions and limitations:

1. The member may engage in the practice of dentistry only as may be required for the program of studies in which he or she is enrolled and only under the supervision of a member of the dental facility or dental school who is also a member of the College.
2. The member may engage in the practice of dentistry only in the faculty or school of dentistry or in a hospital or other facility formally associated with that faculty or school.
3. The member shall not supervise or direct any person respecting the performance of any act or acts authorized to members.

4. The certificate is automatically revoked when the member ceases to be enrolled in the program referred to in paragraph 3 of subsection (1) or when the program terminates.
5. The member may not charge a fee for the performance of any act within the scope of practice of dentistry. O. Reg. 407/04, s. 1; O. Reg. 75/12, s. 12 (3, 4).

(3) The requirement of paragraph 3 of subsection (1) is non-exemptible. O. Reg. 407/04, s. 1.

(4) Paragraph 5 of subsection (2) shall not be interpreted as in any way affecting the ability of the faculty or school of dentistry or hospital or other facility formally associated with that faculty or school to charge fees for services which it has provided. O. Reg. 407/04, s. 1.

ACADEMIC VISITOR CERTIFICATE

**24.** (1) The additional requirements for the issuing of an academic visitor certificate of registration are the following:

1. The applicant has a degree in dentistry evidencing successful completion of a course in dental studies of at least four years duration at a university-based dental school.
2. The applicant has satisfied the Registration Committee that he or she has an established scholarly career in dental teaching or dental research at a dental school outside Ontario and a permanent appointment to the academic staff of a university-based dental school primarily for the purpose of teaching or research.
3. The applicant has an appointment by the Director of a dental school of a university in Ontario or the Dean of a faculty of dentistry of a university in Ontario to provide undergraduate, graduate or postgraduate dental education or dental research or both for a specified period of time that does not exceed 12 months.
4. The applicant has provided an undertaking to the College in a form acceptable to the Registrar that he or she will meet the dental school's expectation that the applicant will return to the appointment referred to in paragraph 2 upon the expiry of this certificate.
5. The applicant has not held a certificate of this class during the previous 12 months.
6. The applicant is a Canadian citizen or a permanent resident of Canada or has received the appropriate authorization under the *Immigration and Refugee Protection Act* (Canada) to permit the applicant to engage in the practice of dentistry in Canada as authorized by the certificate. O. Reg. 407/04, s. 1.

(2) An academic visitor certificate of registration is subject to the following terms, conditions and limitations:

1. The member may engage in the practice of dentistry only in the faculty or school of dentistry to which his or her appointment relates or in a teaching unit formally affiliated with that faculty or school of dentistry and only to the extent required by the teaching or research requirements of that appointment.
2. The certificate automatically expires 12 months from the date of its issuance unless extended by the Registration Committee.
3. The certificate is automatically revoked,
    i. if the appointment referred to in paragraph 3 of subsection (1) expires, is withdrawn or otherwise terminates, or
    ii. if the member ceases to hold the appointment referred to in paragraph 2 of subsection (1).
4. The member may not charge a fee for the performance of any act within the scope of practice of dentistry. O. Reg. 407/04, s. 1.

(3) The Registration Committee may extend the duration of the academic visitor certificate of registration for up to three additional months on any terms and conditions that it considers appropriate if the Committee is satisfied that there is an appropriate reason for doing so. O. Reg. 407/04, s. 1.

(4) Paragraph 4 of subsection (2) shall not be interpreted as in any way affecting the ability of the faculty or school of dentistry or teaching unit formally affiliated with that faculty or school of dentistry to charge fees for services which it has provided. O. Reg. 407/04, s. 1.

**24.1** (1) Where section 22.18 of the Health Professions Procedural Code applies to an applicant, the requirements of paragraphs 1 and 2 of subsection 24 (1) of this Regulation are deemed to have been met. O. Reg. 75/12, s. 13.

(2) It is a non-exemptible registration requirement that an applicant referred to in subsection (1) provide a certificate, letter or other evidence satisfactory to the Registrar or a panel of the Registration Committee confirming that the applicant is in good standing as a dentist in every jurisdiction where the applicant holds an out-of-province certificate. O. Reg. 75/12, s. 13.

(3) Without in any way limiting the generality of subsection (2), "good standing" shall include the fact that,

(a) the applicant is not the subject of any discipline or fitness to practise order or of any proceeding or ongoing investigation or of any interim order or agreement as a result of a complaint, investigation or proceeding; and

(b) the applicant has complied with the continuing competency and quality assurance requirements of the regulatory authority that issued the applicant that out-of-province certificate as a dentist. O. Reg. 75/12, s. 13.

(4) Despite subsection (1), an applicant is not deemed to have met a requirement if that requirement is described in subsection 22.18 (3) of the Health Professions Procedural Code. O. Reg. 75/12, s. 13.

### INSTRUCTIONAL CERTIFICATE

**25.** (1) The additional requirements for the issuing of an instructional certificate of registration are the following:

1. The applicant has a degree in dentistry evidencing successful completion of a course in dental studies of at least four years duration at a university-based dental school.
2. The applicant has a written offer to teach or conduct a course sponsored by a faculty or school of dentistry at a university in Ontario, a public hospital in Ontario, or a body approved by Council to sponsor courses.
3. The applicant has provided an undertaking to the College in a form satisfactory to the Registrar from a member of the College holding a general, specialty or academic certificate of registration in which the member undertakes to be present while the applicant engages in practice in Ontario and to ensure that any necessary follow up care which may be required by a patient, as a result of the treatment performed during the course by the applicant, is provided. O. Reg. 407/04, s. 1.

(2) An instructional certificate of registration is subject to the following terms, conditions and limitations:

1. The member may engage in the practice of dentistry only as may be required to teach or conduct the course for which the certificate was issued.
2. The certificate may be issued only for courses having a duration of 14 days or less.
3. The certificate shall specify an expiry date which shall be the day after the day upon which the course referred to in paragraph 1 is scheduled to end.
4. The certificate automatically expires when the course for which it was issued ends.
5. The member may not charge a fee to a patient for the performance of any act within the scope of practice of dentistry. O. Reg. 407/04, s. 1.

**25.1** (1) Where section 22.18 of the Health Professions Procedural Code applies to an applicant, the requirement set out in paragraph 1 of subsection 25 (1) of this Regulation is deemed to have been met. O. Reg. 75/12, s. 14.

(2) It is a non-exemptible registration requirement that an applicant referred to in subsection (1) provide a certificate, letter or other evidence satisfactory to the Registrar or a panel of the Registration Committee confirming that the applicant is in good standing as a dentist in every jurisdiction where the applicant holds an out-of-province certificate. O. Reg. 75/12, s. 14.

(3) Without in any way limiting the generality of subsection (2), "good standing" shall include the fact that,

(a) the applicant is not the subject of any discipline or fitness to practise order or of any proceeding or ongoing investigation or of any interim order or agreement as a result of a complaint, investigation or proceeding; and

(b) the applicant has complied with the continuing competency and quality assurance requirements of the regulatory authority that issued the applicant that out-of-province certificate as a dentist. O. Reg. 75/12, s. 14.

(4) Despite subsection (1), an applicant is not deemed to have met a requirement if that requirement is described in subsection 22.18 (3) of the Health Professions Procedural Code. O. Reg. 75/12, s. 14.

### SHORT DURATION

**26.** (1) The additional requirements for a short duration certificate of registration are the following:

1. The applicant,
    i. holds an out-of-province certificate that is equivalent to a general or specialty certificate of registration, or

ii. is registered or licensed to practise independently and without restriction or condition as a dentist in one of the states of the United States of America.

2. The applicant is registered to take a course sponsored by a faculty or school of dentistry of a university in Ontario, a public hospital in Ontario, or a body approved by Council to sponsor courses.

3. The applicant has provided a written undertaking to the College in a form satisfactory to the Registrar from a member of the College who holds a general, academic or specialty certificate of registration agreeing to ensure that any necessary follow up care which may be required by a patient, as a result of the treatment performed during the course by the applicant, is provided. O. Reg. 407/04, s. 1; O. Reg. 75/12, s. 15.

(2) A short duration certificate of registration is subject to the following terms, conditions and limitations:

1. The member may engage in the practice of dentistry only as required for the course for which the certificate was issued.

2. The member may engage in the practice of dentistry only under the direct supervision of a member who holds a general, specialty or instructional certificate of registration.

3. The certificate may be issued only for courses having a duration of 14 days or less.

4. The certificate shall specify an expiry date which shall be the day after the day upon which the course referred to in paragraph 1 is scheduled to end.

5. The certificate automatically expires when the course for which it was issued ends.

6. The member may not charge a fee for the performance of any act within the scope of practice of dentistry. O. Reg. 407/04, s. 1.

**EMERGENCY**

**26.1** (1) The additional requirements for the issuing of an emergency certificate of registration are the following:

1. The Minister must have requested that the College initiate registrations under this class based on the Minister's opinion that emergency circumstances call for it or the Council must have determined, after taking into account all of the relevant circumstances that impact the ability of applicants to meet the ordinary registration requirements, that there are emergency circumstances, and that it is in the public interest that the College issue emergency certificates.

2. The applicant has a degree in dentistry evidencing successful completion of a course in dental studies of at least four years duration at a university-based dental school approved by the registration committee.

3. Since the applicant satisfied the requirement of paragraph 2, there has been no three-year period during which the applicant has not engaged in the practice of dentistry on a continuous and regular basis.

4. The applicant is able to demonstrate the ability to speak and write either English or French with reasonable fluency.

5. The applicant has successfully completed an examination in ethics and jurisprudence set or approved by the College.

6. The applicant is a Canadian citizen or a permanent resident of Canada or has received the appropriate authorization under the *Immigration and Refugee Protection Act* (Canada) to permit the applicant to engage in the practice of dentistry in Canada as authorized by the certificate. O. Reg. 280/23, s. 5.

(2) The requirements of paragraphs 1, 2, 4, 5 and 6 of subsection (1) are non-exemptible. O. Reg. 280/23, s. 5.

(3) An emergency certificate of registration is subject to the following terms, conditions and limitations:

1. The member may engage in the practice of dentistry only under the supervision of a member who holds a general, specialty or academic certificate of registration and who has been approved by the Registrar to supervise a member of the Emergency class.

2. The member may engage in the practice of dentistry only while identifying themself as a member of the emergency class.

3. The certificate shall expire one year from the date the certificate was issued, unless extended by the Registrar as long as the Council has not determined that the emergency circumstances have ended.

4. The certificate is automatically revoked,

i. 15 days or a greater period up to 60 days as the Council shall determine, after the Council's determination that the emergency circumstances referred to in paragraph 1 of subsection (1) have ended, or

ii. immediately, if in the opinion of the Registrar or the Registration Committee, the revocation is in the public interest. O. Reg. 280/23, s. 5.

(4) The Registrar may extend an emergency certificate of registration for one or more periods, each of which is not to exceed one year, as long as Council has not determined that the emergency circumstances have ended. O. Reg. 280/23, s. 5.

(5) Where a member who holds an education certificate of registration also holds an emergency certificate of registration, the terms, conditions and limitations listed in subsection 21 (2) do not apply to the member during the time that the member is practising as a member of the emergency class. O. Reg. 280/23, s. 5.

(6) Where a member who holds a post-specialty training certificate of registration also holds an emergency certificate of registration, the terms, conditions and limitations listed in subsection 22 (3) do not apply to the member during the time that the member is practising as a member of the emergency class. O. Reg. 280/23, s. 5.

(7) Where a member who holds a graduate student certificate of registration also holds an emergency certificate of registration, the terms, conditions and limitations listed in subsection 23 (2) do not apply to the member during the time that the member is practising as a member of the emergency class. O. Reg. 280/23, s. 5.

## RESIGNATIONS, SUSPENSIONS AND REINSTATEMENTS

### RESIGNATION

**27~~8~~.** (1) A member may resign by giving notice in writing to the College. O. Reg. 407/04, s. 1.

(2) A notice under subsection (1) is effective on the date the notice is received by the College or the date specified in the notice, whichever is later. O. Reg. 407/04, s. 1.

(3) A member who resigned may apply for reinstatement. O. Reg. 407/04, s. 1.

### SUSPENSION FOR NON-PAYMENT OF FEES

**28~~7~~.** Where the Registrar suspended a member's certificate of registration pursuant to section 24 of the Health Professions Procedural Code ~~for failure to pay a fee that is required by the by-laws of the College or that was previously prescribed by regulation,~~ the Registrar may lift the suspension upon being satisfied that:

(a) all amounts owing to the College at the time of lifting the suspension have been paid; and

(b) any fees required under the by-laws for the lifting of the suspension have been paid; and,

(c) the member has professional liability protection in accordance with the requirements, if any, set out in the by-laws.

~~if the member applies within two years of the suspension and pays all fees required by the by-laws. O. Reg. 407/04, s. 1.~~

~~(2) If a suspension under subsection (1) continues for two years, the certificate of registration is automatically revoked. O. Reg. 407/04, s. 1.~~

~~(3) A member whose certificate was revoked under subsection (2) may apply for reinstatement.~~

### SUSPENSION FOR FAILURE TO PROVIDE INFORMATION

**28.1** (1) If a member fails to provide information about the member as required by the Act, regulations, the *Regulated Health Professions Act, 1991,* the regulations under the *Regulated Health Professions Act, 1991* or the by-laws, in the manner and form as may be required, the Registrar shall give the member notice of intention to suspend the member and may suspend one or more of the member's certificates of registration for failure to provide the information where at least 30 days

have passed after notice is given.

(2) Where the Registrar suspends a member's certificate of registration under subsection (1), the Registrar may lift the suspension upon being satisfied that:

(a) all amounts owing to the College at the time of lifting the suspension have been paid;

(b) the required information has been filed with the College;

(c) any fees required under the by-laws for the lifting of that suspension have been paid; and,

(d) the member has professional liability protection in accordance with the requirements, if any, set out in the by-laws.

**SUSPENSION FOR FAILURE TO PROVIDE EVIDENCE OF PROFESSIONAL LIABILITY PROTECTION**

**28.2** (1) If the Registrar requests evidence that the member holds professional liability protection in accordance with the requirements, if any, set out in the by-laws and the member fails to provide that evidence within 14 days of having been requested to do so or such longer period as is specified by the Registrar, the Registrar shall give the member notice of intention to suspend the member and may suspend the member's certificate of registration for failure to provide the evidence where at least 30 days have passed after notice is given.

(2) Where the Registrar suspends the member's certificate of registration under subsection (1), the Registrar may lift that suspension upon being satisfied that:

(a) all amounts owing to the College at the time of lifting the suspension have been paid;

(b) the member holds professional liability protection in accordance with the requirements, if any, set out in the by-laws

(b) any fees required under the by-laws for the lifting of that suspension have been paid.

**REVOCATION**

**28.3** (1) The Registrar shall revoke the certificate of registration of a member where,

(a) his or her certificate of registration was suspended pursuant to section 24 of the Health Professions Procedural Code or section 28 of the regulation and that suspension continued for at least 60 days; or

(b) his or her certificate of registration was suspended pursuant to subsection 28.1 (1) or 28.2 (1) of this Regulation and the suspension continued for at least 60 days.

**REINSTATEMENT, ON APPLICATION**

**29.** Where a former member's certificate of registration is ordered to be reinstated by a panel of the Discipline or Fitness to Practise Committee, the Registrar shall reinstate the member's certificate of registration upon receipt of the annual fee for the year in which the former member is to be reinstated, if not previously paid, and any other fees required by the by-laws of the College. O. Reg. 407/04, s. 1.

**30.** (1) A former member whose general, specialty or academic certificate of registration was revoked under subsection 28.3 or ~~or was suspended for failure to pay a fee under section 24 of the Health Professions Procedural Code or~~ who resigned as a member may apply for reinstatement of his or her general, specialty or academic certificate of registration by completing an application form supplied by the Registrar.

(2) Subject to subsection (3), the Registrar may reinstate the certificate of registration of a former member who applies under subsection (1) if all the following conditions have been met:

~~1. The applicant pays the fees required by subsection (5).~~

~~2. The applicant is not a person who is ineligible for reinstatement as a result of subsection (6).~~

~~3. The application for reinstatement was made within two years of the date of the suspension or resignation.~~

(a) the Registrar is satisfied that the former member has corrected the deficiency or deficiencies that provided the grounds for the revocation of the former member's certificate pursuant to section 28.3 if applicable

(b) the application for reinstatement was submitted to the Registrar within 2 years of the date on which the former member's certificate of registration was revoked;

(c) the former member has paid,

(i) the reinstatement fees required under the by-laws,

(ii) any other applicable fees required under the by-laws

(iii) any other money otherwise owed by the former member to the College at the date of reinstatement

(d) the member has professional liability protection in accordance with the requirements, if any, set out in the by-laws.

(e) the former member satisfies the Registrar that they engaged in the practice or dentistry, or engaged in the speciality practice of dentistry as applicable, on a continuous and regular basis in Canada or the United States of America or another jurisdiction approved by the Registration Committee within three years before the date on which the former member met all of the other requirements for the reinstatement of his or her certificate of registration.

~~(3) Where the Registrar refuses to reinstate a former member who applies under subsection (1), the application shall be referred by the Registrar to the Registration Committee. O. Reg. 407/04, s. 1.~~

~~(4) The Registration Committee may reinstate the certificate of registration of a former member whose application has been referred under subsection (1) if all of the following conditions have been met:~~

~~1. The applicant pays the fees required by subsection (5).~~

~~2. The applicant is not a person who is ineligible for reinstatement as a result of subsection (6). O. Reg. 407/04, s. 1.~~

~~(5) A former member whose certificate of registration is to be reinstated under subsection (2) or subsection (4) shall pay,~~

~~(a) the fees required by the by-laws of the College;~~

~~(b) the annual fee for the year in which the certificate of registration is reinstated, if not previously paid;~~

~~(c) the annual fee for the year in which the certificate of registration was suspended or the year in which the former member resigned, if not already paid, unless the Registration Committee is satisfied that the member did not engage in the practice of dentistry in Ontario during that year; and~~

~~(d) any money owed to the College at the time the applicant ceased to be a member of the College or that became due and owing at any time thereafter including, without being limited to, costs or expenses ordered to be paid by a panel of the discipline committee, costs awarded by a Court, and money owed to the College under a regulation or by-law or an order or decision of a statutory committee or a panel of a statutory committee. O. Reg. 407/04, s. 1.~~

~~(6)~~(3) A ~~person~~ former member is ineligible for reinstatement if, during the period from immediately prior to when he or she ceased to be a member up to and including the date ~~of receipt of the~~ a determination is made on the application for reinstatement, he or she,

(a) was the subject of a proceeding for professional misconduct, incompetence or incapacity, whether in Ontario or in another jurisdiction either in relation to the dental profession or another health profession, other than a proceeding which was completed based upon its merits;

(b) was the subject of an inquiry or investigation by the Registrar, a committee, a panel of a committee or board of inquiry of the College, which was not completed on its merits or which resulted in the resignation of the member;

(c) was the subject of an outstanding order of a committee, a panel of a committee or a board of inquiry of the College;

(d) was in breach of an order of a committee, a panel of a committee or a board of inquiry of the College;

(e) failed to comply with a decision of a panel of the Inquiries, Complaints and Reports Committee or a predecessor to that committee, including a decision requiring the member to attend to be cautioned;

(f) failed to comply with a written agreement with the College or any undertaking provided to the College;

(g) had terms, conditions or limitations on her or his certificate of registration other than those terms, conditions or limitations which are generally applicable to all members of the particular class of certificate of registration which the applicant previously held; or

(h) was previously refused reinstatement by the Registration Committee either under this Regulation or any predecessor regulation; O. Reg. 407/04, s. 1; O. Reg. 75/12, s. 16.

(i) was charged or found guilty of any criminal offence in any jurisdiction;

(j) was refused registration in any jurisdiction either in dentistry or other profession; or

(k) was, after he or she ceased to be a member, the subject of a finding of professional negligence or malpractice in any jurisdiction in relation to dentistry.

**31.** (1) ~~Section 30 shall not be interpreted as prohibiting~~ A former member who resigned or whose certificate of registration was suspended under s.28, 28.1 or s.28.2~~, cancelled or~~ revoked under section 28.3, who is ineligible for reinstatement or whose application for reinstatement was refused by the Registrar, may make an application for a new ~~for non-payment of a fee from making application for a~~ certificate of registration under the Health Professions Procedural Code. O. Reg. 407/04, s. 1.

(2) An application referred to in subsection (1) shall be treated as an initial application for registration. O. Reg. 407/04, s. 1.

**Appendix B: Consultation feedback**

# Mid-Point Consultation Summary: Registration Regulation Amendment Proposal

## Summary of Results

This is a mid-consultation summary of the feedback received in response to RCDSO's proposed registration regulation amendments.

This summary is inclusive of all consultation feedback received as of **March 10, 2025.**

As of the time of drafting, a total of **114 online surveys** have been received.

A small number of additional inquiries have also been submitted directly via RCDSO's dedicated consultation email address; however, these submissions have included no substantive feedback.

Of the 114 online survey submissions, 44 respondents did not include any substantive feedback in response to the survey's sole question (see below). In other words, 44 respondents submitted incomplete surveys, leaving a total of **70 "valid" or "complete" submissions**.

Of the surveys received, the majority of respondents self-identified as dentists (96.5%). One respondent self-identified as a "patient or member of the public", and no submissions have yet been received from an organization.

## Limitations / Caveats

Participation in this survey/consultation was voluntary and no attempt has been made to ensure that the sample of participants is representative of any sub-population. As a result, this feedback summary is not representative of the opinions of any general demographic group and cannot be generalized.

# Online Survey Results

## Respondent Type

**Q1.** Are you a:

n = 114

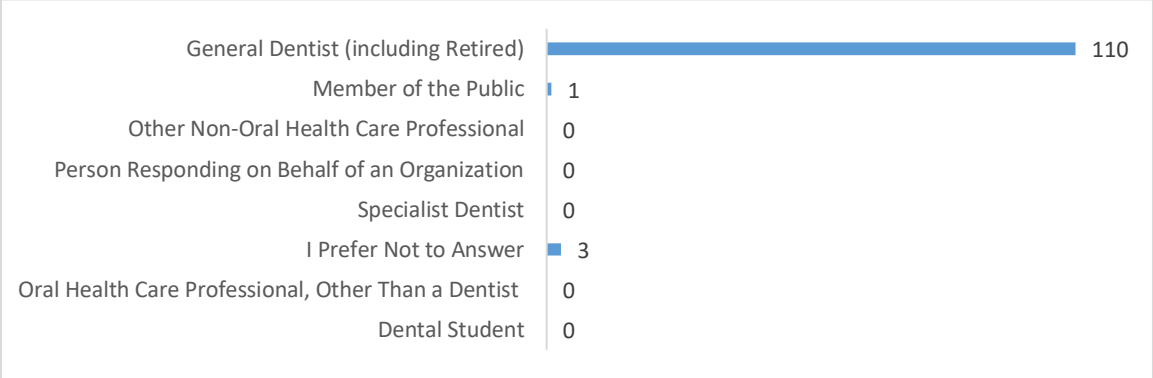



**Figure 1.** Respondent type

## Substantive Questions

**Q3.** Have you read the draft amendments?

n = 98


**Figure 2.** Familiarity with the draft regulation amendments

**Q4.** Do you have any feedback on the proposed regulation amendments?

n = 70

**Summary of feedback:**

- 70 respondents provided written feedback in response to the survey question.
- The vast majority of feedback concerns RCDSO's decision to divest the Professional Liability Program (PLP), and virtually no feedback has been received that relates specifically to the proposed regulation amendments.
- Where a "tone" can be discerned, the survey feedback is predominantly neutral, with significant negative or critical commentary focused on RCDSO's decision to divest PLP and the anticipated financial impact on dentists.

| Overall tone of comments (where this could be discerned) | |
|---|---|
| Positive / complimentary | 2 |
| Neutral | 41 |
| Negative / critical | 19 |

- In general, key themes arising from the survey feedback include:

1. **Lack of understanding of the reason for divestment and a preference for status-quo:** A considerable number of respondents were not aware of the reason for divestment, and expressed a preference for status-quo and the retention of PLP within RCDSO.
2. **Cost and impact on registration fees:** Many survey respondents expressed concern related to the potential financial impact of divestment on dentists (i.e., increasing costs) and requested that RCDSO's registration fees be reduced to offset any increasing cost to dentists of third party insurance coverage.
3. **Non-practising dentists:** Several consultation respondents requested that specific exemptions be created concerning requirements for liability protection coverage for dentists who are "non-practising" (e.g., those that are retired or semi-retired, and dentists who principally work in an academic or research capacity).

**Consultation feedback:**

- The following feedback has been reproduced verbatim.

| | Comment |
|---|---|
| 1 | I would want the college to provide the information to purchase the coverage in a coordinated manner so that we are not looking for our own coverage. |
| 2 | I prefer keeping PLP program with the college |
| 3 | what if a dentist is licensed but does not practice? do they need to maintain insurance? |
| 4 | RCDSO ensures comprehensive and consistent coverage tailored specifically to the needs of our profession, minimizing risks of gaps in individual policies.<br><br>Centralized coverage reduces administrative burdens making less complicated, especially for DDS working in Public field and practicing in community health care.<br><br>RCDSO involvement with complaints facilitates better coordination and less stressful situation for both parties. |

| | Comment |
|---|---|
| 5 | Professional liability coverage must be available to all members at a reasonable cost, regardless of claim history. |
| 6 | no |
| 7 | The changes relating to professional liability protection are straightforward. I have concerns re: the implementation of the continuing practice requirements. It seems that this is not "streamlining" as much as the intention to enforce requirements that were pre-existing. The regulation is silent on enforcement and most dentists will not be fully aware of the implications for them if they cease/discontinue practice while registered because they are not familiar with the relevant sections of the RHPA (particularly the Health Professions Procedural Code) and do not understand the role of the College staff statutory committees and how the registration process actually works. |
| 8 | If RCDSO is a member that only opines as a Dentist, as a Member of a Board of Health, do they need the Liability Insurance? |
| 9 | Please consider amending the regulation to allow dentists that wish to maintain their licence, but not practice, to be exempt from the requirement of having liability insurance.<br><br>As currently written the regulation is unclear whether this would be permitted. Many retired members wish to maintain their license but not practice. A note can be included in the public register which identifies dentists that have a current license that are unable to practice clinically. |
| 10 | While I understand the importance of ensuring all dentists maintain Professional Liability Protection (PLP) and agree with the intent to safeguard patients, I have concerns regarding the financial implications of these changes. If we are required to secure PLP through a third-party provider, the College should reduce the annual registration fees by an amount equivalent to the cost of obtaining liability coverage.<br><br>This adjustment would ensure fairness and prevent placing an additional financial burden on practitioners, especially those in solo or small practices. The shift to third-party PLP management effectively transfers the responsibility of coverage costs to individual dentists adding financial burden to us.<br><br>I urge the College to carefully consider this aspect and ensure that any changes to the PLP model are implemented equitably. Balancing patient protection with the financial sustainability of dental practices is crucial for the long-term success of the profession.<br><br>Thank you for your attention to this matter. |
| 11 | If PLP is outsourced, the third party which is approved by the college can collaborate with the college in the registration process, one fee two registrations. |
| 12 | I think rcdso should continue to provide plp coverage as it is a requisite to practice and will result in additional clerical work to ensure all members are covered, thereby offsetting much of the cost savings by removing it from the rcdso membership fees |
| 13 | Discard changes ! Bring our professional Liability costs down. Bring RCDSO yearly Cost down. |
| 14 | The proposed regulation amendments are clear, easy to understand what the requirements are, scope of who it applies to, penalities, and protection to the public. |
| 15 | Just make it easy to register for both together please! Basically, the way I see it, it will be the same as now, as it is done in one shot already. |
| 16 | I hope if liability insurance is not being provided with RCDSO registration that there is an appropriate reduction in registration fees |
| 17 | No |
| 18 | Insure fare cost of liability insurance for dentists with new third party |
| 19 | No |
| 20 | I am against the college divesting the professional liability protection.<br><br>This is not in the publics best interest |
| 21 | I feel frustrated that the one service provided by our college that truly supports us will no longer be part of our membership. |

| | Comment |
|---|---|
| 22 | Provide sources of obtaining third party liability. Rcdso yearly dues should be reduced significantly to account for rcdso not providing ppl. Especially in Ontario where we have rcdso fees and ODA fees. |
| 23 | I think this is going to be more work for us to do, more expensive for us to do and more mistakes will be made. I think everyone need ms to have liability protection, but having it separate is more difficult. |
| 24 | No |
| 25 | The extra financial burden of this amendment on average dentists is not clear . |
| 26 | Not on the requirement for having professional liability protection, but there's needs to be more transparency on what's to become of PLP. Especially on whether it'll remain a single provider system with one cost for comprehensive coverage. I would be strongly opposed to this becoming like the US system where the provider is for-profit and fee for coverage is ludicrous and unregulated. Lastly, the registration fee should see a proportional decrease now that PLP is separate from registration |
| 27 | That means more and more license renewal fees ,unless RCDsO fees get reduced by the amount the third party sells insurance to us ,I do not agree with this change |
| 28 | It will cost the dentist much more to have this additional liability- this is my concern. When I practiced in Saskatchewan I was spending afew thousand dollars on this, independent of my license there. Ontario RCDSO fees are much better now than other provinces because we don't need a separate liability insurance. |
| 29 | none at this time |
| 30 | Disagree with this change. Believe that the existing system of liability insurance combined with our rcdso dues and the use of the PLP is a better system |
| 31 | I don't like the amendment.<br><br>I want it to stay as it is now. |
| 32 | Retired dentists who do not practice but still remit their license fee payment, should be offered a reduced liability insurance cost or a nil payment option, as long as they sign an undertaking not to practice in Ontario. |
| 33 | Our fees have been increasing regularly year over year.<br><br>One of the reasons I have been told is due to the increased cost of plp and the defence of dentists in Ontario.<br><br>I would like to know how the fees with change. What will our new registration fee be with RCDSO now that our liability is no longer included? How will the fee be justified and what will the new liability fee look like? Is there a seamless transfer being set up with a new liability provider? |
| 34 | This really seems to be an unnecessary change, we as dentists will be faced with increasing costs and insurance companies will no doubt not be as versed in helping us defend against potential claims. |
| 35 | Divesting PLP, adding a step to the registration and renewal process for no good reason. Maintaining the coverages and fees are a must.<br><br>The rationale for divesting needs further clarification to the public and profession. |
| 36 | We as members of RCDSO have been told for many years that there was and is a reserve of funds to pay for liabilities of the PLP. Where are those reserve funds going when the RCDSO is no longer going to have PLP? |
| 37 | It's not a good idea. The current system is much better. Once indemnity is separate it's going to be beneficial for the company to grow and have more claims to increase revenue. In the UK it's been a disaster. The RCDSO is copying the UK in many aspects going forward, which doesn't make sense as the UK has a very broken dental system which is not one we should copy. If you would like to discuss I'd be happy to help. |
| 38 | Do not separate them |
| 39 | The college should continue with PLP. Divesting PLP to third party is a mistake and will lead to increase in fees for all dentists in the long run. |
| 40 | I do not agree ! Please keep the existing regulation as is ! |

| | Comment |
|---|---|
| 41 | it is not acceptable |
| 42 | Professional liability protection that is included in the annual RCDSO membership fee should remain unchanged. |
| 43 | i dont want this amendment to cause extra fees, on top of an already high membership fees. Having extra liability coverage, over what PLP covers at this time should be optional. |
| 44 | What about non-practicing dentists who want to keep their dental licences but not participate in clinical practices? |
| 45 | concerns about costs associated with liability coverage<br><br>concerns that membership fees are not properly adjusted to account for no longer providing liability coverage |
| 46 | How will the costs compare between insurance companies and PLP and how will the member fees for the RCDSO be adjusted to reflect this. |
| 47 | The transfer of PLP to a third party operator should allow different rates to be charged for “repeat offenders” |
| 48 | Part of our annual licensing fee includes paying for PLP coverage. If PLP is outsourced to a third party, there should be a substantial reduction in the annual licensing fee. What % of our current licensing fee is going towards paying for PLP? I assume looking for third party coverage means there is more out of pocket cost incurred on the part of the member. |
| 49 | The current reg fee needs to go down if PLP not included and insurance plus new registration should not be greater than current fees |
| 50 | I will prefer the continuation of PLP as is |
| 51 | I don't agree with this amendment. RCDSO should continue with the PLP program. |
| 52 | I am concerned that professional liability insurance once transferred to a third-party operator may result in gross inflationary costs to dental care providers. What regulations, if any, will the RCDSO place on the quality or quantity of liability insurance by its members, other than Y/N at time of registration?<br><br>I also note this survey seems to only have interest to capture feedback on the regulation amendments regarding insurance, not all amendments. I have concerns about "adding exclusions to reinstatement provisions". It is not clear to me what in the regulation was modified in the circulated document. The areas of amendment should be clearer when seeking consultation.<br><br>I am concerned about the provisions for ineligibility that occur from the time the license should be renewed (expiry) if an investigation is ongoing by the RCDSO. Does this mean that if there is an unresolved investigation, that at the time of annual renewal, you can be barred from practicing dentistry? If so, this is abusive towards dental professionals. In the context of ineligibility to renew during an ongoing investigation, it suggests punishment before the determination that a crime has occurred, which offends both legal justice and laws of natural justice. If this is the intent of the modification, I think this is a biased approach that needs to be corrected so that dental professionals continue to practice until determinations and appeals are finalized. |
| 53 | How will this amendment affect the registration fees we pay? |
| 54 | I have fully retired from practicing dentistry and maintain my license solely to remain registered with the College. I have no intention of engaging in any form of dental practice, including consultations or professional activities.<br><br>Given this, I would appreciate clarification on the following points:<br><br>Applicability of Liability Insurance Requirement: Will the proposed mandate for professional liability insurance apply to members who are fully retired and non-practicing but choose to maintain their license?<br><br>Options for Fully Retired Members: If liability insurance is required for all members, including non-practicing individuals, will there be an alternative category or status that allows retired members like me to remain registered without needing liability insurance? |

| | Comment |
|---|---|
| | I understand that the College does not currently offer a "retired" class of registration, and I want to ensure I comply with future requirements without unnecessary financial or administrative burdens, given my retired status.<br><br>Thank you very much for your time and assistance. I appreciate the opportunity to provide feedback and look forward to your guidance on this matter. |
| 55 | Don’t like because fees will increase! |
| 56 | What about those dental surgeons who work abroad, but maintain their registration. If they are not carrying out any clinical work would it be a requirement for them to have PLP ? |
| 57 | I disagree with PLP being transferred to a third party and believe it should continue to be a service a available under the umbrella of our RCDSO membership fees |
| 58 | PLP would have been great if included with the membership |
| 59 | I believe the amendments to be an excellent idea. |
| 60 | YEP-I DISAGRREE -CONRINUE OLD FORMAT PLP |
| 61 | I think RCDSO should monitor and assess the PLP provider in future to make sure public is protected |
| 62 | This is ridiculous. As a part time dentist with your increased fees and now requiring additional coverage and costs why even continue to practice? I’m supposed to work for free just paying fees for 1/4 of the year?<br><br>Reduce fees back to what they were if you want to add additional expenses on top of your fees. Disagree with this proposal completely. |
| 63 | Please exclude dentists in academic setting, ie. instructor, researcher, lecturer |
| 64 | If you make liability insurance mandatory, then you should consider adding a "license holding" status for members who wish to maintain their licenses but are temporarily unable to actively practice in the province. The reason is, insurance companies might not be willing to cover dentists that are not residents of Ontario. |
| 65 | It sounds like the decision to move away from PLP has already been made and as such, I would expect that our licensing fees will be drastically decreased. |
| 66 | no |
| 67 | Why is the college transferring PLP to a third party for profit operator instead of ODA who interest is to represent dentists of Ontario? |
| 68 | We already have liability with RCDSO. |
| 69 | If you are removing our coverage then your dues need to be lower |
| 70 | You are just making it more expensive to be a dentist introducing so many mandatory requirements. First the minimal sedation fee which I was trained at dental school for in Canada unlike foreign dentists. next you will introduce a license to do a root canal. Can you please make being a dentist more affordable? The licenses for everything keep going up and you have more expectations |

Royal College of
Dental Surgeons of Ontario

# COUNCIL BRIEFING NOTE

**TOPIC: Public Polling/Voice of the Patient**

**FOR INFORMATION**

March 2025

**ISSUE:** Council is being presented the results of public polling research commissioned by Pivotal Research Inc. on the experiences and perception of patients (and non-patients). This is the first time that the College has undertaken public polling, and this item is for Council's information. Pivotal will be presenting the results to Council at this meeting.

## PUBLIC INTEREST:

- This matter furthers or serves the public interest by helping the College and the profession better understand how patients perceive care and what factors influence those who do not regularly receive oral health care.
- This matter relates to the Access to Care Strategic Project as several key questions were designed to better understand the public's experience accessing oral health care; the public's perceptions of what responsibilities dentist have with respect to access to care; accepting patients into oral health practices; and professionalism.

## BACKGROUND:

**Research objective**

Reaching the Ontario public can be a challenge. The RCDSO appears only sporadically in the media and does not advertise to the public at large. Yet, the mission is to serve the publics' interest by helping to ensure that there is access to equitable and competent oral health care. The College uses a variety of tools to be open and transparent with the public including a large and comprehensive website, a social media presence and a means to contact us by email or phone.

The College commissioned public opinion polling research designed to glean the perspectives of the general public in Ontario regarding their experiences with oral health care; beliefs regarding dentists' responsibilities; and awareness of the existence of professional regulation.

- The College was interested in conducting research to ascertain perspectives of the general public, patients and non-patients, across Ontario about dental care experience and regulation.
- The research results will inform strategic initiatives to enhance public trust in the dental profession, improve the quality of and access to care, and strengthen the regulation of the profession.
- This research will provide the RCDSO with a baseline of public awareness about our role and our effectiveness.

- Specifically, the College engaged Pivotal Research Inc. engaged to accomplish the following:
    - Engagement with patients and non-patients to gather insights on their dental care experiences, awareness and access to care, and understanding of dental regulation and dentist responsibilities
    - Engagement with patients to ascertain experience and satisfaction along the dental patient care journey

**Pivotal Research Inc.**

- Pivotal Research Inc. is a Canadian provider of research consulting services with over 25 years of experience delivering market research and evaluation across multiple industries.
- Pivotal Research has worked with close to 50 professional regulators and health professional associations, unlocking insights about their stakeholders that help to shape regulation and policy; drive reform and change initiatives; enhance practice standards; increase member engagement; and ultimately enable evidence-based strategic action. The Profession Regulator Voice of the Public/Patient (VoP) Program allows the public to provide feedback on the services or care they receive from regulated professionals.
- Supported by decades of research on outcome measurement, quality assurance, and customer experience, the Pivotal Research Profession Regulator VoP Program provides regulators with intelligence vital to meeting their mandates.

## CURRENT STATUS:

- The survey was deployed online between October 28 and November 14, 2024 and fielded province-wide to a panel of 2,000 Ontario residents who are over the age of 18. Pivotal developed a sample that is representative of Ontario's population distribution according to health regions and demographics (age and gender). Its methodology is similar to a phone survey.
- 1,998 surveys were completed in English and 2 surveys were completed in French. The survey was also available in Punjabi and Mandarin (the two next-most popularly spoken languages in Ontario).
- The survey meets minimum thresholds to ensure statistical representation and reliability. A sample of this size has an estimated margin of error of +/- 2.19% or a 95% confidence level.
- Key findings include the following:
    - Overall, patients who have recently seen a dentist were satisfied with the care they received. Patients underlined the importance of clear communications and time taken to build rapport.
    - Satisfaction with care varies across groups with older adults and those with higher incomes reporting a higher level of satisfaction. Members of racialized groups, persons with disabilities and newcomers to Canada report lower levels of satisfaction.
    - Access to care is cited as an issue among non-recent patients (individuals who have not received oral health care for the last 12 months).
    - Cost and insufficient insurance coverage were identified as the most significant barriers to care.
    - Respondents who self-identified as members of racialized, 2SLGTBQIA+, persons with disabilities, and newcomers to Canada groups are less likely to agree that they can find a suitable dentist in their community
    - Most respondents agreed that dentists have significant responsibilities in ensuring fair and respectful oral health care, addressing patients' unique needs and barriers to care, and prioritizing the health and well-being of patients above all other interests.

- The majority of respondents identified the urgency of the patient's care needs, the dentist's ability to provide the care based on expertise or scope of practice, and the dentist's time or capacity as the most critical factors for dentists to consider when accepting new patients.
- Awareness of a regulatory body for the dental profession is about 60% for recent patients and 40% for non-recent patients.

## CONSIDERATIONS:

- The College of Dental Hygienists of Ontario (CDHO) has been conducting a survey annually since 2022. The results are available online: Voice of the Patient Dashboard Available – CDHO.
- The British Columbia College of Oral Health Professionals (BCCOHP) has also been surveying the public annually since 2022. The results are available online: Voice of the Dental Patient in British Columbia Research Program | British Columbia College of Oral Health Professionals.

## NEXT STEPS:

An interactive dashboard of the results, Voice of the Patient, will be posted on the RCDSO website for the public and the profession. A summary report (as below) will also be available online.

The results will be used to help inform the Access to Care Strategic Project, including the development of two new College documents on professionalism and accepting patients into oral health practices.

The College's Communications team will develop a strategy to help expand awareness of the regulator (or the registry) in the coming years and will use this data to help craft more patient-focused information.

## DECISION FOR COUNCIL:

This briefing note is for Council's information.

## CONTACT:

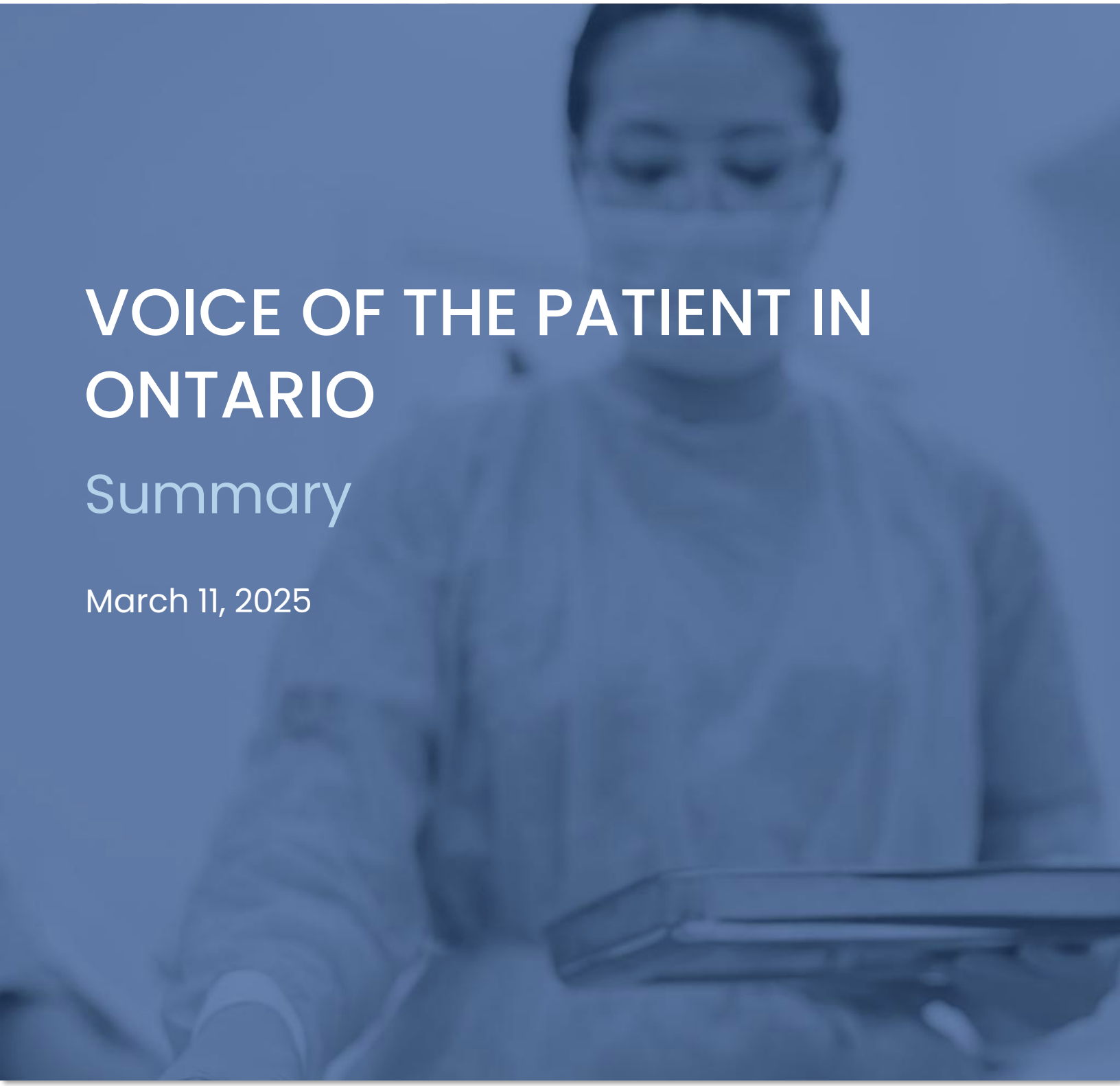
Lesley Byrne, Director, Communications lbyrne@rcdso.org

Michelle Cabrero Gauley, Senior Policy Analyst, mgauley@rcdso.org

Attachments:

Pivotal Voice of the Patient Summary Report

RCDSO | Royal College of Dental Surgeons of Ontario



# VOICE OF THE PATIENT IN ONTARIO

## Summary

March 11, 2025

PIVOTAL RESEARCH Inc.™

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# SUMMARY OF FINDINGS

**Most recent patients in Ontario are satisfied with the oral health care they and/or their dependants receive.** Oral health care being delivered as expected earned particularly high satisfaction scores. Additionally, patient journey attributes, such as clear and understandable communication, time taken to build rapport, and prioritizing patient care were identified as key drivers of overall satisfaction.

**Satisfaction with oral health care varies across different demographic groups.** Higher satisfaction is reported among older adults and those with higher incomes, while lower satisfaction levels are noted among members of racialized groups, persons with disabilities, and newcomers to Canada.

**Access to care may be limited to some Ontarians.** Only four in ten non-recent patients agreed that they are able to find a suitable dental office in their community. Respondents who identify as racialized, 2SLGBTQIA+, persons with disabilities and newcomers to Canada were less likely to agree that they can find a suitable dentist in their community.

**Dentists should ensure fair, respectful, and competent care, prioritizing urgent needs.** Most respondents agreed that dentists are responsible for fair and respectful care, with urgency of patient needs and the dentist's ability to provide care identified as the most critical factors when accepting new patients. Less emphasis was placed on the patient's ability to pay reinforcing the importance of prioritizing patient needs in decision-making.

**Non-recent dental patients in Ontario primarily cite cost and insufficient insurance coverage as barriers to care.** While some reported not feeling a need for oral health care, cost remains the most significant factor influencing access.

**Awareness of a regulatory body for the dental profession is mixed,** with 58% of recent patients and only four in ten (42%) of non-recent patients recognizing there is a regulator.

# RESEARCH BACKGROUND AND METHODOLOGY

## Background and Research Objectives

The Royal College of Dental Surgeons of Ontario (RCDSO or College) is the regulatory and licensing body for the profession of dentistry in Ontario.

The College is responsible for ensuring safe, equitable, and competent oral health care by regulating the dental profession, holding dentists accountable, setting qualification standards, and establishing professional and ethical guidelines.

The College commissioned Pivotal Research Inc. (Pivotal Research), a Canadian independent research firm, to ascertain the perspectives of the general public in Ontario regarding their experiences with oral health care, beliefs regarding dentists' responsibilities and awareness of the profession's regulation.

## Research Methodology

The initiative employed an online survey research methodology based on a non-probability sample. The survey, conducted on behalf of the College and carried out by the sample and data collection experts at Pivotal Research, was deployed using Cint, a globally recognized provider of online sample solutions. Cint's platform connects researchers with a diverse network of pre-recruited individuals who have agreed to participate in surveys and research studies, ensuring a broad and representative reach. A screener was used to ensure that participants met the following criteria:

- They reside in Ontario,
- They were 18 years or older, and
- They were not a dentist.

Eligible respondents were invited to complete a 12-15-minute survey. The survey instrument, developed in collaboration with College staff, was delivered in English, French, Punjabi, and Mandarin.

### Data Collection

Data collection occurred between October 28 and November 14, 2024, resulting in 2,000 completed surveys (1,998 surveys completed in English and 2 surveys completed in French).

The survey sample was divided into two groups.

**Recent patients**: Individuals who had received oral health services or were responsible for accompanying dependants who received such services within the 12 months leading up to the survey period.

**Non-recent patients**: Individuals who had neither received oral health care service nor accompanied a dependant for such services within the past 12 months.

Our sampling approach targeted a final sample composed of 79% **recent patients**, (n=1,587) and 21% **non-recent patients** (n=413). For comparison purposes, a probability sample of this size has an estimated margin of error (which measures sampling variability) of +/-2.19% at the 95% confidence level.

### Research Limitations and Quality Assurance

While online panels strive to represent the general population, they face inherent limitations in fully capturing certain demographic groups, such as individuals without reliable internet access, including those living in remote or rural areas or older adults. Additionally, while respondents were pre-recruited and participated voluntarily rather than through a purely random selection process, the large and diverse panel closely reflects the characteristics of a random sample, providing valuable insights into public perspectives. Despite these limitations, the survey successfully reached individuals in rural areas across Ontario, including the northern region, as well as a notable percentage of adults aged 66 years and older.

To ensure data quality and reliability, survey quality assurance software was utilized to identify and exclude inconsistent or unreliable responses. The software also verified respondent eligibility by excluding individuals using VPNs located outside the Ontario region. These measures were implemented to uphold the integrity of the survey data and ensure it met established quality and relevance standards.

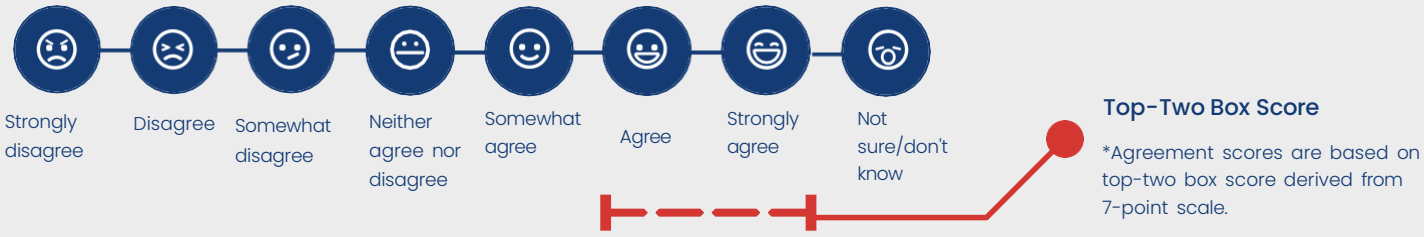
# GENERAL PERCEPTIONS

# PERCEPTIONS OF ORAL HEALTH CARE IN ONTARIO

Both recent and non-recent patients were asked to rate their level of agreement with several statements pertaining to their perceptions of oral health care in Ontario across the following categories:

- Overall perceptions;
- Access to dentist in Ontario;
- Discrimination;
- Dentist responsibilities and obligations; and
- Decision-making in oral health care

For each statement, respondents were presented with a seven-point scale (or agreement continuum) ranging from strongly disagree to strongly agree as shown in the graphic below.

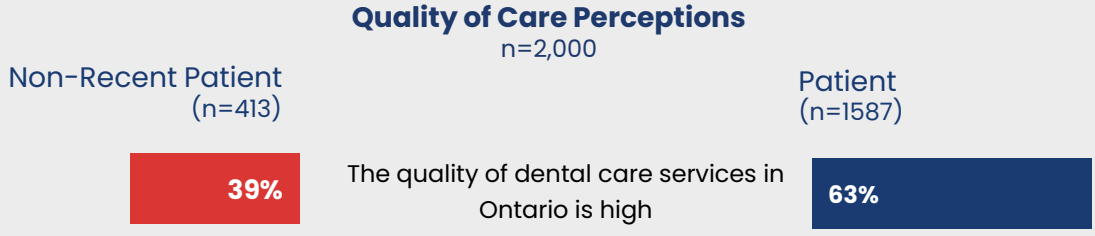



## Overall Perceptions of Oral Health Care

Recent patients tend to have a more favourable view of oral health care compared to non-recent patients. While 63% of recent patients agree or strongly agree that the quality of oral health care services in Ontario is high, only 39% of non-recent patients share this sentiment.

Agreement levels were similar regardless of whether patients had dental insurance or not. However, individuals earning less than $40,000 reported lower levels of agreement. When compared to their demographic counterparts, higher agreement levels were observed among patients aged 46 and older, males, and those who **did not** identify as any of the following:

- Racialized;
- A person with a disability
- New to Canada (within the last five years); or,
- A member of the 2SLGBTQI + community.



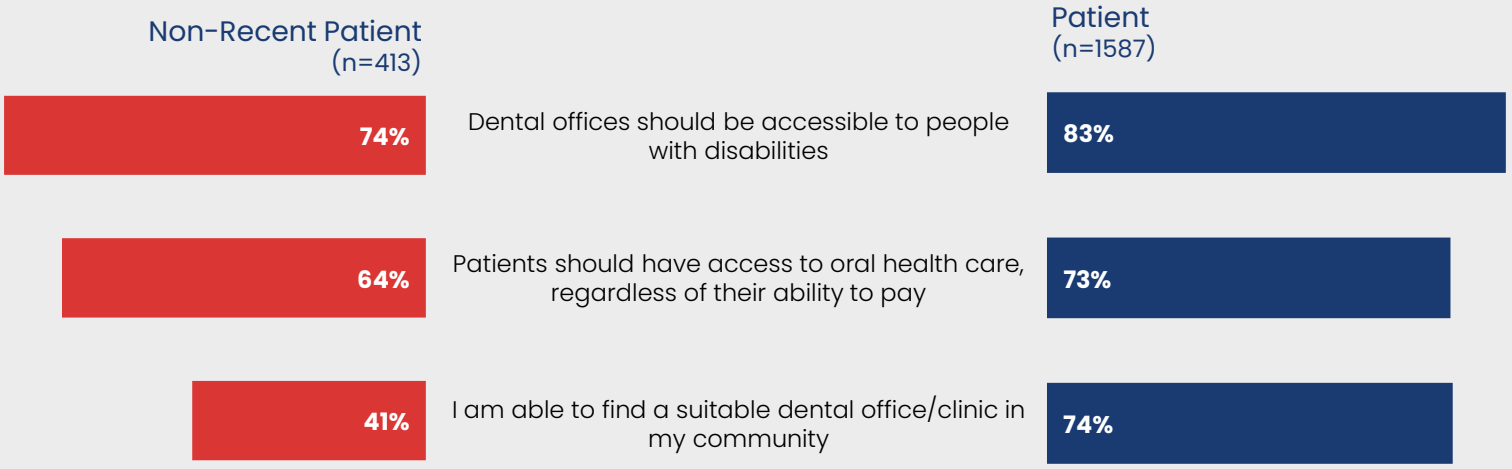
# PERCEPTIONS OF ORAL HEALTH CARE IN ONTARIO

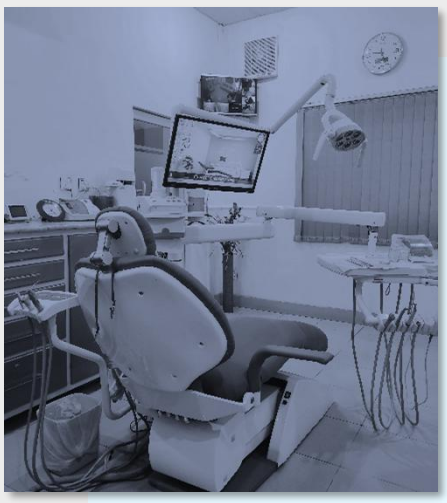
## Access to Oral Health Care

Over eight in ten patients (83%) and three-quarters of non-recent patients (74%) agreed or strongly agreed that dental offices should be accessible to people with disabilities. Fewer respondents—less than three-quarters of patients (73%) and roughly two-thirds of non-recent patients (64%)—agreed or strongly agreed that oral health care should be accessible regardless of a patient's ability to pay.

Recent patients were more likely to find a suitable dentist in their community, with 74% agreeing compared to only 41% of non-recent patients. Agreement was higher among individuals aged 56 and older and those who do not identify with any marginalized groups (e.g., racialized, persons with disabilities, newcomers, 2SLGBTQIA+). Conversely, respondents with household incomes below $39,999 reported lower levels of agreement.

**Access to Dentist**
n=2000



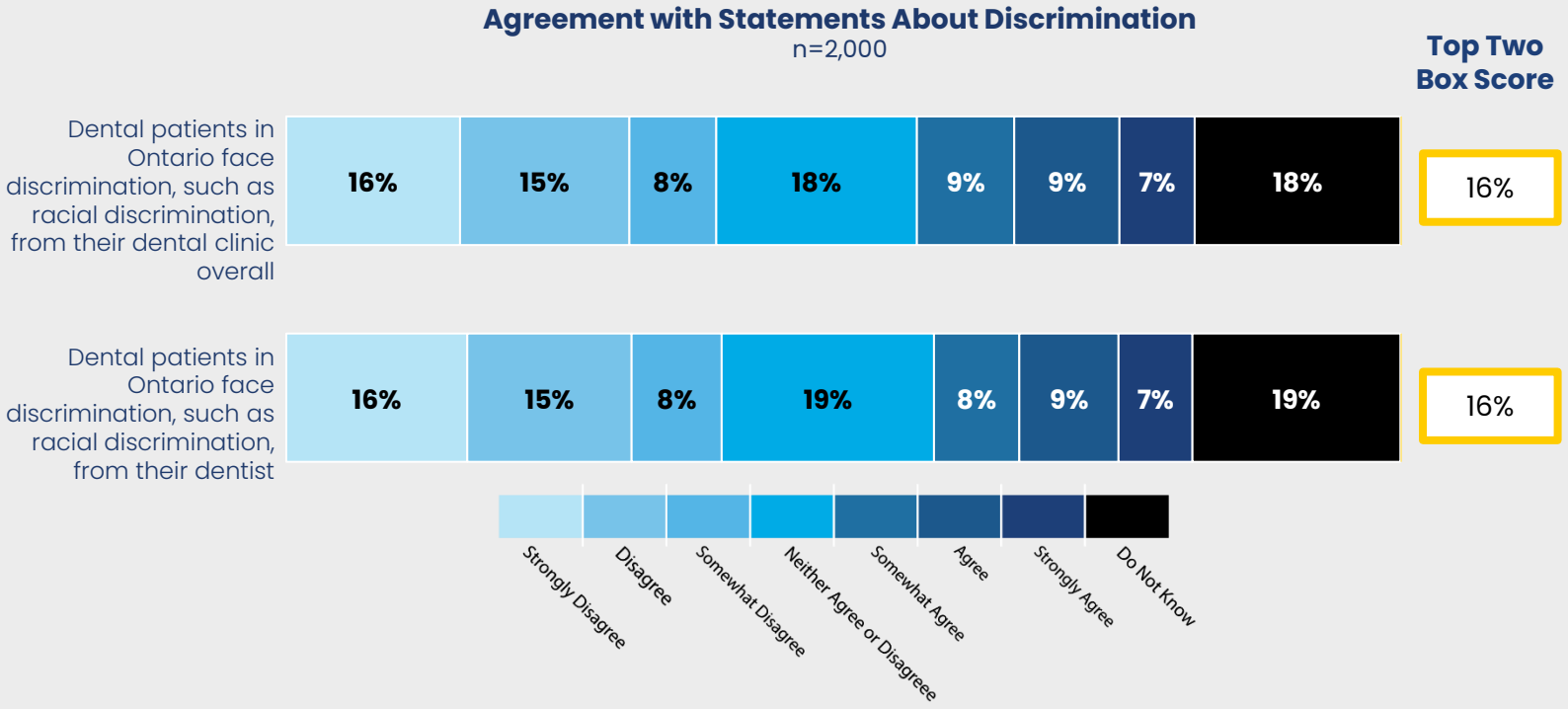



# PERCEPTIONS OF ORAL HEALTH CARE IN ONTARIO

## Discrimination

Respondents were asked about their level of agreement with the following statements regarding discrimination in oral health care: "*Dental patients in Ontario face discrimination, such as racial discrimination, from their dental clinic overall*" and "*Dental patients face discrimination from their dentist.*"

Approximately 16% of respondents agreed or strongly agreed that discrimination exists in both cases. Nearly one-third (31%) disagreed or strongly disagreed, while about one in five respondents selected 'don't know' or remained neutral: 18% for discrimination from the dental clinic overall and 19% for discrimination from the dentist. The results showed minimal differences between recent and non-recent patient groups, and therefore, a breakdown by status is not presented.




Perceptions of discrimination in oral health care varied significantly based on insurance type, demographic characteristics, and age. For instance, respondents with government-provided insurance (26% for clinics, 24% for dentists) and other insurance sources (20% for clinics, 19% for dentists) reported higher perceptions of discrimination compared to those without insurance (10% in both cases). Similarly, racialized individuals, newcomers to Canada, and members of the 2SLGBTQIA+ community reported higher agreement levels. Younger adults under 35 years were also more likely to perceive discrimination than older age groups.

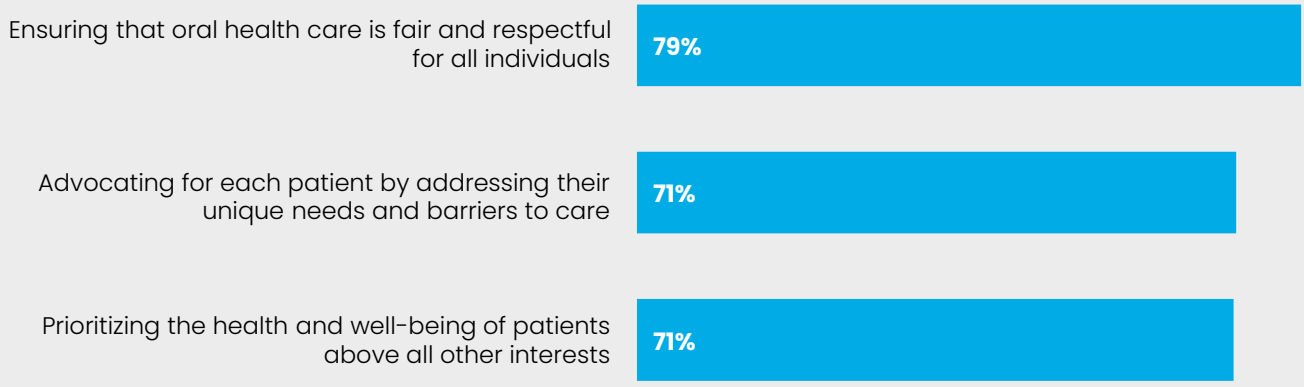
# DENTIST RESPONSIBILITY AND DECISION-MAKING

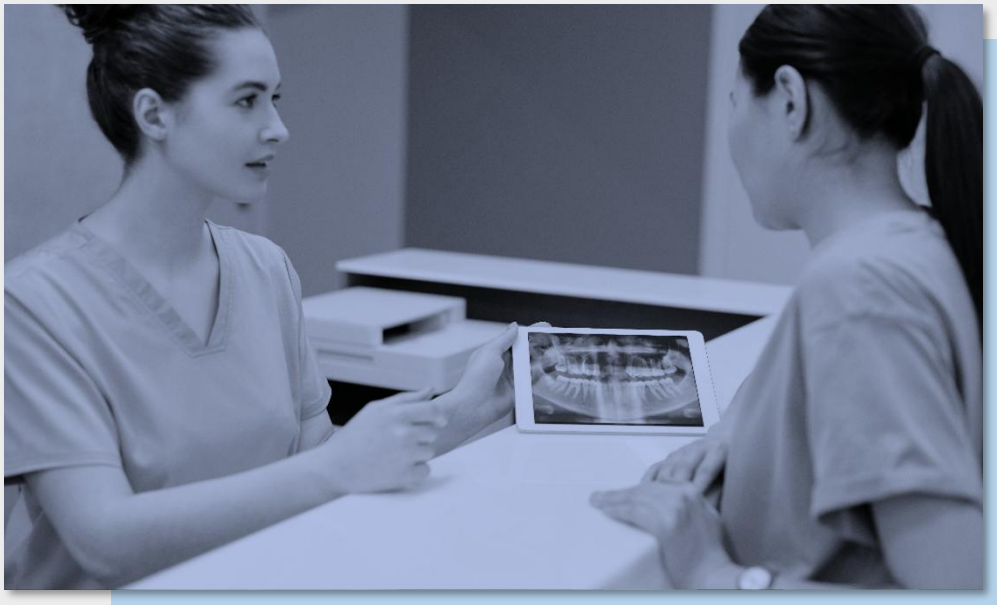
## Dentist Responsibilities

Respondents were asked to evaluate their agreement with various statements regarding the responsibilities and obligations of dentists in Ontario. Most generally agreed that dentists have significant responsibilities in ensuring fair and respectful oral health care, with 79% supporting this statement. Similarly, 71% believed dentists should advocate for patients by addressing unique needs and barriers to care and prioritize patient health above other interests.

The results were similar across patient and non-recent patient groups, so a breakdown by status is not included.

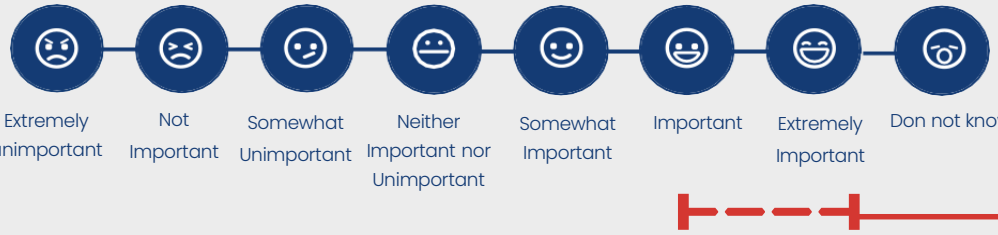
**Top Three Dentist Responsibilities**
n=2,000



# DENTIST RESPONSIBILITY AND DECISION-MAKING

Survey respondents were asked to evaluate a list of factors that dentists might consider when deciding whether to accept a new patient. For each factor, respondents rated its importance on a seven-point scale, ranging from "extremely unimportant" to "extremely important." The results, summarized in the graphic below, provide insight into the priorities and expectations respondents believe should guide a dentist's decision-making process.




**Top-Two Box Score**

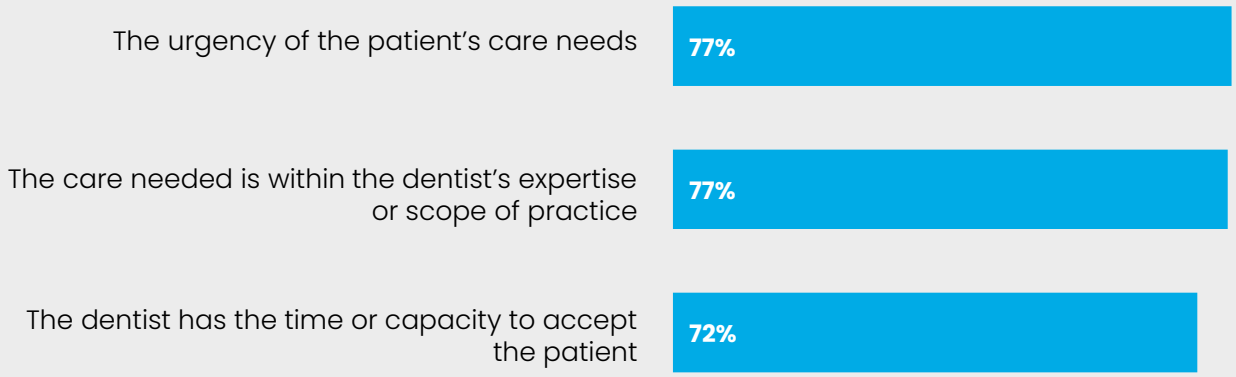
*Importance scores are based on top-two box score derived from 7-point scale.

## Dentist Decision-Making: Accepting New Patients

Respondents were asked to evaluate the importance of various factors in a dentist's decision to accept a new patient. The majority of respondents (77%) identified the urgency of the patient's care needs and the dentist's ability to provide the required care as the most important considerations. Following these, 72% emphasized the importance of the dentist's capacity or time to take on new patients.

The results were similar across patient and non-recent patient groups, so a breakdown by status is not included.

**Top Three Considerations for Dentists When Accepting New Patients**
n=2000



# OVERALL PERCEPTIONS OF ORAL HEALTH CARE

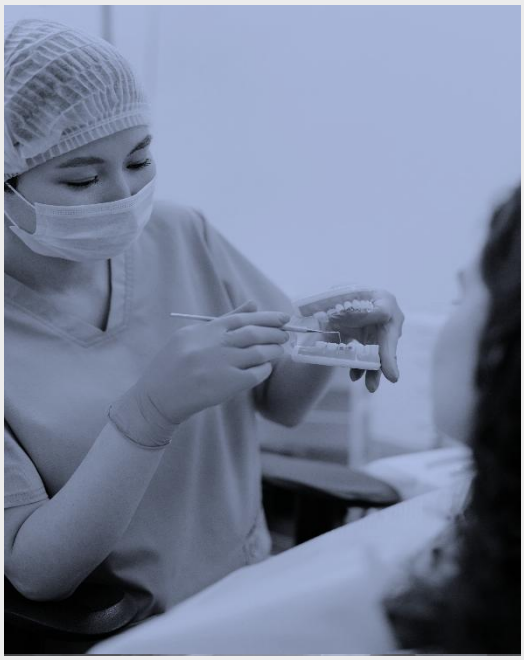
## KEY TAKEAWAYS

1. Patients generally have a more favourable perception of oral health care quality than non-recent patients (63% vs. 39%) However, agreement is lower among individuals with incomes below $40,000 and marginalized groups.

2. Barriers to accessing oral health care persist, with only 41% of non-recent patients able to find a suitable dentist in their community. Income and demographic factors, such as belonging to marginalized groups, significantly influence access.

3. Perception of discrimination in oral health care was reported by 16% of respondents, with higher agreement among racialized individuals, newcomers, 2SLGBTQIA+ respondents, and younger adults. About one-third (31%) disagreed, and 20% were unsure.

4. Patients and non-recent patients agreed that dentists should prioritize fairness, advocacy, and patient well-being.

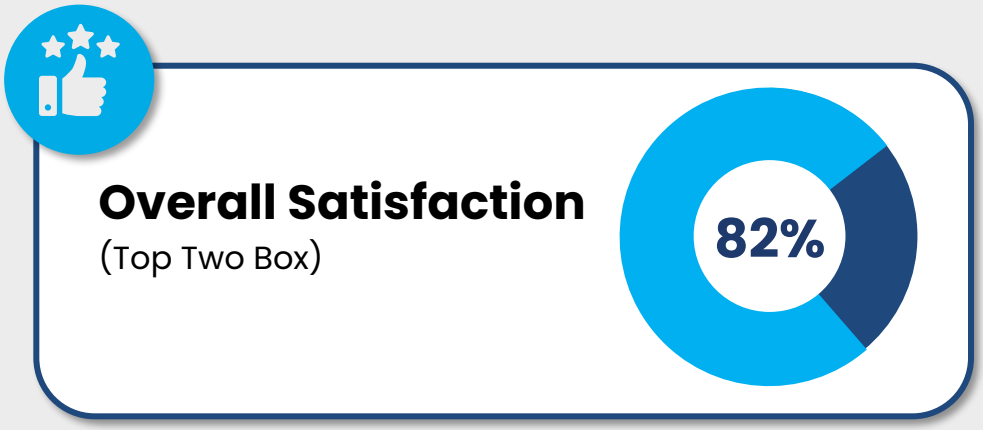


# RECENT PATIENT EXPERIENCE

# ORAL HEALTH CARE PATIENT JOURNEY

## Overall Satisfaction with Experience

Over eight in ten respondents (82%) reported being satisfied or very satisfied with their overall oral health care experience. As with other aspects of the patient journey, demographic characteristics influenced overall satisfaction. Notably, satisfaction was highest among those aged 66 and older (91%). While overall satisfaction was generally high, patients from marginalized communities (77%) and those whose first language is not English (78%) reported lower satisfaction levels.

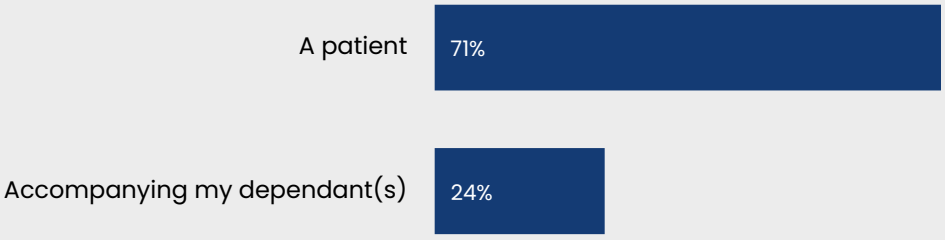



# VISIT TO DENTIST

## Visiting the Dentist

During their last visit, over seven in ten (71%) respondents visited the dentist as patients themselves, while nearly a quarter (24%) accompanied their dependant(s) to the dentist in the last 12 months.

**Visiting the Dentist**
(select all that apply)
n=2,000

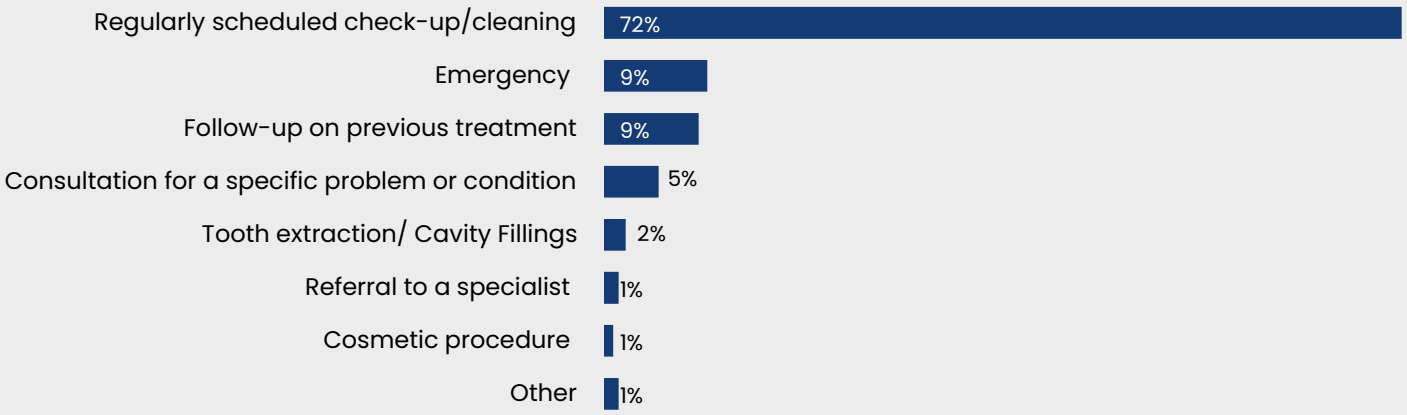



## Reason for Most Recent Dental Visit

Most (72%) respondents who visited the dentist in the last 12 months went for a regularly scheduled check-up/cleaning. About one-in-ten (9%) visited for emergency reasons, with the same proportion (9%) going in for a follow-up on previous treatment.

Patients with insurance from other sources were more likely to visit the dentist for regularly scheduled check-ups or cleaning (78%) compared to those with insurance through a government program (64%) and those with no oral health care insurance (63%). For individuals with lower household incomes (under $60,000), regularly scheduled check-ups and cleanings remain the primary reason for accessing oral health care. However, they are more likely than those with higher incomes to seek care for emergency situations.

**Reason(s) for the Most Recent Visit to the Dentist**
(select all that apply)
n=1,587



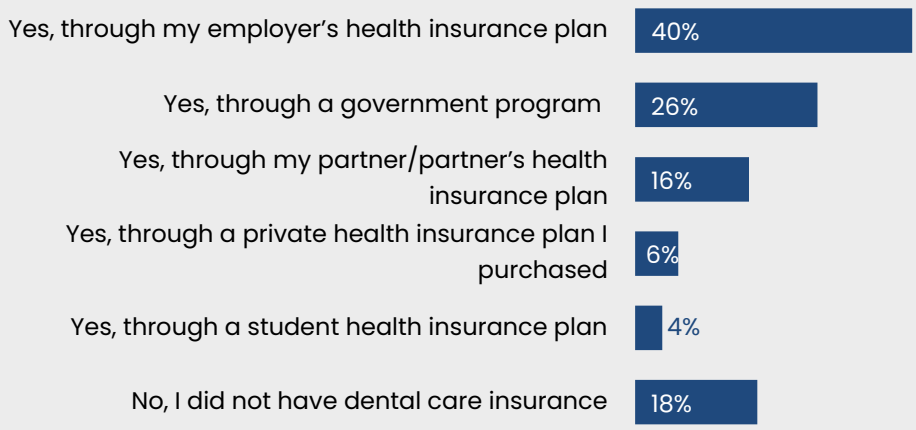
# VISIT TO DENTIST

## Dental Insurance Coverage

Over four in five (82%) recent patients reported having access to oral health care insurance, with the majority (40%) receiving coverage through their employer. Just over a quarter (26%) receive coverage through a government program, and under a fifth (16%) are insured through their partner's plan. A smaller portion of respondents purchased their own coverage (6%) or obtained it through a student health insurance plan (4%).

Close to one in five (18%) respondents indicated that they or their dependants were not covered by insurance during their last visit to the dentist.

**Dental Insurance Coverage For Most Recent Visit**
(select all that apply)
n=1,587




Survey respondents who indicated that they had visited a dentist in the last 12 months, either as a patient or accompanying a dependant are referred to as recent patients. This group, which comprises 79% of the sample, was asked a series of questions about their most recent dental visit.

# ORAL HEALTH CARE PATIENT JOURNEY

Patient respondents were asked to evaluate a series of statements pertaining to their satisfaction with various aspects of their most recent visit to the dentist. Statements shown to respondents covered the following areas:

- Dentist office
- Pre-treatment
- Treatment procedure
- Consent
- Staff interaction
- Post treatment
- Overall satisfaction

For each statement, respondents were presented with a seven-point scale ranging from extremely dissatisfied to extremely satisfied, as shown in the graphic below. This section reports on top-two box satisfaction scores, which are calculated by combining the percentages for 'satisfied' and 'extremely satisfied.


# ORAL HEALTH CARE PATIENT JOURNEY

## Satisfaction Along the Oral Health Care Journey in Ontario 2024

n = 1,587

# ORAL HEALTH CARE PATIENT JOURNEY

## Key Drivers of Satisfaction with Oral Health Care

To gain deeper insights into the oral health care experience in Ontario, an advanced key driver analysis was conducted. This approach identified which service attributes had the highest satisfaction and the greatest impact on overall patient experience, guiding performance improvements. Regression analysis covered 18 service attributes across the patient journey.

Patients reported high satisfaction with oral health care meeting expectations post-treatment (80%), clear communication (78%), and staff rapport-building (74%).

### Key Drivers of Positive Patient Experience

| Attribute | Patient Journey | Satisfaction Score |
|---|---|---|
| Oral health care was delivered as expected | Post Examination/Treatment | 80% |
| Clear and understandable communication (verbal and written) | Staff Interaction | 78% |
| Taking time to build rapport | Staff Interaction | 74% |

This table focuses on patient journey attributes that are critical to overall satisfaction but are currently underperforming compared to others. Patients emphasized the need for better access to care on short notice (62%), sufficient time to consider treatment options (64%), and a stronger focus on patient interests (67%). They also expect clear cost explanations (68%) and thorough procedure discussions, including risks and benefits (71%). These areas highlight where patients feel there is room for improvement to enhance their overall satisfaction.

### Key Drivers for Improving Patient Experience

| Attribute | Patient Journey | Satisfaction Score |
|---|---|---|
| Ability to access oral health care on short notice | Dentist Office | 62% |
| Given enough time and space to think about treatment options before making a decision | Pre-Treatment | 64% |
| My dentist prioritizes my (or my dependant's) oral health care above all other interests | Pre-Treatment | 67% |
| Costs matched what was estimated, and any changes were satisfactorily explained | Post-Treatment | 68% |
| Taking time to explain treatment(s)/procedure(s), including risks and benefits, and answer any questions I might have | Pre-Treatment | 71% |

# ORAL HEALTH CARE PATIENT JOURNEY

## KEY TAKEAWAYS

1. A majority of patients (82%) reported being satisfied or very satisfied with their oral health care experience. The highest satisfaction scores were for cleanliness and infection control measures, as well as respect shown by the oral health care team.

2. The most common reason for visiting the dentist was a regularly scheduled check-up or cleaning (72%). Most patients (82%) had insurance coverage, predominantly through employer health plans (40%) or government programs (26%).

3. High-impact areas contributing to satisfaction included clear communication, rapport-building, and meeting patient expectations. Key drivers for improvement were timely access to care, alignment of cost estimates to actual costs, sufficient time to consider options, thorough explanations of treatments and procedures and the dentist prioritizing the patient's oral health care above all other interests.

4. Satisfaction varied by demographic factors, with older adults patients consistently reporting higher levels of satisfaction compared to the overall sample. In contrast, patients from racially marginalized communities, those whose first language is not English, and individuals residing in the Toronto region reported lower satisfaction compared to other groups.

# NON-RECENT PATIENT EXPERIENCE

# BARRIERS TO ACCESSING CARE

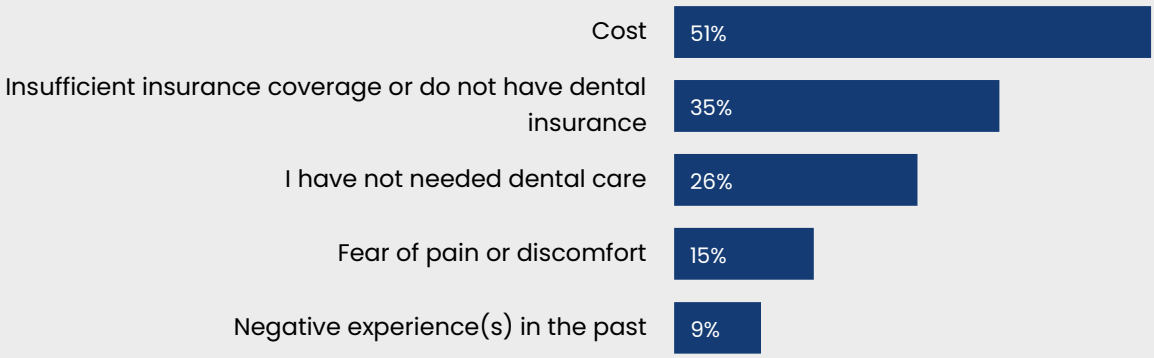
Nearly one in five (19%) respondents indicated that neither they nor their dependant(s) had visited a dentist in the past 12 months. Non-recent patients were asked a series of questions regarding the factors that contributed to their decision not to see a dentist, the timing of their most recent visit, and the actions they take when they are not able to get the care they need.

## Decision Factors

When asked why they had not received oral health care in the past year, half of non-recent patients mentioned cost (51%), while over a third indicated insufficient insurance coverage (35%). Additionally, one quarter (26%) indicated that they simply did not feel a need for oral health care. Other common reasons include fear of pain or discomfort (15%) and prior negative experiences (9%). Most respondents who shared prior negative experiences was related to their anxiety or personal fears of oral health care. Respondents were able to select multiple reasons that influenced their decision.

Both females (54%) and males (47%) identified cost as the primary barrier to accessing oral health care. However, females were more likely to cite insufficient or lack of insurance as a barrier (40%) compared to males (30%). Males were more likely to report that they did not feel a need for oral health care (33% compared to 20% of females). Employment status also played a role; 31% of non-employed respondents indicated they did not need oral health care, compared to 21% of employed individuals.

**Top Reasons for Not Accessing Care**
(select all that apply)
n=387




When asked what factor impacted their decision the most, cost remained the dominant factor (37%), followed by not needing oral health care (26%). One-fifth (16%) mentioned insufficient insurance coverage or not having dental insurance as their primary factor.

# SEEKING ORAL HEALTH CARE

## Most Recent Dental Visit

Within the non-recent patient group, most (59%) had visited a dentist between one and less than five years ago. A quarter (25%), however shared that their most recent visit to a dentist was five or more years ago, while one in ten (10%) had never visited a dentist in Ontario.

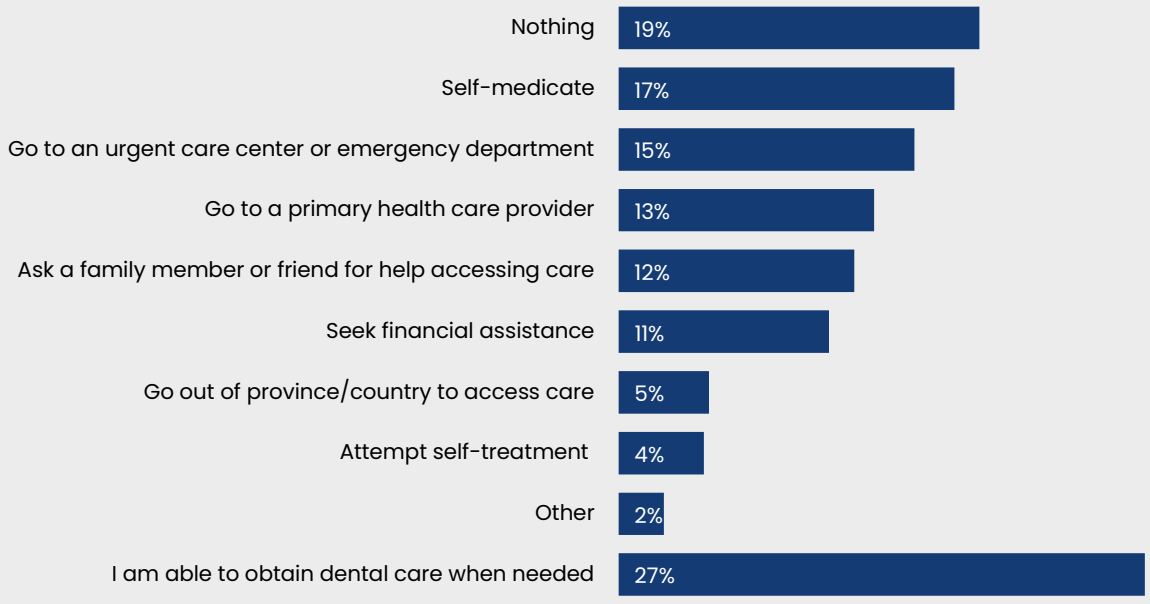
**Last Visit**
n=387


## Actions Taken In Lieu of Dental Visit

Non-recent patients were asked about the steps they take when unable to obtain necessary oral health care. Notably, 27% reported that they are able to access care when needed.

Among those who could not access care, the most common response was taking no action (19%), followed by self-medicating (17%), such as accessing over the counter medications. Others sought help at urgent care centres or emergency departments (15%) or visited a primary healthcare provider (13%).

**Actions Taken When Unable to Access Care**
(select all that apply)
n=387



# NON-RECENT PATIENT FINDINGS

## KEY TAKEAWAYS

1. Key barriers to accessing oral health care for non-recent patients—who are predominantly from income groups earning less than $60,000 and are more likely to be unemployed—include the high cost of dental services and the lack of adequate insurance coverage.

2. A significant proportion of non-recent patients experience long-term gaps in oral health care, with 25% not having visited a dentist in over five years and 10% never having accessed oral health care in Ontario.

3. A quarter (26%) of non-recent patients reported not feeling a need for oral health care, consistently ranking this as their primary reason for not accessing dental services.

4. The most common actions taken instead of visiting the dentist include doing nothing, self-medicating, or seeking care at an emergency department.

# PERCEPTIONS OF THE REGULATOR

# PERCEPTIONS OF REGULATOR & RCDSO'S ROLE

## Awareness of Regulator

A majority of patient respondents reported being aware of a regulatory organization overseeing dentists in Ontario, with awareness higher among patients (58%) compared to non-recent patients (42%).

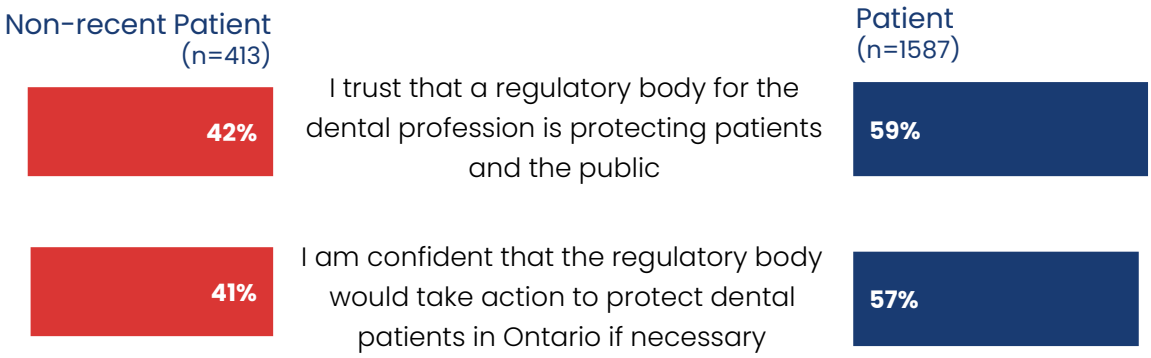
**58%** OF PATIENT RESPONDENTS

**42%** OF NON-RECENT PATIENT RESPONDENTS

ARE AWARE THERE IS A REGULATOR THAT OVERSEES DENTISTS

Six in ten (59%) patients said they trust that a regulatory body for the dental profession is protecting patients and the public. In comparison four in ten (42%) non-recent patients agreed with this statement. Similar proportions of patients (57%) and non-recent patients (41%) said they are confident that the regulatory body would take action to protect dental patients in Ontario.

**Trust and Confidence in Regulator Functions**
n=2000




## Awareness of RCDSO

Both patients and non-recent patients were asked whether they had ever heard of RCDSO. Just over a third (34%) of patients surveyed indicated that they are aware of RCDSO. Awareness of RCDSO was higher among patients than among non-recent patients with just over one-fifth (21%) of non-patients indicating that they are aware of RCDSO. Among those who had heard of RCDSO, most respondents first became aware through their friends or family members (25%) or from their oral health care professional (21%). Promotional materials put out by the College was also an important source of awareness, as 20% of aware respondents had first heard of the RCDSO through these materials.

**34%** OF PATIENT RESPONDENTS

**21%** OF NON-RECENT PATIENT RESPONDENTS

HAVE HEARD OF RCDSO

# PERCEPTIONS OF REGULATOR & RCDSO'S ROLE

## Perceptions of Effectiveness of RCDSO

Participants who were aware of RCDSO were asked to rate how effective they perceive RCDSO to be in carrying out its public protection mandate. Among this group, 56% of patient respondents and 44% of non-patient respondents believe RCDSO is effective in fulfilling its mandate. RCDSO's performance across various aspects of the College's mandate was evaluated by respondents using a seven-point scale, where (7) means extremely effective and (1) means extremely ineffective.

**56%**

OF "AWARE" PATIENT RESPONDENTS

**44%**

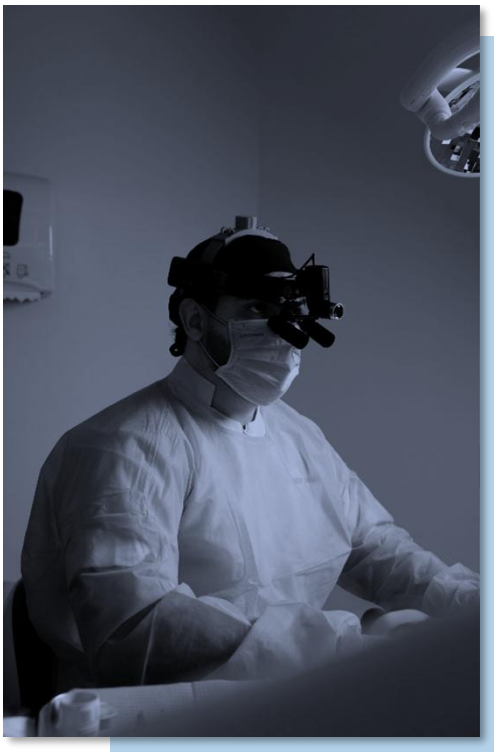
OF "AWARE" NON-RECENT PATIENT RESPONDENTS

BELIEVE RCDSO IS EFFECTIVE IN CARRYING OUT ITS PUBLIC PROTECTION MANDATE

## KEY TAKEAWAYS

1. Awareness of RCDSO is low, with only 34% of patients and 21% of non-recent patients familiar with the organization.

2. Among those who were aware of the College, perceptions of effectiveness were moderate with 56% of patients and 44% of non-patients reporting that they believe the RCDSO is effective in carrying out its public protection mandate.



RCDSO | Royal College of Dental Surgeons of Ontario

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PIVOTAL RESEARCH Inc.™

Royal College of
Dental Surgeons of Ontario

# COUNCIL BRIEFING NOTE

**TOPIC: Foundations of Professionalism: Draft for External Consultation**

March 2025

**FOR DECISION**

## ISSUE:

- In accordance with Council's direction, a new College document on professionalism has been developed as part of the Access to Care strategic project.
- Council is asked for feedback on the draft *Foundations of Professionalism* document and whether it can be released for external consultation.
- This item is for decision.

## PUBLIC INTEREST:

- The draft *Foundations of Professionalism* document serves the public interest by reflecting the high standard of professionalism with which dentists practice. In doing so, dentists seek and maintain the highest possible level of confidence and trust with respect to patients and society.
- The draft document is being developed as part of the Access to Care strategic project. Professionalism can help increase access to oral health care by fostering a culturally safe, inclusive, equitable, and accessible environment that is free from discrimination. Improving access to oral health care has a direct connection to the RCDSO's mandate and will support patients' and society's overall health and wellbeing.

## BACKGROUND:

- Improving access to oral health care is a priority for the RCDSO and the focus of the Access to Care strategic project under the College's 2023-25 Strategic Plan.
- Council provided direction regarding the project's areas of focus over the three year duration of the project. The primary focus in 2024-25 is to:
    - explore the development of two new College documents regarding professionalism and accepting patients into dental practices, with the assistance of a Working Group;
    - engage with the public, profession, and other interested parties in discussions regarding the key foundational concepts and issues that will inform the content of those documents; and

- ensure that the documents contain guidance on the provision of culturally safe, inclusive, equitable, and accessible care that is free from discrimination.

- The development of the two new College documents is being supported by a Working Group, chaired by Dr. Carlos Quiñonez and comprised of Council members (Dr. Erin Walker, Dr. Noha Gomaa, Mr. Brian Smith, and Ms. Vivian Hu), faculty representatives (Dr. Sonica Singhal, Dr. Keith Da Silva), and subject matter experts (Dr. Clive Friedman, Dr. Ian McConnachie). The Working Group is supported by Michelle Cabrero Gauley, policy lead, and Dr. Bonnie Yu, clinical lead.
- The Working Group has been meeting regularly since April 2024 to review the foundational research that has been conducted, along with the feedback that has been obtained via consultation/engagement and outreach tactics, and to begin providing direction on the contents of the two College documents.
- More specifically, the Working Group has considered the following research and feedback:
  - literature and jurisdictional reviews on professionalism and accepting new patients (key findings were reported to Council in September 2024[1]);
  - RCDSO Inquiries, Complaints, and Discipline information and data;
  - an overview of dentists' key legal duties (e.g., under fiduciary and human rights law);
  - feedback obtained from the profession[2], public, Citizen Advisory Group, and other interested parties via the external consultation held in Q1 2024 (Consultation Report provided to Council in June 2024[3] and available online);
  - feedback obtained from attendees at the Alliance for Healthier Communities Conference and RCDSO Connect event in June 2024 (key feedback reported to Council in September 2024[4]); and
  - results of a public poll conducted by an external research firm in Q4 2024 that asked the public questions about their experiences and expectations regarding access to care, professionalism, and accepting patients into dental practices. These results will be shared with Council at its March 2025 meeting via a separate briefing note and presentation.
- The Working Group decided to focus on developing the document on professionalism first, as it is foundational in nature and will help inform the policy positions in the document on accepting patients into dental practices.
- Council was provided with an overview of the Working Group's efforts to develop the draft document on professionalism at the December 2024 meeting[5]. This included a summary of the Working Group's key provisional positions and rationale. In response, Council:

[1] See pages 330-338 of the September Council meeting materials.
[2] This included inviting Ontario Dental Association Annual Spring Meeting attendees to participate in the external consultation in April 2024.
[3] See pages 222-278 of the June Council meeting materials.
[4] See pages 330-338 of the September Council meeting materials.
[5] See pages 203-209 of the December Council meeting materials.

- expressed support for the initial thinking and direction of the Working Group;
- acknowledged the positive impact the document will have on the oral health care environment; and
- brainstormed how to raise awareness of the document and support its implementation after it is approved by Council.

## CURRENT STATUS:

- The Working Group is pleased to share with Council the draft *Foundations of Professionalism* document, attached as **Appendix A.**
- The draft *Foundations of Professionalism* document describes the core principles and duties of the profession. This document will replace the *Code of Ethics* and serve as a foundation for all of the RCDSO's guidance for dentists, as set out in Standards of Practice and other resources.
- An overview of the key features of the draft document, along with the Working Group's rationale for including the content, is set out below.

***Structure***

- The draft document contains an executive summary, introduction, principles and duties, along with a glossary of key terms. The principles and duties section is organized by the classical bioethical principles of patient autonomy, beneficence, nonmaleficence, and justice.

  Rationale:

  - The Working Group thought it would be helpful to organize the draft document by the well-known and accepted bioethical principles in health care.[6] These bioethical principles are common across many different health care professions and appear in the professionalism documents of many other health regulators.
  - The Working Group also thought it would be helpful to define the key terms used in the draft document in a Glossary, where a comprehensive description of the term and/or resources could be provided to enhance clarity and facilitate understanding.

***Introduction***

- The draft document's introduction describes the individual and collective commitments to professionalism that dentists demonstrate throughout their careers. This includes one of the most important components of professionalism -- acting in the best interests of patients and society -- and the key duties health care professionals have through fiduciary law. (Lines 40-54)

  Rationale:

  - The Working Group felt it was important to emphasize dentists' responsibility to act in the best interests of patients and society throughout the document. This aligns with

[6] Beauchamp, T.L. & Childress, J.F. (2019). *Principles of Biomedical Ethics* (8th ed.). Oxford University Press.

RCDSO's duty to serve and protect the public interest[7] and with feedback received through public polling. Public polling results included the following:

- Ontarians believe that dentists have a responsibility to act in the best interests of patients and society.[8]
- A key driver analysis of patient satisfaction with various elements of their dental care journey found that the public perceives that dentists are currently underperforming with respect to prioritizing their patients' oral health care above other interests.[9]

- The Working Group elected to focus on describing professionalism in the context of the key duties dentists have through fiduciary law as they are clear and relatable. The literature describes these duties as contributing to a culture of fidelity, which is an essential component of professionalism.[10]

- The introduction also describes the purpose of the document, why the RCDSO developed it, and how it will be used by dentists and the RCDSO. Key messages include the following:

  ✓ The document can help dentists navigate the ethical complexities that arise in practice and support dentists in attaining the highest possible level of confidence and trust with respect to patients and society. (Lines 62-65)

  ✓ The RCDSO believes there is value in describing the principles and duties of the profession in this document, particularly for new dentists, and for patients and the public, so that they know the high standard of professionalism that is expected from and demonstrated by dentists. (Lines 67-69)

  ✓ Developing the document fulfils a statutory requirement for the RCDSO to "develop, establish and maintain standards of professional ethics".[11] (Lines 70-72)

  ✓ The document will be used, together with Standards of Practice and other College resources, relevant legislation, and case law, by the RCDSO when considering or evaluating dentists' practice and conduct. (Lines 78-80)

  Rationale:

  - The Working Group wanted to clearly communicate these key messages to help ensure that dentists, patients, the public, and other interested parties have a good understanding of why the document was developed and how it will be used.

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[7] Section 3 (2) of the *Health Professions Procedural Code,* Schedule 2 of the *Regulated Health Professions Act, 1991*, S.O. 1001, c.18.
[8] When asked to evaluate their agreement with various statements regarding the responsibilities and obligations of dentists in Ontario, 71% of respondents agreed that dentists should prioritize patient health and wellbeing above all other interests, and 66% agreed that dentists should promote the overall health and wellbeing of the community.
[9] When asked about their satisfaction with their dental care experience, 67% of respondents said "my dentist prioritizes my (or my dependent's) oral health care above all other interests". A key driver analysis was conducted by the research firm and this item was identified as a key driver of satisfaction that dentists were currently underperforming in, compared to other patient journey items.
[10] Litman, M. (2007). Fiduciary law in the hospital context: the prescriptive duty of protective intervention. *Health Law J.*, 15:295-352.
[11] Section 3 (1) 5 of the *Health Professions Procedural Code*, Schedule 2 of the *Regulated Health Professions Act, 1991*, S.O. 1001, c.18.

***Patient Autonomy***

- The draft document contains examples of how dentists respect patient autonomy, including providing care that is responsive to patient needs, values, beliefs, goals, social identities, and economic circumstances. (Lines 105-106) The examples speak to the provision of patient-centered,[12] culturally safe[13] care.

  Rationale:

  - The Working Group acknowledged the importance of patient-centered, culturally safe care in dentistry and wanted to emphasize that it includes considering and responding to patients' social identities and economic circumstances and putting these ahead of dentists' own personal interests.
  - The Working Group thought it may help bring awareness to the social and economic factors that can impede a patient's ability to access dental care, such as race, culture, employment, and income.
  - Including these examples is also consistent with what Ontarians think is important, as 71% of public polling respondents thought dentists have a responsibility to advocate for each patient by addressing their unique needs and barriers to care (i.e., patient-centered, culturally safe care).

***Beneficence***

- The draft document contains examples of how dentists demonstrate beneficence (to do good), including:

  ✓ Acting, first and foremost, for the benefit of, and in service to, the health and wellbeing of patients and society. (Lines 108-109)

  ✓ Leading or participating in initiatives that address the oral health and oral health care needs of individuals, communities, and society. (Lines 119-120)

  ✓ Individually and collectively promoting health and preventing oral disease by understanding and taking reasonable steps to address the broader contexts in which disease occurs. (Lines 121-123)

  Rationale:

  - The Working Group wanted to emphasize one of the most important components of professionalism – to act in the best interests of patients and society – and to include examples that acknowledge the duties dentists have beyond the chairside, individually and collectively. As noted above, including this content is consistent with the public's views on dentists' responsibilities.

[12] Patient-centered care is a concept that integrates the patient's preferences, values, and beliefs into the process of decision-making, producing a treatment plan that is both appropriate and meaningful for the patient. It supports the role of patients making informed and active choices, rather than remaining passive recipients of their care.
[13] Culturally safe care is an outcome based on respectful engagement that recognizes and strives to address the power imbalances inherent in the health care system. It results in an environment free of racism and discrimination, where people feel safe when receiving care and making decisions about their care.

***Nonmaleficence***

- The draft document contains examples of how dentists demonstrate nonmaleficence (to do no harm), including:
  - ✓ Identifying, preventing, and managing conflicts of interest in a manner that ensures patients' best interests remain paramount.[14] (Lines 135-136)
  - ✓ Raising concerns about inappropriate, unprofessional, or otherwise concerning behaviour of staff or colleagues directly with the person, or if needed, with the relevant leadership or authority, where a mandatory report is not required. (Lines 142-144)

  Rationale:

  - The Working Group wanted to emphasize the importance of acting in the best interests of patients when managing conflicts that arise and the importance of safeguarding dentists' professional judgement.
  - In addition to making mandatory reports, the Working Group wanted to encourage dentists to raise concerns about specific behaviours to help protect patients and society from harm. Some health regulators[15] also have a similar ethical requirement to raise concerns.

***Justice***

- The draft document contains examples of how dentists demonstrate justice, including:
  - ✓ Providing services and making administrative decisions in practice that are free from prejudice and discrimination, including discrimination on the basis of the grounds set out in the *Human Rights Code* (such as race, ethnicity, gender identity, disability, etc.).[16] (Lines 150-152)
  - ✓ Seeking to recognize bias and taking reasonable steps to prevent it from negatively influencing professional relationships and patient care. (Lines 154-155)
  - ✓ Recognizing differences in power that exist in professional relationships with patients, staff, colleagues, or other health care professionals, and exploring ways to support or empower the other person. (Lines 156-158)
  - ✓ Participating in initiatives to reduce health inequities that are driven by the determinants of health. (Lines 162-163)

  Rationale:

  - The Working Group wanted to reinforce dentists' legal obligations with respect to human rights. The Working Group perceives that there may be a knowledge gap with respect to this very technical and important area of law so is contemplating other ways

[14] This includes ensuring that business interests and practices do not influence professional judgement.
[15] For example, College of Dental Surgeons of Saskatchewan, Manitoba Dental Association, Newfoundland and Labrador Dental Board, College of Physicians and Surgeons of Ontario, Ontario College of Pharmacists, and College of Physiotherapists of Ontario.
[16] The complete list of protected grounds in the *Human Rights Code* is as follows: citizenship, race, place of origin, ethnic origin, colour, ancestry, disability, age, creed, sex/pregnancy, family status, marital status, sexual orientation, gender identity, and gender expression.

to help dentists implement policies and practices that comply with human rights law (e.g., via implementation resources and continuing education).

- The Working Group recognized justice as being one of the most challenging principles to implement in practice given the systemic nature of the issues and barriers that impact fair and equitable access to oral health care. Despite this, the Working Group still wanted to provide examples of what dentists can do, both individually and collectively, to help support fair and equitable access to oral health care.
- The Working Group acknowledged that many dentists are already voluntarily participating in a variety of initiatives that support equitable access to oral health care and did not feel that it was necessary to make participating in any specific initiative mandatory.
- Inclusion of justice as a principle is well supported by Ontarians as "ensuring that oral health care is fair and respectful for all individuals" was identified by public polling respondents as dentists' top responsibility.[17]

## CONSIDERATIONS:

- The principles and duties set out in this draft document are generally consistent with those articulated by other health regulators in their documents on professionalism.[18]
- Consistent with the RCDSO's commitment to integrate equity, diversity, and inclusion (EDI) in all that we do,[19] the Working Group has embedded these important concepts in the draft document. It is important to note that in some cases, specific EDI terms (e.g., cultural safety and humility) have not been included in the document given that EDI language is constantly changing and the Working Group wanted the *Foundations of Professionalism* document to have longevity.

## NEXT STEPS:

- If Council approves the draft document for external consultation, it will be posted on the RCDSO's Public Consultation webpage and circulated to all interested parties as per the consultation process.[20]
    - The consultation process will include an extra step of personally reaching out to representatives from the Ontario Dental Association, Oral Health Colleges, and organizations with a patient and/or equity focus to help us hear directly from health system partners and those with diverse perspectives to share.

[17] When asked to evaluate their agreement with various statement regarding the responsibilities and obligations of dentists in Ontario, 79% of respondents agreed that dentists should ensure that oral health care is fair and respectful for all individuals.
[18] Professionalism documents of 33 different health regulators were reviewed, including dental regulators (Canada and International), Ontario health regulators, and International medical regulators.
[19] As set out in the RCDSO's 2023-2025 Strategic Plan.
[20] The consultation will be active for a minimum of 60 days and will be supported by targeted reminders. Feedback will principally be solicited via a custom consultation survey asking respondents targeted questions about the draft.

- The Working Group will consider the feedback and propose revisions to the draft document for the Quality Assurance Committee's and Council's consideration at a future meeting.
- Policy and Communications staff will continue to collaborate on implementing a communications strategy to ensure that the profession, public, and other interested parties remain informed of key progress in the Access to Care strategic project.

## DECISION FOR COUNCIL:

- Council is being asked whether it has any feedback on the draft *Foundations of Professionalism* document, and whether it approves the draft document to be released for external consultation.
- The motion before Council is as follows:
    - THAT Council approves the release of the draft *Foundations of Professionalism*, as set out in Appendix A, for external consultation.

## CONTACTS:


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Attachment:

Appendix A: Draft *Foundations of Professionalism*

# Foundations of Professionalism

Approved by Council – Month and Year
Related Resources: TBD

## Contents



## Executive Summary


*Foundations of Professionalism* reflects the individual and collective commitments to professionalism that dentists demonstrate throughout their entire careers. This document describes the core principles and duties that dentists exemplify in managing the oral health care needs of individuals and communities, and in promoting good oral health for all.

*Foundations of Professionalism* replaces the *Code of Ethics* and serves as a foundation for all Royal College of Dental Surgeon of Ontario (RCDSO) Standards of Practice and other resources that guide dentists' conduct. This document sets out the core principles and duties of the profession, which are organized by the classic bioethical principles of patient autonomy, beneficence, nonmaleficence, and justice. Examples of how dentists can meet each principle have been included to illustrate how they can be applied in practice.

This document can help dentists navigate the ethical complexities that arise in practice and support dentists in attaining the highest possible level of confidence and trust with respect to patients and society. Dentists can continue to find more specific legal, professional, and ethical obligations on issues or areas of practice in the RCDSO's Standards of Practice and other resources.

*A glossary of **bolded** terms is provided at the end of this document in Appendix 1.*


## Introduction

Dentists' primary objective as health care professionals is to maintain or enhance the oral health of individuals and communities while upholding the trust of patients and society. Continued trust in the dental profession is dependent on dentists' individual and collective commitment to a high standard of **professionalism**. This commitment to professionalism is expressed throughout dentists' careers, from initial entry into dental school and throughout

their education and training, to becoming a regulated health care professional and practising the profession, right through to retirement.

One of the most important components of professionalism is to *act in the best interests of patients and society*. Dentists consistently demonstrate this in practice by putting patients' best interests first and promoting and advocating for the health and wellbeing of patients and society. The obligation to put patients' interests first is grounded in a specific area of law, called **fiduciary law**. Key duties assigned to health care professionals, including dentists, through fiduciary law include acting in patients' best interests, avoiding conflicts of interest, and acting with integrity, loyalty, honesty, trustworthiness, and the utmost good faith.[1] These elements form the basis of the **principles** and **duties** of professionalism set out by the RCDSO in this document.

The principles and duties:

- reflect dentists' broad responsibilities to patients, society, the profession, and themselves;[2]
- represent what patients, society, and dentists consider important;
- reflect the ethical manner in which dentists are currently practising the profession;
- guide dentists' individual and collective behaviour;
- help dentists navigate clinical and professional practice and the ethical complexities that are certain to arise; and
- support dentists in attaining the highest possible level of confidence and trust with respect to patients and society.

The RCDSO believes there is value in describing the principles and duties of the profession in this document, particularly for new dentists, and for patients and the public, so that they know the high standard of professionalism that is expected from and demonstrated by dentists. Developing this document also fulfils the requirement in the *Health Professions Procedural Code* under the *Regulated Health Professions Act, 1991* for the RCDSO to "develop, establish and maintain standards of professional ethics" for dentists.[3]

The principles and duties described in this document serve as a foundation for all of the RCDSO's guidance for dentists, as set out in Standards of Practice and other resources. This *Foundations of Professionalism* document is a higher-level resource than a Standard of Practice, which relates to a specific issue or area of practice (e.g., boundaries, recordkeeping, virtual care). Together with Standards of Practice and other College resources, relevant legislation, and case law, the *Foundations of Professionalism* will be used by the RCDSO when considering or evaluating dentists' practice and conduct.

[1] These are some of the key duties health care professionals owe as fiduciaries to their beneficiaries (i.e., patients).
[2] These broad responsibilities are set out in the Canadian Dental Association's Principles of Ethics.
[3] Section 3 (1) 5 of the *Health Professions Procedural Code*, Schedule 2 of the *Regulated Health Professions Act, 1991*, S.O. 1001, c.18.

While this document reflects the core principles and duties of the profession, it is not an exhaustive or definitive list of all the legal, professional, and ethical obligations dentists have. Specific requirements are set out in Standards of Practice and other College resources, relevant legislation, and case law.

## Principles and Duties

This section is organized by the classic bioethical principles of patient autonomy, beneficence, nonmaleficence, and justice.[4]

The principles and duties are not listed in any order of priority – they are all important. However, some principles and duties may be more relevant in specific circumstances than others, and some may even conflict at times. Dentists will need to use their professional judgement to determine which are most relevant to their specific circumstances, and how to apply them.

### *1) PATIENT AUTONOMY*

Patients have a right to self-determination, including the right to make their own decisions about their health care, and a right to privacy and confidentiality of their personal health information. These rights need to be acknowledged and respected by health care professionals.

Dentists respect patient autonomy by:

a. Being fully present, focused, and responsive during interactions with patients.
b. Learning about and respecting patients' experiences, values, and beliefs, and being open to their perspectives.
c. Providing clear and accurate information regarding treatment options in a manner that the patient understands.
d. Encouraging active collaboration and shared decision-making with patients, or, when authorized, with the patient's substitute decision-maker, family, or caregiver.
e. Obtaining consent before proceeding with treatment.[5]
f. Providing care that is responsive to patient needs, values, beliefs, goals, **social identities**, and economic circumstances.

### *2) BENEFICENCE*

Health care professionals actively serve and benefit patients and society. They also do good by maintaining and enhancing the health and wellbeing of patients and society, recognizing the interconnectedness between both.

Dentists demonstrate beneficence by:

[4] Beauchamp, T.L. & Childress, J.F. (2019). *Principles of Biomedical Ethics* (8th ed). Oxford University Press.
[5] For more information, see the RCDSO's Standard of Practice on Consent to Treatment.

a. Acting, first and foremost, for the benefit of, and in service to, the health and wellbeing of patients and society.
b. Recognizing and honouring the inherent worth, rights, and dignity of all people.
c. Being kind, empathetic, and compassionate.
d. Creating a **safe environment** where all individuals feel welcome, respected, and valued.[6]
e. Building and maintaining **professional relationships** based on mutual trust and respect.[7]
f. Collaborating and communicating effectively within professional relationships.
g. Facilitating continuity of care, including:
    i) supporting patients throughout the entire treating relationship;
    ii) coordinating care with patients' other health care professionals; and
    iii) providing emergency care or advising how to obtain such care.
h. Leading or participating in initiatives that address the oral health and oral health care needs of individuals, communities, and society.
i. Individually and collectively promoting health and preventing oral disease by understanding and taking reasonable steps to address the broader contexts in which disease occurs.
j. Participating in the regulation of the profession.[8]

### *3) NONMALEFICENCE*

Health care professionals do no harm to patients and society and protect patients and society from harm.

Dentists demonstrate nonmaleficence by:

a. Complying with legal, professional, and ethical obligations set out in law and by the RCDSO.[9,10]
b. Maintaining competence, recognizing limitations, and referring patients to other health care professionals, when necessary.[11]
c. Maintaining appropriate and dignified boundaries in professional relationships.[12]

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[6] For more information, see the Glossary and RCDSO's Standard of Practice on Prevention of Boundary Violations and Sexual Abuse and Infection Prevention and Control.

[7] For more information, see the RCDSO's Practice Advisory on Maintaining a Professional Patient-Dentist Relationship.

[8] Preserving the ability to regulate the profession (i.e., **professional regulation**) requires the profession to maintain an effective and appropriate governance structure and a reliable system of accountability. This means it is not enough for individual dentists to accept regulation; each dentist has a professional duty to actively participate in the regulatory process (e.g., by engaging with the RCDSO, as necessary).

[9] This includes committing to a high standard of professionalism and meeting the standard of care.

[10] For clarity, dentists are ultimately responsible for meeting their legal, professional, and ethical obligations regardless of whether they assign tasks to staff or other health care professionals, or work with an organization or other party in the course of practicing dentistry.

[11] For more information, see the RCDSO's Quality Assurance webpage and Practice Advisory on Most Responsible Dentist.

[12] For more information, see the RCDSO's Standard of Practice on Prevention of Boundary Violations and Sexual Abuse.

d. Being truthful and not representing information about themselves (e.g., education, qualifications, or competence) and/or their practice that is false or misleading.[13]
e. Being collegial and maintaining objectivity when communicating about services provided by other health care professionals.
f. Identifying, preventing, and managing conflicts of interest in a manner that ensures patients' best interests remain paramount.[14]
g. Using technology in a responsible and ethical manner.[15]
h. Addressing harm and misconduct, including:
    i) disclosing any harm that occurs as a result of their actions, decisions, judgement, or competence;
    ii) making mandatory reports as required by law; [16] and
    iii) where a mandatory report is not required, raising concerns about inappropriate, unprofessional, or otherwise concerning behaviour of staff or colleagues directly with the person, or if needed, with the relevant leadership or authority.
i. Balancing personal and professional priorities to maintain dentists' own health and wellbeing.

### *4) JUSTICE*

Health care professionals treat all people fairly and equitably.

Dentists demonstrate justice by:

a. Complying with legal obligations with respect to human rights and accessibility.[17]
b. Providing services and making administrative decisions in practice that are free from **prejudice** and **discrimination**, including discrimination on the basis of the grounds set out in the *Human Rights Code* (such as race, ethnicity, gender identity, disability, etc.).[18]
c. Promoting fair and equitable access to oral health care for all.
d. Seeking to recognize **bias** and taking reasonable steps to prevent it from negatively influencing professional relationships and patient care.
e. Recognizing differences in power that exist in professional relationships with patients, staff, colleagues, or other health care professionals, and exploring ways to support or empower the other person.

[13] For more information, see the RCDSO's Practice Advisory on Professional Advertising.
[14] This includes ensuring that business interests and practices do not influence professional judgement. For more information, see the RCDSO's Guidelines on Conflict of Interest.
[15] For more information, see the RCDSO's Standards of Practice on Dental CT Scanners and Virtual Care.
[16] For more information, see the RCDSO's Mandatory Reporting webpage.
[17] *Human Rights Code* and *Accessibility for Ontarians with Disabilities Act, 2005 (AODA)*. For more information, see Working Together: The Code and the AODA by the Ontario Human Rights Commission.
[18] The complete list of protected grounds in the *Human Rights Code* is as follows: citizenship, race, place of origin, ethnic origin, colour, ancestry, disability, age, creed, sex/pregnancy, family status, marital status, sexual orientation, gender identity, and gender expression.

f. Recognizing the unique opportunities and barriers created by each person's social identities (e.g., based on race, ethnicity, gender identity, disability) and taking reasonable steps to support each person.
g. Participating in initiatives to reduce **health inequities** that are driven by the **determinants of health**.

## Appendix 1: Glossary

**Bias:** An inclination to think something or someone is better or preferred, usually in a way considered to be unfair. Bias can be explicit (or conscious) or implicit (or unconscious). Bias inhibits impartial judgement, thought, or analysis. Biases (particularly implicit or unconscious) are built into and perpetuated by societal systems and structures through socialization and may conflict with our declared beliefs and how we see ourselves.

**Determinants of health:** The broad range of personal, social, economic, and environmental factors that determine individual and population health. The main determinants of health include:

- Income and social status
- Employment and working conditions
- Education and literacy
- Childhood experiences
- Physical environments
- Social supports and coping skills
- Healthy behaviours
- Access to health services
- Biology and genetic endowment
- Gender
- Culture
- Race / Racism[19]

**Discrimination:** When a distinction is made according to which some benefit is withheld or burden assigned to an individual or group of individuals on the basis of a personal characteristic that is irrelevant to the distinction which was made.[20] Discrimination exists where a discriminatory practice occurs on the basis of a prohibited ground[21] for which no justification has been made.

[19] Government of Canada. (2024). Social determinants of health and health inequalities.

[20] Most human rights legislation does not include a formal definition of discrimination. The definition included in this document is from the judgement of McIntyre J. in *Law Society of British Columbia v. Andrews,* [1989] S.C.J. No. 6.

[21] The grounds in the *Human Rights Code* are: citizenship, race, place of origin, ethnic origin, colour, ancestry, disability, age, creed, sex/pregnancy, family status, marital status, sexual orientation, gender identity, and gender expression.

**Duties:** The positive actions that dentists are expected to take in fulfilling their role as a regulated health care professional. These actions are informed by the legal, professional, and ethical obligations of the profession set out in law and by the RCDSO.

**Fiduciary law:** Refers to a specific area of law through which key duties are assigned to fiduciaries (i.e., dentists) and owed to beneficiaries (i.e., patients). Fiduciaries have these duties due to the nature of the relationship with beneficiaries, namely that the fiduciary is in a position of power and has the unilateral ability to act and impact the beneficiary's interests. The specific duties fiduciaries have include, but are not limited to:

- Acting in beneficiaries' best interests
- Acting with integrity, loyalty, honesty, and trustworthiness
- Avoiding conflicts of interest
- Not acting in self-interest/profit
- Protecting confidentiality
- Providing access to records
- Disclosing error, misconduct, and whistleblowing
- Acting with the utmost good faith

**Health inequities:** Systematic differences in health-related exposures and outcomes among different population groups that are unnecessary, avoidable, unfair, unjust, and can be addressed through policy intervention.[22]

**Prejudice:** Refers to a preconceived judgement, opinion or attitude directed toward certain people based on their membership in a particular group. It is a set of attitudes, which supports, causes, or justifies discrimination. Prejudice is a tendency to rely on stereotypes or assumptions.[23]

**Principles:** Fundamental truths or propositions that serve as the foundation for a system of values or behaviours. They are often universal, objective, and used to guide actions and judgements in a consistent manner.

**Professionalism:** Refers to the conduct, aims, and qualities that characterize a profession. It involves a commitment to the mastery of a complex body of knowledge and skills in the service of others. For health care professionals, it includes commitments to ethical practice, clinical and cultural competence, integrity, morality, altruism, and the promotion of the public good. Members of a profession are accountable both to those they serve and to society at large.[24]

[22] Adapted from Whitehead, M. (1992). The concepts and principles of equity and health. *International Journal of Health Services*, 22(3), 429-445.

[23] Rouse, L., Booker, K., Stermer, S.P. (2011). Prejudice. In: Goldstein, S., Naglieri, J.A. (eds) *Encyclopedia of Child Behavior and Development*. Springer.

[24] Adapted from Cruess, S. R., Johnston, S., & Cruess, R. L. (2004). "Profession": A Working Definition for Medical Educators. *Teaching and Learning in Medicine*, 16(1), 74–76.

**Professional regulation:** Refers to an approach or system that ensures members of health professions meet standards of competency and conduct, usually involving registering, licensing, and monitoring members to ensure that they meet the standards. In Ontario, regulatory powers are delegated through the *Regulated Health Professions Act, 1991* by the provincial government to a body, which is comprised of members of the profession and the public. The RCDSO is the regulatory body for the profession of dentistry in Ontario. The RCDSO is responsible for ensuring that the public has safe, equitable, and competent oral health care by providing leadership to the dental profession in regulation, setting the education and other qualifications necessary to become a registered dentist, developing professional and ethical standards and guidelines, and holding registered dentists accountable for their conduct and practice through complaint and investigation processes. Professional regulation is based on the premise that regulated professionals (i.e., dentists) can be trusted to regulate themselves in the public interest.

**Professional relationships:** Relationships between dentists and patients, staff, colleagues, or other health care professionals.

**Safe environment:** Refers to a space where people feel emotionally, psychologically, and physically safe.

- Emotional safety is when people feel accepted and secure enough to share their identities, experiences, thoughts, feelings, and vulnerabilities without fear of negative consequences.
- Psychological safety is when people feel that they can share their thoughts, ideas, concerns, and mistakes in teams or organizational settings without fear of negative consequences.
- Physical safety is when there are practices in place to ensure that people are protected from harm, injury, or health risks. In a dental office, this includes a space where infection is prevented and controlled.

**Social identities**: The aspects of an individual's self-concept that comes from membership in a specific social group (e.g., race, ethnicity, gender identity, sexual orientation, age). An individual may have multiple social identities.

Royal College of
Dental Surgeons of Ontario

# COUNCIL BRIEFING NOTE

**TOPIC: Artificial Intelligence in Dentistry: Draft Guidance for External Consultation**

**FOR DECISION**

March 2025

## ISSUE:

- Council is invited to provide feedback on a new draft *Guidance: Artificial Intelligence in Dentistry*, and is asked for approval to release the draft document for external consultation.
- This item is for decision.

## PUBLIC INTEREST:

- RCDSO Guidance supports the public interest by ensuring that dentists understand and fulfill their legal, professional, and ethical obligations when providing care.
- The draft *Guidance: Artificial Intelligence in Dentistry* serves the public interest by ensuring that dentists use AI responsibly and ethically in their practices.

## BACKGROUND:

- As Council is aware, the policy team is undertaking an initiative to update and modernize RCDSO's guidance to the profession, set out in Standards of Practice, Guidelines, and Practice Advisories. As part of this work, policy staff have assessed all current Standards and resources, along with key several emerging issues, and placed them in a priority sequence for review using the "Standards Prioritization Framework" approved by the Quality Assurance Committee (QAC).[1]
- Of the emerging issues reviewed, the use of artificial intelligence (AI) in dentistry was deemed a high priority by policy staff due to the rapidly evolving nature of this technology and its potential to directly impact patient care and pose a risk to patients.
- AI has growing applications in dentistry, including administrative, operational, and clinical uses. As AI becomes more prevalent in dentistry, its rapid development and a lack of clear guidance for registrants can pose risks to patients.
- At the January 2024 meeting of QAC, the policy team recommended that guidance be developed on the topic of AI in dentistry. QAC supported this recommendation and directed policy staff to develop guidance which balances the potential benefits and risks posed by AI, and which protects patients without stifling innovation or impeding improvements in quality of care.

[1] See page 120 of the June 2023 Council Meeting materials for an overview of the policy team's "prioritization framework".

- The following background outlines relevant research, analysis, and stakeholder feedback that has informed the development of the draft *Guidance: Artificial Intelligence in Dentistry*.

***Research and Analysis***

- Background research and analysis was conducted for the development of this draft document in accordance with the policy's team Standards Review and Development Process. This included a review of internal data (e.g., inquiries and complaints), a jurisdictional scan, and a literature review.

1. *Internal Data*

- Due to the emerging nature of AI, few internal data exist on relevant inquiries and complaints. RCDSO's Practice Advisory Service (PAS), which responds to inquiries from dentists, has reported that from February to November 2024 there have been only a few AI-related inquiries. Of inquiries received, common themes include professional responsibilities when using AI in diagnostics/interpretation of computed tomography scans and radiographs, and the use of AI in practice generally (e.g., practice administration, record-keeping, drafting letters to patients).

2. *Jurisdictional Scan*

- A jurisdictional review of regulators and relevant organizations across Canada and internationally was conducted to determine whether standards and/or guidance on the topic of AI exist in other jurisdictions. Some findings include:
    - Among oral health regulatory colleges in Canada, there are currently no standards or guidelines on AI. Several Ontario health regulatory colleges have published guidance in newsletters or similar publications for their registrants, although some focus solely on the use of AI chatbots.[2]
    - Several medical regulators in Canada (Ontario, Alberta, BC, Saskatchewan, Manitoba, and New Brunswick) have developed "Advice to the Profession" or "Interim Guidance" documents. Some focus only on the use of AI for generating patient record content or as virtual assistants.

- Documents from the Government of Canada, American Medical Association (AMA), Australian Dental Association (ADA), Australian Health Practitioner Regulation Agency (AHPRA), Medical Radiation Practice Board of Australia, and Royal Australian and New Zealand College of Radiologists, among others, were also reviewed and compared.[3]

3. *Literature Review*

- Documents which identify principles for the ethical use of AI were reviewed, such as Ontario's Beta Principles for Ethical Use of AI, the Organization for Economic Co-operation and Development's (OECD) AI Principles, and the World Health Organization's (WHO) Ethics and Governance of Artificial Intelligence for Health (2021). In Principled Artificial Intelligence: Mapping Consensus in Ethical and Rights-based Approaches to Principles for AI (2020), eight key themes emerged from thirty-six principles documents reviewed: privacy, accountability, safety and security, transparency and explainability, fairness and non-discrimination, human control of technology, professional responsibility, and promotion of human values.

[2] These include the College of Audiologists and Speech-Language Pathologists of Ontario, the Ontario College of Social Workers and Social Service Workers, College of Physiotherapists of Ontario, College of Psychologists of Ontario, and College of Registered Psychotherapists of Ontario. The College of Dieticians of Ontario references AI in their updated Code of Ethics.
[3] Additional information is available upon request.

- The documents highlight key challenges related to the use of AI and indicate some of the issues that guidance can address. A few key issues include, but are not limited to, the following:
    - **Data collection and use:** AI relies on the collection, use, and analysis of large amounts of data for training, raising issues of consent, privacy, and security. The security of AI systems is critical to prevent unauthorized access, data breaches, and potential misuse of sensitive information.
    - **Errors and inaccuracies:** AI-generated outputs can sometimes contain errors or inaccuracies. The ability to audit and evaluate systems and the ability for humans to review AI-generated outputs and intervene when needed become important ways to address these risks.
    - **Discrimination and bias:** Discrimination and bias can arise from the data on which AI is trained (e.g., from a lack of representation of certain demographics) as well as in how AI is implemented in the real world, risking replicating bias in data or worsening existing inequalities.

***Preliminary Consultation Feedback***

- A preliminary consultation was held from May 14 to July 14, 2024 to gain insight into how dentists are currently using AI in their practices, as well as the opinions of dentists, patients, and the public on the perceived benefits and risks of AI in dentistry. A detailed summary of the survey feedback can be found in this survey report. A brief overview of the consultation findings follows.[4]

- The consultation garnered a total of 144 responses, with the vast majority received through our online survey. Of online survey respondents, approximately 83% identified themselves as dentists, 11% as members of the public, and 5% as other health-care professionals.
    - Organizational responses were received by email from the Ontario Dental Association (ODA) and the Royal College of Dentists of Canada (RCDC).[5]

- A minority (17%) of survey respondents who identified themselves as dentists answered that they were currently using AI in their practice.
    - Of respondents who stated that they were using AI, the top uses were for assisting with detecting and diagnosing conditions and diseases (50%), treatment planning and outcome prediction (41%), administrative and/or operational uses (32%), and record-keeping (23%).
    - Specific AI tools mentioned included Diagnocat (disease detection), Pearl (disease detection), CareCru (practice management), iTero scanner (intraoral scanner), Invisalign virtual care AI (patient monitoring), CEREC milling machine (AI-supported software to produce dental restorations).

- In response to the question of how likely they think they are to adopt AI technologies in the next five years, roughly a third of dentist respondents indicated “very likely” or “definitely”, and a third indicated they were “somewhat likely” (33%).

- All survey respondents were asked open-ended questions about what they believed were benefits and concerns around the use of AI in dentistry.
    - Top benefits of AI identified fell under the themes of helping with detection and diagnosis, office management/administrative uses, saving time by creating efficiencies, and improving communication with staff and patients.
    - Top risks of AI identified fell under themes of dependence/over-reliance on AI; inaccuracies/errors; source data issues; loss of personal experience, personal touch, and human involvement; over-diagnosis/treatment; and privacy/confidentiality of patient information.

[4] Participation in this survey was voluntary and no attempt has been made to ensure that the sample of participants is representative of any sub-population.
[5] Organizational feedback was not included in the survey report. Responses are available upon request.

***Additional Consultation and Engagement***

- In addition to the research and consultation noted above, other consultation and engagement activities have been undertaken to inform the development of the draft Guidance document.

- Early versions of the draft document were reviewed by the College's internal Standing Policy Working Group[6] and staff Clinical Leads (Dr. Vicky Nguyen and Dr. Kalyani Baldota).

- The draft was also reviewed by external subject-matter experts (SMEs), Dr. Peter Fritz[7] and Dr. Zubin Austin.[8] Revisions were made to strengthen the draft, such as specifying factors that make AI tools higher risk and including guidance on undertaking education and training. The SMEs supported RCDSO's general approach in developing initial guidance to address the use of AI in dentistry, while also noting the importance of engaging in a longer-term system-wide approach to regulating AI.

- In November 2024, nine regulatory health colleges, including RCDSO, co-sponsored a Citizen Advisory Group (CAG) virtual facilitated meeting with a group of patients and caregivers on the topic of healthcare provider use of AI. A report summarizing the meeting is available here. Key themes which emerged from the meeting included:
    - participants felt that transparency, disclosure, and informed consent were important for healthcare providers using AI;
    - participants valued maintaining a personal connection with their health care provider, and preferred a collaborative discussion between health care provider and patient over a one-sided decision-making process;
    - participants expressed concerns with how AI may impact or present a barrier to patients who may lack or have limited technological literacy; and
    - participants indicated they needed more education about AI, confidence in the validity of the tools, and confidence in the privacy and security of data.

## CURRENT STATUS:

***New Draft Guidance: Artificial Intelligence in Dentistry***

- The draft *Guidance: Artificial Intelligence in Dentistry* (**Appendix A**) was developed based on a review and analysis of the abovementioned research and feedback.

***Guidance vs. Standard of Practice***

- This document has not been developed as Standard of Practice. The draft document, which is being called "Guidance", has been developed to provide registrants with advice in an area that is emerging and where best practices are still developing. This is distinct from a Standard of Practice, which sets out specific requirements drawing on established evidence and best practices.

- As AI is an emerging area in dentistry, best practices have not yet been established for a Standard to be developed. The draft Guidance is a new tool intended to address the unique challenges posed by AI. Guidance is more flexible than a Standard, allowing the College to more quickly adapt

[6] Members of the Standing Policy Working Group are Dr. Nalin Bhargava, Dr. Nancy Di Santo, Eleonora Fisher, Nizar Ladak, Patti Latimer, Dr. Antony Liscio, Dr. Anthony Mair, Sharon Rogers, Dr. Harinder Sandhu, Dr. Osama Soliman, and Dr. Deborah Wilson.
[7] Dr. Peter Fritz is a practicing periodontist in Fonthill, Ontario; Chair of RCDC's Task Force on AI and Emerging Digital Technology; Adjunct Assistant Clinical Professor, Department of Surgery, McMaster University; Adjunct Professor, Department of Kinesiology, Brock University; and has completed an LLM focused on cybersecurity and AI.
[8] Dr. Zubin Austin is a Professor at the Leslie Dan Faculty of Pharmacy and Academic Director for the Centre for Practice Excellence at the University of Toronto, whose research focuses on health professionals and the health workforce, and the use of AI in health professional regulation.

to the rapidly evolving nature of AI. Eventually, as best practices develop, the Guidance could be developed into a Standard.

- Given these differences between Guidance and a Standard, the style and format of these documents differ in some ways. In particular, the draft document avoids using mandatory language (e.g., "dentists **must**").

***Definition***

- In the draft document, "Artificial intelligence" refers to "computer systems that can perform tasks commonly associated with human intelligence, such as finding patterns in data, problem solving, learning, and making predictions, recommendations, and decisions."

- This definition is intended to be plain language and borrows elements from other definitions, such as those used by the Government of Canada[9] and WHO.[10]

***Principles***

- The draft document sets out principles that form the foundation for the recommendations that follow, including the overarching importance of the patient's best interests. The principles highlight the values and concepts that underpin the draft Guidance and can assist dentists in understanding and applying the Guidance to specific situations. The principles point to the potential benefits of using AI, as the Guidance aims to balance the objectives of both patient safety and innovation.

***Existing Professional Requirements***

- The draft document reminds dentists of existing duties and responsibilities which remain applicable as they adopt AI into their practice. These include those found in RCDSO's Code of Ethics; existing Standards of Practice and Practice Advisories (e.g., on consent to treatment, conflict of interest, advertising, recordkeeping); and law (e.g., the Professional Misconduct regulation under the *Dentistry Act, 1991*; privacy and accessibility legislation).

- While this section highlights key professional requirements relevant to the use of AI in dentistry, it is not meant to be an exhaustive list.

***Draft Guidance***

- The preamble for this section clarifies the application of the Guidance document to various types of AI tools and a risk-based approach that considers the potential impact on patient care.

- The draft document is organized into the following topics, which align with and focus on addressing key risks which can arise in AI in dentistry:
    - Accountability and Responsibility
        - Assessing the appropriateness of AI (lines 92-128)
        - Using AI (lines 130-153)
    - Transparency and Disclosure (lines 155-169)
    - Protecting Patient Health Information (lines 171-180)

[9] "Information technology that performs tasks that would ordinarily require biological brainpower to accomplish, such as making sense of spoken language, learning behaviours or solving problems." Government of Canada, Directive on Automated Decision-Making (2023).
[10] "The performance by computer programs of tasks that are commonly associated with intelligent beings." World Health Organization, Ethics and Governance of Artificial Intelligence for Health: WHO Guidance (2021).

1. *Accountability and Responsibility*

    - This section includes guidance for registrants to understand an AI tool and evaluate its appropriateness for use (e.g., around a product's legal and regulatory compliance; clinical validity, safety, accuracy, and effectiveness; data used to train the AI; and risks and limitations) (lines 100 to 125). This aligns with guidance from other regulators and organizations to understand the AI tool, including the data used to train the tool.[11]

    - The draft Guidance focuses on the importance of registrants overseeing the use of AI in practice, including by reviewing AI outputs and considering each patient's circumstances, and checking for accuracy, completeness, bias, and/or stereotypical associations (lines 144 to 147). This aligns with guidance from other health regulatory colleges,[12] medical regulators,[13] and legal regulators[14] on addressing risks of inaccuracies and biases in AI outputs.

2. *Transparency and Disclosure*

    - The draft Guidance highlights the importance of disclosure of the use of AI to support patient's informed decision-making, patient autonomy, and patient trust, particularly given the relative novelty of AI use in practice (lines 157 to 167). The Guidance also includes reasonably accommodating patient's wishes around AI use (lines 168 to 169).

    - The draft Guidance on disclosure corresponds with existing requirements to ask for patient consent to use AI scribes,[15] and guidance from medical[16] and legal regulators[17] to consider informing clients of the use of AI. Disclosure when interacting or conversing with AI is also encouraged.[18]

3. *Protecting Patient Health Information*

    - This section provides additional guidance on protecting patient personal health information, in addition to registrants' obligations to comply with *PHIPA* (lines 176 to 180).

    - This draft Guidance aligns with guidance from legal regulators, medical/dental associations, and other organizations[19] to understand privacy and data security settings and/or to opt out of the use of data for other purposes, such as training.

## CONSIDERATIONS:

### *Legislative Developments*

- In Canada, the *Artificial Intelligence and Data Act* (AIDA) (part of Bill C-27) was proposed legislation that included a framework to regulate AI systems, particularly "high-impact" systems. Since Parliament has been prorogued, the AIDA may no longer go forward. "High-impact" systems would have included

[11] For example, the AHPRA, Government of Canada, Law Society of Ontario (LSO), College of Physicians and Surgeons of Manitoba (CPSM).
[12] For example, the College of Physiotherapists and College of Registered Psychotherapists of Ontario.
[13] For example, the College of Physicians and Surgeons of Alberta (CPSA), College of Physicians and Surgeons of British Columbia (CPSBC), CPSM, the College of Physicians and Surgeons of New Brunswick (CPSNB).
[14] Specifically, the Law Society of Alberta, Law Society of British Columbia (LSBC), and LSO.
[15] For example, the Canadian Medical Protective Association, and Ontario Medical Association.
[16] For example, the AMA states, "When AI is used in a manner which directly impacts patient care, access to care, or medical decision making, that use of AI should be disclosed and documented." Resources from College of Physicians and Surgeons of Ontario (CPSO), CPSA, CPSM, CPSNB, and CPSBC also include guidance on disclosure and obtaining informed consent.
[17] For example, the LSO states, "Where the generative AI technology is relevant to the legal services provided and may impact the client's interests or outcome of the matter, or where there is concern about the risks associated with the generative AI technology, licensees should inform clients about the use of such technology."
[18] For example, the AMA and Government of Canada.
[19] For example, the LSO, LSBC, AMA, ADA, Government of Canada, and College of Physicians and Surgeons of Saskatchewan.

those in the health sector, such as AI systems used to help triage decisions. The AIDA would have required that appropriate measures be put in place to identify, assess, and mitigate risks of harm or biased output prior to a high-impact system being made available for use.

    - In September 2023, the federal government published a Voluntary Code of Conduct on the Responsible Development and Management of Advanced Generative AI Systems. This Code's objectives include accountability, safety, fairness and equity, transparency, human oversight and monitoring, and validity and robustness.

- Ontario's *Strengthening Cyber Security and Building Trust in the Public Sector Act, 2024* (Bill 194) received Royal Assent in November 2024. The act sets out a framework for regulating AI use by the public sector (not including regulatory health colleges). Regulations are yet to be established, but may include requirements to provide information, to develop and implement accountability frameworks, take steps respecting risk management, to disclose information, to ensure an individual provides oversight of the use of an AI system, and to set technical standards respecting AI systems.

## NEXT STEPS:

- If Council approves the draft Guidance for external consultation, the draft document will be posted on the RCDSO's Public Consultations webpage and a consultation notice will be sent to registrants, key stakeholders, and relevant system partners.

    - As per the policy team's usual Standards review and development process, the consultation will be active for a minimum of 60 days and will be supported by a number of targeted reminders. Feedback will principally be solicited via a custom consultation survey which will ask respondents targeted questions about the consultation draft.

    - Following the close of the consultation, the draft Guidance will be revised and brought back to Council for consideration prior to final approval.

## DECISION FOR COUNCIL:

- Council is asked whether it has any feedback on the draft, and whether it approves the draft *Guidance: Artificial Intelligence in Dentistry* to be released for external consultation.

- The motion before Council is as follows:
    - THAT Council approves the release of the draft *Guidance: Artificial Intelligence in Dentistry*, as set out in **Appendix A** of the resources, for external consultation.

## CONTACT:

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Attachments:

**Appendix A:** Draft Guidance: Artificial Intelligence in Dentistry

# GUIDANCE: Artificial Intelligence in Dentistry

## Contents



## Introduction

Like many other areas of healthcare, dentists have access to new artificial intelligence (AI) technologies that can significantly impact professional practice and patient care; however, there is not yet a clear body of research or established best practices to inform ethical and professional conduct.

Due to the rapidly evolving nature of this issue, the College has created this guidance to support registrants who are using and exploring AI-supported tools and technologies for professional purposes. This document will also support patients and the public in understanding what to expect from their dentists as AI becomes more commonplace in clinical practices.

This document does not set out new professional requirements, but instead highlights existing responsibilities that may be relevant to the use of AI in dentistry. It also provides guidance to help registrants exercise their professional judgment and make decisions in the best interests of patients when using AI for professional purposes.

## Definition

**Artificial intelligence (AI)** generally refers to computer systems that can perform tasks commonly associated with human intelligence, such as finding patterns in data, problem solving, learning, and making predictions, recommendations, and decisions.[1]

In dentistry, AI can be used for various purposes, including helping dentists with managing their practices, creating patient charts and documentation, diagnosing and detecting conditions and diseases, developing treatment plans, outcome prediction, patient monitoring, and patient education.

[1] There are different types and subsets of AI, including machine learning, generative AI, and large language models. For definitions of related terms, visit the University of Saskatchewan's Glossary of AI Related Terms.

## Principles

The following principles form the foundation for the guidance set out in this document:

1. The responsible and ethical use of AI in dentistry is guided by what is in the best interests of patients.
2. The responsible and ethical use of AI involves implementation of AI in a manner that is safe, transparent, unbiased, non-discriminatory, and safeguards patient privacy and confidentiality.
3. AI in dentistry has the potential to benefit dentists and patients by improving the delivery of safe and quality oral health care, improving patient outcomes, and enhancing the patient experience.
4. AI is not a substitute for dentists' clinical or professional judgment. Dentists remain responsible and accountable for their clinical care, decision-making, and documentation.

## Existing Professional Requirements

Dentists are reminded that adopting AI for professional purposes does not change their fundamental duties and responsibilities which can be found in existing Standards of Practice, Code of Ethics, and law. These include, but are not limited to:

- ethical principles in the College's Code of Ethics, including the principle that the dentist's paramount responsibility is to the health and well-being of their patients;
- professional requirements articulated in the College's Standards of Practice, Guidelines, and Practice Advisories, including, but not limited to those relating to consent to treatment, conflicts of interest, professional advertising, and recordkeeping;
- legal and regulatory requirements,[2] including those under the *Professional Misconduct* regulation under the *Dentistry Act, 1991*; Ontario's *Personal Health Information Protection Act, 2004* (*PHIPA*) with respect to consent for the use, collection, and disclosure of personal health information;[3] and Ontario's *Accessibility for Ontarians with Disabilities Act, 2005*.

## Guidance for the Adoption and Use of AI in Dentistry

This guidance is grounded in existing professional and ethical duties and is intended to assist dentists in interpreting how these can be applied when using AI in practice. The following guidance should be considered carefully by dentists who are exploring or adopting AI in their practices.

**Risk-Based Approach**

AI tools can assist dentists in a range of administrative, operational, and clinical applications; however, risks may vary based on the nature of the AI tool. Generally, where the potential risk is greater, dentists will need to exercise greater caution and oversight.

[2] Additional federal and provincial legislation related to the regulation of AI, such as Canada's *Artificial Intelligence and Data Act*, may be in development at the time of publication of this guidance.

[3] Dentists must be aware of whether they have obligations under the federal *Personal Information Protection and Electronic Documents Act*, SC 2000, c 5, which applies to commercial activities relating to the exchange of personal health information between provinces and territories and to information transfers outside of Canada.

Risk increases when an AI tool

- directly impacts clinical decision-making (e.g., to help formulate a diagnosis or treatment plan for a patient);
- poses a risk of harm to patient health and/or safety (e.g., to inform the diagnosis and treatment of an oral disease or condition);
- involves the use of patient's personal health information.

## 1. Accountability and Responsibility

### *Assessing the Appropriateness of AI*

Dentists have a responsibility for the health and well-being of patients and to provide competent care to patients.[4] This responsibility applies when providing care with the support of AI technology. The following guidance can help dentists fulfill their obligations while assessing the appropriateness of using AI within their practice:

1. Prioritize patients' best interests when making decisions to adopt and use AI in dentistry.
2. Understand the reliability and appropriateness of the AI tool for its intended uses. When there is insufficient information to form a clear understanding, avoid the use of the AI tool.

**Understanding AI Tools**

Transparency from manufacturers and developers can help dentists make informed decisions about whether to use AI for professional purposes. Prior to adopting a particular AI product, dentists may wish to seek information from the manufacturer and developer, including the following details, if applicable:

- legal and regulatory compliance, including with applicable privacy legislation (e.g., *PHIPA*);
- clinical validity, safety, accuracy, and effectiveness of the AI tool;
- data used to train the AI tool (e.g., data diversity, timeframes, size) and any limitations (e.g., underrepresented patient demographics, such as race, ethnicity, age, gender, or socioeconomic status);
- how end users (e.g., health care practitioners) and impacted populations may have been involved in the design, development, and testing of the AI tool;
- intended uses, known limitations, associated risks, and steps taken to mitigate risks, including risk of bias;
- performance monitoring, updates, and handling of errors and/or adverse events.

Dentists are also encouraged to research and seek information from other sources about the AI tool they are considering using.

3. Understand and evaluate the risks (including the nature of the risk, severity, and likelihood) and limitations associated with the AI tool being considered, including, for example, the potential for inaccuracies, errors, and biased outputs.
4. Take steps to prevent and mitigate the potential risks associated with the AI tool.

[4] Royal College of Dental Surgeons of Ontario, *Code of Ethics*.

5. Train staff who will be involved in using any AI tools on their appropriate uses, limitations, risks, and steps to mitigate risks.

### *Using AI*

It is important for dentists to be aware that AI can produce outputs which contain inaccuracies, errors, and misleading information, or which may be incomplete and/or outdated (for instance, when generating documentation or making diagnostic recommendations). AI may also unintentionally perpetuate biases, which can be found in training data that is not representative of the patient population being served, or from biases in the way the tool was developed and designed.

Dentists play a critical role by actively overseeing the use of AI and exercising their clinical judgment to prevent adverse impacts on patients. The following guidance can help dentists using AI provide care that mitigates risks and is appropriate to the patient and their circumstances:

6. Undertake relevant and ongoing training and education, as needed, in order to use AI and specific AI tools safely and appropriately.
7. Critically review and evaluate all AI-generated outputs for accuracy, completeness, and biases and/or stereotypical associations.
8. Ensure that decisions made and implemented with the support of AI take into consideration the patient's unique characteristics, circumstances, and clinical presentation.
9. Maintain an audit system which allows AI-generated outputs and AI-supported decision-making to be tracked and AI performance to be monitored.
10. Review and evaluate AI-generated gaps, errors, and adverse events to identify contributing factors, implement improvements, and take appropriate corrective actions (e.g., report problems to the manufacturer and developer of the AI tool, report privacy breaches to the Information and Privacy Commissioner, ensure the tool is up-to-date, discontinue use of the AI tool).

## 2. Transparency and Disclosure

Being transparent with patients about the use of AI supports informed decision-making, patient autonomy, and patient trust. Especially as the use of AI in dentistry is new and evolving, being transparent and involving patients in decision-making can help build patient trust. The following guidance can help dentists be transparent about their use of AI in their practice:

11. Inform individuals when they are interacting with AI rather than with a human (e.g., the use of a virtual assistant chatbot that simulates human conversation).
12. Prior to its use, inform patients when AI will be used in a manner that will directly impact their care or clinical decision-making (e.g., what AI is being used, for what purposes, its benefits and limitations). The level of information provided may be tailored based on how and when AI is being used, as well as the patient's technological literacy. Document these discussions.
13. Provide reasonable accommodation, when possible, to patients who express a desire for no or minimal involvement of AI in their care.

## 3. Protecting Patient Health Information

In keeping with dentists' obligation to safeguard patient privacy and confidentiality and to comply with *PHIPA*, [5] the following guidance can help dentists meet these obligations while using AI:

14. Understand the privacy and security settings and measures of the AI tool being used and be satisfied that any patient data involved is securely stored.
15. Do not permit AI-generated outputs containing patient health information to be used for other purposes (e.g., training the AI tool, sharing with third parties), unless patients have provided express and knowledgeable consent to the specific use of their health information for that purpose.[6]

# Additional Resources

As the use of AI is more widely adopted in dentistry, it is important for registrants to seek continuing learning and educational opportunities on the responsible and ethical use of AI. Registrants may find the following resources helpful for understanding the various uses of AI in healthcare, learning the principles around the responsible and ethical use of AI, and evaluating and assessing AI tools.

**General Information and Resources**

- **American Dental Association**, SCDI White Paper No. 1106: Dentistry – Overview of Artificial and Augmented Intelligence Uses in Dentistry
- **Canadian Centre for Cyber Security**, Cyber security guidance
- **Centre for Effective Practice,** Artificial Intelligence (AI) Learning Centre
- **National Institute of Standards and Technology**, AI Risk Management Framework
- **Statistics Canada**

**General Principles**

- **Government of Canada**, Responsible use of artificial intelligence in government
- **Government of Ontario**, Principles for Ethical use of AI
- **Health Canada**, Good Machine Learning Practice for Medical Device Development: Guiding Principles
- **Health Canada**, Transparency for machine learning-enabled medical devices: Guiding principles
- **World Health Organization**, Harnessing Artificial Intelligence for Health

**Guidance: Evaluating and Procuring AI**

- **Accessibility Standards Canada**, Accessible and Equitable Artificial Intelligence Systems
- **Government of Canada**, Algorithmic Impact Assessment tool
- **NHSX,** A buyer's guide to AI in health and care

[5] The Office of the Privacy Commissioner of Canada's Principles for responsible, trustworthy and privacy-protective generative AI technologies includes considerations for organizations using generative AI and who are obligated to comply with privacy law.

[6] Section 18 of the *Personal Health Information Protection Act, 2004*, S.O. 2004, c. 3, Sched. A.

**Guidance: Using Generative AI**

- **Canadian Medical Protective Association**, AI Scribes: Answers to frequently asked questions
- **Government of Canada,** Guide on the use of generative artificial intelligence
- **Office of the Privacy Commissioner of Canada**, Principles for responsible, trustworthy and privacy-protective generative AI technologies

Royal College of
Dental Surgeons of Ontario

# COUNCIL BRIEFING NOTE

**TOPIC: Professional Liability Program Committee Chair Appointment**

**FOR DECISION**

March 2025

## ISSUE:

- Council is asked to consider and approve the Governance Committee's recommendation to reappoint Jamie Colliver as the Chair of the Professional Liability Program (PLP) Committee.

**PUBLIC INTEREST:**

- Governance modernization trends support a competency-based selection process for committee members and Chairs. Competency-based selection advances the public interest by promoting fairness, transparency, objectivity, and skills-based selection in committee appointments.

## BACKGROUND/CURRENT STATUS:

- The PLP Committee is a standing committee of Council.
- The PLP Committee considers and reviews expenditures for claims, provides authority for matters to proceed to trial, considers requests for deductible forgiveness, and recommends policy and practices regarding PLP. The PLP Committee is not a decision-making body for the current PLP divestiture but has been kept informed of the process and progress.
- Public Council member, Jamie Colliver, served as the Chair of the PLP Committee during the 2023-2025 term.
- The PLP Committee Chair term expired on January 23, 2025, when the newly elected Council appointed a new slate of Committees.
- The PLP Committee non-Council committee members' terms did not expire at that time, and therefore Jamie Colliver's reappointment was overlooked.
- In December 2024, the Governance Committee discussed that Jamie could not sit on other statutory committees as Chair of the PLP Committee (article 4.13.2 of the bylaws) and it was the intention of the Governance Committee that Jamie Colliver continue to serve as the PLP Committee Chair.
- In March 2025, the Governance Committee approved a motion recommending that Council reappoint Jamie Colliver as Chair of the PLP Committee for the 2025-2027 term.

## ANALYSIS:

- Article 4.13.1 of the bylaws sets out that the PLP Committee shall be composed as follows:
  a) one (1) public member of Council, who shall act as chair of the committee; and
  b) five (5) non-Council committee members.
- Article 4.13.2 of the bylaws states: *"The chair of the Professional Liability Program Committee shall not be a member of any statutory committee of the College."*

- As per article 5.1.3 of the bylaws, every appointment to a committee expires after Council has completed its appointments for that committee at the first regular meeting of Council following the next general election, unless otherwise provided for in the bylaws. The bylaws outline two different cycles (for PLP and for all other committees) and this is likely related to efforts to create a separation between the College and PLP.
- The Governance Committee based its recommendation to reappoint Jamie Colliver as Chair on the Operational Policy of the Governance Committee and selection criteria that includes but is not limited to the candidates' skills and experience as aligned with the Competencies for the PLP Committee, and the needs of the Committee.
- The PLP Committee has not met since the January 23, 2025 Council meeting. The first PLP Committee meeting of 2025 is scheduled to take place on April 4, 2025.

## CONSIDERATIONS

- All final decisions regarding committee appointments rest with Council.
- Any decisions related to the PLP Committee resulting from the divestiture will be addressed at a later date.

## DECISION FOR COUNCIL:

This item is for Council's decision. Council is asked to consider approving the following motion:

Professional Liability Program (PLP) Committee Chair

- THAT Council reappoint Jamie Colliver as the Chair of the Professional Liability Program Committee for the 2025-2027 term.

## CONTACT:

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Attachments

Appendix A – Relevant excerpts of Bylaw 4
Appendix B – Relevant excerpts of Bylaw 5

# Appendix A: Excerpt of Bylaw 4

# 4 COMMITTEES OF THE COLLEGE

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## 4.13 Professional Liability Program Committee

### 4.13.1 Composition

The Professional Liability Program Committee shall be composed of the following members:

a. one (1) public member of Council, who shall act as chair of the committee; and
b. five (5) non-Council committee members.

### 4.13.2 Limitation on chair

The chair of the Professional Liability Program Committee shall not be a member of any statutory committee of the College.

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# Appendix B: Excerpt of Bylaw 5

# 5 COMMITTEE PROCEDURE

## 5.1 Appointments to Committees

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### 5.1.3 Term of committee appointment

Unless otherwise provided for in the by-laws, every appointment to a committee expires after Council has completed its appointments for that committee at the first regular meeting of Council following the next general election.

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Royal College of
Dental Surgeons of Ontario

# COUNCIL BRIEFING NOTE

**TOPIC: Prevention of Boundary Violations and Sexual Abuse: Draft Standard for Final Approval**

**FOR DECISION**

March 2025

## ISSUE:

- A new draft Standard of Practice, "Prevention of Boundary Violations and Sexual Abuse", and an associated "Case Scenarios" document were released for public consultation from October to December 2024.
- Council is provided with an overview of the consultation feedback received and the proposed revisions made to the draft Standard in response.
- Council is asked whether it approves the revised draft Standard of Practice, "Prevention of Boundary Violations and Sexual Abuse" as a final Standard of the College.
- This item is for decision.

## PUBLIC INTEREST:

- RCDSO Standards of Practice support the public interest by ensuring that dentists understand and fulfill their legal, professional, and ethical obligations when providing care.
- The draft Prevention of Boundary Violations and Sexual Abuse Standard serves the public interest by setting out the legal, professional, and ethical obligations that Ontario dentists must meet to prevent boundary violations and sexual abuse.

## BACKGROUND:

***Standards Prioritization Process and QAC's Direction***

- RCDSO's guidance for preventing boundary violations and sexual abuse of patients is currently set out in the following Practice Advisory: Prevention of Sexual Abuse and Boundary Violations (2017).
- By way of reminder, in 2023, this Practice Advisory was reviewed by policy staff as part of the Standards prioritization exercise.[1] The Practice Advisory was determined to be a high priority, and

[1] See pages  See pages 277-283 of the May Council Meeting Materials for a full overview of this process.

based on the policy team's analysis, QAC approved the priority development of a revised draft Standard in January 2024.

***Standard Development***

*Process & Research*

- Following QAC's direction, the policy team initiated the development of a new draft Standard in accordance with the RCDSO's typical Standards review and development process.

- Given the sensitive and urgent nature of this review, the draft Standard was developed on an expedited basis, with the aim of bringing a final Standard into effect as soon as possible.

- As per the Policy Team's usual processes, preliminary research and analysis was undertaken to support the development of the draft Standard, including (as examples):

    - a targeted literature and jurisdictional scan,
    - an analysis of RCDSO's inquiries, complaints, and discipline data, and
    - a review of feedback received from staff in RCDSO's Practice Advisory Service (PAS) and Professional Conduct and Regulatory Affairs (PCRA) department.

*Consultation with RCDSO's New Standing Policy Working Group and Patient Relations Committee (PRC)*

- To help inform the development of the draft Standard, policy staff consulted with RCDSO's new Standing Policy Working Group[2] and the Patient Relations Committee (PRC) in July 2024. The focus of these meetings was updating existing professional expectations and developing new requirements and guidance relating to new areas of focus (e.g., dual relationships, gift-giving and receiving, and trauma and violence-informed care).

- Based on this analysis and the feedback received, a new draft Standard was developed with the following key features:

    - new formatting,
    - updated definitions that are consistent with relevant legislation,
    - new sections on managing gift-giving and receiving, dual relationships, relations with a person closely associated with a patient and trauma and violence-informed care, and
    - a broader range of prohibited conduct that may constitute boundary violations and sexual abuse in the practice of dentistry.

***Approval for Public Consultation***

- The draft Standard was ultimately approved for consultation by QAC and Council in August and September 2024.

## CURRENT STATUS:

- The new draft Standard, "Prevention of Boundary Violations and Sexual Abuse", was released for public consultation between October 7th and December 5th, 2024.

[2] The Working Group consists of Dr. Harinder Sandhu, Dr. Antony Liscio, Dr. Anthony Mair, Dr. Osama Soliman, Dr. Nalin Bhargava, Dr. Nancy DiSanto, Dr. Deborah Wilson, Sharon Rogers, Nizar Ladak, Patti Latimer, and Eleonora Fisher.

- Council is provided with an overview of the consultation feedback received and the key revisions that have been proposed to the revised draft Standard **(Appendix A)**.

- Optionally, a more substantive summary of the consultation feedback can be viewed at this link. Council is not required or expected to review the full report and is welcome to rely on the summary provided in this briefing note.

***Consultation Feedback Summary***

- The public consultation followed RCDSO's usual process whereby a survey was developed and invitations to participate in the survey were sent to a broad range of stakeholders via e-mail. A general invitation was also posted to the College's website and social media platforms.

- Additional, targeted invitations were sent to RCDSO staff, the Citizen's Advisory Group[3] and subject matter experts in the fields of law, health professional regulation, investigations and mental health.

- A total of 95 survey responses were received and 3 organizations provided feedback by e-mail.[4] Most consultation respondents were general dentists (including retired) (54%) and 4% were organizations.

- Overall, the consultation feedback was largely supportive of the draft Standard and associated case scenarios. The consultation feedback can be categorized into the following areas:

    - **General support for the draft:** Overall, respondents were generally supportive of the draft Standard (e.g. they reported that it was clearly written, easy to understand, comprehensive, and included definitions of all essential terms). They were likewise supportive of the associated case scenarios.
    - **Requests for clarification and additional detail:** Some respondents requested more plain language and/or simplification or clarification of some terms. Requests were also made for additional guidance and examples to assist dentists in making decisions regarding dual relationships, relations with persons closely associated with patients, and gift-giving and receiving. There were also specific requests for guidance on managing relationships where dentists are providing dental care to their staff members.
    - **Comments regarding TVIC:** Respondents commented that trauma and violence-informed care (TVIC) will be a new area for many dentists that may require learning opportunities, and it was suggested that the language be modified to emphasize it is an *approach* to care.

- In general, substantive or critical feedback was focused on the following areas:

    - Some respondents expressed the view that the requirement that dentists not become involved in a sexual relationship with a patient for at least one year after the termination of the dentist-patient relationship was unreasonable, unnecessary, and an intrusion into dentists' personal lives. However, this is a critical requirement to protect patient safety and is directly drawn from legislation. Given that some respondents appear to not fully understand dentists' legal obligations, or appreciate the importance of this requirement, policy staff has explained and reinforced its importance in the FAQs.

[3] The Citizen Advisory Group (CAG), which operates under the Health Profession Regulators of Ontario (HPRO), is a shared resource of Ontario's health regulatory Colleges, and brings patient and caregiver voices and perspectives to inform health regulatory initiatives (e.g., Standards development).
[4] The organizations were: Ontario Dental Association (ODA), College of Nurses of Ontario (CNO) and Canadian Dental Protective Association (CDPA).

- Some respondents expressed the view that the recommendation that dentists develop an office policy on gift-giving and receiving is overly burdensome.
- Some respondents also requested the inclusion of new requirements:
  - With respect to trauma and violence-informed care, some respondents suggested that dentists be provided with specific guidance for effective communication, including continually explaining the steps of a treatment or procedure to a patient.
  - An organization suggested that the draft reference the new mandatory reporting requirement under the *Regulated Health Professions Act* (RHPA)*, 1991* pertaining to dentists reporting personal support workers if they have reasonable grounds to believe that they have sexually abused a patient that they provide health care or services to.

***Organizational Feedback***

Ontario Dental Association (ODA)

- The ODA was largely supportive of the draft Standard and found it to be comprehensive. They provided feedback suggesting the incorporation of "sexual exploitation" as a term in the Standard and also suggested addressing relationships where dentists treat their staff members.

- The ODA further suggested clarifying that a marriage or common-law relationship would not nullify a dentist being reported for sexual abuse, if the dentist dated a patient before marrying them or entering into a common-law relationship with them.

Canadian Dental Protective Association (CDPA)

- The CDPA was supportive of RCDSO updating the Practice Advisory and provided feedback suggesting that the draft Standard address the risks of using social media when communicating with patients. They also suggested that the draft Standard address dentists treating their staff members, including the continuation or discontinuation of agreed to treatment if the employer-employee relationship is terminated.

College of Nurses of Ontario (CNO)

- CNO found the draft Standard to be clear, comprehensive and easy to follow in its structure.

- CNO suggested listing "gender identity" and "sexual orientation" in different lines for Provision #5, including a statement about the inappropriateness of soliciting gifts from patients, listing all forms of sexual abuse, and including the new mandatory reporting requirement (see above).

***Additional Engagement with the Standing Policy Working Group and QAC***

- Following initial revisions based on the feedback above, the draft Standard alongside a summary of the consultation feedback was shared with the College's Standing Policy Working Group in January and February, and Quality Assurance Committee (QAC) in March.

- The Standing Policy Working Group and QAC were supportive of the revised draft Standard and provided helpful feedback that was minor in nature and is reflected in the revisions explained below.

- QAC approved the revised draft Standard being brought forward to Council for final approval.

***Key Revisions in Response to Feedback***

- The key revisions that are proposed to the draft Standard are set out below. The revisions reflect some of the consultation feedback received and comments from the Standing Policy Working Group and QAC. They are relatively minor and are primarily for the purpose of ensuring clarity of the requirements.

Definitions Section

- The language in the definition of "boundary violations" has been simplified where possible.
- The language in the definition of "trauma and violence-informed care" has been revised to emphasize that it is an *approach* to health care, and to state that the goal is to avoid re-traumatizing a patient as opposed to re-victimizing a patient.

Provision #2

- "Current or past medical conditions" has been added as factors that may inform a patient's sense of boundaries.

Provision #5

- The reference to "oral health and/or hygiene" has been removed based on feedback from the Standing Policy Working Group (the group was worried that dentists would be inhibited from making appropriate comments related to oral health and/or hygiene).
- "Sexual orientation" and "gender identity" have been separated into different lines to lessen the impression that one can be inferred from the other.
- "Race" has been added as a category in relation to the potential for inappropriate comments.

Provision #6

- Footnote #16 was added to further explain what inappropriate disclosure of personal information to a patient means.

Provision #13

- This provision was revised to clarify that the kinds of relationships that dentists should avoid entering into are *personal* relationships with individuals who are closely associated with a patient.

Provision #14

- This provision was revised to clarify the relationship that should end (i.e. the *dentist-patient* relationship).

Provision #15

- The title of this section was revised to reflect that trauma and violence-informed care is an *approach* to care.
- A new requirement (g.) was added to require dentists to clearly communicate with a patient throughout an examination or treatment about the steps being taken and encourage the patient to

be an active participant in their care. Footnote 25 was added to give an example of how to do this.

- A new footnote was added to requirement i) to make it clear that a dentist cannot rest any instruments or other materials on a patient's chest or elsewhere on a patient's body, even if the patient has a bib or drape on.

Provision #21

- This provision was revised to clarify that the jokes dentists should not be making are those that have a sexual connotation.

Provision #23

- A new mandatory reporting requirement under the RHPA, *1991* was added. This came into effect in December 2024 and requires dentists to report to the Health and Supportive Care Providers Oversight Authority (HSCPOA) if they have reasonable grounds, obtained while practicing dentistry to believe that a personal support worker registered with HSCPOA has sexually abused a patient who receives health care or supportive care services from the personal support worker.

***Key Feedback That Was Not Incorporated into the Revised Draft Standard***

- The ODA suggested that the College use the term "sexual exploitation" in the draft Standard and provided the following definition: "any actual or attempted abuse of a position of vulnerability, differential power, or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another."

- The ODA stated that adding the term "exploitation" is "inclusive of a broader range of themes associated with abuse such as coercion, grooming, manipulation or force and acknowledges and validates the individual experience and the numerous pathways in which a patient can be abused."

- The Standing Policy Working Group considered this feedback and decided not to use the term for the following reasons:

    - It was noted that part of this type of conduct appears to relate to sex trafficking which is already illegal under criminal law.
    - It was also noted that other aspects of exploitation such as "coercion, manipulation or force" are already covered by the draft Standard in Provision #3 by prohibiting dentists from psychologically abusing patients and Provision #18 specifically prohibits grooming behaviour.

## CONSIDERATIONS:

***FAQs and Supplementary Resources***

- As per RCDSO's new approach to communicating guidance, the development of supplementary resources, including FAQs and Case Scenarios, will be critical to supporting dentists, patients, and other stakeholders in understanding the College's expectations for preventing sexual abuse and boundary violations.

- For this review in particular, a significant proportion of stakeholder feedback, including suggestions from both the Standing Policy Working Group and QAC, will be addressed via the FAQs and Case Scenarios.

- While these resources are still in development, with the assistance of RCDSO's Practice Advisory Service (PAS), they will be complete in time to accompany the final draft Standard should it be approved by Council (as a reminder, supplementary resources do not require Council's approval). Key areas of focus will include:

    - an explanation of how a boundary violation can be unintentional,
    - an explanation of why certain terms of legislation have been adopted,
    - additional guidance on communicating professionally with patients, including considerations for communicating with patients on social media,
    - an explanation of how privacy and confidentiality relates to boundaries,
    - additional guidance relating to gift-giving and receiving, including guidance on what to include in an office policy,
    - additional guidance on navigating dual relationships including treating staff members as patients,
    - additional guidance on the appropriateness of a relationship with a person closely associated with a patient,
    - additional guidance and resources relating to incorporating a trauma and violence-informed approach to dental care, and
    - additional information about legislative requirements.

- Additional Case Scenarios were also created in response to consultation feedback, including scenarios related to gift-giving and receiving, dual relationships, managing relations with persons closely associated with patients, and trauma and violence-informed care.

***Implementation and Knowledge Translation***

- As noted in the Policy Report, which is included in Council's meeting materials, policy staff are considering new implementation and knowledge translation strategies that will help ensure that dentists are aware of new Standards of Practice once approved by Council, and are supported in implementing the College's expectations.

- For a general overview of relevant tactics, please see the Policy Report, however, one particular area of relevance to this Standard is trauma and violence-informed care.

    - The section on trauma and violence-informed care (Provision #15) in the draft Standard may result in some questions about how dentists can receive training in this area. The associated FAQs contain resources to assist registrants in learning more about this. In the future, additional training can be offered in the form of courses approved or provided by RCDSO.

## NEXT STEPS:

- If Council approves the revised draft Standard, the Standard, Case Scenarios and FAQs will be posted on the RCDSO's website and interested parties will be notified.

- This new Standard will replace the RCDSO's Practice Advisory on Sexual Abuse and Boundary Violations.

- RCDSO's policy team, in collaboration with staff in Communications, Quality, and other program areas, will continue to explore opportunities to communicate the College's new expectations and

support dentists in practice.

## DECISION FOR COUNCIL:

- Council is being asked whether it has any feedback on the revised draft Standard and whether it approves the revised draft Standard of Practice: “Prevention of Boundary Violations and Sexual Abuse.”

- The motion before Council is as follows:
    - THAT Council approves the revised draft Standard of Practice: “Prevention of Boundary Violations and Sexual Abuse”, as a Standard of Practice of the RCDSO.

## CONTACT:

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Attachments:

Appendix A: Revised Draft Standard of Practice: “Prevention of Boundary Violations and Sexual Abuse”

# Prevention of Boundary Violations and Sexual Abuse

Date:

## Contents



## Executive Summary

This Standard of Practice articulates the requirements for dentists' professional behaviour to prevent boundary violations and sexual abuse of patients. A companion resource, Case Scenarios on Boundary Violations and Sexual Abuse, has also been developed to provide examples of behaviour that may be considered boundary violations and sexual abuse.

## Definitions

**Key terms are defined below for the purposes of interpreting and applying this Standard of Practice. In some cases, these definitions may be specific to this Standard or area of practice, and not applicable to other College documents or areas of dentistry. Where a definition has specific or limited application to this Standard or area of practice, this will be identified in a footnote.**

**Boundary** is a limit of a safe and effective professional dentist-patient relationship.

**Boundary violations** occur when the limits of a safe and effective professional dentist-patient relationship are crossed. The violation can occur intentionally or unintentionally. Boundary violations exploit the power imbalance that naturally exists ~~is inherent~~ in the dentist-patient relationship and place the dentist's personal interest(s) ahead of the best interests of the patient.[1]

**Dual relationships** occur when a dentist has a secondary personal or professional relationship with a patient in addition to the treating relationship. Dual relationships can complicate the treating relationship, risk undermining the provision of safe and effective care, and increase the risk of boundary violations.

**Harassment** is an unwelcomed comment and/or behaviour that offends, embarrasses, demeans or humiliates a person.[2]

**Patient** is an individual receiving care from a dentist if any of the following circumstances exist:

a. the dentist has charged or received payment from the individual (or a third party on behalf of the individual, such as an insurance company) for a health care service provided by the dentist;
b. the dentist has contributed to a health record or file for the individual;
c. the individual has consented to the health care service recommended by the dentist; or
d. the dentist prescribed the individual a drug for which a prescription is needed.[3]

**Sexual abuse** consists of any of the following:

a. sexual intercourse or other forms of physical sexual relations between the dentist and the patient,
b. touching, of a sexual nature, of the patient by the dentist, or
c. behaviour or remarks of a sexual nature by the dentist towards the patient.[4]

Touching, behaviour, or remarks of a clinical nature appropriate to the service provided are not considered to be sexual abuse.[5]

[1] Principle #1 in RCDSO's Code of Ethics states "the paramount responsibility of dentists is to the health and well-being of patients."

[2] Legally defined as "engaging in a course of vexatious comment or conduct that is known or ought reasonably to be known to be unwelcome" in s. 10(1) of the *Human Rights Code*, R.S.O. 1990, c. H. 19.

[3] This definition of "patient" is specific to the sexual abuse and spousal exemption provisions in the RHPA and has been adopted to apply in this Standard. The definition is from s. 1. 1. of O. Reg. 260/18, Patient Criteria Under Subsection 1(6) of the Health Professions Procedural Code (HPPC), Schedule 2 of the *Regulated Health Professions Act* (RHPA)*, 1991*, S.O. 1991, c.18. If none of the listed circumstances exist due to a dentist not meeting their professional obligations (for example, by not obtaining consent for treatment from the individual or not contributing to a health record or file for the individual), the individual is still considered to be a patient.

[4] s. 1(3) of the HPPC, Schedule 2 of the RHPA, *1991*.

[5] s. 1(4) of the HPPC, Schedule 2 of the RHPA, *1991*.

Conduct, behaviour or remarks that would otherwise be sexual abuse are not sexual abuse if the patient is the dentist's spouse and the dentist is not providing dental care to their spouse at the time the conduct, behaviour or remarks occur.[6]

It is also not considered to be sexual abuse if a dentist provides dental care to an individual they are in a sexual relationship with who is not their spouse if all of the following conditions exist:

a. care is provided in emergency circumstances, or the care provided is minor in nature,[7] and
b. the dentist has taken reasonable steps to transfer the care of the individual to another regulated health professional or there is no reasonable opportunity to do so.[8]

**Spouse** is an individual that is married to the dentist or has lived with the dentist in a common-law relationship[9] outside of marriage continuously for at least 3 years.[10]

**Trauma and violence-informed care** is an approach to health care that recognizes the signs, symptoms and widespread impact of trauma and ongoing violence on patients. Using this approach, dentists~~it~~ treat~~s~~ patients by fully integrating knowledge about victim experiences of trauma and ongoing violence into their practices. The approach~~it~~ facilitates a culture of safety, trust, empowerment and healing and seeks to avoid re-~~victimization~~traumatization.

## Principles

The following principles form the foundation for the requirements set out in this Standard:

1. The RCDSO has zero tolerance for sexual abuse.

2. The paramount responsibility of a dentist is to the health and well-being of patients.[11]

[6] s. 1(5) of the HPPC, Schedule 2 of the RHPA, *1991* – applicable due to s. 1 of General Regulation, O. Reg. 205/94 under the *Dentistry Act, 1991*, S.O. 1991, c. 24.
[7] For the purpose of this Standard, "minor care" is short-term, episodic care that does not involve significant intervention by a dentist and is for a relatively less serious condition (e.g. there is no infection and/or bleeding and/or significant pain). An example would be that the individual has a metal retainer that has partially broken and is sharp, and they live in a remote location where care cannot be accessed until the next business day. In this situation, a dentist may remove the individual's retainer until care can be accessed to replace it.
[8] s. 1.2. of O.Reg. 260/18, Patient Criteria Under Subsection 1(6) of the HPPC under the RHPA, *1991*.
[9] Definition of "spouse" is adapted from s. 1(1) of the Family Law Act, R.S.O. 1990, c. F.3. According to relevant case law, a common law relationship is a relationship of some permanence outside of marriage. Some factors that a court may consider in determining if such a relationship exists are shared living arrangements, sexual relations, intimacy, shared performance of household chores, participation together in social activities, being perceived by others in society as a couple, financial interdependence and attitude and conduct towards children (if any). Not all of these factors have to exist in order for a relationship to be considered a common-law relationship.
[10] s. 1(6) of the HPPC, Schedule 2 of the RHPA, *1991*.
[11] Principle #1 in RCDSO's Code of Ethics.

3. The dentist-patient relationship is based on mutual respect and trust.

4. There is an inherent power imbalance that exists in the relationship between a dentist and patient, which can make a patient vulnerable to boundary violations and sexual abuse.

5. Maintaining professional boundaries respects patients, helps ensure the provision of safe and effective care and upholds the public's trust in dentistry.

## Requirements for Preventing Boundary Violations and Sexual Abuse

***PREVENTING BOUNDARY VIOLATIONS***

The following sections set out requirements for preventing boundary violations.

A separate section sets out requirements for preventing sexual abuse.

**Respecting Patients' Boundaries**

1. Dentists **must** establish and maintain appropriate professional boundaries with their patients at all times, including when engaging with patients in a non-clinical context.

2. Dentists **must** respect and be mindful of the ways in which a patient's sense of personal boundaries might be informed by factors such as their age, sex, gender, gender identity, ethnicity, culture, religion, sexual orientation, physical differences, socio-economic status, current or past medical conditions and personal history and experience.

3. Dentists **must** not abuse or harass a patient, including but not limited to, verbal, emotional, psychological, physical abuse or harassment, including sexual harassment.[12]

**Appropriately Communicating with Patients**

4. Dentists **must** communicate (whether in-person, electronically, through social media, or otherwise) in a professional manner[13] and not breach patient privacy and confidentiality.[14] Breaching patient privacy and confidentiality of patients' personal health information can be considered a boundary violation.

5. Dentists **must** not make inappropriate comments that could reasonably cause offense, undermine trust in the dentist and profession or make a patient feel uncomfortable or

[12] This includes abuse or harassment by electronic or technological means.

[13] See the College's Practice Advisory on Maintaining a Professional Patient-Dentist Relationship and the College's Practice Advisory on Professional Use of Social Media.

[14] s. 29 of the *Personal Health Information Protection Act*, S.O. 2004, c.3, Sched A. requires that personal health information be kept confidential unless there is patient consent or disclosure is made in accordance with permitted or required instances under the *Act*.

discriminated against. This includes, but is not limited to, inappropriate comments regarding a patient's:

~~a. oral health and/or hygiene;~~[15]

~~b.~~a. body, clothing and/or accessories;

b. sexual orientation~~; and/or~~

c. gender identity;

d. religious, cultural and/or ethnic background;

~~d.~~e. race;

~~e.~~f. age;

~~f.~~g. disabilities;

~~g.~~h. socio-economic status;

~~h.~~i. relationship status; or

~~i.~~j. insurance or benefits status, including private insurance or reliance on a publicly funded government plan.

6. Dentists **must not** disclose inappropriate personal information to a patient, such as intimate details of their personal life.[16]

**Appropriately Managing Gift-Giving and Receiving with Patients**

When managed appropriately, gift-giving between dentists and patients can reflect mutual care and respect. However, the exchanging of gifts can also introduce risks, such as unclear boundaries, conflicts of interest, and impaired clinical judgment and objectivity. These risks increase as the value of the gift increases, and as the gift becomes more personal.

7. Dentists who accept gifts from, or give gifts to, a patient, **must** do so with the patient's best interests in mind, and in a manner that preserves appropriate professional boundaries and objective clinical judgment.[17]

8. Dentists are **advised** to develop an office policy on gift-giving and receiving to help establish clear expectations.

9. Dentists **must not** give gifts to individuals to become patients or remain patients, and/or refer other patients to them, as this may give rise to a conflict of interest.[18]

~~[15] An example of inappropriate comments about oral health and hygiene are comments about the mouth that are unrelated to dental care that may cause shame or embarrassment.~~

[16] This would include information that can be reasonably regarded as being too personal or private to disclose to a patient, as it would compromise or violate the boundaries of the professional dentist-patient relationship.

[17] There are occasions where giving or accepting gifts may be appropriate, such as giving or accepting a gift of cultural significance or accepting a token gift such as a holiday gift of chocolates for the dental care team.

[18] See Conflict of Interest Guidelines.

**Appropriately Managing Dual Relationships with Patients**

10. Dentists **must** appropriately manage dual relationships, as these can complicate the treating relationship, risk undermining the provision of safe and effective care, and increase the risk of boundary violations.

11. Dentists who provide care within a dual relationship (e.g. provide care to a personal friend, family member, staff member or someone they are in a financial/business relationship with) **must** meet their professional obligations while providing care, including ensuring that:
    a. their clinical judgment and objectivity is not compromised;[19]
    b. patient autonomy in decision-making is maintained, including by obtaining informed consent;
    c. patient privacy and confidentiality of the patient's personal health information is safeguarded;[20] and
    d. conflicts of interest are recognized and managed appropriately.[21]

12. If the dentist believes that the existence of a dual relationship is undermining care and/or if there is a conflict of interest that cannot be resolved, the dentist **must** end the treating relationship in accordance with requirements related to discontinuing dental services[22] and with RCDSO's Practice Advisory on Maintaining a Professional Patient-Dentist Relationship.

**Appropriately Managing Relations with Persons Closely Associated with Patients[23]**

When a dentist enters into a personal relationship with an individual who is closely associated with a patient (e.g., the patient's parent), there is a risk that this relationship will undermine the patient's trust and/or the treating relationship.

13. Dentists are **advised** to avoid entering into personal relationships with individuals who are closely associated with a patient when that relationship is likely to undermine the patient's trust or the treating relationship. Factors that may influence the appropriateness of a personal relationship include:
    a. the nature of the clinical care that is being provided and the potential impact on the patient if that care is compromised or disrupted;
    b. the length of the professional relationship between the dentist and the patient;

[19] See note 11.
[20] See note 14.
[21] See note 17.
[22] s. 14 and 16 of the Professional Misconduct Regulation. O.Reg. 853/93 under the *Dentistry Act*, S.O. 1991, c. 24 sets out requirements for terminating dental services under agreement or otherwise.
[23] Examples of such individuals include but are not limited to: the spouse or partner of a patient, a friend of a patient, the patient's parents, guardians, substitute decision-makers, or persons who hold powers of attorney for personal care.

c. the degree to which the patient is reliant on the person closely associated with them; and
d. whether the person has any decision-making power on the patient's behalf.

14. If a dentist believes that the patient's trust or care has been undermined, the dentist **must** take steps to resolve the situation in the best interests of the patient (e.g., by ending the dentist-patient relationship).

**~~Providing~~ Incorporating a Trauma and Violence-Informed Approach to Care**

15. Dentists **must** provide care in a manner that assumes the possibility that a patient has experienced trauma and/or violence and is consistent with principles of trauma and violence-informed care,[24] including:
    a. being mindful of any known or possible conditions, sensitivities, vulnerabilities, experiences or trauma of the patient that may affect the manner in which care is provided;
    b. assuming a patient is not comfortable with touch, generally avoiding touching a patient unless necessary for providing clinical care and only touching a patient when there is explicit or implied consent, unless there are emergency circumstances;
    c. exercising professional judgment when using touch to comfort a patient and seeking the patient's consent before doing so;
    d. being mindful that there are different cultural norms regarding touch;
    e. using gloves to neutralize physical touch that can be perceived as intimate, such as while performing a head or neck examination;
    f. being mindful of a patient's sense of space and being sensitive to verbal and non-verbal cues from a patient in response to touch, behaviour, language or the practice environment, and responding accordingly to facilitate the provision of care in a manner that feels as safe and comfortable as possible to a patient;
    ~~f.~~g. clearly communicating with a patient throughout an examination or treatment about the steps being taken and encouraging a patient to be an active participant in their care;[25]
    ~~g.~~h. offering or permitting patient supports, as appropriate;[26]
    ~~h.~~i. not resting instruments or other materials on a patient's chest or elsewhere on a patient's body;[27] and
    ~~i.~~j. ensuring that a bib or drape is placed or adjusted on a patient by first advising the patient that it will be placed or adjusted and then placing or adjusting it in a manner that respects areas that may be sensitive for a patient, such as the neck and chest.

[24] For the principles and examples in practice, see the Trauma and Violence Informed Care Tool by Equip Health Care and Handbook of Sensitive Practice for Health Professionals: Lessons from Women Survivors of Childhood Sexual Abuse, 2001, Government of Canada.
[25] For example, a patient can be told that they can ask for a break during a treatment.
[26] Examples of support include a support person or emotional support animal.
[27] This applies even if the patient is covered by a bib or drape.

***PREVENTING SEXUAL ABUSE***

Sexual abuse is a serious act of professional misconduct. Patient consent is never a defence for sexual abuse.

This section sets out requirements for dentists to prevent sexual abuse.

16. Dentists **must not** sexually abuse a patient.[28] In particular, dentists **must not** engage in sexual intercourse or other forms of physical sexual relations with a patient, touch a patient in a sexual manner, or engage in behaviour or make remarks of a sexual nature towards a patient.[29] This applies even if the physical sexual relations, behaviour or remarks are initiated by the patient.

17. Dentists **must not** engage in any conduct, behaviour or remarks that would constitute sexual abuse of a patient, in the act of providing dental care to their spouse.[30]

18. Dentists **must not** communicate with a patient or engage in any behaviour for the purpose of eventually pursuing a sexual relationship with them.

19. Dentists **must not** ask questions or make comments about a patient's sexual history, behaviour or performance, except where the information is relevant to the provision of dental care. When such questions are asked, dentists **must** explain the clinical reason for asking them.

20. Dentists **must not** make any comments or use gestures, tone of voice, expression or engage in any behaviour that may be reasonably interpreted by a patient as romantic, seductive or sexually demeaning.

21. Dentists **must not** make any jokes that have a sexual connotation or display any material that has a sexual connotation that is not relevant to clinical care, either in office or online, when acting in a professional capacity.[31]

22. Dentists **must not** become involved in a sexual relationship with a patient for at least one year after the termination of the dentist-patient relationship.[32]

[28] Abusing a patient is an act of professional misconduct under #8 of s. 2 of the Professional Misconduct Regulation (O.Reg. 853/93) under the *Dentistry Act*, *1991*.
[29] s. 1(3) of the HPPC, Schedule 2 of the RHPA, *1991*.
[30] Doing otherwise results in the spousal exemption no longer applying and the dentist who engaged in the conduct, behaviour or remarks in the act of providing dental care to their spouse can be prosecuted for sexual abuse. See section s. 1(5) of the HPPC, Schedule 2 of the RHPA, *1991* which contains the spousal exemption requirements.
[31] See the College's Practice Advisory on the Professional Use of Social Media.
[32] s. 1(6) of the HPPC, Schedule 2 of the RHPA, *1991*.

**Mandatory Duty to Report Sexual Abuse**[33]

23. Dentists **must** follow mandatory reporting requirements in accordance with the *Regulated Health Professions Act*, *1991* (RHPA) specifically by:
    a. reporting to the Registrar of the appropriate regulatory college, if they have reasonable grounds,[34] obtained while practising dentistry, to believe that a regulated heath professional has sexually abused a patient~~;~~[35]
    ~~a.~~b. reporting to the Health and Supportive Care Providers Oversight Authority (HSCPOA), if they have reasonable grounds, obtained while practising dentistry, to believe that a personal support worker registered with the HSCPOA has sexually abused a patient who receives health care or supportive care services from the personal support worker[36]
    ~~b.~~c. including the following information in the report:
        - their name;
        - the name of the health professional who is the subject of the report;
        - an explanation of the alleged sexual abuse; and
        - the name of the patient of the health professional that is the subject of the report, if the patient consents to their name being included;[37] and

    ~~c.~~d. making the report within 30 days after the obligation to report arises unless there are reasonable grounds to believe that,
        - the health professional will continue to sexually abuse the patient or will sexually abuse other patients

    in which case, the report must be filed immediately.[38]

***RECORDKEEPING REQUIREMENTS***

24. Dentists **must** keep appropriate records in accordance with RCDSO's Dental Recordkeeping Guidelines and Electronic Records Management Guidelines. Dentists **must** specifically note:
    a. any questions asked to the patient of a sexual nature that are relevant to providing dental care;
    b. any incidents of alleged boundary violations and/or sexual abuse, including any relevant observations or statements from a patient, dental staff or others present;
    c. the date of termination of the dentist-patient relationship; and

[33] While this section pertains to reporting actual or suspected sexual abuse of a patient by a regulated health professional, dentists also have a duty to report actual or suspected child abuse to a children's aid society, which includes sexual abuse of a child, under the *Child, Youth and Family Services Act*, *2017* S.O. 2017, c.14, Sched.1. Please see this resource webpage for more information.

[34] According to relevant case law, this means "reasonable probability" or "reasonable belief" that is more than mere suspicion.

[35] s. 85.3(1)(a) of the HPPC, Schedule 2 of the RHPA, *1991*.

[36] s. 85.3(1)(b) of the HPPC, Schedule 2 of the RHPA, *1991*.

[37] s. 85.3(3) of the HPPC, Schedule 2 of the RHPA, *1991*.

[38] s. 85.3(2) of the HPPC, Schedule 2 of the RHPA, *1991*.

d. any reports they make to a regulatory college about alleged sexual abuse by a health professional.

25. Dentists are **advised** to record any instances of physical touch used outside of providing clinical care, such as comforting a patient in distress.

Royal College of
Dental Surgeons of Ontario

# COUNCIL BRIEFING NOTE

**TOPIC: Consent to Treatment: Draft Standard for Final Approval**

**FOR DECISION**

March 2025

## ISSUE:

- RCDSO's new draft Standard of Practice, "Consent to Treatment", was released for public consultation in October 2024.
- Council is provided with an overview of the consultation feedback received and the proposed revisions made to the draft Standard in response.
- Council is asked whether it approves the revised draft Standard, "Consent to Treatment" as a final Standard of College.
- This item is for decision.

## PUBLIC INTEREST:

- RCDSO Standards of Practice support the public interest by ensuring that dentists understand and fulfil their legal, professional, and ethical obligations when providing care.
- The draft Consent to Treatment Standard of Practice serves the public interest by ensuring that treatment is only provided with the patient's full consent, reflecting the right of every patient to make informed choices about their own body and healthcare.

- All Ontario healthcare providers are subject to legal, professional, and ethical obligations related to obtaining consent to treatment. These obligations are primarily set out in the *Health Care Consent Act, 1996*, which is supplemented by the applicable professional guidance of each health profession's regulatory authority.
- RCDSO's guidance for consent is currently set out in the following Practice Advisory: Informed Consent Issues Including Communication with Minors and Other Patients Who May Be Incapable of Providing Consent (2007).[1]

[1] Because the current Practice Advisory does not address every relevant issue related to obtaining consent to treatment, a variety of supplementary resources have also been created, as set out on RCDSO's Informed Consent webpage.

- As Council will recall, this Practice Advisory was reviewed by policy staff as part of the Standards prioritization exercise in the fall of 2023.[2]

- At that time, the Practice Advisory was found to be in need of significant updating due to the identification of several key shortcomings[3]. QAC approved the priority development of a revised draft Standard in January 2024.

- Following QAC's direction, the policy team initiated the development of a new draft Standard in accordance with the College's Standards review and development process.

- Given the priority nature of this review, the draft Standard was developed on an expedited basis, with the aim of bringing a final Standard into effect as soon as possible.

- As per the policy team's usual processes, preliminary research and analysis was undertaken to support the development of the draft Standard. This included (as examples):

    - a targeted literature and jurisdictional review,
    - an analysis of RCDSO's inquiries, complaints, and discipline data, and
    - a review of feedback received from staff in RCDSO's Practice Advisory Service (PAS).

- Based on this analysis, a new draft Standard was developed with the following key features:

    - The draft Standard was developed in alignment with the policy team's new drafting conventions, as approved by QAC and reviewed by Council.
    - Existing guidance and requirements were expanded, edited, or refined as necessary, to ensure comprehensive and accurate guidance.
    - New topics were added to the draft Standard to ensure the provision of comprehensive guidance (e.g., requirements related to refusal or withdrawal of consent, the use of consent forms, and the provision of emergency treatment).

- The new draft Standard, titled "Consent to Treatment", was presented to QAC and Council for feedback in August and September of 2024. Both QAC and Council were supportive of the draft Standard and approved that it be released for public consultation in the fall of 2024.

## CURRENT STATUS:

- The new draft "Consent to Treatment" Standard was released for public consultation between October 7th and December 5th, 2024.

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[2] As Council is aware, the policy team is undertaking a significant initiative to modernize and update RCDSO's guidance for the profession. As a key part of this initiative, the policy team has reviewed and assessed all of RCDSO's guidance for the profession and identified a subset of Standards that require priority review based on criteria approved by the Quality Assurance Committee (see pages 277-283 of the May Council Meeting Materials for more information).

[3] As examples, key shortcomings in the current Practice Advisory include:

- *Lack of currency:* The current Practice Advisory was last reviewed and updated in 2007.
- *Key omissions:* The current Practice Advisory does not set out comprehensive guidance for obtaining consent to treatment.
- *Lack of detail:* The current Practice Advisory lacks important detail that would assist readers in understanding what is required and how to apply the guidance in practice.
- *Lack of clarity / precision:* The current Practice Advisory does not communicate clear or accurate guidance on certain topics (e.g., obtaining consent from minors).

- Below, Council is provided with an overview of the consultation feedback, along with a summary of key revisions.

- Optionally, Council is provided with a detailed summary of the consultation feedback which can be found at the following link. Council is not required or expected to read the full report and is welcome to rely solely on the summary provided in this briefing note.

- Of note, a general overview of the consultation feedback and draft revisions were presented to RCDSO's Standing Policy Working Group[4] on February 3rd and Quality Assurance Committee (QAC) on March 4th, where they were well received.

**A. Consultation Feedback Summary**

- As per the policy team's usual consultation process, this consultation was undertaken principally via an online survey. The survey consisted of 41 questions: 27 questions explored the draft Standard directly, while the remaining questions collected relevant contextual and respondent demographic detail.

- Notification of the consultation was sent via e-mail to a broad range of stakeholders, including the entire RCDSO membership, key system partners, and the policy team's dedicated stakeholder contact list[5]. In addition, passive notification was made via RCDSO's website and social media platforms. Reminders were also sent at strategic points during the consultation cycle.

- Internally, RCDSO staff were invited to participate using a dedicated survey link.

- In total, 99 submissions were received in response to this consultation, including 95 online surveys and 4 email submissions. In addition, aggregate feedback was received directly from RCDSO's staff dentists.

- The vast majority consultation respondents were dentists (88%).

- In total, 3 written responses were received from organizations: the Ontario Dental Association (ODA), the Canadian Dental Protective Association (CDPA), and the College of Nurses of Ontario (CNO).

- Overall, the consultation feedback was largely supportive of the draft Standard, and relatively few substantive recommendations were submitted for changes.

- According to survey respondents:

    - A significant majority "agreed"[6] that the draft Standard was accurate (82%), comprehensive (87%), easy to understand (87%), and clearly written (89%).
    - Over 80% of survey respondents agreed that the draft contained all of the relevant terms and definitions needed to understand and apply the relevant guidance, and another 71% agreed that the draft Standard contained reasonable expectations.

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[4] The Standing Policy Working Group consists of Dr. Harinder Sandhu, Dr. Antony Liscio, Dr. Anthony Mair, Dr. Osama Soliman, Dr. Nalin Bhargava, Dr. Nancy DiSanto, Dr. Deborah Wilson, Sharon Rogers, Nizar Ladak, Patti Latimer, and Eleonora Fisher.

[5] The policy team maintains and updates an evolving list of key stakeholders who are contacted in relation to all new active consultations. More information concerning the membership of that list can be provided upon request, but it includes provincial and national health regulatory bodies, Ontario's faculties of Dentistry, provincial oral health regulators, Ministry contacts, patient advocacy groups, and many others.

[6] Respondents are reported to have "agreed" for the purposes of this summary if they answered either "strongly agree" or "somewhat agree" on a 5-point Likert scale.

- Organizational respondents were similarly supportive of the draft Standard. The CNO noted that the draft was clear, comprehensive, and easy to follow. The ODA stated that key terms were clearly defined.

- In general, substantive or critical feedback can be summarized under the following themes:

    - **Use of the term "valid" consent:** A significant number of respondents expressed confusion around the use of the term "valid" in relation to consent. Although the draft Standard included a definition of "valid consent" (i.e., consent that is not only *informed*, but which meets *all* applicable legal and professional obligations), the overall sentiment within the feedback was that the use of this term would cause confusion.
    - **Documenting the consent discussion:** More than any other section of the draft Standard, the draft recommendations for documentation were the focus of critical feedback. This section of the draft Standard provided *advice* to dentists concerning the information that should be documented in relation to the consent discussion. Many respondents interpreted this section as a requirement, and as a consequence, argued that it was onerous.
    - **Tone:** RCDSO's staff dentists provided some helpful recommendations to adjust the tone of the draft Standard to be more inviting to registrants (e.g., by deleting the preamble emphasizing the potential for professional misconduct).

- Both the ODA and the CDPA noted that it was difficult for dentists to predict fees in advance of treatment, and that specific acknowledgement should be given in the draft Standard to the "approximate" nature of any fees agreed to between the dentist and the patient.

- The ODA and the CDPA were likewise in agreement that the draft Standard should require the treating dentist to obtain consent directly from the patient, and not assign or "delegate" any element of the consent discussion as contemplated in the draft Standard (e.g., to a staff member). Some of RCDSO's staff dentists provided similar feedback.

**B. Revised Draft Standard**

- Based on the consultation feedback received, the changes that are proposed to the draft Standard are relatively minor.

- Key revisions are highlighted for Council's information below; however, a track-changes draft of the Standard is available at **Appendix A**.

    - **Removing the term "valid":** As per the feedback received, the term "valid" has been removed throughout the draft Standard. Instead, the draft Standard uses the more familiar term "consent to treatment". This change does not alter the substance of any draft positions but will hopefully avoid unnecessary confusion.
    - **Adding references to the FAQs:** In anticipation of developing supplementary resources to accompany the final Standard, including a new "Consent to Treatment FAQ", references have been added to the draft Standard (see lines 27 – 28 of the Executive Summary for an example).
    - **"Delegating" the consent discussion:** Given conflicting feedback concerning the permissibility of allowing dentists to assign or "delegate" elements of the consent discussion, it is proposed that this provision be removed from the draft Standard and instead be addressed in the FAQs (see lines 96 – 99 of the draft Standard). This approach will permit a more fulsome and plain language description of dentists' obligations, and it will permit staff to quickly and responsively update the guidance in the FAQ without the need to revisit the full Standard.
    - **Reflecting the "approximate" cost of treatment:** A small edit is proposed at line 142 of the draft Standard to acknowledge that any fees discussed between the dentist and the patient are "predicted" and subject to change.

- **Documenting the consent discussion:** In response to significant stakeholder feedback, the section of the draft Standard concerning documentation (lines 226 – 255) has been revised to emphasize that these are recommendations (not requirements), and to reduce the total number of details that dentists are advised to document.

**C. Feedback of the Standing Policy Working Group and QAC**

- Following initial revisions based on the feedback above, the draft Standard alongside a summary of the consultation feedback was shared with the College's Standing Policy Working Group on February 3rd and QAC on March 4th.

- In general, the Standing Policy Working Group and QAC were supportive of the revised draft Standard and provided helpful feedback that was minor in nature. This feedback is reflected in the track changes at Appendix A.

- QAC approved the revised draft Standard to be brought forward to Council for consideration for final approval.

## CONSIDERATIONS:

**FAQs, Supplementary Resources, and Knowledge Translation**

- As per RCDSO's new approach to communicating guidance, the development of supplementary resources, including an FAQ, will be critical to supporting dentists, patients, and other stakeholders in understanding the College's expectations for obtaining consent to treatment.

- As of submitted this briefing note, the draft "Consent to Treatment FAQ" is still in development, with the assistance of RCDSO's Practice Advisory Service (PAS), however, it is anticipated that a draft will be ready for Council's consideration in March (of note, FAQs do not require Council's approval and will be shared for feedback and information only).

- Although the FAQs are still in development, key topics to be addressed will include (among others):

    - considerations related to obtaining consent from minors with divorced or separated parents,
    - revisiting consent as a result of changes to the treatment plan,
    - guidance for patients who wish to waive or bypass consent discussions,
    - considerations for obtaining consent from patients who may be impaired (e.g., due to consumption of cannabis or alcohol),
    - guidance concerning who should undertake the consent discussion (e.g., the treating dentist or staff), and
    - advice concerning consent forms.

- Staff will also give consideration to effective knowledge translation strategies to ensure that dentists are aware of any new Standards following Council, such as e-blasts to the membership, RCDSO Connect virtual sessions, and the use of continuing education credits to drive awareness of new Standards. More information about these tactics can be found within the Policy Report which is included as part of Council's meeting package.

## NEXT STEPS:

- If approved by Council, the draft Standard and FAQs will be posted on the RCDSO website and relevant stakeholders will be notified (this will include registrants and key system partners, among others).
- The new Standard will replace the current Practice Advisory on RCDSO's website.
- RCDSO's policy team, in collaboration with staff in Communications, Quality, and other program areas will continue to explore opportunities to communicate the College's new expectations and support dentists in practice.

## DECISION FOR COUNCIL:

- Council is being asked whether it has any feedback on the revised draft "Consent to Treatment" Standard of Practice.
- Council is being asked whether it approves the revised draft "Consent to Treatment" Standard as a final Standard of the College.
- The motion before Council is as follows:
    - THAT Council approves the revised draft Standard of Practice: "Consent to Treatment", as a Standard of Practice of the RCDSO.

## CONTACT:

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Attachments:

**Appendix A:** Revised Draft Standard of Practice: Consent to Treatment

# Consent to Treatment

## Contents



## Executive Summary

This Standard of Practice sets out requirements for obtaining ~~valid~~ consent to treatment. The duty to obtain consent arises from fundamental legal, professional, and ethical obligations, which reflect the right of every patient to make informed choices about their own body and healthcare. By obtaining ~~valid~~ the patient's full and informed consent, dentists also help to enhance communication with patients, build trust, and manage risks arising from treatment.[1]

This Standard of Practice is supported by companion resources which provide supplementary information and guidance, including an FAQ and infographic.

## Definitions

**Key terms are defined below to assist with interpreting and applying this Standard of Practice. In some cases, these definitions are drawn directly from legislation and are not applicable to other College documents or areas of dentistry. Where a definition is drawn directly from legislation or has limited application to this Standard or area of practice (i.e., consent to treatment), this is identified in a footnote.**

[1] This Standard of Practice addresses consent to treatment only, and not consent related to other areas of practice, such as consent for the collection, use, and disclosure of personal health information (PHI). Legal requirements for PHI are set out in the *Personal Health Information Protection Act, 2004,* S.O. 2004, c. 3, Sched. A, and additional guidance can be found in applicable RCDSO resources.

**Treatment** includes anything that is done for a therapeutic, preventative, palliative, diagnostic, cosmetic, or other health-related purpose, and includes a course of treatment, plan of treatment, or community treatment plan.[2]

**Capacity** refers to an individual's ability to understand and use information to make a decision concerning treatment. A person has capacity to consent to treatment if they are able to understand the information that is relevant to making a decision, and can appreciate the reasonably foreseeable consequences of a decision or a lack of a decision.[3]

**Emergency** is a situation in which an individual is apparently experiencing severe suffering, or is at risk of sustaining serious bodily harm if treatment is not administered promptly.[4]

**Express consent** is direct, explicit, and unmistakable, and can be given orally or in writing.

**Implied consent** is consent that is not given explicitly, but which can be inferred based on the individual's actions and the facts of a particular situation (e.g., the patient nods their head in agreement).

**Substitute decision-maker (SDM)** is a person who may give or refuse consent to treatment on behalf of a person who lacks capacity. The *Health Care Consent Act, 1996* (HCCA) specifies who may act as an SDM on behalf of an incapable person,[5] and sets out specific requirements that they must meet when exercising their duties.[6]

~~**Valid consent** is consent that has been obtained in accordance with all applicable legal and professional obligations. Valid consent *must* obtained before care is provided.[7]~~

## Principles

The following principles form the foundation for the requirements set out in this Standard:

1. The duty to obtain consent reflects the fundamental right of every patient to make informed decisions about their own body and healthcare.

[2] This definition of "treatment" is specific to the requirements for obtaining consent to treatment and is derived from s. 2(1) of the *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A.
[3] s. 4(1) of the *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A.
[4] This definition of "emergency" is specific to the requirements for obtaining consent to treatment and is derived from s. 25(1) of the *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A.
[5] s. 20(1) of the *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A.
[6] s. 20(2) of the *Health Care Consent Act*, 1996, S.O. 1996, c. 2, Sched. A.
~~[7] Limited exceptions for treatment in emergency situations are set out in s. 25 of the *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A. More information about providing care in emergencies can be found in the final section of this Standard.~~

2. ~~Without valid consent, there can be no treatment~~Treatment cannot be provided without first obtaining consent.[8]

3. The duty to ensure that ~~valid~~ consent is obtained rests with the dentist proposing the treatment.

4. Dentists have a duty to provide an accurate explanation of treatment options, risks, and costs.[9]

5. Consent is a process: it begins before treatment is provided and is renewed throughout the course of treatment.

## General Requirements

1. Dentists must ensure that ~~valid~~ consent has been obtained prior to administering treatment.[10, 11]

2. If dentists are unsure whether the consent that has been obtained is valid (i.e., that it fulfills all applicable legal and professional obligations), dentists must not provide treatment until assured that valid consent has been obtained.

3. If dentists are unsure of their legal or professional obligations for obtaining consent in specific circumstances, they are advised to contact RCDSO's Practice Advisory Service or obtain independent legal advice.

4. ~~Where dentists rely on staff or others to fulfill specific requirements related to obtaining consent (e.g., communicating information about the treatment being proposed), the treating dentist must ensure that this individual has the knowledge, skill, and judgment to fulfill this role.~~

5. Dentists must respect the decision of the patient or their SDM to refuse, withhold, or withdraw consent, even if the dentist disagrees with that decision.[12]

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[8] Limited exceptions for treatment in emergency situations are set out in s. 25 of the *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A. For more information about providing care in emergencies, see the final section of this Standard.

[9] RCDSO Code of Ethics.

[10] Limited exceptions for treatment in emergency situations are set out in s. 25 of the *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A. For more information about providing care in emergencies, see the relevant section of this Standard of Practice and the Consent to Treatment FAQs.

[11] A failure to obtain ~~valid~~ consent to treatment could result in allegations of negligence or battery, and/or a finding of professional misconduct under *O. Reg. 853/93: Professional Misconduct*.

[12] For more information about "informed refusal", see the Consent to Treatment FAQs.

## Obtaining Consent~~Requirements for Valid Consent~~

The *Health Care Consent Act, 1996* (HCCA) sets out the requirements that healthcare providers must fulfill when obtaining consent to treatment, including the information that must be communicated to the patient or their substitute decision-maker (SDM).[13] Dentists are reminded that the requirement that consent be "informed" is only one of several requirements, all of which are set out below.

6. When obtaining consent to treatment, dentists must ensure that it is:[14]
    a. obtained from the patient, if the patient has capacity to consent to treatment, or from the patient's SDM, if the patient does not have capacity to consent to treatment;
    b. related to the specific treatment being proposed,
    c. informed;
    d. given voluntarily and not under duress or coercion; and
    e. not obtained through misrepresentation or fraud.[15]

7. For consent to be "informed", dentists must ensure that the patient or their SDM is provided with the following information:[16]
    a. the nature of the treatment;
    b. the treatment's expected benefits;
    c. the treatment's material risks and material side effects;[17]
    d. information about alternative courses of action; and
    e. the likely consequences of not receiving the treatment.

8. Dentists must be satisfied that the information communicated has been understood by the patient or their SDM and take reasonable steps to facilitate comprehension where needed. For example, dentists can ask follow-up questions, encourage discussion, or consider the use of a translator when a language barrier is present.

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[13] s. 11(1) of the *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A.

[14] s. 10(1) and 11(1) of the *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A.

[15] Unless it is not reasonable to do so in the circumstances, the HCCA (s. 12) permits dentists to presume that consent to treatment includes:

a. consent to variations or adjustments in the treatment, if the nature, expected benefits, material risks and material side effects of the changed treatment are not significantly different; and

~~b.~~ consent to the continuation of the same treatment in a different setting, if there is no significant change in the expected benefits, material risks or material side effects of the treatment as a result of the change in the setting in which it is administered.

[16] s. 2 and 3 of the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A.

[17] Dentists must use judgment when deciding which risks and side effects are to be disclosed. Based on relevant case law, dentists are advised to provide the patient with information that a reasonable person in the same circumstances would require to make a decision about the treatment. This would include disclosure of those risks and side effects that are common, even though not necessarily grave, and those that are rare, but particularly significant. For more information, see the Consent to Treatment FAQs.

9. Dentists must make themselves available to the patient or their SDM upon request to respond to questions or concerns.[18]

10. Dentists must ensure that the patient or SDM has time to consider the information provided, ask and receive answers to any follow-up questions or concerns, and reach a decision concerning consent.

11. As part of the consent discussion, dentists must ensure that information concerning fees are disclosed to the patient or their SDM before treatment is initiated (e.g., the expected cost of treatment, any anticipated additional costs that may arise once treatment is underway, and any relevant information related to insurance coverage).[19]

## Express and Implied Consent

12. While consent can be either express or implied, dentists are advised to obtain express consent when the treatment:
    a. is likely to be more than mildly painful;
    b. carries appreciable risk;
    c. will result in loss or impairment of a bodily function;
    d. is a surgical procedure or an invasive investigative procedure; or
    e. will lead to significant changes in consciousness.

## Determining Capacity

In order ~~for consent to be valid~~to proceed with treatment, the individual giving or refusing ~~it~~consent (i.e., the patient or their SDM) must be 'capable' with respect to the treatment. Importantly, capacity is not static: a person may be capable with respect to some treatments and not others, they may be capable at one point in time and not another, and capacity can be present, fade, or return with the individual's mental well-being or clarity of thought. Where dentists are unsure about an individual's capacity, they are advised to seek guidance from RCDSO's Practice Advisory Service or the Consent and Capacity Board (CCB)[20].

[18] s. 11(2)(b) of the *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A.

[19] This is a requirement of RCDSO to help ensure that patients are fully informed before making a treatment decision. This is not a requirement in legislation (e.g., the *HCCA, 1996)*.

[20] The Consent and Capacity Board (CCB) is a quasi-judicial administrative tribunal which operates at arm's length from the Ministry of Health. The Board convenes hearings and makes decisions under six Acts, including the *Health Care Consent Act*. The Board aims to provide timely, fair and accessible adjudication of issues relating primarily to matters of consent, capacity, and civil detention: https://www.ccboard.on.ca/scripts/english/aboutus/index.asp

***PATIENT CAPACITY***

13. Dentists must ensure that the patient giving or refusing consent is capable with respect to the treatment being proposed.[21] Dentists are entitled to presume capacity unless there are reasonable grounds to believe otherwise (e.g., something in the patient's history or behaviour raises questions about their capacity).

14. Because capacity is not static, dentists must continue to consider the patient's capacity at various points in time and in relation to the specific treatment being proposed or administered.

15. If a patient disagrees with a dentist's determination that they are incapable of consenting to treatment, the dentist must advise the patient of their right to apply to the CCB for a review of the finding.

16. If a patient disputes a dentist's determination that they are incapable of consenting to treatment, the dentist must not provide treatment until the matter can be resolved, or the CCB has rendered a decision. To facilitate a timely resolution, dentists are advised to recommend that the patient submit their formal disagreement to the CCB for review.

***SUBSTITUTE DECISION-MAKERS (SDMs)***

17. When a patient is incapable of giving or refusing consent to treatment, the dentist must ensure that ~~valid~~ consent is obtained from the ~~next~~ highest-ranking person in the hierarchy of substitute decision-makers as set out in the HCCA, 1996 (see Appendix A).[22]

18. If the highest-ranking person in the hierarchy does not satisfy all of the requirements for substitute decision-making under the legislation,[23] the dentist must move to the next-highest-ranking person who meets the requirements.

19. Dentists must ensure that SDMs understand and comply with the principles for giving or refusing consent as set out in the HCCA, 1996.[24]

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[21] The *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A describes the criteria that must be met in order for an individual to be capable of giving or refusing consent: first, the person must be able to understand the information that is relevant to making a decision, and second, the person must be able to appreciate the reasonably foreseeable consequences of a decision or lack of a decision.

[22] s. 10(1) of the *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A

[23] s. 2 of the *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A. Requirements include that the SDM:

a. is capable with respect to the treatment,
b. is at least 16 years old, unless he or she is the incapable person's parent;
c. is not prohibited by court order or separation agreement from having access to the incapable person or giving or refusing consent on their behalf;
d. is available; and
e. is willing to assume the responsibility of giving or refusing consent.

[24] s. 21 of the *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A.

a. the SDM must give or withhold consent in accordance with the most recent and known wish expressed by the patient, while capable and at least 16 years old;
b. if there is no known or applicable wish, the SDM must make a decision guided by the patient's best interests.[25]

20. If a patient disputes the involvement of an SDM, the dentist must advise the patient of their right to direct their concerns to the CCB for review.

***MINORS***

In Ontario, there is no fixed age of capacity to consent to treatment. This means that 'minors' ~~(e.g., patients under the age of 18)~~ may have capacity to give or refuse consent to treatment. The considerations that will inform an assessment of capacity of a minor are the same as those that would inform the assessment of an adult patient (i.e., the patient able to understand the relevant information and the reasonably foreseeable consequences of a decision)

21. If a dentist determines that a minor is capable with respect to treatment, the dentist must obtain consent from the minor directly, even if the minor is accompanied by a parent or guardian.[26] However, dentists are reminded that no one under the age of 18 can enter into a legally binding contract, which means that a payment arrangement cannot be entered into with anyone under the age of 18.

## Documentation

22. Dentists must document information regarding patient consent and capacity, including details of the consent discussion, as set out below, and in-keeping with RCDSO's Dental Recordkeeping Guidelines.

23. In general, dentists are advised that the more complicated or risky the treatment is, the more specific and detailed their documentation should be. This also applies to treatment undertaken for strictly cosmetic or aesthetic reasons.

24. Dentists must use their professional judgment to determine what specific information to document in relation to the consent discussion, taking into consideration the circumstances of each interaction. In general, dentists are advised (but not required) to record the following:
    a. the date;
    b. the names of any individuals who participated in the consent discussion or their relationship to the patient (e.g., "mother" or "father");

[25] If an SDM is not making decisions in accordance with the principles for substitute decision making set in the *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A, dentists may bring a "Form G" application to the Consent and Capacity Board for review.

[26] For more information about obtaining consent from a minor, see the Consent to Treatment FAQs.

c. the specific potential risks and benefits that were communicated, including any risks associated with refusing, withholding, or withdrawing consent;
d. any significant questions or concerns raised by the patient or SDM;
e. any alternative treatments or options that were discussed, including no treatment;
f. whether consent was given or refused, and by whom;
g. what was consented to, if anything; and
h. any discussions or agreements concerning the anticipated cost of treatment.

~~24.~~25. When there has been a determination of incapacity, dentists are advised to record:
a. the information, circumstances, or reasoning that were the basis for the determination of incapacity;
~~b. the advice that was provided to the patient;~~
~~c.~~b. the name and the relationship of the person who has been identified as the patient's SDM; and
~~d.~~c. whether the SDM has been given a power of attorney for personal care for the patient.

## Emergency Treatment

In limited circumstances, dentists may find themselves in emergency situations where it is not possible or in the patient's best interest to obtain ~~valid~~ consent prior to administering treatment. For instance, this could occur in situations where a patient is incapable of communicating their consent, and where administering immediate treatment would relieve severe suffering or reduce the risk of serious bodily harm. The HCCA, 1996 sets out specific requirements that healthcare providers must meet when providing emergency treatment.[27]

~~25.~~26. In emergencies, dentists must obtain ~~valid~~ consent from the patient or their SDM unless:
a. the communication required in order for consent to be given or withheld cannot take place (e.g., because of a language barrier or disability, or because the SDM cannot be reached);
b. steps that are reasonable in the circumstances have been taken to find a practical means of enabling communication, but none have been found;
c. the delay required to find a practical means of enabling communication will prolong the suffering of the patient or put them at risk of serious bodily harm; and
d. there is no reason to believe that the patient does not want the treatment.

~~26.~~27. Dentists must not provide treatment in emergencies if they have reasonable grounds to believe that the patient, while capable and at least 16 years of age, has expressed a wish applicable to the circumstances to refuse consent to the treatment.[28]

[27] s. 25 of The *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A.
[28] s. 26 of The *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A.

## Consent Forms

Consent forms can be a helpful way to reinforce information about the proposed treatment and support informed decision-making, however, dentists are reminded that a signed consent form is not consent itself. A consent form is only as useful as the consent discussion that accompanied it, and forms are not a substitute for the requirements set out in this Standard of Practice or the HCCA, 1996.[29]

~~27.~~28. Dentists must ensure that they fulfill all of the requirements for obtaining ~~valid~~ consent as set out in this Standard of Practice and the HCCA, 1996, regardless of whether they are using supporting documents (e.g., a consent form).

~~28.~~29. Dentists must ensure that ~~signed~~ consent forms that have been signed by the patient or their SDM are retained as part of the patient's record.



[29] For more information about Consent Forms (including a sample form), see the Consent to Treatment FAQs.

## Appendix A: Hierarchy of Substitute Decision-Makers (SDMs)

If a person is incapable with respect to a treatment, consent may be given or refused on their behalf by a person described in one of the following paragraphs:[30]

1. The incapable person's guardian, if authorized to give or refuse consent to the treatment.
2. The incapable person's attorney for personal care, if authorized to give or refuse consent to the treatment.
3. The incapable person's representative appointed by the Consent and Capacity Board (CCB), if authorized to give or refuse consent to the treatment.
4. The incapable person's spouse or partner.
5. A child or parent of the incapable person, or a children's aid society or other person who is entitled to give or refuse consent to the treatment (this does not include a parent who has only a right of access).
6. A parent of the incapable person who has only a right of access.
7. A brother or sister of the incapable person.
8. Any other relative of the incapable person.

The SDM is the highest-ranking person set out in the above list who is also:

1. capable with respect to the treatment;
2. at least 16 years old, unless they are the incapable person's parent;
3. not prohibited by court order or separation agreement from having access to the incapable patient or giving or refusing consent on their behalf;
4. available; and
5. willing to assume the responsibility of giving or refusing consent.



[30] s. 20 (1) of The *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A.