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May 31, 2022

Canadian Dental Regulatory Authorities Federation **Via EMAIL**
Toronto, ON M4W 1T1

Attention: Dr. Jack Gerrow, Executive Director

RE: Recognition of Dental Anaesthesia as a Canadian Dental Specialty: Response to the submission from the Canadian Association of Oral and Maxillofacial Surgeons

Dear Dr. Gerow,

Thank you for bringing to my attention the publication on the CDRAF website of the responses from various organizations to the Canadian Academy of Dental Anesthesia (CADA) application for approval as a dental specialty. As you are aware, I strongly support the CADA application and I am pleased to read that most responses to the CADA application strongly support the designation of dental anaesthesia as a new dental specialty. I am writing to offer my comments in reply to the issues raised by the Canadian Association of Oral and Maxillofacial Surgeons (CAOMS) in its response to the CADA application, especially the issues concerned with governance.

The CAOMS objects to the alteration of the process for recognition of a new dental specialty, stating:

> "The CDRAF made changes to the process for recognition of a new dental specialty in April 2021. At that time the CDRAF eliminated the Canadian National Dental Specialty Recognition Commission (Committee), a third-party independent body responsible for receiving, reviewing, and deciding national dental specialist applications. This body had representation from the Commission on Dental Accreditation (CDAC), Royal College of Dentists of Canada (RCDC), Canadian Dental Association (CDA), the CDRAF, and Association of Canadian Faculties of Dentistry (ACFD). This procedural change resulted in the exclusion of the various branches of Canadian organized dentistry from this process, leaving the decision entirely in the hands of the CDRAF."

Contrary to the suggestion from CAOMS that the alteration in process eliminated review by an independent body, the revised process shifted review from non-independent dental organizations to the purview of the provincial and territorial dental regulators who have a legal and fiduciary responsibility to make decisions in the public interest.

The prior process (copy attached) specifically states that the Canadian National Dental Specialty Recognition Commission Committee (Committee) is not a standing committee of the CDRAF. Under

the prior process, the CDRAF could strike a Committee to review an application on an as-needed basis. Apart from the ACFD and the CDRAF, none of the organizations included in the decision-making process are independent. All are related to the CDA, the largest Canadian dental lobby, with a legal responsibility to act on behalf of its dental members, including the provincial dental associations.

The CDA created the CDAC in 1988, and while the CDAC strives for autonomy, it remains a subsidiary of the CDA. There is no public representation on the board of the CDAC and no requirement for the organization to act in the public interest. The CDA established the RCDC in 1965 pursuant to an Act of Parliament. According to Section 3 of its constitution, the objects of the RCDC are to promote high standards of dental specialization. There is no obligation under the RCDC constitution or bylaws to act in the public interest. Of the sixteen member RCDC board of directors, the one seat reserved for a public member is vacant as of the date of this letter.

The process for specialty recognition in Canada contained serious governance flaws[1], especially concerning transparent regulation, prior to the CDRAF adopting a new process in 2021. The Committee struck for considering the 2013 CADA application for recognition as a dental specialty decided that all comments received from internal and external interested parties would remain confidential and the Committee would not share the comments with the applicant. The Committee decided that members' votes to approve or deny the application would be made, and kept, in secret and individual voting members would not be obligated to justify their decisions.

The 2013 Committee acknowledged that conflicts of interest might exist, or be perceived to exist, but decided not to delay the work of deciding on the application while reviewing that issue. One member was absent from the presentations and discussion, but the vote to deny the application proceeded anyway.

In contrast to the prior process, the CDRAF is entirely comprised of members who have agreed to act in the public interest (notwithstanding that some may deal with a conflict: see footnote 1.) The CDRAF website no longer states that the organization commits to act in the public interest, but the revised Bylaws require at S. 34 (d) that Board members will establish policy in the context of the public interest. Under the prior system, the non-independent decision-makers appointed to decide on new dental specialities could secretly decide to act in a way that served the private interests of existing dental specialties. The revised process under which the CDRAF members will independently and transparently decide on an application has resolved that governance flaw.

It is my opinion that the former process was highly unfair to the applicant CADA. The process and ultimate decision were also extremely detrimental to the best interests of Canadians, especially those

[1] There is some irony in the fact that the CDRAF and Committee received advice on the governance measures concerning the 2013 CADA application from Dr. Gordon Thompson, who was at that time jointly the Registrar and Executive Director of the combined Alberta Dental Association and College. I am glad to note that the province of Alberta has subsequently recognized the inherent conflict of interest in a dental regulator jointly assuming the role of head of the association whose members are subject to regulation and is separating the two functions. Sadly, not all provinces have taken the step of separating the role of the dental regulator from the representative of the provincial dental lobby. It is my view that this inherent conflict of interest among several of its board members impairs dental regulatory positions adopted by the CDRAF.

vulnerable populations who struggle to access medically necessary oral health care without adequate access to anesthesia for dental treatment.

It is this final concern that has caused me to write in reply to the CAOMS response.

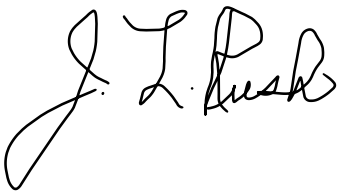
The CAOMS dismiss the severe lack of access to dental care facing disabled adults (and older age children with special needs) by directing them to hospital for all dental treatment. That ineffective resolution causes the 22% of Canadians with disabilities (including the 30% of Indigenous Canadians with disabilities) to suffer the worst unmet oral health needs of all Canadians.

CAOMS argues that persons with complex medical needs require hospitalization for safe oral health treatment, and no one would argue with that position. However, many adults with complex intellectual or neurological disabilities such as autism do not have complex medical co-morbidities and do not need hospitalization for dental treatment. Many individuals in this group (who must be assessed at ASA level I or II to qualify for care in a non-hospital facility in my province of BC) would benefit enormously from prompt access to treatment under anesthesia in community-based anesthesia clinics. The CAOMS solution of sending them to over-booked hospital surgeries leaves these people on years-long wait lists for medically necessary treatment or, too often, unable to access oral health treatment at all. I am sad that a large group of dental specialists, such as CAOMS members, appear to care so little about access to medically necessary oral health care for Canadians with special needs.

There are a variety of errors in the CAOMS submission regarding the former and revised process for Canadian recognition of a dental specialty as well as in its description of the current dental anaesthesia program. The CADA has described these errors in its reply to the CAOMS response. However, since the CAOMS decided to attach its 2013 response as an Appendix to its current submission, I think it is appropriate to also note that its concerns expressed at page 35 under Principal Health Services are incorrect, at least in my province of BC. The CAOMS argue that anesthesia is medical and not dental care, and that dental anesthesiologists will be providing both medical and dental treatment to patients. Pursuant to current guidelines published by the College of Dental Surgeons of BC, dental anesthesiologists must not concomitantly provide dental treatment.[2]

I hope these comments are helpful to the CDRAF members' assessment of the application and the response to the application from the CAOMS.

Sincerely,



Joan L. Rush

c. M[e]. Daoust, Chair, Canadian Dental Regulatory Authorities Federation

Canadian Academy of Dental Anesthesia

[2] General-Anaesthesia-Standards.pdf (cdsbc.org) (See section E)