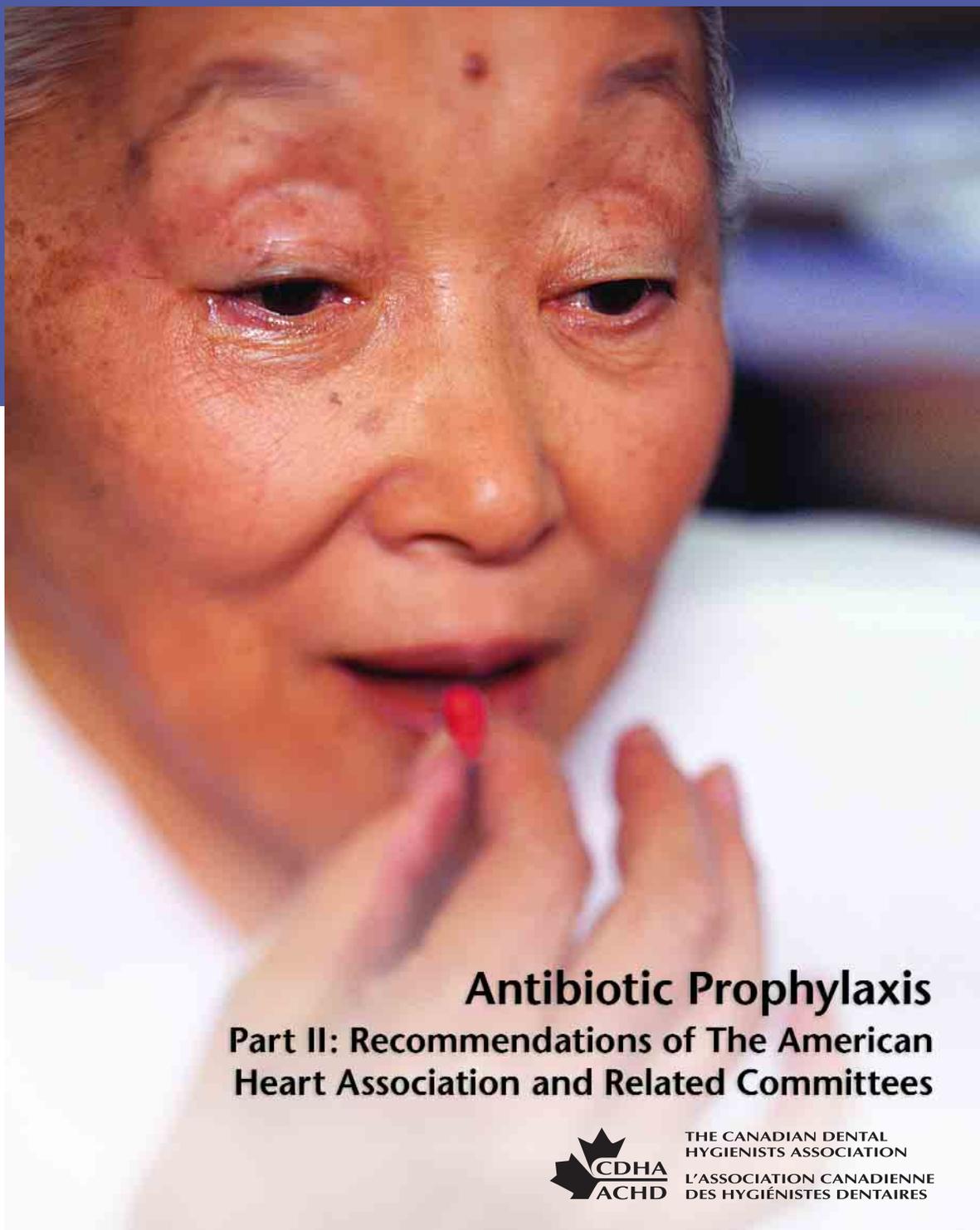


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Antibiotic Prophylaxis Part II: Recommendations of The American Heart Association and Related Committees



THE CANADIAN DENTAL
HYGIENISTS ASSOCIATION
L'ASSOCIATION CANADIENNE
DES HYGIÉNISTES DENTAIRE

THE OFFICIAL JOURNAL OF THE CANADIAN DENTAL HYGIENISTS ASSOCIATION

Re-Member

It's the time of year to reconfirm and renew your commitment to CDHA

By Carol-Ann Yakiwchuk, Dip DH, BSc (DH) candidate



AS I WRITE THIS FIRST MESSAGE TO YOU AS PRESIDENT of the Canadian Dental Hygienist Association (CDHA), a new season is on our doorsteps. Fall is one of my favourite seasons to take long, leisurely walks while enjoying the fresh cooler air, golden leaves crunching underfoot and the call of Canada geese preparing to leave us for warmer skies. There's nothing better than to be welcomed home by the aroma of a pot roast and homemade apple pie in the oven while thinking back with gratitude to the days of summer fun now past and anticipating the promise of another year. Fall, for me and many others, signifies a return to normalcy, a time to refocus energy, embrace new opportunities and learning experiences, and reconfirm and renew commitments—such as the one to your professional association.

Re-member: renew your membership in CDHA and get involved.

As I take over the helm as President, I find myself remembering how important the association has been for me since the moment I first joined. A lecture by Laura MacDonald on the valuable and important role the CDHA plays as the national voice and vision of our profession inspired me to join as a student member. Since then, I have benefited from invaluable resources, such as the CDHA Code of Ethics and Practice Standards, which continue to guide and support me in my professional life. But a CDHA membership not only offers extensive benefits, such as access to current evidence-based position papers, free malpractice insurance and professional publications, it also provides countless opportunities for professional and personal growth. All that's needed is a desire to make a difference.

My fascination with new challenges and opportunities, commitment to lifelong learning and willingness to "seize the moment" has led to many life-changing decisions. At age 30, I changed career paths when, with very small children at home, I enrolled in university to study dental hygiene. Eight years after graduation, I left a secure and satisfying clinical practice to pursue a unique health-promotion opportunity at the University of Manitoba in

Re-member ...continued on page 293

Rappel

L'heure est venue de reconfirmer et de renouveler votre engagement envers l'ACHD

Par Carol-Ann Yakiwchuk, HD dipl., candidate au BSc (HD)

AU MOMENT D'ÉCRIRE CE PREMIER MESSAGE COMME présidente de l'Association canadienne des hygiénistes dentaires, une nouvelle saison est à nos portes. L'automne est l'une de mes saisons préférées pour faire de longues promenades tranquilles tout en profitant de l'air plus frais, des feuilles multicolores qui craquent sous les pieds et du cri de la bernache, qui se prépare à nous quitter pour des ciels plus cléments. Quoi de mieux que de sentir dans la maison l'arôme d'un bœuf braisé et d'une tarte aux pommes maison, de se remémorer les plaisirs de l'été maintenant terminé, tout en embrassant déjà ce que nous réserve la nouvelle année. Pour moi et nombre d'autres personnes, l'automne signale le retour à la normale, l'occasion de recentrer nos énergies, de saisir de nouvelles occasions, de faire de nouveaux apprentissages, de reconfirmer et de renouveler nos engagements, notamment envers notre association professionnelle.

Rappel : renouvelez votre adhésion et participez activement à l'ACHD.

En prenant la barre à titre de présidente, je me souviens de tous les avantages que j'ai retirés de notre association depuis que j'en suis membre. C'est une conférence de Laura MacDonald sur le rôle déterminant et essentiel joué par l'ACHD comme porte-parole national de notre profession et de notre vision d'avenir qui m'a incitée à m'inscrire comme étudiante. Depuis, j'ai profité de ressources inestimables, notamment le Code de déontologie et les normes de pratique de l'ACHD, qui continuent de me guider et de me soutenir dans ma vie professionnelle. Non seulement l'appartenance à l'ACHD offre-t-elle de considérables avantages, dont l'accès aux plus récents exposés de position fondés sur l'expérience clinique, l'assurance gratuite contre la faute professionnelle et des publications spécialisées, mais elle ouvre également d'innombrables perspectives de croissance personnelle et professionnelle. Il suffit qu'on ait le désir de s'engager.

Ma fascination pour les nouveaux défis et les possibilités nouvelles, mon attachement à l'éducation permanente et mon empressement à « saisir l'occasion » m'ont incitée, toute ma vie, à prendre de nombreuses déci-

Rappel ...suite à la page 292

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Transitions

By Susan Ziebarth, BSc, MHA, CHE

Beauty is the moment of transition, as if the form were just ready to flow into other forms
—Ralph Waldo Emerson



WRITE THIS EDITORIAL AGAINST A COGNITIVE BACKDROP of an exhilarating weekend of board meetings. These meetings were welcomingly thought-provoking and exciting as the board of directors actively engaged in leading the organization. The board experienced a transition to its order with three new members stepping into the existing ranks. While some transitions can be difficult, the culture of the Association enabled the fresh inductees to join the discussions and maintain continuity to the legacies of the retired members. The beauty of this transition was in part due to the conscious attention to the values and belief systems that anchor the leadership of our association.

The board experienced a transition to its order with three new members stepping into the existing ranks.

Beliefs filter how we perceive the world because they are so deeply held. As Posen said, “Beliefs are basic premises and assumptions that are held as objective ‘truths’ and that guide our thinking, decisions, and behaviour. They include values, philosophies, and ideas about the nature of things, other people, and ourselves” (Posen, 1994 p.85). They affect what our attention is drawn to, how we process information and how we act upon that information. Rokeach defined values as “a generally agreed upon set of beliefs about preferable modes of conduct or desirable objectives to attain” (Cohen, 1993 p. 344).

Because beliefs and values are intangibles, we sometimes need to consciously step back and examine them to learn how they affect our behaviours and thoughts. Both the board of directors and the CDHA staff have been using evaluation tools and discussion to determine how we contribute to the organization as individuals, and how we work together to form a collective whole. What we realize is that if our beliefs and values are restrictive or inaccurate, they lead to behaviour that creates negative outcomes. Being aware of these two dimensions, we can challenge ourselves to beneficial progress.

Transitions ...continued on page 280

Transitions

par Susan Ziebarth, BSc, MHA, CHE

La beauté est un instant de transition – quand la forme s’apprête à prendre d’autres formes.
— Ralph Waldo Emerson [trad. libre]

JE RÉDIGE CE MESSAGE EN PENSANT À LA RÉCENTE FIN DE semaine de réunions animées à laquelle a participé le conseil d’administration. Ces rencontres ont stimulé notre esprit alors que le conseil s’est engagé activement à orienter notre organisation. Le conseil a vécu une transition avec l’arrivée de trois nouveaux membres. Vivre une transition peut être difficile, mais la culture de l’association a permis aux nouveaux arrivants de se mettre au diapason des discussions et de poursuivre le travail entrepris par leurs prédécesseurs. La beauté de cette transition résidait en partie dans l’attention consciente qui était portée aux valeurs et aux convictions que soutiennent les membres de la direction de notre association.

Le conseil a vécu une transition avec l’arrivée de trois nouveaux membres.

Les conceptions modifient notre perception du monde parce qu’elles sont profondément ancrées. Comme l’écrivait Posen : « Les convictions sont des prémisses et des hypothèses perçues comme des vérités, qui guident nos pensées, nos décisions et notre conduite. Elles comprennent les valeurs, les philosophies et les conceptions que nous avons de la nature des choses, des autres et de nous-mêmes. » (Posen, 1994, p.85, trad. libre). Elles déterminent ce qui retient notre attention, comment nous traitons l’information et comment nous agissons à partir de cette information. Rokeach définit les valeurs comme un ensemble de convictions généralement partagées à l’égard des conduites à suivre et des objectifs à poursuivre ». (Cohen, 1993, p. 344, trad. libre).

Les convictions et les valeurs sont intangibles, et il faut parfois s’en écarter pour mieux évaluer comment elles influencent nos pensées et nos actions. Le conseil et le personnel de l’ACHD ont utilisé des outils d’évaluation et de discussion pour déterminer comment chacun contribue à l’organisation et comment nous pouvons agir collectivement. Nous avons réalisé que des convictions et des valeurs restrictives ou imprécises suscitent des comportements menant à des résultats négatifs. En en étant bien

Transitions ...suite à la page 280

Antibiotic Prophylaxis. Part II: Recommendations of The American Heart Association and Related Committees

By Frieda Pickett, RDH, MS

ABSTRACT

The American Heart Association's (AHA) Rheumatic Fever, Endocarditis, and Kawasaki Disease Committee; the Council on Cardiovascular Disease in the Young; and the Council on Clinical Cardiology, Council on Cardiovascular Surgery and Anesthesia, and Quality of Care and Outcomes Research Interdisciplinary Working Group recently published guidelines for antibiotic prophylaxis prior to dental procedures, respiratory tract procedures and gastrointestinal (GI) or genitourinary (GU) tract procedures. The groups of committees were instructed to use the systematic review process to develop new guidelines to assist oral-health and other health professionals. Major changes include (1) cardiac conditions indicated for prophylaxis pertain only to those that carry the highest risk of developing infective endocarditis (IE); (2) dental procedures requiring prophylaxis in these conditions include any procedure requiring tooth manipulation rather than procedures that are associated with significant bleeding; and (3) timing of the antibiotic is to administer a single dose 30 to 60 minutes prior to the dental procedure rather than the previous 60-minute requirement. The recommendation for a pre-procedural antimicrobial rinse was eliminated. The antibiotics recommended for prophylaxis were not changed.

INTRODUCTION

THE AMERICAN HEART ASSOCIATION'S (AHA) Rheumatic Fever, Endocarditis, and Kawasaki Disease Committee; the Council on Cardiovascular Disease in the Young; and the Council on Clinical Cardiology, Council on Cardiovascular surgery and Anesthesia, and Quality of Care and Outcomes Research Interdisciplinary Working Group recently published new guidelines to assist oral-health and other health professionals in the use of

are discussed in this article, representing Part II of the issue. As well, this article discusses the differences between the two professional recommendations. The writing group of the AHA Committee reported the recent changes are intended to define more clearly those situations when endocarditis prophylaxis is or is not recommended and to provide more uniform and consistent global recommendations.

Recent guideline changes are intended to define more clearly those situations when endocarditis prophylaxis prior to dental treatment is or is not recommended.

antibiotic prophylaxis prior to dental, respiratory tract and gastrointestinal (GI) or genitourinary (GU) tract procedures.¹ The British Antimicrobial Society (BAS) updated their recommendations in 2006. Both the BAS and the AHA, which are equivalent authorities in their respective countries, used the systematic review process to develop the new guidelines. Antibiotic Prophylaxis, Part I: Recommendations of the British Society for Antimicrobial Chemotherapy Working Party, published in the May-June 2007 issue of this journal, reviewed relevant scientific evidence and clinical studies used by the Working Party of the BAS to establish recommendations for dental-health professionals when making judgments related to antibiotic prophylaxis to prevent infective endocarditis (IE). The AHA's recommendations for using antibiotic prophylaxis

SYSTEMATIC REVIEW LEVELS OF EVIDENCE

The AHA Committee, Councils and Working Group were charged with the task of assessing the evidence and giving a classification of recommendations and a level of evidence (LOE) to each recommendation. The group used the American College of Cardiology/American Heart Association classification system (Box1)¹ and determined their recommendations over the past 50 years to be Class IIb, LOE C.

HISTORY OF AHA RECOMMENDATIONS FOR PREVENTION OF IE

The AHA has made recommendations for the prevention of IE for more than 50 years, beginning with the first guidelines in 1955.² The recommendations for the use of

RÉSUMÉ

Le Rheumatic Fever, Endocarditis and Kawasaki Disease Committee, le Council on Cardiovascular Disease in the Young, le Council on Clinical Cardiology, le Council on Cardiovascular Surgery and Anesthesia et le Quality of Care and Outcomes Research Interdisciplinary Working Group de l'American Heart Association (AHA) ont publié dernièrement des directives sur l'antibioprophylaxie préalable aux interventions dentaires et aux interventions touchant les voies respiratoires, le tractus gastro-intestinal et l'appareil génitourinaire. Les groupes de comités devaient appliquer un mécanisme de révision systématique pour élaborer de nouvelles directives d'aide aux professionnels de la santé dentaire et autres professionnels de la santé. Les principaux changements sont, notamment : 1) les troubles cardiaques indiqués pour la prophylaxie sont uniquement ceux qui présentent le risque le plus élevé de développer une endocardite infectieuse; 2) les interventions dentaires nécessitant une prophylaxie dans ces conditions incluent toute intervention exigeant une manipulation dentaire plutôt que les interventions associées à un saignement abondant; 3) l'antibiotique doit être administré sous forme de dose unique entre 30 et 60 minutes avant les interventions dentaires au lieu de 60 minutes, comme auparavant. Le rinçage antimicrobien pré-intervention qui était recommandé a été éliminé. Les antibiotiques recommandés pour la prophylaxie demeurent les mêmes.

Cardiac conditions indicated for antibiotic prophylaxis include only those that carry the highest risk of developing infective endocarditis.

antibiotic prophylaxis prior to dental treatment were made based on the significant morbidity and mortality of IE and the finding that microorganisms found in high numbers in the oral cavity (viridans group streptococci) were the most common microorganisms cultured from early cases.² The 1965 guidelines recognized for the first time the role of enterococci in bacteremias following GI-

or GU-tract procedures.³ Recommendations published in 1972 were endorsed for the first time by the American Dental Association (ADA) and emphasized the importance of maintaining good oral hygiene.⁴ Subsequent recommendations attempted to simplify prophylactic regimens and address the growing problem with antibiotic resistance until the 1997 recommendations stratified cardiac conditions into high-, moderate-, and low-risk categories, advising not to provide antibiotic prophylaxis for low-risk cardiac conditions and to limit pre-procedure dosing to a single dose.⁵ The fundamental principles that led to the formulation of the AHA's new guidelines and the nine previous sets of guidelines are that (1) IE is an uncommon but life-threatening disease and prevention is preferable to treatment of an established infection; (2) certain underlying cardiac conditions predispose to IE; (3) bacteremia with organisms known to cause IE occurs commonly in association with invasive dental, GI- or GU-tract procedures; (4) antimicrobial prophylaxis has proven to be effective in preventing experimental IE in animals; and (5) antimicrobial prophylaxis is thought to be effective in humans for prevention of IE associated with dental, GI- or GU-tract procedures.¹ The 2007 guidelines are based on the results of a large body of evidence published in numerous studies over the past two decades. The guidelines are intended to be in the best interest of clients and care providers, are considered to be reasonable and prudent and represent the collective wisdom of many experts on IE and relevant national and international societies.

- Class 1: Conditions for which there is evidence and/or general agreement that a given procedure or treatment is beneficial, useful and effective.
- Class II: Conditions for which there is conflicting evidence and/or a divergence of opinion about the usefulness/efficacy of a procedure or treatment.
- Class IIa: Weight of evidence/opinion is in favor of usefulness/efficacy.
- Class IIb: Usefulness/efficacy is less well established by evidence/opinion.
- Class III: Conditions for which there is evidence and/or general agreement that a procedure/treatment is not useful/effective and in some cases may be harmful.
- Level of Evidence (LOE):
- LOE A: Data derived from multiple randomized clinical trials or meta-analyses.
- LOE B: Data derived from a single randomized trial or nonrandomized studies.
- LOE C: Only consensus opinion of experts, case studies, or standard of care.

Source: Wilson W et al. J Am Dent Assoc 2007;138(6):740

Box 1. ACC/AHA classification of recommendations and levels of evidence

RATIONALE FOR REVISING THE 1997 GUIDELINES

The AHA Committee explained that the 1997 guidelines were based largely on expert opinion and what seemed to be a rational and prudent attempt to prevent a life-threatening infection. They report the basis for former recommendations for endocarditis prophylaxis was not

Prosthetic cardiac valve
Previous history of IE
Congenital heart disease (CHD)

- Unrepaired cyanotic CHD, including palliative shunts and conduits
- Completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter intervention, during the first six months after the procedure
- Repaired CHD with residual defects at the site or adjacent to the site of a prosthetic patch or prosthetic device (which inhibit epithelialization)

Cardiac transplantation recipients who develop cardiac valvulopathy

Source: Wilson et al. Prevention of Infective Endocarditis. *Circulation* May 8, 2007:10.

Box 2. High-risk cardiac conditions for which prophylaxis prior to dental procedures is recommended

well established and the quality of evidence was limited to a few case-control studies or was based on clinical experience and descriptive studies that utilized surrogate measures of risk.¹ Although many dental and dental-hygiene professionals believed that (based on AHA guidelines) antibiotic prophylaxis prior to dental procedures was effective to prevent endocarditis, research published prior to and following the 1997 guidelines questioned the effectiveness of the then-recommended regimen to prevent IE associated with oral procedures and dental treatment.^{6,7,8,9} The primary reasons for the current revision of guidelines for antibiotic prophylaxis to prevent IE are that (1) IE is much more likely to result from frequent exposure to random bacteremias associated with daily activities than from bacteremia caused by a dental, GI- or GU-tract procedure; (2) only a small number of cases of IE, if any, would be prevented with prophylaxis prior to a dental, GI- or GU-tract procedure; (3) the risk of antibiotic-associated adverse events exceeds the benefit, if any, from prophylactic antibiotic therapy; and (4) maintenance of oral health and hygiene may reduce the incidence of bacteremia from daily activities and is more important than prophylactic antibiotics prior to a dental procedure to reduce the risk of IE.

ROLE OF ORAL HEALTH AND HYGIENE

Oral health and the absence of periodontal inflammation and bleeding have been considered important to reduce bacteremias from the oral cavity. The AHA Committee noted that this presumed relationship is controversial,^{10,11,12,13} however available evidence supports an emphasis on maintaining good oral hygiene and eradicating dental disease to decrease the frequency of bacteremia from routine daily activities.^{14,15,16,17} Because study results vary, the AHA Committee concluded that a precise determination of the relative risk of bacteremia that result from a specific dental procedure in clients with or without dental disease is probably not possible.^{18,19,20.}

PRE-PROCEDURAL RINSE

Results are contradictory with regard to the efficacy of the use of topical antiseptics in reducing the frequency of bacteremia associated with dental procedures, but the preponderance of evidence suggests there is no clear benefit.^{6,21,22,23} The collective published data suggests that the vast majority of dental treatments result in some degree of bacteremia; however, there is no evidence-based method to decide which procedures should require prophylaxis, because no data shows that the incidence, magnitude or duration of bacteremia from any dental procedure increase the risk of IE. In past regimens a pre-procedural use of chlorhexidine was recommended, but the current regimen does not recommend an antiseptic rinse because there is no evidence that demonstrates the practice will prevent IE.

POTENTIAL CONSEQUENCES OF CHANGES IN GUIDELINES

The AHA Committee's writing group recognized that changes in the new guidelines could be confusing to both practitioner and client, because they might violate long-standing expectations and practice patterns. The changes would likely cause concern among clients who previously received antibiotic prophylaxis before dental or other procedures and would now be advised that such prophylaxis is unnecessary. The Committee agrees that for 50 years, since the publication of the first AHA guidelines on the prevention of IE, clients and health-care providers assumed that antibiotics administered in association with a bacteremia-producing procedure effectively prevented IE in clients with underlying cardiac risk factors. Receiving antibiotic prophylaxis may have given clients with underlying cardiac defects a sense of reassurance and comfort that IE would be prevented. Oral health-care providers need to understand the reasons for the changes and communicate this information to those clients who are affected.

CLIENT INFORMATION

Part 1 of the discussion on antibiotic prophylaxis included a sample information sheet, which the BAS proposed to provide to clients, explaining the changes in the new recommendations. The AHA also has a client information sheet that can be printed and provided to clients explaining the changes in the new guidelines and identifying those clients who should have antibiotic prophylaxis prior to dental procedures (<http://www.americanheart.org/presenter.jhtml?identifier=11086>).

RECOMMENDED GUIDELINES FOR ANTIBIOTIC PROPHYLAXIS¹

The cardiac conditions recommended for antibiotic prophylaxis prior to dental procedures include those that carry the highest risk of an adverse outcome from IE (Box 2). Although it has been reported that IV-drug users represent a group who are very likely to develop IE, the AHA Committee did not include this group in their 2007 recommendations. The AHA Committee recommendation

Situation	Antibiotic	Adult dose*	Child dose*
Able to take oral med	amoxicillin	2 g	50 mg/kg
Unable to take oral med	Ampicillin Cefazolin or ceftriaxone	2 g IM or IV 1 g IM or IV	50 mg/kg IM or IV 50 mg/kg IM or IV
Allergic to penicillin – able to take oral med	Clindamycin or Azithromycin or clarithromycin Cephalexin+	600 mg 500 mg 2 g	20 mg/kg 15 mg/kg 50 mg/kg
Allergic to penicillin and unable to take oral med	Clindamycin or Cefazolin or ceftriaxone+	600 mg IM or IV 1 g IM or IV	20 mg/kg IM or IV 50 mg/kg IM or IV

e*taken 30 to 60 min before dental procedure

+ do not use cephalosporin if individual has history of anaphylaxis, angioedema or urticaria with penicillin
on tIM = intramuscular; IV = intravenous

Source: Wilson et al. Prevention of Infective Endocarditis. Circulation. May 8, 2007:12.

Table 1. Antibiotic Regimens for Dental Procedure in those at high-risk for IE

is to be applied to “community-acquired” IE and endocarditis resulting from IV-drug use is not in this category. In the high-risk cardiac conditions identified by the new guidelines, dental procedures that require prophylaxis include all procedures that involve manipulation of gingival tissue or the periapical region of teeth or perforation of the oral mucosa. The appropriate antibiotic should be administered in a single dose 30 minutes to one hour before the procedure. If the dose is *inadvertently* not taken before the dental appointment it may be administered up to two hours after the procedure. This should only be considered if the client failed to take the antibiotic prior to the appointment. Table 1 illustrates the antibiotics recommended for prophylaxis and alterations to the oral-dose regimen for individuals who cannot swallow oral-dose forms. Amoxicillin is the preferred choice for oral therapy because it is well absorbed from the GI tract and provides a rapid and sustained serum concentration of antibiotic. For situations in which the client is currently taking amoxicillin an alternate drug from a different class in Table 1 should be selected for prophylaxis. The current regimen does not discuss situations in which multiple dental appointments are needed, however the AHA Committee states that waiting 10 days after an antibiotic has been taken may allow sufficient time for the usual oral flora to be reestablished. Applying this principle to multiple dental appointments for the individual at high risk of IE, spacing appointments 10 days apart can be considered, as well as selecting an antibiotic from a different class. For example, when treatment needs to be completed within a two-week time period and four quadrants of periodontal therapy are required (and no allergy to antibiotics is reported in the health history), amoxicillin is the drug of first choice for the initial appointment, followed by clindamycin for the second appointment of less than 10 days

later, followed by a macrolide for the third appointment of less than 10 days later, and so on.

Other special situations addressed in the updated recommendations include avoiding intramuscular injections for IE prophylaxis when anticoagulant medication is being taken (Class I, LOE A). In addition, clients who are scheduled to undergo cardiac surgery should have a careful preoperative dental evaluation and the recommended treatment should be completed, whenever possible, before cardiac valve surgery or replacement or repair of coronary heart disease (CHD). There is no evidence that coronary artery bypass graft surgery is associated with a long-term risk of infection, therefore, antibiotic prophylaxis for dental procedures is not necessary in clients who have undergone this surgery. As well, antibiotic prophylaxis prior to dental procedures is not recommended for clients with coronary artery stents (Class III, LOE C). However, endocarditis in a client with a heart transplant is associated with a high risk of adverse outcome,²⁴ so antibiotic prophylaxis is recommended for clients who develop valvular dysfunction after transplantation.

CONCLUSIONS

The Committees concluded major changes in the updated guidelines that include the following: (1) only an extremely small number of cases of IE might be prevented by antibiotic prophylaxis prior to dental procedures even if such prophylactic therapy were 100-percent effective; (2) IE prophylaxis for dental procedures should be recommended only for clients with underlying cardiac conditions associated with the highest risk of adverse outcome from IE; (3) when these underlying cardiac conditions are present, antibiotic prophylaxis is recommended for all dental procedures that involve manipulation of gingival tissue or the periapical region of

teeth or perforation of the oral mucosa; (4) prophylaxis is not recommended based solely on an increased lifetime risk of acquisition of IE; (5) bacteremia resulting from daily activities is much more likely to cause IE than bacteremia associated with a dental procedure; and (6) administration of antibiotics solely to prevent endocarditis is not recommended for clients who undergo genitourinary- or gastrointestinal-tract procedures. The Committees reaffirmed those procedures noted in the 1997 prophylaxis guidelines for which endocarditis prophylaxis is not recommended and extended this prohibition to other common procedures, including ear and body piercing,

The majority of infective endocarditis cases caused by oral microflora likely develop from routine daily activities, such as chewing, toothbrushing, flossing and using toothpicks.

tattooing, and vaginal delivery and hysterectomy. In former recommendations the AHA Committee used the term "bacterial endocarditis" because the antibiotic regimen only covered bacteria, not fungi or nonbacterial cardiac infections. For the first time, the 2007 guidelines terminology was changed to "infective endocarditis" as this is a currently accepted term for the condition.

DIFFERENCES FROM THE BRITISH ANTIMICROBIAL SOCIETY RECOMMENDATIONS

The AHA and BAS regimens are very similar. The cardiac conditions recommended for prophylaxis are similar in both sets of guidelines, however the BAS does not include congenital cardiac conditions nor the heart-transplant client who develops valvular dysfunction. The AHA continues to recommend a two-gram single dose of amoxicillin, whereas the BAS now recommends a three-gram single dose. The AHA does not address multiple dental visits, while the BAS recommends a regimen when multiple dental visits are needed. The AHA does recommend spacing dental appointments 10 days apart to avoid antibiotic resistance and to select an antibiotic from another class when the client is currently taking an antibiotic in the regimen. The AHA does not include a pre-procedure antiseptic mouthrinse in their new guidelines, whereas the BAS recommends this practice. Both sets of guidelines stress the importance of oral health and that clients with cardiac disease should be educated to maintain periodontal and dental health to reduce the risk of IE.

SUMMARY

In the past, it was assumed that taking an antibiotic prior to dental procedures would reduce the formation of a bacteremia and reduce the risk for IE, however no evidence-based studies have verified this assumption. The collective published evidence suggests that antibiotic prophylaxis, if it is effective, would reduce the condition in only a very few cases. The majority of IE cases caused by

oral microflora likely develop from routine daily activities, such as chewing, toothbrushing, flossing and using toothpicks. Dental and periodontal disease may increase the risk of bacteremia and maintaining good oral health is felt to be important to reduce IE. The AHA Committee recognizes a shift is needed away from antibiotic prophylaxis and toward a greater emphasis on improved access to dental care in order to eliminate oral infection and on maintaining good periodontal health in individuals with underlying cardiac conditions associated with the highest risk of IE.

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Transitions (continued from page 271)

We want to continue to have a better understanding of the Canadian dental hygiene community and based on the board's work with values we are designing a research study to do precisely that. The objective is to capture the values of a cross-section of dental hygienists to provide a baseline more profound than what we can gain from a superficial questionnaire. While the methodology of the study has yet to be defined, I would like to plant the thought in your mind and encourage you to participate in the project if you are asked. This exciting opportunity to better understand our community will enable us to bridge

a future that reflects the heart and soul of a profession in transition—the profession of dental hygiene in Canada. 

Cohen, D.V. (1993). Creating and maintaining ethical work climates: Anomie in the workplace and implications for managing change. *Business Ethics Quarterly*, 3(4). p.343-348.

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Transitions (suite de la page 271)

conscients, nous pouvons relever le défi d'un progrès bénéfique.

Nous voulons continuer à mieux comprendre le milieu canadien des hygiénistes dentaires, et préparons un travail de recherche à cette fin en nous appuyant sur les travaux accomplis par le conseil sur le plan des valeurs. Notre objectif est de s'adresser à un échantillon représentatif d'hygiénistes dentaires afin d'obtenir une analyse plus approfondie de leurs valeurs que ce que permettrait un simple questionnaire. Même si la méthodologie de la recherche n'a pas encore été arrêtée, je voulais vous faire part du projet et vous encourager à y participer si on vous

invite à le faire. Cette formidable occasion de mieux comprendre nos valeurs nous permettra de préparer un avenir conforme au cœur et à l'âme d'une profession en transition – la profession d'hygiéniste dentaire au Canada. 

Cohen, D.V. (1993). Creating and maintaining ethical work climates: Anomie in the workplace and implications for managing change. *Business Ethics Quarterly*, 3(4). p.343-348.

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DES HYGIÉNISTES DENTAIRES



Small Change, Big Difference

Bringing dental hygiene to Jamaica

By Leanne Rodine, RDH



Several 1000-watt smiles to light up the 1000 Smiles Project

WHEN YOU THINK OF JAMAICA, YOU PICTURE SANDY beaches, reggae music, warm weather and tropical fruit. The tropical island has all that and more. It is a beautiful country with a diverse landscape, delicious jerk-spiced food and wonderful people. It seems ideal, and in many ways it is. But certainly not when it comes to dental services. There is only *one* dentist for every 80,000 people. And even if everyone could get an appointment, the cost of the visit is often exorbitant compared to an average Jamaican's salary. As a result, many people do not go to the dentist unless they have a problem that causes unbearable pain.

This is why the 1000 Smiles Project provides free dental care to thousands of Jamaican families and health education to hundreds of school-aged children each year. The

project is a partnership between Great Shape! Inc., the International Smile Power Foundation, Sandals Resorts International and the Jamaican Ministry of Health. The first team of dental-care professionals arrived in November 2003. During the two-week visit to rural areas outside Negril, a resort town on the island's west coast, the 31-person volunteer team delivered dental treatment to more than 1,000 patients and preventive education to more than 1,200 school children. The visit was a huge success and the team has grown every year since, with many dentists, hygienists, assistants and other good Samaritans volunteering their time and resources. In 2006, 100 volunteers from four different countries provided dental services to more than 9,000 Jamaicans, making it the largest international humanitarian dental project.¹

I was lucky to be involved in the first visit in 2003 and have returned every year since. Not only has the project given me the opportunity to be the dental hygienist I want to be—helping people—I also have enjoyed many adventures and rich rewards.

For example, there I was one day working in a clinic set up at Askenish All-Age School, located in a picturesque area high on top a mountain and surrounded by lush forests on the northwestern tip of the island. I was using one of my favourite cures to clean the teeth of a pleasant lady. While focusing on doing my best, I was aware other patients were waiting to see me. Sounds familiar? But before you think this was a typical day in the life of a dental hygienist, read on...

As I concentrated on my scaling, a woman came running into the clinic waving a machete and yelling “Stop working! Stop working!” Now, I have steady hands thanks to my dental-hygiene training, but as I sat on my plastic tractor seat I must admit to feeling tremulous at this sight. My heart raced and I think I stopped breathing. As I took a hidden peek at the shouting, machete-swinging woman, I saw Dr. Shinn, the dentist, cautiously approaching her. And then I realized I had seen her earlier in the week.

There is only one dentist for every 80,000 people and the cost of a visit is often exorbitant compared to an average Jamaican’s salary.

The woman had come to the clinic to have her teeth cleaned, but I had to ask her to come back another day because there was a long lineup outside of people who had been waiting since early morning for their chance to be treated. It was going to be a challenge to finish before dark. I thought I had been kind in explaining why I could not clean the woman’s teeth right way but certainly would do it another day. Had I inadvertently driven her to sharpen her machete? Well maybe, but not in the way I first thought.

I watched Dr. Shinn kindly ask her what the reason was for all the fuss. She explained, “You must stop working. You all have been working too hard and I’ve brought some coconuts for you!” We had not upset her at all. Instead, she had been so impressed with our diligence and commitment that she had picked several large, fresh coconuts and wanted to slice them open so we could drink the sweet milk.

Dumbfounded, I remained frozen in place. Maybe her intentions were kind, but she was still holding the machete! Noticing me, she said, “You must stop working!”—emphasizing the urgency of her request with another swing of her machete. I dropped my instruments and forced my brain to make my legs move toward her. As I got closer, I heard a big whack and the coconut was



*Top: Puppet Frog in Opal’s hand captivated the class
Bottom: “We’re here to help”, is Leanne’s reassuring promise*

decapitated. Placing a straw in the fruit, she presented me with the gift of her labour while instructing “Here, drink!” Although I knew from a previous sampling that coconut milk is not my favourite, I did not dare refuse. Sure enough, it did not taste any better this time, but it was infinitely more fulfilling. The woman had hiked through the woods on a hot day to retrieve these coconuts for us. A day that was likely busy enough with work and looking after her family and her house. But she was so grateful for our contribution to her community that she wanted to do something in return.

Who knew the life of a dental hygienist could be so adventurous? I have since learned to expect the unexpected. One Friday afternoon, my friend Judy and I were standing in the school yard of Cave Valley All-Age School

in a rural district about 20 minutes from Negril. The sun was hot and our foreheads were glistening with sweat. Nursing tender throats and hoarse voices, we had arranged for some relief, or so we thought.

We were nearing the end of a wonderful week of visiting local schools to provide oral-health lessons in the classrooms. The students in their colourful uniforms were respectful, intelligent and full of hopes and dreams. But the classrooms were a challenge for us. Often, we faced 50 kids in a small, cement room with three students to each wooden desk. A thin blackboard served as a divider to the next class of many students. The teachers exercised their craft with passion and the students were eager to learn. Positive energy was all around. But with the exuberant interactions, the noise level was high. For the students to hear us, we had to speak much louder than we were accustomed to.

After a week, our throats and voices were feeling the strain and we thought why not give our last presentation outside? It was a beautiful day and we would stay in the shade. The teacher was in favour and suggested we set up in the school yard while she organized the students to join us. As we waited in the pleasant breeze, I caught movement in the corner of my eye. Not only were the students coming outside, but so were their desks! I am sure my mouth fell open in bewilderment. We had thought the

The 1000 Smiles Project provides free dental care to thousands of Jamaican families and health education to hundreds of school-aged children each year.

students would sit on the grass. Well sit they did! So there we were in the school yard—the wind blowing, the sun shining and cars driving by on the bumpy gravel road—practicing flossing with these wonderful students sitting at their desks.

Over the years, people have said it is generous of me to volunteer my time and spend my own money to travel so that I can be involved in this project. While I do not disagree it is a nice thing to do, I get so much in return. It has met new people and made new friends during these trips. When in Jamaica, we work hard but also have a lot of fun together—enjoying meals, entertainment, dancing, jumping in the ocean after work and visiting interesting places. Also, I have had a chance to see the island in a much different way than I would have as a tourist.



Students were delighted to receive goodie bags



Working in a foreign country, even if it is for a short time, gives you some insight into what life is like for local people.

Working in a foreign country, even if it is for a short time, gives you some insight into what life is like for local people. For example, in November 2005, I had the opportunity to visit Pell River Primary School where I met Opal, a passionate teacher. When we unpacked our lesson materials, Opal caught a glimpse of our puppets and her eyes began to sparkle. Seeing her reaction we asked if she wanted to try one. As soon as she slipped it on her hand, our frog with healthy teeth came to life and Opal's grade-three students were enthralled. It was clear she had a gift to motivate her students and instill a desire to learn in each of them.

Since that visit, Opal and I have kept in touch. During one telephone conversation in spring 2006, Opal voiced her concern for about 18 students who were not attending school, even though they were enrolled, because their families could not afford the school uniforms. She explained that uniforms are a requirement in Jamaican schools. And even when the school makes an exception for families who cannot afford the uniform, the children

A resounding vote of confidence for the 1000 Smiles Project

often still do not attend because they do not want to be different from their classmates. I wanted to help, but was not sure how until I spoke with Joseph Wright, Executive Director of Great Shape! Inc. and the person who first conceived of the 1000 Smiles Project. He encouraged me to find out the details of what was required and pledged support.

Why would 1000 Smiles, a dental project, be concerned about school uniforms, you might ask? Opal knew that a lack of education could be detrimental to the future of her students, their families and the larger community. And we knew that education is one of the broad of factors that determine population health. Studies in Canada show that people with low literacy skills "... are more likely to be unemployed and poor, to suffer poorer health, and to die earlier than Canadians with higher literacy levels."² It is for all these reasons that one of the United Nations' Millennium Development Goals is to make primary education universal by 2015.³

Finding uniforms for Opal's students fit perfectly in our mandate as health-care professionals. We discovered that it costs only about US\$10 for each child's school uniform. Imagine, for the amount we may pay for a nice lunch, a child in Jamaica could have a uniform and go to school for a year. During the next 1000 Smiles visit to Jamaica in



The class functions just as well outdoors, with blue skies, desks, bags, et al.

October 2006, the group of volunteers was informed of the need for uniforms and through their contributions we were able to collect enough money to put 50 children back in school by sponsoring them with a uniform. This covered the students at Opal's school plus we were able to make donations to other schools with students in similar situations.

I think Opal's big heart almost exploded when she heard the news. She was thrilled! And so were her students. Before the uniforms could be delivered, a few students eagerly came to see Opal with plastic bags in their hands. Puzzled, she inquired what the bags were for. They were to put the new uniforms in to keep them clean while the students carried them home. Along with the plastic bags, some students had also brought their toothbrushes. Puzzled again, Opal asked about the toothbrushes, which were tattered and worn. The students wanted to know if the people providing them with their uniforms were the same people who had given them these toothbrushes a year ago. Opal confirmed this and mentioned that the toothbrushes needed to be replaced. Given the likelihood their families could not afford new ones, we provided toothbrushes to go with the uniforms.

It was a couple of weeks before the students had uniforms to carry home in their plastic bags. The boys' uniforms were purchased from a store; the girls' uniforms were sewn by a local seamstress from purchased material.

Besides making it possible for these children to attend school, the donations for uniforms also helped local business owners.

Since then I have talked to Opal a few times. She reports that the students are all doing well and love attending school and working hard in class. They and their families are touched and thrilled—the uniforms truly are making a difference in their lives.

In many ways it was easy for us to coordinate the uniform project and make donations. But it is infinitely rewarding, and humbling, to realize that something so simple can provide these children with a world of possibilities. There is every hope that as these children learn, they will grow up to be healthy individuals, with healthy bodies *and* healthy mouths.

ENDNOTES

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Questions About Daily Risk

First steps in developing a risk management process

By Brian Gomes

PROFESSIONAL-LIABILITY MALPRACTICE CLAIM AGAINST a dental hygienist who is not adequately insured can be a financially devastating experience. Even a frivolous allegation can result in crippling defense costs that no individual should have to bear. The sponsored insurance program of the Canadian Dental Hygienists Association (CDHA) was established precisely to protect dental hygienists in such circumstances.

The comprehensive group-insurance program is a membership benefit designed to meet the needs of any dental hygienist, while providing innovative and flexible enhancements to protect individual day-to-day risk exposures. The program also provides value-added coverage options, such as clinical errors and omissions coverage, and an office-package policy for those CDHA members who operate an independent practice.

The two preceding articles in this four-part series on professional liability and insurance for dental hygienists discussed specific situations in which professional-liability coverage may or may not apply. This article focuses on the initial steps to build an effective risk-management process. Any dental hygienist can follow these steps to ensure they understand and strategically assess risk exposures in their daily practice.

In addition to traditional transferable risks, such as those covered by professional-liability insurance, it is important for a dental hygienist also to explore any methods that minimize other risk exposures. This is applicable to a dental hygienist who operates an independent practice or who works in a traditional dental office.

To start the risk-management process, you need to view your practice from an overall perspective, including future goals, and outline any potential day-to-day operational risks by asking and answering questions such as the following:

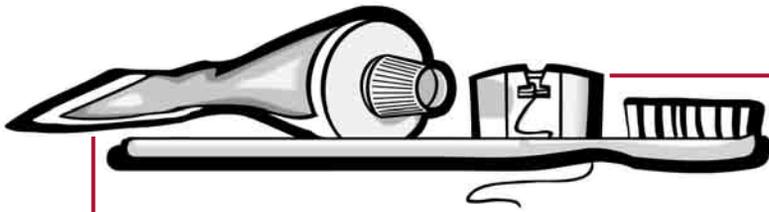
- What potential scenarios could have a negative impact on my reputation as a dental hygienist?
- What can I do to minimize or control these risks?
- What potential scenarios could have a negative impact to the brand or operation of my independent practice? What steps can I take to minimize or control these?
- Is all my work conducted within my regulatory guidelines and scope of practice?
- Am I following the best possible documentation standards, such as protecting client or proprietary information, and separating and duplicating valuable records?



These types of questions are not limited and should address any scenario a dental hygienist may face in their daily professional capacity. The idea is that by asking these types of questions, you will effectively identify day-to-day loss exposures, analyze them and apply a suitable risk-management technique.

A representative at Aon Reed Stenhouse Inc. is available at 1-800-267-9364 to answer any questions you may have about coverage extensions through CDHA's group-insurance program for members. This article is written for informational purposes only. Please reference your policy for coverage information or contact Aon Reed Stenhouse Inc.

Brian Gomes is an account executive at Aon Reed Stenhouse Inc.



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Rappel (suite de la page 267)

sions cruciales. À 30 ans, avec de très petits enfants à la maison, j'ai changé de parcours professionnel en m'inscrivant à l'université en hygiène dentaire. Huit ans après l'obtention de mon diplôme, j'ai abandonné une pratique clinique sûre et satisfaisante pour saisir une occasion unique dans le secteur de la promotion de la santé à l'Université du Manitoba afin d'élaborer des programmes communautaires pour des populations mal desservies. En hygiène dentaire, chaque occasion saisie en a créé d'autres pour moi, qu'il s'agisse de participer à d'importants projets de sensibilisation ou de jouer un rôle gratifiant dans l'enseignement, le mentorat, la recherche, les partenariats de collaboration avec d'autres professionnels de la santé ou de prodiguer des soins cliniques aux gens les plus vulnérables, comme les personnes âgées en perte d'autonomie vivant dans des centres de soins de longue durée. J'ai pris des empreintes pour des protège-dents sur des terrains de sport, prodigué des soins dentaires dans les forêts tropicales boliviennes et animé des semaines de promotion de la santé dentaire dans des régions éloignées du Canada.

Au fil des ans et pour chaque décision, je me suis sentie forte de l'appui de notre association nationale, tant sur le plan professionnel que personnel. Après avoir obtenu mon diplôme, j'ai orienté mon engagement dans l'ACHD

autrement : de simple membre, j'ai décidé de participer activement après avoir été personnellement invitée à assister à une rencontre de la Manitoba Dental Hygienists Association (MDHA). Cette invitation a tout déclenché.

J'ai eu le plaisir de servir ma profession aussi bien à l'échelle locale et provinciale, comme membre de l'actuel Transitional College of Dental Hygienists of Manitoba, dont la préoccupation centrale est l'autoréglementation, que nationale en tant qu'administratrice de l'ACHD depuis 2004 et, maintenant, à titre de nouvelle présidente. En côtoyant tant de gens passionnés, ma vie s'est enrichie et j'ai noué de grandes amitiés. J'ai aussi eu le privilège de voir notre profession évoluer et grandir. J'espère maintenant faire progresser notre vision d'avenir dans un esprit de collaboration afin de servir, de recevoir des services et d'apprendre.

Socialement responsables et très dynamiques, les hygiénistes dentaires cherchent passionnément à contribuer à la santé dentaire et globale des Canadiens. L'hygiéniste dentaire qui est membre de l'ACHD profite de nombreuses possibilités de combler ses attentes, de façonner son avenir et celui de sa profession, tout en ayant aussi du plaisir! Voilà pourquoi je vous invite à renouveler votre adhésion et à participer activement. Ne manquez pas cette chance! ✨

Re-member (continued from page 267)

community-based programming for underserved populations. Every opportunity in dental hygiene has created others for me, from extensive outreach work to a satisfying role in teaching, mentoring, research, collaborative partnerships with other health-care professionals and providing clinical care to some of our most vulnerable people—dependent, older adults living in long-term care. I've taken impressions for mouth guards on sports fields, delivered dental care in the rainforest of Bolivia and ran oral-health promotion weeks in remote communities in Canada.

Throughout the years and with every decision, I have felt empowered by the support from our national association, both professionally and personally. After I graduated, my commitment to CDHA through membership changed to active involvement after receiving a personal invitation to attend a meeting of the Manitoba Dental Hygienists Association (MDHA). This invitation got the ball rolling and rolled it far.

I've had the pleasure to serve my profession locally, as well as provincially as a member of the current Transitional College of Dental Hygienists of Manitoba that is focused on self-regulation, and nationally as a board member of CDHA since 2004 and now as your new President. In the course of working with all of you who share a passion in dental hygiene, my life has been enriched by countless amazing experiences and great friendships. And I have had the privilege to see our profession evolve and mature. Now, I optimistically look forward to advance our vision as we work together to serve, be served and learn.

Dental hygienists are socially conscious, highly driven individuals with a passion to make a difference in the oral and overall health of Canadians. A CDHA membership offers every dental hygienist the promise of many opportunities to be all they can be, shape their future along with that of our profession and have fun doing it. I invite you to re-member: renew your membership and get involved. Seize the moment! 

CDHA Board of Directors Meeting

October 19 through 21, 2007, Ottawa

DELEGATES REPRESENTED ALL THE PROVINCES, AND two leading organizations in dental hygiene. The two observers were Doris Lavoie from National Dental Hygiene Certification Board (NDHCB) and Marina Roberge, a military dental hygienist. Highlights of the meeting were:

Provincial /Organization Reports

Members of the board submitted a report of their province or organization.

ADHA

Representatives from CDHA had met with their colleagues of the American Dental Hygienists Association (ADHA) in October 2007 in Chicago. The members came back from this meeting loaded with valuable inputs and experiences to augment their practice systems. They found several areas of mutual interest.

International Symposium of Dental Hygiene

Over 700 dental hygienists attended the July 2007 symposium in Toronto. The board reviewed the success and strengths of this symposium.

Culture of Dental Hygiene

The board reviewed the culture and profile of dental hygiene based on data provided by CDHA members from various sources. CDHA wishes to further develop its knowledge in this area and will be conducting a research study. A committee was struck to develop the methodology of the study.

CDHA Representative to Commission on Dental Accreditation of Canada

Patricia Grant, of Dalhousie University, Halifax, was appointed as the CDHA representative to Commission on Dental Accreditation of Canada.

Evidence Based Decision Making

Bonnie Blank and Carol-Ann Yakiwchuk conducted a board education session on "Evidence-based decision making—making sense of the research." 



Carol-Ann Yakiwchuk,
President; Manitoba



Bonnie Blank,
Past President;
DHEC



Wanda Fedora,
President-Elect;
Nova Scotia



Arlynn Brodie;
British Columbia



Jacki Blatz;
Alberta



Maureen Bowerman;
Saskatchewan



Evie Jesin;
Ontario



Anna Maria Cuzzolini;
Quebec



Diane Thériault;
New Brunswick



Julie Linzel;
Prince Edward Island



Palmer Nelson;
Newfoundland
and Labrador



Marina Roberge;
Observer,
Military Dental
Hygienist

Plain-Language Communication

By CDHA staff

IN THE PREVIOUS COLUMN, WE DISCUSSED THE NEGATIVE influence of low literacy skills on the health of Canadians. Low literacy skills can affect health both directly and indirectly. While direct effects are more obvious, indirect consequences may be more profound. For example, while people with limited literacy skills may find it difficult to locate and access appropriate health-care providers, they are also more likely to suffer from low self-esteem, encounter high stress in daily living and face increased barriers to healthy practices, such as exercising and not smoking.

One of the persistent myths about low literacy is that “people will tell you if they can’t read.” The fact is that due to the social stigma attached to limited reading and writing skills, nearly all poor readers or non-readers will try to conceal this fact. Another myth is that years of schooling are a good measure of literacy level. In reality, studies show that, on average, adults read at a level three to five years lower than years of schooling completed.

PLAIN LANGUAGE

The term plain language was first used in the 1950s and, while there is no generally accepted definition, most experts in the field of communication agree on the following: Plain language assists people to find what they need, understand what they find and act appropriately on that understanding. Plain language is not about “dumbing down,” but has to do with clear and effective communication.

According to the U.S. Department of Health and Human Services, some key elements of plain language are to:

- Place most important behavioural or action points first
- Break complex information into easily managed components
- Use simple words and short sentences
- Remove unnecessary information
- Provide ample white space so pages are uncluttered and look easy to read.

VERBAL COMMUNICATION

Since health information exchanged between dental hygienists and their clients is frequently communicated verbally, speaking plainly is just as important as writing plainly. Many of the same techniques work with both written and verbal messages. These include avoiding jargon and using everyday, real-life examples to explain unfamiliar dental terms. To make what you say easy to remember consider using these techniques:

- Limit information to between three to five most important points
- Use common words and explanations
- Focus on your clients and not on the chart, x-ray or computer screen
- Maintain eye contact and open-arm postures
- Give your clients a chance to tell their stories and make realistic decisions
- Let your clients know what you are thinking
- Check that your message is understood
- Use written information and visuals as backup materials.

VISUAL COMMUNICATION

Confucius was correct when he said that a picture is worth a thousand words. Visuals assist all of us in understanding new information, but they are even more important for those with low literacy skills. Images have been shown to be more than 40% more persuasive than text or words alone.¹ People understand and remember more when they can see the information and details. Images can be used to show a step-by-step sequence—think of tooth brushing

and flossing, for example. Also, the brain has more access routes and storage capacity for pictures than for words.²

Visuals can be an effective way to communicate health messages to those with low literacy skills, but an understanding of the following points is important:

Skilled readers	Poor readers
Systematically scan the images to find the main concept	Eyes wander about the page and fail to find the central focus of the visual
Quickly identify principal features	Skip over principal features
Separate key points from details	May focus on minor detail
Easily interpret information to decipher meaning	Slow to interpret meanings and concepts and interpret words literally

When you plan your educational materials, keep the following guidelines in mind to simplify the steps and increase your success:

- Focus on the main point (usually this is a desired action on the part of the client)
- Reduce the amount of text by using pictures and diagrams to show procedural steps
- Leave lots of white space and use at least a 12-point, serif font
- Use visual clues and interaction. For example circle dates and highlight key points

The following screening list would be suitable for the following reasons: It is clearly stated that any symptoms require action, only four items are displayed and clients interact with the information.

Do You have Gum Disease?

Anyone can have gum disease and not know it.

Check to see if you have any of these:

- Red gums that bleed when you brush your teeth
- Gums pulled away from your teeth
- Bad breath
- Loose or sensitive teeth

If you checked any of these boxes, you may have gum disease. Talk to your dental hygienist.

(Source: Adapted from Maine Department of Health Services, Augusta, ME)

- Provide motivation by remembering that most people learn well when topics focus on their immediate needs and interests. Information is best presented in a familiar context. For example, compare a new action to a familiar task.

In summary, plain language is relative. Your message is in plain language when your audience understands it. 

1 (Pettersson, Rune. (1989): *Visuals for Information; Research and Practice*. Englewood Cliffs, NJ: Educational Technology Publications, p.73.

2 (Jonassen, DH (1982): *The Technology of Text: Principles for Structuring, Designing, and Displaying Text*. Englewood Cliffs, NJ: Educational Technology Publications, pp. 91-120



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THE CANADIAN DENTAL HYGIENISTS ASSOCIATION
 L'ASSOCIATION CANADIENNE DES HYGIÉNISTES DENTAIRES

Plain-Language Sites in Plain Sight

By CDHA staff

THE CONNECTION BETWEEN GOOD HEALTH CARE AND clear communications is vital. Health professionals can provide clients important health care information in ways that can overcome low literacy levels or other communication barriers to promote healthy living.

There are wealth of sites that focus on effective communication, and we have selected a few.

<http://www.pls.cpha.ca/english/directry.htm>

<http://www.pls.cpha.ca/english/direct/cover.htm>

The Canadian Public Health Association's (CPHA) Plain Language Service (PLS) published a Directory of Plain Language Health Information for North America. The purpose of the directory is to help Canadian health professionals locate excellent examples of plain language health information on a variety of subjects. It comprises 375 titles from 50 organizations. The introduction tells readers how and why the resources that are listed were chosen.

PLS also provides plain language and clear design assessments and revisions as well as focus testing and workshops for the public, private and voluntary sectors.

<http://www.centreforliteracy.qc.ca/health/briefs/no1/no1.pdf>

The Quebec Centre for Literacy, in association with the nursing department of McGill University, offers a series of briefs on evaluative research into alternate means of health communication such as plain language, visual images and interactive media which address "what can be changed about this material... so that the average person can read more easily".

http://ohpe.ca/index.php?Itemid=61&id=24&option=com_content&task=view

This Ontario Health Promotion E-Bulletin on clear language published by Ontario Prevention Clearinghouse and The Health Communication Unit provides a number of resources to make health messages and public materials more than just readable. Users can also contact this department for support or training in making your written messages optimally effective.

<http://www.health.gov/communication/literacy/plainlanguage/IssueBrief.pdf>

The office of Disease Prevention and Health Promotion has a brief discussing the "mismatch" between the health information people receive and what they actually understand. This paper explores why even an individual with high literacy levels may have difficulty in understanding information when involved in a stressful situation.



<http://www.plainlanguage.gov/index.cfm>

Hosted by the Federal Aviation Administration and sponsored by the Web Content Management Working Group of the Interagency Committee on Government Information, it defines plain language (also called plain English) as communication your audience can understand the first time they read or hear it. It discusses a number of writing techniques that can help you achieve this goal. Among the most common of these are: logical organization, active voice, short sentences and everyday words.

<http://www.mb.literacy.ca/Webography.htm>

The Health Literacy Resource Center of the Literacy Partners of Manitoba is a "central resource for health literacy information and training and a one-stop-shop for Web-based health literacy resources." The information is provided for literacy practitioners, health care professionals, adult literacy and ESL students, and anyone who seeks a clear understanding of health information.

http://www.hrsdc.gc.ca/en/gateways/nav/top_nav/program/nls.shtml

The National Literacy Secretariat of Canada works to promote literacy as an essential component of a learning society and to make Canada's social, economic and political life more accessible to people with weak literacy skills. The secretariat focuses on three main areas: increasing Canada's knowledge-base on literacy and essential skills, developing effective training tools, and ensuring both knowledge and tools are shared among stakeholders, partners, and the Canadian public.

<http://www.plainlanguagenetwork.org/conferences/2002/postings/resource/resourcs.htm>

The fourth biennial conference proceedings of the Plain Language Association International (PLAIN) include an extensive list of resources on health-related topics submitted by conference speakers and PLAIN members before the conference.

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