cal dental fees. Because only a few dentists will accept such low fees, and because disabled Canadians are more likely than most Canadians to be poor and unable to pay the remainder of a typical fee, disabled adults often have difficulty finding a dentist. As a result, many people with disabilities have lost teeth that could have been saved with easier and earlier access to treatment.

The Canadian Institute for Health Information reported in 2013 that Canada performed "poorly" relative to the 34 countries that make up the Organisation for Economic Co-operation and Development in ensuring equitable access to dental care.[2]

Provincial dental colleges often pass regulations that benefit dentists rather than society, despite laws that require them to regulate in the public interest. These colleges allowed dentists to administer cosmetic botulinum toxin treatments, but they've done nothing to ensure equitable access to dentistry.

Dental education also suffers from bad regulation. The Canadian Dental Association, which represents dentists' interests, also administers faculty accreditation requirements and does not require these faculties to teach students to treat adults with special needs. Similarly, Canadian dental regulators don't recognize a special-needs specialization, unlike Australia, New Zealand and various European countries.

We don't have to add dental treatment to medicare to make dentistry more accessible. The provinces can regulate dental fees and access. Germany is an example of a country that successfully combines private dental insurance with government regulation over fees and access.

According to an article from *The Canadian Press*, medicare is the number one accomplishment that makes us "most proud to be a Canadian."[3] Our governments must work to put equitable dental care at the top of the next such survey.

Joan L. Rush LLB LLM
Retired lawyer, Vancouver, BC

Competing interests: Joan Rush's report, *Help! Teeth Hurt: Government's Obligation to Provide Timely Access for Dental Treatment to B.C. Adults Who Have Developmental Disabilities: A Legal Analysis*, was funded by a grant from the Law Foundation of BC.

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Oral health and prevention and screening for HPV

Oral health is critical to overall good health and it also serves as a surrogate marker in critical disease. We commend Kelsall and O'Keefe[1] for highlighting the need to eliminate barriers to dental care for some of our most vulnerable patients.

Oropharyngeal cancers are among the most commonly occurring malignancies in Canada. Human papillomavirus (HPV) is the causative factor in 80% oropharyngeal cancers, and it is estimated that, in the United States, these cancers will overtake uterine HPV cancers in the next 15 years;[2] noncervical cancers are dramatically on the rise in Canada as well.[3]

The development of HPV vaccine has changed the face of gynecologic oncology, but an important emerging area is the role of immunization in HPV-related oral malignancies, and research is underway.

It is a common misconception that HPV vaccine is only effective in those who have not yet been exposed to the disease, however there is evidence that patients treated for HPV malignancy benefit from recurrence from other HPV strains with immunization.[4]

Understanding of HPV malignancies is growing. In one study, patients with oropharyngeal squamous-cell carcinoma had a 25-fold increased risk of cervical cancer.[5] Referral and screening across the spectrum is critical.

Patients with HPV disease and malignancy provide an opportunity for interdisciplinary collaboration for those working in primary and secondary prevention, including immunization, oncology, oral health and gynecology.

Research is required to explore the role of immunization against HPV-related diseases, particularly in the senior population. We must collaborate with our dental health colleagues to promote awareness and prevention.

Pamela Liao MD, Vivien Brown MDCM
Family and Community Medicine,
University of Toronto, Toronto, Ont.

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Young's postulate

Young's postulate,[1] which says that that the last doctor to see a patient is also the smartest doctor, rings true.

I know of a situation where a hospital doc found metatarsal fractures in a patient three months after an injury. The fractures were missed because of overlying cellulitis, a sufficient cause for pain, erythema and swelling in a patient with uncontrolled diabetes.

Now, in keeping with Young's postulate, that hospital doc is the smartest doc and has reportedly said to the patient that the rural doctor, the hospital that treated her as an inpatient, and her own family doc (who followed the resolving cellulitis when she returned home), all missed the fractures and shouldn't have. Maybe. Or maybe this is an example of Young's postulate at work. But I have to ask myself — have I spoken this way about other physicians? Do we all do it?

Nancy Craig MD
Family physician, Edmonton, Alta.

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