MDA Bulletin

Summer 2025 Volume 45, Issue 2 ISSN 0707-1717

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[1] Catherine Harris, Best seg funds of 2024 leaned on Magnificent 7, March 13, 2025, Investment Executive. Past performance is not indicative of future results.
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03/25

Manitoba Dental Association

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ON THE COVER:
Tooth Fairy Saturday 2025

President's Message

Dr. Jeff Hein
President, MDA

The snow has moved on and as we look forward to warm summer days, I'd like to brief you on a busy winter at the Manitoba Dental Association (MDA).

April saw yet another very successful MDA Annual Convention. Special thanks to the tireless work of the Annual Convention Committee, the MDA staff and volunteers for staging a wonderful event. On opening day immediately prior to our Keynote Speaker, I was proud to be the first MDA President to deliver a land acknowledgement on behalf of the MDA – our Truth and Reconciliation Committee's work is beginning to take shape. The committee's important work will continue in an effort to create pathways to improve the delivery of safe, culturally appropriate oral healthcare for First Nations, Metis and Inuit peoples of Manitoba.

I want to congratulate Manitoba's own Dr. Joel Antel on the completion of his term as Canadian Dental Association (CDA) president at the beginning of May. As past president of the MDA, CDA representative to the MDA Board, and with his extensive experience in organized dentistry, Joel spent his year advocating for oral health and dentistry on the national stage. The job of CDA President is a taxing one, and Dr. Antel managed to keep 'dentists first' in his agenda – well done, Dr. Antel!

Also on the national front, I'd like to extend a word of congratulations to the four Manitobans who were recipients of CDA Awards in 2025.

Mr. Brian Fawkes, who passed suddenly in 2024, was a posthumous recipient of the **CDA Special Friend of Dentistry Award**. Recipients of this award may be dentists or non-dentists who are engaged in serving or supporting the dental profession. Mr. Fawkes' tireless work promoting dentistry and the improvement of Manitobans' oral health was inspirational, and his award was well deserved.

Receiving the **CDA Award of Merit** was recent MDA Past President **Dr. Thomas Colina**. The Award of Merit recognizes an individual who has served in an outstanding capacity in the governing or service of the Canadian Dental Association over a sustained period of time, or who has made similar outstanding contributions to the dental profession, the dental community or the oral health of Canadians and/or society at large. Dr. Colina's commitment to volunteer work both in Manitoba and internationally, amongst many other achievements, merited this prestigious honour.

The **Honoured Member Award** is given to an individual who has made an outstanding contribution to the dental profession, the dental community or the oral health of Canadians over a sustained period of time. The breadth and scope of achievement is a significant factor in determining this award. Manitoba's **Dr. Amarjit Rihal** was one of two recipients of the **CDA Honoured Member Awards** nationwide. Dr. Rihals' extensive involvement in organized dentistry at the national level has been instrumental in making key improvements to organizations within the CDA.

The **Medal of Honour** is the highest award conferred by the CDA. It is given to a dentist in recognition of a lifetime of outstanding service and professional achievement to the benefit of the dental profession. This award is very distinct in that, due to its very special nature, it is not necessarily conferred every year. In 2025, this award was bestowed upon **Dr. Phil Poon** for his lifetime of contributions to the profession of dentistry in Canada – contributions that forwarded our profession throughout his work and advocacy, especially with regards to great improvements made to the Non-Insured Health Benefits Program.

During the awards luncheon, many attendees were heard to say, "Is this Manitoba day?". We should all be proud of the exceptional Manitobans chosen to receive these national awards – thank you for your dedication to our profession!

Following the election of a new Federal Government on April 28th, a new cohort of Canadians (those aged 55-64 years) became eligible for the Canadian Dental Care Plan (CDCP) on May 1st.

While it may take some months for these newest CDCP-eligible Canadians to receive confirmation of their benefits (and their CDCP cards), it should be expected that ever more Canadians will be seeking dental care. Given that the remaining Canadians (18 to 54-year-olds) will, in stages, become eligible throughout May - the demand for dental services may increase significantly. During the CDA Dental Leaders Forum Meeting held in Toronto on May 1st, there was much strategizing about an advocacy campaign with the Federal Government to try to;

- Slow the expansion of the CDCP for these next patient cohorts, and;
- Advocate for the protection of 3rd party insurances while continuing to advocate for plan changes that will help ensure the long-term financial sustainability of the CDCP.

Until the new government installs its cabinet, this advocacy will happen with existing government staff. Because the previous Health Minister chose not to stand for re-election, and the existing Health Minister lost her seat, the CDA and the Provincial and Territorial Dental Associations (PTDAs) will have a fresh start advocating with a new Minister, once appointed. Our work will continue.

For those Manitoba dentists who do provide treatment to CDCP patients, remember that coverage for existing CDCP patients will lapse on June 30th if they have not applied to renew their coverage – a yearly requirement. A reminder to your patients to renew their coverage could help avoid preventable financial strain on your CDCP patients (and your practice).

Within Manitoba, the Provincial Government has identified the MDA as the next health profession to begin the process of conversion to fall under the Regulated Health Professions Act. What this means for the MDA is the eventual split of our Association (and its membership services functions) and the Regulator or College (and its regulatory functions). This is a mandated change for all of the 31 health professions in Manitoba. This is a long and involved process that will likely take some years to complete.

Work is ongoing to negotiate a new EIA agreement with the province. A very thorough 'business case' has been prepared for the Provincial Government demonstrating the cost savings they can expect from being second payor to the CDCP program. A meeting is set for late May, and we are hopeful a long-overdue renewed deal can be reached.

As spring has arrived, and the prairies are blossoming back to life, the MDA Board, the MDA staff and volunteers continue to do the work of our association. As always, I encourage you to reach out to me with your questions at my personal and confidential email president@manitobadentist.ca.

Enjoy your summer!

MDAA President's Report

Heather Brownlee
President, RDA MDAA

Wow! Where has the year gone? I can't believe summer is right around the corner. As we approach the summer months, things tend to slow down a bit as we all enjoy the long, hot days that Manitoba is always blessed with.

This year, the Manitoba Dental Assistants Association (MDAA) office will be on reduced hours from June to September, as our Executive Director, Tess Peter, is welcoming a new member to her family. Emails and voicemails will continue to be monitored during this time, but please allow up to 72 hours for a response. The best way to reach us during this time will be via email at mdaa@mdaa.ca.

MDAA has had a very busy spring! In March, the Board participated in a Strategic Planning session with Volunteer Manitoba. We identified three specific areas that we will be focusing on. We hope to roll out the plan this fall.

We held our Annual General Meeting (AGM) on the Thursday evening of the Manitoba Dental Association (MDA) Annual Convention on April 12, 2025. It was delivered in a hybrid format, both in-person and virtual. Overall, we felt it was a great success and plan to offer the same format again next year, with some upgraded technology to offer a smoother experience for our virtual participants.

At the convention this year, the MDAA hosted our very own lounge for Registered Dental Assisants (RDAs) to relax and enjoy a beautiful candy bar, along with coffee and tea. We loved the opportunity to connect with so many of our members and hear their ideas on how to strengthen our association, along with the challenges they face in their day-to-day work lives.

On Saturday night at the President's Gala, we were proud to present Jaida Johnson with the Dental Assistant of the Year award, as voted by her peers. She received a certificate of achievement and a gift card to a local spa.

Tess and I have also presented to both the winter and spring graduating classes at CDI College, sharing insights into the work of the MDAA and Canadian Dental Assistants Association. We'll also be participating in the Red River College Polytech graduation later this May.

MDAA is always working to communicate to our members that we are here to advocate for you. Please also remember that we have a representative, elected by you, on the MDA Board. Trina Bourgeois is that representative. She is a strong voice for RDAs in Manitoba and welcomes any suggestions on how we can strengthen our relationship with the MDA. Please don't hesitate to contact the MDAA office if you'd like to share your thoughts with us, and Trina.

In closing, I hope everyone has a beautiful summer. We look forward to seeing you all in the fall at our CE event, planned for October 18, 2025. Save the date and watch for more information coming soon!

MDAA President Heather Brownlee *(right)* presents the MDAA Dental Assistant of the Year to Jaida Johnson *(left),* as voted by her peers, at the MDA President's Gala 2025.

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Registrar's Message

Safeguarding Personal Health Information: Meeting Our Legal and Ethical Obligations

Dr. Arun Misra
Registrar, MDA

As Manitoba dental professionals, we are not only clinical care providers—you are also trustees under The Personal Health Information Act (PHIA). That designation brings rigorous duties around the handling of personal health information (PHI). Since PHIA's initial proclamation in 1997, and particularly following the amendments that came into effect January 1, 2022, trustees have been required to implement enhanced technical, administrative, and physical safeguards, provide timely breach notifications, and ensure protections for whistleblowers who report PHIA violations.

1. Collection, Use and Disclosure: Stick to "minimum necessary"

PHIA mandates that collection, use, and disclosure of PHI be restricted strictly to what is necessary to fulfill care-related purposes. In practice, this means applying the "minimum need to know" rule: only gather essential data, and obtain informed, purposeful consent for any use or disclosure beyond direct patient care.

2. Consent: Context matters

Consent must be meaningful, informed, and appropriately documented. If your clinic relies on verbal consent, it must be clearly recorded in the patient record. For written or electronic consents—such as those related to third-party communication, research, or marketing—the forms must be explicit about scope, duration, and the patient's right to revoke consent at any time.

3. Security & Breach Handling: It's not "if" — it's "when"

PHIA requires all trustees to maintain robust safeguards. These include: role-based access controls within your practice management software, encryption of all PHI shared electronically, secure disposal of physical and electronic records, regular privacy training, and audit logs. Under the 2022 amendments, if a breach of PHI is likely to cause significant harm or embarrassment, both the affected individual and the Manitoba Ombudsman must be notified. A breach response plan should already be in place in every clinic, incorporating identification, containment, risk evaluation, patient notification, and corrective measures.

4. Access & Corrections: Honouring patient rights

Patients have a right under PHIA to access and request corrections to their health records. Clinics must respond to access requests within prescribed timeframes and have clear procedures to manage correction requests and disagreements. If a correction is refused, the patient is entitled to append a statement of disagreement to the record, and any other parties who received the original information must be notified.

5. Trusteeship & Third Parties: Contracts matter

Where PHI is shared with external providers—such as IT vendors, billing services, or cloud storage companies—written information manager agreements are required under PHIA. These must ensure compliance with all legal safeguards, clarify roles and responsibilities, and establish breach reporting expectations. Remember, the trustee remains legally accountable even when work is outsourced.

6. Oversight & Accountability: The Ombudsman's role

The Manitoba Ombudsman has statutory authority to conduct privacy audits, compel the production of documents, and make binding recommendations. Trustees should anticipate compliance reviews and be prepared with thorough documentation of clinic privacy policies, breach history, staff training records, and vendor agreements. Equally important is the cultivation of a culture where staff are encouraged—and feel safe—to identify privacy risks or report concerns, consistent with the whistleblower protections embedded in PHIA.

A Practical Path Forward

To align with both legal obligations and best practices, all dental clinics should take time each year to comprehensively review and update their privacy policies, consent forms, and breach response protocols. Annual staff privacy training should be a routine part of your practice. Access to patient records should be routinely audited, and one staff member should be clearly designated a s the clinic's privacy officer. Regular team discussions about privacy risks and the importance of compliance can further reinforce a proactive and respectful culture of data stewardship.

Conclusion

Trust in the dental profession depends on more than clinical skill—it requires each of us to act as stewards of our patients' most sensitive information. The regulatory framework under PHIA has grown more sophisticated, and our professional obligations must grow alongside it. I encourage every member to take this opportunity to evaluate your privacy practices and ensure they reflect not only compliance—but also a genuine respect for patient dignity and trust.

Summary of MDA Inquiry Panel Decision

Summary of outcome

Dentist pleaded guilty before an Inquiry Panel of the Peer Review Committee to breaching the Code of Ethics of the Manitoba Dental Association ("MDA"), and of being guilty of professional misconduct and conduct unbecoming of a member. The Panel accepted a joint recommendation on penalty submitted on behalf of both the MDA and the member, which penalty included: (a) a reprimand; (b) the reasons for the decision of the Inquiry Panel would be published and made available to the public; (c) the member would not be eligible to seek registration with the MDA for a period of 6 months following the date of the decision; and (d) the member was ordered to pay to the MDA costs of the investigation and hearing in the amount of $30,000.

Facts

On April 21, 2025, the Inquiry Panel of the Peer Review Committee of the Manitoba Dental Association (the "Panel") held a hearing into the charges against Dr. Gary Levine, a former member of the Manitoba Dental Association (the "MDA").

Pursuant to a Notice of Hearing, later amended with the consent of Dr. Levine (the "Amended Notice of Hearing"), Dr. Levine was charged with offences contravening the Code of Ethics of the MDA, and that he was guilty of professional misconduct and conduct unbecoming of the member. The Amended Notice of Hearing alleged that Dr. Levine:

a) crossed and/or violated professional boundaries by pursuing and engaging in a personal and/or sexual relationship with a patient;
b) took advantage of the patient's personal situation in furtherance of the personal and sexual relationship by suspending/waiving fee payments from the patient for dental services provided to her and her family; and
c) his conduct constituted sexual harassment of the patient.

The facts relating to the conduct at issue are summarized as follows:

The MDA received a complaint against Dr. Levine from a former patient, alleging that he had been involved in an inappropriate sexual relationship with her. The patient met Dr. Levine in 2005 when taking her son to him for dental correction. Learning that she was a single mother, he proposed a payment plan wherein she and her two sons could get braces. She became a regular patient of Dr. Levine's for five years. She also received some additional dental services from him in subsequent years.

Shortly after the patient's first appointment, Dr. Levine began engaging in flirtatious behaviour with the patient, which progressed to sexual encounters and intercourse between Dr. Levine and the patient, both at Dr. Levine's home and at his clinic. After their sexual relationship started, Dr. Levine stopped charging the patient fees for dental services.

Dr. Levine retired from the practice of dentistry on April 1, 2024.

Dr. Levine pleaded guilty to and admitted to the facts surrounding the allegations in the Amended Notice of Hearing.

The Panel found that Dr. Levine's conduct was clearly and demonstrably in breach of the Code of Ethics when he:

a) Violated professional boundaries by pursuing and engaging in sexual relations with the patient;
b) Sexually harassed the patient; and
c) Waived fee payments for dental services from the patient during the course of their sexual relationship.

A mitigating factor for the Panel was that Dr. Levine had no disciplinary history with the MDA. Dr. Levine also demonstrated cooperation with the MDA process. He pleaded guilty to and admitted the facts surrounding the allegations, and in doing so confirmed that his conduct constituted professional misconduct and conduct unbecoming of a member of the MDA.

An aggravating factor was that Dr. Levine's boundary violations continued for an extended period of time and involved a financially vulnerable patient. Carrying on a sexual relationship at the clinic and the subsequent waiver of fees was deemed entirely unacceptable.

The parties submitted a Joint Recommendation with respect to penalty.

Decision of the Panel

Following the hearing, the Panel concluded that the conduct of Dr. Levine supported the charges put forward in the Amended Notice of Hearing. The panel found that the Joint Recommendation appropriately addressed and protected the public interest, preserved the confidence of the public in the regulator's ability to govern the profession, provided for the necessary levels of both specific and general deterrence, and imposed sanctions that were consistent with those imposed on healthcare professionals in other similar cases.

Penalty

In accepting the Joint Recommendation, the Panel ordered the following penalty against Dr. Levine:

a) A reprimand;
b) The Panel's Order and Reasons for Decision be published and made available to the public;
c) Dr. Levine will not be eligible to seek registration with the MDA for a period of six (6) months following the date of the Reasons for Decision and that, in the event that he seeks registration with the MDA after the six-month period, he will be subject to the following conditions, which are to be reviewed with the Registrar of the MDA:
    i. a chaperone will be present for any interaction involving a female patient; and
    ii. as directed by the Registrar, Dr. Levine will be required to complete an educational course on maintaining professional boundaries with patients, with the costs of the course to be borne by Dr. Levine; and
d) Dr. Levine will pay costs to the MDA for the investigation and hearing of $30,000 payable within 60 days.

College Corner

Dr. Anastasia Kelekis-Cholakis

Dean, Dr. Gerald Niznick College of Dentistry,
Rady Faculty of Health Sciences, University of Manitoba

Early summer is always a particularly busy time at the Dr. Gerald Niznick College of Dentistry. In May, we were happy to celebrate the accomplishments of the dental hygiene, dental and IDDP classes of 2025 and see them walk across the stage with their diplomas and degrees in hand. In a room fully packed with family members, friends, faculty and staff, the next generation of oral healthcare providers were introduced to all in attendance. The same morning the MDA hosted a wonderful breakfast welcoming the dental hygiene and dental graduates to the profession. The sense of community, based on the long-standing collaboration between the profession and the college, was palpable in the room.

It is with that thought in mind that I wish to share with you some particular challenges affecting the Dr. Gerald Niznick College of Dentistry and many other dental schools across the country. I believe we are currently at an inflection point for Canadian dental education and as a community, we must turn our thoughts towards advocacy.

The launch of the Canadian Dental Care Plan (CDCP) has been a valuable initiative increasing access to care for many Canadians in need. It has, however, created some unintended consequences for teaching institutions.
In Manitoba, this has been felt quite acutely when it comes to patient care in our undergraduate clinics. Most of our college patients are CDCP registered or CDCP eligible and more than 80% are seniors, over the age of 65.

The launch of CDCP for this cohort took place in May 2024 and on November 1, 2025, the College of Dentistry submitted 106 predeterminations for treatment. These represented a significant portion of our students' clinical requirements. Between January and March 2025, we received 20 positive responses while 86 were either denied or pending. Canadian dental schools' approval ratings of predeterminations ranged between 0-40% while the average percentage of positive predeterminations for all 10 dental schools was approximately 25%.

These low predetermination approval ratings, coupled with delayed responses, forced our college to delve into patient care funds, donated by many of you, as well as operational budgets to support free care for our patients. This was necessary to ensure our students completed their clinical experiences by the required term deadlines for graduation and progression in the program.

The challenges we were faced this academic year were threefold:

1. The inability of our college to submit electronic forms and upload patient records to Sunlife due to software incompatibility. This resulted in having to send paper forms back and forth to have treatments approved which exacerbated delays in responses. We are investigating solutions to this issue, but it is complex.
2. The delays in approvals, the low approval ratings and an apparent lack of consideration that the academic year for senior dental learners is nine months and thus requires expediency in operations.
3. The added time and cost for administering this plan as the vast majority of our patients are now CDCP eligible/registered.

While similar to last year, short term solutions for the upcoming academic year could be implemented, we need to think about long term sustainability.

We, as a community, need to advocate for our dental schools. The University of Manitoba provides oral healthcare services to over 3,000 patients yearly while training 70-80% of the Manitoba dental hygiene and dental workforce.

We have had discussions in the past with the Federal Minister of Health representatives and have proposed the following solutions:

Establish a dedicated pathway for dental school predeterminations due to the time constraints to deliver care in our educational facilities.

Subsidize teaching dental clinics similar to other facilities such as hospitals or community clinics that train learners in medicine, pharmacy, nursing and rehabilitative sciences. These subsidies would support patients in need, that come to our teaching clinics to receive "free care" either through the CDCP or through a federal/ provincial endowment. This will ensure that future oral healthcare providers in the province will receive adequate training experiences.

In closing, it is important to reinforce that as a dental college and publicly funded post-secondary institution, we wish to engage with our province's and country's eligible patients. However, in order to maintain a quality education for our students and safeguard the training standards for our profession, it is vital for the dental community to advocate and communicate broadly at the federal and provincial levels for support of our Canadian dental school clinics.

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Conversation on Codes Scaling 2025

Dr. Alex Pappas
Chair, Economics Committee, MDA

Frequently the Manitoba Dental Association (MDA) receives calls and emails from both the public and practitioners inquiring about codes and how procedures should be billed. To assist members and their staff, the Economics Committee is providing articles focusing on common questions related to specific codes. In this Bulletin, we will provide a refresh on the most commonly asked questions pertaining to hygiene treatment time.

There are a number of codes that are unit-based but scaling and root planing are among the most frequently billed. Most often these codes are billed in conjunction with a fee-for-service procedure such as exams, radiographs, fluoride and polishing, which can create confusion.

In the pre-amble of the MDA Fee Guide the definition of a unit of scaling is describe as the following:

- Units of time referenced in the USC&LS are periods of 15 minutes or less. For services where half units of time are coded, a half unit of time is a period of 71/2 minutes or less
- For services coded in terms of "units of times", the time spent on the provision of a service begins when the practitioner begins preparing himself/herself and the patient for its delivery and ends either when another service is initiated or when the patient is discharged from the operatory.
- Treatment time does not include the time spent setting up or breaking down the operatory nor does it include the time spent on administrative tasks such as billing and scheduling the next appointment.
- Total time units do NOT equal time on tooth with an instrument as services directly related to the provision of the main service are included.
- A unit of time, either half or full as appropriate, is added to the total number of units used as soon as the delivery of the service extends into the next unit of time. For example, a service where a code for half-units of time is not available that takes between 1 and 15 minutes to deliver should be recorded as one unit of time. One that takes between 16 and 30 minutes as two units of time.
- Services for which a code representing a half-unit of time is available should be recorded as the number of full units used plus one half-unit if the overage is up to 71/2 minutes or the number of full units used if the overage is more than 71/2 minutes. For example, if a service, for which for which a code representing a half-unit of time is available, took 17 minutes to deliver, it should be coded as one full unit and one half-unit. If the same service took 24minutes, it would be coded as two full units.

What can be included in the unit of time outside of the actual scaling/rootplaning?

- After a patient is seated, reviewing the chart to prepare oneself for the procedure
- Administering a local anesthetic (when required)
- Performing the procedure, and providing post-operative instructions to the patient (when required)
- Also included is the time spent probing and recording periodontal pocket depths as well as recording hygiene treatment notes in the patient's chart.

Note: We can infer from the above definition that scaling billing time includes, but is not limited to just "instrument on tooth time."

> The most important criteria for the identification of which code to use for the representation of a service is **factual accuracy**.

What cannot be included in the unit of time?

- The breakdown, disinfection and set up of the operatory
- The time to take radiographs (if done in the hygiene chair)
- The time the dentist takes to perform an exam (including any idle time while the hygienist is waiting for the dentist, when not performing any procedure or procedure related activity),
- Any remaining appointment time after the patient has been discharged
- The time for administrative functions such as billing and reappointing the patient.
- Time spent measuring and recording oral/dental findings, other than specific hygiene findings such as pocket depths, calculus and plaque levels, would NOT be included in the hygiene treatment time, as they are considered part of the dentist's examination and diagnosis time whether the dentist performs the examination and diagnosis during the hygiene appointment or at a subsequent appointment.

How are the fees to be billed to the patient determined?

The MDA Fee Guide is intended to serve only as a guide to enable development of a structure of fees which are fair and reasonable to both the patient and the dentist providing care. No dentist is under any obligation to accept the fees as identified in the fee guide.

The most important criteria for the identification of which code to use for the representation of a service is factual accuracy. Any misalignment between the service provided and the fully specified descriptor of a code means that the code cannot be used. In cases where more than one code descriptor that accurately matches a service can be identified, the one that provides the best match must be used. In the case of per-unit-of-time procedures such as scaling and root planing, the code used must reflect the amount of time spent providing the service.

Conversation on Codes is provided by the MDA Economics Committee.

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Mentors

Hoda Hosseini, DMD, MDent (Perio), FRCD(C)
Marshall Hoffer, DMD, Prosthodontist

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Registration

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CDA Report

Dr. Marc Mollot
CDA Board Representative

Hello all. Spring marks a special time of year as we look forward to a return to more enjoyment of the great outdoors. We all get to take time to explore our great country for all it has to offer!

Graduation of the Class of 2025

On May 15, I had the distinct pleasure of attending the MDA sponsored Graduation Breakfast held at The Met. Dental and Dental Hygiene students were celebrated as they finished their formal studies at the Dr. Gerald Niznick College of Dentistry. Later that day graduates attended their formal convocation and were officially launched into our wonderful professions. Congratulations to all!

HIGHLIGHTS OF THE CDA AGM – APRIL 2024

The Canadian Dental Association (CDA) recently held its Annual General Meeting (AGM) and related meetings in person from April 30 to May 3, 2025 in Toronto, Ontario. In addition to discussing business matters, the meetings and events served as an opportunity to celebrate the achievements of the profession, recognize CDA's outgoing President, Dr. Joel Antel from Winnipeg, MB, and welcome CDA's incoming President, Dr. Bruce Ward from North Vancouver, BC.

CDA Board of Directors Annual Report by the President

Dr. Joel Antel shared with the assembly select highlights from the past year. In the 2024–25 year, the CDA made notable strides in advancing its core strategic priorities of being a Trusted Voice, enhancing Member Support, and strengthening the Dental Profession. A significant focus was placed on advocacy surrounding the Canadian Dental Care Plan (CDCP), where the CDA successfully pushed for key improvements including simplified provider agreements, increased reimbursement rates, enhanced patient privacy measures and clearer government communications, and more flexible registration processes. These efforts were complemented by strategic government engagement, including over 30 meetings with officials during Days on the Hill and a broader advocacy campaign in the lead-up to the 2025 federal election.

In preparation for the 2025 federal election, CDA implemented an advocacy strategy to engage decision-makers and political parties on maintaining federal oral health investments, mitigating de-insurance risk, and addressing workforce challenges. Dr. Antel also noted the federal government's proposed increase in the capital gains inclusion rate from 50% to 66% which could significantly impact dentists planning to sell their practices for retirement. In response, CDA continued to advocate alongside other health associations for an exemption, while providing dentists with a toolkit to help them voice their concerns to their MPs.

CDA's commitment to supporting dentists was evident through its robust suite of digital services. The organization marked the 20th anniversary of ITRANS, processing over 46 million claims in 2024, many of those a result of the CDCP's implementation. Also, CDA completed a multi-year effort to resolve a major Digital ID issue. First identified in 2022, this issue—caused by non-CDA software—threatened to disrupt all ITRANS claims traffic in October 2024. But, through extensive planning, development, and strong collaboration with CSI and instream, we achieved our goal of updating every dental office submitting CDAnet claims. Dr. Antel noted that beyond CDA's advocacy work on the CDCP, we worked closely with Health Canada and Sun Life to address technical and workflow challenges in its rollout. CDAnet technical experts continue to refine electronic claims processes to align with CDAnet standards and the expectations of dentists.

On the knowledge-sharing front, the CDA continued to serve as a key information hub for the profession and the public. It released three major surveys in collaboration with Abacus Data, published the 2024 Environmental Scan highlighting emerging trends in oral health, and delivered a national oral health campaign during National Oral Health Month. Publications such as CDA Essentials and the organization's ongoing web and social media outreach ensured timely and impactful communication with members and stakeholders.

Member support also extended into new resources, including a comprehensive preparedness guide for dental offices and a suite of dental benefits education tools. CDA also reinforced its commitment to mental health through making available a course available via sponsorship offered in partnership with the Mental Health Commission of Canada's Opening Minds division.

In a major governance milestone, the CDA launched "Forward Focus: Strategic Plan 2024–2029," a five-year

roadmap shaped in collaboration with stakeholders and recognized with a Gold Global Facilitation Impact Award.

CDA continued to deliver excellence through its Seal Program, which added 18 new products, and its Dental Aptitude Test, with over 2,700 tests administered. Internationally, the CDA maintained its leadership role through engagements with the FDI World Dental Federation and international partners, including the American Dental Association. In September 2024, CDA leaders attended the FDI World Dental Congress in Istanbul to collaborate on advancing oral health worldwide and with ISO/TC 106 Dentistry, CDA Chief Knowledge Officer Dr. Benoit Soucy began his term as Chair.

Finally, CDA deepened its work in diversity, equity, inclusion, and accessibility (DEIA), and Dr. Antel encouraged Corporate Members to take full advantage of their free CCDI membership, which offers exclusive benefits such as access to webinars, discounts on services, professional development opportunities, and branding resources. CDA also proudly developed and launched a Land Acknowledgment Toolkit. This guide offers resources to help the CDA respectfully recognize Indigenous Peoples and their traditional territories, promoting understanding, respect, and reconciliation through culturally sensitive protocols and meaningful actions.

Canadian Dental Leaders Forum

The Canadian Dental Leaders Forum (CDLF) meets to address shared issues that shape the future of the dental profession and the broader association landscape—issues that fall outside any one organization's mandate. CDLF membership includes CDA and its Corporate Members, the Provincial and Territorial Dental Associations (PTDAs), each represented by their President, CEO, and one elected representative.

A central focus of the meeting was the Future of the Profession report, a strategic document originally released in 2018 by a 25-member National Advisory Task Force established by CDA. The report, which anticipated major societal and professional changes by 2032, includes four vision statements and 28 recommendations to help the profession evolve alongside public expectations. The CDLF session marked the second in-depth discussion of the report since before the COVID-19 pandemic and served as a springboard for reactivating and modernizing the work. The previous CDLF was held October 2024 to kick start this initiative again.

Recognizing that the dental profession has undergone some of the most significant changes in its history over the past four years, the Future of the Profession Steering Committee introduced a new framework to refocus the original recommendations under three simplified pillars: Successful Dentists, Robust Care System, and Public Confidence. These pillars aim to clarify priorities and encourage collaboration, ensuring the profession is well-prepared, care systems are accessible and high-quality, and public trust is upheld through forward-thinking regulation and education. The CDLF meeting was a critical step in re-organizing the report's recommendations under these new categories and identifying gaps or areas needing renewed attention. Progress on the original report has been uneven in the past, in part due to unclear ownership of recommendations. This revitalized, collaborative approach emphasizes shared leadership across the profession, with CDA, PTDAs, regulators, educators, and professional associations working in coordination. Next steps include consultations with the National Council of the Dental Profession to broaden engagement with national stakeholders and align efforts moving forward.

The last component of the meeting focused on government relations. Mr. Lucas Veiga, Head of Government Relations and Policy at CDA, provided an update on the recent federal election results and their potential implications for the CDCP. The Liberals secured a minority government, while key political figures, including the Liberal Health Minister and Conservative Health Shadow Minister, were defeated. It was noted that conservative leader, Pierre Poilievre, lost a seat, sparking internal party debates, and NDP leader Jagmeet Singh stepped down after losing his seat. With a new wave of government appointments, CDA will need to rebuild many key relationships. Major voting issues included affordability and the impact of U.S. tariffs introduced by President Donald Trump. Prime Minister Mark Carney's focus on fiscal discipline could affect future social program funding, though a commitment remains to expand CDCP coverage to Canadians aged 18-64.

Participants evaluated and prioritized advocacy issues, identifying de-insurance, sustainability, and CDCP implementation challenges—including audits, claw backs, and pre-authorization problems as top concerns. Additional issues such as health human resources and changes to the program's design were also highly ranked. Collectively, participants recommended combining de-insurance and sustainability efforts, supporting program design

CDA Board Representative for Manitoba Dr. Marc Mollot with CDA's 105th President Dr. Joel Antel

(from left) MDA Vice President Dr. Rodrigo Cunha, MDA President Dr. Jeff Hein, CDA Board Rrepresentative for Manitoba Dr. Marc Mollot and MDA CEO Rafi Mohammed

changes, and delaying CDCP expansion where necessary. Concerns were also raised about potential fraud involving CDCP-registered patients with private insurance, prompting a call for legal guidance and clearer public communication about coverage responsibilities and renewals.

National Meetings in Conjunction with the CDA AGM

CDA received written reports from the following national dental organizations. A forum was held to discuss the reports.

- Association of Canadian Faculties of Dentistry (ACFD);
- Canadian Association for Dental Research;
- Canadian Dental Specialities Association;
- Canadian Dental Regulatory Authorities Federation;
- The Federation of Canadian Dentistry Student Associations
- CDSPI;
- The National Dental Examining Board of Canada;
- The Royal College of Dentists of Canada; and
- The Royal Canadian Dental Corps.

The National Council of the Dental Profession held its first meeting under the terms of reference finalized at last year's meeting. The following national organization sent representatives to the meeting:

- Association of Canadian Faculties of Dentistry;
- Association of Prosthodontists of Canada
- Canadian Academy of Dental Anaesthesia
- Canadian Academy of Endodontics
- Canadian Academy of Oral and Maxillofacial Pathology/Oral Medicine
- Canadian Association for Dental Research;
- Canadian Association of Oral and Maxillofacial Radiology
- Canadian Association of Orthodontics
- Canadian Association of Public Health Dentistry
- Canadian Dental Association;
- Canadian Dental Regulatory Authorities Federation;
- Canadian Dental Specialities Association
- CDSPI;
- The Federation of Canadian Dentistry Student Associations
- The National Dental Examining Board of Canada;
- The Royal College of Dentists of Canada; and
- The Royal Canadian Dental Corps.

Participants discussed the follow-up to the 2018 report of the National Advisory Task Force on the Future of the Profession; the ACFD led "not PGY-1" project; and the participation of the profession in the development of standards

Awards and Celebrations

In addition to recognizing CDA's 105th President, Dr. Joel Antel and installing CDA's 106th President, Dr. Bruce Ward, CDA also recognized its 2024-25 Award recipients. The following individuals were honoured on May 2 at both the CDA Awards Luncheon and the President's Dinner and Celebration of the Dental Profession event.

CDA Medal of Honour
Dr. Philip Poon, Winnipeg, MB

CDA Honoured Member Award

- Dr. Anthony Patey, St. John's, NL *to be given in August at the National Convention*
- Dr. Amarjit Rihal, Winnipeg, MB
- Ms. Linda Teteruck, Ottawa, ON

CDA Distinguished Service Award

- Dr. Cheryl Cable, Edmonton, AB
- Dr. Marie Dagenais, Ottawa, ON
- Dr. Anthony Odenbach, Edmonton, AB

CDA Award of Merit

- Dr. Chantal Czerednikow, Montreal, QC
- Dr. Thomas Colina, Winnipeg, MB
- Dr. Caroline Nguyens, Ottawa, ON
- Dr. Joanne Thomas, Dartmouth, NS
- Dr. Bruce Yaholnitsky, Calgary, AB

Oral Health Promotion Award

- The British Columbia Dental Association and The University of British Columbia Faculty of Dentistry's *Save a Smile Program* and Dr. Angelique Leung as its program chair, Vancouver, BC
- Special Olympics Canada, Toronto, ON

Special Friend of Canadian Dentistry Award

- Dr. Karim Khan, Vancouver, BC
- Mr. Brian Fawkes, Winnipeg, MB *posthumously*

Dr. Daniel Boyd from Halifax, NS was also recognized as a recipient of the Special Friend of Canadian Dentistry Award. His award will be presented at a later date.

The CDA's 2024 Student Leadership Award recipients were also recognized.

CDA Meetings / Joint Conventions

- **2025 Joint Convention**
  Held with the Newfoundland and Labrador Dental Association on August 27-30, 2025 in St. John's, NL
- **2026 Joint Convention**
  Held with the Manitoba Dental Association on April 17-18, 2026 in Winnipeg, MB
- **2027 Joint Convention**
  Held with the Ontario Dental Association on May 6-8, 2027 in Toronto, ON.
- **2028 Joint Convention**
  Held with the Dental Association of Prince Edward Island on August 9-12, 2028 in Charlottetown, PEI

ClearCare Periodontal & Implant Centre

Perio-Prostho Corner
Did You Know...

Dr. Katie Chung
DDS MDent (Perio)

...that antibiotics are not the first line of treatment for periodontal abscesses?

Common abscesses in the oral cavity include periapical abscesses and periodontal abscesses. Both arise from a localized bacterial infection which require localized treatment. For example, periapical abscesses result from a bacterial infection of the pulp - a potential treatment option is root canal treatment. Periodontal abscesses develop from a bacterial invasion of the soft tissues surrounding the periodontal pocket, and as such, treatment must involve root debridement.

Impact

- Periodontal abscesses represent up to 14% of dental emergencies which require immediate management.
- They can result in rapid destruction of the periodontium, including the alveolar bone.
- They can disseminate into systemic infections.
- They are the main cause of tooth extractions in maintained periodontitis patients.

Diagnosis

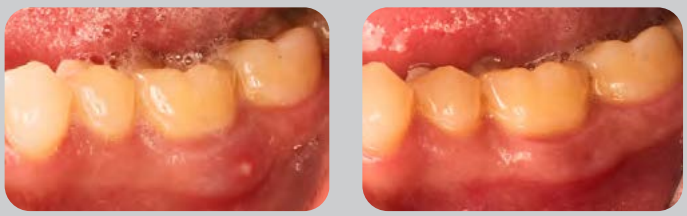
The most apparent sign of a periodontal abscess is an ovoid gingival elevation along the root. A vital pulp, bleeding and suppuration on probing, and a deep periodontal pocket are common findings. The tooth may also exhibit increased mobility due to the acute destruction of surrounding bone which may be observed radiographically.

The presence of a sinus tract is less common as often the pus can spontaneously drain through the sulcus (fun fact: this is how an untreated abscess "goes away" in some patients). Periodontal abscesses can be classified based on their etiology[1]. The affected tooth's prognosis is more compromised in a periodontitis patient compared to a non-periodontitis patient.

Treatment

- If the tooth has a favourable prognosis: root planing under local anaesthesia should be performed. Curettes such as the Mini Five Graceys with a longer terminal shank and a shorter and narrower blade are effective. Drainage of the abscess is often achieved through the sulcus when root planing, though some cases require an incision to permit additional drainage. In the absence of postoperative healing and abscess resolution, differential diagnoses such as endodontic etiology should be ruled out and surgical debridement may be needed. Soft tissue augmentation may also be beneficial to improve the keratinized tissue dimensions to prevent abscess recurrence.
- If the tooth has a questionable/hopeless prognosis: extraction should be considered. Thorough socket debridement will aid in healing. Teeth which experience repeated abscess formation may be considered to have a hopeless prognosis.
- Oral hygiene instruction is important to prevent recurrence of the treated abscess and prevent formation of new periodontal abscesses especially in periodontitis patients.
- In the case of systemic involvement: a course of systemic antibiotics is indicated.

Reference 1: Herrera et al.. Acute periodontal lesions (periodontal abscesses and necrotizing periodontal diseases) and endo-periodontal lesions. J Clin Periodontol. 2018; 45(Suppl 20): S78–S94. https://doi.org/10.1111/jcpe.12941



Before and after successful root planing under local anaesthesia. Midbuccal probing depth reduced from 8 mm to 3 mm.

For more information about this topic and related courses, please visit the website or scan the QR code using your phone's camera.

clearcareperio.com/events-and-courses/

CLASS OF 2025

Manitoba Dental Association

UM | Rady Faculty of Health Sciences

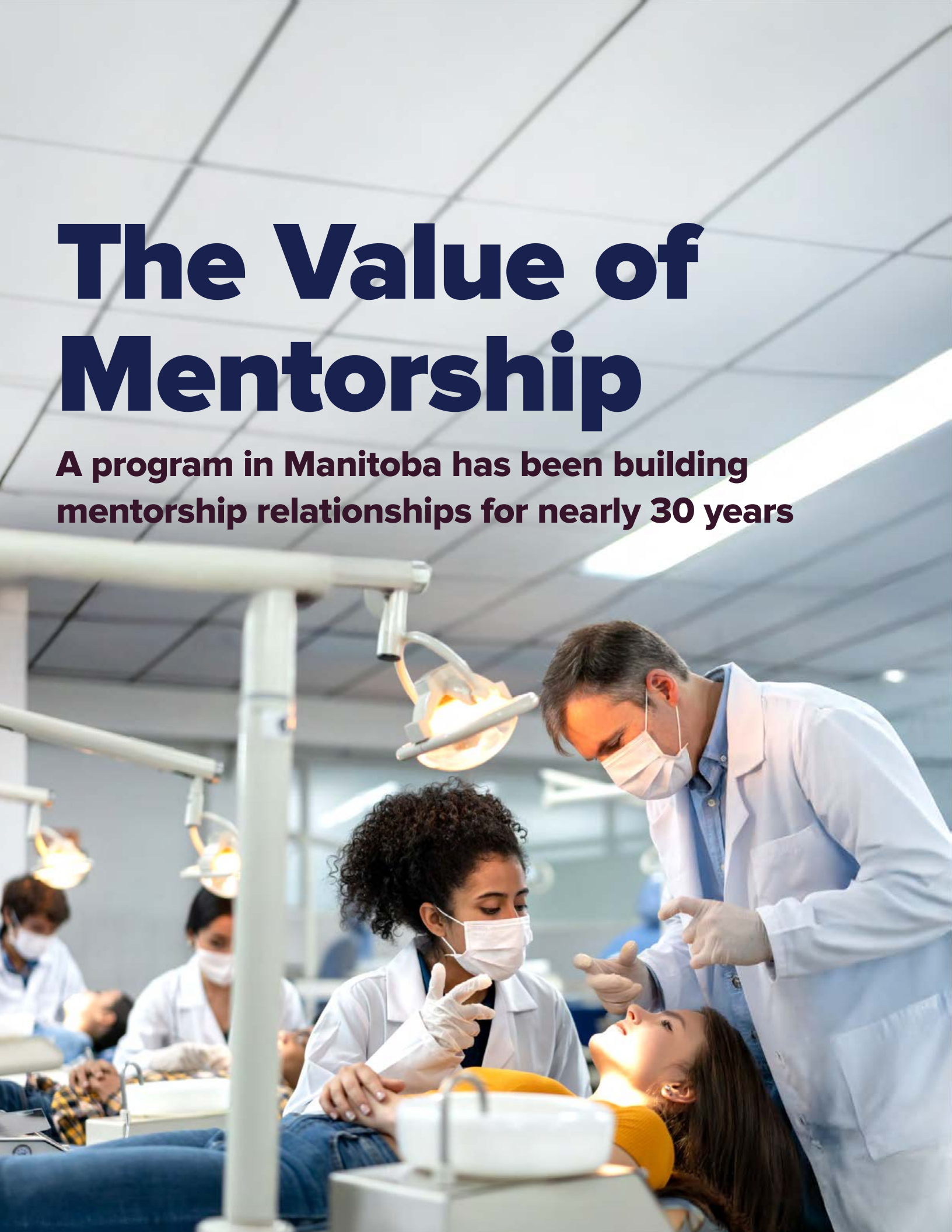
Congratulations!

The Manitoba Dental Association celebrated the University of Manitoba Dr. Gerald Niznick College of Dentistry and School of Dental Hygiene Class of 2025 Graduates by hosting a Graduation Breakfast at The Met, May 15.

Dr. Gerald Niznick College of Dentistry

The Value of Mentorship

A program in Manitoba has been building mentorship relationships for nearly 30 years



Since it was founded in 1996, the Manitoba Dental Association (MDA) and the University of Manitoba (U of M) Dr. Gerald Niznick College of Dentistry Dental Student Mentorship Program has provided mentorship opportunities for almost 900 dental students. Each student is matched with a practising dentist for all four years of their dental school. During the course of the program, a mentorship relationship develops through formal structured events—including seminars, workshops, continuing education programs, panel discussions, and special events where all mentors and mentees come together—and informal activities arranged by the mentor-mentee pairs.

The Mentorship Program

Dr. Huma Sharief and Dr. Craig Fedorowich, who were co-chairs of the program from 2019 until this year, were honoured with the 2023-24 CDA Mentorship Advancement Award for their tireless efforts in building the program, which nurtures a sense of community and a network of supportive relationships as students prepare to enter the profession. "Credit for the success of the program is due to the collaboration of the MDA and the university," says Dr. Fedorowich. "The contributions from administrators and faculty at the dental school have been invaluable."

What starts as a mentor-mentee relationship often grows into a significant friendship and the program provides an important add-on to the dental education experience. Mentors support the dental students with personalized guidance and advisement. The students receive exposure to organized dentistry and professional leadership, which provides a better understanding of the opportunities available to build healthier communities. At the end of program, there is a graduation dinner where mentors welcome new graduates into the profession. "Our formal events are held at the Manitoba Club or the St. Charles Country Club," says Dr. Sharief. "The students and our dentists look forward to getting dressed up and seeing each other outside of our scrubs!"

"When it began, the mentorship program was just for 4th-year students, to help them make the transition into the workforce," says Dr. Fedorowich. "We wanted to make sure that new dentists had the support they needed to prepare themselves for entering the profession."

In 2006, the program expanded to include 3rd-year students and then, in 2011, all four years. The first formal event of the program welcomes first-year students and international students to dentistry in Canada. Then, there is a session modelled on a speed dating format, where students meet a number of prospective mentors for a few minutes to chat and figure out if and how they connect. There are about 85 mentors participating in the program, which includes a good cross section of dentists who work in rural and urban settings, general practitioners and specialists, and dentists of diverse ages and ethnicities. Mentors sign a contract to formalize their commitment to the mission of the program. Ultimately, the mentees and mentors choose who they'd like to be paired up with.

The students receive exposure to organized dentistry and professional leadership, which provides a better understanding of the opportunities available to build healthier communities.

"We have three lectures per year," says Dr. Sharief. "They're an opportunity to talk about important parts of being a dentist that may not be emphasized in course material. For example, how do we make sure to use social media responsibly as dentists?"

"We talk about real-world dilemmas," says Dr. Fedorowich. "The students find it helpful to hear about when things may have gone wrong and how to fix problems that come up. They enjoy a little bit of reality especially while they're still at the stage of drilling plastic teeth!"

Dr. Sharief says that when graduates who have been mentees return to the program as volunteer mentors, the program really shows its effectiveness. "It's a cycle of positive change that builds upon itself," she says.

Why Mentorship is Important

"Life in dentistry is complicated," says Dr. Fedorowich. "And it has grown even more complicated since I began my career. Dental students have the pressure of ever-expanding scholastic activities, but still only have four years to complete their education. Dentists are balancing the expectations of patients, social media and employers. I think dentists tend toward perfectionism, but we are human and sometimes we need help, which can be hard when we expect perfection from ourselves. A mentorship relationship is a place where we can talk through complicated situations with a confidant." "Students face the technical challenge of developing their clinical skills, but they also have to learn how to work with people successfully," says Dr. Sharief. "How do you talk to patients? How do you tell someone that a treatment didn't go as planned? I think mentorship is increasingly important as students have to deal with a much higher student debt load. Mentors act as a safety net. They've walked a similar path, so they can give frank, honest advice."

When Dr. Fedorowich was first entering the profession, he didn't have a formal mentorship relationship to lean on. "But I had amazing instructors in dental school who I continued to talk to

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I don't think mentors always show up in our lives with the formal title of mentor. They are people who share their knowledge and life experiences, and we only realize later on that they've been our guides.

after I graduated, and a friend who was a wonderfully generous dentist who was recently retired," he says.
"Dr. Bob Glenn farmed during the warmer months and spent time at the dental school during the cold months. I had the luxury of bending his ear, and he had the wisdom to be a good listener. Now I realize that I've had several excellent mentors, even though they didn't have the official title."

"I don't think mentors always show up in our lives with the formal title of mentor," says Dr. Sharief. "They are people who share their knowledge and life experiences, and we only realize later on that they've been our guides."
Dr. Sharief graduated from dental school in Zimbabwe before being accepted into the U of M for a qualifying program. "Everyone I met at the U of M took me under their wing and helped me navigate those years of study," she says. "And I was paired with a mentor who was a rural dentist, Dr. Chris Kiazyk, who invited me to visit his practice to see how it was run. I'll never forget when I visited his family home and the sense of belonging I felt. Mentorship was life changing for me."

Being a Mentor

"I enjoy the time I spend in the company of dental students very much, as an instructor or as a mentor," says Dr. Fedorowich. "It's energizing and I feel like I'm getting as much out of it as I'm giving."

"The life-changing support and encouragement that I got from my own mentor motivated me to become one as well," says Dr. Sharief. "I'm especially excited to work with international students. I created a checklist of what I needed to succeed blending in with a new culture, and I want to the share that knowledge."

Dr. Sharief feels that dentists by nature are givers, not takers. Dentist care for patients, give back to the profession and strengthen their communities. "I'm a dentist in everything that I do. It's part of my personality, the very fabric of who I am," she says. "I can reassure, reaffirm, support, share and encourage other dentists. It comes naturally. There are moments in everyone's life when you need someone to build you up, shine you up, and set you back on your path. And that's what good mentors do."

Both Dr. Sharief and Dr. Fedorowich say they give advice on career planning, evolving technology in dentistry, and how to become involved in community service and organized dentistry.
"We have new graduates showing their associate contracts to their mentors and saying, 'Can you go through this with me?'" says Dr. Sharief.

Dr. Fedorowich says the mentorship program helps keep him current on trends and how dentistry is evolving. Both dentists say that in a world where information is increasingly accessible

Dr. Craig Fedorowich (centre) and two University of Manitoba dental students taking part in a mentorship program event.

Dr. Huma Sharief at the podium addressing a group of 2nd year dental students and mentors.

and overwhelming, having fellow dentists to talk with and navigate issues with is helpful.

"The greatest outcome of mentorship is a sense of community," says Dr. Fedorowich. "Isolation can be very hard on us, so putting an emphasis on building relationships, and doing so early in a dental career, can make a huge difference."

What Makes a Mentorship Relationship Successful?

Dr. Fedorowich warns that one potential pitfall is not making enough time for a variety of interactions. "Our program is structured, in part, but it's also important that the pair get together on their own to have casual open-ended conversations," he says.

"As a mentor, I want to be able to help with the unique needs of my mentee."

"A good fit between two personalities helps a lot," adds Dr. Sharief. "Which is why we do the speed-dating type session at the outset instead of assigning students to mentors arbitrarily. Often students want to be paired with people who have chosen a career path that they also plan to do."

Dr. Sharief notes that it is important to feel you can be vulnerable in front of your mentor. "Do you feel safe enough to say when you don't know what you are doing?" she says. "Will you feel safe saying that you're struggling with something?" A mentor needs to be available, both practically and emotionally, to their mentee.

"From my experience, it's usually a good fit when the mentor listens more and talks less," says Dr. Fedorowich. "Often, people can find their own solutions if you simply listen and ask questions. Mentorship is not really a teacher-student relationship. It's a two-way relationship where ideas and knowledge are actually coming from both people."

When they received their CDA award, Dr. Fedorowich thanked Dr. Sharief, calling her the best colleague that he could hope for. Dr. Sharief called Dr. Fedorowich her "guiding-light mentor."

Though their terms as co-chairs of the program have ended, both Dr. Fedorowich and Dr. Sharief have chosen to stay on as mentors.

Listen to a podcast with Dr. Huma Sharief and Dr. Craig Fedorowich on CDA Oasis: *bit.ly/3ALDjer*

Learn more about the Manitoba Mentorship Program at: *bit.ly/3AEN2Dl*

IT'S NOT THE YEARS; IT'S THE HOURS THAT COUNT

By Timothy Brown FRI
Chief Operating Officer and Broker of Record, ROI Corporation

We ask the wrong question all the time: "How many years have you been doing this?"

Here's a better one: "How many hours have you put in?"

Gladwell said that 10,000 hours gets you to mastery. For most post graduate dentists, that's 5 to 7 years in full time clinic.

And yet, most of the young dentists I speak to—when looking to buy a practice—say they'll refer out a lot of what the seller is doing confidently

The pitch is always the same:

"I can't pay what its worth because I can't replicate the gross income."

Is this a strategy to negotiate a lower price? Most often – yes. A bargaining tactic.

They carry on with this: "You have so much more experience than me."

Cue the romantic and flattering music…

My thinking is that its mostly genuine. After all they may not have done the hours yet.

But let's shift the focus.

"Time invested. Not time passed."

These days, I put in at least 75 hours a week. Nights, weekends—you name it. I've racked up over 125,000 hours in this business.

Not to brag. Just a fact.

Time in practice matters.

Not the job title. Not the credentials. Not the trophies.

The hours.

There are people with 30-year licenses who haven't practiced in decades. They've moved on to consulting, insurance, or academia. That's fine—but if you need someone to broker your practice, wouldn't you rather work with someone who's put in the hours?

A suggestion when selecting your next professional advisor:

Stop asking: "How long have you been doing this?"

Start asking:

"How many hours have you invested perfecting your trade?"'

When I say that I care—and when I say my company works hard to protect the value of your life's work—it's not branding.

It's not fluff.

It's thousands of hours grinding, learning, showing up, staying late, and trying to get it right.

Yes, this is shameless self promotion. Have I earned this right?

For me, over 125,000 hours and counting!

Thanks for reading.

P.S. Maybe I'll work 40 hours next week. (probably not!)

Do I have you thinking about your next ten thousand hours?

Work or play.

Grind or travel.

A nap would be nice – I like napping!

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The Joint Commission Journal on Quality and Patient Safety

The Final Steps in Converting a Health Care Organization to a Latex-Safe Environment

Robert H. Brown, M.D., M.P.H.; Mary A. McAllister, M.A.; Ann-Michele Gundlach, Ed.D.; Robert G. Hamilton, Ph.D.

During the past several years, reports of new cases of allergic sensitization and anaphylaxis to natural rubber latex (NRL; *Hevea brasiliensis*) have appeared to abate in Europe and North America.[1–5] This slowing of newly reported cases is believed to be due to an increased awareness as a result of improved diagnostic methods and to a more effective avoidance of Hevea latex exposure.[1–4] Both of these trends have resulted in a focused response to the latex allergy problem. Awareness of latex-induced morbidity (rhinitis, asthma) and potentially fatal anaphylactic reactions to natural rubber latex spread rapidly through the health care, spina bifida, and general scientific communities in the 1990s. With increased awareness came a multifaceted response. The most widely effective and least expensive strategy to minimize allergic reactions in sensitized (immunoglobulin E [IgE]–antibody positive) individuals and to prevent new or further sensitization in at-risk populations is avoidance of exposure to latex-containing products.

In a hospital environment, avoidance of latex allergen exposure to NRL-containing products is not always simple or easy. Avoidance presents numerous problems, including the necessity for continued education of the staff about the risks of latex allergy, identifying latex-containing products used throughout the organization, determining appropriate substitutes for these latex medical products, and banning nonmedical products that contain detectable amounts of natural rubber latex. All these issues need to be addressed while also considering the cost of any change.

In our previous article,[6] we described our approach at The Johns Hopkins Medical Institutions to establishing an organization-wide, latex-safe environment. Such an environment would, ideally, contain minimal latex allergen at levels insufficient to elicit an allergic reaction in sensitized individuals. Our first and most important step, in 1997, was to create an interdisciplinary task force under the direction of the risk management committee of the medical board. This multidisciplinary group [including R.H.B., R.G.H.], allowed all the individuals who were critical to a successful conversion to accept the idea and become vested in the process. The first major hurdle for the committee was converting from latex examination gloves to nonlatex products, as previously described.[6]

Although we had successfully found nonlatex alternatives for the majority of latex-containing medical products used in our institution, the final major hurdle to the creation of a latex-safe environment was the elimination of sterile latex gloves. However, as previously described, this hurdle was not surmountable at that time. In this article, we describe our subsequent efforts to convert all the sterile gloves to nonlatex products and thereby complete the implementation of a latex-safe program at our health care organization.

Continuing the Work of the Latex Task Force

The latex task force has remained committed to creating a latex-safe environment, and the level of awareness about the issue of latex allergy has remained high throughout The Johns Hopkins Medical Institutions. The exclusive use of highly visible, brightly colored nonlatex examination gloves made of nitrile throughout the institution made all aides, technicians, nurses, and physicians aware of their availability and the important reason for the general use of nonlatex gloves. Furthermore, through the work of the latex task force, improved triage and diagnostic methods enhanced our institution's ability to identify patients at risk for both sensitization to NRL and systemic reactions. This, in turn, led to the greater use of nonlatex sterile gloves. As with other forms of allergic disease, such as those involving reactions to antibiotics, when a high-quality, effective, low-risk alternative

This article originally appeared in The Joint Commission Journal on Quality and Patient Safety, Volume 35, Number 4, pp. 224-228.

is readily available, that alternative will be used, especially when there is any question of a possible allergic reaction. With the identification of more at-risk patients through the use of more specific intake questioning by the admitting nurses, the use of sterile nonlatex gloves increased in the operating rooms (ORs). Before the complete conversion to nonlatex sterile gloves, OR use had increased to approximately one-third of our total sterile glove use during the preceding four years (2003–2006).

New Approaches to Converting to All Nonlatex Sterile Gloves

As of 2003, avenues of discussion remained open between the chair of the latex task force [R.H.B.] and the glove manufacturers as to the availability of new sterile glove products. During these ongoing discussions, one glove manufacturer, who was aware of The Johns Hopkins Hospital's goal of establishing a latex-safe environment, suggested a cooperative program that was designed to benefit both parties. The manufacturer would have the marketing advantage of being the sole supplier of nonlatex gloves to The Johns Hopkins Hospital and a secure longterm contract. The Johns Hopkins Hospital would have a cost advantage and would achieve economies of scale in glove pricing and have predictable costs over the terms of the proposed contract.

However, even with predictable costs, the major hurdle for The Johns Hopkins Hospital remained the total cost of conversion. During these discussions, the glove manufacturer developed a new low-protein sterile latex glove. These gloves were reported to have "undetectable" levels of allergic latex proteins. However, the safety of these low-allergen latex gloves when used with latex-allergic patients had not been verified. Although the possibility remained that they were unsafe for use with latex-sensitized individuals, the cost of these low-protein sterile latex gloves was significantly less than nonlatex sterile gloves. As an initial step toward the use of all nonlatex sterile gloves in the ORs, we initially considered converting from high-protein/allergen powdered sterile latex gloves to these low-protein nonpowdered latex sterile gloves, at essentially no additional cost to the hospital.

This idea was presented to the OR executive committee. With the support of the new chair of the department of surgery, the discussion focused on the importance of moving toward latex-safe ORs. It quickly became clear that converting to these low-protein nonpowdered latex gloves, although a significant step forward, would not alleviate the potential risk to patients and staff. In addition, the committee concurred that the cost savings of less

Article-at-a-Glance

Background: In a follow-up to a previous article, which described the approach at The Johns Hopkins Medical Institutions to establishing a latex-safe environment, subsequent efforts to convert all the sterile gloves to nonlatex products and thereby complete the implementation of a latex-safe program are reported. Before the complete conversion to nonlatex sterile gloves, operating room use had increased to approximately one-third of our total sterile glove use during the preceding four years.

New Approaches to Converting to All Nonlatex Sterile Gloves: The final stages of the conversion involved both consistent follow-through with education, training, and personnel involvement at all levels and a change in the culture of the medical facility. New and improved nonlatex glove products were coming to the market, and their costs were decreasing because of increased supply and competition.

Glove Trials: Five synthetic neoprene or polyisoprene gloves—two from one manufacturer and three from the second manufacturer—were evaluated in glove trials. Overall, by manufacturer, a similar rate of acceptance among the various sterile nonlatex gloves (74.2% versus 78.1%) was found. However, to ensure that all users were satisfied, contracts were awarded to both vendors. The weekend before the conversion date of May 1, 2007, all old powdered sterile latex gloves were replaced with the new stock of nonlatex sterile gloves.

The Conversion Process: Once financial and logistical concerns were addressed, conversion to a latex-safe environment entailed readying the organization for the change in organizational culture. Key factors were (1) general acceptance from all the chiefs of the surgical departments; (2) centralization for all purchases of medical supplies, including sterile gloves, through corporate purchasing; and (3) ongoing education and vigilance.

Table 1. Percentage of Acceptable Performance by Glove Type

	Manufacturer A	Manufacturer B
Neoprene	56.3%	59.7%
Neoprene*	62.8%	
Polyisoprene	72.1%	77.8%
Overall	74.2%	78.1%

** Manufacturer A requested and was allowed to test two types of neoprene gloves (see text).*

than a complete conversion to nonlatex sterile gloves was not worth the effort of repeated glove trials and training of the staff, in addition to the cost of changing over the inventory on multiple occasions. The group then focused on the cost and feasibility of converting the entire institution to only nonlatex sterile gloves. Led by the surgery chair, the sentiment of the committee was that converting to all nonlatex sterile gloves was the right thing to do for the institution and that the funds for the additional cost would need to be found through savings in other areas.

In addition, both new and improved glove products were coming to the market. First, although neoprene nonlatex gloves had been on the market for several years, their durability, fit, and feel were found to be marginal. However, by 2006, their fit, feel, and durability had dramatically improved. These newer versions were more acceptable alternatives for surgeons when nonlatex gloves were required for patient safety. In addition, a major hindrance to converting all sterile gloves to nonlatex materials had been the difficulty with double gloving. In the past, it had been nearly impossible to double glove with most nonpowdered nonlatex gloves. However, newer manufacturing processes allowed changes to the external surface of the nonlatex gloves, which now enabled double gloving. The second significant change in the nonlatex glove market was the introduction of synthetic polyisoprene, a petroleum product derivative. This material was the closest yet in feel and fit to natural rubber latex. The drawback of the synthetic polyisoprene gloves was their cost, which was higher than the neoprene gloves. However, it was apparent that polyisoprene gloves were acceptable to most surgeons. In addition, the costs of nonlatex gloves had been decreasing because of increased supply and competition in the marketplace.

Determining the Cost of Conversion

In 2006, the chair of the latex task force met with the head of hospital purchasing to discuss the process of converting to all nonlatex sterile gloves. The purchasing department developed and issued a Request for Purchase (RFP) for glove manufacturers that included requests for information on material safety data, compatibility with various chemicals used in the hospital by staff who wear sterile gloves, quality control information, ease of double-gloving, sterile process information, product availability data, vendor availability for review and trial of product, staff training and in-services, inventory conversion, and pricing structure. Receipt of final, sealed bids was followed by on-campus presentations, product reviews and evaluations, compilation of results, and selections of finalists.

As an incentive for the companies, the initial proposal specified a single-source supplier for all the nonlatex sterile gloves to be used throughout the institution. Four companies identified as potential suppliers on the basis of their capacity to supply sufficient quantities of gloves submitted written proposals. This was the first time that the institution had an accurate and agreed-upon cost for a conversion of all sterile gloves to nonlatex materials. Of the four companies, the two lowest bidders were selected and notified that their gloves would undergo two-week trials by the OR personnel.

Glove Trials

PLANNING

A meeting between the representatives of the two glove manufacturers and a planning committee for the evaluation of the nonlatex sterile gloves was held in Fall 2006. The planning committee consisted of representatives from OR nursing managers, materials management, the latex task force chair, purchasing, risk management, surgery, and health safety and environment.

Samples and announcement posters were made available in the ORs at least one to two weeks before the evaluations, which were conducted in Winter 2006. The planning committee agreed that all ORs, the ICUs, and the catheterization laboratories should simultaneously begin a trial of the sterile gloves. The vendors were asked to work with each area coordinator to determine that all the arrangements (for example, the quantity of gloves needed, where supplies could be placed, what vendor presence was required during the trial in the areas) were sufficient.

At the meeting, representatives from the two companies were given 10 minutes each to present their company's nonlatex sterile gloves and to distribute samples. Vendors were also asked, prior to the trial, to submit any final cost proposal modifications.

A total of five gloves were evaluated—two from one manufacturer and three from the second manufacturer. Initially, the RFP specified one neoprene and one synthetic polyisoprene glove. Before the trial, one of the manufacturers requested permission to include a second neoprene glove that would be used as an underglove for double-gloving. Although some additional expense would be incurred if it were necessary to stock an additional glove in inventory, the cost of the glove was the same as for this company's other neoprene glove, and therefore it would not affect the overall cost of the product. After discussion, the request was approved.

Before the glove evaluation, several surgeons expressed considerable aversion to change of any kind in terms of their

daily OR routines, including changing the type of surgical gloves that they could wear. A few of the surgeons even threatened to leave the institution if the sterile gloves were changed to all nonlatex; however, we are not aware that anyone actually left the institution. Overall, there was only modest discontent with the concept of converting to all nonlatex gloves. The strong support of the surgery chair was critical in preventing this modest discontent from developing into strong opposition, which could have prevented the trial and subsequent conversion.

RESULTS

A total of 608 evaluation forms were completed by 412 health care personnel during the four weeks of the two glove trials. The results of the evaluations were analyzed by manufacturer, product, and department. Overall, by manufacturer, we found a similar rate of acceptance among the various sterile nonlatex gloves (74.2% versus 78.1%; Table 1).

The nonlatex sterile gloves had a high general acceptance rate. However, there were concerns that if only one company was selected, potentially approximately 25% of the personnel who use sterile gloves would be dissatisfied (Table 1). Among all the satisfied users of either glove, only 4% indicated they would be satisfied with the other glove company's gloves. In addition, only 1% of the participating users indicated that none of the gloves tested were acceptable. Thus, the decision was made to award contracts to both vendors, although the value of an exclusive contract could potentially be diluted, and the contract price had been based on using a single-source vendor. The date for conversion to all nonlatex sterile gloves was initially set for January 1, 2007.

Although organizational readiness and learning are integral to changing organizational culture, the impact of leadership, especially in relation to patient and staff safety, should be emphasized.

The Conversion Process

Once the OR executive committee agreed to convert to all nonlatex sterile gloves, the corporate purchasing representative from the latex task force obtained agreement from the manufacturers to adhere to their original price structures, and the contracts were signed.

The decision to select two vendors, then, resulted in the use of five types of sterile gloves (Table 1). This created

a new concern about adequate room for stocking all the types, makes, and sizes of sterile gloves. Representatives from materials management assured the latex task force that maintaining an adequate stock of all the various gloves in the warehouse would not be an issue. Adequacy of shelf space in the storerooms near the Ors and in the ORs was also ensured.

Before the conversion, corporate purchasing and the two vendors determined that the initial stock would consist of 50% from each vendor. Furthermore, to contain costs, there would be an 80% neoprene and 20% polyisoprene glove mix (the neoprene gloves were less expensive). Because our institution predominantly used a low-cost powdered latex sterile glove, our estimated cost increase for conversion was approximately 45%. As glove preferences became apparent, the stock would be adjusted. The weekend before the conversion date of Tuesday, May 1, 2007, all old powdered sterile latex gloves were replaced with the new stock of nonlatex sterile gloves.

During the first weeks of the conversion, representatives from the manufacturers were available for questions from the surgeons. Assistance from representatives regarding proper sizing of the nonlatex gloves was also provided at the start of the conversion.

Several key components were established to ensure the continued success of the conversion to nonlatex sterile gloves, as follows:

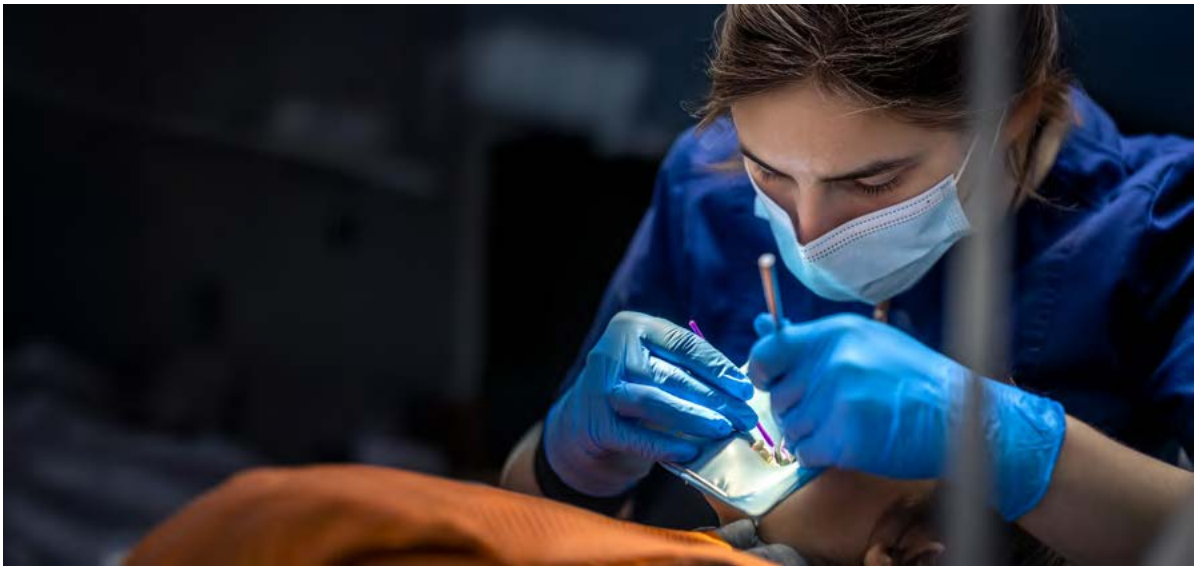
1. There was general acceptance from all the chiefs of the surgical departments, as agreed to at the OR executive committee.
2. The policy for The Johns Hopkins Hospital was for all purchases of medical supplies, including sterile gloves, to be centralized through corporate purchasing.
3. Ongoing education and vigilance among all the healthcare employees was viewed as critical to maintaining a latex-safe environment.

Changing the Organizational Culture

One of the major challenges in making changes in a large institution is the necessity to change the organizational culture, especially when a long tradition exists. During the past decade, organizational culture and leadership in health care organizations have been recognized as key to promoting and improving patient and staff safety.[7,8] After the first attempt in 2002 to convert the ORs to all nonlatex gloves,[6] the surgery chair retired, and the new chair, early in her tenure, voiced support for moving forward and obtaining the funding to create a latex-safe OR environment.

Unlearning processes that were previously successful is one of the greatest challenges to organizational change. In most health care organizations, the tradition of using latex gloves in the OR dates back more than 100 years. At The Johns Hopkins Hospital, this tradition was initiated by Dr. William Halstead in 18899 and has been carried forward with each new group of interns and residents trained to perform surgery using natural rubber latex gloves. Changing standard routines is difficult in most organizations, but it is particularly difficult in "mature" organizations such as The Johns Hopkins Hospital, where tradition and historical practice are integral to the organization's identity and constancy. In addition to not having a general sense of urgency to change, mature organizations are highly experienced in improving the way they do things but lack the capability to question whether they are doing the right things.[10]

The process of organizational culture change takes time and requires a systematic approach. For this reason, the latex task force at The Johns Hopkins Hospital employed a systematic communications strategy to provide informal education to key stakeholders. The strategy first raised awareness throughout the institution of the risks associated with exposure to NRL, the availability of latex-safe alternatives, and the core values of patient and staff safety. A pamphlet, "Glove Conversion," explained the goal of the initial conversion to synthetic exam gloves and provided information



on latex exposure and risk; questions and answers about glove safety, fit, and budget impact; as well as a list of specific "do's and don'ts."[6] Publication of multiple articles about latex safety in the hospital's internal monthly magazine as well as in organization-wide newsletters then followed. Concurrently, the chair of the latex task force conducted an evidence-based study of the hospital's OR physicians pertaining to latex sensitivity,[11] safety,[12] and genetic risk factors for latex sensitivity.[13] Involvement in these studies brought the message directly to the end users in the ORs, providing an additional authoritative base from which the surgeons could evaluate this change in long-term practice. As this information-based strategy evolved, the information technology department revised the OR schedule to specifically include a line on the daily schedule for each surgical patient to note any possible history of a latex allergy.

As awareness of the importance of a latex-safe environment began to take hold, the latex task force incorporated the direct participation of end users in product testing. This phase also involved the education and reeducation of key stakeholder groups, including patients, nurses, and physicians. During this high-involvement product testing and education phase, physicians and nurses were asked for their input about the decision and final selection of the latex-safe products. External reinforcement in the literature also helped to enhance the staff 's understanding of the latex safety issue. At the same time, it became increasingly apparent to surgeons in training that they were at risk of developing an allergy to NRL. As a result, the number who chose to wear only nonlatex gloves in the ORs increased.

Although organizational readiness and learning are integral to changing organizational culture, the impact of leadership, especially in relation to patient and staff safety, should be emphasized. When leaders' actions are congruent with their expressed values and beliefs, the resulting influence on collective effort, learning, and change is increased. To that end, what leaders pay attention to and emphasize sends a strong message to organization members.

Conclusion

When considering the implementation of any significant organizational change, financial and logistical concerns often take precedence. However, as this case of conversion to a latex-safe environment demonstrates, organizational leadership and developing the organization's readiness for change in organizational culture are also critical. In addition, the explicit support of leadership is an essential component of change and will continue to be so as learning and change become a way of life in health care organizations.

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Obituaries

DR. KENNETH ROGALSKI *July 10, 1943 - November 22, 2024*

It is with great sadness that we announce the passing of Kenneth Roy Rogalski, age 81, at the Selkirk Regional Health Centre on November 22, 2024.

Ken will be lovingly remembered by his wife of 57 years, Gloria, son Darren and daughter Shannon, nephews, Matthew (Candace) and Andrew, along with a large extended family and many wonderful lifelong friends. He was predeceased by his father, Roy; mother, Adeline; and sister, Rosemary.

Ken was born in the North End of Winnipeg on July 10, 1943. Upon graduation from high school, he attended the University of Manitoba, attaining a Doctor of Dental Medicine. Ken went on to serve his patients with great care for over 30 years.

Ken's happiest times were spent camping and fishing at Otter Falls, especially with dear friends from Virginia. One of his proudest achievements was his master angler pike. When not at the lake, Ken loved watching sports, especially his beloved Boston Red Sox, listening to some Bruce Springsteen and Jimmy Buffett, reading, and puttering on the acreage in Cooks Creek.

A celebration of Ken's life will take place in the spring. An announcement will follow with details closer to the date.

In lieu of flowers, donations may be made in Ken's memory to the Manitoba Dental Foundation, to help make a difference in the oral health of underserved communities in Manitoba.

DR. COLIN FRANCIS FOSTER *January 25, 1945 - April 6, 2025*

The only child of the late Gordon and Marion Foster. Survived by his wife Monica and four children; Sarah, Caitlin, Neil (Shizuka), and Tiffany. Grandchildren Arisa and Noah, along with many cousins in the UK; Elizabeth Fairfull, Mary Noble, John Foster and Christopher Burfield, Jane, Ian, Georgina, Lucy, Katie, Hannah, Joseph, Thomas and Angus. Predeceased by his favorite Aunt Dorothy Southgate and Aunt Eve. He was a brother-in-law to Jasoda Leila, Barbara Persaud, Cecil Persaud, Jasso Harnett (Maurice), Sandy Forsyth (Don), and the late Veronica Wong. He was a beloved uncle to many nephews and nieces.

Colin boarded at St. Peter's school at age eight in York until graduation. He graduated from St. Andrew's University Scotland in 1968 with a Bachelor of Dental Surgery then came to Canada and pursued a degree in oral surgery at Dalhousie University in Halifax. He completed his Master of Science in surgery and received his FRDC(C) Fellowship of The Royal College of Dentistry in 1973.

Colin had successful practices in Winnipeg, Manitoba and Kenora, Ontario before retiring to Victoria, BC in 2018. An active member of each community he lived in, he was a philanthropist to many causes, the proudest and most rewarding of which was the dental mission he attended with Dr. Bruce McFarlane in the Dominican Republic.

He was a Free Mason and served as worshipful master of Pequonga Lodge #414 in Kenora (2011) and regular attendee at Northern Light Princess Rupert (Fidelity), Lodge #1 in Winnipeg, MB.

Colin never wanted to write or think about his own obituary. True to his scathing and indelible British wit, he said a few years ago, he would want to tell his friends he simply "popped off."

DR. DAVID ANDREW GOERZ DMD, PFA, FICD *March 7, 1965 - May 11, 2025*

Dr. David Andrew Goerz, husband, father, grandfather, son, brother, friend, community builder, gentleman, and man of faith, passed away on Sunday, May 11th, surrounded by his family at St. Boniface Hospital in Winnipeg, Manitoba.

David was born on March 7th, 1965 in Morden, Manitoba to Dietmar (Dick) and Emily Goerz. He was the first of two children, beating his twin sister Caroline by only minutes. He grew up in Morden, Manitoba and graduated from Morden Collegiate Institute before moving on to the University of Manitoba to obtain his Doctorate in Medical Dentistry. In June of 1990, David married his sweetheart Helena, and they started their life together in Winnipeg, before moving to Morden when David joined his father, practicing at the Care Dental Group. They had three children together, Stephen, Danielle, and Kristopher.

David lived a big life with a quiet faith. He loved the Lord and found great joy in supporting God's ministry as he was able. David was also a devoted family man and provider. He often said when family needs help, you help, no questions asked. His greatest joys were his three grandchildren, whom he would spoil every chance he got. David was an avid promoter of the community of Morden and involved himself in many town activities. He was very proud of the Minnewasta Golf and Country Club and has been a driving force behind it for years, as well as multiple hockey clubs in the Pembina Valley. He was recognized for his volunteerism when he received the Queen Elizabeth Platinum Jubilee Award in 2022. Amongst golf and hockey, two of David's greatest passions were cheering on the Winnipeg Jets and Winnipeg Blue Bombers.

David loved his career and was passionate about the dental profession. His patients often spoke of his care and compassion while they were in his chair. His colleagues refer to David's work as art, not just dentistry. He served on the Manitoba Dental Association Board and on various task forces for the Canadian Dental Association. He was also a mentor to the University of Manitoba dental students. He was inducted into the Pierre Fauchard Academy in 2016 and the International College of Dentists in 2018.

David leaves to cherish his memory his loving wife of 35 years, Helena, his children, Stephen and Taylor Goerz, Danielle and Ryan Funk, and Kristopher Goerz, along with three grandchildren, Brooks and Dawson Funk, and Willow Goerz. Also mourning his passing are his mother, Emily Goerz, and his sister, Caroline Goerz, along with many close family and friends. David was predeceased by his father, Dr. Dietmar Goerz.

The family is grateful to Dr. Turner, Dr. Miller and the staff at Boundary Trails Health Centre, STARS Air Ambulance, Dr. Fagan and Dr. Hong, along with the rest of the Cardiac Surgical team, and Intensive Cardiac Care Surgical unit staff at St. Boniface Hospital for their prompt and excellent care.

David will be remembered for many things, mainly for the passionate way he lived life, his dedication to our community, his outstanding career, his big opinions, but even bigger heart, and for his deep love for his family.

Donations in memory of Dr. David Goerz may be made to STARS Air Ambulance or the Manitoba Dental Foundation.

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