MDA Bulletin

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IN THIS ISSUE:

Your Manitoba Dentist

Most Manitoba Dentists offer a child's first dental visit prior to the age of three at no charge through the Free First Visit program. Research has shown it to be highly successful and the profession is held in high regard by grateful parents.

Public acceptance that **a child's first dental visit should take place prior to their first birthday** is growing as parents are becoming aware of the benefits of establishing an early start to their child's professional dental care.

BABY'S FIRST CHECKUP SHOULD BE DONE BY AGE ONE

or within 6 months of the eruption of the first tooth.

Based on the benefits to the public and the profession, the program is continuing with a re-branding that the first visit take place prior to the child's first birthday, even though **it will be available for free until their third birthday.**

Watch for an in-office and multi media campaign this fall.

All dentists are encouraged to participate in this worthwhile program.

FREE FIRST VISIT

Manitoba Dentist.ca

Registrar's Message

DR. MARCEL VAN WOENSEL
REGISTRAR, MDA

Some of you may be aware an issue developed at Dalhousie University where students in the graduating class have allegedly made statements on social media derogatory to classmates and women.

There can be no condonation of the language or activities that were occurring at Dalhousie. A serious investigation and appropriate disciplinary action is necessary. Viewing this as an isolated incident perpetrated by idiots or monsters may overly simplify the situation. It avoids a broader discussion on our individual and collective responsibilities in creating and maintaining an environment where individuals assume this is acceptable. In identifying and focusing on a "villain", it allows us to avoid comparing our own actions and attitudes.

To a greater or lesser degree, we all have a tendency to objectify or dehumanize certain situations. Whether intentional or inadvertent, private insults or public mocking of an individual's physical appearance, gender, socioeconomic status, ethnicity or nation of origin should have no place amongst an educated group. It is important to understand collective silence amounts to passive acceptance. In an ideal situation, we should not think of people that way. Moreover, to expect an individual who is the subject of a derogatory statement alone be responsible to address concerns only emphasizes their vulnerability.

Change, real change, can only be effective if it is done in a positive manner. It can only occur when we are conditioned as a collective to identify issues and request respect. It can only occur if there is an understanding that individuals need support to identify the underlying issues and make change in themselves.

Our knowledge and professional status give us all an aura of authority and respect in our communities. Staff, patients and our communities need to trust that dentists will respect their boundaries and act responsibly. Any conduct - intentional or not - that breaches the trust of patients leaves the dentist open to claims of conduct unbecoming a professional.

Commonsense is important in our communications and conduct with patients and staff. We need to be aware and respect their boundaries, preferences and culture. You must err on the side or prudence in what you say and write. Miscommunication and misunderstanding of intent are significant when it comes to sexual impropriety in the office. As professionals and employers, we are responsible to ensure our conduct is not perceived as crossing the line.

Sexual impropriety by professionals may be verbal, online, physical contact, gestures, suggestions or other behaviours that may be reasonably construed as sexual in nature by staff, patients or their guardians. Direct sexual contact, actions demeaning to the patient, inappropriate references to the patient's health information, comments, innuendo or gestures disrespectful of the patient's privacy and bodily integrity may amount to professional misconduct.

From a regulatory perspective, comments and conduct will be assessed on their face value. Your actual intent is a limited factor for consideration. You may be intending to put the patient ease, be complimentary, be funny, be casual or laidback, but if the patient or staff perceives it as a violation and on the evidence it can be reasonably perceived as such, it will amount to misconduct. Caution must also be taken in personal relationships with patients - current or past. As a general rule, it is inappropriate for a dentist to initiate a personal relationship or make sexual advances to a patient or staff member because of the very real potential for exploitation of a their vulnerabilities and the power differential. If a patient or staff member initiates a relationship, the dentist must be careful to ensure the professional relationship is not an influencing factor in the process. It is prudent to terminate the doctor-patient relationship before entering a personal relationship that may conflict with your professional duties. Personal relationships entered prior to the doctor-patient relationship will have few issues but it is your obligation to ensure the person or third party payers are not being taken advantage of through your personal relationship.

All offices are required to have a harassment policy to manage inappropriate conduct. Employees and patients should not be in a position where they feel vulnerable and uncertain as to how to respond. Dentists as employers and professionals are responsible to ensure a safe work environment.

Although not comprehensive, an office policy should ensure:

1. that you maintain a high level of professionalism throughout your office so that regardless of the patient or staff member's background, your conduct is appropriate and respectful;
2. everyone in the office must be aware and educated about sexually inappropriate behaviours - both obvious and subtle - and the need to respect the boundaries and avoid conduct that demeans the patient of othe3r staff member. Boundary issues include not only respecting a person's physical space, but also must take into account verbal, emotional and cultural matters;
3. office must have a process and opportunities to address concerns of patients and staff members about behaviours they perceive as inappropriate. Open communications is critical to managing issues and avoiding inadvertent offence before they become disciplinary issues.

Enjoy the spring,
Marcel Van Woensel
Registrar, Manitoba Dental Association

President's Message

DR. NANCY AUYEUNG, D.M.D.
PRESIDENT, MDA

It has been a five year journey to finally reach the highest honoured position of the Manitoba Dental Association……President. And as wonderful as that sounds, I realize, as I reflect on these years, that I did not get here as a result of anything I have accomplished but has everything to do with the people who make up the Manitoba Dental Association…….our volunteers. To put it in perspective, that's how I got started and this is what I still am today.

A volunteer is defined as a person who freely gives of his/her time, effort and resources without expectation of anything in return. At the heart of every volunteer is empathy…..the ability to identify with or understand another's situation or feelings. As dental professionals, we aspired to the profession through this common thread. We simply find the ability to help others to be rewarding. So it is only natural and not surprising that many of us volunteer, in some capacity, outside of our busy work life. The gift of time is precious and yet, we give that time and use it to bring awareness and recognition of various issues for the sole purpose of helping others or being part of something to give back to a worthy cause or purpose. The dedication, commitment and tireless work of our volunteers make up the foundation of the MDA.

As President, I have the enviable position to observe all our MDA Committees (and there are many) and their functions. I get to see you, our volunteers, in action. These Committees meet several times a year working on issues, projects and initiatives to enable the MDA to grow, evolve and be able to support not only our members but also help to improve the oral health of all Manitobans. The profession of dentistry is never stagnant. It is dynamic…..always changing and we must change with it. Our Committees work hard to anticipate the changing landscape of dentistry and strategize the best means to engage it. For all your efforts, I thank you.

But as a new graduate, did you know what MDA is all about?? Here are some interesting facts on the history of the Manitoba Dental Association taken right from our own website:

"The first dentist to enter Manitoba was in 1877. By 1883. it became evident that there was a need to protect the health and welfare of the public and guard the ideals of the profession. Fifteen dentists in the Province saw to the passing of the first Dental Act on July 7, 1883. Since then, there have been 90 Presidents

Dentistry is currently structured with the Manitoba Dental Association performing two major functions: (1) protection of the public, and (2) balancing of the interest of the members to ensure meeting the best nterests of the public. The role the MDA has of advancing the interests of members has grown out of the desire of dentists not through legislated responsibilities."

I believe the last statement is the fundamental reason why we volunteer. It speaks to the core of who we are as a profession. When we desire to work together, whether it be on the Board, a Committee, or participate in a dental event, we are part of something greater than ourselves…. contributing our skills and knowledge to make a difference in someone else's life. Isn't that worth a few nights a year to attend Committee meetings or volunteer at Siloam Mission, a weekend to help out at Tooth Fairy Saturday or at the Open Wide Clinic at the College of Dentistry or at the Oral Cancer Screening Event? You don't need to travel abroad to contribute to a dental mission. You need not look any further than your own backyard. The opportunity to help those less fortunate or challenged in accessing reasonable dental care can reap rewards far greater than that which is measured in dollars and cents. And yes, there will be a time in your life when there just isn't enough hours in the day to volunteer. Then consider making a financial donation to organizations that advocate and aid in provision of dental care to those who need it, if that is the most you can do at the time. Remember, to volunteer is to give. Giving can take many forms.

It has been a privilege to serve the Manitoba Dental Association in my capacity as a Board member and now as your President. However, I take greater pride in my role as a member volunteer. The experience has given me the opportunity to learn so much about dentistry beyond the four walls of my own dental practice. A very wise dentist (Dr. Amarjit Rihal) once told me "You will never go wrong doing what's right. If it's worth doing it right, then you will find the time."

Make the most of your talents with the time that you have.

All the best to you,

Dr. Nancy Auyeung
MDA Prseident

Canadian Dental Association's Message

DR. A. MUTCHMOR, D.M.D
CDA BOARD REPRESENTATIVE

Unfortunately, as I prepare this Bulletin article, our next CDA Board of Directors meeting is still a week away and our last meeting was shortly before my last article. Therefore, instead of an accomplishment list, I will talk about some of the dental issues that we are currently looking at discussing at our next meeting.

With regard to CDA's Suite of Electronic Services, we continue to monitor the work to ensure that the problems and delays that ITRANS experienced in the fall have been corrected and that safeguards are in place to ensure continued smooth operation in the future. The system has been stabilized and upgrades to both the hardware and software of the system that were planned for the future, have been fast-tracked to allow ITRANS to handle the tremendous increase in the volume of transactions that this valuable system is presently processing.

We are also looking at the future of the eReferral program. Faxed and emailed patient referrals do not meet the requirements of today's privacy legislation. eReferral was developed as a way to transfer patient information with the required encryption to meet these requirements. CDA staff has been working with CSI staff to improve the usability of eReferral and looking at the potential of having eReferral incorporated into the various practice management software packages.

The CDA's new native app that provides mobile access to CDA Knowledge Networks products such as Oasis Discussions and a new drug database was rolled out last fall. The Board will receive a report on the launch and on the marketing of this product to the profession.

The CDA Dental Aptitude Test (DAT), the CDA Structured Interview and the Commission on Dental Accreditation of Canada (CDAC) contribute to support the availability of a highly educated workforce for the delivery of oral health care. The CDA has been working with the Association of Canadian Faculties of Dentistry (ACFD) on the CDA/ACFD DAT Review Working Group with the goal of providing advice to the CDA Board of Directors on how to maintain and increase the value of the Dental Aptitude Test Program for the dental school admissions process. This has resulted in a recommendation of the creation of a National Admissions Committee under the joint responsibility of CDA and ACFD and the Board of Directors will be reviewing and discussing the "Draft Framework for a National Admissions Committee (NAC)".

On January 1, 2011 the new Corporate Membership model for the CDA came into effect. The MOU has a ten year term with the provision that after five years, before January 1, 2017, a systematic review of the terms of the membership model upon which this MOU is based will be undertaken jointly by CDA and the Corporate Members to evaluate whether the intent of the agreement has been achieved. We will be beginning our planning and preparations for this review process.

Finally, under our Access To Care priority program, CDA continues to focus on children and a first visit by age one, seniors in long-term care facilities, and our input into the process to review the Non-Insured Health Benefits (NIHB) being conducted between the First Nations and Inuit Health Branch of Health Canada and the Assembly of First Nations (AFN). Last year, the CDA hosted the first National Oral Health Action Plan Symposium. The intent of this initiative was to develop a community of support composed of both oral health and non-oral health groups to engage in discussions and agree on possible common policies or initiatives that the participating organizations might endorse. At the conclusion of the symposium, a consensus was reached on three specific priorities on which there could be collaboration among the participating organizations: 1) a common position on community water fluoridation, 2) oral health standards in long-term care facilities, and 3) education programs for children and parents.

This fit very closely with projects that the CDA already had underway and since then, a consensus statement on water fluoridation has been circulated and endorsed by 27 of the attendee organizations and we have circulated a proposed statement on minimum Oral Health Standards for Long-Term Care Facilities. This is expected to be the topic of discussion as the CDA hosts the second symposium in this series, (now called the Canadian Oral Health Roundtable (COHR)), on February 26. The half-day symposium will be framed by a pre-symposium presentation from Canada's Chief Dental Officer on the status of oral health care in Canada and a post symposium networking reception.

As always, we are working very hard to keep improving the practice of Dentistry and the oral health of Canadians.

Dr. A. Mutchmor, D.M.D.
CDA Board Representative

MDA BOARD MEETING SYNOPSIS:
NOVEMBER 1, 2014

The following new appointments were made by the MDA Board: Deputy Registrar – Dr. Patricia Ling, Peer Review Chair – Dr. Lori Stephen-James, and Lead Investigator – Dr. Jean Bodnar.

The MDA Board also appointed the following individuals for a one year term renewable to represent the MDA on National Boards: CDA Board Representative – Dr. Alexander Mutchmor, NDEB Representative – Dr. Amarjit Rihal, and CDRAF Representative– Dr. Amarjit Rihal.

Other appointments included: Dr. Darci Bonar and Dr. Richard Santos, Co-Chairs - New Dentists Committee, Dr. Carla Cohn, MDA Representative - WRHA Oral Health Program's Quality Council, Mr. Rafi Mohammed – Secretary Treasurer, Dr. Marcel Van Woensel – Registrar and Dr. David Goerz as District #2 representative to fulfill the 2nd year of Dr. Michael Sullivan's term of office as he moves to the position of Past-President.

Dr. Jack Gerrow , NDEB Executive Director, presented the following to the MDA Board: historical overview of NDEB and changes to the NDEB examining processes from 1952 to 2012; NDEB certification process in place in 2012 for the countries of Australia, New Zealand and Ireland; Description of current NDEB Equivalency process; the use of psychometrics in evaluating exam questions; and breakdown of NDEB candidates passing NDEB exam – Canadian Facilities – 48%; Quebec Process – 10%, Equivalency Process – 21%; International sites – 21%.

The MDA Board established and approved a code of conduct for appointed representatives and board and committee members.

Manitoba Prescribing Practices: Dr. Marcel Van Woensel is serving on a Federal-Provincial-Territorial (FPT) working group on prescription drugs established to identify areas for potential collaboration. Dr. Van Woensel along with representatives of the Royal College of Dental Surgeons of Ontario (RCDSO) and the Alberta Dental Association and College (ADA+C) are members of this working group. This has led to a review of our own approval system for MPPP pads. New application form has been developed that will not allow for continuous supply of prescription pads but a one-time supply renewable upon application to MDA Registrar. Current application and approval process does not allow for proper monitoring of prescription drugs.

Continuing Competency: The Continuing Competency Committee has reviewed the Continuing Competency models of the Royal College of Dental Surgeons of Ontario, Ordres de Dentistes du Quebec, and the College of Dental Hygienists of Manitoba. Committee is also looking at the need for specific courses for MDA members i.e. CBCT employees, Personal Health corporation, and office development management.

Office Assessments: The MDA Board approved the inclusion of the office assessment resources on the MDA website.

Economic Committee: The MDA Board received as information the 2015 Economic Committee recommendation for an overall increase of 2.9% to all MDA approved fee guides. New procedure codes added to the 2015 fee guides included codes for cone beam images, temporomandibular disorders, pediatric ceramic crowns and bundling services.

Dr. Joel Antel, Chair – MDA Communications Committee presented an overview of the 2015 Marketing and Communication Strategy which included a strategic approach on the use of social media such as Facebook and Twitter. The MDA Board approved its work plan and budget for 2015.

Annual Meeting and Convention: The 2015 MDA Convention is scheduled for April 17 and 18, 2015 in Brandon. The theme is "Spring Fever". The MDA Board decided to continue hosting the convention on the last weekend of January.

Budget and License Fee: The MDA Board approved the 2014-2015 budget which calls for an annual license fee of $3250. This represents an increase of 3%.

Faculty of Dentistry: Dr. Douglas Brothwell, Associate Academic Dean highlighted the following about the College of Dentistry during his presentation to the MDA Board: National Dental Examining Board results in 2014 saw 7 Manitoba students fail. The College has initiated changes for the academic year to ensure better success in NDEB exams; University of Manitoba in addition to its 2.4% budget reduction in 2013-2014 is calling for another 4% budget reduction in 2014-2015.

MDA Life Members: Life Member status is given to a licensed dentist who has reached the age of 65 years and has been licensed with the MDA for 35 years or more. The MDA Board granted Life Member status to the following dentists: Dr. D. Wayne Acheson, Dr. Andrew R. Gauthier, Dr. Frank T. Hechter, Dr. Marshall D. Hoffer, Dr. Kenneth W. Howie, Dr. T. Gordon McKibbin, Dr. Roger W. Moir and Dr. D. Austin O'Brien.

Canadian Dental Association: Dr. Alexander Mutchmor provided the following update: CDA has added "Practice Support" as a priority one program; Creation of NHIB Review Taskforce to assess the proper level of funding and to ensure the program is administered efficiently; Dental Corporatization Taskforce completed its report on dental corporatization in Canada. CDA Seal Committee will be reviewing the CDA protocol for CDA Seal approval; Dental Aptitude Test (DAT) being reviewed by a joint committee of the CDA and Association of Canadian Faculties of Dentistry (ACFD); and CDA 2014 financial deficit will be $167,000 which is less than expected.
Non Insured Health Benefits: The NIHB compensation model effective July 1, 2014 is as follows; fee increase of 2.3% with select preventative codes set at 100% of the 2013 fee guide. Specialist's fees will not exceed 25% paid to general practitioners for the same procedure code.

IT Committee: The IT Committee is working on a strategy on the use of Facebook and Twitter in conjunction with the Communications Committee. The current MDA App for the convention will be expanded to be used as an App for the MDA. The IT Committee is also working on developing guidelines on transferring patient information electronically.

Date of Next Board Meeting will be January 22, 2015.

Manitoba **Dental** Association

OFFICE ASSESSMENT

New

ManitobaDentist.ca
Office Assessment Resource
Click Here

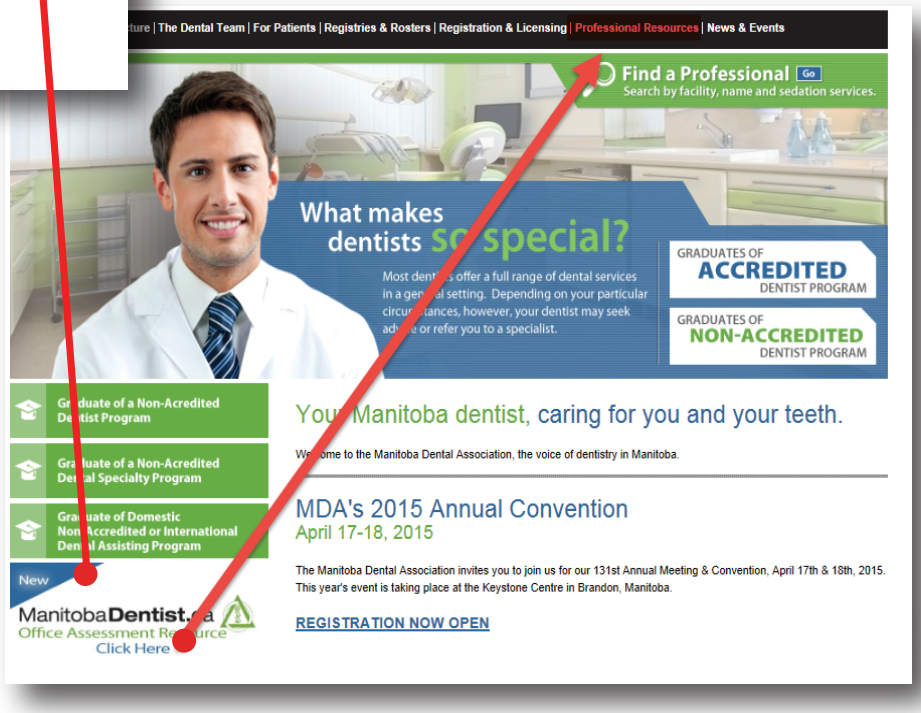
Office Assessment Resources

are **now available** on the Manitoba Dental Association website. (www.ManitobaDentist.ca)

There are two ways to access these resources from the MDA home page:

1. By clicking on the icon (as pictured above) which is located in the bottom left hand corner on the MDA home page, or,

2. By clicking the **"Professional Resources"** tab, scroll down and choose from the drop down menu by clicking on "**Office Assessment Resources"** (Please see illustration on the right)



For more information please call Linda at (204) 988-5300, ext. 7, or email: lberg@manitobadentist.ca

SAFE WORK MANITOBA

For full information on SAFE WORK Manitoba courses, course dates, location and availability, please visit their website at: www.safemanitoba.com

[click on the "Training" tab on their home page]

Manitoba Dental Association

Mission Statement

Manitoba Dental Association is the legislative self-governing body for the profession of dentistry and dental assistants in Manitoba.

"If it is in the best interest of the public then it is the best interest of the profession."

SAVE THE DATE

The Manitoba Chapter of Alpha Omega Fraternity
50th Annual Memorial lecture
Saturday, December 12, 2015

Proudly Presents:

Dr. Howard Farran
"The Business of Dentistry"
RBC Convention Centre
Presentation theatre - 2nd floor

Howard Farran, DDS, MBA, is a practicing dentist & noted international lecturer with over two decades of experience. He graduated from UMKC School of Dentistry, and earned his MBA from ASU. He is the Founder & CEO of Dentaltown Magazine and Dentaltown.com, and has authored many articles and video series.

Gold Sponsor: Crosstown Dental Lab

Manitoba
Health, Healthy Living and Seniors

Donna Hill
Executive Director
Legislative Unit
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August 18, 2014

Sent via email

Health Professions Registrars/Executive Directors,

I am writing to advise you of three important initiatives being implemented in relation to *The Personal Health Information Act* (PHIA) and to ask for your assistance in providing information to your members, particularly those members in private practice, on these initiatives and in relation to PHIA.

In this regard, I am pleased to advise you that Manitoba Health, Healthy Living and Seniors (MHHLS) has developed the following three PHIA online training programs for private practitioners and their staff:

1. **Direct PHI Version** - for health professionals and their staff who are required to access personal health information in providing care and services to patients and clients;

2. **Indirect PHI Version** – for individuals who are not required to access personal health information in carrying out their duties, but may have access to it, including for example custodial staff; and

3. **Administrator Version** – for office managers and IT administrators of a private professional practice who are responsible for developing office policies and procedures.

With regard to the Direct PHI Version only, we would request your consideration and feedback concerning whether your organization is willing to recognize this course as an approved continuing competency activity for your members.

If required to enable you to assess whether to recognize the program as requested, you can access this version, as well as the other training versions noted above, at: http://www.trainingtodo.com/mbhealth/secure/index.asp.

As noted above, we would also appreciate your assistance in notifying your members in private practice of the program.

MHHLS has developed a list of the policies and procedures required by trustees, including health professionals in private practice, to comply with PHIA. This list and other PHIA resources for health professionals are available on the MHHLS website at: http://www.gov.mb.ca/health/phia/resources.html.

As noted above, we would also appreciate your assistance in notifying your members in private practice of the list of required PHIA policies and procedures as well as the other PHIA resources now available on the MHHLS website.

In addition to the training programs and the list of required PHIA policies and procedures, revised Guidelines have been approved respecting the creation and auditing of Records of User Activity by trustees of personal health information under PHIA. These Guidelines are required for the purposes of section 4 of the Personal Health Information Regulation made under PHIA. In this regard, the Regulation requires:

> ***Additional safeguards for electronic health information systems***
>
> ***4(1)*** *In accordance with guidelines set by the minister, a trustee shall create and maintain, or have created and maintained, a record of user activity for any electronic information system it uses to maintain personal health information.*
>
> ***4(3)*** *In the following circumstances, a record of user activity is not required under this section:*
>
> *(a) if personal health information is demographic or eligibility information listed in Schedule B, or is information that qualifies or further describes information listed in Schedule B;*
>
> *(b) if personal health information is disclosed under the authority of clause 22(2)(h) of the Act (disclosure to a computerized health information network) in a routine and documented transmission from one electronic information system to another;*
>
> *(c) if personal health information is accessed or disclosed while a trustee is generating, distributing or receiving a statistical report, as long as the trustee*
>
> > *(i) maintains a record of the persons authorized to generate, distribute and receive such reports, and*
> > *(ii) regularly reviews the authorizations....*
>
> ***4(4)*** *A trustee shall audit records of user activity to detect security breaches, in accordance with guidelines set by the minister.*

As noted above, we would appreciate your assistance in notifying your members of the new Guidelines and how to access them. For your reference, the new Guidelines are available on the MHHLS website at: http://www.gov.mb.ca/health/phia/docs/rua.pdf

We would be pleased to provide you with a draft notice respecting the above initiatives for inclusion in your communications to members if you provide us with an outline of the requirements in this regard, such as how long such a notice should be to fit within your particular communication.

Thank you in advance for your assistance. Please feel free to contact me or Mr. Micheal Harding at 204-788-6612 or at micheal.harding@gov.mb.ca if you have any questions or require further information on any of the above-noted matters.

Sincerely,

Donna Hill

Donna Hill
Executive Director

Faculty Corner

DR. ANTHONY IACOPINO
DEAN OF DENTISTRY
UNIVERSITY OF MANITOBA

Keep Moving Forward. Teamwork, consistency, curiosity key to overall strategy for success

It was the great visionary Walt Disney who was once quoted as saying something to this effect:
"Around here, however, we don't look backwards for very long. We keep moving forward, opening up new doors and doing new things, because we're curious; and curiosity keeps leading us down new paths."

The wisdom of the words is self–evident, not only in the context of the amazing entity that the Disney brand has become, but also because it is a tried and true principle; a formula for success; a lesson in life.

In our collective experience, we have seen abundant, if not countless examples of this principle put in place to amazing effect. Most recently, our college earned the rare and significant achievement of being named a recipient of the prestigious Gies Award for Innovation; the first dental school in all of Canada to be so honoured in this category. This award was the result of a concerted effort by a great number of people here at the institution and beyond, who all worked together towards a common goal. While this was a significant and high profile achievement, it is hardly the only one of its kind we have witnessed in recent months. To that end, I'd like to share with you a short story of a recent experience of mine.

As many of you may know, I try to perform a regular walk-about in our college clinics and departments to see first-hand what's going on and how daily operations are working for all our stakeholders. In this way, I can best see what the problems might be, what's working well, and what issues need to be addressed. I often discuss my impressions with Associate Deans, Department Heads and support staff managers at all levels. Due to the summer break and extra time required to manage the Faculty of Health Sciences merger and current budget reductions, it has been about nine months since my last opportunity to complete such thorough visits.

Well, my most recent tour took place only a matter of weeks ago and I'd like to share my impressions with you. To be blunt, I can't express how proud and happy I was to observe the professionalism of our students, instructors and support staff. Compared to my last thorough walk-about nine months ago, there was a distinct change in spirit, customer service, teamwork and collegiality.

I observed wax-ups and wax work that were very neat and organized, a high level of compliance with infection control policies, and an upbeat spirit where both students, patients and instructors were glad to be there working amongst each other.

I saw students working together as operator and assistant to share endodontics cases so that each student would be able to complete the necessary experiences to achieve competency. Students were able to explain their cases and what they were working on during the appointment to me in a comprehensive and complete manner that demonstrated a thorough understanding and confidence. Instructors knew a lot about their students and were genuinely concerned about their progress.

Support staff was busy, interacting with students and patients in very efficient and productive ways, taking great pride in their contributions. Instructors, support staff and administrators were passionately discussing new ways to improve daily operations. Students in our preclinical lab were excited to be working on their first composite restorations as instructors offered individual assistance along the way.

Of course, these are things that were present in the past, but not to the overall degree and completeness that I observed recently. The energy and spirit were palpable and there was general satisfaction that many of the changes we've been making are working to resolve lingering issues from the past. We still have more to do to continue to improve the student, patient, and teaching experience; but we should never miss an opportunity to recognize progress and positive changes.

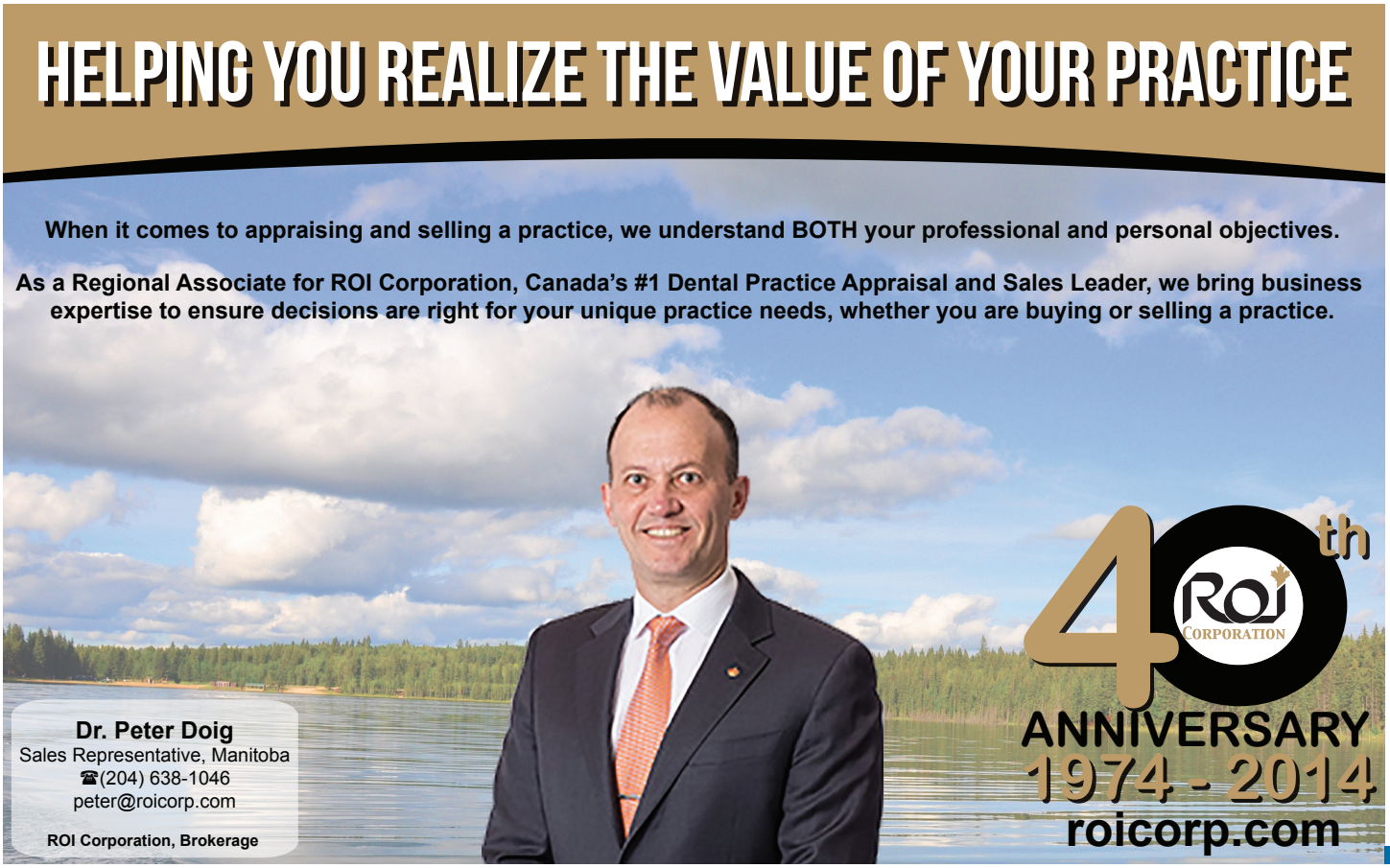
I am also compelled to mention that much of what I witnessed during this last tour was a direct result of the combined efforts of many concerned and dedicated professionals, especially our stakeholders in the community (including our very engaged Alumni Associations and Deans Advisory Council) who bring their observations and concerns forward to my office and our institution. It is exactly this kind of input and feedback that informs what it is that we try to accomplish here, so that we can refine our operations and can sharpen our focus towards optimum results.

And, while we are on the subject, I'd also like to share with you another very exciting development that we are all anticipating will fully unfold in the near future.

The College of Dentistry is looking to implement a new educational model of comprehensive care, which is now becoming the norm in modern dental schools. This new approach is based on Cognitivist educational theory, which informs that the best means to ensure a new graduate can function as a general dentist is to train them in the general practice environment.

A discussion paper is now available on our website and I welcome and encourage you all to visit and review its contents (http://www.umanitoba.ca/faculties/health_sciences/dentistry/media/WEB_Dent_3_-_Comprehensive_Care_Clinic_-_Discussion_Paper_-_Feb_17_2015.pdf). I would be most interested in hearing your feedback on this along with any other aspect of the dental school you might wish to discuss.
I think most of us can agree that there is little to be gained by dwelling on the past, either positive or negative. All we really can do is learn from our experience and apply that knowledge to our activities going forward. Because, at the end of the day, we must and we will, always, keep moving forward.

Grazie.



Smokeless Tobacco In Society

Dr. Dean Kriellaars (BPE, MSc, PhD, CEP)
Associate Professor in the Department of Physical Therapy, School of Medical Rehabilitation in the Faculty of Medicine at the University of Manitoba.

Smokeless tobacco use across the Canadian public sits at about 1%, with a westerly gradient reaching about 3% in Alberta. The interesting part of this story is that smokeless tobacco use in sports is quite high, averaging 14% across all sports, which is clearly and dramatically higher than the Canadian rate of 1%! If one looks deeper into which sports and which sex use the product, one observes a predominant use in baseball, hockey, football, rugby and a growing use in lacrosse, almost exclusively by males.

In fact, the prevalence of smokeless tobacco use hits rates between 30 and 50% for 16 year old male athletes in these sports, with an age of onset starting at 12 year of age! Contrary to logic, the higher the performance level the greater the use of smokeless tobacco! This likely reflects that the culture of the sport positively influences adoption and continued use of the product. In fact most hockey fans will know a professional player that uses. Athletes did not identify use of smokeless tobacco for performance enhancement. Athletes did not identify a conversion from smoking to smokeless tobacco. In fact, majority of athlete users indicate they adopted the behavior in a sport setting, especially while travelling with the team.

Two forms of smokeless tobacco make up the large proportion of those consumed by young and older men in Canada; chew tobacco (notable brand being Redman) and dip (notably Skoal and Copenhagen). The cost of a tin of dip averages around $26 a tin when purchased in Canada. However, a tin purchased in the USA and transported to Canada costs a mere $4 – promoting a large “traffic” of the product across the border. The average young males consumes about a 1.5 tins a week equating to a $2000 habit a year or $312 if purchased from the USA.

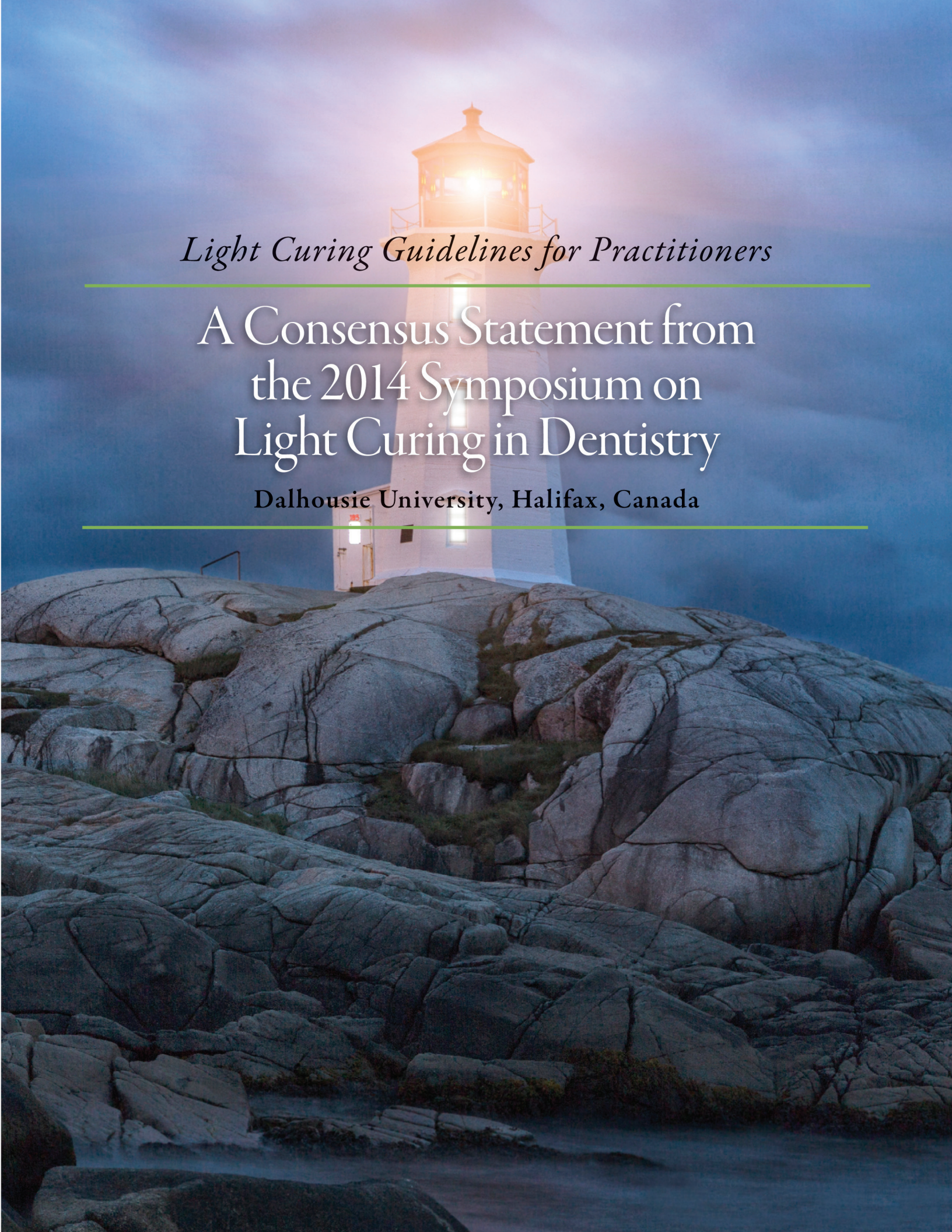
Smokeless tobacco provides about 4-12 cigarettes worth of nicotine! This is quite a high dose of nicotine in one sitting, and results in about 10% of first time users experiencing acute nicotine toxicity (throwing up). In hockey, about 70% of users report adopting smokeless tobacco in the minor or high school hockey setting (<15 years of age). In fact, over 75% of players report trying it once, with about 50% regular users (weekly or daily). The scary aspect of this use is that the vast majority of young males aged 16 to 20 indicate that their parents are still unaware of them adopting this “disgusting and filthy” habit. Interestingly, the teammates that do not use smokeless tobacco identified disgust in the habit and cost as the two reasons for not adopting use.

So what are the health issues associated with this product? The obvious risk is oral cancer. Certainly, smokeless tobacco use is substantially safer than cigarettes. However, the smokeless tobacco users do not overlap with cigarette users. So smokeless tobacco users are a distinct population. That is an asset, as we can target primary prevention programs to the parents and children involved in these sports for ages 12 to 16. Sadly there are no systematically implemented primary prevention programs!

Since the nicotine levels are so high, this makes cessation efforts very difficult, especially since the trigger for use is related to sport participation. So classic “stop smoking” programs do not work for smokeless tobacco users – you can’t easily ask the athlete to stop the “trigger” by leaving the sport! Nicotine replacement therapies have lower nicotine levels and are more expensive than the product itself – further hampering cessation efforts. Approximately 30% of smokeless tobacco users attempted to quit with negligible success. The difficulty in cessation, clearly points to a primary prevention strategy.

From a harm reduction point of view, it is important to teach this well defined user group how to examine their mouths for signs of oral cancer, and to seek the routine examination of their mouths by an oral health care practitioner. Many athlete users are unaware of the existence of leukoplakia. There is a need for athlete education so they can be vigilant for adverse changes in the oral mucosa. Certainly leukoplakia is a warning sign that needs to be monitored. About 60% of smokeless tobacco users exhibit these early stage cellular changes. The rate of oral cancer in men in Canada exceeds 7 cases per 100,000 population, making it the 11 most common form of cancer and about 90 is attributed to combined tobacco (notably smokeless) and alcohol use. Sadly, in sport there is very high incidence of episodic excessive alcohol use and when combined with high smokeless tobacco use in the 4 sports listed above, a near perfect scenario exists for development of oral cancer.

Oral health care providers are trusted by the public and need to rise to help in prevention strategies, as well as early detection/screening. Silence is no longer an option. Stand up and take a stance for the health of these young athletes.



Light Curing Guidelines for Practitioners

A Consensus Statement from the 2014 Symposium on Light Curing in Dentistry

Dalhousie University, Halifax, Canada

When properly performed, light curing of resin-based restorations produces better physical and chemical properties of the restoration, stronger bonds between the restoration and tooth, improved colour stability and a higher probability of a successful long-term clinical outcome. Light curing performed incorrectly can result in premature failure of the restoration and potentially more tooth decay, resulting in larger restorations that may require endodontic treatment, or other costly procedures. Undercuring resin-based fillings—by curing for an insufficient length of time, improperly positioning the light curing unit (LCU) over the restoration, or using the wrong type of LCU—is thought to contribute to the higher failure of resin-based restorations placed in general dental offices compared to the results from controlled clinical trials.

To discuss and address these concerns, an international symposium on light curing in dentistry was held at Dalhousie University in Halifax on May 29–30, 2014. The symposium was attended by 40 key opinion leaders from academia and industry who worked together to develop a Consensus Statement with advice on light curing for practitioners.

The symposium participants were Bob Angelo, Ahmed Abuelyaman, Suham Alexander, Sibel Antonson, Steve Armstrong, Oliver Benz, Uwe Blunck, Ellen Bruzell, John Burgess, Peter Burtscher, Liang Chen, Ivo Correa, Matt Dailey, Colin Deacon, Omar El-Mowafy, Jack Ferracane, Christopher Felix, Reinhard Hickel, Thomas Hill, Neil Jessop, Hilde Kopperud, Daniel Labrie, Hui Lu, Lori Moilanen, Bernhard Möginger, John O'Keefe, Joe Oxman, Frank Pfefferkorn, Jeffrey Platt, Richard Price, Jean-François Roulet, Fred Rueggeberg, Janine Schweppe, Adrian Shortall, Howard Strassler, Jeffrey Stansbury, Byoung Suh, Andreas Utterodt, David Watts and Stacy Wyatt.

The support of Benco, BISCO, BlueLight Analytics, DENTSPLY, 3M-ESPE, Gigahertz-Optik, Henry Schein, Heraeus-Kulzer, Ivoclar Vivadent, Kerr, Patterson Dental, SDI, and Ultradent is gratefully acknowledged.

Additional Resources on Oasis Discussions

- Buyer Beware! Not all Curing Lights are Equal
  oasisdiscussions.ca/2014/07/28/lc-3
- An Enlightening Look at Light Sources in Dentistry
  oasisdiscussions.ca/2014/07/17/cl-2
- Practical How To: How do you clean your light curing unit?
  oasisdiscussions.ca/2014/07/03/htcl
- Effective Use of Dental Curing Lights: A Guide for the Dental Practitioner
  oasisdiscussions.ca/2013/11/29/dcl

• Further resources on light curing will be posted on Oasis Discussions •

Light Curing Guidelines for Practitioners

A Consensus Statement from the 2014 Symposium on Light Curing in Dentistry, Dalhousie University, Halifax, Canada*

When selecting a light curing unit (LCU):

- **Recognize that all lights are not created equal.** Use a LCU from a manufacturer who provides contact information, a user manual, and service. Preferably the LCU should have received a favourable report or certification from a reputable independent 3rd party.
- **Know the key performance parameters of your LCU,** when new: (i) the light output (averaged irradiance over the beam incident area in mW/cm^2 and spectral output from the LCU), (ii) whether the beam has a uniform and effective output (profile) across the light tip, and (iii) the diameter of the light beam.
- **Be cautious** when using high (above 1,500 to 2,000 mW/cm^2) output LCUs that advocate very short (e.g., 1 to 5 seconds) exposure times. When used for such short times, it is critical that the light tip is stabilized over the resin during exposure. Although some resin composites are matched to specific high output curing lights, high output LCUs may not adequately cure all of today's resin-composites to the anticipated depth when used for short exposure times. Seek peer-reviewed literature validating the efficacy and safety of such lights and materials.

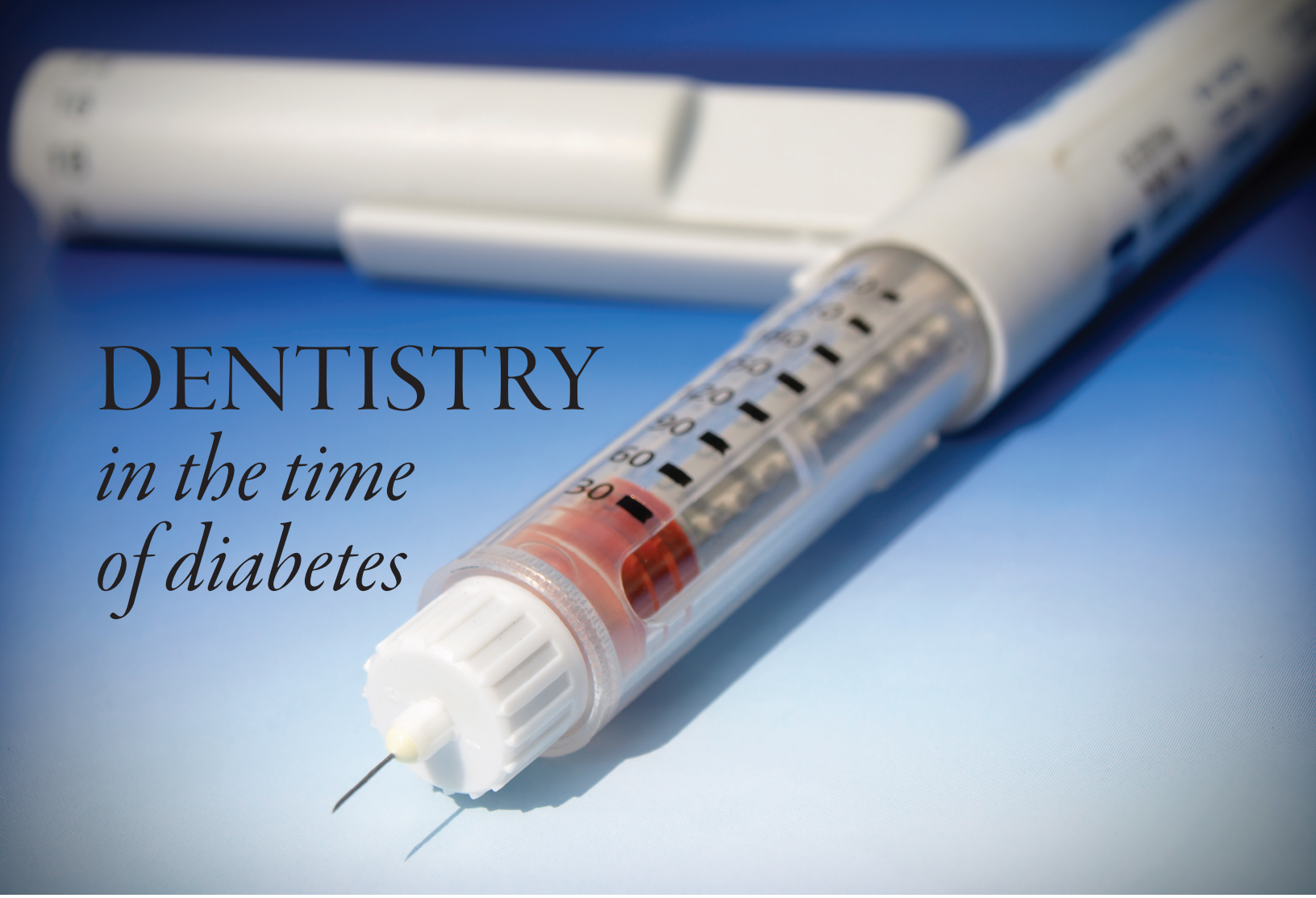
Before you light cure, remember to:

- **Regularly monitor and record** the light output over time, with the same measurement device and light guide. Repair or replace the LCU when it no longer meets the manufacturer's specifications.
- **Inspect and clean** the LCU before use to ensure it is on the correct setting, in good working order, and free of defects and debris.
- **Consider that every resin-based material** has a minimum amount of energy that must be provided at the correct wavelengths to achieve satisfactory results. [Energy ($Joules/cm^2$) = output (W/cm^2) x exposure time (seconds)]. However, minimum irradiation times are also required.
- **Follow the light exposure times and increment thickness recommended** by the resin manufacturer, making allowances if you use another manufacturer's light. Increase your curing times for increased distances and darker or opaque shades.
- **Select a LCU tip that delivers a uniform light output** across the light tip and that covers as much of the restoration as possible. Cure each surface independently, using overlapping exposures if the light tip is smaller than the restoration.
- **Position the light tip as close as possible** (without touching) and parallel to the surface of the resin composite being cured.
- **Stabilize and maintain the tip** of the LCU over the resin composite throughout the exposure. Always use the appropriate "blue blocking" glasses or a shield to protect your eyes as you watch and control the position of the curing light.

Precautions:

- **Avoid** conditions that will reduce light delivery to the resin-composite, e.g.,:
  - Holding the light tip several millimetres away.
  - Holding the light tip at an angle to the resin surface.
  - Dirty or damaged light-guide optics.
- **Supplementary light exposures should be considered** under circumstances that may limit ideal light access, such as shadows from matrix bands, intervening tooth structure, or from restorative material.
- **Beware of potential thermal damage** to the pulp and soft tissues when delivering high energy exposures or long exposure times.
- **Air-cool the tooth** when exposing for longer times, or when using high output LCUs.
- **Never shine the LCU into the eyes**, and avoid looking at the reflected light, except through an appropriate 'blue-blocking' filter.
- **Testing surface hardness** of the resin-composite in the tooth using a dental explorer provides NO information about adequacy of curing depth.

Reprinted with permission of the Canadian Dental Association. A Consensus Statement from the 2014 Symposium of Light Curing in Dentistry (Dalhousie University, Halifax, Canada) CDA Essentials. 2014;1(6):19-21.



DENTISTRY *in the time of diabetes*

With an estimated 3.3 million Canadians suffering from diabetes and an additional 5.7 million showing signs of prediabetes,[1] dentists can look outside the mouth to reinforce key messages and offer optimal care to their patients.

To curb the growing epidemic of diabetes in the United States, the National Diabetes Education Program (NDEP) has taken the initiative of rallying pharmacy, podiatry, optometry and dentistry (PPOD) professionals. The NDEP was established in 1997 to promote early diagnosis of diabetes, improve management and outcomes, and prevent—or at least delay—the development of type 2 diabetes.

The initiative relies on a team approach to engage key health care providers and reinforce consistent diabetes messages across the four PPOD disciplines. "PPOD providers are often a primary point of contact for people with, or at risk of, type 2 diabetes," the NDEP website explains. As such, those practitioners are well positioned to educate patients on diabetes control and prevention, discuss self-management, and refer to other health professionals to ensure appropriate care.

To help PPOD professionals in this endeavour, the NDEP has developed a comprehensive toolkit, called *Working Together to Manage Diabetes*, which includes:

- A **guide** with communication tips, information specific to each PPOD area, and information on other resources and related organizations;
- **Presentation slides** to help implement the PPOD approach;
- **Fact sheets** that health care providers can use to educate patients; and
- An **education sheet** and **checklist** document to help patients control their diabetes and for health care providers to communicate efficiently among themselves.

The NDEP is sponsored by the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH) and involves over 200 federal, state, and private sector agency partners.

Dr. Martin Gillis of Liverpool, Nova Scotia, registrar for the Provincial Dental Board of Nova Scotia and a past member of the consultative section on diabetes education at the International Diabetes Federation (IDF), served as chair of the PPOD update task group. "With this initiative, the NDEP wants to encourage health care providers to form local networks," he says. "I think there's an opportunity to do this in Canada, for actions to take place at the national and local levels. Through a concerted approach, we can not only ensure that our patients' oral health care needs are met but also support our PPOD colleagues by encouraging foot care, eye care and medication reconciliation."

Dr. Gillis emphasizes the importance of giving people the knowledge and tools they need to become active players in their own health management. "Health behaviour is an important aspect to focus on when meeting with patients." Dentists can help their patients form and maintain healthy habits through motivational interviewing. "Discuss risk factors with them," suggests Dr. Gillis. "Poor nutrition is a risk factor for obesity, type 2 diabetes and tooth decay. Help your patients understand those connections and help them identify reasonable changes they can implement in their day-to-day life."

"General positive health behaviours and habits can translate into positive health behaviours in more complex scenarios like diabetes self-management. Building self-efficacy is key," says Dr. Gillis.

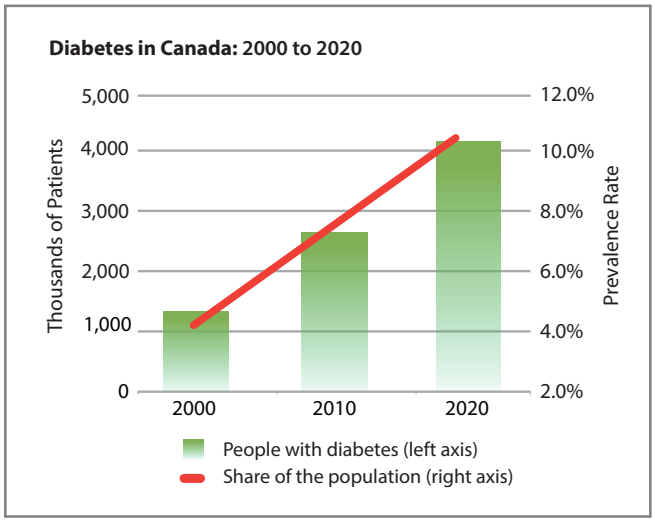


Figure: *In 2010, 2.7 million (7.6%) Canadians had diabetes and it is estimated that this number will grow by 1.5 million over this decade to 4.2 million (10.8%) by 2020.*

Source: Canadian Diabetes Association and Diabetes Quebec. DIABETES: CANADA AT THE TIPPING POINT-Charting a New Path. 2011, p. 16.

The NDEP Toolkit
'Working Together to Manage Diabetes'
is available at:
cdc.gov/diabetes/ndep/ppod.htm

Reference

1. Canadian Diabetes Association. diabetes.ca/getmedia/513a0f6c-b1c9-4e56-a77c-6a492bf7350f/diabetes-charter-backgrounder-national-english.pdf.aspx

Martin Gillis

Poor nutrition is a risk factor for obesity, type 2 diabetes and tooth decay. Help your patients understand those connections and help them identify reasonable changes they can implement in their day-to-day life.

At the international level

The IDF is an umbrella organization of over 230 national diabetes associations in 170 countries and territories. The FDI World Dental Federation and IDF first met in 2007 to discuss how they could cooperate to ensure quality oral care for those with diabetes. "We looked at some projects," Dr. Gillis explains, "one of which was the creation of an oral health guideline for people with diabetes." Dr. Gillis represented the IDF on the task force that lead to the release in 2009 of the **IDF oral health guideline**, which offers evidence-based recommendations for diabetes care providers on oral health care. Guideline available at: **idf.org/guidelines/diabetes-and-oral-health/guideline**.

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Ensemble

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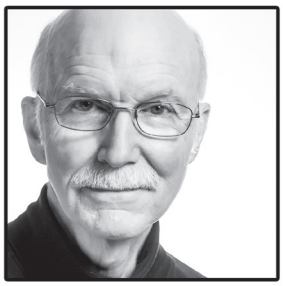
Ensemble

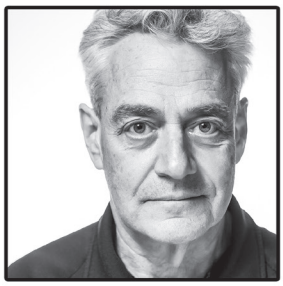
CHRIS COTTICK
"The Monster"

KRISTIN CUTHBERT
Ensemble

KATIE DAVIDSON
"Inga"



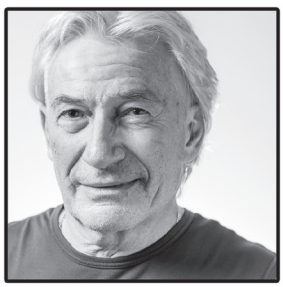
TOM DOBBS
"Dr Victor Von Frankenstein"



FRANK HECHTER
"Igor"

KIRANPAL KAUR SROAY
Ensemble

SARAH KEATING
Ensemble



BILLY KETTNER
"Ziggy"

TRICIA MAGSINO BARNABE
"Elizabeth Benning"

PATRICK MAO
Ensemble

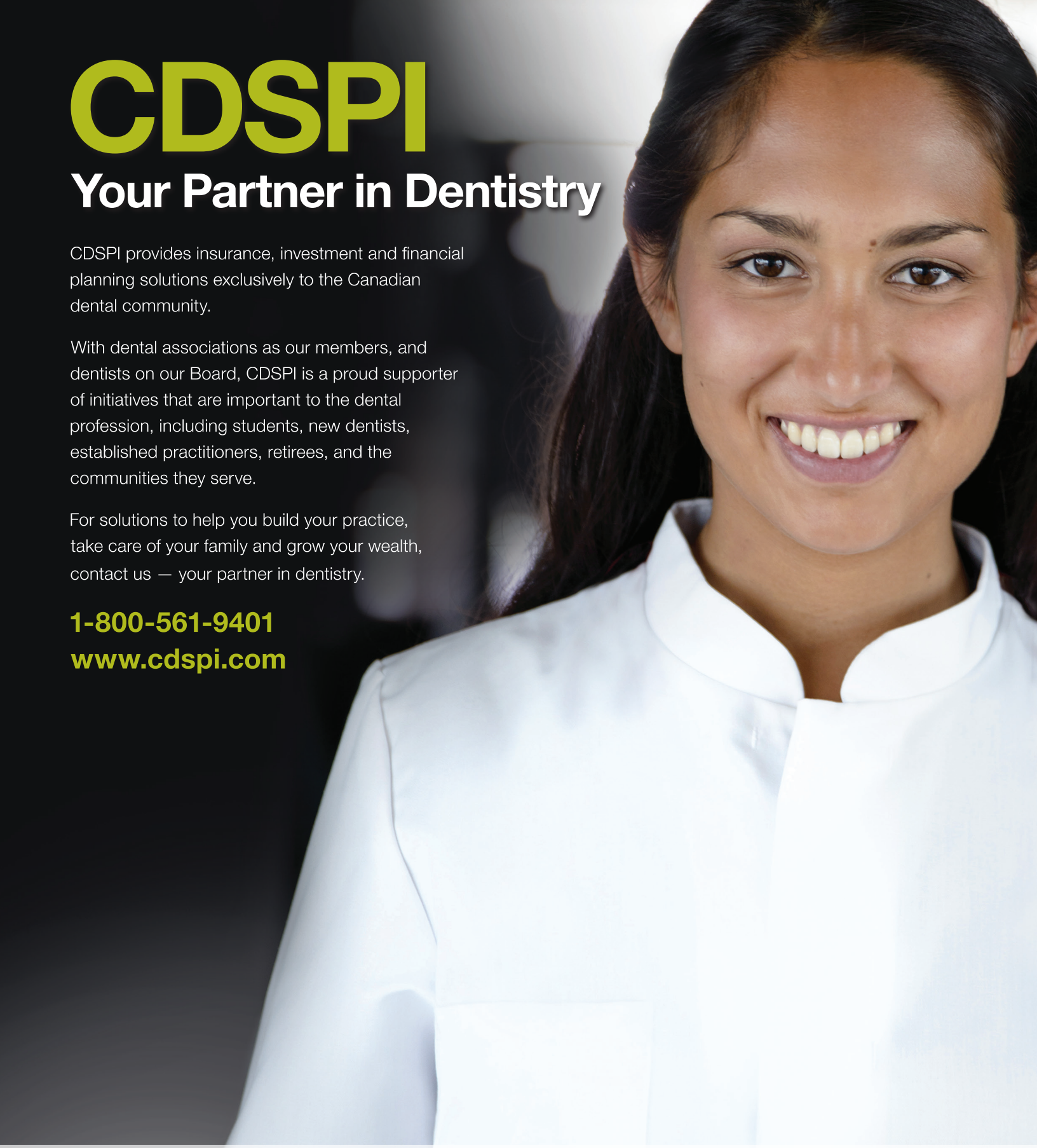
MICHAEL PORCO
"Frederick Frankenstein"

GEORGE STOLARSKYJ
Ensemble

ROBIN SZMADYLA
"Frau Blucher"

RANDY WARKENTIN
"Inspector Kemp"

CHRIS YUE
Ensemble



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Time for Reflection
A Message from the MDA President

DR. NANCY AUYEUNG, D.M.D.
PRESIDENT, MDA

Our clinical and business responsibilities demand so much of our attention, yet we still take time to recall that ours is a helping profession. The work that we do contributes to an improved quality of life for members of our communities. The MDA is fortunate to represent you as professionals serving patients you see regularly and those to whom you extend a helping hand in a time of need.

While we are not always compensated for our efforts, the treatment we provide is of immeasurable relief and value to our patients. This represents our contribution to the proper oral care and health of the people of our province. Time and again our member dentists provide above-and-beyond assistance that confirms the positive impact we have on peoples' lives.

While we willingly give to others, we in the dental profession may also need to turn to others for guidance and advice from time-to-time. Whether it's pressures at home, business challenges or questions related to our personal development, there are available resources at our disposal within the dental community.

CDSPI, as part of the dental community, appreciates the opportunity to work with dental professionals in their capacities as family members, practitioners and community leaders. Along with insurance and investment services, CDSPI offers access to MAP, or Members' Assistance Program, to all members of the dental community and their families. Operated by Shepell, MAP boasts a breadth of services – from short-term counseling to professional referrals for managing your health, finances and relationships.

CDSPI has also been active in providing support and professional development initiatives through student programs. Whether it's helping our future dentists develop financial strategies for managing student debt or helping to prepare them for their careers as dentists, students at the University of Manitoba learn skills that will help them in their professional lives.

Specifically, CDSPI has demonstrated its support to the growth of our future dentists with its sponsorship of our Welcome to the Profession Dinner and Student Mentorship Program. This unique opportunity pairs undergraduate students with practising dentists who act as mentors throughout their university years.
And for our retired dentists who generously offer their services on a voluntary basis, CDSPI introduced pro-bono malpractice coverage. With this protection, dentists who have charitable licenses can treat those who would otherwise not receive the regular and necessary care of a dentist.

The MDA and CDSPI look forward to celebrating your accomplishments in the coming year. To learn more about CDSPI and the Members' Assistance Program (MAP), visit www.cdspi.com.

Corporatization. What Does It Mean, What Have We Learned?

DR. MIKE SULLIVAN, D.M.D.

Many believe that Manitoba is somewhat isolated from the progression of corporatization. In fact it has already arrived. The trend to large corporate dental practices is unfolding all across Can-ada. While this is a fairly recent ownership model in Canada, one can look to other parts of the world where corporatization has been established for a longer period of time to see it's effect. In Australia, 7% of dentists reported that their practice was part of a larger corporate entity that de-livered care at more than one location. This growth has occurred in just the past 10 years. In the United States that number is 15%. So what does this mean for our profession in Manitoba?

First, we need to define the term "corporatization". This term is too encompassing for in reality the majority of dental practices in Manitoba are in fact incorporated. Their ownership models have shares that are owned by the dentist, their partners or family. There are also several group practice models that have a corporate structure. These are both outside of the profession's concerns around corporatization. For this discussion coporatization is defined by practice services being provided via contract with a for-profit third-party organization that is not controlled by the practicing dentist. The concern arises that external corporate ownership and it's investors may be concerned with profit maximization where as a practicing dental practitioner that owns a dental corporation would be obligated to balance this with professional ethical and treatment standards. It has been repeatedly demonstrated that any time in the past where there was external financing in health care, patient-centred care diminished.

Let's look at this further.

Most corporate entities exist where the corporation itself is owned by the practicing dentist. Subsequently, dentists would be free to develop treatment recommendations based on patient needs with no external influences or restrictions. Patient-centred care is best delivered when the dentist/patient relationship is based on the dentist having full autonomy for treatment options.

However there are other corporate entities where external investors have control of the corporate dental practice. They may subsequently exert undue influence on individual dentists. This may include limiting the ability of a dentist to refer to a specialist of choice. You may be forced to strictly refer to a company approved specialist. Similarly, a dentist may only be able to use a company approved laboratory. Perhaps you would be forced to use certain restorative materials. One could also loose the ability to control staffing. However, the most concerning influence would be that of profit maximization. With the potential of production quotas being implemented, the drive to maximize profit may be at odds with the provision of quality patient care. In 2013 the US Senate released a report that alleges fraud and abuse by a number of American dental corporations. It stated dentist employees were pressured or required to perform unnecessary pro-cedures and or prescribing the most expensive treatment available in order to maximize profits, particularly on young children. This report was an insight into what can occur when professional ethics are replaced by the interests of an externally financed corporate entity.

Currently in Manitoba, the Manitoba Dental Association is the statutorily authorized regulatory body for dentists. Our enabling legislation is The Dental Association Act. Dentists are required to have read and abide by the MDA's Code of Ethics in order to receive licensure in Manitoba. To remain onside with these regulations, it is imperative that a dentist's ability to make his/her own practice choices must remain free from corporate influences.

Corporatization is not possible without the participation of dentists. So let's look at the groups of dentists who are being affected the most. The first group would be associates. Today most new graduates quite frequently come out of dental school with extensive debt. They are looking for guaranteed income from day one of practice, a guaranteed salary. Over-saturation of dentists in urban centres can make obtaining an associate position difficult. There is also an increased want for a reconciliation of work and family life. With the ever increasing costs and administration associated with starting or purchasing a new practice, this possibility is out of reach for most new graduates. Dental corporations are positioned and in fact market themselves to this group. As an associate one should never underestimate the impact the first experiences as a dentist will have on your professional career. The second group of dentists that corporatization appeals to are those who are moving out of practice ownership. They are looking for a transition oppor-tunity towards retirement. With increasing regulatory and professional requirements being placed on dental practices they may no longer want this administrative burden. These estab-lished dentists are looking to extend their career while decreasing work hours and cashing-out the value of their practices. There is the potential that dentists may like the idea of a large "cheque upfront" upon sale of their practice, but they may be severely penalized if they do not meet their production targets set out in their sale agreement. This can be especially harmful to those older dentists who are in the decreasing later stages of a dentist's earnings life cycle.

Entering into a corporate arrangement is not a simple decision. In signing corporate contracts, dentists should avoid performance clauses, i.e. don't work under quotas. Are you free to make treatment decisions? Must I do all the work or can I refer the patient to a specialist of my choos-ing? What are the staffing implications? Some of these contracts can be very lengthy and com-plex. Good advise from accountants and lawyers is a must before signing any document. Understand what you are signing. Remember if it seems to good to be true, it probably is.

The primary consideration in healthcare must always be the health of the patient. The concern to our profession occurs when any practice puts the drive to profit maximization ahead of patient care.

The corporatization that we have been discussing can only exist because dentists allow it to exist. By ensuring that we practice dentistry without the influence of outside corporate interests interfering in the dentist/patient relationship and by abiding by our Code of Ethics, the dentists of Manitoba will be able to continue to provide optimal oral health care.

Dr. Mike Sullivan
Member of The Canadian Dental Association's Discussion Group on Practice Ownership and Patient Care

Philanthropy Corner

One to Watch! Meet John Prendergast.

John Prendergast is a human rights activist and best-selling author who has worked for peace in Africa for thirty years. He is the Founding Director of the Enough Project, an initiative to end genocide and crimes against humanity affiliated with the Center for American Progress. John has worked for the Clinton White House, the State Department, two members of Congress, the National Intelligence Council, UNICEF, Human Rights Watch, the International Crisis Group, and the U.S. Institute of Peace. He has been a Big Brother for over 25 years, as well as a youth counselor and a basketball coach.

John is the author or co-author of ten books. His latest book, Unlikely Brothers, is a dual memoir co-authored with his first little brother in the Big Brother program. His previous two books were co-authored with Don Cheadle: Not On Our Watch, a New York Times bestseller and NAACP non-fiction book of the year, and The Enough Moment: Fighting to End Africa's Worst Human Rights Crimes. He is also beginning a project on the Congo with actor Ryan Gosling and New Yorker writer Kelefa Sanneh.

John is a board member and serves as Strategic Advisor to Not On Our Watch, the organization founded by George Clooney, Matt Damon, Don Cheadle, and Brad Pitt.

His recent publications include articles in The Daily Beast, Foreign Policy, Foreign Affairs, and Vice.

During his time in government, John was part of the facilitation team behind the successful two-year mediation led by Anthony Lake which ended the 1998-2000 war between Ethiopia and Eritrea, the deadliest war in the world at the time. He was also part of peace processes for Burundi (led by Nelson Mandela), Sudan (led by Lazaro Sumbeiywo) and Congo.

Under the Enough Project umbrella, John has helped create a number of initiatives and campaigns. With George Clooney, he co-founded the Satellite Sentinel Project, which aims to prevent conflict and human rights abuses through satellite imagery and forensic investigations of stolen assets that fuel violence. With Tracy McGrady and other NBA stars, John launched the Darfur Dream Team Sister Schools Program to fund schools in Darfurian refugee camps and create partnerships with schools in the United States. Through the Enough Project, he conceived the Raise Hope for Congo Campaign, highlighting the issue of conflict minerals that fuel the war there and supporting a more comprehensive peace process, and its companion Conflict-Free Campus Initiative. He also helped direct the Sudan Now campaign, which supported the holding of a peaceful referendum for South Sudan.

John has been awarded six honorary doctorates. He is or has been a visiting professor at Stanford University, Yale Law School, Columbia University, Dartmouth College, Duke University, American University, American University in Cairo, the University of San Diego, the University of Pittsburgh, Temple University, Albright College, St. Mary's College, the University of Massachusetts Lowell, and Eckerd College.

John has appeared in four episodes of 60 Minutes, for which the team won an Emmy Award, and helped create African characters and stories for two episodes of Law and Order: Special Victims Unit, one focusing on the recruitment of child soldiers and the other on rape as a war strategy. John has also traveled to Africa with NBC's Dateline, BC's Nightline, The PBS NewsHour, CNN's Inside Africa, Newsweek/The Daily Beast, and The New York Times Magazine. He has appeared in several documentaries including: Blood in the Mobile, Sand and Sorrow, Darfur Now, 3 Points, and War Child. He also co-produced with Martin Sheen and Melissa Fitzgerald the documentary After Kony: Staging Hope, which focuses on Northern Uganda. John partnered with Downtown Records and Mercer Street Records to create the compilation album "Raise Hope for Congo," combating sexual violence against women and girls in Congo.

John has received the following awards: The Huffington Post Game Changer Award; the United Nations Correspondents Association Global Citizen of the World Award; the Lyndon Baines Johnson Moral Courage Award; the Princeton University Crystal Tiger Award; the U.S. Department of State Distinguished Service Award; the Center for African Peace and Conflict Resolution Award; Outstanding Literary Work for Not on Our Watch at the 39th NAACP Image Awards; 12th Annual Moste Lanterns Award; Global Action Humanitarian Award; American University School of International Services Alumnus of the Year; Southern California Mediation Association Randolph Lowry Lecturer Award; Dispute Resolution Services Louis M. Brown Conflict Prevention Award; Leon H. Sullivan Foundation Special Service Award; Temple University Alumni Fellow; Kean University Human Rights Institute Award; the State Department's Superior Honor Award; and the Champion of Human Life Award from The Values Network.

MEMORIALS

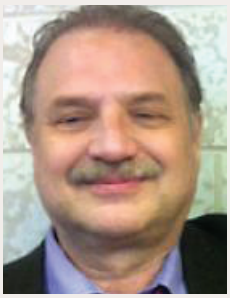
DR. VERNON JAMES ROSNOSKI
June 27, 1929 - December 3, 2014 It is with overwhelming grief and shock that we announce the loss of our father, grandfather, brother, friend. Vern passed away at his home on Wednesday, December 3, 2004 and a small private family service was held on Tuesday, December 9, 2014 at the Russell Funeral Chapel. He was predeceased by his wife Doris Rosnoski, parents Marie and John Rosnoski and brothers Ed and John Rosnoski. Left to cherish his memory are his sisters; Joyce Salstrom and John Moser, Lillian and Rae Josephson and Irene and Bill Ostopowich and families. Vern's son Brent Rosnoski and grandsons Thomas, Jonathon and William Rosnoski daughter; Carla and Bruce Falkevitch and grandchildren Brandy, Tessa and Kolton Falkevitch and daughter; Laverne and Kevin Tomsha and grandchildren Taylor, Triston, and Tori. He will be sadly missed, but forever in our hearts.

DR. CAMERON COUTTS CROLL
Born June 6, 1946 and passed away on January 25, 2014 with family at his side after a brave battle with brain cancer. Cam is survived by his wife Juanita, a sister Heather, sons Dwayne (Michelle) and Brian (Abbi), Grandchildren Anthony, Ashley, Cameron and Adrianne and Great Grandson Kobe. Cam was a former Captain in the Canadian Armed Forces and then a talented dentist but above all was the best dad, best grandparent and best friend. A special thanks to the remarkable staff of the Palliative Care Unit at Saanich Peninsula Hospital. In lieu of flowers please donate to the BC Cancer Foundation.

DR. PHILIP KATZ
Tragically, on March 6, 2014, Philip Katz passed away at the age of 59. He is survived by his wife Fay-Lynn, children, Matthew, Cara, and Jonathan, mother, Esther Katz, and mother-in-law and father-in-law, Toby and Mayer Gutwilik. Phil will also be missed by his brothers-in-law, sisters-in-law, aunt, cousins, nieces, and many friends. He was predeceased by his father, Morris Katz, brother David Katz, and grandparents Edel and Mindel Shore and Bernard and Tilly Katz. Phil graduated from Joseph Wolinsky Collegiate where he was a member of the legendary Cantor Brownstone choir. He attended the University of Manitoba where he quickly became known as a hard working student, first in the Faculty of Science and later in the Faculty of Dentistry. After graduation, Phil began a fulfilling career as a general dentist. He happily celebrated the 35th anniversary of his dental class at a reunion in Las Vegas last April. He was a dedicated and devoted dentist who enjoyed long-lasting relationships with his patients, many of whose families also became his patients. Phil's presence at the McPhillips Dental Health Centre will be deeply missed by his patients, partners and the entire staff. In 1981, Phil met Fay-Lynn and within ten weeks of their first date they both knew that their relationship was meant to last forever. They were married on May 20, 1982 and their bond of almost 32 years was one of true friendship and partnership. They celebrated many joyous occasions together and also served as each other's support through many devastating losses. Only seven months after their wedding, Phil's beloved brother, David, died tragically in his sleep. Several years later, at the age of 59, Phil's father passed away. Phil also lost his maternal grandparents during those first five years of their marriage. In the aftermath of these losses, Phil and Fay-Lynn decided to start their own family. Although this did not happen in the usual manner, on December 2, 1989, Phil and Fay-Lynn delightedly welcomed the safe arrival of their triplets. Right from the start, Phil was a devoted father who shared equally with Fay-Lynn in all aspects of parenting. It was important to both of them that their children learned the value of family, mentcshlechkeit, community service, and that they appreciated the importance of education and hard work. Instilling these values in three children of the same age, at the same time, was a challenge, but Phil and Fay-Lynn did their best to meet it. Phil led his children by example in so many ways, including volunteering at their school. While the children were growing up, Friday night dinners and holiday celebrations were woven into the fabric of life in the Katz household and these traditions continued as they moved into adulthood. Supporting the children and ensuring an equally well-rounded upbringing for each of them involved a great deal of parental time and effort. Phil was there, at Fay-Lynn's side, each step of the way and he derived much joy in seeing the children thrive in their extra-curricular pursuits, graduate from high school, and, ultimately, begin their university careers. Phil was overjoyed when Matthew and Cara were both accepted into medical school and was so proud to be a guest at their white coat ceremony. He was equally elated when Jonathan was accepted into law school last fall and took great pleasure in helping him move to Minneapolis and set up his own apartment. Phil loved to travel, and especially enjoyed his annual summer visits to his family's cottage at Lake Muskoka. He shared a special relationship with his aunt and uncle, Thelma and Victor Shore, both of whom he loved very much, and he considered his first cousins, Ricki, Elaine, Ian, and Steven as brothers and sisters. Phil's warm smile, the twinkle in his eyes, and his affable nature will be forever remembered and sadly missed by all who knew him. Fay-Lynn and family would like to thank their devoted relatives and extraordinary friends who have been unfaltering supports to them during this difficult time. They also extend their heartfelt thanks to the first responders who saved Fay-Lynn's life and to the Health Sciences Centre medical staff, including Dr. Berrington, Dr. Casey, Dr. Ali, and their departments. The family also wishes to extend its sincere thanks to Rabbi Alan Green and the staff at the Shaarey Zedek Synagogue for their compassion and support. Funeral services were officiated by Rabbi Alan Green at the Shaarey Zedek Synagogue on Monday, March 17, 2014. Interment followed at the Shaarey Zedek Cemetery. Pallbearers were Michael Kay, Jeff Marantz, Irv Micflikier, Corey Rochkin, Gary Sandor and Ian Shore. Honorary pallbearers were Keevin Bernstein, Lanny Jacob, Sheldon Mindell, Marty Minuck, Sheldon Permack, Izzy Shore and Jeffrey Stern. In lieu of flowers, those who wish to pay tribute to Phil's memory may make donations to the "Fay-Lynn and Philip Katz Leave More than Memories Endowment Fund" at the Jewish Foundation of Manitoba, or to a charity of their choice.

DR. MORLEY SHUCKETT

Dr. Morley Shuckett died peacefully on February 25, 2014 at St. Boniface Hospital at age 90. He is survived by his devoted and loving wife of 63 years, Sally (nee Schultz) ; son Bruce (Judy) and daughter Rhonda (Doug); grandsons, Brandon, Joshua, Mitchell, Jacob, and Matthew, sister Fritzie Telpner; sister-in-law Bert Shuckett. He will be lovingly remembered and held in high esteem by Sally's surviving family members Ruth Shenback, Alice Halprin, Laurane Schultz and by his many nieces and nephews. Predeceased by parents, Jacob and Rachel Shuckett, brothers Ben, Nathan and Dave, sisters Goldie Genser and Esther Lecker. Morley was born November 13, 1923, the youngest of seven in an active, loving family. His father, Jacob established a thriving business, Winnipeg Lumber and Fuel and helped to establish the Rosh Pina Synagogue and The Sharon Home. Morley was "the baby of the family", which may have explained his perpetually youthful outlook. He was raised at 125 Machray Avenue in Winnipeg's North End, in a bustling Jewish family neighbourhood, aspiring to the Canadian dream. The neighbourhood was filled with children and Morley established boyhood friendships that he maintained and valued his entire life. Athletic, he played football for St. John's Tech High School. He was an enthusiastic hockey player from childhood well into his 70s. The Second World War interrupted his university studies. He volunteered and served with the Royal Canadian Navy in the North Sea, based in Scotland. After his military service, he attended the Faculty of Dentistry at the University of Toronto. Upon graduation, he returned to his beloved Winnipeg. Morley practiced Dentistry in his office at Salter and Matheson for 50 years. He enjoyed and thrived in his chosen profession, enjoying helping his patients. He attended dental emergencies readily any time a patient called. He was a member of the Alpha Omega dental fraternity and continuously upgraded his skills throughout his long career. Enjoyable summers were spent at Clear Lake when his children were growing up, always at the same unit at Johnson's Cabins. Later, Morley and Sally travelled extensively throughout Europe. A highlight was their trip to the Soviet Union for the 1972 Summit Hockey Series. London, England was his favourite destination. He liked to quote Samuel Johnson, "When a man is tired of London, he is tired of life". He had a penchant for Shetland Sheepdogs and always had a "Sheltie" by his side from 1954 to 1991 and especially cherished his last Sheltie, Laird. After retirement, winters were spend in Palm Springs where he delighted in long mountain hikes with Sally. He also arranged and played in tennis tournaments with his friends and neighbours in Palm Springs. He was a member of the Glendale Country Club, eschewing golf for tennis which he played with his characteristic enthusiasm. Always in superb physical condition, the onset of a progressive debilitating neurological condition began in his early 80s, slowly, inexorably preventing him from engaging in the vigorous activities he loved so much. He accepted his deteriorating condition with dignity and grace, always grateful to his doctors and caregivers, never once complaining. He died peacefully with his beloved Sally, family and caregivers by his side. His greatest love was for Sally, their children and five grandsons. He took great pride in his children's accomplishments in medicine, as he had always instilled in them the importance of serving society in a meaningful way. He will live on in our hearts and memories, remembered for his positive outlook, youthful enthusiasm, integrity, his friendship and generosity. With gratitude to caregivers, particularly his long term caregiver Olivia, as well as Jun, Ruth, Racquel, Iris, Doreen, Sheila, and Ronnie. With gratitude for the medical care of Dr. Van Jaarsveldt, Dr. Drobot and staff at St. Boniface Hospital and Dr. Borys at the Neurology Movement Disorder Clinic. In lieu of flowers, donations may be made to The Sally and Morley Shuckett Fund at The Jewish Foundation of Manitoba, or the charity of your choice. "Say not in grief he is no more, but live in thankfulness that he was". - Hebrew proverb



DR. MICHAEL HARRY BAGAN

July 24, 1953 - December 12, 2014

Dr. Michael Harry Bagan passed away early Thursday morning in his home at the age of 62. He now joins his loving parents Ollia and Walter Bagan. This wonderful man is leaving behind his sons Justin, Jonathan, Matthew; daughter Jillian; and his brother Tim. Michael had graduated from the University of Toronto on April 19, 1978 with a degree of dental surgery, given by the Royal College of Dental Surgeons of Ontario. He worked as a dentist at Transcona Medical Center for over 10 years. He loved being with his kids and showing them how his generation had the best movies and music.

DR. MARTIN STITZ

With great sadness, the family of Dr. Martin Brent Stitz announces his passing on April 18, 2014. Marty, as he was known to all, was born in Winnipeg on March 4, 1957, the eldest of three children. He was predeceased by his parents David (d. 1992) and Shaino (d. 2012). Marty is survived by his sons Charles and Michael (Kristen), his brothers Sholom (Freda) and Marshall (Mia), his long-time girlfriend Jean Riggall, as well as his nieces and nephew Dena, Liat and Gilad, and many relatives and friends. Marty graduated from the Faculty of Dentistry at the University of Manitoba in 1981. He began practicing dentistry in Portage la Prairie. A couple of years later he moved back to Winnipeg where he opened a thriving dental practice in Winnipeg Square. He was a selfless practitioner with a gentle touch and was held in the highest regard by his patients. Marty is remembered for his sense of humour, intellect, and generosity. He had a passion for his dogs, travelling, watching documentaries and all Boston sports teams. He was a sociable person who loved to talk to people and he was devoted to his family and anyone close to his heart. He will be deeply missed. The funeral service was held on Sunday, April 20, 2014 at Chesed Shel Emes Chapel. Marty was peacefully laid to rest at Hebrew Sick Benefit Cemetery. Pallbearers were Charles, Michael, Sholom, and Marshall Stitz, Laurie Etkin and Murray Elfenbaum. Shiva is being observed until Monday morning. His family requests that, in lieu of flowers, donations be made to the Heart and Stroke Foundation of Canada, or a charity of your choice.

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