

MDA Bulletin

Winter 2025 Volume 45, Issue 4 ISSN 0707-1717



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The MDA Bulletin is published on a quarterly basis; submission deadlines are: **February 20, May 20, August 25 and November 20.**

- Full colour, 8½" x 11", published quarterly.
- Circulation is approximately 1,000 to Manitoba dentists and dental professionals.
- Published online at ManitobaDentist.ca.

Advertisements may be submitted by email or CD/thumbdrive accompanied by hard copy.

Please email submissions to the Manitoba Dental Association:

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Phone: 204-988-5300
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ON THE COVER:

Chantal Kreviazuk performs at the 2025 Smile Gala
Photo By Corinne Kopansky Photography



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Dr. Scott Leckie
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President's Message

Dr. Jeff Hein
President, MDA

Every year the MDA faces a wide variety of challenges, and the MDA tackles those obstacles as a coordinated team. As MDA President, one's job is quite simply to represent the decisions and outcomes made and achieved by the MDA staff, the Board of Directors (BOD) and the multitude of committees (and their volunteers) that support all we do. I want to start this article by thanking all of the MDA volunteers (far too many to name, but you know who you are), the exceptional staff at the MDA office, our Registrar Dr. Arun Misra and our CEO Mr. Rafi Mohammed (and of course Theresa who keeps Rafi pointed in the right direction!)—you are the engine that makes this association run and thrive. I'd like to mention the exceptional work done by both Ms. Linda Berg (regulatory) and Mr. Greg Guenther (association)—their efforts often happen behind the scenes and are not well enough acknowledged. Thank you! I'd also like to thank my immediate presidential predecessors; Drs. Scott Leckie and Daron Baxter. The job you

each did—the dedication you showed—set a superlative example and made the path much easier for me to follow. You have my deepest respect and appreciation.

As I gathered my thoughts on a final Presidential message, I reflected on the long list of goals I'd set for myself coming into a year as President. It's very humbling. The sheer number of issues that arise in a year, both at the MDA and on the national front, forces one to constantly re-set priorities. The Executive branch of the MDA Board has its own list of goals, and I'll spend this article highlighting just a few of those.

Regulated Health Professions Act (RHPA)

All the 31 regulated health professions in Manitoba will, at some point, be required to come under the regulatory umbrella of the RHPA. This past winter, the Province of Manitoba identified dentistry as the next profession to make this complex transition. It will entail, in its simplest form, splitting our Association (which provides membership services to MDA members) from our College (the

“The job you each did set a superlative example and made the path much easier for me to follow”.

regulatory branch of our operation). The process has officially begun as the MDA has been tasked to complete a transition 'workbook' provided by the province. The MDA Governance and Nomination Committee (GNC) will begin to assemble a new committee to undertake this first task. Fortunately, the Province has not given the MDA a specific timeline to complete the transition. It is expected to take some years to complete and, once done, the MDA and the newly formed College of Dentists of Manitoba will each have a separate Board of Directors and dedicated staff. Aside from New Brunswick, all other provincial dental organizations have completed or are currently completing, this same transition.

“We have a strong voice— especially together”

Dentists as Vaccinators

In August, the MDA Executive met with provincial officials to promote dentists as an important pool of potential vaccinators for Manitobans. This could be very helpful should another pandemic arise, if there is a severe influenza outbreak, or simply to streamline the routine vaccination of Manitobans. The MDA’s approach was to highlight the impact of HPV and its connection to oral cancer—something very relevant to our expertise in matters of oral health, and to use that as a platform to promote Manitoba dentists as knowledgeable health care providers and very safe, already skilled injectors. Further meetings will be held in 2026.

Canadian Dental Care Plan (CDCP)

I cannot write an article without referencing some aspect of the CDCP. As I write this article the newest hurdle dentists across Canada are facing is the seemingly arbitrary ‘cap’ placed on lab fee reimbursement by Health Canada. By the time this article is published, a new CDCP priority may have arisen.

Rest assured, advocacy through the CDA and the combined efforts of a very united group of Provincial and Territorial dental associations (PTDAs) continues. Efforts will continue to advocate for, and protect, the existing model of dentistry that has served Canadians so very well for many years. We have a strong voice—especially together.

I’ve summarized the progress and current state of just three of the fifteen executive goals currently being actioned by the MDA Board of Directors. From the culmination of the work done by the MDAs Truth and Reconciliation Committee to the modernization of MDA Bylaws, and on to advocacy efforts with the Provincial government on several important files, the list is long and the work is important and extensive in scope.

A final word...

Dr. David Goerz, who passed away suddenly this past spring, was instrumental in recruiting me to stand for election to the MDA Board 6 years ago. Dave, when he was MDA President

in 2019, had an opportunity to write his own Presidential Bulletin articles, and I’m sharing a section from his last article as part of mine. In reference to the future of the Manitoba Dental Association, David wrote;

“Moving forward has not and will not be possible without vision, review, preparation and ultimately dedication to our mandate for the Manitoba Dental Association. I remind everyone that mandate is to protect the public we serve.”

Those words are as true today as when Dr. Goerz wrote them 6 years ago. Thank you, Dave, for once again sharing your wisdom.

It has been a true honor to serve as President of the Manitoba Dental Association. I thank you for the opportunity to serve as your President, and I can assure you that the MDA is in steady hands as Dr. Rodrigo Cunha takes up the reins of this wonderful organization for 2026.



Registrar's Message

Safeguarding Electronic Records in a Time of Growing Cyber Risk

Dr. Arun Misra
Registrar, MDA

As more of our work moves to digital systems, the responsibilities we hold under Manitoba's Personal Health Information Act (PHIA) become even more critical. Electronic charting and digital communication have made practice management more efficient, but they also expose clinics to risks that simply did not exist a decade ago. Cyber incidents are now occurring regularly in the health sector, and even small clinics can become targets. When personal health information is compromised, the impact on patient trust and clinic operations can be significant.

PHIA makes no distinction between paper files and digital records. Once a clinic stores information electronically, it must ensure that the safeguards surrounding that information are appropriate for its sensitivity. The expectation is not only that clinics react to incidents, but that they anticipate them. This requires planning, regular review of systems, and a clear understanding of how information flows within a practice.

Breaches occur through simple gaps in routine practice. An email link is opened without thinking, a clinic laptop travels outside the office without proper security, or an older server remains unpatched for too long. These are small events, yet they can open the door to unauthorized access, malware or even a full ransomware attack. Patients assume

that their information is secure the moment they share it with their dentist, and it is our obligation as trustees under PHIA to ensure that assumption holds true.

A number of security practices are now recognized as essential in protecting electronic records. Access to digital files should be limited to those who require it for their duties.

“Cyber incidents are now occurring regularly in the health sector, and even small clinics can become targets”.

Unique computer logins and stronger authentication tools should be used whenever possible. Encryption is one approach that can enhance the protection of electronic information, whether it is stored or transmitted, and clinics may choose to explore its feasibility. Software systems must be kept up to date. Practices should also review their internal settings to confirm that audit logs are active and able to identify inappropriate access. Regular backups are essential so that the clinic can restore its data if an unexpected failure or attack occurs.

Recent amendments to PHIA have created a clearer and more demanding framework for responding to breaches. If an incident involving electronic records is likely to result in harm, or even embarrassment to a patient, the trustee must notify both the patient and the Manitoba Ombudsman. Guidelines on privacy breaches are available on PHIA's website: https://www.gov.mb.ca/health/phia/docs/privacy_breach_guidelines.pdf. Digital breaches can be difficult to detect initially, which is why advance preparation is necessary.

PHIA requires trustees to “protect personal health information by taking reasonable administrative, technical and physical safeguards that ensure the confidentiality, security and integrity of the information.” Best practices for clinics would be to maintain a written plan that outlines how staff will respond if a cyber incident occurs. This plan should identify immediate steps for containing the problem, outline how to determine the scope of the incident, and set out the process for notifying affected individuals. Documentation is crucial. Following the breach, clinics must evaluate what went wrong and implement corrective actions to reduce the likelihood of future issues. Clinics may also wish to explore cyber insurance products that are now widely available. While not a substitute for statutory safeguards under PHIA, these policies can provide valuable support in the event of a cyber incident.

Many clinics rely on external companies for software support, cloud-based services, data hosting or backup systems. Under PHIA, any external provider that collects, maintains, uses or destroys personal health information on behalf of a trustee is considered an information manager. Their involvement must be governed by a written agreement that outlines the services they provide, the safeguards they are expected to maintain, and their obligations under PHIA. These agreements should clearly address security expectations, how and when breaches must be reported to the trustee, and any situations in which

information may be stored or accessed outside Manitoba. Even when an information manager is used, the trustee remains fully responsible for meeting all PHIA requirements. Contracting out technical functions does not transfer or diminish a clinic's legal obligations as the trustee.

Staff behaviour plays a major role in preventing breaches. Ongoing privacy training should be part of every clinic's routine. Staff need to understand how cyber attacks commonly occur, how to recognize suspicious messages, and how to handle devices that contain personal health information. Clinics should

periodically review who has access to which electronic records to confirm that access remains appropriate.

Electronic systems have become central to modern dental practice, but they require deliberate and thoughtful safeguards. PHIA sets clear expectations, and it is our responsibility to ensure those expectations are met.

I encourage every clinic to review its electronic safeguards, confirm that policies are up to date, and ensure the steps it would take in the event of a breach are appropriate for today's cyber risks. It is a commitment to the trust our patients place in us every day.



MDAA President's Report

Heather Brownlee
President, RDA MDAA

Dear RDAs,
It's hard to believe another year has already passed. I hope each of you is able to take some time over the holiday season to relax and enjoy quality moments with family and friends. As the year comes to a close, the

MDAA has been busy working with the MDA on many important issues that impact RDAs across Manitoba. We encourage you to visit our website, where we do our best to keep you updated on what's happening in the Manitoba dental community.

Remember, each of you plays an

important role in shaping what you want us to advocate for. Please don't hesitate to contact our office if there is something you feel needs attention or change to help make your work easier.

In closing, I would like to wish each of you a joyful holiday season and all the very best in the New Year.



College Corner

Dr. Anastasia Kelekis-Cholakis
Dean, College of Dentistry, Rady Faculty of Health Sciences,
University of Manitoba

Dear Colleagues,
The fall term seems to have gone by quickly, filled with meaningful activity and momentum at the Dr. Gerald Niznick College of Dentistry and the School of Dental Hygiene. On September 4, we welcomed our new dental hygiene and dentistry classes at our Opening Assembly and were delighted to host Senator Mary Jane McCallum as our guest speaker. Her message offered genuine inspiration to this new generation of oral healthcare professionals.

On September 5, we met with our orthodontic alumni in Calgary, to celebrate the construction of the new Graduate Orthodontic Clinic and the establishment of the Dr. Billy Wiltshire Graduate Orthodontic Fund. It was heart-warming to hear how strongly our alumni valued their time at the University of Manitoba. Later that month, on September 18, Dr. Jerry Niznick visited the College to share an engaging presentation on the history and innovations of dental implants with both undergraduate and graduate students. The following evening, we honoured our Alumni of Distinction recipients—alumna Dr. Pat Kmet and our own faculty Professor Mary Bertone—at the UMDAA Dinner. The next morning at the RFHS breakfast, alumnus Dr. Allan Winchar addressed students from across the health sciences, reflecting on milestone anniversaries and his own memories as a dental student. At the same time, Dr. M-H. Kadhim our faculty oral medicine/oral pathology specialist, gave an excellent presentation on: The use of neuromodulators in therapeutic and

esthetic dentistry, while we welcomed alumni and friends to an open house.

On October 16, we reconnected with periodontic alumni in Toronto, exchanging updates and sharing enthusiasm about the new periodontal clinic. It was wonderful to hear about the impressive work our alumni are doing across the country and how fondly they remember their educational experience here. Two weeks later, at our annual Awards Evening, we celebrated our students, staff, and faculty in the newly inaugurated Theatre A, surrounded by family and friends. This year, the Department of Dental Diagnostics and Surgical Sciences received the highest number of student nominations for outstanding faculty contributions. Congratulations for all their hard work!

On November 6, Drs. Haimeur and Nowakowski led a morning retreat for faculty focused on strengthening our approach to exam design using best practices in assessment. Our dental hygiene and dentistry students continue to excel in their national board examinations, consistently achieving pass rates between 95–100%. On November 24 and 25, Dr. Bryan Kwak, representing our students, and I attended “Days on the Hill” with the Canadian Dental Association to advocate on behalf of Canadian dental schools and to discuss the impact of the Canadian Dental Care Plan on dental education. We want to thank the Canadian Dental Association for hosting us and supporting us in these activities.

On November 28, faculty, staff, and I attended an announcement from MPs

Duguid and Eyolfson regarding the award of \$6 million in federal grants dedicated to improving access to oral healthcare for Manitobans. These grants are intended to:

1. Assist in the development of standardized, evidence based, patient centered educational modules that will be available nationally to better prepare oral healthcare providers across Canada to deliver culturally competent and accessible care to underserved populations.
2. Pilot a postgraduate clinical apprenticeship in community oral health and dental public health to enhance training for newly graduated dental hygienists and dentists focussing on underserved populations.
3. Assist in the creation of an Oral Health Community liaison role to help foster partnerships between the college and organizations serving individuals who lack access to oral healthcare services.
4. Cover CDCP co-payments at the university Main Clinic for CDCP members for whom cost is an obstacle to accessing appropriate care.*

At the Dr. Gerald Niznick College of Dentistry, we are looking forward engaging in all those initiatives that will allow us to continue fulfilling our mission of “educating our learners to be skilled, evidence-informed, collaborative, and caring oral healthcare professionals and advocates, partnering with and serving our diverse community”.

Please accept my best wishes for a wonderful upcoming holiday season. I look forward reconnecting with many of you in 2026!

*Ref- <https://www.canada.ca/en/news/search.html?q=ohaf&sortCriteria=date%20descending>

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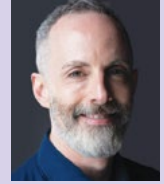
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Economics Committee Report

The Economics Committee is pleased to present guest columnist article, Dr. Jerrold Diamond, on the impact of discounting fees to your dental practice

Dr. Jerrold Diamond

Taking 20% Less Than Your Normal Dental Fees—What it Really Means for Your Practice

Lowering fees to attract more patients sounds straightforward: shave 20% off your usual price, more patients come in, your revenue stays the same (or goes up). In practice it's rarely that simple. Below I'll walk through the math, show how fixed and variable costs change the picture, summarize what the literature says about how patients actually respond to price changes, and finish with practical alternatives to blunt-fee cuts.

The simple math (revenue-only view)

If you cut your fee by 20%, your revenue per patient becomes 80% of what it was. To keep total revenue the same, you must see more patients:

So, purely on revenue, a 20% fee cut requires **25% more patients** to bring revenue back to previous levels.

Example: If you currently see 100 patients/month at \$200 each → revenue = \$20,000. With a 20% reduction to \$160, you'd need 125 patients ($\$160 \times 125 = \$20,000$). (This 25% figure is the baseline "break-even in revenue" result.)

But profit (net income) changes more—variable costs matter

Revenue is only part of the story. Every procedure has costs: staff time, lab fees,

materials, disposables, sterilization, rent and utilities (some fixed, some variable). When you reduce fee per patient, your **profit per patient** often falls proportionally **more** than revenue does.

Example scenario:

- Current fee: \$200
- Variable cost per visit (lab, materials, staff direct time): \$50
- Profit per visit now: \$150

After a 20% fee cut:

- New fee: \$160
- Same variable cost: \$50
- New profit per visit: \$110

To keep the same total profit, you need:

- Patients factor = $150/110 \approx 1.3636$

So you'd need **~36.4% more patients**, not 25%. The smaller your current profit margin per case, the more patients you'll need after a price cut.

What the evidence says: patients are not hugely price-sensitive

Empirical studies of dental demand over decades generally find **low price elasticity**—meaning patients don't increase utilization very strongly when fees fall. Two classic estimates:

- Hay (1982) estimated a net price elasticity for dental services of about **-0.2**—a 1% price drop yields only ~0.2% increase in dental utilization.

With elasticity = -0.2, a **20% price cut** would boost demand by only **~4%**, far short of the 25–36% increases needed to protect revenue or profit.

- Age-specific studies (e.g., Conrad, 1983) show elasticity varies by group; some segments (e.g., uninsured or low-income patients) are more responsive than insured populations, but overall responses are modest.

A recent review and policy commentary also notes that relatively few studies provide precise elasticities and that demand responses differ by service type (preventive vs restorative) and by insurance coverage. This literature suggests fee cuts alone are unlikely to produce enough incremental visits to make up lost revenue.

Capacity, operations, and hidden constraints

Even if demand did rise, practical limits exist:

- **Chair time & staff hours:** 25–36% more patients generally requires more clinic hours, more assistants/hygienists, or faster turnover—each of which raises costs or reduces quality.
- **Supply costs & lab capacity:** labs and suppliers have lead times and cost structures; higher throughput can increase variable costs per case.

Industry surveys show many practices have already experienced supply and labour cost increases in recent years, making fee reductions riskier.

- **Administrative/billing friction:** billing errors and inefficiencies already drain revenue. Before cutting prices, fixing revenue leaks (coding, claims denials) is often a higher-return move. Studies estimate billing errors can cost practices 5–10% of revenue.

Putting the numbers together—three concrete scenarios

Assume current state = 100 patients, fee \$200, variable cost \$50 → profit \$150 × 100 = \$15,000.

1. **Revenue-only target** (ignore costs): 20% fee cut → need **25% more patients** (125 patients) to keep revenue \$20,000.
2. **Profit-preservation** (example above): to restore \$15,000 profit, need **~36.4% more patients** (≈136 patients).
3. **If variable cost rises with volume** (e.g., lab surcharge or overtime pay increases variable cost to \$60): profit per cut patient falls further and required patient increase climbs above 40%.

These show why a blunt 20% discount is rarely revenue-neutral once costs are considered.

Strategic risks beyond numbers

- **Quality erosion:** pushing throughput may reduce appointment time, affecting treatment quality and reputation.
- **Patient mix shift:** discounts can attract price-sensitive patients who may not become loyal, increasing churn.
- **Price anchoring:** lowering published fees can permanently change patients' perception of your value and make it hard to raise fees later.
- **Competition & market context:** in tight-supply markets (dentist shortage), lowering fees may not attract many new patients because access—more than price—drives choices. (E.g., public programs and policy changes can shift demand unpredictably; see analyses of the Canadian Dental Care Plan and practice impacts.)

Bottom line

- A 20% fee cut requires **25% more patients** to preserve revenue—and **significantly more** (often 30–40%+) to preserve profit once variable costs are included. (Simple math + example above.)

- Empirical evidence shows dental demand is **relatively inelastic** (elasticities around **-0.2** in classic studies), so a 20% cut is **unlikely** to bring in enough additional patients to fully offset lost revenue.
- Given rising practice costs and operational constraints, broad fee cuts are risky. Fixing billing/revenue leaks and using targeted, tested pricing strategies will usually be safer and higher-return.

Sources & further reading (key studies and analyses)

- Hay JW. *The demand for dental health*. 1982. (Price elasticity estimate ~ -0.2).
- Conrad DA. *Dental Care Demand: Age-Specific Estimates*. 1983. (Elasticity varies by age/insurance).
- Review / policy commentary noting limited elasticity studies and heterogeneity across services.
- DentistryIQ—reporting on rising supply and labour costs affecting dental practices.
- Analysis showing billing/admin errors can erode revenue—practical alternative to fee cutting.
- Discussion of policy shifts (e.g., Canadian Dental Care Plan) and potential demand impacts.

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Manitoba Dental Association



CDA Report

Dr. Marc Mollot
CDA Board Representative

Greetings to all of you across this great province. I hope you have all had opportunity to enjoy some winter activities or maybe enjoy a warm weather get-away!

CDA Days on the Hill:

Recently I participated in CDA's "Days on the Hill" event where some board members and guests met with select Members of Parliament and their staff in Ottawa. We discussed primarily key advocacy topics which are focus areas for CDA, including:

- Oral health workforce challenges
- Canadian Dental Care Plan (CDCP) operations and improvements
- Dental school capacity and sustainability
- CDA's advocacy activities on Parliament Hill

In addition to CDA's Days on the Hill, CDA President Dr. Bruce Ward met with the Honourable Marjorie Michel, Minister of Health. Their discussion focused on establishing a working relationship and strengthening the oral health care system in Canada for patients and dentists. The Minister spoke highly of the dental profession and thanked dentists for participating in the Canadian Dental Care Plan (CDCP).

Government of Canada recent announcement:

The Oral Health Access Fund—As part of the Oral Health Access Fund Stream 1, Health Canada is providing more than \$35 million over three years to support projects submitted by oral health training institutions that aim to

address competency gaps related to the treatment of targeted populations and training adaptations to ensure sufficient hands-on training opportunities.

<https://www.canada.ca/en/health-canada/news/2025/11/oral-health-access-fund-projects.html>

CDA's advocacy continues to emphasize key initiatives for the federal government to focus on to support and improve the oral health care industry.

Pulse Survey of Dentists—CDCP:

CDA recently completed a national Pulse Survey with dentists on CDCP. Highlights include:

1. Support for the CDCP continues to increase- from 58% in February 2025 to 67% now.
2. 95% report participating in CDCP- with approximately 43% registered and about half (51%) participating on a claim-by-claim basis.
3. Many more dentists reported this time that staffing shortages are preventing them from seeing any CDCP patients (17% compared to 8% in Feb 2025).
4. Overall, about 43% rate their overall experience with CDCP as positive or very positive and conversely about a quarter (24%) rate their experience as negative.
5. Balance billing is a common practice among approximately 8

in 10 respondents (69% Yes + 14% Sometimes)—this level remains consistent from previous waves.

6. The level of satisfaction with the dental benefit grid is slipping with more rating it unsatisfactory (46%) than did in February 2025 (36%).
7. The most common issue faced by over 8 in 10 respondents are delays or denials in preauthorization requests and dealing with misconceptions that CDCP is free.
8. The majority of dentists (88%) report that they have had pre-authorization requests that were denied.

Abacus Survey of Canadians—CDCP:

We recently concluded our latest survey with Canadians (Wave 17) and highlight some of the key findings below. The research was conducted by Abacus Data for the Canadian Dental Association.

This latest public survey aims to get a sense of the public's opinion and experience with the Canadian Dental Care Plan (CDCP), particularly now that it has expanded to the adult age cohort, as well as issues relating to coverage, affordability, dental visits, and office experiences. Wave 17 also evaluates public support, CDCP awareness and program review. A total of 3,501 adults living in Canada were surveyed between October 3 and 26, 2025.

The survey in general found that Canadians who have enrolled in the CDCP are satisfied with the dental care they receive, and most Canadians support the CDCP and want to see it continue. Key findings include:

- More Canadians now have a family dentist, with 71% reporting they have one—an 8-point increase that signals stronger continuity of care nationwide.
- Perceptions of dental care quality continue to rise, with 42% saying oral health care is improving—double the improvement rate for the broader healthcare system.
- Affordability pressures remain significant, with 37% of Canadians reducing spending on essentials due to dental costs.
- Economic conditions are increasingly shaping dental decisions, with 45% reporting that the economic climate has influenced the type or frequency of care they seek.
- Employer plan uncertainty is high, with 62% concerned their benefits may be reduced or dropped due to CDCP.
- Access to care remains stable, with 82% able to book near-term dental appointments and strong satisfaction (76% rating their visit 7–10/10).
- CDCP uptake is broad, with roughly one-third of Canadians applying and a similar share enrolled—demonstrating strong early engagement with the program.
- CDCP is driving improved oral health, with 59% of users reporting better oral health, including 30% who say it has greatly improved.
- User satisfaction with CDCP is high, with 87% rating their experience 7–10/10.
- Continuity of care has largely been preserved, with 85% of CDCP users able to remain with their existing dentist because the dentist participates in the program.
- Cost pressures still affect CDCP users, with about one in four asking not to be charged balance-billed amounts, despite many being comfortable paying the difference.
- Coverage rules influence behaviour modestly, with a small minority adjusting how often they visit, while about half continue following their dentist's recommended care plan.

CDAnet and ITRANS

The CDA ITRANS Claims Service was designed with your needs in mind—security, ease of use, and at no additional cost. We are proud that it remains an invaluable member service offered to our Corporate Members and their member dentists. CDA contributes significantly to the efficient processing of dental benefit claim in Canada, and we do it all with the ethos of 'by dentists, for dentists'. No other country has the benefit of a service similar to ITRANS.

Since its inception, the service has continuously evolved to meet the demands of changing technology, privacy laws, and dynamic business environments. CDAnet and the CDA ITRANS Claims Service also play a crucial role in providing anonymized data on claims transmission, which helps us monitor system efficiency and the provision of dental services across Canada. This information is valuable in advocating for oral health improvement policies.

We are proud of the impact the CDA ITRANS Claims Service has had over the past two decades and remain committed to supporting you in your practice.

CDA Oasis:

CDA Oasis is an online community that keeps dentists up-to-date on current or emerging clinical matters, issues, and technology impacting the dental profession. CDA Oasis typically covers clinical topics, practice support, advocacy, professional issues, people in dentistry, and current affairs. (www.oasisdiscussions.ca)

CDA Essentials:

CDA Essentials is the official print publication of CDA, providing dialogue between the national association and the dental community. It is dedicated to keeping dentists informed about news, issues and clinically relevant information.

www.cda-adc.ca/en/services/essentials/

JCDA.ca

JCDA is an open access journal and Canada's oldest a peer-reviewed publication, indexed in Pubmed, Scopus and Web of Science. Articles published



in JCDA are included in MEDLINE (searchable via PubMed) and the Science Citation Index Expanded (SCIE). JCDA is listed in the Journal Citation Reports (JCR) with an Impact Factor reported by Clarivate, and is of interest to dentists, other health professions, as well as policy makers. <https://jcda.ca>

CDA Annual General Meeting (AGM)—April 24, 2026:

The agenda and schedule of events for the CDA AGM have been set for April 24, 2026 in Toronto. On April 16, 2027, the CDA AGM will be held in Ottawa where we will celebrate our 125th anniversary!

CDA Meetings/ Joint Conventions:

- 2026 Joint Convention with the Manitoba Dental Association—April 17–18, 2026, in Winnipeg, MB.
- 2027 Joint Convention with the Ontario Dental Association Annual Spring Meeting—May 6–8, 2027, in Toronto, ON.
- 2028 Joint Convention with the Dental Association of Prince Edward Island—August 9–12, 2028, in Charlottetown, PEI.

↑ ↑ WCDS ↑ ↑
Increases University Endowments by
\$100,000



The Western Canada Dental Society (WCDS) is a not-for-profit society which has been holding an annual meeting for over 50 years. These purpose of the meetings includes raising funds for our numerous dental student scholarships, continuing education and to improve the camaraderie within the dental profession.

The WCDS funds several scholarships for dental students at the University of Manitoba, University of Saskatchewan, University of Alberta and University of British Columbia. Funding for these is raised via participation in our annual meeting and through the generous sponsorship of our meeting by numerous dental and other allied companies.

Our annual meeting combines a curling bonspiel, with continuing education and a little bit of golf. All profits from the meeting go toward funding scholarships for Western Canadian Dental Students. Our most recent meeting was held September 24–27, 2025 in Victoria, BC where \$15,000 was raised.

The following endowments are supported by the Western Canada Dental Society:

University of Manitoba

- Western Canada Dental Society Graduate Student Scholarship
- Dr. John Clay Medal and Prize
- Dr. John Clay Scholarship

University of Saskatchewan

- Western Canada Dental Society Bursary
- Dr. Walter F. Hancock Scholarship

University of Alberta

- Western Canada Dental Society Research Award
- M H Garvin Scholarships in Dentistry Fund

University of British Columbia

- Western Canada Dental Society Scholarship
- Western Canada Dental Society Leadership Scholarship

The WCDS decided to increase the value of all our endowed scholarships and bursaries to ensure each one annually awards at least \$1,500 in

perpetuity. To make this a reality, in December 2025, we have decided to donate over \$100,000 to the four Western Canadian Dental Schools.

Each year in addition to our endowed scholarships, the WCDS also directly funds two \$1,500 dental student scholarships at each of the four universities listed above:

- The Dr. Cal Waddell—Western Canada Dental Society Memorial Scholarship
- Western Canada Dental Society Student Fellowship Award*

In 2025, our endowed and directly funded scholarships put approximately \$28,000 directly into the hands of Western Canadian Dental Students.

We welcome all dentists, dental auxiliaries and dental related business people to come and participate in our annual meeting. More can be learned about the Western Canada Dental Society and its annual meeting at the websites www.wcdentalsociety.ca and www.wcdsmeeting.org.

The 2026 WCDS Annual Meeting will be held in Calgary from Sept. 23–26. We look forward to seeing you there!

*At UBC this award is called the Western Canada Dental Society Award in Dentistry

Clinical Communication



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MANITOBA DENTAL FOUNDATION CELEBRATES

10 YEARS

OF TRANSFORMING SMILES



On November 1, 2025, the Manitoba Dental Foundation marked its 10th anniversary with a gala event at the RBC Convention Centre featuring the iconic Canadian singer/songwriter Chantal Kreviazuk. The Manitoba Dental Foundation, formed in 2015, has raised over \$950,000 and is the only foundation of its kind in Canada dedicated exclusively to the improvement of oral health of those who are underserved, unhoused and vulnerable.

The Foundation's motto, "Healthy smiles through inspired generosity,"

reflects the professional obligation felt by many of Manitoba's dental professionals. Poor oral health is not just a medical issue, but a social one. By funding clinics like Siloam Mission and Mount Carmel Clinic, the Foundation helps restore dignity, alleviate chronic pain and ensure that basic healthcare is accessible to underserved communities. Also, by supporting the Healthy Smile Happy Child initiative, the Foundation funds education for parents and caregivers to prevent early childhood caries.

"To celebrate our 10th anniversary, we have updated our logo to reflect more

connectedness within our profession, with our patients and the broader communities," says Dr. Carmine Scarpino, President of the Foundation. "Over our 10-year history, the Foundation has awarded over \$430,000 in funding to various charitable organizations that support individuals and families who have limited or no access to oral health care. In addition, through the Dr. Tom Dobbs Oral Health Kit initiative, over 31,500 oral health kits have been donated to schools, outreach centres for the homeless, ministries, seniors' homes and others since 2021."

**Live and
Silent Auction**
\$18,959

100% donated items from
the Winnipeg business and
MDA community

**Smile Gala
Event**
\$44,000

From ticket sales
and sponsorships

**Total
Raised**
\$62,959

Held on a triennial basis, the fourth Smile Gala welcomed over 400 supporters—including oral health professionals, industry partners, suppliers and associates—raising \$62,950 in support of oral health care. The live auction featured Jets, Moose and Grey Cup tickets and experiences including a golfing package, catfishing on the Red River, exquisite dining, winter tires and hotel spa staycations. The silent auction items included fabulous works of art created by Winnipeg artists. All silent and live auction items were generously donated by friends of the Foundation. All told, the auction raised \$18,950 while ticket sales and sponsorships brought in another \$44,000.

The gala would not have been possible without the support of an amazing organizing committee:

- Dr. Carla Cohn, Co-Chair
- Dr. Katie Davidson, Co-Chair
- Dr. Frank Hechter, Executive Director
- Dr. Carmine Scarpino, President
- Rafi Mohammed, MDA CEO
- Dr. Sandy Mutchmor
- Dr. Mike Sullivan
- Theresa Sousa

The night also recognized the leadership group that founded the organization 10 years ago:

Founding Board Members

- President, Dr. Joel Antel
- Vice-President, Dr. Amarjit Rihal
- Treasurer, Dr. Cory Sul
- Secretary, Dr. Betty Dunsmore
- Founding Ceo, Rafi Mohammed

Directors

- Dr. Michael Sullivan
- Dr. Jeffrey Bergen
- Dr. Scott Leckie
- Dr. Gurinder Kler
- Dr. Craig Fedorowich

Advisory Members

- Mr. James Kurz
- Mr. Walter Kulyk

The Manitoba Dental Foundation welcomes donations year-round, please visit ManitobaDentalFoundation.ca—we thank you in advance for your inspired generosity!



(L-R): Dr. Joel Antel, Foundation Founder; Dr. Adrian Musters, award recipient, Dr. Amarjit Rihal, Foundation Founder

Lyle Best Humanitarian Award

The Smile Gala also provides a venue to announce the recipient of the Lyle Best Humanitarian Award. Two of the Foundation's Founding Members, Drs. Amarjit Rihal and Joel Antel, presented Dr. Adrian Musters with the \$20,000 award. A semi-retired dentist, Dr. Musters lives and works in Muskoka, Ontario. The award was based on his efforts to help build a 1,200 sq. ft. dental clinic with three operatories in Guatemala to serve the oral health care needs of a remote and impoverished region. Partnering with local dentists, Guatemalan staff have been trained and countless patients treated, with a particular focus on children in need.



CDSPI

Celebrating Financial Excellence
and Protecting Our Future



By Dr. Jeff Hein
President, MDA



There's a lot we juggle in this profession—patient care, practice management, continuing education, and everything in between. But one area that often gets pushed to the sidelines is our financial health. It plays a significant role in our long-term peace of mind. That's why the Manitoba Dental Association continues to promote resources that help our members build financial security. One of our most trusted resources is CDSPI: a not-for-profit organization created by dentists, for dentists, with deep ties to the MDA and a long history of serving our profession. Whether it's insurance protection, financial planning, or investment management, CDSPI has been a trusted partner in helping Manitoba's dentists secure their futures.

Financial Strength for Your Future

Choosing who manages your investments is one of the most important financial decisions you'll make. Dentistry is a rewarding career, but it's not without its financial risks—from economic uncertainty and business interruptions to potential legal liabilities. That's why it's crucial to have a financial partner who provides access to strong-performing investment solutions while also offering safeguards that help protect what you've worked so hard to achieve. That's where CDSPI stands out.

Canada's Top Fund Family—Two Years Running

CDSPI Funds have once again earned top honours from Morningstar Direct, ranking as the #1 fund family for performance in Canada for the second year in a row. This recognition reflects the disciplined and client-focused approach that CDSPI takes in selecting and offering high-quality funds managed by respected third-party managers, such as CI Investments and Invesco.

CDSPI Segregated Funds: Performance with Protection

CDSPI Funds are group segregated funds—a type of investment held within an insurance contract. These funds don't just provide strong performance and competitive fees, they also come with a powerful and often overlooked feature: protection.

When you name a beneficiary other than your estate, proceeds may pass directly to them, often avoiding probate delays and fees. This designation may also provide creditor protection, particularly when a spouse, child or parent is named as beneficiary. That means your investments may be protected in the event of a lawsuit or insolvency, and your loved ones can receive what you intended for them, faster and with fewer costs.

“The Manitoba Dental Association continues to promote resources that help our members build financial security”.



Is Your Financial Plan Working for You?

With economic uncertainty, rising inflation, and increasing practice costs, having peace of mind about your financial future is more important than ever. I encourage you to review your current financial strategy:

- Are your investments aligned with your long-term goals and risk tolerance?
- Are your assets and lifestyle adequately protected?
- Are you getting advice from professionals who truly understand the risks associated with the profession?

If you're unsure, speak with an Investment Advisor at CDSPI Advisory Services Inc. These Certified Financial Planner® Professionals are salaried—not commissioned—and have a fiduciary duty to act in your best interests. Their services are available at no cost to MDA members, and they can help with everything from setting up TFSAs and RRSPs to reviewing insurance needs and planning your estate.

Support When You Need It Most

In addition to their many products and services, CDSPI also offers the Members' Assistance Program—a confidential support service available to all MDA members, their staff, and their families. Whether you're facing personal challenges, emotional stress, or workplace issues, the program provides access to counselling, wellness resources, and expert guidance to help you navigate life's difficult moments. You can learn more at cdspi.com.

Looking Ahead

At the MDA, we remain committed to supporting your professional, financial, and personal well-being. Our partnership with CDSPI is part of that commitment—giving Manitoba dentists access to trusted financial services, tailored insurance solutions, and expert advice from professionals who understand the realities of our profession.

Beyond investments and insurance, CDSPI also offers a growing library of dentist-focused continuing education—with sessions on buying a practice, disability insurance, cybercrime protection, and best practices for malpractice prevention. These resources are designed to help you plan confidently, protect your future, and make informed decisions at every stage of your career.

When we choose partners like CDSPI who understand our needs and share our commitment to the profession, we strengthen not just our individual futures—but the future of dentistry in Manitoba.

“Beyond investments and insurance, CDSPI also offers a growing library of dentist-focused continuing education”.



Supporting dentists at every career stage

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Find out more at
scotiabank.com/dentists

OBITUARY

John Bosco Curran

John Bosco Curran passed away peacefully on Sunday, November 9, 2025, at the age of 87 years. He was predeceased by his parents, James and Mary Ellen; his siblings Eilish, Mary, Joan, Cecily, Valerie, Michael and his daughter Veronica.

John is lovingly remembered by his wife, Judith; children Ashling, Mark (Julianne), Garrett (Alison), Anne (Chris) and grandchildren Elizabeth, James, Caroline, Thomas, Matthew, Andrew, John, Aurora and Fionn. He also leaves his brother Dermot and numerous nieces and nephews.

John cherished his wife, children and extended family in Ireland. He built a distinguished career as an oral surgeon and longtime faculty member at the University of Manitoba. Guided by his Catholic faith and commitment to service, he balanced a demanding career with being a devoted husband and father.

A Funeral Mass will take place on Monday, November 24, 2025 at 12:30 p.m., at St. Ignatius Parish.

If friends so desire, donations may be made to Camps with Meaning or Salvation Army Winnipeg Community Ventures in memory of John.

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Dr. Marshall Hoffer
DMD, Prosthodontist

Reflections on 43 Years in Implant Dentistry: My Takeaways

I started in implant dentistry at the first Nobel Biocare presentation in North America—the Toronto Conference in 1982. Back then, there were almost no rules. Beyond placing 5–6 implants in the anterior mandible for a full-arch prosthesis, we were figuring it out as we went. Over 43 years, trends have changed, literature exploded, but experience has taught me what really matters.

Cantilevers

Brånemark said six anterior implants could cantilever “back to the spine.” Reality? Even if the implants survive, the materials often fail.

My 2¢ Worth: *Keep cantilevers short—especially distal ones.*

Screw-Retained vs. Cemented

Today, screw retention is trendy because cement has been linked to peri-implantitis. In the early days, everything was cemented, including MUAs, and peri-implantitis was rare. The real change was implant surface roughness, not cement.

Cement is safe with good technique: supragingival margins, minimal cement, and cord packing at subgingival sites. Retrieval is overblown; we deal with problems in teeth the same way.

My 2¢ Worth: *Cement carefully; screw retention isn't required for every case.*

Screw-Retained Bridges on Two MUAs

Two-MUA screw-retained bridges are popular, but my first case in the 1990s failed repeatedly until I added a third implant. The lesson stuck—two MUAs have higher failure rates.

My 2¢ Worth: *Use three or more implants for screw-retained bridges.*

Prefabricated Abutments

Prefabricated Tibase abutments save cost but often fail—debonding, separation, and bone loss from excessive width are common. Custom-milled abutments solve most of these problems.

My 2¢ Worth: *Go custom whenever possible.*

Removing Healthy Teeth

Early implant work focused on saving teeth. Now, the pendulum swings toward removing multiple healthy teeth for full-arch implants. Even top clinicians have failures, so this isn't always in the patient's best interest.

My 2¢ Worth: *Preserve healthy teeth; don't remove them just to place implants.*

Treatment Planning

Implants were once placed wherever bone existed. Today, we start by designing the restoration, then plan implant placement using virtual planning and surgical guides, adding bone or soft tissue where needed.

My 2¢ Worth: *Let restorative design—not bone availability—drive placement.*

Where I Stand Today

I plan the restoration first, place implants to support it, minimize cantilevers, and use screw-retentive single units or cemented multi-unit bridges. Trends change, but solid planning lasts.

To learn more from our seasoned professionals, visit our website or scan the QR code with your phone's camera to explore our events and courses.

➔ clearcareperio.com/events-and-courses/



Where you come from does **INFLUENCE** how you negotiate



By Jackie Joachim
Chief Operating Officer, ROI Corporation

The acquisition of a dental office always comes with a certain level of stress. When two parties enter negotiations over the acquisition of a dental office, one can never underestimate how much cultural background plays a significant role. After all, where we come from shapes our behaviors, values, and communication styles. These factors are crucial in the realm of negotiation and purchasing decisions. Understanding these cultural influences is essential for

buyers, and sellers. A good broker will effectively manage all the personalities involved so that a successful close is the result with “as little blood shed as possible.”

We cannot ignore how different cultures prioritize various aspects of a transaction. Cultural backgrounds influence what individuals consider as a fair offer. In some cultures, haggling is seen as a normal part of the buying process, while in others, it may be viewed as inappropriate or even disrespectful. It can be both

interesting and frustrating to see how a buyers’ negotiation strategies can be deeply rooted in their cultural background. For instance, some groups adopt a more direct approach, focusing on facts and figures, whereas other cultures may prioritize indirect communication and non-verbal cues. It is easy to see why this difference can lead to misunderstandings if one party misinterprets the other’s style as evasive or aggressive. Communication can be complicated at the best of times but the differences in cultures can

“We cannot ignore how different cultures prioritize various aspects of a transaction. Cultural backgrounds influence what individuals consider as a fair offer”.

vary widely in their communication styles, which can significantly impact negotiations. Direct communication involves straightforwardness and clarity. The buyer may explicitly state their needs and expectations. In contrast, indirect communication, involves reading between the lines and using subtle cues. Of course, this also applies to the vendor. The key to successful negotiations regardless of culture is to ask why something is important to the specific party.

In some cultures, the group consensus is valued which results in the buyer seeking input from family, or colleagues before making an offer. This not only slows down the negotiation process, as

multiple voices need to be heard, and consensus must be reached but it can complicate matters. In contrast, in a culture that emphasizes individualism, a buyer may feel empowered to make decisions unilaterally, potentially speeding up the negotiation. This is also seen in the attitudes toward risk which can also affect the negotiation process. In cultures that are more risk-averse, buyers may approach negotiations with caution, leading to offers that are more conservative and focused on security. This contrasts with cultures that embrace risk-taking, where buyers may be more willing to make bold offers.

The sale of a practice has many moving parts. While it is a transactional

event, we can never ignore how cultural backgrounds play a powerful determinant in how buyers formulate their offers and engage in negotiations. By understanding the nuances of cultural influences—such as values, communication styles, and social norms—a good broker can help the parties bridge gaps, foster better relationships, and ultimately achieve more favorable outcomes in their negotiations. Therefore, reducing the stress of the sale. Recognizing and respecting these cultural differences is essential in today’s increasingly global marketplace, where successful practice sales often hinge on the ability to navigate diverse cultural landscapes effectively.

Jackie Joachim has 30 years of experience in the industry as a former banker and now the Chief Operating Officer of ROI Corporation. Please contact her at email: Jackie.joachim@roicorp.com or cell: 416-500-5708 or Instagram: @jackie_joachim_

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Imposter Syndrome IN DENTISTRY



By Dr. Jessica Metcalfe

*Dr. Jessica Metcalfe is a general dentist and leadership and workplace culture consultant. She is an award-winning international speaker and best-selling author of *Speak Kindly, You're Listening*.*

In dentistry, perfection is often the benchmark and even the most skilled dental professional may struggle with self-doubt and feelings of being a fraud. Performance pressure causes many dentists to feel inadequate.

This experience—commonly known as imposter syndrome—affects many dentists, regardless of experience or skill. Dr. Jessica Metcalfe, a general dentist, leadership consultant, and author of *Speak Kindly, You're Listening*, sheds light on the roots of imposter syndrome in the dental profession and offers strategies for building resilience.

Imposter syndrome differs from constructive self-doubt. It combines intense self-criticism with a fear of being exposed as inadequate, often in direct contrast to the individual's achievements in their career. This internal narrative can undermine confidence and professional growth, especially in high-pressure fields like dentistry. Imposter syndrome, originally termed 'imposter phenomenon' in 1978 by psychologists Dr. Pauline Clance and Dr. Suzanne Imes, refers to the persistent belief that one's success is undeserved.

Dr. Metcalfe emphasizes that imposter syndrome is not a clinical diagnosis. "There's nothing wrong with you," she says. "But words matter and when we call it a 'syndrome,' we imply something pathological or broken. In truth, it's a mindset, a pattern of thinking that can be unlearned." Unlike ordinary self-doubt, which can be situational or constructive, imposter syndrome can be pervasive and paralyzing. It erodes self-confidence and often prevents capable professionals from embracing their successes or advancing in their careers.

Dentistry's Perfect Storm

Dentistry, with its emphasis on esthetics and precision, breeds imposter syndrome. Dental students face intense competition from day one. "You go from being at the top of your undergraduate class to sitting among dozens of others who were also top of theirs," she says. "The bar just keeps rising." Within this context, she recalls terms like "golden hands" being tossed around; a phrase meant to praise clinical skill, but which can feed unfair comparisons and insecurity. "You begin to internalize the idea that if you're not perfect right away, you're falling behind," she says. Perfectionism and competition in clinical care create high psychological stakes. Social media also increases the pressure. "We're flooded with before-and-after images and flawless preps at lectures or on social media," she says. "But we don't see the dozens of imperfect attempts, the learning curve or the struggles behind the scenes." This distorted view causes dentists to compare themselves to their colleagues, creating feelings of inadequacy characteristic of imposter syndrome.

From Self-Doubt to Self-Awareness

For Dr. Metcalfe, the realization that she was experiencing imposter syndrome came in dental school. Despite her qualifications, she remembers being anxious on orientation day, convinced that she was admitted by accident. "I remember thinking, they're going to get to my name, realize they made a mistake, and send me back to Toronto," she says. Her accomplishments didn't stop these feelings. "No matter what I achieved, I felt like I didn't belong. Each roadblock or challenge or mistake felt huge and that at any point in time I felt like someone was going to figure out that I was a phoney," she recalls. Identifying this internal dialogue helped to enable change. "Once I had the proper language for this, I started to unravel how I was speaking to myself, and how that was shaping my confidence and experience," she says. Dentists with imposter syndrome view each complication as a personal failure. Dr. Metcalfe advises practitioners to be mindful of their self-talk following

“Unlike ordinary self-doubt, which can be situational or constructive, imposter syndrome can be pervasive and paralyzing”.

difficult procedures. “Do you walk away thinking, ‘That crown will fail because I’m a terrible dentist?’ Or can you acknowledge that maybe the patient was anxious, isolation was tough, visibility was limited and that you did your best under challenging conditions?” she says. The reframing contextualizes clinical errors but doesn’t excuse them.

“Dentistry is called a practise for a reason. It’s not the *perfection* of dentistry; it’s the *practise* of dentistry”.

It moves the narrative away from “I am a failure” to “That was a hard case, and I learned from it.” Creating this kind of awareness is crucial. “You can’t change what you don’t recognize,” she reminds.



Redefining Success and Failure

Redefining success and failure help to defeat imposter syndrome. “Dentistry is called a practise for a reason,” Dr. Metcalfe says. “It’s not the perfection of dentistry; it’s the practise of dentistry. And you are practising for however long you choose to hold your license for.” She reminds us to learn, test, and determine what works via science, education, and research. This mindset encourages continuous learning and growth, acknowledging that setbacks are part of the process and that their value isn’t diminished by them. She recalled a lecture that examined failures alongside successes. “This kind of transparency is powerful. We need to normalize discussion around complications, revisions, and difficult decisions. If we are more equipped to manage the downfalls, because we saw, talked about, and experienced them, then we are more equipped to manage our reaction, emotions and mindset,” she says.

Building Confidence Through Action

If you suspect that you’re dealing with imposter syndrome, Dr. Metcalfe provides steps you can take to counter these feelings. “Let’s say a routine class II restoration becomes complicated: your assistant is out, the temp certified dental assistant is new, the patient is difficult, matrices don’t fit, and the software crashes— what can you do?”

- **Track Your Self-Talk:** Did you leave the procedure thinking you’re awful? That your dentistry is horrible? That you’re horrible? Instead of feeling defeated, reframe your day: “It was challenging, but I used my skills, and

tomorrow is another chance. These phases may last weeks/months, so show yourself the same patience you show patients.

- **Contextualize Challenge:** You didn’t have your usual dental assistant, the patient may have flustered you or you were forced to make decisions differently based on the circumstances.
- **Celebrate Small Wins:** Today you got to perform dentistry and use the skills that you’ve learned. Remind yourself of the first class II you did and how hard it was in comparison to this moment. Look back at your recorded wins to remember the good in dentistry.
- **Avoid Harmful Comparison:** On this particularly bad day, it’s probably best not to use social media or other technology to drown your sorrows. If your algorithm focuses on dental accounts, others’ success will overshadow your performance today.
- **Seek Support:** Consider alone time or talking to someone understanding. Lean on those people, vent, get it out, cry, be angry, or do whatever you need to soothe your mind, body and soul during this moment. Then go back to that selftalk and remind yourself that “this was a bad day, but, I can still do it.”
Imposter syndrome doesn’t discriminate. It affects both new and experienced clinicians. But by recognizing the signs, reshaping your internal dialogue, and leaning into supportive communities, dentists can dismantle the illusion of inadequacy. “Your patients aren’t expecting perfection,” says Dr. Metcalfe. “They’re looking for care, empathy, and your best effort; and you can give them that.”



Scan the QR code to see Dr. Metcalfe talk more about imposter syndrome in dentistry on CDA Oasis.

“By recognizing the signs, reshaping your internal dialogue, and leaning into supportive communities, dentists can dismantle the illusion of inadequacy”.



Why do our implants and implant restorations fail?

PART TWO

By Dr. Jack Lipkin Bsc. D.M.D. Cert. Pros. F.I.C.D.



In our first article published in the Fall 2025 MDA Bulletin, I discussed the objectives that I believe should be at the forefront of every dental practice and practitioner. That is, to create a long term 'plan' so that our patients will have a rigid (or extremely stable) dentition as they head into their golden years. "Rigidity" may be defined as a natural, artificial, (or a combination of the two) dentition that is not removable and "extremely stable" may be defined as having an artificial dentition that is held securely (but removable) with fixed implants or natural teeth (or a combination) helping to retain the removable prosthesis.

Noting Statistics Canada information; the average 50 year old female in 2025 will live well into their late 90's and a 50 year old male in 2025 will live to age 84.

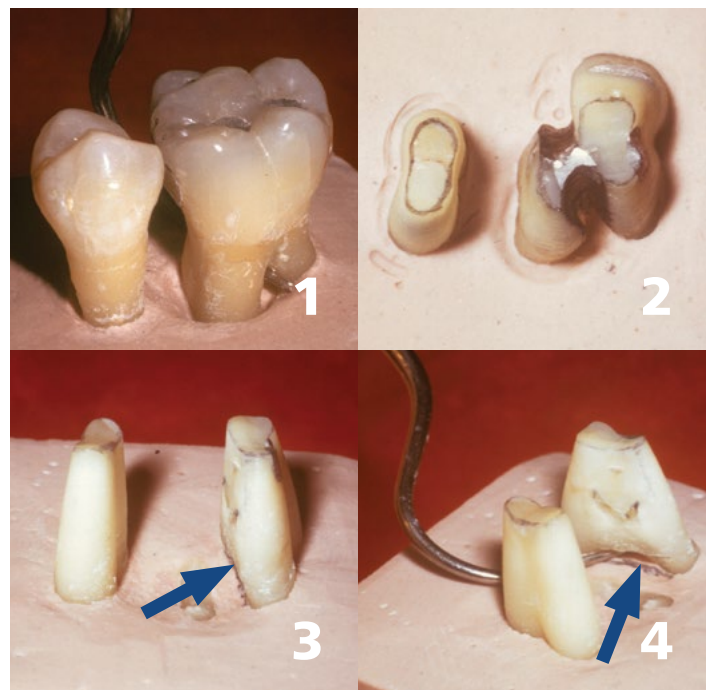
In one study, over half of implants placed in a 10 year follow up period (M.E. Galarraga-Vinueza J. Perio 96:6) were affected by PID's (Peri – implant Diseases), (Peri-implant mucositis (46%) and Peri-implantitis (21%)). Other studies (Berglundh, T: J Perio 2018(89) confirm the challenge of dealing with PID's by careful definitions of what constitutes a PID. As such, careful thought must be given to NOT extracting teeth that are reasonable to restore in patients who are in their 40's, 50's, and perhaps 60's.

Long term retention of teeth with advanced bone loss can be successfully treated (McGuire, MK; J. Perio. 1991: Chace, R; J Perio 1993: Agudio, J., Clin. Perio 2023). My contention is that the identical clinical situation in a 40 or 50 year old may be treated vastly different than in a 65 or 70 year old. If the goal is to have our patients live out their golden years with rigid or very stable dentitions, then I suggest adopting a Phase 1 and Phase 2 approach to treatment.

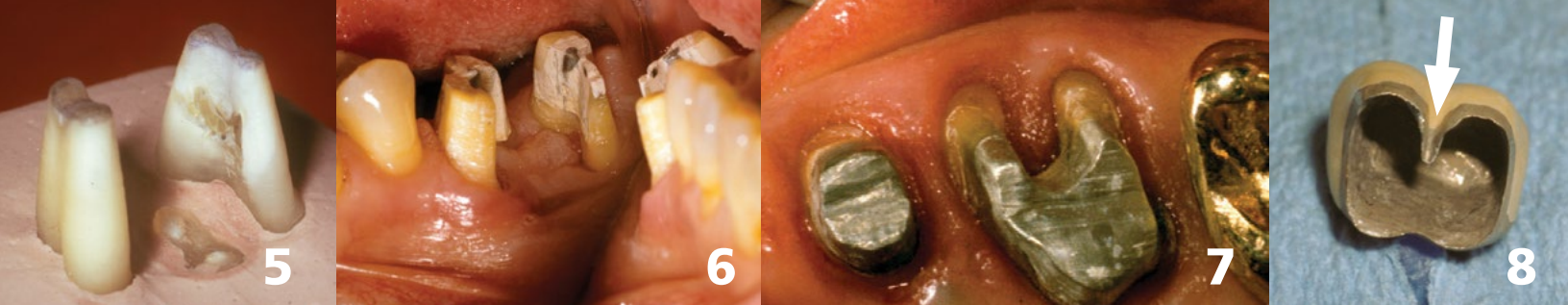
This article will discuss the treatment for three compromised dental scenarios that can be treated successfully as part of a Phase 1 approach.

1. **Root amputation of a maxillary molar**
2. **Treating molars with furcation involvements**
3. **Treating teeth with craze lines – "cracks"**

1. Maxillary molars can be successfully treated by amputating a MB or DB root. Proper endodontic and periodontal diagnosis are one of the keys to deciding whether a tooth with this compromise is worth investing time and money to restore. Once a diagnosis is made,



tooth preparation is the key to long term success. In figure 1 we see a demo of a pre-clinical model prior to performing a MB root amp. Figure 2 shows significant tooth preparation lining up the tooth cuts to isolate the MB root amp. Figure 3 shows the root 'extracted' before the dentist has barrelled into the furcation. Figure 4 shows the tooth preparation in the proximal region prior to the final removal of the anatomical ledge that is left after the root is extracted. Figure 5 shows the final tooth preparation. Figure 6 shows a clinical example of the tooth preps for a DB root amp on #26, and a MB root amp on #27. It is important to note that although it is more difficult to do, the post and core should be done after the root is amputated.



2. Teeth with furcation involvements can be treated very successfully. Periodontal analysis is a crucial diagnostic factor. Once it is determined that a tooth with a furcation involvement can or should be treated with a crown, with or without an endodontic procedure, then once again, tooth preparation is the key to long term survival. The patient must be able to access the furcal area, and be able to clean it properly. This requires that the tooth prep employ a barreling effect in the furcal area (buccal or lingual). The buccal of the tooth is "barrelled" into with a large diamond bur that has a slight taper to it. The prep must completely eliminate the furca and allow for a proper restorative material to be used to allow for maximum and efficient cleansability. In a majority of clinical situations, zirconia is not the material of choice to restore these crowns. Figure 7 shows a picture of a maxillary molar with wide root spread and a tooth prep that opened up the buccal furcation for maximum cleansability. This tooth lasted 18 years until the MB root cracked whereupon Phase 2 treatment was initiated with the placement of an implant. Figure 8 shows the intaglio of a porcelain fused to metal crown with a significant metal collar showing how even a narrow furcation can be opened up for access to clean.

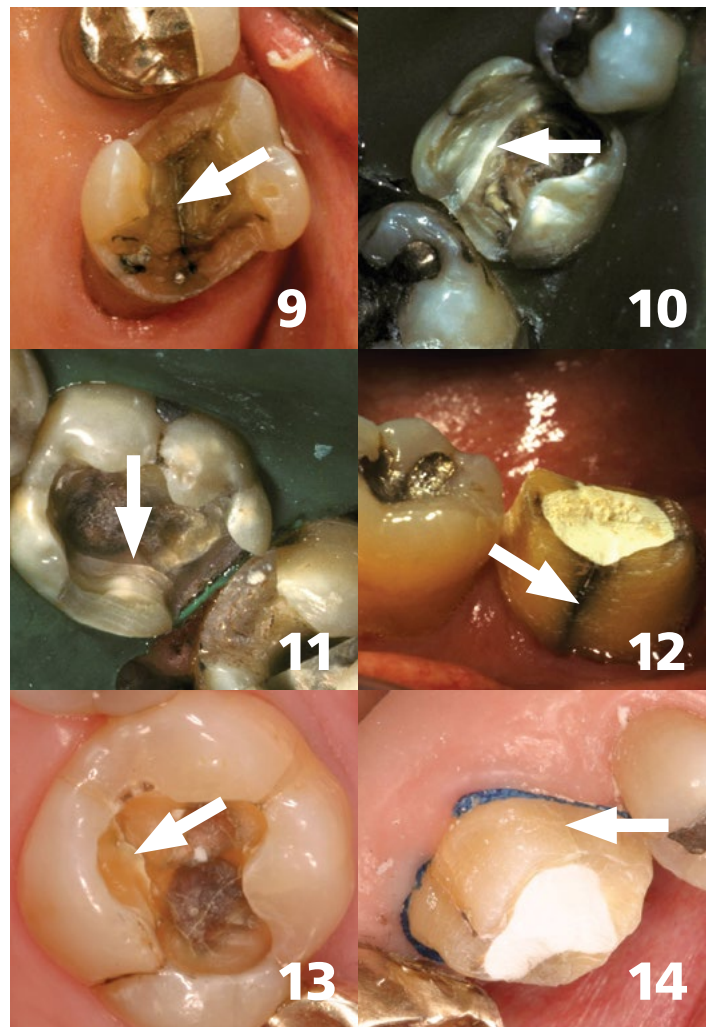
3. Teeth with craze lines or 'crack' lines pose an exceptional diagnostic challenge. Teeth must be assessed for periodontal and endodontic negative factors that would preclude attempting to restore these. As well, patient symptomatology and a thorough evaluation of occlusion, interarch space, health and status of adjacent teeth, overall treatment plan regarding the remainder of the dentition, sleep or awake bruxism, and the patient's age and desires all play a role in determining whether these teeth can or should be restored. That being said, if the tooth passes each of the diagnostic questions, then it can be restored with a very good long term prognosis. Figure 9. – no symptoms, but should it have a vital endodontic procedure anyway? Opinions vary. Figure 10. and 11. Craze 'crack' lines that lie mostly under cuspal walls should be chased until the craze line is eliminated OR just before the tooth becomes unrestorable. A crown lengthening procedure

is often required if it enhances the prognosis of the final restoration. Figure 12 – this tooth (with no perio involvement) must be crowned ASAP. Figure 13. You will notice a more robust palatal wall and the craze line is running closer to the mid pulpal floor. These should not be chased as the odds are one will expose the pulp.

Figure 14. craze lines often run down the proximal walls of the tooth, and every effort should be made to end the crown margin apical to the proximal craze line.

Employing a ferrule in your crown prep is a well-established and agreed upon process that enhances the longevity of restoring broken down teeth.

In our next article, we will discuss implant treatment planning.





Dentists' Role in Measles Prevention



By Dr. Marina Salvadori

Canada is dealing with its largest measles outbreak since the disease was declared eliminated in 1998, with over 4,000 confirmed cases reported across several provinces, according to Dr. Marina Salvadori, senior medical advisor with the Public Health Agency of Canada (PHAC) and professor in the division of pediatric infectious diseases at McGill University.

“The outbreak began in October 2024 when someone visited from overseas for a wedding in New Brunswick attended by a large group of people who are generally under-vaccinated or unvaccinated,” she says. The celebration, part of a tightly knit Anabaptist community, is believed to be the epicentre of sustained transmission.

The outbreak has since spread within other undervaccinated communities in Ontario, Alberta, Manitoba, Saskatchewan, Texas and Chihuahua, Mexico, with occasional spillover into the general population. Dr. Salvadori notes that about 94% of infections are among unvaccinated people and about 75% of cases are among minors under age 18.

While most cases remain contained within the affected communities, the scale of the outbreak is unprecedented in modern Canadian public health. “By far, this is the largest outbreak we’ve had in our professional lives,” she says.

The primary driver of the outbreak, Dr. Salvadori explains, is low vaccine uptake among certain groups. Large gatherings, including events marking the 500th anniversary of the Anabaptist movement, have created ideal conditions for transmission.

Although this outbreak is concentrated in specific populations, Dr. Salvadori cautioned about other demographic vulnerabilities, including children who missed routine vaccinations during the COVID-19 pandemic and have not yet caught up, as well as growing vaccine hesitancy fuelled by misinformation, political polarization and pandemic fatigue. “Only vaccination can prevent large outbreaks,” she says.

How to Help During a Measles Outbreak

Dentists may not be the first health professionals the public thinks of in

The primary driver of the outbreak is low vaccine uptake among certain groups. Large gatherings have created ideal conditions for transmission.

an infectious disease outbreak, but Dr. Salvadori believes they are well-positioned to contribute. “The most important thing is to make sure that the whole dental team is immune to measles,” she says.

Dr. Salvadori’s recommendations for dental practices begin with verifying that all staff are immune to measles—everyone with direct patient care should have two doses of measles-containing

vaccine or an IgG positive for measles, regardless of year of birth. “You work in very close range with your team for long periods of time. This is an airborne disease, one of the most infectious diseases that we know of,” she says. Having 2 doses of a measles-containing vaccine is almost 100% effective at preventing measles.

She also advises screening patients, postponing nonurgent care for anyone suspected of having measles, and, in urgent cases, coordinating with hospitals to follow infection control protocols, including the use of negative pressure rooms, if possible. Dentists can also monitor local outbreak activity by subscribing to public health updates, particularly in high-risk areas.

Dr. Salvadori also suggests that dentists consider having the best protective measures, including N-95 masks and enhanced air exchanges. “The only way to protect yourself in addition to being vaccinated is to wear an N-95 and have good air exchanges,” she says.

Beyond the typical early symptoms—fever, cough, runny nose and conjunctivitis—dentists can look for Koplik spots. “These are little white dots on the buccal mucosa that appear two to three days before the rash,” Dr. Salvadori says. These are symptoms specifically characteristic or indicative for measles and more likely to be noticed by dental professionals than physicians.

Anyone who contracts measles can develop complications, but some people are at greater risk of severe illness. These include children under age five, especially infants who are too young to be vaccinated, pregnant individuals, and people with weakened immune systems. More than 90% of people who are not immune and encounter the virus will become infected. The virus can spread to others before the characteristic rash appears, meaning people can pass it on before they even know they have measles.

Be an Advocate for Vaccines

Dr. Salvadori suggests other practical steps dentists may consider, such as posting vaccine information in waiting

Dr. Salvadori encourages direct contact with local public health units in any case of suspected measles, as these teams can offer immediate advice and support tailored to the specific situation.

rooms, asking new patients about their vaccination status, and expressing your own beliefs about the benefits of vaccination. When addressing misinformation, she cautions against blunt refutation, explaining that “just refuting can actually polarize people more.” Instead, she recommends starting with an open-ended question

newsletters for updates and guidance. Finally, she encourages direct contact with local public health units in any case of suspected measles, noting that these teams can offer immediate advice and support tailored to the specific situation.

Dr. Salvadori believes that a dental office is a high-risk setting for measles transmission, and any suspicion of



like, “Tell me what you’re most worried about,” and responding directly to those concerns. Dentists can also refer patients to physicians or specialized vaccine hesitancy clinics.

To stay informed, Dr. Salvadori recommends several reliable sources that can help dentists keep their knowledge current and respond effectively during outbreaks. The Canadian Immunization Guide, published by PHAC, provides comprehensive information on vaccines and immunization protocols. Dentists can also benefit from regularly checking provincial and local public health websites and subscribing to their

measles should prompt immediate contact with the local public health unit. “People at the public health unit have built strong relationships with the affected communities and are doing a good job of working with them,” she says.

Her final message to dentists: a subtle word from a dentist to a patient about the effectiveness of vaccines and their importance to long term public health can make a difference.



Scan to watch an interview with Dr. Salvadori on measles on CDA Oasis.



A Day of Care, Compassion, and Early Detection

The MDA was pleased to work with the Never Alone Cancer Foundation (NACF) on another successful Oral Cancer Screening Event this past October 25.

A heartfelt thank you to the tremendous volunteers including our MDA Dentists, Registered Dental Assistants, UMB Dental Students, Family Members & NACF Volunteer Team.

110 patient screenings took place with 8 referrals sent to CancerCare Manitoba.



The Non-Insured Health Benefits Program



Play a key role in the oral health of First Nations and Inuit.

By enrolling with Indigenous Services Canada's Non-Insured Health Benefits (NIHB) program, dental providers can submit claims directly to its claims processor, Express Scripts Canada.

When you bill the program directly using NIHB fees, clients do not have to face charges which can be a significant barrier in accessing dental care.



Did you know?

The Express Scripts Canada Provider and Client Website is the gateway for dental providers to work with the NIHB program. Providers can access program policies, forms, quarterly newsletters, the dental claims submission kit, provider billing agreement, and regional dental benefit grids.

To learn more, please scan the code above.



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CONNECTING CARE

FROM COAST TO COAST TO COAST

NATIONAL ORAL HEALTH CONVENTION | APRIL 16-18

KEYNOTE SPEAKERS



STEVEN PAGE

Singer, songwriter,
and mental health
advocate—formerly
of Barenaked Ladies

NIIGAN SINCLAIR

Award-winning
writer, professor
and columnist



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