MANITOBA DENTAL ASSOCIATION

Bulletin

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INSIDE THIS ISSUE

MDA Mentorship Program Expands

All dental students to benefit from U of M, MDA partnership.

The Faculty of Dentistry and the Manitoba Dental Association have rolled out a new and expanded mentorship program that will include all students studying dentistry at the University of Manitoba.

Under the new MDA Mentorship Program, all students, including those in the first and second years of their four year program, will be paired with a practicing professional from the dental community in Manitoba.

The idea is to provide students the opportunity to learn and benefit from the experience of a practicing dentist as they prepare to enter the profession.

"We are hoping that the mentors will provide the experience and the advice so that the student has someone to rely on; a peer that they can talk to about things that are going on as they go through the program," said Dr. Marcel Van Woensel, president of the Manitoba Dental Association.

Now into its seventh year, the MDA Mentorship program began as a method to help fourth-year students make the transition from school into the working world. In recent years, the program was expanded to include third-year students on a voluntary, non-credit basis.

In addition to peer support, mentors also offer advice and perspective on establishing practices and make students aware of the many opportunities that exist throughout the province.

"We've had a specific rural focus to give students in the program a different perspective and different options in terms of private practice in Manitoba, rather than getting stuck in one place and having no idea of what other opportunities are available," he said. "By bringing the students in and seeing the opportunities here, there is the hope that people will stay and benefit the public at large."

The success of the program convinced Dr. Anthony M. Iacopino, Dean of Dentistry at the University of Manitoba, to make it available to all students in the faculty, starting this year. Under Dr. Iacopino's direction, the new version of the program officially kicked off on September 19, at the faculty's opening ceremony for first-year students.

Dr. Van Woensel said members of his association were quick to respond to the challenge of taking on 58 new participants in the program.

"It was relatively short notice that the changes were made to try and involve first-year students," he said. "Yet at the same time, within a week, we were able to find 15 mentors from our membership who were more than happy to be involved and again provide a great insight for the students through that process."

Dr. Van Woensel said the hands-on involvement of Dean Iacopino and the faculty will only lead to a better experience for both the mentors and their protégés.

"We're hoping, with the Dean's commitment, and with the commitments of the students, that we will be in a situation where we can actually get more input and more interaction between the mentors and the students," he said, "so that there is a better integration and involvement so that they will have a more enjoyable and productive experience from it."

Dentists from all across the province have participated in this initiative, many traveling long distances to appear at sanctioned events.

Dr. Van Woensel said the commitment of the participating professionals has been exceptional and reflects the close-knit nature of the dental community in Manitoba.

"When people are called upon to participate, most are willing to do so because they see the value," he said.

"Fortunately, it is not a very competitive atmosphere for most dentists in Manitoba so they see the value here. As we grow together as a community, we want everyone to feel included."

President's Message

Dr. Marcel Van Woensel

"*An error doesn't become a mistake until you refuse to correct it*." Orlando A. Battista

Loose Ends

In prior articles, I focused on a particular theme. With this last column as Association President, it is time to tie up a few loose ends.

New Board Members

The provincial government appointed two new public representatives to join Mr. Wayne Novak. Ms. Barbara Borscht from The Pas and Ms. Cheryse LaRocque from Brandon were appointed in August. I think we all appreciate the perspectives and input of our public representatives.

These two appointments bring to five the year's new Board members (with Dr. Allan Cogan, Dr. Joel Antel and Dean Anthony Iacopino).

Admission Numbers

Concerns were expressed on the impression given by the Autumn 2007 Economics Quarterly on student admissions. Specifically, the lack of clarification on the actual numbers of Manitobans admitted to our Faculty of Dentistry. The MDA Subcommittee on Recruitment and Retention (SRR) - which includes representatives from government, other oral health care professions and the Faculty - has produced a significant amount of research on human resources in oral health care in the province.

With the cooperation and support of the Faculty through Dr. Perry and Ms. Lyons, the SRR has analyzed the number of Manitobans entering the dental programme based on the current University of Manitoba professional faculty definition of "Manitoban" which recognizes graduation from a Manitoba high school and/or residency within Manitoba for at least three years immediately prior to time of acceptance to the professional programme. Over the last 10 years, the average percentage of Manitobans admitted to the first year class was 76.5%. Statistics for the last five years separate the high school and residency components. 85.2% of the Manitobans accepted had graduated from a Manitoba high school while an additional 14.8% of Manitobans accepted were based on the three year residency requirement only.

As chair of the SRR, I believe the intentions of everyone involved are similar. We all want to ensure Manitobans have access to the best dental care possible. We all want competent students who will graduate with the knowledge, skills and judgment to excel at providing that care. We all want the best and brightest Manitobans to enter our profession and achieve our goals for dentistry.

The Faculty has, for more than a decade, established admissions procedures to increase opportunities of acceptance for Manitoban applicants. The new Dean, Tony Iacopino, is in the process of making more changes to improve access for Manitobans. Regardless of the admission's system, we as individual dentists must work to actively encourage and support students in our regions to consider oral health care as a career. By increasing the numbers of great students applying, they will be successful in entering the various oral health care programmes at the University of Manitoba and the colleges. Please consider talking with your young patients or contacting local primary and secondary schools and express your willingness to discuss your profession and the benefits of it as a career.

The MDA has worked to improve the publicly accessible oral health career information on our website (www.manitobaDentist.ca) for students. This was based on input from rural dental students to the SRR on where they obtained their career and application information. Our intent is to make our website the information centre on oral health careers. Any feedback on the career information would be appreciated. The SRR is willing to develop a presentation for member use in public discussions if enough members express a willingness to use the resources.

Proxy Voting

MDA member participation at our general meetings surprises and impresses most out of province observers. The high attendance and involvement of our members – in both relative and absolute terms compared inter-provincially - is a point of pride for the MDA Board. Every effort is made to ensure the AGM continues to be an accessible venue to discuss issues important to the profession. After discussions at the 2006 AGM, the Board reviewed and altered the voting process to allow for secret balloting at the request of the attending members on a motion. A paper vote will necessarily extend the length of any meeting (to tabulate results).

At the 2007 General Meeting, a request was made to consider allowing members to elect a proxy holder to vote on their behalf. The Board has decided not to change the process to allow proxy voting.

Continued on page 9

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Registrar's Column

Dr. Michael Lasko

X-Rays in Dentistry

Two years ago information was provided to MDA members regarding the appointment of the new Head of X-Ray Service for Cancer Care Manitoba – Dr. Inguer Fife.

The 4 steps that x-ray owners must fulfill to comply with Manitoba Safety Regulation 341/88R were provided and they are:

Step 1: Shielding Barrier Specifications Approval:
- Must be provided prior to renovating or constructing the area;

Step 2: Shielding Inspections:
- On-site inspection of facility for approval;

Step 3:
- All x-rays must be registered;
- Personal dosimeters – all x-ray workers must wear personal dosimeters while on duty;

Step 4:
- On-site radiation protection surveys in every facility are mandatory on a scheduled basis.

Radiation Protection Officers conduct an audit for all x-ray locations and you are familiar with their visits to your offices.

The MDA receives regular calls from the public regarding MDA policy with respect to how often radiographs ought to be taken.

The policy of routine periodic radiographic examination of all patients is scientifically unsupportable. The frequency and type of examination, as well as the number of films, should depend on clinical judgment based on individual patient evaluation and in no circumstances should radiographs be prescribed by auxiliary personnel.

Exposure to radiographs should be low as reasonably achievable (ALARA).

The nature of the calls received by the MDA office seems to indicate that in some instances the ALARA principle is not being observed as some offices still appear to be automatically exposing x-rays at recall appointments even before a dentist examines the patient. As earlier noted this approach is no longer acceptable. Please review your x-ray policy with your auxiliary staff to ensure that the above principles are followed.

Consent

The legal age for a person to enter into a contract remains 18 across Canada. However, there is no fixed age of consent for medical or dental treatment.

As a general rule, for patients under the age of 12 consent should be obtained from the parent(s) or guardian(s) of the child. For patients 16 and over, the dentist should presume (in the absence of evidence to the contrary) that the minor can provide consent on his/her own behalf.

For patients between the ages of 12 and 16, the dentist is advised to discuss with the patient to determine whether that patient has the capacity to consent on his/her own. With patient's permission, the parent(s)/guardian(s) can, and should, be involved in the discussion and consent may be obtained from both parties.

Keep in mind that no person under the age of 18 can enter into a legally binding contract so the fees and billings must be handled by entering into that contract with the parent(s)/guardian(s).

Michael A. Lasko, D.M.D.
Registrar,
Manitoba Dental Association

GOODBYE!

After over 13 years as the Association's Executive Secretary, I will be retiring after the 124th Annual Mid-Winter Meeting in January, 2008.

However, I am not ready for a rocking chair yet! My husband, Bob, and I are planning on keeping active and involved during our retirement and plan to pursue our many interests which include travel, gardening, photography, home renovations and reading.

I have made many friends over the years. "Thank-you to the MDA Board, WDS Executive members, Committee Chairs, Ross, Mike and Rafi for 13 year's of friendship and for a rewarding and enjoyable work experience."

Diane Troubridge
Executive Secretary
Manitoba Dental Association

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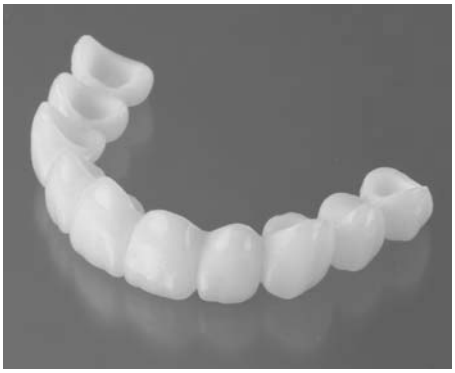

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The Dental Specialist

"The Dental Specialist" is written by Manitoba Dental Specialists. Each issue features one of the dental specialty groups (on a rotational basis). In this month's issue, the article is submitted on behalf of the Prosthodontists.

Rehabilitation of the Edentulous Maxilla

Maxillary complete dentures are generally better accepted than mandibular complete dentures. Patient dissatisfaction with the maxillary complete denture can stem from a poor fit, an occlusal disharmony, or a deficiency in favourable features. Favourable features include prominent hamular notches, deep vestibules with little intrusion from the frena and zygomas, a parabolic alveolar ridge coincident with the mandibular arch, a hard palate with a U-shape of sufficient depth, a soft palate that is elastic yet taut, and saliva of good quality and quantity. Shortcomings in any of the above features will compromise the stability of a maxillary complete denture and its acceptance by the patient.

The advent of endosseous implants has provided a number of good options to deal with potential shortcomings in maxillary complete denture treatments. Patients with good support but poor retention for a maxillary complete denture may consider an over-denture retained by two solitary abutments (IA) or a short bar secured on two implants (IB) in the anterior maxilla. Patients with poor support and poor retention for a maxillary complete denture may consider an over-denture supported by a long bar or two short bars (II), a fixed detachable prosthesis retained by screws (III), or multiple fixed bridges (IV) secured on implants distributed evenly over the maxillary arch.

Thorough examination, informed diagnosis, and careful planning are requirements for successful rehabilitation of the edentulous maxilla prior to surgery. An integral part of rehabilitation of the edentulous maxilla with dental implants is a diagnostic tooth set-up to determine final tooth position. Knowledge of final tooth position is important because it directs the positioning of the implant fixtures

(IA) Over-Denture retained by Solitary Abutments on Two Implants
Solitary abutments require implant fixtures to be placed as far apart as possible while remaining directly under the anterior teeth. An edentulous maxillary arch with a 'tapering' parabola would benefit from solitary abutments in the area of the future lateral incisors, while an edentulous maxillary arch with a 'square' parabola would benefit from solitary abutments in the area of the future canines.

Denture teeth positioned more anterior than the solitary abutments will create a Class I lever and permit the denture to rotate about an axis created by the abutments. Solitary abutments require good parallelism between the fixtures (depends on the type of solitary abutments), and require six to ten millimetres of inter-arch space between the fixture platform and the opposing mandibular teeth (again depends on the type of solitary abutments).

(IB) Over-Denture retained by a Short Bar on Two Implants
A short bar requires implant fixtures to be placed no less than ten millimetres apart but no more than eighteen millimetres apart. The bar is usually planned slightly palatal to the anterior teeth, and rotation of the denture around the bar is resisted by the parallel sides of the bar. Parallelism between the implant fixtures is not a requirement for retention of the denture when the implant fixtures are connected with a bar; however, a minimum inter-arch space of fourteen millimetres is required between the alveolar ridge and the opposing mandibular teeth.

(II) Over-Denture supported by a Long Bar or Two Short Bars on Four or More Implants
There are numerous permutations and combinations for this treatment depending on the number of implants supporting the bar or bars, and whether a bar crosses the midline. The minimum number of implants to support a bar over-denture with partial palatal coverage is four, and positions for implant fixtures should be no less than ten millimetres apart and no more than eighteen millimetres apart. A bar that crosses the midline and is supported by four implants will usually have the most anterior implant no further ahead than the future lateral incisor and the most posterior implant no further back than the future second premolar. Two separate bars that do not cross the midline and are supported by two implants each will usually have the most anterior implant no further ahead than the future canine and the most posterior implant no further back than the future second premolar. An inter-arch space of at least fourteen millimetres between the alveolar ridge and the opposing mandibular teeth is absolutely critical.

(III) Fixed Detachable Prosthesis secured by screws to Four or More Implants
A fixed detachable prosthesis is best described as a fixed denture that can be removed by the dentist only. The prosthesis does not have palatal coverage or a flange as these aspects would interfere with oral hygiene. The absence of a flange means that any provisions for additional lip support are challenging. The prosthesis can experience large occlusal forces, so a substructure in addition to the acrylic and denture teeth is required to give strength. The absolute minimum inter-arch space is ten millimetres between the alveolar ridge and the opposing mandibular teeth. An existing consensus indicates the minimum number of implants to support a maxillary fixed detachable prosthesis as five, although emerging case reports show the minimum number of implants to support a maxillary fixed detachable prosthesis as four. A broad distribution of the implants over the maxillary arch is favourable to minimize the extension of cantilevers. Cantilevers have been shown to increase loads to the most posterior implants by more than three times. The most posterior implants for the maxillary fixed detachable prosthesis are usually in areas of poor bone quality due to the thin cortical bone and the less dense spongiosa, and poor bone quantity due to the enlargement of the maxillary sinuses. Modified implant placements with a distal angulation and zygomatic implant placements with palatal emergence have shown good success when splinted with

Continued on page 7

The Dental Specialist continued from page 6

conventional implants in the anterior maxilla. The palatal emergence of zygomatic implants produces prostheses with bulky palatal contours and unconventional substructure designs which make oral hygiene a challenge and acceptance sometimes difficult.

(IV) Multiple Fixed Bridges on Six to Eight Implants
The provision of multiple fixed bridges supported by implants requires thorough examination and meticulous planning. It may be advantageous but not necessary to perform a CT Scan of the maxilla as part of the examination process, and to integrate computer software to aid in the fabrication of a surgical guide for implant placement as part of the planning process. This option requires patients to have good bone width, good bone height, and good lip support. The absolute minimum inter-arch space is seven millimetres between the fixture platform and the opposing mandibular teeth. The number of implants required for support ranges from six to eight depending upon whether support is being supplied for two to four bridges. The number of bridges is not as important as the selection of sites for implant placement which will allow for proper esthetics, and not as important as the design of the bridge segments which will allow for an implant protected occlusion.

SUMMARY
The placement of at least two implants in the anterior maxilla can provide stability to a maxillary complete denture having good support but poor retention. This treatment is a good option although not often done due to the requirement for good support. The placement of four to eight implants distributed evenly over the maxillary arch can provide a set of prosthetic teeth that resembles natural teeth. The predictability of these prostheses will provide patients having an edentulous maxilla with excellent long-term solutions for improving oral function and quality of life.

Rob McIntosh, D.M.D.
Jack Lipkin, D.M.D.
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President's Message continued from page 2

The decision was based on several reasons (forgive the statements of the obvious). The *Canadian Business Corporations* Act (CBCA) defines proxy as meaning "a completed and executed form of proxy by means of which a shareholder appoints a proxy holder to attend and act on the shareholder's behalf at a meeting of shareholders". It is normal practice for business corporations. In a corporation votes are based on shares, with individuals often owning multiple shares and having an equal number of votes. Shareholders can acquire as many shares or votes as they are willing to pay.
The MDA is not a business corporation but a membership organization and voting rights are connected to individuals not shares. Similar to our public electoral system or business cooperatives each member only has the right to one vote. Proxy votes normally are not compatible with membership organizations as the priority is the individual. Moreover, assessing the validity and extent of the authorization given to a proxy holder would consume significant resources and encumber the entire voting process. The Board believes the disadvantages outweigh the benefits. I encourage all members to take part in the AGM and have your voice heard directly.

Convention

January 25 and 26, 2008 is set for our Annual Convention at the Winnipeg Convention Centre. As always, it is a time to learn, socialize and renew contacts for the entire oral health team. Based on the positive response to the Convention in Brandon, this year's event will be focused on Friday and Saturday with the MDA Business Meeting Thursday night. Both days will have a full education programme including the ever popular Dr. Gordon Christensen.

A big part of the Convention is the opportunity to learn about new equipment, innovative materials and alternative techniques through our exhibitors. The exhibits promise again be a first class affair.

Going on the "It's Showtime!" theme, Friday will have a Hollywood style bar scene with sports and music videos on large screens. I would like to personally invite you to Saturday's President's Gala. It offers an Oscar Night experience complete with a red carpet, awards and the Danny Kramer Band. CDSPI is a proud sponsor of this year's President Gala. If you haven't been to the Convention's social events recently, now is an exciting time attend.

The Annual Meeting and Convention Committee is constantly improving the events. On behalf of myself and the MDA Board, I would like thank them and the volunteers, exhibitors, staff and presenters for their efforts.

Variety Club Campaign and Siloam Mission

The dental clinic at the Saul Sair Health Centre is now up and running. With the tremendous efforts by Siloam Mission, Mr. Gerry Hagglund, his Sinclair Dental Supply crew and Dr. Tana Gilmartin; amazing contributions by ADEC and the Kinsmen Club and advice of Drs. Reid Robertson, Joel Antel and Walter Nider the clinic began providing dental services well ahead of schedule. Ms Kari Enns is the dental coordinator. If you are interested in volunteering, please contact her at (204-943-0658) or email kari.enns@siloam.ca.

The Variety Club tooth fairy campaign is well underway. If you haven't already, please consider supporting this worthy cause.

Finally, I would like to thank everyone for their support during my tenure as President. Especially important to me was the counsel and advice of MDA staff, current and past Board members, and my classmates. I have tried my best.

Best wishes for the holiday season,

Marcel Van Woensel
President,
Manitoba Dental Association

Manitoba Dental Association Directory Amendments

For changes to the MDA Directory please contact:
Diane Troubridge at the MDA office - (204) 988-5300 Ext. 2

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Winnipeg, MB R2W 4N1
Phone: (204) 589-4400

Dr. Irene Mokriy
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Phone: (204) 896_0289

District #3

Dr. Edwin Mah
8 – 50 Selkirk Avenue
Thompson, MB R8N 0M7
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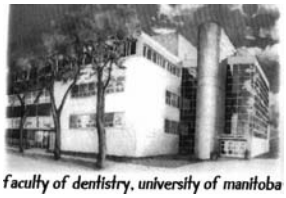

RESEARCH AT THE FACULTY

Characteristics and Features of Graduates of a Dental Undergraduate Research Training Program (B.Sc.(Dent.)) at the University of Manitoba

Introduction

Dental education in Canada dates from the late 1800's when schools such as McGill and the University of Toronto established units, often as separate departments under their respective faculties of Medicine to teach undergraduate dentistry. These units were often affiliated or even run by professional organizations such as the Royal College of Dentists of Ontario and later incorporated as independent faculties within the university setting. Some of these early schools provided both educational and licensing components within their jurisdiction. Today dental schools throughout Canada serve either independently as autonomous faculties or as schools within a faculty of medicine to prepare students for the dental profession. The majority of graduates of these programs undertake the clinical practice of dentistry in private settings. A small number follow a course through hospital dentistry while a similarly small number undertake graduate training in fields such as orthodontics or oral maxillofacial surgery. The general lack of incentive for clinical dentists to follow an academic career course, particularly involving a requirement for original research as part of their job, has resulted in many unfilled faculty positions both in Canada and the United States. Indeed a crisis looms for dental schools in North America as it has become very difficult to fill these faculty positions with full time dental instructors apparently due to low levels of remuneration available to the schools.

Dental education at the University of Manitoba

The Faculty of Dentistry has evolved, from a single undergraduate degree program which graduated its first class of dentists in 1962, into a multi-faceted professional academy offering a four-year dental degree and a two-year dental hygiene diploma with five graduate programs, and a variety of community service activities. Significantly for the existence and support for the B.Sc.(Dent.) program the Faculty has developed significant research profiles and programs without which continued success of the undergraduate research experience would be in question. During the Faculty's evolution, continuing to build on these high quality programs is a priority in our continuous pursuit of excellence.

Located at the University of Manitoba Bannatyne Campus, the Faculty of Dentistry's neighbours include the School of Dental Hygiene, the Faculty of Medicine, and the School of Medical Rehabilitation. Next to the Health Sciences Centre in downtown Winnipeg, Manitoba, this campus is the site for most of the University's programs in health sciences, providing a unique opportunity to interact with fellow students, faculty, and colleagues in other health-related disciplines. Furthermore the Faculty provides the only site in the province capable of undertaking nationally and internationally recognized dental research.

The Faculty of Dentistry houses seminar and lecture rooms, computer laboratories, pre-clinical teaching and research laboratories, state-of-the-art clinics, student lounges and offices – all dedicated to an environment conducive to oral health teaching, research and community service.

Within this context, both basic medical/dental research and clinical dental research exists. Compared to the B.Sc.(Med.) program which began in 1917, the B.Sc.(Dent.) at the University of Manitoba and indeed at other faculties of Dentistry in Canada is relative new. Nevertheless the importance and need for dental research both for ongoing dental sciences development, for the dental practitioner and as a means of developing student feeder mechanisms for graduate programs is essential.

Background to the B.Sc. (Dent.) programs – Researcher base

Unlike faculties of Medicine which have the capabilities to conduct many large scale research initiatives and thus employ many students and provide many interactive experiences, most faculties of dentistry in Canada are relatively small. In addition ongoing research often is easily divisible into basic science and clinical research. The potential for basic science research for the B.Sc. (Dent.) experience is generally provided by medically trained basic science researchers often coming from traditional departments in medicine such as Pharmacology, Biochemistry or Anatomy. In some schools these individuals have remained or returned to their medical-based departments as the teaching of dental and paramedical streams is undertaken through the faculty of medicine under university mandate. This results in a major loss of research and training potential for any Faculty of Dentistry in these circumstances. The clinical research potential for students wishing to undertake a B.Sc. (Dent.) is often a popular option as it relates directly to the dental fundaments taught in the first year of the dental curriculum.

As is the case with many clinical specialties both in Medicine and Dentistry, major barriers exist to exploiting potential interactions between basic and clinical researchers. Heavy teaching loads on clinically dental faculty help to discourage faculty members who might be interested in pursuing either independent research or collaborative work with basic scientists. The B.Sc. (Dent.) program began at the University of Manitoba in 1982 as an attempt to bring the undergraduate research experience to the Faculty to stimulate both clinical and basic research, and possibly to induced collaborative interactions between the two. Funding at the time was through a number of Farquason scholarships supplied by the Medical Research Council of Canada (now the CIHR) intended to enable undergraduates to gain research training during the summer months. The scholarships had a value of approximately $2,000 and students taking up thee awards were to have completed the first year of study in a

Continued on page 13

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Insertion Date: January 2008

Research at the Faculty continued from page 11

professional school and must rank in the top 20 per cent of their class. It should be noted that no academic degree was tied to these studentships. Initially three awards were provided from 1981 – 1983; from 1983 – 1989 five awards per year were funded. In 1989 this program was discontinued and shortly after Manitoba Medical Service Foundation became involved (see figure 2).

B.Sc. (Dent.) Completion Process.

The B.Sc. (Dent.) program differs somewhat from the corresponding program in Medicine. Completion of the program through presentation of the research results does not occur in a defined time frame but is individualized for each student. Thus more flexibility of the program exists which benefits researchers as the students often return for a third summer, funded entirely by the researcher, thereby maximizing the research experience and the opportunity to produce a publishable study. The research presentation is styled after the M.Sc. thesis defense. A verbal presentation by the student summarizes the findings. Generally 2 – 3 examiners provide oral feedback/questions to the student in front of an audience. Written feedback is provided to the student and often revisions are required before final acceptance of the manuscript. Copies of the study are filed with the supporting agency and in the library.

Methods

Compared to the B.Sc. (Med.) program which could draw on records from 336 graduates over a 25 year period [2], the relatively small size of the B.Sc. (Dent.) cohort of 76 students did not provide sufficient numbers for parametric statistical analysis. Nevertheless a descriptive statistical approach could be applied. Student records were obtained from the University of Manitoba and from the Dean of Dentistry's office. All individual identifiers were removed prior to acquisition of the records. Other studentship records were obtained from Manitoba Medical Service Foundation, Winnipeg. Funding information prior to 1994 was sought from CIHR. Statistical analyses where appropriate were undertaken using Student's t-test [4].

Results

Comparisons of students' entering grade point averages (GPA), dental aptitude test results (DAT) and GPA during the four years of dental school in the general and B.Sc. (Dent.) program are shown in Table 1. Students entering the B.Sc. (Dent.) program had mean entering GPA's of 3.45 while those in the non-B.Sc. (Dent.) program showed GPA's of 3.39 upon entrance into dental school. The DAT was only slightly different between the two groups. On the other hand the overall GPA while in dental school was 3.14 for the general group but 3.42 for the B.Sc. (Dent.) program group.

The characteristics of the students passing through the B.Sc. (Dent.) program at the University of Manitoba and their exit undertakings are shown in Table 2. The program has had a range of 1 – 11 students in it during the course of its existence. The median student number did not occur until 1997 although the program began about 1980. This reflects the increasing popularity of the program and we believe a view that some students feel the program provides a step up into some of the graduate programs. It is interesting that four faculty gold medalists have passed through the program although only one of the four have apparently gone on to utilize the research experience by undertaking further training for a faculty position. The majority (60%) of graduates of the program remained in Manitoba providing dental care to Manitobans. About 14% of graduates maintain a connection with the faculty through instruction and/or appointment as junior faculty members. This includes former students who hold clinical instructor positions. A significant number have also entered graduate orthodontics programs (10%) either here at the University of Manitoba or elsewhere in North America.

The distribution of the number of B.Sc. (Dent.) students as a function of the year of the program from its inception is shown in figure 1. There has been substantial growth in the program over the years. Initially only one student was registered. The regression analysis showed a positive slope of 0.64 and a significant correlation (r^2 = 0.778) between years and numbers of students registered in the program. The last three years for which we have data showed a mean of 11 students taking part in the program. From a four year class size of about 100 students this represents approximately a 10% participation rate. Furthermore, and more importantly the B.Sc. (Dent.) program continues to flourish and grow.

The proportional funding of the B.Sc. (Dent.) program through the Manitoba Medical Service Foundation (MMSF), our primary funder, is shown in Figure 2. Prior to 1994 funding for the B.Sc. (Dent.) program came from Farquason studentships which originated from the Medical Research Council of Canada (CIHR). The funding from MMSF has constituted the majority and in some years the sole source of funds to support students in the B.Sc. (Dent.) program. This occurred in 1994 – 1997. Subsequently MMSF remained the majority funder of the program. Other fund sources have included research grants to individual faculty members and recently funds from the **Network for Oral Research Training and Health (NORTH)** which represents a CIHR research training initiative. It should be noted that NORTH funded students are not necessarily required to undertake a B.Sc. (Dent.) degree. The faculty has however reserved all MMSF studentships for students undertaking the B.Sc. (Dent.). Therefore in some respects MMSF support is of longer duration (2 years) thus providing more research experience as well as upon successful completion, a degree.

Discussion

As early as 1978 a survey of Deans of Canadian and American dental schools showed that while there was not a large number of dental students seeking research involvement during their undergraduate training, most school provided some opportunity for research training [5]. Indeed the importance of such experience may be the foundation on which dental education can be revitalized [6]. A report by the Institute of Medicine in 1995 suggested dental education was, at that time, at a crossroads. Due in part to funding cuts, more demonstrated evidence of accountability and effectiveness and expanded research on the effectiveness of alternative preventive, diagnostic and treatment strategies

Continued on page 14

Research at the Faculty continued from page 13

would be demanded [7]. As approaches to rectify this situation, various alternatives were suggested such as "collaborative research and teaching, service to the profession through high quality continuing education, participation in health plans organized by academic health centers and creative strategies for helping communities serve disadvantaged populations. The mix of contributions will vary from school to school, but the fundamental point is clear: dentistry cannot afford isolation if it is to secure the financial and other resources necessary for a successful passage into the 21st." [7]. As a means to move dental education towards such an all encompassing whole patient evidence-based model, many schools have incorporated some form of research training for students, often occurring during the summers of the undergraduate curriculum. More than a decade later similar themes are advanced [8], and dental education and dental research are now established as fundamental essentials of the undergraduate experience. Furthermore while accessibility may be an issue, increasing student involvement in research has many potential rewards for both faculty and students [9].

The data from the present study show little differences between the general student population and that of the B.Sc. (Dent.) program students in either their entering GPA or the scores achieved on their DAT. However a higher overall GPA in B.Sc. (Dent.) students was observed over the four year dental program. In this context, a self selection process may be operating as minimal criteria set for the program require a GPA of 3.0 to enter. Nevertheless this does not preclude the majority of the students who generally enter dentistry with GPA's over 3.0 from entering the program.

The outcomes measures presented in Table 2 provide an interesting picture of where program graduates have moved. While only four gold medalists from the faculty took part in the B.Sc. (Dent.) program, over the approximate 25 year course of the program, this represents about a 15% involvement rate. One might also argue that while this number is low, the gold medal is given for performance in the undergraduate dental curriculum and does not reflect any parameter of the B.Sc. (Dent.) program.

The end occupation of program graduates shows that a significant number have taken up appointments in the faculty either on a full or part time basis. Significant numbers have also entered the Orthodontics graduate program probably as their research experience as an undergraduate student has given them the tools to undertake further research as required at the graduate level.

The popularity of the program as a summer research experience has continued to grow since its inception. The support of MMSF in funding this program of obviously clear and throughout most years, without their support few students would have this option. Continued growth of the program is anticipated; applications to enter have exceeded available funded studentships for about the last three years, even with addition of internal funds and researchers' grant contributions.

We conclude that while many statistical comparisons were not possible due to low sample size which is in turn due to the relative age of the B.Sc. (Dent.) program, valuable research experience has nevertheless provided significant interest for graduates who wish further research experiences, and junior faculty members who pursue research in a dental faculty setting.

Acknowledgements:
This report was generated to outline the history of the B.Sc. (Dent.) program at the University of Manitoba and to acknowledge the continuing financial support of the Manitoba Medical Service Foundation without whom the program could not continue.

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Dean, Faculty of Dentistry, University of Adelaide

Manitoba Dental Association

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Winnipeg Convention Centre

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MDA Board Meeting Synopsis
October 27, 2007

Government Representatives:
The Province of Manitoba appointed the following public members to serve on the MDA Board: Wayne Novak, Barbara Borsch, and Cheryse LaRocque. MDA Board approved the extension of the MDA Expense Board policy to the public representatives and dental assistant representative.

Transitional Council Dental Hygiene:
The MDA Board directed the Registrar to communicate with the Members on the new supervision requirements for dental hygienists in a private dental office. Currently the Transitional Council regulations do not provide an opportunity for dental hygienists to establish independent practices. Any changes to Scope of Practice must be developed collaboratively with all stakeholders, including representatives of the MDA.

Dental Assistants By-laws:
The MDA Board approved the following by-laws for distribution and ratification by the Members including registered dental assistants: Provisional Registration, Continuing Education, Professional Liability Insurance, Election of a Dental Assistant to the MDA Board, and Peer Review Committee.

Umbrella Legislation:
Representatives of the 21 Regulated Health Professions have been meeting with Government to draft the principles to be included in Umbrella Legislation relating to complaints procedures and restricted actions. The "White Paper" on the legislation will available in early 2008 for review.

CDRAF:
The Canadian Dental Regulatory Authorities met in October 2007. MDA representatives at the meeting were Dr. Marcel Van Woensel and Dr. Michael Lasko. At that meeting a national process to recognize foreign-trained specialists, an evaluation and develop gap education was discussed. Once the final document outlining the above is finalized it will be available to all stakeholders.

CDSPI:
CDSPI has recommended that all licensed dentists in Canada can obtain malpractice insurance through them irrespective of their having membership in either the CDA or a provincial dental association.

Siloam Mission:
MDA had taken a leadership position in the establishment of a dental centre in the Sair Health Clinic at the Siloam Mission – a facility to house and feed Winnipeg's homeless people. The treatment to be offered to patients would likely be basic prevention, restorative and extraction and denture services. Donations of equipment and supplies from dental companies will allow the dental centre to open in November, 2007. An announcement of the facility and a request for donations will be sent to the membership.

Communications:
The 2008 Marketing and Strategy Campaign and budget was approved by the MDA Board. The three main goals of the program are: improve office busyness; create a positive image for dentists; and help to inform dentists about communication with patients in order to reduce formal complaints. Programs being supported by the Communication program include the 2008 Safeway Select Curling Championship, International Children's Festival (Tooth Fairy Saturday), and Manitoba Tobacco Reduction Alliance.

Life Members:
The following dentists will be recognized as Life Members at the Annual Business Meeting, January 24, 2008: Drs. Les Allen, Semih Berker, Jack Braun, Michael Helper, Richard Konzelman, Terry Mancer, Ken Nielsen, Preston Segal, Gene Solmundson, Harvey Spiegel, and Errol Wright.

2008 Budget:
The MDA Board approved the 2008 budget which calls for no increase to the license fee, salary adjustment of 4% for MDA staff, and a transitional fund for the new Registrar as well as a $23 per dentist increase in the CDA grant. The Board also approved the establishment of a Trust Fund for the Development of an Examination Process by the CDRAF to assess foreign trained dental specialists.

Economics Committee:
The MDA Board received as information the following from the MDA Economics Committee: an overall increase to the MDA fee guides of 3.88% with the exception of the Paediatric fee guide where a 6.00% increase was given. The Board also approved the 2008 work plan and budget for Michael Loyd & Associates.

The Board was also made aware that Dr. Barry Rayter, long-time serving Chair of the Committee has retired from private practice and resigned as Chair. As a result, the MDA Board appointed Dr. Murray White as its new Chair.

The Dean's Report:
The new Dean of the Faculty of Dentistry, Dr. Anthony Iacopino, spoke to the Board about the faculty changes, 50th Anniversary Plans, new mentorship program, and other new initiatives.

CDA Report:
Dr. Peter Doig, CDA Director, provided the Board with an overview of the CDA Strategic Plan. Dr. Doig indicated that the plan focus on four main activities: relationships with corporate members; roles and responsibilities; finances; and CEO search.

If you have questions relating to the activities of the Board please feel free to contact your respective Board representative or the MDA office.

Rafi Mohammed
Membership Services Director

faculty of dentistry
The University of Manitoba

FACULTY CORNER

Drive for Top Five Is Alive

Join Us on February 1, 2008 and Come Along for the Ride

By now, you have likely heard the word: the Drive for Top Five is Alive!

Our message is being heard and the community is starting to take notice.

With our 50th anniversary year fast approaching, faculty staff has been very busy preparing for what we know will be an exciting and memorable time ahead.

As you may be aware, 2008 marks the Golden Anniversary year at the Faculty of Dentistry. Plans for a year-long series of celebrations have been in the works for the past several months, and we are on the verge of making the first of several major announcements to begin this most eventful year.

At this time, I would like to extend my personal invitation to you to attend our gala anniversary and kick off celebration, Friday, February 1 at the Fairmont Hotel.

Many of you may have already received your invitation that outlines all the events that we have planned. Among the evening's highlights will be a tribute to the Class of 1962, the first graduating class of our faculty. We will also note and acknowledge other events, graduating classes, families and individuals that have reflected well upon our institution over the years.

It will be a time to look back and acknowledge those who went on to establish themselves in the profession and in the community. As you likely know, many of our graduates have gone on to long and illustrious careers; many have ascended to the pinnacle of the profession. We have, for example, no fewer than nine graduates that went on to serve as president of the Canadian Dental Association. I'm pleased to learn and share with you that that this past year, Dr. Keith Morley of the Class of 1969, was named the president of the American Academy of Pediatric Dentistry. We congratulate Dr. Morley on this most unique honour and distinction. In 2006, Dr. Lorne Golub, from the Class of 1963, received a gold medal in research from the American Dental Association. And the list goes on. The achievements of graduates of our school could literally fill a book. And that is a wonderful thing. We want to thank and acknowledge all graduates who came from this institution over the past five decades for their achievements, great and small. The example set by these talented and accomplished professionals stands as the true legacy of our faculty; an example of how the skills and training they received at the Faculty of Dentistry can lead to successful lives, careers and families and contribute to building a strong and caring community.

Our gala on February 1 will be our showcase; it will be our time to pay tribute to those that went before us. And what better way to acknowledge the past than to build for a brighter future?

And what a future it will be. Our Faculty of Dentistry is poised on the brink of a spectacular new chapter of unprecedented achievement that will be realized through our Drive to the Top Five. This drive will be based on a series of nine "pillars of innovation" that represent expansion of existing areas of strength or first-of-their-kind programs/initiatives that do not exist in any other dental school. These pillars will provide a distinct competitive advantage for the Faculty of Dentistry and establish us as international leaders in dental education, research, and service.

Topping the list is the creation of the **International Centre for Oral-Systemic Health**, a world-class facility dedicated to advancing the science of oral-systemic medicine.
We plan to introduce a **Virtual Simulation and Electronic Digital Curriculum** – cutting edge technology that represents "the next generation" of teaching dentistry.

A state-of-the-art **Imaging Centre** will also be created for improved diagnostics and outcomes of surgical procedures, especially with regard to temporomandibular joint disorders, orthognathic reconstruction, oral cancer, and implant dentistry. The faculty will also be home to a new **Centre for Implant Dentistry** that will include a Prosthodontics graduate program and "2+2" Periodontics/Prosthodontics dual specialty track.

A **Head and Neck Pain Program** will be created to take advantage of our faculty's unique expertise in head/neck pain and temporomandibular disorders. To address the pain and suffering of children afflicted with oral health problems, we will establish the **Centre for Children's Oral Health**. This Centre will house a graduate pediatric dentistry program and meet a critical need within the province while vaulting the faculty to the forefront as an international leader in children's oral health issues.

Our leadership in the design and delivery of community-based oral health will be enhanced through the expansion of **The Centre for Community Oral Health.** This internationally recognized centre has been a long-standing source of pride and achievement for the faculty due its highly developed infrastructure that targets underserved populations at high risk for oral disease. The faculty will also invest in facility renovations and recruitment of new researchers to reclaim its

position of prominence in **Oral Biology Research**. And, last but certainly not least, the University of Manitoba will be seen as the "place to go" for the best **Practice Management** education through a comprehensive new business training program for students and practicing professionals. Our graduates will receive thorough and proper training in running a practice, something that has been lacking within our profession for years.

And there is more, much, much more that I can and will share with you on February 1.
On Friday, February 1 it all begins: Our Drive for Top Five gala at the Fairmont Hotel. And it's only going to get more exciting as we go forward. So please accept this as my invitation for you to join with us and come along for what promises to be a year like no other. Our 50th anniversary year of 2008 will be one of celebration, renewal, promise, and of unparalleled achievement. The Faculty of Dentistry is the place where "the action is" and we invite you to come along for the ride.

Anthony M. Iacopino DMD PhD
Dean, Faculty of Dentistry
University of Manitoba

How to Choose Bond Funds

If you're looking for long-term steady growth in your investment fund portfolio, a conservative bond fund is hard to beat.

"Fixed-income" investments such as bond funds offer regular and set interest income payments. A conservative bond fund can also provide capital gains in the "medium" range, compared to the potentially higher returns of higher-risk equity funds.

Due to their generally lower returns compared to equity funds, you'd be wise to choose bond funds with low management expense ratios (MERs) of 1 per cent or less.

A common mistake I've seen from investors is that they'll have just a single bond fund in their portfolio. As is the case with equity fund investing, you need to take a more diversified approach. After all, there are many different kinds of bond funds with varying advantages.

Funds holding a majority of short-term investments, typically with maturity dates from 90 days to one year, can usually respond more quickly to changing interest rates as securities in the portfolio are turned over more rapidly. However, these short-term fixed income funds may provide lower returns compared to longer-term bond funds, which can command higher interest rates since they are lending their money for a longer period, for example, 10 years or more.

Bond funds that include U.S. dollar denominated bonds can provide a hedge against the Canadian dollar. When the Canadian dollar drops, there is the potential for additional capital gains with these funds. Conversely, losses can occur when the Canadian dollar rises.

Generally, bond fund managers make their investment choices based on factors including forecasted interest rate direction and current economic activity and outlook. However, fund managers will have their own investing styles, so you can benefit by adding funds from different fund managers to your portfolio.

You could buy bonds directly, and bypass the management fee associated with all investment funds. To obtain the right diversification of laddered bonds (a portfolio that has a bond maturing each year), you'll need at least half a million dollars. Even then, you may not be able to take full advantage of short-term changes in interest rate direction in the same way that professional bond fund managers can, given their access to higher cash flows and timely analysis and research.

With bonds and bond funds, there is a risk that rising interest rates will lower the value of existing bonds. Then again, when interest rates are falling, bonds can outperform equities as demand increases for existing bonds paying higher rates of interest.

Very high yield bonds or junk bonds are issued by companies with lower credit ratings, which means they may not pay back their debts. For investment stability, it's prudent to stick to funds holding government bonds or corporate bonds from proven, blue-chip companies.

With an investment portfolio that is well-balanced between fixed-income and equity investments, you'll be better prepared to ride out any market volatility and you'll sleep better at night.

Michael Holmes, CFP, CIMA

Michael Holmes, CFP, CIMA, is the Vice President of Investment Services at Professional Guide Line Inc. — A CDSPI Affiliate.

*For help building your bond fund portfolio, contact an accredited financial planner at **1-877-293-9455 or (416) 296-9455, extension 5023**.*

WINNIPEG DENTAL SOCIETY
Clinic Session

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"Saving Marriages, Improving Health and Growing Your Practice Through Treatment of Snoring, Obstructive Sleep Apnea and Bruxism"

Jonathan A. Parker, D.D.S.

CDSPI: Truly Your Company

Annually, representatives of the Manitoba Dental Association attend the Annual General Meeting of the Canadian Dental Service Plans Inc. (CDSPI). One of the messages put forth by CDSPI at its last meeting was its desire to be more involved with the provincial dental associations. While most Canadian dentists are familiar with CDSPI, many lack a true understanding of what CDSPI really is — and who stands behind it.

CDSPI is a non-profit organization that administers insurance and investment products for the dentists of Canada under an administration agreement with the Canadian Dental Association. The Canadian Dentists' Insurance Program and the Canadian Dentists' Investment Program are sponsored by the CDA, with the Insurance Program co-sponsored by nine provincial associations, including the MDA.

The MDA is also one of the ten voting members of CDSPI. Our representatives provide input into the direction the company takes on behalf of our members.

CDSPI is unique in that it was formed almost 50 years ago by the dental community for the benefit of dentists. It is your company. You have a stake in its well being and, through the CDA and the MDA, a way to express your views on insurance and investment concerns.

Thanks to the group purchasing power created by our members' use of the plans, our members have access to CDA's affordable insurance products designed especially for dentists, as well as high yielding investment solutions.

In those provinces where CDSPI administers the Insurance program's malpractice insurance plan, essentially 100 per cent of dentists are participants. In addition to malpractice, MDA members make strong use of other insurance plans in the Program. For example, approximately 50 per cent of our members are covered by the TripleGuard™ Insurance office plan. That product is very much tailored to dentists' needs, as most recently demonstrated by the addition of pandemic coverage (one of the first of its kind in Canada) because we as dentists asked for it.

On the investment side, the Investment Program provides us with a wide variety of superior plans (including RRSP, RRIF, RESP and non-registered) and investment funds to meet our needs. The Program currently has over $400-million under management, allowing for low fund MER fees — so more money can continue to grow within investors' plans. In addition, through CDSPI's advisory affiliate, Professional Guide Line Inc., we can obtain no-cost advice on all our investment needs from non-commissioned advisors.

CDSPI is not just another vendor to the dental community. It is your company, providing you with valuable services. As CDSPI begins to take a more active role in reaching out to dentists through our provincial association, I would encourage you to pass along your concerns, needs and issues to the MDA or CDSPI. With this feedback we can make CDSPI and the products it administers that much more valuable to us as dentists.

Marcel Van Woensel
President, Manitoba Dental Association

CDA Working on Your Behalf

Canadian Dental Association

A New Membership Model

The Canadian Dental Association met in Ottawa on Nov. 14 – 17 2007. At the meeting an interactive session was held to deal with the issues of Roles and Responsibilities of the CDA and the Provincial Dental Associations (PDAs) and membership models for the CDA.

For many years the CDA has functioned under a hybrid membership model. The CDA dealt with both the PDAs and individual dentist members providing direct services to both groups. The CDA under this model was accountable to both groups. In eight provinces the PDA collected a mandatory individual membership fee on behalf of the CDA as part of the PDA membership. In Ontario and Quebec the CDA sold memberships in the CDA directly to individual dentists.

The nature of the membership model required that the CDA offer services to individual members to provide tangible benefits to justify the cost of membership. This was in addition to the intangible benefits, such as public and government advocacy that the CDA provides to all dentists in Canada.

The provision of benefits has caused friction in the dental community on a couple of levels. The intangible benefits provided by the CDA accrue to all dentists in Canada whether they are members of the CDA or not while the CDA providing tangible services and benefits to its members raises concerns with those PDAs who provide similar services to its members. Obviously this is mainly a concern in Ontario where membership in either the PDA or CDA is not mandatory, a situation dictated by legislation. In Ontario this situation has led to competition for members between the CDA and the ODA. Until recently a similar situation existed in Quebec, although since Quebec's PDA has withdrawn as a corporate member of the CDA the situation has become more complicated.

At the recent interactive sessions in Ottawa a new Membership Model for the CDA was suggested. A Joint Membership Model was suggested as the ideal for both the CDA and the PDAs. Joint membership requires that when a dentist joins a PDA he/she automatically becomes a member in the CDA. In this new membership model the CDA would theoretically provide services to the PDAs and services to individual dentists through the PDAs and all the benefits provided by both the PDA and CDA would accrue as a result of joint membership.

While this model, if adopted, would not cause an appreciable change in membership status in the eight mandatory PDA membership provinces, it may have an effect in Ontario. In Ontario there are ODA members who are not CDA members and CDA members who are not ODA members. There are also many dentists who are members of both CDA and ODA.

Under the suggested new membership model there is a potential increase in membership in both the CDA and the ODA by dentists in Ontario. The new Joint Membership Model may also protect the CDA and PDAs from the possibility that any of the mandatory provinces would change to a voluntary model. Protection that would arise from a need to belong to the PDA/CDA to receive those services necessary to practice dentistry effectively: fee guides, insurance and investment services and claims transmission.

The provision of services to individual dentists through the PDA could also remove a source of friction between the CDA and PDAs. In a number of provinces, those primarily with large PDA memberships, the PDA provides a number of tangible member benefits to its members. In these provinces the provision of similar products by the CDA is a cause of concern. The new model could prevent duplication of services and by working through the PDAs the messaging used to members would be consistent. The CDA could still be available to provide member benefits in those provinces where the PDA membership was too small to have the critical mass to go alone, but these benefits would be provided as joint benefit of the PDA/CDA.

The proposal of this new membership model is an exciting evolution in the relationship of the CDA and its PDAs. It is the result of a lot of introspection and discussion between all the parties involved over a number of years. However, the discussions of the new model must still be considered preliminary. As with all agreements the devil is in the details.

The Interactive sessions tasked a potential start date of Jan. 1, 2009, it will take a lot more work to accomplish implementation of the new Membership Model, but I am confident that with the improvement in communication between the CDA and PDAs a new mutually acceptable membership model can be developed.

As always the CDA continues to work on your behalf.

Peter J. Doig, D.M.D.
CDA Board Member

Professional Classified

The Manitoba Dental Association offers a referral service for: **(I) Dentists with Opportunities**: (practices for sale, space to share and associateship/locums) and **(II) Dentists Seeking Opportunities**: (full or part-time associateships, short-term locums and practice purchases/buy-ins). To list with this service please contact Diane Troubridge at the Manitoba Dental Association Office, Phone: (204) 988 5300, Ext 2.

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Golden, BC
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Exceptional, well-trained staff – including three hygienists. Highly productive track record. Come for the work, stay for the lifestyle. Growing, safe mountain community, vibrant arts scene, French immersion – the good life.
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Experienced dentist available for short-term locums (i.e. Sick leave, vacations, etc.). References available upon request.
Please contact: Dr. I. R. Battel
(204) 489-4507

Winnipeg, MB
Experienced dentist available for part-time associateship.
Please contact: (204) 489-7679

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Experienced dentist available for locums (sick leave, vacations, etc.)
Please contact: Dr. Neil Winestock
(204) 269-4314

Practices for Sale

Winnipeg, MB
Busy, well-established 3-operatory dental practice for sale in North Winnipeg. Low overhead and high net earnings.
Please contact: (204) 997-3978

Southern Manitoba
Professionally appraised, non-assignment, general dental office located in Southern Manitoba – 45 minutes from Winnipeg. $800K in 2007 in 191 days. Low overhead, fully computerized, fantastic long-term staff. Practice located in a medical clinic with great exposure.
Please contact: (204) 745-2394 or aaron@drteeth.ca

Looking for a Dental Hygienist?

The Manitoba Dental Hygienists Association's job placement service is your connection to dental hygienists that are looking for full-time/part-time and temporary placement.

This service has no fees attached, so if you are looking please leave a message for Cindy.
Phone: (204) 981-7327
Email: mdhajobplacement@hotmail.com

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