# Reaction Paper

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**Abstract**

*The dental research community has a social and civic responsibility to participate actively in promoting the public's oral health, but participation should be carefully orchestrated with other groups. The ADHA "Hearing on Needs" has stimulated a coalescing of groups and individuals to contribute to the welfare of society's oral health. Dental organizations—especially dental public health organizations—need to work more cooperatively together to work, in turn, with other organizations. "In union, there is strength."*

*Key Words: coalition, dental public health, dental hygiene, public health*

Thank you Jean, fellow panelists, and members and guests of the Dental Health Section. It was a delight to read Ernie Newbrun's paper when I received it and to realize the vehemence with which he had been caught up in the fluoridation debate in the Bay area. Speak of déjà vu! Welcome to public health, Ernie. He himself used the term "thrust"—clearly he had the challenge of entering the fluoridation debate as a scientist-politician "thrust" upon him. I suspect that his personal commitment came about because his integrity and that of science had been challenged. What he knew to be fact had been questioned and he perforce had the role of scientific expert thrust upon him and was caught up willy-nilly in the contest. Great, I'm all for it—but only if the scientists leave their laboratories to work in the political arena *cooperatively*—cooperatively, I repeat—with others, not charging ahead on their own. It has been said that a certain large city not far from Ann Arbor might have been fluoridated 10 years sooner had not certain "experts"—and experts who were clearly *pro*fluoridationists—charged into the arena without a plan, without cooperation, without working with others. Sincere, dedicated, without question.

I could not have been more delighted, as I read on about the San Francisco brouhaha and as I listened to Ernie tell about being caught up in the fray more and more, to see that Ernie indeed was working cooperatively with others—with the other folks at UCSF Dental School, especially with John Greene, with the San Francisco Dental Society, and with the School of Public Health—to outline their strategy for how they would work cooperatively to face and solve a mutual problem. I could not agree more with Ernie's "Summary and Conclusions" that people in the dental research community have a social and civic responsibility to participate actively in promoting the public's oral health and that they may not have the privilege of remaining merely passive observers.

When I was active in the fluoridation fray as a state dental director in New Mexico out on the firing line, fighting the battles, I was delighted to be able to turn to people in those decades who were the Ernie Newbruns of their time—Wally Armstrong from the University of Minnesota, Phil Jay from the University of Michigan, and Roy Doty of the American Dental Association. They were all willing to come to New Mexico to provide expert testimony in court for the good of the cause with no suggestion of recompense other than that they had done their duty. On at least two occasions in New Mexico, the fact that we had these people ready to testify resulted in the other side's dropping the suits.

In regard to Ernie's contribution, let me agree wholeheartedly with all he said; but, let me agree with a caveat: such participation must be planned with careful orchestration of who says what and when. The San Francisco story as recounted by Dr. Newbrun certainly illustrates my point.

The "Dental Health Initiative" of the American Dental Hygienists' Association about which Ms. Westphal spoke was brought home forcefully to me when I had the good fortune to participate as a member of the hearing board on two different occasions along with my fellow responder, Alice Horowitz, to listen as testimony was gathered for this Dental Health Initiative. At both the hearings in Chicago and in Washington, DC, I was struck by the number of people representing so many diverse organizations and associations who came together—yes, who coalesced, if you will—to present their testimony. Sometimes their testimony was quite elementary, although more moving because it was simple; other times it was highly sophisticated, but almost too cautious, when given by professional representatives of various organizations with a constituency to represent. Out of it emerged this coalition—this coalescence, again if you will—of thoughtful points, ideas, of what dental hygiene (and dentistry, too) could contribute to the welfare of society's oral health.

We who have been active in dental public health over the years tend to sell dental public health short. We forget just how important dental health is to people. One example came home to me just this past year. It was reinforced by the testimony in these hearings of the Dental Health Initiative of the ADHA, but it happened at just about the same time so it was doubly impressed upon me. That example is of my 96-year-old aunt who had an apartment in an independent living unit attached to a nursing home. She had all of her own teeth except her third molars (and maybe she'd still have them had Jay Friedman been around) and she was most distressed to find that she felt she had a cavity in a central incisor. She was concerned and wanted to have that cavity filled. She even phoned me long distance—which for her generation is a measure of the depth of her concern. When I suggested that she might get the dentist who regularly visited the nursing home to use some of the new plastic bonding materials, she was incensed because that "plastic stuff," as she called it, had always been considered as "temporary" in the days when her brother (my father), who was a dentist, had cared for her teeth. And in those days, silicates were temporary. She wanted a permanent filling that would last. She valued her dental health, even at the age of 96.

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The people from these special population groups who testified before the Dental Health Initiative also valued their dental health. And I was impressed by how much they valued the care provided them by dental hygienists—people who took special care of them, paid them attention, and whom they saw on a regular basis and whom they loved. I was struck by the fact that depriving them of the preventive services offered by a dental hygienists through some change in Medicaid regulations was a real deprivation, a real loss. Ms. Westphal's paper brought all of this back to me. Her mention of the title of their national project, "A Beautiful Smile Is Ageless," brought home to me how important it is that we work with the groups we serve—that we get together in a participatory, decision-making mode to solve our mutual problems. These mutual problems could be the barriers to which Ms. Westphal alluded in getting dental hygiene care to people. Such barriers are not always physical obstacles, such as a curb or steps, but are those barriers put in place by our societal establishments—for example, dental insurance's not being paid directly to the provider.

Just this last week I was on the telephone with a reviewer of a set of papers offered by three dental hygienists to the *Journal of Public Health Dentistry*, which I am privileged to edit. That reviewer, a periodontist of established repute, felt strongly that in dealing with the subject of "future horizons for dental hygienists in periodontal disease" these authors had failed to face directly the issue of supervision of hygienists by dentists. He felt strongly that

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if ever we were to attack the problem of periodontal disease and bring dental health to more people, dental hygienists must become to dentists as nurses are to physicians—strongly allied, closely linked, but with a significant degree of self-governance. Clearly, these traditional barriers must be addressed: if they are found to be artificial, and one suspects many of them are, they should be breached. I have one bit of disagreement with Ms. Westphal, regarding her comment that the APHA and the ADHA should work together to provide access to care and establish the dental hygienist as *the* provider of preventive dental care. Certainly the dental hygienist is an important provider of dental care—a *primary* provider of preventive care, perhaps, but not *the* provider. For instance, the dentists or physicians who prescribe fluoride tablets or a fluoride mouthrinsing regimen at home certainly are providers of preventive care, not to mention their direct, clinical contributions of a preventive nature.

Now some concluding thoughts about what we—and I say *we* advisedly—can do to build a coalition for the purpose of improving the public's oral health. First, we can stop competing with ourselves. The Dental Health Section of APHA and the AAPHD can combine newsletters and, miracle of miracles, might even work out joint memberships, now that the AAPHD is no longer as restrictive. A little collective bargaining between the officers of the two groups just might result in one membership fee, larger than either alone, but not as large as both. Certainly there is room in the *Journal of Public Health Dentistry* for the quality papers of the APHA Dental Health Section. I see no reasons why there could not be two annual national scientific sessions run by the joint dental public health groups—one tied to APHA and one tied to ADA with coordinated planning of the two sessions. People could attend the one most appropriate for them, if one is all they could attend. With a little imagination and a little flexibility, some economies of scale might be

effected. And isn't there a saying to the effect: "In union there is strength"?

Alice Horowitz emphasized that small groups such as dental public health must seek support through coalition.

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Dental public health, when it has dispersed itself or let itself be dispersed, as happened in the past decade with dental public health in the Public Health Service, become weak. It loses visibility. It loses focus. Sure, we might squabble internally; but, like a family, we turn together to present a united front to the outside world.

Another opportunity for coalition building that strikes me as just ripe is introducing dental public health into the general practice residencies. Have we offered our services? Have we demonstrated what we have to offer? For example, community outreach, skill in working with consumers, in surveying, in research design, in statistical analysis, in quality assurance mechanisms, in health care provisions, in working with other disciplines, in evaluating preventive agents, in clinical trials, in health education—well, I could go on. We have a lot to offer to all kinds of groups. Let's reach out. Let's give of ourselves.