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, 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 profluoridationists—charged into the arena without a plan, without cooperation, without working with others. Sincere, dedicated, without question.

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.

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 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, but 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.

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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.

"We have a lot to offer to all kinds of groups. Let’s reach out. Let’s give of ourselves."

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.

THE UNIVERSITY OF MICHIGAN: Advanced Training in Oral Epidemiology

Applications are invited for the doctoral program in oral epidemiology at the University of Michigan School of Public Health. Successful applicants receive full tuition and stipend in accordance with NIH rates for three years. Both dentists and dental hygienists who are US citizens, nationals, or permanent residents may apply. Applicants must have an MPH or equivalent degree and be able to demonstrate superior scholastic ability. Application deadline is February 1, 1986; the program begins July 1, 1986. Personal interview recommended where possible. The program consists of advanced coursework in biostatistics, computer management, epidemiology, and research design, followed by a research dissertation in some area of epidemiology of oral conditions. Graduates receive the Doctor of Public Health (DrPH) degree from the University of Michigan. For further information and application materials contact:

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THE UNIVERSITY OF MICHIGAN RESIDENCY IN DENTAL PUBLIC HEALTH

The Department of Community Dentistry, School of Dentistry, and the Program in Dental Public Health, School of Public Health, are cosponsoring a one-year Dental Public Health Residency, to begin September 1986. Residents who already have a one-year MPH degree will thus complete their educational requirements for specialist certification by the American Board of Dental Public Health. The residency includes selected academic coursework, and supervised practical experiences both through the Program in Dental Public Health and the Department of Community Dentistry. Residents will have the opportunity to participate in ongoing teaching and research commitments; the residency experience is based on guidelines established by the American Board of Dental Public Health. Facilities and faculties at both schools will be available, and the resources of the university at large are also accessible.

Financial support includes stipend plus tuition. Applicants must apply to be accepted by the School of Public Health; enrollment forms are available from Dr. Brian Burt (address below). Applicants must already have completed an MPH degree or equivalent from an accredited School of Public Health. Application deadline is March 1, 1986. Send completed applications to:

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Further details can be obtained from Dr. Burt (313-764-5477) or Dr. Robert Bagramian (313-763-2105).

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