**DENTAL SOCIETY MEETINGS—May 1974**

| 1. Alabama Dental Association (cont. from April 28) | May 1     |
| 2. Academy of Denture Prosthetics                  | May 19-24 |
| 3. American Academy of Oral Pathology (cont. from April 29) | May 1-3    |
| 4. American Academy of Pedodontics                 | May 19-22 |
| 5. American Association of Orthodontists, The      | May 19-23 |
| 6. American Board of Oral Pathology (cont. from April 29) | May 1-3    |
| 7. American Board of Pedodontics, The              | May 22-23 |
| 8. California Dental Association                   | May 4-6   |
| 9. Colorado Dental Association                     | May 5-8   |
| 10. Connecticut State Dental Association            | May 14-16 |
| 11. Dental Society of the State of New York, The   | May 19-23 |
| 12. Florida Dental Association                      | May 17-24 |
| 13. Indiana Dental Association                      | May 4-7   |
| 14. Illinois State Dental Society                   | May 5-8   |
| 15. Iowa Dental Association                         | May 6-8   |
| 16. Kansas State Dental Association                 | May 19-22 |
| 17. Massachusetts Dental Society                    | May 5-8   |
| 18. Michigan Dental Association (cont. from April 28) | May 1     |
| 19. Missouri Dental Association                     | May 5-8   |
| 20. New Jersey Dental Association                   | May 15-19 |
| 21. New Mexico Dental Association                   | May 15-18 |
| 22. North Carolina Dental Society                   | May 12-15 |
| 23. Pennsylvania Dental Association                 | May 12-15 |
| 24. South Carolina Dental Association                | May 2-4   |
| 25. South Dakota Dental Association                 | May 23-25 |
| 26. Tennessee Dental Association                    | May 19-22 |
| 27. Texas Dental Association (cont. from April 28)  | May 1     |
| 28. Utah Dental Association                         | May 8-10  |
| 29. Washington State Dental Association             | May 19-22 |
| 30. Wisconsin Dental Association                    | May 6-8   |
Driving through Mexico, Nicaragua, the Canal Zone, Ecuador, and Colombia, he quipped that he used his automotive tool kit as much as his dental instruments. The dental profession can be justly proud of Frank Low, a future colleague who believes in serving his fellow-man.

SUCCESSFUL SURGERY POINTERS

The success of surgical procedures, like others in dentistry, depends not only on the correct technical procedures but on the extra attending cares. Here are a half-dozen pointers to observe in surgical procedures:

1. Always tie your sutures with the knot to the side of the incision. This makes it easier to cut and remove the suture.
2. Apply a lubricant to the corners of the mouth if you are going to work on posterior teeth. It lessens the tension on the lips and makes the patient more comfortable.
3. Don't be in a hurry or take short cuts and always have a clear, unhindered view of the operating site.
4. Contact the patient by telephone the same evening or next day to check on the patient's condition. Patients appreciate personal interest and checking up immediately will save headaches in the future.
5. Use finger pressure to compress the socket after the tooth is removed. Cracked bone can easily be spotted this way and loose pieces can be removed.
6. Never minimize any procedure. It's better to have the patient pleasantly surprised at the ease of an operation than have him doubt your ability if a procedure becomes involved. At the same time, do not exaggerate any operation so as to unduly alarm the patient.

NATIONAL INSTITUTE OF DENTAL HEALTH REPORT

With a funding request of over $38 million dollars for 1974, the NIDH promises an all-out effort that "will change dentistry." High on the priority list is the prevention of dental caries, which costs the American public $2 billion annually. Of caries, they report: "It's elimination as a public health problem... is now a realistic expectation." Their research program includes:

1. Testing of promising antiplacids for plaque control and caries prevention
2. Investigation of sucrose substitutes
3. Addition of phosphates to chewing gum to reduce the caries inducing effects of sweets
4. Clinical evaluation of teeth scalants

FOCUS ON PATIENT RELATIONS

At the Seventh National Conference on Public Relations held last year, the complaints of patients and the necessity of "grievance committees" set up by dental societies was discussed. The best way to prevent patient complaints is to:

1. Always explain the reason for the office procedures, especially the taking of x-rays; (2) always explain your fees and break down your charges; (3) be sure the patient understands and agrees to the payment plan offered; and (4) never comment on another man's work. The majority of complaints come about because of the lack of adequate communication between the dentist and the patient. A science writer at the meeting, commenting on patient relations, urged that dentistry must be vigilant in curbing the "bad guys" of the profession who do not meet the high standards practiced by the great majority.

MY LONG STRUGGLE WITH THE MANDIBULAR BLOCK

Every practitioner will read this presentation with profit.

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A veteran adviser to business tells us you why

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Doctor, here are cases to avoid

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ANGELS AND IMPRESSIONS

Relax, indulge, and entertain yourself with dentistry's best-known commentator

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When I questioned more experienced men I got the impression that no other dentist in practice ever missed. I soon realized that no one likes to admit failure. The dry socket situation is similar. Even with today's honesty and outspokenness it amazes me to learn how few men have ever had a patient with a dry socket.

In my first year of general practice I took an externship in the oral surgery clinic of a large city hospital. It was a busy place with only three chairs. We were so hard pressed that chair time was restricted to actual surgery after anesthesia was established. This meant that frequently I was injecting patients who were lined up against the wall. For utilization anesthesia in the upper jaw it was not too bad but for a block in the lower jaw we needed a chair. The procedure was to "borrow" a chair for half a minute between patients, make the injection, and tend the patient back to stand against the wall. All three chairs were equipped with nitrous oxide and oxygen for general anesthesia.

There was no accurate way of determining when a patient with novocaine was ready. If, in the mind of the operator who made the injection, enough time had elapsed, the patient was ready. This led to some uncomfortable moments, on some occasions, with the dentist asserting, "Of course, it's numb!"

Because I wanted to avoid that situation I used to wait longer than the others. As a result, I was constantly prodded by the chief of staff with "We haven't got all day!"

The Patient Decides

Even now in my office I probably wait longer than most practitioners because I have noticed a wide variation in time span. Perhaps there is a difference among patients or perhaps my injection technique is not precisely the same each time. At any rate, the rule in my office is that no work is started until the patient decides that the numbness has achieved a satisfactory level. Some of my colleagues shake their heads and say, "The patient does not know what's going on!"

WWW.DOC, HERE'S HER FOR SMALL-CAR STEAL AT SECOND CAR FOR YOUR WIFE. AND OUR CHIEF MECHANIC FOLLOWS HER FOR THE FIRST 10 MILES."
concerning the mandibular block. He said, 'When you do a block on the left side you inject with your left hand. That is an order.' Before I could respond he walked away. I singled out one of the younger men on the staff and repeated the conversation. I asked: 'He isn’t serious, is he?'

'Certainly,' you and better learn it.' It was a unique experience but I finally mastered it. Today I consider it one of the most valuable and rewarding techniques I have learned. At the time, I didn’t realize that it would prove to be indispensable for a mandibular block technique that I was subsequently to adopt.

Mastering the left hand injection was not as difficult as I had anticipated. I learned that if I selected the point of entry very deliberately and came to it slowly, I had no trouble. But trying to impress the patient, or my colleagues, with a swift, deft motion usually got me into trouble. The trouble’s insistence on using a long needle added an extra bit of unwieldiness. Today in my office I use the short infiltration needle (25 gauge) for everything. It affords good control and gives me a better feeling for judging where the end of the needle is.

The long needle has an important function. In case it snaps off, the piece remaining in the tissue can be easily held by the lip or cheek, for a full two minutes at least. Either set a clock or ask the patient if she feels a very slight tingles. I know from personal experience, when a friend of mine used a topical before scaling, that the tingle becomes pronounced and unmistakable. But it takes time.

Now that the tingle has been established the patient is ready for the first part of the injection. If the cotton is still in place, I stretch the lip or cheek, remove the cotton, and lay the point of the needle gently against the tissue without going through it. Once contact has been made, pressure to pierce the tissue is increased ever so gradually until just the tip of the needle penetrates — no more than two millimeters — and a few drops are deposited. You don’t need much or want much.

The needle is removed and the syringe placed on the bracket table. Again, a waiting period of two to three minutes or, better yet, until the patient feels a pronounced numbness.

Don’t ‘Save Time’!

Before making the final injection, let us put to rest that poor old horse, ‘save time,’ that has been beaten to death. I must mention that six years ago I had a dental assistant applying for a job asked the dentist interviewing her if she would get a two-week vacation. ‘No,’ said the dentist, ‘you get four weeks. Two weeks when I take my vacation and two weeks when you take yours.’

DENTAL PROFILE

A soon-to-graduate student at the School of Dentistry at the Medical College of Virginia made friends and a name for himself last summer traveling south of the border. He is Frank Low, who, armed with a dental surgery kit and driving an MG, traveled through Mexico and Central and South America tending to the emergency dental needs of the inhabitants in underdeveloped areas.

Under the auspices of the Amigos de los Americas Vaccinations program, which sends volunteers into underdeveloped areas, Low took a six-week crash course in Spanish and embarked on a three-month journey. Stopping for three or four days in small towns he set up his office in a health center or public school. The equipment was usually the kit he carried and a few folding chairs. Generally, so many people showed up for dental work that he was forced to limit his treatment to those in pain.

Says Low: ‘I felt that the best service I could provide was to relieve pain. I was sorry that I could not take out all the teeth that were bad.’

by Maurice J. Teitelbaum, D.D.S.

THISA AND DATA

Under the auspices of the ADA an extensive study of dental health manpower in the United States will be conducted at the University of Pennsylvania. The study will probe manpower supply, production, and demand. . . . Market research specialists report that the National Institute of Health will be introducing new drugs and medical devices in the months ahead. Among imminent developments are: plastic dental sealants and drugs for dissolving gallstones. . . . The use of laser in dentistry has been proven ‘disappointing, very disappointing’ reports the NIDH. . . . Good and Bad Dept.: A study of diet at the Alabama Institute of Dental Research says that a protein deficiency coupled with sugar consumption could account for the increased incidence of dental caries. Meanwhile, scientists at Cornell University suggest that the high-protein diet of Americans may be related to the prevalence of cancer in the country. . . . Our ‘arty’ friends: During his latter years Pablo Picasso rarely left his home. On his 85th birthday in 1966 a gala celebration in his honor was planned in Paris. But Picasso refused to attend, saying, ‘I go to Paris only to see my dentists.’ When the famed writer James Joyce left his native Ireland for the Continent, his partners wrote: ‘I’m a vagabond with a mouth full of decayed teeth and my soul of decayed ambition.’ . . . The Electric Energy Commission is gearing for what it believes will be the widespread use of battery-powered vehicles in the 1980’s. The group has lined up 55 utilities to take part in a research program to get under way this year. One will commented that the electric auto would be very inexpensive — it’s the extension cord that will be costly! . . . Travel Hint: If you’re planning to travel abroad and have an expected passport don’t throw it away. It is useful in getting a new one more easily. It eliminates the need for a birth certificate and the photos and signature make any other identification unnecessary. . . . The affinity dentists have for the game of golf may be traced back to 1922 when Dr. William Lowell, a New Jersey dentist, invented the wooden golf tee. Dr. Lowell felt that using wet sand to ‘tee up’ the ball was unsanitary, so he whittled a tee out of wood. Naturally, his friends laughed at him. But the dentist had the last laugh. Two years later, the famed golfer Walter Hagen began using it. Dr. Lowell patented the idea and started a successful business. From Dr. Ely Williams the ‘Singe of Red Bank’: Reservation is a stronger word, A much more binding token. Appointment seems the weaker sort, That’s why it’s easily broken.

GAGGING

One consolation of old age is that you can whistle while you brush your teeth.

A young dentist trying to impress a patient flipped the intercom key in his office and ordered his secretary to get his broker on the telephone. Replied the secretary, ‘Which one, stock or pawn?’

A dental assistant applying for a job asked the dentist interviewing her if she would get a two-week vacation. ‘No,’ said the dentist, ‘you get four weeks. Two weeks when I take my vacation and two weeks when you take yours.’

"WHY WOULDN'T I BE DEPRESSED THIRTY YEARS A TOOTH FAIRY, AND ALL I'VE GOT TO SHOW FOR IT IS A CRUMBY PILE OF OLD TEETH!"
developing occlusions should receive spaced re-exam-
inations to determine a valid diagnosis.

Indications for Treatment in the Deciduous Dentition.
Treatment in the primary dentition should be in-
stituted when the teeth are complete and before root
resorption makes the teeth easily dislodged. The po-
sition of permanent teeth can be influenced favorably
by moving the overlying primary tooth by means of a
pace maintainer. The space maintainer should receive
inspection and adjustment at frequent inter-
vals and be removed when no longer needed.

Indications for Space Maintainers. The following
can serve as a guide for the use of space maintainers:
1. Actual measurement of the space required for
the succeeding permanent tooth shown as long. Space
retention will make eventual treatment of
malocclusion when necessary less involved.
The following conditions should be met by space
maintainers.
1. Maintain the desired mesiodistal dimension of the
space.
2. Should not interfere with the eruption of the
permanent teeth.
3. Should not interfere with speech and functional
movements of the mandible.
4. Provide sufficient mesiodistal space opening for
the normal alignment of the permanent teeth.
Space maintainers are contraindicated under the
following:
1. When there is no alveolar bone overlying the
crown of the erupting permanent tooth and the space
is sufficient to permit its eruption, as shown by meas-
urements on the radiogram, and where repeated ex-
aminations show that the space is not closing.
2. When there is a general lack of sufficient dental
arch length which indicates eventual extractions as
an adjunct to orthodontic therapy.
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DON'T DUN!
by Joseph Arkin, C.P.A.

Act is that ingredient put into collection efforts which helps to achieve results without alienating patients to the extent of losing them.

To enable you to use tact, it is necessary to first understand why a delinquent paying patient has not made prompt and full payment. Especially during the Age of Shortages, when all kinds of people are losing jobs and businesses.

A slow payer may be the victim of unexpected misfortune or of unwise family money management or a person who is completely irresponsible and does not care if financial obligations are met or not.

To know how to apply soft-sell collection techniques to best advantage it is incumbent that we examine the aforementioned classes of delinquent patients.

The victim of misfortune usually has been the "good" patient who, up to now, has made payment considered timely and satisfactory. What has happened is beyond his control. It may be that he had a setback in his business through the bankruptcy of one of his larger customers, or the loss of one of his best customers. He may have been the victim of a fire, flood or other catastrophe for which there wasn't adequate insurance coverage. Or perhaps he is undergoing financial pressure because of unexpected hospital or other medical expenses.

In our economy, particularly among certain ethnic groups and the newly married, there is a tendency to buy now and pay later. This is perfectly alright if done in moderation and consistent with one's ability to pay, for a great deal of the growth of the American economy has been attributed to the installment system.

Many dentists administer novocaine without considering the patient's needs. In this climate of local anesthesia acceptance what could be more useful than a proper mandibular injection? One endodontist stated that he now uses only infiltration anesthesia in the lower jaw with better results. This is hard to believe but understandable when the lack of the necessary data can spell disaster.

Occlusal guidance includes the following:
1. Correction of malocclusions and malrelations of the dental arches.
2. Prevention of space loss following premature loss of primary teeth and extraction of prolonged retention primary teeth.
3. Recognition and treatment of harmful habits affecting the position, relation and function of the dentofacial complex.
4. Elminination of conditions that interfere with the establishment of normal occlusion.

The Child As An Orthodontic Patient. Orthodontic treatment usually extends over months or years. Proper dental-patient relation must be established before treatment is undertaken if successful results are to be obtained. The child is a captive patient who is usually forced by the parents to accept treatment and may be un-
signals. In most cases, the barrel of the syringe will be parallel to the plane of occlusion. In some, it will not. If the notch under the ear where the finger rests is higher than the thumb, the syringe will have to be pointed slightly upwards.

Another nugget of information is the upright position of the ramus. Is it really upright or does it flare or tilt outward? If it is fairly straight there is no need to swing the syringe to the opposite side. If it flares, it is important to get over across the tops of the opposite bicusps before injecting.

It is one thing to practice the block on the mandible of a skeleton but quite another to do it in the mouth. I recall as a student how clear and precise the textbook made everything look. But in the mouth I found all kinds of tissues obliterating my landmarks. Where do you start?

The Starting Point

I still meet that situation on rare occasions. The last one was a heavily-set man with thick, firm tissue surrounding the ramus. At first, I thought all my landmarks had disappeared. But as I continued to probe and grasp the edges of the ramus more firmly, the field became more familiar.

The point of entry can be confusing at times. If the ball of the thumb is resting on the narrowest width of the ramus, the syringe is held close to the thumb and the needle enters at about the middle of the thumb-nail. It should just miss the anterior border of the ramus. At this point the syringe can be carried to the opposite side of the mouth if the shape and position of the ramus require it.

When the needle reaches the area midway between the borders the solution is deposited slowly. Where is the middle? It is a guess. But concentration on picturing the distance between the thumb and forefinger will give you a pretty good idea of where the middle is. If a short infiltration needle is used it will go in (on the average) about three-quarters of its length.

Not only should the solution be expressed slowly, it should meet little resistance as it goes in. If it does meet resistance, chances are it is in the muscle. Forcing the fluid in under considerable pressure will cause a trismus and no little discomfort to the patient.

If the operator senses this resistance, it would be wise to stop, remove the needle, and start over. The patient will be exhilarating grateful if the reason is explained. The solution should always go in rather easily, as though the end of the needle is in a free space which, in a sense, it is.

Most patients today have accepted local anesthesia for certain dental procedures. In many cases, they insist on having it. I recall some instances when I suggested that novocaine was not needed, only to have the patient say, "If you have no objection, I'd rather have it. Then I can relax."

will allow for the airing of grievances—both real and imaginary.

In most cities you can arrange with a local credit-checking bureau for a short-form credit report. The low-cost ($3-$5) report will tell you of pending lawsuits, judgments obtained and unsatisfied, and other data which will tend to confirm or deny what was told to you.

These insights now allow you to have some knowledge of his true financial standing, his ability to pay in the future, and an idea of the general attitude you should take. Most of all, however, you've gained his confidence in showing a genuine concern by asking why payment wasn't made instead of when payment is going to be made.

Question No. 2

The second step is to ask: "How can you make payments?" Asking about plans expresses an interest in his plight and allows the patient to tell you about the steps he is taking to clear up his delinquencies. He might talk about debt consolidation, refinancing of existing mortgage on shop or private residence, or an arrangement through an attorney or credit bureau for the establishment of a partial payment schedule based on each creditor's granting an extension for time to pay.

Use this opportunity to offer your good offices to assure the plan's success and offer to accept any reasonable part-payment plan which will help the patient to extricate himself from his predicament. You've got little if anything to lose. In some instances you can force full payment if you take a strong enough position, but adverse word will be bound to get around that you threatened to put a man out of business, attach a man's automobile (vital in some communities), or took steps to attach his house (taking the shelter and roof away from his family).

Question No. 3

Now, following a genuine measure of concern, is time to ask: "When are you going to start making payments?" He knows by this time that you're interested in his welfare, he gave you information about his financial condition you didn't know before, and you gave your assurance of trying to help him overcome his present embarrassing position.

There is an opposing point of view which should be noted at this stage. Does all of this amount to coddling? Shouldn't the professional be paid for the services furnished and not be "hung-up" for payment? Surely, but our objective was not to lose the patient. We tried to salvage the good-will and continuing relationship with the patient who is the victim of unexpected misfortune or perhaps the victim of poor family money management.

No attempt was made to coddle the dishonest or "dead-beat." With these persons we should exercise full and even punitive collection procedures. Ground rules may work for big business, but with the professional the prime consideration is the personal approach—handling each situation on its own particular set of merits. Elasticity is a key word here and allows for giving a little leeway where a little extra time may solve the situation.

All of this has only produced what was due to you in the first place, but it has kept your patient's confidence, allowed him a measure of self-respect, and made him one of your loyal patients and boosters. There will be patients who will not respond to this approach, and, however unpleasant, the full resources of effecting collections should be utilized.
A Guide for the Evaluation of Dental Care

Jay W. Friedman

The purposes of this guide are to describe the basic content of dental care and to provide a method of direct and indirect evaluation of its quality. The determination of what is good dental care is no longer a concern only of the individual dentist and the patient. Third parties enter the picture with the development of comprehensive dental care programs. Dental service organizations, commercial health insurance companies, Blue Cross and Blue Shield, public health departments, public assistance programs, military and veterans' programs, and pre-paid consumer dental care programs are more and more interested in the establishment of standards of quality to aid in the purchase or provision of group dental care. Although these organizations may be occupied largely with financial and administrative activities, they recognize that the quality of care is not independent of its costs. Therefore, a guide is necessary for administrative and clinical decisions aimed to assure uniformity of care for the population served, regardless of the individual dentist rendering treatment. It should also facilitate impartial evaluation of dental treatment and aid in the responsible growth and development of dental care programs. (91 p, Los Angeles, University of California School of Public Health, 1972)

Fluorides and Dental Caries: Contemporary Concepts for Practitioners and Students

Ernest Neumann, editor

The editor has been joined by seven contributors (Stanley B. Heifetz, Harold C. Hodge, Herschel S. Hodge, Howard M. Myer, Steven J. Silverstein, Samuel J. Wycoff, and Isadore Zipkin) in the preparation of this book, primarily for the teaching of undergraduate dental students and dental hygienists. A second, but important, appeal to the practitioner for it will provide him with a comprehensive and up-to-date review of the many aspects of fluoride therapy. This is particularly so as there has been a remarkable upsurge in the emphasis on preventive dentistry in private practice, in public health, and in dental education. Fluoride practices are a cornerstone in good preventive practices.

This book describes the results of water fluoridation studies, and information provided for prescribing systemic fluoride in communities lacking fluoridated water supplies. The currently available fluoride dentifrices are evaluated, as is the status of topical fluoride procedures in preventive dentistry. Of particular interest to public health officials is the latest information concerning self-administration of topical fluorides. Sociological aspects of fluoridation from the point of view of the public's attitude, economics, and legal aspects are discussed. Theories of the mechanism of anti-caries action of fluoride on the crystal phase of enamel, and the role of fluoride as an enzyme inhibitor are presented. The metabolism and toxicity of fluoride are covered, and some objections to water fluoridation are critically examined. (146 p, 15 figures, 19 tables, index, Springfield, Ill, Charles C. Thomas, 1972, $9.50)

Psychological Aspects of Terminal Care

Bernard Schoenber, Arthur C. Carr, David Perez, and Austin H. Kutscher, editors

The acceptance of and preparation for death is a perplexing psychological task in the life of man. Members of the health professions are realizing increasingly the failure in theory and practice to face directly the cardinal anxiety of man—his concern over his own existence. Modern society tends to consider death as unnatural; it is avoided, denied, and repressed. It must be faced by all, however, and in an added sense by health profession personnel who must deal with dying patients and their families.

This work covers a wide range of questions involving the treatment and care of the terminally ill patient and his family. Deficiencies in the present education of health personnel are highlighted, and the need for new approaches to the care of the dying and the bereaved is stressed. Such topics as the problems generated by a child's death, the behavior and attitude of the doctor of a terminally ill patient—his concern over his own existence. Modern society tends to consider death as unnatural; it is avoided, denied, and repressed. It must be faced by all, however, and in an added sense by health profession personnel who must deal with dying patients and their families.

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"Fools Rush In. . . ."
by Maurice J. Teitelbaum, D.D.S.

He was a large, gruff-looking man but he possessed the proverbial heart of gold. His practice was a very lucrative one, about a hundred thousand a year at a time when such gross incomes were unusual. He had five chairs, a full-time assistant, a part-time dentist and three dental assistants—when most dental practices were one-man operations. It was a time when "four-handed" more aptly described a pinhole game than a way of practicing dentistry. True, his practice was geared more toward quantity rather than quality, but it could hardly have been otherwise when patients were scheduled by the day rather than the hour and some patients a day was not infrequent.

Yet, he himself was an excellent exodontist and prosthodontist. Above all, he knew how to handle patients. He had never taken a course in practice management or patient-dentist relations, it just came to him naturally—he was that kind of a man.

When young patients were particularly well behaved he didn't pass out a badge, balloon, or trinket but he made appointments, were more impressed with the half dollars. The children might have been happier with a 10-cent toy, but the parents, who paid the bills and made the appointments, were more impressed with the half dollars.

With over 30 years of experience, he had some sage advice for the young practitioners he knew. One of his favorite admonishments was, "Don't be a hero!" Which could be more positively interpreted as, "Fools rush in where angels fear to tread." For the eager, competent, and idealistic dentist this was as good a bit of sober advice then as now. Not every case responds to rejection work that might assuredly lead to frustration and disappointment both for the dentist and the patient.

A verbal understanding about the possibility of the failure of a dental procedure, even when apparently agreed upon by the patient, offers little consolation. Too often patients who are initially willing and cooperative with respect to the treatment plan, become resentful months later when a collapse is apparent, and insist that the work was "guaranteed" to last longer, even though the word was never used. Although patients accept a written plan, they often express disappointment and anger when the case fails. Naturally, there are times when we take the risk, try to be heroes—and succeed. And even when we fail, some patients are understanding, but for the most part, unless one is masochistic, when the odds for success are against us we should tread very carefully.

When do fools rush in? When they accept the following types of cases. An affable patient, in good health, comes to the office for a full set of dentures.

Before you are able to question her, not alone examine the edentulous mouth, she opens her pocketbook and places three sets of dentures on the bracket table with the comment: "I hope you can make me a good set of teeth. I had these made this year and none of them fit." When you examine the dentures and try them in the mouth you find that the retention, occlusion, centers, and esthetics are all fairly good.

"What seems to be the trouble?" you ask her, "I just can't stand them," she says, and then adds: "I'll pay whatever you ask after I'm able to wear them." It's tempting but only a fool would rush to accept this case.

Another case that should be approached with caution is one wherein the patient wearing 15-year-old dentures has no complaint other than a loss of vertical height. The patient's request is legitimate, for upon closure her chin and nose have ceased to be total strangers; they seem to be approaching each other. In the construction of a new set of dentures there is no problem in giving the patient a beautiful new profile by opening the bite. However, in doing so, one can expect a patient who must subsist on liquids. The patient may be cooperative but her maculecture will not. If you don't want to invite failure, remake, and a patient who becomes a fixture in the waiting room—don't be a hero! The best you can offer in these cases is a little esthetic improvement by opening the bite slightly.

Angels fear to tread on other cases, like those wherein mobile teeth guard edentulous areas for which a patient wants a fixed bridge; or the case with short teeth in a hard bite with which the patient wants covered with porcelain jackets; or the broken down molar with less than a half-wall standing which the patient wants to have restored without any root canal therapy.

Most of us are eager to perform miracles and are stimulated by a challenge that allows us to soar above the daily routine. But before you see yourself sitting upon a white steed in a shiny coat of armor and the talk of a large down payment sounds too small don't you become a sculptor? At 21, Dr. Fox finished his training and became the youngest practising dentist in the state. He never forgot the sculptor's suggestion or his own decision to take up art when he reached 40.

A nearly fatal boiling accident in 1960 made Dr. Fox more aware that the milestone birthday was approaching. "When you are 40 you either advance or stagnate," he believes, "That's a crucial year." He was ready to take up sculpting when the important birthday arrived.

KENNETH FOX:
The Artisan Dentist
by Harold Rubin

Dr. Kenneth Fox believes that dentists and sculptors use the same basic techniques and skills. For proof, he can point to the more than 70 pieces he has sculpted in the past seven years.

He will also tell you that preparing a tiny filling is similar to building a 120-ton, 42-foot-high figure of a Chinese mother. His piece was done to honor the 10-ton figure of a Chinese mother which a patient wants a fixed bridge; or the case with a patient who wants a gold panner, a 70-ton Chinese coin, and a 25-ton figure struggling to free himself from bondage.

At the entrance of Dr. Fox's dental office is a praying woman who weighs 13 tons.

His three-acre domain, which includes the dental office, studio, gallery, and outdoor work area was built by Dr. Fox and his sons long before his work became a major attraction of the Mother Lode community of Auburn, California, about 35 miles due east of Sacramento on Interstate 80.

When he is able to manage a personally conducted tour through the figure-crammed gallery and studio, he explains that he didn't take up sculpture on a whim. When young patients were particularly well behaved he didn't pass out a badge, balloon, or trinket but he made the appointments, were more impressed with the half dollars. The children might have been happier with a 10-cent toy, but the parents, who paid the bills and made the appointments, were more impressed with the half dollars.

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Dr. Fox inspects a small crack in the leg of the 13-ton praying maiden that guards the entrance to his dental office.

appealing. "I would like to do Vincent Price, and I'm sorry Boris Karloff is dead. He had a good head." Aztec Indian and Egyptian faces also have unique beauty in Dr. Fox's eyes.

"Spiritually and in my soul I am a different person than I was before I took up sculpting. Now I can appreciate the grace, beauty, and intelligence of the human body. There are no homely people. Even a club foot can be beautiful to a sculptor."

He has no formal association with any church, but he has found inspiration in the Bible for the Prodigal Son and the Virgin Mary figures. History has provided him with Claude Chana, who is famous for his gold discovery and for offering to lead the Donner Party out of their fatal trap in the Sierras (they refused the offer); and with the Chinese coolie who had an important role in the California gold rush and in railroad building. Greek mythology is represented in the figures of the Amazon Archer and Deianira, the wife of Hercules.

When Dr. Fox completed the Amazon Archer, the Chinese coolie, and Claude Chana he demonstrated that his techniques are sound. The strength and durability of these pieces were proved during the May 1973 celebration in Auburn of the 125th anniversary of Chana's discovery of gold in the Auburn Ravine.

They loaded the 45-ton gold panner on a flatbed truck and it occupied the position of honor in the parade through town. The concrete figure withstood the ride superbly. While the years of experimentation are beginning to pay off, the sculptor realizes his larger pieces are not likely to bring him a profit. The monumental pieces begin with a miniature version in clay. Generally he works from a live model. Then he builds a full-scale scaffold in his workyard, using telephone poles and railway ties. Next comes the skeletal structure of welded steel rods and wire mesh.

For the final step he hires commercial transit mixers to pour the cement base. At that point Dr. Fox and his three sons take over. Working as a team they put in 18-hour days to complete the mixing and pouring of concrete and mortar. While erecting the 45-ton figure of Chana they put in a 36-hour stretch of nonstop concrete mixing and pouring. The 120-ton Amazon Archer required two months for the scaffold and armature and 20 days of concrete work.

When Dr. Fox talks about future projects it is plain he has only begun to release his full creative energies. The next giant will be an 80-foot-tall prehistoric man. A small-scale model and a study of the structural stresses have already been completed. This figure is the prelude to his ultimate colossus. What the sculptor-dentist has in mind is a 160-foot-tall statue of an Indian chief standing on a 150-foot pedestal. He wants to build the figure on Alcatraz Island in the San Francisco Bay. Overall it would be nine feet taller than the Statue of Liberty.

Questions about his preoccupation with bigness do not offend Dr. Fox, who describes himself as a "wiry little guy." He is five-foot, seven inches tall. He may be a small man, but he has big dreams. Those who know him will not be surprised if he actually erects his giant on Alcatraz Island. Dr. Fox has a way of turning his dreams into concrete.