Addressing Oral Health Disparities: Developing and Deploying a New Member of the Dental Team

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Introduction

Oral Health in America: A Report of the Surgeon General documented the profound and significant disparities that exist in the oral health among children in the United States. Among the significant factors contributing to the disparities problem is the access to oral health care by disadvantaged populations. There are inadequate numbers of dentists able and willing to care for the underserved, particularly poor and minority children. Today I want to promote the conversation the California Dental Association has already begun regarding how to address these disparities by further discussing the development and deployment of a new member to the dental team. I am not going to rehearse data that document the disparities, as time is limited.

Permit me to be direct at the outset. I believe a new member for the dental team must be developed and deployed to help address oral disparities among children in the United States. Furthermore, I believe the competencies of this new team member should be comparable to those of the internationally recognized dental therapist. I will attempt to support this position as we proceed. I want to speak for 40-45 minutes, and reserve the last 15-20 minutes for questions and comments. During the presentation I will briefly address: the history, development, and current status of dental therapists internationally; the history of initiatives in the United States; our Alaska Project; justifying a dental therapist for children's care; why a dental therapist should focus on children; the potential role of dental hygienists in relation to dental therapy; and potential practice settings and supervision for a dental therapist.

Let us turn first to:

History and Development of Dental Therapists Internationally

New Zealand

In 1921 a group of 30 young women entered a two year training program at Wellington, New Zealand to study to become "school dental nurses," and in so doing transformed the oral health of the children of a country, and laid the basis for what was to become an international movement. New Zealand's School Dental Service continues to this day, and has developed an enviable record of caring for the oral health of all children in New Zealand. The program's mantra through the years has been, "we train first rate technicians, not second rate dentists." It is worthy of noting that the inscription on the traditional medallion worn by the school dental therapist is the Latin *Ut Prosim*: "that I may do good." Obviously, there have been changes in the School Dental Service through the years, as well as in the training program for school dental nurses. However, the basic education and service strategies of over 80 years ago remain intact, having stood the test of time.

In 1988 the terminology school dental nurse was changed to school dental therapist. Admission to dental therapy training in New Zealand has been based on graduation from high school. The curriculum was offered over two academic years, each of 32 weeks duration. The total curriculum clock hours were approximately 2,400 over these two years. Approximately 760 hours of these were spent in the clinic treating children. School dental therapists are employees of the health care system, and are licensed to perform oral examinations; develop treatment plans; provide preventive services; administer local anesthesia; prepare and restore primary and young permanent teeth; and extract primary teeth, all under the general supervision of a Ministry of Health dentist. Until very recently, oral health care by dental therapists was limited to children through the School Dental Service. Legislation now permits dental therapists to provide some care for adults, following completion of additional training. They can also now work in private dental practices and may also practice independently, but only with a consultative agreement with a dentist. At this time, essentially none do.

The educational program for dental therapy took a significant turn last year when New Zealand, following the lead of Australia, decided to merge the education of dental therapists and dental hygienists. Today, the two dental therapy/dental hygiene training programs in New Zealand are of three years duration and offer a degree that will enable an individual to practice as either a dental therapist or a dental hygienist, or both.

Australia

The success of the New Zealand School Dental Service led to the approval of school dental nurses practicing in Australia in 1965, with the recommendation that the course of training should be as short as possible in order to maintain the cost-effectiveness of the dental nurse while ensuring competence. Dental nurses were also to be female, and to have their employment restricted to the government service. Prior to 2000, school dental therapists were taught largely in non-university schools in a two academic year program. However, as in New Zealand, dental therapy and dental hygiene education are now merged and now all programs are university-based three academic year curricula.

Canada

Lacking sufficient dentists to care for the general population, much less the Native Indian and Eskimo populations, and recognizing the success of school dental nurses in New Zealand and Australia, a program to train dental nurses was established at Fort Smith, Northwest Territories in 1972, under the guidance of the Faculty of Dentistry of the University of Toronto.

In 1984, the training program for dental nurses moved from Fort Smith to Prince Albert, Saskatchewan. Today, the National School of Dental Therapy at Prince Albert, a component of First Nations University, is the only training program for dental therapists in Canada. It admits 20 students/year to its two academic-year curriculum with the goal of preparing dental therapists to address issue of access to care for First Nations people.

At present there are approximately 300 dental therapists practicing in Canada, primarily in Saskatchewan and Manitoba, with the majority practicing the private sector.

Great Britain

Great Britain initiated training of dental nurses in 1960 at New Cross Hospital. In the mid-1990s a combined dental hygiene and dental therapy curriculum was introduced. Now training programs offer the combined program varying in length from 27 to 36 months (two to three academic years), with the length determined by whether a certificate or degree is awarded. Two hundred students are accepted each year in 15 programs, all but one of which are affiliated with dental schools.

Currently, 700 dental therapists are practicing in a variety of settings and are considered to be full members of the dental team. They treat children and adults and are capable of independent practice, but must practice with a treatment plan developed by a dentist.

The Netherlands

The Netherlands serves as an example of how countries are coming to realize the importance of adding dental therapists to the workforce. Dental therapists had not previously been a component of the Dutch oral health care delivery system. Just last year Holland initiated dental therapy training and chose to adopt a combined curriculum for dental therapy and dental hygiene as in Australia, New Zealand, and Great Britain. The Dutch are now enrolling 300 individuals a year in their training programs. Interestingly, at the same time, the number of dentists educated is being reduced by 20%, and the dental curriculum is being expanded by one year. The Dutch rationale: in the future, significant aspects of basic preventive and restorative care will be provided by these dental hygienists/therapists, with dentists performing more complex procedures and treating medically compromised patients. The new Dutch policy is intended to reduce costs and improve access to care.

World-wide

As our recent article in the International Dental Journal documents, there are now 53 countries in the world who utilize dental therapists as members of the dental team, with approximately 14,000 therapists practicing internationally. Dental therapists practice in both developing countries as well as developed countries, and in countries with both a high dentist/population ratio and a low dentist/population ratio.

A Brief History of Initiatives in the United States

In 1970 the Forsyth Dental Center in Boston initiated what was subsequently designated, and described in a book by the same title, *The Forsyth Experiment*. That year the House of Delegates of the Massachusetts Dental Association had passed a resolution favoring research on expanded function dental auxiliaries. Forsyth communicated to both the Massachusetts Board of Dental Examiners and to the Massachusetts Dental Society its plans to initiate a research project to train dental hygienists in restorative procedures for children, which were typically reserved for dentists alone. According to Dr. Ralph Lobene, the program director, no problems were encountered between 1970 and 1973. However, in 1973 the Board of Dental Examiners voted unanimously that the drilling of teeth by hygienists was a direct violation of the Dental Practice Act of Massachusetts. Forsyth was forced to close its "experiment" in June of 1974, but not before it was able to objectively document that hygienists could be taught to provide quality restorative dental services for children. Whereas the projected curriculum time to achieve the competencies desired was 47 thirty-hour weeks, the project was able to achieve its desired educational outcomes in 25 thirty-hour weeks.

In 1972, Dr. John Ingle, Dean of the University of Southern California School of Dentistry (USC), proposed the use of school dental nurses, as employed in New Zealand, to address the problem of dental caries among America's school children. USC submitted a proposal for a grant to train dental nurses, with Dr. Jay Friedman as the program director. At the same time, then Governor of California, Ronald Reagan, established a committee to study the functions of all dental auxiliaries. As a result of these two

significant developments the (then) two California Dental Associations established a committee to study the New Zealand school dental service. The Committee was chaired by Dr. Dale Redig, then Dean of the University of the Pacific School of Dentistry (later Executive Director of the CDA), and included three additional individuals, all of whom visited New Zealand in late 1972. (As a personal aside-Dale was chair of the Department of Pediatric Dentistry at the University of Iowa and my professor when I was a graduate student there!) The Committee's report stated that "there is little doubt that dental treatment needs related to caries for most of the New Zealand children age 2 ½ to 15 have been met." However, the report concluded that the public of California would "probably not" accept the New Zealand type of school dental service, as it would be perceived as a "second class system." Drs. Ingle and Friedman wrote sharp rebukes of the Committee's report pointing out the inconsistencies of the objective findings of the investigation in relation to the subjective conclusions of the report, which they judged to be drawn to placate the practicing profession in California.

Between 1972 and 1974, at the University of Kentucky, another expanded functions project, supported by the Robert Wood Johnson Foundation, took place. Thirty-six dental hygiene students, who were completing a four-year baccalaureate program in dental hygiene, participated in a compressed curriculum that allowed for 200 hours of preclinical instruction in children's dentistry, as well as 150 hours of clinical care for children. The program was specifically addressed to providing basic restorative care for children, including administration of local anesthesia, restoration of teeth with amalgams and stainless steel crowns, and pulpal therapy. Toward the conclusion of the curriculum these hygienists participated in a double blind study comparing their restorative skills with fourth year student dentists. No significant differences were found between the quality of their work and that of the student dentists.

In the early 1970s, at the College of Dentistry at the University of Iowa, a five year project, supported by the W.K. Kellogg Foundation, trained dental hygienists to perform expanded functions in restorative dentistry and periodontal therapy, and for both children and adults. The results were the same as the studies at Forsyth and Kentucky. Hygienists

could be effectively trained, in a relatively brief time period, to perform, at a comparable quality level, procedures that traditionally are reserved for dentists.

The Alaska Project

In November of 2000, Oral Health America sponsored a conference in Boca Raton, Florida on the Surgeon's General's Report, *Oral Health in America*. At that meeting I invited two friends and colleagues, Dominick DePaola, president of Forsyth Institute and Wendy Mouradian, professor of pediatrics and pediatric dentistry at the University of Washington, to meet with me to discuss the potential that introducing a New Zealand style "school dental nurse/therapist" could have in addressing oral health disparities among America's children. As a result of that discussion, a larger meeting of interested parties was held in February of 2001 at the Forsyth Institute in Boston. At that meeting, the decision was made to work with the Indian Health Service and to focus on American Indians/Alaska Natives, as this population experiences an inordinate disparity in oral health. Additionally, the Tribes are sovereign and the ability to develop and deploy dental therapists could be facilitated in such an environment.

Ron Nagel, a consultant to the Alaska Native Tribal Health Consortium and an officer in the Indian Health Service of the USPHS, was involved in the conversations emanating from the Forsyth meeting, and assumed the lead in implementation. The Tribal Health Consortium wanted to pursue training dental therapists for their clinics. The School of Dentistry at the University of Otago in New Zealand agreed to accept six Alaska Native students into their dental therapy training program. In February, 2003, six Alaska Native students traveled to New Zealand to participate in a two academic year curriculum to be trained as dental therapists. In May of that year, I joined them at the University of Otago for a previously arranged sabbatical to study the "school dental therapist" in New Zealand, and its potential applicability to the disparities problem in the U.S. I returned later that year to write my views about the potential for a dental therapist caring for children to address the disparities problem in the United States. The students returned to Alaska in 2005 to begin practicing dental therapy in rural villages. They were rapidly met with a lawsuit by the American Dental Association to stop what the Association

considered to be the illegal practice of dentistry. The Alaska attorney general's office issued a ruling that dental therapists in the Alaska Tribal health system are not subject to the state dental practice act because they are certified under federal law. Subsequently, the ADA dropped the lawsuit in Alaska—but, in my judgment, only after considerable harm had been done to the reputation of our profession. An independent assessment of the quality of care provided by the first cohort of Alaskan dental therapists returning from New Zealand concluded that they met every standard of care evaluated and were "competent providers." Currently, eleven dental therapists who were trained in New Zealand are practicing in Alaska.

Training of dental therapists has now been initiated in Alaska in a program developed by the University of Washington School of Medicine's physician assistant program in cooperation with the Alaska Tribal Health System. Major grants from a number of philanthropic foundations supported the development of the program. Training began in January of 2007, with seven students enrolled in the first year of preclinical training in Anchorage at a new facility developed specifically for the program. The second year of clinical training is in existing Tribal clinics in Alaska. The American Association of Public Health Dentistry and the American Public Health Association have endorsed the practice of dental therapists in Alaska.

I must add that the term used for the dental therapists practicing in Alaska is Dental Health Aide Therapist (DHAT). I hear this term used frequently in discussing the addition of a dental therapist to the dental team. However, this is an incorrect usage. The term Dental Health Aide Therapist (DHAT) is a term specific to the personnel classification system of the Indian Health Service, and would not be appropriate to apply to dental therapists generally.

Justifying a Dental Therapist for Children

While there has been documentation of the ability of individuals other than dentists to successfully provide quality restorative care for children, both in the United States and internationally, in general, the American practice community has been immovable in its

resistance to such. The crisis faced today, as represented by the disparities in oral health among our more disadvantaged populations, demands challenging the traditional practice paradigm, and advocating the addition of a dental therapist to the dental team.

- There are profound disparities in oral health between the children of the rich and the poor in America.
- There is a general lack of access to care for the nation's disadvantaged children.
- There is a general deficiency of training of general dentists in pediatric dentistry in current predoctoral dental curricula.
- There are inadequate numbers of dentists in urban inner cities and in rural areas, where children are most in need of care.
- There is a declining dentist to population ratio.
- There are far too few pediatric dentists to have an impact on access for disadvantaged populations.
- There is a general lack of interest on the part of many dentists in treating children, given the current demand for other dental therapies.
- There is even less interest by dentists in treating low-income children, particularly if their care is being financed by Medicaid or S-CHIP programs.
- There is a need to provide care in a cost effective manner, particularly for patients whose care is being publicly funded.
- There is ample evidence, from within the United States and internationally, that high school graduates can be trained in a two-year academic program to render, under general supervision by a dentist, safe, effective, quality primary care for children.

All of these circumstances point to the reasonableness and value of developing and deploying dental therapists to help our profession care for the nation's children.

Why Focus on Children?

I must acknowledge that there is a trend beginning internationally to permit dental therapists to treat adults. I must also acknowledge that the program in Alaska, with which

I have been involved, currently treats adults. In Alaska, dental therapists practice in isolated rural villages of generally less than a 1,000 inhabitants. The dental therapist is the only dental resource for hundreds of miles. Thus it does not make sense for them not to treat basic dental needs of the adults in the village. However, I believe that therapists in the remainder of the United States should only treat children, thus my use of the term pediatric oral health therapists. There are four reasons for this.:

International experience and research considerations support dental therapists focusing care on children. The international experience of over 80 years of dental therapists providing basic, primary care is essentially all with children, not adults. All of the research on the effectiveness of care by dental therapists, and it is significant, is in relationship to children. However, there is research currently in Alaska that will no doubt provide further data on therapists treating adults.

Scope and length of training support dental therapists focusing care on children. In my judgment, it is not possible to train a para-professional in a period of time less than that of the traditional education of dentists to provide care, even basic restorative care, for the complex scope of oral health issues facing the adult population.

Practical political considerations support dental therapists focusing care on children. The American Dental Association has been opposed to any one other than a dentist providing basic restorative care. This is evidenced by the aggressive stance taken against dental therapists practicing in Alaska. Dentistry as a profession understands that society is becoming increasingly distressed with the profession's inability to effectively address the issue of access to care for our most vulnerable population, our children. While speculation, it is possible that the organized practice community will be less threatened, and will more readily accept, a paraprofessional on the dental team whose focus of care is specifically on children.

Moral considerations support therapists focusing care on children. In a paper entitled *"The U.S. Health Delivery System: Inefficient and Unfair to Children,* the authors

conclude that which ever of the four major ethical theories of social justice you chose, children should receive priority consideration in receiving health care. Norman Daniels, professor of bioethics and population health at the Harvard School of Public Health, argues that a just society should provide basic health care to all, but redistribute health care more favorably to children. He justifies this conclusion based on the affect health care has on equality of opportunity for children, with equality of opportunity being a fundamental requirement of justice. As noted, poor and minority children, the most vulnerable individuals in our nation, have the highest prevalence of oral disease, the poorest access to oral health care, and the poorest overall oral health. The opportunity to realize one's potential in life is markedly affected by one's childhood. President Kennedy expressed it cogently and well: "Children may be the victims of fate....they must never be the victims of neglect."

As a result of these considerations, I am an advocate of dental therapists focusing their care on children, not adults.

Integrating Dental Hygiene and Dental Therapy

In the past and in the work I have published I have been an advocate for developing a two academic year curriculum to develop pediatric oral health therapists. Such a curriculum would be patterned after that which existed in New Zealand and Australia. However, as I have indicated, there is a very recent international movement that integrates dental therapy training with training in dental hygiene. This is occurring in New Zealand, Australia, Great Britain and the Netherlands. The leadership of our profession in these countries has concluded, based on their experience, that integrating training in dental education and dental therapy is a more appropriate way to train these important members of the dental team.

So rather than establish separate two year training programs in the United States to develop pediatric oral health therapists, as has been the history and tradition in the world, it may be more rational and economical to build on the current educational infrastructure for dental hygienists by adding the traditional competencies of the dental therapist, that

is, basic restorative care for children to the curriculum. In doing so we would be following the lead of our international colleagues.

Much of the curriculum of current dental hygiene programs is inclusive of clinical competencies of traditional international dental therapists' programs; few additional competencies would need to be added to the curriculum to qualify one to provide the services traditionally provided by dental therapists for children.

Research in the United States, cited previously, has demonstrated that dental hygienists can be trained in a relatively short period of time to providing basic, primary care for children; certainly within one additional academic year and potentially less.

Integrating traditional dental therapy into the dental hygiene curriculum could not only potentially help address the access to care problem for children, but it would also help address an issue that has been in the forefront of dental hygiene for some time. Dental hygienists, functioning as therapists, utilizing new skills, expanding their scope of practice, and participating in new practice settings, will be able to experience the enriched professional lives and work they have desired for many years.

While expanding two year dental hygiene programs to three years can prepare therapists of the future, provision must be made for hygienists currently in practice who want to expand their skills to provide basic restorative care for children. This can be accomplished by establishing continuing professional development programs in dental therapy. While some significant period of time would have to be spent on-site at a clinical facility to gain required preclinical and clinical skills, the actual time required in such a setting could be reduced through distributive education strategies, such as the Internet, for much of the didactic course work basic to dental therapy.

In Australia and New Zealand, the designation used for the integrated role of dental therapist/dental hygienist is *oral health therapist*. Obviously, the designation of dental hygienist would not longer be appropriate for one who also provides restorative care for children.

Advanced Dental Hygiene Practitioner or Oral Health Therapist

The American Dental Hygienist's Association realized that what was transpiring in Alaska with dental therapists would have an impact on their future with regard expanding the scope of practice for hygienists. As a result, they rapidly developed an alternative model, which they designate an Advanced Dental Hygiene Practitioner (ADHP). The ADHP would be able to care for both children and adults and would be able to: prepare cavities and restore primary and permanent teeth using direct placement of appropriate dental materials; place temporary restorations; place preformed crowns; temporarily re-cement restorations; pulp cap primary and permanent teeth; perform pulpotomies on primary teeth, and extract primary teeth and permanent teeth. While competencies in leadership, administration, and research are included in the ADHP model, the basic clinical skills are generally consistent with those traditionally associated with the international dental therapist.

The ADHA has explicitly stated that the ADHP is being developed as a response to the Surgeon General's Report of 2000 in order to improve access to care and help reduce disparities of oral health among Americans. However, structuring the ADPH so as to require a master's degree entry level, ostensibly six years of education, severely restricts the number of dental hygienists who could be trained to address the issue of access to care. This extended time period is not required to achieve the basic level of clinical skills necessary to provide the scope of care of a dental hygienist and a traditional dental therapist. The international standard is now three years of education.

The ADHP would be limited to those individuals able to attend universities offering graduate education. Only a minority of dental hygienists hold a bachelor's degree and would be able to meet the entrance requirements for graduate education. The model would effectively deny the majority of dental hygienists the opportunity to expand their scope of practice to include restorative skills. The need is for thousands of therapists to provide basic care for children. All of the nation's 255 two year dental hygiene programs could be expanded to three years to include dental therapy in the curriculum. All fifty

states and the District of Columbia have entry level associate degree program in dental hygiene.

A critically important concern in the expansion of dental hygienist's skills to include dental therapy is the potential loss of significant numbers of individuals (or hours of care) to provide traditional dental hygiene services. Dental hygienists are in great need and demand absent the expansion of their scope of practice and role. It will be incumbent on society to significantly expand the number of educational positions available for these new oral health therapists to ensure adequate numbers of clinicians are available to meet the needs of both adults requiring periodontal care and children requiring restorative care.

The costs to society of training hygienists to include dental therapy skills in a three year program would be far less than that of educating a comparable number of Advanced Dental Hygiene Practitioners in master's degree programs.

As a footnote to this discussion, it is my belief that the American Dental Hygiene Association has advocated a master's degree entry level for their Advanced Dental Hygiene Practitioner because a master's degree entry level is that traditionally expected for one to be designated a "mid-level practitioner." Nurse practitioners and physicians' assistants are the prototypical mid-level practitioners—both requiring a master's degree entry level. I know it is increasingly popular to refer to dental therapists as mid-level practitioners; however, they are not. They are paraprofessionals that are really no different in training and function than a dental hygienist. The only difference is that they provide basic restorative care to treat dental caries, traditionally for children; whereas, dental hygienists provide basic care to prevent and manage periodontal disease, generally in adults. And, we have never considered dental hygienists "mid-level practitioners."

Practice Settings and Supervision of Therapists

Therapists, trained separately or integrated with dental hygiene as an oral health therapist-- would be in demand in dental practices as dental hygienists are today. They

could serve as a member of the dentist team, providing primary care for children.. It does not make economic sense for dentists to routinely perform scaling, root curettage and polishing of teeth, and other procedures able to be competently performed by dental hygienists. In like manner, it is not reasonable for dentists to perform basic restorative for children when someone trained in the traditional skills of a dental therapist can do so safely and effectively. There is an important role for dentists, that is, focusing on problems that cannot be managed by a therapist; problems that only a dentist can address.

It is speculated that dentists who do not currently care for children in their practices might expand their care to include children, should such care be able to be managed by another member of the practice's dental team. Adding a therapist to the dental team could result in an increase in the numbers of dentists providing care for children, as well as expand the capacity for dentists already caring for children to see more children. Many dentists do not accept children in their practices whose care is publicly insured, ostensibly due to the inability to manage the costs of care given overhead considerations and the lower reimbursement schedule. Therapists could help mitigate this issue as care could be provided in a more cost-effective manner for the practice. This situation is analogous to the economics of dental hygiene practice in a practice setting today. Few dentists would want to practice without the collaboration of a dental hygienist due to a dental hygienist's ability to enable the practice to provide more care. Yet, the profession generally fought the advent of dental hygienists in the early part of the last century. It is my belief that the addition of a therapist to the dental team will enhance the practice of dentistry in much the same manner dental hygienists have.

Therapists could care for children in the public sector in public health clinics, health departments, federally qualified health centers, and with not-for-profit organizations. School-based programs would be a cost-benefit effective way of managing the oral health needs of many of our children. In New Zealand, the school dental therapist also provides care for preschool children from birth, thus enabling preventive therapies to be instituted among infants and toddlers to address early childhood caries.

The issue of supervision always emerges in discussions of therapists. The international tradition for dental therapists has been one of general supervision. In New Zealand, school dental therapists care for children with general oversight by district dental officers who provide consultative services as well as visit and audit dental therapists' practices on a periodic basis. There is a similar tradition in other countries utilizing dental therapists.

I believe for therapists to be effective and have an impact on access to care for children they must have the ability to practice with general supervision.

Leadership for Change

The time has come for the profession of dentistry to seriously and courageously provide access to oral health care for all of America's children; access in such a manner that major barriers are destroyed; and parents, no matter their economic status, ethnicity, or cultural circumstance, can be assured their children will be treated justly by society, in that they have an equal opportunity, with other children, for good oral health. A method that can be effective in achieving such is the development and deployment of dental therapists, allied professionals uniquely trained to care for the oral health of children. If justice is to be served, if the good society is to be realized, the dramatic inequities which exist in health and health care for children must be addressed.--and addressed by us!

The 'silent epidemic' of dental caries is no longer silent. It is screaming at us: *"Do something!"* The tragic and unnecessary death young Deamonte Driver from an infected tooth calls out to us: *"Do something!"* If we as a profession fail to act, fail to provide leadership for change in addressing this problem, we can be assured that society will act for us, and maybe in ways we would find very undesirable. Today we need thoughtful, committed—yes, and courageous leadership from the profession—from the California Dental Association. I challenge you to find your voice and to speak out boldly; to distinguish yourself by your leadership as one of our Nation's most important and powerful dental professional organization. Make a moral commitment to "doing

something" about access to care for our Nation's children. Educate our policy leaders to a more effective and less expensive way to ensure oral health care for our children, and advocate for expanding our dental team by adding an individual trained to provide basic oral health care for children. Let us not be content until all of America's children have access to the oral health care they deserve. Justice demands that we do no less! Our disadvantaged children cry out to us: *"Do Something...please, do something"*